Mental Disorders and Other Limited Conditions – Tackling the Challenges of Handling Mental/Nervous Claims and Establishing Objective Proof of Subjective, "Non-Visible" Disorders

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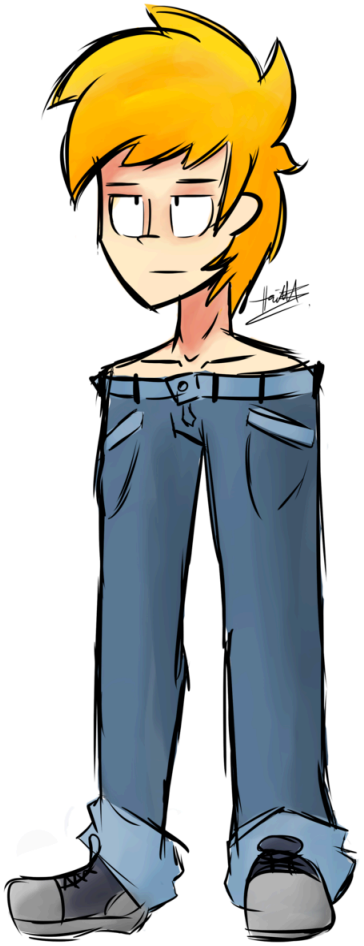
Origins of Mental Illness:

With so-called "**Subjective Disorders**," always remember that…

the Neck Bone is connected to

The thigh bone….



Origins of Mental Illness:

- **Organic vs. Functional:**

  Organic = caused by altered neurophysiology, CNS structure and/or genetics:

  - Neurodevelopmental Disorders
  - Schizophrenia Spectrum & Other Psychotic Disorders
  - Bipolar & Related Disorders. i.e., SMI (= Severe Mental Illness)
  - Neurocognitive Disorders (e.g., Secondary to TBI, Degenerative Brain Disease, Birth Injury)
  - Psychiatric Symptoms caused by a Medical Condition (e.g. Brain Toxicity, Infection, Inflammation)

Origins of Mental Illness:

- **Organic vs. Functional:**

  Functional = caused by disturbed psycho-social development, experiential and/or environmental factors:

  - Depressive Disorders.
  - Anxiety Disorders.
  - Obsessive-Compulsive & Related Disorders.
  - Trauma and Stressor Related Disorders, e.g., PTSD.
  - Dissociative Disorders.
  - **Somatic Symptom & Related Disorders**

Origins of Mental Illness:

- **Organic vs. Functional:**

  Mixed = caused by a combination of constitutional and environmental factors:

  - **Personality Disorders**
  - **Substance-Related & Addictive Disorders**
  - Sexual Dysfunction
  - Gender Dysphoria

Somatic Symptom & Related Disorders:

= Turning Emotional Dysphoria Into Physical Dysphoria

Symptoms caused or aggravated by psychological factors:

- Headache
- Chronic pain
- Gastro-intestinal syndromes
- Hypertension
- Memory impairment
- Brain Injury

