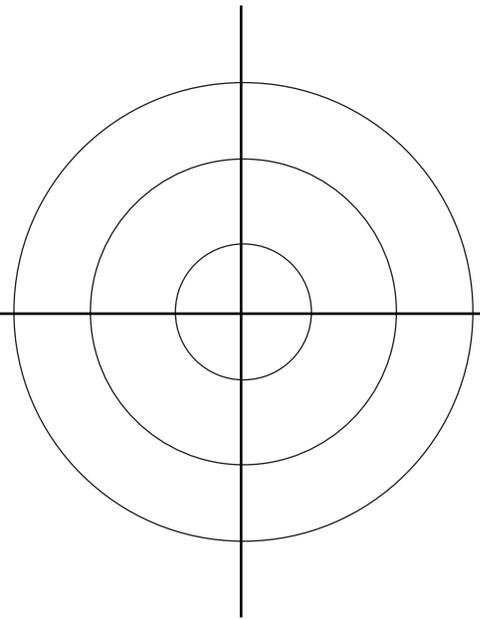


# The Defense Deposition Atlas

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**Second Edition**



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### **The Defense Deposition Atlas, Second Edition,**

is a compendium of deposition questions developed from the analysis of over 3,000 psychological and neurological injury claims. The authors, Peter and Pamela Silvain are defense analysts in complex injury cases. Peter Silvain holds three graduate degrees in forensic evidence and behavioral studies, Pamela Silvain earned her Ph.D. degree in 1992, from the University of Maryland. The Silvains, and the MEDpsych Headquarters team, work for casualty, workers compensation, self-insured corporations and defense counsel throughout the United States and Canada. Their Defense Case Analysis is designed to provide defense counsel with trial strategy including an assessment of the plaintiff's claimed damages and the defense theories that apply to each case.

Peter Silvain continues to present educational programs for the insurance and defense law communities including lectures for 15,000 claims and law professionals in over 425 seminars, conferences and other defense programs. He has presented his program for several state bar associations and defense associations as well as the American Bar Association and the Defense Research Institute DRI®.

The Silvain's coordinate a national network of experienced defense analysts. For information regarding these and other defense services call (800) 251-0799.

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*Dedicated to our parents*

*Ernest and Regina Silvain  
and  
Roy and Verne Hoffman*

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# THE DEFENSE DEPOSITION ATLAS

*Second Edition*

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# CHAPTER 1

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# CHAPTER 1

## DEPOSITION OF THE PLAINTIFF

### INTRODUCTION

Many plaintiffs that claim emotional injury have histories of pre-existing psychopathology, including clinical mental disorders and personality disorders. The defense counsel must assemble a thorough history of the plaintiff for several reasons:

1. To counter the egg-shell skull theory.
2. To show that the plaintiff was not a well-functioning person prior to the injury in question.
3. To show that the plaintiff's level of functioning has not been decreased by the injury in question.
4. To show that the plaintiff's symptom pattern is not new but a continuation of a pre-existing illness.
5. To show that the plaintiff's expert witness has failed to obtain important information when forming his or her diagnosis.
6. To show that the plaintiff's symptoms are related to disorders other than those claimed in the litigation.

The questions and tables in this chapter are designed to assist the defense counsel in obtaining detailed historical information from the plaintiff. When deposition of the plaintiff is complete, the defense counsel will know more about the plaintiff's history than the treating doctors. It is this detailed discovery that can lead to an admission of diagnostic weakness and error during the deposition and cross-examination of an expert witness. Failure of the plaintiff's doctors to take a thorough clinical history is often a primary cause of error in emotional injury litigation.

## SECTION 1.0: GENERAL HISTORY

### A. GENERAL INFORMATION

Name: \_\_\_\_\_

Previous Address: (1) \_\_\_\_\_

Maiden name or other names used in the past:

City/State: \_\_\_\_\_

Maiden: \_\_\_\_\_

From: \_\_\_\_\_ to: \_\_\_\_\_

Other: \_\_\_\_\_

Owned

Rented

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Previous Address: (2) \_\_\_\_\_

How old are you today? \_\_\_\_\_

City/State: \_\_\_\_\_

Country, city, state of birth: \_\_\_\_\_

From: \_\_\_\_\_ to: \_\_\_\_\_

\_\_\_\_\_

Owned

Rented

\_\_\_\_\_

**Q: Who is presently living with you?**

Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

**Q: What is their relationship to you?**

Present Address: \_\_\_\_\_

1. \_\_\_\_\_

City/State: \_\_\_\_\_

2. \_\_\_\_\_

From: \_\_\_\_\_ to: \_\_\_\_\_

3. \_\_\_\_\_

Own

Rent

### B. INSURANCE INFORMATION

**Q: Have you applied for social security disability?**

Doctor's name: \_\_\_\_\_

No

Approved

Denied

Address: \_\_\_\_\_

Reason for denial: \_\_\_\_\_

Date of Application: \_\_\_\_\_

**Q: What disability insurance policies do you have?**

Company: \_\_\_\_\_

Date of Application: \_\_\_\_\_

Amount: \_\_\_\_\_

Company: \_\_\_\_\_

Was a physical exam taken for this policy? \_\_\_\_\_

Amount: \_\_\_\_\_

Doctor's name: \_\_\_\_\_

Was a physical exam taken for this policy? \_\_\_\_\_

Address: \_\_\_\_\_

**Q: What health insurance policies do you have?**

Date of Application: \_\_\_\_\_

Company: \_\_\_\_\_

Amount: \_\_\_\_\_

Was a physical exam taken for this policy?

Doctor's name: \_\_\_\_\_

Address: \_\_\_\_\_

**Q: Have you ever been refused any type of life, disability, or health insurance because of a disease or other medical condition?**

**C. EDUCATION**

**Q: Describe your educational background.**

*Defense counsel should ask the plaintiff about some or all grade level experiences. For each grade level, refer to the following questions.*

1. What were your school activities and interests?
2. Describe any school disciplinary action.
3. Describe any school achievements or honors.
4. What were your grades?

**TABLE 1.0-1. EDUCATIONAL CHECK LIST**

| School                      | Location | Dates Attended | Degree |
|-----------------------------|----------|----------------|--------|
| Grade school                |          | to             |        |
| Junior high / Middle school |          | to             |        |
| High school                 |          | to             |        |
| Trade school                |          | to             |        |
| Military school             |          | to             |        |
| College                     |          | to             |        |
| Graduate school             |          | to             |        |
| Other schools               |          | to             |        |

**Q: Did you have any dramatic changes in school success or failure? Why?**

**Q: Were you ever told that you had a learning disability?**

**Q: Did you repeat any grade? If so, why?**

**Q: Did you leave school before graduating? If so, why?**

**Q: Did you ever receive any special education? If so, why?**

**Q: Did you complete high school? If not, did you receive a GED (high school equivalency)?**

**Q: Did you ever have special testing or evaluations? If so, why?**

**D. EMPLOYMENT**

**1. PAST EMPLOYMENT**

**Q: What is your past employment history?**

*For each job, refer to the following questions.*

1. Why did the job end? (quit, fired)
2. Were you transferred?
3. Describe any disciplinary action while you were an employee.
4. Describe circumstances where you may have been injured or exposed to toxic materials while employed.

5. Describe your relationship(s) with co-workers.

**Q: Are you now or were you ever self-employed?**

- How did you get started in business?
- How long were you self-employed?
- Why did you stop?

**TABLE 1.0-2. EMPLOYMENT CHECK LIST**

| <b>Employment</b>  | <b>Employer/Location</b> | <b>Benefits</b> | <b>Injuries</b> |
|--|--------------------------|-----------------|-----------------|
| <p style="text-align: center;"><b>Job 1</b></p> <p>Title:</p> <p>Description:</p> <p>Date:       to</p> <p>Entry Pay:</p> <p>Exit Pay:</p> |                          |                 |                 |
| Reason for Leaving:  |                          |                 |                 |
| <p style="text-align: center;"><b>Job 2</b></p> <p>Title:</p> <p>Description:</p> <p>Date:       to</p> <p>Entry Pay:</p> <p>Exit Pay:</p> |                          |                 |                 |
| Reason for Leaving:  |                          |                 |                 |

*(continued)*

**TABLE 1.0-2. EMPLOYMENT CHECK LIST (continued)**

|                     |  |  |  |
|---------------------|--|--|--|
| <b>Job 3</b>        |  |  |  |
| Title:              |  |  |  |
| Description:        |  |  |  |
| Date:           to  |  |  |  |
| Entry Pay:          |  |  |  |
| Exit Pay:           |  |  |  |
| Reason for Leaving: |  |  |  |

**2. PRESENT EMPLOYMENT**

**Q: Where are you currently employed?**

Name of firm: \_\_\_\_\_

Location: \_\_\_\_\_

Length of employment: \_\_\_\_\_

- Approximately how many hours do you work each week?
- During the past two years, describe the circumstances for any work absence.
- Describe your level of job satisfaction.
- Have you had any disagreements or conflicts with coworkers?

**Q: Have you ever filed for unemployment benefits?**

- When did you receive unemployment benefits?
- How long did you receive the benefits?
- What were the reasons for unemployment?
- How much money did you receive in benefits?

**Q: What is your current yearly income?**

**Q: Do you have any other income or financial assistance?**

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_

**Q: What is your estimated total household income?**

**Q: What is your estimated debt?**

**Q: Are you receiving any financial assistance from your lawyer?**

**E. MILITARY SERVICE**

**Q: Have you ever served in the armed forces?**

- When did you serve and for how long?
- What branch of the service?
- Did you attend a technical school in the service?

**Q: Were you ever turned down for military service?**

**Q: Did you receive any decorations or honors while in the military?**

**Q: Have you ever had any disciplinary actions against you while in the military?**

**Q: Did you experience any combat or war zone fighting?**

- Where were you?
- How long were you in combat?

**Q: Do you have any service-connected disability? (amount awarded)**

**Q: Did you experience any *emotional illness or problems* as a result of combat or experiences in the service?**

- Did you receive any treatment for these emotional changes or problems?
- Do you have any continuing emotional problems as a result of service?

**Q: Did you experience any *physical illness or problems* as a result of combat or experiences in the service?**

- Did you receive any treatment for these physical changes or problems?
- Do you have any continuing physical problems as a result of service?

**Q: What type of discharge did you receive?**

**Q: Are you currently under any military or reserve commitment?**

**F. THE INJURY IN QUESTION (CAUSE OF ACTION)**

**Q: Explain in your own words, why you have filed this law suit.**

**Q: What were your activities for the 24 hour period prior to the injury?**

**Q: What happened at the time of the injury?**

- Were you able to walk?
- Who witnessed the injury?
- Who did you talk to following the injury?
- Did anyone record your conversation?
- Did anyone take your statement?
- Did anyone take any pictures?

**Q: Describe your *physical condition* immediately following the injury.**

**Q: Describe your *mental status* immediately following the injury.**

**Q: Did you have any prior relationship with your attorney or other members of his/her law firm before this injury case?**

**Q: How were you referred to your attorney?**

**Q: When did you obtain your attorney?**

See chart on the following page.

**TABLE 1.0-3 POST-INJURY SYMPTOM CHECK LIST**

| <b>Symptom</b>                          | <b>Yes</b> | <b>No</b> | <b>Date Ended</b> |
|---|------------|-----------|-------------------|
| Aches or pains (except head)            |            |           |                   |
| Anxiety                                 |            |           |                   |
| Change in ability to stand or sit       |            |           |                   |
| Change in ability to think              |            |           |                   |
| Change in attitude                      |            |           |                   |
| Change in concentration                 |            |           |                   |
| Change in appetite                      |            |           |                   |
| Change in energy level                  |            |           |                   |
| Change in self-perception               |            |           |                   |
| Change in memory                        |            |           |                   |
| Change in mood                          |            |           |                   |
| Change in control of movement           |            |           |                   |
| Change in sexual interest or behavior   |            |           |                   |
| Change in sleep                         |            |           |                   |
| Change in speech                        |            |           |                   |
| Change in strength                      |            |           |                   |
| Change in sensitivity to touch          |            |           |                   |
| Change in vision                        |            |           |                   |
| Change in gait                          |            |           |                   |
| Change in orientation to time and place |            |           |                   |
| Fears (of what)                         |            |           |                   |
| Headaches                               |            |           |                   |
| Stiffness                               |            |           |                   |
| Other symptoms:                         |            |           |                   |

**G. RELATED SYMPTOMS**

**Q: Did you receive an examination by a health care person at the scene of the accident or immediately following the accident (e.g., hospital ER)?**

- What was the approximate time and date of treatment?
- Where were you treated?
- What was the diagnosis?
- Were you admitted to the hospital?
- What were the recommendations for further treatment?
- Did you follow the recommendations?

**Q: Describe in detail, all symptoms that you believe are related to the injury.**

*For each symptom, refer to the questions below. (See Table 1.0-3)*

1. How often do you have the symptom?
2. How long does it last?
3. How severe is it?
4. What changes have you made in work or daily life because of the symptom?
5. Has the symptom stopped or become less severe? If so, when?
6. Is there any event or circumstance that brings on the symptom?
7. Did you ever experience the symptom before this injury?

**SECTION 1.1: THE PLAINTIFF'S PHYSICAL HISTORY**

**A. CHILDHOOD MEDICAL HISTORY**

**Q: Did you have any childhood illnesses or injuries? If so, list.**

1. What was the approximate date of treatment?
2. Where did you receive the treatment?

3. What was the name of the physician?
4. What was the diagnosis?
5. What were the recommendations?
6. Did you follow the recommendations?
7. Were there any residual sequelae from the injury / illness?

*See chart on the following page.*

**TABLE 1.1-1. CHILDHOOD/ADOLESCENT ILLNESS CHECK LIST**

| <b>Condition</b>                   | <b>Early<br/>(Birth-3)</b> | <b>Middle<br/>(3-11)</b> | <b>Adolescence<br/>(11-18)</b> |
|------------------------------------|----------------------------|--------------------------|--------------------------------|
| Appendicitis                       |                            |                          |                                |
| Asthma                             |                            |                          |                                |
| Bone disorders                     |                            |                          |                                |
| Bronchitis                         |                            |                          |                                |
| Chicken pox                        |                            |                          |                                |
| Chronic allergy                    |                            |                          |                                |
| Chronic diarrhea                   |                            |                          |                                |
| Chronic bacterial infection        |                            |                          |                                |
| Diphtheria                         |                            |                          |                                |
| Diseases of the ears, nose, throat |                            |                          |                                |
| Dysentery                          |                            |                          |                                |
| Emotional problems                 |                            |                          |                                |
| Gastrointestinal disorders         |                            |                          |                                |
| Measles                            |                            |                          |                                |
| Meningitis                         |                            |                          |                                |
| Mononucleosis                      |                            |                          |                                |
| Mumps                              |                            |                          |                                |
| Neoplasms including cancer         |                            |                          |                                |
| Pneumonia                          |                            |                          |                                |
| Scarlet fever                      |                            |                          |                                |
| Skin conditions                    |                            |                          |                                |
| Trauma                             |                            |                          |                                |
| Tuberculosis                       |                            |                          |                                |
| Whooping cough                     |                            |                          |                                |
| Other                              |                            |                          |                                |

**SCHOOL ABSENCES DUE TO ILLNESS**

**Q: Did you miss school because of any illness or injury?**

*For each absence due to illness or injury, refer to the following questions.*

1. What grade were you in when the illness or injury occurred?
2. How long were you absent from school?
3. Did it affect your grades?
4. Did it affect your long-term school success?

**TABLE 1.1-2. SCHOOL ABSENCE CHECK LIST**

| Grade | Approximate time lost from school/reason |
|-------|--|
| K     |  |
| 1     |  |
| 2     |  |
| 3     |  |
| 4     |  |
| 5     |  |
| 6     |  |
| 7     |  |
| 8     |  |
| 9     |  |
| 10    |  |
| 11    |  |
| 12    |  |

**B. PRE-INJURY ADULT MEDICAL HISTORY**

**Q: Did you have any adult illness or medical conditions before the injury in question?**

*For each condition, refer to the following questions.*

- |   |  |
|---|--|
| <ol style="list-style-type: none"> <li>1. What was the approximate date of treatment?</li> <li>2. Where did you receive the treatment?</li> <li>3. What was the name of the physician?</li> </ol> | <ol style="list-style-type: none"> <li>4. What was the diagnosis?</li> <li>5. Describe your response to the treatment.</li> <li>6. What were the recommendations?</li> <li>7. Did you follow the recommendations?</li> <li>8. Were there any residual sequelae from the injury / illness?</li> </ol> |
|---|--|

*See chart on the following page.*

**TABLE 1.1-3. PRE-INJURY ILLNESS, MEDICAL CONDITION CHECK LIST**

| <b>Conditions</b>                                     | <b>Date</b> | <b>Treatment</b> |
|---|-------------|------------------|
| Abdominal pains                                       |             |                  |
| Abnormal bleeding                                     |             |                  |
| Adverse reactions to food                             |             |                  |
| Allergies   |             |                  |
| Blindness, double vision, spots, eye pain             |             |                  |
| Body hair changes                                     |             |                  |
| Bowel or bladder changes, diarrhea, constipation, gas |             |                  |
| Broken bones  |             |                  |
| Chest pain  |             |                  |
| Coughing, wheezing, sputum, shortness of breath       |             |                  |
| Deafness, ringing sounds, internal itching, discharge |             |                  |
| Decreased sexual drive, pain, bleeding                |             |                  |
| Easy bruising   |             |                  |
| Excessive itching                                     |             |                  |
| Finger or toe nail changes                            |             |                  |
| Headaches   |             |                  |
| Heart beat changes                                    |             |                  |
| Hemorrhoids, rectal bleeding                          |             |                  |
| Infected cuts or wounds                               |             |                  |
| Joint pain or swelling                                |             |                  |
| Lumps or masses under the skin                        |             |                  |
| Masses in the breasts, nipple discharge               |             |                  |
| Muscle pain or stiffness                              |             |                  |

*continued*

**TABLE 1.1-3. PRE-INJURY ILLNESS, MEDICAL CONDITION CHECK LIST (continued)**

| Conditions  | Date | Treatment |
|---|------|-----------|
| Nausea, vomiting                                    |      |           |
| Nose bleeds, sinus problems, excessive discharge    |      |           |
| Painful or frequent urination, blood in urine       |      |           |
| Skin diseases/rashes                                |      |           |
| Temperature tolerance changes                       |      |           |
| Transfusions  |      |           |
| Trouble swallowing                                  |      |           |
| Venereal disease                                    |      |           |
| Voice changes, hoarseness                           |      |           |
| Weight changes of more than ten pounds in two weeks |      |           |
| Other   |      |           |

**PRIOR HOSPITALIZATIONS**

**Q: Were you hospitalized before the injury in question?**

*For each hospitalization, refer to the following questions.*

1. What was the approximate date of hospitalization and length of stay?
2. What was the name of the hospital?
3. Why were you hospitalized?
4. What was the diagnosis?

**TABLE 1.1-4. HOSPITALIZATION CHECK LIST**

|    | Date | Reason | Hospital | Surgery | Other Treatment |
|----|------|--------|----------|---------|-----------------|
| 1. |      |        |          |         |                 |
| 2. |      |        |          |         |                 |
| 3. |      |        |          |         |                 |
| 4. |      |        |          |         |                 |
| 5. |      |        |          |         |                 |
| 6. |      |        |          |         |                 |

**C. ALCOHOL HISTORY**

**Q: Do you drink alcohol?**

**Q: Has the use of alcohol ever caused a serious occupational or social problem for you?**

**Q: How much do you drink at one time?**

**Q: Describe your behavior when drinking.**

**Q: How often do you drink?**

For each symptom or behavior refer to the following questions.

**Q: When do you drink?**

1. How often does this symptom occur?
2. When does it usually occur?
3. Is it a concern to you?
4. Is it a concern to others?
5. Is the symptom becoming more or less severe?

**Q: What do you usually drink?**

**Q: What is your perception of your drinking habits?** (alcoholic, problem drinker, social drinker, occasional, etc.)

**Q: Has the use of alcohol ever caused a serious family problem for you?**

**TABLE 1.1-5. ALCOHOL CHECK LIST**

| Symptom                                       | Date | Frequency |
|---|------|-----------|
| Absenteeism from work or school               |      |           |
| Abstinence attempts                           |      |           |
| Alcohol use with other drugs                  |      |           |
| Alcohol treatment                             |      |           |
| Alcoholic accusations from others             |      |           |
| Arrests for disorderly conduct                |      |           |
| Arrests for DUI (driving under the influence) |      |           |
| Blackouts                                     |      |           |
| Convulsions                                   |      |           |
| Drinking for confidence in new situations     |      |           |
| Drinking alone                                |      |           |
| Drinking more than intended                   |      |           |
| Emotional problems                            |      |           |
| Financial problems                            |      |           |
| Hallucinations                                |      |           |
| Job dismissal                                 |      |           |

(continued)

**TABLE 1.1-5. ALCOHOL CHECK LIST (continued)**

|   |  |  |
|---|--|--|
| Loss of consciousness                     |  |  |
| Loss of memory                            |  |  |
| Marital or interpersonal problems         |  |  |
| Physical problems                         |  |  |
| Reduced level of motivation or ambition   |  |  |
| School suspension                         |  |  |
| Shaking or tremors                        |  |  |
| Symptoms of alcohol withdrawal            |  |  |
| Unintentional action                      |  |  |
| Violent or physically assaultive behavior |  |  |
| Other                                     |  |  |

**D. DRUG HISTORY**

**Q: Do you use prescribed drugs, street drugs, or non-prescribed medications?**

- Have you ever been treated for drug related problems?
- If so, when, where, and reason for treatment?
- What is your perception of your current drug use? (addicted, recreational use)

*For each of the drugs used, refer to the following questions.*

1. When did you first use the drug?
2. Why did you use the drug?
3. Do you use the drug now? Why?
4. When and how often do you use it?

**Q: Have you ever been involved in any hospitalization or treatment program for drug use?**

**Q: Do you have a family history of drug abuse?**

**Q: Has drug use or abuse ever caused family problems for you?**

**Q: Has drug use or abuse ever caused occupational or social problems for you?**

*See chart on the following page.*

**TABLE 1.1-6. DRUG USE CHECK LIST**

| <b>Drug</b>  | <b>Amount (mg)</b> | <b>Frequency</b> | <b>Duration</b> |
|--|--------------------|------------------|-----------------|
| Prescription drug 1                                  |                    |                  |                 |
| Prescription drug 2                                  |                    |                  |                 |
| Prescription drug 3                                  |                    |                  |                 |
| Prescription drug 4                                  |                    |                  |                 |
| Prescription drug 5                                  |                    |                  |                 |
| Prescription drug 6                                  |                    |                  |                 |
| Prescription drug 7                                  |                    |                  |                 |
| Prescription drug 8                                  |                    |                  |                 |
| Cocaine  |                    |                  |                 |
| Crack  |                    |                  |                 |
| Heroin   |                    |                  |                 |
| Ecstasy  |                    |                  |                 |
| Marijuana  |                    |                  |                 |
| LSD  |                    |                  |                 |
| Stimulants (non-prescription)                        |                    |                  |                 |
| Barbiturates (non-prescription)                      |                    |                  |                 |
| Narcotics (non-prescription – painkillers, morphine) |                    |                  |                 |
| Other drugs  |                    |                  |                 |

**DRUG RELATED SYMPTOMS AND SIDE-EFFECTS**

**Q: Do these drugs cause you to experience any side-effects?**

*For each symptom, behavior, or side-effect refer to the following questions.*

1. How often has it occurred?
2. When has it occurred?
3. Is it a concern to you?
4. Is it a concern to others?
5. Is it becoming more or less severe?

*See chart on the following page.*

**TABLE 1.1-7 DRUG SYMPTOM/BEHAVIOR CHECK LIST**

| <b>Symptom</b>                            | <b>Date</b> | <b>Frequency</b> |
|---|-------------|------------------|
| Absenteeism from work or school           |             |                  |
| Abstinence attempts                       |             |                  |
| Addiction references from others          |             |                  |
| Arrests                                   |             |                  |
| Blackouts                                 |             |                  |
| Drug use alone                            |             |                  |
| Drug overdose                             |             |                  |
| Drugs for social confidence               |             |                  |
| Emotional problems                        |             |                  |
| Financial problems                        |             |                  |
| Hallucinations                            |             |                  |
| Job dismissal                             |             |                  |
| Marital or interpersonal problems         |             |                  |
| Memory loss                               |             |                  |
| Multiple drug use                         |             |                  |
| Passing out                               |             |                  |
| Physical problems                         |             |                  |
| Reduced motivation                        |             |                  |
| School suspension                         |             |                  |
| Shakes or tremors                         |             |                  |
| Unintended actions                        |             |                  |
| Unintended overuse                        |             |                  |
| Violent or physically assaultive behavior |             |                  |
| Withdrawal symptoms                       |             |                  |
| Other side-effects                        |             |                  |

**E. POST-INJURY MEDICAL HISTORY (NON-PSYCHIATRIC)**

**Q: List every health care professional that you have seen since the injury in question.**

*For each health care professional refer to the following questions:*

1. Why did you seek medical care?
2. What were you being treated for?
3. Are you still being treated?
4. Was this the first time you have been treated for this condition?
5. Describe the treatment procedures.
6. What was the physician’s diagnosis?
7. Describe the effects of the treatment on your illness.
8. When did treatment stop and why?

**TABLE 1.1-8. HEALTH CARE PROFESSIONAL CHECK LIST**

|    | Physician | Dates of Treatment | Symptoms | Treatment |
|----|-----------|--------------------|----------|-----------|
| 1. |           |                    |          |           |
| 2. |           |                    |          |           |
| 3. |           |                    |          |           |
| 4. |           |                    |          |           |
| 5. |           |                    |          |           |

**F. FAMILY MEDICAL HISTORY**

**Q: Do you have a family history of physical or emotional health problems?**

*For each physical or emotional family health problem, refer to the following questions.*

1. What family member had the health problem?
2. How did the health problem affect the family member?
3. How did the problem affect your relationship?
4. How did this affect you emotionally?

*See chart on the following page.*

**TABLE 1.1-9. FAMILY MEDICAL HISTORY CHECK LIST**

| <b>Disorder</b>                                   | <b>Family Member</b> | <b>Date</b> |
|---|----------------------|-------------|
| Accident proneness                                |                      |             |
| Alcoholism  |                      |             |
| Anemia  |                      |             |
| Arthritis, rheumatism                             |                      |             |
| Back problems                                     |                      |             |
| Cancer  |                      |             |
| Cardiac problems                                  |                      |             |
| Deafness  |                      |             |
| Diabetes  |                      |             |
| Down's syndrome                                   |                      |             |
| Drug abuse  |                      |             |
| Eating disorders                                  |                      |             |
| Epilepsy  |                      |             |
| Glaucoma  |                      |             |
| Hepatitis   |                      |             |
| Hypertension                                      |                      |             |
| Kidney problems                                   |                      |             |
| Liver disease                                     |                      |             |
| Mental health problems: Depression and/or Anxiety |                      |             |
| Obesity   |                      |             |
| Obstetric problems                                |                      |             |
| Rheumatic fever                                   |                      |             |
| Stroke  |                      |             |
| Thyroid disease                                   |                      |             |
| Other physical/mental problems                    |                      |             |

## SECTION 1.2: THE PLAINTIFF’S SOCIAL HISTORY

### A. GENERAL FAMILY INFORMATION

*Family interaction patterns, illnesses, and life stressors can affect a plaintiff’s personality development, mental and physical health.*

#### 1. PLAINTIFF HISTORY

**Q: Describe your childhood history.**

- Did you have any legal or criminal problems?
- Did you have any academic problems?
- Describe your emotional health as a child and teenager.

- Did you have many friends?
- What age did you leave home?

*Be sure to obtain the basic information indicated by the check list for all immediate and extended family members.*

**Q: Are you grieving the loss of (relative)?**

**TABLE 1.2-1. FAMILY CHECK LIST**

| Relation   | Name | Age | Occupation | Residence |
|------------|------|-----|------------|-----------|
| Mother     |      |     |            |           |
| Father     |      |     |            |           |
| Stepmother |      |     |            |           |
| Stepfather |      |     |            |           |
| Sibling 1  |      |     |            |           |
| Sibling 2  |      |     |            |           |
| Sibling 3  |      |     |            |           |
| Sibling 4  |      |     |            |           |
| Spouse 1   |      |     |            |           |
| Spouse 2   |      |     |            |           |
| Child 1    |      |     |            |           |
| Child 2    |      |     |            |           |
| Child 3    |      |     |            |           |
| Child 4    |      |     |            |           |

\*If family members are deceased, obtain the date and cause of death.

**2. CHARACTERISTICS OF THE PLAINTIFF'S MOTHER**

Mother's name: \_\_\_\_\_ Age: \_\_\_\_\_

Occupation: \_\_\_\_\_

*Defense counsel should ask the following questions about the plaintiff's mother now and when the plaintiff was a child.*

**Q: Is your mother emotionally healthy?**

**Q: Is your mother physically healthy?**

**Q: Does your mother use alcohol?**

**Q: Does your mother use drugs?**

**Q: Does your mother have any criminal record or arrests?**

**Q: Has your mother remarried? If so, describe the relationship in her marriage.**

**Q: Does your mother treat you emotionally or physically different from other members of your family?**

**Q: What is your relationship with your mother?**

**Q: How does your relationship now compare with your past relationship?**

**Q: When did you last see your mother?**

**Q: Were you ever abused by your mother?**

**3. CHARACTERISTICS OF THE PLAINTIFF'S FATHER**

Father's name: \_\_\_\_\_ Age: \_\_\_\_\_

Occupation: \_\_\_\_\_

*Defense counsel should ask the following questions about the plaintiff's father now and when the plaintiff was a child.*

**Q: Is your father emotionally healthy?**

**Q: Is your father physically healthy?**

**Q: Does your father use alcohol?**

**Q: Does your father use drugs?**

**Q: Does your father have any criminal records or arrests?**

**Q: Has your father remarried? If so, describe the relationship in his marriage.**

**Q: Does your father treat you emotionally or physically any different than other members of your family?**

**Q: What is your relationship with your father?**

**Q: How does your relationship now compare with your past relationship?**

**Q: When did you last see your father?**

**Q: Were you ever abused by your father?**

**4. CHARACTERISTICS OF THE PLAINTIFF'S SIBLINGS**

Sibling names: \_\_\_\_\_

Occupations: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Ages: \_\_\_\_\_

*Deposition of the Plaintiff*

*Defense counsel should ask the following questions about the plaintiff's brothers and sisters now and when the plaintiff was a child.*

**Q: What is your relationship with your brothers and sisters?**

**Q: How does your relationship now compare with the past?**

**Q: Do any of your brothers and sisters have emotional problems?**

**Q: Do any of your brothers and sisters have learning problems or disabilities?**

**Q: Do your brothers and sisters drink alcohol?**  
(details)

**Q: Do your brothers and sisters use drugs?**  
(details)

**Q: Have any of your brothers and sisters been arrested?**

**Q: Were you ever abused by your brothers or sisters?**

**B. MARITAL HISTORY**

**Q: Have you ever been married? If so, describe your relationship with your spouse.**

*For each marital problem indicated, refer to the following questions.*

1. Describe the circumstances of the problem.
2. Describe the severity and frequency of the problem.
3. When did this problem first occur?

**TABLE 1.2-2. MARITAL HISTORY CHECK LIST**

| <b>Marital Problems</b>    | <b>Duration</b> | <b>Severity</b> | <b>Effect on Relationship</b> |
|----------------------------|-----------------|-----------------|-------------------------------|
| Frequent arguments         |                 |                 |                               |
| Poor sexual relations      |                 |                 |                               |
| Financial problems         |                 |                 |                               |
| Lack of common interests   |                 |                 |                               |
| Jealousy                   |                 |                 |                               |
| Communication difficulties |                 |                 |                               |
| Alcohol abuse              |                 |                 |                               |
| Drug abuse                 |                 |                 |                               |
| Extramarital affairs       |                 |                 |                               |
| Legal problems             |                 |                 |                               |
| Mental illness             |                 |                 |                               |
| Physical illness           |                 |                 |                               |
| Physical abuse             |                 |                 |                               |
| Emotional abuse            |                 |                 |                               |

**Q: Were you married before?**

*If the plaintiff has been married, defense counsel should refer to the following questions.*

Date of marriage: \_\_\_\_\_ to \_\_\_\_\_

Ex-spouse (name): \_\_\_\_\_

Location of marriage: \_\_\_\_\_

Ex-spouse's current employment: \_\_\_\_\_

Current name: \_\_\_\_\_

Current address: \_\_\_\_\_

Separated or divorced: \_\_\_\_\_

**Q: Was there a divorce hearing? (jurisdiction, date)**

**Q: Describe the reason for the separation or divorce.**

**1. PLAINTIFF'S CHILDREN**

**Q: Do you have children?**

**Q: How many children do you have?**

Name:                      Residence:                      Age:

(1) \_\_\_\_\_

(2) \_\_\_\_\_

(3) \_\_\_\_\_

**Q: How many children live with you?**

**Q: Are any of your children deceased?**

**Q: How would you describe your relationship with your children?**

**Q: How would you describe your children's behavior?**

**Q: Do your children have any school problems?**

**Q: Do your children have any legal or criminal records?**

**Q: Do your children have any emotional or physical problems?**

**Q: Have you ever abused your children?**

**C. INTERPERSONAL HISTORY**

**Q: Have you had any other significant relationships?**

**Q: Have you had any other relationships where you lived together?**

Names: \_\_\_\_\_

Dates of co-habitation: \_\_\_\_\_ to \_\_\_\_\_

Locations: \_\_\_\_\_

**Q: What was your reason for living together?**

**Q: What was the reason for the separation?**

**Q: What is the status of your current relationship?**

**Q: Where is s/he living now?**

**D. SEXUAL HISTORY**

*The plaintiff's sexual loss is frequently used for a damage claim. Defense counsel should not hesitate to ask reasonable and relevant questions pertaining to the plaintiff's sexual history and current level of activity.*

**Q: Have you ever experienced any past sexual trauma?**

**Q: Are you undergoing any sexually related treatment?**

**Q: How is your past ability or sexual desire different than your present desire or ability?**

**Q: What is your current level of sexual activity?**

- How many sexual partners do you have?
- Describe your ability to enter into a sexual relationship.
- Do you feel that you are sexually well adjusted?
- Since the injury in question, have you had sexual relations with anyone other than your spouse?

**Q: Do you have any history of a sexually transmitted disease, such as:**

- |           |        |       |
|-----------|--------|-------|
| Gonorrhea | AIDS   | Other |
| Syphilis  | Herpes |       |

**E. RECREATIONAL / SOCIAL**

*The plaintiff may claim social loss, loss of peer relationships, anhedonia (the loss of pleasure of life), and the loss of institutional social relationships (clubs, teams, etc.) as damages in an injury suit.*

*Defense investigation can show that the plaintiff may not have been an active social participant prior to the injury in question. This data may also support the defense position of a pre-existing personality disorder or clinical mental disorder.*

**1. ACTIVITIES**

**Q: Describe past and present interests and activities you have enjoyed.**

*For each activity or interest of the plaintiff, refer to the questions below.*

1. When did you participate in the activity? (pre- or post-injury)
2. How often did you participate?
3. Were these activities related to a school or other enjoyment?

**TABLE 1.2-3. ACTIVITY CHECK LIST**

| Type               | Example                              | Date |
|--------------------|--------------------------------------|------|
| Sports             | tennis/golf/racquetball              |      |
| Physical fitness   | running/swimming/dancing/exercises   |      |
| Camping            | tenting/recreational vehicle touring |      |
| Hunting or fishing | trapping/bow hunting/scuba fishing   |      |
| Dangerous sports   | sky diving/cliff diving/auto racing  |      |
| Boating            | motorboats/sailing                   |      |

*(continued)*

TABLE 1.2-3. ACTIVITY CHECK LIST (continued)

| Type                        | Example                                      | Date |
|-----------------------------|--|------|
| Home computers              | video games/programming                      |      |
| Electronics                 | building electrical devices                  |      |
| Do it yourself projects     | remodeling/building/ landscaping/woodworking |      |
| Handicrafts                 | pottery making/kit building                  |      |
| Sewing                      | all types of needlecraft                     |      |
| Gardening                   | indoor or outdoor                            |      |
| Automotive work             | fixing/building/customizing                  |      |
| Music                       | playing or listening to music                |      |
| Art work                    | pencil/pens/oils/photography                 |      |
| Board games/cards           | monopoly/chess/checkers/bridge               |      |
| Gambling games              | races/cards                                  |      |
| Collecting                  | stamps/coins/books                           |      |
| Attending popular events    | concerts/nightclubs/rock concerts            |      |
| Traveling                   | touristing/junkets                           |      |
| Attending cultural events   | symphony/opera/plays                         |      |
| Religious activities        | choir/social groups/fund raising             |      |
| Health, natural foods       | special diets/yoga                           |      |
| Wines                       | tasting/making                               |      |
| Fashion clothes             | acquiring/designing                          |      |
| Home decorating             | designing/re-doing                           |      |
| Reading                     | novels/mechanics/science                     |      |
| Investments                 | real estate/stocks and bonds                 |      |
| Community civic activities  | Scouts/Jaycees/Women's League                |      |
| Breeding or raising animals | dogs/cats/horses                             |      |
| Cooking                     | gourmet cooking/canning/dining out           |      |
| Volunteer activities        | hospital/charities                           |      |
| Other                       |  |      |

**2. FRIENDSHIPS**

**Q: Describe your friendships before the injury.**

*For each friendship of the plaintiff now or before the injury, refer to the questions below.*

**Q: Describe your friendships since the injury.**

**Q: Describe any similarities or differences in friends.**

1. Has the friendship changed? If so, why?
2. When and how often do you see or talk to your friend?
3. How long has this friendship been maintained?

**TABLE 1.2-4. FRIENDSHIP CHECK LIST**

| Activity               | Name | Frequency of Contact |
|------------------------|------|----------------------|
| 1 <sup>st</sup> friend |      |                      |
| 2 <sup>nd</sup> friend |      |                      |
| 3 <sup>rd</sup> friend |      |                      |
| 4 <sup>th</sup> friend |      |                      |

**3. RELIGION**

**Q: What is your current religion?**

Active       Not Active

- What precipitated the change in religion?
- Explain how this change has affected your life.
- Explain how other family members view this change.
- When did this religious change take place?

**Q: Have you changed your religious beliefs or affiliations within the past two years?**

*Defense counsel should ask the following questions if the plaintiff indicates a major change in religion.*

## **F. LIFE THREATENING BEHAVIOR**

### **1. PLAINTIFF'S SUICIDAL TENDENCIES**

**Q: Have you ever had suicidal thoughts or feelings?**

- What did you think about?
- Where were you?
- When did you have these thoughts?
- Why did you think about suicide?
- How long have you been thinking about suicide?
- How often do you feel like committing suicide?

**Q: Have you communicated your suicidal feelings to someone? If so, to whom?**

**Q: Have you engaged in any other life-threatening behaviors or activities?**

- Why do you do this?
- How often do you do this?
- When do you do this?
- Are others concerned about this behavior/activity?
- Are you able to stop this behavior?

### **2. PLAINTIFF'S EXPERIENCES WITH VIOLENCE**

**Q: Has anyone ever (including childhood) committed an act of violence against you?**

- What happened to you?
- Was the violence planned or unintentional?
- Was anyone else with you?
- Where were you?
- When did this happen?
- Who committed the violence against you?
- How long have there been violent acts against you?
- How often does this happen?
- Describe your feelings about the violence.
- Why was the attack made against you?

**Q: Have you ever committed any act of violence against someone else?**

- What did you do?
- Was the violence planned or unintentional?
- Was anyone else with you?
- Where were you?
- When did this happen?
- Who was the violence against?
- Why were you violent?
- How long have you had episodes of violence?
- How often are you violent?
- Has your violence ever resulted in punishment, legal or otherwise?

## **G. CRIMINAL LEGAL HISTORY**

**Q: Have you ever been arrested?**

**Q: Are you currently on probation or parole?**

**Q: What is your criminal attorney's name and address?**

*For each arrest or criminal act, refer to the following questions.*

1. How many times were you arrested for this offense?
2. Did you appear in court?
3. Describe any probationary periods.
4. Were you placed in a correctional institution?
5. Did you ever live in a halfway house or similar facility because of the offense?

See chart on the following page.

**TABLE 1.2-5. CRIMINAL HISTORY CHECK LIST**

| <b>Offense</b>        | <b>Age</b> | <b>Outcome/Charge</b> | <b>Time Served</b> |
|-----------------------|------------|-----------------------|--------------------|
| Arson                 |            |                       |                    |
| Assault               |            |                       |                    |
| Auto-theft            |            |                       |                    |
| Battery               |            |                       |                    |
| Blackmail             |            |                       |                    |
| Curfew violation      |            |                       |                    |
| Burglary              |            |                       |                    |
| Property damage       |            |                       |                    |
| Drug distribution/use |            |                       |                    |
| Prescription forgery  |            |                       |                    |
| Other forgery         |            |                       |                    |
| Homicide              |            |                       |                    |
| Manslaughter          |            |                       |                    |
| Mugging               |            |                       |                    |
| Petty theft           |            |                       |                    |
| Solicitation for sex  |            |                       |                    |
| Prostitution          |            |                       |                    |
| Rape                  |            |                       |                    |
| Robbery/Shoplifting   |            |                       |                    |
| Soliciting            |            |                       |                    |
| Theft                 |            |                       |                    |
| Truancy               |            |                       |                    |
| Disorderly conduct    |            |                       |                    |
| Vandalism             |            |                       |                    |
| Other                 |            |                       |                    |

## SECTION 1.3: THE PLAINTIFF’S PSYCHOLOGICAL HISTORY

### A. PRE-INJURY PSYCHOLOGICAL TREATMENT

**Q: What was your pre-injury mental status?**

**Q: Did you receive any mental health care for a disorder before the injury in question?**

**Q: If you had mental health problems, but did not receive care, why not?**

*For each mental health problem treated, refer to the following questions.*

1. Was the therapy individual, family, or marital?
2. What was the purpose of the therapy?
3. When did you have therapy?
4. Did you attend any group therapy?
5. How long was the treatment?
6. Was the therapy effective?
7. Were you satisfied with your mental health care?

**TABLE 1.3-1. PRE-INJURY PSYCHOLOGICAL CHECK LIST**

| Disorders                                      | Date | Doctor/<br>Facility | Treatment/<br>Medications | Result |
|--|------|---------------------|---------------------------|--------|
| <b>Disorder 1:</b><br><br>Location of Records: |      |                     |                           |        |
| Nature of Intervention:                        |      |                     |                           |        |
| <b>Disorder 2:</b><br><br>Location of Records: |      |                     |                           |        |
| Nature of Intervention:                        |      |                     |                           |        |
| <b>Disorder 3:</b><br><br>Location of Records: |      |                     |                           |        |
| Nature of Intervention:                        |      |                     |                           |        |

**Q: Did you receive psychological testing during therapy?**

**Q: Were you hospitalized for any mental health problem?**

**Q: Were you given any medications for the treatment of mental health problems?**

*If the plaintiff responds in the affirmative, refer to the following questions.*

1. What type of medication were you taking and for what condition?

2. Did you have any side-effects related to the taking of this medication?

3. Were you on this medication at the time of the cause of action?

**Q: Did you receive any other psychological or psychiatric intervention before the injury in question?**

**Q: Were you involved in litigation at the time of this prior treatment? If so, explain.**

**B. POST-INJURY PSYCHOLOGICAL TREATMENT**

**Q: Have you received any psychological treatment or evaluation since the injury in question for a mental health disorder?**

*For each emotional or behavioral disorder treated, refer to the questions below.*

1. What do you believe to be the cause(s) of the problem?
2. Was the therapy individual, family, or marital?
3. What was the purpose of the therapy?
4. When and how long was the treatment?
5. Do you feel the therapy was effective?

**Q: Did you have any psychological testing during therapy?**

**Q: Were you hospitalized for any emotional or behavioral problems?**

**Q: Did you receive any medications for the treatment of emotional or behavioral problems since the injury in question?**

*If the plaintiff responds in the affirmative, refer to the following questions.*

1. What type of medication were you taking and for what condition?
2. Did you have any side-effects related to the taking of this medication?
3. Are you currently on this medication?

**Q: Have there been any other psychological or psychiatric interventions since the injury in question?**

**TABLE 1.3-2. POST-INJURY PSYCHOLOGICAL CHECK LIST**

| Disorders   | Date | Doctor/<br>Facility | Treatment/<br>Medications | Result |
|---|------|---------------------|---------------------------|--------|
| <p><b>Disorder 1:</b></p> <p>Location of Records:</p> |      |                     |                           |        |
| Nature of Intervention:                               |      |                     |                           |        |

*(continued)*

**TABLE 1.3-2. POST-INJURY PSYCHOLOGICAL CHECK LIST** (continued)

| Disorders   | Date | Doctor/<br>Facility | Treatment/<br>Medications | Result |
|---|------|---------------------|---------------------------|--------|
| <p><b>Disorder 2:</b></p> <p>Location of Records:</p> |      |                     |                           |        |
| Nature of Intervention:                               |      |                     |                           |        |
| <p><b>Disorder 3:</b></p> <p>Location of Records:</p> |      |                     |                           |        |
| Nature of Intervention:                               |      |                     |                           |        |

**C. DEVELOPMENTAL HISTORY**

**Q: Have you ever experienced any extensive separation from your parents? If so, describe the circumstances and your reaction to the separation.**

**Q: Were you ever physically or emotionally abused or traumatized as a child, adolescent, or adult?**

**Q: What is your general emotional status when life is going well?**

**Q: What is your emotional status when life is not going well?**

**Q: How do you typically cope with everyday stressors? With unusual/unexpected stressors?**

**D. CURRENT PSYCHOLOGICAL PROBLEMS**

**Q: Do you have any mental health problems or symptoms that you believe are related to the injury in question?**

1. Describe the symptom (when it began, severity, duration).
2. Did you ever have this symptom in the past?
3. Do you believe there could be other reasons for this symptom?

**Q: Describe your current mental health in relation to your pre-injury mental condition.**

**Q: Do you believe that you will fully recover?**

**Q: Are you anxious or depressed over this litigation?**

*See chart on the following page.*

**TABLE 1.3-3. SYMPTOM CHECK LIST**

| <b>Symptoms</b>       | <b>Example</b>  | <b>Yes</b> | <b>No</b> |
|-----------------------|---|------------|-----------|
| Poor concentration    | cannot pay attention/easily distracted/mind goes blank at times           |            |           |
| Poor memory           | cannot remember things as well as before                                  |            |           |
| Indecision            | cannot make decisions as well as before                                   |            |           |
| Restlessness          | cannot sit still for long, feels agitated                                 |            |           |
| Unrealistic fears     | fears things, people, places  |            |           |
| Uncontrolled impulses | acts quickly without thought  |            |           |
| Harmful habits        | behaves in a manner that could cause serious problem                      |            |           |
| Easily hurt feelings  | feels people are unfriendly, superior, not understanding                  |            |           |
| Regret or shame       | feels guilty, wrong, regretful  |            |           |
| Depression            | feels blue, low, down much of the time                                    |            |           |
| Hopelessness          | feels nothing will work out right   |            |           |
| Tension or anxiety    | worries and is keyed up about important or unimportant things             |            |           |
| Fearfulness           | feels that something bad is going to happen                               |            |           |
| Self-consciousness    | feels uncomfortable around other people, especially when people watch     |            |           |
| Loss of interest      | does not care about things, apathetic                                     |            |           |
| Inferior feelings     | feels like they are not as good as other people/feel uneasy around others |            |           |
| Loneliness            | feels like no one cares about them  |            |           |
| Loss of self-control  | cannot control behavior or emotions                                       |            |           |
| Repetitive thoughts   | cannot stop thinking about someone or something                           |            |           |
| Irritability          | upsets easily, is touchy, easily angered                                  |            |           |
| Panic attacks         | becomes terrified or very frightened                                      |            |           |
| Crying spells         | cries easily, at the wrong time, cannot stop crying at times              |            |           |
| Suicidal thoughts     | wants to die, would rather be dead than alive                             |            |           |
| Suspiciousness        | cannot trust others, needs to be on guard around other people             |            |           |
| Social problems       | cannot get along with others, argues about everything                     |            |           |

(continued)

TABLE 1.3-3. SYMPTOM CHECK LIST (continued)

| Symptoms            | Example   | Yes | No |
|---------------------|---|-----|----|
| Few close friends   | talks with no one about serious things  |     |    |
| Shyness             | avoids people or social events, feels uncomfortable with the opposite sex                     |     |    |
| Uneasiness          | feels nervous in crowds or open places, or when left alone                                    |     |    |
| Fear of failure     | feels unable to cope, fears failing at work or school   |     |    |
| Sexual problems     | feels sexually inadequate or dissatisfied   |     |    |
| Feeling ignored     | feels invisible, unnoticed, unloved, unimportant  |     |    |
| Poor appetite       | does not eat enough, has no desire to eat   |     |    |
| Feeling mistreated  | believes they are treated unfairly, taken advantage of  |     |    |
| Sleep problems      | cannot sleep, nightmares or night terrors, difficulty falling asleep, early morning awakening |     |    |
| Morning depression  | cannot get up in the morning  |     |    |
| Anger               | feels like hurting someone, smashing or breaking things                                       |     |    |
| Loss of control     | feels like someone or something is controlling their mind                                     |     |    |
| Chronic pain        | headache, stomach, back pain  |     |    |
| Heart problems      | pounding, palpitations, racing or slowed heartbeat, pain                                      |     |    |
| Hot or cold flashes | sweating, chills that are not related to the air temperature                                  |     |    |
| Loss of energy      | tires easily, fatigued, lethargic much of the time  |     |    |
| Increased energy    | is hyperactive, body seems to be nervous  |     |    |
| Dizziness           | feels faint, fears falling  |     |    |
| Tingling            | prickling sensation in hands, feet or other body parts  |     |    |
| Numbness            | lacks sensation in one or more body parts   |     |    |
| Distortions         | sees, hears, feel things that are not real  |     |    |
| Other               |   |     |    |

**E. LIFE STRESSORS**

**1. TRAUMATIC OR SIGNIFICANT EVENTS**

**Q: Have there been any significant or traumatic events that you either personally experienced or witnessed?**

*For each significant traumatic event, refer to the following questions.*

1. Describe your physical symptoms or changes from the event.
2. Describe your emotional symptoms or changes from the event.
3. Do you continue to experience these symptoms or changes?

**TABLE 1.3-4. TRAUMATIC EVENT CHECK LIST**

| Trauma              | Changes                  | Frequency | Severity | Duration |
|---------------------|--------------------------|-----------|----------|----------|
| <b>DATE:</b>        | <b>Physical</b>          |           |          |          |
|                     | 1. Sleep                 |           |          |          |
|                     | 2. Appetite              |           |          |          |
| <b>Description:</b> | 3. Work                  |           |          |          |
|                     | 4. Social                |           |          |          |
|                     | 5. Interpersonal         |           |          |          |
|                     | 6. Sexual                |           |          |          |
|                     | 7. Daily routine         |           |          |          |
|                     | 8. Motor ability         |           |          |          |
|                     | <b>Psychological</b>     |           |          |          |
|                     | 1. Speech                |           |          |          |
|                     | 2. Mood                  |           |          |          |
|                     | 3. Sensorium             |           |          |          |
|                     | 4. Insight               |           |          |          |
|                     | 5. Judgement             |           |          |          |
|                     | 6. Dreams                |           |          |          |
|                     | 7. Flashbacks            |           |          |          |
|                     | 8. Intrusive thoughts    |           |          |          |
|                     | 9. Emotional instability |           |          |          |
|                     | 10. Grief                |           |          |          |

**2. SOCIAL STRESSORS**

**Q: Are there any other social stressors in your life now?**

*For each stressor, refer to the following questions.*

1. Did the stressor occur before or after the injury in question?

2. Are you still experiencing the stressor?

3. What effects have you experienced as a result of the stressor?

4. What are you doing to relieve the effects of the stressor?

**TABLE 1.3-5. SOCIAL STRESSOR CHECK LIST**

| Category  | Before | After | Present |
|---|--------|-------|---------|
| <b><i>I. SPOUSE</i></b>                                 |        |       |         |
| Suicide of spouse                                       |        |       |         |
| Death of spouse (other causes)                          |        |       |         |
| Divorce   |        |       |         |
| Marital separation                                      |        |       |         |
| Marital reconciliation                                  |        |       |         |
| Sex difficulties  |        |       |         |
| Marriage  |        |       |         |
| Change in number of arguments with spouse               |        |       |         |
| Spouse begins or stops work                             |        |       |         |
| <b><i>II. CHILDREN/FAMILY</i></b>                       |        |       |         |
| Death of child  |        |       |         |
| Death of a close family member                          |        |       |         |
| Child leaving home                                      |        |       |         |
| Birth of child  |        |       |         |
| Change in health of family member                       |        |       |         |
| Trouble with in-laws                                    |        |       |         |
| <b><i>III. INTERPERSONAL</i></b>                        |        |       |         |
| Death of a close friend                                 |        |       |         |
| Break up with boyfriend/girlfriend                      |        |       |         |
| Change in number of arguments with boyfriend/girlfriend |        |       |         |

*(continued)*

**TABLE 1.3-5. SOCIAL STRESSOR CHECK LIST (continued)**

| <b>Category</b>   | <b>Before</b> | <b>After</b> | <b>Present</b> |
|---|---------------|--------------|----------------|
| <b>III. INTERPERSONAL (continued)</b>                   |               |              |                |
| Sexual difficulties with boyfriend/girlfriend           |               |              |                |
| Change in living arrangements with boyfriend/girlfriend |               |              |                |
| Change in social activities                             |               |              |                |
| <b>IV. PHYSICAL</b>                                     |               |              |                |
| Rape  |               |              |                |
| Miscarriage   |               |              |                |
| Physical illness (serious) diagnosed                    |               |              |                |
| Personal injury or illness                              |               |              |                |
| Pregnancy   |               |              |                |
| Revision of personal habits                             |               |              |                |
| Change in recreation                                    |               |              |                |
| <b>V. HOME</b>  |               |              |                |
| Leaving home  |               |              |                |
| Change in residence                                     |               |              |                |
| Change in living conditions                             |               |              |                |
| Change in eating habits                                 |               |              |                |
| Change in sleeping habits                               |               |              |                |
| Change in number of family get-togethers                |               |              |                |
| <b>VI. SCHOOL</b>                                       |               |              |                |
| Failing/low grades in school                            |               |              |                |
| Change in schools                                       |               |              |                |
| Begin or end school                                     |               |              |                |
| <b>VII. WORK</b>  |               |              |                |
| Fired from work place                                   |               |              |                |
| Laid off  |               |              |                |

(continued)

**TABLE 1.3-5. SOCIAL STRESSOR CHECK LIST (continued)**

| Category                               | Before | After | Present |
|--|--------|-------|---------|
| <b>VII. WORK (continued)</b>           |        |       |         |
| Trouble with boss or co-workers        |        |       |         |
| Career change                          |        |       |         |
| Change in hours or conditions          |        |       |         |
| Change in responsibilities             |        |       |         |
| <b>VIII. FINANCIAL</b>                 |        |       |         |
| Bankruptcy                             |        |       |         |
| Foreclosure of mortgage or loan        |        |       |         |
| Change in financial state              |        |       |         |
| Loan (personal, car)                   |        |       |         |
| Mortgage                               |        |       |         |
| <b>IX. OTHER</b>                       |        |       |         |
| Natural disaster (earthquake, tornado) |        |       |         |
| Christmas/Holidays                     |        |       |         |
| Jail term/arrest                       |        |       |         |
| Minor violations of the law            |        |       |         |
| Retirement                             |        |       |         |
| Vacation                               |        |       |         |
| Change in church activities            |        |       |         |
| Outstanding personal achievement       |        |       |         |

## SECTION 1.4: DOCUMENTS TO DISCOVER

*Defense counsel should obtain signed releases for plaintiff's records at the time of deposition.*

### A. CREDIT

*Manic-depressive plaintiff's frequently have credit problems. Psychosomatic plaintiff's often have a history of unpaid doctor bills.*

1. Types of credit (bank loans, credit cards, student loans)
  - a. When received
  - b. Amount owed
  - c. Payment delinquencies

**B. DRIVING RECORDS (all jurisdictions)**

1. Accident reports from police and insurance companies
2. Records of DUI or DWI
3. Evidence of drivers license suspension or reported recklessness
4. Driving school

**C. SCHOOL RECORDS (all grades)**

1. Transcripts
2. Disciplinary reports
3. Health records
4. Evidence of special testing, classes, or school service

**D. EMPLOYMENT RECORDS**

1. Employment applications
2. Performance reviews, work evaluations
3. Attendance record, sick leave, unexcused leaves
4. Medical reports, workers compensation claims
5. Grievances
6. Union hearing records
7. Disciplinary reports
8. Commendations
9. Unemployment files
10. Local and state civil service records

**E. INCOME TAX RETURNS  
(plaintiff and spouse)**

1. Returns from the past five years or more, especially with frequent job changes and economic changes

**F. INSURANCE RELATED RECORDS**

1. Insurance applications for auto, life, disability, medical
  - a. Limits and terms of policies
  - b. Recipients of policy benefits
  - c. Past claims for insurance reimbursement

**G. INVESTIGATORY REPORTS**

1. Civil, criminal, or traffic matters
2. Police reports

3. Witness statements
4. Private investigator reports

**H. LEGAL RECORDS**

1. Criminal records
2. Civil suits
3. Police records

**I. MARITAL RECORDS**

1. Divorce or separation records
2. Reports of abuse or neglect
3. Police intervention
4. Counseling (marriage or spouse)

**J. MEDICAL RECORDS**

1. Hospital records (pre-injury and post-injury)
  - a. Admission summaries  
ER entry sheets  
Previous treatments, hospitalizations, physicians  
Personal & medical history data  
Medications
  - b. Discharge summaries  
Treatments, physicians  
Medications  
Recommendations for follow-up treatment
  - c. Diagnostic charts, tests, and summaries  
Previous injuries  
Pre-existing illnesses  
Toxicology screens for alcohol or drug use  
Personal & medical data  
Medications  
Diagnostic tests (CT scans, MRI, EEG, etc.)  
Recommendations for further testing
  - d. Intake questionnaire, inpatient mini-history, or nursing assessment  
Reason for hospitalization  
Personal, medical data  
Symptom list
  - e. Medication orders  
Types, amounts, frequency, duration  
Ordering physicians
  - f. Nurse's notes on patient's daily progress  
Symptom list  
Plaintiff's cooperation, motivation for recovery
  - g. Physician's orders on treatment status  
Restraint or seclusion orders  
Treatment orders

- Diagnostic and surgical considerations
- Passes and discharge considerations
- Diagnosis and review of symptoms
- Consultation notes
- h. Occupational, physical, speech therapy notes
  - Patient cooperation and motivation for recovery
  - Symptom list
  - Medical history
- i. Social work or social services report
  - Biological/psychological/social history
  - Support system analysis
  - Psychodiagnostic information
- j. Treatment and intervention reports
  - Pre-existing conditions
  - Medical history

2. Outpatient records

- a. Doctor's notes
- b. Diagnostic tests
- c. Summary reports
- d. Medication orders
- e. Prescription notes
- f. Billing statements

**K. MILITARY RECORDS**

- 1. Discharge papers
- 2. Disciplinary reports
- 3. Fitness or performance reviews
- 4. Recommendations
- 5. Medical reports
- 6. Job descriptions (MOS number)
- 7. Combat experience

**L. PREVIOUS LITIGATION**

- 1. Transcripts
- 2. Depositions
- 3. Medical and psychological records

**M. DRUG OR ALCOHOL TREATMENT  
CLINIC RECORDS**

**N. PRIVATE THERAPY RECORDS**

- 1. Referral source
- 2. Clinical history
  - a. Any treatments or evaluations not already obtained
  - b. Clinical history forms

- 3. Current mental status examination
  - a. Mental status history forms
- 4. Psychological testing (obtain all test data, answer sheets)
  - a. MMPI
  - b. WAIS-R; WAIS III
  - c. Other testing including neuropsychological tests
- 5. Conclusions
  - a. Diagnosis (Axis I-V)
  - b. Prognosis
  - c. Compare with current complaints
- 6. Recommendations
  - a. Additional discovery, patient compliance, motivation for recovery
  - b. Recommended therapy
  - c. Recommended medications
- 7. Original scratch notes
  - a. Dual sets of notes, personal and professional
- 8. Billing statements
  - a. Correspondences with dated notes of treatment and billing (diagnostic) codes used
- 9. Additional services
  - a. Notes and records

**O. PSYCHOLOGICAL OR  
NEUROPSYCHOLOGICAL TESTS**

- 1. Purpose of testing
- 2. Procedures or tests used
  - a. Protocols, notes, scratch notes
  - b. Examiner
- 3. Mental status examination of current functioning and symptoms
- 4. Clinical history
  - a. Treatments or evaluations not obtained
  - b. Previous testing
  - c. Protocols, notes, and reports
- 5. Conclusions
  - a. Diagnosis (Axis I-V)
  - b. Prognosis compared with current complaints
- 6. Recommendations
  - a. Source of discovery, patient compliance, motivation for recovery

*Deposition of the Plaintiff*

- b. Recommended therapy
- c. Recommended medications

7. Original scratch notes

8. Billing statements

- a. Correspondence with dated notes

9. Additional services

- a. Notes and records

***P. VITAE OF OPPOSING EXPERTS***

1. Professional resume

2. Supplemental addendum showing clinical experience, publications, lectures

***Q. MISCELLANEOUS DISCOVERY  
SOURCES/CONSIDERATIONS***

1. Interview of ex-spouse or person close to plaintiff for pre-injury functioning information

2. Plaintiff diary or daily calendar

3. Prescriptions

4. Letters or instruction forms

5. Liens held by doctors against the plaintiff

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## **Chapter 2**

# **Qualifications and Experience of the Plaintiff’s Expert Witness**

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SECTION

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## **CHAPTER 2**

# **QUALIFICATIONS AND EXPERIENCE OF THE PLAINTIFF'S EXPERT WITNESS**

### **INTRODUCTION**

Mental health professionals have a wide variety of backgrounds and experience. The defense counsel commonly conducts depositions of psychiatrists, psychologists, neuropsychologists, and clinical social workers. Each field has many approaches to patient evaluation and treatment. While many experts have excellent credentials in their field, they may also be testifying in an unfamiliar area. For example, few psychologists know the psychopharmacological effects of prescribed drugs and psychiatrists are usually unfamiliar with neuropsychological testing.

Expert witnesses that fail to recognize the boundaries of their own training, may make serious diagnostic errors. Others, who have not remained current, may still use tests and procedures developed thirty to fifty years ago.

This chapter provides a basis to evaluate the competency of an expert witness and questions to determine the witness' own mental health, legal history, and extent of his or her forensic practice.

## **SECTION 2.1: GENERAL INFORMATION**

**Q: Please state your full name and the address of your office.**

**Q: What are the locations and addresses of your past practices?**

**Q: Do you have partners or other employees in your practice?**

**Q: What is the registered name of your practice?**

**Q: Are you an owner, partner or employee of any other firm or business?**

## **SECTION 2.2 AND 2.3: EXPERT WITNESS**

### **A. EDUCATION**

**Q: Describe your formal education including each school attended and the dates, location, degrees, or honors you received.**

**Q: What was your major field of undergraduate study?**

**Q: What was your field of post-graduate study or residency?**

**Q: (Psychologist) Did you write a dissertation?**

- What is the name of your dissertation?
- What year was your dissertation completed?
- Does your university maintain a copy in the graduate library?
- Is it registered with Dissertation Abstracts International (DAI)?

### **B. CLINICAL TRAINING**

**Q: Describe your clinical training, especially with regard to testing and clinical psychotherapy.**

- Where was the clinical practice? (e.g., mental health center, hospital, out-patient)
- How long was the clinical training?
- What was the nature of training? (e.g., classroom lecture, active therapy)
- Describe the supervision you had during training.
- If you had patients, what disorders did you treat?

- How many patients did you treat?
- What psychological tests did you use and how many did you administer, score, or interpret?
- What was the nature of the client population? (e.g., child, adult, forensic)
- What type of therapy did you practice? (e.g., individual, family, marital)
- What therapy modality did you use? (e.g., client-centered, gestalt, analytic, etc.)
- How long were the patients in therapy?

**C. CONTINUING CLINICAL EXPERIENCE OR TRAINING**

**Q: Describe any other clinical experience or additional training in individual psychotherapy, group psychotherapy, or clinical diagnosis.**

- Where did you obtain this additional experience?

- What techniques or theories did you use?
- Did you receive CE or CME credits?
- Did you conduct psychological testing?

**D. PROFESSIONAL MEMBERSHIPS**

**Q: What professional organizations do you belong to?**

- What is the status of your membership?
- What are the requirements for membership?
- Are you serving in any official capacity within those organizations?

**Q: Has your membership ever been suspended or terminated?**

**Q: Describe any clinical experience or additional training in psychological testing or intelligence testing.**

- What specific tests did you use?
- Did you receive CE credit?

**E. LICENSURE & CERTIFICATION**

**Q: Where are you licensed?**

*For each state and jurisdiction ask the following questions:*

- When did you receive your license?
- What type of license did you receive?
- Describe how you obtained licensure.

**Q: What area of psychiatry or psychology are you certified in or do you specialize in? (e.g., clinical, child, forensic, women's issues)**

- What is the basis for your specialization?

**Q: Are you board certified?**

- What areas are you certified in?
- When were you certified?
- What is the name of the certifying board?
- Have you ever failed a board examination?
- How many times have you failed?

**Q: Has your license or certification ever been suspended or terminated?**

**F. PUBLICATIONS AND LECTURES**

**Q: Describe any articles you have had published in a peer reviewed journal. (name, journal, volume, and date)**

**Q: Have you authored any books, book chapters, or monographs that have been published? (name of publication, publisher, and date)**

**Q: Have you published articles in a forensic journal? (name, journal, volume, and date)**

**Q: What public speaking have you done specific to clinical psychological or psychiatric practitioners?**

- What was the name of the group?
- What was the subject of your lecture?
- Where and when did you speak?
- Who was the audience?

## ***G. NATURE OF CURRENT PRACTICE***

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**Q: Describe your current practice or professional position.**

- What is your job title?
- How long have you been in your current practice?
- What are your responsibilities?

**Q: Describe the settings where you provide therapeutic or professional services.**

- What type of setting?
- What is the duration?
- What is the type of service provided?

**Q: In your current practice, describe the nature and amount of time spent per week engaging in professional activities.**

- How much time is spent on individual psychotherapy?
- How much time is spent on group psychotherapy?
- How much time is spent on psychological testing?
- How much time is spent administering medication?
- How much time is spent consulting? (nature of consultation)
- How much time is spent on lecturing or teaching? (nature of teaching)
- How much time is spent serving as an expert witness including the review of documents and examination of plaintiffs?

**Q: Describe your current client population.**

**Q: What therapy modality do you use?** (individual, group, psychopharmacological, other)

**Q: How many patients do you usually see each week?**

**Q: What is the average duration of therapy?**

**Q: How are your patients usually referred to you?** (e.g., walk-ins, court or attorney referred, advertisement)

**Q: Describe any other aspects of your current professional practice.**

- What is the nature of your responsibility?
- How much time do you spend doing this?
- How long have you been doing this?
- What special training or education have you acquired to prepare for this service or practice?

**Q: What are the names of the hospitals where you have practiced?**

**Q: What are your treatment fee rates?**

**Q: What are your forensic fee rates?**

## H. TREATMENT MODALITY

**Q: Do most psychiatrists and psychologists in the United States use the DSM-IV (Diagnostic and Statistical Manual of Mental Disorders, 4th Edition or the DSM-IV TR) in formulating a patient's diagnosis?**

- What is its function?
- When do you conduct psychological testing?
- Do you test your own patients?
- Do you give a personality test?

**Q: Did you use that manual in arriving at your diagnosis in this case?**

**Q: What are the ways psychologists (psychiatrists) determine a client's problems?**

**Q: Did you submit diagnostic codes from the DSM-IV or DSM-IV-TR on any health insurance forms?**

1. Clinical history
2. Psychological Testing
3. Other medical records
4. Collateral interviews with other persons

**Q: In your field, is it required or advised that a doctor review a patient's medical records before a diagnosis is issued?**

**Q: What are the functions of history taking in your clinical practice?**

**Q: What is the purpose of reviewing these records?**

- Under what circumstances do you usually take a client's history?
- What type of information is gathered in a clinical history?
- How is the information gathered?
- Who gathers the information?

**Q: Under what circumstances do you consult a patient's past medical records?**

**Q: What are the components of a psychological evaluation?**

## I. REFERRAL OF PATIENTS

**Q: What are the sources of your referral?**

**Q: Have you ever acted as a consultant or advisor to the plaintiff's attorney or any other member of his or her law firm?**

**Q: Has the plaintiff's attorney ever referred any professional matter to you in the past?**

- What are the names of the cases?

**Q: Do you or any member of your family or practice know the plaintiff's attorney on a social basis?**

## J. DISCIPLINARY ACTION

**Q: Have you ever been investigated regarding any area of your professional practice by any of the following:**

3. Local police
4. A professional organization investigation

1. A state licensure board
2. A district or states attorney

**Q: Have you ever been sued or had a claim against you?**

**Q: Have you ever been the subject of disciplinary action by a hospital or other medical group?**

**Q: Have you ever been denied hospital privileges?**

**Q: Have any of your clients committed suicide?**

- Do you have any reason to believe a claim will be filed against you as a result of this or any other treatment problem or failure?

***K. TESTIMONY, FORENSIC, AND DEPOSITION EXPERIENCE***

**Q: What is the ratio of plaintiff/defense cases in which you have offered your opinion or in any way consulted?**

- List all the names and locations of your past forensic cases.

**Q: What percent of your income is derived from forensic activities?**

**Q: Do you have a standard retainer form or letter of retainer?**

- Please produce a copy of this document.

**Q: How many times have you testified in court?**

- What was the jurisdiction?
- Was it a criminal or civil case?
- Were you a plaintiff or defense witness?
- What was the case name?

- Who were the attorneys?
- What was your diagnosis in the case?

**Q: How many times have you been deposed?**

- Where were you deposed?
- What was the case name?
- Who were the attorneys?
- What was your diagnosis in the case?

**Q: Do you work for or obtain cases from a service that finds expert witnesses for attorneys?**

**Q: Does this service charge the client's attorney a referral fee or a percent of the plaintiff's award or settlement?**

- What is the name of the service?
- What is the address?
- How many cases have you completed or are you currently working on for this service?

***L. PERSONAL INFORMATION***

**Q: Are you currently undergoing treatment by any mental health care provider?**

**Q: Are you taking any psychoactive medication?**

**Q: Do you use any controlled substances? (street drugs or prescribed drugs)**

- If so, what is the frequency, why and when do you use them?

**Q: Have you ever been indicted or arrested?**

**Q: Have you ever received bonus gifts or trips from drug companies?**

***M. OTHER CONCLUDING QUESTIONS***

**Q: How do you define your role in this case?**  
(consultant, treatment provider, expert)

**Q: How much money has been paid to you to date  
for your forensic work in this case?**

**Q: What is the plaintiff's outstanding balance for  
treatment?**

**Q: How much are you being paid for this  
deposition? (deposition time)**

- When was the balance paid?
- Who is paying the bill?

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# CHAPTER 3

## The Examination and Treatment of the Plaintiff

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# CHAPTER 3

## THE EXAMINATION AND TREATMENT OF THE PLAINTIFF

### INTRODUCTION

This chapter provides questions to determine the goals of therapy and the examination and treatment protocols used with the plaintiff. Plaintiffs may see a psychiatrist or psychologist for litigation purposes rather than for treatment. The relevance and purpose of treatment may become a trial issue. Questions are provided to determine litigation planning during treatment sessions, improper prescriptions or medication supervision, witness bias, and conflicts in billing and trial diagnoses (one diagnosis is used for the trial, another diagnosis for billing).

Although many of the following questions are designed for the treating doctor or therapist, certain questions may be used in deposing the non-treating, forensic evaluator.

*The witness examination and treatment of the plaintiff is highly susceptible to attack. Frequent errors made by the examining and treating psychiatrists or psychologists occur when:*

- 1. Psychological testing is conducted by a technician.**
- 2. Psychological tests are given to the plaintiff to complete at home.**
- 3. The plaintiff sees the therapist infrequently to establish a litigation record, not to receive psychotherapy.**
- 4. The therapist has a financial stake in the outcome of the trial (e.g., lien).**
- 5. The therapist prescribes multiple medications and improperly supervises their use.**
- 6. The therapist allows the treatment periods to become litigation planning sessions.**
- 7. The therapist fails to communicate with other treating professionals in the case.**
- 8. The therapist or evaluator fails to conduct objective tests and measures.**
- 9. The therapist or evaluator fails to record important information about the plaintiff.**
- 10. The therapist or evaluator fails to obtain a proper medical, social and psychological history of the plaintiff.**

**A. PLAINTIFF REFERRAL AND TREATMENT**

**Q: When did you first meet the plaintiff?**

**Q: How did you meet the plaintiff?**

- Was the plaintiff referred, a walk-in, or a telephone appointment?

**Q: If the plaintiff was referred to you:**

- Who did the referral?
- Why was the referral made?
- When did the referral take place?

**Q: Describe the reasons that the plaintiff came to you for treatment or evaluation.**

**Q: Did the plaintiff tell you that he or she was in litigation during the first session?**

**Q: How often did you see and treat the plaintiff?**

- On what dates were treatments given?
- How does the plaintiff get to the sessions?
- How long are the sessions?
- Who determines the plaintiff's treatment schedule?
- Was the schedule ever changed?
- Why were there changes?
- How long has the plaintiff been in treatment?
- How many sessions has the plaintiff missed or cancelled?
- Is the plaintiff motivated in your sessions?

**Q: Describe your mode of treatment used with the plaintiff.**

*Defense counsel should ask the following questions for each technique used by the witness:*

- What psychological theory did you use?
- What was the rationale for using the theory?

- Why did you choose this type of treatment?
- What did you do to implement this theory?
- Was the plaintiff responsive to this technique?
- Is there an alternate approach for treating the plaintiff?

**Q: Describe the content of the sessions.**

*NOTE: Defense counsel should look for signs of litigation planning.*

**Q: How did you determine the plaintiff's symptoms?**

- How were the symptoms validated?

**Q: What alternate diagnosis did you consider?**

- On what information did you base the alternate diagnosis?

**Q: Have you ruled out the alternate diagnosis?**

**Q: Did you inform the plaintiff of your diagnosis?**

- Why or why not?
- What was the plaintiff's response to your diagnosis?

**Q: What does the diagnosis mean?**

**Q: Are you familiar with the DSM-IV and IV-TR?**

- What are they?

**Q: Describe the Multiaxial System.**

- What do Axis I, II, III, IV, & V describe?

**Q: Did you use the Multiaxial system in your assessment of the plaintiff?**

**Q: Describe your diagnosis of the plaintiff based on these Axes.**

**Q: If you did not base your diagnosis on the Multiaxial System, what diagnostic system did you use?**

**Q: Did you obtain a clinical history?**

- If not, why not?
- If not, wouldn't this provide you with significant clinical information with which to appropriately determine the nature of the plaintiff's problems?

**Q: Did you obtain the plaintiff's past records?**

- If not, why not?
- If not, wouldn't this provide you with important, additional clinical information with which to appropriately determine the nature of the plaintiff's problems?

**Q: Did you conduct a psychiatric (or psychological, neuropsychological) assessment of the plaintiff?**

- How long did you interview the plaintiff and on how many occasions?

*Defense counsel should refer to the chapter on neuropsychological testing for additional questions in this area.*

**Q: Have you prescribed any medications for the plaintiff?**

- If so, what are the medications and why are they being prescribed?
- What are the plaintiff's reactions to these medications?
- Does the plaintiff adhere to his or her medication regimen?
- Are you aware of any medications being prescribed for the plaintiff by other health care providers?
- Have you made medication recommendations to other health care providers in this case?

**Q: Describe the plaintiff's progress in therapy with you.**

- In your opinion, how did the plaintiff respond to therapy?
- Was the plaintiff cooperative?
- If the plaintiff did not benefit, why not?
- What could have been done differently?

**Q: In what way do you evaluate the efficacy of your treatment?**

- Did you evaluate the efficacy of the treatment in this case?
- Do your notes address this evaluation?

**Q: Describe the future treatment plan for the plaintiff.**

- Is this plan outlined in your notes?

**Q: Has treatment been terminated? If so, why?**

- Since termination, describe any other contacts you have had with the plaintiff.

**Q: How and at what fee rate have you billed the plaintiff?**

- How is the treatment being billed? (insurance, other)
- What type of payment arrangements have you made with the plaintiff?
- Does the plaintiff owe you any money?
- Is there a lien in the case?

**Q: What billing codes will you use?**

1. DSM-IV
2. DSM-IV-TR
3. ICD-9
4. ICD-10 (International Statistical Classification of Disease and related Health Problems, 10th edition)
5. Other

**Q: Describe any other treatment services that the plaintiff is receiving.**

Why were these recommended?

Who provided the treatment?

When was the treatment given?

How long did it last?

## **B. RECORDS FROM OTHERS**

**Q: Have you conducted collateral interviews with the plaintiff's family members, friends, or work associates?**

**Q: Did you obtain records from other treatment providers?**

What did you learn from these records?

How was this information applied in your examination or treatment of the plaintiff?

**Q: Have you been in contact with these providers?**

If yes, describe the nature of contact and information shared.

If not, why not?

**Q: Identify any other records or documents that you have reviewed during the course of your professional association with the plaintiff.**

How did you learn about the records and documents?

How did you get them?

What did you learn from these records?

How was this information applied in your examination or treatment of the plaintiff?

**Q: What notes did you take in your treatment of the plaintiff?**

What is the function of these treatment notes?

When do you make file notations?

**Q: Have you provided the counsel with a copy of every notation regarding the plaintiff that you have written?**

*Defense counsel should ask the witness to read his or her notes into the record.*

## **C. OTHER QUESTIONS**

**Q: Did the plaintiff discuss his or her legal case during the treatment sessions?**

How frequently was the case discussed?

What was discussed?



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## CHAPTER 4

### The Plaintiff's Diagnosis

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# **CHAPTER 4**

## **THE PLAINTIFF'S DIAGNOSIS**

### **INTRODUCTION**

The examination of the doctor's clinical notes, the identification of the specific symptoms and behaviors used to develop the plaintiff's diagnosis, and the determination of the actual level of plaintiff functioning completes the discovery portion of the deposition. The plaintiff's responses to Chapter 1 questions, plus the witness' responses to questions from Chapter 4, allow the defense counsel to determine if the plaintiff's psychological diagnosis is based on incomplete or possibly incorrect information. After concluding the Chapter 4 questions, the defense counsel can begin to challenge the expert's findings and conclusions. Depending upon the defense strategy, the challenge may begin at deposition or during the cross examination of the witness at trial.

Errors are common in the plaintiff's proof of damages. Symptoms are usually not verified and a thorough differential diagnosis is rarely completed. The defense counsel should carefully determine each symptom used by the expert and use the symptom related questions from Chapter 5 to challenge the proof of damages.

## SECTION 4.1: TESTING THE DOCTOR'S KNOWLEDGE OF THE PATIENT'S HISTORY

### GENERAL INFORMATION ABOUT THE PATIENT

#### A. MISCELLANEOUS DATA

**Q: Do your records reflect a maiden name or other named used in the past?**

**Q: Do you know if the patient is presently living alone or with others?**

**Q: What is the patient's date of birth?**

**Q: What is the relationship between the patient and anyone else living in the same home?**

**Q: Where does the patient live?**

#### B. INSURANCE INFORMATION

**Q: Do you know if the patient has ever applied for social security disability?**

**Q: Have you filled out disability insurance claim forms for the patient?**

If so, was the patient approved or denied for the disability?

What companies are the policies with?

Have you filled out SSI forms for the patient?

What are the dates of application?

#### C. EDUCATION

**Q: Did you inquire about the patient's education?**

**Q: Did the patient have any dramatic changes in school success or failure? If so, why?**

*Defense counsel should ask the witness about some or all of the patient's school experiences. For each grade level, refer to the questions below.*

**Q: Did the patient ever attend any special education classes? If so, why?**

1. What were the patient's school activities and interests?

**Q: Was the patient ever given special testing or evaluations? If so, why?**

2. Did the patient have any school disciplinary actions?

**Q: Do you know if the patient was ever told that he or she had a learning disability?**

3. Did the patient receive any school achievements or honors?

**Q: Did the patient complete high school?**

4. What were the patient's grades?

If not, do you know if the patient received a GED (high school equivalency diploma)?

**Q: Did the patient repeat any grades? If so, why?**

*See chart on the following page.*

**TABLE 4.1-1. EDUCATIONAL CHECK LIST**

| School                      | Location | Dates Attended | Degree |
|-----------------------------|----------|----------------|--------|
| Grade school                |          | to             |        |
| Junior high / Middle school |          | to             |        |
| High school                 |          | to             |        |
| Trade school                |          | to             |        |
| Military school             |          | to             |        |
| College                     |          | to             |        |
| Graduate school             |          | to             |        |
| Other schools               |          | to             |        |

**D. EMPLOYMENT**

**1. PAST EMPLOYMENT**

**Q: Did you inquire about the patient's past employment experiences?**

*For each job, refer to the questions below.*

1. Why did the patient's job end? (quit, fired)
2. Was the patient transferred?
3. Was any disciplinary action taken while the patient was an employee?
4. Do you know of any circumstances where the patient may have been injured or exposed to toxic materials while employed?

