

Includes Claims HelpLine

MED CORPORATION **Psych**

Guide to Psychological Injury Claims

For claims of Head Injury, Stress Disorders, Depression, Chronic Pain Syndrome and other Cases of Psychiatric and Psychological Injury

Designed for Insurance and Corporate Claims Professionals
and Defense Counsel

The **MEDPsych** Guide to Psychological Injury Claims is developed and published for claims professionals as well as insurance defense counsel. The Guide is designed to be a quick reference source of information for those professionals that are responsible for evaluating and administering the claims and legal aspects of these complex, psychological injury cases.

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Claims HELPLINE

If you have any questions regarding the material in this Guide or a specific psychological injury claim, call (800) 251-0799. Please have the claims file available when you call. The HelpLine is available Monday – Friday, 10:00a.m. – 4:00p.m., EST. There is no charge for this service and questions can be as specific as possible.

Table of Contents

Chapter 1 - Introduction	5
1.1 Psychological Injury Defined.....	5
1.2 The Causes of Psychological Injury.....	5
1.3 The Five Most Common Psychological Injury Claims	5
1.4 Setting Reserves in Psychological Injury Cases.....	5
1.5 Alternate Causes of the Claimant's Symptoms.....	6
1.6 Important Steps in the Management of a Psychological Injury Claim.....	7
1.7 Locating an Experienced and Qualified Independent Examiner	7
Chapter 2 - Essential Information about the Claimant	8
2.1 Introduction.....	8
2.2 Writing to the Claimant's Psychiatrist or Psychologist	8
Chapter 3 - Post-traumatic Stress Disorder (PTSD).....	12
3.1. Description:.....	12
3.2 Summary of Required Symptoms: Post-Traumatic Stress Disorder	12
3.3 The Medical and Psychological Examinations in PTSD cases	13
3.4 Documents that are especially important in cases of PTSD:.....	13
3.5 Claims Analysis Questions: PTSD.....	13
Chapter 4 - Generalized Anxiety Disorder (GAD).....	14
4.1. Description:.....	14
4.2 Summary of Required Symptoms: Generalized Anxiety Disorder	14
4.3 The Medical and Psychological Examinations in GAD cases	15
4.4 Documents that are especially important in cases of GAD:.....	15
4.5 Claims Analysis Questions: GAD.....	15
Chapter 5 - Phobias	16
5.1 Description:.....	16
5.2 Summary of Required Symptoms: Phobia	16
5.3 The Medical and Psychological Examinations in Phobia cases	16
5.4 Documents that are especially important in cases of Phobia:	16
5.5 Claims Analysis Questions:	17
Chapter 6 - Panic Disorder	18
6.1 Description:.....	18
6.2 Summary of Required Symptoms: Panic Disorder	18
6.3 The Medical and Psychological Examinations in Panic Disorder cases	19
6.4 Documents that are especially important in cases of Panic Disorder:.....	19
6.5 Claims Analysis Questions:	19
Chapter 7 - Conversion Disorder	20
7.1 Description:.....	20
7.2 Summary of Required Symptoms: Conversion Disorder	20
7.3 The Medical and Psychological Examinations in Conversion Disorder cases	20
7.4 Documents that are especially important in cases of Conversion Disorder:	21
7.5 Claims Analysis Questions:	21

Table of Contents

Chapter 8 - Chronic Pain Syndrome	21
8.1 Description:.....	21
8.2 Summary of Required Symptoms: Chronic Pain Syndrome.....	22
8.3 The Medical and Psychological Examinations in Chronic Pain Syndrome cases should include:.....	22
8.4 Documents that are especially important in cases of Chronic Pain Syndrome:.....	22
8.5 Claims Analysis Questions: Chronic Pain Syndrome.....	23
Chapter 9 - Depressive Illness	24
9.1 Description:.....	24
9.2 Summary of Required Symptoms: Depression.....	24
9.2.1 Dysthymic Disorder.....	24
9.2.2 Major Depression and Major Depressive Episodes.....	25
9.3 The Medical and Psychological Examinations in Depression cases.....	26
9.4 Documents that are especially important in cases of Depression:.....	26
9.5 Claims Analysis Questions: Depression.....	26
Chapter 10 - Organic Brain Syndrome and Post-concussion Syndrome (Head Injury)	27
10.1 Description: Organic Brain Syndrome (OBS).....	27
10.2 Summary of Required Symptoms: Organic Brain Syndrome.....	27
10.3 The Medical and Neuropsychological Examinations in Organic Brain Syndrome cases.....	28
10.4 Documents that are especially important in cases of Organic Brain Syndrome:.....	29
10.5 Claims Analysis Questions: Organic Brain Syndrome.....	29
10.6 Post-Concussion Syndrome.....	29
Chapter - 11 Adjustment Disorders	31
11.1 Description:.....	31
11.2 Summary of Required Symptoms: The Adjustment Disorder.....	31
11.3 The Medical and Psychological Examinations in Adjustment Disorder cases.....	31
11.4 Documents that are especially important in Adjustment Disorder cases:.....	31
11.5 Claims Analysis Questions:.....	31
Appendixes	32
APPENDIX A: Glossary of Psychological Injury Terms.....	33
APPENDIX B: Glossary of Psychological and Neuropsychological Tests.....	40
APPENDIX C: Glossary of Medical Tests and Signs.....	44
APPENDIX D: Symptom Manipulation, Malingering and Other Related Conditions.....	49
APPENDIX E: The 20 most important questions to ask the claimant's mental health specialists and examiners.....	50

Note: The diagnostic data in this Guide has been summarized from the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition – Text Revision (DSM-4-TR). To order copies of the DSM (DSM-4-TR), call APA Press in Washington, D.C. at 1-800-368-5777. If there are any questions regarding the changes in the diagnostic criteria or how they affect insurance claims, call the Claims HelpLine at (800) 251-0799.

Chapter 1 - Introduction

1.1 Psychological Injury Defined

Psychological injury refers to a variety of mental harm claims. The claim may result from actual organic damage to the brain or emotional upset with no medical evidence of brain damage. Psychological injury claims are common in both liability cases and workers' compensation matters. The cases are generally divided into two categories:

The Organic Brain Syndrome (OBS) case. The claimant alleges that the insured event or cause of action produced a change in the structure or metabolism of his or her brain. These cases are also known as traumatic brain injury (TBI) and can result from any type of head injury or toxic exposure. In some cases, a claim of organic brain syndrome is made even though the CT and MRI scans do not show a visible lesion in the brain. This is a high risk type of claim for the insurer and frequently results from overinterpreted or misinterpreted neuropsychological test data.

The emotional harm only case. The claimant alleges that the insured event or cause of action produced an anxiety, depressive or other type of mental illness. These cases can result from any insured event. Physical injury is frequently involved but is not necessary. For example, in some jurisdictions, persons may claim Post-traumatic Stress Disorder (PTSD) from witnessing a traumatic event or from the intentional infliction of emotional harm such as in work-place harassment claims. In these cases, there is no physical injury but emotional harm is claimed.

In many cases, there are combinations of causes and events that lead to a psychological injury claim. Although the organic brain syndrome case is usually considered to be the most serious, plaintiffs have been successful in obtaining large jury awards and settlements in emotional harm cases where there is no evidence of a severe physical injury.

1.2 The Causes of Psychological Injury

The most common claims of psychological injury are related to automobile accidents. In addition to these, mass transportation accidents, slip and fall cases, toxic exposure, back and neck injuries and other types of chronic pain cases, premises liability, traumatic occurrences such as being trapped in a burning building and even work-place harassment are commonly used as the basis for psychological injury claims. In many cases, the physical injury is minor but the claimant

states that he or she is totally disabled because of a resulting mental illness. There are very few limits, if any, as to the types of insured events (cause of action) that can be the basis for claims of psychological injury.

1.3 The Five Most Common Psychological Injury Claims

1. Organic Brain Syndrome associated with a claimed concussion
2. Post-traumatic Stress Disorder (PTSD)
3. Depressive illness claims
4. Anxiety disorders other than PTSD
5. Chronic pain cases with related depression

1.4 Setting Reserves in Psychological Injury Cases

Each insurer has policies and procedures for setting reserves. However, there are several signs and signals that a physical injury case will eventually become a psychological injury claim with added settlement or jury verdict costs. The early documents, patterns and information to look for are:

- ⊕ Referral of the claimant for psychological testing
- ⊕ Referral of the claimant for neuropsychological testing
- ⊕ Claim of prolonged disability from a mild concussion
- ⊕ Chronic pain with little response to therapy
- ⊕ The prescription of anti-depressant, anti-anxiety or other psychotropic medications without a referral for psychiatric or other mental health treatment
- ⊕ Any report of nervousness, fears, chronic fatigue or depression that prevents the claimant from working or participation in other normal activities conducted before the injury.
- ⊕ Reports of behavior change or self-damaging behavior
- ⊕ Loss of physical functions with no objective evidence of neurological damage
- ⊕ Documented or claimed seizure or blackout activity
- ⊕ Any case of disfigurement or paralysis
- ⊕ Any case with positive CT or MRI brain findings or a positive EEG suggesting seizure activity

Serious physical injuries are always a sign that a psychological injury claim may follow. However, many claims of psychological injury occur from relatively mild head injury. Psychological injury can be the basis for a "policy limits claim," even when the claimant's physical injuries are minor and heal without complication. Psychological injuries are the fastest growing source of increased jury awards and settlement costs in liability claims and workers' compensation cases.

1.5 Alternate Causes of the Claimant's Symptoms

A significant number of all psychological injury claims are inflated and the subject of “file building” on the part of the claimant and his or her mental health examiners and health providers. In many cases, the claimant's emotional problems actually stem from other causes that are not related to the insured event or, the evidence of psychological injury is grossly overinterpreted by the claimant's examiners. A thorough analysis of the case documents will generally indicate one or more alternate causes of the claimant's organic or emotional harm related symptoms and behaviors.

***Example:** Pre-existing clinical mental disorder: The Delusional Paranoid Disorder*

David C. is a 59-year-old sports writer for an eastern newspaper. He functioned well in his job and his co-workers were surprised when he abruptly filed for both workers' compensation and a medical retirement. Both of these claims were filed after a psychologist had reported that the claimant had a nervous disorder secondary to job harassment. Before departing, David told his co-workers that the new editor was “out to get him” and that he was quitting because the publisher and the editor had conspired to ruin his reputation. He also told co-workers and his attorney that the editor had sent persons to spy on him and that a man was photographing him at a local shopping mall. His delusions were so well systemized that his attorney felt that they must be true and that his client had a valid workers' compensation claim.

The following is a list of 17 common errors in the claimant's psychiatric or psychological examination or testing process:

1. The psychological or neuropsychological test data was overinterpreted
2. The wrong psychological or neuropsychological tests were used
3. The tests were improperly administered or scored
4. The claimant manipulated his or her test responses
5. The examiner failed to obtain past school records, medical records, psychiatric records or other important information that should be used in forming clinical judgments, diagnoses and treatment recommendations
6. The examiner failed to conduct an adequate interview of the claimant
7. The examiner is financially vested in the outcome of the case (he or she has a lien or other financial interest in the settlement or jury award)

8. The diagnosis is based on insufficient symptoms
9. Failure to consider pre-existing psychological conditions
10. Failure to communicate with other treating specialists
11. Failure to rule out malingering or the Factitious Disorder
12. Failure to consider the transient effects of the claimant's medications
13. Failure to use the full diagnostic system and perform a differential diagnosis
14. Psychological testing was never conducted
15. The examiner has insufficient training or experience
16. Insufficient basis in the research literature for the clinical opinions issued in the case
17. The claimant is seen infrequently, in a litigation or claims pattern, not a legitimate treatment pattern.

Medications are frequently prescribed in these types of cases; although medications can be very effective in the treatment of many diseases and conditions, they can have very serious side-effects that can mimic and be mistaken for claimed injuries. Therefore, it is important to note all the medications the claimant is taking or been prescribed since the cause of action.

Because claimants frequently do not have a clear wellness agenda, (the desire to be symptom free) they continue to report symptoms and reject medications as, “not helpful.” In some cases, this causes doctors to use a polypharmaceutical, “shotgun” approach to medication. The claimant may then develop further symptoms from the drug effects and interactions. Claimants that are non-compliant with their medications, complicate the clinical picture through drug toxicity and withdrawal. Medications also distort the claimant’s case in that they can change the physical and psychological functions that are the subject of neurological and neuropsychological testing. In many cases, the claimant's psychiatric and psychological examiners cannot adequately control or separate the transient effects of medication from the original effects of the patient's injury.

The claims examiner and insurance counsel should ask the following 12 medication related questions when reviewing the file and conducting an investigation of the claim:

1. What medications were being taken before the insured accident or injury?
2. What medications were being taken on the day of injury?
3. What medications have been prescribed since the injury?
4. Is the claimant taking the prescribed medications at the proper rate and dosage?

5. Are multiple physicians prescribing the same or similar medications?
6. Is it possible that the claimant is selling his or her drugs, including narcotic analgesics, to others?
7. Is there evidence that the claimant may be addicted to his or her medications?
8. Have the doctors conducted any blood or urine tests to determine if the claimant is actually taking the prescribed medications at the proper rate and dosage?
9. Are the claimant's symptoms and behaviors actually related to the insured injury, or are they simply the transient effects of medication that will remit when the medications are withdrawn?
10. Is it possible to obtain the claimant's pharmacy records (computer printout) for the period since the claimed injury and for several years prior to the claimed injury?
11. Does the claimant's medication history tell us about past diseases and disorders that the claimant has not admitted in his or her clinical history or in deposition?
12. Are the medications that have been prescribed for the claimed injury, appropriate for the treatment of that condition?

- ⊕ Continue to gather all appropriate information about the claimant and the accident and injury. Information recorded within the first 48-72 hours after the injury may become very important in determining if there is any clinical basis for later complaints, symptoms and behaviors.
- ⊕ Identify the medical and mental health care providers that have treated the claimant before and after the insured injury.
- ⊕ Conduct an early analysis of the case records.
- ⊕ Review the 23 key elements of information listed in Chapter 2 of this booklet.
- ⊕ Use the questions listed in Chapter 2 of this booklet, when writing the claimant's mental health care providers.
- ⊕ Look for alternate and pre-existing causes of mental illness such as personality disorders and transient medication effects.
- ⊕ Use experienced examiners to conduct the independent psychiatric and psychological examinations of the claimant.

1.6 Important Steps in the Management of a Psychological Injury Claim.

Obtain thorough statements from the claimant and witnesses as soon after the accident or injury, as possible. If you contact the claimant, ask detailed questions that require the claimant to use memory and concentration. Record all responses.

1.7 Locating an Experienced and Qualified Independent Examiner

Most cases of psychological injury will require an independent examination by a licensed psychiatrist, psychologist, neuropsychologist and/or neurologist. The claims examiner should select an evaluator that has forensic experience. If possible, the examiner should be board certified.

For assistance in locating an independent examiner in the fields of psychiatry, psychology, neurology or neuropsychology, call the claims HelpLine at (800) 251-0799.

Chapter 2 - Essential Information about the Claimant

2.1 Introduction

The key to limiting and defending damages in a psychological injury case is the discovery of documents and historical information about the claimant. Unlike purely physical injury matters, psychological injury claims are very complex and require the claims examiner and defense counsel to learn detailed information about the claimant's medical, psychological and social history. Much of the information needed to defend or limit damages and control settlement costs in these cases cannot be obtained until subpoena power is granted and the case is in litigation. However, the claims examiner should note any important information that becomes available and is appropriate for the claims file.

There are 23 key elements of claimant information that are very important to prepare for the analysis, defense or limitation of costs and damages in a psychological injury case:

1. School and other educational information
2. Childhood, adolescent or developmental social history (behavioral problems)
3. Employment history and performance ratings
4. Military service information, disciplinary action or health record
5. Past medical history including childhood conditions and injuries or any current degenerative physical disorder that may cause psychological symptoms
6. Health status before the insured injury
7. Past history of hospitalization
8. Current mental health history and treatment including the existence of mental disorders or personality disorders. When litigation has been filed and full discovery is permitted, in addition to any written reports, ALWAYS ask for the handwritten clinical notes of the plaintiff's psychotherapists or other evaluators. When asking for psychological test data, ALWAYS ask for the raw data (test sheets).
9. Alcohol and substance abuse history including DWI
10. Driving and accident record
11. Any criminal history
12. Post-injury symptoms
13. Post-injury treatment records
14. Familial or inherited medical disorders
15. Family structure and recent changes in the family
16. Family deaths within the past several years
17. Marital history

18. Information regarding the claimant's spouse and children
19. Pre- and post-injury recreational-social history (changes in recreational-social patterns)
20. The claimant's medications (and street drugs) before and after the injury in question, including any medications taken within the 24 hour period prior to the accident (if possible, obtain the pharmacy print-out for several years prior to the accident)
21. Recent or anticipated changes, problems or stresses in the claimant's life (occupational, social, legal, familial)
22. Insurance or workers' compensation claims history including a check of the claims index system
23. Comparison of the claimant's pre-injury income status to his or her present level of income (is the claimant making more on disability and compensation than he or she was prior to the injury)?

In a number of cases, the claimant's pre-existing physical or mental disorders may have contributed to the cause of action. For example; the claimant may have liver disease causing low alcohol tolerance, inability to control a motor vehicle because of the onset of a neurological disorder or the effects of vascular disorders, endocrinopathies, prior head trauma, seizures or the transient effects of medications. A thorough medical history is essential for the defense of damages and may provide important information regarding the cause (liability) or circumstances of the injury.

2.2 Writing to the Claimant's Psychiatrist or Psychologist

When writing to the claimant's treating psychiatrist, psychologist or other mental health therapist or evaluator, the claims examiner should ask the following mental health related questions:

NOTE 1: A signed and properly executed medical release form must accompany any request for the following information.