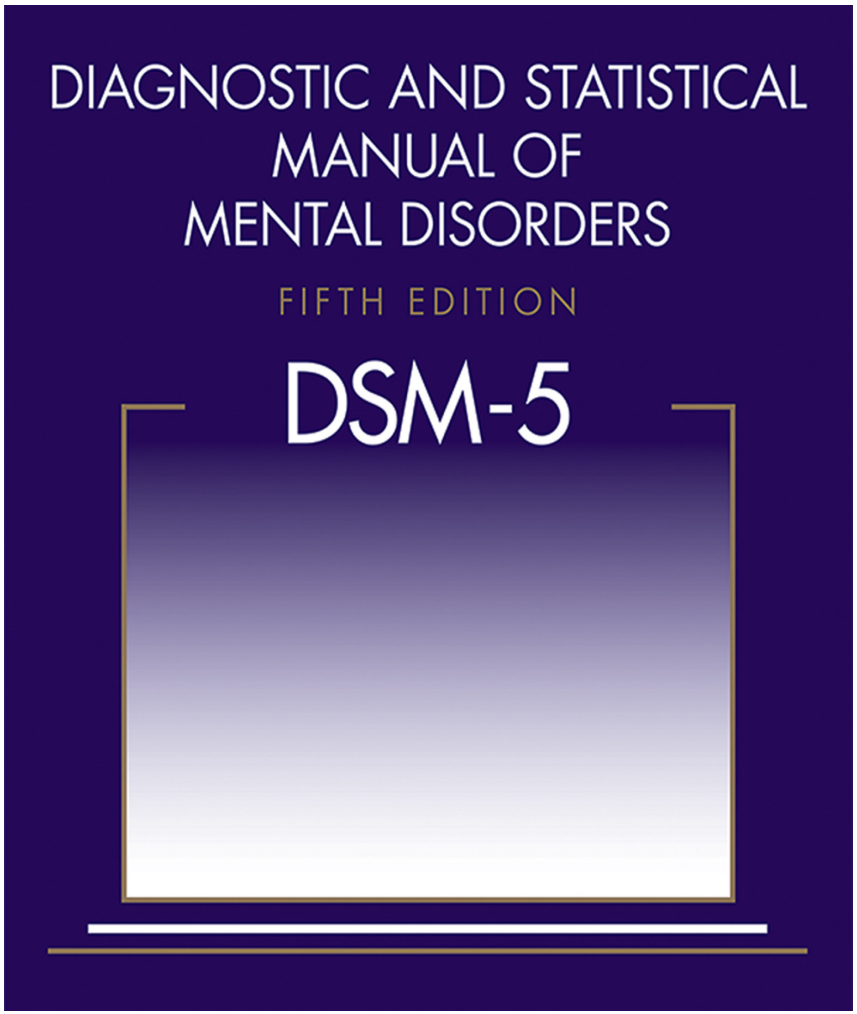
Causes of Somatic Symptom Disorders

- Psychosocial *stressors.*
- *Denial* of personal contribution to one's problems.
- *Inability to accept* one's limitations.
- *Externalization of responsibility*: Need to attribute to others, *even to one's own body,* the cause of pain, discomfort or unhappiness.

Benefits of Somatic Symptom Disorders

- Primary &/or Secondary Gain of Illness.
- May be conscious or unconscious.
- Need for assistance, attention & sympathy.
- Need for recognition for being special.
- Avoidance of unwanted or stressful activities.
- Provides a reasonable externalized justification for disability ("It's not my fault that I am sick").

Somatic Symptom Disorders in the DSM-5: Potential Impact Upon Disability Litigation



Although the DSM-5 diagnostic criteria and text are primarily designed to assist clinicians in conducting clinical assessment, case formulation, and treatment planning, DSM-5 is also used as a reference for the courts and attorneys in assessing the forensic consequences of mental disorders.

As a result**, it is important to note that the definition of mental disorder included in DSM-5 was developed to meet the needs of clinicians, public health professionals, and research investigators rather than all of the technical needs of the courts and legal professionals**.

It is also important to note that DSM-5 does not provide treatment guidelines for any given disorder.

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New Somatic Symptoms & Related Disorders in DSM-5

- **Conversion Disorder (functional neurological symptom disorder)**
  - Emphasis on neurological examination
  - Relevant psychological factors may not be demonstrable at time of diagnosis
- **Psychological Factors Affecting Other Medical Conditions**
- **Factitious Disorder**
  - Somatic symptoms predominate in both Conversion Disorder & Factitious Disorder
  - Both are most often encountered in medical settings

SOMATIC SYMPTOM DISORDER 300.82 (F45.1)

Diagnostic Criteria:

A. One or more somatic symptoms that are distressing or result in significant disruption of daily life.

B. Excessive thoughts, feelings, or behaviors related to the somatic symptoms or associated health concerns as manifested by at least one of the following:

1. Disproportionate and persistent thoughts about the seriousness of one's symptoms.
2. Persistently high level of anxiety about health or symptoms.
3. Excessive time and energy devoted to these symptoms or health concerns.

C. Although any one somatic symptom may not be continuously present, the state of being symptomatic is persistent (typically more than 6 months).

Specify if:

With predominant pain (previously pain disorder).

Specify if:

Persistent: (more than 6 months).

Specify current severity:

Mild: Only one of the symptoms specified in Criterion B is fulfilled.

Moderate: Two or more of the symptoms specified in Criterion B are fulfilled.

Severe: Two or more of the symptoms specified in Criterion B are fulfilled, plus multiple somatic complaints (or one very severe somatic symptom).

ILLNESS ANXIETY DISORDER 300.7 (F45.21)

A. Preoccupation with having or acquiring a serious illness.

B. Somatic symptoms are not present or, if present, are only mild in intensity. If another medical condition is present or there is a high risk for developing a medical condition (e.g., strong family history is present), the preoccupation is clearly excessive or disproportionate.

