

Factitious Disorders in Civil Litigation: Twenty Cases Illustrating the Spectrum of Abnormal Illness-Affirming Behavior

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Physical symptoms are commonly alleged in civil litigation. In some instances these symptoms are originally produced by psychological factors and antedate the alleged injury being claimed as a tort. These cases reflect abnormal illness-affirming behavior. Factitious physical disorders represent a special category of these individuals because they produce their signs and symptoms consciously. This article reviews common features of 20 cases of factitious disorder in which the patients were involved in civil litigation. Attention to these factors can facilitate differential diagnosis, which can lead to improved understanding of causation and appropriate clinical interventions. The authors discuss how the actions of such individuals often shift along the entire spectrum of abnormal illness-affirming behavior over time.

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Physical complaints and symptoms are common in civil litigation. They often precipitate the initiation of litigation and frequently are major grounds for monetary damages. Plaintiffs may claim physical symptoms as the cause of occupational disability, emotional suffering, and loss of ability to fulfill marital, occupational, and other social roles. Clearly, these symptoms may arise as a result of physical damages due to a tort that serves as the basis for the litigation. This article, however, will illustrate some instances in which these symptoms arose from the plaintiff's psychological makeup and antedated any tort. The tort then serves as the vehicle for the plaintiff to convert physical symptoms into reimbursable injuries. Factitious physical disorders represent a special group in which the individual's psychology leads to the conscious production of signs and symptoms of disease.

This study will examine identifiable characteristics of factitious physical disorders by reviewing 20 cases

that occurred in individuals involved in civil litigation. We will also describe how the factitious disorder is often only one stop along the spectrum of abnormal illness-affirming behavior in these individuals. Recognition of the potential for this process is important because these cases may involve millions of dollars in awards. Moreover, failure to identify such cases also dooms the individual to focus on achieving improvement by obtaining an external victory rather than recognizing and thus being able to change an internal state. Medical costs for a patient with an unrecognized factitious disorder can become enormous.¹

Pilowsky² coined the term "abnormal illness-affirming behavior" to describe individuals who produce or amplify signs and symptoms of illness far out of proportion to the biomedical disease that is present. This type of behavior can occur with varying levels of conscious production and motivation.³ Two forms of abnormal illness-affirming behavior feature conscious production of signs or symptoms: factitious disorders and malingering. In factitious disorders, which in their severe forms are sometimes referred to as Munchausen syndrome, the individual produces the symptomatology primarily to achieve the patient role.^{3–6} Indeed, the patient with facti-

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tious disorder is usually unaware of his or her motivations for producing the behavior. An observer is likely to have difficulty understanding the patient's motivation because the behavior serves no other obvious goal, such as receiving a monetary award in litigation, obtaining narcotics, or gaining relief from a noxious situation. When these latter motivations are present, the individual's behavior is typically categorized as malingering.⁶⁻⁸

Some individuals with a history of factitious disorder eventually become plaintiffs in lawsuits in which they seek compensation for physical injuries they have produced. With the additional obvious motivation of financial rewards for their consciously produced symptoms, according to the DSM-IV, their behavior may shift to include features of malingering.⁷ The purpose of this study was to describe a series of individuals who illustrate this pattern.

Methods

Selection of Study Group

The authors reviewed the records of cases they had evaluated over a 15-year period, to identify a series of individuals with a diagnosis of factitious physical disorder who were plaintiffs in civil litigation; 20 such cases were identified. One or both of the authors had served as expert witnesses or consultants on these cases. Their roles included reviewing case histories, performing independent examinations as indicated, and formulating opinions that often were delivered in deposition. None of the cases went to trial.

In the preponderance of these cases, the expert was requested by the defense, possibly as a result of several factors. One of the authors (S.E.) has academic expertise in the area of abnormal illness behavior, particularly factitious disorders. As a consequence, defense attorneys who had begun to raise a question of amplified physical symptoms being present in plaintiffs would often discuss such cases with the author. It is uncommon, although not unknown, as Case C (described later) indicates, for a plaintiff's attorney to question the origin of the clients' physical symptoms by requesting a psychiatric consultation. In the circumstance in which an attorney knows that his or her client has a factitious disorder, the diagnosis is rarely the focus of the case. For example, when an attorney had a plaintiff whose spouse had died of a factitiously induced bacterial infection, the medical malpractice case of the surviving spouse focused on

the incorrect treatment given and avoided discussing the cause of the infection. In fact, that attorney used the author (S.E.) only for consultation and did not designate him as an expert for the discovery process. Thus, because of these selection factors, most of the cases described in this article were derived from defense attorney referrals.