NOTE 2: The following questions are based on the American Psychiatric Association's published Multiaxial Evaluation System. They are appropriate questions to ask any counselor, psychiatrist, psychologist or other mental health care provider.

a. The Patient's Current and Past Mental Disorders (Axis I)

Axis I is the designation for mental disorders. Examples of Axis I diagnoses are: 309.89 Post-

traumatic Stress Disorder, 296.32 Major Depression, etc.

When writing the claimant's mental health therapist or evaluator, the claims examiner should ask the following questions regarding mental disorders:

- ⊕ Did the injury in question cause an Axis I, clinical mental disorder? If so, what is the diagnosis?
- ⊕ Do you believe or suspect that the patient had an Axis I, clinical mental disorder, before the insured accident or injury? If so, what was the diagnosis?
- ⊕ Please list all past and present periods of psychiatric or psychological treatment that you or your mental health facility has provided including any form of counseling or psychotherapy given before the insured accident or injury.
- ⊕ Please describe the type of therapy given during those periods (in-patient hospitalization in a psychiatric facility, out-patient psychotherapy, etc.)
- ⊕ Please list all medications and dosage given for current mental disorders and any prior conditions.
- ⊕ Are you aware of any current or past mental health treatment received from other providers? If so, please list the name of the mental health provider or facility, the approximate dates and the diagnosis.
- ⊕ Does the patient have any current or past substance abuse or dependence?

b. The Patient's Developmental or Personality Disorders (Axis II)

Example: Pre-existing Personality Disorder

John B., a 26 year old welder, works on a track crew for the Grand Central and Lakeshore System. He has worked for the railroad for three years. Prior to his employment with the railroad, he served in

the Army for twenty months and received an honorable discharge. However, his military records note that he was discharged for "the convenience of the U.S. Army." In deposition, this plaintiff claimed that he was discharged early because of a military budget cut-back. However, the defense investigation produced evidence that he was discharged because of instability, reckless handling of a government vehicle, recurrent fights and frequent bouts of depression. His supervisors listed depression as a major reason for his poor productivity. Now comes this plaintiff under The Federal Employers' Liability Act charging that his railroad supervisors harassed him causing a depressive illness requiring psychotherapy and antidepressant medication.

Axis II is the designation for developmental and personality disorders that generally begin in childhood and adolescence and have life-long, enduring traits and features. Examples of Axis II personality disorders are: 301.50 Histrionic Personality Disorder, 301.83 Borderline Personality Disorder, etc. Examples of Axis II developmental disorders are: 315.00 Developmental Reading Disorder, 315.10 Developmental Arithmetic Disorder, etc.

When writing the claimant's mental health therapist or evaluator, the claims examiner should ask the following questions regarding developmental and personality disorders:

- ⊕ Does the patient have significant personality disorder traits or a diagnosable personality disorder, as defined by DSM-3-R or DSM-4? If so, please list the personality disorder diagnosis or the personality disorder trait pattern.
- ⊕ Does the patient have a history of any other learning or developmental disorder?

c. The Patient's Related Medical Conditions (Axis III)

Axis III is the designation for any physical or medical condition that could cause or contribute to the

development or presentation of a mental disorder or psychiatric symptoms. Examples of Axis III disorders include hypoglycemia, hypo or hyper thyroidism, mitral valve prolapse, etc.

When writing the claimant's mental health therapist or evaluator, the claims examiner should ask the following questions regarding medical conditions:

- ⊕ Does the patient have any Axis III medical condition that may be related to any of the Axis I mental disorders listed above?
- ⊕ Please list a brief summary of the patient's past medical history. If possible, please list the patient's age or the year in which the patient had the injury, disease or disorder.

d. The Patient's Life Stressors (Axis IV)

Please list the patient's primary life stressors. In your response, please consider the following:

- ⊕ Stress related to injury
- ⊕ Disease or medical conditions other than injury
- ⊕ Marital stress or dysfunction
- ⊕ Stress from an interpersonal relationship other than marriage
- ⊕ Stress from problems with children
- ⊕ Bereavement (the death of a family member or close friend)
- ⊕ Loss of relationship
- ⊕ Occupational stress
- ⊕ Stress related to school
- ⊕ Financial stress
- ⊕ Stress related to aging or phase of life
- ⊕ Other stress, please specify

If possible, please rate the severity of the stressors (mild, moderate, severe and; acute or enduring circumstances).

e. Assessment of the Patient's Functioning (Axis V)

The GAF Scale is a 100 point system for rating mental health that is published by the American Psychiatric Association.

The mental health therapist or evaluator should be asked to rate the claimant's mental health functioning, using the GAF scale. The claims examiner should ask the following questions:

- ⊕ What is the patient's Global Assessment of Functioning Scale (GAF Scale) rating at this time?
- ⊕ What was the patient's Global Assessment of Functioning Scale (GAF Scale) rating during the past 12 months?
- ⊕ What do you believe the patient's Global Assessment of Functioning Scale (GAF Scale) rating was prior to the accident or injury in question?

The GAF Scale is as follows:

Consider psychological, social, and occupational functioning on a hypothetical continuum of mental health-illness. Do not include impairment in functioning due to physical (or environmental) limitations.

100	Superior functioning in a wide range of activities
90 to 81	Absent or minimal symptoms (e.g., mild anxiety before an exam), good functioning in all areas, interested and involved in a wide range of activities, socially effective, generally satisfied with life, no more than everyday problems or concerns (e.g., an occasional argument with family members).
80 to 71	If symptoms are present, they are transient and expectable reactions to psychosocial stressors (e.g., difficulty concentrating after family argument); no more than slight impairment in social, occupational, or school functioning (e.g., temporarily falling behind in school work).
70 to 61	Some mild symptoms (e.g., depressed mood and mild insomnia) OR some difficulty in social, occupational, or school functioning (e.g., occasional truancy, or theft within the household), but generally functioning pretty well, has some meaningful interpersonal relationships.
60 to 51	Moderate symptoms (e.g., flat affect and circumstantial speech, occasional panic attacks) OR moderate difficulty in social, occupational, or school functioning (e.g., few friends, conflicts with co-workers).

50 to 41	Serious symptoms (e.g., suicidal ideation, severe obsessional rituals, frequent shoplifting) OR any serious impairment in social, occupational, or school functioning (e.g., no friends, unable to keep a job).
40 to 31	Some impairment in reality testing or communication (e.g., speech is at times illogical, obscure, or irrelevant) OR major impairment in several areas, such as work or school, family relations, judgment, thinking, or mood (e.g., depressed man avoids friends, neglects family, and is unable to work; child frequently beats up younger children, is defiant at home, and is failing at school).
30 to 21	Behavior is considerably influenced by delusions or hallucinations OR serious impairment in communication or judgment (e.g., sometimes incoherent, acts grossly inappropriately, suicidal preoccupation) OR inability to function in almost all areas (e.g., stays in bed all day; no job, home, or friends).
20 to 11	Some danger of hurting self or others (e.g., suicide attempts without clear expectation of death, frequently violent, manic excitement) OR occasionally fails to maintain minimal personal hygiene (e.g., smears feces) OR gross impairment in communication (e.g., largely incoherent or mute).
10 to 1	Persistent danger of severely hurting self or others (e.g., recurrent violence) OR persistent inability to maintain minimal personal hygiene OR serious suicidal act with clear expectation of death.

f. The Patients Testing, Evaluation, Observations and Return to Prior Levels of Functioning.

- ⊕ Please list any neurological, psychological or neuropsychological tests given to the patient along with the dates and results of those tests.
- ⊕ Please describe any other methods of patient evaluation used in this case.
- ⊕ Please summarize your observations of this patient.
- ⊕ Please estimate the length and type of future treatment needed.
- ⊕ If the patient was employed or in school before his or her injury, and has not returned to those activities, please estimate when a return to normal functioning will occur.

Chapter 3 - Post-traumatic Stress Disorder (PTSD)

3.1. Description:

Post-traumatic Stress Disorder is an anxiety condition brought on by a distressing event outside the range of usual human experience (DSM-IV-TR). It can occur at any age, including childhood and both males and females can be equally affected.

This disorder can occur more readily in individuals with pre-existing psychological conditions. However, the hallmark symptoms of flashbacks and nightmares must be of the current traumatic event. Symptoms usually begin immediately after the event, although there can be a latency period of several months. Less than a fourth of all patients who experience such stress actually develop the full range of symptoms required for the diagnosis of Post-traumatic Stress Disorder.

The diagnostic criteria for PTSD are in four key areas: (1) the nature of the experience itself; (2) the occurrence of dreams and recollections of the specific event; (3) avoidance behaviors and numbing reactions; and (4) increased arousal. Depression is commonly associated with PTSD and, in some cases, a separate depressive disorder may be diagnosed.

Anxiety conditions including PTSD (or at least some symptoms of PTSD) are relatively common. In most cases, the symptoms of PTSD will remit within weeks or months. However, some persons have more difficulty than others, in extinguishing the symptoms. These include children and the elderly.

Example: *Post-traumatic Stress Disorder (PTSD)*

Jeannette K. is a secretary on the 86th floor of a high rise building in Chicago. An electrical explosion on the 60th floor caused smoke to rise through the building. Most of her co-workers had already left for the day and Jeannette was alone for over 45 minutes before being rescued.

The analysis of Jeannette's claim included an independent psychiatric examination conducted by the insurer. The examination was conducted over one year after the explosion and the examiner concluded in part, "Jeannette's PTSD has greatly resolved. She has occasional nightmares but the content of her dreams has more to do with childhood issues than the explosion and fire."

"She has returned to work in the same office but still has some anxiety for the first 20-30 minutes after arriving at the 86th

floor. After that, her anxiety subsides. There is no withdrawal from activities, insomnia or increased arousal such as an exaggerated startle response. It is my opinion that her PTSD has resolved although she will have some minor remaining symptoms for some time, perhaps for several years. This will take the form of nonspecific anxiety. These are artifacts of PTSD and not the actual condition itself. I do not believe that further behavioral therapy for PTSD will be productive nor do I recommend anxiolytic (anti-anxiety) medication. She may need to participate in group therapy to work through her childhood abuse issues but this is not related to her claim against the building owner and electrical contractor."

3.2 Summary of Required Symptoms: Post-Traumatic Stress Disorder

- | |
|---|
| <p>A. The person has been exposed to a traumatic event in which both of the following were present:</p> <ol style="list-style-type: none"> 1. the person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others 2. the person's response involved intense fear, helplessness, or horror. <p style="margin-left: 40px;">Note: In children, this may be expressed instead by disorganized or agitated behavior</p> <p>B. The traumatic event is persistently reexperienced in one (or more) of the following ways:</p> <ol style="list-style-type: none"> 1. recurrent and intrusive distressing recollections of the event, including images, thoughts, or perceptions. Note: In young children, repetitive play may occur in which themes or aspects of the trauma are expressed. 2. recurrent distressing dreams of the event. Note: In children, there may be frightening dreams without recognizable content. 3. acting or feeling as if the traumatic event were recurring Note: In young children, trauma-specific reenactment may occur. 4. intense psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event 5. physiological reactivity on exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event <p>C. Persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness (not present before the trauma), as indicated by three (or more) of the</p> |
|---|

following:

1. efforts to avoid thoughts, feelings, or conversations associated with the trauma
2. efforts to avoid activities, places, or people that arouse recollections of the trauma
3. inability to recall an important aspect of the trauma
4. markedly diminished interest or participation in significant activities
5. feeling of detachment or estrangement from others
6. restricted range of affect (e.g., unable to have loving feelings)
7. sense of a foreshortened future (e.g., does not expect to have a career, marriage, children, or a normal life span)

D. Persistent symptoms of increased arousal (not present before the trauma), as indicated by two (or more) of the following:

1. difficulty falling or staying asleep
2. irritability or outbursts of anger
3. difficulty concentrating
4. hypervigilance
5. exaggerated startle response

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

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

3.3 The Medical and Psychological Examinations in PTSD cases

PTSD is primarily diagnosed from the claimant's self reported symptoms. Psychological testing can be helpful and specific tests for PTSD are currently undergoing validation studies. Symptom Inventory Questionnaires have been developed but again, these depend on the accuracy and honesty of the claimant. The MMPI-2 has subscales that have been designed to detect PTSD. However, these are new and the validation studies have been conducted on a combat veteran population and may not apply to persons claiming PTSD from non-combat situations.

Psychiatrists and psychologists that conduct forensic examinations of PTSD claimants should avoid symptom checklists that prompt the individual to make false-positive responses. In addition to the areas listed in Sections 1 and 2 of

this Guide, any psychiatric or psychological examination of the claimant should address:

The exact circumstances of the claimed trauma

- ⊕ A full description of the claimed dreams and flashbacks
- ⊕ A comparison of the claimant's occupational, social and recreational activities, before and after the trauma
- ⊕ The names of all medications taken by the claimant as well as caffeine, alcohol and other substance use
- ⊕ A detailed medical, psychological and social history of the claimant including past trauma.

3.4 Documents that are especially important in cases of PTSD:

- ⊕ The claimant's work and job performance records
- ⊕ The claimant's pharmacy records
- ⊕ The reports and handwritten clinical notes of the claimant's psychologist or psychiatrist
- ⊕ The claimant's past medical history and records.

SEE Chapter 2 of this Guide for further documents and information needed for the analysis of a psychological injury claim.

3.5 Claims Analysis Questions: PTSD

- ⊕ Does the claimant have the required criteria for PTSD?
- ⊕ Instead of PTSD, does the claimant have the less chronic condition known as Acute Stress Disorder, SEE the note regarding Acute Stress Disorder below.
- ⊕ Has the diagnosis been based solely on self-reported information?
- ⊕ Does the claimant have a history of past childhood or adult trauma? (are the current symptoms actually from an earlier life trauma)?

NOTE: The Diagnosis of Acute Stress Disorder

A new stress disorder was first included in the 1994, Diagnostic Manual, DSM-4. This condition is the Acute Stress Disorder and it differs from PTSD, in that it lasts for only two days to one month. This new diagnosis should be very helpful to the claims process. In the past, persons would claim a full Post-traumatic Stress Disorder even though their symptoms lasted only a few days. The diagnosis of Acute Stress Disorder provides for a short-term diagnosis with no the possibility of no lasting impairment.

Chapter 4 - Generalized Anxiety Disorder (GAD)

4.1. Description:

Generalized Anxiety Disorder is a member of the anxiety family of mental disorders. It is generally found to have been present for many years before a claim or lawsuit is filed. Claimants sometimes deny that the symptoms existed before the insured accident or injury. However, a thorough clinical examination by an experienced forensic psychiatrist or psychologist may show that the condition pre-existed the injury. Age of onset is most common in the 20's and 30's and affects males and females equally.

GAD is characterized by chronic fearful anticipation of an unpleasant event in the future with frequent stress-related exacerbations and fluctuations in the course of the illness. The essential feature of this disorder is unrealistic anxiety and worry about multiple life circumstances.

Although this disorder is not particularly disabling, the physical symptoms are quite distressing. GAD is sometimes diagnosed when the actual cause of the symptoms is Caffeine Intoxication, Organic Mental Disorders, Organic Anxiety Disorder and hyperthyroidism.

Example: Betty A. is a 42-year-old woman that has been employed as a bank records clerk for eight years. Sixteen months ago, the bank installed a new computer based transaction system that automatically keeps productivity records on each clerical worker. She was notified by her supervisor that her productivity was poor and she was placed on probation. She complained to her co-workers that she was "getting nervous" and began to see a psychologist. He diagnosed her as having Generalized Anxiety Disorder based on three reported symptoms: trembling, a constant feeling of being on the edge and trouble sleeping. She has been on sick leave for four months and has filed a workers' compensation claim charging that her supervisor's demands for increased production caused a nervous disorder.

4.2 Summary of Required Symptoms: Generalized Anxiety Disorder

- A. Excessive anxiety and worry (apprehensive expectation), occurring more days than not for at least 6 months, about a number of events or activities (such as work or school performance).
- B. The person finds it difficult to control the worry.
- C. The anxiety and worry are associated with three (or more) of the following six symptoms (*with at least some symptoms present for more days than not for the past 6 months*).

Note: Only one item is required in children.

1. restlessness or feeling keyed up or on edge
 2. being easily fatigued
 3. difficulty concentrating or mind going blank
 4. irritability
 5. muscle tension
 6. sleep disturbance (difficulty falling or staying asleep, or restless unsatisfying sleep)
- D. The focus of the anxiety and worry is not confined to features of an Axis I disorder, e.g., the anxiety or worry is not about having a Panic Attack (as in Panic Disorder), being embarrassed in public (as in Social Phobia), being contaminated (as in Obsessive-Compulsive Disorder), being away from home or close relatives (as in Separation Anxiety Disorder), gaining weight (as in Anorexia Nervosa), having multiple physical complaints (as in Somatization Disorder), or having a serious illness (as in Hypochondriasis), and the anxiety and worry do not occur exclusively during Posttraumatic Stress Disorder.
 - E. The anxiety, worry, or physical symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.
 - F. The disturbance is not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition (e.g., hyperthyroidism) and does not occur exclusively during a Mood Disorder, a Psychotic Disorder, or a Pervasive Developmental Disorder.

4.3 The Medical and Psychological Examinations in GAD cases

Because many symptoms used for the diagnosis of GAD are also common symptoms of physical illness, the mental health evaluator must be very thorough in conducting a differential diagnosis. Consideration must be given to medication side effects, street drugs, cardiovascular, gastrointestinal, urological, endocrinological (thyroid), neurological and other physical and psychiatric disorders. A detailed medical history must be taken and a general physical examination with blood chemistry is recommended. The use of personality testing such as the MMPI-2 or the MCMI is also recommended.