C. There is a high level of anxiety about health, and the individual is easily alarmed about personal health status.

D. The individual performs excessive health-related behaviors (e.g., repeatedly checks his or her body for signs of illness) or exhibits maladaptive avoidance (e.g., avoids doctor appointments and hospitals).

E. Illness preoccupation has been present for at least 6 months, but the specific illness that is feared may change over that period of time.

F. The illness-related preoccupation is not better explained by another mental disorder, such as somatic symptom disorder, panic disorder, generalized anxiety disorder, body dysmorphic disorder, obsessive-compulsive disorder, or delusional disorder, somatic type.

Specify whether:

Care-seeking type: Medical care, including physician visits or undergoing tests and procedures, is frequently used.

Care-avoidant type: Medical care is rarely used.

CONVERSION DISORDER – (Functional Neurological Symptom Disorder)300.11

A. One or more symptoms of altered voluntary motor or sensory function.

B. Clinical findings provide evidence of incompatibility between the symptom and recognized neurological or medical conditions.

C. The symptom or deficit is not better explained by another medical or mental disorder.

D. The symptom or deficit causes clinically significant distress or impairment in social, occupational, or other important areas of functioning or warrants medical evaluation.

(F44.4) With weakness or paralysis

(F44.4) With abnormal movement (e.g., tremor, dystonic movement, myoclonus, gait disorder)

(F44.4) With swallowing symptoms

(F44.4) With speech symptom (e.g., dysphonia, slurred speech)

(F44.5) With attacks or seizures

(F44.6) With anesthesia or sensory loss

(F44.6) With special sensory symptom (e.g., visual, olfactory, or hearing disturbance)

(F44.7) With mixed symptoms

Specify if:

Acute episode: Symptoms present for less than 6 months.

Persistent: Symptoms occurring for 6 months or more.

Specify if:

With psychological stressor*(specify stressor)*

Without psychological stressor

PSYCHOLOGICAL FACTORS AFFECTING OTHER MEDICAL CONDITIONS 316 (F54)

A. A medical symptom or condition (other than a mental disorder) is present.

B. Psychological or behavioral factors adversely affect the medical condition in one of the following ways:

1. The factors have influenced the course of the medical condition as shown by a close temporal association between the psychological factors and the development or exacerbation of, or delayed recovery from, the medical condition.
2. The factors interfere with the treatment of the medical condition (e.g., poor adherence).
3. The factors constitute additional well-established health risks for the individual.
4. The factors influence the underlying pathophysiology, precipitating or exacerbating symptoms or necessitating medical attention.

C. The psychological and behavioral factors in Criterion B are not better explained by another mental disorder (e.g., panic disorder, major depressive disorder, posttraumatic stress disorder).

Specify current severity:

Mild: Increases medical risk (e.g., inconsistent adherence with antihypertension treatment).
Moderate: Aggravates underlying medical condition (e.g., anxiety aggravating asthma).
Severe: Results in medical hospitalization or emergency room visit.
Extreme: Results in severe, life-threatening risk (e.g., ignoring heart attack symptoms).

FACTITIOUS DISORDER
IMPOSED ON SELF, OR ON ANOTHER
(Previously Factitious Disorder by Proxy) 300.19 (F66.10)

A. Falsification of physical or psychological signs or symptoms, or induction of injury or disease (in self or another), associated with identified deception.

B. The individual presents himself or herself (or another individual, victim) to others as ill, impaired, or injured.

C. The deceptive behavior is evident even in the absence of obvious external rewards.

D. The behavior is not better explained by another mental disorder, such as delusional disorder or another psychotic disorder.

Specify:

on Self

on Another

Specify:

Single episode

Recurrent episodes (two or more events of falsification of illness and/or induction of injury)

OTHER SPECIFIED SOMATIC SYMPTOM & RELATED DISORDER 300.89 (F45.8)

This category applies to presentations in which symptoms characteristic of a somatic symptom and related disorder that cause clinically significant distress or impairment in social, occupational, or other important areas of functioning predominate but do not meet the full criteria for any of the disorders in the somatic symptom and related disorders diagnostic class.

Examples of presentations that can be specified using the "other specified" designation include the following:

1. **Brief somatic symptom disorder:** Duration of symptoms is less than 6 months.
2. **Brief illness anxiety disorder:** Duration of symptoms is less than 6 months.
3. **Illness anxiety disorder without excessive health-related behaviors:** Criterion D for illness anxiety disorder is not met.
4. **Pseudocyesis:** A false belief of being pregnant that is associated with objective signs and reported symptoms of pregnancy.