Method of Record Review

For this study, the authors reviewed the case records of the 20 individuals in which a diagnosis of factitious disorder had been made. The study was approved by the Committee on Human Research at the University of California, San Francisco. Because the study was based on retrospective chart review, no patient consent was required. The data source included reports, medical records, and outcomes as available for each case. We conducted a structured review that included both demographic information and the presence or absence of psychological factors that have been described in the literature as being associated with abnormal illness-affirming behavior.⁹ The case review included the following variables:

- I. Factitious disorder diagnosis. To be included in the study, the plaintiff had to have a diagnosis of factitious disorder with predominantly physical signs and symptoms, based on the DSM-IV criteria.⁷
 - A. The person intentionally produces or feigns physical signs or symptoms.
 - B. The motivation for the behavior is to assume the role of a sick person.
 - C. External incentives for the behavior are absent.
- II. Data that are supportive of a diagnosis of factitious disorder.
 - A. Indicators of factitious origin of symptoms: because the DSM-IV criteria rely on judgment and inference, in accordance with these criteria, indicators of a factitious etiology that are commonly found in the medical literature were recorded.^{3,5,10,11} The following indicators of factitious etiology were used in the case review to establish a diagnosis of factitious disorder.
 1. Direct observation: a record existed of personal observation of the patient's factitiously producing illness.

2. Nonphysiologic physical signs: the patient reported physical signs or symptoms that contradicted typical pathological findings or were nonphysiologic (e.g., elevated temperature reading without increased pulse) and that appeared to require conscious production.
 3. Physical evidence: physical evidence of a factitious cause of symptoms (e.g., a syringe or surreptitious medication) was discovered during the course of medical treatment.
 4. Atypical course of illness: the course of illness did not follow the natural history of the presumed biomedical disease process on a repeated basis.
- B. Associated features: in addition, we reviewed the cases for the following features, which are associated with factitious disorders^{11–15} although not diagnostic of them
1. Patient predicts worsening: the individual made accurate and repeated predictions of worsening of his or her condition.
 2. Invites invasive procedures: the individual requested invasive medical procedures such as surgery.
 3. Previous diagnosis of factitious disorder: history includes prior diagnosis by a clinician of factitious disorder.
 4. Numerous prior poor outcomes: the patient had had an extraordinary number (more than five) of poor outcomes or failure to respond to medical procedures.
 5. Worked in a health-related occupation: the individual worked or had worked in a health-related field.
- III. Other factors associated with abnormal illness-affirming behavior: these factors have been described in the medical-psychiatric literature as commonly occurring in individuals who show this behavior^{16–24}
- A. Symptom model: the individual's history included a close friend or relative who had previously had similar symptoms; psychological symptoms often are based on such a prototype.
 - B. Recent loss: the individual reported an event involving significant psychological loss and associated it with the onset of illness.
 - C. Multiple somatic complaints: the patient had a history of reporting multiple somatic symptoms that appeared to be unexplained or were out of proportion to any biomedical disease that may have been present.
 - D. History of childhood loss: the patient had a history of significant childhood loss (e.g., death of a parent); such events have been associated with later somatic complaints.
 - E. Psychiatric illness: the patient had a history of a psychiatric disorder. There is often comorbidity between somatic symptoms and a psychiatric disorder.
 - F. History of secondary gain: the patient had received "rewards" for illness (secondary gain), such as disability income, a successful litigation that produced a financial award, or relief from a noxious situation. "History" meant that physical symptoms had yielded a secondary gain in a situation that had occurred before the litigation that brought the individual to the attention of the authors.
 - G. History of childhood illness: the patient had had a childhood illness that required hospitalization or surgery, a factor that has been associated with later somatic symptoms.

