Staying on Track: Differentiating Between Genuine and False PTSD Claims in Railroad Litigation

NARTC Meeting

July 25, 2016
9:00 a.m.

www.fpamed.com/stayingontrack/

The Westin St. Francis Hotel
San Francisco, CA

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Staying On Track

Staying on Track:

Differentiating Between Genuine and False PTSD Claims in Railroad Litigation – Including Both Individual and Mass Torts

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Staying On Track – Key Issues

- **PTSD: What It Is…and What It Is Not**
- **New DSM-5 criteria for PTSD**
- **How forensic psychiatrists and psychologists evaluate emotional distress claims**
- **Assessment Issues unique to mass torts**
- **Key differences between independent forensic psychiatric and psychological experts and treating psychiatrists and psychologists**
- **Psychological testing**

- **Q&A**

Staying On Track – Audience Questions

How do you differentiate between a diagnosis of PTSD and depression? Are the treatments relatively the same?

Staying On Track – Audience Questions

Do you find that hypnotherapy can be useful in the treatment of PTSD?

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Staying On Track – Audience Questions

Does PTSD manifest itself only when the individual is placed in similar circumstances to the triggering event (e.g., sexual assault victim in an intimate setting, soldier around loud war-like noises), or does it increase the individuals' fight or flight response/anxiety levels in any type of somewhat stressful situation (minor traffic accident, big presentation at work, etc.)?

Staying On Track – Audience Questions

Can PTSD remain latent and then manifest weeks, months, or years later?

Staying On Track – Audience Questions

How can you identify the cause(s)of PTSD, particularly if the patient has experienced multiple traumatic events during his or her lifetime?

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Staying On Track – Audience Questions

Can testing and diagnosis of PTSD be impacted by having a person's treating provider vs. an independent forensic psychiatrist or other neutral evaluator conduct the testing and diagnose? If so, how and discuss potential issues associated with having a treating provider test/diagnose PTSD.

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Staying On Track – Audience Questions

How do you differentiate between a diagnosis of anxiety and PTSD? How are the treatments similar or different?

Staying On Track – Audience Questions

What are some of the factors that correlate to the severity of symptoms experienced by a victim of a traumatic event?

How is it that two people could go through the same event and have dramatically different symptoms?

Staying On Track – Audience Questions

What environmental factors (i.e stable employment, family life, supportive friends, etc.) impact the efficacy of treatments for PTSD symptoms?

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PTSD What It Is, and What It Is Not

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Stress: What Is It?

Engineering:

Stress = A Force Which Deforms Physical Bodies

Biology & Medicine:

Stress = A Process Within the Human Body

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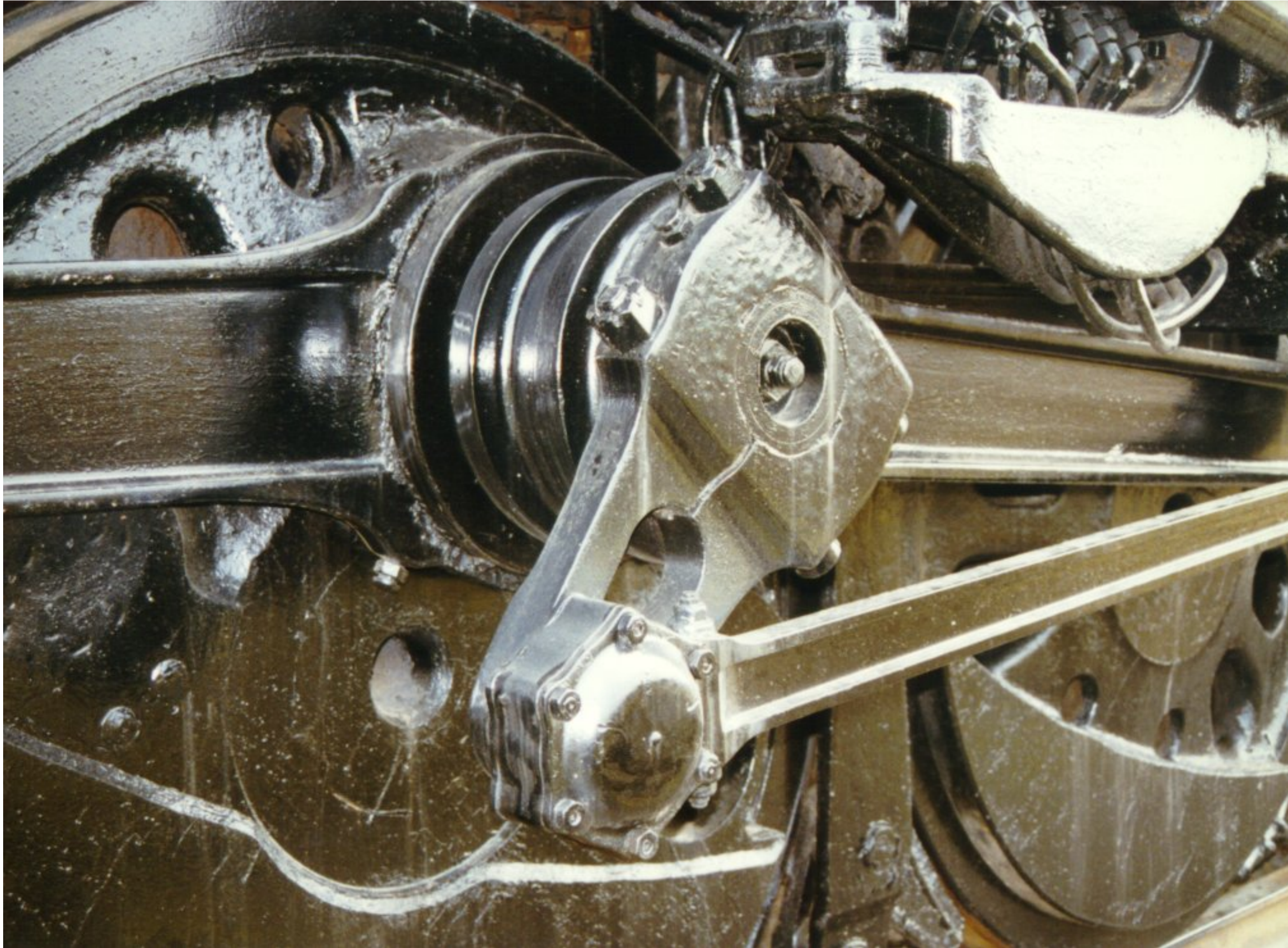
Stress: Mechanical



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Stress: Structural

Stress & Structural Failure

1940 Tacoma Narrows Bridge:

Slender, elegant and graceful, the Tacoma Narrows Bridge stretched like a steel ribbon across Puget Sound in 1940. The third longest suspension span in the world opened on July 1st. Only four months later, the great span's short life ended in disaster. "Galloping Gertie," collapsed in a windstorm on November 7,1940.

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Mechanical Stress Causes Structural Failure

GALE CAUSES
BRIDGE
TO SWAY

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PTSD: Overwhelming Emotional Stress Causes Mental Collapse….

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PTSD: Overwhelming Emotional Stress Causes Mental Collapse...

DON MCCULLIN/HAMILTONS GALLERY

Shell Shocked US Soldier, 1968, Battle of Hue, Viet Nam War

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PTSD: "A rose called by any other name...."

- **"PTSD**" – label first used in Viet Nam War
- **"War Neurosis"** – WWII
- **"Shell Shock"** – WWI
- **"Railway Spine"** – 19th Century

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“Railway Spine”

Montparnasse Derailment

1895 train wreck at Gare Montparnasse, Paris, France.

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"Railway Spine"

"Railway spine" was a nineteenth-century diagnosis for the post-traumatic symptoms of passengers involved in railroad accidents.

John Eric Erichsen's classic book, ***On Railway and Other Injuries of the Nervous System*** was he first full length medical study of the condition "railway spine" - often known as "Erichsen's disease".

Railway collisions were a frequent occurrence in the early 19th century. Exacerbating the problem was the fact that railway cars were flimsy, wooden structures with no protection for the occupants.