**Q: Do you know if the patient was ever self-employed?**

- If so, how did the patient get started in business?
- How long was the patient self-employed?
- Do you know why the patient ended the business?

*See chart on the following page.*

**TABLE 1.0-2. EMPLOYMENT CHECK LIST**

| Employment   | Employer/Location | Benefits | Injuries |
|--|-------------------|----------|----------|
| <p style="text-align: center;"><b>Job 1</b></p> <p>Title:</p> <p>Description:</p> <p>Date:       to</p> <p>Entry Pay:</p> <p>Exit Pay:</p> |                   |          |          |
| Reason for Leaving:  |                   |          |          |
| <p style="text-align: center;"><b>Job 2</b></p> <p>Title:</p> <p>Description:</p> <p>Date:       to</p> <p>Entry Pay:</p> <p>Exit Pay:</p> |                   |          |          |
| Reason for Leaving:  |                   |          |          |

(continued)

## 2. PRESENT EMPLOYMENT

### **Q: Where is the patient currently employed?**

- How long has the patient been employed with this business?
- Approximately how many hours does the patient work each week?

- During the past two years, do you know the amount and the circumstances for any work absences?
- Is the patient satisfied with his or her job? If not, why not?
- Do you know of any disagreements or conflicts with co-workers?

## E. MILITARY SERVICE

### **Q: Did you inquire about the patient's service in the armed forces?**

- If so, when did the patient serve and for how long?
- In what branch of the service did the patient serve?
- Did the patient attend technical school while in the service?
- Do you know if the patient was ever turned down for military service?

### **Q: Did you inquire about decorations or honors the patient received while in the military?**

### **Q: Did you inquire about disciplinary actions against the patient while in the military?**

### **Q: Did the patient experience any combat or war zone duty?**

- If so, where was the patient stationed?
- How long was the patient in combat?

### **Q: Did you inquire about *emotional illness or problems* the patient has as a result of combat or other experiences in the service?**

- If so, did the patient receive treatment for these emotional changes or problems?
- Does the patient have continuing emotional problems as a result of service?

### **Q: Did you inquire about *physical illness or problems* the patient has as a result of combat or other experiences in the service?**

- If so, did the patient receive any treatment for these physical changes or problems?
- Does the patient have any continuing physical problems as a result of service?

### **Q: Did you inquire about service-connected disability?**

### **Q: Do you know what type of discharge the patient received?**

### **Q: Do you know if the patient is currently under any military or reserve commitment?**

**F. THE INJURY IN QUESTION (CAUSE OF ACTION)**

**Q: What were the patient's activities for the 24 hour period prior to the injury?**

**Q: Did you inquire about the patient's *physical condition* immediately following the injury?**

**Q: Do you know what happened at the time of the injury?**

**Q: Did you inquire about the patient's *mental status* immediately following the injury?**

Was the patient able to walk?

**Q: Who referred the patient to you?**

Did the patient talk to anyone following the injury?

**SECTION 4.2: THE PATIENT'S PHYSICAL HISTORY**

**A. CHILDHOOD MEDICAL HISTORY**

**Q: What were the patient's childhood illnesses or injuries?**

3. What was the physician's diagnosis?

*For each illness, refer to the following questions.*

4. Describe the patient's response to diagnosis.

1. Do you know the approximate date of treatment?

5. What were the physician's recommendations?

2. What was the name of the treating physician?

6. Did the patient follow the recommendations?

*See chart on the following page.*

**TABLE 4.2-1. CHILDHOOD/ADOLESCENT ILLNESS CHECK LIST**

| <b>Condition</b>                  | <b>Early<br/>(Birth-3)</b> | <b>Middle<br/>(3-11)</b> | <b>Adolescence<br/>(11-18)</b> |
|-----------------------------------|----------------------------|--------------------------|--------------------------------|
| Appendicitis                      |                            |                          |                                |
| Asthma                            |                            |                          |                                |
| Bone disorders                    |                            |                          |                                |
| Bronchitis                        |                            |                          |                                |
| Chicken pox                       |                            |                          |                                |
| Chronic allergy                   |                            |                          |                                |
| Chronic diarrhea                  |                            |                          |                                |
| Chronic bacterial infection       |                            |                          |                                |
| Diphtheria                        |                            |                          |                                |
| Diseases of the ear, nose, throat |                            |                          |                                |
| Dysentery                         |                            |                          |                                |
| Emotional problems                |                            |                          |                                |
| Gastrointestinal disorders        |                            |                          |                                |
| Measles                           |                            |                          |                                |
| Meningitis                        |                            |                          |                                |
| Mononucleosis                     |                            |                          |                                |
| Mumps                             |                            |                          |                                |
| Neoplasm including cancer         |                            |                          |                                |
| Pneumonia                         |                            |                          |                                |
| Scarlet fever                     |                            |                          |                                |
| Skin conditions                   |                            |                          |                                |
| Trauma                            |                            |                          |                                |
| Tuberculosis                      |                            |                          |                                |
| Whooping cough                    |                            |                          |                                |
| Other                             |                            |                          |                                |

**SCHOOL ABSENCES**

**Q: Did the patient miss school because of a major illness or injury?**

*For each absence due to illness or injury, refer to the following questions.*

1. What grade was the patient in when the illness or injury occurred?
2. How long was the absence from school?
3. Did it affect the patient's grades?
4. Did it affect long-term school success?

**TABLE 4.2-2. SCHOOL ABSENCE CHECK LIST**

| GRADE | APPROXIMATE TIME LOST FROM SCHOOL/REASON |
|-------|--|
| K     |  |
| 1     |  |
| 2     |  |
| 3     |  |
| 4     |  |
| 5     |  |
| 6     |  |
| 7     |  |
| 8     |  |
| 9     |  |
| 10    |  |
| 11    |  |
| 12    |  |

**B. PRE-INJURY ADULT MEDICAL HISTORY**

**Q: What is the patient's history of adult illnesses or conditions that occurred before the injury in question?**

*For each illness or condition, refer to the following questions*

1. Do you know the approximate date of treatment?
2. Where did the patient receive treatment?
3. What was the name of the treating physician?

4. What was the physician's diagnosis?
5. Do you know the patient's response to the treatment?
6. Do you know the physician's recommendations?

*See chart on the following page.*

**TABLE 4.2-3. PRE-INJURY ILLNESS, MEDICAL CONDITION CHECK LIST**

| <b>Conditions</b>                                     | <b>Date</b> | <b>Treatment</b> |
|---|-------------|------------------|
| Abdominal pains                                       |             |                  |
| Abnormal bleeding                                     |             |                  |
| Adverse reactions to food                             |             |                  |
| Allergies   |             |                  |
| Blindness, double vision, spots, eye pain             |             |                  |
| Body hair changes                                     |             |                  |
| Bowel or bladder changes, diarrhea, constipation, gas |             |                  |
| Broken bones  |             |                  |
| Chest pain  |             |                  |
| Coughing, wheezing, sputum, shortness of breath       |             |                  |
| Deafness, ringing sounds, internal itching, discharge |             |                  |
| Decreased sexual drive, pain, bleeding                |             |                  |
| Easy bruising   |             |                  |
| Excessive itching                                     |             |                  |
| Finger or toe nail changes                            |             |                  |
| Headaches   |             |                  |
| Heart beat changes                                    |             |                  |
| Hemorrhoids, rectal bleeding                          |             |                  |
| Infected cuts or wounds                               |             |                  |
| Joint pain or swelling                                |             |                  |
| Lumps or masses under the skin                        |             |                  |
| Masses in the breasts, nipple discharge               |             |                  |
| Muscle pain or stiffness                              |             |                  |
| Nausea, vomiting                                      |             |                  |
| Nose bleeds, sinus problems, excessive discharge      |             |                  |

*continued*

**TABLE 4.2-3. PRE-INJURY ILLNESS, MEDICAL CONDITION CHECK LIST (continued)**

| Conditions  | Date | Treatment |
|---|------|-----------|
| Painful or frequent urination, blood in urine       |      |           |
| Skin diseases/rashes                                |      |           |
| Temperature tolerance changes                       |      |           |
| Transfusions  |      |           |
| Trouble swallowing                                  |      |           |
| Venereal disease                                    |      |           |
| Voice changes, hoarseness                           |      |           |
| Weight changes of more than ten pounds in two weeks |      |           |
| Other   |      |           |

**HOSPITALIZATION**

**Q: What is the patient's history of hospitalization before the injury in question?**

2. Do you know the name of the hospital?
3. What was the reason for the hospitalization?
4. What was the diagnosis?

*For each hospitalization, refer to the following questions.*

1. Do you know the approximate date of hospitalization and length of stay?

**TABLE 4.2-4. HOSPITALIZATION CHECK LIST**

|    | Date | Reason | Hospital | Surgery | Other Treatment |
|----|------|--------|----------|---------|-----------------|
| 1. |      |        |          |         |                 |
| 2. |      |        |          |         |                 |
| 3. |      |        |          |         |                 |
| 4. |      |        |          |         |                 |
| 5. |      |        |          |         |                 |
| 6. |      |        |          |         |                 |

**C. ALCOHOL HISTORY**

**Q: Does the patient drink alcohol or have an alcohol abuse history?**

- Do you know how much the patient drinks at one time?
- Do you know how frequently the patient drinks?
- Do you know when the patient drinks?
- Do you know what the patient usually drinks?
- Do you know about the patient's behavior when drinking?

**Q: Has the use of alcohol ever caused a serious family problem for the patient?**

*For each symptom or behavior the patient experiences from drinking alcohol, refer to the questions below.*

1. How often does the symptom occur?
2. When does it usually occur?
3. Is it a concern to the patient?
4. Is it a concern to others?
5. Is the symptom becoming more or less severe?

**TABLE 4.2-5. ALCOHOL CHECK LIST**

| Symptom                                       | Date | Frequency |
|---|------|-----------|
| Absenteeism from work or school               |      |           |
| Abstinence attempts                           |      |           |
| Alcohol use with other drugs                  |      |           |
| Alcohol treatment                             |      |           |
| Alcoholic accusations from others             |      |           |
| Arrests for disorderly conduct                |      |           |
| Arrests for DUI (driving under the influence) |      |           |
| Blackouts                                     |      |           |
| Convulsions                                   |      |           |
| Drinking for confidence in new situations     |      |           |
| Drinking alone                                |      |           |
| Drinking more than intended                   |      |           |
| Emotional problems                            |      |           |
| Financial problems                            |      |           |
| Hallucinations                                |      |           |
| Job dismissal                                 |      |           |

*(continued)*

**TABLE 1.2-5. ALCOHOL CHECK LIST** (continued)

|   |  |  |
|---|--|--|
| Loss of consciousness                     |  |  |
| Loss of memory                            |  |  |
| Marital or interpersonal problems         |  |  |
| Physical problems                         |  |  |
| Reduced level of motivation or ambition   |  |  |
| School suspension                         |  |  |
| Shaking or tremors                        |  |  |
| Symptoms of alcohol withdrawal            |  |  |
| Unintentional action                      |  |  |
| Violent or physically assaultive behavior |  |  |
| Other                                     |  |  |

**D. DRUG HISTORY**

**Q: Did you inquire about the patient's use of prescribed drugs, street drugs, or non-prescribed medications?**

- If so, how often has the patient used drugs within the last three months?
- Has the patient ever been treated for drug related problems? If yes, when, where, and what was the reason?
- What is the patient's perception of his or her drug use? (addicted or recreational use)

*For each of the drugs used, refer to the following questions.*

1. When did the patient first use the drugs?
2. Why did the patient use the drugs?
3. Does the patient use the drug now? Why?
4. When and how often does the patient use it?

**Q: Do you know if the patient has ever been involved in any hospitalization or treatment program for drug use?**

**Q: Does the patient have a family history of drug abuse?**

**Q: Has drug abuse ever caused family problems for the patient? Occupational problems?**

*See chart on the following page.*

**TABLE 4.2-6. DRUG USE CHECK LIST**

| <b>Drug</b>  | <b>Amount (mg)</b> | <b>Frequency</b> | <b>Duration</b> |
|--|--------------------|------------------|-----------------|
| Prescription drug 1                                  |                    |                  |                 |
| Prescription drug 2                                  |                    |                  |                 |
| Prescription drug 3                                  |                    |                  |                 |
| Prescription drug 4                                  |                    |                  |                 |
| Prescription drug 5                                  |                    |                  |                 |
| Prescription drug 6                                  |                    |                  |                 |
| Prescription drug 7                                  |                    |                  |                 |
| Prescription drug 8                                  |                    |                  |                 |
| Cocaine  |                    |                  |                 |
| Crack  |                    |                  |                 |
| Heroin   |                    |                  |                 |
| Ecstasy  |                    |                  |                 |
| Marijuana  |                    |                  |                 |
| LSD  |                    |                  |                 |
| Stimulants (non-prescription)                        |                    |                  |                 |
| Barbiturates (non-prescription)                      |                    |                  |                 |
| Narcotics (non-prescription – painkillers, morphine) |                    |                  |                 |
| Other drugs  |                    |                  |                 |

**DRUG SYMPTOMS**

**Q: Describe the patient’s symptoms, behavior, or side-effects when using the drug.**

For each symptom or behavior, refer to the following questions.

1. How often does it occur?
2. When does it usually occur?
3. Is it a concern to the patient?
4. Is it becoming more or less severe?

*See chart on the following page.*

**TABLE 4.2-7. DRUG SYMPTOM/BEHAVIOR CHECK LIST**

| Symptom                                   | Date | Frequency |
|---|------|-----------|
| Absenteeism from work or school           |      |           |
| Abstinence attempts                       |      |           |
| Addiction references from others          |      |           |
| Arrests                                   |      |           |
| Blackouts                                 |      |           |
| Drug use alone                            |      |           |
| Drug overdose                             |      |           |
| Drugs for social confidence               |      |           |
| Emotional problems                        |      |           |
| Financial problems                        |      |           |
| Hallucinations                            |      |           |
| Job dismissal                             |      |           |
| Marital or interpersonal problems         |      |           |
| Memory loss                               |      |           |
| Multiple drug use                         |      |           |
| Passing out                               |      |           |
| Physical problems                         |      |           |
| Reduced motivation                        |      |           |
| School suspension                         |      |           |
| Shakes or tremors                         |      |           |
| Unintended actions                        |      |           |
| Unintended overuse                        |      |           |
| Violent or physically assaultive behavior |      |           |
| Withdrawal symptoms                       |      |           |
| Other side-effects                        |      |           |

**E. POST-INJURY MEDICAL HISTORY (NON-PSYCHIATRIC)**

**Q: What is the patient's medical history under your care?**

Describe your treatment of the patient.

**Q: What is the patient's medical history under the care of others?**

*For each health care professional, refer to the following questions.*

1. Why did the patient seek medical care from this doctor?

2. What was the patient being treated for?

3. Is the patient still being treated?

4. Was this the first time the patient had been treated for this condition?

5. What were the treatment procedures?

6. What was the physician's diagnosis?

7. Was the treatment effective?

8. When did the patient's treatment stop and why?

**TABLE 4.2-8. HEALTH CARE PROFESSIONAL CHECK LIST**

|    | Physician | Dates of Treatment | Symptoms | Treatment |
|----|-----------|--------------------|----------|-----------|
| 1. |           |                    |          |           |
| 2. |           |                    |          |           |
| 3. |           |                    |          |           |
| 4. |           |                    |          |           |
| 5. |           |                    |          |           |

**F. FAMILY MEDICAL HISTORY**

**Q: Does the patient have any family history of physical or mental health problems?**

*For each physical or mental problem in the patient's family, refer to the following questions.*

1. Which family member had the health problem?

2. How did the health problem affect the family member?

3. Did the problem affect the patient's relationship with the family member?

4. Has this problem affected the patient's life?

5. Has the patient ever manifested any signs or symptoms of this physical or mental problem?

*See chart on the following page.*

**TABLE 4.2-9. FAMILY MEDICAL HISTORY CHECK LIST**

| <b>Disorder</b>                | <b>Family Member</b> | <b>Date</b> |
|--------------------------------|----------------------|-------------|
| Accident proneness             |                      |             |
| Alcoholism                     |                      |             |
| Anemia                         |                      |             |
| Arthritis, rheumatism          |                      |             |
| Back problems                  |                      |             |
| Cancer                         |                      |             |
| Cardiac problems               |                      |             |
| Deafness                       |                      |             |
| Diabetes                       |                      |             |
| Down's syndrome                |                      |             |
| Drug abuse                     |                      |             |
| Eating disorders               |                      |             |
| Epilepsy                       |                      |             |
| Glaucoma                       |                      |             |
| Hepatitis                      |                      |             |
| Hypertension                   |                      |             |
| Kidney problems                |                      |             |
| Liver disease                  |                      |             |
| Mental health problems         |                      |             |
| Obesity                        |                      |             |
| Obstetric problems             |                      |             |
| Rheumatic fever                |                      |             |
| Stroke                         |                      |             |
| Thyroid disease                |                      |             |
| Other physical/mental problems |                      |             |

## SECTION 4.3: THE PATIENT'S SOCIAL HISTORY

### A. GENERAL FAMILY INFORMATION

*Family interaction patterns, illnesses, and life stressors can affect a patient's personality development, mental and physical health.*

#### 1. PATIENT HISTORY

**Q: Did you inquire about the patient's childhood history?**

- Did the patient have any legal or criminal problems?
- How was the patient's emotional health as a child and teenager?
- Did the patient have a lot of friends?

- What age did the patient leave home?
- How does the patient describe his or her childhood?

**Q: Did you inquire about the patient's family?**

**Q: Is the patient grieving the loss of a relative?**

*Defense counsel should obtain the basic information indicated by Table 4.1-12 for all immediate and extended family members.*

**TABLE 4.3-1. FAMILY CHECK LIST**

| Relation   | Name | Age | Occupation | Residence |
|------------|------|-----|------------|-----------|
| Mother     |      |     |            |           |
| Father     |      |     |            |           |
| Stepmother |      |     |            |           |
| Stepfather |      |     |            |           |
| Sibling 1  |      |     |            |           |
| Sibling 2  |      |     |            |           |
| Sibling 3  |      |     |            |           |
| Sibling 4  |      |     |            |           |
| Spouse 1   |      |     |            |           |
| Spouse 2   |      |     |            |           |
| Child 1    |      |     |            |           |
| Child 2    |      |     |            |           |
| Child 3    |      |     |            |           |
| Child 4    |      |     |            |           |

\*If family members are deceased, obtain the date and cause of death.

## 2. CHARACTERISTICS OF THE PATIENT'S MOTHERS

*Defense counsel should ask the witness the following questions about the patient's mother now and when the patient was a child.*

**Q: Did you inquire about the emotional and physical health of the patient's mother?**

**Q: Was the patient abused by his or her mother?**

**Q: Did you inquire about previous or other marriages?**

**Q: Can you describe the mother's marriage relationships?**

**Q: Do you know if the patient's mother treated the patient emotionally or physically different than any other members of the family?**

**Q: What is the patient's relationship with his or her mother now?**

**Q: Do you know when the patient last saw his or her mother?**

## 3. CHARACTERISTICS OF THE PATIENT'S FATHER

*Defense counsel should ask the witness the following questions about the patient's father now and when the patient was a child.*

**Q: Did you inquire about the emotional and physical health of the patient's father?**

**Q: Was the patient abused by his or her father?**

**Q: Did you inquire about previous or other marriages of the patient's father?**

**Q: Can you describe the father's marriage relationships?**

**Q: Do you know if the patient's father treated the patient emotionally or physically any different than other members of the family?**

**Q: What is the patient's relationship with his or her father now?**

**Q: Do you know when the patient last saw his or her father?**

## 4. CHARACTERISTICS OF THE PATIENT'S SIBLINGS

*Defense counsel should ask the witness the following questions about the patient's brothers and sisters now and when the patient was a child.*

**Q: Did you inquire about the patient's relationship with his or her brothers and sisters?**

**Q: Was the patient abused by his or her siblings?**

**Q: Did you inquire about any emotional or physical problems of the patient's brothers or sisters?**

**Q: Do you know if the patient's brothers and sisters have any learning problems or disabilities?**

**Q: Do you know when the patient last saw his or her brothers or sisters?**

**B. MARITAL HISTORY**

**Q: Is the patient married?**

- If so, what is the patient's relationship with his or her spouse?
- Do you know if there have been any physical or emotional problems in the marriage?

*For each marital problem indicated, refer to the questions and chart below.*

1. What are the circumstances of the marital problems?
2. What is the severity and frequency of the problem?
3. How do the marital problems affect the patient?

**Q: Did you inquire about previous marriages?**

- What was the former spouse's name?
- When was the patient previously married?

- How long did the marriage last?
- What is the ex-spouse's current name, address, and place of employment?
- Is the patient separated or divorced from this spouse?

**Q: Did you inquire about any marital problems in previous marriages?**

*If the witness indicates that there were marital problems in previous marriages, refer again to the questions and marital check list. Similar patterns of problematic relationships may suggest a personality or mental disorder.*

**Q: Do you know the reason for the separation or divorce?**

**Q: Do you know if there was a divorce hearing? (jurisdiction, date)**

**TABLE 4.3-2. MARITAL HISTORY CHECK LIST**

| Marital Problems           | Duration | Severity | Effect on Relationship |
|----------------------------|----------|----------|------------------------|
| Frequent arguments         |          |          |                        |
| Poor sexual relations      |          |          |                        |
| Financial problems         |          |          |                        |
| Lack of common interests   |          |          |                        |
| Jealousy                   |          |          |                        |
| Communication difficulties |          |          |                        |
| Alcohol abuse              |          |          |                        |
| Drug abuse                 |          |          |                        |
| Extramarital affairs       |          |          |                        |
| Legal problems             |          |          |                        |
| Mental illness             |          |          |                        |
| Physical illness           |          |          |                        |
| Physical abuse             |          |          |                        |
| Emotional abuse            |          |          |                        |

## 1. PATIENT'S CHILDREN

**Q: Did you inquire about the patient's children?**

**Q: How many children does the patient have from current and past marriages?**

**Q: How many children live with the patient?**

**Q: Has the patient lost any children?**

**Q: How would you describe the patient's relationship with their children?**

**Q: How would you describe the behavior of the patient's children?**

**Q: Do the patient's children have any school problems?**

**Q: Do the patient's children have any legal or criminal problems?**

**Q: Do the patient's children have any emotional or physical problems?**

**Q: Has the patient ever abused his or her children?**

## C. INTERPERSONAL HISTORY

**Q: Did you inquire about any other significant relationships in the patient's life?**

**Q: Did you inquire about other relationships where the patient lived with another person?**

What is the person's name?

When and where did the patient live with this person?

Do you know why they separated?

What is the patient's current relationship with that person?

## D. SEXUAL HISTORY

*The patient's sexual loss is frequently used in the damages claim. Defense counsel should ask reasonable and relevant questions pertaining to the patient's sexual history and current level of activity.*

**Q: Did you inquire about sexual problems or trauma in the patient's past?**

**Q: Did you inquire about the patient's current level of sexual activity?**

How many sexual partners does the patient have?

What is the patient's ability to enter into a sexual relationship?

Do you feel that the patient is sexually well adjusted?

**Q: Did you inquire about the patient's past level of sexual activity?**

**Q: Do you know if the patient has undergone any sexually related treatment?**

**Q: Does the patient have a history of any sexually transmitted disease, such as:**

Gonorrhea

Herpes

AIDS

Other

Syphilis,

**E. RECREATIONAL/SOCIAL**

*The patient may claim social loss, loss of peer relationships, anhedonia, (the loss of pleasure of life) and the loss of institutional social relationships (clubs, teams, etc.).*

*Defense investigation may show that the patient did not have an active social life prior to the injury in question. This data may also support the defense position of a pre-existing personality disorder or clinical mental disorder.*

**1. ACTIVITIES**

**Q: Did you inquire about the patient's past and present interests and activities?**

*For each activity or interest of the patient, refer to the questions below.*

1. When did the patient participate in the activity?
2. How often did the patient participate?

**TABLE 4.3-3. ACTIVITY CHECK LIST**

| Type                    | Example   | Date |
|-------------------------|---|------|
| Sports                  | tennis/golf/racquetball                         |      |
| Physical fitness        | running/swimming/dancing/exercises              |      |
| Camping                 | tenting/recreational vehicle touring            |      |
| Hunting or fishing      | trapping/bow hunting/scuba fishing              |      |
| Dangerous sports        | sky diving/cliff diving/auto racing             |      |
| Boating                 | motorboats/sailing                              |      |
| Home computers          | video games/programming                         |      |
| Electronics             | building electrical devices                     |      |
| Do it yourself projects | remodeling/building/landscaping/<br>woodworking |      |
| Handicrafts             | pottery making/kit building                     |      |
| Sewing                  | all types of needlecraft                        |      |
| Gardening               | indoor or outdoor                               |      |
| Automotive work         | fixing/building/customizing                     |      |
| Music                   | playing or listening to music                   |      |
| Art work                | pencil/pens/oils/photography                    |      |
| Board games/cards       | monopoly/chess/checkers/bridge                  |      |
| Gambling games          | races/cards                                     |      |
| Collecting              | stamps/coins/books                              |      |

*(continued)*

**TABLE 4.3-3. ACTIVITY CHECK LIST (continued)**

| <b>Type</b>                 | <b>Example</b>                     | <b>Date</b> |
|-----------------------------|------------------------------------|-------------|
| Attending popular events    | concerts/nightclubs/rock concerts  |             |
| Traveling                   | touristing/junkets                 |             |
| Attending cultural events   | symphony/opera/plays               |             |
| Religious activities        | choir/social groups/fund raising   |             |
| Health, natural foods       | special diets/yoga                 |             |
| Wines                       | tasting/making                     |             |
| Fashion clothes             | acquiring/designing                |             |
| Home decorating             | designing/re-doing                 |             |
| Reading                     | novels/mechanics/science           |             |
| Investments                 | real estate/stocks and bonds       |             |
| Community civic activities  | Scouts/Jaycees/Women's League      |             |
| Breeding or raising animals | dogs/cats/horses                   |             |
| Cooking                     | gourmet cooking/canning/dining out |             |
| Volunteer activities        | hospital/charities                 |             |
| Other                       |                                    |             |

## 2. FRIENDSHIPS

**Q: Did you inquire about the patient's friendships before and since the injury in question?**

*For each friendship of the patient now or before the injury, refer to the questions below.*

**Q: Did you inquire about any similarities or differences in new friendships made by the patient before or after the injury?**

1. Has the friendship changed and if so, why?
2. How often does the patient see or talk to his or her friend?
3. How long has the friendship been maintained?

**TABLE 4.3-4. FRIENDSHIP CHECK LIST**

| Activity               | Name | Frequency of Contact |
|------------------------|------|----------------------|
| 1 <sup>st</sup> friend |      |                      |
| 2 <sup>nd</sup> friend |      |                      |
| 3 <sup>rd</sup> friend |      |                      |
| 4 <sup>th</sup> friend |      |                      |

## 3. RELIGION

**Q: Did you inquire about the patient's religious activities?**

- Is the patient active in religion?

- What precipitated the change in religion?
- How has this change affected the patient's life?
- How do other family members view this change?

**Q: Did you inquire about any recent change in the patient's religious beliefs or affiliations?**

- When was the change in religion or religious activities?

*Defense counsel should ask the following questions if the witness indicates that the patient has had a major change in religion.*

## F. LIFE THREATENING BEHAVIOR

### 1. PATIENT SUICIDAL TENDENCIES

**Q: Did you inquire if the patient has had any suicidal thoughts or feelings?**

**Q: Do you know of any other life-threatening behaviors or activities of the patient?**

- When does the patient do this?
- How often does the patient do this?

**Q: Do you know if the patient has ever attempted suicide?**

- Who or what stopped the patient from completing the act?

**Q: Do you consider these acts as gestures only, without real intent of self-harm?**

*If the witness states that the acts are gestures only, see the section on Borderline Personality Disorder for further questions.*

**2. PATIENT EXPERIENCES WITH VIOLENCE**

**Q: Do you know if the patient ever committed an act of violence?**

- What did the patient do?
- Do you know if this was one event or a pattern of violent behavior?

**Q: Do you know if anyone ever committed an act of violence against the patient?**

- What happened to the patient?
- Do you know if this was one event or a pattern of violent behavior against the patient?

**G. CRIMINAL LEGAL HISTORY**

**Q: Did you inquire about any criminal acts or arrests of the patient?**

**Q: Do you know if the patient is currently on probation or parole?**

*For each arrest or criminal act, refer to the following questions.*

1. How many times has the patient been arrested?
2. Was the patient ever placed in a correctional institution?
3. What is the patient's attitude about his or her arrests?

**TABLE 4.3-5. CRIMINAL HISTORY CHECK LIST**

| Offense                    | Age | Outcome/Charge | Time Served |
|----------------------------|-----|----------------|-------------|
| Arson                      |     |                |             |
| Assault/Battery            |     |                |             |
| Blackmail                  |     |                |             |
| Curfew violation/Truancy   |     |                |             |
| Burglary/Theft/Shoplifting |     |                |             |
| Property damage            |     |                |             |
| Drug distribution/use      |     |                |             |
| Prescription forgery       |     |                |             |
| Other forgery              |     |                |             |
| Homicide                   |     |                |             |
| Manslaughter               |     |                |             |
| Rape                       |     |                |             |
| Soliciting                 |     |                |             |
| Disorderly conduct         |     |                |             |
| Vandalism                  |     |                |             |

## SECTION 4.4: THE PATIENT'S PSYCHOLOGICAL HISTORY

### A. PRE-INJURY PSYCHOLOGICAL TREATMENT

**Q: Did you inquire about the patient's pre-injury mental health status?**

*For each mental health problem treated, refer to the following questions.*

1. If the patient had therapy, was the therapy individual, family, marital?
2. Who provided the therapy or treatment?
3. What was the purpose of the therapy or treatment?

4. When did the patient have therapy or treatment?
5. How long was the therapy or treatment?
6. Was the therapy or treatment effective?
7. Was the patient given psychological tests?
8. Was the patient given medication?
9. Do you know if the patient was hospitalized?

**Q: Was there any litigation by the patient at the time of this past treatment?**

**TABLE 4.4-1. PRE-INJURY PSYCHOLOGICAL CHECK LIST**

| Disorders  | Date | Doctor/<br>Facility | Treatment/<br>Medications | Result |
|--|------|---------------------|---------------------------|--------|
| <div style="background-color: black; color: white; padding: 2px; text-align: center;"><b>Disorder 1:</b></div><br>Location of Records: |      |                     |                           |        |
| Nature of Intervention:  |      |                     |                           |        |
| <div style="background-color: black; color: white; padding: 2px; text-align: center;"><b>Disorder 2:</b></div><br>Location of Records: |      |                     |                           |        |
| Nature of Intervention:  |      |                     |                           |        |
| <div style="background-color: black; color: white; padding: 2px; text-align: center;"><b>Disorder 3:</b></div><br>Location of Records: |      |                     |                           |        |
| Nature of Intervention:  |      |                     |                           |        |

**B. POST-INJURY PSYCHOLOGICAL TREATMENT**

**Q: Since the injury in question, has the patient had any psychological treatment or evaluation other than that provided by you?**

*For each emotional or behavioral disorder treated, refer to the following questions.*

1. If the patient had therapy, was the therapy individual, family, marital?
2. Who provided the therapy or treatment?
3. What was the purpose of the therapy or treatment?
4. When did the patient have therapy or treatment?
5. How long was the therapy or treatment?
6. Was the therapy or treatment effective?
7. Was the patient given psychological tests?
8. Was the patient given any medication for the problem?
9. Do you know if the patient was hospitalized?
10. Did the psychological problems interfere with the patient's work? Family life?

**TABLE 4.4-2. POST-INJURY PSYCHOLOGICAL CHECK LIST**

| Disorders                                      | Date | Doctor/<br>Facility | Treatment/<br>Medications | Result |
|--|------|---------------------|---------------------------|--------|
| <b>Disorder 1:</b><br><br>Location of Records: |      |                     |                           |        |
| Nature of Intervention:                        |      |                     |                           |        |
| <b>Disorder 2:</b><br><br>Location of Records: |      |                     |                           |        |
| Nature of Intervention:                        |      |                     |                           |        |
| <b>Disorder 3:</b><br><br>Location of Records: |      |                     |                           |        |
| Nature of Intervention:                        |      |                     |                           |        |

**C. LIFE STRESSORS**

**1. TRAUMATIC OR SIGNIFICANT EVENTS**

**Q: Did you inquire about significant or traumatic events that the patient either personally experienced or witnessed?**

*For each significant or traumatic event, refer to the following questions.*

1. Did the patient have any *physical symptoms* or changes from the event?
2. Did the patient have any *emotional symptoms* or changes from the event?
3. Does the patient continue to experience these symptoms or changes?

**TABLE 4.4-3. TRAUMATIC EVENT CHECK LIST**

| Trauma              | Changes                  | Frequency | Severity | Duration |
|---------------------|--------------------------|-----------|----------|----------|
| <b>DATE:</b>        | <b>Physical</b>          |           |          |          |
|                     | 1. Sleep                 |           |          |          |
|                     | 2. Appetite              |           |          |          |
| <b>Description:</b> | 3. Work                  |           |          |          |
|                     | 4. Social                |           |          |          |
|                     | 5. Interpersonal         |           |          |          |
|                     | 6. Sexual                |           |          |          |
|                     | 7. Daily routine         |           |          |          |
|                     | 8. Motor ability         |           |          |          |
|                     | <b>Psychological</b>     |           |          |          |
|                     | 1. Speech                |           |          |          |
|                     | 2. Mood                  |           |          |          |
|                     | 3. Sensorium             |           |          |          |
|                     | 4. Insight               |           |          |          |
|                     | 5. Judgement             |           |          |          |
|                     | 6. Dreams                |           |          |          |
|                     | 7. Flashbacks            |           |          |          |
|                     | 8. Intrusive thoughts    |           |          |          |
|                     | 9. Emotional instability |           |          |          |
|                     | 10. Grief                |           |          |          |

**2. SOCIAL STRESSORS**

**Q: Did you inquire about social stressors in the patient's life now?**

For each stressor, refer to the following questions.

1. Did the stressor occur before or after the injury?

2. Is the patient still experiencing the stressor?

3. What are the effects of the stressor on the patient?

4. What is the patient doing to relieve the effects of the stressor?

**TABLE 4.4-4. SOCIAL STRESSOR CHECK LIST**

| Category  | Before | After | Present |
|---|--------|-------|---------|
| <b><i>I. SPOUSE</i></b>                                 |        |       |         |
| Suicide of spouse                                       |        |       |         |
| Death of spouse (other causes)                          |        |       |         |
| Divorce   |        |       |         |
| Marital separation                                      |        |       |         |
| Marital reconciliation                                  |        |       |         |
| Sex difficulties  |        |       |         |
| Marriage  |        |       |         |
| Change in number of arguments with spouse               |        |       |         |
| Spouse begins or stops work                             |        |       |         |
| <b><i>II. CHILDREN/FAMILY</i></b>                       |        |       |         |
| Death of child  |        |       |         |
| Death of a close family member                          |        |       |         |
| Child leaving home                                      |        |       |         |
| Birth of child  |        |       |         |
| Change in health of family member                       |        |       |         |
| Trouble with in-laws                                    |        |       |         |
| <b><i>III. INTERPERSONAL</i></b>                        |        |       |         |
| Death of a close friend                                 |        |       |         |
| Break up with boyfriend/girlfriend                      |        |       |         |
| Change in number of arguments with boyfriend/girlfriend |        |       |         |

(continued)

**TABLE 4.4-4. SOCIAL STRESSOR CHECK LIST** (continued)

| Category  | Before | After | Present |
|---|--------|-------|---------|
| <b>III. INTERPERSONAL</b> (continued)                   |        |       |         |
| Sexual difficulties with boyfriend/girlfriend           |        |       |         |
| Change in living arrangements with boyfriend/girlfriend |        |       |         |
| Change in social activities                             |        |       |         |
| <b>IV. PHYSICAL</b>                                     |        |       |         |
| Rape  |        |       |         |
| Miscarriage   |        |       |         |
| Physical illness (serious) diagnosed                    |        |       |         |
| Personal injury or illness                              |        |       |         |
| Pregnancy   |        |       |         |
| Revision of personal habits                             |        |       |         |
| Change in recreation                                    |        |       |         |
| <b>V. HOME</b>  |        |       |         |
| Leaving home  |        |       |         |
| Change in residence                                     |        |       |         |
| Change in living conditions                             |        |       |         |
| Change in eating habits                                 |        |       |         |
| Change in sleeping habits                               |        |       |         |
| Change in number of family get-togethers                |        |       |         |
| <b>VI. SCHOOL</b>                                       |        |       |         |
| Failing/low grades in school                            |        |       |         |
| Change in schools                                       |        |       |         |
| Begin or end school                                     |        |       |         |
| <b>VII. WORK</b>  |        |       |         |
| Fired from work place                                   |        |       |         |
| Laid off  |        |       |         |

(continued)

**TABLE 4.4-4. SOCIAL STRESSOR CHECK LIST** (continued)

| Category                               | Before | After | Present |
|--|--------|-------|---------|
| <b>VII. WORK</b> (continued)           |        |       |         |
| Trouble with boss or co-workers        |        |       |         |
| Career change                          |        |       |         |
| Change in hours or conditions          |        |       |         |
| Change in responsibilities             |        |       |         |
| <b>VIII. FINANCIAL</b>                 |        |       |         |
| Bankruptcy                             |        |       |         |
| Foreclosure of mortgage or loan        |        |       |         |
| Change in financial state              |        |       |         |
| Loan (personal, car)                   |        |       |         |
| Mortgage                               |        |       |         |
| <b>IX. OTHER</b>                       |        |       |         |
| Natural disaster (earthquake, tornado) |        |       |         |
| Christmas/Holidays                     |        |       |         |
| Jail term/arrest                       |        |       |         |
| Minor violations of the law            |        |       |         |
| Retirement                             |        |       |         |
| Vacation                               |        |       |         |
| Change in church activities            |        |       |         |
| Outstanding personal achievement       |        |       |         |

## SECTION 4.5: EXAMINATION OF THE DOCTOR'S CLINICAL NOTES

**Q: What type of clinical notes did you keep in this case?**

1. Notes written during treatment sessions
2. Notes written after treatment sessions
3. Notes tape recorded after treatment sessions
4. Notes typed after treatment sessions

**Q: Is this process of note-taking consistent with your protocol in non-litigation cases?**

**Q: Do you have all of the notes taken in this case?**

1. Clinical notes
2. Patient telephone messages
3. Prescription notations

**Q: PLEASE READ YOUR CLINICAL NOTES INTO THE RECORD (*in date order*).**

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## SECTION 4.6: THE PATIENT'S DIAGNOSIS

*The Diagnostic and Statistical Manual of Mental Disorders, DSM-IV*, published by the American Psychiatric Association, outlines a five part mental health-illness diagnostic system that is accepted and used by a majority of mental health care professionals in the United States and Canada. The multi-axial system outlines five areas that clinicians must examine to fully understand, diagnose, and treat their patients. Without these guidelines, clinicians tend to only look at a narrow band of the patient's behavior, causing an incomplete and incorrect diagnosis and treatment.

### *The Multi-axial Diagnostic System*

**AXIS I: CLINICAL DISORDERS**

Other Conditions That May Be a Focus of Clinical Attention

**AXIS II: PERSONALITY DISORDERS**

Mental Retardation

**AXIS III: GENERAL MEDICAL CONDITIONS**

**AXIS IV: PSYCHOSOCIAL and ENVIRONMENTAL PROBLEMS**

**AXIS V: GAF: GLOBAL ASSESSMENT OF FUNCTIONING—A 100 point rating scale**

**Q: What is your AXIS I diagnosis in this case?**  
(clinical disorders)

This category includes almost 200 mental disorders. It is further subdivided into groups or "families" of mental illnesses. Examples include depressive illnesses; anxiety conditions; somatoform or psychosomatic illnesses; organic brain syndromes caused by trauma; toxic exposure or anoxia; adjustment disorders; schizophrenia and other thought disorders. For further questions, see Chapter 5.

Diagnosis of each mental disorder requires the observance or history of specific symptoms. When plaintiffs present mixed symptoms, a multiple Axis I diagnosis may be made.

Within this category are V Codes which represent psychological difficulty that is not attributable to any other mental disorder. The various areas include academic problems, adult antisocial behavior, borderline intellectual functioning, childhood or adolescent antisocial behavior, malingering, partner relational problems, noncompliance with medical treatment, occupational problems, parent-child relational problems, other relational problems, other specified family circumstances, phase of life problems or other life circumstance problems, and bereavement. Frequently experts overlook V Codes in making

their diagnosis and treatment plan. Defense counsel should pursue this area as part of the Axis I diagnosis. For further questions, see the section on V Codes.

**Q: What is your AXIS II diagnosis in this case?**  
(personality disorders, mental retardation)

Personality is formed between childhood and young adulthood. As each person grows and develops, his or her life experiences, physical health, social environment and genetic traits 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 eleven pathological personality types. Plaintiff’s frequently have definite, Axis II personality disorders that pre-exist the injury in question and drive most of their behavior. It is the personality disorder characteristics that often are the basis of the litigation. Plaintiff’s psychological and psychiatric witnesses rarely admit the existence of these non-proximate cause conditions as such as an admission would cloud their Axis I diagnosis. See the section on Personality Disorders for further questions.

**Q: What is your AXIS III diagnosis in this case?**  
(general medical conditions)

All current medical conditions, injuries, and diseases impacting the patient’s psychological condition should be listed in Axis III.

**Q: What is your AXIS IV finding in this case?**  
(psychosocial and environmental problems)

Although stressors may be discussed individually in a theoretical framework, stress is a cumulative

phenomenon. All major life stressors should be listed. If the plaintiff has multiple sources of stress, they should be considered under Axis IV.

*Defense counsel should refer to the chart entitled Social Stressors Checklist for more information on this topic.*

**Q: What are your AXIS V findings in this case?**  
(current overall level of functioning and past year)

This axis is for reporting the clinician’s judgment of the individual’s overall level of functioning. It is a composite of psychological, social and occupational functioning. It is important to note that many plaintiff’s social profiles have always been constricted and limited by their life-long personality traits. The Global Assessment of Functioning Scale is a 100 point scale broken down into 10 ranges of functioning.

**The GAF Scale can be made for two time periods:**

- 1) *Current*—The level of functioning at the time of evaluation.
- 2) *Past year*—The highest level of functioning for at least a few months during the past year. Children and adolescents should include at least one month of the school year.

Ratings of current functioning will generally reflect the more immediate treatment and care needs. The highest rating for the past year frequently have prognostic significance. The plaintiff usually returns to his or her previous level of functioning after an episode of illness.

*The witness must consider psychological, social, and occupational functioning on a hypothetical continuum of mental health-illness. Impaired functioning due to physical or environmental limitations should not be included.*

**Code**    *Use intermediate codes when appropriate.*

100-91 Superior functioning in a wide range of activities, life’s problems never seem to get out of hand, is sought out by others because of his or her many positive qualities. No symptoms.

90—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—71 If symptoms are present, they are transient and expected 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—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—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—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—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).
- 30-21 Behavior is considerably influenced by delusions of 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—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—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.

---

*After determining the experts witnesses' diagnoses, defense counsel should immediately proceed to the section entitled Symptoms and Behaviors That Are the Basis of the Patient's Claim to investigate the symptoms used as the basis for these diagnoses.*

**Q: What is the patient's current diagnosis?**

Axis I: \_\_\_\_\_

Axis II: \_\_\_\_\_

Axis III: \_\_\_\_\_

Axis IV: \_\_\_\_\_

Axis V: \_\_\_\_\_

*Multiple diagnoses may be listed for each diagnostic area (axis).*

## SECTION 4.7: SYMPTOMS AND BEHAVIORS THAT ARE THE BASIS OF THE PATIENT'S CLAIM

**Q: What are the patient's symptoms?**

**Q: List the symptoms that support your diagnosis.**

*For each symptom, refer to the following questions.*

1. How often does the patient have the symptom?
2. How long does the patient's symptom last?

3. Do you know how severe the symptom is?
4. Do you know if the patient has made changes in work or daily life because of the symptom?
5. Has the symptom stopped or become less severe? If so, why?
6. Did the patient ever have these symptoms in the past?
7. Could there be other reasons for these symptoms?

**TABLE 4.7-1. SYMPTOM CHECK LIST**

| Symptom                               | Yes | No | Date Ended |
|---------------------------------------|-----|----|------------|
| Aches or pains (except head)          |     |    |            |
| Anxiety                               |     |    |            |
| Change in ability to stand or sit     |     |    |            |
| Change in ability to think            |     |    |            |
| Change in attitude                    |     |    |            |
| Change in concentration               |     |    |            |
| Change in appetite                    |     |    |            |
| Change in energy level                |     |    |            |
| Change in self-perception             |     |    |            |
| Change in memory                      |     |    |            |
| Change in mood                        |     |    |            |
| Change in control of movement         |     |    |            |
| Change in sexual interest or behavior |     |    |            |
| Change in sleep                       |     |    |            |
| Change in speech                      |     |    |            |
| Change in strength                    |     |    |            |
| Change in sensitivity to touch        |     |    |            |

*(continued)*

**TABLE 4.7-1. SYMPTOM CHECK LIST** (continued)

| Symptom                                 | Yes | No | Date Ended |
|---|-----|----|------------|
| Change in vision                        |     |    |            |
| Change in gait                          |     |    |            |
| Change in orientation to time and place |     |    |            |
| Fears (of what)                         |     |    |            |
| Headaches                               |     |    |            |
| Stiffness                               |     |    |            |
| Other symptoms:                         |     |    |            |

## SECTION 4.8: DOCUMENTS TO DISCOVER

*Defense counsel should obtain notes, records, messages, forms, and other correspondences from the plaintiff's witness.*

1. All clinical notes
2. Patient telephone messages
3. Prescription records
4. Health insurance claim forms
5. SSI disability application forms
6. The patient's writings and correspondence to the doctor
7. Lab reports
8. Other medical records
9. Psychological test records, including answer sheets
10. Lien records (filed by the doctor)

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## CHAPTER 5

### Challenging the Proof of Damages

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#### SECTION

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# CHAPTER 5

## CHALLENGING THE PROOF OF DAMAGES

### INTRODUCTION

Witnesses for the plaintiff consistently fail to conduct a differential diagnosis and frequently do not rule out many of the non-proximate causes of the plaintiff's symptoms. The questions in Chapter 5 will demonstrate that many witnesses are not even aware of alternate causes.

**Chapter 5** provides questions directly challenging the expert witness' diagnosis of *Posttraumatic Stress Disorder, Acute Stress Disorder, Generalized Anxiety Disorder, Anxiety Due to a General Medical Condition, Specific Phobia, Panic Disorder, Dysthymic Disorder, Major Depressive Disorder, Psychological Factors Affecting a Medical Condition and Adjustment Disorder*. These diagnosed disorders account for over 90 percent of the plaintiff's psychological injury claims.

**Defense Strategies** have been provided throughout Chapter 5 to further assist defense counsel in challenging plaintiff's proof of damages in high-risk psychological injury cases. These strategies are presented within a text box for quick review.

**The Symptom Index** located in the front and back of the book will refer defense counsel to the appropriate Chapter 5 questions to challenge and attack the foundation of the psychological and neurological injury diagnosis.

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## ***DIRECT CHALLENGE TO THE DIAGNOSIS***

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### **SECTION 5.1: DIRECT CHALLENGE TO THE DIAGNOSIS OF POSTTRAUMATIC STRESS DISORDER (PTSD) CLAIMS**

#### **INTRODUCTION**

Posttraumatic Stress Disorder (PTSD) is one of the most common claims in psychological injury litigation. PTSD is event specific. Symptoms relate only to a specific life trauma, not to a general increased level of stress or anxiety.

The defense of damages should focus on insufficient symptoms and on symptoms not caused by the injury in question. PTSD is treatable and is rarely severe enough to cause incapacitation or an inability to work. While early treatment is important, the plaintiff frequently fails to mitigate his or her own damages by seeking therapy.

Defense counsel should obtain a list of the plaintiff's claimed PTSD symptoms by using the deposition questions in Chapters 1 and 4. Section 5.1 provides questions to challenge the accuracy of a PTSD diagnosis. Questions are provided for each PTSD symptom.

---

**Challenging the Plaintiff's Diagnosis of Posttraumatic Stress Disorder**

---

TABLE 5.1-1.

**Diagnostic criteria for 309.81: Posttraumatic Stress Disorder (PTSD)**

- A.** The person has been exposed to a traumatic event in which both of the following were present:
- (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. **Note:** In children, this may be expressed instead by disorganized or agitated behavior.
- B.** The traumatic event is persistently re-experienced in one (or more) of the following ways:
- (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 (includes a sense of reliving the experience, illusions, hallucinations, and dissociative flashback episodes, including those that occur on awakening or when intoxicated). **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.
- 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 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

## Challenging the Plaintiff's Diagnosis of Posttraumatic Stress Disorder

TABLE 5.1-1. (CONTINUED)

- 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.

*Specify if:*

**Acute:** duration of symptoms is less than 3 months

**Chronic:** duration of symptoms is 3 months or more

*Specify if:*

**With Delayed Onset:** if onset of symptoms is at least 6 months after the stressor

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### SYMPTOM

### DEPOSITION QUESTIONS

#### Note: Familial Pattern

The DSM-IV-TR states that there [may be] evidence of a heritable (inherited) component to the transmission of PTSD. The Comprehensive Textbook of Psychiatry, Seventh Edition, reports that genetic factors [may] play only a moderate role, in the development of anxiety disorders. PTSD is the least studied anxiety disorder with respect to heritable or genetic contributions to etiology.

#### General Questions

**Q: Describe the plaintiff's trauma.**

The event should be an extreme traumatic event or stressor in which 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; AND the person's response involved intense fear, helplessness, or horror (criterion A).

**DEFENSE THEORY—THE TRAUMATIC EVENT: The event was not an extreme traumatic stressor that involved actual or threatened death or serious injury**

**Q: Has the plaintiff re-experienced the traumatic event?**

The witness must indicate at least one way the plaintiff re-experiences the traumatic event (criterion B).

# Posttraumatic Stress Disorder (PTSD)

**SYMPTOM**

**DEPOSITION QUESTIONS**

**General Questions**

*(continued)*

- Q: Has the plaintiff avoided stimuli associated with the trauma or experienced a numbing of responsiveness?**  
 The witness must indicate at least three avoidance behaviors or numbing experiences. (criterion C)

---
- Q: Has the plaintiff experienced any symptoms of increased arousal?**  
 The witness must indicate at least two symptoms of persistent, increased arousal. (criterion D)

---
- Q: How long have the symptoms persisted?**  
 The symptoms (in criteria B, C, and D) must have persisted for at least one month. (criterion E)

---
- Q: Is the plaintiff's behavior a distinct change from the plaintiff's pre-traumatic condition?**  
 The symptoms must not have been present before the trauma.

---
- Q: Is the plaintiff's behavior causing clinically significant impairment in any area of functioning?**  
 The trauma must cause clinically significant distress or impairment in social, occupational, or other important areas of functioning. (criterion F)

---
- Q: Describe the symptom onset (time) in relation to the traumatic event.**  
 A delayed onset may occur when the symptoms begin at least six months after the trauma.

---
- Q: Are the symptoms becoming less severe or occurring less often?**

---
- Q: Has the plaintiff ever been traumatized before this event?**

---
- Q: Was the plaintiff ever in the military service?**  
 If so, did the plaintiff experience combat?

---
- Q: Did the plaintiff develop a Posttraumatic Stress Disorder from combat?**

---
- Q: Has the plaintiff been traumatized since this event?**  
 If so, describe the event.

---

**SYMPTOM**

**DEPOSITION QUESTIONS**

**General Questions**

(continued)

**Q: Did you rule out an *adjustment disorder with anxiety* as a cause of the plaintiff's symptoms?**

An adjustment disorder is a *transient over-reaction* to stress that usually occurs within 90 days and remits within six months. The adjustment disorder with anxiety is characterized by symptoms of nervousness, worry, jitteriness, and motor tension. (reference 7, pp. 679-683; reference 4, pp.1098-1099)

*If the witness indicates the possibility of an adjustment disorder, see the section on adjustment disorder for further questions.*

**DEFENSE THEORY—DIAGNOSTIC CRITERIA:** The plaintiff's symptoms do not meet the diagnostic criteria listed in the Diagnostic and Statistical Manual IV (DSM IV). The correct diagnosis may actually be a simple Adjustment Disorder.

**DEFENSE THEORY—CHRONIC VS. ACUTE CLAIM:** The plaintiff's symptoms may be more consistent with those of an Acute Stress Disorder, a condition that appears and resolves within four weeks of the stressor.

**Recurrent and Intrusive Distressing Recollections**

**Q: Describe the plaintiff's recurring recollections (memories).**

**Q: Describe the plaintiff's reaction to these memories.**

The recollections must be *intrusive and distressing re-experiences of the traumatic event*.

**DEFENSE THEORY—RE-EXPERIENCING THE TRAUMA:** The traumatic event is re-experienced through recurrent and intrusive recollections, images and thoughts of the claimed event. Recurrent intrusive thoughts may actually be related to an Obsessive-Compulsive disorder. Also, the recurrent distressing recollections must be of the claimed event.

**Q: When and how often do the recollections occur?**

**Q: Does the plaintiff have a history of recurring recollections (memories) from other traumatic events?**

**Q: Is the plaintiff taking any *medications or substances* that may cause recurring recollections (memories), such as Nardil?**

## SYMPTOM

## DEPOSITION QUESTIONS

**Recurrent  
and Intrusive  
Dreams  
(Nightmares)**

**Q: Describe the plaintiff's recurrent distressing dreams or nightmares.**

The dreams / nightmares *must be of the traumatic event.*

**Q: When and how often do the nightmares occur?**

The nightmares of the traumatic event must be persistently experienced.

**Q: Does the plaintiff have a history of nightmares before the traumatic event?**

The plaintiff may have a lifelong condition of experiencing **nightmares**. S/he may have a certain vulnerability to schizophrenia. (reference 4, p. 1260)

**Q: Did you rule out other *life stressors* as a cause of the plaintiff's nightmares?**

In the susceptible plaintiff, **nightmares** may occur frequently at any time of stress, fatigue, or after consuming alcohol. (reference 4, pp. 67, 1260; reference 1, p.1321)

*If the witness indicates the possibility of a life stressor or other condition, see the section on other life stressors for further questions.*

**Q: Did you rule out *hyperthyroidism* as a cause of the plaintiff's nightmares?**

Hyperthyroidism produces symptoms that resemble an anxiety disorder or *hypomania*. The plaintiff with a history of hyperthyroidism frequently has persisting anxiety, including **night terrors**, crying spells and temper outbursts. The older hyperthyroid plaintiff may be apathetic, depressed, lethargic, weak, and experience weight loss, muscular wasting, and cardiovascular dysfunction. (reference 4, pp. 876, 893)

*If the witness indicates the possibility of hyperthyroidism, see the section on hyperthyroidism for further questions.*

**Q: Did you rule out a *childhood separation anxiety disorder* as a cause of the plaintiff's nightmares?**

A childhood separation anxiety disorder begins before the age of eighteen. For many years after the disorder's onset, the adult plaintiff may experience recurrences of excessive anxiety when separated from significant people or familiar places.

Associated symptoms include excessive worry about possible harm to loved ones, avoidance of being alone, **nightmares**, temper outbursts or uneasy tension, sweating hands, headaches, stomachaches, nausea and vomiting. (reference 7, pp. 121-124; reference 4, pp. 887, 1747-1750; reference 1, p. 1864)

*Defense counsel should obtain the plaintiff's early school and health records to look for evidence of this disorder.*

**Q: Did you rule out a *nightmare disorder* as a cause of the plaintiff's nightmares?**

The plaintiff awakens from sleep at least three times a week with a detailed account of a **recurring nightmare**. The nightmares may be long, lifelike, and often involve physical danger to the individual or self-esteem. The dream anxieties occur more frequently with mental stress, physical fatigue, or changes in sleep environment. The

SYMPTOM

DEPOSITION QUESTIONS

**Recurrent and Intrusive Dreams (Nightmares)**  
(continued)

disorder usually begins before age twenty. In most cases a major stressful life event precedes the onset of the disorder. (reference 7, pp. 631-634)

**Q: Did you rule out *sleep terror disorder* as a cause of the plaintiff's nightmares?**

Sleep terror disorder causes the plaintiff to **awaken with a sense of intense terror** from a single frightening image not associated with a dream. The plaintiff usually falls asleep and forgets the episode. These occurrences seldom require specific treatment. (reference 4, p. 1260; reference 7, p. 634)

**Q: Did you rule out the *onset of psychosis or schizophrenia* as a cause of the plaintiff's nightmares?**

The schizophrenic or pre-psychotic plaintiff has an increasing incidence and severity of **nightmares** and other sleep difficulties often caused by guilt, anxiety, or both. If it increases in severity, the plaintiff may develop a psychotic state within a few weeks. (reference 4, pp. 67, 1252)

**Q: Does the plaintiff have any *other medical conditions* that may cause nightmares, such as *Grave's disease (thyrotoxicosis)*?**

**Q: Is the plaintiff taking any *medications or substances* that may cause nightmares, such as:**

|           |               |           |
|-----------|---------------|-----------|
| ALDOMET   | FLOXIN        | RISPERDAL |
| ALDORIL   | HALCION       | SE-AP-ES  |
| AMYTAL    | LOPRESSOR     | SINEMET   |
| ASENDIN   | LUDIOMIL      | SURMONTIL |
| BUTICAPS  | MEBARAL       | TEMARIL   |
| CATAPRES  | NEMBUTAL      | TIMOPTIC  |
| CLOZARIL  | NOLUDAR       | TOFRANIL  |
| COMBIPRES | NORPRAMIN     | TOPROL-XL |
| DESYREL   | PAMELOR       | TRIAVIL   |
| DORAL     | PARLODEL      | VANTIN    |
| ELAVIL    | PHENOBARBITAL | VIVACTIL  |
| ENDEP     | RELAFEN       |           |
| ETRAFON   | REVIA         |           |

**DEFENSE THEORY—RECURRENT DISTRESSING DREAMS**

**(NIGHTMARES):** The claimed recurrent distressing dreams are not of the cause of action. The distressing dreams must be of the traumatic event (event specific). Many of the plaintiff's medications can produce distressing dreams / nightmares. Plaintiff's nightmares may be of other life events, or related to a physical disorder or previous trauma (e.g., war trauma).

## Posttraumatic Stress Disorder (PTSD)

---

*SYMPTOM*

*DEPOSITION QUESTIONS*

---

**Reliving the Experience (Flashbacks)**

**Q:** Describe the plaintiff's recurrent distressing recollections (flashbacks).

---

**Q:** Did the plaintiff admit that the recurrent distressing recollections were intense experiences of reliving the event or did s/he only report distressing memories?

---

**Q:** Are the recurrent distressing recollections associated with a specific stimulus?  
 Give some examples.

---

**Q:** When and how often do the recurrent distressing recollections occur?

---

**Q:** Does the plaintiff have a history of recurrent distressing recollections before the traumatic event?

---

**Q:** Did you rule out *alcohol withdrawal* as a cause of the plaintiff's recurrent distressing recollections?

The *reduction or cessation* of drinking for at least several days may cause characteristic symptoms: coarse tremor of hands, tongue, or eyelids; nausea or vomiting; malaise or weakness; autonomic hyperactivity (tachycardia, sweating, and elevated blood pressure); anxiety, depressed mood or irritability; **transient hallucinations or illusions**; headache; insomnia; dizziness; fatigue; restlessness; and agitation. (reference 7, pp. 215-216; reference 2, pp. 722, 618; reference 9, pp. 50-54)

---

**Intense Psychological Distress**

**Q:** Describe the plaintiff's distress with events similar to the trauma.

The plaintiff must experience intense psychological distress at exposure to events that symbolize or resemble an aspect of the traumatic event, including anniversaries of the trauma.

**DEFENSE THEORY—RE-EXPOSURE DISTRESS:** Distress must be intense when exposed to actual or symbolic cues. In many cases, after time, there is mild distress that remains when most of the other PTSD symptoms resolve. This is a remaining artifact of the condition, but it is not PTSD. Litigation itself may serve to keep the symptoms alive.

**Q:** When and how often does the plaintiff experience the distress?

---

**Q:** Does the plaintiff have a history of psychological distress with events other than those similar to the traumatic event?

---

**Q:** Did you rule out other *life stressors* as a cause of the plaintiff's distress with similar events?

*If the witness indicates the possibility of a life stressor or other condition, see the section on other life stressors for further questions.*

---

*SYMPTOM*

*DEPOSITION QUESTIONS*

**Intense Psychological Distress**  
(continued)

**Q: Did you rule out *specific phobia* as a cause of the plaintiff's distress with similar events?**

A phobic disorder is characterized by the presence of irrational or **exaggerated fears of a clearly discernible object, situation, or bodily function**. The situation or object of the fear is not inherently dangerous or an appropriate source of anxiety. The plaintiff may have symptoms of panic, sweating, tachycardia, shakiness, and difficulty breathing. S/he either avoids the object of the phobia or endures the situation with intense anxiety. There is also a marked distress about having the irrational fear. (reference 7, pp. 443-449; reference 4, pp. 899-900)

*If the witness indicates the possibility of a specific phobia, see the section on phobias for further questions.*

**Physiological Reactivity**

**Q: Describe the plaintiff's intense physical reaction to events that symbolize or resemble the traumatic event.**

**Q: When and how often does the plaintiff have the intense physical reaction to events resembling the trauma?**

**Q: Does the plaintiff have a history of intense physical reaction to these kinds of events before the trauma?**

**Q: Did you rule out other *life difficulties or stressors* as a cause of the plaintiff's intense physical reaction?**

*If the witness indicates the possibility of a life stressor or other condition, see the section on other life stressors for additional questions.*

**Q: How did you measure the physiological reactivity of the plaintiff?**

**Q: Did you rule out a *childhood overanxious disorder* as a cause of the plaintiff's intense physical reaction to events similar to the trauma?**

A child with an overanxious disorder has excessive anxiety or worry for at least six months. Overanxious disorder has been subsumed under Generalized Anxiety Disorder (GAD) in the DSM-IV-TR. Only one of six symptoms of restlessness, fatigue, difficulty with concentration, irritability, muscle tension, and sleep disturbance is required to make the diagnosis of generalized anxiety disorder in children. Affected older children and adolescents have more symptoms than younger children. GAD in children is distinguished from other anxiety disorders on the basis of persistent symptoms and a lack of specific focus for the anxiety. The real worries of children who are ill, poor, or with impaired parents must not be confused with GAD. (reference 7, pp. 472-476; reference 4, pp. 1752-1754; reference 18, p. 2773-4)

*Defense counsel should obtain the plaintiff's early school and health records to look for evidence of this disorder.*

## SYMPTOM

## DEPOSITION QUESTIONS

**Physiological Reactivity***(continued)*

**Q: Did you rule out a *generalized anxiety disorder* as a cause of the plaintiff's intense physical reaction to events similar to the trauma?**

A generalized anxiety disorder is a persistent anxiety that lasts at least six months. The plaintiff has an unrealistic or excessive worry about two or more life circumstances. S/he may be anxious about harm coming to a child or having financial difficulties when there is no apparent reason to worry. Symptoms include muscle tension, restlessness or feeling keyed up, fatigue, difficulty concentrating, sleep disturbance, and irritability. (reference 7, pp. 472-476)

**Q: Did you rule out *specific phobia* as a cause of the plaintiff's intense physical reaction to events similar to the trauma?**

A phobic disorder is characterized by the presence of **irrational** or **exaggerated fears** of objects, situations, or bodily functions. The situation or object of the fear is not inherently dangerous or an appropriate source of anxiety. The plaintiff may have symptoms of panic, sweating, tachycardia, shakiness, and difficulty breathing. S/he either avoids the object of the phobia or endures the situation with intense anxiety. There is also a marked distress about having the irrational fear. (reference 7, pp. 443-449; reference 4, pp. 899-900)

*If the witness indicates the possibility of a phobia, see the section on phobias for further questions.*

**Q: (Female) Did you rule out *premenstrual dysphoric disorder* as a cause of the plaintiff's intense physical reaction to events similar to the trauma?**

Premenstrual dysphoric disorder is characterized by emotional and behavioral symptoms which usually occur during the last week before the menstrual cycle and remit within a few days after menses begins. Symptoms may include tears, sadness, **irritability, anger, tension**, depression, self-deprecating thoughts, decreased interest in usual activities, fatigability, loss of energy, a subjective sense of difficulty in concentration, changes in appetite, and sleep disturbance. Physical symptoms may also include breast tenderness or swelling, tachycardia, sweating, headaches, joint or muscle pain, a sensation of bloating, or weight gain. (reference 7, pp. 771-774; reference 18, pp. 1955)

**Avoidance of Thoughts**

**Q: Describe the plaintiff's *avoidance of thoughts* or feelings associated with the traumatic event.**

**Q: When and how often does the plaintiff avoid thoughts or feelings associated with the traumatic event?**

**Q: Does the plaintiff have a history of *avoidance of thoughts* or feelings of other traumas or difficult situations?**

**Avoidance of Activities**

**Q: Describe the *avoidance* behaviors of situations that arouse memories of the trauma.**

**SYMPTOM**

**DEPOSITION QUESTIONS**

**Avoidance of Activities**

*(continued)*

**Q:** When and how often does the plaintiff *deliberately avoid* activities or situations that arouse memories of the trauma?

**DEFENSE THEORY—AVOIDANCE/NUMBING:** The plaintiff may have a pre-existing Avoidant or Schizoid Personality Disorder which would account for these same behaviors.

**Q:** Does the plaintiff have a history of *avoidance behaviors* before the traumatic event?

**Q:** Has the plaintiff reported deliberate or phobic efforts to *avoid activities or situations* that arouse memories of the traumatic event or is the plaintiff only avoiding thoughts and feelings associated with the traumatic event?

**Q:** Has the plaintiff ever been diagnosed with a *phobic disorder*?

*If the witness indicates that the plaintiff has a phobic disorder, s/he may be diagnosed with a phobia and not PTSD. See the section on specific phobia for additional questions.*

**Inability to Recall**

**Q:** Describe the plaintiff's inability to recall important aspects of the trauma.

**Q:** Does the plaintiff's loss of memory or amnesia for the event conflict with other reports of recurrent recollections?

**DEFENSE THEORY—RECALL PROBLEMS:** Several medical conditions and medications can interfere with recall (memory). Depression, headaches, and hypertension can disrupt recall, as well as cardiovascular, antidepressant, and sedative medications.

**Q:** When and how often is the plaintiff unable to recall important aspects of the trauma?

**Q:** What are some of the events that are not remembered?

**Q:** What are the events that are remembered?

**Q:** Does the plaintiff have a history of being unable to recall important aspects of events other than the trauma?

**SYMPTOM**

**DEPOSITION QUESTIONS**

**Inability to Recall**

(continued)

**Q: Does the plaintiff have a history of any *medical conditions* that may cause an inability to recall important aspects of the trauma?**

*The witness may indicate the possibility of the following medical conditions: please refer to the sections pertaining to these medical conditions for further questions.*

**TABLE 5.1-2**

|                         |                        |
|-------------------------|------------------------|
| Addison's disease       | Hepatic encephalopathy |
| Alzheimer's disease     | Hypertension           |
| Brain tumors            | Hyperthyroidism        |
| Combined system disease | Hypothyroidism         |
| Cushing's syndrome      | Polycythemia           |
| Epilepsy                | Postpartum disorder    |

**Q: Did you rule out the early phase of *dementia of the Alzheimer's type* as a cause of the plaintiff's inability to recall important aspects of the trauma?**

This primary degenerative dementia is caused by Alzheimer's disease. The plaintiff's **intellectual abilities**, personality, and behavior progressively **deteriorate**.

Depressive symptoms may complicate the condition. (reference 7, pp. 154-158)

*Age at onset: Senile onset (after age 65) is much more common than pre-senile onset. Few cases develop before the age of 49.*

**Q: Did you rule out *HIV-associated dementia or HIV-associated mild neurocognitive disorder* as a cause of the plaintiff's easy fatigability?**

HIV dementia is a severe cognitive disorder that interferes substantially with work, home life and social activities. Symptoms of mild neurocognitive disorder associated with HIV infection include difficulty concentrating, unusual fatigability with demanding mental tasks, feeling slowed down and **memory difficulties**. Problem solving, abstract reasoning, and motor performance may also be affected. (reference 18, pp. 308-316; reference 7, p. 163)

**Q: Did you rule out *hypothyroidism* as a cause of the plaintiff's inability to recall important aspects of the trauma?**

Hypothyroidism results from inadequate synthesis of thyroid hormone.

Hypothyroidism can produce psychiatric, as well as physical symptoms. The most notable psychiatric symptoms include depression, lethargy, poor concentration, **impaired memory**, apathy, and syncope. The numerous physical symptoms are: cold intolerance, constipation, muscle cramps, paresthesias, menstrual disorders, dyspnea, dizziness, reduced hearing, poor appetite, weight gain, brittle and thinning hair, and bradycardia (slowed heart action). Panic attacks are associated with endocrinological disorders including hypothyroidism and hyperthyroidism. (reference 18, pp. 743, 1810-1812, 1928)

## SYMPTOM

## DEPOSITION QUESTIONS

**Inability to Recall***(continued)***Q: Did you rule out *depressive pseudodementia* as a cause of the plaintiff's inability to recall aspects of the trauma?**

Cognitive disturbances seen in severe major depressive episodes are usually referred to as depressive pseudodementia. Treatment for the depression can restore both mood and memory to normal. Anxiety, irritability, a loss of social skills, and **memory gaps for specific periods or events** are characteristic symptoms. (reference 4, pp. 150-151; reference 18, p. 809)

**Q: Did you rule out *transient global amnesia* as a cause of the plaintiff's inability to recall aspects of the trauma?**

Transient global amnesia is characterized by the **loss of the ability to recall recent events** or to record new memories. The distant past is easily remembered. Attacks last six to twenty-four hours and can occur at any age, especially in men. Recovery is usually complete. (reference 1, p. 1310)

**Q: Did you rule out *dissociative (psychogenic) amnesia* as a separate cause of the plaintiff's inability to recall aspects of the trauma?**

The plaintiff with this disorder has a sudden **inability to recall** important personal information. During the amnesia, perplexity, disorientation, and purposeless wandering may occur. Termination is abrupt and recovery is complete. (reference 7, pp. 520-523)

**Q: Did you rule out *muscle contraction headaches* as a cause of the plaintiff's inability to recall some aspects of the trauma?**

Chronic muscle contraction headaches may produce nausea, vomiting, lightheadedness, difficulty in falling asleep, restless sleep with frequent awakenings, loss of energy, **impaired memory** and concentration, and symptoms of depression. (reference 2, pp. 72-73; reference 4, p. 1204)

*If the witness indicates the possibility of headaches, see the section on headaches for further questions.*

**Q: Did you rule out *Ganser's syndrome* as a cause of the plaintiff's inability to recall aspects of the trauma?**

Ganser's syndrome is characterized by giving approximate answers to questions. It may be associated with **amnesia**, disorientation, perceptual disturbances, fugue, and conversion symptoms. (reference 7, p. 533)

**Q: Did you rule out *vascular (multi-infarct) dementia* as a cause of the plaintiff's inability to recall some aspects of the trauma?**

Vascular dementia is caused by cerebrovascular disease (disease of the brain's blood supply or blood vessels) that quickly produces an irregular deterioration in intellectual functioning. The resulting dementia involves **disturbances in memory**, abstract thinking, judgment, impulse control, and personality. Combined with depression, the dementia often causes many cognitive symptoms. (reference 7, pp. 158)

**SYMPTOM**

**DEPOSITION QUESTIONS**

**Inability to Recall**

*(continued)*

**Q: Did you rule out early onset of *Wilson's disease* as a cause of the plaintiff's inability to recall some aspects of the trauma?**

Wilson's disease is characterized by brain degeneration. Defective copper excretion causes an accumulation of copper in the liver, brain, and other tissues. Symptoms may include tremor exaggerated with movement, difficulty speaking and swallowing, incoordination, personality changes, explosive anger, abdominal pain, diarrhea, nausea and vomiting, **memory loss** and dementia. (reference 9, pp. 1158-1159)

*If the witness indicates the possibility of Wilson's disease, see the section on Wilson's disease for further questions.*

**Q: Did you rule out *pernicious anemia* as a cause of the plaintiff's inability to recall aspects of the trauma?**

Pernicious anemia results from a lack of vitamin B12. The disease slowly causes both physical and mental symptoms. The plaintiff may experience feelings of depression, worthlessness and guilt, irritability, paranoia, and a **loss of memory**. Physical symptoms may include anorexia, abdominal pain, intermittent constipation and diarrhea, weight loss, and weakness. Pernicious anemia often leads to combined systems disease. (reference 4, p. 1276; reference 1, pp. 1077-1079; reference 2, pp. 576, 570)

**Q: Is the plaintiff taking any *medications or substances* that may cause the inability to recall aspects of the trauma, such as:**

- |            |                 |                |
|------------|-----------------|----------------|
| ALTACE     | HYZAAR          | RIFAMATE       |
| AMBIEN     | INDERAL         | RISPERDAL      |
| ANAFRANIL  | INDERIDE        | SEROQUEL       |
| ANSAID     | KERLONE         | SERZONE        |
| AVONEX     | LAMICTOL        | SONATA         |
| CARDIZEM   | LESCOL          | SULAR          |
| CARDURA    | LEVO-DROORAM    | TENORMIN       |
| CELEXA     | LIPITOR         | TIAZAC         |
| CLARITAN-D | LOPRESSOR       | TIMOPTIC       |
| CLARITIN   | LUDIOMIL        | TRANSDERM-SCOP |
| CLOZARIL   | LUVOX           | TRILEPTAL      |
| COGNEX     | MARPLAN         | TROVAN         |
| CORGARD    | MAXALT          | ULTRAM         |
| COZAAR     | MEXITIL         | ZESTORETIC     |
| DESYREL    | MIRAPEX         | ZESTRIL        |
| DORAL      | NEURONTIN       | ZOCOR          |
| DURACT     | ORUDISOXYCONTIN | ZOMIG          |
| DURAGESIC  | PAXIL           | ZYBAN          |
| ELDEPRYL   | PRAVACHOL       | ZYLOPRIM       |
| ESKALITH   | PREVACID        | ZYPREXA        |
| EXCELON    | PROSOM          | ZYRTEC         |
| HALCION    | PROZAC          |                |

SYMPTOM

DEPOSITION QUESTIONS

**Diminished Interest**

**Q:** Describe the plaintiff's diminished interest in significant activities.

**Q:** What specific activities was the plaintiff involved in before the trauma?

**DEFENSE THEORY—DIMINISHED INTEREST:** Look for other life stressors, personality disorders, medical conditions, substance abuse and polypharmacy.

**Q:** What is the extent of involvement in those activities now?

**Q:** When and how often has the plaintiff expressed disinterest in these activities?

**Q:** Is the plaintiff showing new interest in other areas?

**Q:** What is the plaintiff's explanation for this change in interest?

**Q:** Does the plaintiff have a history of losing interest in significant activities before the traumatic event?

**Q:** Does the plaintiff have a history of any *medical conditions* that may cause a diminished interest in significant activities?

*The witness may indicate the possibility of the following medical conditions: please refer to the sections pertaining to these medical conditions for further questions.*

**TABLE 5.1-3.**

|                    |                              |
|--------------------|------------------------------|
| Addison's disease  | Pancreatic carcinoma         |
| Brain tumors       | Pernicious anemia            |
| Cushing's syndrome | Postpartum disorder          |
| Epilepsy           | Rheumatoid arthritis         |
| Hyperthyroidism    | Menopausal distress          |
| Hypoglycemia       | Systemic lupus erythematosus |
| Multiple sclerosis |                              |

**Q:** Did you rule out an *avoidant personality disorder* as a cause of the plaintiff's diminished interest in significant activities?

