

January 2010

All in Your Head: A Comprehensive Approach to Somatoform Disorders in Adult Disability Claims

Gregory C. Flatt

Follow this and additional works at: https://openscholarship.wustl.edu/law_lawreview



Part of the [Administrative Law Commons](#), [Disability Law Commons](#), and the [Insurance Law Commons](#)

Recommended Citation

Gregory C. Flatt, *All in Your Head: A Comprehensive Approach to Somatoform Disorders in Adult Disability Claims*, 87 WASH. U. L. REV. 1397 (2010).

Available at: https://openscholarship.wustl.edu/law_lawreview/vol87/iss6/4

This Note is brought to you for free and open access by the Law School at Washington University Open Scholarship. It has been accepted for inclusion in Washington University Law Review by an authorized administrator of Washington University Open Scholarship. For more information, please contact digital@wumail.wustl.edu.

ALL IN YOUR HEAD: A COMPREHENSIVE APPROACH TO SOMATOFORM DISORDERS IN ADULT DISABILITY CLAIMS

I. THE CONFUSION SURROUNDING SOMATOFORM DISORDERS—A HYPOTHETICAL¹

A. *The Patient*

The Patient is a married woman in her late twenties. She has a diagnosed history of depression, anxiety, post-traumatic stress disorder, and high blood pressure, and she was sexually abused as a child. In recent years, she has suffered seizures that occur as frequently as several in a single day and as rarely as two in a month. Because of the frequency and severity of the seizures, the Patient finds it impossible to hold a steady job, has difficulty with complex tasks, and is embarrassed to leave her house without her husband. She has been hospitalized several times for the seizures and has been examined by many physicians. To her dismay, no physiological cause for her seizures has been diagnosed. Electroencephalogram (EEG) tests,² generally helpful in identifying epileptic seizures,³ have produced no evidence of epileptic seizure activity in the brain, despite the fact that family, friends, and medical personnel have all observed the effects of the seizures firsthand. Doctors have prescribed numerous medications for her and she has undergone psychotherapy, but neither option has resulted in a demonstrable change in her condition. She feels that because of her debilitating condition, and its effect on her social, physical, and occupational well-being, she has no

1. The facts in this hypothetical scenario are an amalgamation of situations from several disability cases involving somatoform and related disorders, most notably *Boiles v. Barnhart*, 395 F.3d 421 (7th Cir. 2005).

2. EEG tests provide a graphic recording of the electrical activity of the brain by using electrodes placed on the scalp to detect and record the brain's electrical impulses. They are used to help diagnose and identify epileptic disorders, which often manifest themselves in seizure activity. KATHLEEN DESKA PAGANA & TIMOTHY JAMES PAGANA, *MOSBY'S DIAGNOSTIC AND LABORATORY TEST REFERENCE* 347 (5th ed. 2001).

3. Epilepsy is a neurological disorder caused by an uncontrollable electrical discharge in the brain, which often manifests itself in epileptic seizures and is sometimes "associated with cerebral trauma, intracranial infection, brain tumor, vascular disturbances, intoxication, or chemical imbalance." *MOSBY'S MEDICAL, NURSING, & ALLIED HEALTH DICTIONARY* 575-76 (Kenneth N. Anderson et al. eds., 5th ed. 1998) [hereinafter *MOSBY'S MEDICAL*].

choice but to file for disability with the Social Security Administration (SSA).⁴

Her condition was examined by her own physicians, as well as those employed as a part of the SSA's disability evaluation process.⁵ However, because there is no demonstrable physiological cause for her condition, no medically generated evidence that it exists, and no methodological evaluation or test which can attest to how her condition actually affects her (beyond what she claims is happening to her), the SSA denied her request for disability.⁶ Her application was again denied after she requested reconsideration, and she was subsequently granted an appeal hearing before an Administrative Law Judge (ALJ) to make a more formal evaluative determination.⁷ But how can she demonstrate to the ALJ that she has a debilitating condition when even her physicians can offer no physiological evidence of its cause and no physical evidence to substantiate its effects?

B. The Lawyer

The Lawyer has taken up the case of the Patient, which is set to go before the ALJ. He has spoken with the Patient's friends, family, and treating physician, who have convinced the Lawyer that the Patient's condition is sufficiently serious to prohibit work, and the Lawyer has observed the patient firsthand during seizure activity. The bulk of medical diagnoses certainly suggest that medical personnel who have treated the Patient have determined that she has a substantially limiting condition.

However, even as the effects of the condition appear clearly disabling, providing convincing proof of that condition is problematic. Physicians are doubtful that the seizures are a result of an epileptic condition and have most frequently diagnosed the Patient as having "pseudoseizures,"⁸ indicating that the seizures represent physical symptoms which genuinely manifest themselves without a demonstrable physiological cause. One treating physician documented skepticism about the legitimacy of the

4. See *infra* note 58 and accompanying text.

5. See *infra* note 10.

6. See *infra* notes 58–59 and accompanying text.

7. See *infra* notes 60–72 and accompanying text.

8. Pseudoseizures (also referred to as psychogenic nonepileptic seizures, nonepileptic seizures, nonepileptic events, or psychogenic seizures) are seizures that resemble epileptic seizures, but do not result from an abnormal electrical discharge in the brain, as with epileptic seizures. Instead, pseudoseizures generally occur because of the physical manifestation of a disturbance that is psychological in nature. Selim R. Benbadis, *Psychogenic Nonepileptic Seizures*, Feb. 18, 2010, <http://emedicine.medscape.com/article/1184694-overview>.

Patient's condition and noted that the condition may be primarily malingering⁹ or otherwise fraudulent. No drugs seem to counteract the condition, and no treatment seems to affect it in any significant way. The only one who can attest to the actual effects of the condition is the Patient. How does the Lawyer go about proving that the Patient hasn't simply fabricated the condition as a means of receiving disability benefits?

C. The Administrative Law Judge

The ALJ is hearing the case of the Patient on appeal. She has read the accounts of the Patient's friends, family, and treating physician, testifying to the significantly limiting effects of the claimed condition. She has read the medical reports of physicians, which are unable to tie the Patient's symptoms to any specified malady beyond a diagnosis of pseudoseizures. No tests indicate the presence of a seizure disorder, either at rest or during one of the Patient's seizures. Several medications have been prescribed in an attempt to alleviate the seizures, but medicine seems to have little to no lasting effect on the Patient. The ALJ has consulted a report from the state's office of Disability Determination Services (DDS),¹⁰ which has concluded, on the basis of the medical documentation, that no significant barrier exists to prevent the Patient from work beyond some minor environmental limitations. The ALJ talks to the Patient, who seems genuine in her account of her claimed disability. However, the ALJ has seen many people appear before her who have tried to fake a disability to receive benefits, and she has been instructed by the SSA to be alert for false or malingering claims.¹¹ How does she go about making a decision that balances the apparently genuine limiting effects of the Patient's condition with the lack of medical evidence and an interest in discouraging malingering or fraudulent disability claims?

9. Malingering is used by physicians to denote a belief that the patient is "willful[ly] and deliberate[ly] feigning . . . the symptoms of disease . . . to gain some consciously desired end." MOSBY'S MEDICAL, *supra* note 3, at 982.

10. Disability Determination Services are federally funded state agencies responsible for the investigation of medical evidence in making an initial determination on a claimant's disability status. Social Security Administration, Disability Programs: Disability Determination Process, <http://www.socialsecurity.gov/disability/determination.htm> (last visited May 10, 2010).

11. *See infra* note 126.

II. THE NECESSITY OF REEVALUATING SOMATOFORM DISORDERS IN THE DISABILITY DETERMINATION PROCESS

Somatoform disorders,¹² including the aforementioned pseudoseizures, present a unique and challenging problem at all phases of disability determinations. Characterized by physical symptoms or complaints that cannot be substantiated by medical examination or treatment,¹³ somatoform disorders force evaluators to confront difficult questions about the existence of a condition that all too often only the claimant is able to appreciate with any certainty and can seem to both the lay person and the medical evaluator to be “all in one’s head.”¹⁴ As much as somatoform disorders are gaining understanding, recognition, and acceptance in the medical industry,¹⁵ the law is still struggling to catch up.¹⁶

This tension between the legal analysis of somatoform disorders and medical understanding of the conditions is perhaps best demonstrated within the disability determination context.¹⁷ The purpose of the SSA’s disability determination process is to “assure a minimum level of income for people who are age 65 or over, or who are blind or disabled and who do not have sufficient income and resources to maintain a standard of living at the established Federal minimum income level.”¹⁸ When a claim is made pursuant to disability, the claimant’s impairments must be compared with the corresponding statutory requirements.¹⁹ The imperfect nature of comparing a specific claimant’s impairments to comparable listings in the Code of Federal Regulations, and the potential economic impact the determination’s outcome presents to the claimant, indicate that

12. Somatoform disorders are “any of a group of disorders, characterized by symptoms suggesting physical illness or disease, for which there are no demonstrable organic causes or physiologic dysfunctions,” which usually involve “physical manifestations of some unresolved intrapsychic factor or conflict.” MOSBY’S MEDICAL, *supra* note 3, at 1513.

13. GHAZI ASAAD, PSYCHOSOMATIC DISORDERS: THEORETICAL AND CLINICAL ASPECTS 3 (1996).

14. *Treating Somatoform Disorders*, HARV. MENTAL HEALTH LETTER, Nov. 2009, at 6.

15. See E.R.S. NIJENHUIS, SOMATOFORM DISSOCIATION: PHENOMENA, MEASUREMENT, AND THEORETICAL ISSUES 211–12 (2004); EDWARD SHORTER, FROM PARALYSIS TO FATIGUE: A HISTORY OF PSYCHOSOMATIC ILLNESS IN THE MODERN ERA 295–323 (1992).

16. See Terence M. Davidson & Jennifer J. Tung, *The Difficult Plaintiff: The Influence of Somatoform Disorders in Civil Tort*, 75 DEF. COUNS. J. 36 (2008) (documenting the personal injury complications of somatoform disorders).

17. FRANK S. BLOCH, DISABILITY DETERMINATION: THE ADMINISTRATIVE PROCESS AND THE ROLE OF MEDICAL PERSONNEL 55 (1992) (“Medical-legal issues are at the center of every disability claim.”).

18. 20 C.F.R. § 416.110 (2008).

19. *Id.* § 416.901.