Soon a group of people started coming forward who claimed that they had been injured in train crashes, but had no obvious evidence of injury. The railroads rejected these claims as fake.

The nature of symptoms caused by "railway spine" was hotly debated in the late 19th century, notably at the meetings of the (Austrian) Imperial Society of Physicians in Vienna, 1886. Germany's leading neurologist, **Hermann Oppenheim**, claimed that **all railway spine symptoms were due to physical damage to the spine or brain**

French and British scholars, notably Jean-Martin Charcot and Herbert Page, insisted that some symptoms could be caused by hysteria (now known as conversion disorder).

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What Is Not PTSD

The probability of an event causing PTSD in a particular individual, is only *partially* related to the *severity* of the stressor.

i.e.,

Not Every Big, Bad Traumatic Event Causes PTSD….

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What Is Not PTSD

Actual Examples of Bad experiences that did NOT cause PTSD:

- **A secretary, after a board meeting, ate left-over pastry *contaminated with rat feces…a* truly disgusting experience, but it DID NOT CAUSE PTSD.**
- **A supervisor's unwelcome sexually explicit remarks and propositions to a supervisor were offensive & unwelcome, but they DID NOT CAUSE PTSD.**
- **In fact, a majority of people who experience a traumatic and stressful event DO NOT DEVELOP PTSD!**
- **According to multiple research studies, as many as 40% - 50% of women who are violently raped DO NOT DEVELOP PTSD.**
- **WHY?**

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WHY?

Resiliency

vs.

Vulnerability

(not an appellate case!)

Resiliency!

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PTSD Vulnerability Factors

PTSD Risk Factors:*

- prior trauma
- prior psychiatric history
- family psychiatric history
- peritraumatic dissociation
- acute stress symptoms
- the nature of the biological response
- autonomic hyperarousal

*****Mcfarlane, A., “Posttraumatic stress disorder: A model of longitudinal course and the roles of risk factors,” *J. Clin. Psychiatry,* 61, Suppl. 5:15-20, Jan 2000.

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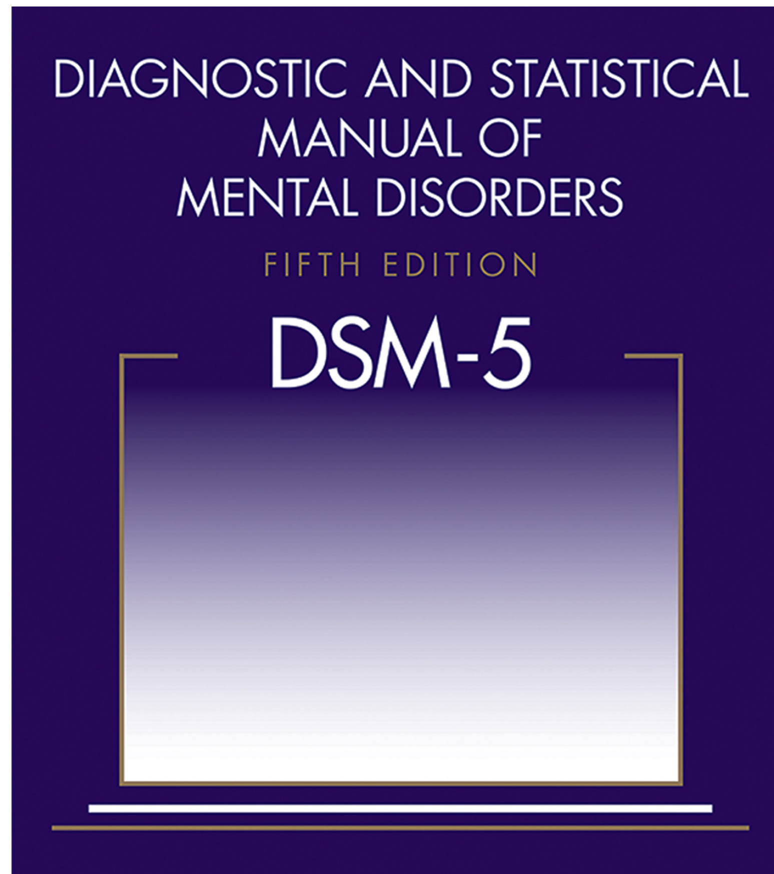
PTSD: *DSM-5* Diagnostic Criteria



Summary of *DSM-5* PTSD Diagnostic Criteria

A. Exposure to actual or threatened death, serious injury, or sexual violence.

B. Presence of one (or more) intrusion symptoms associated with the traumatic event(s).

C. Persistent avoidance of stimuli associated with the traumatic event(s), beginning after the traumatic event(s) occurred.