4.4 Documents that are especially important in cases of GAD:

The claimant's work and job performance records with special attention to periods of work absence prior to the insured injury

- ⊕ The claimant's pharmacy records
- ⊕ The reports and handwritten clinical notes of the claimant's psychologist or psychiatrist.
- ⊕ The claimant's past medical history and records.
- ⊕

SEE Chapter 2 of this Guide for further documents and information needed for the analysis of a psychological injury claim.

4.5 Claims Analysis Questions: GAD

- ⊕ Was a detailed medical history and examination completed in this case?
- ⊕ Does the claimant have the required symptoms to be diagnosed with GAD?
- ⊕ Instead of GAD, does the claimant have pre-existing physical conditions that would produce the same or similar symptoms? Are the symptoms actually the side-effects of the claimant's medications.
- ⊕ Does the claimant have signs of hypochondriasis or the Somatization Disorder? (A psychosomatic type condition where there is a belief that one is sickly or has been preoccupied with illness for many years).

Chapter 5 - Phobias

5.1 Description:

Phobia is an anxiety condition. The predominant feature of phobia is a persistent avoidance behavior secondary to irrational fears of a specific object, activity or situation. Although fears are common, phobias are unreasonable and unwarranted fears given the actual dangerousness of the object, activity or situation avoided. The most common circumstances are fears of streets and open spaces, fears of enclosed spaces or situations where there is no rapidly accessible escape (such as bridges and tunnels), and fears of vehicles of transportation (most notably airplanes). The degree of the syndrome's severity, as well as the incapacity resulting from it, depends on the practical significance of the phobic stimulus.

For example, the person with a fear of airplanes that does not fly often is less affected than the person with a fear of planes who is required to fly on a regular basis. Under the best circumstances, persons with actual phobic symptoms find their lives constricted to some degree.

The most popular and most effective treatment for phobias is a behavioral approach called systematic desensitization in combination with appropriate medications. This approach relies on the gradual exposure of the patient to the phobic stimulus until the entire stimulus can be presented without the patient suffering from an anxiety reaction. This type of treatment is most often prescribed for simple phobias such as claustrophobia, agoraphobia, social phobia and safety phobia.

Example: Phobia

Ben J. was a traveling sales representative for a major clothing manufacturer. While staying at a local hotel, he was the victim of an armed robbery. He was not shot but he was forced to lie on the floor of his room while the intruder searched his belongings. Ben now claims to be agoraphobic and will not leave home. He has a workers' compensation claim as well as a claim against the hotel.

5.2 Summary of Required Symptoms: Phobia

- A. Marked and persistent fear that is excessive, or unreasonable, cued by the presence or anticipation of a specific object or situation (e.g., flying, heights, animals, receiving an injection, seeing blood).

- B. Exposure to the phobic stimulus almost invariably provokes an immediate anxiety response, which may take the form of a situationally bound or situationally predisposed Panic Attack.

Note: In children, the anxiety may be expressed by crying, tantrums, freezing, or clinging.

- C. The person recognizes that the fear is excessive or unreasonable. Note: In children, this feature may be absent.
- D. The phobic situation(s) is avoided or else is endured with intense anxiety or distress.
- E. The avoidance, anxious anticipation, or distress in the feared situation(s) interferes significantly with the person's normal routine, occupational (or academic) functioning, or social activities or relationships, or there is marked distress about having the phobia.
- F. In individuals under age 18 years, the duration is at least 6 months.
- G. The anxiety, Panic Attacks, or phobic avoidance associated with the specific object or situation are not better accounted for by another mental disorder, such as Obsessive-Compulsive Disorder (e.g., fear of dirt in someone with an obsession about contamination), Posttraumatic Stress Disorder (e.g., avoidance of stimuli associated with a severe stressor), Separation Anxiety Disorder (e.g., avoidance of school), Social Phobia (e.g., avoidance of social situations because of fear of embarrassment), Panic Disorder With Agoraphobia, or Agoraphobia Without History of Panic Disorder.

5.3 The Medical and Psychological Examinations in Phobia cases

The use of personality testing such as the MMPI-2 or the MCMI is recommended. The clinical interview should include questions regarding early childhood, school phobia and other signs of anxiety during the developmental period of life.

5.4 Documents that are especially important in cases of Phobia:

- ⊕ Early school records are very important (even in the case of an adult claimant)
- ⊕ Past pharmacy records (look for anti-anxiety or other psychotropic medications)
- ⊕ Past work or school attendance records.

SEE Chapter 2 of this Guide for further documents and information needed for the analysis of a psychological injury claim.

5.5 Claims Analysis Questions:

- ⊕ Did the claimant have a childhood history of school or other phobia?
- ⊕ Is there a history of anti-anxiety (anxiolytic) medications?
- ⊕ What are the specific objects or situations that evoke fear and anxiety?
- ⊕ Does the fear of these objects or situations actually interfere with the claimant's daily functioning?
- ⊕ Is it reasonable to assume that the claimed fears are related to the insured accident or event in any way?
- ⊕ Has the claimant sought appropriate psychiatric or psychological treatment to extinguish these fears?
- ⊕ Have there been any prior episodes of these fears? What triggered the fears at that time?
- ⊕ Are the claimed fears actually persistent, irrational fears with a compelling desire to avoid, an object or a situation? If not, the claimed fears may not qualify for the diagnosis of phobia.

Chapter 6 - Panic Disorder

6.1 Description:

Panic Disorder is an anxiety condition, which has been found to be fairly common among the general population. Panic disorders appear to be more common among first-degree biologic relatives, than among a random sample of the general population. The average age of onset is in the late 20's and Panic Disorder without Agoraphobia is equally common among men and women, however Panic Disorder with Agoraphobia (fear of being in a place where escape would be difficult) is twice as common among females.

The essential features are recurrent panic attacks with discrete periods of intense fear or discomfort, with at least four associated symptoms. The attacks usually last minutes, and are unexpected. The symptoms experienced during an attack include a range of physiological responses such as: shortness of breath; smothering sensations; dizziness; faintness; choking; sweating; chest pains; flushes or chills; fear of dying or going crazy.

Childhood separation anxiety or a sudden loss of social supports or a disruption of important relationships can predispose one to the development of this disorder.

Example: Panic Disorder

Ralph K. is a 45-year-old TV sportscaster. He is a former athlete and still plays several sports. During the past three years, he has experienced panic attacks that began while he was driving on freeways. He now lives in fear of these attacks and drives on side roads because of this fear. He is ashamed to tell his family about these fears. In fact, the only person that he has told about the attacks has been his family doctor and that physician has prescribed a benzodiazepine medication. His panic attacks include shortness of breath, sweating, fear of losing consciousness, palpitations and numbness in his arms and hands. Recently, Ralph injured his leg when he stepped in an open TV cable access hole at a sports arena. He has retained an attorney and has told the attorney that the panic attacks began after his recent fall. The defendant insurer will discover the truth in this matter only after obtaining the claimant's past medical history from his family doctor and a printout of his pharmacy records.

6.2 Summary of Required Symptoms: Panic Disorder

- A. The presence of Panic Attacks:
- B. Discrete and unexpected, rapidly developing, period of intense apprehension, fear or discomfort with at least four of the following:
 1. Dyspnea (short of breath)
 2. Palpitations
 3. Chest pain or discomfort
 4. Choking or smothering sensations
 5. Dizziness, faintness or unsteady feelings
 6. Feelings of unreality
 7. Paresthesias (numbness or tingling in hands or feet)
 8. Flushes, hot flashes or chills
 9. Sweating
 10. Depersonalization (being detached from oneself) or derealization (feelings of unreality)
 11. Trembling or shaking
 12. Fear of dying, going crazy, or doing something uncontrolled during an attack
 13. Nausea or abdominal distress
- C. Persistent worry about having additional attacks.
- D. Not due to a physical disorder (See below) or another mental disorder, such as PTSD, Separation Anxiety Disorder, Phobia, etc.

NOTE 1: In some cases, the claimant will be diagnosed with Panic Attacks (See criterion A above) and not the full Panic Disorder. For claims purposes, these are essentially the same situation.

NOTE 2: Panic Disorder may be diagnosed with, or without Agoraphobia. The addition of Agoraphobia means that the claimant has specific anxiety about being in places or situations in which escape might be difficult (e.g. in a tunnel or on a bridge) or embarrassing (e.g. in a concert hall). Agoraphobics sometimes require the presence of a companion and fear being outside of the home.

6.3 The Medical and Psychological Examinations in Panic Disorder cases

Anxiety is a feature of many medical, psychiatric and neurological illnesses that must be ruled out in order to make a diagnosis of Panic Disorder. In fact, many persons diagnosed with Panic attacks actually have a cardiovascular condition known as Mitral Valve Prolapse (MVP). Mitral Valve Prolapse is a congenital ballooning of a heart valve causing a prolapse into the atrium during ventricular systole. It can be associated with arrhythmias of the heart, chest pain, palpitations, dyspnea, weakness, fatigue, dizziness, syncope, and anxiety. These symptoms resemble panic or anxiety attacks and the presence of a midsystolic click and a systolic murmur, as well as echocardiograph findings are important in the differential diagnosis. Many persons claiming Panic Disorder, actually have a cardiovascular or medication related condition that is, in fact, not a Panic Disorder.

Conditions and substances that must be ruled out in the diagnosis of Panic Disorder and other anxiety conditions:

- ⊕ Mitral Valve Prolapse (most common cause of misdiagnosis)
- ⊕ Other cardiovascular conditions
- ⊕ Hypoglycemia
- ⊕ Pheochromocytoma
- ⊕ Hyperthyroidism
- ⊕ Hypothyroidism
- ⊕ Third ventricle brain tumors
- ⊕ Epilepsy involving the diencephalon (the region of the hypothalamus, thalamus and other areas posterior of the forebrain).
- ⊕ Chronic Obstructive Pulmonary Disease (COPD)
- ⊕ Pulmonary embolus
- ⊕ Aspirin intolerance
- ⊕ Collagen-vascular disease
- ⊕ Brucellosis
- ⊕ Vitamin B12 deficiency
- ⊕ Demyelinating disease
- ⊕ Heavy metal intoxication
- ⊕ Caffeineism
- ⊕ Amphetamine use
- ⊕ Diet pills
- ⊕ Cocaine
- ⊕ Alcohol or sedative withdrawal

6.4 Documents that are especially important in cases of Panic Disorder:

- ⊕ Medication records (very important)
- ⊕ Past and current medical records
- ⊕ Cardiology records and tests
- ⊕ Blood chemistry records

6.5 Claims Analysis Questions:

- ⊕ Does the claimant have a real Panic Disorder or are the symptoms actually from a Mitral Valve Prolapse or other cardiovascular condition? Does the claimant have hypoglycemia, pheochromocytoma or hyperthyroidism and have these, and the other disorders listed above, been ruled out as a source of the panic-like symptoms?
- ⊕ Is the claimant taking any medication or using any substance that could be causing the panic-like symptoms (caffeine, amphetamines, diet pills, cocaine or withdrawal from alcohol or sedatives)?
- ⊕ In the case of a claimed Panic Disorder with Agoraphobia, is there evidence that the claimant regularly leaves his or her home and conducts normal activities and travel?

Chapter 7 - Conversion Disorder

7.1 Description:

Conversion Disorder is a member of the group or family of mental conditions known as Somatoform Mental Disorders. The distinguishing feature is an alteration or loss of physical functioning that suggests a physical disorder, but actually is an expression of psychological conflict. It is sometimes referred to as psychogenic paralysis, blindness, etc. Somatoform means that the illness takes the form of a physical or bodily condition but it appears because of a deep psychological need to be disabled.

Symptoms appear suddenly under conditions of extreme psychological stress and the usual age of onset is in adolescence or early adulthood, however, appearance in middle age is not uncommon. Persons with pre-existing Histrionic or Dependent Personality Disorders are more vulnerable to this disorder.

In the Conversion Disorder, there is a strong presumption that the physical symptoms are linked to psychological factors or conflicts. Unlike factitious disorder or malingering, the symptom production in somatoform disorders is not under voluntary control, i.e. the individual does not experience the sense of controlling the production of the symptoms. Although the symptoms of somatoform disorders are "physical," the specific loss of physical functioning is not demonstrable or understandable by existing medical or laboratory procedures and is most clearly explained with psychological concepts. For that reason, these disorders are not classified as "physical disorders." The family of somatoform disorders includes somatization disorder, conversion disorder (hysterical neurosis), psychogenic pain disorder, hypochondriasis and the Body Dysmorphic Disorder which is an imagined defect in physical appearance.

Example: *The Conversion Disorder*

Dolores G. is a 61-year-old woman that slipped and fell in a local department store three months ago. She now claims that she has no feeling or ability to move her lower extremities. Exhaustive medical tests and scans have failed to locate a lesion in the central nervous system. The department store's insurer has retained a neurologist that, among other tests, gave the claimant the Hoover and Thigh Adduction Tests. The neurologist has reported that the claimant's disability is not due to a physical injury but is probably, "functional." The insurer then retained a psychiatrist who has reported that the claimant actually has a Conversion Disorder. She has a

history of being abused by her first husband who then committed suicide and she was later abandoned by her second husband. There is also a family history of depression. The insurer's psychiatric examiner has reported that the conversion disorder is treatable and that she can regain sufficient use of her lower extremities to remain independent in her activities of daily living. However, to be effective, the conversion disorder treatment must begin without further delay.

7.2 Summary of Required Symptoms: Conversion Disorder

- A. A loss of or alteration in physical functioning suggesting a physical disorder.
- B. Psychological factors are judged to be associated with the symptom because of a psychological conflict or need.
- C. The person is not intentionally producing the symptom or loss of functioning as in malingering or the Factitious Disorder.
- D. The condition cannot be explained by neurological or general medical evidence and is not a culturally sanctioned or explained behavior.
- E. The condition causes significant distress or impairment in social, occupational or other important areas of functioning.
- F. The condition is not limited to pain or sexual dysfunction and is not caused by another mental disorder.

NOTE 1: Conversion Disorders appear in many forms. There are cases of conversion paralysis, blindness, aphonia (inability to speak), seizures, coordination disturbances, akinesia, deafness, dyskinesia, tunnel vision, anosmia (inability to smell), anesthesia (loss of feeling or sensation), paresthesia (abnormal sensation) and pseudocyesis (false pregnancy).

7.3 The Medical and Psychological Examinations in Conversion Disorder cases

Conversion hysteria simulates many specific medical and neurological diseases; therefore, the claimant's evaluator should have a thorough knowledge of neuroanatomy and neurophysiology in order to make the diagnosis. A previous history of conversion is the most valid and reliable diagnostic indicator of the Conversion Disorder. Over one-third of

conversion patients have previously had a conversion reaction and one-third have had a prior Somatization Disorder.

7.4 Documents that are especially important in cases of Conversion Disorder:

- ⊕ All past and current medical records
- ⊕ All past and current mental health records including reports, handwritten clinical notes and psychological test data and reports
- ⊕ Records of past injuries including head injuries.

NOTE: This condition may first appear in adolescence. Pediatric records should be obtained to determine if the Conversion Disorder initially appeared in the claimant's developmental years.

SEE Chapter 2 of this Guide for further documents and information needed for the analysis of a psychological injury claim.

Chapter 8 - Chronic Pain Syndrome

8.1 Description:

Chronic Pain Syndrome is a very complex physical and psychological disorder which requires an assessment of the pain from both perspectives. Certain psychological conditions such as anxiety and depression magnify the perception of pain for some patients. A relationship of chronic pain and personality disorders, specifically histrionic and dependent personality disorders, has been identified. It is also very common for claimants to treat their pain with alcohol or other drugs that not only fail to relieve pain, but in some cases, make the pain more intense.

There are generally four possible bases for the claimant's chronic pain complaints:

1. **ACTUAL PAIN:** In many cases, the perception of actual pain is magnified by depression. In other cases, the claimant has a pre-existing injury or an arthritic condition. If depression is reported, it should

7.5 Claims Analysis Questions:

- ⊕ Has the claimant ever had a prior episode of Conversion Disorder or any other psychosomatic type of condition (Somatization Disorder, Hypochondriasis, Somatoform Pain Disorder, etc.)?
- ⊕ Has the claimant received a very thorough medical examination to rule out an undiagnosed condition such as the early stages of lupus, Multiple Sclerosis and tumors of the nervous system or other neoplasia that could cause the reported loss or change of functioning?
- ⊕ Do the reported symptoms follow known anatomical patterns?
- ⊕ Do the symptoms improve with suggestion or the reduction of stress?
- ⊕ Are there any known, underlying psychological conflicts or needs?
- ⊕ Is the claimant exposed to a person with similar disabling symptoms?
- ⊕ Has the claimant been diagnosed with the Histrionic or Dependent Personality Disorder? When combined with the Dependent Personality Disorder, patients tend to develop a chronic "sick role."
- ⊕ Does the claimant show La belle indifference? This is a lack of concern or indifference (not just stoicism) regarding the symptoms, even though the claimant reports severe impairment.

- ⊕ be treated along with orthopedic and neurological efforts to end the painful condition.
- 2. **MALINGERING:** The claimant has no real pain but is consciously manipulating his or her symptoms to avoid responsibility or receive compensation.
- 3. **THE FACTITIOUS DISORDER:** The claimant has no real pain but is consciously manipulating his or her symptoms to receive care, treatment and attention from others. In many cases, claimants continue their pain behavior after compensation is received because they are unwilling to give up their source of personal care and attention from doctors and others.
- 4. **THE SOMATOFORM PAIN DISORDER:** Like other Somatoform Disorders such as the Conversion Disorder, the Somatoform Pain Disorder is involuntary. The claimant is producing pain behavior because of unconscious psychological conflicts or needs.