“for all [benefit] programs[,] disability stands out as the most important and most difficult issue to resolve, both at the initial decision-making level and on appeal.”²⁰

As a result, while several existing statutes can be utilized effectively to handle somatoform disorders,²¹ confusion about the medical nature of the disorders, lack of uniformity in applying the relevant statute, and the tendency to cling to traditional notions of disabling conditions have dulled efficient use of those statutes and hindered effective analysis of somatoform disorders presented for disability determination. Therefore, this Note will demonstrate that the issues of identification, understanding, and resolution within the present system at every level prevent somatoform disorders from receiving adequate adjudication.

In response, I will present a comprehensive approach to somatoform disorders in disability claims, which can be followed to ensure that claims are appropriately examined at all levels of evaluation. In Part III, I will explain the medical aspects of somatoform disorders, including their diagnosis, prevalence, and acceptance in the medical community. I will then turn, in Part IV, to an examination of the disability process, including the sequential analysis used to determine if disability status should be awarded, relevant statutes that are useful when dealing with somatoform disorders, and available methods for meeting the statutory qualifications.²² In Part V, I will discuss the aspects of somatoform disorder terminology, acceptance, and assessment that prevent somatoform disorder determinations from being efficiently and consistently made when examined within the framework of current disability determination protocol. Accordingly, Part VI will offer an appropriate and comprehensive approach to somatoform disorders to counteract or eliminate these systemic problems and to ensure that those impairments that suggest a somatoform diagnosis are properly reviewed. Finally, Part VII will address potential complications with my proposal and explain why those complications do not overwhelm the systemic advantages of the process I propose.

20. BLOCH, *supra* note 17, at xiv.

21. *See infra* notes 83–104 and accompanying text.

22. This Note will only deal with adult disability claimants and will therefore not touch upon the separate standards for children who claim disability, partially because children are less likely to be afflicted by somatoform disorders. *See infra* notes 49–57 and accompanying text. The disability evaluation for child claimants is governed separately by 20 C.F.R. § 416.924 (2008).

III. THE MEDICAL ASPECTS OF SOMATOFORM DISORDERS

Discussion of somatoform disorders is inherently difficult because analysis of the problem requires the evaluator, whether conducting a medical review or a legal review, to attempt to “bridge the gap” between medicine and psychiatry.²³ As noted above, somatoform disorders are essentially psychiatric problems that manifest themselves in physical symptoms.²⁴ This tension can often lead to misdiagnosis²⁵ and confusion²⁶ on the part of the treating physicians.

Effective diagnosis and identification of somatoform disorders are further complicated by the fact that conditions with somatoform aspects can be referred to by several different names,²⁷ which may or may not suggest to others the somatoform component. Beyond “somatoform disorder,” the medical terms with somatoform components include, but are by no means limited to, conversion disorder,²⁸ psychosomatic disorder,²⁹ psychophysiological disorder,³⁰ psychogenic disorder,³¹ pseudoneurological disorder,³² and hysteria.³³ Additionally, any other existing condition or

23. ASAAD, *supra* note 13, at x.

24. *See supra* notes 12–13.

25. KATHERINE A. PHILLIPS, SOMATOFORM AND FACTITIOUS DISORDERS 116 (2001) (concerning the misdiagnosis of conversion disorder).

26. ASAAD, *supra* note 13, at 130 (“A patient with Somatization Disorder . . . may undergo highly expensive diagnostic procedures unnecessarily before the real diagnosis is recognized and addressed appropriately.”).

27. *See infra* notes 35, 110 and accompanying text.

28. ASAAD, *supra* note 13, at 11 (“Conversion Disorder may be defined as a Somatoform Disorder in which the patient may exhibit symptoms or deficits involving motor or sensory functions that cannot be substantiated on the basis of physical examination or diagnostic procedures.”).

29. Psychosomatic disorders are defined by “the expression of an emotional conflict through physical symptoms.” MOSBY’S MEDICAL, *supra* note 3, at 1349.

30. A psychophysiological disorder is “any of a large group of mental disorders that is characterized by the dysfunction of an organ or organ system controlled by the autonomic nervous system and that may be caused or aggravated by emotional factors.” *Id.* at 1348.

31. Also referred to as “psychogenetic” disorder, wherein a “physical symptom, disease process, or emotional state . . . is of psychologic rather than physical origin.” *Id.* at 1347.

32. “Conversion symptoms are related to voluntary motor or sensory functioning and are thus referred to as ‘pseudoneurological.’” AM. PSYCHIATRIC ASS’N, DIAGNOSTIC AND STATISTICAL MANUAL OF MEDICAL DISORDERS 493 (4th ed. 2000) [hereinafter DSM-IV-TR].

33. Hysteria was one of the earliest and most consistently recognized of the somatoform disorders, having been appreciated by early Egyptian and Greek cultures, as well as the work of Sigmund Freud, who identified it as “an expression of unconscious conflicts displayed through bodily symptoms.” SUSAN K. JOHNSON, MEDICALLY UNEXPLAINED ILLNESS: GENDER AND BIOPSYCHOSOCIAL IMPLICATIONS 13–14 (2008). A variant of hysteria, called Briquet’s syndrome, characterized by the presence of at least twenty-five medically unexplained symptoms in at least nine of ten symptom groups, also gained recognition in the 1970s. *Id.* at 16. Hysteria and Briquet’s syndrome provided the early template for what has evolved into the diagnosis of somatoform disorder today. *Id.* at 17.

disorder may be identified as one without demonstrable physical cause by the “pseudo” prefix, as in pseudoseizure.³⁴ Indeed, “[t]he term ‘somatization,’ . . . has been used in at least seven different ways.”³⁵

However, the overwhelming aspect of all somatoform disorders remains the manifestation of physical symptoms without an identifiable physiological cause,³⁶ and “[l]aboratory test results are remarkable for the absence of findings to support the subjective complaints.”³⁷ Neither medication nor therapy options are generally effective in treating symptoms.³⁸ It is important to note that despite this lack of physical evidence, “there is nothing imaginary or simulated about the patient’s perception of his or her illness.”³⁹ Somatoform disorders are recognized as legitimate mental health conditions in recent editions of the Diagnostic and Statistical Manual of Mental Disorders (commonly referred to as the DSM-IV-TR)⁴⁰ in several incarnations,⁴¹ including somatization

34. The “pseudo” prefix most literally translates as “false.” MOSBY’S MEDICAL, *supra* note 3, at 1341. Nevertheless, it is a mistake to infer that such “pseudo” conditions are false in that they are made up, as in most cases the term refers to the fact that their physiological cause cannot be determined. NIJENHUIS, *supra* note 15, at ix.

35. See Michael Finch, *Law and the Problem of Pain*, 74 U. CIN. L. REV. 285, 306 (2005).

36. Some studies have purported to identify physiological indicia which accompany certain types of somatoform disorders, and courts have proven receptive to such evidence. For instance, in *Sims v. Barnhart*, 442 F.3d 536 (7th Cir. 2006), medical evidence that brain scans could distinguish real conversion disorder from faked conversion disorder was admitted and evaluated. Because the claimant had not had the brain scan, the court found that it was proper to deny disability. *Id.* at 539. The study in question showed altered brain activity in three women with conversion disorder examined with a functional MRI. Amy Norton, *Brain Scans Validate Freudian View of Hysteria*, REUTERS, Dec. 11, 2006, <http://www.reuters.com/article/idUSCOL17452720061211>. However, there has been little evidence since of the legitimacy or applicability of those findings to conversion disorder generally or to other manifestations of somatoform disorders.

37. DSM-IV-TR, *supra* note 32, at 487. Paradoxically, it is a lack of any medical evidence, laboratory or otherwise, that provides substantial proof that a somatization or conversion finding is appropriate. *Id.* at 495 (“No specific laboratory abnormalities are associated with Conversion Disorder. In fact, it is the absence of expected findings that suggests and supports the diagnosis of Conversion Disorder.”).

38. See *Rodewald v. Astrue*, Civil No. 08-5911 (RHK/SRN), 2009 WL 1026286, at *19 (D. Minn. Apr. 16, 2009).

39. SHORTER, *supra* note 15, at ix.

40. DSM-IV-TR, *supra* note 32, at 485. *The Diagnostic and Statistical Manual of Mental Disorders* is a categorical classification system for mental disorders designed to “enable clinicians and investigators to diagnose, communicate about, study, and treat people with various mental disorders.” *Id.* at xxxvii. It is widely used by clinicians, researchers, psychiatrists, social workers, counselors, and other health and mental professionals for mental disorder identification and treatment. *Id.* at xxiii.

41. *Id.* at 485–500. The DSM-IV-TR evaluation of somatoform disorders focuses on “the presence of physical symptoms that suggest a general medical condition . . . and are not fully explained by a general medical condition, by the direct effects of a substance, or by another mental disorder . . .” *Id.* at 485. However, the classification of somatoform disorders for the upcoming DSM-V revision remains one of its “most critically discussed diagnostic categories.” Bernd Löwe et al., *Validity of Current Somatoform Disorder Diagnoses: Perspectives for Classification in DSM-V and*

disorder,⁴² undifferentiated somatoform disorder,⁴³ conversion disorder,⁴⁴ pain disorder,⁴⁵ and hypochondriasis.⁴⁶ The DSM-IV-TR suggests that somatoform disorders may be distinguished from more general medical conditions by the “1) involvement of multiple organ systems, 2) early onset and chronic course without development of physical signs or structural abnormalities, and 3) absence of laboratory abnormalities that are characteristic of the suggested general medical condition.”⁴⁷ There is, as one might expect, some overlap in somatoform-related disorders even within the listings of the DSM.⁴⁸

It has been estimated that approximately 10% of all adult patients seeking health care suffer from some degree of somatoform disorder,⁴⁹ although studies covering both the general population and inpatients tend

ICD-11, 41 PSYCHOPATHOLOGY 4 (2007). For arguments against, and proposed revisions to, the current DSM-IV classifications, see Richard Mayou et al., *Somatoform Disorders: Time for a New Approach in DSM-V*, 162 AM. J. PSYCHIATRY 847 (2005); see also Francis Creed, *Medically Unexplained Symptoms—Blurring the Line between “Mental” and “Physical” in Somatoform Disorders*, 67 J. PSYCHOSOMATIC RES. 185, 186 (2009) (“It is the aim that the next generation of diagnostic classification (*DSM-V*) will enhance, not inhibit, [investigations which measure psychological and physical phenomena simultaneously].”).

42. “[A] polysymptomatic disorder that begins before age 30 years, extends over a period of years, and is characterized by a combination of pain, gastrointestinal, sexual, and pseudoneurological symptoms.” DSM-IV-TR, *supra* note 32, at 485.