Overview of Data Analysis

Descriptive statistics were derived to characterize the factitious disorder group. After presentation of these quantitative data, several case examples involving patients with factitious disorders will be presented to illustrate the manifestations of the syndrome.

Results

Quantitative Data

The plaintiffs with factitious disorder had a mean (\pm SD) age of 43 ± 8.6 years. Ninety-five percent ($n = 19$) were women, 45 percent ($n = 9$) were married, 40 percent ($n = 8$) were divorced, and 15 percent ($n = 3$) were single. All were white.

Figure 1 shows clinical findings that support the diagnosis of factitious disorders in the plaintiffs. All of the plaintiffs had histories of physical signs and symptoms that did not correspond to their presumed biomedical syndromes, and almost all of them had a course of illness that was not characteristic of their presumed biomedical syndromes. Similarly, most of

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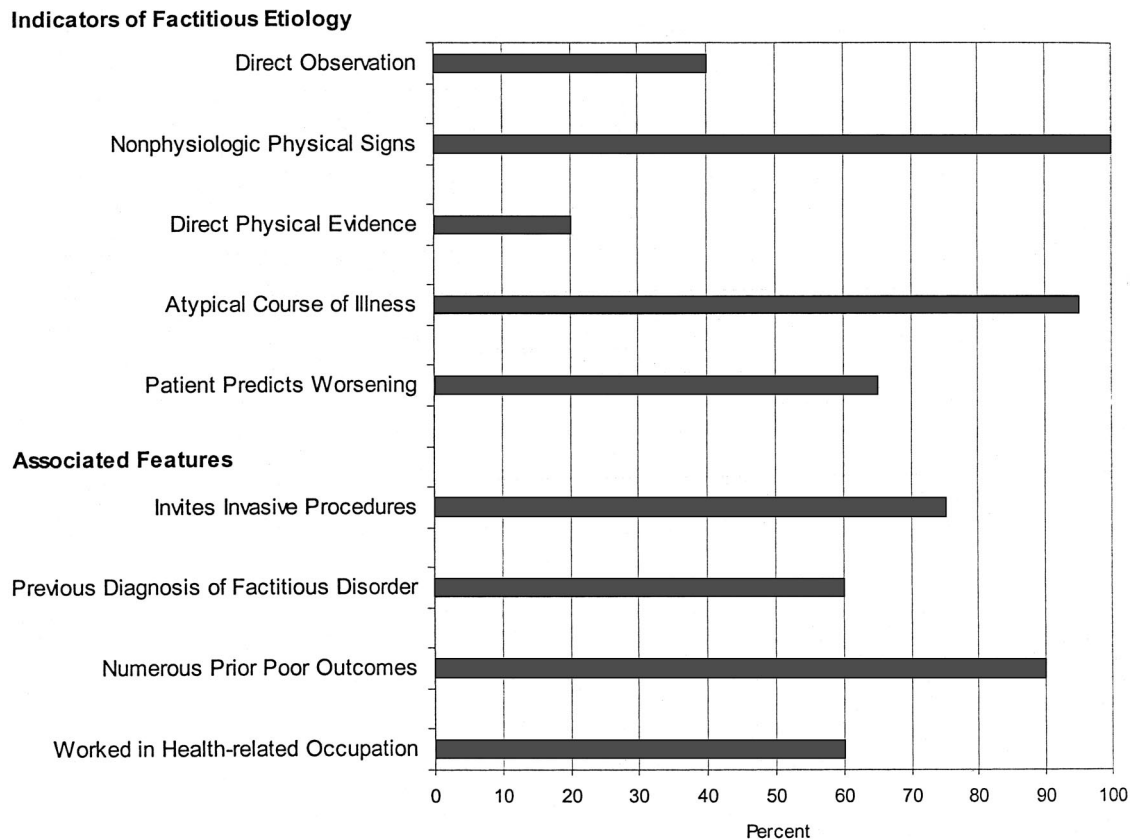


Figure 1. Findings supporting diagnoses of factitious disorders in 20 plaintiffs.

the plaintiffs displayed features widely accepted to be associated with factitious disorders, such as having invited multiple invasive medical procedures that had equivocal clinical justification and having had numerous prior poor outcomes of medical procedures.