The characteristics of pain as experienced and reported are the products of physiological, psychological, and social

determinants. Any profile of pain must take into account the relative importance of the peripheral, neurogenic and psychogenic sources of input underlying each pain complaint and must consider the pain in terms of six dimensions:

- ⊕ Associated physiological factors
- ⊕ Behavioral and psychosocial factors
- ⊕ Description of the pain
- ⊕ Duration of the pain
- ⊕ Intensity of the pain
- ⊕ Location of the pain

Some pain behavior is aimed at soliciting help. The claimant's personal style, as well as cultural influence, can determine the patterns of pain behavior; Patients for whom suffering serves important psychological ends behave as though they are more concerned with how others respond to them as sufferers, than they are with the relief of pain. They include persons with deep underlying feelings of guilt and masochism or with intense aggressive impulses. Such persons are likely to invite injury or to suffer pain as a conversion symptom.

For some, pain may serve intrapsychic needs, to atone for intolerable feelings of guilt or as a means of controlling aggression. These types of patients may be designated as "pain-prone," and efforts to provide relief to them may not be possible since the pain may be playing an important psychological role for the patient. Some pain-prone patients become pain-free when they are being abused by others, only to relapse when conditions improve.

There are six indicators of psychological complications in a chronic pain case:

1. A vague history of present illness with confused chronology and irrelevant information
2. Expression of either open or veiled resentment toward the insurance company or the medical profession for supposed neglect
3. Dramatic description of pain and related symptoms
4. Difficulty in localization and description of pain
5. Failure of the usual forms of treatment to give significant relief from pain
6. Accompanying psychological symptoms including depression and anxiety

Example: Chronic Pain Syndrome

Jose' is a 23-year-old garage attendant. He is married and has a one-year-old son. Six months ago, he was injured while assisting a customer get out of her vehicle. The customer was quite heavy and he

strained his back when she began to slip on an icy sidewalk. He prevented her fall but now suffers severe low back pain. He is angry at his former boss because he feels that he should have been commended for his actions but instead was fired when he missed work for over one week. He now has a workers' compensation claim and has not returned to work. The examining psychologist reports that his chronic pain may also have a factitious basis in that his wife must now take care of him, in addition to caring for their young child. (SEE appendix D for further information on the Factitious Disorder)

8.2 Summary of Required Symptoms: Chronic Pain Syndrome

Chronic pain is defined as, preoccupation with the daily occurrence of pain, over an extended period of time (more than six months).

8.3 The Medical and Psychological Examinations in Chronic Pain Syndrome cases should include:

- ⊕ A medical review of organic (injury) factors
- ⊕ Consideration of personality and psychiatric disorders
- ⊕ Socioenvironmental factors (e.g. the claimant's prior occupational and family functioning)
- ⊕ A thorough patient history
- ⊕ A family interview when possible
- ⊕ Psychological testing including the Minnesota Multiphasic Personality Inventory (MMPI-2) and pain behavior screening tests.

8.4 Documents that are especially important in cases of Chronic Pain Syndrome:

- ⊕ Psychological test results
- ⊕ All medical records
- ⊕ Pharmacy records
- ⊕ Surveillance, if appropriate and available.

SEE Chapter 2 of this Guide for further documents and information needed for the analysis of a psychological injury claim.

8.5 Claims Analysis Questions: Chronic Pain Syndrome

- ⊕ Is there a reasonable relationship between the insured injury and the pain pattern reported by the claimant?
- ⊕ Is there a known or suspected history of narcotic analgesic or other drug abuse? What medications are being taken for pain? Has the medication pattern changed since the injury?
- ⊕ Are the reports of pain consistent?
- ⊕ Have the claimant's doctors ruled out malingering, the Factitious Disorder or the Somatoform Pain Disorder?
- ⊕ Is there medical evidence of any basis for continued complaints of pain?
- ⊕ Does the claimant have a dysfunctional family or social life?
- ⊕ Is the pain presentation and description overly dramatic?
- ⊕ Does the claimant have a reported depression?
- ⊕ Does the claimant have greater income now because of disability or compensation payments?
- ⊕ Is there a pending trial, hearing or settlement conference that could be the basis for continued complaints of pain?
- ⊕ Do observations of the claimant by doctors and others match the claimed level of pain and associated disability?

Chapter 9 - Depressive Illness

9.1 Description:

There are several types of depression including Major Depression, Dysthymic Disorder, Bipolar Disorder (manic-depressive illness), and Cyclothymia (less severe than Bipolar Disorder). Insurance claims of depression are generally for Dysthymia, (chronic, low level depression) or for Major Depression.

Example: Depressive Illness

Allen D. is a 55-year-old former store manager. He has a claim of disability because of severe depression. He has attempted suicide on several occasions by overdose. Each time however, the attempt was done in a manner that led to his discovery and subsequent emergency treatment. He claims that he was terminated by his employer because of age discrimination although his termination was part of a general reduction in force.

The claimant has a history of depression that first became evident during college. He has been diagnosed as having the Borderline Personality Disorder and there is a family history of alcoholism and depression. His last suicide attempt led to psychiatric hospitalization for one month.

Dysthymic Disorder

Dysthymic Disorder is a mood disorder that appears as a chronic, low-level depression extending over two years with several psychological or physical complaints. This disorder usually begins in childhood, adolescence or early adult life and is fairly common. In children, males and females are equally affected, however in adults the disorder is more common in females.

There is also evidence that Dysthymic Disorder is more common among first-degree biologic relatives of people with Major Depression than among the general population.

Dysthymia and Major Depression share similar symptoms but differ in duration and severity. Major Depression usually consists of a discrete episode that can be distinguished from the person's usual functioning, whereas dysthymia cannot be distinguished from the person's "usual" functioning.

The differential diagnosis in Dysthymic Disorder includes Major Depression; medical illnesses, medication effects,

normal fluctuations of mood; chronic mental disorders such as Obsessive Compulsive Disorder or Alcohol Dependence, when associated with depressive symptoms.

Major Depression

This condition is classified as a mood disorder and can be quite severe. It can occur as a single episode with sudden onset and a dramatic change in mood, or with recurring depressive episodes. All mood disorder symptoms are on a continuum from mild feelings of sadness to thoughts of suicide.

Risk factors associated with Major Depression are gender, social class, heredity and life events.

- ⊕ Gender: In all studies of Major Depression it was found to be twice as common in females as males.
- ⊕ Social Class: Twice the risk of depression has been found in lower socioeconomic groups than occurs in higher socioeconomic groups.
- ⊕ Heredity: Most family studies have shown that Major Depression is 1.5 to 3 times more common among first-degree biologic relatives of people with this disorder than among the general population.
- ⊕ Life Events: Depression is a normal human emotion. The chronology of the patient's symptoms may indicate that some depression actually began before the so-called precipitating event.

9.2 Summary of Required Symptoms: Depression

9.2.1 Dysthymic Disorder

- A. Depressed mood for most of the day, for more days than not, as indicated either by subjective account or observation by others, for at least 2 years.

Note: In children and adolescents, mood can be irritable and duration must be at least 1 year.

- B. Presence, while depressed, of two (or more) of the following:
1. poor appetite or overeating
 2. insomnia or hypersomnia
 3. low energy or fatigue

- 4. low self-esteem
 - 5. poor concentration or difficulty making decisions
 - 6. feelings of hopelessness
- C. During the 2-year period (1 year for children or adolescents) of the disturbance, the person has never been without the symptoms in Criteria A and B for more than 2 months at a time.
- D. No Major Depressive Episode has been present during the first 2 years of the disturbance (1 year for children and adolescents); i.e., the disturbance is not better accounted for by chronic Major Depressive Disorder, or Major Depressive Disorder, In Partial Remission.
- Note: There may have been a previous Major Depressive Episode provided there was a full remission (no significant signs or symptoms for 2 months) before development of the Dysthymic Disorder. In addition, after the initial 2 years (1 year in children or adolescents) of Dysthymic Disorder, there may be superimposed episodes of Major Depressive Disorder, in which case both diagnoses may be given when the criteria are met for a Major Depressive Episode.
- E. There has never been a Manic Episode (See linked section), a Mixed Episode (See linked section), or a Hypomanic Episode (See linked section), and criteria have never been met for Cyclothymic Disorder.
- F. The disturbance does not occur exclusively during the course of a chronic Psychotic Disorder, such as Schizophrenia or Delusional Disorder.
- G. The symptoms are not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition (e.g., hypothyroidism).
- H. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

9.2.2 Major Depression and Major Depressive Episodes

- A. Five (or more) of the following symptoms have been present during the same 2-week period and represent a change from previous functioning; at least one of the symptoms is either (1) depressed mood or (2) loss of interest or pleasure.
- 1. depressed mood most of the day, nearly every day, as indicated by either subjective report or observation made by others.
- Note: In children and adolescents, can be irritable mood.
- 2. markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day
 - 3. significant weight loss when not dieting or weight gain, or decrease or increase in appetite nearly every day. Note: In children, consider failure to make expected weight gains.
 - 4. insomnia or hypersomnia nearly every day
 - 5. psychomotor agitation or retardation nearly every day
 - 6. fatigue or loss of energy nearly every day
 - 7. feelings of worthlessness or excessive or inappropriate guilt nearly every day
 - 8. diminished ability to think or concentrate, or indecisiveness, nearly every day
 - 9. recurrent thoughts of death, recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide
- Note: Do not include symptoms that are clearly due to a general medical condition, or mood-incongruent delusions or hallucinations.
- B. The symptoms do not meet criteria for a Mixed Episode.
- C. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.
- D. The symptoms are not due to the direct physiological effects of a substance or a general medical condition.

E. The symptoms are not better accounted for by Bereavement, i.e., after the loss of a loved one, the symptoms persist for longer than 2 months or are characterized by marked functional impairment, morbid preoccupation with worthlessness, suicidal ideation, psychotic symptoms, or psychomotor retardation.

CAUTION: The DSM-4-TR also defines a condition known as, Mood Disorder Due to a Medical Condition. This diagnosis may be used in an attempt to relate the claimant's depression to his or her claimed injury.

9.3 The Medical and Psychological Examinations in Depression cases

In most insurance claims, the injured party denies any prior depression. However, mood disorders are extremely common and can last for months and years. In fact, depression can be a prominent feature of other mental and physical disorders as well as personality disorders. Fifty percent of those persons that have had a Major Depression in the past will have a second episode and many of those will develop recurrent depressions as they get older.

The following is a list of some of the alternate causes of depression that should be ruled out before the insurer accepts the diagnosis of depression secondary to the insured event:

Addison's or Cushing's disease	Cardiovascular Conditions
Gastrointestinal Illness	Hyperparathyroidism
Hyperthyroidism	Hypothyroidism
Infectious diseases	Malnutrition
Neurological Conditions	Personality Disorders
Rheumatoid arthritis	Various neoplasia (tumors)

In addition to common illnesses, several medications and classes of drugs are known to cause depression including:

Barbiturates	Benzodiazepines
Corticosteroids	Digitalis
Antihypertensive drugs	Alcohol and other street drugs

Antineoplastics	Antiparkinsonism drugs
Adrenal cortical steroids	Cortisone acetate
Antibacterials	Cycloserine
Cardiovascular preparations	Progestational agents
Estrogen agents	

If an independent examination is required, the claimant should be sent to a psychiatrist. The psychiatrist should be board certified in general psychiatry and, if possible, a psychiatrist should be selected that is experienced and board certified in forensic psychiatry (SEE Section 1.7 of this guide).

9.4 Documents that are especially important in cases of Depression:

- ⊕ Psychological test results including the MMPI-2 and depression inventories
- ⊕ All medical records including the claimant's past medical and psychological history and records
- ⊕ Pharmacy records
- ⊕ The claimant's work and job performance records
- ⊕ The reports and handwritten clinical notes of the claimant's psychologist or psychiatrist
- ⊕ Blood chemistry records, lab tests

SEE Chapter 2 of this Guide for further documents and information needed for the analysis of a psychological injury claim.

9.5 Claims Analysis Questions: Depression

- ⊕ Does the claimant have a Personality Disorder such as the Borderline Personality Disorder with imbedded depression?
- ⊕ Is the claimant taking any medications known to cause depression?
- ⊕ Does the claimant have a history of any medical conditions known to cause depression?
- ⊕ Is there a familial history of depression?
- ⊕ Has the claimant suffered a major loss such as divorce or loss of a family member or close friend within the past two years?
- ⊕ Does the claimant have a past history of depression?
- ⊕ Has the claimant ever been prescribed antidepressant medication?

Chapter 10 - Organic Brain Syndrome and Post-concussion Syndrome (Head Injury)

10.1 Description: Organic Brain Syndrome (OBS)

The claimant alleges that the insured event or cause of action produced a change in the structure or metabolism of his or her brain. These cases are also known as traumatic brain injury (TBI) and can result from any type of head injury or toxic exposure. In some cases, a claim of organic brain syndrome is made even though the CT and MRI scans do not show a visible lesion in the brain. This is high risk type of claim for the insurer and frequently results from overinterpreted or misinterpreted neuropsychological test data. The organic brain syndrome claim can arise from head injury and toxic exposure cases.

Since organic mental disorders encompass such a wide range of psychopathological syndromes and organic etiologies, no single course characterizes them all. The course of illness is also extremely variable. A major factor in determining the course is the nature of the underlying pathology. Metabolic disorders, psychoactive substance intoxications and systemic illnesses tend to cause temporary brain dysfunction, and may be followed by full recovery. Pathological processes causing structural damage to the brain are more likely to cause permanent residual impairment.

Example: Organic Brain Syndrome

The claimant, Dana B. is a 38-year-old homemaker. She was waiting to turn left at a traffic signal when she was struck from behind. Although she was wearing her seatbelt, she claims to have suffered a whiplash type injury and now claims Organic Brain Syndrome. Upon arrival at the emergency room, it was noted that she was alert, oriented and her pupils were reactive to light. She was noted to have a perfect Glasgow Coma Scale of 15 and she had no neurological signs of injury. No loss of consciousness was reported by the emergency room personnel, the ambulance crew or by the claimant herself. Her diagnosis was cervical sprain and she was told to wear a collar and see her private physician within one week.

Within one year, the claimant had seen six specialists in neurology, orthopaedics, rheumatology and sports medicine. In addition, she had begun psychotherapy for depression with a psychiatric social worker and

her neuropsychological testing showed, "severe cognitive loss." The claimant now seeks to enter a long-term head injury rehabilitation program.

10.2 Summary of Required Symptoms: Organic Brain Syndrome

Organic Brain Syndrome is a generic term and may actually refer to many different conditions. These may include delirium, dementia, amnesia, hallucinations, organic mood disorder, organic anxiety disorder and organic personality disorder. The most common insurance claim is dementia, (the loss of cognitive ability, loss of memory, inability to concentrate, etc.).

In most cases, the claim of Organic Brain Syndrome will include:

Aversion to loud noise	Aversion to bright lights
Dizziness	Fatigue
Headache	Impaired vision
Insomnia	Loss of memory
Loss of concentration	Nausea

Frequently, the early records will indicate that there was no loss of consciousness. However, the claim is eventually changed to include a loss of consciousness (frequently because the claimant changes his or her story when discussing the accident details with various doctors). Other claimed signs and symptoms may include seizures and/or blackouts. There are several types of organic brain syndrome cases. These are:

1. Actual head trauma with moderate or severe injury. Recovery varies but may be excellent.
2. Very mild concussion with a claim of long-term disability and severe cognitive loss (SEE Section 10.3 below).
3. No actual head injury, but a claim of organic brain syndrome is made regardless of the facts of the case. (SEE Section 10.3 below).

Can there be a Head Injury claim without a Head Injury?

Every year there are thousands of head injury claims that do not involve actual organic brain injury. The most common profile in these cases is as follows:

- ⊕ There is a low speed, minor impact accident.
- ⊕ There is no loss of consciousness or possibly a very mild concussion with a questionable loss of consciousness.

- ⊕ The claimant has a number of non-related life stressors that may involve job dissatisfaction, a dysfunctional family or problems related to a personality disorder. Usually, the claimant has experienced some important personal loss within the past months or even years.
- ⊕ The claimant sees several physicians with complaints of a continual, generalized, dull headache that is accompanied by nonspecific impairments such as easy fatigability, "dizziness" (lightheadedness), insomnia, and other mental difficulties.
- ⊕ The claimant is prescribed antidepressant, antianxiety, narcotic analgesic, anti-inflammatory and hypnotic medications. Frequently, claimants take more than eight different medications each day.
- ⊕ The claimant is sent for neuropsychological testing.

In many cases, the "neuropsychologist," is not well trained or qualified. The "neuropsychologist" or other head injury evaluator fails to:

- ⊕ Rule out the effects of prescribed medication and other drugs
- ⊕ Review the claimant's past school records
- ⊕ Rule out the effects of peripheral nerve damage
- ⊕ Rule out the effects of depression and anxiety
- ⊕ Rule out the effects of aging
- ⊕ Rule out the effects of prior head injury or disease
- ⊕ Rule out the effects of prior exposure to neurotoxins
- ⊕ Rule out the effects of personality disorders
- ⊕ Rule out test response manipulation
- ⊕ Consider that neuropsychological deficits are typically demonstrated in the normal population

The above factors and other weaknesses in the neuropsychological test protocol such as inaccurate information that is self-reported by the claimant, failure to obtain past medical records and gross overinterpretation of test data all contribute to the Head Injury claim without a Head Injury. In other words, insurers are currently paying for claims of organic brain syndrome where no head injury exists. These claims are based on multiple failures in the forensic head injury evaluation system.

10.3 The Medical and Neuropsychological Examinations in Organic Brain Syndrome cases

There are over two million head injuries in the U.S. each year. Approximately 25% of these are severe enough to involve extensive evaluation and treatment. Many of the remaining 1.5 million persons reporting head injury, become claimants under auto, homeowners, workers' compensation or other insurance policies. Frequently, the evaluations received by the insurer are contaminated with incorrect or overinterpreted data. Many times, there has been a failure to rule out the alternate causes of a cognitive loss.