43. Undifferentiated Somatoform Disorder is distinguished “from Somatization Disorder by the requirement in Somatization Disorder of a multiplicity of symptoms of several years’ duration and an onset before age 30 years.” *Id.* at 491.

The essential feature of Undifferentiated Somatoform Disorder is one or more physical complaints . . . that persist for 6 months or longer Frequent complaints include chronic fatigue, loss of appetite, or gastrointestinal or genitourinary symptoms. These symptoms cannot be fully explained by any known general medical condition or the direct effects of a substance (e.g., the effects of injury, substance use, or medication side effects), or the physical complaints or resultant impairment are grossly in excess of what would be expected from the history, physical examination, or laboratory findings

Id. at 490–91.

44. Conversion disorder is characterized by “unexplained symptoms or deficits affecting voluntary motor or sensory function that suggest a neurological or other general medical condition. Psychological factors are judged to be associated with the symptoms or deficits.” *Id.* at 485.

45. In pain disorder, as one would expect, pain is the “predominant focus of clinical attention,” though the pain is recognized by its relation to psychological factors “associated with the symptoms or deficits.” *Id.*

46. “Hypochondriasis is the preoccupation with the fear of having, or the idea that one has, a serious disease based on the person’s misinterpretation of bodily symptoms or bodily functions.” *Id.*

47. *Id.* at 488.

48. “[R]ecent studies . . . suggest that somatoform dissociation is strongly correlated with psychological dissociation, and that somatoform dissociation is characteristic of DSM-IV conversion disorder.” NIJENHUIS, *supra* note 15, at 199.

49. See Davidson & Tung, *supra* note 16, at 39 (citing Lynne Lamberg, *New Mind/Body Tactics Target Medically Unexplained Physical Symptoms and Fears*, 294 JAMA 2152–54 (2005)).

to vary dramatically.⁵⁰ Somatoform disorders have been found most prevalent in women and people under thirty.⁵¹ According to the findings published in the DSM-IV-TR, the lifetime prevalence rates for somatization disorder range from 0.2–2% among women, and less than 0.2% in men.⁵² While no conclusive genetic link has been made, somatization disorder has been “observed in 10%–20% of female first-degree biological relatives of women with Somatization Disorder.”⁵³ Research further indicates that complaints related to somatoform disorders are more frequent in those suffering from depression and/or anxiety.⁵⁴ There is also significant contemporary empirical evidence that “traumatized individuals, in particular adult survivors of childhood sexual and physical abuse,” are prone to somatoform symptoms,⁵⁵ as are young women of “low socioeconomic status.”⁵⁶ Therefore, the most likely claimant of somatoform disorder would tend to be a female of low socioeconomic status in her twenties or early thirties with some indication of depression or anxiety and/or a history of abuse. Even so, somatoform disorder symptoms “are not limited to any age, gender, or sociocultural group.”⁵⁷

50. See DSM-IV-TR, *supra* note 32, at 496 (finding that “[r]eported rates of Conversion Disorder have varied widely, ranging from 11/100,000 to 500/100,000 in general population samples” and that conversion symptom rates among general medical/surgical inpatients range from one percent to fourteen percent).

51. See ASAAD, *supra* note 13, at 3. While the prevalence of somatoform disorders among women is “well documented and established . . . the reasons for this gender disparity are still unclear.” JOHNSON, *supra* note 33, at 4.

52. DSM-IV-TR, *supra* note 32, at 487. A similar trend has been observed with respect to conversion disorder, with ratios of women to men “varying from 2:1 to 10:1.” *Id.* at 496.

53. *Id.* at 488. Male relatives display “an increased risk of Antisocial Personality Disorder and Substance-Related Disorders.” *Id.*

54. See ASAAD, *supra* note 13, at 6–7; JOHNSON, *supra* note 33, at 9–10. However, there is little consensus on the degree to which either depression or anxiety contributes to the manifestation of a somatoform disorder, or if a somatoform disorder results in feelings of anxiety and depression. ASAAD, *supra* note 13, at 7. For instance, in pain-related somatoform disorders, “[u]nemployment, disability, and family problems are frequently encountered among individuals” who claim the disorder, leading to “additional psychological problems (e.g., depression) and a reduction in physical endurance that results in fatigue and additional pain.” DSM-IV-TR, *supra* note 32, at 500.

55. NIJENHUIS, *supra* note 15, at 89.

56. DSM-IV-TR, *supra* note 32, at 491. “Conversion disorder has been reported to be more common in rural populations, individuals of lower socioeconomic status, and individuals less knowledgeable about medical and psychological concepts.” *Id.* at 495.

57. *Id.* at 491.

IV. THE DISABILITY PROCESS AND RELEVANT STATUTES

If an individual suffering from a somatoform disorder feels significantly limited in his or her ability to work or function because of the disorder, he or she may choose to file for disability. A disability claimant must first complete an application to the SSA.⁵⁸ In the application, the claimant is instructed to identify a medical basis for his or her disability and indicate how the disability limits the claimant's ability to work and/or perform daily tasks.⁵⁹ If a claim is initially denied, the claimant has a right to reconsideration.⁶⁰ If the claimant is again denied, he or she may request a hearing before an ALJ.⁶¹

The Social Security regulations enumerate a five-step sequential evaluation in the Code of Federal Regulations to be followed when, on appeal, the ALJ is determining whether a claimant has met the burden of establishing a disability.⁶² In step one, the ALJ examines whether the claimant is presently employed or otherwise engaged in "substantial gainful activity."⁶³ If the ALJ answers in the negative, the process moves on to step two.⁶⁴ In step two, the ALJ considers whether the claimant suffers from an impairment or combination of impairments that "significantly limit[] . . . [his or her] physical or mental ability to do basic work activities."⁶⁵ If the ALJ finds evidence of severe limitations, the ALJ moves on to step three, where it is determined whether or not that severe limitation meets or is medically equivalent to any of the statutorily identified listing of impairments.⁶⁶ If the impairment does meet a listing, the limitation is deemed sufficient to grant disability status to the claimant.⁶⁷ Otherwise, the ALJ will, in step four, examine whether the

58. BLOCH, *supra* note 17, at 31.

59. *Id.*

60. 20 C.F.R. § 416.1407 (2008) ("Reconsideration is the first step in the administrative review process that we provide if you are dissatisfied with the initial determination. If you are dissatisfied with our reconsideration determination, you may request a hearing before an administrative law judge.").

61. *Id.*

62. *Id.* § 416.920. This process is used for the initial disability determination only. If the claimant is already receiving disability benefits, a separate set of steps is used in the evaluation process. *Id.* § 416.920(a)(5).

63. *Id.* § 416.920(b).

64. *Id.* § 416.920(a)(4)(i).

65. *Id.* § 416.920(c). This is considered a "severe impairment" for the purposes of the disability determination process. *Id.*

66. *Id.* § 416.920(d).

67. *Id.*

claimant can engage in his or her past relevant work.⁶⁸ If the claimant is found to have engaged in past relevant work since the onset of the impairment or impairments, disability will be denied.⁶⁹ If not, the process moves on to step five, where the burden now shifts to the SSA,⁷⁰ who must establish that the claimant is both capable of performing other work and that such work is available in the national economy.⁷¹ If the ALJ finds that the claimant is unable to engage in past relevant work and there is no other work in the national economy he or she may engage in, a finding that the claimant is disabled is appropriate.⁷²

In the event that the claimant remains unsatisfied with the outcome, the claimant may request that the decision be brought before an Appeals Council for review.⁷³ The Appeals Council will review a case if the circumstances indicate the appearance of an abuse of discretion by the ALJ, the presence of an error of law, the lack of substantial evidence supporting the ALJ's decision, or a "broad policy or procedural issue that may affect the general public interest."⁷⁴ If the appeal is denied, the claimant has the right to file an action in federal district court within sixty days after notification of the Appeals Council's decision.⁷⁵

There are three medical-legal issues that are commonly raised during the disability determination process.⁷⁶ First, the claimant's impairments are examined to determine if the claimant suffers from the specified medical condition.⁷⁷ Second, if a condition is present, the evaluator must decide whether the medical condition results in functional limitations.⁷⁸ Third, if there are functional limitations, the evaluator must establish the degree to which those functional limitations affect the claimant's ability to

68. *Id.* § 416.920(e). This step also involves the determination of the claimant's residual functional capacity (RFC), which analyzes the totality of the claimant's impairments to determine what kind of activity could be completed in a work setting based on relevant medical and other evidence on record. *Id.* § 416.945(a); BLOCH, *supra* note 17, at 66–67.

69. 20 C.F.R. § 416.920(f) (2008).

70. The SSA is frequently referenced in proceedings by the name or title of the Commissioner of the Social Security Administration.

71. 42 U.S.C. § 423(d)(2) (2008); 20 C.F.R. § 416.920(g) (2008). This determination also involves consideration of the claimant's RFC coupled with the claimant's vocational background to evaluate claimant's ability to perform work available in the national economy. *Id.* § 416.945(a)(5)(ii). For details on the evaluation of work within the "national economy," see *id.* § 416.966.

72. *Id.* § 416.920(a)(4)(v).

73. *Id.* § 404.970.

74. *Id.* § 404.970. For details on the procedure of review followed by the Appeals Council, see *id.* § 404.976.

75. *Id.* § 416.981.

76. BLOCH, *supra* note 17, at 56–58.

77. *Id.* at 56.

78. *Id.*

perform work.⁷⁹ When dealing with a claim predicated on somatoform disorder, proving the existence of the impairment requires examination of these concerns in varying degrees.

If a claimant purports to suffer from a somatoform disorder, it first must be established that the claimant is not engaged in substantial gainful activity and that the claimant's impairments are sufficiently limiting in order to pass the first two steps of the sequential evaluation.⁸⁰ The ALJ must then determine, in step three, whether or not the claimant's impairment meets one of the statutorily identified listings.⁸¹ The responsibility for making this determination is on the medical member of the disability determination team.⁸² The most directly applicable listing is the Somatoform Disorder listing.⁸³ It provides that a finding of somatoform disorder must satisfy two statutory requirements:

- A. Medically documented by evidence of one of the following:
 1. A history of multiple physical symptoms of several years duration, beginning before age 30, that have caused the individual to take medicine frequently, see a physician often and alter life patterns significantly; or
 2. Persistent nonorganic disturbance of one of the following:
 - a. Vision; or
 - b. Speech; or
 - c. Hearing; or
 - d. Use of a limb; or
 - e. Movement and its control (e.g., coordination disturbance, psychogenic seizures, akinesia,⁸⁴ dyskinesia);⁸⁵ or
 - f. Sensation (e.g., diminished or heightened).
 3. Unrealistic interpretation of physical signs or sensations associated with the preoccupation or belief that one has a serious disease or injury;

79. *Id.*

80. *Supra* notes 63–65 and accompanying text.