The avoidant plaintiff is often **socially uncomfortable and timid**, exaggerates potential difficulties or dangers, is easily hurt, and fears negative comments. While greatly desiring companionship, the plaintiff has few close friends and is unwilling to get involved with others without certainty of being liked. The plaintiff may become depressed, anxious, and angry. This disorder is diagnosed only after the behavior has persisted for many years and the plaintiff is at least 20 years old. (reference 7, pp. 718-721; reference 4, pp. 981-982, 1752)

*If the witness indicates the possibility of an avoidant personality disorder, see the section on avoidant personality disorder for further questions.*

## SYMPTOM

## DEPOSITION QUESTIONS

**Diminished Interest***(continued)***Q: Did you rule out an *adjustment disorder with depressed mood* as a cause of the plaintiff's diminished interest in significant activities?**

This adjustment disorder is accompanied by depression, tearfulness, sleep disturbance, and feelings of hopelessness to a stressor. **Diminished interest** in activities is often a component of depression. It is important to note that an adjustment disorder is a *transient over-reaction* to stress and should remit within six months. (reference 7, pp. 679-683)

*If the witness indicates the possibility of an adjustment disorder with depressed mood, see the section on adjustment disorder for further questions.*

**Q: Did you rule out an *adjustment disorder with anxiety* as a cause of the plaintiff's diminished interest in significant activities?**

An adjustment disorder is a transient over-reaction to stress that usually occurs within 90 days and remits within six months. The adjustment disorder with anxiety is characterized by symptoms of nervousness, worry, jitteriness, **diminished interest in activities**, and motor tension. (reference 7, pp. 679-683; reference 4, pp. 1098-1099)

*If the witness indicates the possibility of an adjustment disorder with anxiety, see the section on adjustment disorder for further questions.*

**Q: Did you rule out *depressive pseudodementia* as a cause of the plaintiff's diminished interest in significant activities?**

Cognitive disturbances seen in severe major depressive episodes are usually referred to as depressive pseudodementia. Treatment for the depression can restore both mood and memory to normal. Anxiety, irritability, **a loss of social skills**, and memory gaps for specific periods or events are characteristic symptoms. (reference 4, pp. 150-151; reference 18, p. 809)

**Q: Did you rule out the *depressive phase of a Bipolar disorder* as a cause of the plaintiff's diminished interest in significant activities?**

During *major depressive episodes*, the plaintiff may be depressed for at least two weeks. The plaintiff may experience an appetite disturbance, weight change, sleep disturbance, psychomotor agitation or retardation, decreased energy, feelings of worthlessness, difficulty thinking or concentrating, **diminished interest in significant activities**, and recurrent thoughts of death or suicide. (reference 4, pp. 408-409, 761; reference 7, pp. 382-391)

**Q: Did you rule out *somatoform (psychogenic) pain disorder* as a cause of the plaintiff's diminished interest in significant activities?**

Somatoform (psychogenic) pain disorder is characterized by pain as the predominant focus of clinical attention. In addition, psychological factors are judged to have an important role in its onset, severity, exacerbation or maintenance. Symptoms associated with somatoform pain disorder include depression, anxiety, **anhedonia (an inability to experience pleasure)**, insomnia, and irritability. The symptoms may

## SYMPTOM

## DEPOSITION QUESTIONS

**Diminished Interest***(continued)*

become so severe that the plaintiff feels incapacitated and quits working. (reference 7, pp. 498-503; reference 4, p. 1109)

*If the witness indicates the possibility of a somatoform (psychogenic) pain disorder, see the section on somatoform disorders for questions.*

**Q: Did you rule out a *borderline personality disorder* as a cause of the plaintiff's diminished interest in significant activities?**

A borderline personality disorder is characterized by unstable interpersonal relationships, behavior, mood, and self-image. The plaintiff may experience temporary mood shifts including depression, irritability, and anxiety. S/he may also have chronic **feelings of emptiness or boredom**, inappropriate anger, and recurrent suicidal thoughts. **Social contrariness** and a generally pessimistic outlook often accompany the disorder. Premature death may result from suicide. (reference 7, pp. 706-710)

*If the witness indicates the possibility of a borderline personality disorder, see the section on personality disorders for further questions.*

**Q: Did you rule out *inhalant intoxication* as a cause of the plaintiff's diminished interest in significant activities?**

Following inhalant use of a toxic substance, the plaintiff may experience behavioral and physical changes. Behavioral changes may include belligerence, assaultiveness, apathy, impaired judgment, and **impaired social or occupational functioning**. Physical signs may include dizziness, nystagmus, slurred speech, unsteady gait, lethargy, depressed reflexes, tremor, psychomotor weakness, blurred vision or diplopia, stupor or coma, and euphoria. (reference 7, pp. 259-260)

*Note: The following question is to be asked if the plaintiff has experienced the loss of a family member or a close friend during the past two years.*

**Q: Did you rule out *bereavement* as a cause of the plaintiff's diminished interest in significant activities?**

Mourning is a normal grief reaction to a loss, such as the death of a loved one. The plaintiff may feel depressed and dejected, have **diminished interest in the outside world**, a decreased capacity to love, and an inhibition of activity. People tend to feel as if all their energy is taken up with thoughts and memories of the loss. Fatigue and weariness are characteristic symptoms. Sighing, feeling empty, disinterested, listless, eating more or less than normal, losing weight, and having trouble sleeping are common experiences. (reference 4, p. 1286-1293; reference 7, pp. 740-741; reference 2, p. 617)

**Q: (Female) Did you rule out *premenstrual dysphoric disorder* as a cause of the plaintiff's diminished interest in significant activities?**

Premenstrual dysphoric disorder is characterized by emotional and behavioral symptoms which usually occur during the last week before the menstrual cycle and remit within a few days after menses begins. Symptoms may include tears, sadness, irritability, anger, tension, depression, self-deprecating thoughts, **decreased interest**

## SYMPTOM

## DEPOSITION QUESTIONS

**Diminished Interest***(continued)*

**in usual activities**, fatigability, loss of energy, a subjective sense of difficulty in concentration, changes in appetite, and sleep disturbance. Physical symptoms may also include breast tenderness or swelling, tachycardia, sweating, headaches, joint or muscle pain, a sensation of bloating, or weight gain. (reference 7, pp. 771-774; reference 18, pp. 1955)

**Q: Did you rule out *infections* as a cause of the diminished interest in significant activities, such as:** (reference 2, p. 617)

Brucellosis

Meningitis

Chronic urinary tract infections

Subacute bacterial endocarditis

Infectious mononucleosis

Syphilis

Influenza

Tuberculosis

Malaria

Viral hepatitis

**Q: Did you rule out an *allergic reaction* as a cause of the plaintiff's diminished interest in significant activities?**

Allergic rhinitis is a seasonal or perennial inflammatory disease of the nasal membranes. Symptoms may include: sneezing, a stuffy and itching nose, postnasal drainage, and itching eyes. The plaintiff with allergies may feel generally ill and uncomfortable, tired, weak, despondent, irritable, and **uninterested in eating or significant activities**. (reference 9, pp. 1867-1868)

**Q: Did you rule out *heart disease* as a cause of the plaintiff's diminished interest in significant activities?**

Fatigue may be caused when body tissues do not receive sufficient nutrients and oxygen. A diseased heart is often unable to pump adequately for the lungs to oxygenate the blood. **Lethargy, diminished interest in significant activities**, and fatigue may be the result of heart diseases such as: (reference 2, pp. 617-618)

Congestive heart failure

Chronic atrial fibrillation

Chronic obstructive or restrictive pulmonary disease

Ischemic heart disease

Valvular heart disease

*If the witness indicates the possibility of heart disease, see the section on heart disease for further questions.*

**Q: Did you rule out an *identity problem* as a cause of the plaintiff's diminished interest in significant activities?**

The plaintiff with an identity problem may experience an uncertainty about identity, long-term goals, career choices, friendship patterns, sexual behavior, religious identification, value systems, and group loyalties. Associated symptoms may include mild anxiety, depression, self-doubt, doubt about the future, and **impaired social functioning** or work performance. The plaintiff may be unable to make decisions, may feel empty or isolated, have a distorted time perspective, and may feel negative or hostile toward others. The disorder is most common for late adolescents, but also

*SYMPTOM*

*DEPOSITION QUESTIONS*

**Diminished Interest**

*(continued)*

occurs in young adults and in middle age when earlier life decisions are questioned. (reference 7, pp. 741; reference 4, pp. 1762-1765; reference 19, p. 741; reference 18, p. 2922)

**Q: Did you rule out a somatization disorder (psychosomatic) as a cause of the plaintiff's diminished interest in significant activities?**

The plaintiff with a somatization disorder has many physical complaints for several years. S/he sees multiple physicians only to discover no physical cause for the symptoms. The plaintiff often has exaggerated and vague complaints focusing on either organs or types of symptoms such as pseudoneurologic or conversion symptoms, gastrointestinal, female reproductive, psychosexual, pain, and cardiopulmonary symptoms. Anxiety, depression, suicide attempts, **social withdrawal**, and work or interpersonal relationship difficulties are common. (reference 7, pp. 486-490; reference 4, pp. 389, 940)

*If the witness indicates the possibility of a somatization disorder, see the section on somatoform disorders for further questions.*

**Q: Does the plaintiff have any other medical conditions that may cause diminished interest in significant activities, such as:**

Central nervous system disease  
Metabolic failures

**Q: Is the plaintiff taking any medications or substances that may cause diminished interest in significant activities?**

*Decreased sexual activity is one of the diminished interests caused by the following drugs:*

|           |                |           |
|-----------|----------------|-----------|
| ADAPIN    | ESKALITH       | PROCARDIA |
| ALDOMET   | ESTROGEN PATCH | REVIA     |
| ALDORIL   | FLEXERIL       | RISPERDAL |
| ANADROL   | LIMBITROL      | SER-AP-ES |
| ANAFRANIL | LUDIOMIL       | SURMONTIL |
| AVAPRO    | MARPLAN        | TEMARIL   |
| CELEXA    | MAXZIDE        | TIAZAC    |
| COMBIPRES | MONOPRIL       | TIMOPTIC  |
| CORGARD   | MOTRIN         | TOFRANIL  |
| DESYREL   | NARDIL         | TRIAVIL   |
| ELAVIL    | NORPRAMIN      | VIVACTIL  |
| ELDEPRYL  | NORVASC        | ZOLOFT    |
| ENDEP     | PAMELOR        |           |

**Detachment**

**Q: Describe the plaintiff's feelings of detachment or estrangement.**

**Q: When and how often does the plaintiff feel detached or estranged?**

**SYMPTOM**

**DEPOSITION QUESTIONS**

**Detachment**

*(continued)*

**Q: Has the plaintiff remained close to other important people in his or her life?**

**Q: Has the plaintiff's relationship to others changed since the traumatic event?**

**Q: Does the plaintiff have a history of feeling detached or estranged before the traumatic event?**

**Q: Did you rule out an *avoidant personality disorder* as a cause of the plaintiff's feelings of detachment or estrangement?**

The avoidant plaintiff is often socially uncomfortable and timid, exaggerates potential difficulties or dangers, is easily hurt, and fears negative comments. While greatly desiring companionship, the plaintiff has few close friends and is **unwilling to get involved with others** without certainty of being liked. The plaintiff may become depressed, anxious, and angry. This disorder is diagnosed only after the behavior has persisted for many years and the plaintiff is at least 20 years old. (reference 7, pp. 718-721; reference 4, pp. 981-982, 1752)

*If the witness indicates the possibility of any personality disorder or maladaptive traits, see the section on personality disorders for further questions.*

**Q: Did you rule out a *histrionic personality disorder* as a cause of the plaintiff's feelings of detachment or estrangement?**

The histrionic plaintiff is self-centered, dramatic, emotionally excessive, shallow, and exhibits considerable mood instability. S/he is often uncomfortable when not the center of attention and seeks reassurance, approval, or praise from others. The plaintiff may complain of poor health, weakness, headaches, or **feelings of depersonalization**. While an overconcern with physical attractiveness and an inappropriate sexually seductive appearance or behavior is common, plaintiffs with this disorder often have troubled interpersonal relationships and can be sexually naive or unresponsive. (reference 7, pp. 711-714; reference 4, pp. 586)

**Q: Did you rule out a *depersonalization disorder* as a cause of the plaintiff's feelings of detachment or estrangement?**

The plaintiff with this disorder has very stressful recurrences of depersonalization. S/he may feel detached from **mind, body, and reality**. Associated symptoms may include dizziness, depression, obsessive rumination, somatic concerns, anxiety, fear of going insane, and difficulty with a sense of time and recall (reference 7, pp. 530-532)

**Q: Did you rule out pre-existing *temporal lobe epilepsy* as a cause of the plaintiff's feelings of detachment or estrangement?**

Epileptic seizures are difficult and sometimes impossible to clinically differentiate from similar brief behavioral disturbances of psychological origin, such as hysterical reactions or **feelings of detachment**. (reference 4, p. 153)

*If the witness indicates the possibility of epilepsy, see the section on epilepsy for further questions.*

## SYMPTOM

## DEPOSITION QUESTIONS

**Detachment***(continued)***Q: Did you rule out *migraine headaches* as a cause of the plaintiff's feelings of detachment or estrangement?**

A classic migraine (vascular) headache may be accompanied by visual disturbances, sensory motor or speech disturbances, nausea or vomiting, and emotional changes. On rare occasions, the plaintiff may experience **depersonalization or derealization**. Migraine headaches may be precipitated by: (reference 4, p. 1204; reference 2, pp. 65-66)

- Emotional conflicts or stress
- Fluctuating estrogen levels in women
- Birth control pills
- Food:
  - Monosodium glutamate (Chinese restaurant syndrome)
  - Tyramine-containing foods (cheese or other fermented dairy products and chocolate)
  - Phenylethylamine-containing foods

**Q: Did you rule out a *borderline personality disorder* as a cause of the plaintiff's feelings of detachment or estrangement?**

A borderline personality disorder is characterized by unstable interpersonal relationships, behavior, mood, and self-image. The plaintiff may experience temporary mood shifts including depression, irritability, and anxiety. S/he may also have chronic feelings of **emptiness or boredom**, inappropriate anger, and recurrent suicidal thoughts. Social contrariness and a generally pessimistic outlook often accompany the disorder. Premature death may result from suicide. (reference 7, pp. 706-710)

*Note: The following question is to be asked if the plaintiff has experienced the loss of a family member of a close friend during the past two years.*

**Q: Did you rule out *bereavement* as a cause of the plaintiff's feelings of detachment or estrangement?**

Mourning is a normal grief reaction to a loss, such as the death of a loved one. The plaintiff may feel depressed and dejected, have **diminished interest in the outside world, a decreased capacity to love**, and an inhibition of activity. People tend to feel as if all their energy is taken up with thoughts and memories of the loss. Fatigue and weariness are characteristic symptoms. Sighing, feeling empty, disinterested, listless, eating more or less than normal, losing weight, and having trouble sleeping are common experiences. (reference 4, pp. 1286-1293; reference 7, pp. 740-741; reference 2, p. 617)

**Q: Did you rule out *cannabis (marijuana) consumption* as a cause of the plaintiff's feelings of detachment or estrangement?**

*Cannabis intoxication* can occur from marijuana, hashish, or tetrahydrocannabinol (THC). Characteristic symptoms include tachycardia, increased appetite, dry mouth, euphoria, anxiety, sensation of slowed time, impaired judgment, and **social withdrawal**. Inappropriate laughter, panic attacks, and a dysphoric mood may occur

*SYMPTOM*

*DEPOSITION QUESTIONS*

**Detachment**  
(continued)

in the plaintiff who has not developed a tolerance to the substance. (reference 7, pp. 236-241; reference 4, pp. 1326, 754)

**Q: Did you rule out a *schizotypal personality disorder* as a cause of the plaintiff's feelings of detachment or estrangement?**

A schizotypal personality has oddities of thinking, perception, communication, and **behavior that resembles schizophrenia**. The plaintiff may experience anxiety, depression, and other dysphoric moods that disrupt concentration and the ability to function socially or at work. S/he may have few close friends except for immediate family. (reference 7, pp. 697-701)

**Q: Did you rule out a *schizoid personality disorder* as a cause of the plaintiff's feelings of detachment or estrangement?**

The schizoid plaintiff is introverted, withdrawn, and prefers to be alone. S/he tends to be indifferent to social relationships and has few close friends outside the family (first-degree relatives). Appearing cold and aloof to others, the plaintiff's emotions and expressions are bland and unresponsive to praise, criticism or comment. The plaintiff is unable to express aggression or anger, lacks goals or direction, is indecisive, self-absorbed, and absentminded. Often beginning in childhood or early adolescence, the disorder is found more frequently in males. (reference 7, pp. 694-697; reference 4, pp. 1741-1743)

**Restricted Range of Affect**

**Q: Describe the plaintiff's capacity for feelings, especially those of intimacy, tenderness, and sexuality.**

**Q: What feelings does the plaintiff have about significant others in his or her life?**

**Q: When and how often does the plaintiff experience decreased emotional capacity?**

**DEFENSE THEORY—RESTRICTED AFFECT: Look for medication side-effects, personality disorders, neurological illness, bereavement, marital conflict, other stressors, life-stage crisis, onset of new medical condition or a low-level (possibly pre-existing) depression known as dysthymic disorder.**

**Q: Does the plaintiff have a history of restricted range of affect before the traumatic event?**

**Q: Describe the frequency of sexual activity by the plaintiff before and after the traumatic event.**

Sexual dysfunction is a physical or emotional inability to have or complete the sexual act.

## SYMPTOM

## DEPOSITION QUESTIONS

**Restricted  
Range of  
Affect**

(continued)

**Q: Did you rule out an *adjustment disorder with depressed mood* as a cause of the plaintiff's restricted range of affect?**

This adjustment disorder is accompanied by depression, tearfulness, sleep disturbance, feelings of hopelessness, and **decreased emotional capacity**. It is important to note that an adjustment disorder is a transient over-reaction to stress and should remit within six months. (reference 7, pp. 679-683)

*If the witness indicates the possibility of an adjustment disorder with depressed mood, see the section on adjustment disorders for further questions.*

**Q: Did you rule out the *depressive phase of a Bipolar disorder* as a cause of the plaintiff's restricted range of affect?**

A Bipolar disorder has a circular pattern of high and low emotional states (*mania and depression*). During the *manic episodes*, the plaintiff may feel grandiose, have a decreased need for sleep, and **decreased emotional capacity**, experience a surge of ideas and conversation, and may be easily distracted or pleased. It is often thought that the manic high represents an escape from inner depression and pain. While the plaintiff is extremely active, s/he is often fragmented and unable to finish projects. The plaintiff typically does not realize that s/he is ill.

During *major depressive episodes* the plaintiff may be depressed for at least two weeks. The plaintiff may experience an appetite disturbance, weight change, sleep disturbance, psychomotor agitation or retardation, **decreased energy and emotional capacity**, feelings of worthlessness, difficulty thinking or concentrating, and recurrent thoughts of death or suicide. (reference 4, pp. 408-409, 761; reference 7, pp. 382-391)

**Q: Did you rule out *antisocial personality disorder* as a cause of the plaintiff's restricted range of affect?**

The antisocial plaintiff may have a lifetime history of irresponsible and antisocial behavior. Childhood behaviors may include lying, stealing, truancy, vandalism, initiating fights, running away from home, and physical cruelty. Adolescents may also become abusers of tobacco, alcohol, and other drugs, or engage in early sexual activity. Adults with antisocial personalities tend to be irritable, aggressive, reckless, and promiscuous. They may be **unable to keep a job, friendship, or sexual relationship**. The plaintiff shows no remorse or guilt when hurting or mistreating others. Frequently this disorder is accompanied by signs of personal distress, tension, an inability to tolerate boredom, depression, a conviction that others are hostile, and suicidal attempts. (reference 7, pp. 701-706; reference 4, pp. 1865, 1868-1869)

*If the witness indicates the possibility of any personality disorder or maladaptive traits, see the section on personality disorders for further questions.*

**Q: Did you rule out a *histrionic personality disorder* as a cause of the plaintiff's restricted range of affect?**

The histrionic plaintiff is self-centered, dramatic, **emotionally excessive, shallow**, and exhibits considerable mood instability. S/he is often uncomfortable when not the

## SYMPTOM

## DEPOSITION QUESTIONS

**Restricted  
Range of  
Affect***(continued)*

center of attention and will seek reassurance, approval, or praise from others. The plaintiff may complain of poor health, weakness, headaches, or feelings of depersonalization. While an overconcern with physical attractiveness and an inappropriate sexually seductive appearance or behavior is common, plaintiffs with this disorder often have troubled interpersonal relationships and can be sexually naive or unresponsive. (reference 7, pp. 711-714; reference 4, pp. 586)

**Q: Did you rule out a *paranoid personality disorder* as a cause of the plaintiff's restricted range of affect?**

The paranoid plaintiff has a history of unwarranted suspicion and mistrust of others. Often expecting to be exploited or harmed, s/he may be excessively sensitive, jealous, hypervigilant, and tense. The plaintiff may find it difficult to relax or forgive, and is argumentative when threatened by innocent remarks or events. His or her mood is often humorless, **cold and unemotional**. These plaintiffs rarely seek help because of a tendency to be moralistic, grandiose, and extrapunitive. (reference 7, pp. 690-694; reference 4, pp. 748-753)

*Note: The following question is to be asked if the plaintiff has experienced the loss of a family member or a close friend during the past two years.*

**Q: Did you rule out *bereavement* as a cause of the plaintiff's restricted range of affect?**

Mourning is a normal grief reaction to a loss, such as the death of a loved one. The plaintiff may feel depressed and dejected, have diminished interest in the outside world, a **decreased capacity to love**, and an inhibition of activity. People tend to feel as if all their energy is taken up with thoughts and memories of the loss. Fatigue and weariness are characteristic symptoms. Sighing, feeling empty, disinterested, listless, eating more or less than normal, losing weight, and having trouble sleeping are common experiences. (reference 4, pp. 1286-1293; reference 7, pp. 740-741; reference 2, p. 617)

**Q: Did you rule out a *borderline personality disorder* as a cause of the plaintiff's restricted range of affect?**

A borderline personality disorder is characterized by unstable interpersonal relationships, behavior, mood, and self-image. The plaintiff may experience temporary mood shifts including depression, irritability, and anxiety. S/he may also have chronic feelings of emptiness or boredom, **decreased emotional capacity**, inappropriate anger, and recurrent suicidal thoughts. Social contrariness and a generally pessimistic outlook often accompany the disorder. Premature death may result from suicide. (reference 7, pp. 706-710)

*If the witness indicates the possibility of any personality disorder, see the section on personality disorders for further questions.*

**Q: Did you rule out a *schizotypal personality disorder* as a cause of the plaintiff's restricted range of affect?**

A schizotypal personality has oddities of thinking, perception, communication, and behavior that resemble schizophrenia. The plaintiff may experience anxiety,

*SYMPTOM*

*DEPOSITION QUESTIONS*

**Restricted Range of Affect**

(continued)

depression, and other dysphoric moods that disrupt concentration and the ability to function socially or at work. S/he may **have few close friends** except for immediate family. (reference 7, pp. 697-701)

**Q: Did you rule out a *schizoid personality disorder* as a cause of the plaintiff's restricted range of affect?**

The schizoid plaintiff is introverted, withdrawn, and prefers to be alone. S/he tends to be indifferent to social relationships and has few close friends outside the family (first-degree relatives). Appearing cold and aloof to others, the plaintiff's **emotions and expressions are bland and unresponsive** to praise, criticism or comment. The plaintiff is unable to express aggression or anger, lacks goals or direction, is indecisive, self-absorbed, and absentminded. Often beginning in childhood or early adolescence, the disorder is found more frequently in males. (reference 7, pp. 694-697; reference 4, pp. 1741-1743)

**Q: Did you rule out a *narcissistic personality disorder* as a cause of the plaintiff's restricted range of affect?**

A narcissistic plaintiff has a grandiose sense of self-importance, exaggerating accomplishments, talents, and achievements. S/he believes they are special or unique. They are often sensitive to criticism and lack empathy for others. While the plaintiffs may be **preoccupied with themselves** and expect special treatment or entitlements, they often are very fragile and constantly seek attention or admiration. (reference 7, pp. 714-717)

**Q: Does the plaintiff have any *other medical conditions* that may cause restricted range of affect, such as:**

- Cardiovascular disease
- Central nervous system disease
- Metabolic and pulmonary failures

**Q: Is the plaintiff taking any *medications or substances* that may cause restricted range of affect, such as:**

- |            |           |           |
|------------|-----------|-----------|
| ACCUTANE   | DEPAKENE  | LUVOX     |
| AMBIEN     | DEPAKOTE  | MOTRIN    |
| ANAFRANIL  | DURACT    | MYSOLINE  |
| ANSAID     | EFFEXOR   | NEORAL    |
| ARICEPT    | EXCELON   | NEURONTIN |
| AVAPRO     | FLOXIN    | OXYCONTIN |
| AVONEX     | GABITRIL  | PAXIL     |
| BACTRIM    | INDERAL   | PAXIPAM   |
| CALAN      | INDERIDE  | PROSOM    |
| CARDURA    | KERLONE   | PROTONIX  |
| CELEXA     | LANOXIN   | PROZAC    |
| CLARITIN-D | LEVAQUIN  | REMERON   |
| CRINONE    | LIPITOR   | RISPERDAL |
| DECADRON   | LOPRESSOR | RITALIN   |

# Posttraumatic Stress Disorder (PTSD)

*SYMPTOM*

*DEPOSITION QUESTIONS*

**Restricted  
Range of  
Affect**  
(continued)

|          |                   |          |
|----------|-------------------|----------|
| RUFEN    | TENORETIC         | ULTRAM   |
| SEPTRA   | TENORMIN          | ZANAFLEX |
| SEROQUEL | TIMOPTIC          | ZOMIG    |
| SERZONE  | TOPROL-XLTRANDATE | ZYBAN    |
| SONATA   | TRILEPTAL         | ZYRTEC   |

**Sense of  
Foreshortened  
Future**

- Q:** Describe how the plaintiff feels about the future in regard to career, marriage, children, and long life.
- 
- Q:** When and how often does the plaintiff have a sense of foreshortened future?

**DEFENSE THEORY—SENSE OF FORESHORTENED FUTURE:**  
Expectations of a foreshortened future may stem from physical illness, depression and personality disorder.

- Q:** Is there any evidence that the plaintiff's life-span has been shortened?
- 
- Q:** Does the plaintiff have a history of familial illnesses or disorders that cause a reduced life-span?
- 
- Q:** Does the plaintiff have a history of sensing a foreshortened future for any other reasons?
- 
- Q:** Has the plaintiff taken any steps that demonstrate this claimed sense of foreshortened future?  
The plaintiff with a sense of no future may begin buying insurance, changing financial habits of spending or saving money, drafting a will, or giving away keepsakes or valuables.
- 
- Q:** Did you rule out the plaintiff's reaction to an *existing illness or medical condition* as a cause of the sense of foreshortened future?  
Psychological reactions to illness may include a mixture of **helplessness, hopelessness**, guilt, and shame. The plaintiff will feel helpless if the illness is serious and not under his or her own control with respect to cure and cause. The plaintiff will feel hopeless if no one can help. (reference 4, p. 1270)
- 
- Q:** Did you rule out a *borderline personality disorder* as a cause of the plaintiff's sense of foreshortened future?

A borderline personality disorder is characterized by unstable interpersonal relationships, behavior, mood, and self-image. The plaintiff may experience temporary mood shifts including depression, irritability, and anxiety. S/he may also have chronic feelings of emptiness or boredom, inappropriate anger, and **recurrent suicidal thoughts**. Social contrariness and a **generally pessimistic outlook** often accompany the disorder. Premature death may result from suicide. (reference 7, pp. 706-710)

## SYMPTOM

## DEPOSITION QUESTIONS

**Sense of  
Foreshortened  
Future**

(continued)

**Q: Did you rule out an *adjustment disorder with depressed mood* as a cause of the plaintiff's sense of foreshortened future?**

This adjustment disorder is accompanied by depression, tearfulness, sleep disturbance, and **feelings of hopelessness** to a stressor. It is important to note that an adjustment disorder is a transient over-reaction to stress and should remit within six months. (reference 7, pp. 679-683)

*If the witness indicates the possibility of an adjustment disorder with depressed mood, see the section on adjustment disorders for further questions.*

**Q: Did you rule out a recent *myocardial infarction (heart attack)* as a cause of the plaintiff's sense of foreshortened future?**

Despondency is almost a universal response to heart attack. Even without complications, the plaintiff may feel a sense of loss (ego infarction), damage, and **vulnerability to further injury**. Weakness and fatigue are the most distressing symptoms of the condition. The plaintiff may also experience insomnia, daytime hypersomnia, and practical worries. Complications cause the plaintiff's despondency and **hopelessness** to be intensified. (reference 4, p. 1156-1157)

*If the witness indicates the possibility of a recent heart attack, see the section on heart attacks for further questions.*

**Q: Did you rule out a *major depressive episode* as a cause of the plaintiff's sense of a foreshortened future?**

A major depressive episode is characterized by either a depressed mood or a loss of interest and pleasure in most activities. Symptoms last for at least two weeks and can be distinguished from normal behavior. The plaintiff may feel tired and lethargic. Other common symptoms may include weight loss or gain; a decrease or increase in appetite; psychomotor agitation or retardation; feelings of worthlessness or excessive guilt; a decreased ability to concentrate or make decisions; and **frequent thoughts of hopelessness, death and suicide**. (reference 4, pp. 794, 1251; reference 2, pp. 615-616; reference 7, pp. 349-356)

*If the witness indicates the possibility of a major depressive episode, see the section on major depression for further questions.*

**Insomnia**

**Q: Describe the plaintiff's difficulty falling or staying asleep.**

**Q: When and how often does the plaintiff have difficulty falling or staying asleep?**

**DEFENSE THEORY—SLEEP DYSFUNCTION:** Also can be caused by medication side-effects, chaotic wake-sleep cycle, caffeine, some illnesses such as metabolic, gastro, pulmonary, cardiovascular conditions, other stressors, age related insomnia, sleep apnea, restless leg syndrome, nocturnal myoclonus, alcohol, depression, menopause onset and headaches.

*SYMPTOM*

*DEPOSITION QUESTIONS*

**Insomnia**

(continued)

**Q: Does the plaintiff sleep during the day?**

**Q: What are the plaintiff's pre-bedtime patterns?**

**Q: Does the plaintiff have a history of difficulty falling or staying asleep before the traumatic event?**

Insomnia may be persistent from childhood or early adolescence into adulthood. (reference 4, p. 1253)

**Q: Does the plaintiff have a history of any *medical conditions* that may cause difficulty falling or staying asleep?**

*The witness may indicate the possibility of the following medical conditions: please refer to the sections pertaining to these medical conditions for further questions. (reference 9, p. 1988)*

**TABLE 5.1-4.**

|                         |                                     |
|-------------------------|-------------------------------------|
| Alzheimer's disease     | Menopausal distress                 |
| Bruxism                 | Nocturnal nyctolonus                |
| Cardiopulmonary disease | Pain                                |
| Circadian rhythm shifts | Postpartum disorder                 |
| Enuresis                | Sleep apnea syndromes               |
| Fever                   | Subacute sclerosing panencephalitis |

**Q: Did you rule out *other life difficulties or stressors* as a cause of the plaintiff's difficulty falling or staying asleep?**

**Insomnia** may be caused by life stressors such as marital difficulties, problems at work, guilt over sexual conflicts, or concerns about health. (reference 1, p. 1322)

*If the witness indicates the possibility of a life stressor or other condition, see the section on other life stressors for further questions.*

**Q: Did you rule out a *childhood overanxious disorder* a cause of the plaintiff's difficulty falling or staying asleep?**

A child with an overanxious disorder has excessive or unrealistic anxiety or worry for at least six months. S/he tends to be self-conscious and worried about future events and past behavior. Symptoms may include feeling a lump in the throat, headaches, gastrointestinal distress, shortness of breath, nausea, dizziness, **difficulty falling asleep**, nervousness, and other bodily discomforts. The disorder occurs most often in families where there is an unusual emphasis on high achievement. An overanxious disorder may be accompanied by other phobias. It can persist into adult life as an anxiety disorder, such as a generalized anxiety disorder or a social phobia (social anxiety disorder). (reference 7, pp. 472-476; reference 4, pp. 1752-1754)

*Defense counsel should obtain the plaintiff's early school and health records to look for evidence of this disorder.*

## SYMPTOM

## DEPOSITION QUESTIONS

**Insomnia***(continued)***Q: Did you rule out a *nightmare disorder* as a cause of the plaintiff's difficulty in falling or staying asleep?**

The plaintiff **awakens from sleep** at least three times a week with a detailed account of a recurring nightmare. The nightmares may be long, lifelike, and often involve physical danger to the individual or self-esteem. The dream anxieties occur more frequently with mental stress, physical fatigue, or changes in sleep environment. The disorder usually begins before age twenty. In most cases, a major stressful life event precedes the onset of the disorder. (reference 7, pp. 631-634)

**Q: Did you rule out *sedative, hypnotic, anxiolytic or nicotine withdrawal* as a cause of the plaintiff's difficulty in falling or staying asleep?**

Withdrawal symptoms develop when the plaintiff reduces or stops the prolonged moderate or heavy use of these substances. Symptoms may include nausea or vomiting; malaise or weakness; autonomic hyperactivity (such as tachycardia and sweating); anxiety or irritability; orthostatic hypotension; coarse tremor of the hands, tongue and eyelids; **insomnia**; and grand mal seizures. (reference 7, pp. 201-209; reference 4, p. 1549; reference 18, p. 1034)

**Q: Did you rule out *nightmares* as a cause of the plaintiff's difficulty falling or staying asleep?**

Nightmares (dream anxiety attacks) cause the plaintiff to **awaken from REM sleep** with a detailed account of a disturbing dream. S/he may feel anxious and experience autonomic arousal. Nightmares may occur frequently in the more susceptible plaintiff that is stressed, fatigued, or who has consumed alcohol. (reference 4, p. 1260; reference 1, p. 1321)

**Q: Did you rule out *sleep terror disorder* as a cause of the plaintiff's difficulty falling or staying asleep?**

Sleep terror disorder causes the plaintiff to **awaken with a sense of intense terror** from a single frightening image not associated with a dream. The plaintiff usually falls asleep and forgets the episode. These occurrences seldom require specific treatment. (reference 4, p. 1260)

**Q: Did you rule out *caffeine consumption* as a cause of the plaintiff's difficulty in falling or staying asleep?**

Characteristic symptoms of caffeine intoxication include restlessness, nervousness, excitement, **insomnia**, flushed face, diuresis, gastrointestinal disturbance, muscle twitching, rambling flow of thought and speech, tachycardia or cardiac arrhythmia, periods of inexhaustibility, and psychomotor agitation. When consumed near bedtime, caffeine often disrupts sleep. Symptoms may appear when the plaintiff consumes as little as 250 mg. of caffeine per day. The plaintiff that consumes one gram per day usually experiences more severe symptoms. Products which contain caffeine include: coffee, tea, soda, chocolate and weight-loss aids. (reference 7, pp. 231-234; reference 4, p. 1029)

## SYMPTOM

## DEPOSITION QUESTIONS

**Insomnia**

(continued)

If the witness indicates the possibility of excess caffeine consumption, see the caffeine consumption chart in Appendix A.

**Q: Did you rule out *habit insomnia* as a cause of the plaintiff's trouble falling or staying asleep?**

**Habit insomnia** is a conditioned reflex. The plaintiff associates going to bed with restlessness and **wakefulness**, rather than with sleep. (reference 4, p. 1251)

**Q: Did you rule out *age* as a cause of the plaintiff's difficulty falling or staying asleep?**

The number of awakenings per night and the amount of **time awake during the night increases** gradually with age. These changes may be distressing enough for the plaintiff to seek treatment. (reference 4, p. 1261; reference 1, pp. 1321-1322)

**Q: Did you rule out *sleep apnea* as a cause of the plaintiff's difficulty staying asleep?**

Sleep apnea is the cessation or suspension of breathing during sleep, causing the plaintiff to **awaken periodically throughout the night**. These hesitations may cause sleep disturbance but the plaintiff's main complaint may be excessive daytime drowsiness. (reference 4, pp. 132, 1252)

**Q: (Obese plaintiff) Did you rule out an *obstructive sleep apnea* as a cause of the plaintiff's difficulty staying asleep?**

Obesity, sometimes combined with a physical defect, may lead to pulmonary failure or upper airway narrowing. The obstruction causes **repeated awakenings** during the night and a cycle of night and day episodes of awakenings and drowsiness. Weight reduction can be an effective treatment. (reference 1, p. 1321)

**Q: Did you rule out *restless leg syndrome* as a cause of the plaintiff's difficulty falling or staying asleep?**

Restlessness and an uncomfortable or painful crawling sensation in the muscles and bones of the lower legs are signs of the restless legs syndrome. The symptoms usually occur at night, **disturbing sleep**, or when the plaintiff is resting. There is no known cause of the syndrome. (reference 4, pp. 132, 1253)

**Q: Did you rule out *nocturnal myoclonus* as a cause of the plaintiff's difficulty falling or staying asleep?**

Rhythmic muscle twitches and involuntary movements of the extremities **disrupt the plaintiff's sleep**. The disorder usually begins during late middle age and in the elderly. (reference 9, pp. 1988-1989)

**Q: Did you rule out any *pain or discomfort* as a cause of the plaintiff's difficulty falling or staying asleep?**

Almost any medical, toxic, or environmental condition associated with pain and discomfort can produce insomnia.

## SYMPTOM

## DEPOSITION QUESTIONS

**Insomnia***(continued)***Q: Did you rule out *self-imposed chaotic sleep schedules* as a cause of the plaintiff's difficulty falling or staying asleep?**

Frequently changing sleep-awake schedules causes sleep **insomnia** and daytime somnolence (drowsiness). This condition is becoming more prevalent and occurs in plaintiffs that fly frequently or in those that repeatedly change their work schedule. (reference 4, p. 1259)

**Q: Did you rule out *alcohol consumption* as a cause of the plaintiff's difficulty falling or staying asleep?**

Alcohol intoxication may cause aggressiveness, impaired judgment and attention, irritability, euphoria, depression, emotional lability, and impaired social or occupational functioning. Physical symptoms may include slurred speech, incoordination, unsteady gait, nystagmus, occasional dizziness, and flushed face. Heavy alcohol consumption may cause **abnormal sleep patterns**. The plaintiff often falls asleep quickly but **wakes up earlier and earlier with uncomfortable feelings**. Chronic alcoholics may have irregular, unsteady, and slow tremulous movements. (reference 7, pp. 212-215; reference 4, p. 67; reference 9, p. 52)

The *reduction or cessation* of drinking for at least several days may cause characteristic symptoms: coarse tremor of hands, tongue, or eyelids; nausea or vomiting; malaise or weakness; autonomic hyperactivity (tachycardia, sweating, and elevated blood pressure); anxiety, depressed mood or irritability; transient hallucinations or illusions; headache; **insomnia**; dizziness; fatigue; restlessness; and agitation. (reference 7, pp. 129-130; reference 2, pp. 722, 618; reference 9, pp. 50-54)

**Q: Did you rule out a *major depressive episode* as a cause of the plaintiff's difficulty falling or staying asleep?**

A major depressive episode is characterized by either a depressed mood or a loss of interest and pleasure in most activities. Symptoms last for at least two weeks and can be distinguished from normal behavior. The plaintiff may feel tired and lethargic. Other common symptoms may include weight loss or gain; a decrease or increase in appetite; psychomotor agitation or retardation; feelings of worthlessness or excessive guilt; a decreased ability to concentrate or make decisions; and frequent thoughts of hopelessness, death and suicide.

**Depression typically affects sleep.** The plaintiff may be awake repeatedly during the second half of the night and may awaken in early morning with uncomfortable feelings. Morning is the worst time of day for the plaintiff experiencing depression. (reference 4, pp. 794, 1251; reference 2, pp. 615-616; reference 7, pp. 349-356)

*If the witness indicates the possibility of a major depressive episode, see the section on Depressive Disorder for further questions.*

**Q: Did you rule out an *adjustment disorder with depressed mood* as a cause of the plaintiff's difficulty in falling or staying asleep?**

This adjustment disorder is accompanied by depression, tearfulness, **sleep disturbance**, and feelings of hopelessness to a stressor. It is important to note that

## SYMPTOM

## DEPOSITION QUESTIONS

**Insomnia***(continued)*

an adjustment disorder is a *transient over-reaction* to stress and should remit within six months. (reference 7, pp. 679-683)

*If the witness indicates the possibility of an adjustment disorder with depressed mood, see the section on adjustment disorders for further questions.*

**Q: Did you rule out a *generalized anxiety disorder* as a cause of the plaintiff's difficulty falling or staying asleep?**

A generalized anxiety disorder is a persistent anxiety that lasts at least six months. The plaintiff has an unrealistic or excessive worry about two or more life circumstances. S/he may be anxious about harm coming to a child or having financial difficulties when there is no apparent reason to worry. Symptoms include trembling and muscle tension, restlessness, fatigue, shortness of breath, tachycardia, sweating, dry mouth, dizziness, nausea or abdominal distress, flushes or chills, frequent urination, trouble swallowing or lump in the throat, feeling keyed up, exaggerated startle response, difficulty concentrating, **trouble falling or staying asleep**, and irritability. (reference 7, pp. 472-476)

*If the witness indicates the possibility of a generalized anxiety disorder, see the section on generalized anxiety disorder for further questions.*

**Q: Did you rule out *cocaine withdrawal* as a cause of the plaintiff's difficulty falling or staying asleep?**

The abrupt *cessation or reduction of cocaine*, after several days use, may cause the plaintiff to feel tired, dysphoric, irritable, depressed, and to crave more of the drug. An anxiety reaction may cause psychomotor agitation, **insomnia** or hypersomnia, high blood pressure, tachycardia, and paranoia. The symptoms may persist for more than a day. (reference 7, pp. 245-246; reference 4, pp. 1008-1009)

*Note: The following question is to be asked if the plaintiff has experienced the loss of a family member or a close friend during the past two years.*

**Q: Did you rule out *bereavement* as a cause of the plaintiff's difficulty falling or staying asleep?**

Mourning is a normal grief reaction to a loss, such as the death of a loved one. The plaintiff may feel depressed and dejected, have diminished interest in the outside world, a decreased capacity to love, and an inhibition of activity. People tend to feel as if all their energy is taken up with thoughts and memories of the loss. Fatigue and weariness are characteristic symptoms. Sighing, feeling empty, disinterested, listless, eating more or less than normal, losing weight, and having **trouble sleeping** are common experiences. (reference 4, pp. 1286-1293; reference 7, pp. 740-741; reference 2, p. 617)

**Q: (Female) Did you rule out *premenstrual dysphoric disorder* as a cause of the plaintiff's diminished interest in significant activities?**

Premenstrual dysphoric disorder is characterized by emotional and behavioral symptoms which usually occur during the last week before the menstrual cycle and remit within a few days after menses begins. Symptoms may include tears, sadness,

## SYMPTOM

## DEPOSITION QUESTIONS

**Insomnia***(continued)*

irritability, anger, tension, depression, self-deprecating thoughts, decreased interest in usual activities, fatigability, loss of energy, a subjective sense of difficulty in concentration, changes in appetite, and **sleep disturbance**. Physical symptoms may also include breast tenderness or swelling, tachycardia, sweating, headaches, joint or muscle pain, a sensation of bloating, or weight gain. (reference 7, pp. 771-774; reference 18, pp. 1955)

**Q: Did you rule out *masked depression* as a cause of the plaintiff's difficulty falling or staying asleep?**

The plaintiff with masked depression hides a dysphoric mood with gastrointestinal problems, chronic pain, **insomnia**, weight loss, and other physical complaints. The elderly experience symptoms of hypertension, cardiac arrhythmias, emphysema, diabetes, urinary frequency, dizziness, disturbed bowel functions, and backaches. Masked depression is a common condition frequently missed by physicians. (reference 4, p. 796)

**Q: Did you rule out the onset of *psychosis or schizophrenia* as a cause of the plaintiff's difficulty falling or staying asleep?**

The schizophrenic or pre-psychotic plaintiff has increasing incidence and severity of nightmares and other **sleep difficulties** often caused by guilt, anxiety or both. If it increases in severity, the plaintiff may develop a psychotic state within a few weeks. (reference 4, pp. 67 and 1252)

**Q: Did you rule out *Cushing's disease (hyperadrenalism)* as a cause of the plaintiff's difficulty falling or staying asleep?**

Plaintiffs often experience emotional changes before physical signs of the disease appear. Depression is the most common symptom. Other psychological symptoms include irritability, anxiety, confusion, **insomnia**, and impaired memory or concentration. Some of the characteristic physical signs include an increased appetite, weakness, buffalo hump, truncal and facial obesity, heightened facial color, and abdominal striae (stripes). (reference 4, pp. 1171-1172)

*If the witness indicates the possibility of Cushing's syndrome, see the section on Cushing's syndrome for further questions.*

**Q: (Female) Did you rule out *menopause* as a cause of the plaintiff's difficulty falling or staying asleep?**

Menopausal distress may cause anxiety, fatigue, GI disturbances, urinary frequency, back pain, palpitations, tension, emotional lability, irritability and nervousness, depression, dizziness, **insomnia**, and hot flashes. (reference 4, p. 1173; reference 9, p. 21)

*If the witness indicates the possibility of menopausal distress, see the section on menopause for further questions.*

**SYMPTOM**

**DEPOSITION QUESTIONS**

**Insomnia**

(continued)

**Q: Did you rule out *muscle contraction headaches* as a cause of the plaintiff's difficulty falling or staying asleep?**

Chronic muscle contraction headaches may produce nausea, vomiting, lightheadedness, **difficulty in falling asleep, restless sleep with frequent awakenings**, loss of energy, impaired memory and concentration, and symptoms of depression. (reference 2, pp. 72-73; reference 4, p. 1204)

*If the witness indicates the possibility of headaches, see the section on headaches for further questions.*

**Q: Did you rule out other *primary insomnia* as a cause of the plaintiff's difficulty falling or staying asleep?**

Primary insomnia involves **difficulty initiating or maintaining sleep or experiencing non-restorative sleep**. This pattern lasts for at least a month. The disorder may be severe enough to cause daytime fatigue, irritability, or an impaired memory and concentration. (reference 7, p. 599-604; reference 2, p. 601)

**Q: Did you rule out *amphetamine or similarly acting sympathomimetic drug withdrawal* as a cause of the plaintiff's difficulty falling or staying asleep?**

Drug withdrawal symptoms may include a dysphoric mood (depression, irritability, anxiety), fatigue, sweating, headaches, **insomnia with nightmares**, hypersomnia, and psychomotor agitation. Symptoms begin after the cessation of prolonged drug use (at least two days) and last more than 24 hours. (reference 7, p. 201; reference 4, p. 1008)

The following drugs may be classified as amphetamines:

|  |   |
|--|---|
| <p>Appetite Suppressants (diet pills)<br/>                 Dextroamphetamines<br/>                 Ma-huang (ephedra)<br/>                 (reference 24, pp. 488-489)</p> | <p>Methamphetamines (speed)<br/>                 Methylphenidates (Ritalin)<br/>                 (reference 17, p. 586)</p> |
|--|---|

**Q: Did you rule out a recent *myocardial infarction (heart attack)* as a cause of the plaintiff's sense of foreshortened future?**

Despondency is almost a universal response to heart attack. Even without complications, the plaintiff may feel a sense of loss (ego infarction), damage, and vulnerability to further injury. Weakness and fatigue are the most distressing symptoms of the condition. The plaintiff may also experience **insomnia**, daytime hypersomnia, and practical worries. Complications cause the plaintiff's despondency and hopelessness to be intensified. (reference 4, pp. 1156-1157)

*If the witness indicates the possibility of a heart attack, see the section on heart attack pre-existing general medical conditions for further questions.*

*SYMPTOM*

*DEPOSITION QUESTIONS*

**Insomnia**  
(continued)

**Q: Did you rule out long-term treatment with adrenal cortical steroids or ACTH as a cause of the plaintiff's difficulty falling or staying asleep?**

Plaintiffs with a long-term history of adrenal cortical steroid or ACTH treatment commonly develop major mental disturbances. While taking the drugs, they may experience euphoria, severe mania, severe depression, delirium, paresthesia (abnormal tightness or tingling around a limb or trunk), **insomnia**, restlessness, or agitation. Symptoms usually disappear when the drugs are reduced or discontinued. (reference 4, p. 876)

**Q: Did you rule out dysthymic disorder (depression) as a cause of the plaintiff's difficulty falling or staying asleep?**

Dysthymic disorder is characterized by chronic depressive symptoms less severe than major depression. Always feeling despondent or melancholic, the plaintiff believes that depression is part of their personality. Other symptoms may include a poor appetite or overeating, **insomnia** or hypersomnia, low energy or fatigue, low self-esteem, poor concentration, difficulty making decisions, and feelings of hopelessness. The disorder may begin in childhood for both sexes, but is more common in adult females. (reference 7, pp. 376-381; reference 4, pp. 803-804)

**Q: Does the plaintiff have any central nervous system or non-central nervous system conditions that may cause the plaintiff's difficulty falling or staying asleep, such as:**

*CNS conditions:*

Degenerative conditions  
Neoplasms

*Non-CNS conditions:*

Endocrine diseases  
Metabolic diseases

**Q: Did you rule out the cessation of medications or substances that have withdrawal symptoms which may cause the plaintiff's difficulty falling or staying asleep, such as:** (reference 4, pp. 67, 1252)

Benzodiazepines  
Depressant medication  
Hypnotics  
Marijuana

Opiates  
Phenothiazines  
Sedating tricyclics  
Tranquilizing agents

**Q: Does the plaintiff have any other medical conditions that may cause difficulty falling or staying asleep, such as:**

Abnormal swallowing  
Asthma  
Cardiovascular symptoms  
Cluster headaches

Gastroesophageal reflux  
Metabolic and pulmonary failures  
Sleep-related painful erections (male)

*SYMPTOM**DEPOSITION QUESTIONS***Insomnia***(continued)*

**Q:** Is the plaintiff taking any medications or substances that may cause difficulty falling or staying asleep, such as:

|                 |              |                  |
|-----------------|--------------|------------------|
| ACCUTANE        | COLESTID     | HALCION          |
| ADALAT          | COMBIPRES    | HALDOL           |
| ADAPIN          | COMBIVENT    | HISTUSSIN        |
| ADDERALL        | COMPAZINE    | HYTRIN           |
| ADIPEX          | CONCERTA     | HYZAAR           |
| AEROBID         | COZAAR       | IMDUR            |
| ALTACE          | CYCRIN       | INDERAL          |
| AMBIEN          | CYLERT       | INDERIDE         |
| AMPHETAMINES    | DALMANE      | INDOCIN          |
| AMYTAL          | DANTRIUM     | IONAMIN          |
| ANAFRANIL       | DECADRON     | KERLONE          |
| ANAPROX         | DEPO-PROVERA | KLONOPIN         |
| ANSAID          | DEPROL       | LESCOL           |
| ARICEPT         | DESOXYN      | LEVAQUIN         |
| ARTHROTEC       | DESYREL      | LEVO-DROMORAM    |
| ASENDIN         | DEXEDRINE    | LEVOTHROID       |
| ATROVENT        | DILACOR      | LEVSIN           |
| AUGMENTIN       | DILANTIN     | LIORESAL         |
| AZULFIDINE      | DIMETANE     | LIPITOR          |
| BACTRIM         | DIOVAN       | LODINE           |
| BELLERGAL       | DITROPAN     | LOPRESSOR        |
| BENADRYL        | DOLOBID      | LOTENSIN         |
| BENTYL          | DONNATAL     | LOTREL           |
| BIPHETAMINE     | DORAL        | LOZOL            |
| BUSPAR          | DURACT       | LUDIOMIL         |
| BUTICAPS        | DURAVENT     | LUFYLLIN-GG      |
| CAFFEINE        | DYNACIRC     | LUVOX            |
| CARAFATE-TOO    | EFFEXOR      | MARPLAN          |
| CARDIZEM        | ELAVIL       | MAVIK            |
| CATAPRES        | ELDEPRYL     | MAXAIR-AUTOHALER |
| CEFZIL          | ENDEP        | MAXALT           |
| CELEBREX        | ENTEXLA      | MAXIDE           |
| CELEXA          | EPHEDRA      | MEBARAL          |
| CELONTIN        | ETRAFON      | MECLOMEN         |
| CHLORAL-HYDRATE | EXCELON      | METHADONE-       |
| CHLORTRIMETON   | FASTIN       | HYDROCHLORIDE    |
| CIPRO           | FELBATOL     | MIRAPEX          |
| CLARITAN-D      | FELDENE      | MODURETIC        |
| CLARITIN        | FLAGYL       | MONOPRIL         |
| CLINDEX         | FLEXERIL     | MORPHINE-SULFATE |
| CLINORIL        | FLOMAX       | MOTRIN           |
| CLONOPIN        | FLOXIN       | NALDECON         |
| CLOZARIL        | GABITRIL     | NALFON           |
| COGNEX          | HABITROL     | NAPROSYN         |

**SYMPTOM****DEPOSITION QUESTIONS****Insomnia***(continued)*

|               |                |            |
|---------------|----------------|------------|
| NAVANE        | PROSOM         | THEO-DUR   |
| NEMBUTAL      | PROTONIX       | THORAZINE  |
| NEURONTIN     | PROVENTIL      | THIAZAC    |
| NICORETTE     | PROVERA        | TIMOPTIC   |
| NOLUDAR       | PULMICORT      | TINDAL     |
| NOREPHEDRINE  | REDUX          | TOFRANIL   |
| NOROXIN       | REGLAN         | TOPAMAX    |
| NORPACE       | RELAFEN        | TOPROL-XL  |
| NORPRAMIN     | REMERON        | TORADOL    |
| NORVASC       | RESTORIL       | TRANXENE   |
| OMNICEF       | REVIA          | TRIAVIL    |
| OPTIMINE      | RISPERDAL      | TRILAFON   |
| ORAP          | RITALIN        | TRILEPTAL  |
| ORNADE        | RONDEC-DM      | TRINALIN   |
| ORUDIS        | RUFEN          | TROVAN     |
| OXYCONTIN     | SANOREX        | TUINAL     |
| PAMELOR       | SANSERT        | VALIUM     |
| PARLODEL      | SECONAL-ELIXIR | VANTIN     |
| PARNATE       | SECONAL-SODIUM | VASOTEC    |
| PBZ-SR        | SELDANE        | VENTOLIN   |
| PEDIAZOLE     | SEPTRA         | VERELAN    |
| PEPCID        | SEREVENT       | VIAGRA     |
| PERIACTIN     | SEROQUEL       | VICOPROFEN |
| PERMAX        | SERTRALINE     | VIOXX      |
| PERMITIL      | SERZONE        | VIVACTIL   |
| PHENOBARBITAL | SINEMET        | VOLTAREN   |
| PHENYL-       | SLO-BID        | WELLBUTRIN |
| PROPANOLAMINE | SLO-PHYLLIN    | XANAX      |
| PLACIDYL      | SOMA           | ZANTAC     |
| PLAVIX        | SOMA-COMPOUND  | ZAROXOLY   |
| PLENDIL       | SONATA         | ZESTORETIC |
| POLARIMINE    | SPORANOX       | ZESTRIL    |
| PONDIMIN      | STADOL         | ZOCOR      |
| PRAVACHOL     | SULAR          | ZOLOFT     |
| PREMPHASE     | SULINDAC       | ZOMIG      |
| PREMPRO       | SURMONTIL      | ZYBAN      |
| PRILOSEC      | SYMMETREL      | ZYLOPRIM   |
| PRINZIDE      | TALECEN        | ZYPREXA    |
| PROAMATINE    | TALWIN-NX      | ZYRTEC     |
| PROKETAZINE   | TAVIST         |            |
| PROPULSID     | TEMARIL        |            |

*SYMPTOM*

*DEPOSITION QUESTIONS*

**Irritability**

**Q:** Describe the plaintiff's irritability or angry outbursts.

**Q:** When and how often does the plaintiff experience irritability or angry outbursts?

**DEFENSE THEORY—IRRITABILITY AND OUTBURSTS OF ANGER:**  
 Also consider personality disorders, medication-effects, general medical illnesses including thyroid, hypertension and hypoglycemia. Look for other life stressors and losses, intermittent explosive disorder, Adjustment Disorder, substance abuse and withdrawal including nicotine and caffeine.

**Q:** Does the plaintiff fear loss of control?

**Q:** Could the moodiness or temper outbursts be the result of external circumstances (stressors), that may normally cause such a reaction?

*If the witness indicates the possibility of other life stressors or circumstances, see the section on other life stressors for further questions.*

**Q:** Does the plaintiff have a history of irritability or angry outbursts before the traumatic event?

**Q:** Does the plaintiff have a history of any *medical conditions* that may cause irritability or angry outbursts?

*The witness may indicate the possibility of the following medical conditions: please refer to the sections pertaining to these medical conditions for further questions.*

**TABLE 5.1-5.**

|                           |                                     |
|---------------------------|-------------------------------------|
| Addison's disease         | Hypoglycemia                        |
| Alzheimer's disease       | Hypothyroidism                      |
| Anemia                    | Menopausal distress                 |
| Brain tumor               | Parkinson's disease                 |
| Combined system disease   | Pernicious anemia                   |
| Creutzfeldt-Jakob disease | Porphyria                           |
| Cushing's syndrome        | Postpartum disorder                 |
| Hypertension              | Subacute sclerosing panencephalitis |
| Hyperthyroidism           | Wilson's disease                    |

**Q:** Did you rule out an *intermittent explosive disorder* as a cause of the plaintiff's irritability or angry outbursts?

An intermittent explosive disorder is characterized by several discrete, **aggressive episodes or loss of control**. The degree of aggressiveness is out of proportion to any of the causing stressors. There is no indication of generalized impulsiveness or

## SYMPTOM

## DEPOSITION QUESTIONS

**Irritability***(continued)*

aggressiveness between the episodes. The plaintiff may describe these events as "spells" or "attacks" and may regret the consequences of the action following each episode. (reference 7, pp. 663-667)

**Q: Did you rule out a *borderline personality disorder* as a cause of the plaintiff's irritability or angry outbursts?**

A borderline personality disorder is characterized by unstable interpersonal relationships, behavior, mood, and self-image. The plaintiff may experience temporary mood shifts including depression, **irritability**, and anxiety. S/he may also have chronic feelings of emptiness or boredom, **inappropriate anger**, and recurrent suicidal thoughts. Social contrariness and a generally pessimistic outlook often accompany the disorder. Premature death may result from suicide. (reference 7, pp. 706-710)

*If the witness indicates the possibility of a borderline personality disorder, see the section on personality disorders for further questions.*

**Q: Did you rule out an *adjustment disorder with depressed mood* as a cause of the plaintiff's irritability or angry outbursts?**

This adjustment disorder is accompanied by depression, tearfulness, sleep disturbance, and feelings of hopelessness to a stressor. **Irritability** is often a component of the depression. It is important to note that an adjustment disorder is a transient over-reaction to stress and should remit within six months. (reference 7, pp. 679-683)

**Q: Did you rule out a *generalized anxiety disorder* as a cause of the plaintiff's irritability or angry outbursts?**

A generalized anxiety disorder is a persistent anxiety that lasts at least six months. The plaintiff has an unrealistic or excessive anxiety about a number of life circumstances. S/he may be anxious about harm coming to a child or having financial difficulties when there is no apparent reason to worry. Symptoms include muscle tension, restlessness or feeling keyed up, fatigue, difficulty concentrating, sleep disturbance, and **irritability**. (reference 7, pp. 472-476)

*If the witness indicates the possibility of a generalized anxiety disorder, see the section on generalized anxiety disorder for further questions.*

**Q: Did you rule out *antisocial personality disorder* as a cause of the plaintiff's irritability or angry outbursts?**

The antisocial plaintiff may have a lifetime history of irresponsible and antisocial behavior. Childhood behaviors may include lying, stealing, truancy, vandalism, **initiating fights**, running away from home, and physical cruelty. Adolescents may also become abusers of tobacco, alcohol, and other drugs, or engage in early sexual activity. Adults with antisocial personalities tend to be **irritable, aggressive**, reckless, and promiscuous. They may be unable to keep a job, friendship, or sexual relationship. The plaintiff shows no remorse or guilt when hurting or mistreating others. Frequently this disorder is accompanied by signs of personal distress,

## SYMPTOM

## DEPOSITION QUESTIONS

**Irritability***(continued)*

tension, an inability to tolerate boredom, depression, a conviction that others are hostile, and suicidal attempts. (reference 7, pp.701-706; reference 4, pp. 1865, 1868-1869)

*If the witness indicates the possibility of any personality disorder or maladaptive traits, see the section on personality disorders for further questions.*

**Q: Did you rule out *inhalant intoxication* as a cause of the plaintiff's irritability or angry outbursts?**

Following *inhalant (toxic substance)* use, the plaintiff may experience behavioral and physical changes. Behavioral changes may include belligerence, **assaultiveness**, apathy, impaired judgment, and impaired social or occupational functioning. Physical signs may include dizziness, nystagmus, slurred speech, unsteady gait, lethargy, depressed reflexes, tremor, psychomotor weakness, blurred vision or diplopia, stupor or coma, and euphoria. (reference 7, pp. 259-260)

**Q: Did you rule out *opioid withdrawal* as a cause of the plaintiff's irritability or angry outbursts?**

Symptoms of *opioid withdrawal* may include lacrimation (tearing), rhinorrhea (runny nose), dilated pupils, sweating, diarrhea, yawning, mild hypertension, tachycardia (increased heart rate), fever, insomnia, and gooseflesh. Associated features may include restlessness, **irritability**, depression, tremor, weakness, nausea, vomiting, and muscle or joint pain. These signs, often resembling influenza symptoms, may be precipitated by the abrupt ending of one or two weeks of continuous opiate use. The withdrawal symptoms may last days or weeks. During the final stages of withdrawal, the plaintiff may experience overconcern for bodily discomfort, poor self-image, and a decreased ability to tolerate stress. (reference 7, pp. 272-273; reference 4, pp. 990-991)

**Q: Did you rule out *niacin deficiency (B complex)* as a cause of the plaintiff's irritability or angry outbursts?**

Niacin is one of the B complex vitamins essential for the normal carbohydrate metabolism of yeast cells and animal tissues. As the body's level of niacin decreases, the plaintiff may initially experience a burning tongue after eating hot or spicy foods. Symptoms are often more severe in the spring and fall and may be associated with mild anorexia, fatigue, nervousness, **irritability**, alternating periods of constipation and diarrhea, or burning sensations in the epigastrium (upper and middle abdomen). (reference 2, pp. 121-123)

**Q: Did you rule out *nicotine withdrawal* as a cause of the plaintiff's irritability or angry outbursts?**

*Nicotine withdrawal* symptoms include a strong craving for nicotine, anxiety, **irritability**, frustration or **anger**, impaired attention, coughing, headaches, insomnia, a mental preoccupation with actions associated with tobacco use, restlessness, drowsiness, gastrointestinal disturbances, an increased appetite, and weight gain. The symptoms appear within 24 hours after the cessation or reduction in the use of cigarettes, cigars, pipes, chewing tobacco, or nicotine gum. The plaintiff experiences

## SYMPTOM

## DEPOSITION QUESTIONS

**Irritability***(continued)*

a decrease in the intensity of the symptoms with time. (reference 7, pp. 265-266; reference 4, pp. 1031-1032)

**Q: Did you rule out *alcohol withdrawal* as a cause of the plaintiff's irritability or angry outbursts?**

The *reduction or cessation* of drinking for at least several days may cause characteristic symptoms: coarse tremor of hands, tongue, or eyelids; nausea or vomiting; malaise or weakness; autonomic hyperactivity (tachycardia, sweating, and elevated blood pressure); anxiety, depressed mood or **irritability**; transient hallucinations or illusions; headache; insomnia; dizziness; fatigue; restlessness; and agitation. (reference 7, pp. 215-216; reference 2, pp. 722, 618; reference 9, pp. 50-54)

**Q: Did you rule out *amphetamine or similarly acting sympathomimetic drug consumption or withdrawal* as a cause of the plaintiff's irritability or angry outbursts?**

Symptoms of amphetamine or similarly acting sympathomimetic *drug consumption* may include **fighting**, grandiosity, elation, hypervigilance, psychomotor agitation, impaired judgment, and impaired social or occupational functioning. Physical symptoms may include flushing, difficulty breathing, tachycardia, pupil dilation, elevated blood pressure, sweating or chills, nausea, and vomiting. (reference 4, pp. 1007-1008; reference 7, pp. 223-227)

*Drug withdrawal* symptoms may include a dysphoric mood (depression, **irritability**, anxiety), fatigue, sweating, headaches, insomnia with nightmares, hypersomnia, and psychomotor agitation. Symptoms begin after the cessation of prolonged drug use (at least two days) and last more than 24 hours. (reference 7, pp. 227-228; reference 4, p. 1008)

The following drugs may be classified as amphetamines:

|                                    |                            |
|------------------------------------|----------------------------|
| Appetite Suppressants (diet pills) | Methamphetamines (speed)   |
| Dextroamphetamines                 | Methylphenidates (Ritalin) |
| Ma-huang (ephedra)                 | (reference 17, p. 586)     |
| (reference 24, pp. 488-489)        |                            |

**Q: (Female) Did you rule out *premenstrual dysphoric disorder* as a cause of the plaintiff's irritability or angry outbursts?**

Premenstrual dysphoric disorder is characterized by emotional and behavioral symptoms which usually occur during the last week before the menstrual cycle and remit within a few days after menses begins. Symptoms may include tears, sadness, **irritability**, **anger**, tension, depression, self-deprecating thoughts, decreased interest in usual activities, fatigability, loss of energy, a subjective sense of difficulty in concentration, changes in appetite, and sleep disturbance. Physical symptoms may also include breast tenderness or swelling, tachycardia, sweating, headaches, joint or muscle pain, a sensation of bloating, or weight gain. (reference 7, pp. 771-774; reference 18, pp. 1955)

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*SYMPTOM*

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*DEPOSITION QUESTIONS*

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**Irritability***(continued)*

**Q: Did you rule out *attention-deficit hyperactivity disorder (ADHD)* as a cause of the plaintiff's irritability and angry outbursts?**

The essential characteristics of ADHD include inattention, impulsiveness, and hyperactivity. ADHD is usually diagnosed during elementary school years, and can persist throughout childhood. Persons diagnosed with ADHD have a higher prevalence of mood and anxiety disorders, learning disorders, substance-related disorders and the potential for the development of an antisocial personality disorder. Approximately one-third of the children diagnosed with ADHD show some signs of the disorder in adulthood. Associated symptoms may include low self-esteem, mood lability, **low frustration tolerance**, and **temper outbursts**. (reference 7, pp. 85-93)

**Q: Did you rule out *riboflavin deficiency (ariboflavinosis)* as a cause of the plaintiff's irritability or angry outbursts?**

Riboflavin is one of the B complex vitamins essential for the normal carbohydrate metabolism of yeast cells and animal tissues. Initial oral symptoms include a mild burning sensation in the tongue, oral lesions, and buccal mucosa of the cheeks. Other symptoms are sore and cracking lips, burning and itching eyes, loss of appetite, weakness, and **irritability**. (reference 2, pp. 121, 124-125)

**Q: Did you rule out *primary insomnia* as a cause of the plaintiff's irritability or angry outbursts?**

Primary insomnia involves difficulty initiating or maintaining sleep or experiencing non-restorative sleep. This pattern lasts for at least a month. The disorder may be severe enough to cause daytime fatigue, **irritability**, or an impaired memory and concentration. (reference 7, p. 599-604; reference 2, p. 601)

**Q: (Female) Did you rule out *menopause* as a cause of the plaintiff's irritability or angry outbursts?**

Menopausal distress may cause anxiety, fatigue, GI disturbances, urinary frequency, back pain, palpitations, tension, emotional lability, **irritability** and nervousness, depression, dizziness, insomnia, and hot flashes. (reference 4, p. 1173; reference 9, p. 21)

*If the witness indicates the possibility of menopausal distress, see the section on menopausal for further questions.*

**Q: Did you rule out an *allergic reaction* as a cause of the plaintiff's irritability or angry outbursts?**

Allergic rhinitis is a seasonal or perennial inflammatory disease of the nasal membranes. Symptoms may include: sneezing, a stuffy and itching nose, postnasal drainage, and itching eyes. The plaintiff with allergies may feel generally ill and uncomfortable, tired, weak, despondent, **irritable**, and uninterested in eating. (reference 9, pp. 1867-1868)

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*SYMPTOM*

*DEPOSITION QUESTIONS*

**Irritability**

(continued)

**Q: Did you rule out *pernicious anemia* as a cause of the plaintiff's irritability or angry outbursts?**

Pernicious anemia results from a lack of vitamin B12. The disease slowly causes both physical and mental symptoms. The plaintiff may experience feelings of depression, worthlessness and guilt, **irritability**, paranoia, and a loss of memory. Physical symptoms may include anorexia, abdominal pain, intermittent constipation and diarrhea, weight loss, and weakness. Pernicious anemia often leads to combined systems disease. (reference 4, p. 1276; reference 1, pp. 1077-1079; reference 2, pp. 576, 570)

**Q: Does the plaintiff have any *other medical conditions* that may cause irritability or angry outbursts, such as:**

Cardiovascular disease  
 Central nervous system disease  
 Metabolic and pulmonary failures

**Q: Is the plaintiff taking any *medications or substances* that may cause irritability or angry outbursts, such as:**

|               |             |               |
|---------------|-------------|---------------|
| AEROBID       | ELDEPRYL    | SLO-BID       |
| AMPHETAMINES  | FIORICET    | SLO-PHYLLIN   |
| ANAFRANIL     | FLAGYL      | SOMA          |
| ARICEPT       | GABITRIL    | SOMA-COMPOUND |
| ARTHROTEC     | GUAIFED     | SYMMETREL     |
| BENADRYL      | HALCION     | TALECEN       |
| BROMFED       | LOZOL       | TALWIN-NX     |
| BUSPAR        | LUFYLLIN-GG | TAVIST        |
| CELONTIN      | MAXALT      | THEO-DUR      |
| CHLORTRIMETON | MECLIZINE   | TRANXENE      |
| CIPRO         | MESANTOIN   | TRINALIN      |
| CLARITAN-D    | OPTIMINE    | VENTOLIN      |
| CLOMID        | ORNADE      | VOLTAREN      |
| CLOZARIL      | PBZ-SR      | YOCON         |
| CYLERT        | PERIACTIN   | ZARONTIN      |
| CYTOMEL       | PLENDIL     | ZEPHREX       |
| DALMANE       | POLARIMINE  | ZESTORETIC    |
| DESOXYN       | PROVENTIL   | ZESTRIL       |
| DIMETANE      | PULMICORT   | ZOMIG         |
| DIMETAPP      | REVIA       | ZYBAN         |
| DORAL         | SELDANE     |               |
| DURAVENT      | SKELAXIN    |               |

**Difficulty Concentrating**

**Q: Describe the plaintiff's difficulty concentrating.**

**Q: When and how often does the plaintiff have difficulty concentrating?**

*SYMPTOM*

*DEPOSITION QUESTIONS*

**Difficulty Concentrating**

*(continued)*

**DEFENSE THEORY—DIFFICULTY CONCENTRATING:** Routinely caused by depression and anxiety, medications, many diseases and illnesses, dementia of any type, Adjustment Disorders, specific cerebrovascular disease, headaches, personality disorders and life-long learning deficits. This problem may have pre-existed the accident.

**Q:** Does the plaintiff have a history of difficulty concentrating before the traumatic event?

**Q:** Has the plaintiff completed any course work (school work) since the claimed trauma?

If so, did the plaintiff pass or fail?

**Q:** Does the plaintiff have a history of any *medical conditions* that may cause difficulty concentrating?

*The witness may indicate the possibility of the following medical conditions: please refer to the sections pertaining to these medical conditions for further questions.*

**TABLE 5.1-6.**

|                          |                                     |
|--------------------------|-------------------------------------|
| Addison's disease        | Hypotension                         |
| Combined systems disease | Hypothyroidism                      |
| Cushing's syndrome       | Multiple sclerosis                  |
| Epilepsy                 | Pernicious anemia                   |
| Hepatic encephalopathy   | Polycythemia                        |
| HIV                      | Porphyria                           |
| Huntington's disease     | Postpartum disorder                 |
| Hypertension             | Subacute sclerosing panencephalitis |
| Hyperthyroidism          | Uremic encephalopathy               |
| Hypoglycemia             | Wilson's disease                    |

**Q:** Did you rule out *other life difficulties or stressors* as a cause of the plaintiff's difficulty concentrating?

*If the witness indicates the possibility of a life stressor or other condition, see the section on life stressors for further questions.*

**Q:** Did you rule out *depressive pseudodementia* as a cause of the plaintiff's difficulty concentrating?

Cognitive disturbances seen in severe major depressive episodes are usually referred to as depressive pseudodementia. Treatment for the depression can restore both mood and memory to normal. Anxiety, irritability, a loss of social skills, and **memory gaps** for specific periods or events are characteristic symptoms. (reference 4, pp. 150-151; reference 18, p. 809)

## SYMPTOM

## DEPOSITION QUESTIONS

**Difficulty Concentrating***(continued)***Q: Did you rule out *dementia of the Alzheimer's type* as a cause of the plaintiff's difficulty concentrating?**

This primary degenerative dementia is caused by Alzheimer's disease. The plaintiff's **intellectual abilities**, personality, and behavior progressively deteriorate. Depressive symptoms may complicate the condition. (reference 7, pp. 154-158)

*Age at onset: Senile onset (after age 65) is much more common than pre-senile onset. Few cases develop before the age of 49.*

**Q: Did you rule out *vascular dementia* as a cause of the plaintiff's difficulty concentrating?**

Vascular dementia is caused by cerebrovascular disease (disease of the brain's blood supply or blood vessels) that quickly produces an irregular deterioration in intellectual functioning. The resulting dementia involves **disturbances in memory, abstract thinking**, judgment, impulse control, and personality. Combined with depression, the dementia often causes many cognitive symptoms. (reference 7, p. 158)

**Q: Did you rule out a *generalized anxiety disorder* as a cause of the plaintiff's difficulty concentrating?**

A generalized anxiety disorder is a persistent anxiety that lasts at least a number of months. The plaintiff has an unrealistic or excessive worry about two or more life circumstances. They may be anxious about harm coming to a child or having financial difficulties when there is no apparent reason to worry. Symptoms include muscle tension, restlessness or feeling keyed up, fatigue, **difficulty concentrating**, sleep disturbance, and irritability. (reference 7, pp. 472-476)

**Q: Did you rule out an *adjustment disorder with depressed mood* as a cause of the plaintiff's difficulty concentrating?**

This adjustment disorder is accompanied by depression, tearfulness, sleep disturbance, and feelings of hopelessness to a stressor. **Difficulty concentrating** is often a component of the depression. It is important to note that an adjustment disorder is a transient over-reaction to stress and should remit within six months. (reference 7, pp. 679-683)

**Q: Did you rule out an *adjustment disorder with anxiety* as a cause of the plaintiff's difficulty concentrating?**

An adjustment disorder is a transient over-reaction to stress that usually occurs within 90 days and remits within six months. The adjustment disorder with anxiety is characterized by symptoms of nervousness, worry, jitteriness, and motor tension. **Difficulty concentrating** is often a component of anxiety. (reference 7, pp. 679-683; reference 4, pp. 1098-1099)

*If the witness indicates the possibility of an adjustment disorder, see the section on adjustment disorders for further questions.*

## SYMPTOM

## DEPOSITION QUESTIONS

**Difficulty Concentrating***(continued)***Q: Did you rule out *dysthymic disorder* (depression) as a cause of the plaintiff's difficulty concentrating?**

Dysthymic disorder is characterized by chronic depressive symptoms less severe than major depression. Always feeling despondent or melancholic, the plaintiff believes that depression is part of their personality. Other symptoms may include a poor appetite or overeating, insomnia or hypersomnia, low energy or fatigue, low self-esteem, **poor concentration**, difficulty making decisions, and feelings of hopelessness. The disorder may begin in childhood for both sexes, but is more common in adult females. (reference 7, pp. 376-381; reference 4, pp. 803-804)

*If the witness indicates the possibility of a dysthymic disorder, see the section on dysthymic disorder for further questions.*

**Q: Did you rule out the *depressive phase of a Bipolar disorder* as a cause of the plaintiff's difficulty concentrating?**

A Bipolar disorder has a circular pattern of high and low emotional states (*mania and depression*). During the *manic episodes*, the plaintiff may feel grandiose, have a decreased need for sleep, and decreased emotional capacity, experience a surge of ideas and conversation, and may be **easily distracted** or pleased. It is often thought that the manic high represents an escape from inner depression and pain. While the plaintiff is extremely active, s/he is often fragmented and unable to finish projects. The plaintiff typically does not realize that s/he is ill.

During *major depressive episodes* the plaintiff may be depressed for at least two weeks. The plaintiff may experience an appetite disturbance, weight change, sleep disturbance, psychomotor agitation or retardation, decreased energy, feelings of worthlessness, **difficulty thinking or concentrating**, and recurrent thoughts of death or suicide. (reference 4, pp. 408-409, 761; reference 7, pp. 382-391)

**Q: Did you rule out an *obsessive compulsive disorder* as a cause of the plaintiff's difficulty concentrating?**

The obsessive compulsive plaintiff has persistent unwanted and **uncontrolled thoughts** or impulses that may be characterized by violence, contamination, or doubt. These obsessions often cause the plaintiff to feel anxious. The plaintiff's repeated compulsive behaviors are attempts to control the impulses and the accompanying anxiety. Other symptoms may include an exclusive devotion to work or productivity, depression, anxiety, and restlessness. (reference 4, pp. 910-911; reference 7, pp. 456-463)

*If the witness indicates the possibility of an obsessive compulsive disorder, see the section on OCD for further questions.*

*NOTE: In addition to the obsessive compulsive disorder, there is an obsessive compulsive personality disorder. The personality disorder does not have true obsessions and compulsions, but has a clear pattern of perfectionism and rigidity. If the witness indicates the possibility of an obsessive compulsive personality disorder see the section on personality disorders for further questions.*

## SYMPTOM

## DEPOSITION QUESTIONS

**Difficulty Concentrating***(continued)***Q: Did you rule out a *schizotypal personality disorder* as a cause of the plaintiff's difficulty concentrating?**

A schizotypal personality has oddities of thinking, perception, communication, and behavior that resemble schizophrenia. The plaintiff may experience anxiety, depression, and other dysphoric moods that **disrupt concentration** and the ability to function socially or at work. S/he may have few close friends except for immediate family. (reference 7, pp. 697-701)

*If the witness indicates a schizotypal personality disorder, see the section on personality disorders for further questions.*

**Q: Did you rule out *anemia* as a cause of the plaintiff's difficulty concentrating?**

Vertigo, pounding headaches, fainting, dimness of vision, tinnitus (a ringing in one or both ears), irritability, restlessness, **inability to concentrate**, lethargy, fatigue, drowsiness, GI complaints, and congestive heart failure are common symptoms of anemia. (reference 2, pp. 566-571)

**Q: Did you rule out *muscle contraction headaches* as a cause of the plaintiff's difficulty concentrating?**

Chronic muscle contraction headaches may produce nausea, vomiting, light headedness, difficulty in falling asleep, restless sleep with frequent awakenings, loss of energy, **impaired memory and concentration**, and symptoms of depression. (reference 2, pp. 72-73; reference 4, p. 1204)

**Q: Did you rule out *hypothyroidism* as a cause of the plaintiff's inability to recall important aspects of the trauma?**

Hypothyroidism results from inadequate synthesis of thyroid hormone. Hypothyroidism can produce psychiatric, as well as physical symptoms. The most notable psychiatric symptoms include depression, lethargy, **poor concentration**, impaired memory, apathy, and syncope. The numerous physical symptoms are: cold intolerance, constipation, muscle cramps, paresthesias, menstrual disorders, dyspnea, dizziness, reduced hearing, poor appetite, weight gain, brittle and thinning hair, and bradycardia (slowed heart action). Panic attacks are associated with endocrinological disorders including hypothyroidism and hyperthyroidism. (reference 18, pp. 743, 1810-1812, 1928)

**Q: Did you rule out *migraine headaches* as a cause of the plaintiff's difficulty concentrating?**

A classic migraine (vascular) headache may be accompanied by visual disturbances, sensory motor or speech disturbances, nausea or vomiting, **impaired concentration**, and emotional changes. On rare occasions, the plaintiff may experience depersonalization or derealization. Migraine headaches may be precipitated by: (reference 4, p. 1204; reference 2, pp. 65-66)

- Emotional conflicts or stress
- Fluctuating estrogen levels in women
- Birth control pills

---

*SYMPTOM*

---

*DEPOSITION QUESTIONS*

---

**Difficulty  
Concentrating***(continued)*

- Food:
    - Monosodium glutamate (Chinese restaurant syndrome)
    - Tyramine-containing foods (cheese or other fermented dairy products and chocolate)
    - Phenylethylamine-containing foods
- 

**Q: (Female) Did you rule out *premenstrual dysphoric disorder* as a cause of the plaintiff's difficulty concentrating?**

Premenstrual dysphoric disorder is characterized by emotional and behavioral symptoms which usually occur during the last week before the menstrual cycle and remit within a few days after menses begins. Symptoms may include tears, sadness, irritability, anger, tension, depression, self-deprecating thoughts, decreased interest in usual activities, fatigability, loss of energy, a **subjective sense of difficulty in concentration**, changes in appetite, and sleep disturbance. Physical symptoms may also include breast tenderness or swelling, tachycardia, sweating, headaches, joint or muscle pain, a sensation of bloating, or weight gain. (reference 7, pp. 771-774; reference 18, pp. 1955)

---

*Note: The following question is to be asked if the plaintiff has experienced the loss of a family member or a close friend during the past two years.*

**Q: Did you rule out *bereavement* as a cause of the plaintiff's difficulty concentrating?**

Mourning is a normal grief reaction to a loss, such as the death of a loved one. The plaintiff may feel depressed and dejected, have diminished interest in the outside world, a decreased capacity to love, and an inhibition of activity. People tend to feel as if all their **energy is taken up with thoughts and memories of the loss**. Fatigue and weariness are characteristic symptoms. Sighing, feeling empty, **disinterested**, listless, eating more or less than normal, losing weight, and having trouble sleeping are common experiences. (reference 4, pp. 1286-1293; reference 7, pp. 740-741; reference 2, p. 617)

---

**Q: Did you rule out a *major depressive episode* as a cause of the plaintiff's difficulty concentrating?**

A major depressive episode is characterized by either a depressed mood or a loss of interest and pleasure in most activities. Symptoms last for at least two weeks and can be distinguished from normal behavior. The plaintiff may feel tired and lethargic. Other common symptoms may include weight loss or gain; a decrease or increase in appetite; psychomotor agitation or retardation; feelings of worthlessness or excessive guilt; a **decreased ability to concentrate or make decisions**; and frequent thoughts of hopelessness, death and suicide.

Depression typically affects sleep. The plaintiff may be awake repeatedly during the second half of the night and may awaken in early morning with uncomfortable feelings. Morning is the worst time of day for the plaintiff experiencing depression. (reference 4, pp. 794, 1251; reference 2, pp. 615-616; reference 7, pp. 349-356)

*If the witness indicates the possibility of a major depressive episode, see the section on major depression for further questions.*

---

## SYMPTOM

## DEPOSITION QUESTIONS

**Difficulty Concentrating***(continued)***Q: Did you rule out *nicotine withdrawal* as a cause of the plaintiff's difficulty concentrating?**

Nicotine withdrawal symptoms include a strong craving for nicotine, anxiety, irritability, frustration or anger, **impaired attention**, coughing, headaches, insomnia, a **mental preoccupation** with actions associated with tobacco use, restlessness, drowsiness, gastrointestinal disturbances, an increased appetite, and weight gain. The symptoms appear within 24 hours after the cessation or reduction in the use of cigarettes, cigars, pipes, chewing tobacco, or nicotine gum. The plaintiff experiences a decrease in the intensity of the symptoms with time. (reference 7, pp. 265-266; reference 4, pp. 1031-1032)

**Q: Did you rule out *systemic lupus erythematosus* as a cause of the plaintiff's difficulty concentrating?**

Systemic lupus erythematosus (SLE) causes inflammation in body organs such as the kidneys and the tissue surrounding the heart, lungs, thoracic cavity and blood vessels. The plaintiff may become depressed, **confused** and have other **thought disorders**. Physical symptoms may include anorexia, fatigue, fever, migraine headaches, and weight loss. (reference 9, pp. 1924-1928; reference 1, pp. 1207-1209)

*If the witness indicates the possibility of systemic lupus erythematosus, see systemic lupus erythematosus in the pre-existing medical condition section for further questions.*

**Q: Did you rule out *chronic fatigue syndrome* as a cause of the plaintiff's difficulty concentrating?**

Chronic fatigue syndrome presents with six months or more of severe, debilitating fatigue accompanied by myalgia, headaches, pharyngitis, low-grade fever, cognitive complaints, gastrointestinal symptoms, and tender lymph nodes. There is a high rate (15-54%) of depressive disorders among patients with chronic fatigue syndrome. Persons most likely to be plagued by persistent fatigue after an acute viral illness are patients with pre-existing or co-morbid psychiatric problems. Chronic fatigue syndrome is considered to be a special class of mood disorder with somatic symptoms. (reference 18, pp. 1531-1532)

**Q: Did you rule out a *brain tumor (intracranial tumors)* as a cause of the plaintiff's difficulty concentrating?**

Brain tumors occur in the skull, brain, or membrane covering the brain or spinal cord. Symptoms vary depending on the size of the tumor and rate of growth. The plaintiff may experience anxiety, **dementia**, irritability, dizziness, fatigue, headache, vomiting, hyperthermia (high body temperature), and changes in appetite and personality. (reference 4, pp. 139, 834-835, 855, 860, 1276; reference 9, pp. 2161-2164; reference 1, pp. 1351, 1296)

*If the witness indicates the possibility of a brain tumor, see the section on brain tumors for further questions.*

# Posttraumatic Stress Disorder (PTSD)

*SYMPTOM*

*DEPOSITION QUESTIONS*

**Difficulty Concentrating**

*(continued)*

**Q: Did you rule out *HIV-associated dementia or HIV-associated mild neurocognitive disorder* as a cause of the plaintiff's easy fatigability?**

HIV dementia is a severe cognitive disorder that interferes substantially with work, home life and social activities. Symptoms of mild neurocognitive disorder associated with HIV infection include difficulty concentrating, unusual fatigability with demanding mental tasks, feeling slowed down and **memory difficulties**. Problem solving, abstract reasoning, and motor performance may also be affected. (reference 18, pp. 308-316; reference 7, p. 163)

**Q: Is the plaintiff taking any *medications or substances* that may cause difficulty concentrating, such as:**

|             |            |            |
|-------------|------------|------------|
| ARTHROTEC   | ETRAFON    | TIMOPTIC   |
| ASENDIN     | EXCELON    | TRIAVIL    |
| BUSPAR      | GABITRIL   | TRILEPTAL  |
| CARDURA     | HABITROL   | TROVAN     |
| CELEXA      | IMDUR      | ULTRAM     |
| CLARITAN-D  | KERLONE    | VIVACTIL   |
| CLARITIN    | LEVAQUIN   | WELLBUTRIN |
| CODEINE     | LIMBITROL  | ZARONTIN   |
| CYCLOSPORIN | PAXIL      | ZIAC       |
| DEPROL      | RESTORIL   | ZOLOFT     |
| DESYREL     | RISPERDAL  | ZYRTEC     |
| ELAVIL      | SERTRALINE |            |
| ENDEP       | SERZONE    |            |

**Hypervigilance**

**Q: Describe the plaintiff's excessive watchfulness (hypervigilance).**

**Q: When and how often is the plaintiff watchful?**

**Q: Could there be other reasons for the plaintiff's excessive watchfulness?**

**Q: Does the plaintiff have a history of *excessive watchfulness* before the traumatic event?**

**DEFENSE THEORY—HYPERVIGILANCE & EXAGGERATED STARTLE RESPONSE:** Also can be caused by general anxiety, paranoid personality, hearing disorder, paranoid mental disorders, street drugs and medications and hyperreflexia (jumpiness) (rare).