The independent insurance examination should include an investigation of the claimant's past medical history. The examination should rule out the following alternate causes of Organic Brain Syndrome:

- ⊕ Chronic disorders of electrolyte metabolism
- ⊕ Degenerative diseases of the central nervous system
- ⊕ Disorders of the hematopoietic system (the formation of blood)
- ⊕ Encephalitis of any cause
- ⊕ Endocrinopathies such as hypothyroidism
- ⊕ Exposure to heavy metals or carbon monoxide
- ⊕ Hepatic, renal, or pulmonary failure
- ⊕ Hepatolenticular degeneration
- ⊕ Hypoxia or anoxia of any origin
- ⊕ Infections including meningitis
- ⊕ Intracranial space-occupying lesions
- ⊕ Long-term alcohol and other drug abuse
- ⊕ Metabolic, endocrine, and nutritional disorders
- ⊕ Multiple sclerosis
- ⊕ Past electric injury
- ⊕ Past effects of seizures
- ⊕ Past heat stroke
- ⊕ Remote effects of carcinoma and lymphomas
- ⊕ Vascular disorders
- ⊕ Vitamin intoxication or avitaminosis

Thorough medical and psychological examinations in organic brain syndrome cases can save the insurer millions of dollars annually. The recommended evaluation team includes specialists from the fields of neurology, psychiatry and neuropsychology.

10.4 Documents that are especially important in cases of Organic Brain Syndrome:

- ⊕ Neuropsychological and psychological test results and raw data
- ⊕ All medical records including the claimant's past medical and psychological history and records
- ⊕ Pediatric records and birth records if available
- ⊕ Pharmacy records
- ⊕ The claimant's work and job performance records
- ⊕ The reports and handwritten clinical notes of the claimant's psychologist or psychiatrist
- ⊕ Blood chemistry records, lab tests
- ⊕ The claimant's school records (all grades)
- ⊕ Military records - (any claimant that served in the armed forces)
- ⊕ Driving and accident history
- ⊕ Employment exposures to toxic substances
- ⊕ The actual CT or MRI films that are being used to support the claimant's case (obtain an independent reading of the films).

SEE Chapter 2 of this Guide for further documents and information needed for the analysis of a psychological injury claim.

10.5 Claims Analysis Questions: Organic Brain Syndrome

- ⊕ Has the claimant had a previous head injury or toxic exposure?
- ⊕ Do the medical records support the level of injury being claimed?
- ⊕ Were the claimant's school records taken into consideration in determining if he or she has actually had a cognitive loss?
- ⊕ Have the many diseases and disorders that present with a dementia been ruled out?
- ⊕ Are the claimant's examiners qualified as neuropsychologists or were the examinations done by trainees or psychologists with minimal training and experience in neuropsychology? Does the neuropsychologist have a prior relationship with claimant's attorney? Was the claimant sent for testing by his or her attorney or was the referral made by a treating specialist? Who paid for the neuropsychological testing?
- ⊕ Was the claimant taking medications or other substances at the time of testing that could affect the test results?
- ⊕ Was an adequate clinical interview done at the time of testing to rule out the effects of a severe

depression (depressive pseudodementia) or other intervening variables such as medical illnesses, severe stress, peripheral nerve damage, prior language or reading deficiencies?

- ⊕ Were the claimant's tests administered and scored properly? Were accepted neuropsychological tests and test batteries used in the evaluation? Were the complete tests given or did the examiner use only selected portions of the tests?
- ⊕ Did the examiner control for the effects of education and aging on the tests?
- ⊕ Are the claimant's neuropsychological test results and findings consistent with other samples of his behavior and cognitive ability such as deposition responses and life accomplishments since the time of injury?
- ⊕ Is there any medical evidence to corroborate the neuropsychological test findings such as MRI, CT or other medical tests that would confirm changes in the structure or metabolism of the brain?

10.6 Post-Concussion Syndrome

Following a mild head injury, a number of neurobehavioral symptoms are reported with enough frequency to be referred to as the postconcussive syndrome (PCS). Recovery from PCS appears to be a complex process, and may be further mitigated by a host of psychological variables and/or secondary gain issues, particularly in cases involving litigation. It is important to note that PCS and PTSD share symptoms, although PTSD is relatively uncommon in mild TBI.

The potential role of expectancy or symptoms attribution should also be carefully considered; benign to "normal" lapses in mental efficiency may be automatically attributed to the alleged head injury. This can be a particularly issue for patients who suffer persistent PCS, because they can become attuned to or overly focused on these benign lapses. This can in turn lead to further emotional distress, in addition to providing ongoing "evidence" of their brain impairment. Accordingly, feelings of stress following head injury may lead to hyperarousal, which may subsequently continue to decreased attention.

Post concussion symptoms (PCS) do not in themselves provide evidence of a head injury because PCS may also occur on a psychological or motivational basis. Furthermore, PCS do not correlate consistently with indicators of initial injury severity. The occurrence of PCS is related to CT abnormalities, but not to loss of consciousness (LOC) or post traumatic amnesia (PTA). Although sensitivity of MRI to

nonhemorrhagic intracranial pathology after a mild head injury is well documented, the relationship of abnormal MRI to chronic residual impairment is not. In general, discrepancies between injury severity and severity of sequelae create confusion in labeling all levels of head injury. The correlation between cases with severe initial injury is not a perfect one. A minority of cases with severe initial injury, as measured for instance by the Glasgow Coma Scale, recover with only mild sequelae. Conversely, a small percentage of cases of mild head injury result in severe and persistent cognitive and behavioral impairments.

Chapter - 11 Adjustment Disorders

11.1 Description:

The Adjustment Disorder is defined as a short-term disturbance of non-psychotic proportions that is provoked by an explicit stressor (s). The stressor is generally within normal life experiences, e.g., divorce or being fired. The individual becomes overwhelmed with an intensity of emotion that is disproportionate to the stimulus. If it lasts longer than six months, another diagnosis may be in order.

Adjustment disorders may begin at any age and appear to be fairly common. Onset of the disorder begins within three months of the stressful event, possibly within a few days.

There are several subtypes of Adjustment Disorders, the most common diagnosis being Adjustment Disorder with Depressed Mood. In most cases however, symptoms remit without treatment and the stress of litigation itself, can be the source of these symptoms.

Example: Adjustment Disorder

Linda A. works as a dispatcher for a city 911 system. She has accused a male co-worker of making an obscene comment. The male co-worker admitted making the comment but stated that it was in response to her rudeness. Linda now claims that the event has caused her to have anxiety and depression. Linda's attorney has sent her to a psychologist. The resulting diagnosis was Adjustment Disorder with mixed anxiety and depression.

11.2 Summary of Required Symptoms: The Adjustment Disorder

- ⊕ The development of symptoms in response to an identifiable psychosocial stressor, that occurs within three months of the onset of the stressor.
- ⊕ The symptoms are clinically significant as indicated by either of the following:
- ⊕ Impairment in social, academic or occupational functioning
- ⊕ Marked distress that is in excess of what would be expected from the stressor

- ⊕ The disturbance is not merely one instance of a pattern of overreaction to stress or an exacerbation of another clinical mental disorder.
- ⊕ The symptoms do not persist for more than six months after the termination of the stressor
- ⊕ The disturbance does not represent Bereavement.

11.3 The Medical and Psychological Examinations in Adjustment Disorder cases

- ⊕ The exact circumstances of the claimed event or stressor
- ⊕ A full description of the claimed symptoms or impairment
- ⊕ A comparison of the claimant's occupational, social and recreational activities, before and after the claimed stressor
- ⊕ The names of all medications taken by the claimant as well as caffeine, alcohol and other substance use
- ⊕ A detailed medical, psychological and social history of the claimant including past trauma and an inventory of his or her stressors.

11.4 Documents that are especially important in Adjustment Disorder cases:

- ⊕ The claimant's work, school and job performance records
- ⊕ The claimant's pharmacy records
- ⊕ The reports and handwritten clinical notes of the claimant's psychologist or psychiatrist
- ⊕ The claimant's past medical history and records.

SEE Chapter 2 of this Guide for further documents and information needed for the analysis of a psychological injury claim.

11.5 Claims Analysis Questions:

- ⊕ Does the claimant have the required criteria for the diagnosis of an Adjustment Disorder?
- ⊕ Has the diagnosis been based solely on self-reported information?
- ⊕ What are the claimant's other life stressors?
- ⊕ Has the cause of the stress ceased?

Appendixes

Appendix A: Glossary of Psychological Injury Terms (Terms that are frequently found in Psychological Injury Cases)

Appendix B: Glossary of Psychological and Neuropsychological Tests

Appendix C: Glossary of Medical Tests and Terms

Appendix D: Symptom Manipulation, Malingering and other conditions

Appendix E: The 20 most important questions to ask the claimant's treating or evaluating mental health specialists

APPENDIX A: Glossary of Psychological Injury Terms

(Terms that are frequently found in Psychological Injury Cases)

Adjustment Disorder with Anxious Mood - A maladaptive reaction to a clearly identifiable event accompanied by anxiety.

Adjustment Disorder with Depressed Mood - A maladaptive reaction to a clearly identifiable event accompanied by depression.

Adrenal Cortical Insufficiency (Addison's Disease) - Diminished functioning of the adrenal glands leading to weakness, fatigability, weight loss and hypotension.

Affect - A pattern of observable behaviors that is the expression of a subjectively experienced feeling state (emotion). Examples of affect are euphoria, anger, and sadness. Affect is variable over time, in response to changing emotional states.

Aminophylline - Prescribed to relax smooth muscles (i.e. Bronchial muscles in asthma). Also stimulates CNS and can cause G.I. irritation.

Amnesic Syndrome - An organic mental disorder with memory impairment as the single predominant cognitive defect.

Amphetamines - Synthetic drugs which produce a sense of increased energy; used in treatment of narcolepsy, attention deficit and weight depression.

Anorectics - Used for weight control. Examples: Phenmetrazine diethylpropin and Chlorophentermine.

Antiarrhythmia Agents - Prescribed to control abnormal heart rhythms. Examples: Norpace, Procan SR, CinQuin, Quinidex, Quinora and Tonoca-d.

Anticonvulsants - Prescribed to control seizure attacks. Examples: Amytal, Clonopin, Zarontin, Cloentin, (Phenobarbital), Milontin, (Primidone), (Valproic Acid) and (Butabarbital), Dilantin and Tegretol.

Antihypertensive - Prescribed to counteract elevated blood pressure. Examples: (Aldoril), Apresazide, Capoten, Diupres, Hyloril, Ismelin, Alazine, Loniten and Salutensin.

Antineoplastic Agents - Highly toxic agents used to combat and destroy tumor cells. Examples: Vinka Alkaloids; vinblastine and vincristine and methotrexate.

Antiparasite Drugs - Prescribed to destroy or inhibit parasites such as Roundworms, Tapeworms, Flukes and Protozoa. Examples: Quinacrine, Metronidazole, Mebendazole, Thiabendazole and Paromomycin.

Antisocial Personality Disorder - Personality disorder in which there is a history of continuous and chronic antisocial behavior in which others are violated. Also called character disorders, they are life-long patterns of dealing with one's environment.

Anti-ulcer Drugs - Inhibit gastric acid secretion. Adverse reactions of confusion and depression can occur in cases of renal insufficiency, organic brain syndrome or when taken in combination with other drugs that slow it's metabolism. Example: Cimetidine.

Antivirus Agents - Prescribed to prevent penetration of virus into host cells. Examples: Symmetrel, Idoxuridine, Acyclovir, Vidarabine, and Trifluridine.

Anxiety - Apprehension, tension, or uneasiness that stems from the anticipation of danger, which may be internal or external. The manifestations of anxiety include motor tension, autonomic hyperactivity, apprehensive expectation, and vigilance and scanning.

Asprin - ASA: Acetylsalicylic Acid.

Attention - The ability to focus in a sustained manner on one activity. A disturbance in attention may be manifested by difficulty in finishing tasks that have been started, easy distractibility, or difficulty in concentrating on work.

Avoidant Personality Disorder - Excessive shrinking from contact with strangers and an increased desire for affection, acceptance and relations with family members.

Barbiturates - Drugs that depress the activities of the CNS. Examples: Amytal, Nembutal, Seconal, Luminal and Tuinal.

Belladonna Alkaloids - An antispasmodic used in cardiac and respiratory stimulation. Examples: Atropine, Hyoscine and Hyoscyamine.

Borderline Personality Disorder - Instability in interpersonal relationships, behavior, mood, and self-image.

Bromides - Prescribed for sedation; antiemetic, aphrodisiac and anticonvulsant effects accompanying. Examples: Ammonium Bromide, Bromide 5 elixir and Calcium Bromide.

Caffeine Intoxication - Recent consumption of caffeine; characterized by restlessness, nervousness, insomnia, diuresis and gastrointestinal complaints.

Cancerphobia - An imprecise term used in litigation. It refers to a variable and vague class of symptoms and generally refers to the fear of contracting cancer. Not a true phobia, the term generally refers to multiple anxiety and depressive symptoms. Used as the focus of litigation in cases where a person alleging toxic exposure from carcinogens has not yet developed a cancerous disease. The fear of cancer may have unconscious meanings and may symbolize internalized rage, guilt or a troubled relationship. Frequently the symptoms displayed do not meet the diagnostic criterion for any specific mental disorder.

Cardiovascular Disease - Disease of the heart and surrounding blood vessels.

Central Nervous System Diseases - Includes meningitis and encephalitis.

Circumstantiality - A term used to describe speech that is indirect and delayed in reaching the point because of unnecessary, tedious details and parenthetical remarks. Circumstantial replies or statements may be prolonged for many minutes if the speaker is not interrupted and urged to get to the point. Circumstantiality is common in an Obsessive Compulsive Personality Disorder and in many people without mental disorder.

Cocaine Intoxication - Acute anxiety reaction with high blood pressure, racing heart beat and paranoia.

Compulsion - Repetitive and seemingly purposeful behavior that is in response to an obsession, or performed according to certain rules or in a stereotyped fashion. Performing the act is not pleasurable, although it may afford some relief of tension. A person feels compelled to wash her hands every time she shakes hands because of a fear of contamination, which she recognizes as excessive. Compulsions are characteristic of the Obsessive Compulsive Disorder.

Confabulation - Fabrication of facts or events in response to questions about situations or events that are not recalled because of memory impairment. It differs from lying in that the person is not consciously attempting to deceive. Confabulation is common in the Amnesic Disorder.

Conversion Symptom - A loss or alteration of physical functioning that suggests a physical disorder, but is actually a direct expression of a psychological conflict or need. The disturbance is not under voluntary control and is not explained by any physical disorder (this possibility having been excluded by appropriate examinations). Conversion symptoms are observed in Conversion Disorder, and may occur in Schizophrenia.

Corticosteroids - Hormones or hormone-like substances used in multiple therapies. Examples: Glucocorticoids, Mineralocorticoids and Androgens.

Defense Mechanisms - Patterns of feelings, thoughts, or behaviors that are relatively involuntary and arise in response to perceptions of psychic danger. They are designed to hide or to alleviate the conflicts or stressors that give rise to anxiety. Some defense mechanisms, such as projection, splitting, and acting-out, are almost invariably maladaptive. Others, such as suppression and denial, may be either maladaptive or adaptive, depending on their severity, their inflexibility, and the context in which they occur.

Displacement - A mechanism in which the person generalizes or redirects a feeling about an object or a response to an object onto another, usually less threatening object.

Dissociation - A mechanism in which the person sustains a temporary alteration in the integrative functions of consciousness or identity.

Passive Aggression - A mechanism in which the person indirectly and unassertively expresses aggression toward others.

Projection - A mechanism in which the person falsely attributes his or her own unacknowledged feelings, impulses, or thoughts to others.

Reaction Formation - A mechanism in which the person substitutes behavior, thoughts, or feelings that are diametrically opposed to his or her own unacceptable ones.

Repression - A mechanism in which the person is unable to remember or to be cognitively aware of disturbing wishes, feelings, thoughts, or experiences.

Somatization - A mechanism in which the person becomes preoccupied with physical symptoms disproportionate to any actual physical disturbance.

Suppression - A mechanism in which the person intentionally avoids thinking about disturbing problems, desires, feelings, or experiences.

Degenerative Cerebral Disease - Gross atrophy of the brain and corpus striatum. Example: Huntington's Chorea.

Delusion - A false personal belief based on incorrect inference about external reality and firmly sustained in spite of what almost everyone else believes and in spite of what constitutes incontrovertible and obvious proof or evidence to the contrary. The belief is not one ordinarily accepted by other members of the person's culture or subculture. When a false belief involves an extreme value judgment, it is regarded as a delusion only when the judgment is so extreme as to defy credibility. Delusions are subdivided according to their content.

Delusion, persecutory. A delusion in which the central theme is that a person or group is being attacked, harassed, cheated, persecuted, or conspired against. Usually the subject or someone or some group or institution close to him or her is singled out as the object of the persecution.

Delusion of reference. A delusion whose theme is that events, objects, or other people in the person's immediate environment have a particular and unusual significance, usually of a negative or pejorative nature.

Delusion, somatic. A delusion whose main content pertains to the functioning of one's body. Examples: One's brain is rotting; one is pregnant despite being postmenopausal.

Dementia (True Dementia) - An organic mental disorder in which there is a deterioration of previously acquired intellectual abilities of sufficient severity to interfere with social or occupational functioning.

Depersonalization - An alteration in the perception or experience of the self so that the feeling of one's own reality is temporarily lost. This is manifested in a sense of self-estrangement or unreality, which may include the feeling that one's extremities have changed in size, or a sense of seeming to perceive oneself from a distance (usually from above). Depersonalization is seen in Depersonalization Disorder, and may also occur in Schizotypal Personality Disorder and Schizophrenia. It is sometimes observed in people without any mental disorder who are experiencing overwhelming anxiety, stress, or fatigue.

Depressive Disorders - A feeling of sadness, despair and discouragement. Includes organic and non-organic causes. Depression can easily reach disabling levels without adequate treatment.