81. *Supra* note 66.

82. BLOCH, *supra* note 17, at 146.

83. 20 C.F.R. § 404 subpart P, app. 1, 12.07 (2008).

84. Akinesia is “an abnormal state of motor and psychic hypoactivity or muscular paralysis.” MOSBY’S MEDICAL, *supra* note 3, at 53–54.

85. Dyskinesia is “an impairment of the ability to execute voluntary movements.” *Id.* at 525.

AND

- B. Resulting in at least two of the following:
1. Marked restriction of activities of daily living; or
 2. Marked difficulties in maintaining social functioning; or
 3. Marked difficulties in maintaining concentration, persistence, or pace; or
 4. Repeated episodes of decompensation, each of extended duration.⁸⁶

Despite the reference to medical documentation, it is important to note that no part of the statutory language requires any medically demonstrable cause for the condition, which presents one of the key difficulties for the evaluation of somatoform disorders in the disability process. The introductory notes to the Mental Disorders section, where the Somatoform Disorder listing is found, indicate that ALJs should generally rely on a combination of medical evidence,⁸⁷ information from the individual,⁸⁸ and other information in making their disability determinations with regard to a mental disorder.⁸⁹

In somatoform disorders, however, the physical medical evidence that would be offered and evaluated in analyzing other listings as a way to attest to reactions in the body, or to prove the legitimacy of certain symptoms or effects, is not present.⁹⁰ In fact, the lack of physical evidence can be seen to strengthen a somatoform claim in certain circumstances because, by definition, somatoform disorders are characterized by a lack of demonstrable physical cause.⁹¹ Additionally, courts have held that the inability to find a demonstrable physical cause for a claimed impairment should not preclude the finding of a disability.⁹² The initial difficulty, then,

86. 20 C.F.R. § 404 subpart P, app. 1, 12.07 (2008) (footnotes added).

87. Medical evidence is defined as “evidence from an acceptable medical source showing that you have a medically determinable mental impairment.” *Id.* § 404, subpart P, app. 1, 12.00 (D)(1)(a).

88. While the statute finds that claimants “can often provide accurate descriptions of their limitations,” it also cautions the ALJ to “carefully examine” those statements “to determine if they are consistent with the information about, or general pattern of, the impairment as described by the medical and other evidence” *Id.* § 404, subpart P, app. 1, 12.00 (D)(1)(b).

89. Other information may be provided by “other professional health care providers” as well as “nonmedical sources, such as family members,” and “records from work evaluations and rehabilitation progress notes.” *Id.* § 404, subpart P, app. 1, 12.00 (D)(1)(c). Most notably for those with somatoform disorder, the nonmedical information can include the fact that the claimants repeatedly sought medical treatment or evidence that friends and family members were legitimately concerned about the claimant’s condition as a way to substantiate the claimed severity of the condition. *Cox v. Astrue*, No. 3:07-CV-234 PS, 2008 WL 4858384, at *2 (N.D. Ind. Nov. 7, 2008).

90. *See supra* note 28.

91. *See* 3 SOCIAL SECURITY LAW AND PRACTICE § 42:140 (Michael A. Rosenhouse et al. eds., 2007); *see also supra* note 37.

92. *See Sims v. Barnhart*, 442 F.3d 536, 537 (7th Cir. 2006) (internal citations omitted).

becomes attempting to evaluate somatoform disorders, which are characterized by the lack of physiological evidence and often inconsistent symptoms, within the standards of a process which relies, to a large degree, on the presence of demonstrable medical evidence and reliable observation of effects.

To ease the restrictions of the process, the Code of Federal Regulations indicates that the claimant is not strictly limited to a by-the-letter comparison with a single listed impairment, but instead may be compared with other listings through the concept of “medical equivalence.”⁹³ If a claimed disability does not exactly mirror the substantive requirements of a listing, the Commission is instructed to compare the effects of the impairment to those of any other listing through the medical equivalence test.⁹⁴ The test provides that if a listing is not exactly met, the ALJ should “compare [its] findings with those for closely analogous listed impairments.”⁹⁵ Medical equivalence is appropriate when the findings of the impairment are “at least of equal medical significance” to those of a listing.⁹⁶

Medical equivalence has proven to be particularly helpful when evaluating somatoform disorders.⁹⁷ For instance, pseudoseizures, where the impairment mirrors the effects or symptoms of a listed impairment (such as epilepsy) but does not provide the physiological indicia of that specific listing (such as the corresponding EEG or other medical testing data), may be compared with the epilepsy listings⁹⁸ to determine if the

93. 20 C.F.R. § 404.1526 (2008).

94. *Id.* § 404.1526(b); *id.* § 404.1526(e).

95. *Id.* § 404.1526(b)(2).

96. *Id.* The statute does not explicitly specify the meaning of the term “medical significance,” although it appears to consist of a comparison of the claimed impairment and its effects with a listed impairment and its statutorily enumerated limitations. *Id.* § 404.1526(c).

97. *See infra* notes 101–04, 188–98.

98. The relevant epilepsy listings:

Epilepsy—convulsive epilepsy, (grand mal or psychomotor), documented by detailed description of a typical seizure pattern, including all associated phenomena; occurring more frequently than once a month in spite of at least 3 months of prescribed treatment. With:

A. Daytime episodes (loss of consciousness and convulsive seizures) or

B. Nocturnal episodes manifesting residuals which interfere significantly with activity during the day.

20 C.F.R. § 404 subpart P, app. 1, 11.02 (2008).

Epilepsy—nonconvulsive epilepsy (petit mal, psychomotor, or focal), documented by detailed description of a typical seizure pattern, including all associated phenomena; occurring more frequently than once weekly in spite of at least 3 months of prescribed treatment. With alteration of awareness or loss of consciousness and transient postictal manifestations of unconventional behavior or significant interference with activity during the day.

Id. § 404 subpart P, app. 1, 11.03. In some situations, a claimant may introduce evidence of a diagnosis

effect of the pseudoseizures on the claimant is equivalent to the effects detailed in the epilepsy listing.⁹⁹ If so, the presence of a disability should be recognized.¹⁰⁰ In addition, the combination of several diagnosed medical conditions that, taken individually, would not meet the threshold to constitute an affirmative disability determination, may be medically equivalent to the effects of a listing when evaluated together in terms of their overall limiting effects on the health of the claimant.¹⁰¹ Examples of the combinations of limitations which have been found to be medically equivalent to existing listings include: borderline intellectual functioning, depression, and anxiety disorder;¹⁰² diabetes with automatic nervous disease;¹⁰³ and borderline intellectual functioning, psychiatric affective disorders, and physical disabilities.¹⁰⁴

V. PROBLEMS WITH THE CURRENT TREATMENT OF SOMATOFORM DISORDERS

Despite the presence of the specific somatoform listing in the Code of Federal Regulations¹⁰⁵ and the medical equivalence test,¹⁰⁶ the real-world evaluation of somatoform disorders in the disability context remains problematic. The lack of consistent terminology,¹⁰⁷ the inherent skepticism that surrounds somatoform disorders,¹⁰⁸ and legal misunderstandings of the medical intricacies of somatoform symptoms¹⁰⁹ all contribute to

that includes both epileptic seizures and pseudoseizures. *See* *Rebensdorf v. Astrue*, No. CV-08-1529-PHX-SRB, 2009 WL 648892, at *2 (D. Ariz. Mar. 11, 2009).

99. *See supra* note 94 and accompanying text.

100. *See infra* text accompanying notes 188–98.

101. *See* *Williams v. Astrue*, No. 5:07-cv-119-Oc-10GRJ, 2008 WL 4456460, at *10 (M.D. Fla. Sept. 30, 2008) (where the combination of affective disorder, back injury, and somatoform disorder was found to meet the limiting requirements of affective disorder); 20 C.F.R. § 416.923 (2008) (establishing that the disability process “will consider the combined effect of all of your impairments without regard to whether any such impairment, if considered separately, would be of sufficient severity”). When two or more concurrent impairments are present and the combination is found to be “severe,” that severity must nonetheless persist in combination for the statutorily designated time frame. 20 C.F.R. § 416.922 (2008).

102. *Davis v. Astrue*, 545 F. Supp. 2d 973, 988 (D. Neb. 2008).

103. *Williams v. Bowen*, 684 F. Supp. 1579, 1583–84 (M.D. Ga. 1988).

104. *Shontos v. Barnhart*, 328 F.3d 418, 427 (8th Cir. 2003).

105. 20 C.F.R. § 404 subpart P, app. 1, 12.07 (2008).

106. *Id.* § 404.1526(b)(2).

107. *See supra* notes 27–35.

108. *See infra* notes 122–24 and accompanying text.

109. *See supra* note 16.

inconsistent disability determinations. It is important to examine how each of these problems arise and persist if we are to arrive at a better approach to the process.

A. Terminology

There are several different terms which can indicate a somatoform component¹¹⁰ and several methods by which somatoform disorders may be referenced without specifically flagging one of those terms, such as where the “pseudo” prefix is used.¹¹¹ This can put the onus on the claimant, the ALJ, or the lawyer to make the appropriate medical association or assessment. Further, since the Code of Federal Regulations references only “Somatoform Disorder,”¹¹² one of the parties examining the impairment in the disability hearing must make the necessary connection to the relevant listing if the stated diagnosis specifies another analogous term for the claimant’s condition.¹¹³ The medically understood association between a diagnosis of conversion disorder and the Somatoform Disorder listing, for instance, may not be intuitive to nonmedical personnel.¹¹⁴

Even among the various terms that reflect some presence of a somatoform disorder, subtle differences that seem to indicate a different disorder altogether can frustrate effective diagnosis or effective disability evaluation. If the medical history is not well developed, the court or the claimant can be misled.¹¹⁵ For instance, in *Mowery v. Apfel*,¹¹⁶ the claimant was diagnosed by different physicians with conversion disorder, personality disorder, and schizoaffective disorder.¹¹⁷ As a result, the claimant’s condition was characterized by a “lack of clear medical

110. See *supra* notes 27–35. In fact, “[d]espite the size and importance of this problem [of somatoform disorders], medicine—especially Western medicine—has found these conditions difficult to name, conceptualize, and classify. The names proposed have been bewildering in their variety and include somatization, somatoform disorders, medically unexplained symptoms, and functional symptoms.” Mayou et al., *supra* note 41, at 847 (footnote omitted).