**Q: Did you rule out other *life difficulties or stressors* as a cause of the plaintiff's excessive watchfulness?**

*If the witness indicates the possibility of a life stressor or other condition, see the section on other life stressors for further questions.*

*SYMPTOM*

*DEPOSITION QUESTIONS*

**Hypervigilance**  
(continued)

**Q: Does the plaintiff have a history of any *medical conditions* that may cause excessive watchfulness?**

*The witness may indicate the possibility of the following medical conditions: please refer to the sections pertaining to these medical conditions for further questions.*

**TABLE 5.1-7.**

|  |                   |
|--|-------------------|
| Cushing's syndrome<br>Huntington's disease | Pernicious anemia |
|--|-------------------|

**Q: Did you rule out a *childhood overanxious disorder* as a cause of the plaintiff's excessive watchfulness?**

A child with an overanxious disorder has **excessive anxiety** or **worry** for at least six months. Overanxious disorder has been subsumed under Generalized Anxiety Disorder (GAD) in the DSM-IV-TR. Only one of six symptoms of **restlessness or feeling keyed up**, fatigue, difficulty with concentration, irritability, muscle tension, and sleep disturbance is required to make the diagnosis of generalized anxiety disorder in children. Affected older children and adolescents have more symptoms than younger children. GAD in children is distinguished from other anxiety disorders on the basis of persistent symptoms and a lack of specific focus for the anxiety. The real worries of children who are ill, poor, or with impaired parents must not be confused with GAD. (reference 7, pp. 472-476; reference 4, pp. 1752-1754; reference 18, p. 2773-4)

*Defense counsel should obtain the plaintiff's early school and health records to look for evidence of this disorder.*

**Q: Did you rule out a *generalized anxiety disorder* as a cause of the plaintiff's excessive watchfulness?**

A generalized anxiety disorder is a persistent anxiety that lasts at least six months. The plaintiff has an unrealistic or excessive anxiety about a number of life circumstances. S/he may be anxious about harm coming to a child or having financial difficulties when there is no apparent reason to worry. Symptoms include muscle tension, **restlessness or feeling keyed up**, fatigue, difficulty concentrating, sleep disturbance, and irritability. (reference 7, pp. 472-476)

*If the witness indicates the possibility of a generalized anxiety disorder, see the section on generalized anxiety disorder for further questions.*

**Q: Did you rule out a *paranoid personality disorder* as a cause of the plaintiff's excessive watchfulness?**

The paranoid plaintiff has a history of unwarranted suspicion and mistrust of others. Often **expecting to be exploited or harmed**, s/he may be excessively sensitive, jealous, **hypervigilant**, and tense. The plaintiff may find it difficult to relax or forgive, and is argumentative when threatened by innocent remarks or events. His or her mood is often humorless, cold and unemotional. These plaintiffs rarely seek help

*SYMPTOM*

*DEPOSITION QUESTIONS*

**Hypervigilance**

(continued)

because of a tendency to be moralistic, grandiose, and extra punitive. (reference 7, pp. 690-694; reference 4, pp. 748-753)

*If the witness indicates the possibility of a paranoid personality disorder or other maladaptive traits, see the section on personality disorders for further questions.*

**Q: Did you rule out cocaine consumption as a cause of the plaintiff's excessive watchfulness?**

*Cocaine users* often experience increased energy and confidence or irritability and **paranoia** with physical aggressiveness. Other behavioral symptoms may include euphoria, **hypervigilance**, psychomotor agitation, impaired judgment, and impaired social or occupational functioning. Physical symptoms may include tachycardia, dilated pupils, elevated blood pressure, perspiration or chills, nausea, vomiting, and hallucinations.

The abrupt *cessation or reduction of cocaine*, after several days use, may cause the plaintiff to feel tired, dysphoric, irritable, depressed, and to crave more of the drug. An anxiety reaction may cause psychomotor agitation, insomnia or hypersomnia, high blood pressure, tachycardia, and **paranoia**. The symptoms may persist for more than a day. (reference 7, pp. 241-245; reference 4, pp. 1008-1009)

**Q: Did you rule out the early or prodromal symptoms of schizophrenia-paranoid type as a cause of the plaintiff's excessive watchfulness?**

Schizophrenia-paranoid type is characterized by delusions of persecution or grandeur. The plaintiff is typically **anxious, suspicious**, guarded, reserved, and often hostile, aggressive, or violent. S/he does not have the other symptoms of schizophrenia such as incoherence, inappropriate affect, catatonic, or disorganized behavior. (reference 7, pp. 313-314; reference 4, pp. 694-695)

*If the witness indicates the possibility of schizophrenia-paranoid type, see the section on schizophrenia for further questions.*

**Q: Is the plaintiff taking any medications or substances that may cause excessive watchfulness, such as:**

|            |           |           |
|------------|-----------|-----------|
| AMBIEN     | LEVAQUIN  | TINDAL    |
| ANAFRANIL  | LUDIOMIL  | TRILAFON  |
| ARTANE     | MICRO-K   | TRILEPTAL |
| CELEXA     | PERMITIL  | VALTREX   |
| CLARITAN-D | PULMICORT | ZARONTIN  |
| CRINONE    | RISPERDAL | ZYPREXA   |
| ETRAFON    | SANSERT   |           |
| EXCELON    | SINEMET   |           |

**Exaggerated Startle Response**

**Q: Describe the plaintiff's exaggerated startle response.**

**Q: When and how often does the plaintiff have an exaggerated startle response?**

SYMPTOM

DEPOSITION QUESTIONS

**Exaggerated Startle Response**  
(continued)

**Q:** Could the plaintiff's response be normal for the stimuli?

**DEFENSE THEORY—PHYSIOLOGICAL REACTIVITY:** The physiological symptoms may actually be from a non-related medical condition, medication side-effect, phobia or anxiety

**Q:** Does the plaintiff have a history of an *exaggerated startle response* before the traumatic event?

**Q:** Did you rule out *other life difficulties or stressors* as a cause of the plaintiff's **exaggerated startle response**?

*If the witness indicates the possibility of a life stressor or other condition, see the section on other life stressors for further questions.*

**Q:** Did you rule out *genetic hyperexplexia (jumpiness)* as a cause of the plaintiff's **exaggerated startle response**?

Genetic hyperexplexia is a rare disorder.

**Q:** Did you rule out a *generalized anxiety disorder* as a cause of the plaintiff's **exaggerated startle response**?

A generalized anxiety disorder is a persistent anxiety that lasts at least six months. The plaintiff has an unrealistic or excessive worry about two or more life circumstances. S/he may be anxious about harm coming to a child or having financial difficulties when there is no apparent reason to worry. Symptoms include muscle tension, **restlessness or feeling keyed up**, fatigue, difficulty concentrating, sleep disturbance, and irritability. (reference 7, pp. 472-476)

*If the witness indicates the possibility of a generalized anxiety disorder, see the section on generalized anxiety disorder for further questions.*

**Q:** Did you rule out *hyperthyroidism* as a cause of the plaintiff's **feeling keyed up**?

Hyperthyroidism, or thyrotoxicosis, results from overproduction of thyroid hormone by the thyroid gland. The most common cause is Graves' disease. The signs and symptoms of hyperthyroidism include both physical and psychiatric complaints. Psychiatric features include nervousness, fatigue, insomnia, mood lability, and dysphoria. There may be a heightened activity level. Cognitive symptoms include a short attention span, impaired recent memory, and an **exaggerated startle response**.

Physical signs and symptoms of hyperthyroidism include increased pulse, arrhythmias (irregular heart rhythm), elevated blood pressure, fine tremor, heat intolerance, excessive sweating, increased appetite, weight loss, palpitations (abnormal rapid beating of heart), tachycardia (rapid heart beat), frequent bowel movements, menstrual irregularities, and muscle weakness. Panic attacks are associated with endocrinological disorders including hyperthyroidism, as well as hypothyroidism. (reference 18, pp. 743, 1809-1810, 1928)

*SYMPTOM*

*DEPOSITION QUESTIONS*

**Exaggerated Startle Response**  
(continued)

**Q: Did you rule out an *adjustment disorder with anxiety* as a cause of the plaintiff's exaggerated startle response?**

An adjustment disorder is a *transient over-reaction* to stress that usually occurs within 90 days and remits within six months. The adjustment disorder with anxiety is characterized by symptoms of **nervousness**, worry, **jitteriness**, and motor tension. (reference 7, pp. 679-683; reference 4, pp. 1098-1099)

*If the witness indicates the possibility of an adjustment disorder, see the section on adjustment disorder for further questions.*

**Q: Did you rule out *amphetamine or similarly acting sympathomimetic drug consumption* as a cause of the plaintiff's exaggerated startle response?**

Symptoms of amphetamine or similarly acting sympathomimetic *drug consumption* may include fighting, grandiosity, elation, **hypervigilance**, psychomotor agitation, impaired judgment, and impaired social or occupational functioning. Physical symptoms may include flushing, difficulty breathing, tachycardia, pupil dilation, elevated blood pressure, sweating or chills, nausea, and vomiting. (reference 4, pp. 1007-1008; reference 7, pp. 223-227)

The following drugs may be classified as amphetamines:

- |                                    |                            |
|------------------------------------|----------------------------|
| Appetite Suppressants (diet pills) | Methamphetamines (speed)   |
| Dextroamphetamines                 | Methylphenidates (Ritalin) |
| Ma-huang (ephedra)                 | (reference 17, p. 586)     |
| (reference 24, pp. 488-489)        |                            |

**Additional Defense Theories**

**DEFENSE THEORY—RESOLUTION OVER TIME:** By the time most PTSD cases go to trial, there is only an artifact of the condition remaining and this does not constitute the full diagnosis of PTSD.

**DEFENSE THEORY—REPORTED SYMPTOMS VS. FUNCTIONAL LEVEL:** The plaintiff has reported significant symptomatology but continues to function with minimal impairment. Criterion F requires significant distress or impairment in social, occupational, or other important areas of functioning, when diagnosing PTSD.

**DEFENSE THEORY—QUALIFICATIONS OF PLAINTIFF'S EXPERTS:** The plaintiff's expert may not be qualified, by virtue of training or experience to diagnose PTSD

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*SYMPTOM*

*DEPOSITION QUESTIONS*

---

**Additional  
Defense  
Theories**

**DEFENSE THEORY—DID THE EXAMINER ADHERE TO THE RECOMMENDED GUIDELINES?:** Posttraumatic Stress Disorder in Litigation, Guidelines for Forensic Assessment, Edited by Robert I. Simon, MD, was published in 1995, and has formal patient assessment recommendations which include:

1. Adherence to the published diagnostic criteria
2. Consideration of multiple stressors
3. Review of all past records
4. Subjective reporting by itself is insufficient
5. The use of standard assessment methods
6. The search for collateral data
7. The avoidance of "false positive" data collection methods
8. Recognition of known patterns of true PTSD
9. Investigation of malingering and the use of an expanded evaluation protocol when manipulation of symptoms or information is suspected.



## **SECTION 5.1A: DIRECT CHALLENGE TO THE DIAGNOSIS OF ACUTE STRESS DISORDER CLAIMS**

### **INTRODUCTION**

Acute stress disorder is not a very common claim in psychological injury litigation. Nevertheless, it is a valid condition that may occur after a trauma. Thus, it may be one of the plaintiff's post-trauma diagnoses. The defense of damages should focus on the fact that Acute Stress Disorder is a transient condition which by definition, should not last beyond 30 days. It is a strong reaction to a traumatic stressor which is of short duration. There should be no permanent sequelae if this diagnosis has been claimed by the plaintiff.

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**Challenging the Plaintiff's Diagnosis of Acute Stress Disorder**

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**TABLE 5.1A-1.****Diagnostic Criteria for 308.3 Acute Stress Disorder**

- A.** The person has been exposed to a traumatic event in which both of the following were present:
- (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
- B.** Either while experiencing or after experiencing the distressing event, the individual has three (or more) of the following dissociative symptoms:
- (1) a subjective sense of numbing, detachment, or absence of emotional responsiveness
  - (2) a reduction in awareness of his or her surroundings (e.g., "being in a daze")
  - (3) derealization
  - (4) depersonalization
  - (5) dissociative amnesia (i.e., inability to recall an important aspect of the trauma)
- C.** The traumatic event is persistently re-experienced in at least one of the following ways: recurrent images, thoughts, dreams, illusions, flashback episodes, or a sense of reliving the experience; or distress on exposure to reminders of the traumatic event.
- D.** Marked avoidance of stimuli that arouse recollections of the trauma (e.g., thoughts, feelings, conversations, activities, places, people).
- E.** Marked symptoms of anxiety or increased arousal (e.g., difficulty sleeping, irritability, poor concentration, hypervigilance, exaggerated startle response, motor restlessness).
- F.** The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning or impairs the individual's ability to pursue some necessary task, such as obtaining necessary assistance or mobilizing personal resources by telling family members about the traumatic experience.
- G.** The disturbance lasts for a minimum of 2 days and a maximum of 4 weeks and occurs within 4 weeks of the traumatic event.
- H.** 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, is not better accounted for by Brief Psychotic Disorder, and is not merely an exacerbation of a preexisting Axis I or Axis II disorder. (reference 7, pp. 27-34)

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*SYMPTOM*

*DEPOSITION QUESTIONS*

---

**General Questions**

**Q: Describe the plaintiff's trauma.**

The event should be an extreme traumatic event or stressor in which 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; AND the person's response involved intense fear, helplessness, or horror. (criterion A)

---

**Q: Describe the plaintiff's posttraumatic anxiety symptoms.**

The individual should report three or more dissociative symptoms including numbing, detachment, or absence of emotional responsiveness; a reduction in awareness of his or her surroundings (e.g., "being in a daze"); derealization; depersonalization; and/or dissociative amnesia (i.e., inability to recall an important aspect of the trauma). (criterion B)

---

**Q: Has the plaintiff re-experienced the traumatic event?**

The witness must indicate at least one way the plaintiff re-experiences the traumatic event (recurrent images, thoughts, dreams, illusions, flashbacks, a sense of reliving the experience and/or distress upon exposure to reminders of the traumatic event. (criterion C)

---

**Q: How often does the plaintiff re-experience the event?**

The event must be persistently re-experienced to meet criterion C.

---

**Q: Has the plaintiff avoided stimuli associated with the trauma or experienced a numbing of responsiveness?**

The plaintiff must display marked avoidance of stimuli that arouse recollections of the trauma (e.g., thoughts, feelings, conversations, activities, places, people). (criterion D)

---

**Q: Has the plaintiff experienced any symptoms of increased arousal?**

The witness must indicate that the plaintiff suffers from marked symptoms of anxiety or increased arousal including difficulty sleeping, irritability, poor concentration, hypervigilance, exaggerated startle response, and/or motor restlessness. (criterion E)

---

**Q: Do the plaintiff's anxiety symptoms interfere with important areas of functioning or cause clinically significant distress?**

The disturbance must cause clinically significant distress or impairment in social, occupational, or other important areas of functioning or impairs the individual's ability to pursue some necessary task, such as obtaining necessary assistance or mobilizing personal resources by telling family members about the traumatic experience. (criterion F)

---

## SYMPTOM

## DEPOSITION QUESTIONS

## General Questions

*(continued)***Q: How long have the symptoms persisted?**

The disturbance lasts for a minimum of 2 days and a maximum of 4 weeks. (criterion G)

**DEFENSE THEORY–TIME LIMITED DIAGNOSIS:** By definition, the symptoms of an Acute Stress Disorder last a maximum of 4 weeks. Because this is a short lived mental disturbance, most plaintiff's prefer the diagnosis of PTSD. PTSD cases have a higher settlement and jury value.

**Q: When did the plaintiff first report symptoms of distress?**

The onset of symptoms must be within four weeks of the traumatic event. (criterion G)

**Q: Is the plaintiff on any medications which may cause symptoms similar to those in Acute Stress Disorder?**

The disturbance may not be the result of the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition, is not better accounted for by Brief Psychotic Disorder, and is not merely an exacerbation of a preexisting Axis I or Axis II disorder. (criterion H; reference 7, pp. 27-34)

**Q: Does the plaintiff have any medical or psychological conditions whose symptoms mimic those of Acute Stress Disorder?**

The disturbance may not be due to the effects of a general medical condition or other psychological disorder. It may not be an exacerbation of a preexisting Axis I or Axis II disorder. (reference 7, pp. 27-34)

**Q: Are the symptoms becoming less severe or occurring less often?**

Symptoms should remit within four weeks of the trauma. If they are still present, the diagnosis of PTSD should have been considered.

**Q: Has the plaintiff ever been traumatized before this event?****Q: Did you rule out an adjustment disorder with anxiety as a cause of the plaintiff's symptoms?**

An adjustment disorder is a *transient over-reaction* to stress that usually occurs within 90 days and remits within six months. The adjustment disorder with anxiety is characterized by symptoms of nervousness, worry, jitteriness, and motor tension. (reference 7, pp. 679-683; reference 4, pp. 1098-1099)

*If the witness indicates the possibility of an adjustment disorder, see the section on adjustment disorder for further questions.*

**Q: Does the plaintiff have a history of recurring recollections (memories) from other traumatic events?**

## **SECTION 5.2: DIRECT CHALLENGE TO THE DIAGNOSIS OF GENERALIZED ANXIETY DISORDER (GAD) CLAIMS**

### **INTRODUCTION**

Generalized anxiety disorder (GAD) is common in the general population. Almost everyone has developed some GAD symptoms during times of increased stress. Primary symptoms include excessive anxiety, an inability to control the anxiety, and a level of anxiety that causes clinical distress. To make a GAD diagnosis, the plaintiff's witness must admit that this disorder requires *excessive* anxiety and worry about a number of events or activities. The worry is accompanied by at least three additional symptoms that contribute to the plaintiff's subjective distress. The witness frequently overlooks these criteria and claims that the anxiety is entirely due to the injury in question.

Since the physical symptoms of GAD are commonly caused by many disorders and diseases, the defense of damages should focus on the failure of the plaintiff's expert witness to conduct an adequate differential diagnosis.

Defense counsel should obtain a list of the plaintiff's claimed GAD symptoms by using the deposition questions in Chapters 1 and 4. Section 5.2 provides questions to challenge the accuracy of that diagnosis. Questions are provided for each GAD symptom.

**Challenging the Plaintiff's Diagnosis of Generalized Anxiety Disorder**

TABLE 5.2-1.

**Diagnostic criteria for 300.02: Generalized Anxiety Disorder (GAD)**

- 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.

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**Note:**  
**Familial**  
**Pattern**

**This may be a familial disorder. Anxiety as a trait, has a familial association and may have pre-existed the cause of action.**

*SYMPTOM*

*DEPOSITION QUESTIONS*

**Excessive Anxiety and Worry**

**DEFENSE THEORY—SYMPTOMS ASSOCIATED WITH GAD:** GAD is a chronic, fluctuating anxiety condition in which 50% of the cases begin in childhood or adolescence. Worries associated with GAD are difficult to control and interfere significantly with social and occupational functioning. Symptoms must be present more days than not for at least six months.

Physical symptoms which generally accompany GAD include; restlessness, easily fatigued, difficulty concentrating, irritability, muscle tension and sleep disturbance. Three or more are required to meet the diagnosis of GAD.

**Q: Describe the plaintiff's excessive anxieties and worries or apprehensive expectation.**

**Q: How many unrealistic or excessive anxieties and worries does the plaintiff have?**

The plaintiff must be excessively anxious or worried about a number of events or activities. (criterion A)

**Q: How long has the plaintiff experienced these anxieties and worries?**

Symptoms must be present more days than not for at least six months. (criterion A)

**Q: Is the plaintiff able to control the worry?**

The plaintiff finds it difficult to control the worry. (criterion B)

**Q: Is the worry accompanied by any symptoms?**

The worry must be associated with three (or more) symptoms including restlessness, fatigue, difficulty concentrating, irritability, muscle tension, and sleep disturbance. (criterion C)

**Q: Describe the plaintiff's symptoms that led to the diagnosis of a generalized anxiety disorder.**

Again, the witness must indicate the occurrence of at least three of the six GAD symptoms. (criterion C)

**Q: When do the plaintiff's anxieties and worries occur?**

The symptoms must occur at times other than during a panic attack or other mood or psychotic disorder. (criterion D)

**Q: Does the plaintiff have an Axis I disorder that causes unrealistic or excessive anxiety and worry?**

The focus of anxiety and worry described for GAD must be unrelated to the worries of other conditions. Axis I disorders are clinical mental disorders. (reference 7, pp. 27-34)

**SYMPTOM****DEPOSITION QUESTIONS****Excessive Anxiety and Worry***(continued)*

**Q: Did you rule out the possibility of an organic cause for the plaintiff's anxiety and worry?**

The possibility that organic factors may be causing the symptoms must be eliminated.

**Q: What were your sources of information about the plaintiff's symptoms?**

**Q: Does the plaintiff have a history of excessive anxiety and worry?**

Since GAD has a lifetime prevalence rate of about 5%, this condition may have pre-existed the cause of action.

**Q: Did you rule out *stressors or other conditions not attributable to a mental disorder as a cause of the plaintiff's excessive anxiety and worry?***

*If the witness indicates the possibility of a life stressor or other condition, see the section on life stressors for further questions.*

**Q: Did you rule out a *childhood separation anxiety disorder as a cause of the plaintiff's excessive anxiety and worry?***

A childhood separation anxiety disorder begins before the age of eighteen. For many years after the disorder's onset, the adult plaintiff may experience **recurrences of the excessive anxiety** when separated from significant people or familiar places. Associated symptoms include **excessive worry about possible harm to loved ones**, avoidance of being alone, nightmares, temper outbursts or uneasy tension, sweating hands, headaches, stomachaches, and vomiting. (reference 7, pp. 121-125; reference 4, pp. 887, 1747-1750; reference 1, p. 1864)

*Defense counsel should obtain the plaintiff's early school and health records to look for evidence of this disorder.*

**Q: Did you rule out a *childhood overanxious disorder as a cause of the plaintiff's excessive anxiety and worry?***

A child with an overanxious disorder has **excessive or unrealistic anxiety or worry for at least six months**. S/he tends to be self-conscious and worried about future events and past behavior. Symptoms may include feeling a lump in the throat, headaches, gastrointestinal distress, shortness of breath, nausea, dizziness, difficulty falling asleep, **nervousness**, and other bodily discomforts. The disorder occurs most often in families where there is an unusual emphasis on high achievement. An overanxious disorder may be accompanied by other phobias. It can persist into adult life as an anxiety disorder, such as a generalized anxiety disorder or a social phobia. (reference 7, pp. 472-476; reference 4, pp.1752-1754)

*Defense counsel should obtain the plaintiff's early school and health records to look for evidence of this disorder.*

*SYMPTOM*

*DEPOSITION QUESTIONS*

**Excessive Anxiety and Worry**  
(continued)

**Q: Did you rule out an *identity problem* as a cause of the plaintiff's excessive anxiety and worry?**

The plaintiff with an identity problem may experience an uncertainty about identity, long-term goals, career choices, friendship patterns, sexual behavior, religious identification, value systems, and group loyalties. Associated symptoms may include **mild anxiety**, depression, self-doubt, doubt about the future, and impaired social functioning or work performance. The plaintiff may be unable to make decisions, may feel empty or isolated, have a distorted time perspective, and may feel negative or hostile toward others. The disorder is most common for late adolescents, but also occurs in young adults and in middle age when earlier life decisions are questioned. (reference 7, p. 741; reference 4, pp. 1762-1765)

**Q: Did you rule out a *panic disorder* as the cause of the plaintiff's excessive anxiety and worry?**

A panic disorder is characterized by *discrete periods of panic* or **intense anxiety**. Between attacks, the plaintiff will also experience nervousness and apprehension focused on the fear of having another attack. Panic symptoms include dizziness, shortness of breath, heart palpitations, smothering or choking sensations, feelings of unreality, tingling in hands or feet, hot and cold flashes, sweating, faintness, trembling or shaking, and the fear of dying or going crazy. The plaintiff with a panic disorder often has accompanying depression. (reference 7, pp. 433-440; reference 4, pp. 889-891)

*If the witness indicates that the plaintiff's excessive anxiety and worry is focused only on the fear of having another panic attack, the plaintiff may be experiencing a panic disorder and not GAD. See the section on Panic disorder for further questions.*

**DEFENSE THEORY—THE DIAGNOSIS OF GAD: The symptoms of GAD overlap with those of other anxiety conditions.**

**Plaintiff's medical history (and pharmacy records) may show evidence of pre-existing treatment for an anxiety condition.**

**DIFFERENTIAL DIAGNOSIS**

- 1) **Are plaintiff's experts familiar with their patient's medical history? Has the plaintiff ever been treated for GAD prior to the accident?**
- 2) **Is the plaintiff taking a medication or abusing drugs which could provoke a Substance-Induced Anxiety Disorder?**
- 3) **Does the plaintiff have a general medical condition which may be the basis for their anxiety symptoms? Without a physical exam and lab work, this diagnosis cannot be ruled out.**
- 4) **Many physical symptoms of GAD are similar to those seen in PTSD. In fact, PTSD is frequently diagnosed when GAD would be a more appropriate diagnosis.**

*SYMPTOM*

*DEPOSITION QUESTIONS*

**Muscle Tension**

**Q:** Describe the plaintiff's muscle tension (or pain, aches, soreness, etc.).

**Q:** When and how often does the plaintiff experience muscle tension?

**Q:** Does the plaintiff have a history of muscle tension before the injury in question?

**Q:** Does the plaintiff have a history of any *medical conditions* that may cause the muscle tension (or pain, aches, or soreness)?

*The witness may indicate the possibility of the following medical conditions: please refer to the sections pertaining to these medical conditions for further questions.*

**TABLE 5.2-2.**

|                             |                       |
|-----------------------------|-----------------------|
| Arteriovenous malformations | Meningitis            |
| Coronary artery disease     | Parkinson's disease   |
| Epilepsy                    | Syphilis              |
| Hepatitis B                 | Uremic encephalopathy |

**Q:** Did you rule out the *onset of muscle disease* as a cause of the plaintiff's muscle tension?

Muscle diseases often begin with pain as the chief or only symptom.  
(reference 4, p. 155)

**Q:** Did you rule out *somatoform (psychogenic) pain disorder* as a cause of the plaintiff's muscle tension?

Somatoform (psychogenic) pain disorder is characterized by pain as the predominant focus of clinical attention. In addition, psychological factors are judged to have an important role in the onset, severity, exacerbation, or maintenance of the pain.  
(reference 7, pp. 498-503 )

*If the witness indicates the possibility of a somatoform pain disorder, see the section on somatoform pain disorder for further questions.*

**Q:** Did you rule out an *adjustment disorder with physical complaints* as a cause of the plaintiff's muscle tension?

An adjustment disorder is a transient over-reaction to stress that usually occurs within 90 days and remits within six months. The adjustment disorder with physical complaints is characterized by symptoms of fatigue, **headache, backache, or other aches and pains**. This condition is diagnosed as adjustment disorder unspecified.  
(reference 7, pp. 679-683)

*If the witness indicates the possibility of an adjustment disorder, see the section on adjustment disorders for further questions.*

## SYMPTOM

## DEPOSITION QUESTIONS

**Muscle Tension***(continued)***Q: Did you rule out a *conversion disorder* as a cause of the plaintiff's muscle tension?**

A conversion disorder is characterized by the presence of symptoms or deficits affecting voluntary motor or sensory function that suggest a neurological or other general medical condition. Psychological factors are judged to be associated with the symptom or deficit and the symptoms are not intentionally feigned or produced. Conversion symptoms are defense mechanisms that change the unconscious emotional conflict into a physical disability that often symbolizes the nature of the conflict. (reference 12, p. 315; reference 2, pp. 625, 630; reference 7, pp. 492-498)

*If the witness indicates the possibility of a conversion disorder, see the section on conversion disorder for further questions.*

**Q: Did you rule out a *somatization disorder (psychosomatic)* as a cause of the plaintiff's muscle tension?**

The plaintiff with a somatization disorder has many physical complaints for several years. S/he sees multiple physicians only to discover no physical cause for the symptoms. The plaintiff often has exaggerated and vague complaints focusing on either organs or types of symptoms such as pseudoneurologic or conversion symptoms, gastrointestinal, female reproductive, psychosexual, **pain**, and cardiopulmonary symptoms. Anxiety, depression, suicide attempts, social withdrawal, and work or interpersonal relationship difficulties are common. (reference 7, pp. 486-490; reference 4, pp. 389, 940)

*If the witness indicates the possibility of a somatization disorder, see the section on somatization disorders for further questions.*

**Q: Did you rule out *hypochondriasis* as a cause of the plaintiff's muscle tension, pain, aches or soreness?**

The hypochondriac fears or believes that s/he has a serious disease based on their own interpretation of physical symptoms. Medical evaluations do not support the fears of disease. The plaintiff is preoccupied with bodily functions such as heartbeat, sweating, peristalsis, minor physical abnormalities, or a specific organ such as the heart. **Headaches** and fatigue are common complaints. (reference 7, pp. 504-507; reference 4, p. 1204)

*If the witness indicates the possibility of hypochondriasis, see the section on hypochondriasis for further questions.*

**Q: Did you rule out a *neuroendocrine disorder, such as pheochromocytoma*, as a cause of the plaintiff's muscle tension?**

Symptoms of a neuroendocrine disorder include sudden **headaches**, excessive sweating, and palpitations. Often there are associated tremors, weakness, nausea, and epigastric discomfort. The plaintiff may also complain of **chest pain**, shortness of breath, lightheadedness, blurred vision, and flushing. (reference 2, p. 612)

Pheochromocytoma is a tumor of the sympathetic nervous system which specifically causes **headaches**, lightheadedness, nausea, sweating, trembling, and elevated blood pressure during anxiety attacks. (reference 4, p. 1276)

## SYMPTOM

## DEPOSITION QUESTIONS

**Muscle Tension***(continued)*

*If the witness indicates the possibility of pheochromocytoma, see the section on pre-existing medical conditions for further questions.*

**Q: Did you rule out porphyria as a cause of the plaintiff's muscle tension?**

Porphyria is an inherited disorder of middle-aged and young adults. It is characterized by episodes of **abdominal pain, peripheral neuropathy**, weakness, anorexia, nausea, vomiting, tachycardia, fever, confusion, depression, and severe anxiety. Mood swings and mental abnormalities are common symptoms. (reference 4, pp. 121, 1276, 1326; reference 9, p. 1156; reference 1, pp. 958, 960)

*If the witness indicates the possibility of porphyria, see the section on pre-existing medical conditions for further questions.*

**DEFENSE THEORY—PAIN FROM ALTERNATE SOURCES: Many plaintiff's experience muscle tension and pain from alternate sources, such as exercise, a lack of exercise or arthritis.**

**Q: Did you rule out rheumatoid arthritis as a cause of the plaintiff's muscle tension?**

Rheumatoid arthritis is a progressive disease that causes **long-lasting pain in the joints and muscles**. Associated symptoms of severe rheumatoid arthritis may include depression, fatigue, weight loss, anorexia, pale skin, and weakness. (reference 4, pp. 1185, 1189, 1194; reference 9, p. 1913)

*If the witness indicates the possibility of rheumatoid arthritis, see the section on arthritis for further questions.*

**Q: Did you rule out malingering as a cause of the plaintiff's muscle tension?**

Malingering may be associated with attempts to avoid work or evade legal responsibilities. Plaintiff complaints may include vertigo (illusion of movement), weakness, loss of consciousness, seizures, **headaches**, visual impairment, and loss of skin sensation. (reference 4, p. 1863)

*If the witness indicates the possibility of malingering, see the section on malingering for further questions.*

**Q: Did you rule out muscle cramps as a cause of the plaintiff's muscle tension?**

Muscle cramps are sudden **painful muscle spasms**. Cramps may occur when the plaintiff has a peripheral vascular disease, motor neuron disease, or when the plaintiff exercises excessively. (reference 2, p. 682; reference 9, p. 2199)

**Q: Did you rule out metabolic alkalosis as a cause of the plaintiff's muscle tension?**

Metabolic alkalosis is an increased blood PH that may cause symptoms of edginess, weakness, **muscle cramps** and postural hypotension (a drop in blood pressure when standing). (reference 2, p. 761)

## SYMPTOM

## DEPOSITION QUESTIONS

**Muscle Tension***(continued)***Q: Did you rule out *acute pyelonephritis* as a cause of the plaintiff's muscle tension?**

The often gradual onset of acute pyelonephritis causes early symptoms of urinary frequency, dysuria, and fever. Severe symptoms of chills, **flank pain**, nausea, and vomiting may appear after several days. (reference 2, p. 191)

**Q: Did you rule out a *postural defect* as a cause of the plaintiff's muscle tension?**

A plaintiff with **dull back pain** may have a postural defect. The plaintiff maintains posture through voluntary muscle control that often leads to fatigue, **back pain**, and strain of the back as a whole. (reference 2, p. 205)

**Q: (Female) Did you rule out *premenstrual dysphoric disorder* as a cause of the plaintiff's muscle tension?**

Premenstrual dysphoric disorder is characterized by emotional and behavioral symptoms which usually occur during the last week before the menstrual cycle and remit within a few days after menses begins. Symptoms may include tears, sadness, irritability, anger, tension, depression, self-deprecating thoughts, decreased interest in usual activities, fatigability, loss of energy, a subjective sense of difficulty in concentration, changes in appetite, and sleep disturbance. Physical symptoms may also include breast tenderness or swelling, tachycardia, sweating, **headaches**, joint or **muscle pain**, a sensation of bloating, or weight gain. (reference 7, pp. 771-774; reference 18, p. 1955)

**Q: Did you rule out *opioid withdrawal* as a cause of the plaintiff's muscle tension?**

Symptoms of opioid withdrawal may include lacrimation (tearing), rhinorrhea (runny nose), dilated pupils, sweating, diarrhea, yawning, mild hypertension, tachycardia (increased heart rate), fever, insomnia, and gooseflesh. Associated features may include restlessness, irritability, depression, tremor, weakness, nausea, vomiting, and **muscle or joint pain**. These signs, often resembling influenza symptoms, may be precipitated by the abrupt ending of one or two weeks of continuous opioid use. The withdrawal symptoms may last days or weeks. During the final stages of withdrawal, the plaintiff may experience overconcern for bodily discomfort, poor self-image, and a decreased ability to tolerate stress. (reference 7, pp. 272-273; reference 4, pp. 990-991)

**Q: Did you rule out *caffeine withdrawal* as a cause of the plaintiff's muscle tension?**

The most common caffeine withdrawal symptom is a withdrawal headache. **Headaches** will occur in about one-third of moderate to high caffeine consumers when their daily intake is stopped. Other withdrawal symptoms include **muscle tension**, anxiety, drowsiness, lethargy, rhinorrhea (runny nose), disinterest in work, irritability, nervousness, mild feelings of depression, yawning, nausea, and fatigue. (reference 4, p. 1029; reference 2, p. 618; reference 7, p. 764)

## SYMPTOM

## DEPOSITION QUESTIONS

**Muscle Tension***(continued)***Q: Did you rule out *restless leg syndrome* as a cause of the plaintiff's muscle tension?**

Restlessness and an uncomfortable or **painful crawling sensation in the muscles** and bones of the lower legs are signs of the restless leg syndrome. The symptoms usually occur at night, disturbing sleep, or when the plaintiff is resting. There is no known cause of the syndrome. (reference 4, pp. 132, 1253)

**Q: Did you rule out *mitral valve prolapse (MVP)* as a cause of the plaintiff's muscle tension?**

Mitral valve prolapse (MVP) is a common and sometimes serious congenital ballooning of a heart valve often associated with arrhythmias of the heart. MVP and panic attacks share many common symptoms including **chest pain**, palpitation, dyspnea, weakness, fatigue, dizziness, syncope (a faint), and anxiety. (reference 4, pp. 1149, 1551)

*If the witness indicates the possibility of mitral valve prolapse, see the section on pre-existing medical conditions for further questions.*

**Q: Did you rule out an *adjustment disorder with anxiety* as a cause of the plaintiff's muscle tension?**

An adjustment disorder is a transient over-reaction to stress that usually occurs within 90 days and remits within six months. The adjustment disorder with anxiety is characterized by symptoms of nervousness, worry, jitteriness, and **motor tension**. (reference 7, pp. 679-683; reference 4, pp. 1098-1099)

*If the witness indicates the possibility of an adjustment disorder, see the section on adjustment disorders for further questions.*

**Q: Did you rule out *masked depression* as a cause of the plaintiff's muscle tension?**

The plaintiff with masked depression hides a dysphoric mood with gastrointestinal problems, chronic pain, insomnia, weight loss, and other physical complaints. The elderly experience symptoms of hypertension, cardiac arrhythmias, emphysema, diabetes, urinary frequency, dizziness, disturbed bowel functions, and **backaches**. Masked depression is a common condition frequently missed by physicians. (reference 4, p. 796)

**Q: Did you rule out long-term treatment with *adrenal cortical steroids or ACTH* as a cause of the plaintiff's muscle tension?**

Plaintiffs with a long-term history of adrenal cortical steroid or ACTH treatment commonly develop major mental disturbances. While taking the drugs, s/he may experience euphoria, severe mania, severe depression, delirium, **paresthesia** (abnormal tightness or tingling around a limb or trunk), insomnia, restlessness, or agitation. Symptoms usually disappear when the drugs are reduced or discontinued. (reference 4, p. 876)

## SYMPTOM

## DEPOSITION QUESTIONS

**Muscle  
Tension***(continued)***Q: Did you rule out *hypothyroidism* as a cause of the plaintiff's muscle tension?**

Hypothyroidism results from inadequate synthesis of thyroid hormone. Hypothyroidism can produce psychiatric, as well as physical symptoms. The most notable psychiatric symptoms include depression, lethargy, poor concentration, impaired memory, apathy, and syncope. The numerous physical symptoms are: cold intolerance, constipation, **muscle cramps**, paresthesias, menstrual disorders, dyspnea, dizziness, reduced hearing, poor appetite, weight gain, brittle and thinning hair, and bradycardia (slowed heart action). Panic attacks are associated with endocrinological disorders including hypothyroidism and hyperthyroidism. (reference 18, pp. 743, 1810-1812, 1928)

*If the witness indicates the possibility of hypothyroidism, see the section on pre-existing medical conditions for further questions.*

**Q: (Female) Did you rule out *menopausal distress* as a cause of the plaintiff's muscle tension?**

Menopausal distress may cause anxiety, fatigue, GI disturbances, urinary frequency, **back pain**, palpitations, tension, emotional lability, irritability and nervousness, depression, dizziness, insomnia, and hot flashes. (reference 4, p. 1173; reference 9, p. 21)

*If the witness indicates the possibility of menopausal distress, see the section on medical conditions for further questions.*

**Q: Did you rule out *pernicious anemia* as a cause of the plaintiff's muscle tension?**

Pernicious anemia results from a lack of vitamin B12. The disease develops slowly causing both physical and mental symptoms. The plaintiff may experience feelings of depression, worthlessness and guilt, irritability, paranoia, and a loss of memory. Physical symptoms may include anorexia, **abdominal pain**, intermittent constipation and diarrhea, weight loss, and weakness. Pernicious anemia often leads to combined systems disease. (reference 4, p. 1276; reference 1, pp. 1077-1079; reference 2, pp. 576, 570)

*If the witness indicates the possibility of pernicious anemia or combined systems disease, see the section on pre-existing medical conditions for further questions.*

**Q: Did you rule out the possibility of *enlarged abdominal lymph nodes* as the cause of the plaintiff's muscle tension?**

The enlargement of both abdominal lymph nodes may mechanically interfere with the motor activity of the gut and thus cause constipation, **pain**, fever, **backache**, bloating and belching. (reference 2, p. 514)

**SYMPTOM****DEPOSITION QUESTIONS****Muscle  
Tension***(continued)*

**Q: Does the plaintiff have any *other medical conditions* that may cause muscle tension?**

*The witness may indicate the possibility of the following medical conditions: please refer to the sections pertaining to these medical conditions for further questions.*

|                             |                                    |
|-----------------------------|------------------------------------|
| Acute infectious bronchitis | Pneumococcal pneumonia             |
| Attacks of myoglobinuria    | Polymyositis                       |
| Dermatomyositis             | Pseudotumor cerebri                |
| Myalgia                     | (benign intracranial hypertension) |

**Q: Is the plaintiff taking any *medications or substances* that may cause muscle tension such as:**

|             |                    |                 |
|-------------|--------------------|-----------------|
| ADALAT      | CORTISONE          | HYZAAR          |
| ALDACTAZIDE | COUMADIN           | IMDUR           |
| ALDORIL     | COZAAR             | INDERIDE        |
| AMERGE      | CYTOTEC            | INDOCIN         |
| ANAPROX     | DALALONE           | INTROPIN        |
| APRESOLINE  | DALMANE            | KEFLEX          |
| ARICEPT     | DANTRIUM           | KERLONE         |
| ARTHRITIC   | DARVOCET-N         | KLONOPIN        |
| ASENDIN     | DARVON COMPOUND-65 | LASIX           |
| AVAPRO      | DESYREL            | LESCOL          |
| AVONEX      | DIOVAN             | LEVAQUIN        |
| AXOCET      | DIURIL             | LIORESAL        |
| BACTRIM     | DOLOBID            | LITHIUM-CITRATE |
| BRETHINE    | DONNATAL           | LOPRESSOR       |
| BRICANYL    | DYAZIDE            | LOTREL          |
| BUMEX       | ELDEPRYL           | LOZOL           |
| BUPRENEX    | EMPIRIN W/CODEINE  | LUVOX           |
| BUSPAR      | ENDURON            | MACRODANTIN     |
| CAFERGOT    | ESIDRIX            | MAVIK           |
| CALAN       | ESKALITH           | MAXALT          |
| CAPOTEN     | EXCELON            | MAXIDE          |
| CARAFATE    | FELDENE            | MEVACOR         |
| CATAPRES    | FIORICET           | MINIPRESS       |
| CELESTON    | FIORINAL-CODEINE   | MODURETIC       |
| CELEXA      | FLEXERIL           | MONOPRIL        |
| CELONTIN    | FOSAMAX            | MOTRIN          |
| CENTRAX     | GYNERGEN           | NALFON          |
| CLINORIL    | HALCION            | NAPROSYN        |
| CLOXACILLIN | HYDRO-             | NICORETTE       |
| CLOZARIL    | CHLOROTHIAZIDE     | NORPACE         |
| COMBIPRES   | HYDRODIURIL        | NORVASC         |
| COMPAZINE   | HYGROTON           | ORAP            |

# Generalized Anxiety Disorder (GAD)

**SYMPTOM**

**DEPOSITION QUESTIONS**

**Muscle  
Tension**  
(continued)

|           |                |              |
|-----------|----------------|--------------|
| ORNADE    | RUFEN          | TROVAN       |
| PARNATE   | SE-AP-ES       | VALIUM       |
| PERMITIL  | SECONAL SODIUM | VANCOGIN-HCL |
| PHENERGAN | SEREVENT       | VASOTEC      |
| PRILOSEC  | SINEMET        | VENTOLIN     |
| PRINIVIL  | SLO-PHYLLIN    | VERELAN      |
| PRINZIDE  | TEGRETOL       | WELLBUTRIN   |
| PROCARDIA | TENORETIC      | WIGRAINE     |
| PROSOM    | TENORMIN       | ZANTAC       |
| PROVENTIL | THEO-DUR       | ZARONTIN     |
| PROVERA   | THORAZINE      | ZESTORETIC   |
| PROZAC    | TIAZAC         | ZESTRIL      |
| QUESTRAN  | TIGAN          | ZIAC         |
| QUINAMM   | TIMOPTIC       | ZOCOR        |
| REVIA     | TINDAL         | ZYBAN        |
| RISPERDAL | TOLECTIN       | ZYLOPRIM     |
| RITALIN   | TRANDATE       |              |
| ROCALTROL | TRILAFON       |              |

**DEFENSE THEORY—PRE-EXISTING ANXIETY CONDITION:** The plaintiff may have a life-long history of anxiety and nervousness beginning in early childhood. GAD is chronic but fluctuating and often worsens during times of stress. Therefore, the anxiety observed following an accident may, in fact, be a continuation of a pre-existing anxiety condition.

**Feeling  
Keyed Up,  
On Edge, or  
Restless**

- Q:** Describe the plaintiff's restlessness or feelings of being keyed up and/or on edge.
- 
- Q:** When and how often is the plaintiff restless, feeling keyed up and/or on edge?
- 
- Q:** Does the plaintiff have a history of restlessness, feeling keyed up and/or being on edge before the injury in question?
- 

**Q:** Does the plaintiff have a history of any *medical conditions* that may cause *restlessness*? (reference 2, pp. 124, 569-570, 697)  
*The witness may indicate the possibility of the following medical conditions: please refer to the sections pertaining to these medical conditions for further questions.*

**TABLE 5.2-3.**

|                     |                       |
|---------------------|-----------------------|
| Alzheimer's disease | Restless leg syndrome |
| Anemia              | Vasopressor syncope   |
| Niacin deficiency   |                       |

*SYMPTOM*

*DEPOSITION QUESTIONS*

**Feeling Keyed Up, On Edge, or Restless**

(continued)

**Q: Does the plaintiff have a history of any *medical conditions* that may cause feeling keyed up or on edge?**

*The witness may indicate the possibility of the following medical conditions: please refer to the sections pertaining to these medical conditions for further questions.*

**TABLE 5.2-4.**

|                         |                                     |
|-------------------------|-------------------------------------|
| Coronary artery disease | Myocardial infarction               |
| Epilepsy                | Subacute sclerosing panencephalitis |
| Hyperthyroidism         | Syphilis                            |

**Q: Did you rule out an *adjustment disorder with anxiety* as a cause of the plaintiff's restlessness?**

An adjustment disorder is a transient over-reaction to stress that usually occurs within 90 days and remits within six months. The adjustment disorder with anxiety is characterized by symptoms of **nervousness**, worry, **jitteriness**, and motor tension. (reference 7, pp. 679-683; reference 4, pp. 1098-1099)

*If the witness indicates the possibility of an adjustment disorder, see the section on adjustment disorders for further questions.*

**Caution: Do not ask the following question if the cause of action involves a head injury or toxic exposure.**

**Q: Did you rule out any head injuries or other conditions leading to *organic brain syndrome* as a cause of the plaintiff's restlessness, feeling keyed up and/or on edge?**

Organic brain syndrome is a term for the symptoms produced by head injury, toxic exposure, hypoxia (oxygen deficiency), anoxia (extreme oxygen deficiency in tissues) or other causes. Common symptoms of head injuries include vertigo, syncope (faint) lightheadedness, impaired concentration and memory, easy fatigability, irritability, **restlessness**, lack of energy, depression, **anxiety**, phobia, a lowered tolerance for alcohol, and headaches. (reference 2, pp. 75, 111)

**Q: Did you rule out a *specific phobia* (simple phobia) as a cause of the plaintiff's restlessness, feeling keyed up and/or on edge?**

A phobic disorder is characterized by the presence of irrational or exaggerated fears of objects, situations, or bodily functions. The situation or object of the fear is not inherently dangerous or an appropriate source of anxiety. The plaintiff may have symptoms of panic, sweating, tachycardia, shakiness, **restlessness**, and difficulty breathing. S/he either avoids the object of the phobia or endures the situation with **intense anxiety**. There is also a marked distress about having the irrational fear. (reference 7, pp. 443-449; reference 4, pp. 899-900)

## SYMPTOM

## DEPOSITION QUESTIONS

**Feeling  
Keyed Up,  
On Edge, or  
Restless**  
(continued)

**Q: Did you rule out an *obsessive compulsive disorder* as a cause of the plaintiff's restlessness, feeling keyed up and/or on edge?**

The obsessive compulsive plaintiff has persistent unwanted and uncontrolled thoughts or impulses that may be characterized by violence, contamination, or doubt. These obsessions often cause the plaintiff to **feel anxious**. The plaintiff's repeated compulsive behaviors are attempts to control the impulses and the accompanying anxiety. Other symptoms may include an exclusive devotion to work or productivity, depression, anxiety, and **restlessness**. (reference 4, pp. 904-917; reference 7, pp. 456-463)

*If the witness indicates the possibility of an obsessive compulsive disorder, see the section on obsessive-compulsive disorders for further questions. NOTE: In addition to the obsessive compulsive disorder, there is an obsessive compulsive personality disorder. The personality disorder does not have true obsessions and compulsions, but has a clear pattern of perfectionism and rigidity.*

**Q: Did you rule out a *histrionic personality disorder* as a cause of the plaintiff's restlessness, feeling keyed up and/or on edge?**

The histrionic plaintiff is self-centered, dramatic, emotionally excessive, shallow, and exhibits **restless posturing and considerable mood instability**. S/he is often uncomfortable when not the center of attention and will seek reassurance, approval, or praise from others. The plaintiff may complain of poor health, weakness, headaches, or feelings of depersonalization. While an over-concern with physical attractiveness and an inappropriate sexually seductive appearance or behavior is common, plaintiffs with this disorder often have troubled interpersonal relationships and can be sexually naive or unresponsive. (reference 7, pp. 711-714; reference 4, p. 586)

*If the witness indicates the possibility of a histrionic personality disorder or other maladaptive personality traits, see the section on personality disorders for further questions.*

**DEFENSE THEORY: Feeling keyed-up, on-edge and restless is commonly associated with caffeine, nicotine, alcohol, over-the-counter diet pills and stimulants, as well as some herbal remedies (ephedra).**

**Q: Did you rule out a *paranoid personality disorder* as a cause of the plaintiff's restlessness?**

The paranoid plaintiff has a history of unwarranted suspicion and mistrust of others. Often expecting to be exploited or harmed, s/he may be excessively sensitive, jealous, **hypervigilant, and tense**. The plaintiff may find it difficult to relax or forgive, and is argumentative when threatened by innocent remarks or events. His or her mood is often humorless, cold and unemotional. These plaintiffs rarely seek help because of a tendency to be moralistic, grandiose, and extrapunitive. (reference 7, pp. 690-694; reference 4, pp. 748-753)

## SYMPTOM

## DEPOSITION QUESTIONS

**Feeling  
Keyed Up,  
On Edge, or  
Restless**  
(continued)

**Q: Did you rule out *restless leg syndrome* as a cause of the plaintiff's restlessness?**  
Restlessness and an uncomfortable or painful crawling sensation in the muscles and bones of the lower legs are signs of the restless leg syndrome. The symptoms usually occur at night, disturbing sleep, or when the plaintiff is resting. There is no known cause of the syndrome. (reference 4, pp. 132, 1253)

**Q: Did you rule out *anemia* as a cause of the plaintiff's restlessness?**  
Vertigo, pounding headaches, fainting, dimness of vision, tinnitus (a ringing in one or both ears), irritability, **restlessness**, inability to concentrate, lethargy, fatigue, drowsiness, and GI complaints are common symptoms of anemia. (reference 2, pp. 566-571)

*If the witness indicates the possibility of anemia, see the section on pre-existing medical conditions for further questions.*

**Q: Did you rule out *niacin deficiency (B complex)* as a cause of the plaintiff's restlessness?**  
Niacin is one of the B complex vitamins essential for the normal carbohydrate metabolism of yeast cells and animal tissues. As the body's level of niacin decreases, the plaintiff may initially experience a burning tongue after eating hot or spicy foods. Symptoms are often more severe in the spring and fall and may be associated with mild anorexia, fatigue, **nervousness**, irritability, alternating periods of constipation and diarrhea, or burning sensations in the epigastrium (upper and middle abdomen). (reference 2, pp. 121-123)

**Q: Did you rule out *caffeine consumption* as a cause of the plaintiff's restlessness?**  
Characteristic symptoms of caffeine intoxication include **restlessness**, **nervousness**, excitement, insomnia, flushed face, diuresis, gastrointestinal disturbance, muscle twitching, rambling flow of thought and speech, tachycardia or cardiac arrhythmia, periods of inexhaustibility, and psychomotor agitation. When consumed near bedtime, caffeine often disrupts sleep. Symptoms may appear when the plaintiff consumes as little as 250 mg of caffeine per day. The plaintiff that consumes one gram per day usually experiences more severe symptoms. Products which contain caffeine include: coffee, tea, soda, chocolate and weight-loss aids. (reference 7, pp. 231-234; reference 4, p. 1029)

*If the witness indicates the possibility of excess caffeine consumption, see the caffeine consumption chart in Appendix A.*

**Q: Did you rule out *amphetamine or similarly acting sympathomimetic drug consumption or withdrawal* as a cause of the plaintiff's restlessness?**  
Symptoms of amphetamine or similarly acting sympathomimetic *drug consumption* may include fighting, grandiosity, elation, **hypervigilance**, **psychomotor agitation**, impaired judgment, and impaired social or occupational functioning. Physical symptoms may include flushing, difficulty breathing, tachycardia, pupil dilation, elevated blood pressure, sweating or chills, nausea, and vomiting. (reference 12; reference 4, pp. 1007-1008; reference 7, pp. 223-227)

## SYMPTOM

## DEPOSITION QUESTIONS

**Feeling  
Keyed Up,  
On Edge, or  
Restless**

*(continued)*

*Drug withdrawal* symptoms may include a dysphoric mood (depression, irritability, anxiety), fatigue, sweating, headaches, insomnia with nightmares, hypersomnia, and **psychomotor agitation**. Symptoms begin after the cessation of prolonged drug use (at least two days) and last more than 24 hours. (reference 7, pp. 227-228; reference 4, p. 1008)

The following drugs may be classified as amphetamines:

|                                    |                            |
|------------------------------------|----------------------------|
| Appetite Suppressants (diet pills) | Methamphetamines (speed)   |
| Dextroamphetamines                 | Methylphenidates (Ritalin) |
| Ma-huang (ephedra)                 | (reference 17, p. 586)     |
| (reference 24, pp. 488-489)        |                            |

**Q: Did you rule out *alcohol withdrawal* as a cause of the plaintiff's restlessness?**

The reduction or cessation of drinking for at least several days may cause characteristic symptoms: coarse tremor of hands, tongue, or eyelids; nausea or vomiting; malaise or autonomic hyperactivity (tachycardia, sweating, and elevated blood pressure); anxiety, depressed mood or irritability; transient hallucinations or illusions; headache; insomnia; dizziness; fatigue; **restlessness; and agitation**. (reference 7, pp. 215-216; reference 2, pp. 722, 618; reference 9, pp. 50-54)

**Q: Did you rule out *antisocial personality disorder* as a cause of the plaintiff's restlessness?**

The antisocial plaintiff may have a lifetime history of irresponsible and antisocial behavior. Childhood behaviors may include lying, stealing, truancy, vandalism, initiating fights, running away from home, and physical cruelty. Adolescents may also become abusers of tobacco, alcohol, and other drugs, or engage in early sexual activity.

Adults with antisocial personalities tend to be irritable, aggressive, reckless, and promiscuous. They may be unable to keep a job, friendship, or sexual relationship. The plaintiff shows no remorse or guilt when hurting or mistreating others.

Frequently this disorder is accompanied by signs of personal distress, **tension, an inability to tolerate boredom**, depression, a conviction that others are hostile, and suicidal attempts. (reference 7, pp. 701-706; reference 4, pp. 1865, 1868-1869)

*If the witness indicates the possibility of an antisocial personality disorder, see the section on personality disorders for further questions.*

**Q: Did you rule out *cocaine consumption or withdrawal* as a cause of the plaintiff's restlessness?**

*Cocaine users* often experience increased energy and confidence or irritability and paranoia with physical aggressiveness. Other behavioral symptoms may include euphoria, **hypervigilance, psychomotor agitation**, impaired judgment, and impaired social or occupational functioning. Physical symptoms may include tachycardia, dilated pupils, elevated blood pressure, perspiration or chills, nausea, vomiting, and hallucinations.

## SYMPTOM

## DEPOSITION QUESTIONS

**Feeling  
Keyed Up,  
On Edge, or  
Restless**

(continued)

The abrupt *cessation or reduction of cocaine*, after several days use, may cause the plaintiff to feel tired, dysphoric, irritable, depressed, and to crave more of the drug. An anxiety reaction may cause **psychomotor agitation**, insomnia or hypersomnia, high blood pressure, tachycardia, and paranoia. The symptoms may persist for more than a day. (reference 7, pp. 241-246; reference 4, pp. 1008-1009)

**Q: Did you rule out *sedative, hypnotic, or anxiolytic withdrawal* as a cause of the plaintiff's restlessness?**

Withdrawal symptoms develop when the plaintiff reduces or stops the prolonged moderate or heavy use of these substances. Symptoms may include nausea or vomiting; malaise or weakness; **autonomic hyperactivity** (such as tachycardia and sweating); **anxiety** or irritability; orthostatic hypotension; coarse tremor of the hands, tongue and eyelids; insomnia; and grand mal seizures. (reference 7, pp. 201-202; reference 4, p. 1549)

**Q: Did you rule out *opioid withdrawal* as a cause of the plaintiff's restlessness?**

Symptoms of opioid withdrawal may include lacrimation (tearing), rhinorrhea (runny nose), dilated pupils, sweating, diarrhea, yawning, mild hypertension, tachycardia (increased heart rate), fever, insomnia, and gooseflesh. Associated features may include **restlessness**, irritability, depression, tremor, weakness, nausea, vomiting, and muscle or joint pain. These signs, often resembling influenza symptoms, may be precipitated by the abrupt ending of one or two weeks of continuous opioid use. The withdrawal symptoms may last days or weeks. During the final stages of withdrawal, the plaintiff may experience over-concern for bodily discomfort, poor self-image, and a decreased ability to tolerate stress. (reference 7, pp. 272-273; reference 4, pp. 990-991)

**Q: Did you rule out *hallucinogen consumption* as the cause of the plaintiff's restlessness?**

A hallucinogen mood disorder may develop shortly after hallucinogen use and persist for more than 24 hours. Common symptoms include depression or **anxiety** (with symptoms of a major depressive episode), self-reproach or guilt, fearfulness, tension, and physical **restlessness**. Psychological effects of the disorder may cause severely impaired judgement leading to dangerous decisions and accidents. The plaintiff may be preoccupied with thoughts that s/he has destroyed their brain or driven themselves crazy. Suicide attempts may occur because of extreme despondency. (reference 7, pp. 250-259; reference 1, p. 1429)

**Q: Did you rule out a *major depressive episode* as a cause of the plaintiff's restlessness?**

A major depressive episode is characterized by either a depressed mood or a loss of interest and pleasure in most activities. Symptoms last for at least two weeks and can be distinguished from normal behavior. The plaintiff may feel tired and lethargic. Other common symptoms may include weight loss or gain; a decrease or increase in appetite; **psychomotor agitation** or retardation; feelings of worthlessness or excessive guilt; a decreased ability to concentrate or make decisions; and frequent

## SYMPTOM

## DEPOSITION QUESTIONS

**Feeling  
Keyed Up,  
On Edge, or  
Restless**

(continued)

thoughts of hopelessness, death and suicide. Depression typically affects sleep. The plaintiff may be awake repeatedly during the second half of the night and may awaken in early morning with uncomfortable feelings. Morning is the worst time of day for the plaintiff experiencing depression. (reference 4, pp. 794, 1251; reference 2, pp. 615-616; reference 7, pp. 349-356)

*If the witness indicates the possibility of a major depressive episode, see the section on major depression for further questions.*

**Q: Did you rule out a bipolar disorder as a cause of the plaintiff's restlessness?**

A bipolar disorder has a circular pattern of high and low emotional states (mania and depression). During the *manic episodes*, the plaintiff may feel grandiose, have a decreased need for sleep, and decreased emotional capacity, experience a surge of ideas and conversation, and may be easily distracted or pleased. It is often thought that the manic high represents an escape from inner depression and pain. While the plaintiff is **extremely active**, s/he is **often fragmented** and unable to finish projects. The plaintiff typically does not realize that s/he is ill.

During *major depressive episodes* the plaintiff may be depressed for at least two weeks. The plaintiff may experience an appetite disturbance, weight change, sleep disturbance, **psychomotor agitation** or retardation, decreased energy and emotional capacity, feelings of worthlessness, difficulty thinking or concentrating, and recurrent thoughts of death or suicide. (reference 4, pp. 408-409, 761; reference 7, pp. 382-391)

**Q: Did you rule out cyclothymic disorder as a cause of the plaintiff's restlessness?**

Cyclothymic disorder is a chronic disturbance that resembles manic and depressive syndromes. The symptoms are not severe enough to meet the criteria for a major depressive or manic episode. The plaintiff may have impaired social and occupational functioning. This disorder may cause **restlessness** as a component of the manic episodes. Occurring most often in females, cyclothymic disorder usually begins in early adulthood. (reference 7, pp. 398-400 ; reference 4, pp. 760-761, 804)

**Q: Did you rule out long-term treatment with adrenal cortical steroids or ACTH as a cause of the plaintiff's restlessness?**

Plaintiffs with a long-term history of adrenal cortical steroid or ACTH treatment commonly develop major mental disturbances. While taking the drugs, they may experience euphoria, severe mania, severe depression, delirium, paresthesia (abnormal tightness or tingling around a limb or trunk), insomnia, **restlessness, or agitation**. Symptoms usually disappear when the drugs are reduced or discontinued. (reference 4, p. 876)

**Q: (Female) Did you rule out a postpartum disorder as a cause of the plaintiff's restlessness?**

Postpartum disorders are associated with pregnancy and the period after birth. Symptoms may include insomnia, **restlessness**, fatigue, depression, irritability, headaches, and lability of mood. Later in the postpartum period, the plaintiff may become suspicious, confused or incoherent, irrational, excessively concerned over trivialities, and refuse food. Depressed women may experience an overconcern for

## SYMPTOM

## DEPOSITION QUESTIONS

**Feeling  
Keyed Up,  
On Edge, or  
Restless**

(continued)

the baby, guilt, or feelings of inadequacy. Hallucinations, infanticide, and suicide are infrequent occurrences. (reference 4, pp. 1238-1241; reference 1, p. 1720)

*If the witness indicates the possibility of a postpartum disorder, see the section on medical conditions for further questions.*

**Q: Did you rule out *nicotine withdrawal* as a cause of the plaintiff's restlessness?**

Nicotine withdrawal symptoms include a strong craving for nicotine, anxiety, irritability, frustration or anger, impaired attention, coughing, headaches, insomnia, a mental preoccupation with actions associated with tobacco use, **restlessness**, drowsiness, gastrointestinal disturbances, an increased appetite, and weight gain. The symptoms appear within 24 hours after the cessation or reduction in the use of cigarettes, cigars, pipes, chewing tobacco, or nicotine gum. The plaintiff experiences a decrease in the intensity of the symptoms with time. (reference 7, pp. 265-266; reference 4, pp. 1031-1032)

**Q: Did you rule out *muscle contraction headaches* as a cause of the plaintiff's restlessness?**

Chronic muscle contraction headaches may produce nausea, vomiting, lightheadedness, difficulty in falling asleep, **restless sleep** with frequent awakenings, loss of energy, impaired memory and concentration, and symptoms of depression. (reference 2, pp. 72-73; reference 4, p. 1204)

**Q: Does the plaintiff have any *other medical conditions* that may cause restlessness, such as:**

Pulmonary embolism (thromboembolism)

Sinus tachycardia

**Q: Did you rule out a *schizotypal personality disorder* as a cause of the plaintiff's feeling keyed up or on edge?**

A schizotypal personality has oddities of thinking, perception, communication, and behavior that resemble schizophrenia. The plaintiff may experience **anxiety**, depression, and other dysphoric moods that disrupt concentration and the ability to function socially or at work. S/he may have few close friends except for immediate family. (reference 7, pp. 697-701)

*If the witness indicates the possibility of a schizotypal personality disorder, see the section on personality disorders for further questions.*

**Q: Did you rule out *attention-deficit hyperactivity disorder (ADHD)* as a cause of the plaintiff's feeling keyed up or on edge?**

The essential characteristics of ADHD include inattention, impulsiveness, and **hyperactivity**. ADHD is usually diagnosed during elementary school years, and can persist throughout childhood. Persons diagnosed with ADHD have a higher prevalence of mood and anxiety disorders, learning disorders, substance-related disorders and the potential for the development of an antisocial personality disorder. Approximately one-third of the children diagnosed with ADHD show some signs of the disorder in

## SYMPTOM

## DEPOSITION QUESTIONS

**Feeling  
Keyed Up,  
On Edge, or  
Restless**  
(continued)

adulthood. Associated symptoms may include low self-esteem, mood lability, low frustration tolerance, and temper outbursts. (reference 7, pp. 85-93)

**Q: Did you rule out *Cushing's Disease* (hyperadrenalism) as a cause of the plaintiff's feeling keyed up or on edge?**

Plaintiffs often experience emotional changes before physical signs of the disease appear. Depression is the most common symptom. Other psychological symptoms include irritability, **anxiety**, confusion, insomnia, and impaired memory or concentration. Some of the characteristic physical signs include an increased appetite, weakness, buffalo hump, truncal and facial obesity, heightened facial color, and abdominal striae (stripes). (reference 4, pp. 1171-1172)

*If the witness indicates the possibility of Cushing's syndrome, see the section on pre-existing medical conditions for further questions.*

**Q: Did you rule out *niacin deficiency* (B complex) as a cause of the plaintiff's feeling keyed up or on edge?**

Niacin is one of the B complex vitamins essential for the normal carbohydrate metabolism of yeast cells and animal tissues. As the body's level of niacin decreases, the plaintiff may initially experience a burning tongue after eating hot or spicy foods. Symptoms are often more severe in the spring and fall and may be associated with mild anorexia, fatigue, **nervousness**, irritability, alternating periods of constipation and diarrhea, or burning sensations in the epigastrium (upper and middle abdomen). (reference 2, pp. 121-123)

**Q: Did you rule out *hyperthyroidism* as a cause of the plaintiff's feeling keyed up?**

Hyperthyroidism, or thyrotoxicosis, results from overproduction of thyroid hormone by the thyroid gland. The most common cause is Graves' disease. The signs and symptoms of hyperthyroidism include both physical and psychiatric complaints. Psychiatric features include **nervousness**, fatigue, insomnia, mood lability, and dysphoria. **There may be a heightened activity level.** Cognitive symptoms include a short attention span, impaired recent memory, and an **exaggerated startle response.**

Physical signs and symptoms of hyperthyroidism include increased pulse, arrhythmias (irregular heart rhythm), elevated blood pressure, fine tremor, heat intolerance, excessive sweating, increased appetite, weight loss, **palpitations** (abnormal rapid beating of heart), **tachycardia** (rapid heart beat), frequent bowel movements, menstrual irregularities, and muscle weakness. Panic attacks are associated with endocrinological disorders including hyperthyroidism, as well as hypothyroidism. (reference 18, pp. 743, 1809-1810, 1928)

**Q: Did you rule out *Meniere's syndrome* as a cause of the plaintiff's feeling keyed up or on edge?**

Meniere's syndrome is sometimes confused with **acute anxiety**. The most common symptom is dizziness. Associated symptoms include nystagmus (tremulous movement of the eyeballs), deafness, and other signs of middle-ear disease. (reference 4, p. 893)

**SYMPTOM****DEPOSITION QUESTIONS**

**Feeling  
Keyed Up,  
On Edge, or  
Restless**  
(continued)

**Q: Did you rule out *metabolic alkalosis* as a cause of the plaintiff's feeling keyed up or on edge?**

Metabolic alkalosis is an increased blood PH that may cause symptoms of **edginess**, weakness, muscle cramps and postural hypotension (a drop in blood pressure when standing). (reference 2, p. 761)

**Q: Did you rule out *depressive pseudodementia* as a cause of the plaintiff's feeling keyed up or on edge?**

Cognitive disturbances seen in severe major depressive episodes are usually referred to as depressive pseudodementia. Treatment for the depression can restore both mood and memory to normal. **Anxiety**, irritability, a loss of social skills, and memory gaps for specific periods or events are characteristic symptoms. (reference 4, pp. 150-151; reference 18, p. 809)

**Q: Did you rule out *anorexia nervosa* as a cause of the plaintiff's feeling keyed up or on edge?**

The anorexic plaintiff weighs fifteen percent less than the minimal weight normal for his or her age and height. S/he refuses to maintain body weight and has a distorted body image. Other symptoms may include depressed feelings, crying spells, sleep disturbance, obsessive rumination, obsessive compulsive behavior, **anxiety**, and occasional suicidal thoughts. Many anorexic adolescents have delayed psychosexual development. Adults with the disorder often have a decreased interest in sex. (reference 7, pp. 583-589; reference 1, pp.1904-1905; reference 4, pp. 1145, 1731)

**Q: Is the plaintiff taking any *medications or substances* that may cause restlessness, feeling keyed up, and/or feeling on edge such as:**

|               |           |                |
|---------------|-----------|----------------|
| ADDERALL      | CLOZARIL  | ENTOLIN        |
| ADIPEX        | COGENTIN  | ESIDRIX        |
| AKINETON      | COMBIPRES | ESKALITH       |
| ALDACTAZIDE   | COMPAZINE | ETRAFON        |
| AMERGE        | DALMANE   | FASTIN         |
| AMPHETAMINES  | DELTASONE | FLEXERIL       |
| ARICEPT       | DEMEROL   | FLOXIN         |
| ARTANE        | DESOXYN   | HALCION        |
| ASENDIN       | DESYREL   | HALDOL         |
| ATIVAN        | DEXEDRINE | HISTUSSIN      |
| BELLERGAL     | DIMETANE  | HYDRO-         |
| BENADRYL      | DITROPAN  | CHLOROTHIAZIDE |
| BIPHETAMINE   | DIURIL    | HYDRODIURIL    |
| BUSPAR        | DONNATAL  | HYGROTON       |
| BUTICAPS      | DURAVENT  | HYZAAR         |
| CAFFEINE      | ELAVIL    | INAPSINE       |
| CATAPRES      | ELDEPRYL  | INDERIDE       |
| CHLORTRIMETON | ENDEP     | INDOCIN        |
| CIPRO         | ENDURON   | INSULIN        |
| CLARITAN-D    | ENTEXLA   | IONAMIN        |

# Generalized Anxiety Disorder (GAD)

**SYMPTOM**

**DEPOSITION QUESTIONS**

**Feeling  
Keyed Up,  
On Edge, or  
Restless**  
*(continued)*

|                 |               |                |
|-----------------|---------------|----------------|
| ISORDIL         | PERIACTIN     | ST JOHN'S WORT |
| LASIX           | PERMITIL      | STELAZINE      |
| LIMBITROL       | PHENERGAN-VC- | SUDAFED        |
| LITHIUM-CITRATE | CODEINE       | SURMONTIL      |
| LOMOTIL         | PHENOBARBITAL | TAVIST         |
| LUDIOMIL        | PHENYL-       | TEGRETOL       |
| LUFYLLIN-GG     | PROPANOLAMINE | TENORETIC      |
| MARCAINE        | POLARIMINE    | THEO-DUR       |
| MAXIDE          | PROKETAZINE   | THORAZINE      |
| MECLIZINE       | PROLIXIN      | TINDAL         |
| MELLARIL        | PROVENTIL     | TOFRANIL       |
| MEPERGAN        | QUINAMM       | TORECAN        |
| NALDECON        | REGLAN        | TRANSDERM-SCOP |
| NAVANE          | REVIA         | TRIAVIL        |
| NEMBUTAL        | SANOREX       | TRILAFON       |
| NEO-SYNEPHRINE  | SE-AP-ES      | TRINALIN       |
| NOREPHEDRINE    | SELDANE       | VENTOLIN       |
| NORPRAMIN       | SERENTIL      | VESPRIN        |
| NUBAIN          | SINEMET       | VIVACTIL       |
| OPTIMINE        | SLO-BID       | ZANTAC         |
| ORAP            | SLO-PHYLLIN   | ZAROXOLYN      |
| PAMELOR         | SOMA          | ZIAC           |
| PARNATE         | SORBITRATE    |                |

**Fatigability**

- Q: Describe the plaintiff's easy fatigability.**

---

- Q: When and how often is the plaintiff tired?**

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- Q: Does the plaintiff have a history of easy fatigability before the injury in question?**

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- Q: Does the plaintiff have a history of any *medical conditions* that may cause easy fatigability?**

*The witness may indicate the possibility of the following medical conditions: please refer to the sections pertaining to these medical conditions for further questions.*

**TABLE 5.2-5.**

|                                       |                       |
|---------------------------------------|-----------------------|
| Addison's disease                     | Hepatitis B           |
| Chronic fatigue syndrome              | Hypertension          |
| Chronic obstructive pulmonary disease | Meningitis            |
| Combined system disease               | Polycythemia          |
| Coronary artery disease               | Syphilis              |
| Hepatic encephalopathy                | Uremic encephalopathy |

## SYMPTOM

## DEPOSITION QUESTIONS

**Fatigability***(continued)*

**DEFENSE THEORY: Major losses in the plaintiff's life (outside the cause of action) will produce severe anxiety which may become the focus of treatment. (Refer to the Social Stressor Chart and Axis IV)**

**Q: Did you rule out a *daytime sleep pattern* as a cause of the plaintiff's easy fatigability?**  
Many plaintiffs that are unemployed, **sleep during the day**, and have insomnia at night.

**Q: Did you rule out *primary insomnia* as a cause of the plaintiff's easy fatigability?**  
Primary insomnia involves difficulty initiating or maintaining sleep or nonrestorative sleep. This pattern lasts for at least a month. The disorder may be severe enough to cause **daytime fatigue**, irritability, or impaired memory and concentration. (reference 7, pp. 599-604; reference 2, p. 601)

**Q: Did you rule out *sleep apnea* as a cause of the plaintiff's easy fatigability?**  
Sleep apnea is the cessation or suspension of breathing during sleep, causing the plaintiff to awaken periodically throughout the night. These hesitations may cause sleep disturbance but the plaintiff's main complaint may be **excessive daytime drowsiness**. (reference 4, pp. 132, 1252)

**Q: Did you rule out *recent travel* as a cause of the plaintiff's easy fatigability?**  
Jet travel commonly causes a change in sleep patterns. The plaintiff may experience sleepiness and **fatigue** during the day and insomnia during the night. The disorder usually disappears spontaneously in two to seven days. (reference 4, p. 1259)

**Q: Did you rule out an *adjustment disorder with physical complaints* as a cause of the plaintiff's easy fatigability?**  
This adjustment disorder is accompanied by physical complaints such as **fatigue**, headache, backache, or other aches and pains. It is important to note that an adjustment disorder is a transient over-reaction to stress and should remit within six months. This condition is diagnosed as adjustment disorder unspecified. (reference 7, pp. 679-683)

*If the witness indicates the possibility of an adjustment disorder, see the section on adjustment disorders for further questions.*

**Q: Did you rule out an *adjustment disorder with depressed mood* as a cause of the plaintiff's easy fatigability?**

This adjustment disorder is accompanied by depression, tearfulness, sleep disturbance, and feelings of hopelessness to a stressor. **Easy fatigability** is often a component of the depression. It is important to note that an adjustment disorder is a *transient over-reaction* to stress and should remit within six months. (reference 7, pp. 679-683)

*If the witness indicates the possibility of an adjustment disorder with depressed mood, see the section on adjustment disorder for further questions.*

## SYMPTOM

## DEPOSITION QUESTIONS

**Fatigability***(continued)*

*Note: The following question is to be asked if the plaintiff has experienced the loss of a family member or a close friend during the past two years.*

**Q: Did you rule out bereavement as a cause of the plaintiff's easy fatigability?**

Mourning is a normal grief reaction to a loss, such as the death of a loved one. The plaintiff may feel depressed and dejected, have diminished interest in the outside world, a decreased capacity to love, and an inhibition of activity. People tend to feel as if all their energy is taken up with thoughts and memories of the loss. **Fatigue and weariness** are characteristic symptoms. Sighing, feeling empty, disinterested, listless, eating more or less than normal, losing weight, and having trouble sleeping are common experiences. (reference 4, pp. 1286-1293; reference 7, pp. 740-741; reference 2, p. 617)

**Q: Did you rule out HIV-associated dementia or HIV-associated mild neurocognitive disorder or as a cause of the plaintiff's easy fatigability?**

HIV dementia is a severe cognitive disorder that interferes substantially with work, home life and social activities. Symptoms of mild neurocognitive disorder associated with HIV infection include difficulty concentrating, **unusual fatigability with demanding mental tasks**, feeling slowed down and memory difficulties. Problem solving, abstract reasoning, and motor performance may also be affected. (reference 18, pp. 308-316; reference 7, p. 163)

*Caution: Do not ask the following question if the cause of action involves a head injury or toxic exposure.*

**Q: Did you rule out any head injuries or other conditions leading to organic brain syndrome as a cause of the plaintiff's easy fatigability?**

Organic brain syndrome is a term for symptoms produced by head injury, toxic exposure, hypoxia (oxygen deficiency), anoxia (extreme oxygen deficiency in tissues) or other causes. Common symptoms of head injuries include vertigo, lightheadedness, syncope, impaired concentration and memory, **easy fatigability**, irritability, **lack of energy**, depression, anxiety, phobia, a lowered tolerance for alcohol, and headaches. Symptoms may appear days or weeks after the injury but usually appear within 24 hours. (reference 2, pp. 75, 111)

**Q: Did you rule out a histrionic personality disorder as a cause of the plaintiff's easy fatigability?**

The histrionic plaintiff is self-centered, dramatic, emotionally excessive, shallow, and exhibits considerable mood instability. S/he is often uncomfortable when not the center of attention and will seek reassurance, approval, or praise from others. The plaintiff may complain of poor health, **weakness**, headaches, or feelings of depersonalization. While an over-concern with physical attractiveness and an inappropriate sexually seductive appearance or behavior is common, plaintiffs with this disorder often have troubled interpersonal relationships and can be sexually naive or unresponsive. (reference 7, pp. 711-714; reference 4, p. 586)

*If the witness indicates the possibility of a histrionic personality disorder, see the section on personality disorders for further questions.*

## SYMPTOM

## DEPOSITION QUESTIONS

**Fatigability***(continued)***Q: Did you rule out a bipolar disorder as a cause of the plaintiff's easy fatigability?**

A bipolar disorder has a circular pattern of high and low emotional states (*mania and depression*). During the *manic episodes*, the plaintiff may feel grandiose, have a decreased need for sleep, and decreased emotional capacity, experience a surge of ideas and conversation, and may be easily distracted or pleased. It is often thought that the manic high represents an escape from inner depression and pain. While the plaintiff is extremely active, s/he is often fragmented and unable to finish projects. The plaintiff typically does not realize that s/he is ill.