Depressive Pseudodementia - In many insurance claims, depressive pseudodementia is misdiagnosed as true organic brain syndrome by the claimant's examiners. It is differentiated from true dementia by several clinical features including: The onset can be dated with precision and there is a rapid progression of symptoms. The patient complains of cognitive loss with detailed descriptions of his disability. The patient highlights his failures and makes little effort to perform even simple tasks. He communicates a strong sense of distress and does not try to keep up. The depression is prominent as are the loss of social skills. There is an incongruence in symptoms of cognitive dysfunction and there is a nocturnal accentuation of problems. Although attention and concentration may be well preserved, "I don't know" answers are typical and the memory loss for recent and remote events are equally severe. Memory gaps exist for specific periods or events and there is a marked variability in performance on tasks of similar difficulty.

Digitalis - A drug which causes the heart to beat more forcefully and slower. Examples: Digoxin and Digitoxin.

Diuretic - A drug which promotes urine formation. Examples: Aldactazide, Bumex, Diuril, Hyalidone, Lasix and Lozol.

Epilepsy - A disorder characterized by periodic motor or sensory seizures or their equivalents, and sometimes accompanied by a loss of consciousness.

Estrogen Agents - A female sex hormone producing agent. Examples: Benzestrol, Diethylstilbestrol, Estradiol, Quinestrol, Hexestrol and Estrone.

Factitious Disorder (Munchausen Syndrome) - Repeated and voluntary simulation of a physical or mental illness for no apparent purpose other than obtaining psychiatric or medical treatment or to become a patient. Also known as pathomimicry.

Flight of Ideas - A nearly continuous flow of accelerated speech with abrupt changes from topic to topic, usually based on understandable associations, distracting stimuli, or plays on words. When severe, speech may be disorganized and incoherent.

Flight of ideas is most frequently seen in manic episodes, but may also be observed in some cases of

organic mental disorders, Schizophrenia, other psychotic disorders, and, occasionally, acute reactions to stress.

Ganser Syndrome - Phenomenon when the patient gives an utterly incorrect reply, although it is clear he understood the sense of the question. Appears most frequently but is not limited to prison and military populations. The individual consciously or unconsciously misleads others regarding his/her mental state in order to gain an advantage or escape responsibility. Although the patient appears to be disoriented in time and place, his general behavior gives the distinct impression that he is alert. The syndrome may include a lack of insight, circumscribed amnesia, and hysterical analgesia. Ganser Syndrome is midway between a true disorder and malingering. The syndrome can appear after head injury and when litigation is involved. The symptoms including a loss of acquired intelligence may continue until the legal matters are resolved. The disorder is characterized by answering "past the point", and "I don't know" answers. This condition occurs in insurance claims when the claimant is attempting to convince his examiners that he has a brain injury.

Generalized Anxiety Disorder - A persistent anxiety of at least one month's duration that includes symptoms of motor tension, autonomic hyperactivity, apprehensive expectation, vigilance and scanning. Sometimes accompanied by a mild depression. Impairment in social or occupational functioning is rarely more than mild.

Hallucination - A sensory perception without external stimulation of the relevant sensory organ. A hallucination has the immediate sense of reality of a true perception, although in some instances the source of the hallucination may be perceived as within the body (e.g., an auditory hallucination may be experienced as coming from within the head rather than through the ears).

Hematopoietic Disorders (Blood Cell) - Disruption of cell renewal system, characterized by anorexia, apathy, nausea, and vomiting.

Hepatic Encephalopathy - A neuropsychiatric syndrome due to liver disease and usually associated with portal-systemic shunting of venous blood.

Histrionic Personality Disorder - A personality disorder in which there are overly dramatic, reactive and intensely expressed behavior and characteristic disturbances in interpersonal relations.

Hyperadrenalism (Cushing's Disease) - Constellation of clinical abnormalities due to chronic exposure to excesses of cortisol or related corticosteroids.

Hyperthyroidism (Thyrotoxicosis) - A high thyroid hormone level causing increased protein metabolism and oxygen absorption.

Hypnotics - Drugs which induce sleep. Examples: Amytal, Buticap, Oradrate, Placidyl, Doriden, Noludar, Nembutal, Luminal, Sedadrops, PBR/12, Seconal, Restoril and Tuinal.

Hypoglycemia - Abnormally low blood sugar level.

Hypothyroid (Myxedema) - A thyroid hormone deficiency. In severe prolonged cases there can be personality changes.

Ideas of Reference - An idea, held less firmly than a delusion, that events, objects, or other people in the person's immediate environment have a particular and unusual meaning specifically for him or her.

Indomethacin (Anti-inflammatory) - An indole derivative which has analgesic, antipyretic and anti-inflammatory action. Treatment for rheumatoid arthritis.

Insomnia - Difficulty falling or staying asleep. Initial insomnia is difficulty in falling asleep. Middle insomnia involves an awakening, followed by difficulty returning to sleep, but eventually doing so. Terminal insomnia is awakening at least two hours before one's usual waking time and being unable to return to sleep.

Insulin - Stimulates carbohydrate and fat metabolism.

Intracranial Tumors - Brain tumors of the skull, the meninges, the cranial nerves, the supportive tissue of the brain or the pineal body.

L-Dopa - Used in treatment of idiopathic Parkinson's disease. Mimicks dopamine, a neurotransmitter.

Lithium Carbonate - Antipsychotic, antimanic drug. Used in the treatment of the manic-depressive illness.

Major Tranquilizers - Antipsychotic drugs that fall into six major categories including the phenothiazines. The major tranquilizers are primarily responsible for the massive reductions in the number of hospitalized mental patients. Side effects may include Parkinsonian Syndrome and Tardive Dyskinesia. Examples: Thorazine, Stelazine, Prolixin, Tindal, Mellaril, Serentil, Haldol, Navane and Serpasil.

Male Hypoandrogen Secretion - Androgenic male hormone. Examples: Methyltestosterone, Fluoxymesterone.

Malingering - A condition not attributable to a mental or physical disorder. The voluntary production and presentation of false or grossly exaggerated physical or psychological symptoms for financial gain or to avoid responsibility.

MAO Inhibitor Antidepressants - Drugs that elevate the moods of patients by supplying the MAO enzyme which increases the CNS catecholamine concentration. Examples: Isocarboxazid, Phenelzine Sulfate, and Tranylcypromine Sulfate.

Masked Depression - Absence of consciously experienced depression. Patient may experience chronic pain, insomnia, weight loss or other bodily complaints.

Menopausal Distress - May include psychological symptoms of anxiety, fatigue, tension, emotional lability, irritability, depression, dizziness and insomnia. Can accompany surgical or natural processes.

Metabolic and Pulmonary Failures - Malfunction of the digestive and respiratory systems.

Minor Tranquilizers - Examples: Librium, Lipoxide, (Diazepam), Valium, Ativan, (Lorazepam) and (Meprobamate).

Mood - A pervasive and sustained emotion that, in the extreme, markedly colors the person's perception of the world. Common examples of mood include depression, elation, anger, and anxiety.

Mood, dysphoric. An unpleasant mood, such as depression, anxiety, or irritability.

Mood, euthymic. Mood in the "normal" range, which implies the absence of depressed or elevated mood.

Multiple Sclerosis - A focal disorder of the optic nerves, spinal cord, and brain which occurs over a period of years in young adults.

Noncompliance with Medical Treatment - Intentional failure to take medication, receive treatment, follow a prescribed diet. Not a mental disorder.

Obsessive Compulsive Disorder - A persistent intrusion of unwanted and uncontrollable thoughts or urges causing a repeated compulsive action.

Opioid Intoxication - Characterized by euphoria, flushing, itching skin, drowsiness, decreased respiratory rate and depth, hypotension, bradycardia, and decreased body temperature.

Organic Brain Syndrome - A global term for symptoms produced by head injury, toxic exposure, hypoxia, anoxia and other causes. The term "organic" refers to a structural change in the brain or neurochemical environment or metabolism.

Pancreatic Carcinoma - Cancer of the pancreas. Causes a decrease in the enzymes: lipid, glucagon, and insulin.

Panic Attacks - Discrete periods of sudden onset of intense apprehension, fearfulness, or terror, often associated with feelings of impending doom. During the attacks there are such symptoms as dyspnea, palpitations, chest pain or discomfort, choking or smothering sensations, and fear of going crazy or losing control. Panic attacks are characteristic of Panic Disorder, but may also occur in Somatization Disorder, Major Depression, and Schizophrenia.

Panic Disorder - A neurotic disorder characterized by chronic, unrealistic anxiety often punctuated by acute attacks of anxiety of panic.

Paranoid Ideation - Ideation, of less than delusional proportions, involving suspiciousness or the belief that one is being harassed, persecuted, or unfairly treated.

Paranoid Personality Disorder - Pervasive and long-standing suspiciousness and mistrust of others without delusions and hallucinations.

Passive Aggressive Personality Disorder - Aggressive behavior manifested in passive ways such as obstructionism, pouting, procrastination, intentional inefficiency and obstinacy.

Pernicious Anemia (Addisonian Anemia) - Vitamin B12 deficiency causing abnormality in hemopoiesis.

Perseveration - Persistent repetition of words, ideas, or subjects so that, once a person begins speaking about a particular subject or uses a particular word, it continually recurs. Perseveration differs from the repetitive use of "stock words" or interjections such as "you know" or "like."

Personality - Deeply ingrained patterns of behavior, which include the way one relates to, perceives, and thinks about the environment and oneself.

Personality Disorders - Personality is formed between childhood and young adulthood. As each person grows and develops, their life experiences, physical health, social environment and genetic traits all work to form the "persona" or personality. Personality then becomes the life-long manner in which we perceive and deal with our environment, other persons and our self-image.

There are approximately 12 pathological types of personalities and claimants frequently have definite personality disorders that pre-exist the insured accident and that drives most of their behavior. It is the personality disorder characteristics that may be the actual basis of litigation. Claimant's psychological and psychiatric examiners rarely admit the existence of these conditions because such an admission would cloud their claim or litigation related diagnosis.

Phenacetin - An acetaminophen used as an analgesic and antipyretic.

Phenylbutazone (Anti-inflammatory) - A drug used in inflammatory conditions such as gout and arthritis.

Pheochromocytoma - A tumor of the sympathetic nervous system, usually in the adrenal medulla but sometimes in the thorax or paraganglia.

Phobia - A persistent, irrational fear of a specific object, activity, or situation that results in a compelling desire to avoid the dreaded object, activity, or situation (the phobic stimulus). More commonly, the person does actually avoid the feared situation or object, although they realize the fear is unreasonable and unwarranted.

Phobic Disorders - A neurotic disorder characterized by the presence of irrational or exaggerated fears of objects, situations, or bodily functions not inherently dangerous or an appropriate source of anxiety.

Porphyria - A metabolic disorder characterized by the excretion of porphyrins in the urine and accompanied by attacks of abdominal pain, peripheral neuropathy, and other mental symptoms.

Post-traumatic Stress Disorder - Develops after experiencing a psychologically distressing event. Characterized by reexperiencing the event and by overresponsiveness to, or involvement with, stimuli that recall

the event. The precipitating event must be beyond the range of normal human experience.

Postpartum Disorders - Maternal disorder occurring within 90 days of birth.

Poverty of Speech - Restriction in the amount of speech, so that spontaneous speech and replies to questions are brief and not elaborated. Poverty of speech occurs frequently in Schizophrenia, Major Depressive Episodes, and Organic Mental Disorders, such as Dementia.

Pressure of Speech - Speech that is increased in amount, accelerated, and difficult or impossible to interrupt. Usually it is also loud and emphatic. Frequently the person talks without any social stimulation, and may continue to talk even though no one is listening. Pressure of Speech is most often seen in manic episodes, but may also occur in some cases of Organic Mental Disorders, Major Depression with psychomotor agitation, Schizophrenia, other psychotic disorders, and, occasionally, acute reactions to stress.

Prodromal - Early signs or symptoms of a disorder.

Progestational (Drugs) - A drug prescribed for cancer of the breast or endometrium. Example: Megace. Also can refer to the menstrual cycle.

Pseudodementia - Clinical features resembling a Dementia that are not due to organic brain dysfunction or disease. Pseudodementia may occur in a Major Depressive Episode or may be seen in Factitious Disorder with Psychological Symptoms.

Psychogenic Amnesia - Amnesia due to psychological or mental problems; not organically caused.

Psychogenic Cardiac Nondisease - Cardiac pain or illness caused by mental or psychic factors as opposed to organic factors.

Psychogenic Pain Disorder - Pain due to mental or psychological factors not due to organic cause.

Psychomotor Agitation - Excessive motor activity associated with a feeling of inner tension; the activity is usually nonproductive and repetitious. When the agitation is severe, it may be accompanied by shouting or loud complaining.

Psychomotor Retardation - Generalized slowing of physical and emotional reactions and activity.

Reflex Sympathetic Dystrophy - RSD is a syndrome characterized by burning pain, hyper skin sensitivity, swelling, excessive perspiration and trophic changes in the skin and bone of the affected extremity. It can be either hot or cold dystrophy and its causes range from trauma, infection and tendonitis to myocardial infarction and pulmonary fibrosis. Treatments are varied and prognosis is best when early, active and aggressive intervention is pursued. A cause cannot be determined in at least one third of all reported cases.

Rheumatoid Arthritis - A chronic systemic disease in which connective tissue inflammation occurs.

Schizophrenia - A group of disorders characterized by disturbances of language and communication, thought, perception, affect, and behavior which last longer than six months.

Schizotypal Personality Disorder - Characterized by oddities of thinking, perception, communication, and behavior that suggest schizophrenia but are never severe enough to meet the criteria for that disorder.

Sexual Dysfunction - Organic or emotional inability to have or complete the sexual act.

Syndrome - A group of symptoms that occur together and that constitute a recognizable condition. "Syndrome" is less specific than "disorder" or "disease."

Systemic Lupus Erythematosus - A disease characterized by fever, muscle and joint pains, anemia and leukopenia. Leads to alteration of connective tissue.

Thyroxin - An iodine containing hormone (symbol T), secreted by the thyroid gland. Used in treating hypothyroidism, it stimulates cell metabolism.

Transient Global Amnesia - Characterized by loss of ability to recall recent events or to record new memories. Events of the distant past are readily recalled.

Tricyclic Antidepressants - An antidepressant drug that works by blocking the reuptake of norepinephrine or serotonin. Examples: Imipramine, Amitriptyline, Desipramine, Nortriptyline, and Protriptyline.

Uncomplicated Bereavement - A full depressive syndrome that is part of the normal reaction to the death of a loved one (bereavement). Can last for up to two years and differs from pathological grief in that the self-image of the grieving survivor is left intact. Uncomplicated bereavement may not occur immediately but rarely occurs after the first two or three months. The extent of normal grieving varies considerably among different sub-cultural groups.

Uremic Encephalopathy - Acute or chronic failure of normal renal functions leading to serious systemic metabolic changes such as alterations in memory, orientation and consciousness.

Vascular Disorders - Disorder of circulatory vessels.

Vitamin Deficiency-B1 - Abnormal glucose levels and decreased lactate metabolism.

APPENDIX B: Glossary of Psychological and Neuropsychological Tests

Beck Depression and Hopelessness Survey: This scale was developed to measure both the level of depression and assess the current potential of suicide. It includes 42 questions which requires patient endorsement or denial of a thought or feeling. Intended use with patients over 17 years old and a 5th grade reading level. The test easily permits symptom exaggeration.

Beck Depression Inventory: A paper and pencil inventory of 21 questions, it was developed for use in a treatment setting to measure the severity of the patient's depression. An accurate measure of depression only in the past 7 days prior to testing. Not predictive of future depressive episodes or a psychiatric disorder.

Bender Visual Motor Gestalt Test: This test is used to evaluate learning disabilities, organic brain dysfunction, visual motor functioning and motor coordination in children and adults. The test involves looking at nine designs and reproducing the shapes on a blank page. Patient manipulation is relatively easy and interpreting results can be somewhat subjective if the proper scoring techniques are not used.

Benton Revised Visual Retention Test: This ten item test measures visual memory. The patient must reproduce from memory geometric shapes which requires visual recall, spatial perception and visuomotor reproduction. Low scores may indicate neuropsychological impairment, as well as, low motivation, medication side effects, anxiety, depression and pain.

Boston Diagnostic Aphasia Examination (BDAE): Developed to evaluate aphasic syndromes on 34 subtests. The patient is rated on fluency of speech, auditory comprehension, naming, oral reading, reading comprehension, writing and parietal lobe functioning. The test is extremely sensitive to subtle communication and aphasic disturbances however, the examiner must have a strong background in aphasic disturbances.

California Verbal Learning Test: Evaluates verbal learning and memory deficits by testing the patients ability to learn a list of words and then after a delay, recall those words. Scores above average are difficult to obtain however, even when no impairment exists. Thus creating the appearance of a loss or deficit.

Category Test: Part of the Halstead-Reitan Neuropsychological Battery, it assesses the patient's

conceptual and problem solving skills. Stimulus cards are presented and the patient must decide whether it represents the numbers 1,2,3,4. Poor performance can be due to several non-neurological factors, such as depression, anxiety, lack of motivation, poor eye-sight or medications.

Dichotic Listening Test: A measure of ear advantage to determine the hemisphere of speech-dominance. It has not been determined however, if this is a valid measure of speech dominance, hemisphere specialization, or laterality. A diagnosis of brain damage based on this test is speculative, at best.

Finger Tapping Test: Part of the Halstead-Reitan test battery. Brain damage can effect the tapping speed of the index finger of each hand. The score is the average obtained over five trials for each hand. This test alone is not appropriate to evaluate coordination and motor ability. Medications can impact tapping speed and poor performance can be due to conscious manipulation.

Grooved Pegboard Test: Measures fine motor coordination and manual dexterity. A part of the Halstead-Reitan test battery. The test requires the patient to place pegs into slots as quickly as possible using the dominant and non-dominant hands. Poor performance can be due to conscious manipulation, orthopedic, visual or motivational problems.