111. See *supra* note 34.

112. See 20 C.F.R. § 404 subpart P, app. 1, 12.07 (2008).

113. While the party may offer any evidence related to a claim, it is the ALJ who determines what evidence will be considered and what issues will be discussed. *Id.* § 404.944.

114. See *infra* notes 137–45 and accompanying text. A relevant example is provided by *Smith v. Astrue*, No. 08-4050-JAR, 2009 WL 975144, at *10 (D. Kan. Apr. 9, 2009), where the ALJ acknowledged that the plaintiff had both a severe seizure disorder attributed to conversion disorder and a nonsevere mental disorder. *Id.* at *10. The district court appropriately concluded that as conversion disorder was, in and of itself, a mental disorder, the ALJ’s determination was “logically inconsistent.” *Id.*

115. See *infra* notes 199–200 and accompanying text.

116. No. 99-2974, 2000 WL 12828, at *1 (7th Cir. Jan. 3, 2000).

117. *Id.*

findings and differing psychological diagnoses.”¹¹⁸ After being initially denied by the ALJ, the claimant asked to be reevaluated under the listing for Schizoaffective Disorder because of a newly specified diagnosis of schizoaffective disorder.¹¹⁹ The claimant was again denied on the grounds that the additional information provided with the diagnosis would not have changed the opinion of the ALJ.¹²⁰ However, there is no evidence that the claimant, her lawyer, or the ALJ ever examined her claim under the Somatoform Disorder listing, which would appear to be appropriate given the diagnosis of possible conversion disorder and the noted lack of medical evidence that troubled the ALJ initially.¹²¹ The connection of terminology between the Somatoform Disorder listing and the diagnosis of conversion disorder, it seems, was simply never made at any level of disability review.

B. Acceptance

Because somatoform disorders are either largely or entirely subjective and do not show up on medical tests, it is easy for a reviewing party to be skeptical of those claimants who request review under Somatoform Disorder standards, and “[d]oubt and disparagement inhere in the very notion of psychosomatic illness.”¹²² Psychological conditions, both historically and in current practice, are consistently seen as less legitimate than more organically based conditions.¹²³ In fact, many who hear the term “somatoform” or “somatization” automatically associate it with malingering or fraud.¹²⁴

The DSM-IV-TR, in examining somatoform disorders, admitted that the line between somatoform disorders and “somatic symptoms . . . intentionally produced to assume the sick role or for gain” can often

118. *Id.*

119. *Id.* at *2.

120. *Id.* at *4.

121. It is questionable whether this evaluation would have made a significant difference in this case, since the basis for the ALJ’s denial was that he was “[f]aced with a lack of clear medical findings and differing psychological diagnoses from various doctors, none of whom had examined Mowery for an extended period of time” *Id.* at *1. Nevertheless, the fact that no analysis of the conversion disorder diagnosis took place with respect to the Somatoform Disorder listing is indicative of the difficulty courts face in making the conceptual connection between the two.

122. Finch, *supra* note 35, at 292.

123. JOHNSON, *supra* note 33, at 15.

124. Finch, *supra* note 35, at 316 (“Among many critics, somatization has become code for malingering and fraud.”).

blur.¹²⁵ Even the SSA has identified mental disorders as one of the categories of listings most susceptible to fraud.¹²⁶ The problem is further exacerbated by the fact that the account of the claimant suffering from a legitimate somatoform disorder is often marked by exaggeration and unrealistic claims,¹²⁷ and the “more medically naive the person, the more implausible are the presenting symptoms.”¹²⁸ The claimant is therefore truly an “inconsistent historian[]” of his or her condition.¹²⁹ This inconsistency can infiltrate the persistence of the symptoms, so that the reported and observed effects vary wildly from instance to instance and affect the perceived legitimacy of the condition,¹³⁰ leaving courts less likely to validate the claim.

Nevertheless, even statutes that do not deal explicitly with somatoform disorders are relaxing their requirements for the presence of demonstrable physical symptoms or causes in their listings. For instance, in May of 2002, the SSA decided that documented EEG abnormality was no longer required to support the presence of epilepsy.¹³¹ The change was subsequently used in *Rebrook v. Astrue*¹³² to confirm that seizures that did not appear to the ALJ to be sufficiently “real” because they continued “in spite of prescribed treatment and medication” could not affirmatively be found to be invalid because of a lack of physical evidence.¹³³ As such, it appears that both the SSA and reviewing courts are acknowledging with

125. DSM-IV-TR, *supra* note 32, at 489. In such cases, where the appropriate non-somatoform diagnosis would be Factitious Disorder With Predominantly Physical Signs or Malingering, intentionally produced symptoms “should not count toward a diagnosis of Somatization Disorder. However, the presence of some factitious or malingered symptoms, mixed with other nonintentional symptoms, is not uncommon” and may require a diagnosis of both Somatization Disorder and one of those non-somatoform conditions. *Id.*

126. U.S. GEN. ACCOUNTING OFFICE, SUPPLEMENTAL SECURITY INCOME: ADDITIONAL ACTIONS NEEDED TO REDUCE PROGRAM VULNERABILITY TO FRAUD AND ABUSE 2–3 (1999), *available at* <http://gao.gov/archive/1999/he99151.pdf>. Among those impairments found to be “susceptible to feigning” were “psychoses and neuroses,” “schizophrenia,” and “epilepsy.” *Id.* at 7.

127. DSM-IV-TR, *supra* note 32, at 486 (“Individuals with Somatization Disorder usually describe their complaints in colorful, exaggerated terms, but specific factual information is often lacking.”).

128. *Id.* at 493. It can be particularly confusing when trying to determine the presence of a condition when the claims fail to match a physiological understanding of the body, but it is quite common that symptoms of a somatoform disorder “do not conform to known anatomical pathways and physiological mechanisms, but instead follow the individual’s conceptualization of a condition.” *Id.*

129. *Id.* at 486.

130. *Id.* at 493 (“A conversion ‘seizure’ will vary from convulsion to convulsion, and paroxysmal activity will not be evident on an EEG.”).

131. Technical Revisions to Medical Criteria for Determinations of Disability, 67 Fed. Reg. 20,018, 20,019 (Apr. 24, 2002).

132. Civil Action No. 5:07CV39, 2008 WL 822104 (N.D. W. Va. Mar. 26, 2008).

133. *Id.* at *21.

increased frequency that physical evidence is not required to find the presence of a disability,¹³⁴ which has obvious somatoform disorder implications if it can be efficiently and uniformly applied.¹³⁵

C. Assessment and Court Examination

Unfortunately, this understanding of somatoform disorders and related disorders is far from universal. Stymied by issues of terminology and identification and clinging to more traditional notions of assessing a patient's complaints (particularly as they relate to pain), ALJs and reviewing district court judges continue to struggle to make appropriate findings.¹³⁶ Several cases illustrate this enduring misunderstanding at all levels of the disability review process.

134. See *Carradine v. Barnhart*, 360 F.3d 751, 754 (7th Cir. 2004) (“The question whether the experience is more acute because of a psychiatric condition is different from the question whether the applicant is pretending to experience pain, or more pain than she actually feels. . . . The cases involving somatization recognize this distinction.”); *Easter v. Bowen*, 867 F.2d 1128, 1131 (8th Cir. 1989) (“[T]he ALJ is not free to reject [the claimant’s] subjective experiences . . . since she has a diagnosed mental disorder that causes a distorted perception of her physical ailments.”); *Parks v. Sullivan*, 766 F. Supp. 627, 635 (N.D. Ill. 1991) (“Any shortcomings in the objective medical data . . . are irrelevant since her primary disorder, as clinically diagnosed, causes her to exaggerate her physical problems in her mind beyond what medical data indicate.”). The SSA has also made it clear that when it refers to “medical signs” and “laboratory findings,” such terms are not necessarily limited to medical hard data, but may be presented through observed reaction or examination. See Soc. Sec. Rul. 99-2p: Policy Interpretation Ruling Titles II and XVI: Evaluating Cases Involving Chronic Fatigue Syndrome (CFS) (Apr. 30, 1999), available at http://www.socialsecurity.gov/OP_Home/rulings/di/01/SSR99-02-di-01.html (where ongoing problems in “short-term memory, information processing, visual-spatial difficulties, comprehension, concentration, speech, word-finding, calculation, and other symptoms suggesting persistent neurocognitive impairment” that have been “documented by mental status examination or psychological testing . . . constitute medical signs or (in the case of psychological testing) laboratory findings that establish the presence of a medically determinable impairment”).

135. The ability to distinguish between epileptic seizures and pseudoseizures, and between pseudoseizures and malingering or fraud, continues to be controversial and inconsistent. One recent study suggested that ictal eye closure, the involuntary opening or closing of the eyelid during a seizure, was a reliable indicator for differentiating between epileptic seizures and psychogenic nonepileptic seizures (PNES), as fifty of fifty-two patients with PNES closed their eyes during seizure activity, while 152 of 156 patients with epileptic seizures opened their eyes during seizure activity. Steve S. Chung et al., *Ictal Eye Closure Is a Reliable Indicator for Psychogenic Nonepileptic Seizures*, 66 *NEUROLOGY* 1730 (2006). Other studies have found ictal eye activity to be a less than consistent indicator for differentiation between PNES and epileptic seizures. See Matthew T. Hoerth et al., *Clinical Predictors of Psychogenic Nonepileptic Seizures: A Critically Appraised Topic*, 14 *NEUROLOGIST* 266 (2008).

