UNDERSTANDING AND EVALUATING MENTAL DAMAGES

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Unlike a pure psychiatric disability evaluation, which most treating psychiatrists at one time or another are asked to conduct on their patients, mental and emotional damage claims also require an assessment of causation, which is far more complicated. And, today, treating psychiatrists are increasingly called upon to provide this assessment, since mental and emotional damages are widely claimed in the United States as a remedy in legal actions. Such claims are driven by a number of factors: (1) employment stress is a routine component of workers compensation claims; (2) intentional or negligent infliction of emotional distress is frequently seen in personal injury litigation; (3) federal claims of discrimination and harassment often have an emotional damage component; (4) in addition, where there are claims of physical injury, psychological or emotional factors may be associated either as a consequence of the injury or as generating poorly explained physical symptoms.

Of course, not every claim of mental or emotional damages requires a psychiatric evaluation. For example, in personal injury litigation, the law permits plaintiffs to raise issues of *pain and suffering, loss of enjoyment of life,* and *loss of consortium* as part of their suits because they can testify themselves about their subjective distress - thus professional psychiatric testimony is not required. Concomitantly, lay jurors are assumed capable of assessing the reasonableness of such claims based on ordinary experience. In contrast, plaintiffs may not testify as to their diagnosis without expert testimony, as that does not fall within the realm of "ordinary experience" and so requires professional clarification.[1]

In general, when treating psychiatrists testify as to their patient's diagnosis, the prognosis, and the type of treatment necessary, they do not need a sophisticated understanding of the law. And, arguably, because they regularly address opinions about impairment and disability as well, these issues, too, should fall within the scope of usual psychiatric practice. Specifically, to the extent that treating psychiatrists confine themselves to such opinions and qualify their testimony by stating that it is based primarily on the patient's account and their own limited observations, further investigation of mental damage issues may not be necessary. However, while psychiatrists may be asked or subpoenaed to testify about their personal knowledge of the patient's condition by virtue of their treatment relationship, there are ethical guidelines which discourage this. Specifically, the American Academy of Psychiatry and the Law points out that in a forensic evaluation, such as one that addresses mental damages, it may be necessary to interview other parties (or obtain corroborating information) and that testimony may affect the therapeutic relationship.[2]

All that said, however, a comprehensive assessment of disability and causation can be perplexing without an understanding of the law and the principles of a forensic psychiatry evaluation. This is seen in workers compensation claims where causation depends on whether the psychiatric injury *arose out of and in the course of employment.*[3]

This general language is expanded and modified in various ways depending upon the jurisdiction. There may be an exclusion, for example, if the psychiatric injury does not involve a physical impact or physical manifestation; or if it is a result of a personnel action; or if it is not due to a clearly identified stressful circumstance. Some jurisdictions will not allow a claim if the stress is considered part of the ordinary stresses of the employment to which all workers are subjected. Therefore, evaluating whether a psychiatric injury was *work-related* involves more than accepting the common-sense meaning of that language, and raises a number of possible questions. Is the stress of losing a promotion work-related? Or the shock of being fired? Or the aggravation of bipolar disorder by job stress? Thus, it is in the best interest of treating psychiatrists who provide such opinions to familiarize themselves with the workers compensation laws in their jurisdiction, to ensure their opinions on causation are consistent with the respective legal definitions.

In personal injury litigation that is not part of workers compensation, the most frequent claims of mental damage are intentional or negligent infliction of emotional distress, emotional effects of a physical injury, stress as a result of discrimination or harassment, emotional harm from defamation and libel, and the psychological impact of malpractice. In all cases, a scientific connection must be established between the defendant's conduct and the mental damage - that is, it cannot be only a possibility; such a connection must be shown to exist in the plaintiff's case.[4] The threshold question is: Was there a cause in fact, a threshold causal connection, that rests on a but-for analysis - i.e. but-for the defendant's conduct, the plaintiff would not have been harmed. Alternatively, a cause in fact may depend on whether the defendant's conduct was a substantial factor - i.e. a necessary element. Therefore, it may be harder to show that an alleged cause was really necessary for a particular consequence rather than just something that preceded it.

The second analysis in causation, particularly in negligence claims, is that of *proximate cause*. Proximate cause may appear to be a refinement on the question of causation itself; but in actuality it is merely a means of limiting the scope of a defendant's liability. In other words, while there may be some causal connection, the harm is too insignificant, remote, logically unrelated, or just beyond what a defendant should be held liable for. So, for example, should years of emotional distress be attributed to an innocuous insult? Typically, proximate cause centers on the question of whether or not the harm was foreseeable. This does not mean that the full extent of mental damage must be foreseeable, only the nature of the damage. This is tied closely to the principle of the *thin skull or eggshell skull rule*. Here, the defendant may have no reason to know of a particular susceptibility of the plaintiff, but must take that plaintiff as he or she is found. This is typically applied where even dramatic and/or unusually persistent symptoms follow a relatively minor trauma. As a medical example, a patient with severe osteoporosis could suffer incapacitating injuries by a trauma that would not injure someone else; and, yet, the one who caused the trauma is responsible.