D. Negative alterations in cognitions and mood associated with the traumatic event(s), beginning or worsening after the traumatic event(s).

E. Marked alterations in arousal and reactivity associated with the traumatic event(s).

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Summary of *DSM-5* PTSD Diagnostic Criteria

F. Duration of the disturbance (Criteria B, C, D, and E) is more than 1 month.

G. Functional Impairment: The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

H. The disturbance is not attributable to the physiological effects of a substance (e.g., medication, alcohol) or another medical condition

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PTSD Co-Morbidities

In the majority of cases, PTSD is accompanied by another condition:

- **Major Depression and/or**
- **An Anxiety Disorder and/or**
- **Substance Abuse.**

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Changed PTSD Criteria: Differences Between *DSM-IV(TR)* & *DSM-5*

- ***DSM-5*** criteria for **PTSD** differ significantly from the *DSM-IV (TR)* criteria, e.g.:
  - The **stressor criterion (Criterion A) is more explicit** with regard to events that qualify as "traumatic" experiences.
    - **"Exposure to actual or threatened death, serious injury, or sexual violence."**
  - Also, *DSM-IV(TR)* Criterion A2 **(subjective reaction) has been eliminated.**

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Changed PTSD Criteria: Differences Between *DSM-IV(TR)* & *DSM-5*

- Whereas **there were three major symptom clusters in *DSM-IV(TR)*—reexperiencing, avoidance/numbing, and arousal**—there are now **four symptom clusters in *DSM-5*,** because the **avoidance/numbing cluster is divided into two distinct clusters:**
  - **avoidance** and
  - **persistent negative alterations in cognitions and mood**. This latter category, which retains most of the *DSM-IV* numbing symptoms, also includes new or reconceptualized symptoms, such as **persistent negative emotional states.**

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Changed PTSD Criteria: Differences Between *DSM-IV(TR)* & *DSM-5*

- **The final cluster—alterations in arousal and reactivity—retains most of the DSM-IV arousal symptoms**. It also includes irritable behavior or angry outbursts and reckless or self-destructive behavior.

- **PTSD is now developmentally sensitive in that diagnostic thresholds have been lowered for children and adolescents.**

- Furthermore, separate criteria have been added for children age 6 years or younger with this disorder.

What PTSD Is: Full *DSM-5* Diagnostic Criteria

Diagnostic Criteria

309.81 (F43.10)

Posttraumatic Stress Disorder

A. Exposure to actual or threatened death, serious injury, or sexual violence in one (or more) of the following ways:

1 Directly experiencing the traumatic event(s).

2 Witnessing, in person, the event(s) as it occurred to others.

3 Learning that the traumatic event(s) occurred to a close family member or close friend. In cases of actual or threatened death of a family member or friend, the event(s) must have been violent or accidental.

4 Experiencing repeated or extreme exposure to aversive details of the traumatic event(s) (e.g., first responders collecting human remains; police officers repeatedly exposed to details of child abuse).

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What PTSD Is: Full *DSM-5* Diagnostic Criteria

B. Presence of one (or more) of the following intrusion symptoms associated with the traumatic event(s), beginning after the traumatic event(s) occurred:

1. Recurrent, involuntary, and intrusive distressing memories of the traumatic event(s).
2. Recurrent distressing dreams in which the content and/or affect of the dream are related to the traumatic event(s).
3. Dissociative reactions (e.g., flashbacks) in which the individual feels or acts as if the traumatic event(s) were recurring. (Such reactions may occur on a continuum, with the most extreme expression being a complete loss of awareness of present surroundings.)