Figure 2 shows that most of the plaintiffs had other characteristics that are suggested in the medical-psychiatric literature to be correlated with factitious disorders. For example, most had a chronic history of multiple somatic symptoms that antedated the injury that formed the basis of their current litigation and also had a history of having received financial compensation for physical complaints before the current lawsuit. The majority (60%) of the patients with factitious disorder had experienced a significant childhood illness.

Qualitative Data

The following case examples illustrate how these factors can become manifest in individuals with factitious disorder who initiate civil litigation alleging that others have caused their symptoms.

Case A

This case highlights a patient with long-standing somatic symptoms who used the symptoms to support litigation. Ms. A was a 29-year-old woman who was suing the maker of silicone breast implants, claiming that they had produced a variety of medical symptoms, including skin lesions, multiple pains, fatigue, dizziness, and poor concentration. She had received the implants at age 25 and had had them removed at age 28. She began litigation after viewing a television show describing side effects of silicone breast implants that featured an attorney whom she then contacted. She had multiple physical examinations and a neuropsychological report submitted by her attorney. These documented multiple subjective symptoms with few actual signs of disease. The neuropsychological testing report indicated that she was estimated to have lost “30 points on her IQ” due to the implants and that her full-scale IQ was now 102.

The attorney for the defense requested a psychiatric examination. The psychiatric consultant learned

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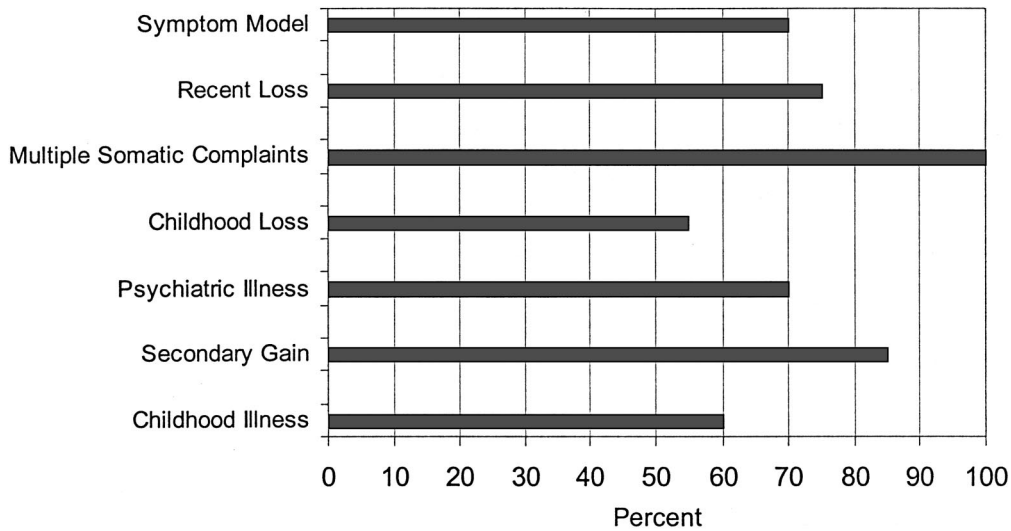


Figure 2. Rates of occurrence of factors associated with abnormal illness-affirming behavior in 20 plaintiffs.

that she had a long-standing history of somatic symptoms. At age 20, she had begun treatment with a family practitioner who used the Cornell Medical Index²⁵ as an initial visit screening device. On that index, she scored at the 99th percentile for frequency of somatic symptoms. She also had undergone IQ testing while in high school, with results showing a full-scale IQ of 94. The psychiatrist examined her and she again scored at the 99th percentile on the Cornell Medical Index. The psychiatrist noted the presence of numerous excoriations that had been diagnosed by a dermatologist as being due to skin-picking. The dermatology records indicated that these lesions had been present before the silicone implants and that the patient had sought help for this behavior on several occasions (implying conscious awareness). She had never admitted, however, that she had produced the lesions. Her history indicated childhood and spousal abuse, multiple somatic symptoms, frequent surgical procedures, and severe marital discord. She and her husband were planning to divorce as soon as her litigation was finished. A settlement, including a financial award, was reached shortly before the trial was to begin.