136. Several court decisions have determined that a record of a claimant's complaints of pain alone, without medical evidence of an underlying cause, are not enough to support the presence of disability. See *Haseler v. Acting Comm’r of Soc. Sec.*, 33 Fed. App’x 631, 634 (3d Cir. 2002); *Stickle v. Comm’r of Soc. Sec.*, No. 1:07-cv-230, 2008 WL 4412158 (W.D. Mich. Sept. 24, 2008); *Franks v. Astrue*, No. 7:07-CV-139 (WLS), 2008 WL 4280160, at *6 (M.D. Ga. Sept. 15, 2008) (stating that pain complaints and other symptoms without “medical signs and laboratory findings which show . . . a medical impairment[]” do not establish that a claimant is disabled). Many of these determinations stem

In *Scott v. Shalala*,¹³⁷ the Fifth Circuit Court of Appeals evaluated a denied disability claim for a female claimant. After several work-related accidents, the claimant complained of debilitating lower back pain.¹³⁸ She was eventually referred to a psychologist, who noted that the claimant appeared “greatly distressed” by her situation, and diagnosed her with “Psychological Factors Affecting a Physical Condition.”¹³⁹ He was of the opinion that “[the patient]’s psychological response to her physical problems and financial worries exacerbated the pain she associated with her physical problems.”¹⁴⁰ The claimant was denied disability at the initial level, the ALJ level, and the district court level.¹⁴¹ She appealed on the grounds that the proper legal standards were not applied and that the decision was not supported by substantial evidence on the record.¹⁴²

The ALJ’s initial finding had evaluated the claim under the Somatoform Disorder listing, but determined that the diagnosis of Psychological Factors Affecting a Physical Condition “by definition rules out Conversion Disorder and other Somatoform Disorders.”¹⁴³ The Fifth Circuit, on appeal, appropriately corrected the ALJ’s misunderstanding of the nature of conversion and somatoform disorders, pointing out that the psychologist’s diagnosis and somatoform disorder were far from “mutually exclusive.”¹⁴⁴ Because the ALJ improperly dismissed the possibility of a somatoform disorder, the record was not even sufficiently developed to allow the Fifth Circuit to make an affirmative finding, forcing the court to remand the case for a due consideration of the existence of a somatoform disorder.¹⁴⁵ In this way, the Fifth Circuit was

from the review of a statutory declaration that “statements about [a claimant’s] pain or other symptoms will not alone establish that [the claimant is] disabled.” 20 C.F.R. § 416.929 (2008). Nevertheless, determinations of pain complaints remain “[o]ne of the most difficult aspects of disability evaluations.” BLOCH, *supra* note 17, at 72. As a result, the disability determination process has been heavily scrutinized in recent years for its process of evaluating subjective symptoms like complaints of pain. See, e.g., David J. Agatstein, *Beyond the Threshold: Wincing at Social Security’s Process of Evaluating Pain*, 17 J. NAT’L ASS’N ADMIN. L. JUDGES 231 (1997); Finch, *supra* note 35, at 298–301.

137. No. 94-50096, 1994 WL 725034, at *1 (5th Cir. Dec. 19, 1994).

138. *Id.*

139. *Id.* While they can be closely related, the distinction between the diagnosis of a somatoform disorder and one of Psychological Factors Affecting a Medical Condition is that in a somatoform disorder “there is no diagnosable general medical condition to fully account for the physical symptoms.” DSM-IV-TR, *supra* note 32, at 485.

140. *Scott*, 1994 WL 725034, at *1.

141. *Id.* at *2.

142. *Id.*

143. *Id.* at *3.

144. *Id.* at *4.

145. *Id.* at *4, *6.

able to correct the critical misunderstanding by the ALJ at the review level.

The Fifth Circuit's difficulty in making an affirmative disability determination based on the development of the record also foreshadows the inherent problems stemming from a misunderstanding of somatoform disorders at the early stages. A dismissal without proper evidentiary development forces subsequent courts to clog the system with remands to make factual determinations either misapplied or absent in the earlier proceedings.¹⁴⁶

However, the federal court level is just as vulnerable to confusion and misunderstanding when faced with somatoform disorders. In *Harrington v. Secretary of Health & Human Services*,¹⁴⁷ the Sixth Circuit affirmed the district court's and ALJ's decisions to deny disability. The claimant complained of several medically documented maladies, including disabling chest pain, a peptic ulcer, and mild coronary artery disease.¹⁴⁸ Most notably, the claimant complained of "preinfarction angina,"¹⁴⁹ which the physician found was "not . . . typical of angina pectoris"¹⁵⁰ and suggested there was "no clear medical basis for the claimant's pain."¹⁵¹ As a result, the treating psychologist diagnosed the claimant as having a somatization or conversion disorder, which impaired the claimant's ability to cope with stress in a work environment.¹⁵² The Sixth Circuit affirmed the district court's decision to deny disability benefits to the claimant, finding that despite the somatization and conversion disorder diagnoses, the tests conducted by other doctors "indicated no physiological basis for the claimant's chest pain."¹⁵³ If the claimant's impairments had been evaluated with a decreased emphasis on the physical evidence requirement, as has become more common in recent years,¹⁵⁴ the court may have come to a very different conclusion.

146. See *infra* notes 199–204 and accompanying text.

147. No. 85-4069, 1986 WL 18406, at *1 (6th Cir. Nov. 18, 1986).

148. *Id.* There was also evidence that the claimant appeared to be of "borderline intelligence" but "reads a variety of materials regularly and has better reading and spelling skills than his IQ would indicate." *Id.*

149. *Id.* Preinfarction angina (or unstable angina) is the sensation of a spasmodic, cramplike choking feeling characterized by sudden onset, sudden worsening, and stuttering recurrence over days and weeks. MOSBY'S MEDICAL, *supra* note 3, at 89.

150. *Harrington*, 1986 WL 18406, at *1. Angina pectoris generally results in pain down the inner left arm accompanied by the feeling of suffocation, often in relation to exertion, emotional stress, or cold exposure. MOSBY'S MEDICAL, *supra* note 3, at 89.

151. *Harrington*, 1986 WL 18406, at *1.

152. *Id.*

153. *Id.* at *2.

154. See *supra* notes 132–35 and accompanying text.

The Fourth Circuit adopted a similar approach when faced with a similarly diagnosed claimant in *Gross v. Heckler*.¹⁵⁵ The claimant had been granted disability by the ALJ, but this determination was overruled on review by the Appeals Council.¹⁵⁶ The claimant's chest pain was examined by a physician and found to be "atypical of angina pectoris."¹⁵⁷ The Appeals Council determined that the claimant's condition had "no specific clinical findings, and no neurological, sensory, or reflex abnormalities which would explain Gross' chest pain, blackouts, or anxiety."¹⁵⁸ The majority of the court found that it was reasonable for the Appeals Council to conclude that the claimant's pain was not disabling because of the absence of medical evidence supporting the existence of the pain.¹⁵⁹ The dissent, more directly addressing the possibility of somatoform-related symptoms, asserted instead that because treating physicians had diagnosed the claimant with variations of somatization and conversion disorder, those diagnoses provided appropriate grounds to find the presence of a disability.¹⁶⁰

Even when the possibility of a somatoform disorder is secondary to other diagnoses, the potential impact of a somatoform finding should be considered in the ALJ's decision.¹⁶¹ In a more recent case, *Dewald v. Astrue*,¹⁶² a claimant alleged several impairments, including abdominal pain.¹⁶³ The state agency's psychological evaluation of the claimant's

155. 785 F.2d 1163 (4th Cir. 1986).

156. *Id.* at 1164. The Appeals Council has the right to initiate review of a disability determination. 20 C.F.R. § 416.969 (2008).

157. *Gross*, 785 F.2d at 1166.

158. *Id.* (citing *Foster v. Heckler*, 780 F.2d 1125 (4th Cir. 1986)).

159. *Id.*; see also *Parker v. Sec'y of Health & Hum. Servs.*, No. 90-2084, 1991 WL 100547, at *2 (6th Cir. June 11, 1991) ("[A]llegations of psychogenic pain must be supported by objective evidence.").

160. *Gross*, 785 F.2d at 1171 (Hall, J., dissenting). The majority referred vaguely to the presence of unexplainable physical symptoms and determined that the claimant "might have a psychological disorder." *Id.* at 1166. The dissent cited findings by two treating psychologists. *Id.* at 1168 (Hall, J., dissenting). One of the psychologists characterized the claimant as an "old-fashioned somatizer," and the other diagnosed the claimant with conversion disorder and suggested that the psychological impairment constituted a disability. *Id.* This further illustrates the confusion that can result from a misunderstanding of the nature of somatoform disorders and the importance of framing the disability correctly.

161. The impact of a somatoform disorder is felt not simply in the impairment determination step. In *Wools v. Astrue*, No. 3:07-cv-135-WGH-RLY, 2009 WL 1148219 (S.D. Ind. Apr. 28, 2009), the reviewing court determined that hypothetical vocational scenarios presented to a vocational expert in order to determine the claimant's work limitations that did not include consideration of a substantiated somatoform disorder were incomplete and in error. *Id.* at *15. See also *Pittman v. Astrue*, No. 4:08-CV-50-BO, 2009 WL 424178, at *1 (E.D.N.C. Feb. 19, 2009).

162. 590 F. Supp. 2d 1184 (D.S.D. 2008).

163. *Id.* at 1191.

history, based on the examinations conducted by two treating physicians, suggested a secondary diagnosis of somatoform and personality disorders.¹⁶⁴ The ALJ determined that the abdominal pain had “no organic basis” and was not to be considered a severe physical impairment.¹⁶⁵ The district court noted that both the state agency and treating physicians referenced the possibility that a somatoform disorder was the source of the complaints of abdominal pain.¹⁶⁶ Because the ALJ failed to consider, or even discuss, the somatoform disorder diagnosis, the court found that the ALJ’s determination was in error, since such a diagnosis would have provided sufficient justification as to why there was no organic basis for the allegations.¹⁶⁷

While ALJs and reviewing courts are encouraged to use the medical equivalence test as a way to avoid complications with matching a listing exactly,¹⁶⁸ traditional notions of asserting a medically demonstrable cause for a claimed disability continue to harm the effectiveness of the rule. In *Bowden v. Commissioner of Social Security*,¹⁶⁹ the Sixth Circuit reviewed an ALJ’s denial of disability to a woman with a history of seizure activity. After one of her seizure episodes required her to be hospitalized, the claimant was examined, and the treating physician opined that the claimant did not suffer from “real seizures,” as her EEG tests did not indicate seizure activity.¹⁷⁰ She was subsequently examined by a neurologist who found her EEG to be only “mildly abnormal.”¹⁷¹ The neurologist was “not really sure” if the claimant suffered from actual seizures.¹⁷² Several other treating physicians characterized these episodes as “pseudoseizures,”¹⁷³ with one psychiatrist determining that the pseudoseizures were occurring with the requisite frequency and severity to constitute a disability.¹⁷⁴

The court determined that despite the treating physician’s opinion, “the majority of objective medical evidence” suggested that the seizures were not as serious as the claimant purported them to be, since “numerous

164. *Id.* at 1194.