At the same time, the chain of causation can be broken by an intervening cause, and some jurisdictions are taking into account a plaintiff's *unusual sensitivity* to a particular stressor in order to limit liability.[5] For example, did a minor car accident cause a

psychotic breakdown in a person with borderline personality disorder, just because the psychosis followed the accident? What if a conversion disorder followed the accident? Or a disabling depression? A complete discussion on issuing opinions of causation is far beyond the scope of this article, but hopefully this overview establishes how complex this undertaking can be.

Typically, opinions regarding mental damage are made by treating psychiatrists or other mental health providers about their patients who are later injured or whose injury brought them to treatment. Attorneys often will refer a plaintiff to a psychiatrist both for treatment and expert opinion, under the assumption that the treating psychiatrist will be in the best position to give an opinion because the doctor will have intimate knowledge of the patient and will have been in contact with him or her over a period of time. A number of serious problems arise in this regard. First, the psychiatrist may not be trained in the evaluation of these often complex legal cases. The initial treatment opinion and recommendations may have been given after a relatively brief interview, during which the history provided was almost exclusively based on the subjective reports of the patient. Rarely has the treating psychiatrist reviewed in advance, recorded information, other opinions, past medical records, or statements from collateral sources. Second, the treating psychiatrist inherently will tend to accept the patient's account, and, in the absence of obvious inconsistencies, become allied to the patient's interests. Indeed, it would be difficult for a treatment relationship to continue if the psychiatrist did not believe the patient or, even worse, expressed an opinion contrary to the patient's position in the claim. Third, the treating psychiatrist may suffer adverse financial consequences if he or she does not support the claim since at times payment of therapy bills depends on such an opinion.

In contrast, independent forensic psychiatrists conducting such assessments - while not without their own potential for bias - typically have access to a great deal of information from collateral sources, and are not influenced by a doctor-patient treatment relationship. The forensic psychiatrist also may have a greater understanding of the law and how it may apply to a particular mental damage claim.

Even when an evaluation is conducted by an experienced forensic psychiatrist, the subjective nature of mental disorders and of mental damage claims must be emphasized. In this regard, three contaminating factors to the patient's history are commonly encountered, thereby distorting the account. The first is that psychiatric histories provided by a patient are in some sense a *mythical narrative*. Research has shown that memories decay over time and are influenced by a number of interfering factors, both biological and psychological. All of us to some extent create personal myths or themes in which our story becomes part of how we want to see ourselves, or how we have learned to see ourselves over time. This may be an idealized, inflated self-view, or a self-deprecating one. Furthermore, a process of memory reconstruction takes place, with or without a theme, and this reconstruction is influenced by numerous factors such as postevent information, suggestibility, biases, and environmental influences. In addition, social psychologists recognize the concept of *attribution theory*, which means that by identifying a cause for their distress, human beings can see themselves as less vulnerable

even if that cause is erroneous. This can lead to finding reasons where no reasons exist, or ignoring the real reasons, or identifying reasons that are convenient.

Another commonly known process, called *secondary gain*, can play a role in sustaining mental as well as physical symptoms. This refers to those, perhaps unexpected, environmental responses to symptoms or impairment that sustain a disorder by reinforcing it. Secondary gain may be triggered by financial reimbursement, attention from the family, or avoidance of less than satisfactory life conditions. Whatever the prompt, the history a patient provides is not necessarily consciously fabricated, but the effects of exaggeration and distortion due to any of these factors can be powerful.

Along with recognizing the subjective nature of mental damage claims, and the possible contaminating factors, a good evaluation relies heavily on *corroborating information*, which can come from various sources, both internal and external. Internal sources include the history as delivered by the person being evaluated and the mental observations of that person; external sources include reports from family, friends, employers, or other witnesses. To properly chronicle a mental disorder, then, medical and psychiatric records from both the current treatment as well as past, seemingly unrelated treatment, may be necessary. Similarly, medical and psychiatric records, employment files, even IRS returns may help chronicle a person's functioning before and after the claim of mental damage.

Of course, the reliability of all sources of information must be taken into account. And should further corroboration be necessary, the issue of surveillance arises. This is a controversial area, particularly in mental damage claims, for it is difficult to assume that a discreet period of surveillance is representative of an individual's functioning ability; and a surveillance camera cannot capture internal emotional states. But, if a person has represented that certain activities are impossible or never performed, then surveillance may be able to show inconsistency.