Case B

This case illustrates how an individual with multiple somatic symptoms can first apply for workers' compensation and then seek additional compensation in civil litigation. Ms. B was a 40-year-old

woman employed as a nursing assistant in a rehabilitation facility. She was struck by a slow-moving truck while walking from one building to another at work. She sustained a back sprain and pain in one leg. One month later, her primary care physician referred her to an anesthesia pain specialist after she told him that she thought she had developed reflex sympathetic dystrophy (RSD) in the leg, similar to that which she had experienced in an arm several years earlier. The specialist completed multiple sympathetic blockades with decreasing effectiveness. Her apparent RSD spread to all four limbs. The pain specialist eventually implanted two spinal cord stimulators at the cervical and lumbar levels with very modest results. She was totally disabled, according to the pain specialist, and she received a workers' compensation settlement. She then sued the truck owner in civil court.

The defense requested a psychiatric examination. A detailed review of her records revealed that she had had 25 instances of somatic symptoms since her teenage years. These included temporomandibular joint pain, blackouts, chronic fatigue, headaches, backaches, and pelvic pain, among others. She had insisted on and had received a hysterectomy for pelvic pain at age 22, without having had any children. There was documentation of her recounting grossly conflicting histories to various doctors, even on the same day. For example, she told one physician she had received a diagnosis of optic neuritis a few hours after being told by a neuro-ophthalmologist that she

was free of any disease. Her providing such misleading information appeared to require conscious intent. She had been fired from one job for stealing and from another for episodes of lying. She had reportedly had an episode of RSD in an arm after an intravenous line infiltrated the surrounding tissue after one of her numerous surgeries. The RSD did not respond to multiple nerve blocks, and eventually she underwent a surgical sympathectomy. She also pursued malpractice litigation due to the infiltration and received a monetary settlement. An MMPI-2 suggested the likelihood that she was exaggerating and elaborating her symptoms. The psychiatrist suggested that she had a spectrum of somatoform conditions, including somatization disorder, factitious disorder, and a possibility of malingering, given the presence of litigation. A settlement was reached prior to trial.

Case C

This case highlights how the presence of a factitious disorder may influence a plaintiff's attorney's decision making. Ms. C was a 42-year-old former medical office assistant. She was pursuing a claim for damages secondary to bilateral silicone breast implants. Her primary complaint was of breast pain. She had received the implants after numerous episodes of subcutaneous breast cellulitis but had never had a diagnosis of cancer. The episodes had been unexplained and were associated with polymicrobial organisms, including *Acinetobacter*, *Xanthomonas*, and *Flavomonas*. After receiving the breast implants, she had gone to her surgeon's office with unexplained superficial scabs on her breasts. She had entered into litigation claiming that the silicone breast implants were the source of her symptoms, even though the implants had been removed two years earlier.

The plaintiff's attorney asked for a psychiatric consultation because some of her doctors had raised a suspicion of Munchausen syndrome and the attorney was unfamiliar with that diagnosis. The psychiatric consultant learned that the plaintiff had a longstanding history of somatic complaints. For example, after one of her children was born, she had an episode of neurologically unexplained paraplegia for several months. Later she had generalized seizures that could be interrupted by speaking to her. These were diagnosed as nonepileptic in origin. She also had a history of abdominal pain, dyspareunia, joint pain, fatigue, and skin excoriations. She had undergone multiple

surgeries, including a hysterectomy, cholecystectomy, lumbar fusion, and exploratory laparotomy, in addition to the breast surgery. She had received multiple courses of antibiotics delivered by indwelling intravenous Groshong catheter, until the catheter became repeatedly infected with unusual organisms. Several physicians had raised the question of her having produced some of her illnesses by self-injection with bacteria.

The psychiatric consultant discussed with the plaintiff's attorney the likelihood that the patient had a factitious disorder. The attorney did not name the consultant in the discovery process and decided to settle the case immediately for an award that was much lower than he had originally sought.