165. *Id.* (internal citation omitted).

166. *Id.*

167. *Id.*

168. *See supra* notes 94–96 and accompanying text.

169. No. 97-1629, 1999 WL 98378, at *1 (6th Cir. Jan. 29, 1999).

170. *Id.* at *2.

171. *Id.* at *3.

172. *Id.*

173. *Id.* at *4, *5.

174. *Id.* at *5 (“I feel that the patient is currently disabled on the basis of her increased frequency of seizures.”).

EEGs performed on Plaintiff failed to indicate any evidence of seizure dysfunction.”¹⁷⁵ The claimant had urged that the court consider her condition under the epilepsy listings,¹⁷⁶ as well as the Somatoform Disorder listing.¹⁷⁷ The court concluded that because the majority of her tests were “within normal range” and she was not consistently diagnosed with a somatoform disorder, neither listing was appropriate.¹⁷⁸ Once again, the lack of physical evidence appears to play a significant role in rejecting a claimant’s complaints, even when substantiated by a treating physician with regard to both existence and effect,¹⁷⁹ without any consideration for whether the effects of the malady, no matter how psychological it may be, are sufficiently limiting.

It is clear that while some courts evaluate somatoform disorders in accordance with the appropriate medical and legal standards, misunderstandings continue at all levels, which undermine the efficiency and effectiveness of the system. Therefore, it is necessary to generate a system for effectively evaluating potential somatoform disorder claims to avoid the problems that plague the system.

VI. A COMPREHENSIVE APPROACH TO SOMATOFORM DISORDERS IN DISABILITY DETERMINATIONS

A. Non-Somatoform Impairments

First, reviewers of disability claims should, in step three of the evaluation process,¹⁸⁰ determine if the impairment meets a statutorily

175. *Id.* at *7.

176. *Id.* at *8; *see supra* note 98.

177. *Bowden*, 1999 WL 98378, at *8.

178. *Id.* Because of this presumed legitimacy of physical evidence, a reviewing ALJ may also implicitly give more weight to a physician’s negative diagnosis according to an absence of indicative test results than one who comes to a positive diagnosis for the same reason. For instance, in *Robinson v. Astrue*, C/A No. 2:08-303-JFA-RSC, 2008 WL 5278435, at *4 (D.S.C. Dec. 18, 2008), an ALJ rejected a treating physician’s determination that the claimant met the listing for Somatoform Disorder in favor of the determinations of a nonexamining consultant who found no diagnosis of depression and was therefore not “medically determinable.” *Id.* at *4. On review, the district court determined that rejection of the treating physician’s determination was in error, particularly because “the presence or absence of such data has no relevance to the viability of [the treating physician]’s evaluation.” *Id.*; *see also* *Baapir v. Astrue*, No. 5:08cv00059, 2009 WL 1586583, at *4 (W.D. Va. June 4, 2009) (finding that a lack of clinical conclusions or test results justifies a finding of only mild limitation); *Wilson v. Astrue*, Civil Action No. 5:08-377-JMH, 2009 WL 1322795, at *4 (E.D. Ky. May 12, 2009) (determining that a physician’s opinion, without “significant findings that would yield such limitations on an MRI or physical examination” was properly dismissed).

179. *See* *Grimmett v. Astrue*, No. 07-1373-JTM, 2009 WL 641279 (D. Kan. Mar. 12, 2009) (where the ALJ determined that normal EEGs and CT scans indicated a “less severe” seizure disorder).

180. *See* 20 C.F.R. § 416.920(d) (2008); *supra* notes 66–67 and accompanying text.

prescribed non-somatoform listing. There will occasionally be sufficient indicia of a statutory listing for a condition with somatoform aspects that, because of the severity of the effects or a relaxed requirement of physiological evidence, will meet the listing on its face. In the aforementioned case, *Rebrook v. Astrue*,¹⁸¹ the court found that because a claim under the epilepsy listing did not require physiological evidence, it was possible for claimant's seizures, which were unsupported by a physical cause and did not respond to treatment or medication, to still meet the listed impairment for epilepsy.¹⁸² This line of analysis can help to alleviate the confusion between somatoform and non-somatoform disorders by strengthening the lines of distinction between the two.

B. Medical Equivalence

Second, reviewers of the disability claim should determine if the impairment meets the "medical equivalence" standard under 20 C.F.R. § 404.1526¹⁸³ to determine if, even without the required physiological indicia of a listed impairment, the claim is medically equivalent to any listed impairment. The medical equivalence analysis should be made not only with respect to the somatoform-related condition but to the totality of the claimant's conditions, which may in combination present the requisite limitations to meet another relevant listing.¹⁸⁴ This requires consideration of all analogous listed impairments¹⁸⁵ and a fully developed record on

181. Civil Action No. 5:07CV39, 2008 WL 822104 (N.D. W. Va. Mar. 26, 2008); *see supra* note 132 and accompanying text.

182. *Rebrook*, 2008 WL 822104, at *21. By the same token, a listing that appears on its face to match up with a listed impairment that is designated by a demonstrable physical or physiological cause may in fact be more appropriately evaluated under the Somatoform Disorder listing or the listing for another mental impairment. *See Boiles v. Barnhart*, 395 F.3d 421, 427 (7th Cir. 2005) ("[P]seudoseizures may be more analogous to an impairment described in a listing other than 11.02, such as one that describes a psychological impairment.").

183. *See supra* notes 94–104 and accompanying text.

184. *See supra* note 101.

185. This may often represent a departure from the normal disability determination process in certain circuits. Several circuits only require the ALJ to evaluate specific listings, limited to either those brought forth by the claimant or those the claimant has articulated in previous proceedings. *See, e.g., Abreu v. Astrue*, No. 07-15475, 2008 WL 5268555, at *1 (9th Cir. Dec. 16, 2008) ("The ALJ is not required to perform a detailed analysis for every possible listing."). Similarly, some circuits have determined that when a claimant requests a limited review of an ALJ's determination, the Appeals Council may not revisit issues not challenged unless it notifies the claimant that it intends to do so. *Bivines v. Bowen*, 833 F.2d 293 (11th Cir. 1987); *Chrupcala v. Heckler*, 829 F.2d 1269 (3d Cir. 1987). *Contra Gronda v. Sec'y of Health & Hum. Servs.*, 856 F.2d 36, 39 (6th Cir. 1988) (concluding that there is "no fundamental unfairness" in reviewing the entirety of a claimant's case, including aspects that the claimant did not request in the Appeals Council review).

which the ALJ and reviewing courts can base their decision.¹⁸⁶ One author providing an overview of the disability process has noted, “[a]s disability determinations are largely fact-based evaluations, it is extremely important that a full and complete record is prepared before a decision is made.”¹⁸⁷

The consequences of proceeding with an underdeveloped record are illustrated by the Seventh Circuit’s ruling in *Boiles v. Barnhart*.¹⁸⁸ The claimant reported frequent seizures, which had been diagnosed by several physicians as pseudoseizures.¹⁸⁹ She appealed the ALJ’s denial of disability and asserted that, contrary to the ALJ’s findings, her pseudoseizures were medically equivalent to a listed impairment.¹⁹⁰ At the ALJ level, nontreating physicians testified that while the pseudoseizures were not epileptic in nature, they were nonetheless “real,” with nothing to suggest that she was “malingering or faking.”¹⁹¹ The ALJ evaluated the claimant under the Epilepsy listings¹⁹² but did not find the claimant “totally credible”¹⁹³ because there was no EEG evidence, the frequency of the seizures was open to question, and there was no evidence of “residual symptoms” during the day that interfered with the claimant’s daily life.¹⁹⁴

The Seventh Circuit did not find the ALJ’s decision to be justified.¹⁹⁵ First of all, the ALJ did not explain why the absence of EEG evidence had an effect on the medical equivalence of the pseudoseizures, since it was clear from the record that a lack of EEG evidence was consistent with her particular disorder.¹⁹⁶ Secondly, the court was particularly troubled by the ALJ’s determination that the frequency of the seizures remained an open question, since the ALJ failed to make an affirmative finding of fact related to the frequency and severity of the seizures pursuant to his

186. The ALJ is expected to ensure that a fully developed record is generated by the proceeding which adequately represents all sides, including that of the public interest. CHARLES H. KOCH, JR., 2 ADMINISTRATIVE LAW AND PRACTICE § 5.25 (2d ed. 2008). Even as the burden of demonstrating the presence of a disability is on the claimant, the ALJ has an affirmative duty to assist in developing the record. See *Reed v. Massanari*, 270 F.3d 838, 841 (9th Cir. 2001). This duty is heightened when the appeal involves a pro se litigant. *Castillo v. Barnhart*, 325 F.3d 550, 552–53 (5th Cir. 2003); see also *infra* note 199.

187. BLOCH, *supra* note 17, at 124.

188. 395 F.3d 421 (7th Cir. 2005).

189. *Id.* at 423.

190. *Id.* at 422.

191. *Id.* at 424.

192. See *supra* note 98.

193. *Boiles*, 395 F.3d at 424.

194. *Id.* at 425.

195. *Id.* at 427.

196. *Id.* at 425; see also *Cox v. Astrue*, No. 3:07-cv-234 PS, 2008 WL 4858384, at *1 (N.D. Ind. Nov. 7, 2008) (finding that while negative EEG test results affect a claim of epilepsy, they do “nothing to undercut [the claimant]’s argument that she suffered from conversion, or non-epileptic, seizures”).

determination.¹⁹⁷ The Seventh Circuit found that “[w]hether Boiles’s pseudoseizures are of equal medical significance to epilepsy will depend in part upon how frequently they occur; thus the record must be more developed on this point.”¹⁹⁸

This fully developed record assists the disability process because it ensures that no cases fall through the cracks.¹⁹⁹ A lack of sufficient medical knowledge has frequently been cited as an area of concern in the disability determination process.²⁰⁰ Evaluations of the current process have already established that the presence of an incomplete or underdeveloped evidentiary record represents one of the most significant threats to the efficiency and accuracy of the system.²⁰¹ Affirmative findings of fact relating to medical equivalence can prove significant in determining that somatoform disorders are positively identified, not only for the lower court, but also for subsequent review of the court’s decision, if necessary.²⁰² It is even conceivable that such a policy may decrease appeals in general because the more fully developed the record is, the less likely it is that an appeal will be needed to correct a flaw in the prior ruling.²⁰³ This step helps to stress the statutory emphasis on the effects of

197. *Boiles*, 395 F.3d at 427.