UNSPECIFIED SOMATIC SYMPTOM & RELATED DISORDER 300.82 (F45.9)

This category applies to presentations in which symptoms characteristic of a somatic symptom and related disorder that cause clinically significant distress or impairment in social, occupational, or other important areas of functioning predominate but do not meet the full criteria for any of the disorders in the somatic symptom and related disorders diagnostic class. The unspecified somatic symptom and related disorder category should not be used unless there are decidedly unusual situations where there is insufficient information to make a more specific diagnosis.

Co-Morbid Conditions

- There is no substitute for obtaining and reviewing a complete medical history and all medical records.
- If the record review is limited to current symptoms it may be very difficult to identify and chart the natural course of pre-existing conditions.
- Patients often have an incomplete recall of all of their prior medical symptoms and diagnoses.
- Litigants have complex motivations causing them to sometimes omit or “forget” relevant prior psychiatric symptom history, even when informing plaintiff’s experts.

Medical Conditions Leading to Psychological Symptoms

- These are usually fairly easy to identify.
- If a disabling or life threatening illness exists, it should be well documented in the records.
- The course of the symptoms should usually be consistent with the severity of the medical condition.
- The more medically ill the person is, the more anxious and depressed they become.
- As their medical condition improves, their psychological condition improve as well.
- ***EXCEPTIONS***: Some jurisdictions require physical injury as pre-requisite to making PTSD claims.
- **FELA**: No Train Engineers can make PTSD claims without evidence of physical injury.

Psychological Problems Leading to Physical Symptoms

e.g., claims of job stress → physical illness.

- These are much harder to identify.
- Individuals with these symptoms tend to minimize pre-existing emotional problems.
- They are prone to rely upon psychological defense mechanisms of repression and denial.
- Out of sight, out of mind.
- They tend to lack insight.
- They are often psychologically unsophisticated.

Team Assessment Process: Multimodal Examination

Psychiatrist's Role:

- Record Review of Past Medical & Psychiatric History.
- Review of Deposition Transcripts & Exhibits, Witness Declarations, Responses to Interrogatories.
- In Depth, Multi Hour, Clinical Interview Examination.
- Collateral Interviews, if Indicated & Permitted.

ON WEARING TWO HATS

Comparing the Profoundly Different Roles of Treating Clinicians vs. Forensic Psychiatric & Psychological Experts

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

TREATING CLINICIAN:

Mission:

- To heal, alleviate suffering (Hippocratic Oath)

Method:

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

Ethical Duty:

- To the patient Hippocratic Oath: *primum non nocere* – *advocates* for patient's best interests

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

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

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To Examine, Or Not To Examine

AMERICAN ACADEMY OF PSYCHIATRY AND THE LAW
ETHICS GUIDELINES FOR THE PRACTICE OF FORENSIC PSYCHIATRY

Adopted May 2005

IV. Honest & Striving for Objectivity:

Psychiatrists should not distort their opinion in the service of the retaining party. **Honesty, objectivity and the adequacy of the clinical evaluation may be called into question when an expert opinion is offered without a personal examination**. For certain evaluations (such as record reviews for malpractice cases), a personal examination is not required. In all other forensic evaluations, if, after appropriate effort, it is not feasible to conduct a personal examination, an opinion may nonetheless be rendered on the basis of other information. Under these circumstances, it is the responsibility of psychiatrists to make earnest efforts to ensure that their statements, opinions and any reports or testimony based on those opinions**, clearly state that there was no personal examination and note any resulting limitations to their opinions**.

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Team Assessment Process: Multimodal Examination

Psychologist's Role:

- Review of all Psychological Reports & Records , including "Raw Data" from Prior Psychological Testing and Neurology Reports & Imaging Studies, when indicated.
- Personality Testing.
- Neurocognitive Testing.
- Symptom Validity Testing
- Pain Assessment, when indicated.