Discussion

Conversion disorder, pain disorder associated with psychological factors (formerly called Somatoform Pain in DSM III-R), hypochondriasis, somatization disorder, factitious disorder, and malingering all represent abnormal illness-affirming behavior. In the first four conditions, the production of signs and symptoms and the motivation for the behavior are unconscious. Because the production of symptoms is unconscious, the motivations for the behavior must be similarly outside the individual's awareness. An example of this is found in an individual who has a conversion disorder with an apparent limb paralysis. For example, a man who is angry and wants to strike a family member while experiencing conflicting feelings about taking such an action, may experience arm paralysis that replaces the psychological problem with an ostensibly somatic one.

Other unconsciously produced symptom disorders include somatization disorder, pain disorder associated with psychological factors, and hypochondriasis. In somatization disorder, the individual has multiple symptoms that appear in various body systems over many years. Pain disorder associated with psychological factors features pain symptoms out of proportion to any biomedical disease present. Individuals with hypochondriacal disorder typically have a firm belief that they have a single illness, despite clinical testing that fails to provide any verification of it.

In malingering and factitious disorder, the behavior is consciously produced, although only in malingering is the individual fully aware of the motivations for the behavior. This study describes features of a

DIAGNOSIS	MOTIVATION	SYMPTOM PRODUCTION
MALINGERING	CONSCIOUS	CONSCIOUS
↕	↕	↕
FACTITIOUS DISORDER	UNCONSCIOUS	CONSCIOUS
↕	↕	↕
CONVERSION DISORDER	UNCONSCIOUS	UNCONSCIOUS
PAIN WITH PSYCHOLOGICAL FACTORS		
SOMATIZATION DISORDER		
HYPOCHONDRIASIS		

Figure 3. Spectrum of abnormal illness-affirming behavior.

series of cases in which patients who had a history of factitious disorder became plaintiffs in litigation seeking compensation for their alleged injuries, which raised the question of a possible shift to malingering.

Our case series had several features in common with the literature regarding somatization disorder. Most (95%) of our patients with factitious disorder were women, and in the literature on somatization disorder, women far outnumber men.²⁶ There is some theoretical basis for considering that somatization may have genetic determinants that are more likely to occur in women.^{26,27} Some have speculated that women may be more socialized to express psychological distress with somatic symptoms, whereas men may have more of a tendency to abuse substances or resort to sociopathic behavior.^{26,28} For example, most patients with the less severe forms of factitious disorder are women, whereas the more severe sociopathic behavior seen in Munchausen syndrome has a higher incidence in men. Eighty percent of our patients with factitious disorder were in the fourth or fifth decade of life. They had a long history of using somatic complaints as a way of getting their emotional needs met, typically with little biomedical disease to support the symptoms. In many of the cases, before the litigation that brought them to our attention, these individuals would most likely have had diagnoses of somatization disorder, pain disorder

associated with psychological factors, or factitious disorder.

This point is illustrated in Figure 3. The actions of most of the individuals shift over time through a spectrum of abnormal illness-affirming behavior and cannot be categorized in only one classification, except in a cross-sectional view obtained at a single time point. For example, Case A illustrates an individual who would meet the criteria for somatization disorder, with many unsubstantiated multisystem symptoms documented by the Cornell Medical Index at two different time points. The excoriations, which clearly required conscious activity, strongly suggest the presence of an element of factitious disorder. Later, her initiation of litigation for a variety of complaints that had been present for years raised the possibility of malingering, with an attempt to attribute her problems to a reimbursable cause. Case B represents another individual with a shifting spectrum of abnormal illness-affirming behavior, from somatization disorder, to factitious disorder, to malingering.

The initiation of litigation appears to shift a patient's behavior to malingering. In our series, the shift was often associated with events that presented opportunities to obtain compensation for physical symptoms. Not only does DSM-IV note that litigation should raise the possibility of malingering when symptoms are being created, but in addition, the litigation can serve as a way for the individuals to

organize their psychological lives. For example, a woman may face criticism from family, friends, or coworkers for her multiple somatic complaints and disability until she decides to pursue litigation and can then deflect any blame. Kellner *et al.*²⁹ have even described hypochondriasis as serving as a coping mechanism and rationale for individuals who believe they have failed to meet their goals in life. In this respect, complaints focus on the body and its dysfunction as if they represent an internal enemy. With the introduction of litigation, there is a shift to an identified external enemy to combat. As an example, the presence of Internet chat sites devoted to a multitude of somatic problems gives an individual the opportunity to join a community and gain a sense of unity in their battle against the enemy. Several of our patients were quite active in Internet- and/or community-based illness support groups. In some instances, these groups referred members to specific attorneys specializing in litigation related to the members' disorders.