198. *Id.*; see also *Rodewald v. Astrue*, Civil No. 08-5911 (RHK/SRN), 2009 WL 1026286, at *19 (D. Minn. Apr. 16, 2009) (where a diagnosis of somatization disorder should have put the ALJ on notice to further develop the record); *Kallio v. Astrue*, Cause No. 2:07-CV-406-JVB, 2009 WL 500552, at *8 (N.D. Ind. Feb. 27, 2009).

199. It has further been suggested that a more inquisitorial approach by ALJs in the disability determination process, particularly when dealing with pro se litigants, results in a more fully developed record and helps to ensure a full and fair hearing. Paris R. Baldacci, *A Full and Fair Hearing: The Role of the ALJ in Assisting the Pro Se Litigant*, 27 J. NAT’L ASS’N ADMIN. L. JUDICIARY 447, 483–86 (2007).

200. BLOCH, *supra* note 17, at xvii–xviii.

201. FRANK BLOCH ET AL., INTRODUCING NONADVERSARIAL GOVERNMENT REPRESENTATIVES TO IMPROVE THE RECORD FOR DECISION IN SOCIAL SECURITY DISABILITY ADJUDICATIONS: A REPORT TO THE SOCIAL SECURITY ADVISORY BOARD 70 (2003), available at <http://www.ssab.gov/documents/Bloch-Lubbers-Verkuil.pdf>.

202. The breadth of the subsequent review can vary depending on the level at which review takes place. Because the ALJ proceeding has been characterized as “informal” and “nonadversarial,” there is a less stringent administrative exhaustion requirement that allows the initial district court review to consider issues and arguments not raised in the ALJ proceeding. *Sims v. Apfel*, 530 U.S. 103, 111 (2000); see also *Vasquez v. Astrue*, No. 06-16817, 2008 WL 4791860, at *9 (9th Cir. Nov. 5, 2008) (finding *res judicata* should not be rigidly applied to administrative proceedings). However, if the matter is further appealed beyond the district court level, issues not raised in district court are waived. See, e.g., *Lopes v. Astrue*, No. 06-16370, 2008 WL 2019584 (9th Cir. May 12, 2008); *Butler v. Barnhart*, No. 03-31052, 2004 WL 1240504 (5th Cir. June 2, 2004); *Castillo v. Barnhart*, 325 F.3d 550 (5th Cir. 2003); *Crow v. Shalala*, 40 F.3d 323 (10th Cir. 1994).

203. The increased emphasis on a review of the record is acting as a surrogate for what would otherwise require the increased use of medical personnel. The process should, therefore, result in similar benefits, which include “more complete medical records at the initial decision level and more accurate initial disability determinations,” which will “reduce the need for appeals and improve the

the condition, not the cause of the condition, and fosters a heightened understanding of somatoform disorders going forward—particularly important as disability claims have become more numerous and more complex in recent years.²⁰⁴

C. *Somatoform Listing*

Finally, the claimant's impairment should be evaluated under the Somatoform Listing 12.07 in the Code of Federal Regulations.²⁰⁵ The evaluator should be careful not to examine the condition in the traditional "cause-effect" method, and should instead allow for significant input from physicians (particularly that of treating physicians) as to whether or not, beyond the lack of physiological evidence, the claimant's impairment is "real," to be augmented by other accounts of the condition in accordance with the Mental Disorder guidelines.²⁰⁶ Still, the diagnosis of somatoform disorder (or related disorder) is not by itself sufficient to establish the presence of a disability if a determination is made that the symptoms do not limit the claimant to the extent enumerated in the statute.²⁰⁷

VII. COMPLICATIONS AND RESPONSES

A. *Fraud and Malingering*

The stated approach is most vulnerable on the grounds that it will both encourage and reward applicants who attempt to fake the symptoms of a somatoform disorder in order to receive disability benefits, whereas such somatoform claims have traditionally been evaluated with more skepticism.²⁰⁸ By recommending an approach that might suggest a presumption of legitimacy for applicants, the system may be more vulnerable to fraud and malingering cases, which the SSA has already identified as a concern.²⁰⁹ Even so, the educational component of this full

quality of appeals when taken but will not obviate the need for administrative appeals from agency-level disability decisions or for comprehensive judicial review." BLOCH, *supra* note 17, at 179.

204. Administrative Review Process for Adjudicating Initial Disability Claims, 71 Fed. Reg. 16,424 (Mar. 31, 2006).

205. 20 C.F.R. § 404 subpart P, app. 1, 12.07 (2008).

206. *See supra* notes 84–89.

207. *See Jerin v. Astrue*, No. 07-1708, 2008 WL 4614105, at *3 (W.D. Pa. Oct. 15, 2008) (finding that while the claimant was diagnosed with a somatoform disorder, the treating physician gave the claimant only "slight to moderate restrictions in her ability to perform daily activities" and determined that the claimant was therefore "not severely limited or affected by the disorder").

208. *See supra* notes 122–24 and accompanying text.

209. *See supra* note 126.

evaluation will encourage a greater understanding of somatoform disorders, which should in fact increase the efficiency and accuracy of the process.²¹⁰

A similar development has been observed in the medical community. Somatoform disorders had first been integrated into the DSM in the DSM-III as a speculative diagnostic category in 1980.²¹¹ Since that time, the progress of “increased awareness of the disorder, as well as improved knowledge and diagnostic techniques,” has succeeded in decreasing the numbers of misdiagnoses.²¹² While there may be growing pains at the beginning of the reform process, the same increased awareness observed in the medical community should spread similarly in the legal context, and, just as misdiagnoses decreased in the medical context, the number of misapplications regarding somatoform disorders at all levels of legal review should decrease.

B. Costliness of Adjudication

Because of the enhanced emphasis on affirmative findings of fact and the additional steps that should be taken to ensure proper evaluation, the possibility of lengthier or more intensive and costly proceedings does exist. The SSA has often found itself accused of inefficiency, both procedurally and economically, and its process has been “challenged on all sides, as too costly and inefficient and as stingy and anti-claimant.”²¹³ The Commissioner of the SSA has already demonstrated a concern for the backlog of disability hearings and a commitment to limiting that number in the future.²¹⁴

However, what this additional fact finding may add to earlier proceedings, it will relieve in later proceedings by creating a more developed record and decreasing appeals. The interests of fairness and justice further require that inequities in the system are corrected if it is practicable to do so without increasing injustice elsewhere. If the fairness of the system is threatened and can be alleviated by a greater emphasis on

210. *See supra* note 203.

211. Mayou et al., *supra* note 41, at 847.

212. DSM-IV-TR, *supra* note 32, at 493.

213. BLOCH, *supra* note 17, at xv.

214. *See* OFFICE OF DISABILITY ADJUDICATION & REVIEW, SOC. SEC. ADMIN., PLAN TO ELIMINATE THE HEARING BACKLOG AND PREVENT ITS RECURRENCE: SEMI-ANNUAL REPORT FISCAL YEAR 2008 (2008), available at http://www.ssa.gov/disability/Semiannual_Report_FY08.pdf; SOC. SEC. ADMIN., PLAN TO REDUCE THE HEARINGS BACKLOG AND IMPROVE PUBLIC SERVICE AT THE SOCIAL SECURITY ADMINISTRATION (2007), available at <http://www.ssa.gov/hearingsbacklog.pdf>.

medical resources and understanding, that aspect of the disability determination process “must be considered seriously.”²¹⁵ Given the misinformation inherent in the system, it is difficult to see how an increase of education on this topic could be outweighed by an initial increase in costs. If the central concerns are, as observed above, the system’s inefficiency and stinginess, an approach that reduces appeals, provides for a more informed process, and suggests a greater emphasis on medical equivalence would effectively address those concerns.²¹⁶

Finally, because I am urging this approach at every stage of disability review, it is conceivable, if not likely, that efficiency will increase, not decrease. If at the initial review stage, or at the lawyer’s review of the case, correct and effective determinations are made about the claimant’s impairments and the record is fairly developed and understood as it relates to every plank of the approach, the ALJ’s decision will be less difficult and intensive, not more so. In fact, determinations related to the Listing of Impairments are much more common at the earlier stages of the process than on appeal,²¹⁷ so if there is an oversight or misapplication early in the process, it seems likely to endure to the claimant’s detriment. The proposed approach above should help to limit those early mistakes.

VIII. CONCLUSION

Somatoform disorders continue to evolve within the medical community,²¹⁸ which will no doubt cause ripples in all other disciplines that attempt to synthesize these changes with their own doctrines. But our understanding of somatoform disorders has already come a long way, to the point that they are now considered legitimate medical diagnoses²¹⁹ that

215. BLOCH, *supra* note 17, at 124.

216. Particularly helpful is the fact that increased knowledge on the part of those making the disability determinations provides an integration of two aspects of the disability determination process, with medical personnel judging the veracity of medical evidence and ALJs providing credibility determinations:

Some judges and advocates feel that medical experts should be used to evaluate subjective complaints of pain, which is the central issue in a large number of Social Security disability claims at the administrative hearing level. . . . Those who favor the use of medical experts in these cases argue that doctors have a greater understanding of the difficult medical issues relating to pain and can be more objective than administrative law judges. Others argue that medical experts are not helpful in pain cases since the most important determination is the claimant’s credibility.

Id. at 135; *see also supra* note 136.

217. BLOCH, *supra* note 17, at 55.

218. *See supra* note 41.

219. *See sources cited supra* note 15.

deserve to be evaluated on their own terms within the disability determination process—terms which consider and respect the unique fusion of mental and physical illness characterizing somatoform disorders. An essential aspect of this evaluation is limiting the misapplication, misinformation, and misunderstanding that plague somatoform disorder adjudication proceedings. To revisit the hypothetical scenario which opened this Note, the process I have articulated demonstrates to the Patient that there is a clear and unambiguous approach to establishing the existence of her condition, presents the Lawyer with an appropriate standard for proving that the Patient's claims are disabling, and provides a template for the Administrative Law Judge to consult in making the disability determination. By ensuring that this condition, which has historically received inconsistent treatment, is adequately and efficiently assessed, those involved in disability determinations can help legitimize both somatoform disorders and the process by which they are evaluated.

*Gregory C. Flatt**

* J.D. (2010), Washington University School of Law; B.A. English (2002), University of Iowa. I would like to thank my friends and family for their encouragement and support and the editors of the *Washington University Law Review* for their invaluable guidance and insight during the writing of this Note.