What PTSD Is: Full *DSM-5* Diagnostic Criteria

4 Intense or prolonged psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event(s).

5 Marked physiological reactions to internal or external cues that symbolize or resemble an aspect of the traumatic event(s).

What PTSD Is: Full *DSM-5* Diagnostic Criteria

C. Persistent avoidance of stimuli associated with the traumatic event(s), beginning after the traumatic event(s) occurred, as evidenced by one or both of the following:

1 Avoidance of or efforts to avoid distressing memories, thoughts, or feelings about or closely associated with the traumatic event(s).

2 Avoidance of or efforts to avoid external reminders (people, places, conversations, activities, objects, situations) that arouse distressing memories, thoughts, or feelings about or closely associated with the traumatic event(s).

What PTSD Is: Full *DSM-5* Diagnostic Criteria

D. Negative alterations in cognitions and mood associated with the traumatic event(s), beginning or worsening after the traumatic event(s) occurred, as evidenced by two (or more) of the following:

1 Inability to remember an important aspect of the traumatic event(s) (typically due to dissociative amnesia and not to other factors such as head injury, alcohol, or drugs).

2 Persistent and exaggerated negative beliefs or expectations about oneself, others, or the world (e.g., “I am bad,” “No one can be trusted,” “The world is completely dangerous,” “My whole nervous system is permanently ruined”).

3 Persistent, distorted cognitions about the cause or consequences of the traumatic event(s) that lead the individual to blame himself/herself or others.

What PTSD Is: Full *DSM-5* Diagnostic Criteria

4 Persistent negative emotional state (e.g., fear, horror, anger, guilt, or shame).

5 Markedly diminished interest or participation in significant activities.

6 Feelings of detachment or estrangement from others.

7 Persistent inability to experience positive emotions (e.g., inability to experience happiness, satisfaction, or loving feelings).

What PTSD Is: Full *DSM-5* Diagnostic Criteria

E. Marked alterations in arousal and reactivity associated with the traumatic event(s), beginning or worsening after the traumatic event(s) occurred, as evidenced by two (or more) of the following:

1 Irritable behavior and angry outbursts (with little or no provocation) typically expressed as verbal or physical aggression toward people or objects.

2 Reckless or self-destructive behavior.

3 Hypervigilance.

4 Exaggerated startle response.

5 Problems with concentration.

6 Sleep disturbance (e.g., difficulty falling or staying asleep or restless sleep).

What PTSD Is: Full *DSM-5* Diagnostic Criteria

F. Duration of the disturbance (Criteria B, C, D, and E) is more than 1 month.

G. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

H. The disturbance is not attributable to the physiological effects of a substance (e.g., medication, alcohol) or another medical condition

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What PTSD Is: Full *DSM-5* Diagnostic Criteria

Specify whether:

With dissociative symptoms:

1 **Depersonalization:** Persistent or recurrent experiences of feeling detached from, and as if one were an outside observer of, one's mental processes or body (e.g., feeling as though one were in a dream; feeling a sense of unreality of self or body or of time moving slowly).

2 **Derealization:** Persistent or recurrent experiences of unreality of surroundings (e.g., the world around the individual is experienced as unreal, dreamlike, distant, or distorted).

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What PTSD Is: Full *DSM-5* Diagnostic Criteria

Specify if:

With delayed expression: If the full diagnostic criteria are not met until at least 6 months after the event (although the onset and expression of some symptoms may be immediate).

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Cases Involving Emotional Injuries

- **Refinery explosion**
- **Airplane or train crash**
- **Chemical spill**
- **Toxic exposure**
- **Serious injury**
- **Assault**
- **Harassment**
- **Discrimination**

Emotional Injuries

- **Pain & Suffering**
- **Annoyance & Discomfort**
- **Emotional Distress**
- **Fear of Cancer**

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Pain & Suffering

“Non-economic damages" means subjective, non-monetary losses including, but not limited to, pain, suffering, inconvenience, mental suffering, emotional distress, loss of society and companionship, loss of consortium, injury to reputation and humiliation.