During *major depressive episodes* the plaintiff may be depressed for at least two weeks. The plaintiff may experience an appetite disturbance, weight change, sleep disturbance, psychomotor agitation or retardation, **decreased energy** and emotional capacity, feelings of worthlessness, difficulty thinking or concentrating, and recurrent thoughts of death or suicide. (reference 4, pp. 408-409, 761; reference 7, pp. 382-391)

**Q: Did you rule out a major depressive episode as a cause of the plaintiff's easy fatigability?**

A major depressive episode is characterized by either a depressed mood or a loss of interest and pleasure in most activities. Symptoms last for at least two weeks and can be distinguished from normal behavior. The plaintiff may **feel tired and lethargic**. Other symptoms may include weight loss or gain; a decrease or increase in appetite; psychomotor agitation or retardation; feelings of worthlessness or excessive guilt; a decreased ability to concentrate or make decisions; and frequent thoughts of hopelessness, death and suicide.

Depression typically affects sleep. The plaintiff may be awake repeatedly during the second half of the night and may awaken in the early morning with uncomfortable feelings. Morning is the worst time of day for the plaintiff experiencing depression. (reference 4, pp. 794, 1251; reference 2, pp. 615-616; reference 7, pp. 349-356)

*If the witness indicates the possibility of a major depressive episode, see the section on major depression for further questions.*

**Q: Did you rule out metabolic alkalosis as a cause of the plaintiff's easy fatigability?**

Metabolic alkalosis is an increased blood PH that may cause symptoms of edginess, **weakness**, muscle cramps and postural hypotension (a drop in blood pressure when standing). (reference 2, p. 761)

**Q: Did you rule out niacin deficiency (B complex) as a cause of the plaintiff's easy fatigability?**

Niacin is one of the B complex vitamins essential for the normal carbohydrate metabolism of yeast cells and animal tissues. As the body's level of niacin decreases, the plaintiff may initially experience a burning tongue after eating hot or spicy foods. Symptoms are often more severe in the spring and fall and may be associated with mild anorexia, **fatigue**, nervousness, irritability, alternating periods of constipation and diarrhea, or burning sensations in the epigastrium (upper and middle abdomen). (reference 2, pp. 121-123)

## SYMPTOM

## DEPOSITION QUESTIONS

**Fatigability***(continued)*

**DEFENSE THEORY: Almost all medical conditions and surgical procedures contribute to easy fatigability.**

**Q: Did you rule out *riboflavin deficiency* (aribo flavinosis) as a cause of the plaintiff's easy fatigability?**

Riboflavin is one of the B complex vitamins essential for the normal carbohydrate metabolism of yeast cells and animal tissues. Initial oral symptoms include a mild burning sensation in the tongue, oral lesions, and buccal mucosa of the cheeks. Other symptoms are sore and cracking lips, burning and itching eyes, loss of appetite, **weakness**, and irritability. (reference 2, pp. 121, 124-125)

**Q: Did you rule out a *conversion disorder* as a cause of the plaintiff's easy fatigability?**

A conversion disorder is characterized by the presence of symptoms or deficits affecting voluntary motor or sensory function that suggest a neurological or other general medical condition. Psychological factors are judged to be associated with the symptom or deficit and the symptoms are not intentionally feigned or produced. Conversion symptoms are defense mechanisms that change the unconscious emotional conflict into a physical disability that often symbolizes the nature of the conflict. (reference 12, p. 315; reference 2, pp. 625, 630; reference 7, pp. 492-498)

*If the witness indicates the possibility of a conversion disorder, see the section on conversion disorder for further questions.*

**Q: Did you rule out *hypochondriasis* as a cause of the plaintiff's easy fatigability?**

The hypochondriac fears or believes that s/he has a serious disease based on their own interpretation of physical symptoms. Medical evaluations do not support the fears of disease. The plaintiff is preoccupied with bodily functions such as heartbeat, sweating, peristalsis, minor physical abnormalities, or a specific organ such as the heart. Headaches and **fatigue** are common complaints. (reference 7, pp. 504-507; reference 4, p. 1204)

*If the witness indicates the possibility of hypochondriasis, see the section on pre-existing medical conditions for further questions.*

**Q: Did you rule out a *postural defect* as a cause of the plaintiff's easy fatigability?**

A plaintiff with dull back pain may have a postural defect. The plaintiff maintains posture through voluntary muscle control that often leads to **fatigue**, back pain, and strain of the back as a whole. (reference 2, p. 205)

**Q: Did you rule out *mitral valve prolapse* (MVP) as a cause of the plaintiff's easy fatigability?**

Mitral valve prolapse (MVP) is a common and sometimes serious congenital ballooning of a heart valve often associated with arrhythmias of the heart. MVP

**SYMPTOM****DEPOSITION QUESTIONS****Fatigability***(continued)*

and panic attacks share many common symptoms including chest pain, palpitation, dyspnea, **weakness, fatigue**, dizziness, syncope (a faint), and anxiety. (reference 4, pp. 1149, 1551)

*If the witness indicates the possibility of mitral valve prolapse, see the section on pre-existing medical conditions for further questions.*

**Q: Did you rule out heart disease as a cause of the plaintiff's easy fatigability?**

Fatigue may be caused when body tissues do not receive sufficient nutrients and oxygen. A diseased heart is often unable to pump adequately for the lungs to oxygenate the blood. **Lethargy and fatigue** may be the result of heart diseases such as: (reference 2, pp. 617-618)

Chronic atrial fibrillation

Chronic obstructive or restrictive pulmonary disease

Congestive heart failure

Ischemic heart disease

Valvular heart disease

*If the witness indicates the possibility of coronary artery disease, see the section on pre-existing medical conditions for further questions.*

**DEFENSE THEORY: In many persons, increased fatigue can be a normal consequence of aging.**

**Q: Did you rule out a recent heart attack as a cause of the plaintiff's easy fatigability?**

Despondency is almost a universal response to heart attack. Even without complications, the plaintiff may feel a sense of loss and vulnerability to further injury. **Weakness and tiredness** are the single most distressing symptoms of the depression. The plaintiff may also experience insomnia, daytime hypersomnia, and practical worries. Complications cause the plaintiff's despondency and hopelessness to be intensified. (reference 4, pp. 1156-1157)

*If the witness indicates the possibility of a recent heart attack, see the section on medical conditions for further questions.*

**Q: Did you rule out caffeine withdrawal as a cause of the plaintiff's easy fatigability?**

The most common caffeine withdrawal symptom is a withdrawal headache. Headaches will occur in about one-third of moderate to high caffeine consumers when their daily intake is stopped. Other withdrawal symptoms include muscle tension, anxiety, drowsiness, **lethargy**, rhinorrhea (runny nose), disinterest in work, irritability, nervousness, mild feelings of depression, yawning, nausea, and **fatigue**. (reference 4, p. 1029; reference 2, p. 618; reference 7, p. 764)

*See the caffeine consumption and symptom chart in Appendix A for further details.*

## SYMPTOM

## DEPOSITION QUESTIONS

**Fatigability***(continued)***Q: Did you rule out *alcohol withdrawal* as a cause of the plaintiff's easy fatigability?**

The reduction or cessation of drinking for at least several days may cause characteristic symptoms: coarse tremor of hands, tongue, or eyelids; nausea or vomiting; **malaise or weakness**; autonomic hyperactivity (tachycardia, sweating, and elevated blood pressure); anxiety, depressed mood or irritability; transient hallucinations or illusions; headache; insomnia; dizziness; **fatigue**; restlessness; and agitation. (reference 7, pp. 215-216; reference 2, pp. 722, 618; reference 9, pp. 50-54)

**Q: Did you rule out *amphetamine or similarly acting sympathomimetic drug consumption or withdrawal* as a cause of the plaintiff's easy fatigability?**

Symptoms of amphetamine or similarly acting sympathomimetic *drug consumption* may include fighting, grandiosity, elation, hypervigilance, psychomotor agitation, impaired judgment, and impaired social or occupational functioning. Physical symptoms may include flushing, difficulty breathing, tachycardia, pupil dilation, elevated blood pressure, sweating or chills, nausea, and vomiting. Amphetamines and sympathomimetic drugs are central nervous system stimulants. The plaintiff often discovers that these stimulants can dominate their life, preoccupy their thoughts, and destroy family relationships or work behaviors. (reference 4, pp. 1007-1008; reference 7, pp. 223-227)

*Drug withdrawal* symptoms may include a dysphoric mood (depression, irritability, anxiety), **fatigue**, sweating, headaches, insomnia with nightmares, hypersomnia, and psychomotor agitation. Symptoms begin after the cessation of prolonged drug use (at least two days) and last more than 24 hours. (reference 7, pp. 227-228; reference 4, p. 1008)

The following drugs may be classified as amphetamines:

|                                    |                            |
|------------------------------------|----------------------------|
| Appetite Suppressants (diet pills) | Methamphetamines (speed)   |
| Dextroamphetamines                 | Methylphenidates (Ritalin) |
| Ma-huang (ephedra)                 | (reference 17, p. 586)     |
| (reference 24, pp. 488-489)        |                            |

**Q: Did you rule out *sedative, hypnotic, or anxiolytic withdrawal* as a cause of the plaintiff's easy fatigability?**

Withdrawal symptoms develop when the plaintiff reduces or stops the prolonged moderate or heavy use of these substances. Symptoms may include nausea or vomiting; **malaise or weakness**; autonomic hyperactivity (such as tachycardia and sweating); anxiety or irritability; orthostatic hypotension; coarse tremor of the hands, tongue and eyelids; insomnia; and grand mal seizures. (reference 7, pp. 201-202; reference 4, p. 1549)

**SYMPTOM****DEPOSITION QUESTIONS****Fatigability***(continued)***Q: Did you rule out *opioid consumption or withdrawal* as a cause of the plaintiff's easy fatigability?**

*Opioid intoxication* is characterized by euphoria, flushing, itching skin, miosis, **drowsiness**, decreased respiratory rate and depth, hypotension, bradycardia, and decreased body temperature. The initial euphoria is often followed by apathy, unpleasant mood, psychomotor retardation, impaired judgment, and impaired social or occupational functioning. While dependence on opioids is less common than on alcohol or tobacco, it has been estimated that fifteen percent of males and nine percent of females have used an opioid (nonmedical) during their lifetime. (reference 7, pp. 269-272; reference 4, pp. 987-988)

Symptoms of *opioid withdrawal* may include lacrimation (tearing), rhinorrhea (runny nose), dilated pupils, sweating, diarrhea, yawning, mild hypertension, tachycardia (increased heart rate), fever, insomnia, and gooseflesh. Associated features may include restlessness, irritability, depression, tremor, **weakness**, nausea, vomiting, and muscle or joint pain. These signs, often resembling influenza symptoms, may be precipitated by the abrupt ending of one or two weeks of continuous opioid use. The withdrawal symptoms may last days or weeks. During the final stages of withdrawal, the plaintiff may experience over-concern for bodily discomfort, poor self-image, and a decreased ability to tolerate stress. (reference 7, pp. 272-273; reference 4, pp. 990-991)

**Q: Did you rule out *cocaine withdrawal* as a cause of the plaintiff's easy fatigability?**

The abrupt cessation or reduction of cocaine, after several days use, may cause the plaintiff to feel **tired**, dysphoric, irritable, depressed, and to crave more of the drug. An anxiety reaction may cause psychomotor agitation, insomnia or **hypersomnia**, high blood pressure, tachycardia, and paranoia. The symptoms may persist for more than a day. (reference 7, pp. 245-246; reference 4, pp. 1008-1009)

**Q: Did you rule out a *neuroendocrine disorder*, such as *pheochromocytoma*, as a cause of the plaintiff's easy fatigability?**

Symptoms of a neuroendocrine disorder include sudden headaches, excessive sweating, and palpitations. Often there are associated tremors, **weakness**, nausea, and epigastric discomfort. The plaintiff may also complain of chest pain, shortness of breath, lightheadedness, blurred vision, and flushing. (reference 2, p. 612)

Pheochromocytoma is a tumor of the sympathetic nervous system which specifically causes headaches, lightheadedness, nausea, sweating, trembling, and elevated blood pressure during anxiety attacks. (reference 4, p. 1276)

*If the witness indicates the possibility of pheochromocytoma, see the section on pre-existing medical conditions for further questions.*

**Q: (Female) Did you rule out *premenstrual dysphoric disorder* as a cause of the plaintiff's easy fatigability?**

Premenstrual dysphoric disorder is characterized by emotional and behavioral symptoms which usually occur during the last week before the menstrual cycle and

## SYMPTOM

## DEPOSITION QUESTIONS

**Fatigability***(continued)*

remit within a few days after menses begins. Symptoms may include tears, sadness, irritability, anger, tension, depression, self-deprecating thoughts, decreased interest in usual activities, **fatigability, loss of energy**, a subjective sense of difficulty in concentration, changes in appetite, and sleep disturbance. Physical symptoms may also include breast tenderness or swelling, tachycardia, sweating, headaches, joint or muscle pain, a sensation of bloating, or weight gain. (reference 7, pp. 771-774; reference 18, p. 1955)

**Q: Did you rule out *inhalant intoxication* as a cause of the plaintiff's easy fatigability?**

Following inhalant (toxic substance) use, the plaintiff may experience behavioral and physical changes. Behavioral changes may include belligerence, assaultiveness, apathy, impaired judgment, and impaired social or occupational functioning. Physical signs may include dizziness, nystagmus, slurred speech, unsteady gait, lethargy, depressed reflexes, tremor, psychomotor **weakness**, blurred vision or diplopia, stupor or coma, and euphoria. (reference 7, pp. 259-260)

**Q: Did you rule out *cyclothymic disorder* as a cause of the plaintiff's easy fatigability?**

Cyclothymic disorder is a chronic disturbance that resembles manic and depressive syndromes. The symptoms are not severe enough to meet the criteria for a major depressive or manic episode. The plaintiff may have impaired social and occupational functioning. This disorder may cause **fatigue** as a component of the depressive episodes. Occurring most often in females, cyclothymic disorder usually begins in early adulthood. (reference 7, p. 398; reference 4, pp. 760-761, 804)

**Q: Did you rule out an *allergic reaction* as a cause of the plaintiff's easy fatigability?**

Allergic rhinitis is seasonal or perennial inflammatory disease of the nasal membranes. Symptoms may include sneezing; a stuffy and itching nose; postnasal drainage; and itching eyes. The plaintiff with allergies may feel generally ill and uncomfortable, **tired, weak**, despondent, irritable, and uninterested in eating. (reference 9 pp. 1867-1868)

**Q: Did you rule out *anemia* as a cause of the plaintiff's easy fatigability?**

Vertigo, pounding headaches, fainting, dimness of vision, tinnitus (a ringing in one or both ears), irritability, restlessness, inability to concentrate, **lethargy, fatigue**, drowsiness, and GI complaints are common symptoms of anemia. (reference 2, pp. 566-571)

*If the witness indicates the possibility of anemia, see the section on pre-existing medical conditions for further questions.*

**Q: Did you rule out *hypothyroidism* as a cause of the plaintiff's easy fatigability?**

Hypothyroidism results from inadequate synthesis of thyroid hormone. Hypothyroidism can produce psychiatric, as well as physical symptoms. The most notable psychiatric symptoms include depression, **lethargy**, poor concentration,

**SYMPTOM****DEPOSITION QUESTIONS****Fatigability***(continued)*

impaired memory, apathy, and syncope. The numerous physical symptoms are: cold intolerance, constipation, muscle cramps, paresthesias, menstrual disorders, dyspnea, dizziness, reduced hearing, poor appetite, weight gain, brittle and thinning hair, and bradycardia (slowed heart action). Panic attacks are associated with endocrinological disorders including hypothyroidism and hyperthyroidism. (reference 18, pp. 743, 1810-1812, 1928)

*If the witness indicates the possibility of hypothyroidism, see the section on pre-existing medical conditions for further questions.*

**Q: Did you rule out *chronic fatigue syndrome* as a cause of the plaintiff's easy fatigability?**

Chronic fatigue syndrome presents with six months or more of severe, **debilitating fatigue** accompanied by myalgia, headaches, pharyngitis, low-grade fever, cognitive complaints, gastrointestinal symptoms, and tender lymph nodes. There is a high rate (15-54%) of depressive disorders among patients with chronic fatigue syndrome. Persons most likely to be plagued by persistent fatigue after an acute viral illness are patients with pre-existing or co-morbid psychiatric problems. Chronic fatigue syndrome is considered to be a special class of mood disorder with somatic symptoms. (reference 18, pp. 1531-1532)

**Q: (Female) Did you rule out a *postpartum disorder* as a cause of the plaintiff's easy fatigability?**

Postpartum disorders are associated with pregnancy and the period after birth. Symptoms may include insomnia, restlessness, **fatigue**, depression, irritability, headaches, and lability of mood. Later in the postpartum period, the plaintiff may become suspicious, confused or incoherent, irrational, excessively concerned over trivialities, and refuse food. Depressed women may experience an over-concern for the baby, guilt, or feelings of inadequacy. Hallucinations, infanticide, and suicide are infrequent occurrences. (reference 4, pp. 1238-1241; reference 1, p. 1720)

**DEFENSE THEORY: Over 50% of plaintiff's medications may be known to cause fatigue.**

**Q: Did you rule out *other nutritional deficiencies or electrolyte disturbances* as a cause for the plaintiff's fatigability such as: (reference 2, p. 618)**

Folate  
Iron  
Pyridoxine

Thiamine  
Vitamin B12

**Q: Did you rule out *hypoglycemia* as a cause of the plaintiff's easy fatigability?**

Hypoglycemia is an abnormally low blood sugar level. It often produces personality changes, **tiredness**, confusion, dizziness, tremor, anxiety, tachycardia, and sweating during acute attacks. Other psychiatric symptoms include fear and dread, **depression with fatigue**, and agitation with confusion. Hypoglycemia can develop from an

*SYMPTOM*

*DEPOSITION QUESTIONS*

**Fatigability**

*(continued)*

insulin overdose, insulinoma or islet cell tumor, extensive liver disease, or functional diseases. (reference 2, p. 702; reference 4, pp. 1176-1177; reference 18, pp. 1929, 1479 )

*If the witness indicates the possibility of hypoglycemia, see the section on pre-existing medical conditions for further questions.*

**Q: Did you rule out *multiple sclerosis* as a cause of the plaintiff's easy fatigability?**

Multiple sclerosis is a common disease of young adults. The disease causes a disorder of the optic nerves, spinal cord, and brain. Symptoms may include depression, apathy, lack of judgement, inattention, tremor, vertigo, incoordination, **weakness, fatigue**, dysarthria (speech impairment), and urinary frequency or hesitancy. (reference 4, p. 1276; reference 1, pp. 1354-1356)

*If the witness indicates the possibility of multiple sclerosis, see the section on medical conditions for further questions.*

**Q: Did you rule out *infections* as a cause of the plaintiff's easy fatigability?**

(reference 2, p. 617)

- |                                  |                                 |
|----------------------------------|---------------------------------|
| Brucellosis                      | Meningitis                      |
| Chronic urinary tract infections | Syphilis                        |
| Infectious mononucleosis         | Subacute bacterial endocarditis |
| Influenza                        | Tuberculosis                    |
| HIV                              | Viral hepatitis                 |
| Malaria                          |                                 |

**Q: Did you rule out a *brain tumor* as a cause of the plaintiff's easy fatigability?**

Brain tumors occur in the skull, brain, or membrane covering the brain or spinal cord. Symptoms vary depending on the size of the tumor and rate of growth. The plaintiff may experience anxiety, dementia, irritability, dizziness, **fatigue**, headache, vomiting, hyperthermia (high body temperature), and changes in appetite and personality. (reference 4, pp. 139, 834-835, 855, 860, 1276; reference 9, pp. 2161-2164; reference 1, pp. 1351, 1296)

*If the witness indicates the possibility of a brain tumor, see the section on medical conditions for further questions.*

**Q: Did you rule out *pancreatic carcinoma* as a cause of the plaintiff's easy fatigability?**

Pancreatic carcinoma is a cancer of the pancreas that causes a decrease in enzymes, lipids, glucagens, and insulin. Symptoms may include abdominal pain radiating to the back, weight loss, anorexia, **weakness**, diarrhea, vomiting, depression, irritability, and a sense of doom. (reference 1, p. 751; reference 4, p. 1276; reference 9, pp. 777-779; reference 2, p. 425)

*If the witness indicates the possibility of pancreatic carcinoma, see the section on medical conditions for further questions.*

## SYMPTOM

## DEPOSITION QUESTIONS

**Fatigability***(continued)***Q: Did you rule out *porphyria* as a cause of the plaintiff's easy fatigability?**

Porphyria is an inherited disorder of young to middle-aged adults. It is characterized by episodes of abdominal pain, peripheral neuropathy, **weakness**, anorexia, nausea, tachycardia, fever, confusion, depression, and severe anxiety. Mood swings and mental abnormalities are common symptoms. (reference 4, pp. 121, 1276, 1326; reference 9, p. 1156; reference 1, pp. 958, 960)

*If the witness indicates the possibility of porphyria, see the section on pre-existing medical conditions for further questions.*

**Q: Did you rule out *rheumatoid arthritis* as a cause of the plaintiff's easy fatigability?**

Rheumatoid arthritis is a progressive disease that causes long lasting pain in the joints and muscles. Associated symptoms of severe rheumatoid arthritis may include depression, **fatigue**, weight loss, anorexia, pale skin, and **weakness**. (reference 4, pp. 1185, 1189, 1194; reference 9, p. 1913)

*If the witness indicates the possibility of rheumatoid arthritis, see the section on arthritis for further questions.*

**Q: Did you rule out *malingering* as a cause of the plaintiff's easy fatigability?**

Malingering may be associated with attempts to avoid work or evade legal responsibilities. The plaintiff's complaints may include vertigo (illusion of movement), **weakness**, loss of consciousness, seizures, headaches, visual impairment, and loss of skin sensation. (reference 4, p. 1863)

*If the witness indicates the possibility of malingering, see the section on malingering for further questions.*

**Q: (Female) Did you rule out *menopausal distress* as a cause of the plaintiff's easy fatigability?**

Menopausal distress may cause anxiety, **fatigue**, GI disturbances, urinary frequency, back pain, palpitations, tension, emotional lability, irritability and nervousness, depression, dizziness, insomnia, and hot flashes. (reference 4, p. 1173; reference 9, p. 21)

*If the witness indicates the possibility of menopausal distress, see the section on medical conditions for further questions.*

**Q: Did you rule out *pernicious anemia* as a cause of the plaintiff's easy fatigability?**

Pernicious anemia results from a lack of vitamin B12. The disease develops slowly causing both physical and mental symptoms. The plaintiff may experience feelings of depression, worthlessness and guilt, irritability, paranoia, and a loss of memory. Physical symptoms may include anorexia, abdominal pain, intermittent constipation and diarrhea, weight loss, and **weakness**. Pernicious anemia often leads to combined system disease. (reference 4, p. 1276; reference 1, pp. 1077-1079; reference 2, pp. 576, 570)

## SYMPTOM

## DEPOSITION QUESTIONS

**Fatigability***(continued)***Q: Did you rule out *systemic lupus erythematosus* as a cause of the plaintiff's easy fatigability?**

Systemic lupus erythematosus (SLE) causes inflammation in body organs such as the kidneys, the tissue surrounding the heart, lungs, thoracic cavity and blood vessels. The plaintiff may become depressed, confused and have other thought disorders. Physical signs may include anorexia, **fatigue**, fever, migraine headaches, and weight loss. (reference 9, pp. 1924-1928; reference 1, pp. 1207-1209)

*If the witness indicates the possibility of systemic lupus erythematosus, see the section on medical conditions for further questions.*

**DEFENSE THEORY: Generalized Anxiety Disorder requires apprehension and worry about multiple events. Defense counsel should determine what other events (in addition to the cause of action), may be the basis of plaintiff's anxiety.**

**Q: Did you rule out *muscle contraction headaches* as a cause of the plaintiff's easy fatigability?**

Chronic muscle contraction headaches may produce nausea, vomiting, lightheadedness, difficulty falling asleep, restless sleep with frequent awakenings, **loss of energy**, impaired memory and concentration, and symptoms of depression. (reference 2, pp. 72-73; reference 4, p. 1204).

*If the witness indicates the possibility of headaches, see the section on headaches for further questions.*

**Q: Did you rule out *Cushing's syndrome (hyperadrenalism)* as a cause of the plaintiff's easy fatigability?**

Plaintiffs often experience emotional changes before physical signs of the disease appear. Depression is the most common symptom. Other psychological symptoms include irritability, anxiety, confusion, insomnia, and impaired memory or concentration. Some of the characteristic physical signs include an increased appetite, **weakness**, buffalo hump, truncal and facial obesity, heightened facial color, and abdominal striae (stripes). (reference 4, pp. 1171-1172)

*If the witness indicates the possibility of Cushing's syndrome, see the section on pre-existing medical conditions for further questions.*

**SYMPTOM****DEPOSITION QUESTIONS****Fatigability***(continued)*

**Q: Did you rule out *dysthymic disorder* (depression) as a cause of the plaintiff's easy fatigability?**

Dysthymic disorder is characterized by chronic depressive symptoms less severe than major depression. Always feeling despondent or melancholy, the plaintiff believes that depression is part of their personality. Other symptoms may include a poor appetite or overeating, insomnia or hypersomnia, **low energy or fatigue**, low self-esteem, poor concentration, difficulty making decisions, and feelings of hopelessness. The disorder may begin in childhood for both sexes, but is more common in adult females. (reference 7, pp. 376-381; reference 4, pp. 803-804)

**Q: Did you rule out *other medical conditions* that may cause easy fatigability, such as:**

|                                    |                                  |
|------------------------------------|----------------------------------|
| Acute infectious bronchitis        | Dehydration                      |
| CO <sub>2</sub> retention          | Diabetes                         |
| Cancer                             | Metabolic and pulmonary failures |
| Cardiovascular disease             | Myasthenia gravis                |
| Central nervous system disease     | Panhypopituitarism               |
| Chronic renal and liver disease    | Pseudotumor cerebri              |
| (benign intracranial hypertension) | Uremic encephalopathy            |
| Chronic pyelonephritis             |                                  |

**Q: Is the plaintiff taking any *medications or substances* that may cause easy fatigability, such as:**

|                 |               |                  |
|-----------------|---------------|------------------|
| ACCUPRIL        | BUMEX         | CYTOTEC          |
| ACCUTANE        | BUPRENEX      | DANTRIUM         |
| ADALAT          | BUSPAR        | DEPO-PROVERA     |
| ADAPIN          | CALAN         | DESOXYN          |
| AEROBID         | CARAFATE      | DESYREL          |
| ALLEGRA         | CARBATROL     | DETROL           |
| ALTACE          | CARDURA       | DEXEDRINE        |
| AMBIEN          | CATAPRES      | DIBENZYLINE      |
| AMERGE          | CELEBREX      | DIMETANE         |
| ANAFRANIL       | CELEXA        | DOLOBID          |
| ANAPROX         | CENTRAX       | DORAL            |
| ANDRODERM PATCH | CHLORTRIMETON | DYNACIRC         |
| ANTABUSE        | CLOZARIL      | EDECIN           |
| ARICEPT         | COGNEX        | ELAVIL           |
| ARTHROTEC       | COLESTID      | EMPIRIN-CODEINE  |
| ASENDIN         | COMBIPRES     | ENDEP            |
| AVANDIA         | COMBIVENT     | EPTRA            |
| AVAPRO          | CORGARD       | ESKALITH         |
| AXOCET          | COUMADIN      | FAMVIR           |
| BACTRIM         | COZAAR        | FELDENE          |
| BENADRYL        | CRINONE       | FIORICET         |
| BIPHETAMINE     | CYCRIN        | FIORINAL-CODEINE |

# Generalized Anxiety Disorder (GAD)

*SYMPTOM*

*DEPOSITION QUESTIONS*

**Fatigability**

(continued)

|                          |                 |                 |
|--------------------------|-----------------|-----------------|
| FLEXERIL                 | MODURETIC       | SERTRALINE      |
| FLOXIN                   | MONOPRIL        | SINEMET         |
| GABITRIL                 | MYSOLINE        | SINEQUAN        |
| HALCION                  | NALFON          | SINGULAIR       |
| HUMULIN                  | NAPROSYN        | ST. JOHN'S WORT |
| HYDRO-<br>CHLOROTHIAZIDE | NARDIL          | STELAZINE       |
| HYZAAR                   | NAVANE          | SURMONTIL       |
| IMDUR                    | NEURONTIN       | SYMMETREL       |
| IMITREX                  | NORPACE         | TAVIST          |
| IMMODIUM                 | NORPLANT-SYSTEM | TEGRETOL        |
| INDERAL                  | NORPRAMIN       | TEMARIL         |
| INDERIDE                 | W/CODEINE       | TENORMIN        |
| INDOCIN                  | NORPRAMIN       | TIMOPTIC        |
| INSULIN                  | NORVASC         | TOFRANIL        |
| K-LYTE                   | OPTIMINE        | TOLINASE        |
| KEFLEX                   | PAMELOR         | TOPAMAX         |
| KEFTAB                   | PARAFON FORTE   | TOPROL-XL       |
| KERLONE                  | PARLODEL        | TRANDATE        |
| LAMISIL                  | PAXIPAM         | TRANXENE        |
| LESCOL                   | PERIACTIN       | TRIAVIL         |
| LEVAQUIN                 | PHENERGAN VC    | TRILEPTAL       |
| LIMBITROL                | PINDOLOL        | TRINALIN        |
| LIORESAL                 | PLAVIX          | TROVAN          |
| LITHIUM-CITRATE          | POLARAMINE      | VALIUM          |
| LOPID                    | PONDIMIN        | VANTIN          |
| LOPRESSOR                | PRAVACHOL       | VASOTEC         |
| LOTENSIN                 | PREMPHASE       | VERELAN         |
| LOTREL                   | PREMPRO         | VIVACTIL        |
| LOZOL                    | PRILOSEC        | WELLBUTRIN      |
| LUDIOMIL                 | PRINIVIL        | XANAX           |
| MACRODANTIN              | PRINZIDE        | ZANTAC          |
| MARPLAN                  | PROVERA         | ZARONTIN        |
| MAXAIR-AUTOHALER         | QUESTRAN        | ZAROXOLYN       |
| MAXALT                   | REGLAN          | ZESTORETIC      |
| MAXIDE                   | RELAFEN         | ZITHROMAX       |
| MECLIZINE                | REVIA           | ZOFRAN          |
| MECLOMEN                 | RIFAMATE        | ZOLOFT          |
| MESANTOIN                | RISPERDAL       | ZOVIRAX         |
| METHOTREXATE             | SELDANE         | ZYLOPRIM        |
| MEXITIL                  | SEPTRA          | ZYRTEC          |
|                          | SEREVENT        |                 |

**DEFENSE THEORY:** The six symptoms required for a diagnosis of Generalized Anxiety Disorder, are also symptoms found in depression. Defense counsel should look for a proximate history of depression.

## Generalized Anxiety Disorder (GAD)

*SYMPTOM*

*DEPOSITION QUESTIONS*

**Difficulty Concentrating, Mind Going Blank**

**Q:** Describe the plaintiff's difficulty concentrating or mind going blank.

**Q:** When and how often does the plaintiff have difficulty concentrating?

**Q:** Does the plaintiff have a history of difficulty concentrating or mind going blank before the injury in question?

**Q:** Does the plaintiff have a history of any *medical conditions* that may cause difficulty concentrating or mind going blank?

*The witness may indicate the possibility of the following medical conditions: please refer to the sections pertaining to these medical conditions for further questions.*

**TABLE 5.2-6.**

|                          |                                     |
|--------------------------|-------------------------------------|
| Addison's disease        | Hypothyroidism                      |
| Alzheimer's disease      | Meningitis                          |
| Chronic fatigue syndrome | Parkinson's disease                 |
| Combined system disease  | Polycythemia                        |
| Epilepsy                 | Subacute sclerosing panencephalitis |
| Hepatic encephalopathy   | Syphilis                            |
| Hypertension             | Systemic lupus erythematosus        |
| Hypotension              | Uremic encephalopathy               |

**Q:** Did you rule out signs, symptoms, or history of *hysteria* as a cause of the plaintiff's difficulty concentrating or mind going blank?

A plaintiff with hysteria is prone to phobias, dissociative states, fugues, and **amnesia**. Depression, suicidal tendencies and medication dependence is common. (reference 2, p. 633)

**Q:** Did you rule out *attention-deficit hyperactivity disorder (ADHD)* as a cause of the plaintiff's difficulty concentrating or mind going blank?

The essential characteristics of ADHD include **inattention**, impulsiveness, and hyperactivity. ADHD is usually diagnosed during elementary school years, and can persist throughout childhood. Persons diagnosed with ADHD have a higher prevalence of mood and anxiety disorders, learning disorders, substance-related disorders and the potential for the development of an antisocial personality disorder. Approximately one-third of the children diagnosed with ADHD show some signs of the disorder in adulthood. Associated symptoms may include low self-esteem, mood lability, low frustration tolerance, and temper outbursts. (reference 7, pp. 85-93)

**Q:** Did you rule out a *dissociative fugue* (formerly psychogenic fugue) as a cause of the plaintiff's difficulty concentrating or mind going blank?

This disorder is characterized by sudden, unexpected travel away from home or work. The plaintiff assumes a new identity and is **unable to recall** their previous

*SYMPTOM*

*DEPOSITION QUESTIONS*

**Difficulty Concentrating, Mind Going Blank**

(continued)

identity. While recovery is rapid and recurrences are rare, the plaintiff is apt to be very **perplexed and disoriented**. (reference 7, pp. 523-526)

**Q: Did you rule out *dissociative amnesia* (formerly psychogenic amnesia) as a cause of the plaintiff's difficulty concentrating or mind going blank?**

The plaintiff with this disorder has a sudden **inability to recall important personal information**, usually of a traumatic or stressful nature. During the **amnesia**, perplexity, disorientation, and purposeless wandering may occur. Termination is abrupt and recovery is complete. (reference 7, pp. 520-523)

**Q: Did you rule out *Ganser's syndrome* as a cause of the plaintiff's difficulty concentrating or mind going blank?**

Ganser's syndrome is an uncommon dissociative condition which is characterized by giving approximate answers to questions. It may be associated with **amnesia**, disorientation, perceptual disturbances, fugue, and conversion symptoms. (reference 7, pp. 532-533)

**Q: Did you rule out a *bipolar disorder* as a cause of the plaintiff's difficulty concentrating or mind going blank?**

A bipolar disorder has a circular pattern of high and low emotional states (*mania and depression*). During the *manic episodes*, the plaintiff may feel grandiose, have a decreased need for sleep, and decreased emotional capacity, experience a surge of ideas and conversation, and may be **easily distracted** or pleased. It is often thought that the manic high represents an escape from inner depression and pain. While the plaintiff is extremely active, s/he is often **fragmented and unable to finish projects**. The plaintiff typically does not realize that s/he is ill.

During *major depressive episodes* the plaintiff may be depressed for at least two weeks. The plaintiff may experience an appetite disturbance, weight change, sleep disturbance, psychomotor agitation or retardation, decreased energy and emotional capacity, feelings of worthlessness, **difficulty thinking or concentrating**, and recurrent thoughts of death or suicide. (reference 4, pp. 408-409, 761; reference 7, pp. 382-398)

**Q: Did you rule out *cyclothymic disorder* as a cause of the plaintiff's difficulty concentrating or mind going blank?**

Cyclothymic disorder is a chronic disturbance that resembles manic and depressive syndromes. However, the symptoms are not severe enough to meet the criteria for a major depressive or manic episode. The plaintiff may have impaired social and occupational functioning. This disorder may cause **difficulty concentrating** during the depressive episodes. Occurring most often in females, cyclothymic disorder usually begins in early adulthood. (reference 7, p. 398; reference 4, pp. 760-761, 804)

**DEFENSE THEORY: Defense counsel should try to obtain plaintiff's school records to determine if concentration was an issue in childhood. The most valuable school records are kindergarten through sixth grades (K-6).**

## SYMPTOM

## DEPOSITION QUESTIONS

**Difficulty  
Concentrating,  
Mind Going  
Blank**

(continued)

**Q: Did you rule out an *obsessive compulsive disorder* as a cause of the plaintiff's difficulty concentrating or mind going blank?**

The obsessive compulsive plaintiff has persistent **unwanted and uncontrolled thoughts** or impulses that may be characterized by violence, contamination, or doubt. These obsessions often cause the plaintiff to feel anxious. The plaintiff's repeated compulsive behaviors are attempts to control the impulses and the accompanying anxiety. Other symptoms may include an exclusive devotion to work or productivity, depression, anxiety, and restlessness. (reference 4, pp. 910-911; reference 7, pp. 456-463)

*If the witness indicates the possibility of an obsessive compulsive disorder, see the section on obsessive-compulsive disorder for further questions.*

**Note:** *In addition to the obsessive compulsive disorder, there is an obsessive compulsive personality disorder. The personality disorder does not have true obsessions and compulsions, but has a clear pattern of perfectionism and rigidity.*

**Q: Did you rule out *cannabis (marijuana) consumption* as a cause of the plaintiff's difficulty concentrating or mind going blank?**

Cannabis intoxication can occur from marijuana, hashish, or tetrahydrocannabinol (THC). Characteristic symptoms include tachycardia, increased appetite, dry mouth, euphoria, anxiety, sensation of slowed time, **impaired judgment**, and social withdrawal. Inappropriate laughter, panic attacks, and a dysphoric mood may occur. (reference 7, pp. 236-241; reference 4, pp. 1326, 764)

**Q: Did you rule out a *major depressive episode* as a cause of the plaintiff's difficulty concentrating or mind going blank?**

A major depressive episode is characterized by either a depressed mood or a loss of interest and pleasure in most activities. Symptoms last for at least two weeks and can be distinguished from normal behavior. The plaintiff may feel tired and lethargic. Other common symptoms may include weight loss or gain; a decrease or increase in appetite; psychomotor agitation or retardation; feelings of worthlessness or excessive guilt; a **decreased ability to concentrate or make decisions**; and frequent thoughts of hopelessness, death and suicide. (reference 4, pp. 794, 1251; reference 2, pp. 615-616; reference 7, pp. 349-356)

*If the witness indicates the possibility of a major depressive episode, see the section on major depression for further questions.*

**Q: Did you rule out a *depersonalization disorder* as a cause of the plaintiff's difficulty concentrating or mind going blank?**

The plaintiff with this disorder has very stressful recurrences of depersonalization characterized by a feeling of detachment or estrangement from oneself. Associated symptoms may include dizziness, depression, obsessive rumination, somatic concerns, anxiety, fear of going insane, and **difficulty with a sense of time and recall**. (reference 7, p. 530)

## SYMPTOM

## DEPOSITION QUESTIONS

**Difficulty  
Concentrating,  
Mind Going  
Blank**

(continued)

**Q: Did you rule out *dementia* as a cause of the plaintiff's difficulty concentrating or mind going blank?**

Dementia is an organic mental syndrome that causes a **reduction in intellectual ability** severe enough to interfere with social or occupational functioning. An impaired memory is the first symptom of the disorder. The plaintiff may experience **impaired judgment** and control of impulses, as well as a general disregard of the conventional rules of social conduct. A normally active person may become increasingly apathetic and have a distinct personality change. Dementia varies in the same person over time, but is generally a changing and worsening condition. Eventually the **memory loss** becomes so severe that the plaintiff is unable to recognize family members. (reference 7, p. 147; reference 4, pp. 851-853)

**Q: Did you rule out *depressive pseudodementia* as a cause of the plaintiff's difficulty concentrating or mind going blank?**

**Cognitive disturbances** seen in severe major depressive episodes are usually referred to as depressive pseudodementia. Treatment for the depression can restore both mood and memory to normal. Anxiety, irritability, a loss of social skills, and **memory gaps** for specific periods or events are characteristic symptoms. (reference 4, pp. 150-151; reference 18, p. 809)

**Q: Did you rule out an *adjustment disorder with anxiety* as a cause of the plaintiff's difficulty concentrating or mind going blank?**

An adjustment disorder is a *transient over-reaction* to stress that usually occurs within 90 days and remits within six months. The adjustment disorder with anxiety is characterized by symptoms of nervousness, worry, jitteriness, and motor tension. The plaintiff may have **difficulty concentrating** as part of the anxiety. (reference 7, pp. 679-683; reference 4, pp. 1098-1099)

*If the witness indicates the possibility of an adjustment disorder, see the section on adjustment disorders for further questions.*

**Caution: Do not ask the following question if the cause of action involves a head injury or toxic exposure.**

**Q: Did you rule out the possibility of a *previous head injury or other condition leading to organic brain syndrome* as a cause of the plaintiff's difficulty concentrating or mind going blank?**

Organic brain syndrome is a term for symptoms produced by head injury, toxic exposure, hypoxia (oxygen deficiency), anoxia (extreme oxygen deficiency in tissues) or other causes. Common symptoms of head injuries include vertigo, lightheadedness, syncope, **impaired concentration and memory**, easy fatigability, irritability, lack of energy, depression, anxiety, phobia, a lowered tolerance for alcohol, and headaches. (reference 2, pp. 75, 111)

**Q: Did you rule out a *passive aggressive (negativistic) personality disorder* as a cause of the plaintiff's difficulty concentrating or mind going blank?**

A passive aggressive personality passively resists both the demands of work and society. S/he may express this through procrastination, dawdling, stubbornness,

## SYMPTOM

## DEPOSITION QUESTIONS

**Difficulty  
Concentrating,  
Mind Going  
Blank**

(continued)

intentional inefficiency, and **forgetfulness**. The plaintiff may be sulky, irritable, or argumentative. Associated symptoms include dependency, lack of self-confidence, and a pessimism for the future with no sense of responsibility for their problems. (reference 7, pp.789-791; reference 4, p. 985)

**Q: Did you rule out *anemia* as a cause of the plaintiff's difficulty concentrating or mind going blank?**

Vertigo, pounding headaches, fainting, dimness of vision, tinnitus (a ringing in one or both ears), irritability, anorexia, restlessness, **inability to concentrate**, lethargy, fatigue, drowsiness, and GI complaints are common symptoms of anemia. (reference 2, pp. 566-571)

*If the witness indicates the possibility of anemia, see the section on medical conditions for further questions.*

**DEFENSE THEORY: Concentration is a fragile process and may be disrupted by common stressors.**

**Q: Did you rule out *muscle contraction headaches* as a cause of the plaintiff's difficulty concentrating or mind going blank?**

Chronic muscle contraction headaches may produce nausea, vomiting, lightheadedness, difficulty in falling asleep, restless sleep with frequent awakenings, loss of energy, **impaired memory and concentration**, and symptoms of depression. (reference 2, pp. 72-73; reference 4, p. 1204)

*If the witness indicates the possibility of headaches, see the section on medical conditions for further questions.*

**Q: Did you rule out *migraine headaches* as a cause of the plaintiff's difficulty concentrating or mind going blank?**

A classic migraine (vascular) headache may be accompanied by visual disturbances, sensory motor or speech disturbances, nausea or vomiting, **difficulty concentrating**, and emotional changes. On rare occasions, the plaintiff may experience depersonalization or derealization. Migraine headaches may be precipitated by: (reference 4, p. 1204; reference 2, pp. 65-66)

- Emotional conflicts or stress
- Fluctuating estrogen levels in women
- Birth control pills
- Food:

Monosodium glutamate (Chinese restaurant syndrome)

Phenylethylamine-containing foods

Tyramine-containing foods (cheese or other fermented dairy products and chocolate)

## SYMPTOM

## DEPOSITION QUESTIONS

**Difficulty  
Concentrating,  
Mind Going  
Blank**

(continued)

**Q: Did you rule out *chronic fatigue syndrome* as a cause of the plaintiff's difficulty concentrating or mind going blank?**

Chronic fatigue syndrome presents with six months or more of severe, debilitating fatigue accompanied by myalgia, headaches, pharyngitis, low-grade fever, **cognitive complaints**, gastrointestinal symptoms, and tender lymph nodes. There is a high rate (15-54%) of depressive disorders among patients with chronic fatigue syndrome. Persons most likely to be plagued by persistent fatigue after an acute viral illness are patients with pre-existing or co-morbid psychiatric problems. Chronic fatigue syndrome is considered to be a special class of mood disorder with somatic symptoms. (reference 18, pp. 1531-1532)

**Q: Did you rule out *amphetamine or similarly acting sympathomimetic drug consumption or withdrawal* as a cause of the plaintiff's difficulty concentrating or mind going blank?**

Symptoms of amphetamine or similarly acting sympathomimetic *drug consumption* may include fighting, grandiosity, elation, hypervigilance, psychomotor agitation, **impaired judgment**, and impaired social or occupational functioning. Physical symptoms may include flushing, difficulty breathing, tachycardia, pupil dilation, elevated blood pressure, sweating or chills, nausea, and vomiting. Amphetamines and sympathomimetic drugs are central nervous system stimulants. The plaintiff often discovers that these stimulants can dominate their life, **preoccupy their thoughts**, and destroy family relationships or work behaviors. (reference 4, pp. 1007-1008; reference 7, pp. 223-227)

*Drug withdrawal* symptoms may include a dysphoric mood (depression, irritability, anxiety), fatigue, sweating, headaches, insomnia with nightmares, hypersomnia, and psychomotor agitation. Symptoms begin after the cessation of prolonged drug use (at least two days) and last more than 24 hours. (reference 7, pp. 227-228; reference 4, p. 1008)

The following drugs may be classified as amphetamines:

|                                    |                            |
|------------------------------------|----------------------------|
| Appetite Suppressants (diet pills) | Methamphetamines (speed)   |
| Dextroamphetamines                 | Methylphenidates (Ritalin) |
| Ma-huang (ephedra)                 | (reference 17, p. 586)     |
| (reference 24, pp. 488-489)        |                            |

**Q: Did you rule out *caffeine consumption or withdrawal* as a cause of the plaintiff's difficulty concentrating or mind going blank?**

Characteristic symptoms of *caffeine intoxication* include restlessness, nervousness, excitement, insomnia, flushed face, diuresis, gastrointestinal disturbance, muscle twitching, **rambling flow of thought and speech**, tachycardia or cardiac arrhythmia, periods of inexhaustibility, and psychomotor agitation. When consumed near bedtime, caffeine often disrupts sleep. Symptoms may appear when the plaintiff consumes as little as 250 mg of caffeine per day. The plaintiff that consumes one gram per day usually experiences more severe symptoms. Products which contain caffeine include: coffee, tea, soda, chocolate and weight-loss aids. (reference 7, pp. 231-234; reference 4, p. 1029)

## SYMPTOM

## DEPOSITION QUESTIONS

**Difficulty  
Concentrating,  
Mind Going  
Blank**

(continued)

The most common *caffeine withdrawal* symptom is a withdrawal headache. Headaches will occur in about one-third of moderate to high caffeine consumers when their daily intake is stopped. Other withdrawal symptoms include muscle tension, anxiety, drowsiness, lethargy, rhinorrhea (runny nose), **disinterest in work**, irritability, nervousness, mild feelings of depression, yawning, nausea, and fatigue. (reference 4, p. 1029; reference 2, p. 618; reference 7, p. 764)

See *caffeine consumption and symptom chart in Appendix A for further details.*

**Q: Did you rule out *inhalant intoxication* as a cause of the plaintiff's difficulty concentrating or mind going blank?**

Following inhalant (toxic substance) use, the plaintiff may experience behavioral and physical changes. Behavioral changes may include belligerence, assaultiveness, apathy, **impaired judgment**, and impaired social or occupational functioning. Physical signs may include dizziness, nystagmus, slurred speech, unsteady gait, lethargy, depressed reflexes, tremor, psychomotor weakness, blurred vision or diplopia, stupor or coma, euphoria. (reference 7, pp. 259-260)

**Q: Did you rule out *vascular dementia* (formerly *multi-infarct dementia*) as a cause of the plaintiff's difficulty concentrating or mind going blank?**

Vascular dementia is caused by cerebrovascular disease (disease of the brain's blood supply or blood vessels) that quickly produces an irregular **deterioration in intellectual functioning**. The resulting dementia involves **disturbances in memory, abstract thinking**, judgment, impulse control, and personality. Combined with depression, the dementia often causes many depressive symptoms. (reference 7, pp.158-160)

**Q: Did you rule out *dementia of the Alzheimer's type* as a cause of the plaintiff's difficulty concentrating or mind going blank?**

This primary degenerative dementia is caused by Alzheimer's disease. The plaintiff's **intellectual abilities**, personality, and behavior **progressively deteriorate**. Depressive symptoms may complicate the condition. (reference 7, pp.154-157)

*Age at onset: Senile onset (after age 65) is much more common than pre-senile onset. Few cases develop before the age of 49.*

**Q: Did you rule out *HIV-associated dementia* or *HIV-associated mild neurocognitive disorder* or as a cause of the plaintiff's difficulty in concentrating or mind going blank?**

HIV dementia is a severe cognitive disorder that interferes substantially with work, home life and social activities. Symptoms of mild neurocognitive disorder associated with HIV infection include **difficulty concentrating**, unusual fatigability with demanding mental tasks, feeling slowed down and **memory difficulties**.

Problem solving, abstract reasoning, and motor performance may also be affected. (reference 18, pp. 308-316; reference 7, p. 163)

## SYMPTOM

## DEPOSITION QUESTIONS

**Difficulty  
Concentrating,  
Mind Going  
Blank**

(continued)

**Q: Did you rule out *sedative, hypnotic, or anxiolytic consumption* as a cause of the plaintiff's difficulty concentrating or mind going blank?**

Sedative, hypnotic, or anxiolytic drug consumption can cause behavioral and physical changes. Behavioral symptoms may include disinhibition of sexual or aggressive impulses, mood lability, impaired judgment, and impaired social or occupational functioning. Physical symptoms may include slurred speech, incoordination, unsteady gait, and **impaired memory or attention span**. The effects of two or more drugs, such as sedatives and alcohol, may cause significant behavioral impairment. (reference 7, p. 286; reference 4, p. 1548)

**DEFENSE THEORY: To qualify for the diagnosis of Generalized Anxiety Disorder, the plaintiff must experience the anxiety, worry or physical symptoms or impairment in social, occupational, or other important areas of functioning.**

**Q: (Female) Did you rule out *premenstrual dysphoric disorder* as a cause of the plaintiff's difficulty concentrating or mind going blank?**

Premenstrual dysphoric disorder is characterized by emotional and behavioral symptoms which usually occur during the last week before the menstrual cycle and remit within a few days after menses begins. Symptoms may include tears, sadness, irritability, anger, tension, depression, self-deprecating thoughts, decreased interest in usual activities, fatigability, loss of energy, a subjective sense of **difficulty in concentration**, changes in appetite, and sleep disturbance. Physical symptoms may also include breast tenderness or swelling, tachycardia, sweating, headaches, joint or muscle pain, a sensation of bloating, or weight gain. (reference 7, pp. 771-774; reference 18, p. 1955)

**Q: Did you rule out *primary insomnia* as a cause of the plaintiff's difficulty concentrating or mind going blank?**

Primary insomnia involves difficulty initiating or maintaining sleep or experiencing non-restorative sleep. This pattern lasts for at least a month. The disorder may be severe enough to cause daytime fatigue, irritability, or an **impaired memory and concentration**. (reference 7, pp. 599-604; reference 2, p. 601)

*Note: The following question is to be asked if the plaintiff has experienced the loss of a family member or a close friend during the past two years.*

**Q: Did you rule out *bereavement* as a cause of the plaintiff's difficulty concentrating or mind going blank?**

Mourning is a normal grief reaction to a loss, such as the death of a loved one. The plaintiff may feel depressed and dejected, have diminished interest in the outside world, a decreased capacity to love, and an inhibition of activity. People tend to feel as if **all their energy is taken up with thoughts and memories of the loss**. Fatigue and weariness are characteristic symptoms. Sighing, feeling empty, disinterested, listless, eating more or less than normal, losing weight, and having trouble sleeping

## SYMPTOM

## DEPOSITION QUESTIONS

**Difficulty  
Concentrating,  
Mind Going  
Blank**

(continued)

are common experiences. (reference 4, pp. 1286-1293; reference 7, pp. 740-741; reference 2, p. 617)

**Q: Did you rule out *dysthymic disorder* (depression) as a cause of the plaintiff's difficulty concentrating or mind going blank?**

Dysthymic disorder is characterized by chronic depressive symptoms less severe than major depression. Always feeling despondent or melancholy, the plaintiff believes that depression is part of their personality. Other symptoms may include a poor appetite or overeating, insomnia or hypersomnia, low energy or fatigue, low self-esteem, **poor concentration, difficulty making decisions**, and feelings of hopelessness. The disorder may begin in childhood for both sexes, but is more common in adult females. (reference 7, pp. 376-381; reference 4, pp. 803-804)

*If the witness indicates the possibility of dysthymic disorder, see the section on dysthymia for further questions.*

**Q: Did you rule out the use of lithium as a cause of the plaintiff's difficulty concentrating or mind going blank?**

Lithium and the tricyclics are often given as medication for depression. Tremor is one of the most common side effects. Other symptoms may include nausea, diarrhea, polyuria (the passage of an excessive quantity of urine), polydipsia (excessive thirst), and weight gain. Toxic effects may include gross tremor, increased deep tendon reflexes, persistent headaches, vomiting, **mental confusion progressing to stupor**, seizures, or cardiac arrhythmias. (reference 1, pp. 1460-1461)

**Q: Did you rule out a *schizotypal personality disorder* as a cause of the plaintiff's difficulty concentrating or mind going blank?**

A schizotypal personality has oddities of thinking, perception, communication, and behavior that resemble schizophrenia. The plaintiff may experience anxiety, depression, and other dysphoric moods that **disrupt concentration** and the ability to function socially or at work. S/he may have few close friends except for immediate family. (reference 7, pp. 697-701)

*If the witness indicates the possibility of a schizotypal personality disorder or any other maladaptive personality traits, see the section on personality disorders for further questions.*

**Q: Did you rule out *multiple sclerosis* as a cause of the plaintiff's difficulty concentrating or mind going blank?**

Multiple sclerosis is a common disease of young adults. The disease causes a disorder of the optic nerves, spinal cord, and brain. Symptoms may include depression, apathy, **lack of judgement, inattention**, tremor, vertigo, incoordination, weakness, fatigue, dysarthria (speech impairment), and urinary frequency or hesitancy. (reference 4, p. 1276; reference 1, pp. 1354-1356)

*If the witness indicates the possibility of multiple sclerosis, see the section on medical conditions for further questions.*

## SYMPTOM

## DEPOSITION QUESTIONS

**Difficulty  
Concentrating,  
Mind Going  
Blank**

*(continued)*

**Q: Did you rule out *hypothyroidism* as a cause of the plaintiff's difficulty concentrating or mind going blank?**

Hypothyroidism results from inadequate synthesis of thyroid hormone. Hypothyroidism can produce psychiatric, as well as physical symptoms. The most notable psychiatric symptoms include depression, lethargy, **poor concentration, impaired memory**, and apathy. The numerous physical symptoms are: syncope, cold intolerance, constipation, muscle cramps, paresthesias, menstrual disorders, dyspnea, dizziness, reduced hearing, poor appetite, weight gain, brittle and thinning hair, and bradycardia (slowed heart action). Panic attacks are associated with endocrinological disorders including hypothyroidism and hyperthyroidism. (reference 18, pp. 743, 1810-1812, 1928)

*If the witness indicates the possibility of hypothyroidism, see the section on pre-existing medical conditions for further questions.*

**Q: Did you rule out *hyperthyroidism* as a cause of the plaintiff's difficulty concentrating or mind going blank?**

Hyperthyroidism, or thyrotoxicosis, results from overproduction of thyroid hormone by the thyroid gland. The most common cause is Graves' disease. The signs and symptoms of hyperthyroidism include both physical and psychiatric complaints. Psychiatric features include nervousness, fatigue, insomnia, mood lability, and dysphoria. There may be a heightened activity level. Cognitive symptoms include a **short attention span, impaired recent memory**, and an exaggerated startle response.

Physical signs and symptoms of hyperthyroidism include increased pulse, arrhythmias (irregular heart rhythm), elevated blood pressure, fine tremor, heat intolerance, excessive sweating, increased appetite, weight loss, palpitations (abnormal rapid beating of heart), tachycardia (rapid heart beat), frequent bowel movements, menstrual irregularities, and muscle weakness. Panic attacks are associated with endocrinological disorders including hyperthyroidism, as well as hypothyroidism. (reference 18, pp. 743, 1809-1810, 1928)

**Q: Did you rule out a *postpartum disorder* as a cause of the plaintiff's difficulty concentrating or mind going blank?**

Postpartum disorders are associated with pregnancy and the period after birth. Symptoms may include insomnia, restlessness, fatigue, depression, irritability, headaches, and lability of mood. Later in the postpartum period, the plaintiff may become suspicious, **confused or incoherent**, irrational, excessively concerned over trivialities, and refuse food. Depressed women may experience an over-concern for the baby, guilt, or feelings of inadequacy. Hallucinations, infanticide, and suicide are infrequent occurrences. (reference 4, pp. 1238-1241; reference 1, p. 1720)

*If the witness indicates the possibility of a postpartum disorder, see the section on medical conditions for further questions.*

## SYMPTOM

## DEPOSITION QUESTIONS

**Difficulty  
Concentrating,  
Mind Going  
Blank**

*(continued)*

**Q: Did you rule out *transient global amnesia* as a cause of the plaintiff's difficulty concentrating or mind going blank?**

Transient global amnesia is characterized by the **loss of the ability to recall recent events** or to record new memories. The distant past is easily remembered. Attacks last six to twenty-four hours and can occur at any age, especially in men. Recovery is usually complete. (reference 1, p. 1310)

**Q: Did you rule out *nicotine withdrawal* as a cause of the plaintiff's difficulty concentrating or mind going blank?**

Nicotine withdrawal symptoms include a strong craving for nicotine, anxiety, irritability, frustration or anger, **impaired attention**, coughing, headaches, insomnia, a **mental preoccupation** with actions associated with tobacco use, restlessness, drowsiness, gastrointestinal disturbances, an increased appetite, and weight gain. The symptoms appear within 24 hours after the cessation or reduction in the use of cigarettes, cigars, pipes, chewing tobacco, or nicotine gum. The plaintiff experiences a decrease in the intensity of the symptoms with time. (reference 7, pp. 265-266; reference 4, pp. 1031-1032)

**Q: Did you rule out *metabolic brain disease* as a cause of the plaintiff's difficulty concentrating or mind going blank?**

The plaintiff with a metabolic brain disease is **inattentive**, perplexed, preoccupied, and **unable to concentrate**. **Changes in mental abilities, alertness, awareness**, and perception are common. Characteristic physical symptoms include tremor, asterixis, (flapping tremor of the extremities), and multifocal myoclonus (sudden gross muscle contractions). (reference 9, pp. 1974-1975)

**Q: Did you rule out *hypoglycemia* as a cause of the plaintiff's difficulty concentrating or mind going blank?**

Hypoglycemia is an abnormally low blood sugar level. It often produces personality changes, tiredness, **confusion**, dizziness, tremor, anxiety, tachycardia, and sweating during acute attacks. Other psychiatric symptoms include fear and dread, depression with fatigue, and **agitation with confusion**. Hypoglycemia can develop from an insulin overdose, insulinoma or islet cell tumor, extensive liver disease, or functional diseases. (reference 2, p. 702; reference 4, pp. 1176-1177; reference 18, pp. 1929 and 1479 )

*If the witness indicates the possibility of hypoglycemia, see the section on medical conditions for further questions.*

**Q: Did you rule out a *brain tumor* as a cause of the plaintiff's difficulty concentrating or mind going blank?**

Brain tumors occur in the skull, brain, or membrane covering the brain or spinal cord. Symptoms vary depending on the size of the tumor and rate of growth. The plaintiff may experience anxiety, **dementia**, irritability, dizziness, fatigue, headache, vomiting, hyperthermia (high body temperature), and changes in appetite and

## SYMPTOM

## DEPOSITION QUESTIONS

**Difficulty  
Concentrating,  
Mind Going  
Blank***(continued)*

personality. (reference 4, pp. 139, 834-835, 855, 860, 1276; reference 9, pp. 2161-2164; reference 1, pp. 1351, 1296)

*If the witness indicates the possibility of a brain tumor, see the section on medical conditions for further questions.*

**Q: Did you rule out porphyria as a cause of the plaintiff's difficulty concentrating or mind going blank?**

Porphyria is an inherited disorder of middle-aged and young adults. It is characterized by episodes of abdominal pain, peripheral neuropathy, weakness, anorexia, nausea, vomiting, tachycardia, fever, **confusion**, depression, and severe anxiety. Mood swings and **mental abnormalities** are common symptoms. (reference 4, pp. 121, 1276, 1326; reference 9, p. 1156; reference 1, pp. 958, 960)

*If the witness indicates the possibility of porphyria, see the section on medical conditions for further questions.*

**Q: (Female) Did you rule out menopausal distress as a cause of the plaintiff's difficulty concentrating or mind going blank?**

Menopausal distress may cause anxiety, fatigue, GI disturbances, urinary frequency, back pain, palpitations, tension, emotional lability, irritability and nervousness, depression, dizziness, insomnia, and hot flashes. **Difficulty concentrating** may occur as a part of the depression. (reference 4, p. 1173; reference 9, p. 21)

*If the witness indicates the possibility of menopausal distress, see the section on medical conditions for further questions.*

**Q: Did you rule out pernicious anemia as a cause of the plaintiff's difficulty concentrating or mind going blank?**

Pernicious anemia results from a lack of vitamin B12. The disease develops slowly causing both physical and mental symptoms. The plaintiff may experience feelings of depression, worthlessness and guilt, irritability, paranoia, and **a loss of memory**. Physical symptoms may include anorexia, abdominal pain, intermittent constipation and diarrhea, weight loss, and weakness. Pernicious anemia often leads to combined system disease. (reference 4, p. 1276; reference 1, pp. 1077-1079; reference 2, pp. 576, 570)

*If the witness indicates the possibility of pernicious anemia, see the section on medical conditions for further questions.*

**Q: Did you rule out systemic lupus erythematosus as a cause of the plaintiff's difficulty concentrating or mind going blank?**

Systemic lupus erythematosus (SLE) causes inflammation in body organs such as the kidneys; the tissue surrounding the heart, lungs, thoracic cavity; and blood vessels. The plaintiff may become depressed, **confused**, and have **other thought disorders**. Physical symptoms may include anorexia, fatigue, fever, migraine headaches, and weight loss. (reference 9, pp. 1924-1928; reference 1, pp. 1207-1209)

*If the witness indicates the possibility of systemic lupus erythematosus, see the section on medical conditions for further questions.*

# Generalized Anxiety Disorder (GAD)

*SYMPTOM*

*DEPOSITION QUESTIONS*

**Difficulty Concentrating, Mind Going Blank**

*(continued)*

**Q: Did you rule out *Cushing's disease* (hyperadrenalism) as a cause of the plaintiff's difficulty concentrating or mind going blank?**

Plaintiffs often experience emotional changes before physical signs of the disease appear. Depression is the most common symptom. Other psychological symptoms include irritability, anxiety, **confusion**, insomnia, and **impaired memory or concentration**. Some of the characteristic physical signs include an increased appetite, weakness, buffalo hump, truncal and facial obesity, heightened facial color, and abdominal striae (stripes). (reference 4, pp. 1171-1172)

*If the witness indicates the possibility of Cushing's syndrome, see the section on medical conditions for further questions.*

**Q: Did you rule out *infections* as a cause of the plaintiff's difficulty concentrating or mind going blank?** (reference 2, pp. 617, 450-451)

- |                                  |                                 |
|----------------------------------|---------------------------------|
| Brucellosis                      | Meningitis                      |
| Chronic urinary tract infections | Postpartum infections           |
| HIV                              | Subacute bacterial endocarditis |
| Infectious mononucleosis         | Syphilis                        |
| Influenza                        | Tuberculosis                    |
| Malaria                          | Viral hepatitis                 |

**Q: Is the plaintiff taking any *medications or substances* that may cause difficulty concentrating or mind going blank, such as:**

- |           |           |           |
|-----------|-----------|-----------|
| ALTACE    | EXCELON   | RISPERDAL |
| AMBIEN    | HALCION   | SEROQUEL  |
| ANSAID    | KERLONE   | SONATA    |
| AVONEX    | LAMICTAL  | SULAR     |
| CARDIZEM  | LIPITOR   | TIAZAC    |
| CARDURA   | LUVOX     | TRILEPTAL |
| CELEXA    | MIRAPEX   | TROVAN    |
| CLARITIN  | NEURONTIN | ULTRAM    |
| CLOZARIL  | ORUDIS    | ZOMIG     |
| COGNEX    | OXYCONTIN | ZYBAN     |
| DORAL     | PAXIL     | ZYLOPRIM  |
| DURACT    | PREVACID  | ZYPREXA   |
| DURAGESIC | PROZAC    | ZYRTEC    |

**Sleep Disturbance**

**Q: Describe the plaintiff's trouble falling or staying asleep (primary insomnia).**

**Q: When and how often does the plaintiff have trouble falling or staying asleep?**

**Q: Does the plaintiff sleep during the day?**

**Q: What are the plaintiff's pre-bedtime patterns?**

*SYMPTOM*

*DEPOSITION QUESTIONS*

**Sleep Disturbance**

*(continued)*

**Q: Does the plaintiff have a history of not being able to fall asleep or stay asleep before the injury in question?**

Insomnia may be persistent from childhood or early adolescence into adulthood. (reference 4, p. 1253)

**Q: Does the plaintiff have a history of any *medical conditions* that may cause trouble falling or staying asleep?**

*The witness may indicate the possibility of the following medical conditions: please refer to the sections pertaining to these medical conditions for further questions.*

**TABLE 5.2-7.**

|                               |                                     |
|-------------------------------|-------------------------------------|
| Alzheimer's disease           | Heart Failure                       |
| Autonomic dysfunction         | Kleine-Levin syndrome               |
| Circadian rhythm disturbances | Hepatic encephalopathy              |
| Creutzfeldt-Jakob disease     | Subacute sclerosing panencephalitis |
| Fibromyalgia                  |                                     |

**Q: Did you rule out *caffeine consumption* as a cause of the plaintiff's trouble falling or staying asleep?**

Characteristic symptoms of *caffeine intoxication* include restlessness, nervousness, excitement, **insomnia**, flushed face, diuresis, gastrointestinal disturbance, muscle twitching, rambling flow of thought and speech, tachycardia or cardiac arrhythmia, periods of inexhaustibility, and psychomotor agitation. When consumed near bedtime, caffeine often disrupts sleep. Symptoms may appear when the plaintiff consumes as little as 250 mg of caffeine per day. The plaintiff that consumes one gram per day usually experiences more severe symptoms. Products which contain caffeine include: coffee, tea, soda, chocolate and weight-loss aids. (reference 7, pp. 231-234; reference 4, p. 1029)

*If the witness indicates the possibility of excess caffeine consumption, see the caffeine consumption chart in Appendix A.*

**Q: Did you rule out *stressors or other conditions not attributable to a mental disorder* as a cause of the plaintiff's difficulty falling or staying asleep?**

*If the witness indicates the possibility of a life stressor or other condition, see the section on life stressors for further questions.*

**Q: Did you rule out *nightmare disorder* (formerly dream anxiety disorder) as a cause of the plaintiff's difficulty falling or staying asleep?**

Nightmare disorder causes the plaintiff to **awaken from REM sleep** with a detailed account of a disturbing dream. S/he may feel anxious and experience autonomic arousal. Nightmares may occur frequently in the more susceptible plaintiff that is stressed, fatigued, or who has consumed alcohol. (reference 4, p. 1260; reference 1, p. 1321; reference 7, pp. 631-634)

## SYMPTOM

## DEPOSITION QUESTIONS

**Sleep  
Disturbance***(continued)*

**Q: Did you rule out *sleep terror disorder* as a cause of the plaintiff's trouble falling or staying asleep?**

Sleep terror disorder causes the plaintiff to **awaken with a sense of intense terror** from a single frightening image not associated with a dream. The plaintiff usually falls asleep and forgets the episode. These occurrences seldom require specific treatment. (reference 4, p. 1260; reference 7, p. 634)

**DEFENSE THEORY: Sleep disturbance related to any medical condition does not qualify as a symptom in the diagnosis of GAD.**

**Q: Did you rule out *rebound insomnia* as a cause of the plaintiff's trouble falling or staying asleep?**

Rebound insomnia follows the use of drugs, such as: (reference 9, pp. 1988-1989)  
Temazepam (Restoril)  
Triazolam (Halcion)

**Q: Did you rule out *habit insomnia* as a cause of the plaintiff's trouble falling or staying asleep?**

Habit insomnia is a conditioned reflex. The plaintiff associates going to bed with **restlessness and wakefulness**, rather than with sleep. (reference 4, p. 1251)

**Q: Did you rule out *recent travel* as a cause of the plaintiff's trouble falling or staying asleep?**

Jet travel commonly causes a change in sleep patterns. The plaintiff may experience **sleepiness and fatigue** during the day and **insomnia** during the night. The disorder usually disappears spontaneously in two to seven days. (reference 4, p. 1259)

**Q: Did you rule out *age* as a cause of the plaintiff's trouble falling or staying asleep?**

The number of awakenings per night and the amount of time **awake during the night increases** gradually with age. These changes may be distressing enough for the plaintiff to seek treatment. (reference 4, p. 1261; reference 1, pp. 1321-1322)

**Q: Did you rule out any *pain or discomfort* as a cause of the plaintiff's trouble falling or staying asleep?**

Almost any medical, toxic, or environmental condition associated with pain and discomfort can produce **insomnia**.

## SYMPTOM

## DEPOSITION QUESTIONS

**Sleep  
Disturbance***(continued)***Q: Did you rule out *sleep apnea* as a cause of the plaintiff's trouble staying asleep?**

Sleep apnea is the cessation or suspension of breathing during sleep. These hesitations may cause the plaintiff to **awaken periodically throughout the night**. The most common complaint of plaintiffs with this disorder is excessive daytime drowsiness. (reference 4, pp. 132, 1252)

**Q: (Obese plaintiff) Did you rule out an *obstructive sleep apnea* as a cause of the plaintiff's trouble staying asleep?**

Obesity, sometimes combined with a physical defect, may lead to pulmonary failure or upper airway narrowing. The obstruction causes repeated awakenings during the night and a cycle of night and day **episodes of awakenings and drowsiness**. Weight reduction can be an effective treatment. (reference 1, p. 1321)

**Q: Did you rule out *restless leg syndrome* as a cause of the plaintiff's trouble falling or staying asleep?**

Restlessness and an uncomfortable or painful crawling sensation in the muscles and bones of the lower legs are signs of the restless leg syndrome. The symptoms usually occur at night, **disturbing sleep**, or when the plaintiff is resting. There is no known cause of the syndrome. (reference 4, pp. 132, 1253)

**Q: Did you rule out *nocturnal myoclonus* as a cause of the plaintiff's trouble falling or staying asleep?**

Rhythmic muscle twitches and involuntary movements of the extremities **disrupt the plaintiff's sleep**. The disorder usually begins during late middle age and in the elderly. (reference 9, pp. 1988-1989)

**Q: Did you rule out any *work shift change* as a cause of the plaintiff's trouble falling or staying asleep?**

Work shift changes cause **sleep-wake symptoms** that begin immediately when the work period is scheduled during the night. Symptoms are usually worse the first few days. Some plaintiffs experience **disrupted sleep-wake patterns** for a long time after the shift change. (reference 4, p. 1259)

**Q: Did you rule out *self-imposed chaotic sleep schedule* as a cause of the plaintiff's trouble falling or staying asleep?**

Frequently changing sleep-awake schedules cause sleep **insomnia** and daytime somnolence (drowsiness). This condition is becoming more prevalent and occurs in plaintiffs that fly frequently or that repeatedly change their work schedule.

**Q: Did you rule out *somatoform (psychogenic) pain disorder* as a cause of the plaintiff's trouble falling or staying asleep?**

Somatoform pain disorder is characterized by pain as the predominant focus of clinical attention. In addition, psychological factors are judged to have an important role in the onset, severity, exacerbation, or maintenance of the pain. Some of the emotionally caused symptoms may be depression, anxiety, anhedonia (an inability

## SYMPTOM

## DEPOSITION QUESTIONS

**Sleep  
Disturbance***(continued)*

to experience pleasure), **insomnia**, and irritability. The symptoms may become so severe that the plaintiff feels incapacitated and quits working. (reference 7, pp. 498-503; reference 4, p. 1109)

*If the witness indicates the possibility of a somatoform (psychogenic) pain disorder, see the section on somatoform pain disorder for further questions.*

**Q: Did you rule out *manic or hypomanic episodes* as a cause of the plaintiff's trouble falling or staying asleep?**

A *manic episode* is a period during which the predominant mood is either elevated, expansive, or irritable. Manic symptoms include a true reduction in the need for sleep. The plaintiff may have **difficulty falling asleep** but often wakes up refreshed after two to four hours of rest.

*Hypomanic episodes* are mood disturbances severe enough to require hospitalization or to greatly impair social and occupational functioning. (reference 4, p. 1251; reference 7, pp. 357, 365)

**DEFENSE THEORY: If plaintiff's expert has related the sleep disturbance to a depressive illness, it may not qualify or be included under the diagnosis of GAD (DSM-IV-TR, p. 476).**

**Q: Did you rule out a *bipolar disorder* as a cause of the plaintiff's trouble falling or staying asleep?**

A bipolar disorder has a circular pattern of high and low emotional states (*mania and depression*). During the *manic episodes*, the plaintiff may feel grandiose, have a **decreased need for sleep**, and decreased emotional capacity, experience a surge of ideas and conversation, and may be easily distracted or pleased. It is often thought that the manic high represents an escape from inner depression and pain. While the plaintiff is extremely active, s/he is often fragmented and unable to finish projects. The plaintiff typically does not realize that s/he is ill.

During *major depressive episodes* the plaintiff may be depressed for at least two weeks. The plaintiff may experience an appetite disturbance, weight change, **sleep disturbance**, psychomotor agitation or retardation, decreased energy and emotional capacity, feelings of worthlessness, difficulty thinking or concentrating, and recurrent thoughts of death or suicide. (reference 4, pp. 408-409, 761; reference 7, pp. 382-391)

**Q: Did you rule out *cyclothymic disorder* as a cause of the plaintiff's trouble falling or staying asleep?**

Cyclothymic disorder is a chronic disturbance that resembles manic and depressive syndromes. The symptoms are not severe enough to meet the criteria for a major depressive or manic episode. The plaintiff may have impaired social and occupational functioning. This disorder may cause **sleep disturbance** as a component of the depressive episodes. Occurring most often in females, cyclothymic disorder usually begins in early adulthood. (reference 7, pp. 398-400; reference 4, pp. 760-761, 804)

## SYMPTOM

## DEPOSITION QUESTIONS

**Sleep  
Disturbance***(continued)***Q: Did you rule out the onset of psychosis or schizophrenia as a cause of the plaintiff's trouble falling or staying asleep?**

The schizophrenic or prepsychotic plaintiff will have increasing incidence and severity of nightmares and other **sleep difficulties** often caused by guilt, anxiety or both. If it increases in severity, the plaintiff may develop a psychotic state within a few weeks. (reference 4, pp. 67, 1252)

**Q: Did you rule out opioid withdrawal as a cause of the plaintiff's trouble falling or staying asleep?**

Symptoms of *opioid withdrawal* may include lacrimation (tearing), rhinorrhea (runny nose), dilated pupils, sweating, diarrhea, yawning, mild hypertension, tachycardia (increased heart rate), fever, **insomnia**, and goose pimples. Associated features may include restlessness, irritability, depression, tremor, weakness, nausea, vomiting, and muscle or joint pain. These signs, often resembling influenza symptoms, may be precipitated by the abrupt ending of one or two weeks of continuous opioid use. The withdrawal symptoms may last days or weeks. During the final stages of withdrawal, the plaintiff may experience over-concern for bodily discomfort, poor self-image, and a decreased ability to tolerate stress. (reference 7, pp. 272-273; reference 4, pp. 990-991)

*Note: The following question is to be asked if the plaintiff has experienced the loss of a family member or a close friend during the past two years.*

**Q: Did you rule out bereavement as a cause of the plaintiff's trouble falling or staying asleep?**

Mourning is a normal grief reaction to a loss, such as the death of a loved one. The plaintiff may feel depressed and dejected, have diminished interest in the outside world, a decreased capacity to love, and an inhibition of activity. People tend to feel as if all their energy is taken up with thoughts and memories of the loss. Fatigue and weariness are characteristic symptoms. Sighing, feeling empty, disinterested, listless, eating more or less than normal, losing weight, and having **trouble sleeping** are common experiences. (reference 4, pp. 1286-1293; reference 7, pp. 740-741; reference 2, p. 617)

**Q: Did you rule out an adjustment disorder with depressed mood as a cause of the plaintiff's trouble falling or staying asleep?**

This adjustment disorder is accompanied by depression, tearfulness, **sleep disturbance**, and feelings of hopelessness to a stressor. It is important to note that an adjustment disorder is a *transient over-reaction* to stress and should remit within six months. (reference 7, pp. 679-683)

*If the witness indicates the possibility of an adjustment disorder with depressed mood, see the section on adjustment disorder for further questions.*

## SYMPTOM

## DEPOSITION QUESTIONS

## Sleep Disturbance

(continued)

**Q: Did you rule out *Cushing's disease* (hyperadrenalism) as a cause of the plaintiff's trouble falling or staying asleep?**

Plaintiffs often experience emotional changes before physical signs of the disease appear. Depression is the most common symptom. Other psychological symptoms include irritability, anxiety, confusion, **insomnia**, and impaired memory or concentration. Some of the characteristic physical signs include an increased appetite, weakness, buffalo hump, truncal and facial obesity, heightened facial color, and abdominal striae (stripes). (reference 4, pp. 1171-1172)

*If the witness indicates the possibility of Cushing's syndrome, see the section on pre-existing medical conditions for further questions.*

**Q: Did you rule out *hyperthyroidism* as a cause of the plaintiff's trouble falling or staying asleep?**

Hyperthyroidism, or thyrotoxicosis, results from overproduction of thyroid hormone by the thyroid gland. The most common cause is Graves' disease. The signs and symptoms of hyperthyroidism include both physical and psychiatric complaints. Psychiatric features include nervousness, fatigue, **insomnia**, mood lability, and dysphoria. There may be a heightened activity level. Cognitive symptoms include a short attention span, impaired recent memory, and an exaggerated startle response.