Halstead-Reitan Neuropsychological Test Battery (HRNB): This battery consists of 12 tests taking 6-8 hours to administer. It can discriminate between brain-damaged patients and normal controls, as well as brain-damaged and psychiatric patients. The battery can also determine the extent or severity of the brain damage. However, test scores can be influenced by a variety of non-neurological factors and the battery cannot detect all neuropsychological impairments, particularly recent memory. Due to time constraints, the entire battery is frequently not used, but portions of the HRNB are often combined with other tests and presented as if they were a valid battery. Even when the full battery is administered, it needs to be supplemented by other neuropsychological tests to provide a complete patient profile.

Hendler Screening Test (experimental): This questionnaire was developed to distinguish between valid and invalid complaints of back pain. Due to it's recent development and lack of cross-validation studies the results may be misleading. Patients with poor reading skills may have difficulty with the questionnaire.

Hooper Visual Organization Test: This test was designed to detect organic brain pathology through the process of

identifying simple drawings which have been cut into several pieces and rearranged. Several studies have found a high level of misclassification of brain-impaired examinees. Results can be easily manipulated by the patient.

Human Figure Drawing: Designed to provide clues to the psychological functioning of the patient, this projective technique cannot provide scientific evidence that the patient is disabled, or suffering emotional distress.

Millon Behavioral Health Inventory: The 150 item questionnaire was designed for a general medical population receiving medical care (not psychiatric). It would provide insight into the psychological characteristics of a medically ill patient in order to formulate a treatment plan. Medications and apprehension can effect the outcome.

Millon Clinical Multiaxial Inventory-III: Used in the evaluation of personality disorders, it should be used cautiously since there is a tendency of producing many false positives. A high score on the debasement measure suggests that the patient is trying to appear to be suffering emotional distress.

Mini-Mental State Exam: It is a quick "reality check". The patient is asked eleven questions regarding, day, date, time, place, and purpose of the interview.

Minnesota Multiphasic Personality Inventory-2 (MMPI-2): Updated version of the MMPI, an objective personality test, it assesses a wide range of personality characteristics relevant to current daily functioning. The test is sensitive to a variety of personality disorders and psychiatric problems. The test is not valid if read to the patient, or if the patient takes the test home. There are a number of scales on the MMPI-2 which are useful in assessing the validity of the results. It was never designed to evaluate or diagnose brain-damaged patients.

Peabody Individual Achievement Test (PIAT): Designed to evaluate the level of scholastic attainment of an individual in grades kindergarten through the 12th. May not be appropriate for emotionally disturbed or culturally deprived children. Assumes optimal performance has been elicited.

Peabody Picture Vocabulary Test (PPVT and PPVT-Revised): This is an intelligence test designed to estimate an examinee's verbal intelligence through measuring the individual's hearing vocabulary. Wide use in schools for academic or educational counseling. A vocabulary measure can be a good indicator of general intelligence.

Porteus Maze Tests: Designed to evaluate the mental capacity of verbally handicapped examinees. Three versions of the test have been developed to allow for follow-up evaluations. The tests are vulnerable to impulsiveness, suggestibility, irresolution, and excitability. Highly suggestible, hysterical or uncooperative patients may produce invalid results.

Purdue Pegboard Test: This test was designed to assess manual dexterity for employment selection. However, it is often used as a test for neuropsychological impairment. The score is determined by the number of pegs placed correctly with the right and left hands and then both. Factors affecting scoring are finger size, medications, motivation and pain.

Raven's Progressive Matrices: This test of conceptual thinking and problem solving, it requires the patient to accurately discriminate between visual patterns with increasing difficulty. Carelessness or deliberately giving wrong answers can easily impact the score. It is not sensitive to brain-damage.

Reitan-Indiana Aphasia Screening Test: Aphasia is impairment in language understanding and/or production due to brain injury. This test evaluates the patient's ability to spell, name objects, read and write and understand the spoken language. Some clinicians look for observable signs of impairment, while others use specific cutoffs in terms of number of errors. Education, anxiety and mental disorders can effect the outcome.

Reitan-Klove Sensory Perceptual Examination: This is one of the 12 tests comprising the Halstead-Reitan Battery. Tactile, visual and auditory modalities are tested by very light touches to the hands and face. Poor performance can reflect an indication of lateralized lesions or a number of other conditions e.g., anxiety, paranoia or malingering.

Rey Auditory Verbal Learning Test (AVLT): A measure of auditory memory, it was normed on French subjects. May have limited applicability to English speaking patients. Limited validity and reliability data. Lack of effort can effect the outcome.

Rey-Osterrieth Complex Figure Test: This test evaluates the perceptual organization and visual memory in brain damaged patients. The patient copies a complex geometric figure onto a sheet of paper, each segment with a different colored pencil. All materials are removed and after a three minute delay the patient is asked to draw the figure from memory. Frequently the drawing improves simply from repetition. The test is sensitive to perceptual difficulties. However, since the

performance is under conscious control a poor performance could be malingered.

Rorschach Inkblot: Although originally developed to detect schizophrenia, it is currently used as a general diagnostic instrument and description of personality. The Exner scoring system has become the standard. However, it is complex and constantly being updated which can effect the diagnosis. The test does not screen for faking and studies have shown that there is a high false positive rate for normals and an even higher false negative rate for psychotics.

Rotter Incomplete Sentences Blank: By interpreting the completion of sentences as either unhealthy response, neutral response or positive response, the clinician can provide a personality profile. Studies of projective tests have shown that the interpretation of test results are subjective with very little scientific basis.

Seashore Rhythm Test: Designed to discriminate between different patterns of nonverbal sounds the test requires sustained attention and concentration with good ear, eye, hand coordination. Impaired hearing can lead to a diagnosis of brain damage! Inattention or losing one's place on the test can create significant errors, also.

Short Category Test (Booklet Form): This test is correlated with intelligence and requires problem solving, judgment, abstract reasoning and concept formation. Picture cards are presented to the patient with geometric shapes and figures and asked which number from one to four the card suggests. A one-word response is all that is required. A lack of interest or motivation can easily effect the outcome. This test can also produce false positives for normals, (normals whose score places them in the brain damaged range).

Sixteen Personality Factor Questionnaire: A measure of 16 personality traits, it is used in employment, vocational and educational guidance settings. The test can assess positive, as well as, negative traits. The test does not discriminate at the high level its publisher claims.

Social Readjustment Rating Scale: Developed by Holmes and Rahe, this scale assesses the stressful events the patient has experienced in the past year. Each item on the scale has a numerical rating, and scores over 300 indicate that the patient has 9 out of 10 chances of experiencing illness due to the high stress level. Withholding information or including false information would effect the score. May point to other areas of stress which are producing symptoms. The scale was developed several years ago and no longer represents current stressors.

Speech-Sounds Perception Test: A test to evaluate brain damage, the patient must match a spoken word from a group of similar printed "nonsense words". Distractions or noisy test environment, hearing loss, anxiety, lack of sleep, pain or medications can all impact test results.

Strength of Grip: A measure of motor weakness, the dominant hand commonly has 10% greater strength than the non-dominant. Impairment greater than 10% between the two sides might indicate brain damage. However, poor performance could also be due to orthopedic or peripheral neurological disorders or malingering.

Stroop Neuropsychological Screening: There are three versions of this test, the latest appearing in 1989, and each version has its own criticisms. Generally, this test has been described as a measure of attention, concentration, impulse control, and self-regulation. The examinee must name the background color rather than the name of the color printed (e.g., the word "red" appears on a "green" background. The background color "green" must be named, not the word "red"). Because the test is timed, slow responses may appear to be due to impairment rather than malingering. Guidelines for administration are confusing and errors are easy to make.

The Symptom Checklist 90-R (SCL-90-R): This psychological symptom checklist is completed by the patient and the symptoms fall into nine dimensions, (e.g. depression, anxiety, obsessive-compulsive etc.). There are no formal scales to detect faking, which has been found to be rather easy.

Tactual Performance Test: Designed to evaluate tactile perception, incidental memory and visual mapping, the patient is blindfolded in front of a puzzle board. Beginning with the dominant hand, large, distinctive shaped puzzle pieces are to be placed in the appropriate locations on the board. Each hand is timed, as well as a trial with both hands. Then the blindfold is removed and the patient draws the board and the correct location of each piece. Anxious or emotionally disturbed patients may find this form of testing highly frustrating and agitating, which may produce low scores.

Thematic Apperception Test (TAT): A projective test in which the patient makes up stories based on pictures they are shown. Responses are scored on emotional maturity, psychological insight, creativity, sense of reality, imagination and an understanding of family dynamics. This test is highly vulnerable to idiosyncratic interpretation by the clinician. There are no standard scoring methods.

Trail Making Test: Similar to connect the dots, the patient connects the circles with lines in numerical order, as quickly as possible. Part B requires connecting circles alternating between alphabetical order and numerical order (e.g., A 1, B 2, C 3 etc). This test is very sensitive to brain damage. However, the false positive rate is fairly high (normals that are incorrectly classified as impaired). Knowledge of pre-injury I.Q. is very important to the interpretation of test results. Medications or anxiety or depression may effect concentration.

Wechsler Adult Intelligence Scale-3rd edition (WAIS-III): Designed to evaluate verbal, performance and full-scale IQ. There are six verbal subtests and five performance subtests. The scores are added together for a full-scale IQ score. More than a 10 point difference between the verbal and performance scores may indicate brain damage or not. The difference in scores does not indicate origin (developmental or injury) and does not necessarily indicate brain damage. Many of the subtests are insensitive to brain damage. IQ scores can be affected by emotional and motivational factors, as well as, medications.

Wechsler Memory Scale-3rd edition (WMS-III): Assesses a patient's memory (immediate and recall) for verbal and nonverbal stimuli. Research on the earlier version of the Wechsler Memory Scale may not be applicable to the revised version. Poor scores may be due to low premorbid IQ, English not patient's native language, anxiety, depression, pain, fatigue, medications or lack of motivation.

Wide Range Achievement Test-3rd edition (WRAT-3): Current version is 5th revision. Assesses patient's achievement levels in reading, spelling and arithmetic. The reading and spelling scores tend to be more reliable than the arithmetic scores. Scores can be converted to grade equivalency. Not designed to evaluate head injury. Poor performance may be due to medications, motivation, anxiety or depression.

Wisconsin Card Sorting Test (WCST): Designed to evaluate problem solving skills, concept formation and cognitive flexibility. The patient must correctly match 128 cards to one of four cards according to the appropriate categories (color, form, or number) based on a correct or incorrect response from the examiner. This test is sensitive to brain damage and frontal lobe pathology. Performance is highly correlated with IQ. Poor performance can be due to inattention, medication, anxiety, depression and fatigue.

APPENDIX C: Glossary of Medical Tests and Signs

Abdominal Reflex: The quadrants of the abdomen are stroked towards the midline above, parallel to and below the umbilicus. In corticospinal tract lesions, the reflex contraction of the abdominal muscles is lost on the side ipsilateral (same side) as the lesion.

Achilles Reflex: (SEE Ankle Jerk Reflex.)

Allochiria Tests: Errors in identifying left from right assist in locating lesions near the angular gyrus.

Anal Reflex: The skin about the perineum and anal ring is stroked with a pin. In normals, the sphincter contracts and this reflex is lost in lesions in the lower sacral nerve segments.

Ankle Jerk Reflex: The Achilles tendon is struck by the examiner to test the reflex reactions related to L5-S1.

Anosognosia Tests: In cases of non-dominant side, frontal and parietal lobe lesions, the patient denies his paralysis of an affected side or limb.

Auditory Reflex: Momentary closure of both eyes upon a sudden sound.

Autopagnosia Tests: The patient is asked to hold up, point to and identify body parts such as fingers, arms, etc. Lesions of the parietal lobe causing autopagnosia, may prompt the patient to fail in the identification of his body parts or even identify the examiners hand as his own.

Babinski Toe Sign (SEE Plantar Reflex.)

Baresthesia Tests: In testing for parietal lobe lesions, the patient holds, with eyes closed, two weights that are unequal by one to two grams. Normals can generally discriminate between the weights. Sensation of weight may be lost in the contralateral limb. (SEE also Stereognosis.)

Beevor's Sign: (SEE also the Hoover Test and Thigh Adduction Test). In functional paralysis, inability to inhibit the antagonist muscles.

Biceps Reflex: The tendon of the biceps is tapped. Normally there is a contraction of the bicep muscles accompanied by a jerk of the forearm. In corticospinal tract lesions, the reflex is excessive. In lesions of the peripheral reflex arc or damage to the C5-C6 segments of the cord on the side being tested, there is a depressed or absent response.

Brachioradialis Reflex: This wrist reflex test is conducted to determine lesions at C5-C6 segments of the cord on the side being tested, there is a depressed or absent response.

Brudzinski's Sign: When the neck is flexed, flexion of the knees also occurs (present in meningeal irritation). (SEE also Kernig's sign.)

Brain Mapping: (SEE EEG)

Chewing Reflex: When a tongue depressor is placed in the mouth, the patient chews or clenches his teeth on the depressor. Reflex chewing is seen in diffuse bilateral lesions of the frontotemporal cortex and is frequently seen in cases of dementia, incomplete paralysis (generalized paresis) and brain injury related to a lack of oxygen.

Coombs' Test: For the detection of red cell antibodies.

Cortical Sensation Tests: (SEE Graphism.)

Cremasteric Reflex (Males): A pin is used to stroke the inside of the thighs. In normal individuals, the testis will rise on the same side. The reflex is lost with males with damage to the corticospinal tract at or above L1-L2.

Deep Reflex: A sharp tap on a tendon or muscle produces a brief stretch of the muscle.

EEG and QEEG: (Quantitative Electroencephalograph)

Electroencephalography is a method of graphically recording the electrical activity of the brain, particularly the cerebral cortex.

EEG brain mapping is a term commonly used for several quantitative (computerized) EEG techniques. These include (a) EEG frequency analysis, (b) topographic display, (c) statistical comparisons to a normative database and (d) other similar computer-based calculations based on EEG or evoked potentials. EEG brain mapping can help highlight or identify regional features of the EEG. Occasionally this will identify subtle features that escaped identification by traditional visual inspection of the polygraph EEG alone. EEG brain mapping can also help in communication of EEG features and their localization, especially for communication to persons who are not expert in EEG. Quantification of EEG features can help in the assessment of whether some features are present to an abnormal degree. Computer

based EEG processing can also calculate abstract features that cannot be visualized.

However, despite these potential advantages, the clinical application of the EEG brain mapping is still very limited. Most scientific reports on these techniques have demonstrated research applications rather than clinical usefulness. Among those clinical reports, few have been prospectively verified or reproduced. Techniques used in EEG brain mapping vary substantially among laboratories, and any clinical usefulness found with one specific technique may not apply when using a different technique. A substantial number of technical and clinical problems interfere with many simple applications.

These problems can easily mislead interpretation, sometimes in subtle ways. Traditional EEG artifacts can appear in unusual and surprising ways, and new artifacts can be caused by data processing and computer processing algorithms. For example, epileptic spikes are generally overlooked or considered artifactual. Also, transient slowing can be missed or washed out. The computer may consider as "abnormal" some of the unusual EEG activity known to have clinical importance such as psychomotor variant, alpha harmonics and other normal variations. Automated assessment of normality would have to take into account the subjects age, state of alertness, medication and other facts; but ways to do this are still not defined, especially when the patient is on a central nervous system active medication. Substantial unresolved statistical issues are critical in automated assessment of normality.

Little has been published on how these various tests could impact the diagnosis or treatment of individual patients. Cerebrovascular disease is one area in which these tests may fill occasional specific needs. Several quantified EEG parameters are highly correlated with regional cerebral bloodflow. Sensitivity is high for detection of ischemia-related cerebral impairment and false positive rates are low. These tests can be quite abnormal even when the CT scan is still normal, such as in the first 2-3 days after a CVA (cerebrovascular accident) or when the degree of ischemia is mild enough to cause dysfunction without infarction. However, localization ability is very inferior to that found with CT or MRI. EEG changes are unable to differentiate infarction from hemorrhage, tumor or other focal cerebral lesions.

EEG brain mapping cannot diagnose epilepsy. Some computer techniques can help to differentiate primary generalized discharges from secondary bilateral synchrony, or can help determine the location of a focus.

In dementia evaluations, the findings of an EEG abnormality can suggest an organic basis rather than depression. However, the tests cannot yet reliably distinguish between types of dementia. Most EEG changes of early dementia are seen well on routine EEG testing, and the extra yield for EEG brain mapping is small.

On the basis of the present medical literature, the sensitivity and specificity fail to completely substantiate a role for these tests in the clinical diagnostic evaluation of individual patients for possible tumors, multiple sclerosis, minor head injury, dyslexia, attention deficit disorder, schizophrenia, depression, alcoholism or drug abuse. Some research studies have shown small, reproducible differences between groups of such patients and groups of normal subjects, but the group findings are not directly relevant for diagnosis of an individual patient are situation. If EEG brain mapping is done in any of those settings and an abnormality is found, the abnormality may suggest an organic impairment but it is non-specific for the cause or type of pathology and does not necessarily correspond to any patient symptom. Careful clinical correlation is required for interpretation for any such abnormality.

Any clinical use of EEG brain mapping must be a direct extension of routine EEG testing. The actual EEG polygraph waveforms must be preserved on paper or on magnetic or optical storage medium. These EEG tracings should be interpreted thoroughly before interpretation of the computer based analysis. The technical quality of these EEG readings must be satisfactory for purposes of clinical interpretation, according to the accepted guidelines. At present, there is no clinical application for computer based clinical EEG analysis separate from analysis of the polygraph EEG. In order for these tests to be useful in clinical settings, they should be interpreted only by physicians with satisfactory skills, knowledge and abilities in routine EEG and well as additional knowledge and experience with the relevant additional technical problems, artifacts, normal variants, and statistical issues encountered in EEG brain mapping.