Understanding the *nature of the injury* is extremely important as well as is ascertaining whether the injury even occurred as claimed. A percentage of plaintiffs will grossly misrepresent or fabricate an injury; it is more common, though, for individuals to embellish or exaggerate a claim. It is important, therefore, to obtain verification of what actually occurred, in particular in the form of police records, personnel records, and witness statements.

Another critical factor in making a proper diagnosis - and especially to determine causation in mental damage claims - is a longitudinal life history. There is probably nothing more valuable in assessing the relative weight of stressors and life events on an individual than a carefully obtained personal chronology. Therefore, the timing of when symptoms began is an important consideration in order to objectify a mental damage claim. Patients often relate their history in a generalized or impressionistic way, which may or may not be consistent with the actual history. Establishing a careful timetable that is corroborated by records and other outside information can help show the consistency or inconsistency of the patient's account. Claims of persistent unrelenting symptoms and

permanent impairment must also be weighed against the efforts at rehabilitation. Did the person ever try to return to work? Did he or she participate in vocational rehabilitation efforts, retraining, or educational opportunities? Is there evidence of compliance with treatment? What has been the motivation to recover?

Finally, *alternative explanations* must be considered. The patient may have found it difficult to function due to a number of unrelated or accumulating factors in his or her life - for example, social consequences of personality disorders, substance abuse, economic hardship, or personal and family stressors. Often, personal life crises can incite unresolvable conflicts for which a face-saving solution through a mental injury claim is sought, perhaps for a coincidental and relatively minor trauma.

Although evaluating impairment and disability is the most common forensic task that clinical psychiatrists perform, they must take care to objectify these opinions as well.[6] In addition to diagnosing a mental disorder and assessing its severity, it is helpful to specifically address various categories of function that can result in disability. All disability determinations are an approximation, so psychiatrists should know that it is impossible to completely know a person's functioning. That means disability must be demonstrated, not just presumed. A disability opinion can also have a negative effect on the welfare of a patient by eroding a potential for recovery. (Note: The American Academy of Psychiatry and the Law is currently drafting *Guidelines for Forensic Evaluation of Psychiatric Disability* to help practitioners address these issues.)

Mental damage claims have been based on a variety of psychiatric diagnoses (e.g. major depressive disorder, adjustment disorder, panic disorder, psychotic disorder, pain disorder associated with psychological factors, and others). At times substance abuse is part of a claim (e.g. opioid abuse/dependence as a result of a pain disorder). Even personality disorders have been proposed to constitute mental harm (e.g. borderline personality disorder as a consequence of early childhood abuse). In general, the *Diagnostic and Statistical Manual of Mental Disorders-IV-TR (DSM-IV-TR)* does not focus on the etiology of psychiatric diagnoses and, by extension, the issue of causation.[7] However, the most common courtroom diagnosis, posttraumatic stress disorder (PTSD), has causation built into its name. This helps explain the utility of PTSD as a diagnosis in mental damage claims, but has led in some ways to a dilution of the concept of trauma experienced, from extreme life-threatening conditions as rape, torture, and severe burns to ordinary life events such as a minor automobile accident or employer harassment. In *Posttraumatic Stress Disorder in Litigation - Guidelines for Forensic Assessment (2nd edition)*, editor Robert Simon details assessment guidelines that focus on five basic questions[8]:

1. Does the alleged PTSD claim actually meet specific clinical criteria for this disorder?
2. Is the traumatic stressor that is alleged to have caused the PTSD of sufficient severity to produce this disorder?
3. What is the pre-incident psychiatric history of the claimant?

4. Is the diagnosis of PTSD based solely on the subjective reporting of symptoms by the claimant?
5. What is the claimant's actual level of functional psychiatric impairment?

Where PTSD is raised in mental damage claims, psychiatric evaluations should be prepared to adequately address these questions.

Clinical treating psychiatrists may believe, rightfully, that entering into this forensic arena is not their responsibility. Nevertheless, these questions may be difficult to avoid when one of their patients is involved in litigation. In this case, it is perfectly appropriate for the treating psychiatrist to merely present a clinical and contingent impression from the limited information available. At the same time, the doctor should acknowledge the relative weakness of such an opinion, stating, for example: "Based on what the patient has told meâ€¦" or "If the circumstances of injury are as claimedâ€¦" Where opinions with a greater degree of medical certainty are sought, a referral to a forensic psychiatrist may be desirable. (See also the table, "Tips for Evaluating Mental Damage Claims.").

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