Physical signs and symptoms of hyperthyroidism include increased pulse, arrhythmias (irregular heart rhythm), elevated blood pressure, fine tremor, heat intolerance, excessive sweating, increased appetite, weight loss, palpitations (abnormal rapid beating of heart), tachycardia (rapid heart beat), frequent bowel movements, menstrual irregularities, and muscle weakness. Panic attacks are associated with endocrinological disorders including hyperthyroidism, as well as hypothyroidism. (reference 18, pp. 743, 1809-1810, 1928)

**DEFENSE THEORY: Defense counsel should obtain the plaintiff's past medical and pharmacy records to determine if s/he has a prior history of sedative or other sleep medications.**

**Q: Did you rule out *alcohol consumption or cessation* as a cause of the plaintiff's trouble falling or staying asleep?**

*Alcohol intoxication* may cause aggressiveness, impaired judgment and attention, irritability, euphoria, depression, emotional lability, and impaired social or occupational functioning. Physical symptoms may include slurred speech, incoordination, unsteady gait, nystagmus, occasional dizziness, and flushed face. Heavy alcohol consumption may cause **abnormal sleep patterns**. The plaintiff often falls asleep quickly but **wakes up earlier and earlier** with uncomfortable feelings. Chronic alcoholics may have irregular, unsteady, and slow tremulous movements. (reference 7, pp. 212-215; reference 4, p. 67; reference 9, p. 52)

The *reduction or cessation* of drinking for at least several days may cause characteristic symptoms: coarse tremor of hands, tongue, or eyelids; nausea or vomiting; malaise or weakness; autonomic hyperactivity (tachycardia, sweating,

## SYMPTOM

## DEPOSITION QUESTIONS

**Sleep  
Disturbance***(continued)*

and elevated blood pressure); anxiety, depressed mood or irritability; transient hallucinations or illusions; headache; **insomnia**; dizziness; fatigue; restlessness; and agitation. (reference 7, pp. 215-216; reference 2, pp. 722, 618; reference 9, pp. 50-54)

**Q: (Female) Did you rule out *menopausal distress* as a cause of the plaintiff's trouble falling or staying asleep?**

Menopausal distress may cause anxiety, fatigue, GI disturbances, urinary frequency, back pain, palpitations, tension, emotional lability, irritability and nervousness, depression, dizziness, **insomnia**, and hot flashes. (reference 4, p. 1173; reference 9, p. 21)

*If the witness indicates the possibility of menopausal distress, see the section on medical conditions for further questions.*

**Q: Did you rule out *muscle contraction headaches* as a cause of the plaintiff's trouble falling or staying asleep?**

Chronic muscle contraction headaches may produce nausea, vomiting, lightheadedness, **difficulty in falling asleep, restless sleep with frequent awakenings**, loss of energy, impaired memory and concentration, and symptoms of depression. (reference 2, pp. 72-73; reference 4, p. 1204)

*If the witness indicates the possibility of headaches, see the section on medical conditions for further questions.*

**Q: Did you rule out *dysthymic disorder (depression)* as a cause of the plaintiff's trouble falling or staying asleep?**

Dysthymic disorder is characterized by chronic depressive symptoms less severe than major depression. Always feeling despondent or melancholy, the plaintiff believes that depression is part of their personality. Other symptoms may include a poor appetite or overeating, **insomnia** or hypersomnia, low energy or fatigue, low self-esteem, poor concentration, difficulty making decisions, and feelings of hopelessness. The disorder may begin in childhood for both sexes, but is more common in adult females. (reference 7, pp. 376-381; reference 4, pp. 803-804)

*If the witness indicates the possibility of dysthymic disorder, see that section for further questions.*

**Q: Did you rule out *cocaine withdrawal* as a cause of the plaintiff's trouble falling or staying asleep?**

The abrupt cessation or reduction of cocaine, after several days use, may cause the plaintiff to feel tired, dysphoric, irritable, depressed, and to crave more of the drug. An anxiety reaction may cause psychomotor agitation, **insomnia** or hypersomnia, high blood pressure, tachycardia, and paranoia. The symptoms may persist for more than a day. (reference 7, pp. 245-246; reference 4, pp. 1008-1009)

**SYMPTOM****DEPOSITION QUESTIONS****Sleep  
Disturbance***(continued)***Q: Did you rule out *sedative, hypnotic, or anxiolytic withdrawal* as a cause of the plaintiff's trouble falling or staying asleep?**

Withdrawal symptoms develop when the plaintiff reduces or stops the prolonged moderate or heavy use of these substances. Symptoms may include nausea or vomiting; malaise or weakness; autonomic hyperactivity (such as tachycardia and sweating); anxiety or irritability; orthostatic hypotension; coarse tremor of the hands, tongue and eyelids; **insomnia**; and grand mal seizures. (reference 7, pp. 201-209; reference 4, p.1549)

**Q: (Female) Did you rule out *premenstrual dysphoric disorder* as a cause of the plaintiff's trouble falling or staying asleep?**

Premenstrual dysphoric disorder is characterized by emotional and behavioral symptoms which usually occur during the last week before the menstrual cycle and remit within a few days after menses begins. Symptoms may include tears, sadness, irritability, anger, tension, depression, self-deprecating thoughts, decreased interest in usual activities, fatigability, loss of energy, a subjective sense of difficulty in concentration, changes in appetite, and **sleep disturbance**. Physical symptoms may also include breast tenderness or swelling, tachycardia, sweating, headaches, joint or muscle pain, a sensation of bloating, or weight gain. (reference 7, pp. 771-774; reference 18, p. 1955)

**Q: Did you rule out *amphetamine or similarly acting sympathomimetic drug withdrawal* as a cause of the plaintiff's trouble falling or staying asleep?**

*Drug withdrawal* symptoms may include a dysphoric mood (depression, irritability, anxiety), fatigue, sweating, headaches, **insomnia with nightmares**, hypersomnia, and psychomotor agitation. Symptoms begin after the cessation of prolonged drug use (at least two days) and last more than 24 hours. (reference 7, pp. 227-228; reference 4, p. 1008)

The following drugs may be classified as amphetamines:

|                                    |                            |
|------------------------------------|----------------------------|
| Appetite Suppressants (diet pills) | Methamphetamines (speed)   |
| Dextroamphetamines                 | Methylphenidates (Ritalin) |
| Ma-huang (ephedra)                 | (reference 17, p. 586)     |
| (reference 24, pp. 488-489)        |                            |

**Q: Did you rule out *psychogenic dyspnea* as a cause of the plaintiff's trouble falling or staying asleep?**

Plaintiffs with chronic psychogenic breathlessness may be depressed or have a reactive depression to stress. Others may have a depressive psychosis with associated symptoms of anorexia, weight loss, **early morning awakening**, psychomotor retardation, and daytime mood variations. S/he may complain of smothering or being unable to breath, feeling lightheaded, dizzy, or numb in the extremities and around the mouth. (reference 2, p. 342)

*Defense counsel should note that some plaintiffs with this disorder desire financial compensation and may be malingering. See the section on malingering for further questions*

## SYMPTOM

## DEPOSITION QUESTIONS

**Sleep  
Disturbance***(continued)***Q: Did you rule out a recent *heart attack* as a cause of the plaintiff's trouble falling or staying asleep?**

Despondency is almost a universal response to heart attack. Even without complications, the plaintiff may feel a sense of loss, and vulnerable to further injury. Weakness and tiredness are the single distressing symptoms of the depression. The plaintiff may also experience **insomnia**, daytime hypersomnia, and practical worries. Complications cause the plaintiff's despondency and hopelessness to be intensified. (reference 4, pp. 1156-1157)

*If the witness indicates the possibility of a recent heart attack, see the section on medical conditions for further questions.*

**Q: Did you rule out long-term treatment with *adrenal cortical steroids* or *ACTH* as a cause of the plaintiff's trouble falling or staying asleep?**

Plaintiffs with a long-term history of adrenal cortical steroid or ACTH treatment commonly develop major mental disturbances. While taking the drugs, they may experience euphoria, severe mania, severe depression, delirium, paresthesia (abnormal tightness or tingling around a limb or trunk), **insomnia**, restlessness, or agitation. Symptoms usually disappear when the drugs are reduced or discontinued. (reference 4, p. 876)

**Q: Did you rule out *anorexia nervosa* as a cause of the plaintiff's trouble falling or staying asleep?**

The anorexic plaintiff weighs fifteen percent less than the minimal weight normal for his or her age and height. S/he refuses to maintain body weight and has a distorted body image. Other symptoms may include depressed feelings, crying spells, **sleep disturbance**, obsessive rumination, obsessive compulsive behavior, anxiety, and occasional suicidal thoughts. Many anorexic adolescents have delayed psychosexual development. Adults with the disorder often have a decreased interest in sex. (reference 7, pp. 583-589; reference 1, pp. 1904-1905; reference 4, pp. 1145, 1731)

**Q: Did you rule out *nicotine withdrawal* as a cause of the plaintiff's trouble falling or staying asleep?**

Nicotine withdrawal symptoms include a strong craving for nicotine, anxiety, irritability, frustration or anger, impaired attention, coughing, headaches, **insomnia**, a mental preoccupation with actions associated with tobacco use, restlessness, drowsiness, gastrointestinal disturbances, an increased appetite, and weight gain. The symptoms appear within 24 hours after the cessation or reduction in the use of cigarettes, cigars, pipes, chewing tobacco, or nicotine gum. The plaintiff experiences a decrease in the intensity of the symptoms with time. (reference 7, pp. 265-266; reference 4, pp. 1031-1032)

**Q: Did you rule out a *nightmare disorder* (formerly *dream anxiety disorder*) as a cause of the plaintiff's trouble falling or staying asleep?**

The plaintiff **awakens from sleep** at least three times a week with a detailed account of a recurring nightmare. The nightmares may be long, lifelike, and often involve

*SYMPTOM*

*DEPOSITION QUESTIONS*

**Sleep Disturbance**

*(continued)*

threats of survival or self-esteem. The dream anxieties occur more frequently with mental stress, physical fatigue, or changes in sleep environment. The disorder usually begins before age of twenty. In most cases a major stressful life event precedes the onset of the disorder. (reference 7, pp. 631-634)

**Q: Did you rule out the possibility of a *postpartum disorder* as a cause of the plaintiff's trouble falling or staying asleep?**

Postpartum disorders are associated with pregnancy and the period after birth. Symptoms may include **insomnia**, restlessness, fatigue, depression, irritability, headaches, and lability of mood. Later in the postpartum period, the plaintiff may become suspicious, confused or incoherent, irrational, excessively concerned over trivialities, and refuse food. Depressed women may experience an over-concern for the baby, guilt, or feelings of inadequacy. Hallucinations, infanticide, and suicide are infrequent occurrences. (reference 4, pp. 1238-1241; reference 1, p. 1720)

*If the witness indicates the possibility of a postpartum disorder, see the section on medical conditions for further questions.*

**Q: Did you rule out *cluster headaches* as a cause of the plaintiff's trouble falling or staying asleep?**

Cluster headaches usually occur in clusters of daily headaches that recur for several weeks. They may last from twenty minutes to two hours and cause severe pain, flushing and facial sweating. Sleep-related cluster headaches are severe unilateral headaches that appear intermittently during REM sleep and cause **sleep disturbances**. (reference 4, pp. 1205, 1261; reference 2, p. 70)

*If the witness indicated the possibility of headaches, see the section on medical conditions for further questions.*

**Q: Did you rule out *infections* as a cause of the plaintiff's trouble falling or staying asleep?** (reference 2, pp. 617, 450-451)

|                                  |                                 |
|----------------------------------|---------------------------------|
| Brucellosis                      | Postpartum infections           |
| Chronic urinary tract infections | Subacute bacterial endocarditis |
| Infectious mononucleosis         | Syphilis                        |
| Influenza                        | Tuberculosis                    |
| Malaria                          | Viral hepatitis                 |
| Meningitis                       |                                 |

**Q: Did you rule out the *cessation of medications or substances* as a cause of the plaintiff's trouble falling or staying asleep?**

Abrupt cessation of the following medications may contribute to sleep disturbance:

|                           |                      |
|---------------------------|----------------------|
| Antidepressant medication | Marijuana            |
| Benzodiazepines           | Phenothiazines       |
| Hypnotics                 | Sedating tricyclics  |
| Opioids                   | Tranquilizing agents |

# Generalized Anxiety Disorder (GAD)

**SYMPTOM**

**DEPOSITION QUESTIONS**

**Sleep Disturbance**

(continued)

**Q: Does the plaintiff have any *other medical conditions* that may cause trouble falling or staying asleep, such as:**

- |                     |  |
|---------------------|--|
| Abnormal swallowing | Gastroesophageal reflux                |
| Asthma              | Metabolic and pulmonary failures       |
| Cystic fibrosis     | Sleep-related painful erections (male) |

**Q: Is the plaintiff taking any *medications or substances* that may cause trouble falling or staying asleep, such as:**

- |                 |              |               |
|-----------------|--------------|---------------|
| ACCUTANE        | CLARITIN     | EPHEDRA       |
| ADALAT          | CLINDEX      | ETRAFON       |
| ADAPIN          | CLINORIL     | EXCELON       |
| ADDERALL        | CLOZARIL     | FASTIN        |
| ADIPEX          | COGNEX       | FELBATOL      |
| AEROBID         | COLESTID     | FELDENE       |
| ALTACE          | COMBIPRES    | FLAGYL        |
| AMBIEN          | COMBIVENT    | FLEXERIL      |
| AMPHETAMINES    | COMPAZINE    | FLOMAX        |
| AMYTAL          | CONCERTA     | FLOXIN        |
| ANAFRANIL       | COZAAR       | GABITRIL      |
| ANAPROX         | CYCRIN       | HABITROL      |
| ANSAID          | CYLERT       | HALCION       |
| ARICEPT         | DALMANE      | HALDOL        |
| ARTHROTEC       | DANTRIUM     | HISTUSSIN     |
| ASENDIN         | DECADRON     | HYTRIN        |
| ATROVENT        | DEPO-PROVERA | HYZAAR        |
| AUGMENTIN       | DEPROL       | IMDUR         |
| AVONEX          | DESOXYN      | INDERAL       |
| AZULFIDINE      | DESYREL      | INDERIDE      |
| BACTRIM         | DEXEDRINE    | INDOCIN       |
| BENADRYL        | DILACOR      | IONAMIN       |
| BENTYL          | DILANTIN     | KERLONE       |
| BIPHETAMINE     | DIMETANE     | KLONOPIN      |
| BUSPAR          | DIOVAN       | LAMICTAL      |
| BUTICAPS        | DITROPAN     | LESCOL        |
| CAFFEINE        | DOLOBID      | LEVAQUIN      |
| CARAFATE-TOO    | DONNATAL     | LEVO-DROMORAM |
| CARDIZEM        | DORAL        | LEVOTHROID    |
| CARDURA         | DURACT       | LEVSIN        |
| CATAPRES        | DURAGESIC    | LIORESAL      |
| CEFZIL          | DURAVENT     | LIPITOR       |
| CELEBREX        | DYNACIRC     | LODINE        |
| CELEXA          | EFFEXOR      | LOPRESSOR     |
| CELONTIN        | ELAVIL       | LOTENSIN      |
| CHLORAL-HYDRATE | ELDEPRYL     | LOTREL        |
| CHLORTRIMETON   | ENDEP        | LOZOL         |
| CIPRO           | ENTEXLA      | LUDIOMIL      |

**Generalized Anxiety Disorder (GAD)****SYMPTOM****DEPOSITION QUESTIONS****Sleep  
Disturbance***(continued)*

|                             |             |            |
|-----------------------------|-------------|------------|
| LUVOX                       | PLAVIX      | SYMMETREL  |
| MARPLAN                     | PLENDIL     | TALECEN    |
| MAVIK                       | POLARIMINE  | TALWIN-NX  |
| MAXAIR                      | PONDIMIN    | TAVIST     |
| MAXALT                      | PRAVACHOL   | TEMARIL    |
| MAXIDE                      | PREMPHASE   | THEO-DUR   |
| MEBARAL                     | PREMPRO     | THORAZINE  |
| MECLOMEN                    | PREVACID    | TIAZAC     |
| METHADONEHYDRO-<br>CHLORIDE | PRILOSEC    | TIMOPTIC   |
| MIRAPEX                     | PRINZIDE    | TINDAL     |
| MODURETIC                   | PROAMATINE  | TOFRANIL   |
| MONOPRIL                    | PROKETAZINE | TOPAMAX    |
| MORPHINE-SULFATE            | PROPULSID   | TOPROL-XL  |
| MOTRIN                      | PROSOM      | TORADOL    |
| NALDECON                    | PROTONIX    | TRANXENE   |
| NALFON                      | PROVENTIL   | TRIAVIL    |
| NAPROSYN                    | PROVERA     | TRILAFON   |
| NAVANE                      | PROZAC      | TRILEPTAL  |
| NEMBUTAL                    | PULMICORT   | TRINALIN   |
| NEURONTIN                   | REDUX       | TROVAN     |
| NICORETTE                   | REGLAN      | ULTRAM     |
| NOLUDAR                     | RELAFEN     | VALIUM     |
| NOREPHEDRINE                | REMERON     | VANTIN     |
| NOROXIN                     | RESTORIL    | VASOTEC    |
| NORPACE                     | REVIA       | VENTOLIN   |
| NORPRAMIN                   | RISPERDAL   | VERELAN    |
| NORVASC                     | RITALIN     | VIAGRA     |
| OMNICEF                     | RUFEN       | VICOPROFEN |
| OPTIMINE                    | SANOREX     | VIOXX      |
| ORAP                        | SANSERT     | VIVACTIL   |
| ORNADE                      | SECONAL     | VOLTAREN   |
| ORUDIS                      | SELDANE     | WELLBUTRIN |
| OXYCONTIN                   | SEPTRA      | XANAX      |
| PAMELOR                     | SEREVENT    | ZANTAC     |
| PARLODEL                    | SEROQUEL    | ZAROXOLY   |
| PARNATE                     | SERTRALINE  | ZESTORETIC |
| PAXIL                       | SERZONE     | ZESTRIL    |
| PEDIAZOLE                   | SINEMET     | ZOCOR      |
| PEPCID                      | SLO-BID     | ZOLOFT     |
| PERIACTIN                   | SLO-PHYLLIN | ZOMIG      |
| PERMAX                      | SOMA        | ZYBAN      |
| PERMITIL                    | SONATA      | ZYLOPRIM   |
| PHENOBARBITAL               | SPORANOX    | ZYPREXA    |
| PHENYL-<br>PROPANOLAMINE    | STADOL      | ZYRTEC     |
| PLACIDYL                    | SULAR       |            |
|                             | SULINDAC    |            |
|                             | SURMONTIL   |            |

*SYMPTOM*

*DEPOSITION QUESTIONS*

## Irritability

**DEFENSE THEORY:** Irritability is a universal human emotion. Plaintiff's expert should be asked to describe the plaintiff's pattern of irritability prior to the cause of action.

**Q:** Describe the plaintiff's irritability.

---

**Q:** When and how often is the plaintiff irritable?

---

**Q:** What is the plaintiff's pre-existing temperament or ability to cope with anger?

---

**Q:** Does the plaintiff have a history of irritability before the injury in question?

---

**Q:** Does the plaintiff have a history of any *medical conditions* that may cause irritability?

*The witness may indicate the possibility of the following medical conditions: please refer to the sections pertaining to these medical conditions for further questions.*

**TABLE 5.2-8.**

|                         |                                       |
|-------------------------|---------------------------------------|
| Addison's disease       | Hypertension                          |
| Chronic pain condition  | Subacute sclerosing panencephalopathy |
| Combined system disease | Syphilis                              |
| Hepatic encephalopathy  |                                       |

**Q:** Did you rule out an *intermittent explosive disorder* as a cause of the plaintiff's irritability?

An intermittent explosive disorder is characterized by several discrete, **aggressive episodes or loss of control**. The degree of aggressiveness is out of proportion to any of the causing stressors. There is no indication of generalized impulsiveness or aggressiveness between the episodes. The plaintiff may describe these events as "spells" or "attacks", and may experience regret or self-reproach about the consequences of the action following each episode. (reference 7, pp. 663-667)

---

**Q:** Did you rule out *attention-deficit hyperactivity disorder (ADHD)* as a cause of the plaintiff's irritability?

The essential characteristics of ADHD include inattention, impulsiveness, and hyperactivity. ADHD is usually diagnosed during elementary school years, and can persist throughout childhood. Persons diagnosed with ADHD have a higher prevalence of mood and anxiety disorders, learning disorders, substance-related disorders and the potential for the development of an antisocial personality disorder. Approximately one-third of the children diagnosed with ADHD show some signs of the disorder in adulthood. Associated symptoms may include low self-esteem, mood lability, **low frustration tolerance, and temper outbursts**. (reference 7, pp. 85-93)

---

**SYMPTOM****DEPOSITION QUESTIONS****Irritability***(continued)***Q: Did you rule out a *borderline personality disorder* as a cause of the plaintiff's irritability?**

A borderline personality disorder is characterized by unstable interpersonal relationships, behavior, mood, and self-image. The plaintiff may experience temporary mood shifts including depression, **irritability**, and anxiety. S/he may also have chronic feelings of emptiness or boredom, **inappropriate anger**, and recurrent suicidal thoughts. Social contrariness and a generally pessimistic outlook often accompany the disorder. Premature death may result from suicide. (reference 7, pp. 706-710)

*If the witness indicates the possibility of a borderline personality disorder or other maladaptive personality traits, see the section on personality disorders for further questions.*

**Q: Did you rule out an *adjustment disorder with depressed mood* as a cause of the plaintiff's irritability?**

This adjustment disorder is accompanied by depression, tearfulness, sleep disturbance, and feelings of hopelessness to a stressor. **Irritability** is often a component of the depression. It is important to note that an adjustment disorder is a transient over-reaction to stress and should remit within six months. (reference 7, pp. 679-683)

*If the witness indicates the possibility of an adjustment disorder with depressed or anxious mood, see the section on adjustment disorder for further questions.*

**Q: Did you rule out an *adjustment disorder with anxiety* as a cause of the plaintiff's irritability?**

An adjustment disorder is a transient over-reaction to stress that usually occurs within 90 days and remits within six months. The adjustment disorder with anxiety is characterized by symptoms of nervousness, worry, jitteriness, and motor tension. The plaintiff may have **irritability** as part of the anxiety. (reference 7, pp. 679-683; reference 4, pp. 1098-1099)

**Q: Did you rule out *manic or hypomanic episodes* as a cause of the plaintiff's irritability?**

A *manic episode* is a period during which the predominant mood is either elevated, expansive, or **irritable**. Manic symptoms include a true reduction in the need for sleep. The plaintiff may have difficulty falling asleep but often wakes up refreshed after two to four hours of rest.

*Hypomanic episodes* are mood disturbances severe enough to require hospitalization or to greatly impair social and occupational functioning. (reference 4, p. 1251; reference 7, pp. 357, 365)

**Q: Did you rule out *cyclothymic disorder* as a cause of the plaintiff's irritability?**

Cyclothymic disorder is a chronic disturbance that resembles manic and depressive syndromes. The symptoms are not severe enough to meet the criteria for a major

## SYMPTOM

## DEPOSITION QUESTIONS

**Irritability***(continued)*

depressive or manic episode. The plaintiff may have impaired social and occupational functioning. This disorder may cause **irritability** as a component of the manic episodes. Occurring most often in females, cyclothymic disorder usually begins in early adulthood. (reference 7, pp. 398-401; reference 4, pp. 760-761, 804)

**Q: Did you rule out opioid withdrawal as a cause of the plaintiff's irritability?**

Symptoms of opioid withdrawal may include lacrimation (tearing), rhinorrhea (runny nose), dilated pupils, sweating, diarrhea, yawning, mild hypertension, tachycardia (increased heart rate), fever, insomnia, and gooseflesh. Associated features may include restlessness, **irritability**, depression, tremor, weakness, nausea, vomiting, and muscle or joint pain. These signs, often resembling influenza symptoms, may be precipitated by the abrupt ending of one or two weeks of continuous opioid use. The withdrawal symptoms may last days or weeks. During the final stages of withdrawal, the plaintiff may experience over-concern for bodily discomfort, poor self-image, and a decreased ability to tolerate stress. (reference 7, pp. 272-273; reference 4, pp. 990-991)

*Caution: Do not ask the following question if the cause of action involves a head injury or toxic exposure.*

**Q: Did you rule out any head injuries or other conditions leading to organic brain syndrome as a cause of the plaintiff's irritability?**

Organic brain syndrome is a term for symptoms produced by head injury, toxic exposure, hypoxia (oxygen deficiency), anoxia (extreme oxygen deficiency in tissues) or other causes. Common symptoms of *head injuries* include vertigo, lightheadedness, syncope, impaired concentration and memory, easy fatigability, **irritability**, lack of energy, depression, anxiety, phobia, a lowered tolerance for alcohol, and headaches. Symptoms may appear days or weeks after the injury but usually appear within 24 hours. (reference 2, pp. 75, 111)

**Q: Did you rule out Cushing's syndrome (hyperadrenalism) as a cause of the plaintiff's irritability?**

Plaintiffs often experience emotional changes before physical signs of the disease appear. Depression is the most common symptom. Other psychological symptoms include **irritability**, anxiety, confusion, insomnia, and impaired memory or concentration. Some of the characteristic physical signs include an increased appetite, weakness, buffalo hump, truncal and facial obesity, heightened facial color, and abdominal striae (stripes). (reference 4, pp. 1171-1172)

*If the witness indicates the possibility of Cushing's syndrome, see the section on pre-existing medical conditions for further questions.*

**Q: Did you rule out alcohol consumption or cessation as a cause of the plaintiff's irritability?**

*Alcohol intoxication* may cause **aggressiveness**, impaired judgment and attention, **irritability**, euphoria, depression, emotional lability, and impaired social or occupational functioning. Physical symptoms may include slurred speech,

## SYMPTOM

## DEPOSITION QUESTIONS

**Irritability***(continued)*

incoordination, unsteady gait, nystagmus, occasional dizziness, and flushed face. Heavy alcohol consumption may cause abnormal sleep patterns. The plaintiff often falls asleep quickly but wakes up earlier and earlier with uncomfortable feelings. Chronic alcoholics may have irregular, unsteady, and slow tremulous movements. (reference 7, pp. 212-215; reference 4, p. 67; reference 9, p. 52)

The *reduction or cessation* of drinking for at least several days may cause characteristic symptoms: coarse tremor of hands, tongue, or eyelids; nausea or vomiting; malaise or weakness; autonomic hyperactivity (tachycardia, sweating, and elevated blood pressure); anxiety, depressed mood or **irritability**; transient hallucinations or illusions; headache; insomnia; dizziness; fatigue; restlessness; and agitation. (reference 7, pp. 215-216; reference 2, pp. 722, 618; reference 9, pp. 50-54)

**Q: (Female) Did you rule out *menopausal distress* as a cause of the plaintiff's irritability?**

Menopausal distress may cause anxiety, fatigue, GI disturbances, urinary frequency, back pain, palpitations, tension, **emotional lability, irritability** and nervousness, depression, dizziness, insomnia, and hot flashes. (reference 4, p. 1173; reference 9, p. 21)

*If the witness indicates the possibility of menopausal distress, see the section on medical conditions for further questions.*

**Q: Did you rule out *somatoform (psychogenic) pain disorder* as a cause of the plaintiff's irritability?**

Somatoform (psychogenic) pain disorder is characterized by pain as the predominant focus of clinical attention. In addition, psychological factors are judged to have an important role in the onset, severity, exacerbation, or maintenance of the pain. Emotionally caused symptoms may be depression, anxiety, anhedonia (an inability to experience pleasure), insomnia, and **irritability**. The symptoms may become so severe that the plaintiff feels incapacitated and quits working. (reference 7, pp. 498-503; reference 4, p. 1109)

*If the witness indicates the possibility of a somatoform (psychogenic) pain disorder, see the section on somatoform disorders for further questions.*

**Q: Did you rule out *antisocial personality disorder* as a cause of the plaintiff's irritability?**

The antisocial plaintiff may have a lifetime history of irresponsible and antisocial behavior. Childhood behaviors may include lying, stealing, truancy, vandalism, initiating fights, running away from home, and physical cruelty. Adolescents may also become abusers of tobacco, alcohol, and other drugs, or engage in early sexual activity. Adults with antisocial personalities **tend to be irritable, aggressive, reckless, and promiscuous**. S/he may be unable to keep a job, friendship, or sexual relationship. The plaintiff shows no remorse or guilt when hurting or mistreating others. Frequently this disorder is accompanied by signs of **personal distress**,

## SYMPTOM

## DEPOSITION QUESTIONS

**Irritability***(continued)*

**tension**, an inability to tolerate boredom, depression, a conviction that others are hostile, and suicidal attempts. (reference 7, pp. 701-706; reference 4, pp. 1865, 1868-1869)

*If the witness indicates the possibility of an antisocial personality disorder, see the section on personality disorders for further questions.*

**Q: Did you rule out anemia as a cause of the plaintiff's irritability?**

Vertigo, pounding headaches, fainting, dimness of vision, tinnitus (a ringing in one or both ears), **irritability**, anorexia, restlessness, inability to concentrate, lethargy, fatigue, drowsiness, GI complaints, and congestive heart failure are common symptoms of anemia. (reference 2, pp. 566-571)

*If the witness indicates the possibility of anemia, see the section on medical conditions for further questions.*

**Q: Did you rule out niacin deficiency (B complex) as a cause of the plaintiff's irritability?**

Niacin is one of the B complex vitamins essential for the normal carbohydrate metabolism of yeast cells and animal tissues. As the body's level of niacin decreases, the plaintiff may initially experience a burning tongue after eating hot or spicy foods. Symptoms are often more severe in the spring and fall and may be associated with mild anorexia, fatigue, nervousness, **irritability**, alternating periods of constipation and diarrhea, or burning sensations in the epigastrium (upper and middle abdomen). (reference 2, pp. 121-123)

**Q: Did you rule out riboflavin deficiency (ariboflavinosis) as a cause of the plaintiff's irritability?**

Riboflavin is one of the B complex vitamins essential for the normal carbohydrate metabolism of yeast cells and animal tissues. Initial oral symptoms include a mild burning sensation in the tongue, oral lesions, and buccal mucosa of the cheeks. Other symptoms are sore and cracking lips, burning and itching eyes, loss of appetite, weakness, and **irritability**. (reference 2, pp. 121, 124-125)

**Q: Did you rule out caffeine withdrawal as a cause of the plaintiff's irritability?**

The most common caffeine withdrawal symptom is a withdrawal headache. Headaches will occur in about one-third of moderate to high caffeine consumers when their daily intake is stopped. Other withdrawal symptoms include muscle tension, anxiety, drowsiness, lethargy, rhinorrhea (runny nose), disinterest in work, **irritability**, nervousness, mild feelings of depression, yawning, nausea, and fatigue. Products which contain caffeine include: coffee, tea, soda, chocolate and weight-loss aids. (reference 4, p. 1029; reference 2, p. 618; reference 7, pp. 764-765)

*If the witness indicates the possibility of excess caffeine consumption, see the caffeine consumption chart in Appendix A.*

## SYMPTOM

## DEPOSITION QUESTIONS

**Irritability***(continued)***Q: Did you rule out *primary insomnia* as a cause of the plaintiff's irritability?**

Primary insomnia involves difficulty initiating or maintaining sleep or experiencing non-restorative sleep. This pattern lasts for at least a month. The disorder may be severe enough to cause daytime fatigue, **irritability**, or an impaired memory and concentration. (reference 7, pp. 599-604; reference 2, p. 601)

**Q: Did you rule out *cocaine consumption and/or withdrawal* as a cause of the plaintiff's irritability?**

*Cocaine users* often experience increased energy and confidence or **irritability** and paranoia with physical **aggressiveness**. Other behavioral symptoms may include euphoria, hypervigilance, psychomotor agitation, impaired judgment, and impaired social or occupational functioning. Physical symptoms may include tachycardia, dilated pupils, elevated blood pressure, perspiration or chills, nausea, vomiting, and hallucinations.

The abrupt *cessation or reduction of cocaine*, after several days use, may cause the plaintiff to feel tired, dysphoric, **irritable**, depressed, and to crave more of the drug. An anxiety reaction may cause psychomotor agitation, insomnia or hypersomnia, high blood pressure, tachycardia, and paranoia. The symptoms may persist for more than a day. (reference 7, pp. 241-245 and 245-246; reference 4, pp. 1008-1009)

**Q: Did you rule out *sedative, hypnotic, or anxiolytic withdrawal* as a cause of the plaintiff's irritability?**

Withdrawal symptoms develop after the reduction or cessation of the prolonged moderate or heavy use of these substances. Symptoms may include nausea or vomiting; malaise or weakness; autonomic hyperactivity (such as tachycardia and sweating); anxiety or **irritability**; orthostatic hypotension; coarse tremor of the hands, tongue and eyelids; insomnia; and grand mal seizures. (reference 7, pp. 201-209; reference 4, p. 1549)

**Q: (Female) Did you rule out *premenstrual dysphoric disorder* as a cause of the plaintiff's irritability?**

Premenstrual dysphoric disorder is characterized by emotional and behavioral symptoms which usually occur during the last week before the menstrual cycle and remit within a few days after menses begins. Symptoms may include tears, sadness, **irritability**, **anger**, tension, depression, self-deprecating thoughts, decreased interest in usual activities, fatigability, loss of energy, a subjective sense of difficulty in concentration, changes in appetite, and sleep disturbance. Physical symptoms may also include breast tenderness or swelling, tachycardia, sweating, headaches, joint or muscle pain, a sensation of bloating, or weight gain. (reference 7, pp. 771-774; reference 18, p. 1955)

**Q: Did you rule out *inhalant intoxication* as a cause of the plaintiff's irritability?**

Following inhalant (toxic substance) use, the plaintiff may experience behavioral and physical changes. Behavioral changes may include **belligerence**, **assaultiveness**, apathy, impaired judgment, and impaired social or occupational functioning.

*SYMPTOM*

*DEPOSITION QUESTIONS*

**Irritability**

(continued)

Physical signs may include dizziness, nystagmus, slurred speech, unsteady gait, lethargy, depressed reflexes, tremor, psychomotor weakness, blurred vision or diplopia, stupor or coma, and euphoria. (reference 7, pp. 259-260)

**Q: Did you rule out a *paranoid personality disorder* as a cause of the plaintiff's irritability?**

The paranoid plaintiff has a history of unwarranted suspicion and mistrust of others. Often expecting to be exploited or harmed, s/he may be excessively sensitive, jealous, hypervigilant, and tense. The plaintiff may find it difficult to relax or forgive, and is **argumentative** when threatened by innocent remarks or events. His or her mood is often humorless, cold and unemotional. These plaintiffs rarely seek help because of a tendency to be moralistic, grandiose, and extrapunitive. (reference 7, pp. 690-694; reference 4, pp. 748-753)

*If the witness indicates the possibility of a paranoid personality disorder or other maladaptive personality traits, see the section on personality disorders for further questions.*

**Q: Did you rule out *amphetamine or similarly acting sympathomimetic drug consumption and/or withdrawal* as a cause of the plaintiff's irritability?**

Symptoms of amphetamine or similarly acting sympathomimetic *drug consumption* may include **fighting**, grandiosity, elation, hypervigilance, **psychomotor agitation**, impaired judgment, and impaired social or occupational functioning. Physical symptoms may include flushing, difficulty breathing, tachycardia, pupil dilation, elevated blood pressure, sweating or chills, nausea, and vomiting. (reference 4, pp. 1007-1008; reference 7, pp. 223-227)

*Drug withdrawal* symptoms may include a dysphoric mood (depression, **irritability**, anxiety), fatigue, sweating, headaches, insomnia with nightmares, hypersomnia, and **psychomotor agitation**. Symptoms begin after the cessation of prolonged drug use (at least two days) and last more than 24 hours. (reference 7, pp. 227-228; reference 4, p. 1008)

The following drugs may be classified as amphetamines:

- |                                    |                            |
|------------------------------------|----------------------------|
| Appetite Suppressants (diet pills) | Methamphetamines (speed)   |
| Dextroamphetamines                 | Methylphenidates (Ritalin) |
| Ma-huang (ephedra)                 | (reference 17, p. 586)     |
| (reference 24, pp. 488-489)        |                            |

**Q: Did you rule out an *allergic reaction* as a cause of the plaintiff's irritability?**

Allergic rhinitis is seasonal or perennial inflammatory disease of the nasal membranes. Symptoms may include sneezing; a stuffy and itching nose; postnasal drainage; and itching eyes. The plaintiff with allergies may feel generally ill and uncomfortable, tired, weak, despondent, **irritable**, and uninterested in eating. (reference 9, pp. 1867-1868)

**SYMPTOM****DEPOSITION QUESTIONS****Irritability***(continued)***Q: Did you rule out a *postpartum disorder* as a cause of the plaintiff's irritability?**

Postpartum disorders are associated with pregnancy and the period after birth. Symptoms may include insomnia, restlessness, fatigue, depression, **irritability**, headaches, and lability of mood. Later in the postpartum period, the plaintiff may become suspicious, confused or incoherent, irrational, excessively concerned over trivialities, and refuse food. Depressed women may experience an over-concern for the baby, guilt, or feelings of inadequacy. Hallucinations, infanticide, and suicide are infrequent occurrences. (reference 4, pp. 1238-1241; reference 1, p. 1720)

**Q: Did you rule out *nicotine withdrawal* as a cause of the plaintiff's irritability?**

Nicotine withdrawal symptoms include a strong craving for nicotine, anxiety, **irritability**, frustration or anger, impaired attention, coughing, headaches, insomnia, a mental preoccupation with actions associated with tobacco use, restlessness, drowsiness, gastrointestinal disturbances, an increased appetite, and weight gain. The symptoms appear within 24 hours after the cessation or reduction in the use of cigarettes, cigars, pipes, chewing tobacco, or nicotine gum. The plaintiff experiences a decrease in the intensity of the symptoms with time. (reference 7, pp. 265-266; reference 4, pp. 1031-1032)

**Q: Did you rule out *hypoglycemia* as a cause of the plaintiff's irritability?**

Hypoglycemia is an abnormally low blood sugar level. It often produces personality changes, tiredness, confusion, dizziness, tremor, anxiety, tachycardia, and sweating during acute attacks. Other psychiatric symptoms include fear and dread, depression with fatigue, and **agitation** with confusion. Hypoglycemia can develop from an insulin overdose, insulinoma or islet cell tumor, extensive liver disease, or functional diseases. (reference 2, p. 702; reference 4, pp. 1176-1177; reference 18, pp. 1929, 1479 )

*If the witness indicates the possibility of hypoglycemia, see the section on medical conditions for further questions.*

**Q: Did you rule out early onset of *Wilson's disease* as a cause of the plaintiff's irritability?**

Wilson's disease is characterized by brain degeneration. Defective copper excretion causes an accumulation of copper in the liver, brain and other tissues. Symptoms may include tremor exaggerated with movement, difficulty speaking and swallowing, incoordination, personality changes, **explosive anger**, abdominal pain, diarrhea, nausea and vomiting, and dementia. (reference 9, pp. 1158-1159)

*If the witness indicates the possibility of Wilson's disease, see the section on pre-existing medical conditions for further questions.*

**Q: Did you rule out a *brain tumor* as a cause of the plaintiff's irritability?**

Brain tumors occur in the skull, brain, or membrane covering the brain or spinal cord. Symptoms vary depending on the size of the tumor and rate of growth. The plaintiff may experience anxiety, dementia, **irritability**, dizziness, fatigue, headache,

## SYMPTOM

## DEPOSITION QUESTIONS

**Irritability***(continued)*

vomiting, hyperthermia (high body temperature), and changes in appetite and personality. (reference 4, pp. 139, 834-835, 855, 860, 1276; reference 9, pp. 2161-2164; reference 1, pp. 1351, 1296)

*If the witness indicates the possibility of a brain tumor, see the section on medical conditions for further questions.*

**Q: Did you rule out long-term treatment with adrenal cortical steroids or ACTH as a cause of the plaintiff's irritability?**

Plaintiffs with a long-term history of adrenal cortical steroid or ACTH treatment commonly develop major mental disturbances. While taking the drugs, they may experience euphoria, severe mania, severe depression, delirium, paresthesia (abnormal tightness or tingling around a limb or trunk), insomnia, restlessness, or **agitation**. Symptoms usually disappear when the drugs are reduced or discontinued. (reference 4, p. 876)

**Q: Did you rule out pancreatic carcinoma as a cause of the plaintiff's irritability?**

Pancreatic carcinoma is a cancer of the pancreas that causes a decrease in enzymes, lipids, glucagens, and insulin. Symptoms may include abdominal pain radiating to the back, weight loss, anorexia, weakness, diarrhea, vomiting, depression, **irritability**, and a sense of doom. (reference 1, p. 751; reference 4, p. 1276; reference 9, pp. 777-779; reference 2, p. 425)

*If the witness indicates the possibility of pancreatic carcinoma, see the section on medical conditions for further questions.*

**Q: Did you rule out porphyria as a cause of the plaintiff's irritability?**

Porphyria is an inherited disorder of young to middle-aged adults. It is characterized by episodes of abdominal pain, peripheral neuropathy, weakness, anorexia, nausea, vomiting, tachycardia, fever, confusion, depression, and severe anxiety. **Mood swings** and mental abnormalities are common symptoms. (reference 4, pp. 121, 1276, 1326; reference 9, p. 1156; reference 1, pp. 958, 960)

*If the witness indicates the possibility of porphyria, see the section on medical conditions for further questions.*

**Q: Did you rule out pernicious anemia as a cause of the plaintiff's irritability?**

Pernicious anemia results from a lack of vitamin B12. The disease develops slowly causing both physical and mental symptoms. The plaintiff may experience feelings of depression, worthlessness and guilt, **irritability**, paranoia, and a loss of memory. Physical symptoms may include anorexia, abdominal pain, intermittent constipation and diarrhea, weight loss, and weakness. Pernicious anemia often leads to combined system disease. (reference 4, p. 1276; reference 1, pp. 1077-1079; reference 2, pp. 576, 570)

*If the witness indicates the possibility of pernicious anemia, see the section on medical conditions for further questions.*

*SYMPTOM*

*DEPOSITION QUESTIONS*

**Irritability**

(continued)

**Q: Did you rule out *depressive pseudodementia* as a cause of the plaintiff's irritability?**

Cognitive disturbances seen in severe major depressive episodes are usually referred to as depressive pseudodementia. Treatment for the depression can restore both mood and memory to normal. Anxiety, **irritability**, a loss of social skills, and memory gaps for specific periods or events are characteristic symptoms. (reference 4, pp. 150-151; reference 18, pp. 809)

**Q: Did you rule out a *passive aggressive (negativistic) personality disorder* as a cause of the plaintiff's irritability?**

A passive aggressive personality passively resists both the demands of work and society. S/he may express this through procrastination, dawdling, stubbornness, intentional inefficiency, and forgetfulness. The plaintiff may be **sulky, irritable, or argumentative**. Associated symptoms include dependency, lack of self-confidence, and a pessimism for the future with no sense of responsibility for their problems. (reference 7, pp.789-791; reference 4, p. 985)

**Q: Did you rule out *infections* as a cause of the plaintiff's irritability?**  
(reference 2, pp. 617, 450-451)

|                                  |                                 |
|----------------------------------|---------------------------------|
| Brucellosis                      | Postpartum infections           |
| Chronic urinary tract infections | Subacute bacterial endocarditis |
| Infectious mononucleosis         | Syphilis                        |
| Influenza                        | Tuberculosis                    |
| Malaria                          | Viral hepatitis                 |
| Meningitis                       |                                 |

**Q: Does the plaintiff have any *other medical conditions* that may cause irritability, such as:**

Cardiovascular disease  
Central nervous system disease  
Metabolic and pulmonary failures

**Q: Is the plaintiff taking any *medications or substances* that may cause the irritability, such as:**

|              |               |          |
|--------------|---------------|----------|
| AEROBID      | CHLORTRIMETON | DIMETANE |
| AMPHETAMINES | CIPRO         | DIMETAPP |
| ANAFRANIL    | CLARITAN-D    | DORAL    |
| ARICEPT      | CLOMID        | DURAVENT |
| ARTHROTEC    | CLOZARIL      | ELDEPRYL |
| BENADRYL     | CYLERT        | FIORICET |
| BROMFED      | CYTOMEL       | FLAGYL   |
| BUSPAR       | DALMANE       | GABITRIL |
| CELONTIN     | DESOXYN       | GUAIFED  |

# Generalized Anxiety Disorder (GAD)

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*SYMPTOM*

*DEPOSITION QUESTIONS*

---

**Irritability**

*(continued)*

- |            |             |            |
|------------|-------------|------------|
| HALCION    | REVIA       | TRINALIN   |
| LOZOL      | SELDANE     | VENTOLIN   |
| MAXALT     | SKELAXIN    | VOLTAREN   |
| MECLIZINE  | SLO-BID     | YOCON      |
| MESANTOIN  | SLO-PHYLLIN | ZARONTIN   |
| OPTIMINE   | SOMA        | ZEPHREX    |
| ORNADE     | SYMMETREL   | ZESTORETIC |
| PERIACTIN  | TALECEN     | ZESTRIL    |
| PLENDIL    | TALWIN-NX   | ZOMIG      |
| POLARIMINE | TAVIST      | ZYBAN      |
| PROVENTIL  | THEO-DUR    |            |
| PULMICORT  | TRANXENE    |            |



## **SECTION 5.2A: ADDITIONAL ANXIETY SYMPTOMS COMMONLY REPORTED BY PLAINTIFFS**

**(Formerly Classified in DSM-III-R as Symptoms Consistent with Generalized Anxiety Disorder)**

### **INTRODUCTION**

The symptoms, conditions and behaviors noted in this section were listed under Generalized Anxiety Disorder in the DSM-III-R edition of the Diagnostic Manual. However, in the current edition (DSM-IV-TR), they have been omitted or transferred to other sections. Because these symptoms, conditions and behaviors continue to occur in claims and litigation, we have listed them in this section.

## Additional Anxiety Symptoms

*SYMPTOM*

*DEPOSITION QUESTIONS*

**Trembling,  
Twitching,  
Feeling Shaky**

- Q:** Describe the plaintiff's trembling, twitching, or feeling shaky.
- 
- Q:** When and how often does the plaintiff experience trembling, twitching, or feeling shaky?
- 
- Q:** Does the plaintiff have a history of trembling, twitching, or feeling shaky before the injury in question?
- 
- Q:** Does the plaintiff have a history of any *medical conditions* that may cause trembling, twitching, or feeling shaky?
- The witness may indicate the possibility of the following medical conditions: please refer to the sections pertaining to these medical conditions for further questions.*

**TABLE 5.2A-1.**

|                          |                                     |
|--------------------------|-------------------------------------|
| Addison's disease        | Hypotension                         |
| Combined systems disease | Parkinson's disease                 |
| Epilepsy                 | Subacute sclerosing panencephalitis |
| Hepatic encephalopathy   | Syphilis                            |

- Q:** Did you rule out *essential tremor* as a cause of the plaintiff's trembling, twitching, or feeling shaky?
- Essential tremor may be identified by a **tremor of the hands, head**, and least frequently, the voice. It typically begins before age 25 and persists throughout life gradually spreading to other parts of the body. There is a strong familial incidence. Physical or social disability may result. (reference 9, pp. 2073-2074)
- 
- Q:** Did you rule out a *conversion disorder* as a cause of the plaintiff's trembling, twitching, or feeling shaky?
- A conversion disorder is characterized by the presence of symptoms or deficits affecting **voluntary motor** or sensory function that suggest a neurological or other general medical condition. Psychological factors are judged to be associated with the symptom or deficit and the symptoms are not intentionally feigned or produced. Conversion symptoms are defense mechanisms that change the unconscious emotional conflict into a physical disability that often symbolizes the nature of the conflict. (reference 12, p. 315; reference 2, pp. 625, 630; reference 7, p. 492)
- If the witness indicates the possibility of a conversion disorder, see the section on conversion disorder for further questions.*
- 
- Q:** Did you rule out a *somatization disorder (psychosomatic)* as a cause of the plaintiff's trembling, twitching, or feeling shaky?
- The plaintiff with a somatization disorder has many physical complaints for several years. S/he sees multiple physicians only to discover no physical cause for the symptoms. The plaintiff often has exaggerated and vague complaints focusing on either organs or types of symptoms, such as **pseudoneurologic** or conversion

## SYMPTOM

## DEPOSITION QUESTIONS

**Trembling,  
Twitching,  
Feeling Shaky**

(continued)

symptoms, gastrointestinal, female reproductive, psychosexual, pain, and cardiopulmonary symptoms. Anxiety, depression, suicide attempts, social withdrawal, and work or interpersonal relationship difficulties are common. (reference 7, p. 486; reference 4, pp. 389, 940)

*If the witness indicates the possibility of a somatization disorder, see the section on somatization disorder for further questions.*

**Q: Did you rule out *specific phobia* as a cause of the plaintiff's trembling, twitching, or feeling shaky?**

A phobic disorder is characterized by the presence of irrational or exaggerated fears of objects, situations, or bodily functions. The situation or object of the fear is not inherently dangerous or an appropriate source of anxiety. The plaintiff may have symptoms of panic, sweating, tachycardia, **shakiness**, and difficulty breathing. S/he either avoids the object of the phobia or endures the situation with intense anxiety. There is also a marked distress about having the irrational fear. (reference 7, p. 443; reference 4, pp. 899-900)

*If the witness indicates the possibility of a specific phobia, see the section on specific phobia for further questions.*

**Q: Did you rule out *opioid withdrawal* as a cause of the plaintiff's trembling, twitching, or feeling shaky?**

Symptoms of opioid withdrawal may include lacrimation (tearing), rhinorrhea (runny nose), dilated pupils, sweating, diarrhea, yawning, mild hypertension, tachycardia (increased heart rate), fever, insomnia, and gooseflesh. Associated features may include restlessness, irritability, depression, **tremor**, weakness, nausea, vomiting, and muscle or joint pain. These signs, often resembling influenza symptoms, may be precipitated by the abrupt ending of one or two weeks of continuous opioid use. The withdrawal symptoms may last days or weeks. During the final stages of withdrawal, the plaintiff may experience over-concern for bodily discomfort, poor self-image, and a decreased ability to tolerate stress. (reference 7, p. 272; reference 4, pp. 990-991)

**Q: Did you rule out *hallucinogen consumption* as the cause of the plaintiff's trembling, twitching, or feeling shaky?**

Hallucinogen consumption causes changes in perception such as feelings of detachment, illusions, hallucinations, and synesthesia (seeing colors when a loud sound occurs). Behavioral symptoms may include anxiety or depression, ideas of reference, fear of losing one's mind, paranoia, impaired judgment, and impaired social or occupational functioning. Physical symptoms may include dilated pupils, tachycardia, sweating, palpitations, blurred vision, **tremors**, and incoordination. Flashbacks of experiences may recur several months or years after hallucinogen use. Many plaintiffs may have gross thought process disturbances. Unlike schizophrenics, they are able to talk in detail about their hallucinations. (reference 7, p. 250; reference 4, p. 874)

## SYMPTOM

## DEPOSITION QUESTIONS

**Trembling,  
Twitching,  
Feeling Shaky***(continued)***Q: Did you rule out *inhalant intoxication* as a cause of the plaintiff's trembling, twitching, or feeling shaky?**

Following inhalant (toxic substance) use, the plaintiff may experience behavioral and physical changes. Behavioral changes may include belligerence, assaultiveness, apathy, impaired judgment, and impaired social or occupational functioning. Physical signs may include dizziness, nystagmus, slurred speech, unsteady gait, lethargy, depressed reflexes, **tremor**, psychomotor weakness, blurred vision or diplopia, stupor or coma, and euphoria. (reference 7, p. 257)

**Q: Did you rule out *ecstasy use* as a cause for the plaintiff's trembling or twitching?**

MDMA (methylenedioxymethamphetamine) use can sometimes result in severe dehydration or exhaustion, or other adverse effects such as nausea, hallucinations, chills, sweating, increases in body temperature, **tremors**, involuntary teeth clenching, muscle cramping, and blurred vision. MDMA users have also reported after-effects such as anxiety, paranoia, aggression and depression. An MDMA overdose is characterized by high blood pressure, faintness, panic attacks, and, in more severe cases, loss of consciousness, seizures, and a drastic rise in body temperatures to 105-106 degrees Fahrenheit. MDMA overdoses can be fatal, as they may result in heart failure or extreme heat stroke. (reference 20)

**Q: Did you rule out *sedative, hypnotic, or anxiolytic consumption or withdrawal* as a cause of the plaintiff's trembling, twitching, or feeling shaky?**

Sedative, hypnotic, or anxiolytic drug consumption can cause behavioral and physical changes. Behavioral symptoms may include disinhibition of sexual or aggressive impulses, mood lability, impaired judgment, and impaired social or occupational functioning. Physical may include slurred speech, incoordination, **unsteady gait**, and impaired memory or attention span. Sedative drugs and minor tranquilizers cause impairment on many behavioral tasks. They may also improve some plaintiff's work or social functioning by reducing severe anxiety. The effects of two or more drugs, such as sedatives and alcohol, may cause significant behavioral impairment. (reference 7, pp. 201-209; reference 4, p. 1548)

*Withdrawal symptoms* develop when the plaintiff reduces or stops the prolonged moderate or heavy use of these substances. Symptoms may include nausea or vomiting; malaise or weakness; autonomic hyperactivity (such as tachycardia and sweating); anxiety or irritability; orthostatic hypotension; coarse **tremor of the hands, tongue and eyelids**; insomnia; and grand mal seizures. (reference 7, pp. 201-209; reference 4, p. 1549)

**Q: Did you rule out *alcohol consumption or withdrawal* as a cause of the plaintiff's trembling, twitching, or feeling shaky?**

*Alcohol intoxication* may cause aggressiveness, impaired judgment and attention, irritability, euphoria, depression, emotional lability, and impaired social or occupational functioning. Physical symptoms may include slurred speech, incoordination, unsteady gait, nystagmus, occasional dizziness, and flushed face.

## SYMPTOM

## DEPOSITION QUESTIONS

**Trembling,  
Twitching,  
Feeling Shaky***(continued)*

Heavy alcohol consumption may cause abnormal sleep patterns. The plaintiff often falls asleep quickly but wakes up earlier and earlier with uncomfortable feelings. Chronic alcoholics may have **irregular, unsteady, and slow tremulous movements**. (reference 7, p. 212; reference 4, p. 67; reference 9, p. 52)

The *reduction or cessation* of drinking for at least several days may cause characteristic symptoms: coarse **tremor of hands, tongue, or eyelids**; nausea or vomiting; malaise or weakness; autonomic hyperactivity (tachycardia, sweating, and elevated blood pressure); anxiety, depressed mood or irritability; transient hallucinations or illusions; headache; insomnia; dizziness; fatigue; restlessness; and agitation. (reference 7, p. 215; reference 2, pp. 722, 618; reference 9, pp. 50-54)

**Q: Did you rule out *metabolic brain disease* as a cause of the plaintiff's trembling, twitching, or feeling shaky?**

The plaintiff with a metabolic brain disease is inattentive, perplexed, preoccupied, and unable to concentrate. Changes in mental abilities, alertness, awareness, and perception are common. Characteristic physical symptoms include **tremor, asterixis**, (flapping tremor of the extremities), and multifocal myoclonus (sudden gross muscle contractions). (reference 9, pp. 1974-1975)

**Q: Did you rule out *hypoglycemia* as a cause of the plaintiff's trembling, twitching, or feeling shaky?**

Hypoglycemia is an abnormally low blood sugar level. It often produces personality changes, tiredness, confusion, dizziness, **tremor**, anxiety, tachycardia, and sweating during acute attacks. Other psychiatric symptoms include fear and dread, depression with fatigue, and agitation with confusion. Hypoglycemia can develop from an insulin overdose, insulinoma or islet cell tumor, extensive liver disease, or functional diseases. (reference 2, p. 702; reference 4, pp. 1176-1177; reference 18, pp. 1929 and 1479 )

*If the witness indicates the possibility of hypoglycemia, see the section on hypoglycemia for further questions.*

**Q: Did you rule out a *neuroendocrine disorder*, such as pheochromocytoma, as a cause of the plaintiff's trembling, twitching, or feeling shaky?**

Symptoms of a neuroendocrine disorder include sudden headaches, excessive sweating, and palpitations. Often there are associated **tremors, weakness, nausea**, and epigastric discomfort. The plaintiff may also complain of chest pain, shortness of breath, lightheadedness, blurred vision, and flushing. (reference 2, p. 612)

*Pheochromocytoma* is a tumor of the sympathetic nervous system which specifically causes headaches, lightheadedness, nausea, sweating, **trembling**, and elevated blood pressure during anxiety attacks. (reference 4, p. 1276)

*If the witness indicates the possibility of pheochromocytoma, see the section on pre-existing medical conditions for further questions.*

## SYMPTOM

## DEPOSITION QUESTIONS

**Trembling,  
Twitching,  
Feeling Shaky***(continued)***Q: Did you rule out *multiple sclerosis* as a cause of the plaintiff's trembling, twitching, or feeling shaky?**

Multiple sclerosis is a common disease of young adults. The disease causes a disorder of the optic nerves, spinal cord, and brain. Symptoms may include depression, apathy, lack of judgement, inattention, **tremor**, vertigo, incoordination, weakness, fatigue, dysarthria (speech impairment), and urinary frequency or hesitancy. (reference 4, p. 1276; reference 1, pp. 1354-1356)

*If the witness indicates the possibility of multiple sclerosis, see the section on MS for further questions.*

**Q: Did you rule out *restless leg syndrome* as a cause of the plaintiff's trembling, twitching, or feeling shaky?**

**Restlessness** and an uncomfortable or painful crawling sensation in the muscles and bones of the lower legs are signs of the restless leg syndrome. The symptoms usually occur at night, disturbing sleep, or when the plaintiff is resting. There is no known cause of the syndrome. (reference 4, pp. 132, 1253)

**Q: Did you rule out *early onset of Wilson's disease* as a cause of the plaintiff's trembling, twitching, or feeling shaky?**

Wilson's disease is characterized by brain degeneration. Defective copper excretion causes an accumulation of copper in the liver, brain and other tissues. Symptoms may include **tremor exaggerated with movement**, difficulty speaking and swallowing, incoordination, personality changes, explosive anger, abdominal pain, diarrhea, nausea and vomiting, and dementia. (reference 9, pp. 1158-1159)

*If the witness indicates the possibility of Wilson's disease, see the section on pre-existing medical conditions for further questions.*

**Q: Did you rule out *chorea* as a cause of the plaintiff's trembling, twitching, or feeling shaky?**

Chorea is characterized by irregular, jerky, involuntary movements while the plaintiff is at rest. It may include **twitching movements** of the tongue, face, and lower extremities. Chorea is a symptom of Huntington's disease and Sydenham's chorea. (reference 2, p. 685)

**Q: Did you rule out *Shy-Dragger syndrome* as a cause of the plaintiff's trembling, twitching, or feeling shaky?**

Shy-Dragger syndrome (primary orthostatic hypotension) is a degeneration of preganglionic sympathetic neurons. Symptoms may include **tremor, ataxia** (incoordination of voluntary muscles), rigidity, impotence, atonicity of the urinary bladder, and impaired sweating in the lower part of the body. (reference 10, p. 1099; reference 2, p. 701)

*SYMPTOM*

*DEPOSITION QUESTIONS*

**Trembling,  
Twitching,  
Feeling Shaky**  
*(continued)*

**Q: Did you rule out *lithium use* as a cause of the plaintiff's trembling, twitching, or feeling shaky?**

Lithium and the tricyclics are often given as medication for depression. **Tremor** is one of the most common side effects. Other symptoms may include nausea, diarrhea, polyuria (the passage of an excessive quantity of urine), polydipsia (excessive thirst), and weight gain. Toxic effects may include gross **tremor**, increased deep tendon reflexes, persistent headaches, vomiting, mental confusion progressing to stupor, **seizures**, or cardiac arrhythmias. (reference 1, pp. 1460-1461)

**Q: Did you rule out a *brain tumor* as a cause of the plaintiff's trembling, twitching, or feeling shaky?**

Brain tumors occur in the skull, brain, or membrane covering the brain or spinal cord. Symptoms vary depending on the size of the tumor and rate of growth. The plaintiff may experience anxiety, dementia, irritability, **trembling**, dizziness, fatigue, headache, vomiting, hyperthermia (high body temperature), and changes in appetite and personality. (reference 4, pp. 139, 834-835, 855, 860, 1276; reference 9, pp. 2161-2164; reference 1, pp. 1351, 1296)

*If the witness indicates the possibility of a brain tumor, see the section on pre-existing medical conditions for further questions.*

**Q: Did you rule out *Meniere's syndrome* as a cause of the plaintiff's trembling, twitching, or feeling shaky?**

Meniere's syndrome is sometimes confused with acute anxiety. The most common symptom is dizziness. Associated symptoms include **nystagmus** (tremulous movement of the eyeballs), deafness, and other signs of middle-ear disease. (reference 4, p. 893)

**Q: Did you rule out *infections* as a cause of the plaintiff's trembling, twitching, or feeling shaky?**

|                                  |                                 |
|----------------------------------|---------------------------------|
| Brucellosis                      | Meningitis                      |
| Chronic urinary tract infections | Subacute bacterial endocarditis |
| Infectious mononucleosis         | Syphilis                        |
| Influenza                        | Tuberculosis                    |
| Malaria                          | Viral hepatitis                 |

**Q: Did you rule out *caffeine consumption* as a cause of the plaintiff's trembling, twitching, or feeling shaky?**

Characteristic symptoms of caffeine intoxication include restlessness, nervousness, excitement, insomnia, flushed face, diuresis, gastrointestinal disturbance, **muscle twitching**, rambling flow of thought and speech, tachycardia or cardiac arrhythmia, periods of inexhaustibility, and psychomotor agitation. When consumed near bedtime, caffeine often disrupts sleep. Symptoms may appear when the plaintiff consumes as little as 250 mg of caffeine per day. The plaintiff that consumes one

## SYMPTOM

## DEPOSITION QUESTIONS

**Trembling,  
Twitching,  
Feeling Shaky**

(continued)

gram per day usually experiences more severe symptoms. Products which contain caffeine include: coffee, tea, soda, chocolate and weight-loss aids. (reference 7, p. 231; reference 4, p. 1029)

*If the witness indicates the possibility of excess caffeine consumption, see the caffeine consumption chart in Appendix A.*

**Q: Does the plaintiff have any other medical conditions that may cause trembling, twitching, or feeling shaky, such as:**

|                                  |                              |
|----------------------------------|------------------------------|
| Benign essential familial tremor | Thyrotoxicosis               |
| Dystonia                         | Tics                         |
| Myasthenia gravis                | Tremors of brain stem origin |
| Myoclonic activity               |                              |

**Q: Is the plaintiff taking any medications or substances that may cause the trembling, twitching, or feeling shaky, such as:**

|              |               |              |
|--------------|---------------|--------------|
| ACCUPRIL     | BUPRENEX      | CYTOMEL      |
| ACCUTANE     | BUSPAR        | DALALONE     |
| ADALAT       | BUTICAPS      | DALMANE      |
| ADDERALL     | CARDENE       | DANTRIUM     |
| ADIPEX       | CARDIZEM      | DEMEROL      |
| AEROBID      | CARDURA       | DEPAKENE     |
| ALTACE       | CATAPRES      | DEPAKOTE     |
| ALUPENT      | CEFZIL        | DEPO-PROVERA |
| AMBIEN       | CELEBREX      | DEPROL       |
| AMERGE       | CELEXA        | DESOGEN      |
| AMPHETAMINES | CELONTIN      | DESYREL      |
| AMYTAL       | CENTRAX       | DETROL       |
| ANAFRANIL    | CHLORTRIMETON | DEXEDRINE    |
| ANSAID       | CIPRO         | DILANTIN     |
| ARICEPT      | CLARITAN-D    | DIMETANE     |
| ARTANE       | CLARITIN      | DOLOBID      |
| ARTHROTEC    | CLINORIL      | DONNATAL     |
| ASENDIN      | CLONOPIN      | DORAL        |
| ATROVENT     | CLOZARIL      | DURACT       |
| AVAPRO       | COGENTIN      | DURAGESIC    |
| AXID         | COGNEX        | DURAVENT     |
| AXOCET       | COMBIPRES AM  | DYNACIRC     |
| BACTRIM      | COMBIVENT     | EFFEXOR      |
| BENADRYL     | COZAAR        | ELDEPRYL     |
| BENTYL       | CRINONE       | ENTEXLA      |
| BIPHETAMINE  | CYCLOSPORIN   | ESKALITH     |
| BRETHINE     | CYCRIN        | EXCELON      |
| BRICANYL     | CYSTOSPAZ     | FASTIN       |

## Additional Anxiety Symptoms

*SYMPTOM*

*DEPOSITION QUESTIONS*

**Trembling,  
Twitching,  
Feeling Shaky**

(continued)

|                  |                  |               |
|------------------|------------------|---------------|
| FELDENE          | MONOPRIL         | PROVERA       |
| FIORICET         | MORPHINE-SULFATE | PROZAC        |
| FIORINAL-CODEINE | MOTRIN           | RELAFEN       |
| FLEXERIL         | NALDECON         | REMERON       |
| FLOXIN           | NALFON           | RESTORIL      |
| GABITRIL         | NARDIL           | REVIA         |
| HALCION          | NEMBUTAL         | RHINOCORT     |
| HISTUSSIN        | NEURONTIN        | RITALIN       |
| HUMULIN          | NORDETTE         | RONDEC-DM     |
| HYTRIN           | NOREPHEDRINE     | RUFEN         |
| HYZAAR           | NORINYL          | SANOREX       |
| IMDUR            | NORPACE          | SE-AP-ES      |
| INDOCIN          | NORPLANT-SYSTEM  | SELDANE       |
| IONAMIN          | NORVASC          | SEPTRA        |
| ISUPREL          | NUBAIN           | SERAX         |
| KERLONE          | OPTIMINE         | SEREVENT      |
| KLONOPIN         | ORAP             | SEROQUEL      |
| LAMICTAL         | ORNADE           | SERTRALINE    |
| LESCOL           | ORTH-NOVUM       | SERZONE       |
| LEVAQUIN         | ORTHO-CEPT       | SINEMET       |
| LEVO-DROMORAM    | ORTHOCYCLEN      | SKELAXIN      |
| LEVOTHROID       | ORUDIS           | SLO-BID       |
| LEVSIN           | OXYCONTIN        | SLO-PHYLLIN   |
| LIBRAX           | PARLODEL         | SOMA          |
| LIDODERM PATCH   | PBZ-SR           | SOMA-COMPOUND |
| LIMBITROL        | PERIACTIN        | SONATA        |
| LIRESAL          | PERMAX           | SPORANOX      |
| LITHIUM-CITRATE  | PHENERGAN-VC-    | STADOL        |
| LO/OVRAL         | CODEINE          | SUDAFED       |
| LODINE           | PHENOBARBITAL    | SULAR         |
| LORABID          | PHENYL-          | SULINDAC      |
| LOTENSIN         | PROPANOLAMINE    | TALECEN       |
| LOTREL           | PLENDIL          | TALWIN-NX     |
| LOZOL            | POLARIMINE       | TAVIST        |
| LUDIOMIL         | PONDIMIN         | TEMARIL       |
| LUFYLLIN-GG      | PRAVACHOL        | THEO-DUR      |
| LUVOX            | PREMPHASE        | TIAZAC        |
| MARPLAN          | PREMPRO          | TIMOPTIC      |
| MAXAIR-AUTOHALER | PREVACID         | TORADOL       |
| MAXALT           | PRILOSEC         | TORECAN       |
| MEBARAL          | PRIMAXIN-IV      | TRANXENE      |
| MEPERGAN         | PRINZIDE         | TRENTAL       |
| MESANTOIN        | PROCARDIA        | TRILEPTAL     |
| MEXITIL          | PROPULSID        | TRINALIN      |
| MINIPRESS        | PROSOM           | TROVAN        |
| MIRAPEX          | PROTONIX         | ULTRAM        |
| MODURETIC        | PROVENTIL        | UNIVASC       |

## Additional Anxiety Symptoms

*SYMPTOM*

*DEPOSITION QUESTIONS*

**Trembling,  
Twitching,  
Feeling Shaky**  
*(continued)*

|            |            |         |
|------------|------------|---------|
| VALIUM     | XANAX      | ZOCOR   |
| VASOTEC    | XYLOCAINE  | ZOLOFT  |
| VENTOLIN   | YOCON      | ZOMIG   |
| VIAGRA     | ZANAFLEX   | ZYBAN   |
| VICOPROFEN | ZESTORETIC | ZYPREXA |
| VISTARIL   | ZESTRIL    | ZYRTEC  |
| WELLBUTRIN | ZIAC       |         |

**Shortness of  
Breath,  
Smothering  
Sensations**

**Q: Describe the plaintiff's shortness of breath or smothering sensations.**

**Q: When and how often does the plaintiff have trouble breathing?**

**Q: Does the plaintiff have a history of shortness of breath or smothering sensations before the injury in question?**

**Q: Does the plaintiff have a history of any *medical conditions* that may cause shortness of breath or smothering sensations?**

*The witness may indicate the possibility of the following medical conditions: please refer to the sections pertaining to these medical conditions for further questions.*

**TABLE 5.2A-2.**

|                                       |                                |
|---------------------------------------|--------------------------------|
| Airway obstruction                    | Gram-negative pneumonias       |
| Amyotrophic lateral sclerosis         | HIV infection                  |
| Anemia                                | Interstitial lung disease      |
| Aortic regurgitation                  | Mitral stenosis                |
| Aspergillosis                         | Pleural disorders              |
| Asthma                                | Pneumocystis carinii pneumonia |
| Bronchiectasis                        | Pulmonary embolism             |
| Cardiac tamponade                     | Pulmonary hypertension         |
| Cardiovascular disease                | Radiation injury               |
| Chest wall disorders                  | Sarcoidosis                    |
| Chronic obstructive pulmonary disease | Scleroderma                    |
| Congestive heart failure              | Smoke inhalation injury        |
| Coronary artery disease               | Systemic lupus erythematosus   |
| Diaphragmatic paralysis               | Transfusion reaction           |
| Diphtheria                            | Tuberculosis                   |
| Fat embolism                          |                                |

**Q: Did you rule out a *physically stressful schedule* as cause of the plaintiff's shortness of breath or smothering sensations?**

Heart pounding, palpitations, and tachycardia are often associated with indigestion, overexertion, a specific emotion, or fatigue. Other symptoms may include fullness in the neck, **shortness of breath**, nervousness, dizziness, and apprehension. (reference 2, pp.302, 304)

## SYMPTOM

## DEPOSITION QUESTIONS

**Shortness of  
Breath,  
Smothering  
Sensations**

*(continued)*

**Q: Did you rule out *psychogenic dyspnea* as a cause of the plaintiff's shortness of breath or smothering sensations?**

Plaintiffs with chronic psychogenic breathlessness may be depressed or have a reactive depression to stress. Others may have a depressive psychosis with associated symptoms of anorexia, weight loss, early morning awakening, psychomotor retardation, and daytime mood variations. They may complain of **smothering or being unable to breath**, and feeling lightheaded, dizzy, or numb in the extremities and around the mouth. (reference 2, p.342)

*Defense counsel should note that some plaintiffs with this disorder desire financial compensation and may be malingering. See the section on malingering for additional information.*

**Q: Did you rule out a *conversion disorder* as a cause of the plaintiff's shortness of breath or smothering sensations?**

A conversion disorder is characterized by the presence of symptoms or deficits affecting voluntary motor or sensory function that suggest a neurological or other general medical condition. Psychological factors are judged to be associated with the symptom or deficit and the symptoms are not intentionally feigned or produced. Conversion symptoms are defense mechanisms that change the unconscious emotional conflict into a physical disability that often symbolizes the nature of the conflict. (reference 12, p. 315; reference 2, pp. 625, 630; reference 7, p. 492)

*If the witness indicates the possibility of a conversion disorder, see the section on conversion disorder for further questions.*

**Q: Did you rule out a *somatization disorder (psychosomatic)* as a cause of the plaintiff's shortness of breath or smothering sensations?**

The plaintiff with a somatization disorder has many physical complaints for several years. S/he sees multiple physicians only to discover no physical cause for the symptoms. The plaintiff often has exaggerated and vague complaints focusing on either organs or types of symptoms such as pseudoneurologic or conversion symptoms, gastrointestinal, female reproductive, psychosexual, pain, and **cardiopulmonary symptoms**. Anxiety, depression, suicide attempts, social withdrawal, and work or interpersonal relationship difficulties are common. (reference 7, p. 486; reference 4, pp. 389, 940)

*If the witness indicates the possibility of a somatization disorder, see the section on somatoform disorder for further questions.*

**Q: Did you rule out an *airway obstruction* as a cause of the plaintiff's shortness of breath or smothering sensations such as:**

A foreign body

Blocking by the tongue

Blood Inflammation, neoplasm, constriction, or air passage trauma

Mucus

Spasm or edema of the vocal cords

## SYMPTOM

## DEPOSITION QUESTIONS

**Shortness of  
Breath,  
Smothering  
Sensations**

(continued)

**Q: Did you rule out an allergic reaction as a cause of the plaintiff's shortness of breath or smothering sensations?**

Allergic rhinitis is seasonal or perennial inflammatory disease of the nasal membranes. Symptoms may include sneezing; a **stuffy and itching nose**; postnasal drainage; and itching eyes. The plaintiff with allergies may feel generally ill and uncomfortable, tired, weak, despondent, irritable, and uninterested in eating. (reference 9, pp. 1867-1868)

**Q: Did you rule out early onset of Wilson's disease as a cause of the plaintiff's shortness of breath or smothering sensations?**

Wilson's disease is characterized by brain degeneration. Defective copper excretion causes an accumulation of copper in the liver, brain and other tissues. Symptoms may include tremor exaggerated with movement, **difficulty speaking and swallowing**, incoordination, personality changes, explosive anger, abdominal pain, diarrhea, nausea and vomiting, and dementia. (reference 9, pp. 1158-1159)

*If the witness indicates the possibility of Wilson's disease, see the section on pre-existing medical conditions for further questions.*

**Q: Did you rule out a neuroendocrine disorder, such as pheochromocytoma, as a cause of the plaintiff's shortness of breath or smothering sensations?**

Symptoms of a neuroendocrine disorder include sudden headaches, excessive sweating, and palpitations. Often there are associated tremors, weakness, nausea, and epigastric discomfort. The plaintiff may also complain of chest pain, **shortness of breath**, lightheadedness, blurred vision, and flushing. (reference 2, p. 612)

*Pheochromocytoma* is a tumor of the sympathetic nervous system which specifically causes headaches, lightheadedness, nausea, sweating, trembling, and elevated blood pressure during anxiety attacks. (reference 4, p. 1276)

*If the witness indicates the possibility of pheochromocytoma, see the section on pre-existing medical conditions for further questions.*

**Q: Did you rule out asthma as a cause of the plaintiff's shortness of breath or smothering sensations?**

Asthma is a chronic and episodic illness, characterized by widespread narrowing of the tracheobronchial tree. Symptoms include coughing, wheezing, chest tightness and **dyspnea (shortness of breath)**. Nocturnal symptoms and exacerbations are common. Psychiatric forces may affect the clinical expression of asthma in several ways: altered awareness of airway resistance, suggestibility to airway constriction, and comorbidity with panic disorder and depression. (reference 18, pp. 1803-1804)

**Q: Did you rule out chronic obstructive pulmonary disease (COPD) as a cause of the plaintiff's shortness of breath or smothering sensations?**

COPD manifests itself in two ways; chronic bronchitis and emphysema. Smoking is the single greatest risk factor and most important cause of chronic obstructive pulmonary disease. COPD affects more than 16 million Americans. Symptoms of COPD include hypoxemia (deficient oxygenation in the blood), bronchial symptoms,

*SYMPTOM*

*DEPOSITION QUESTIONS*

**Shortness of  
Breath,  
Smothering  
Sensations**

*(continued)*

and **dyspnea (shortness of breath) upon exertion**. Psychiatric issues affect many facets of the course of COPD. As for asthma, prevalence rates for both panic disorder and anxiety disorders are increased among COPD patients. (reference 18, pp. 1805-1806)

**Q: Did you rule out *hyperventilation* as a cause of the plaintiff's shortness of breath or smothering sensations?**

Hyperventilation is **abnormal, rapid, deep breathing** usually due to anxiety. Exercise and strong emotion causes hyperventilation or it can begin spontaneously. Symptoms may include lightheadedness, faintness, ringing in the ears, weakness, blurring of vision, and tingling around the mouth or in the extremities. (reference 2, p. 613)

**Q: Did you rule out *specific phobia* as a cause of the plaintiff's shortness of breath or smothering sensations?**

A phobic disorder is characterized by the presence of irrational or exaggerated fears of objects or situations. The situation or object of the fear is not inherently dangerous or an appropriate source of anxiety. The plaintiff may have symptoms of panic, sweating, tachycardia, shakiness, and **difficulty breathing**. S/he either avoids the object of the phobia or endures the situation with intense anxiety. There is also a marked distress about having the irrational fear. (reference 7, p. 443; reference 4, pp. 899-900)

*If the witness indicates the possibility of a specific phobia, see the section on specific phobia for further questions.*

**Q: Does the plaintiff have any *other medical conditions* that may cause shortness of breath or smothering sensations, such as:**

- |  |  |
|--|--|
| Acute infectious bronchitis                  | Midbrain lesions                       |
| Acute respiratory distress syndrome          | Myasthenia                             |
| Asthma                                       | Obesity                                |
| Bronchiolitis bifurcation                    | Obstruction above or below the trachea |
| Chronic asthmatic bronchitis                 | Pneumococcal pneumonia                 |
| Chronic emphysema                            | Pulmonary fibrosis                     |
| Chronic obstructive pulmonary disease (COPD) | Pulmonary embolism (thromboembolism)   |
| Medullary lesions                            | Respiratory muscle illness             |

**Q: Is the plaintiff taking any *medications or substances* that may cause shortness of breath or smothering sensations, such as:**

- |           |            |           |
|-----------|------------|-----------|
| ACCUPRIL  | ANAPROX    | ATROVENT  |
| ADALAT    | ANSAID     | AVAPRO    |
| AEROBID   | ANTABUSE   | AVONEX    |
| ALTACE    | APRESOLINE | AXOCET    |
| AMBIEN    | ARICEPT    | CARBATROL |
| ANAFRANIL | ARTHROTEC  | CARDENE   |

**Additional Anxiety Symptoms****SYMPTOM****DEPOSITION QUESTIONS****Shortness of  
Breath,  
Smothering  
Sensations***(continued)*

|                          |                   |                   |
|--------------------------|-------------------|-------------------|
| CIPRO                    | LIORESAL          | QUESTRAN          |
| CLARITAN-D               | LIPITOR           | REMERON           |
| CLARITIN                 | LOMOTIL           | REVIA             |
| CLOMID                   | LOPRESSOR         | RHINOCORT         |
| CLONOPIN                 | LOTENSIN          | RISPERDAL         |
| CLOZARIL                 | MACRODANTIN       | SER-AP-ES         |
| COGNEX                   | MAVIK             | SEREVENT          |
| COLESTID                 | MAXALT            | SINEMET           |
| COMBIVENT                | MAXIDE            | SOMA COMPOUND     |
| COUMADIN                 | MECLIZINE         | SONATA            |
| COZAAR                   | MEGACE            | STADOL            |
| CYTOTEC                  | METHERGIE         | SULAR             |
| DALAMANE                 | MEXITIL           | SULINDAC          |
| DESYREL                  | MINIPRESS         | SYMMETREL         |
| DILACOR                  | MIRAPEX           | TEGRETOL          |
| DIOVAN                   | MODURETIC         | TENORMIN          |
| DOLOBID                  | MONOPRIL          | TIAZAC            |
| DURACT                   | NALFON            | TIMOPTIC          |
| DURAGESIC                | NAPROSYN          | TOPROL-XL         |
| DYNACIRC                 | NEURONTIN         | TORADOL           |
| EFFEXOR                  | NICORETTE         | TRENTAL           |
| ELDEPRYL                 | NOROXIN           | TRILEPTAL         |
| ESTROGEN PATCH           | NORPACE           | TROVAN            |
| FELDENE                  | NORVASC           | TYLENOL W/CODEINE |
| FIORICET                 | NOVOLIN           | ULTRAM            |
| FIORINAL-CODEINE         | NUBAIN            | UNIVASC           |
| FLEXERIL                 | ORUDIS            | VALIUM            |
| FLOXIN                   | OXYCONTIN         | VALTREX           |
| GUAIFED                  | PARLODEL          | VANCOCIN-HCI      |
| HYDRO-<br>CHLOROTHIAZIDE | PAXIL             | VASOTEC           |
| HYTRIN                   | PERMAX            | VERELAN           |
| HYZAAR                   | PHENAPHEN-CODEINE | VIAGRA            |
| IMDUR                    | PLAVIX            | VICODIN           |
| INDOCIN                  | PLENDIL           | VICOPROFEN        |
| INTROPIN                 | PRAVACHOL         | VIOXX             |
| K-LYTE                   | PREVACID          | VOLTAREN          |
| KERLONE                  | PRIMAXIN-IV       | ZEPHREX           |
| KLONOPIN                 | PRINZIDE          | ZESTORETIC        |
| LESCOL                   | PROCARDIA         | ZESTRIL           |
| LEVAQUIN                 | PROSOM            | ZIAC              |
|                          | PROTONIX          | ZOCOR             |

*SYMPTOM*

*DEPOSITION QUESTIONS*

**Palpitations,  
Accelerated  
Heart Rate**

**Q:** Describe the plaintiff's palpitations or accelerated heart rate.

**Q:** When and how often does the plaintiff experience palpitations or accelerated heart rate?

**Q:** Does the plaintiff have a history of palpitations or accelerated heart rate before the injury in question?

**Q:** Did you rule out *caffeine consumption* as a cause of the plaintiff's palpitations or accelerated heart rate?

Characteristic symptoms of *caffeine intoxication* include restlessness, nervousness, excitement, insomnia, flushed face, diuresis, gastrointestinal disturbance, muscle twitching, rambling flow of thought and speech, **tachycardia or cardiac arrhythmia**, periods of inexhaustibility, and psychomotor agitation. When consumed near bedtime, caffeine often disrupts sleep. Symptoms may appear when the plaintiff consumes as little as 250 mg of caffeine per day. The plaintiff that consumes one gram per day usually experiences more severe symptoms. Products which contain caffeine include: coffee, tea, soda, chocolate and weight-loss aids. (reference 7, p. 231; reference 4, p. 1029)

*If the witness indicates the possibility of excess caffeine consumption, see the caffeine consumption chart in Appendix A.*

**Q:** Did you rule out *sinoatrial tachycardia* as a cause of the plaintiff's palpitations or accelerated heart rate?

Sinoatrial **tachycardia** occurs in many healthy persons and may be a normal family trait. For the adult over eighteen, it is usually defined as a sustained increased heart rate of 100 beats or more per minute. (reference 2, p. 302)

**Q:** Did you rule out *nausea or vomiting* as a cause of the plaintiff's palpitations or accelerated heart rate?

The plaintiff may have unpleasant and distressing sensations in the throat, epigastrium, or abdomen. **Tachycardia**, watery salivation, and a sudden drenching sweat occur with nausea and vomiting. (reference 2, p. 365)

**Q:** Did you rule out a *physically stressful schedule* as a cause of the plaintiff's palpitations or accelerated heart rate?