Fabere's Sign: (SEE Patrick's Test.)

Finger Jerk Reflex: The fingers are flexed and tapped in the direction of extension. In cases of corticospinal tract damage between C7-C8-T1, there may be an excessive contraction of the fingers.

Graphism Tests: As in Stereognism and Baresthesia, parietal lobe dysfunction is detected in tests of graphism. Two point discrimination and numbers written on the skin assist in the detection of parietal brain lesions.

Grasp Reflex / (Palmer Reflex): The palm is stroked. If the patient grasps the examiner's finger and frequently is unable to release the examiner's finger, the test is termed positive. This reflex disappears in the infant by the age of nine months, but is seen in the adult with frontal lobe injury, anoxic and severe toxic states.

Glabella Reflex: The forehead is tapped lightly between the eyes. If the patient responds with persistent spasm of the eye muscles and closing of the eyes, the Glabella is positive. This may indicate damage to the connections between the frontal cortex and the facial nerve complex in the pons. The reflex is seen in Parkinson's disease, frontal lobe tumors and frequently appears with dementia.

Hoover Test: Similar to the thigh adduction test, the examiner differentiates true organic paralysis from hysterical, factitious or malingered paralysis by instructing the plaintiff to move "the good leg" while monitoring the involuntary movement of the "paralyzed" leg.

Jaw Jerk Reflex: The mandible is tapped with a rubber hammer when the jaw is half open. If there is brain injury to the motor portion of the fifth cranial nerve, the jaw jerks closed. When the jaw jerk reflex is increased on the opposite side, a unilateral frontal lobe lesion may be suspected.

Kernig's Sign: In meningeal irritation, leg straightening is limited when the hips are flexed. (SEE also Brudzinski's Sign.) Note: In cases of a herniated lumbosacral disk, straight leg raising with flexion of the hip may be limited on the affected side.

Knee Jerk Reflex: This test is conducted by striking the Patellar tendons of the knee for reflex indications of a lesion in the L2, L3-L4 segments.

Laseque's Sign: A limitation of straight leg raising usually associated with lumbar nerve root compression. Also, in

sciatica, flexion of the hip is painful with the knee extended but painless when the knee is flexed.

MMPI: The Minnesota Multiphasic Personality Inventory, a global test of personality used by the defense to detect pre-existing personality disorders and the "fake-bad" F-K scale pattern. Also contains an addiction scale and other scales to detect the manipulation of answers. The MMPI-2 is currently being used.

Orientation in Space Tests: Holding objects in space and describing how to get from one point to another (the doctors office to home), are orientation in space tests used to locate dominant hemisphere parieto-occipital lesions.

Patellar Reflex: (SEE knee jerk reflex.)

Patrick's Test: With the patient supine, the thigh and knee are flexed. The external malleolus rests on the patella of the opposite leg and the knee is depressed. Production of pain indicates arthritis of the hip. Also called the Fabere sign after the initial letters for Flexion, ABduction, External Rotation and Extension.

Pectoral Reflex: The anterior, (frontal) fold of the axilla, (armpit) that contains the pectoral muscle is tapped with a reflex hammer. In cortical spinal lesions above C5, there is a brisk and sometimes excessive contraction.

PET Scan: Advances in the fields of computerized tomography and in the production and detection of short-lived radioactive isotopes has enabled the construction of scanners which monitor the course of radioactive labeled biological molecules. A variety of tracers can be administered which provide detailed images of cerebral functions such as metabolism, blood flow, and receptor distribution. The normal brain may be examined at rest as well as following activation can be observed. A variety of different pathological states have also been examined.

PET starts with isotopes such as ^{15}O , ^{18}F , and ^{11}C which have half lives that range from 75 seconds to 110 minutes. These isotopes are produced by a particle accelerator, a cyclotron, from which a proton beam is extracted which is in turn focused on to a target. The target contains stable elements which when bombarded results in the production of a molecule of positron emitting isotope. The unstable isotope has a short half life and decays by emission of a positron. The positron annihilates in contact with electrons to produce two photons. PET detects the

number and location of these photon pairs, producing a record of the distribution of these radioactivity.

The short lived radioactive isotopes may be incorporated into a number of biological molecules. Two types of study can be undertaken. Metabolism can be assessed using either a glucose analogue labelled with ^{18}F or by the ^{15}O method, with which cerebral oxygen metabolism, blood flow and volume can be assessed together.

Secondly, a variety of binding site ligands can be produced and these can be used to determine the distribution of receptor populations in both diseased and normal brains or following a drug challenge. Studies in dementia have been made using both types of approaches. At this time, the PET scan has limited use in the analysis of injury claims (SEE also SPECT scan).

Plantar Reflex (Babinski's Toe Sign): Dorsiflexion of the big toe on stimulation of the plantar surface (sole), occurring in lesions of the pyramidal tract (nerve fibers arising in the brain and passing down through the spinal cord).

Pupillary Reflex: Contraction of the pupil after application of light, loud noise or other stimulus.

Righting Reflex: The assumption of an optimal body position after the patient has been moved from it.

Rinne Test: In a normal individual, air conduction of sound is greater than bone conduction. When there is an injury or disease that reduces the level of air conduction and bone conduction is greater than air conduction the Rinne test is said to be negative. When both air and bone conduction are diminished through disease or injury to the auditory apparatus or the auditory division of the eighth cranial nerve, or when there is no diminished hearing, the test is termed positive.

Romberg's Sign: Swaying of the body or falling when the eyes are closed with the feet placed close together.

Shilling Test: For vitamin B12 in the diagnosis of pernicious anemia. In injury cases, pernicious anemia is a variable that may be a non-proximate cause of degeneration of the brain and spinal cord.

Snout Reflex: Similar to the Glabella, the patient is tapped lightly on the nose. Excessive grimace of the face is a positive sign and may be due to a brainstem (Corticopontine), lesion.

SPECT or SPET Scan: Functional brain imaging with single photon emission tomography (SPET), also known as single photon emission computed tomography (SPECT), enables three-dimensional images of regional cerebral blood flow (rCBF) to be derived from two-dimensional data. Positron emission tomography (SEE PET) can be used to measure regional cerebral metabolism and neurotransmitter receptor characteristics in addition to rCBF. It sets the standards for spatial resolution by which SPET is judged. However, PET requires sophisticated and expensive technology, including a cyclotron on site, and has less of a prospect of general clinical application. In contrast, SPET is relatively inexpensive and is widely available for clinical use. The radiotracers used in SPET emit a single gamma ray (or photon), as opposed to dual simultaneous gamma rays of PET radiotracers, hence the term 'single photon' in SPET. There have now been a number of SPET studies investigating changes in rCBF in dementia.

The use of the SPECT scan in claims: In addition to the effects of normal aging, functional imaging studies in dementia have three further problems: (1) the normal variation in measures of cerebral blood flow or metabolism; (2) uncertainty of diagnosis of type of dementia, e.g. Alzheimer's disease (AD) or multi-infarct dementia (MID) - AD accounts for over 50% of cases, but can only be diagnosed definitively by cerebral autopsy; (3) the presence of cerebral atrophy. Brain atrophy occurs with aging in normal individuals and is greater in severity in patients with dementia than age-matched controls. However, some demented individuals have little atrophy while some normals show considerable atrophy. Consequently areas of apparently reduced rCBF in patients with dementia may be due to reduced flow to a normal volume of brain, normal flow to a reduced volume of brain, or reduced flow to a reduced volume of brain.

Stereognosis Tests: To examine for parietal lobe lesions, objects are placed in the patients hands and they are asked to identify them. Inability to identify shapes or discriminate between objects may indicate a (contralateral) parietal lobe lesion.

Suckling Reflex: The patient's lip is stroked. If this produces a pout or sucking movements, the reflex is positive and is an indication of diffuse frontal lobe injury. Although this reflex is normal in the infant until weaning, the adult should have no suckling response. A Positive Suckling Reflex frequently accompanies dementia (the loss of acquired intelligence from disease, trauma or anoxia).

Supratentorial: Literally refers to an area of the brain but is used in medical records to indicate that the plaintiff's symptoms and complaints are functional and not organic.

Tendon Reflex: Contraction of the muscle caused by percussion of its tendon.

Thigh Adduction Test (paralysis of one leg): (SEE the Hoover Test.)

Tinnel's Sign: A tingling sensation in the distal end of a limb when percussion is made over the site of a divided nerve. Indicates a partial lesion.

Triceps Reflex: Testing for lesions at the C6-C7 level, the patient flexes his arms or places them on his hips. The short tendon above the elbow is tapped for a reflex response in the triceps muscle.

VDRL Test: For syphilis.

Vital Signs: Pulse, respiration and temperature.

Weber Test: A vibrating tuning fork is placed in the center of the patient's forehead. If the patient reports that the sound originates in the midline of the forehead, there is no impairment in air conduction. When the sound is referred to the involved or damaged side, the Weber test is positive. When there is disease of the cochlea or nerve deafness, the sound is lateralized to the opposite side, the test is said to be negative.

APPENDIX D: Symptom Manipulation, Malingering and Other Related Conditions

Malingering

Malingering is not a mental disorder, it is simply adaptive behavior; the behavior is produced to obtain money or to avoid responsibility. The distinction between a Factitious Disorder (SEE below) and malingering is difficult to make if the clinician does not have forensic training or experience. The diagnosis of malingering is made when the recognizable goal of obtaining money is more prominent than the goal of becoming a patient.

The four elements of the index of suspicion in malingering are:

1. Any medicolegal context such as the filing of a claim or lawsuit or any attorney referred treatment
2. Complaints of illness that are far beyond objective findings.
3. Lack of cooperation in treatment and diagnosis.
4. The presence of an Antisocial Personality Disorder

Malingering is a conscious or voluntary act or set of actions.

The Factitious Disorder

Factitious disorders are characterized by the repeated, knowing simulation of a physical or mental illness for no apparent purpose other than obtaining immediate medical or psychiatric treatment. The unique aspect of a Factitious Disorder is that the sole objective is to assume the role of a patient. Many of these patients make treatment or hospitalization primary objectives and often a way of life. The factitious manipulation of symptoms is very common in insurance claims and is often produced to receive care from the claimant's spouse, children or parents. Malingering is known as, "pay me!" and the Factitious Disorder is known as, "Pay attention to me and take care of me!" Like malingering, the Factitious Disorder is a conscious or voluntary act that is designed to obtain a goal.

The Somatoform Illnesses

The essential features of this group of disorders are physical symptoms suggesting physical disorder (hence, Somatoform) for which there are no demonstrable organic findings or known physiological mechanisms and for which there is positive evidence, or a strong presumption, that the symptoms

are linked to psychological factors or conflicts. Unlike Factitious Disorder or Malingering, the symptom production in Somatoform Disorders is not under voluntary control. Although the symptoms of Somatoform Disorders are "physical," the specific pathophysiological processes involved are not demonstrable or understandable by existing laboratory procedures and are conceptualized most clearly using psychological constructs. For that reason, these disorders are not classified as "physical disorders."

Conversion Disorder (a specific type of Somatoform Disorder)

1. A loss of or alteration in physical functioning suggesting a physical disorder. However, the symptom cannot, after appropriate investigation, be explained by a known physical disorder or pathophysiological mechanism.
2. Psychological factors are judged to be involved in the production of the symptom, as evidenced by one of the following:
3. There is a temporal relationship between an environmental stimulus that is apparently related to a psychological conflict or need and the initiation or exacerbation of the symptom.
4. The symptom enables the individual to avoid some activity that is noxious to him or her and the symptom enables the individual to get support from the environment that otherwise might not be forthcoming.
5. It has been determined that the symptom is not under voluntary control.
6. The symptom is not limited to pain or disturbance in sexual functioning.

The Ganser Syndrome

The plaintiff's use of the "I don't know" answer in deposition, when it is obvious that he does know the answer to the question (Q: What is your wife's name? A: I don't know) as well as his general presentation of symptoms is suggestive of Ganser Syndrome. This condition is on the borderline between true mental illness and malingering and it includes features described by Ganser in 1898, which were 'answering past the point', or giving approximate answers which are patently absurd, fluctuating levels of consciousness, and an abrupt end to the disorder. In the Ganser syndrome, the claimant is attempting to convince his examiners and the insurer that he has brain injury or another serious mental disorder related to his claimed injury. In some cases, the claimant will deny that he remembers his wife or children's names, yet in other areas he appears to function quite well.

APPENDIX E: The 20 most important questions to ask the claimant's mental health specialists and examiners

When writing to the claimant's treating psychiatrist, psychologist or other mental health therapist or evaluator, the claims examiner should ask the mental health related questions listed below [SEE Chapter 2.2) for further details]:

NOTE 1: A signed and properly executed medical release form must accompany any request for the following information:

NOTE 2: The questions listed below are based on the American Psychiatric Association's Multiaxial Evaluation System. They are appropriate questions for any counselor, psychiatrist, psychologist or other mental health care provider:

1. Did the injury in question cause an Axis I - clinical mental disorder? If so, what is the diagnosis and what are the patient's symptoms?
2. Did the patient have an Axis I, clinical mental disorder, before the insured accident or injury? If so, what was the diagnosis?
3. Please list all past and present periods of psychiatric or psychological treatment that you or your mental health facility has provided including any form of counseling or psychotherapy given before the insured accident or injury.
4. Please describe the type of therapy given during those periods (in-patient hospitalization in a psychiatric facility, out-patient psychotherapy, etc.)
5. Please list all medications and dosage given for current mental disorders and any prior conditions.
6. Are you aware of any current or past mental health treatment received from other providers? If so, please list the name of the mental health provider or facility, the approximate dates and the diagnosis.
7. Does the patient have significant personality disorder traits or a diagnosable personality disorder, as defined by DSM-3-R or DSM-4? If so, please list the personality disorder diagnosis or the personality disorder trait pattern.
8. Does the patient have a history of any other learning or developmental disorder?

9. Does the patient have any Axis III, medical condition that may be related to any of the Axis I, mental disorders listed above?

10. Please list a brief summary of the patient's past medical history. If possible, please list the patient's age or the year in which the patient had the injury, disease or disorder.

11. Does the patient have any current or past substance abuse or dependence?

12. Please list the patient's primary life stressors. In your response, please consider the following:

- Stress related to injury
- Disease or medical conditions other than injury
- Marital stress or dysfunction
- Stress from an interpersonal relationship other than marriage
- Stress from problems with children
- Bereavement (the death of a family member or close friend)
- Loss of relationship
- Occupational stress
- Stress related to school
- Financial stress
- Stress related to aging or phase of life
- Other Stress, please specify
- If possible, please rate the severity of the stressors (mild, moderate, severe and; acute or enduring circumstances).

Rate the claimant's mental health functioning, using the GAF scale. The claims examiner should ask the following questions:

13. What is the patient's Global Assessment of Functioning Scale (GAF Scale) rating at this time?

14. What was the patient's Global Assessment of Functioning Scale (GAF Scale) rating during the past 12 months?

15. What do you believe the patient's Global Assessment of Functioning Scale (GAF Scale) rating was prior to the accident or injury in question?

The GAF Rating Scale is as follows:

100	Superior functioning
90 - 81	Absent or minimal symptoms
80 - 71	If symptoms are present, they are transient and expectable reactions to psychosocial stressors
70 - 61	Some mild symptoms
60 - 51	Moderate symptoms
50 - 41	Serious symptoms
40 - 31	Some impairment in reality testing or communication
30 - 21	Behavior is considerably influenced by delusions or hallucinations OR serious impairment in communication or judgment
20 - 11	Some danger of hurting self or others
10 - 1	Persistent danger of severely hurting self or others OR persistent inability to maintain minimal personal hygiene OR serious suicidal act with clear expectation of death.

16. Please list any neurological, psychological or neuropsychological tests given to the patient along with the dates and results of those tests.

17. Please describe any other methods of patient evaluation used in this case.

18. Please summarize your observations of this patient.

19. Please estimate the length and type of future treatment needed.

20. If the patient was employed or in school before his or her injury, and has not returned to those activities, please estimate when a return to normal functioning will occur.

MEDPsych has served the corporate, law and insurance communities in the United States and Canada since 1983 with education, research, publishing and consulting services in matters of psychological injury claims.

MEDPsych Headquarters

Claims Programs and Services

Psychological injury claims including Organic Brain Syndrome, Post-traumatic Stress Disorder and other anxiety and depressive illnesses are costing the casualty and workers' compensation insurance industries, hundreds of millions of dollars each year. These cases are complex and it is often very difficult to separate true claims of injury from the cases of exaggerated claims with manipulated symptoms. **MEDPsych** offers several programs that will help you effectively manage these types of cases to help reduce the cost of your psychological injury claims.

The Analysis of Your High Risk Cases

We conduct the analysis of psychological injury claims in cases of Organic Brain Syndrome, Post-traumatic Stress Disorder and other anxiety and depressive illnesses. These confidential analyses of the case documentation have been used by over 150 insurance companies in the United States and Canada to reduce the costs of settlement and litigation. Send us a copy of the claimant's medical records and we will help you reduce the cost of settlement as well as the limitation and defense of litigation related jury awards.

In-House Claims Training

A second educational program that has been developed in association with the Program in Psychiatry and Law of the Georgetown University School of Medicine is the Insurance Lecture Series. This program is brought to your claims department training facility and is available for groups of 10 to 300 claims professionals, house counsel and medical personnel.

The MEDPsych Guide to Psychological Injury Claims

This easy-to-use claims manual will assist the claims professional in the analysis and administration of psychological injury claims. The Guide includes a description of the commonly claimed disorders, the diagnostic criteria for each condition, the questions that each claims examiner should ask and lists of the documents and information needed to set and adjust reserves, as well as administer, settle or defend each case. The Guide is an essential document for every personal injury or workers' compensation claims examiner.

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