Cal. Civ. Code§1431.2

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Pain and Suffering

- **No claim is being made for mental and emotional distress over and above that usually associated with the physical injuries claimed.**

- **No expert testimony regarding this usual mental and emotional distress will be presented at trial in support of the claim for damages.**

Cal. Civ. Proc. Code § 2032.320

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Annoyance and Discomfort

Annoyance and discomfort damages are intended to compensate a plaintiff for the loss of his or her peaceful occupation and enjoyment of the property … [which] generally refers to distress arising out of physical discomfort, irritation, or inconvenience caused by odors, pests, noise, and the like. * * * Our cases have permitted recovery for annoyance and discomfort damages on nuisance and trespass claims while at the same time precluding recovery for "pure" emotional distress.

Kelly v. CB&I Constructors, Inc., 179 Cal.App.4th 442 (2009)

Emotional Distress

Emotional distress includes suffering, anguish, fright, horror, nervousness, grief, anxiety, worry, shock, humiliation, and shame. Serious emotional distress exists if an ordinary, reasonable person would be unable to cope with it.

CACI 1620 (NIED)

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Emotional Distress

"Severe emotional distress" is not mild or brief; it must be so substantial or long lasting that no reasonable person in a civilized society should be expected to bear it. Plaintiff is not required to prove physical injury to recover damages for severe emotional distress.

CACI 1604 (IIED)

Fear of Cancer

Plaintiff must prove:

- That plaintiff was **exposed** to carcinogen as a result of defendant's negligence;
- That plaintiff **suffered serious emotional distress from a fear** that he will develop cancer as a result of the exposure;
- That reliable **medical or scientific opinion confirms** that it is **more likely than not that plaintiff will develop cancer as a result of the exposure**; and
- That defendant's negligence was a **substantial factor** in causing plaintiff's serious emotional distress.

CACI 1622

Forensic Psychiatry

An Independent

Forensic Psychiatric Expert

Differs from

a Treating Psychiatrist or Psychologist

On Wearing Two Hats:

The Profound Differences Between Treaters and Forensic Psychiatric Experts

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Mission, Method & Ethical Duty: Treating Clinician vs. Forensic Expert

TREATING CLINICIAN:

Mission: To alleviate suffering (Hippocratic Oath)

Method: Relies almost exclusively on patient's self-report of *subjective* reality.

Ethical Duty: To the patient (Hippocratic Oath) – *advocates* for patient's best interests

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Mission, Method & Ethical Duty: Treating Clinician vs. Forensic Expert

INDEPENDENT FORENSIC PSYCHIATRIC EXPERT:

Mission: To determine what is *objectively* true

Method: Reviews all medical/legal/employment documents AND performs objective (neuro)psych testing AND conducts detailed psychiatric IME interview exam

Ethical Duty: Provides evidence-based opinions to the trier of fact

Description of Forensic Psychiatric IME

Components:

1. **Psychological** (& Neuropsych if indicated) **Testing Assessment:**

Description:

- Precedes Psychiatric Examination
- Psych (4 - 6 hours)
- Neuropsych (6 - 8 hours)

2. **Psychiatric Examination:**

- Detailed Psychiatric History (4 – 6 hours)
  - Including developmental, medical, psychiatric, medication, substance use, relationship, educational, employment, legal (civil & criminal), military histories & history of event.

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Psychiatric Assessments in Mass Torts

Types of Mass Torts:

- **Natural Disasters**
- **Man-made Disasters**
- **Toxic Torts**
  - Mold
  - Water Supply Contamination
  - Exposure to Chemicals and/or Radiation
  - Fear of Cancer
- **Discrimination**
- **Product Liability**

Issues Unique to Mass Tort IMEs

- Advantages of a **psychiatric & psychological assessment team** vs. assembling a panel of individual experts.
- Screening and examining a **representative sample** vs. entire population.
- "Normal" or **"Bell Curve" distribution of damages.**
- Problems with sampling – the "Barbell" effect.
- **Increased accuracy and credibility of forensic opinions when population is assessed by one team of experts.**

Advantages of a Psychiatric /Psychological Team vs. Law Firm Retaining Separate Experts

1. **Experience** With Mass Tort Population Assessments.
2. **Quality** of Individual Experts.
3. **Cohesion** – Team Used to Working Together.
4. **Collateral Informants** – Each Examined Claimant is a Collateral Informant for Every Other Claimant.
5. **Increased Accuracy and Credibility** of Forensic Opinions When One Population is Assessed by **One Team** of Experts: **Ability to Compare & Contrast Uninjured Claimants With Injured Claimants**.