**Heart pounding, palpitations, and tachycardia** are often associated with indigestion, overexertion, a specific emotion, or fatigue. Other symptoms may include fullness in the neck, shortness of breath, nervousness, dizziness, and apprehension. (reference 2, pp. 302, 304)

**Q:** Did you rule out *recent surgery* as a cause of the plaintiff's palpitations or accelerated heart rate?

The plaintiff may experience a **fluttering, skipping, or pounding heart** (atrial fibrillation) after surgery. (reference 2, p. 308)

## SYMPTOM

## DEPOSITION QUESTIONS

**Palpitations,  
Accelerated  
Heart Rate**

(continued)

**Q: Did you rule out *specific phobia* as a cause of the plaintiff's palpitations or accelerated heart rate?**

A phobic disorder is characterized by the presence of irrational or exaggerated fears of objects or situations. The situation or object of the fear is not inherently dangerous or an appropriate source of anxiety. The plaintiff may have symptoms of panic, sweating, **tachycardia**, shakiness, and difficulty breathing. S/he either avoids the object of the phobia or endures the situation with intense anxiety. There is also a marked distress about having the irrational fear. (reference 7, p. 443; reference 4, pp. 899-900)

*If the witness indicates the possibility of a specific phobia, see the section on specific phobia for further questions.*

**Q: Did you rule out an *adjustment disorder with anxiety* as a cause of the plaintiff's palpitations or accelerated heart rate?**

An adjustment disorder is a *transient over-reaction* to stress that usually occurs within 90 days and remits within six months. The adjustment disorder with anxiety is characterized by symptoms of nervousness, worry, jitteriness, and motor tension. The plaintiff may experience **palpitations** as part of the anxiety. (reference 7, p. 680; reference 4, pp. 1098-1099)

*If the witness indicates the possibility of an adjustment disorder, see the section on adjustment disorders for further questions.*

**Q: Did you rule out *somatoform (psychogenic) pain disorder* and as a cause of the plaintiff's palpitations or accelerated heart rate?**

Somatoform pain disorder is characterized by pain as the predominant focus of clinical attention. In addition, psychological factors are judged to have an important role in the onset, severity, exacerbation, or maintenance of the pain. (reference 7, p. 485)

*If the witness indicates the possibility of somatoform pain disorder, see the section on somatoform disorders for further questions.*

**Q: Did you rule out *neuroendocrine disorder, such as pheochromocytoma*, as a cause of the plaintiff's palpitations or accelerated heart rate?**

Symptoms of a neuroendocrine disorder include sudden headaches, excessive sweating, and **palpitations**. Often there are associated tremors, weakness, nausea, and epigastric discomfort. The plaintiff may also complain of chest pain, shortness of breath, lightheadedness, blurred vision, and flushing. (reference 2, p. 612)

*Pheochromocytoma* is a tumor of the sympathetic nervous system which specifically causes headaches, lightheadedness, nausea, sweating, trembling, and elevated blood pressure during anxiety attacks. (reference 4, p. 1276)

*If the witness indicates the possibility of pheochromocytoma, see the section on pre-existing medical conditions for further questions.*

## SYMPTOM

## DEPOSITION QUESTIONS

**Palpitations,  
Accelerated  
Heart Rate**

(continued)

**Q: Did you rule out *hyperthyroidism* as a cause of plaintiff's palpitations or accelerated heart rate?**

Hyperthyroidism, or thyrotoxicosis, results from overproduction of thyroid hormone by the thyroid gland. The most common cause is Graves' disease. The signs and symptoms of hyperthyroidism include both physical and psychiatric complaints. Psychiatric features include nervousness, fatigue, insomnia, mood lability, and dysphoria. There may be a heightened activity level. Cognitive symptoms include a short attention span, impaired recent memory, and an exaggerated startle response.

Physical signs and symptoms of hyperthyroidism include **increased pulse, arrhythmias** (irregular heart rhythm), elevated blood pressure, fine tremor, heat intolerance, excessive sweating, increased appetite, weight loss, **palpitations (abnormal rapid beating of heart), tachycardia (rapid heart beat)**, frequent bowel movements, menstrual irregularities, and muscle weakness. Panic attacks are associated with endocrinological disorders including hyperthyroidism, as well as hypothyroidism. (reference 18, pp. 743, 1809-1810, 1928)

**Q: Did you rule out *alcohol withdrawal* as a cause of the plaintiff's palpitations or accelerated heart rate?**

The reduction or cessation of drinking for at least several days may cause characteristic symptoms: coarse tremor of hands, tongue, or eyelids; nausea or vomiting; malaise or weakness; autonomic hyperactivity (**tachycardia**, sweating, and elevated blood pressure); anxiety, depressed mood or irritability; transient hallucinations or illusions; headache; insomnia; dizziness; fatigue; restlessness; and agitation. (reference 7, p. 215; reference 2, pp. 722, 618; reference 9, pp. 50-54)

**Q: Did you rule out *cocaine consumption or withdrawal* as a cause of the plaintiff's palpitations or accelerated heart rate?**

*Cocaine users* often experience increased energy and confidence or irritability and paranoia with physical aggressiveness. Other behavioral symptoms may include euphoria, hypervigilance, psychomotor agitation, impaired judgment, and impaired social or occupational functioning. Physical symptoms may include **tachycardia**, dilated pupils, elevated blood pressure, perspiration or chills, nausea, vomiting, and hallucinations.

The abrupt *cessation or reduction of cocaine*, after several days use, may cause the plaintiff to feel tired, dysphoric, irritable, depressed, and to crave more of the drug. An anxiety reaction may cause psychomotor agitation, insomnia or hypersomnia, high blood pressure, **tachycardia**, and paranoia. The symptoms may persist for more than a day.(reference 7, p. 241; reference 4, pp. 1008-1009)

**Q: Did you rule out *opioid withdrawal* as a cause of the plaintiff's palpitations or accelerated heart rate?**

Symptoms of opioid withdrawal may include lacrimation (tearing), rhinorrhea (runny nose), dilated pupils, sweating, diarrhea, yawning, mild hypertension, **tachycardia** (increased heart rate), fever, insomnia, and gooseflesh. Associated features may include restlessness, irritability, depression, tremor, weakness, nausea,

## SYMPTOM

## DEPOSITION QUESTIONS

**Palpitations,  
Accelerated  
Heart Rate***(continued)*

vomiting, and muscle or joint pain. These signs, often resembling influenza symptoms, may be precipitated by the abrupt ending of one or two weeks of continuous opioid use. The withdrawal symptoms may last days or weeks. During the final stages of withdrawal, the plaintiff may experience overconcern for bodily discomfort, poor self-image, and a decreased ability to tolerate stress. (reference 7, p. 272; reference 4, pp. 990-991)

**Q: Did you rule out a *conversion disorder* as a cause of the plaintiff's palpitations or accelerated heart rate?**

A conversion disorder is characterized by the presence of symptoms or deficits affecting voluntary motor or sensory function that suggest a neurological or other general medical condition. Psychological factors are judged to be associated with the symptom or deficit and the symptoms are not intentionally feigned or produced. Conversion symptoms are defense mechanisms that change the unconscious emotional conflict into a physical disability that often symbolizes the nature of the conflict. (reference 12, p. 315; reference 2, pp. 625, 630; reference 7, p. 492)

*If the witness indicates the possibility of a conversion disorder, see the section on conversion disorder for further questions.*

**Q: Did you rule out *hypochondriasis* as a cause of the plaintiff's palpitations or accelerated heart rate?**

The hypochondriac fears or believes that s/he has a serious disease based on their own interpretation of physical symptoms. Medical evaluations do not support the fears of disease. The plaintiff is **preoccupied with** bodily functions such as **heartbeat**, sweating, peristalsis, minor physical abnormalities, or a specific organ such as the heart. Headaches and fatigue are common complaints. (reference 7, p. 504; reference 4, p. 1204)

*If the witness indicates the possibility of hypochondriasis, see the section on hypochondriasis for further questions.*

**Q: Did you rule out a *somatization disorder (psychosomatic)* as a cause of the plaintiff's palpitations or accelerated heart rate?**

The plaintiff with a somatization disorder has many physical complaints for several years. S/he sees multiple physicians only to discover no physical cause for the symptoms. The often has exaggerated and vague complaints focusing on either organs or types of symptoms such as pseudoneurologic or conversion symptoms, gastrointestinal, female reproductive, psychosexual, pain, and **cardiopulmonary symptoms**. Anxiety, depression, suicide attempts, social withdrawal, and work or interpersonal relationship difficulties are common. (reference 7, p. 486; reference 4, pp. 389, 940)

*If the witness indicates the possibility of a somatization disorder, see the section on somatoform disorders for further questions.*

## SYMPTOM

## DEPOSITION QUESTIONS

**Palpitations,  
Accelerated  
Heart Rate***(continued)***Q: Did you rule out *amphetamine or similarly acting sympathomimetic drug consumption* as a cause of the plaintiff's palpitations or accelerated heart rate?**

Symptoms of amphetamine or similarly acting sympathomimetic drug consumption may include fighting, grandiosity, elation, hypervigilance, psychomotor agitation, impaired judgment, and impaired social or occupational functioning. Physical symptoms may include flushing, difficulty breathing, **tachycardia**, pupil dilation, elevated blood pressure, sweating or chills, nausea, and vomiting. (reference 4, pp. 1007-1008; reference 7, p. 223)

The following drugs may be classified as amphetamines:

|                                    |                            |
|------------------------------------|----------------------------|
| Appetite Suppressants (diet pills) | Methamphetamines (speed)   |
| Dextroamphetamines                 | Methylphenidates (Ritalin) |
| Ma-huang (ephedra)                 | (reference 17, p. 586)     |
| (reference 24, pp. 488-489)        |                            |

**Q: (Female) Did you rule out *premenstrual dysphoric disorder* as a cause of the plaintiff's palpitations or accelerated heart rate?**

Premenstrual dysphoric disorder is characterized by emotional and behavioral symptoms which usually occur during the last week before the menstrual cycle and remit within a few days after menses begins. Symptoms may include tears, sadness, irritability, anger, tension, depression, self-deprecating thoughts, decreased interest in usual activities, fatigability, loss of energy, a subjective sense of difficulty in concentration, changes in appetite, and sleep disturbance. Physical symptoms may also include breast tenderness or swelling, **tachycardia**, sweating, headaches, joint or muscle pain, a sensation of bloating, or weight gain. (reference 7, p. 771; reference 18, pg. 1955)

**Q: Did you rule out *mitral valve prolapse (MVP)* as a cause of the plaintiff's palpitations or accelerated heart rate?**

Mitral valve prolapse (MVP) is a common and sometimes serious congenital ballooning of a heart valve often associated with **arrhythmias of the heart**. MVP and panic attacks share many common symptoms including chest pain, **palpitations**, dyspnea, weakness, fatigue, dizziness, syncope (a faint), and anxiety. (reference 4, pp. 1149, 1551)

*If the witness indicates the possibility of mitral valve prolapse, see the section on pre-existing medical conditions for further questions.*

**Q: Did you rule out *hypoglycemia* as a cause of the plaintiff's palpitations or accelerated heart rate?**

Hypoglycemia is an abnormally low blood sugar level. It often produces personality changes, tiredness, confusion, dizziness, tremor, anxiety, **tachycardia**, and sweating during acute attacks. Other psychiatric symptoms include fear and dread, depression with fatigue, and agitation with confusion. Hypoglycemia can develop from an insulin overdose, insulinoma or islet cell tumor, extensive liver disease, or functional

## SYMPTOM

## DEPOSITION QUESTIONS

**Palpitations,  
Accelerated  
Heart Rate***(continued)*

diseases. (reference 2, p. 702; reference 4, pp. 1176-1177; reference 18, pp. 1929 and 1479 )

*If the witness indicates the possibility of hypoglycemia, see the section on hypoglycemia for further questions.*

**Q: Did you rule out *sedative, hypnotic, or anxiolytic withdrawal* as a cause of the plaintiff's palpitations or accelerated heart rate?**

Withdrawal symptoms develop when the plaintiff reduces or stops the prolonged moderate or heavy use of these substances. Symptoms may include nausea or vomiting; malaise or weakness; **autonomic hyperactivity** (such as **tachycardia** and sweating); anxiety or irritability; orthostatic hypotension; coarse tremor of the hands, tongue and eyelids; insomnia; and grand mal seizures. (reference 7, p. 286; reference 4, p. 1549)

**Q: Did you rule out *hallucinogen consumption* as the cause of the plaintiff's palpitations or accelerated heart rate?**

Hallucinogen consumption causes perceptual changes such as feelings of detachment, illusions, hallucinations, and synesthesia (seeing colors when a loud sound occurs). Behavioral symptoms may include anxiety or depression, ideas of reference, fear of losing one's mind, paranoia, impaired judgment, and impaired social or occupational functioning. Physical symptoms may include dilated pupils, **tachycardia**, sweating, palpitations, blurred vision, tremors, and incoordination. Flashbacks of experiences may recur several months or years after hallucinogen use. Many plaintiffs may have gross thought process disturbances. Unlike schizophrenics, they are able to talk in detail about their hallucinations. (reference 7, p. 250; reference 4, p. 874)

**Q: Did you rule out *lithium use* as a cause of the plaintiff's palpitations or accelerated heart rate?**

Lithium and the tricyclics are often given as medication for depression. Tremor is one of the most common side effects. Other symptoms may include nausea, diarrhea, polyuria (the passage of an excessive quantity of urine), polydipsia (excessive thirst), and weight gain. Toxic effects may include gross tremor, increased deep tendon reflexes, persistent headaches, vomiting, mental confusion progressing to stupor, seizures, or **cardiac arrhythmias**. (reference 1, pp. 1460-1461)

**Q: Did you rule out *porphyria* as a cause of the plaintiff's palpitations or accelerated heart rate?**

Porphyria is an inherited disorder of young to middle-aged adults. It is characterized by episodes of abdominal pain, peripheral neuropathy, weakness, anorexia, nausea, vomiting, **tachycardia**, fever, confusion, depression, and severe anxiety. Mood swings and mental abnormalities are common symptoms. (reference 4, pp. 121, 1276, 1326; reference 9, p. 1156; reference 1, pp. 958, 960)

*If the witness indicates the possibility of porphyria, see the section on pre-existing medical conditions for further questions.*

*SYMPTOM*

*DEPOSITION QUESTIONS*

**Palpitations,  
Accelerated  
Heart Rate**

*(continued)*

**Q: Did you rule out *heart disease* as a cause of the plaintiff's palpitations or accelerated heart rate?**

Fatigue may be caused when body tissues do not receive sufficient nutrients and oxygen. A diseased heart is often unable to pump adequately for the lungs to oxygenate the blood. **Palpitations** or an **accelerated heart rate** are also symptoms of heart diseases such as: (reference 2, pp. 617-618)

|                             |                        |
|-----------------------------|------------------------|
| Chronic atrial fibrillation | Myocardial infarction  |
| Congestive heart failure    | Organic heart disease  |
| Hypertensive heart disease  | Valvular heart disease |
| Ischemic heart disease      |                        |

*If the witness indicates the possibility of heart disease, see the section on pre-existing medical conditions for further questions.*

**Q: Did you rule out *infections* as a cause of the plaintiff's easy palpitations or accelerated heart rate?**

|                                  |                                 |
|----------------------------------|---------------------------------|
| Brucellosis                      | Meningitis                      |
| Chronic urinary tract infections | Subacute bacterial endocarditis |
| Infectious mononucleosis         | Syphilis                        |
| Influenza                        | Tuberculosis                    |
| Malaria                          | Viral hepatitis                 |

**Q: Did you rule out *cannabis (marijuana) consumption* as a cause of the plaintiff's palpitations or accelerated heart rate?**

Cannabis intoxication can occur from marijuana, hashish, or tetrahydrocannabinol (THC). Characteristic symptoms include **tachycardia**, increased appetite, dry mouth, euphoria, anxiety, sensation of slowed time, impaired judgment, and social withdrawal. Inappropriate laughter, panic attacks, and a dysphoric mood may occur. (reference 7, pp. 236-241; reference 4, pp. 1326, 764)

**Q: Does the plaintiff have any *other medical conditions* that may cause palpitations or accelerated heart rate (tachycardia), such as:**

|                                  |   |
|----------------------------------|---|
| Acute coronary thrombosis        | Potassium imbalance                     |
| Adrenal gland secretion          | Pulmonary embolism                      |
| Atrial septal defects            | Pulmonary disease                       |
| Bradycardia-tachycardia syndrome | Rheumatic fever                         |
| Hormonal disorders               | Thyrotoxicosis                          |
| Metabolic disorders              | Thyroxin                                |
| Neurocirculatory asthenia        | Vagus or sympathetic nerve malfunctions |
| Organic heart disease            | Various myopathies                      |

## SYMPTOM

## DEPOSITION QUESTIONS

**Palpitations,  
Accelerated  
Heart Rate**

(continued)

**Q:** Is the plaintiff taking any *medications or substances* that may cause palpitations or accelerated heart rate (tachycardia), such as:

|               |                  |                  |
|---------------|------------------|------------------|
| ACCUPRIL      | COGNEX           | IMITREX          |
| ACCUTANE      | COLESTID         | IMITREX-TABLETS  |
| ADALAT        | COMBIPRES        | IMROBAXIN        |
| ADAPIN        | COMBIVENT        | INAPSINE         |
| ADDERALL      | CORGARD          | INDERAL          |
| ADIPEX        | COUMADIN         | INDERIDE         |
| ADRENALIN     | CYSTOSPAZ        | INDOCIN          |
| AEROBID       | CYTOMEL          | INSULIN          |
| ALDOMET       | DALMANE          | INTROPIN         |
| ALDORIL       | DANTRIUM         | IONAMIN          |
| ALUPENT       | DEMEROL          | ISUPREL          |
| AMBIEN        | DEPROL           | LAMICTAL         |
| AMPHETAMINES  | DESOXYN          | LANOXIN          |
| ANAFRANIL     | DESYREL          | LEVAQUIN         |
| ANAPROX       | DEXEDRINE        | LEVO-DROMORAM    |
| ANTABUSE      | DIBENZYLINE      | LEVOPHED         |
| APRESOLINE    | DILACOR          | LEVOTHROID       |
| ARAMINE       | DIMETANE         | LEVSIN           |
| ARICEPT       | DIMETAPP         | LIBRAX           |
| ARTANE        | DITROPAN         | LIBRIUM          |
| ARTHROTEC     | DONNATAL         | LIMBITROL        |
| ASENDIN       | DURAVENT         | LIORESAL         |
| AVONEX        | ELAVIL           | LOMOTIL          |
| AXOCET        | ELDEPRYL         | LOPRESSOR        |
| BELLERGAL     | EMPIRINW/CODEINE | LOXITANE         |
| BENADRYL      | ENDEP            | LOXITANE C       |
| BIPHETAMINE   | EQUAGESIC        | LUDIOMIL         |
| BRETHINE      | EQUANIL          | LUFYLLIN-GG      |
| BRONTEX       | ESKALITH         | LUVOX            |
| BUPRENEX      | ETRAFON          | MARCAINE         |
| BUSPAR        | FASTIN           | MAXAIR-AUTOHALER |
| BUTICAPS      | FELDENE          | MAXALT           |
| CAFERGOT      | FIORICET         | MAXIDE           |
| CAFERGOT-PB   | FLEXERIL         | MEBARAL          |
| CALAN         | FLOXIN           | MECLOMEN         |
| CAPOTEN       | GUAIFED          | MEPERGAN         |
| CARDIZEM      | GYNERGEN         | MINIPRESS        |
| CELEBEX       | HALCION          | MIRAPEX          |
| CELEXA        | HALDOL           | MOBAN            |
| CHLORTRIMETON | HISTUSSIN        | MODURETIC        |
| CLARITAN-D    | HYDRO-           | MONOPRIL         |
| CLARITIN      | CHLOROTHIAZIDE   | MORPHINE-SULFATE |
| CLOMID        | HYTRIN           | MOTRIN           |
| CLONOPIN      | HYZAAR           | NALDECON         |
| CLOZARIL      | IMDUR            | NALFON           |

## Additional Anxiety Symptoms

*SYMPTOM*

*DEPOSITION QUESTIONS*

**Palpitations,  
Accelerated  
Heart Rate**

*(continued)*

|                 |               |                 |
|-----------------|---------------|-----------------|
| NAPROSYN        | PROCARDIA     | THIAZAC         |
| NAVANE          | PROKETAZINE   | TIMOPTIC        |
| NEMBUTAL        | PROLIXIN      | TINDAL          |
| NEO-SYNEPHERINE | PROTONIX      | TOFRANIL        |
| NEURONTIN       | PROVENTIL     | TRANSDERM-NITRO |
| NICORETTE       | PROZAC        | TRENTAL         |
| NITRO-DUR       | QUIDE         | TRIAVIL         |
| NITROSTAT       | QUINAGLUTE    | TRILAFON        |
| NOREPHEDRINE    | REMERON       | TRILEPTAL       |
| NORFLEX         | RESTORIL      | TRINALIN        |
| NORGESIC        | REVIA         | TROVAN          |
| NORPACE         | RISPERDAL     | TUINAL          |
| NORPRAMIN       | RITALIN       | ULTRAM          |
| NORVASC         | RONDEC DM     | URECHOLINE      |
| NUBAIN          | RUFEN         | VALIUM          |
| OPTIMINE        | SANOREX       | VALTRES         |
| ORAP            | SANSERT       | VASOTEC         |
| ORNADE          | SE-AP-ES      | VENTOLIN        |
| ORUDIS          | SERENTIL      | VESPRIN         |
| PAMELOR         | SEREVENT      | VIAGRA          |
| PARNATE         | SEROQUEL      | VICOPROFEN      |
| PAXIL           | SINEMET       | VIOXX           |
| PAXIPAM         | SINEQUAN      | VIVACTIL        |
| PBZ-SR          | SLO-BID       | VOLTAREN        |
| PERIACTIN       | SLO-PHYLLIN   | WELLBUTRIN      |
| PERMAX          | SOMA          | WIGRAINE        |
| PERMITIL        | SOMA COMPOUND | XANAX           |
| PHENERGAN VC    | SONATA        | ZANAFLEX        |
| W/CODEINE       | SURMONTIL     | ZANTAC          |
| PHENOBARBITAL   | TALECEN       | ZAROXOLYN       |
| PHENYL-         | TALWIN NX     | ZEPHREX         |
| PROPANOLAMINE   | TARACTAN      | ZESTORETIC      |
| PLENDIL         | TAVIST        | ZYBAN           |
| POLARIMINE      | TEMARIL       | ZYLOPRIM        |
| PRILOSEC        | TENORMIN      | ZYPREXA         |
| PRIMAXIN-IV     | THEO-DUR      | ZYRTEC          |
| PRINZIDE        | THORAZINE     |                 |
| PROCAN-SR       | THYROID       |                 |

**Sweating, Cold  
Clammy Hands**

- Q:** Describe the plaintiff's sweating or cold clammy hands.
- 
- Q:** When and how often does the plaintiff sweat or have cold clammy hands?
- 
- Q:** Does the plaintiff have a history of sweating or cold clammy hands before the injury in question?
-

## SYMPTOM

## DEPOSITION QUESTIONS

**Sweating, Cold  
Clammy Hands***(continued)*

**Q: Does the plaintiff have a history of any medical conditions that may cause sweating or cold clammy hands?**

*If the witness indicates the possibility of a myocardial infarction, see the section on pre-existing medical conditions for further questions.*

**Q: Did you rule out a somatization disorder (psychosomatic) as a cause of the plaintiff's sweating or cold clammy hands?**

The plaintiff with a somatization disorder has many physical complaints for several years. S/he sees multiple physicians only to discover no physical cause for the symptoms. The plaintiff often has exaggerated and vague complaints focusing on either organs or types of symptoms such as **pseudoneurologic or conversion symptoms**, gastrointestinal, female reproductive, psychosexual, pain, and cardiopulmonary symptoms. Anxiety, depression, suicide attempts, social withdrawal, and work or interpersonal relationship difficulties are common. (reference 7, p. 486; reference 4, pp. 389, 940)

*If the witness indicates the possibility of somatization disorder, see the section on somatoform disorder for further questions.*

**Q: Did you rule out fainting as a cause of the plaintiff's sweating or cold clammy hands?**

**Sweating** may occur just prior to the common faint (vasodepressor syncope).

**Q: Did you rule out specific phobia as a cause of the plaintiff's sweating or cold clammy hands?**

A phobic disorder is characterized by the presence of irrational or exaggerated fears of objects or situations. The situation or object of the fear is not inherently dangerous or an appropriate source of anxiety. The plaintiff may have symptoms of panic, **sweating**, tachycardia, shakiness, and difficulty breathing. S/he either avoids the object of the phobia or endures the situation with intense anxiety. There is also a marked distress about having the irrational fear. (reference 7, p. 443; reference 4, pp. 899-900)

*If the witness indicates the possibility of a specific phobia, see the section on specific phobia for further questions.*

**Q: Did you rule out an adjustment disorder with anxiety as a cause of the plaintiff's sweating or cold clammy hands?**

An adjustment disorder is a transient over-reaction to stress that usually occurs within 90 days and remits within six months. The adjustment disorder with anxiety is characterized by symptoms of nervousness, worry, jitteriness, and motor tension. The plaintiff may experience **sweating** as part of the anxiety. (reference 7, p. 680; reference 4, pp. 1098-1099)

*If the witness indicates the possibility of an adjustment disorder, see the section on adjustment disorders for further questions.*

## SYMPTOM

## DEPOSITION QUESTIONS

**Sweating, Cold  
Clammy Hands***(continued)*

**Q: Did you rule out *somatoform (psychogenic) pain disorder* and as a cause of the plaintiff's sweating or cold clammy hands?**

Somatoform (psychogenic) pain disorder is characterized by pain as the predominant focus of clinical attention. In addition, psychological factors are judged to have an important role in the onset, severity, exacerbation, or maintenance of the pain. The symptoms may become so severe that the plaintiff feels incapacitated and quits working. (reference 7, p. 485; reference 4, p. 1109)

*If the witness indicates the possibility of a somatoform (psychogenic) pain disorder, see the section on somatoform disorders for questions.*

**Q: Did you rule out *neuroendocrine disorder, such as pheochromocytoma*, as a cause of the plaintiff's sweating or cold clammy hands?**

Symptoms of a neuroendocrine disorder include sudden headaches, **excessive sweating**, and palpitations. Often there are associated tremors, weakness, nausea, and epigastric discomfort. The plaintiff may also complain of chest pain, shortness of breath, lightheadedness, blurred vision, and flushing. (reference 2, p. 612)

Pheochromocytoma is a tumor of the sympathetic nervous system which specifically causes headaches, lightheadedness, nausea, **sweating**, trembling, and elevated blood pressure during anxiety attacks. (reference 4, p. 1276)

*If the witness indicates the possibility of pheochromocytoma, see the section on pre-existing medical conditions for further questions.*

**Q: Did you rule out *alcohol withdrawal* as a cause of the plaintiff's sweating or cold clammy hands?**

The reduction or cessation of drinking for at least several days may cause characteristic symptoms: coarse tremor of hands, tongue, or eyelids; nausea or vomiting; malaise or weakness; autonomic hyperactivity (tachycardia, **sweating**, and elevated blood pressure); anxiety, depressed mood or irritability; transient hallucinations or illusions; headache; insomnia; dizziness; fatigue; restlessness; and agitation. (reference 7, p. 215; reference 2, pp. 722, 618; reference 9, pp. 50-54)

**Q: Did you rule out *cocaine consumption* as a cause of the plaintiff's sweating or cold clammy hands?**

Cocaine users often experience increased energy and confidence or irritability and paranoia with physical aggressiveness. Other behavioral symptoms may include euphoria, psychomotor agitation, impaired judgment, and impaired social or occupational functioning. Physical symptoms may include tachycardia, dilated pupils, elevated blood pressure, **perspiration or chills**, nausea, vomiting, and hallucinations. (reference 7, p. 241; reference 4, pp. 1008-1009)

**Q: Did you rule out *opioid consumption or withdrawal* as a cause of the plaintiff's sweating or cold clammy hands?**

*Opioid intoxication* is characterized by euphoria, flushing, itching skin, miosis, drowsiness, decreased respiratory rate and depth, hypotension, bradycardia, and **decreased body temperature**. The initial euphoria is often followed by apathy,

## SYMPTOM

## DEPOSITION QUESTIONS

**Sweating, Cold  
Clammy Hands***(continued)*

unpleasant mood, psychomotor retardation, impaired judgment, and impaired social or occupational functioning. While dependence on opioids is less common than on alcohol or tobacco, it has been estimated that fifteen percent of males and nine percent of females have used an opioid (nonmedical) during their lifetime. (reference 7, p. 272; reference 4, pp. 987-988)

Symptoms of *opioid withdrawal* may include lacrimation (tearing), rhinorrhea (runny nose), dilated pupils, **sweating**, diarrhea, yawning, mild hypertension, tachycardia (increased heart rate), fever, insomnia, and gooseflesh. Associated features may include restlessness, irritability, depression, tremor, weakness, nausea, vomiting, and muscle or joint pain. These signs, often resembling influenza symptoms, may be precipitated by the abrupt ending of one or two weeks of continuous opioid use. The withdrawal symptoms may last days or weeks. During the final stages of withdrawal, the plaintiff may experience overconcern for bodily discomfort, poor self-image, and a decreased ability to tolerate stress. (reference 7, pp. 272-273; reference 4, pp. 990-991)

**Q: Did you rule out *ecstasy use* as a cause for the plaintiff's sweating?**

MDMA (Methylenedioxymethamphetamine) use can sometimes result in severe dehydration or exhaustion, or other adverse effects such as nausea, hallucinations, chills, **sweating**, increases in body temperature, tremors, involuntary teeth clenching, muscle cramping, and blurred vision. MDMA users have also reported after-effects such as anxiety, paranoia, aggression and depression. An MDMA overdose is characterized by high blood pressure, faintness, panic attacks, and, in more severe cases, loss of consciousness, seizures, and a drastic rise in body temperatures to 105-106 degrees Fahrenheit. MDMA overdoses can be fatal, as they may result in heart failure or extreme heat stroke. (reference 20)

**Q: (Female) Did you rule out *menopause* as a cause of the plaintiff's sweating or cold clammy hands?**

Menopausal distress may cause anxiety, fatigue, GI disturbances, urinary frequency, back pain, palpitations, tension, emotional lability, irritability and nervousness, depression, dizziness, insomnia, and **hot flashes**. (reference 4, p. 1173; reference 9, p. 21)

*If the witness indicates the possibility of menopausal distress, see the section on menopause for further questions.*

**Q: Did you rule out *hypochondriasis* as a cause of the plaintiff's sweating or cold clammy hands?**

The hypochondriac fears or believes that s/he has a serious disease based on their own interpretation of physical symptoms. Medical evaluations do not support the fears of disease. The plaintiff is preoccupied with bodily functions such as heartbeat, **sweating**, peristalsis, minor physical abnormalities, or a specific organ such as the heart. Headaches and fatigue are common complaints. (reference 7, p. 504; reference 4, p. 1204)

*If the witness indicates the possibility of hypochondriasis, see the section on hypochondriasis for further questions.*

## SYMPTOM

## DEPOSITION QUESTIONS

**Sweating, Cold  
Clammy Hands***(continued)*

**Q: Did you rule out *amphetamine or similarly acting sympathomimetic drug consumption or withdrawal* as a cause of the plaintiff's sweating or cold clammy hands?**

Symptoms of amphetamine or similarly acting sympathomimetic *drug consumption* may include fighting, grandiosity, elation, hypervigilance, psychomotor agitation, and impaired social or occupational functioning. Physical symptoms may include **flushing**, difficulty breathing, tachycardia, pupil dilation, elevated blood pressure, **sweating or chills**, nausea, and vomiting. (reference 4, pp. 1007-1008; reference 7, p. 223)

*Drug withdrawal* symptoms may include a dysphoric mood (depression, irritability, anxiety), fatigue, **sweating**, headaches, insomnia with nightmares, hypersomnia, and psychomotor agitation. Symptoms begin after the cessation of prolonged drug use (at least two days) and last more than 24 hours. (reference 7, pp. 227-228; reference 4, p. 1008)

The following drugs may be classified as amphetamines:

|                                    |                            |
|------------------------------------|----------------------------|
| Appetite Suppressants (diet pills) | Methamphetamines (speed)   |
| Dextroamphetamines                 | Methylphenidates (Ritalin) |
| Ma-huang (ephedra)                 | (reference 17, p. 586)     |
| (reference 24, pp. 488-489)        |                            |

**Q: (Female) Did you rule out *premenstrual dysphoric disorder* as a cause of the plaintiff's sweating?**

Premenstrual dysphoric disorder is characterized by emotional and behavioral symptoms which usually occur during the last week before the menstrual cycle and remit within a few days after menses begins. Symptoms may include tears, sadness, irritability, anger, tension, depression, self-deprecating thoughts, decreased interest in usual activities, fatigability, loss of energy, a subjective sense of difficulty in concentration, changes in appetite, and sleep disturbance. Physical symptoms may also include breast tenderness or swelling, tachycardia, **sweating**, headaches, joint or muscle pain, a sensation of bloating, or weight gain. (reference 7, p. 771; reference 18, pg. 1955)

**Q: Did you rule out *mitral valve prolapse (MVP)* as a cause of the plaintiff's sweating or cold clammy hands?**

Mitral valve prolapse (MVP) is a common and sometimes serious congenital ballooning of a heart valve often associated with arrhythmias of the heart. MVP and panic attacks share many common symptoms including chest pain, palpitation, dyspnea, weakness, fatigue, dizziness, syncope (a faint), and anxiety with **sweating**. (reference 4, pp. 1149,1551)

*If the witness indicates the possibility of mitral valve prolapse, see the section on pre-existing medical conditions for further questions.*

## SYMPTOM

## DEPOSITION QUESTIONS

**Sweating, Cold  
Clammy Hands***(continued)*

**Q: Did you rule out *hypoglycemia* as a cause of the plaintiff's sweating or cold clammy hands?**

Hypoglycemia is an abnormally low blood sugar level. It often produces personality changes, tiredness, confusion, dizziness, tremor, anxiety, tachycardia, and **sweating** during acute attacks. Other psychiatric symptoms include fear and dread, depression with fatigue, and agitation with confusion. Hypoglycemia can develop from an insulin overdose, insulinoma or islet cell tumor, extensive liver disease, or functional diseases. (reference 2, p. 702; reference 4, pp. 1176-1177; reference 18, pp. 1929 and 1479 )

*If the witness indicates the possibility of hypoglycemia, see the section on pre-existing medical conditions for further questions.*

**Q: Did you rule out *sedative, hypnotic, or anxiolytic withdrawal* as a cause of the plaintiff's sweating or cold clammy hands?**

Withdrawal symptoms develop when the plaintiff reduces or stops the prolonged moderate or heavy use of these substances. Symptoms may include nausea or vomiting; malaise or weakness; autonomic hyperactivity (such as tachycardia and **sweating**); anxiety or irritability; orthostatic hypotension; coarse tremor of the hands, tongue and eyelids; insomnia; and grand mal seizures. (reference 7, p. 286; reference 4, p. 1549)

**Q: Did you rule out *cluster headaches* as a cause of the plaintiff's sweating or cold clammy hands?**

Cluster headaches are characterized by severe unilateral pain in the eye or temple. They tend to recur in a series of attacks, affecting primarily men. They may last from twenty minutes to two hours and cause severe pain, flushing and **facial sweating**. Sleep-related cluster headaches are severe unilateral headaches that appear intermittently during REM sleep. (reference 4, pp. 1205, 1261; reference 2, p. 70)

*If the witness indicates the possibility of headaches, see the section on headaches for further questions.*

**Q: Did you rule out *migraine headaches* as a cause of the plaintiff's sweating or cold clammy hands?**

A classic migraine (vascular) headache may be accompanied by visual disturbances, sensory motor or speech disturbances, **sweating**, nausea or vomiting, and emotional changes. On rare occasions, the plaintiff may experience depersonalization or derealization. Migraine headaches may be precipitated by:

- Birth control pills
- Emotional conflicts or stress
- Fluctuating estrogen levels in women
- Food:
  - Monosodium glutamate (Chinese restaurant syndrome)
  - Phenylethylamine-containing foods
  - Tyramine-containing foods (cheese, fermented dairy products and chocolate)

*SYMPTOM*

*DEPOSITION QUESTIONS*

**Sweating, Cold Clammy Hands**

*(continued)*

**Q: Did you rule out *infections* as a cause of the plaintiff's sweating or cold clammy hands?**

|                                  |                                 |
|----------------------------------|---------------------------------|
| Brucellosis                      | Postpartum infections           |
| Chronic urinary tract infections | Subacute bacterial endocarditis |
| Infectious mononucleosis         | Syphilis                        |
| Influenza                        | Tuberculosis                    |
| Malaria                          | Viral hepatitis                 |
| Meningitis                       |                                 |

**Q: Did you rule out the possibility of *enlarged abdominal lymph nodes* as the cause of the plaintiff's sweating or cold clammy hands?**

The enlargement of both abdominal lymph nodes may mechanically interfere with the motor activity of the gut and thus cause constipation, **fever**, backache, bloating, and belching. (reference 2, p. 514)

**Q: Did you rule out *hallucinogen consumption* as the cause of the plaintiff's sweating or cold clammy hands?**

Hallucinogen consumption causes changes in perception such as feelings of detachment, illusions, hallucinations, and synesthesia (seeing colors when a loud sound occurs). Behavioral symptoms may include anxiety or depression, ideas of reference, fear of losing one's mind, paranoia, impaired judgment, and impaired social or occupational functioning. Physical symptoms may include dilated pupils, tachycardia, **sweating**, palpitations, blurred vision, tremors, and incoordination. Flashbacks of experiences may recur several months or years after hallucinogen use. Many plaintiffs may have gross thought process disturbances. Unlike schizophrenics, they are able to talk in detail about their hallucinations. (reference 7, p. 252; reference 4, p. 874)

**Q: Did you rule out *caffeine consumption* as a cause of the plaintiff's sweating or cold clammy hands?**

Characteristic symptoms of caffeine intoxication include restlessness, nervousness, excitement, insomnia, **flushed face**, diuresis, gastrointestinal disturbance, muscle twitching, rambling flow of thought and speech, tachycardia or cardiac arrhythmia, periods of inexhaustibility, and psychomotor agitation. When consumed near bedtime, caffeine often disrupts sleep. Symptoms may appear when the plaintiff consumes as little as 250 mg of caffeine per day. The plaintiff that consumes one gram per day usually experiences more severe symptoms. Products which contain caffeine include: coffee, tea, soda, chocolate and weight-loss aids. (reference 7, p. 231; reference 4, p. 1029)

*If the witness indicates the possibility of excess caffeine consumption, see the caffeine consumption chart in Appendix A.*

*SYMPTOM*

*DEPOSITION QUESTIONS*

**Sweating, Cold  
Clammy Hands**

*(continued)*

**Q: Did you rule out *hyperthyroidism* as a cause of plaintiff's sweating or cold clammy hands?**

Hyperthyroidism, or thyrotoxicosis, results from overproduction of thyroid hormone by the thyroid gland. The most common cause is Graves' disease. The signs and symptoms of hyperthyroidism include both physical and psychiatric complaints. Psychiatric features include nervousness, fatigue, insomnia, mood lability, and dysphoria. There may be a heightened activity level. Cognitive symptoms include a short attention span, impaired recent memory, and an exaggerated startle response.

Physical signs and symptoms of hyperthyroidism include increased pulse, arrhythmias (irregular heart rhythm), elevated blood pressure, fine tremor, heat intolerance, **excessive sweating**, increased appetite, weight loss, palpitations (abnormal rapid beating of heart), tachycardia (rapid heart beat), frequent bowel movements, menstrual irregularities, and muscle weakness. Panic attacks are associated with endocrinological disorders including hyperthyroidism, as well as hypothyroidism. (reference 18, pp. 743, 1809-1810, 1928)

*If the witness indicates the possibility of hyperthyroidism, see the section on pre-existing medical conditions for further information.*

**Q: Does the plaintiff have any *other medical conditions* that may cause sweating or cold clammy hands, such as:**

Acute osteomyelitis  
Circulatory disorder  
Pneumococcal pneumonia

**Q: Is the plaintiff taking any *medications or substances* that may cause sweating or cold clammy hands, such as:**

|                |                   |             |
|----------------|-------------------|-------------|
| ADAPIN         | DANTRIUM          | HYDRODIURIL |
| ALDACTAZIDE    | DELTASONE         | INDERAL     |
| ALDOMET        | DEMEROL           | INDERIDE    |
| ALDORIL        | DESYREL           | INDOCIN     |
| ANAPROX        | DIABINESE         | ISORDIL     |
| APRESOLINE     | DILANTIN          | ISUPREL     |
| ASENDIN        | DIURIL            | LIBRAX      |
| BACTRIM        | DOLOBID           | LOMOTIL     |
| BENTYL         | DONNATAL          | LOPRESSOR   |
| BRETHINE       | EMPIRIN W/CODEINE | LOXITANE    |
| BUMEX          | EQUAGESIC         | LOXITANE IM |
| BUTICAPS       | EQUANIL           | LOXITANE C  |
| CAPOTEN        | ESKALITH          | LUDIOMIL    |
| CHLOR-TRIMETON | ETRAFON           | MACRODANTIN |
| CLONOPIN       | FELDENE           | MEBARAL     |
| COMPAZINE      | FLEXERIL          | MEDROL      |
| CORGARD        | HALDOL            | MEPERGAN    |
| COUMADIN       | HYDRO-            | MINIPRESS   |
| DALMANE        | CHLOROTHIAZIDE    | MOTRIN      |

## Additional Anxiety Symptoms

*SYMPTOM*

*DEPOSITION QUESTIONS*

**Sweating, Cold  
Clammy Hands**

(continued)

|               |               |           |
|---------------|---------------|-----------|
| NALFON        | PROVERA       | TAGAMET   |
| NAPROSYN      | QUIDE         | TALWIN NX |
| NAVANE        | QUINAGLUTE    | TARACTAN  |
| NEMBUTAL      | QUINAMM       | TEGRETOL  |
| NOLUDAR       | RITALIN       | TENORMIN  |
| NORPACE       | ROBAXIN       | THORAZINE |
| NORPRAMIN     | ROBAXISAL     | THYROID   |
| PAMELOR       | RUFEN         | TIMOPTIC  |
| PEDIAZOLE     | SEPTRA        | TINDAL    |
| PENICILLIN VK | SER-AP-ES     | TOFRANIL  |
| PERMITIL      | SINEMET       | TOLECTIN  |
| PHENERGAN VC  | SINEQUAN      | TRILAFON  |
| W/CODEINE     | SOMA          | VCILLIN K |
| PROCAN SR     | SOMA COMPOUND | VIVACTIL  |
| PROCARDIA     | STELAZINE     | ZANTAC    |
| PROKETAZINE   | SUMYCIN       | ZYLOPRIM  |

**Dry Mouth**

**Q:** Describe the plaintiff's dry mouth.

**Q:** Does the plaintiff have a history of a dry mouth before the injury in question?

**Q:** When and how often does the plaintiff complain of a dry mouth?

**Q:** Did you rule out a *somatization disorder (psychosomatic)* as a cause of the plaintiff's dry mouth?

The plaintiff with a somatization disorder has many physical complaints for several years. S/he sees multiple physicians only to discover no physical cause for the symptoms. The plaintiff often has exaggerated and vague complaints focusing on either organs or types of symptoms such as **pseudoneurologic or conversion symptoms**, gastrointestinal, female reproductive, psychosexual, pain, and cardiopulmonary symptoms. Anxiety, depression, suicide attempts, social withdrawal, and work or interpersonal relationship difficulties are common. (reference 7, p. 486; reference 4, pp. 389, 940)

*If the witness indicates the possibility of a somatization disorder, see the section on somatoform disorders for further questions.*

**Q:** Did you rule out *hyperventilation* as a cause of the plaintiff's dry mouth?

Hyperventilation is abnormal, rapid, deep breathing usually due to anxiety. Exercise and strong emotion causes hyperventilation or it can begin spontaneously. Symptoms may include lightheadedness, faintness, ringing in the ears, weakness, blurring of vision, and **tingling around the mouth** or in the extremities. (reference 2, p. 613)

## SYMPTOM

## DEPOSITION QUESTIONS

**Dry Mouth***(continued)*

**Q: Did you rule out *cannabis (marijuana) consumption* as a cause of the plaintiff's dry mouth?**

Cannabis intoxication can occur from marijuana, hashish, or tetrahydrocannabinol (THC). Characteristic symptoms include tachycardia, increased appetite, **dry mouth**, euphoria, anxiety, sensation of slowed time, impaired judgment, and social withdrawal. Inappropriate laughter, panic attacks and a dysphoric mood may occur. (reference 7, pp. 236-241; reference 4, pp. 1326, 764)

**Q: Did you rule out *riboflavin deficiency (ariboflavinosis)* as a cause of the plaintiff's dry mouth?**

Riboflavin is one of the B complex vitamins essential for the normal carbohydrate metabolism of yeast cells and animal tissues. Initial oral symptoms include a **mild burning sensation in the tongue**, oral lesions, and buccal mucosa of the cheeks. Other symptoms are sore and **cracking lips**, burning and itching eyes, loss of appetite, weakness, and irritability. (reference 2, pp. 121, 124-125)

**Q: Did you rule out *early onset of Wilson's disease* as a cause of the plaintiff's dry mouth?**

Wilson's disease is characterized by brain degeneration. Defective copper excretion causes an accumulation of copper in the liver, brain and other tissues. Symptoms may include tremor exaggerated with movement, **difficulty speaking and swallowing**, incoordination, personality changes, explosive anger, abdominal pain, diarrhea, nausea and vomiting, and dementia. (reference 9, pp. 1158-1159)

*If the witness indicates the possibility of Wilson's disease, see the section on pre-existing medical conditions for further questions.*

**Q: Does the plaintiff have any *other medical conditions* that may cause a dry mouth, such as *atrophic glossitis*?**

**Q: Is the plaintiff taking any *medications or substances* that may cause a dry mouth, such as:**

|           |             |               |
|-----------|-------------|---------------|
| ACCUPRIL  | ARTHROTEC   | CARDURA       |
| ACCUTANE  | ASENDIN     | CELEBREX      |
| ADALAT    | ATARAX      | CELEXA        |
| ADAPIN    | AVONEX      | CENTRAX       |
| AEROBID   | AXOCET      | CHLORTRIMETON |
| AKINETONE | AZMACORT    | CLARITAN-D    |
| ALTACE    | BACTROBAN   | CLARITIN      |
| AMBIEN    | BELLERGA    | CLINORIL      |
| AMERGE    | BENADRYL    | CLOZARIL      |
| ANAFRANIL | BENTYL      | CODEINE       |
| ANSAID    | BIPHETAMINE | COGENTIN      |
| ANTIVERT  | BUPRENEX    | COGNEX        |
| ARICEPT   | BUSPAR      | COMBIVENT     |
| ARTANE    | CARAFATE    | COMPAZINE     |

**SYMPTOM****DEPOSITION QUESTIONS****Dry Mouth***(continued)*

|                  |                  |             |
|------------------|------------------|-------------|
| CORGARD          | LEVAQUIN         | PAMELOR     |
| COZAAR           | LEVO-DROMORAM    | PARNATE     |
| CRINONE          | LIMBITROL        | PATANOL     |
| CYCLOSPORIN      | LIORESAL         | PAXIL       |
| DALMANE          | LIPITOR          | PAXIPAM     |
| DEMEROL          | LITHIUM CITRATE  | PBZ-SR      |
| DEPROL           | LODINE           | PEPCID      |
| DESYREL          | LOTREL           | PERMAX      |
| DETROL           | LOXITANE IM      | PERMITIL    |
| DEXEDRINE        | LOXITANE         | PHENERGAN   |
| DILACOR          | LOZOL            | PLENDIL     |
| DIMETANE         | LUDIOMIL         | POLARAMINE  |
| DIMETAPP         | LUVOX            | PONDIMIN    |
| DIOVAN           | MARPLAN          | PREVACID    |
| DITROPAN         | MAXAIR-AUTOHALER | PRILOSEC    |
| DM TINDAL        | MAXALT           | PRINZIDE    |
| DOLOBID          | MAXIDE           | PROAMATINE  |
| DORAL            | MECLIZINE        | PROKETAZINE |
| DURACT           | MEPERGAN         | PROLIXIN    |
| DURAGESIC        | METHADONE-       | PROSOM      |
| DYAZIDE          | HYDROCHLORIDE    | PROTONIX    |
| DYNACIRC         | MEXITIL          | PROZAC      |
| EFFEXOR          | MINIPRESS        | PULMICORT   |
| ELAVIL           | MIRAPEX          | QUIDE       |
| ELDEPRYL         | MOBAN            | REDUX       |
| ENDEP            | MODURETIC        | RELAFEN     |
| ESKALITH         | MONOPRIL         | REMERON     |
| ETRAFON          | MORPHINE-SULFATE | REVIA       |
| EXCELON          | MOTRIN           | RHINOCORT   |
| FIORICET         | NALDECON         | RISPERDAL   |
| FIORINAL-CODEINE | NALFON           | ROCALTROL   |
| FLOXIN           | NARDIL           | RONDEC      |
| GUAIFED          | NASACORT         | RONDEC-DM   |
| HABITROL         | NAVANE           | RUFEN       |
| HALCION          | NEURONTIN        | SANOREX     |
| HALDOL           | NICORETTE        | SELDANE     |
| HYDRO-           | NORFLEX          | SERENTIL    |
| CHLOROTHIAZIDE   | NORGESIC         | SEROQUEL    |
| HYTRIN           | NORPACE          | SERTRALINE  |
| HYZAAR           | NORPRAMIN        | SERZONE     |
| IMDUR            | NORVASC          | SINEMET     |
| IMMODIUM         | NUBAIN           | SINEQUAN    |
| INDERAL          | OMNICEF          | SONATA      |
| KERLONE          | OPTIMINE         | STADOL      |
| KLONOPIN         | ORAP             | STELAZINE   |
| LAMICTAL         | OXYCONTIN        | SULAR       |

## Additional Anxiety Symptoms

**SYMPTOM**

**DEPOSITION QUESTIONS**

**Dry Mouth**

*(continued)*

|           |                |            |
|-----------|----------------|------------|
| SULINDAC  | TRANDATE       | VIOXX      |
| SURMONTIL | TRANSDERM-SCOP | VISTARIL   |
| SYMMETREL | TRANXENE       | VIVACTIL   |
| TARACTAN  | TRENTAL        | WELLBUTRIN |
| TAVIST    | TRIAVIL        | XANAX      |
| TEMARIL   | TRILAFON       | ZANAFLEX   |
| TENORMIN  | TRILEPTAL      | ZEPHREX    |
| THORAZINE | TROVAN         | ZESTORETIC |
| TIAZAC    | ULTRAM         | ZIAC       |
| TIMOPTIC  | UNIVASC        | ZOLOFT     |
| TINDAL    | VASOTEC        | ZOMIG      |
| TOFRANIL  | VERELAN        | ZYBAN      |
| TOPAMAX   | VESPRIN        | ZYRTEC     |
| TOPROL-XL | VIAGRA         |            |
| TORADOL   | VICOPROFEN     |            |

**Dizziness or Lightheadedness**

**Q:** Describe the plaintiff's dizziness or lightheadedness.

**Q:** When and how often does the plaintiff experience dizziness or lightheadedness?

**Q:** Does the plaintiff have a history of dizziness or lightheadedness before the injury in question?

There are a number of hereditary, familial, or developmental labyrinthine degenerative diseases of the ear in which vertigo (sensation or illusion of motion) occurs. (reference 2, p. 718)

**Q:** Does the plaintiff have a history of any *medical conditions* that may cause dizziness or lightheadedness?

*The witness may indicate the possibility of the following medical conditions: please refer to the sections pertaining to these medical conditions for further questions.*

**TABLE 5.2A-3.**

|                |              |
|----------------|--------------|
| Hypertension   | Meningitis   |
| Hypotension    | Polycythemia |
| Hypothyroidism |              |

**Q:** Did you rule out a *labyrinthine or vestibular disease* as a cause of the plaintiff's dizziness or lightheadedness?

There are a number of labyrinthine or vestibular diseases of the ear in which vertigo occurs. (reference 2, p. 718)

## SYMPTOM

## DEPOSITION QUESTIONS

**Dizziness or Lightheadedness***(continued)*

**Q: Did you rule out a *physically stressful schedule* as a cause of the plaintiff's dizziness or lightheadedness?**

Heart pounding, palpitations, and tachycardia are often associated with indigestion, overexertion, a specific emotion, or fatigue. Other symptoms may include fullness in the neck, shortness of breath, nervousness, **dizziness**, and apprehension. (reference 2, pp.302, 304)

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*Caution: Do not ask the following question if the cause of action involves a head injury or toxic exposure.*

**Q: Did you rule out any head injuries or other conditions leading to *organic brain syndrome* as a cause of the plaintiff's dizziness or lightheadedness?**

Organic brain syndrome is a term for symptoms produced by head injury, toxic exposure, hypoxia (oxygen deficiency), anoxia (extreme oxygen deficiency in tissues) or other causes. Common symptoms of head injuries include vertigo, **lightheadedness**, syncope, impaired concentration and memory, easy fatigability, irritability, lack of energy, depression, anxiety, phobia, a lowered tolerance for alcohol, and headaches. Symptoms may appear days or weeks after the injury but usually appear within 24 hours. (reference 2, pp. 75, 111)

**Q: Did you rule out *specific phobia* as a cause of the plaintiff's dizziness or lightheadedness?**

A phobic disorder is characterized by the presence of irrational or exaggerated fears of objects or situations. The situation or object of the fear is not inherently dangerous or an appropriate source of anxiety. The plaintiff may have symptoms of panic, **dizziness or lightheadedness**, sweating, tachycardia, shakiness, and difficulty breathing. S/he either avoids the object of the phobia or endures the situation with intense anxiety. There is also a marked distress about having the irrational fear. (reference 7, p. 443; reference 4, pp. 899-900)

*If the witness indicates that the possibility of a specific phobia, see the section on specific phobia for further questions.*

**Q: Did you rule out *hyperventilation* as a cause of the plaintiff's dizziness or lightheadedness?**

Hyperventilation is abnormal, rapid, deep breathing usually due to anxiety. Exercise and strong emotion causes hyperventilation or it can begin spontaneously. Symptoms may include **lightheadedness**, **faintness**, ringing in the ears, weakness, blurring of vision, and tingling around the mouth or in the extremities. (reference 2, p. 613)

**Q: Did you rule out an *adjustment disorder with anxiety* as a cause of the plaintiff's dizziness or lightheadedness?**

An adjustment disorder is a transient over-reaction to stress that usually occurs within 90 days and remits within six months. The adjustment disorder with anxiety

## SYMPTOM

## DEPOSITION QUESTIONS

**Dizziness or Lightheadedness***(continued)*

is characterized by symptoms of nervousness, worry, jitteriness, and motor tension. The plaintiff may experience **dizziness** as part of the anxiety. (reference 7, p. 680; reference 4, pp. 1098-1099)

*If the witness indicates the possibility of an adjustment disorder, see the section on adjustment disorder for further questions.*

**Q: Did you rule out a neuroendocrine disorder, such as pheochromocytoma, as a cause of the plaintiff's dizziness or lightheadedness?**

Symptoms of a neuroendocrine disorder include sudden headaches, excessive sweating, and palpitations. Often there are associated tremors, weakness, nausea, and epigastric discomfort. The plaintiff may also complain of chest pain, shortness of breath, **lightheadedness**, blurred vision, and flushing. (reference 2, p. 612)

Pheochromocytoma is a tumor of the sympathetic nervous system which specifically causes headaches, **lightheadedness**, nausea, sweating, trembling, and elevated blood pressure during anxiety attacks. (reference 4, p. 1276)

*If the witness indicates the possibility of a pheochromocytoma, see the section on pre-existing medical conditions for further questions.*

**Q: Did you rule out *malingering* as a cause of the plaintiff's dizziness or lightheadedness?**

Malingering may be associated with attempts to avoid work or evade legal responsibilities. Plaintiff complaints may include **vertigo** (illusion of movement), weakness, loss of consciousness, seizures, headaches, visual impairment, and loss of skin sensation. (reference 4, p. 1863)

*If the witness indicates the possibility of malingering, see the section on malingering for further questions.*

**Q: Did you rule out *Meniere's syndrome* as a cause of the plaintiff's dizziness or lightheadedness?**

Meniere's syndrome is sometimes confused with acute anxiety. The most common symptom is **dizziness**. Associated symptoms include nystagmus (tremulous movement of the eyeballs), deafness, and other signs of middle-ear disease. (reference 4, p. 893)

**Q: Did you rule out *anemia* as a cause of the plaintiff's dizziness or lightheadedness?**

**Vertigo**, pounding headaches, fainting, dimness of vision, tinnitus (a ringing in one or both ears), irritability, anorexia, restlessness, inability to concentrate, lethargy, fatigue, drowsiness, and GI complaints are common symptoms of anemia. (reference 2, pp. 566-571)

*If the witness indicates the possibility of anemia, see the section on pre-existing medical conditions for further questions.*

## SYMPTOM

## DEPOSITION QUESTIONS

**Dizziness or Lightheadedness***(continued)***Q: Did you rule out a *conversion disorder* as a cause of the plaintiff's dizziness or lightheadedness?**

A conversion disorder is characterized by the presence of symptoms or deficits affecting voluntary motor or sensory function that suggest a neurological or other general medical condition. Psychological factors are judged to be associated with the symptom or deficit and the symptoms are not intentionally feigned or produced. Conversion symptoms are defense mechanisms that change the unconscious emotional conflict into a physical disability that often symbolizes the nature of the conflict. (reference 12, p. 315; reference 2, pp. 625, 630; reference 7, p. 492)

*If the witness indicates the possibility of a conversion disorder, see the section on conversion disorder for further questions.*

**Q: Did you rule out *hypothyroidism* as a cause of the plaintiff's dizziness or lightheadedness?**

Hypothyroidism results from inadequate synthesis of thyroid hormone. Hypothyroidism can produce psychiatric, as well as physical symptoms. The most notable psychiatric symptoms include depression, lethargy, poor concentration, impaired memory, apathy, and **syncope**. The numerous physical symptoms are: cold intolerance, constipation, muscle cramps, paresthesias, menstrual disorders, dyspnea, **dizziness**, reduced hearing, poor appetite, weight gain, brittle and thinning hair, and bradycardia (slowed heart action). Panic attacks are associated with endocrinological disorders including hypothyroidism and hyperthyroidism. (reference 18, pp. 743, 1810-1812, 1928)

*If the witness indicates the possibility of hypothyroidism, see the section on pre-existing medical conditions for further questions.*

**Q: Did you rule out *muscle contraction headaches* as a cause of the plaintiff's dizziness or lightheadedness?**

Chronic muscle contraction headaches may produce nausea, vomiting, **lightheadedness**, difficulty in falling asleep, restless sleep with frequent awakenings, loss of energy, impaired memory and concentration, and symptoms of depression. (reference 2, pp. 72-73; reference 4, p. 1204)

*If the witness indicate the possibility of headaches, see the section on headaches for further questions.*

**Q: Did you rule out *alcohol consumption or withdrawal* as a cause of the plaintiff's dizziness or lightheadedness?**

*Alcohol intoxication* may cause aggressiveness, impaired judgment and attention, irritability, euphoria, depression, emotional lability, and impaired social or occupational functioning. Physical symptoms may include slurred speech, incoordination, unsteady gait, nystagmus, **occasional dizziness**, and flushed face. Heavy alcohol consumption may cause abnormal sleep patterns. The plaintiff often falls asleep quickly but wakes up earlier and earlier with uncomfortable feelings. Chronic alcoholics may have irregular, unsteady, and slow tremulous movements. (reference 7, p. 212; reference 4, p. 67; reference 9, p. 52)

## SYMPTOM

## DEPOSITION QUESTIONS

**Dizziness or Lightheadedness***(continued)*

The *reduction or cessation* of drinking for at least several days may cause characteristic symptoms: coarse tremor of hands, tongue, or eyelids; nausea or vomiting; malaise or weakness; autonomic hyperactivity (tachycardia, sweating, and elevated blood pressure); anxiety, depressed mood or irritability; transient hallucinations or illusions; headache; insomnia; **dizziness**; fatigue; restlessness; and agitation. (reference 7, p. 215; reference 2, pp. 722, 618; reference 9, pp. 50-54)

**Q: Did you rule out *anti-ulcer drugs* as a cause of the plaintiff's dizziness or lightheadedness?**

Anti-ulcer drugs inhibit gastric acid secretion. Adverse drug reactions of confusion, **lightheadedness**, and depression can occur when the plaintiff has renal (kidney) insufficiency, an organic brain syndrome, or when the anti-ulcer drugs are taken in combination with other drugs that slow metabolism. (Cimetidine [Tagamet] is an example). (reference 19)

**Q: Did you rule out *mitral valve prolapse (MVP)* as a cause of the plaintiff's dizziness or lightheadedness?**

Mitral valve prolapse (MVP) is a common and sometimes serious congenital ballooning of a heart valve often associated with arrhythmias of the heart. MVP and panic attacks share many common symptoms including chest pain, palpitation, dyspnea, weakness, fatigue, **dizziness**, syncope (a faint), and anxiety. (reference 4, pp. 1149, 1551)

*If the witness indicates the possibility of mitral valve prolapse, see the section on pre-existing medical conditions for further questions.*

**Q: Did you rule out a *somatization disorder (psychosomatic)* as a cause of the plaintiff's dizziness or lightheadedness?**

The plaintiff with a somatization disorder has many physical complaints for several years. S/he sees multiple physicians only to discover no physical cause for the symptoms. The plaintiff often has exaggerated and vague complaints focusing on either organs or types of symptoms such as **pseudoneurologic or conversion symptoms**, gastrointestinal, female reproductive, psychosexual, pain, and cardiopulmonary symptoms. Anxiety, depression, suicide attempts, social withdrawal, and work or interpersonal relationship difficulties are common. (reference 7, p. 486; reference 4, pp. 389, 940)

*If the witness indicates the possibility of a somatization disorder, see the section on somatoform disorders for further questions.*

**Q: Did you rule out *inhalant intoxication* as a cause of the plaintiff's dizziness or lightheadedness?**

Following inhalant (toxic substance) use, the plaintiff may experience behavioral and physical changes. Behavioral changes may include belligerence, assaultiveness, apathy, impaired judgment, and impaired social or occupational functioning. Physical signs may include **dizziness**, nystagmus, slurred speech, unsteady gait,

## SYMPTOM

## DEPOSITION QUESTIONS

**Dizziness or Lightheadedness***(continued)*

lethargy, depressed reflexes, tremor, psychomotor weakness, blurred vision or diplopia, stupor or coma, and euphoria. (reference 7, p. 257)

**Q: (Female) Did you rule out *menopause* as a cause of the plaintiff's dizziness or lightheadedness?**

Menopausal distress may cause anxiety, fatigue, GI disturbances, urinary frequency, back pain, palpitations, tension, emotional lability, irritability and nervousness, depression, **dizziness**, insomnia, and hot flashes. (reference 4, p. 1173; reference 9, p. 21)

*If the witness indicates the possibility of menopausal distress, see the section on menopause for further questions.*

**Q: Did you rule out *migraine headaches* as a cause of the plaintiff's dizziness or lightheadedness?**

A classic migraine (vascular) headache may be accompanied by **visual disturbances**, sensory motor or speech disturbances, nausea or vomiting, and emotional changes. On rare occasions, the plaintiff may experience depersonalization or derealization. Migraine headaches may be precipitated by: (reference 4, p. 1204; reference 2, pp. 65-66)

- Emotional conflicts or stress
- Fluctuating estrogen levels in women
- Birth control pills
- Food:
  - Monosodium glutamate (Chinese restaurant syndrome)
  - Tyramine-containing foods (cheese, fermented dairy products and chocolate)
  - Phenylethylamine-containing foods

**Q: Did you rule out *masked depression* as a cause of the plaintiff's dizziness or lightheadedness?**

The plaintiff with masked depression hides a dysphoric mood with gastrointestinal problems, chronic pain, insomnia, weight loss, and other physical complaints. Masked depression is a common condition frequently missed by physicians. (reference 4, p. 796)

**Q: Did you rule out *hypoglycemia* as a cause of the plaintiff's dizziness or lightheadedness?**

Hypoglycemia is an abnormally low blood sugar level. It often produces personality changes, tiredness, confusion, **dizziness**, tremor, anxiety, tachycardia, and sweating during acute attacks. Other psychiatric symptoms include fear and dread, depression with fatigue, and agitation with confusion. Hypoglycemia can develop from an insulin overdose, insulinoma or islet cell tumor, extensive liver disease, or functional diseases. (reference 2, p. 702; reference 4, pp. 1176-1177; reference 18, pp. 1929 and 1479 )

*If the witness indicates the possibility of hypoglycemia, see the section on pre-existing medical conditions for further questions.*

## SYMPTOM

## DEPOSITION QUESTIONS

**Dizziness or Lightheadedness***(continued)***Q: Did you rule out *multiple sclerosis* as a cause of the plaintiff's dizziness or lightheadedness?**

Multiple sclerosis is a common disease of young adults. The disease causes a disorder of the optic nerves, spinal cord, and brain. Symptoms may include depression, apathy, lack of judgement, inattention, tremor, **vertigo**, incoordination, weakness, fatigue, dysarthria (speech impairment), and urinary frequency or hesitancy. (reference 4, p. 1276; reference 1, pp. 1354-1356)

*If the witness indicates the possibility of multiple sclerosis, see the section on MS for further questions.*

**Q: Did you rule out a *brain tumor* as a cause of the plaintiff's dizziness or lightheadedness?**

Brain tumors occur in the skull, brain, or membrane covering the brain or spinal cord. Symptoms vary depending on the size of the tumor and rate of growth. The plaintiff may experience anxiety, dementia, irritability, **dizziness**, fatigue, headache, vomiting, hyperthermia (high body temperature), and changes in appetite and personality. (reference 4, pp. 139, 834-835, 855, 860, 1276; reference 9, pp. 2161-2164; reference 1, pp. 1351, 1296)

*If the witness indicates the possibility of a brain tumor, see the section on brain tumors for further questions.*

**Q: Did you rule out *psychogenic dyspnea* as a cause of the plaintiff's dizziness or lightheadedness?**

Plaintiffs with chronic psychogenic breathlessness may be depressed or have a reactive depression to stress. Others may have a depressive psychosis with associated symptoms of anorexia, weight loss, early morning awakening, psychomotor retardation, and daytime mood variations. S/he may complain of smothering or being unable to breath, feeling **lightheaded**, **dizzy**, or numb in the extremities and around the mouth. (reference 2, p.342)

*Defense counsel should note that some plaintiffs with this disorder desire financial compensation and may be malingering. See the section on malingering for additional information.*

**Q: Did you rule out *infections* as a cause of the plaintiff's dizziness or lightheadedness?**

|                                  |                                 |
|----------------------------------|---------------------------------|
| Brucellosis                      | Postpartum infections           |
| Chronic urinary tract infections | Subacute bacterial endocarditis |
| Infectious mononucleosis         | Tuberculosis                    |
| Influenza                        | Viral hepatitis                 |
| Malaria                          |                                 |

*SYMPTOM*

*DEPOSITION QUESTIONS*

**Dizziness or Lightheadedness**

(continued)

**Q: Does the plaintiff have any *other medical conditions* that may cause dizziness or lightheadedness, such as:**

- |  |  |
|--|--|
| Acoustic trauma                        | Herpes simplex   |
| Atrial flutter                         | Infectious diseases                                    |
| Brain stem vascular diseases           | Mumps  |
| Carcinoma                              | Neoplastic diseases                                    |
| Cerebella-pontine-angle lesion         | Nutritional diseases                                   |
| Cerumen or foreign bodies in the canal | Ocular dizziness                                       |
| Cervical spine disturbances            | Otitis externa   |
| Chronic or acute infections            | Otosclerosis   |
| Demyelinative diseases                 | Pseudotumor cerebri (benign intracranial hypertension) |
| Eustachian tube malfunction            | Temporomandibular joint syndrome                       |
| Friedreich's ataxia                    | Trauma by middle ear surgery                           |
| German measles                         | Tumors of the vestibular nerve                         |
| Glomus tumor                           | Tympanic perforation                                   |
| Granuloma                              |  |
| Herpes zoster otitis                   |  |

**Q: Is the plaintiff taking any *medications or substances* that may cause dizziness or lightheadedness, such as:**

- |             |             |                 |
|-------------|-------------|-----------------|
| ACCOLATE    | AUGMENTIN   | CHLORAL-HYDRATE |
| ACCUPRIL    | AVAPRO      | CHLORTRIMETON   |
| ACCUTANE    | AVONEX      | CIPRO           |
| ADALAT      | AXID        | CLARITAN-D      |
| ADAPIN      | AXOCET      | CLARITIN        |
| ADDERALL    | BACTROBAN   | CLIMARA         |
| ADIPEX      | BECONASE    | CLINORIL        |
| AEROBID     | BENADRYL    | CLOZARIL        |
| ALDACTAZIDE | BIPHETAMINE | CODEINE         |
| ALDOMET     | BRICANYL    | COGNEX          |
| ALDORIL     | BRONTEX     | COLBENAMID      |
| ALTACE      | BUMEX       | COLESTID        |
| AMBIEN      | BUPRENEX    | COMBIPRES       |
| AMERGE      | BUSPAR      | COMBIVENT       |
| AMYTAL      | BUTICAPS    | COMPAZINE       |
| ANAFRANIL   | CALAN       | CONCERTA        |
| ANAPROX     | CARAFATE    | CORGARD         |
| ANSAID      | CARBATROL   | COUMADIN        |
| ANTIVERT    | CARDENE     | COZAAR          |
| APRESOLINE  | CARDURA     | CYCRIN          |
| ARICEPT     | CEFTIN      | CYLERT          |
| ARTANE      | CEFZIL      | DALMANE         |
| ARTHROTEC   | CELEBREX    | DANTRIUM        |
| ASENDIN     | CELEXA      | DARVOCET-N      |
| ATIVAN      | CELONTIN    | DARVON-COMPOUND |
| ATROVENT    | CENTRAX     | DECADRON        |

**SYMPTOM****DEPOSITION QUESTIONS****Dizziness or  
Lightheadedness***(continued)*

|                 |                  |                  |
|-----------------|------------------|------------------|
| DELTASONE       | FIORINAL         | LO/OVRAL         |
| DEMADEX         | FIORINAL-CODEINE | LODINE           |
| DEPAKENE        | FLAGYL           | LOMOTIL          |
| DEPAKOTE        | FLEXERIL         | LOPID            |
| DEPO-PROVERA    | FLOMAX           | LOPRESSOR        |
| DEPROL          | FLONASE          | LORABID          |
| DESOGEN         | FLOVENT          | LORCET           |
| DESOXYN         | FLOXIN           | LOTENSIN         |
| DESYREL         | FORTAZ           | LOTREL           |
| DETROL          | FOSAMAX          | LOXITANE         |
| DEXEDRINE       | GABITRIL         | LOZOL            |
| DILANTIN        | GLUCOTROL        | LUDIOMIL         |
| DILAUDID        | GUAIFED          | LUVOX            |
| DIMETANE        | HABITROL         | MACROBID         |
| DIMETAPP        | HALCION          | MACRODANTIN      |
| DIOVAN          | HISTUSSIN        | MARCAINE         |
| DIPYRIDAMOLE    | HYDERGINE        | MARPLAN          |
| DITROPAN        | HYDRO-           | MAVIK            |
| DIURIL          | CHLOROTHIAZIDE   | MAXAIR-AUTOHALER |
| DOLOBID         | HYDRODIURIL      | MAXALT           |
| DONNATAL        | HYGROTON         | MAXIDE           |
| DORAL           | HYTRIN           | MEBARAL          |
| DURACT          | HYZAAR           | MECLIZINE        |
| DURAGESIC       | IMDUR            | MECLOMEN         |
| DYAZIDE         | IMITREX          | MEPERGAN         |
| DYNACIRC        | IMITREX-TABLETS  | MESANTOIN        |
| EFFEXOR         | IMMODIUM         | METHADONE-       |
| ELAVIL          | INAPSINE         | HYDROCHLORIDE    |
| ELDEPRYL        | INDERAL          | METHERGIE        |
| EMPIRIN-CODEINE | INDERIDE         | METHOTREXATE     |
| ENDEP           | INDOCIN          | MEVACOR          |
| ENDURON         | IONAMIN          | MEXITIL          |
| EQUAGESIC       | ISORDIL          | MICRONOR         |
| EQUANIL         | KEFLEX           | MIDRIN           |
| ESGIC           | KEFTAB           | MILONTIN         |
| ESIDRIX         | KERLONE          | MINIPRESS        |
| ESKALITH        | LASIX            | MIRAPEX          |
| ESTRACE         | LESCOL           | MOBIC            |
| ESTRATAB        | LEVAQUIN         | MODURETIC        |
| ESTRATEST       | LEVO-DROMORAM    | MONOPRIL         |
| ESTROGEN PATCH  | LEVSIN           | MORPHINE-SULFATE |
| ETRAFON         | LIBRAX           | MOTRIN           |
| EXCELON         | LIDODERM PATCH   | NALDECON         |
| FAMVIR          | LIMBITROL        | NALFON           |
| FASTIN          | LIORESAL         | NAPROSYN         |
| FELDENE         | LIPITOR          | NARDIL           |
| FIORICET        | LITHIUM-CITRATE  | NEMBUTAL         |

**SYMPTOM****DEPOSITION QUESTIONS****Dizziness or  
Lightheadedness***(continued)*

|                   |             |                 |
|-------------------|-------------|-----------------|
| NICORETTE         | PINDOLOL    | SINEMET         |
| NIMOTOP           | PLACIDYL    | SINEQUAN        |
| NITRO-BID         | PLAQUENIL   | SINGULAIR       |
| NITRO-DUR         | PLAVIX      | SKELAXIN        |
| NITROSTAT         | PLENDIL     | SOMA            |
| NIZORAL           | POLARIMINE  | SOMA-COMPOUND   |
| NOLUDAR           | PONDIMIN    | SONATA          |
| NOLVADEX          | PRAVACHOL   | SORBITRATE      |
| NORCO             | PREMARIN    | SPORANOX        |
| NORDETTE          | PREMPHASE   | STADOL          |
| NORFLEX           | PREMPRO     | STELAZINE       |
| NORGESIC          | PREVACID    | SUDAFED         |
| NORINYL           | PRIMAXIN-IV | SULINDAC        |
| NOROXIN           | PRINIVIL    | SUMYCIN         |
| NORPACE           | PRINZIDE    | SUPRAX          |
| NORPLANT-SYSTEM   | PROAMATINE  | SURMONTIL       |
| NORPRAMIN         | PROCAN-SR   | SYMMETREL       |
| NORVASC           | PROCARDIA   | SYNALGOS-DC     |
| NUBAIN            | PROKETAZINE | TAGAMET         |
| OCUFLOX           | PROSOM      | TALECEN         |
| OGEN              | PROTONIX    | TALWIN-NX       |
| OMNICEF           | PROVENTIL   | TARACTAN        |
| OPTIMINE          | PROVERA     | TAVIST          |
| ORAP              | QUESTRAN    | TEGRETOL        |
| ORNADE            | QUIDE       | TEMARIL         |
| ORTH-NOVUM        | REGLAN      | TENORMIN        |
| ORTHO-CEPT        | RELAFEN     | TESSALON        |
| ORTHOCYCLEN       | REMERON     | TIAZAC          |
| ORTHOEST          | RESTORIL    | TICLID          |
| ORUDIS            | REVIA       | TIGAN           |
| OXYCONTIN         | REZULIN     | TIMOPTIC        |
| PAMELOR           | RIFAMATE    | TINDAL          |
| PARAFON-FORTE     | RISPERDAL   | TOFRANIL        |
| PARLODEL          | RITALIN     | TOLECTIN        |
| PARNATE           | ROBAXIN     | TOLINASE        |
| PAXIPAM           | ROBAXISAL   | TOPROL-XL       |
| PBZ-SR            | RONDEC-DM   | TORADOL         |
| PEPCID            | ROXICET     | TORECAN         |
| PERCOCET          | RUFEN       | TRANCOPAL       |
| PERCODAN          | SANOREX     | TRANDATE        |
| PERIACTIN         | SANSERT     | TRANSDERM-NITRO |
| PERMAX            | SE-AP-ES    | TRANSDERM-SCOP  |
| PERMITIL          | SERAX       | TRANXENE        |
| PERSANTINE        | SERENTIL    | TRENTAL         |
| PHENAPHEN-CODEINE | SEROQUEL    | TRIAVIL         |
| PHENERGAN         | SERTRALINE  | TRILAFON        |
| PHENOBARBITAL     | SERZONE     | TRILEPTAL       |

## Additional Anxiety Symptoms

**SYMPTOM**

**DEPOSITION QUESTIONS**

**Dizziness or  
Lightheadedness**

*(continued)*

|                 |            |            |
|-----------------|------------|------------|
| TRILISATE       | VIAGRA     | ZESTORETIC |
| TRINALIN        | VICODIN    | ZESTRIL    |
| TRIPHASIL       | VICOPROFEN | ZITHROMAX  |
| TROVAN          | VIVACTIL   | ZOCOR      |
| TUSSI-ORGANIDIN | VOLTAREN   | ZOFRAN     |
| TYLENOL-CODEINE | WELLBUTRIN | ZOLOFT     |
| TYLOX           | WYGESIC    | ZOMIG      |
| ULTRAM          | XANAX      | ZOVIRAX    |
| URISED          | XYLOCAINE  | ZYBAN      |
| VANCENASE       | YOCON      | ZYLOPRIM   |
| VANCOGIN-HCI    | ZANAFLEX   | ZYPREXA    |
| VANTIN          | ZANTAC     | ZYRTEC     |
| VASOTEC         | ZARONTIN   |            |
| VENTOLIN        | ZAROXOLY   |            |
| VERELAN         | ZEPHREX    |            |

**Nausea,  
Diarrhea, or  
Abdominal  
Distress**

**Q:** Describe the plaintiff's nausea, diarrhea, or abdominal distress.

**Q:** When and how often does the plaintiff have nausea, diarrhea, or abdominal distress?

**Q:** Does the plaintiff have a history of nausea, diarrhea, or abdominal distress before the injury in question?

**Q:** Does the plaintiff have a history of any *medical conditions* that may cause nausea, diarrhea, or abdominal distress?