The possibility of receiving a monetary award for prevailing against the external enemy serves two functions: it is a directly positive reinforcement for the illness behavior and it validates the individuals' explanation for difficulties in life. Thus, even in malingering, there may be multiple shifting motivations, both conscious and unconscious, that compel an individual to prove he or she has been wronged by some external cause that can become the target of litigation.

In summary, our findings suggest that a thorough analysis of cases involving complaints of physical symptoms can benefit from consideration of the possibility of abnormal illness-affirming behavior in the person's history. When such a picture is present, there are several important implications. First, the appropriate attribution of causation can be clarified. In addition, clinical interventions may be initiated and designed to address the abnormal illness-affirming behavior. These have been described in detail elsewhere.²⁹ Unfortunately, these interventions may meet with limited success until the civil litigation has been concluded and the question of obtaining the external validation of a monetary award has been resolved. It is hard for a patient to get well if there is a strong need to prove illness. This point, however, is by no means simple, because many patients continue to have symptoms well after litigation has con-

cluded.^{31,32} For example, the individual may feel compelled to continue the created role, lest he or she be branded overtly as a malingerer.³³ Other psychological factors may also perpetuate physical symptoms. In some of our cases in which follow-up data were available, even when the individual had received substantial awards (in one case more than \$3 million), the disability persisted essentially unabated. This highlights the powerful psychological gains that may derive from factitious symptomatology and the role of the patient.

Because of the challenges of evaluating these individuals, we recommend obtaining extensive information from collateral sources whenever possible. Medical and psychiatric records that antedate the injury in question are often critical to understanding the somatization-factitious-malingering spectrum. It is often helpful to organize illnesses on a timeline to understand the sequence of creation of a disease. Psychological testing can also provide useful information. For example, a number of psychological tests, such as the MMPI-2,³⁴ include validity scales that assess a respondent's propensity to exaggerate or minimize problems.

This case series is a preliminary study that has limitations: the sample was small, the cases were mostly referred by defense attorneys, and it was a retrospective review. Nevertheless, we have illustrated a phenomenon that may be useful to forensic practitioners in broadening the differential diagnostic possibilities for some plaintiffs who seek compensation for complex physical complaints. Future research could investigate the extent to which the psychological factors we have described in this study differentiate between groups of litigating and non-litigating patients.

References

1. Powell R, Boast N: The million dollar man: resource implications for chronic Munchausen's syndrome. *Br J Psychiatry* 162:253-6, 1993
2. Pilowsky I: A general classification of abnormal illness behaviors. *Br J Med Psychol* 51:131-7, 1978
3. Eisendrath SJ: Factitious illness: a clarification. *Psychosomatics* 25:110-17, 1984
4. Asher R: Munchausen's syndrome. *Lancet* 1:339-41, 1951
5. Kapfhammer HP, Rothenhausler HB, Dietrich E, *et al*: Artificial disorders—between deception and self-mutilation: experiences in consultation psychiatry at a university clinic [in German]. *Nervenzart* 69:401-9, 1998
6. Goldstein AB: Identification and classification of factitious disorders: an analysis of cases reported during a ten year period. *Int J Psychiatry Med* 28:221-41, 1998
7. American Psychiatric Association: Diagnostic and Statistical