Personality Testing

- Need to determine if basic personality characteristics are influencing the symptoms
- Patients are frequently unaware of their underlying emotional problems
- It is common to which to believe that there is a medical basis for one's symptoms
- It is more difficult to accept that there are psychological explanations

Predisposing Character Traits

- Dependent Traits (problems with autonomy and independence; need to be led by others; need to let others make decisions; need to let others take responsibility; goes to great length to obtain nurturance and support)
- Histrionic Traits (need for special attention, recognition and treatment; has an impressionistic style leading to vague complaints; is highly suggestible; may act in a dramatic fashion)

Unique Presentation of Symptoms

- Symptomatic complaints combined with unusual thoughts, feelings and behaviors
- Their symptoms become a center of attention
- Presentation in medical rather than psychiatric setting
- Cannot be explained on the basis of objective medical findings
- Do not resolve in spite of extensive and varied forms of treatment

Personality Tests

- Objective Assessment
- Standardized Personality Testing
- Do not have Confirmatory Bias
- Built-in Validity Scales
- Measures potential exaggeration
- May identify profiles of emotional difficulty the claimant is not be aware of

Validity Scales

- Special scales designed to assess the minimization or exaggeration of symptoms
- MMPI-2; PAI; MCMI-IV have built in validity scales
- R-PAS may be helpful to cross validate self-report on written personality testing

Endorsement Questionnaires

- These are not personality tests although many have the word “test” in their name
- Traditionally used by non-psychiatric physicians to screen for medications or referral to a psychiatric specialist
- All subject to confirmatory bias
- High rate of false positive findings

Cognitive Aspects of Claims

- Anxiety Disorders
- PTSD
- Depressive Disorders
- Pain Disorders
- Sleep Disorders
- Chronic Fatigue
- Fibromyalgia

When Should Cognitive Impairment Be Classified as "Mental/Nervous?"

- There is no history of serious brain injury.
- Mild Traumatic Brain Injuries (mTBI) in which symptoms last more than a year.
- Perception of cognitive impairment with normal results on cognitive testing.
- Mild cognitive impairment that arises due to anxiety, depression, sleep impairment or problems with pain.

Symptom Validity Testing

- Symptom Performance Testing
- Also referred to as Malingering Testing
- Assesses reliability of performance on neurocognitive testing
- Assesses level of effort
- Identifies motivational problems
- Enables the examiner to opine regarding the validity of the neurocognitive testing

Standards of Symptom Validity Testing

The National Academy of Neuropsychology (NAN) position paper regarding Symptom Validity Testing:

Symptom validity assessment: Practice issues and medical necessity by the NAN policy and planning committee. Bush, et al. Archives of Clinical Neuropsychology, 20 (2005) 419-426

May be downloaded at nanonline.org

Physical/Pain Assessment

- Helps evaluate reliability of reported symptoms
- Helps identify patterns of consistent reporting
- Helps identify patterns of over reporting
- Must be considered in light of objective medical findings
- Assists in evaluation of subjective complaints versus confirmed medical diagnoses

Physical/Pain Tests

- Whaler Physical Symptoms Inventory
- Life Assessment Questionnaire - 2 (LAQ-2)
- Pain Patient Profile (P-3®)
- MMPI-2
- Personality Assessment Inventory (PAI)

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 at the conclusion of litigation

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

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

Third Parties to an Examination

- The presence of third parties introduces an expectable and predictable source of disruption
- The presence of third parties may introduce a source of bias and contaminate the exam
- The National Academy of Neuropsychology (NAN) and other professional agencies have taken the position that third parties should not be present during a neuropsych exam

NAN Position Paper

- Policy Statement of the Presence of Third Party Observers in Neuropsychological Assessments. Official Statement of the National Academy of Neuropsychology.
- Archives of Clinical Neuropsychology, Vol. 15, No. 5, pps 379 – 380 (2000) or may be downloaded at nanonline.org

The Recording of Examinations

- Recording an exam may be equivalent to the presence of a third party and may compromise the examination
- Recording introduces predictable distractions for both the tester giver and test taker which may compromise the results
- NAN has taken the position that the recording of testing is inappropriate
- Recording is often a matter of law
- Audio recording is allowed in California but videotaping is not (see *Golfland Entertainment vs. Sup Ct.*)

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California Law*

- Third parties are not permitted to be present during mental examinations
- Videotaping is recognized as being potentially disruptive and is not allowed
- Third parties may not listen to the examination remotely
- Audio Recording is permitted*

*(*Golfland Entertainment Centers, Inc. v. Superior Court,* 108 Cal. App. 4th 739)

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Repeat Testing

- Every psychologist must do their own testing even if testing has been done in the past
- Technical manuals help assess “Practice Effects”
- If an earlier test is valid, mild increases may be attributed to practice with the test
- Repeat testing helps assess the reliability of the test results