Screening and Examining a Representative Sample vs. Entire Population

Sampling Issues:

“Bell” Curve

vs.

“Barbell”

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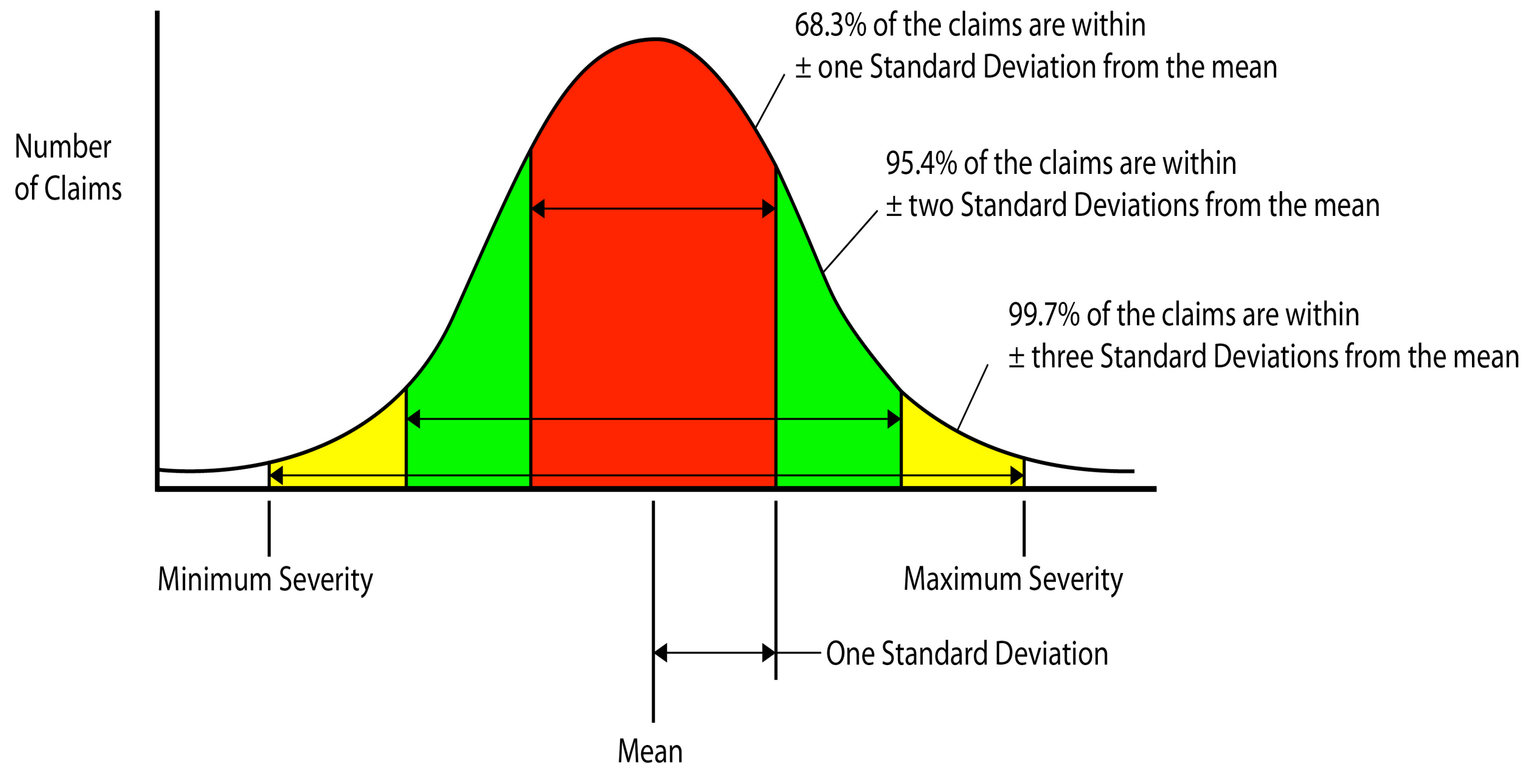
Distribution of Damages Produced by a Catastrophic Event:

A Gaussian (Normal) or "Bell" Curve Distribution of Claims



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Sampling Problems When "Representative" Plaintiffs Selected by Plaintiff & Defense Counsel

The "Barbell" Effect

Defense counsel:

Minimal or no damages

Plaintiffs' counsel:

Very significant damages

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Psychological Testing for PTSD

- Difference between Clinical and Forensic Applications
- Difference Tests are Used
- Importance of Validity Scales
- The Limitations of Self Report Measures
- Best Practice Approach

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Clinical Testing

- The Doctor Trusts what the Patient Says
- Tests that Measure Symptoms are Helpful for Treatment Planning
- No Effort made to Evaluate the Reliability and Validity of the Test Results
- No Effort to Evaluate Malingering

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Forensic Testing

- There is No Doctor Patient Relationship
- The Doctor Recognizes there may be Issues of Secondary gain
- Assessment of the Reliability and Validity of the Symptoms is Critical
- Patients are often Not Reliable Historians
- Pre-existing Conditions are Frequently Denied
- Usually the First Doctor to Look at the Big Picture

Best Practice Testing

- Tests are Designed with Multiple Built In Validity Scales
- Identify Problems with Bias
- Identify Many Kinds of Psychological Problems
- Do Not Cherry Pick One Specific Problem
- Identify Potential Malingering

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Best Practice Tests

- Minnesota Multiphasic Personality Inventory (MMPI-2 or MMPI-RF)
- Personality Assessment Inventory (PAI)
- Rorschach Performance Assessment System (R-PAS)

Clinical Endorsement Questionnaires

- Clinician Administered PTSD Scale (CAPS) the “Gold Standard” of the VA
- Structured Clinical Interview for DSM Disorders (SCID)
- PTSD Checklist for DSM-5 (PCL-5)
- Posttraumatic Stress Diagnostic Scale
- Davidson Trauma Scale (DTS)

Problems With Clinical Endorsement Questionnaires

- Allows the Person to Endorse a Potentially Biased List of Symptoms
- Some of the Tests are Poorly Designed
- The PTSD Checklist Tests Allow Anyone of Average Intelligence to Score Positive for PTSD
- There are Limited Validity Indicators
- They Can Be Useful in a Clinical Practice

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Trauma Specific Tests

- Trauma Symptom Inventory I & II
- Detailed Assessment of Posttraumatic Stress (DAPS)
- Provide a Laundry List of PTSD Symptoms
- Limited Validity Scales Triggered by Endorsement of Extreme Items
- Based on Mailed Out Questionnaires

Raw Test Data

- Test data is best exchanged directly between psychologists on each side of a case
- When test data is required by an attorney there should be a stipulated protective order which insures that the data will not become part of the public domain and will only be used as needed by counsel and/or their retained experts and all copies will be returned or destroyed at the conclusion of litigation

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Retention of Data

- The Psychologist has the duty to retain all original notes
- The Psychologist has the duty to retain all test data
- Destruction of any notes or data is potentially grounds to limit or exclude testimony
- Data must be sufficiently legible that it can be assessed by the opposing psychologist

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Test Data vs. Test Manuals

- The ethics code of the American Psychological Association (APA) allows for the exchange of test data
- The ethics code does not allow psychologists to copy or provide copies of test manuals
- Any competent psychologist should have access to any test manuals needed
- Test manuals are trade secret and confidential

Repeat Testing

- Every Psychologist Must do their Own Testing
- They Cannot Rely Solely Upon Testing Done in the Past
- Even When the Same Test is Used it May Give a Different Result
- Repeat Testing Helps Assess the Reliability of the Test Results
- Repeat Testing May Also Show Improvement