- Manual of Mental Disorders (ed 4). Washington, DC: American Psychiatric Press, 1994
8. Kalivas J: Malingering versus factitious disorder. *Am J Psychiatry* 153:1108, 1996
 9. Eisendrath SJ, Way LW, Ostroff JW, Johanson C: Identification of psychogenic abdominal pain. *Psychosomatics* 27:705–10, 1986
 10. Overholser JC: Differential diagnosis of malingering and factitious disorder with physical symptoms. *Behav Sci Law* 8:55–60, 1990
 11. Ford CV: The Munchausen syndrome: a report of four new cases and a review of psychodynamic considerations. *Int J Psychiatry Med* 4:31–45, 1973
 12. Folks DG, Houck CA: Somatoform disorders, factitious disorders, and malingering, in *Psychiatric Care of the Medical Patient*. Edited by Stoudemire A, Fogel B. New York: Oxford University Press, 1993, pp 267–87
 13. Eisendrath SJ: When Munchausen becomes malingering: factitious disorders that penetrate the legal system. *Bull Am Acad Psychiatry Law* 23:471–81, 1996
 14. Folks DG, Freeman AM: Munchausen syndrome and other factitious illness. *Psychiatr Clin North Am* 8:263–78, 1985
 15. Ford CV, Feldman MD: Factitious disorders and malingering, in *The American Psychiatric Press Textbook of Consultation-Liaison Psychiatry*. Edited by Wise MG, Rundell JR. Washington, DC: American Psychiatric Press, 1996, pp 533–40
 16. Raskin M, Talbott JA, Myerson AT: Diagnosis of conversion disorders. *JAMA* 197:102–6, 1966
 17. Lazare A: Current concepts in psychiatry: conversion symptoms. *N Engl J Med* 305:745–8, 1981
 18. Hatfield PD, Guze SB: Prognosis and differential diagnosis of conversion reactions. *Dis Nerv Syst* 23:623–31, 1962
 19. Merskey H: The characteristics of persistent pain in psychological illness. *J Psychosom Res* 9:291–3, 1965
 20. Hackett TP: The pain patient: evaluation and treatment, in *Massachusetts General Hospital Handbook of General Hospital Psychiatry*. Edited by Hackett TP, Cassem NH. St. Louis: CV Mosby, 1978, pp. 103–9
 21. Devaul RA, Faillace LA: Persistent pain and illness insistence. *Am J Surg* 135:828–33, 1978
 22. Watson CG, Tilleskor C: Interrelationships of conversion, psychogenic pain and dissociative disorder symptoms. *J Consult Clin Psychol* 51:788–9, 1983
 23. Engel GL: Psychogenic pain and the pain-prone patient. *Am J Med* 26:899–918, 1959
 24. Eisendrath SJ: Psychiatric aspects of chronic pain. *Neurology* 45(Suppl 9):S26–S34, 1995
 25. Brodman K, Erdmann AJ, Lorge I, *et al*: The Cornell Medical Index. *JAMA* 140:530–4, 1949
 26. Gillespie NA, Zhu G, Hickie IB, *et al*: The genetic aetiology of somatic distress. *Psychol Med* 30:1051–61, 2000
 27. Kellner R: Somatization: theories and research. *J Nerv Ment Dis* 178:150–60, 1990
 28. Kellner R: Psychosomatic syndromes, somatization, and somatoform disorders, in *Handbook of Psychosomatic Medicine*. Edited by Fava GA, Freyberger H. Madison, CT: International Universities Press, Inc., 1998, pp 125–60
 29. Kellner R, Hernandez J, Pathak D: Hypochondriacal fears and beliefs, anxiety, and somatisation. *Br J Psychiatry* 160:525–32, 1992
 30. Eisendrath SJ: Factitious physical disorders: treatment without confrontation. *Psychosomatics* 30:383–7, 1989
 31. Ogloff JRP: The admissibility of expert testimony regarding malingering and deception. *Behav Sci Law* 8:27–43, 1990
 32. Binder RL, Trimble MR, McNeil DE: The course of psychological symptoms after resolution of lawsuits. *Am J Psychiatry* 148:1073–5, 1991
 33. Binder RL, Trimble MR, McNeil DE: Is money a cure?—Follow-up of litigants in England. *Bull Am Acad Psychiatry Law* 19:151–60, 1991
 34. Butcher JN, Dahlstrom WG, Graham JR, *et al*: *MMPI-2: Manual for Administration and Scoring*. Minneapolis, MN: University of Minnesota Press, 1989