

**A Closer Look at Psychological
Evaluations in Personal Injury
Proceedings: Standards of Practice and
Strategies for Cross Examination**

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Presentation Overview

1. Sources of best practices and references
2. Differences between clinical and forensic evaluations
3. Who was the plaintiff before the alleged trauma – establishing pre-injury psychological functioning
4. Consideration of base rates of psychological disorders
5. Causation: What is the nexus between the alleged trauma and alleged psychiatric impairment
6. Appropriate and inappropriate use of psychological tests
7. Empirically based assessment of malingering
8. Identifying Sources of Expert Bias
9. Cross Examination Checklist

Ethical Basis of Use of Multiple Sources of Information

Specialty Guidelines in Forensic Psychology 9.02: Use of Multiple Sources of Information:

Forensic practitioners ordinarily avoid relying solely on one source of data, and corroborate important data whenever feasible (American Educational Research Association, American Psychological Association, & National Council on Measurement in Education, in press). When relying upon data that have not been corroborated, forensic practitioners seek to make known the uncorroborated status of the data, any associated strengths and limitations, and the reasons for relying upon the data.

Systematic Use of Multiple Sources of Information:

	Increased Depression After Alleged Trauma	Decreased Social Interaction After Alleged Trauma	Reduced Ability to Focus After Alleged Trauma
SELF REPORT	Plaintiff reported increased depression		
TESTING	Testing suggested active depression at mild range of severity		
RECORDS	Psychotherapy and medical records do not note worsened depression		
Collateral Interviews	Spouse said depression worsened, co-workers didn't notice a change		

Pre-Injury Psychological Functioning

- Issue at hand is not the individuals current psychological status but to what degree his/her status differs from before the alleged injury
- Review records to establish baseline functioning at least 3 to 5 years prior to trauma (psychiatric, interpersonal, medical, occupational functioning)
- Create timeline of major life pre-trauma life events
- Pre and Post Injury Records: medical, mental health, school, arrest, employment
- Collaterals: best is unbiased individuals who can compare pre and post-injury psychological functioning

Consideration of Base Rates of Mental Disorders and Symptoms

Base rates of symptoms common in personal injury claims in litigants and a control group of 50 outpatients from a family group practice (Less-Haley and Brown, 1993 as described in Kane and Dvoskin 2011)

- Nervousness: 93% of claimants vs. 54% of control group
- Headaches: 88% of claimants vs. 62% of controls
- Poor Concentration: 78% of claimants vs. 26% of controls
- Poor memory: 53% of claimants vs. 20% of controls

Consideration of Base Rates of Mental Disorders and Symptoms

Base rates of mental disorders (National Institute of Mental Health)

- Mood disorders: 9.5% of U.S. Population
- Anxiety Disorders: 18.1% of U.S. Population

Base Rates of Posttraumatic Stress Disorder

PTSD is the exception not the rule (Kilpatrick et al, 2013)

- 89.7% of U.S. census matched population reported trauma exposure, with multiple traumas being the norm
- 7.3% of sample met diagnostic criteria for PTSD
- Prevalence of trauma highest among victims of interpersonal violence and combat

Analysis of Base Rates: Take Home Points

- Presence of psychological symptoms, a mood disorder, or an anxiety disorder, in and of itself, is not sufficient evidence that an individual is suffering from the effects a claimed trauma
- Evaluator bears burden of justifying that PTSD developed due to an alleged trauma even though this is a low probability event

Psychological Testing

Take Home Points

1. Personal Injury Evaluations should almost always include an MMPI or PAI, objective psychological tests
2. You are entitled to have a consultant review the test data
3. Self-report inventories are not objective sources of data
4. Response style and profile validity should be explicitly described prior to objective test interpretations
5. Test interpretations are hypotheses and often have known error rates

Malingering: How Common is it

Mittenberg 2002:

- Estimates of neuropsychological symptom exaggeration as high as 30% in personal injury cases, 20% in criminal cases, to a low of 8% for non-contested medical cases.

General Research Findings:

- Malingering exists in 15-17% of cases

Common Malingering Myths

- Malingering is a Trait vs. Context Driven Behavior
- Malingering precludes genuine disorders
- All symptom exaggeration or feigning is driven by malingering:
- Malingering rates are the same across different types of evaluations
- DSM IV-TR and DSM-5 diagnostic criteria for malingering is reliable
 - Inaccurate 4 out of 5 times in forensic settings (Rogers and Shuman, 2005)

How Good are Psychologists and Psychiatrists at Detecting Malingering From Clinical Interview Alone

- Experts in lie detection rarely do better than untrained lay persons (Vrij, 2008)
- 2006 meta-analysis of 193 studies: psychologists are only slightly more accurate in deception detection than are student research participants (62% accuracy compared with 54, respectively) (Aamodt and Custer 2006)
- Rosenhan study (1973): In this study eight individuals without mental illness admitted to 12 mental hospitals. All diagnosed with schizophrenia or bipolar and none discovered to be malingering.

Best Practices of Malingering Assessment

1. Use of multiple sources of information
2. Use of validity scales of objective tests such as MMPI and PAI
3. Use of pure psychological symptom and neuropsychology malingering measures: MFAST, SIRS-2, SIMS, VIP, TOMM
4. Consideration of risk factors (i.e. litigiousness, irregular employment, evasiveness, non-cooperation in the evaluation.)

Causation: What is the Nexus Between the Alleged Trauma

If there is evidence of a psychological condition, there are five possibilities:

1. The alleged trauma is the sole cause of the psychological injury (rarely the case).
2. The event was the proximate cause of the psychological injury, and but for the psychological injury, the person would not have his present level of pathology, disability, or distress.
3. The traumatic event materially contributed to the assessed pathology or other psychological distress but was not the primary cause.
4. The traumatic event had little identifiable effect on the individual
5. The traumatic event had no identifiable effect on the individual.
(Kane and Dvoskin, 2011)

Considerations in Causation Analysis

- Does research provide a basis for asserting that the alleged trauma could reasonably cause this psychological impact?
- Was there a change in psychological functioning temporally close to the alleged traumatic event?
- Thin Skull vs. Crumbling Skull

Considerations in Causation Analysis: Contextual and Iatrogenic Factors

- Social Support, occupational support, and overall life satisfaction may contribute to adjustment to traumatic event.
- Litigation process may exacerbate psychological symptoms:
 - Shorter the interval between trauma and settlement in a tort case, the less psychological impairment (Binder et al., 1991)

Sources of Evaluator Bias

Anchoring Bias: Tendency of Information received early in the evaluative process (usually from the retaining attorney) to be more used than information received later in the process:

- Corrective Action: Actively look for data that disconfirms initial hypotheses

Hindsight Bias: Tendency of experts who are aware of how an event turned out, to believe that the outcome could have been easily predicted.

- Corrective Action: Generate potential alternative outcomes and attempt to attach probabilities to them

Sources of Evaluator Bias

Overconfidence: When an expert feels certain his conclusions are correct. Research indicates that confidence in opinions and validity of opinions are not well correlated.

- Corrective Action: Actively search for limitations to ones opinions

Misestimating covariation: Determining if a disorder is present due to a symptoms, without knowledge of the rates the symptom is present without the disorder.

- Corrective Action: Make these determinations empirically (Borum, Otto & Golding, 1993)

Thank you for the Opportunity to Present

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