*The witness may indicate the possibility of the following medical conditions: please refer to the sections pertaining to these medical conditions for further questions.*

**TABLE 5.2A-4.**

|  |                                  |
|--|----------------------------------|
| Acute infectious diarrhea                  | Functional diarrhea              |
| -Antibiotic-associated diarrheas           | Functional (non-ulcer) dyspepsia |
| -Travelers' diarrhea                       | Hepatitis B                      |
| -Sexually transmitted and<br>AIDS diarrhea | Hyperthyroidism                  |
| -Day Care diarrhea                         | Irritable bowel syndrome         |
| Addison's disease                          | Malabsorption syndromes          |
| Chronic Diarrheal diseases                 | Meningitis                       |
| Colonic motility disorders                 | Myocardial infarction            |
| Coronary artery disease                    | Surreptitious abuse of laxatives |
| Crohn's disease                            | Syphilis                         |
| Diverticular disease                       | Ulcerative colitis               |
|  | Uremic encephalopathy            |

*SYMPTOM*

*DEPOSITION QUESTIONS*

**Nausea,  
Diarrhea, or  
Abdominal  
Distress**  
*(continued)*

**Q: Did you rule out an *adjustment disorder with anxiety* as a cause of the plaintiff's nausea, diarrhea, or abdominal distress?**

An adjustment disorder is a transient over-reaction to stress that usually occurs within 90days and remits within six months. The adjustment disorder with anxiety is characterized by symptoms of nervousness, worry, jitteriness, and motor tension. The plaintiff may experience nausea or **abdominal distress** as part of the anxiety. (reference 7, p. 680; reference 4, pp. 1098-1099)

*If the witness indicates the possibility of an adjustment disorder, see the section on adjustment disorders for further questions.*

**Q: Did you rule out *migraine headaches* as a cause of the plaintiff's nausea, diarrhea, or abdominal distress?**

A classic migraine (vascular) headache may be accompanied by visual disturbances, sensory motor or speech disturbances, **nausea or vomiting**, and emotional changes. On rare occasions, the plaintiff may experience depersonalization or derealization. Migraine headaches may be precipitated by: (reference 4, p. 1204; reference 2, pp. 65-66)

- Emotional conflicts or stress
- Fluctuating estrogen levels in women
- Birth control pills
- Food:
  - Monosodium glutamate (Chinese restaurant syndrome)
  - Tyramine-containing foods (cheese, fermented dairy products and chocolate)
  - Phenylethylamine-containing foods

**Q: Did you rule out *chronic motion sickness* as a cause of the plaintiff's nausea, diarrhea, or abdominal distress?**

The plaintiff that is susceptible to motion sickness may experience anorexia, **nausea and vomiting** during or following transportation by most any moving vehicle. As the symptoms develop, the plaintiff may experience profound apathy, salivation, and sweating. (reference 2, p. 371)

**Q: Did you rule out *niacin deficiency (B complex)* as a cause of the plaintiff's nausea, diarrhea, or abdominal distress?**

Niacin is one of the B complex vitamins essential for the normal carbohydrate metabolism of yeast cells and animal tissues. As the body's level of niacin decreases, the plaintiff may initially experience a burning tongue after eating hot or spicy foods. Symptoms are often more severe in the spring and fall and may be associated with mild anorexia, fatigue, nervousness, irritability, **alternating periods of constipation and diarrhea**, or burning sensations in the epigastriuin (upper and middle abdomen).(reference 2, pp. 121-123)

## SYMPTOM

## DEPOSITION QUESTIONS

**Nausea,  
Diarrhea, or  
Abdominal  
Distress**

*(continued)*

**Q: Did you rule out a neuroendocrine disorder, such as pheochromocytoma, as a cause of the plaintiff's nausea, diarrhea, or abdominal distress?**

Symptoms of a neuroendocrine disorder include sudden headaches, excessive sweating, and palpitations. Often there are associated tremors, weakness, **nausea**, and epigastric discomfort. The plaintiff may also complain of chest pain, shortness of breath, lightheadedness, blurred vision, and flushing. (reference 2, p. 612)

Pheochromocytoma is a tumor of the sympathetic nervous system which specifically causes headaches, lightheadedness, **nausea**, sweating, trembling, and elevated blood pressure during anxiety attacks. (reference 4, p. 1276)

*If the witness indicates the possibility of pheochromocytoma, see the section on pre-existing medical conditions for further questions.*

**Q: Did you rule out muscle contraction headaches as a cause of the plaintiff's nausea, diarrhea, or abdominal distress?**

Chronic muscle contraction headaches may produce **nausea, vomiting, lightheadedness**, difficulty in falling asleep, restless sleep with frequent awakenings, loss of energy, impaired memory and concentration, and symptoms of depression. (reference 2, pp. 72-73; reference 4, p. 1204)

**Q: Did you rule out alcohol withdrawal as a cause of the plaintiff's nausea, diarrhea, or abdominal distress?**

The reduction or cessation of drinking for at least several days may cause characteristic symptoms: coarse tremor of hands, tongue, or eyelids; **nausea or vomiting**; malaise or weakness; autonomic hyperactivity (tachycardia, sweating, and elevated blood pressure); anxiety, depressed mood or irritability; transient hallucinations or illusions; headache; insomnia; dizziness; fatigue; restlessness; and agitation. (reference 7, pp. 215-216; reference 2, pp. 722, 618; reference 9, pp. 50-54)

**Q: Did you rule out the possibility of enlarged abdominal lymph nodes as the cause of the plaintiff's nausea, diarrhea, or abdominal distress?**

The enlargement of both abdominal lymph nodes may mechanically interfere with the motor activity of the gut and thus cause constipation, pain, fever, backache, **bloating and belching**. (reference 2, p. 514)

**Q: (Female) Did you rule out pregnancy as a cause of the plaintiff's nausea, diarrhea, or abdominal distress?**

**Nausea and vomiting** often occur in the first trimester. (reference 2, p. 370)

**Q: Did you rule out opioid withdrawal as a cause of the plaintiff's nausea, diarrhea, or abdominal distress?**

Symptoms of opioid withdrawal may include lacrimation (tearing), rhinorrhea (runny nose), dilated pupils, sweating, **diarrhea**, yawning, mild hypertension, tachycardia (increased heart rate), fever, insomnia, and gooseflesh. Associated features may include restlessness, irritability, depression, tremor, weakness, **nausea**,

## SYMPTOM

## DEPOSITION QUESTIONS

**Nausea,  
Diarrhea, or  
Abdominal  
Distress**

(continued)

**vomiting**, and muscle or joint pain. These signs, often resembling influenza symptoms, may be precipitated by the abrupt ending of one or two weeks of continuous opioid use. The withdrawal symptoms may last days or weeks. During the final stages of withdrawal, the plaintiff may experience overconcern for bodily discomfort, poor self-image, and a decreased ability to tolerate stress. (reference 7, pp. 272, 273; reference 4, pp. 990-991)

**Q: Did you rule out a *somatization disorder (psychosomatic)* as a cause of the plaintiff's nausea, diarrhea, or abdominal distress?**

The plaintiff with a somatization disorder has many physical complaints for several years. S/he sees multiple physicians only to discover no physical cause for the symptoms. The plaintiff often has exaggerated and vague complaints focusing on either organs or types of symptoms such as pseudoneurologic or conversion symptoms, **gastrointestinal**, female reproductive, psychosexual pain, and cardiopulmonary symptoms. Anxiety, depression, suicide attempts, social withdrawal, and work or interpersonal relationship difficulties are common. (reference 7, p. 486; reference 4, pp. 389, 940)

*If the witness indicates the possibility of a somatization disorder, see the section on somatoform disorders for further questions.*

**Q: Did you rule out *renal, or ureteral pain* as a cause of the plaintiff's nausea, diarrhea, or other abdominal distress?**

Referred renal or ureteral pain may cause **nausea and vomiting**. (reference 2, pp.184-185)

**Q: Did you rule out *amphetamine or similarly acting sympathomimetic drug consumption* as a cause of the plaintiff's nausea, diarrhea, or other abdominal distress?**

Symptoms of amphetamine or similarly acting sympathomimetic drug consumption may include fighting, grandiosity, elation, hypervigilance, psychomotor agitation, impaired judgment, and impaired social or occupational functioning. Physical symptoms may include flushing, difficulty breathing, tachycardia, pupil dilation, elevated blood pressure, sweating or chills, **nausea, and vomiting**. (reference 4, pp. 1007-1008; reference 7, p. 223)

The following drugs may be classified as amphetamines:

|                                    |                            |
|------------------------------------|----------------------------|
| Appetite Suppressants (diet pills) | Methamphetamines (speed)   |
| Dextroamphetamines                 | Methylphenidates (Ritalin) |
| Ma-huang (ephedra)                 | (reference 17, p. 586)     |
| (reference 24, pp. 488-489)        |                            |

**Q: Did you rule out *sedative, hypnotic, or anxiolytic withdrawal* as a cause of the plaintiff's nausea, diarrhea, or abdominal distress?**

Withdrawal symptoms develop after the reduction or cessation of the prolonged moderate or heavy use of these substances. Symptoms may include **nausea or**

## SYMPTOM

## DEPOSITION QUESTIONS

**Nausea,  
Diarrhea, or  
Abdominal  
Distress**

(continued)

**vomiting**; malaise or weakness; autonomic hyperactivity (such as tachycardia and sweating); anxiety or irritability; orthostatic hypotension; coarse tremor of the hands, tongue and eyelids; insomnia; and grand mal seizures. (reference 7, p. 286; reference 4, p. 1549)

**Q: (Female) Did you rule out *premenstrual dysphoric disorder* as a cause of the plaintiff's nausea, diarrhea, or abdominal distress?**

Premenstrual dysphoric disorder is characterized by emotional and behavioral symptoms which usually occur during the last week before the menstrual cycle and remit within a few days after menses begins. Symptoms may include tears, sadness, irritability, anger, tension, depression, self-deprecating thoughts, decreased interest in usual activities, fatigability, loss of energy, a subjective sense of difficulty in concentration, changes in appetite, and sleep disturbance. Physical symptoms may also include breast tenderness or swelling, tachycardia, sweating, headaches, joint or muscle pain, a sensation of **bloating**, or weight gain. (reference 7, pp.771-774; reference 18, pg. 1955)

**Q: Did you rule out *cocaine consumption* as a cause of the plaintiff's nausea, diarrhea, or abdominal distress?**

Cocaine users often experience increased energy and confidence or irritability and paranoia with physical aggressiveness. Other behavioral symptoms may include euphoria, hypervigilance, psychomotor agitation, impaired judgment, and impaired social or occupational functioning. Physical symptoms may include tachycardia, dilated pupils, elevated blood pressure, perspiration or chills, **nausea, vomiting**, and hallucinations. (reference 7, pp. 241-245; reference 4, pp. 1008-1009)

**Q: Did you rule out *ecstasy use* as a cause for the plaintiff's nausea, diarrhea, or abdominal distress?**

MDMA (Methylenedioxymethamphetamine) use can sometimes result in severe dehydration or exhaustion, or other adverse effects such as **nausea**, hallucinations, chills, sweating, increases in body temperature, tremors, involuntary teeth clenching, muscle cramping, and blurred vision. MDMA users have also reported after-effects such as anxiety, paranoia, aggression and depression. An MDMA overdose is characterized by high blood pressure, faintness, panic attacks, and, in more severe cases, loss of consciousness, seizures, and a drastic rise in body temperatures to 105-106 degrees Fahrenheit. MDMA overdoses can be fatal, as they may result in heart failure or extreme heat stroke. (reference 20)

**Q: Did you rule out *caffeine consumption or withdrawal* as a cause of the plaintiff's nausea, diarrhea, or abdominal distress?**

Characteristic symptoms of *caffeine intoxication* include restlessness, nervousness, excitement, insomnia, flushed face, diuresis, **gastrointestinal disturbance**, muscle twitching, rambling flow of thought and speech, tachycardia or cardiac arrhythmia, periods of inexhaustibility, and psychomotor agitation. When consumed near bedtime, caffeine often disrupts sleep. Symptoms may appear when the plaintiff consumes as little as 250 mg of caffeine per day. The plaintiff that consumes one

## SYMPTOM

## DEPOSITION QUESTIONS

**Nausea,  
Diarrhea, or  
Abdominal  
Distress**

(continued)

gram per day usually experiences more severe symptoms. Products which contain caffeine include: coffee, tea, soda, chocolate and weight-loss aids. (reference 7, p. 231; reference 4, p. 1029)

The most common *caffeine withdrawal* symptom is a withdrawal headache. Headaches will occur in about one-third of moderate to high caffeine consumers when their daily intake is stopped. Other withdrawal symptoms include muscle tension, anxiety, drowsiness, lethargy, rhinorrhea (runny nose), disinterest in work, irritability, nervousness, mild feelings of depression, yawning, **nausea**, and fatigue. (reference 4, p. 1029; reference 2, p. 618)

*If the witness indicates the possibility of excess caffeine consumption, see the caffeine consumption chart in Appendix A.*

**Q: Did you rule out *hypochondriasis* as a cause of the plaintiff's nausea, diarrhea, or abdominal distress?**

The hypochondriac fears or believes that s/he has a serious disease based on their own interpretation of physical symptoms. Medical evaluations do not support the fears of disease. The plaintiff is preoccupied with bodily functions such as heartbeat, sweating, **gastrointestinal functioning**, peristalsis, minor physical abnormalities, or a specific organ such as the heart. Headaches and fatigue are common complaints. (reference 7, p. 504; reference 4, p. 1204)

*If the witness indicates the possibility of hypochondriasis, see the section on hypochondriasis for further questions.*

**Q: Did you rule out *porphyria* as a cause of the plaintiff's nausea, diarrhea, or abdominal distress?**

Porphyria is an inherited disorder of young and middle-aged adults. It is characterized by episodes of **abdominal pain**, peripheral neuropathy, weakness, anorexia, nausea, vomiting, tachycardia, fever, confusion, depression, and severe anxiety. Mood swings and mental abnormalities are common symptoms. (reference 4, pp. 121, 1276, 1326; reference 9, p. 1156; reference 1, pp. 958, 960)

*If the witness indicates the possibility of porphyria, see the section on pre-existing medical conditions for further questions.*

**Q: Did you rule out acute *pyelonephritis* as a cause of the plaintiff's nausea, diarrhea, or abdominal distress?**

The often gradual onset of acute pyelonephritis causes early symptoms of urinary frequency, dysuria, and fever. Severe symptoms of chills, flank pain, **nausea**, and **vomiting** may appear after several days. (reference 2, p. 191)

**Q: Did you rule out *lithium use* as a cause of the plaintiff's nausea, diarrhea, or abdominal distress?**

Lithium and the tricyclics are often given as medication for depression. Tremor is one of the most common side effects. Other symptoms may include nausea, diarrhea, polyuria (the passage of an excessive quantity of urine), polydipsia (excessive thirst),

## SYMPTOM

## DEPOSITION QUESTIONS

**Nausea,  
Diarrhea, or  
Abdominal  
Distress**  
(continued)

and weight gain. Toxic effects may include gross tremor, increased deep tendon reflexes, persistent headaches, **vomiting**, mental confusion progressing to stupor, seizures, or cardiac arrhythmias. (reference 1, pp. 1460-1461)

**Q: Did you rule out *masked depression* as a cause of the plaintiff's nausea, diarrhea, or abdominal distress?**

The plaintiff with masked depression hides a dysphoric mood with **gastrointestinal problems**, chronic pain, insomnia, weight loss, and other physical complaints. Masked depression is a common condition frequently missed by physicians. (reference 4, p. 796)

**Q: Did you rule out *nicotine withdrawal* as a cause of the plaintiff's nausea, diarrhea, or abdominal distress?**

Nicotine withdrawal symptoms include a strong craving for nicotine, anxiety, irritability, frustration or anger, impaired attention, coughing, headaches, insomnia, a mental preoccupation with actions associated with tobacco use, restlessness, drowsiness, **gastrointestinal disturbances**, an increased appetite, and weight gain. The symptoms appear within 24 hours after the cessation or reduction in the use of cigarettes, cigars, pipes, chewing tobacco, or nicotine gum. The plaintiff experiences a decrease in the intensity of the symptoms with time. (reference 7, pp. 265-266; reference 4, pp. 1031-1032)

**Q: Did you rule out *early onset of Wilson's disease* as a cause of the plaintiff's nausea, diarrhea; or abdominal distress?**

Wilson's disease is characterized by brain degeneration. Defective copper excretion causes an accumulation of copper in the liver, brain and other tissues. Symptoms may include tremor exaggerated with movement, difficulty speaking and swallowing, incoordination, personality changes, explosive anger, **abdominal pain, diarrhea, nausea and vomiting**, and dementia. (reference 9, pp. 1158-1159)

*If the witness indicates the possibility of Wilson's disease, see the section on pre-existing medical conditions for further questions.*

**Q: Did you rule out a *brain tumor* as a cause of the plaintiff's nausea, diarrhea, or abdominal distress?**

Brain tumors occur in the skull, brain, or membrane covering the brain or spinal cord. Symptoms vary depending on the size of the tumor and rate of growth. The plaintiff may experience anxiety, dementia, irritability, dizziness, fatigue, headache, **vomiting**, hyperthermia (high body temperature), and changes in appetite and personality. (reference 4, pp. 139, 834-835, 855, 860, 1276; reference 9, pp. 2161-2164; reference 1, pp. 1351, 1296)

*If the witness indicates the possibility of a brain tumor, see the section on brain tumors for further questions.*

*SYMPTOM*

*DEPOSITION QUESTIONS*

**Nausea,  
Diarrhea, or  
Abdominal  
Distress**  
*(continued)*

**Q: Did you rule out *anemia* as a cause of the plaintiffs nausea, diarrhea, or abdominal distress?**

Vertigo, pounding headaches, fainting, dimness of vision, tinnitus (a ringing in one or both ears), irritability, anorexia, restlessness, inability to concentrate, lethargy, fatigue, drowsiness, and **Gastrointestinal complaints** are common symptoms of anemia. (reference 2, pp. 566-571)

*If the witness indicates the possibility of anemia, see the section on pre-existing medical conditions for further questions.*

**Q: Did you rule out *infections* as a cause of the plaintiff's nausea, diarrhea, or abdominal distress?**

|                                  |                                 |
|----------------------------------|---------------------------------|
| Brucellosis                      | Meningitis                      |
| Chronic urinary tract infections | Subacute bacterial endocarditis |
| Infectious mononucleosis         | Syphilis                        |
| Influenza                        | Tuberculosis                    |
| Malaria                          | Viral hepatitis                 |

**Q: (Female) Did you rule out *menopause* as a cause of the plaintiff's nausea, diarrhea, or abdominal distress?**

Menopausal distress may cause anxiety, fatigue, **GI disturbances**, urinary frequency, back pain, palpitations, tension, emotional lability, irritability and nervousness, depression, dizziness, insomnia, and hot flashes. (reference 4, p. 1173; reference 9, p. 21)

*If the witness indicates the possibility of menopausal distress, see the section on menopause for further questions.*

**Q: Did you rule out *pernicious anemia* as a cause of the plaintiff's nausea, diarrhea, or abdominal distress?**

Pernicious anemia results from a lack of vitamin B12. The disease develops slowly causing both physical and mental symptoms. The plaintiff may experience feelings of depression, worthlessness and guilt, irritability, paranoia, and a loss of memory. Physical symptoms may include anorexia, **abdominal pain, intermittent constipation and diarrhea**, weight loss, and weakness. Pernicious anemia often leads to combined systems disease. (reference 4, p. 1276; reference 1, pp. 1077-1079; reference 2, pp. 576, 570)

*If the witness indicates the possibility of pernicious anemia, see the section on pre-existing medical conditions for further questions.*

## Additional Anxiety Symptoms

**SYMPTOM**

**DEPOSITION QUESTIONS**

**Nausea,  
Diarrhea, or  
Abdominal  
Distress**  
*(continued)*

**Q: Does the plaintiff have any *other medical conditions* which may also cause nausea, diarrhea, or abdominal distress, such as:**

|                                  |  |
|----------------------------------|--|
| Abdominal lymphadenopathy        | Local otitic infection                                 |
| Acute appendicitis               | Malabsorption of fats, carbohydrates or water          |
| Acute gastroenteritis            | Mechanical obstruction of the gastrointestinal tract   |
| Alcoholic hepatitis              | Meniere's disease                                      |
| Angle-closure glaucoma           | Neurasthenia   |
| Appendicitis                     | Neuromuscular disorders                                |
| Cholecystitis                    | Peptic ulcer   |
| Chromaffin tumors                | Pneumococcal pneumonia                                 |
| Cystitis                         | Pseudotumor cerebri (benign intracranial hypertension) |
| Diabetic ketoacidosis            | Regional enteritis                                     |
| Enzyme deficiency                | Salmonella   |
| Febrile infectious disease       | Ulcerative colitis                                     |
| Gastrointestinal tract disorders | Uremia   |
| Hyperparathyroidism              | Vagotomy (post-surgery)                                |
| Incomplete bowel obstruction     | Zollinger-Ellison syndrome                             |
| Inflammation of the bowel        |  |
| Intestinal flu                   |  |
| Intra-abdominal disorders        |  |

**Q: Is the plaintiff taking any *medications or substances* that may cause nausea, diarrhea, or abdominal distress, such as:**

|              |            |                      |
|--------------|------------|----------------------|
| ACCOLATE     | AMPICILLIN | BACTRIM              |
| ACCUPRIL     | AMYTAL     | BACTROBAN            |
| ACROMYCIN-V  | ANAFRANIL  | BECONASE             |
| ADALAT       | ANAPROX    | BELLERGAL            |
| ADAPIN       | ANSAID     | BENADRYL             |
| ADDERALL     | ANTABUSE   | BENTYL               |
| ADIPEX       | ANTIVERT   | BETHANECHOL-CHLORIDE |
| AEROBID      | APRESOLINE | BIAXIN               |
| ALDACTAZIDE  | ARICEPT    | BIPHETAMINE          |
| ALDACTONE    | ARTANE     | BRETHINE             |
| ALDOMET      | ARTHROTEC  | BRICANYL             |
| ALDORIL      | ASENDIN    | BROMFED              |
| ALLEGRA      | ATIVAN     | BRONTEX              |
| ALTACE       | ATROVENT   | BUMEX                |
| ALUPENT      | AUGMENTIN  | BUPRENEX             |
| AMBIEN       | AVANDIA    | BUSPAR               |
| AMCILL       | AVAPRO     | BUTAZOLIDIN          |
| AMERGE       | AVONEX     | BUTICAPS             |
| AMOXICILLIN  | AXID       | CAFERGOT             |
| AMOXIL       | AXOCET     | CAFERGOT-PB          |
| AMPHETAMINES | AZULFIDINE |                      |

## Additional Anxiety Symptoms

**SYMPTOM**

**DEPOSITION QUESTIONS**

**Nausea,  
Diarrhea, or  
Abdominal  
Distress**  
*(continued)*

|                 |                 |                    |
|-----------------|-----------------|--------------------|
| CALAN           | DARVON-COMPOUND | EQUANIL            |
| CARAFATE        | DAYPRO          | ERGOMAR            |
| CARAFATE-TOO    | DECADRON        | ERYC               |
| CARBATROL       | DELTASONE       | ERYTHOMYCIN        |
| CARDENE         | DEMADEX         | ESGIC              |
| CARDIZEM        | DEMEROL         | ESIDRIX            |
| CATAPRES        | DEPAKENE        | ESKALITH           |
| CAVERJECT       | DEPAKOTE        | ESTRACE            |
| CECLOR          | DEPO-PROVERA    | ESTRATAB           |
| CEFTIN          | DEPROL          | ESTRATEST          |
| CEFZIL          | DESOXYN         | ESTROGEN PATCH     |
| CELEBREX        | DESYREL         | ETRAFON            |
| CELEXA          | DETROL          | EXCELON            |
| CELONTIN        | DEXEDRINE       | FAMVIR             |
| CHLORAL-HYDRATE | DIABETA         | FASTIN             |
| CHLORTRIMETON   | DIABINESE       | FELBATOL           |
| CILOXIN         | DIAMOX          | FELDENE            |
| CIPRO           | DIFLUCAN        | FIORICET           |
| CLARITAN-D      | DILACOR         | FIORINAL           |
| CLARITIN        | DILANTIN        | FIORINAL W/CODEINE |
| CLEOCIN         | DILAUDID        | FLAGYL             |
| CLIMARA         | DIMETANE        | FLEXERIL           |
| CLINDEX         | DIMETAPP        | FLOMAX             |
| CLINORIL        | DIOVAN          | FLOMASE            |
| CLOMID          | DIPYRIDAMOLE    | FLOVENT            |
| CLOXACILLIN     | DISALCID        | FLOXIN             |
| CLOZARIL        | DITROPAN        | FORTAZ             |
| CODEINE         | DIURIL          | FOSAMAX            |
| COGENTIN        | DOLOBID         | GABITRIL           |
| COGNEX          | DONNATAL        | GLUCOPHAGE         |
| COLBENAMID      | DORAL           | GLUCOTROL          |
| COLESTID        | DURACT          | GUAIFED            |
| COMBIPRES       | DURAGESIC       | GYNERGEN           |
| COMBIVENT       | DURICEF         | HABITROL           |
| COMPAZINE       | DYAZIDE         | HALCION            |
| CORGARD         | DYNACIRC        | HALDOL             |
| CORTISONE       | E-MYCIN         | HISTUSSIN          |
| COUMADIN        | ECOTRIN         | HYDERGINE          |
| COZAAR          | EDECIN          | HYDRO-             |
| CRINONE         | EFFEXOR         | CHLOROTHIAZIDE     |
| CYCRIN          | ELAVIL          | HYDRODIURIL        |
| CYLERT          | ELDEPRYL        | HYGROTON           |
| CYTOTEC         | EMPIRIN-CODEINE | HYTRIN             |
| DALALONE        | ENDEP           | HYZAAR             |
| DALMANE         | ENDURON         | ILOSONE            |
| DANTRIUM        | ENTEXLA         | IMDUR              |
| DARVOCET-N      | EQUAGESIC       | IMMODIUM           |

**Additional Anxiety Symptoms****SYMPTOM****DEPOSITION QUESTIONS****Nausea,  
Diarrhea, or  
Abdominal  
Distress***(continued)*

|                 |                  |                   |
|-----------------|------------------|-------------------|
| INAPSINE        | MAXAIR-AUTOHALER | NORDETTE          |
| INDERAL         | MAXALT           | NORFLEX           |
| INDERIDE        | MAXIDE           | NORGESIC          |
| INDOCIN         | MEBARAL          | NORINYL           |
| INTROPIN        | MECLIZINE        | NOROXIN           |
| IONAMIN         | MECLOMEN         | NORPACE           |
| ISORDIL         | MEGACE           | NORPLANT-SYSTEM   |
| K-DUR           | MELLARIL         | NORPRAMIN         |
| K-LYTE          | MEPERGAN         | NORVASC           |
| K-TAB           | MESANTOIN        | NUBAIN            |
| KEFLEX          | METHADONE-       | NYSTANTIN         |
| KEFZOL          | HYDROCHLORIDE    | OGEN              |
| KERLONE         | METHERGIE        | OMNICEF           |
| KLONOPIN        | METHOTREXATE     | OPTIMINE          |
| KLOTRIX         | METRONIDAZOLE    | ORAP              |
| LAMISIL         | MEVACOR          | ORINASE           |
| LANOXIN         | MEXITIL          | ORNADE            |
| LASIX           | MICRO-K          | ORTHO-NOVUM       |
| LESCOL          | MICRONOR         | ORTHO-CEPT        |
| LEVAQUIN        | MILONTIN         | ORTHOCYCLEN       |
| LEVO-DROMORAM   | MINIPRESS        | ORTHOEST          |
| LEVOTHROID      | MINOCIN          | OXYCONTIN         |
| LEVSIN          | MIRAPEX          | PAMELOR           |
| LIBRAX          | MOBIC            | PARLODEL          |
| LIBRIUM         | MODURETIC        | PARNATE           |
| LIMBITROL       | MONOPRIL         | PATANOL           |
| LIORESAL        | MORPHINE-SULFATE | PAXIL             |
| LIPITOR         | MOTRIN           | PAXIPAM           |
| LITHIUM-CITRATE | MYCELEX TROCHES  | PBZ-SR            |
| LO/OVRAL        | MYCOSTATIN       | PEDIAZOLE         |
| LODINE          | MYSOLINE         | PENICILLIN-VK     |
| LOMOTIL         | NALDECON         | PEPCID            |
| LOPID           | NALFON           | PERCOCET          |
| LOPRESSOR       | NAPROSYN         | PERCODAN          |
| LORABID         | NASACORT         | PERI-COLACE       |
| LORCET          | NASONEX          | PERIACTIN         |
| LOTENSIN        | NAVANE           | PERMAX            |
| LOTREL          | NEMBUTAL         | PERMITIL          |
| LOVENOX         | NEURONTIN        | PERSANTINE        |
| LOZOL           | NICORETTE        | PHENAPHEN-CODEINE |
| LUDIOMIL        | NITRO-BID        | PHENERGAN         |
| LUFYLLIN-GG     | NITRO-DUR        | PHENERGAN-VC-     |
| LUVOX           | NITROSTAT        | CODEINE           |
| MACROBID        | NIZORIL          | PHENOBARBITAL     |
| MACRODANTIN     | NOLUDAR          | PLACIDYL          |
| MARCAINE        | NOLVADEX         | PLAQUENIL         |
| MAVIK           | NORCO            | PLAVIX            |

*SYMPTOM*

*DEPOSITION QUESTIONS*

**Nausea,  
Diarrhea, or  
Abdominal  
Distress**  
*(continued)*

|             |                 |                 |
|-------------|-----------------|-----------------|
| PLAVIX      | SE-AP-ES        | TICLID          |
| PLENDIL     | SECONAL-SODIUM  | TIGAN           |
| POLARIMINE  | SELDANE         | TIMENTIN        |
| POLYCILLIN  | SEPTRA          | TIMOPTIC        |
| POLYMOX     | SERAX           | TINDAL          |
| PONDIMIN    | SERENTIL        | TOFRANIL        |
| PRAVACHOL   | SEREVENT        | TOLECTIN        |
| PRECOSE     | SEROQUEL        | TOLINASE        |
| PREMARIN    | SERTRALINE      | TOPAMAX         |
| PREMPHASE   | SERZONE         | TOPROL-XL       |
| PRIMAXIN    | SINEMET         | TORADOL         |
| PRIMAXIN-IV | SINEQUAN        | TORECAN         |
| PRINIVIL    | SKELAXIN        | TRANCOPAL       |
| PRINZIDE    | SLO-BID         | TRANDATE        |
| PROAMATINE  | SLO-PHYLLIN     | TRANSDERM-NITRO |
| PROCAN-SR   | SLOW-K          | TRANSDERM-SCOP  |
| PROCARDIA   | SOLU-MEDROL     | TRIAVIL         |
| PROKETAZINE | SOMA            | TRILAFON        |
| PROLIXIN    | SOMA-COMPOUND   | TRILEPTAL       |
| PROPULSID   | SONATA          | TRILISATE       |
| PROSOM      | SORBITRATE      | TRIMPEX         |
| PROTONIX    | SPORANOX        | TRINALIN        |
| PROVENTIL   | ST. JOHN'S WORT | TRIPHASIL       |
| PROVERA     | STADOL          | TROVAN          |
| PROZAC      | STELAZINE       | TUINAL          |
| PULMICORT   | SUDAFED         | TUSSI-ORGANIDIN |
| QUESTRAN    | SULAR           | TYLENOL-CODEINE |
| QUINAMM     | SULINDAC        | TYLOX           |
| REDUX       | SUMYCIN         | ULTRAM          |
| REGLAN      | SUPRAX          | URECHOLINE      |
| RELAFEN     | SURMONTIL       | V-CILLIN-K      |
| REMERON     | SYMMETREL       | VALIUM          |
| RESTORIL    | SYNALGOS-DC     | VALTREX         |
| REVIA       | TAGAMET         | VANCENASE       |
| REZULIN     | TALECEN         | VANCOCIN-HCI    |
| RIFAMATE    | TALWIN-NX       | VANTIN          |
| RISPERDAL   | TAVIST          | VASOTEC         |
| RITALIN     | TEGRETOL        | VENTOLIN        |
| ROBAXIN     | TEMARIL         | VERELAN         |
| ROBAXISAL   | TENORMIN        | VESPRIN         |
| ROCALTROL   | TESSALON        | VIAGRA          |
| RONDEC-DM   | TESTODERM       | VIBRAMYCIN      |
| ROXICET     | TETRACYCLINE    | VICODIN         |
| RUFEN       | THEO-DUR        | VICOPROFEN      |
| SALFLEX     | THORAZINE       | VISTARIL-       |
| SANOREX     | THYROID         | INTRAMUSCULAR   |
| SANSERT     | TIAZAC          | VIVACTIL        |

## Additional Anxiety Symptoms

*SYMPTOM*

*DEPOSITION QUESTIONS*

**Nausea,  
Diarrhea, or  
Abdominal  
Distress**  
*(continued)*

|            |            |          |
|------------|------------|----------|
| VOLTAREN   | ZANTAC     | ZOFRAN   |
| WELLBUTRIN | ZARONTIN   | ZOLOFT   |
| WIGRAINE   | ZAROXOLY   | ZOMIG    |
| WYGESIC    | ZEPHREX    | ZOVIRAX  |
| XANAX      | ZESTORETIC | ZYLOPRIM |
| YOCON      | ZESTRIL    | ZYRTEC   |
| ZANAFLEX   | ZITHROMAX  |          |

**Trouble  
Swallowing,  
Lump in  
Throat**

**Q: Describe the plaintiff's trouble swallowing (dysphagia) or lump in the throat.**

**Q: When and how often does the plaintiff have trouble swallowing or a lump in the throat?**

**Q: Does the plaintiff have a history of having trouble swallowing or lump in the throat before the injury in question?**

**Q: Does the plaintiff have a history of any *medical conditions* that may cause trouble swallowing or a lump in the throat?**

*The witness may indicate the possibility of the following medical conditions: please refer to the sections pertaining to these medical conditions for further questions.*

**TABLE 5.2A-5.**

|                                 |                              |
|---------------------------------|------------------------------|
| Amyotrophic lateral sclerosis   | Iron-deficiency anemia       |
| Esophageal disorders            | Parkinson's disease          |
| Gastroesophageal reflux disease | Scleroderma                  |
| HIV infection                   | Systemic lupus erythematosus |
| Inflammatory myopathies         | Tetanus                      |

**Q: Did you rule out a *childhood overanxious disorder* as a cause of the plaintiff's trouble swallowing or lump in the throat?**

A child with an overanxious disorder has excessive or unrealistic anxiety or worry for at least six months. S/he tends to be self-conscious and worried about future events and past behavior. Symptoms may include **feeling a lump in the throat**, headaches, gastrointestinal distress, shortness of breath, nausea, dizziness, difficulty falling asleep, nervousness, and other bodily discomforts. The disorder occurs most often in families where there is an unusual emphasis on high achievement. An overanxious disorder may be accompanied by other phobias. It can persist into adult life as an anxiety disorder, such as a generalized anxiety disorder or a social phobia. (reference 7, p. 472; reference 4, pp.1752-1754)

*Defense counsel should obtain the plaintiff's early school and health records to look for evidence of this disorder.*

*SYMPTOM*

*DEPOSITION QUESTIONS*

**Trouble Swallowing, Lump in Throat**  
*(continued)*

**Q: Did you rule out *nausea or vomiting* as the cause of the plaintiff's trouble swallowing or lump in the throat?**

The plaintiff may have unpleasant and **distressing sensations in the throat**, epigastrium, or abdomen. Tachycardia, watery salivation, and a sudden drenching sweat occur with nausea and vomiting. (reference 2, p. 365)

**Q: Did you rule out *acute laryngitis* as a cause of the plaintiff's trouble swallowing or lump in the throat?**

Symptoms of acute laryngitis may include an inflammation of the upper or lower respiratory tract, hoarseness, cough, sore throat, and painful swallowing. (reference 2, p. 322)

**Q: Did you rule out a *conversion disorder* as a cause of the plaintiff's trouble swallowing or lump in the throat?**

A conversion disorder is characterized by the presence of symptoms or deficits affecting voluntary motor or sensory function that suggest a neurological or other general medical condition. Psychological factors are judged to be associated with the symptom or deficit and the symptoms are not intentionally feigned or produced. Conversion symptoms are defense mechanisms that change the unconscious emotional conflict into a physical disability that often symbolizes the nature of the conflict. (reference 12, p. 315; reference 2, pp. 625, 630; reference 7, p. 492)

*If the witness indicates the possibility of a conversion disorder, see the section on conversion disorder for further questions.*

**Q: Did you rule out a *chronic airway obstruction* as a cause of the plaintiff's trouble swallowing or lump in the throat?**

Types of airway obstructions may include: (reference 1, p514)

A foreign body

Blood Tumor

Blocking by the tongue

Inflammation, neoplasm, constriction, or air passage trauma

Mucus

Spasm or edema of the vocal cords

**Q: Did you rule out an *allergic reaction* as a cause of the plaintiff's trouble swallowing or lump in the throat?**

Allergic rhinitis is seasonal or perennial inflammatory disease of the nasal membranes. Symptoms may include sneezing; a stuffy and itching nose; **postnasal drainage**; and itching eyes. The plaintiff with allergies may feel generally ill and uncomfortable, tired, weak, despondent, irritable, and uninterested in eating. (reference 9, pp. 1867-1868)

## Additional Anxiety Symptoms

*SYMPTOM*

*DEPOSITION QUESTIONS*

**Trouble Swallowing, Lump in Throat**  
(continued)

**Q: Did you rule out early onset of *Wilson's disease* as a cause of the plaintiff's trouble swallowing or lump in the throat?**

Wilson's disease is characterized by brain degeneration. Defective copper excretion causes an accumulation of copper in the liver, brain and other tissues. Symptoms may include tremor exaggerated with movement, **difficulty speaking and swallowing**, incoordination, personality changes, explosive anger, abdominal pain, diarrhea, nausea and vomiting, and dementia. (reference 9, pp. 1158-1159)

*If the witness indicates the possibility of Wilson's disease, see the section on pre-existing medical conditions for further questions.*

**Q: Did you rule out *psychogenic dyspnea* as a cause of the plaintiff's trouble swallowing or lump in the throat?**

Plaintiffs with chronic psychogenic breathlessness may be depressed or have a reactive depression to stress. Others may have a depressive psychosis with associated symptoms of anorexia, weight loss, early morning awakening, psychomotor retardation, and daytime mood variations. S/he may complain of **smothering or being unable to breath**, feel lightheaded, dizzy, or numb in the extremities and around the mouth. (reference 2, p. 342)

*Defense counsel should note that some plaintiffs with this disorder desire financial compensation and may be malingering.*

**Q: Does the plaintiff have any *other medical conditions* that may cause trouble swallowing or lump in the throat, such as:**

|                              |   |
|------------------------------|---|
| Asthma                       | Cystic fibrosis (mucoviscidosis)                  |
| Chronic asthmatic bronchitis | Obstruction <i>above</i> the tracheal bifurcation |
| Chronic bronchitis           | Obstruction <i>below</i> the tracheal bifurcation |
| Chronic emphysema            |   |

**Q: Is the plaintiff taking any *medications or substances* that may cause trouble swallowing or lump in the throat, such as:**

|               |             |                  |
|---------------|-------------|------------------|
| ACCUPRIL      | CLARITAN-D  | FIORICET         |
| AEROBID       | CLOXACILLIN | FIORINAL-CODEINE |
| ALLEGRA       | CLOZARIL    | IMTARACTAN       |
| AMERGE        | COGNEX      | INDERAL          |
| AMYTAL        | COLESTID    | INDERALOR        |
| ARICEPT       | COMBIVENT   | INDERIDE         |
| AVAPRO        | COMPAZIN    | KERLONE          |
| AXOCET        | COMPAZINE   | LOPRESSOR        |
| AZMACORT      | CORGARD AM  | LOXITANE         |
| BECONASE      | DANTRIUM    | LOXITANE C       |
| BENADRYL      | DIMETANE    | MAVIK            |
| BENTYL        | DURAVENT    | MAXAIR-AUTOHALER |
| BRONTEX       | ELDEPRYL    | MAXALT           |
| BUSPAR        | ELOXITANE   | MECLIZINE        |
| CHLORTRIMETON | ETRAFON     | NADETRILAFON     |

## Additional Anxiety Symptoms

**SYMPTOM**

**DEPOSITION QUESTIONS**

**Trouble Swallowing, Lump in Throat**  
(continued)

|               |           |              |
|---------------|-----------|--------------|
| NASACORT      | PROCARDIA | TOPROL-XL    |
| NEURONTIN     | QUESTRAN  | TRANDATE     |
| NICORETTE     | QUIDE     | TRENTAL      |
| NIMOTOP       | REVIA     | TRILAFON     |
| NORPACE       | RHINOCORT | TRINALIN     |
| OPTIMINE      | SELDANE   | VALIUM       |
| ORNADE        | SEREVENT  | VANCENASE    |
| PAXIPAM       | SUMYCIN   | VANCOCIN-HCI |
| PAXIPAM       | TARACTAN  | VASOTEC      |
| PBZ-SR        | TAVIST    | VIOXX        |
| PERIACTIN     | TEMARIL   | ZESTORETIC   |
| PERMITIL      | TENORMIN  | ZESTRIL      |
| PHENOBARBITAL | THORAZINE | ZOMIG        |
| POLARAMINE    | TIMOPTIC  | ZOVIRAX      |
| POLARIMINE    | TINDAL    |              |

**Exaggerated Startle Response**

- Q: Describe the plaintiff's exaggerated startle response.**

---

- Q: When and how often does the exaggerated startle response occur?**

---

- Q: Does the plaintiff have a history of an exaggerated startle response before the injury in question?**

---

- Q: Does the plaintiff have a history of any *medical or psychological conditions* that may cause an exaggerated startle response?**  
*The witness may indicate the possibility of the following medical or psychological conditions: please refer to the sections pertaining to these conditions for further questions.*

**TABLE 5.2A- 6.**

|                         |                             |
|-------------------------|-----------------------------|
| Coronary artery disease | Schizophrenia-paranoid type |
| Hyperthyroidism         |                             |

- Q: Did you rule out *genetic hyperexplexia* (jumpiness) as a cause of the plaintiff's exaggerated startle response?**  
Genetic hyperexplexia is a rare disorder.

---

- Q: Did you rule out an *adjustment disorder with anxiety* as a cause of the plaintiff's exaggerated startle response?**  
An adjustment disorder is a transient over-reaction to stress that usually occurs within 90 days and remits within six months. The adjustment disorder with anxiety

## SYMPTOM

## DEPOSITION QUESTIONS

**Exaggerated  
Startle  
Response**

(continued)

is characterized by symptoms of nervousness, worry, jitteriness, and motor tension. The plaintiff may have an **exaggerated startle response** as part of the anxiety. (reference 7, p. 680; reference 4, pp. 1098-1099)

*If the witness indicates the possibility of an adjustment disorder, see the section on adjustment disorders for further questions.*

**Q: Did you rule out *niacin deficiency (B complex)* as a cause of the plaintiff's exaggerated startle response?**

Niacin is one of the B complex vitamins essential for the normal carbohydrate metabolism of yeast cells and animal tissues. As the body's level of niacin decreases, the plaintiff may initially experience a burning tongue after eating hot or spicy foods. Symptoms are often more severe in the spring and fall and may be associated with mild anorexia, fatigue, **nervousness**, irritability, alternating periods of constipation and diarrhea, or burning sensations in the epigastrium (upper and middle abdomen). (reference 2, pp. 121-123)

**Q: Did you rule out a *paranoid personality disorder* as a cause of the plaintiff's exaggerated startle response?**

The paranoid plaintiff has a history of unwarranted suspicion and mistrust of others. Often expecting to be exploited or harmed, s/he may be excessively sensitive, jealous, **hypervigilant, and tense**. The plaintiff may find it difficult to relax or forgive, and is argumentative when threatened by innocent remarks or events. His or her mood is often humorless, cold and unemotional. These plaintiffs rarely seek help because of a tendency to be moralistic, grandiose, and extrapunitive. (reference 7, p. 690; reference 4, pp. 748-753)

*If the witness indicates the possibility of a paranoid personality disorder, see the section on paranoid personality disorder for further questions.*

**Q: Did you rule out *caffeine consumption* as a cause of the plaintiff's exaggerated startle response?**

Characteristic symptoms of caffeine intoxication include restlessness, **nervousness, excitement**, insomnia, flushed face, diuresis, gastrointestinal disturbance, muscle twitching, rambling flow of thought and speech, tachycardia or cardiac arrhythmia, periods of inexhaustibility, and psychomotor agitation. When consumed near bedtime, caffeine often disrupts sleep. Symptoms may appear when the plaintiff consumes as little as 250 mg of caffeine per day. The plaintiff that consumes one gram per day usually experiences more severe symptoms. Products which contain caffeine include: coffee, tea, soda, chocolate and weight-loss aids. (reference 7, p. 231; reference 4, p. 1029)

*If the witness indicates the possibility of excess caffeine consumption, see the caffeine consumption chart in Appendix A.*

## SYMPTOM

## DEPOSITION QUESTIONS

**Exaggerated Startle Response***(continued)*

**Q: Did you rule out *amphetamine or similarly acting sympathomimetic drug consumption or withdrawal* as a cause of the plaintiff's exaggerated startle response?**

Symptoms of amphetamine or similarly acting sympathomimetic *drug consumption* may include fighting, grandiosity, elation, **hypervigilance**, **psychomotor agitation**, impaired judgment, and impaired social or occupational functioning. Physical symptoms may include flushing, difficulty breathing, tachycardia, pupil dilation, elevated blood pressure, sweating or chills, nausea, and vomiting. (reference 4, pp. 1007-1008; reference 7, p. 223)

Drug *withdrawal symptoms* may include a dysphoric mood (depression, **irritability**, **anxiety**), fatigue, sweating, headaches, insomnia with nightmares, hypersomnia, and **psychomotor agitation**. Symptoms begin after the cessation of prolonged drug use (at least two days) and last more than 24 hours. (reference 7, pp. 223-227; reference 4, p. 1008)

The following drugs may be classified as amphetamines:

|                                    |                            |
|------------------------------------|----------------------------|
| Appetite Suppressants (diet pills) | Methamphetamines (speed)   |
| Dextroamphetamines                 | Methylphenidates (Ritalin) |
| Ma-huang (ephedra)                 | (reference 17, p. 586)     |
| (reference 24, pp. 488-489)        |                            |

**Q: Did you rule out *cocaine consumption or withdrawal* as a cause of the plaintiff's exaggerated startle response?**

*Cocaine users* often experience increased energy and confidence or irritability and paranoia with physical aggressiveness. Other behavioral symptoms may include euphoria, **hypervigilance**, psychomotor agitation, impaired judgment, and impaired social or occupational functioning. Physical symptoms may include tachycardia, dilated pupils, elevated blood pressure, perspiration or chills, nausea, vomiting, and hallucinations.

The abrupt *cessation or reduction* of cocaine, after several days use, may cause the plaintiff to feel tired, dysphoric, irritable, depressed, and to crave more of the drug. An anxiety reaction may cause *psychomotor agitation*, insomnia or hypersomnia, high blood pressure, tachycardia, and paranoia. The symptoms may persist for more than a day. (reference 7, p. 241; reference 4, pp. 1008-1009)

**Q: Did you rule out *hallucinogen consumption* as the cause of the plaintiff's exaggerated startle response?**

Hallucinogen consumption causes changes in perception such as feelings of detachment, illusions, hallucinations, and synesthesia (seeing colors when a loud sound occurs). Behavioral symptoms may include anxiety or depression, ideas of reference, fear of losing one's mind, paranoia, impaired judgment, and impaired social or occupational functioning. Physical symptoms may include dilated pupils, tachycardia, sweating, palpitations, blurred vision, tremors, and incoordination. Flashbacks of experiences may recur several months or years after hallucinogen use.

## SYMPTOM

## DEPOSITION QUESTIONS

**Exaggerated  
Startle  
Response**

(continued)

Many plaintiffs may have gross thought process disturbances. Unlike schizophrenics, s/he is able to talk in detail about their hallucinations. (reference 7, p. 250; reference 4, p. 874)

An *hallucinogen-induced mood disorder* may develop shortly after hallucinogen use and persist for more than 24 hours. Common symptoms include depression or anxiety (with symptoms of a major depressive episode), self-reproach or guilt, **fearfulness, tension, and physical restlessness**. Psychological effects of the disorder may cause severely impaired judgement leading to dangerous decisions and accidents. The plaintiff may be preoccupied with thoughts that s/he has destroyed their brain or driven themselves crazy. Suicide attempts may occur because of extreme despondency. (reference 7, pp. 254-257; reference 1, p. 1429)

**Q: Did you rule out *nightmares* as a cause of the plaintiff's exaggerated startle response?**

Nightmares cause the plaintiff to awaken from REM sleep with a detailed account of a disturbing dream. S/he may feel anxious and experience **autonomic arousal**. Nightmares may occur frequently in the more susceptible plaintiff that is stressed, fatigued, or who has consumed alcohol. (reference 4, p. 1260; reference 1, p. 1321)

**Q: Did you rule out *nicotine withdrawal* as a cause of the plaintiff's exaggerated startle response?**

Nicotine withdrawal symptoms include a strong craving for nicotine, anxiety, **irritability, frustration or anger**, impaired attention, coughing, headaches, insomnia, a mental preoccupation with actions associated with tobacco use, restlessness, drowsiness, gastrointestinal disturbances, an increased appetite, and weight gain. The symptoms appear within 24 hours after the cessation or reduction in the use of cigarettes, cigars, pipes, chewing tobacco, or nicotine gum. The plaintiff experiences a decrease in the intensity of the symptoms with time. (reference 7, p. 264; reference 4, pp. 1031-1032)

**Q: Did you rule out *porphyria* as a cause of the plaintiff's exaggerated startle response?**

Porphyria is an inherited disorder of middle-aged and young adults. It is characterized by episodes of abdominal pain, peripheral neuropathy, weakness, anorexia, nausea, vomiting, tachycardia, fever, confusion, depression, and **severe anxiety**. Mood swings and mental abnormalities are common symptoms. (reference 4, pp. 121, 1276, 1326; reference 9, p. 1156; reference 1, pp. 958, 960)

*If the witness indicates the possibility of porphyria, see the section on pre-existing medical conditions for further questions.*

**Q: Did you rule out the possibility of a *postpartum disorder* as a cause of the plaintiff's exaggerated startle response?**

Postpartum disorders are associated with pregnancy and the period after birth. Symptoms may include insomnia, restlessness, fatigue, depression, irritability, headaches, and lability of mood. Later in the postpartum period, the plaintiff may

## SYMPTOM

## DEPOSITION QUESTIONS

**Exaggerated  
Startle  
Response***(continued)*

become suspicious, confused or incoherent, **irrational, excessively concerned** over trivialities, and refuse food. Depressed women may experience an overconcern for the baby, guilt, or feelings of inadequacy. Hallucinations, infanticide, and suicide are infrequent occurrences. (reference 4, pp. 1238-1241; reference 1, p. 1720)

*If the witness indicates the possibility of a postpartum disorder, see the section on postpartum disorder for further questions.*

**Q: Did you rule out *hyperthyroidism* as a cause of plaintiff's exaggerated startle response?**

Hyperthyroidism, or thyrotoxicosis, results from overproduction of thyroid hormone by the thyroid gland. The most common cause is Graves' disease. The signs and symptoms of hyperthyroidism include both physical and psychiatric complaints. Psychiatric features include nervousness, fatigue, insomnia, mood lability, and dysphoria. There may be a heightened activity level. Cognitive symptoms include a short attention span, impaired recent memory, and an **exaggerated startle response**.

Physical signs and symptoms of hyperthyroidism include increased pulse, arrhythmias (irregular heart rhythm), elevated blood pressure, fine tremor, heat intolerance, excessive sweating, increased appetite, weight loss, palpitations (abnormal rapid beating of heart), tachycardia (rapid heart beat), frequent bowel movements, menstrual irregularities, and muscle weakness. Panic attacks are associated with endocrinological disorders including hyperthyroidism, as well as hypothyroidism. (reference 18, pp. 743, 1809-1810, 1928)

**Q: Is the plaintiff taking any *medications or substances* that may cause an exaggerated startle response, such as:**

BUSPAR  
ESKALITH



## **SECTION 5.3: DIRECT CHALLENGE TO THE DIAGNOSIS OF CLAIMS OF ANXIETY DISORDER DUE TO A GENERAL MEDICAL CONDITION**

### **INTRODUCTION**

The essential feature of an anxiety disorder due to a general medical condition is clinically significant anxiety that is judged to be due to the direct physiological effects of a general medical condition. Symptoms can include prominent, generalized anxiety symptoms, Panic attacks, or obsessions or compulsions.

---

**Challenging the Plaintiff's Diagnosis of an Anxiety Disorder Due to a General Medical Condition**

---

**TABLE 5.3-1.****Diagnostic criteria for 293.84: Anxiety Disorder Due to. . . [Indicate the General Medical Condition]**

- A.** Prominent anxiety, Panic Attacks, or obsessions or compulsions predominate in the clinical picture.
- B.** There is evidence from the history, physical examination, or laboratory findings that the disturbance is the direct physiological consequence of a general medical condition.
- C.** The disturbance is not better accounted for by another mental disorder (e.g., Adjustment Disorder With Anxiety in which the stressor is a serious general medical condition).
- D.** The disturbance does not occur exclusively during the course of a delirium.
- E.** The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

*Specify if:*

**With Generalized Anxiety:** if excessive anxiety or worry about a number of events or activities predominates in the clinical presentation

**With Panic Attacks:** if Panic Attacks predominate in the clinical presentation

**With Obsessive-Compulsive Symptoms:** if obsessions or compulsions predominate in the clinical presentation

**Coding note:** Include the name of the general medical condition on Axis I, e.g., 293.84 Anxiety Disorder Due to Pheochromocytoma, With Generalized Anxiety; also code the general medical condition on Axis III.

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---

*SYMPTOM*

---

*DEPOSITION QUESTIONS*

---

**General Questions**

**Q: What symptoms led to the diagnosis of *anxiety disorder due to a general medical condition*?**

Symptoms can range from generalized anxiety symptoms (worry, restlessness, etc) to panic attacks (discrete periods of intense fear or discomfort) to obsessions or compulsions. (criterion A)

---

**Q: Is there evidence that the onset of the *anxiety symptoms* is related to a general medical condition?**

There must be evidence from the history, physical examination, or laboratory findings that the disturbance is the direct physiological consequence of a general medical condition. (criterion B)

---

**Q: Is there another *Axis I mental disorder* in this case?**

The diagnosis of an *anxiety disorder due to a general medical condition* cannot be made if the symptoms can be accounted for by another mental disorder (e.g., adjustment disorder with anxiety, in which the stressor is a general medical condition). (criterion C)

---

**Q: Is there any evidence of *delirium* in this case?**

The disturbance cannot occur exclusively during the course of delirium. (criterion D)

---

**Q: Is the plaintiff's behavior causing a clinically *significant impairment* in any areas of functioning?**

The disturbance must cause clinically significant distress or impairment in social, occupational, or other important areas of functioning. (criterion E)

---

**Q: Is there a *temporal association* between the onset of the anxiety symptoms and a general medical condition?**

This link must be made with some relative certainty, in order for the diagnosis to be accurate.

---

**Q: Is there any evidence of recent or prolonged *substance use* (including medications with psychoactive effects)?**

The use of many illicit substances such as amphetamines, marijuana, cocaine, ecstasy, alcohol, and prescription medications may lead to symptoms of **anxiety**. The diagnosis of substance-induced anxiety disorder may be more appropriate.

---

**Q: Is there any evidence of *withdrawal from a substance*?**

Like substance use, withdrawal from a substance can include **anxiety** symptoms. The diagnosis of a substance-related anxiety disorder may be more appropriate.

---

*SYMPTOM*

*DEPOSITION QUESTIONS*

**General Questions**

(continued)

**Q: Is there any evidence of exposure to a toxin?**

The diagnosis of substance-induced anxiety disorder may be more appropriate.

*If the witness indicates the possibility of exposure to a toxin, see the section on toxic exposure for additional questions.*

**Q: How did you distinguish anxiety disorder due to a general medical condition from other primary anxiety disorders (panic disorder, GAD, Obsessive-compulsive disorder, etc.)?**

There must be a *prominent* general medical condition for the diagnosis of anxiety disorder due to a general medical condition. In primary anxiety disorders, there is typically no specific and direct causative physiological mechanism associated with the onset of the anxiety symptoms. (reference 7, p. 478)

**Q: Is the general medical condition that is causing the anxiety symptoms directly related to the cause of action?**

A variety of general medical conditions may cause **anxiety** symptoms, including endocrine conditions (thyroid disease, pheochromocytoma, etc), cardiovascular conditions (congestive heart failure, arrhythmia, etc), respiratory conditions (pneumonia, hyperventilation, etc), metabolic conditions (porphyria), and neurological conditions (neoplasms, encephalitis, etc). (reference 7, p. 478)

*Some of these conditions may have pre-existed the cause of action OR they may be unrelated to the cause of action.*

**Q: Does the plaintiff have a history of any medical conditions that may cause anxiety or panic attacks? (reference 23)**

**Table 5.3-2.**

|                                       |                              |
|---------------------------------------|------------------------------|
| Arrhythmia                            | Hypoglycemia                 |
| Asthma                                | Hypothyroidism               |
| Chronic obstructive pulmonary disease | Neoplasms                    |
| Congestive heart failure              | Pheochromocytoma             |
| Encephalitis                          | Pneumonia                    |
| Fibromyalgia                          | Porphyria                    |
| Hyperthyroidism                       | Systemic lupus erythematosus |
| Hyperventilation                      |                              |

**Q: Is the plaintiff taking any medications or substances that may cause anxiety or panic attacks, such as:**

|            |                 |            |
|------------|-----------------|------------|
| ADALAT     | AMERGE          | APRESOLINE |
| ADRENALINE | AMPHETAMINES    | ARTHROTEC  |
| AEROBID    | AMYTAL          | ASENDIN    |
| ALPHGAN    | ANAFRANIL       | AUGMENTIN  |
| ALTACE     | ANDRODERM PATCH | AVAPRO     |
| AMBIEN     | ANSAID          | AVONEX     |

*SYMPTOM*

*DEPOSITION QUESTIONS*

**General Questions**

*(continued)*

|                |                  |                 |
|----------------|------------------|-----------------|
| AXID           | LEVAQUIN         | QUESTRAN        |
| BUTICAPS       | LORCET           | RELAFEN         |
| CATAPRES       | LOTENSIN         | REMERON         |
| CELEBREX       | LOTREL           | REVIA           |
| CELEXA         | LOZOL            | RISPERDAL       |
| CLARITAN-D     | LUDIOMIL         | SE-AP-ES        |
| CLARITIN       | LUVOX            | SEROQUEL        |
| CLOMID         | MARCAINE         | SERTRALINE      |
| CLOZARIL       | MAVIK            | SERZONE         |
| COGNEX         | MAXAIR-AUTOHALER | SINEMET         |
| COMBIPRES      | MAXALT           | SONATA          |
| COZAAR         | MAXIDE           | SPORANOX        |
| CYCLOSPORIN    | MIRAPEX          | ST. JOHN'S WORT |
| CYTOTEC        | NARDIL           | STADOL          |
| DEPROL         | NEMBUTAL         | SULAR           |
| DESOXYN        | NEURONTIN        | SURMONTIL       |
| DILAUDID       | NOLUDAR          | SYMMETREL       |
| DIOVAN         | NORCO            | TAGAMET         |
| DORAL          | NOREPHEDRINE     | TESTODERM       |
| DURACT         | NOROXIN          | TIMOPTIC        |
| DURAGESIC      | NORPLANT-SYSTEM  | TOFRANIL        |
| DURAVENT       | NORPRAMIN        | TRENTAL         |
| EFFEXOR        | NORVASC          | TRILEPTAL       |
| ELAVIL         | OXYCONTIN        | TRINALIN        |
| ELDEPRYL       | PAMELOR          | TROVAN          |
| ENDEP          | PARLODEL         | ULTRAM          |
| EQUAGESIC      | PARNATE          | UNIVASC         |
| ESTRATEST      | PEPCID           | VALIUM          |
| ETRAFON        | PERMAX           | VANTIN          |
| EXCELON        | PHENERGAN-VC-    | VIAGRA          |
| FLEXERIL       | CODEINE          | VICODIN         |
| FLOXIN         | PHENOBARBITAL    | VICOPROFEN      |
| GOODY HEADACHE | PHENYLPROPANOLA  | VIOXX           |
| POWDER         | MINE             | VIVACTIL        |
| HALDOL         | PLAVIX           | VOLTAREN        |
| HISTUSSIN      | PLENDIL          | WELLBUTRIN      |
| HYTRIN         | PONDIMIN         | ZANAFLEX        |
| HYZAAR         | PRAVACHOL        | ZIAC            |
| IMDUR          | PREVACID         | ZOCOR           |
| INAPSINE       | PRILOSEC         | ZOFRAN          |
| INDOCIN        | PROAMATINE       | ZOLOFT          |
| INSULIN        | PROPULSID        | ZOMIG           |
| K-LYTE         | PROSOM           | ZYPREXA         |
| LAMICTAL       | PROTONIX         | ZYRTEC          |
| LESCOL         | PULMICORT        |                 |



## **SECTION 5.4: DIRECT CHALLENGE TO THE DIAGNOSIS OF SPECIFIC PHOBIA CLAIMS**

**(formerly known as Simple Phobia)**

### **INTRODUCTION**

Specific Phobia is common in the general population but is uncommon in litigation. The plaintiff with Specific Phobia experiences a marked and persistent fear of a clearly discernible object or situation. Exposure to the situation or stimulus causes an immediate anxiety response. The person recognizes that the fear is excessive or unreasonable.

Many phobias begin in childhood and are not related to the injury in question. Plaintiffs claiming a specific phobia often have an early history of childhood fears, including school phobia.

Defense counsel should obtain the plaintiff's early mental health and school records and the plaintiff's claimed phobia symptoms by using the deposition questions in Chapters 1 and 4. Section 5.4 provides questions to challenge the accuracy of that diagnosis.

---

**Challenging the Plaintiff's Diagnosis of a Specific Phobia Claim**


---

TABLE 5.4-1.

**Diagnostic criteria for 300.29: Specific Phobia (formerly simple 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 or social anxiety disorder (e.g., avoidance of social situations because of fear of embarrassment), Panic Disorder With Agoraphobia, or Agoraphobia Without History of Panic Disorder.

**Specify type:**

- Animal Type
- Natural Environment Type (e.g., heights, storms, water)
- Blood-Injection-Injury Type
- Situational Type (e.g., airplanes, elevators, enclosed places)
- Other Type (e.g., fear of choking, vomiting, or contracting an illness)

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**Note:  
 Familial  
 Pattern**

**This may be a familial disorder. Familial conditions are more common in biological relatives, and may have pre-existed the cause of action. In the case of Specific Phobia, fears of blood and injury have a particularly strong familial pattern. Thus, there is often an excessive reaction to a minor trauma.**

*SYMPTOM*

*DEPOSITION QUESTIONS*

**General Questions**

**Q: Describe the plaintiff's phobia.**

The phobic stimulus must be unrelated to the fear of having another panic attack (panic disorder), the humiliation of certain social situations (social phobia or social anxiety disorder), the content of obsessions (obsessive compulsive disorder), or the trauma of PTSD. (criterion G)

**Q: When and how often does the plaintiff experience the phobia?**

The fear must be a persistent fear of an object or situation. (criterion A)

**Q: What is the plaintiff's behavior when confronted with exposure to the feared object or situation?**

The plaintiff suffers from an immediate anxiety response in the form of a situationally bound or situationally predisposed panic attack. (criterion B)

**Q: Is the plaintiff's fear reasonable for the situation described?**

The fear must be excessive, unreasonable or irrational. (criterion C)

*If the witness indicates that the plaintiff does not view his or her fear as excessive or unreasonable yet avoids certain activities because of the fear, schizophrenia or another non-proximately caused mental disorder may be the diagnosis. See the section on pre-existing clinical mental disorders for further questions.*

**Q: What is the plaintiff's behavior when confronted with potential exposure to the feared object or situation?**

The plaintiff may try to avoid the situation or if not possible, he/she may endure it with intense anxiety or distress as described above. (criterion D)

**Q: Is the phobic reaction becoming less frequent or less severe?**

**Q: What is the plaintiff's ability to engage in a normal routine, social activities or relationships with others?**

The phobic plaintiff's behavior significantly interferes with normal routine, occupational (or academic) functioning, social activities, and relationships. (criterion E)

**Q: How long has the phobia persisted?**

In individuals under 18, the duration must be at least six months. (criterion F)

**DEFENSE THEORY: The first symptoms of a Specific Phobia usually occur in childhood or early adolescence. In many cases, the anxiety and avoidance behaviors would have pre-existed the cause of action.**

**Q: Does the plaintiff have a history of phobic reactions?**

## SYMPTOM

## DEPOSITION QUESTIONS

**General Questions**  
(continued)

**Q: Did you rule out *stressors or other conditions* not attributable to a mental disorder as a cause of the plaintiff's fears?**

*If the witness indicates the possibility of other life stressors or other conditions, see the section on life stressors for further questions.*

**Q: Did you rule out *mitral valve prolapse (MVP)* as a cause of the plaintiff's fears?**

Mitral valve prolapse (MVP) is a common and sometimes serious congenital ballooning of a heart valve often associated with arrhythmias of the heart. MVP and panic attacks share many common symptoms including chest pain, palpitation, dyspnea, weakness, fatigue, dizziness, syncope (a faint), and **anxiety**. (reference 4, pp. 1149, 1551)

*If the witness indicates the possibility of mitral valve prolapse, see the section on pre-existing medical conditions for further questions.*

**Q: Did you rule out the onset of *hypoglycemia* as a cause of the plaintiff's fears?**

Hypoglycemia is an abnormally low blood sugar level. It often produces personality changes, confusion, dizziness, tremor, **anxiety**, tachycardia, and sweating during **acute attacks**. Other psychiatric symptoms include fear and dread, depression with fatigue, and agitation with confusion. Hypoglycemia can develop from an insulin overdose, insulinoma or islet cell tumor, extensive liver disease, or functional diseases. (reference 2, p. 702; reference 4, pp. 1176-1177; reference 18, pp. 1929, 1479)

*If the witness indicates the possibility of hypoglycemia, see the section on pre-existing medical conditions for further questions.*

**Q: Did you rule out a *panic disorder* as a cause of the plaintiff's fears?**

A panic disorder is characterized by discrete periods of panic or intense anxiety. Between attacks, the plaintiff is **anxious, worried**, and fears having another attack. Panic symptoms include dizziness, shortness of breath, heart palpitations, smothering or choking sensations, feelings of unreality, tingling in hands or feet, hot and cold flashes, sweating, faintness, trembling or shaking, and the fear of dying or going crazy. The plaintiff with a panic disorder often has an accompanying depression. (reference 7, p. 433; reference 4, pp. 889-891)

*If the witness indicates that the plaintiff's excessive anxiety and worry is focused only on the fear of having another panic attack, the plaintiff may be experiencing a panic disorder and not specific phobia. See the section on panic disorder for further questions.*

**Q: Did you rule out a *panic disorder with agoraphobia* as a cause of the plaintiff's fears?**

A panic disorder with agoraphobia is characterized by a **fear and avoidance** of places and situations in which the plaintiff would be unable to escape or get help if

## SYMPTOM

## DEPOSITION QUESTIONS

**General Questions***(continued)*

s/he had a panic attack. The plaintiff typically avoids crowds, being outside alone, standing in line, crossing a bridge, or riding in a vehicle. (reference 7, p. 441)

*If the witness indicates the possibility of a panic disorder with agoraphobia, see the section on panic disorder with agoraphobia for further questions.*

**Q: Did you rule out agoraphobia without a history of panic disorder as a cause of the plaintiff's fears?**

Agoraphobia is the **fear and avoidance** of places and situations in which the plaintiff would be unable to escape or get help if s/he had embarrassing symptoms. Symptoms of a limited agoraphobic attack may include dizziness or falling, depersonalization or derealization, loss of bladder or bowel control, vomiting, and cardiac distress. This plaintiff may not have a history of a panic disorder. (reference 7, p. 441)

**Q: Did you rule out an avoidant personality disorder as a cause of the plaintiff's fears?**

The avoidant plaintiff is characterized by social inhibition or discomfort, **fear of negative evaluation, and timidity**, along with a great desire for companionship and guarantees of uncritical acceptance. The plaintiff may be easily hurt by disapproval, exaggerate potential difficulties or dangers, and fear being embarrassed or hurt by others. Associated symptoms may include depression, **anxiety** and anger. This disorder is diagnosed only after the behavior has persisted for many years and the plaintiff is at least 20 years old. (reference 7, p. 718; reference 4, pp. 981-982, 1752)

*If the witness indicates the possibility of an avoidant personality disorder or other maladaptive personality traits, see the section on pre-existing personality disorders for further questions.*

**Q: Did you rule out a paranoid personality disorder as a cause of the plaintiff's fears?**

The paranoid plaintiff has a history of unwarranted suspicion and mistrust of others. Often expecting to be exploited or harmed, s/he may be excessively sensitive, jealous, **hypervigilant, and tense**. The plaintiff may find it difficult to relax or forgive, and is argumentative when threatened by innocent remarks or events. His or her mood is often humorless, cold and unemotional. These plaintiffs rarely seek help because of a tendency to be moralistic, grandiose, and extrapunitive. (reference 7, p. 690; reference 4, pp. 748-753)

**Q: Did you rule out social phobia (also known as social anxiety disorder) as a cause of the plaintiff's fears?**

The plaintiff with social phobia or social anxiety disorder, fears situations in which s/he may be scrutinized by others or in which s/he may do something humiliating or embarrassing. The plaintiff **avoids or endures with intense anxiety situations** such as public speaking, eating or writing in front of others, using public toilets, or answering questions in social situations. The plaintiff's normal routine or social functioning may be impaired. S/he recognizes the fear and is distressed by it. (reference 7, p. 450)

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*SYMPTOM*

*DEPOSITION QUESTIONS*

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**General  
Questions**

*(continued)*

**Q:** Did you rule out a *schizoid personality disorder* as a cause of the plaintiff's fears?

The schizoid plaintiff is introverted, **withdrawn, and prefers to be alone**. S/he tends to be indifferent to social relationships and has few close friends outside the family. (reference 7, p. 694; reference 4, pp. 1741-1743)

## **SECTION 5.5: DIRECT CHALLENGE TO THE DIAGNOSIS OF PANIC ATTACKS AND PANIC DISORDER CLAIMS**

### **INTRODUCTION**

A *Panic Attack* is a discrete period of intense fear or discomfort, in the absence of real danger, in which four to thirteen anxiety symptoms (both physical and mental), develop abruptly and reach a peak within 10 minutes. Panic attacks also occur in disorders other than panic disorder such as, mood disorders, in certain intoxication and withdrawal syndromes—in fact, any mental disorder. In addition, panic attacks may be observed in certain nonpsychiatric medical conditions (e.g., hyperthyroidism). In some persons, the fear of having a panic attack becomes associated with certain situations, most commonly, using public transportation, driving across a bridge, being in a crowd, waiting in line, or leaving familiar settings alone.

In *Panic Disorder*, anxiety manifests as recurrent panic attacks. If a pattern of recurrent, unexpected panic attacks is experienced and the individual becomes distressed in anticipation of future attacks, their consequences, or implications, or if there is a significant change in the individual's behavior that is associated with the attacks, then that individual is said to have panic disorder without agoraphobia (fear of places or situations from which escape might be difficult or embarrassing).

There are many alternate causes for panic attacks and the numerous symptoms related to this disorder. Defense counsel should obtain a list of the plaintiff's claimed panic attack symptoms by using the deposition questions in Chapters 1 and 4. Section 5.5 provides questions to challenge the accuracy of this diagnosis and each of the thirteen panic attack symptoms.

***Challenging the Plaintiff's Diagnosis of Panic Attacks and Panic Disorder*****TABLE 5.5-1.****Diagnostic criteria for 300.01 Panic Disorder Without Agoraphobia**

(See section 5.5A for the diagnostic criteria for Panic Disorder With Agoraphobia)

**A. Both (1) and (2):**

- (1) recurrent unexpected Panic Attacks (See linked section)
- (2) at least one of the attacks has been followed by 1 month (or more) of one (or more) of the following:
  - (a) persistent concern about having additional attacks
  - (b) worry about the implications of the attack or its consequences (e.g., losing control, having a heart attack, "going crazy")
  - (c) a significant change in behavior related to the attacks

**B. Absence of Agoraphobia**

**C.** The Panic Attacks 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., hyperthyroidism).

**D.** The Panic Attacks are not better accounted for by another mental disorder, such as Social Phobia or social anxiety disorder (e.g., occurring on exposure to feared social situations), Specific Phobia (e.g., on exposure to a specific phobic situation), Obsessive-Compulsive Disorder (e.g., on exposure to dirt in someone with an obsession about contamination), Posttraumatic Stress Disorder (e.g., in response to stimuli associated with a severe stressor), or Separation Anxiety Disorder (e.g., in response to being away from home or close relatives).

**Criteria for Panic Attack**

**Note:** A Panic Attack is not a DSM-IV-TR codable disorder.

A discrete period of intense fear or discomfort, in which four (or more) of the following symptoms developed abruptly and reached a peak within 10 minutes:

- (1) palpitations, pounding heart, or accelerated heart rate
- (2) sweating
- (3) trembling or shaking
- (4) sensations of shortness of breath or smothering
- (5) feeling of choking
- (6) chest pain or discomfort
- (7) nausea or abdominal distress
- (8) feeling dizzy, unsteady, lightheaded, or faint
- (9) derealization (feelings of unreality) or depersonalization (being detached from oneself)
- (10) fear of losing control or going crazy
- (11) fear of dying
- (12) paresthesias (numbness or tingling sensations)
- (13) chills or hot flushes

**Note:** Attacks involving four or more symptoms are panic attacks; attacks involving fewer than four symptoms are limited symptom attacks (see Agoraphobia Without History of Panic Disorder).

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*SYMPTOM*

*DEPOSITION QUESTIONS*

**Note:  
Familial  
Pattern**

**Panic Disorder may have a familial pattern. First-degree biological relatives of individuals with Panic Disorder are up to 8 times more likely to develop Panic Disorder (reference 7, p.437). This suggests that the plaintiff's Panic Disorder may have pre-existed the cause of action.**

**General  
Questions**

**Q: Describe the pattern of intense fear, anxiety, and panic.**

Panic disorder is characterized by the presence of recurrent, unexpected panic attacks followed by concern about having other panic attacks. Panic attacks are characterized by discrete periods of intense fear or discomfort with varying degrees of symptomology which develop abruptly.

*If the witness indicates that the fear between attacks is not associated with having another attack, the plaintiff may be experiencing generalized anxiety disorder and not panic disorder. See the section on GAD for additional information.*

**Q: How many panic attacks has the plaintiff experienced?**

Panic attacks must be recurring. (criterion A)

**Q: Are the attacks in any way predictable?**

The panic attacks must be unexpected. (criterion A)

*If the attacks are predictable or triggered by a situation, then the diagnosis of specific phobia may be more appropriate. See the section on specific phobia for additional information.*

**Q: Does the plaintiff have concern about having another attack, worry about the implications of the attack or a change in behavior related to the attack?**

Along with recurrent unexpected panic attacks, at least one of the attacks in one month must be accompanied by concern about another attack, worry about the implications of the attack and/or a change in behavior related to the attack. (criterion A)

**DEFENSE THEORY: The physical symptoms of Panic Attack are commonly reported during many other medical conditions. It is very difficult for any clinician to determine the cause of panic attacks, with any degree of certainty, without the completion of a thorough medical examination, blood-work including a thyroid study and a cardiovascular examination. Many experts diagnose this condition without a full differential diagnosis.**

**Q: How long do the attacks last?**

Panic attacks usually last only a few minutes.

**SYMPTOM****DEPOSITION QUESTIONS****General Questions***(continued)*

**Q: Are the periods of intense anxiety and panic becoming less frequent or less severe?**

**Q: Describe the circumstances in which the intense anxiety and panic attacks occur.**

Panic attacks are not triggered by situations or events, but are unexpected. Later in the illness certain situations may become so associated with panic attacks that the likelihood of having an attack increases, but the plaintiff can not be certain when an attack will occur or if it will occur at all. These are known as situationally bound attacks. (reference 7, p. 434)

*If the witness indicates that the attacks are triggered only by being the focus of attention, the plaintiff may have a social phobia or social anxiety disorder. If the witness indicates that the attacks occur immediately before or on exposure to a situation that almost always causes anxiety, the plaintiff may have a specific phobia.*

**Q: Describe the plaintiff's symptoms during the panic attacks.**

The witness must indicate the occurrence of at least four panic symptoms during one attack. (see criteria for panic attacks)

**Q: Describe the onset of the symptoms and the intensity during the panic attacks.**

During the attacks, symptoms may develop suddenly and increase in intensity.

**Q: Did you rule out any organic causes of the panic attacks?**

**Q: Does the plaintiff have a history of intense anxiety and panic before the injury in question?**

**Q: Did you rule out a *childhood overanxious disorder* as a cause of the plaintiff's periods of intense anxiety and panic?**

A child with an overanxious disorder has excessive or unrealistic anxiety or worry for at least six months. S/he tends to be self-conscious and worried about future events and past behavior. Symptoms may include feeling a lump in the throat, headaches, gastrointestinal distress, shortness of breath, nausea, dizziness, difficulty falling asleep, **nervousness**, and other bodily discomforts. The disorder occurs most often in families where there is an unusual emphasis on high achievement. An overanxious disorder may be accompanied by other phobias. It can persist into adult life as an anxiety disorder, such as a generalized anxiety disorder or a social phobia. (reference 7, p. 472; reference 4, pp.1752-1754)

*Defense counsel should obtain the plaintiff's early school and health records to look for evidence of this disorder.*

**SYMPTOM****DEPOSITION QUESTIONS****General Questions***(continued)***Q: Did you rule out *generalized anxiety disorder* as a cause of the plaintiff's periods of intense anxiety and panic?**

A generalized anxiety disorder is a persistent anxiety that lasts at least one month. The plaintiff has an **excessive anxiety** about two or more life circumstances. S/he may be anxious about harm coming to a child or having financial difficulties when there is no apparent reason to worry. Symptoms include muscle tension, restlessness, fatigue, difficulty concentrating, sleep disturbance, and irritability. (reference 7, p. 472)

*If the witness indicates the possibility of a generalized anxiety disorder, see the section on generalized anxiety disorder for further questions.*

**Q: Did you rule out a *specific phobia* as a cause of the plaintiff's periods of intense anxiety and panic?**

A phobic disorder is characterized by the presence of irrational or exaggerated fears of objects, situations, or bodily functions. The situation or object of the fear is not inherently dangerous or an appropriate source of anxiety. The plaintiff may have symptoms of **panic, sweating, tachycardia, shakiness, and difficulty breathing**. S/he either avoids the object of the phobia or endures the situation with intense anxiety. There is also a marked distress about having the irrational fear. (reference 7, p. 443; reference 4, pp. 899-900)

*If the witness indicates the possibility of a specific phobia, see the section on specific phobia for further questions.*

**Q: Did you rule out *hyperthyroidism* as a cause of the plaintiff's periods of anxiety or panic?**

Hyperthyroidism, or thyrotoxicosis, results from overproduction of thyroid hormone by the thyroid gland. The most common cause is Graves' disease. The signs and symptoms of hyperthyroidism include both physical and psychiatric complaints. Psychiatric features include **nervousness**, fatigue, insomnia, mood lability, and dysphoria. There may be a heightened activity level. Cognitive symptoms include a short attention span, impaired recent memory, and an exaggerated startle response.

Physical signs and symptoms of hyperthyroidism include increased pulse, arrhythmias (irregular heart rhythm), elevated blood pressure, fine tremor, heat intolerance, excessive sweating, increased appetite, weight loss, palpitations (abnormal rapid beating of heart), tachycardia (rapid heart beat), frequent bowel movements, menstrual irregularities, and muscle weakness. **Panic attacks** are associated with endocrinological disorders including hyperthyroidism, as well as hypothyroidism. (reference 18, pp. 743, 1809-1810, 1928)

*If the witness indicates the possibility of hyperthyroidism, see the section on pre-existing medical conditions for further questions.*

*SYMPTOM*

*DEPOSITION QUESTIONS*

**General Questions**

*(continued)*

**Q: What were the plaintiff's T3 and T4 (thyroid) levels on the day of your examination?**

The diagnosis of thyroid disease is made on the basis of characteristic physical and laboratory findings. (reference 4, p. 893)

**Q: Did you rule out mitral valve prolapse (MVP) as a cause of the plaintiff's anxiety and panic?**

Mitral valve prolapse (MVP) is a common and sometimes serious congenital ballooning of a heart valve often associated with arrhythmias of the heart. MVP and panic attacks share many common symptoms including chest pain, palpitation, dyspnea, weakness, fatigue, dizziness, syncope (a faint), and **anxiety**. (reference 4, pp. 1149, 1551)

*If the witness indicates the possibility of mitral valve prolapse, see the section on pre-existing medical conditions for further questions.*

**Q: Did you rule out substance intoxication as a cause of the plaintiff's anxiety and panic?**

Intoxication with the following substances may cause an organically based anxiety syndrome and anxiety symptoms. (reference 7, p. 192)

|              |             |
|--------------|-------------|
| Alcohol      | Cocaine     |
| Amphetamines | Heavy metal |
| Caffeine     |             |

Adverse drug reactions may also cause severe anxiety and panic:

|           |                       |
|-----------|-----------------------|
| Marijuana | Other hallucinogens   |
| Ecstasy   | Sedatives / hypnotics |

**Q: Did you rule out a childhood separation anxiety disorder as a cause of the plaintiff's periods of anxiety and panic?**

A childhood separation anxiety disorder begins before the age of eighteen. For many years after the disorder's onset, the adult plaintiff may experience recurrences of the **excessive anxiety when separated from significant people or familiar places**.

Associated symptoms include excessive worry about possible harm to loved ones, avoidance of being alone, nightmares, temper outbursts or uneasy tension, sweating hands, headaches, stomachaches, nausea and vomiting. (reference 7, p. 121; reference 4, pp. 887, 1747-1750; reference 1, p. 1864)

*Defense counsel should obtain the plaintiff's early school and health records to look for evidence of this disorder.*

**Q: Did you rule out ecstasy use as a cause for the plaintiff's periods of anxiety and panic?**

MDMA (methylenedioxymethamphetamine) use can sometimes result in severe dehydration or exhaustion, or other adverse effects such as nausea, hallucinations, chills, sweating, increases in body temperature, tremors, involuntary teeth clenching, muscle cramping, and blurred vision. MDMA users have also reported after-effects

*SYMPTOM*

*DEPOSITION QUESTIONS*

**General Questions**

*(continued)*

such as **anxiety**, paranoia, and depression. An MDMA overdose is characterized by high blood pressure, faintness, **panic attacks**, and, in more severe cases, loss of consciousness, seizures, and a drastic rise in body temperatures to 105-106 degrees Fahrenheit. MDMA overdoses can be fatal, as they may result in heart failure or extreme heat stroke. (reference 20)

**Q: Did you rule out *asthma* as a cause of the plaintiff's periods of anxiety and panic?**

Asthma is a chronic and episodic illness, characterized by widespread narrowing of the tracheobronchial tree. Symptoms include coughing, wheezing, chest tightness and dyspnea (shortness of breath). Nocturnal symptoms and exacerbations are common. Psychiatric forces may affect the clinical expression of asthma in several ways: altered awareness of airway resistance, suggestibility to airway constriction, and comorbidity with panic disorder and depression. (reference 18, pp. 1803-1804)

**Q: Did you rule out *chronic obstructive pulmonary disease (COPD)* as a cause of the plaintiff's periods of anxiety and panic?**

COPD manifests itself in two ways: chronic bronchitis and emphysema. Smoking is the single greatest risk factor and most important cause of chronic obstructive pulmonary disease. COPD affects more than 16 million Americans. Symptoms of COPD include hypoxemia (deficient oxygenation in the blood), bronchial symptoms, and dyspnea (shortness of breath) upon exertion. Psychiatric issues affect many facets of the course of COPD. As for asthma, prevalence rates for both **panic disorder and anxiety disorders** are increased among COPD patients. (reference 18, pp. 1805-1806)

**Q: Does the plaintiff have any other *medical conditions* that may cause anxiety and panic, such as:**

- |                           |   |
|---------------------------|---|
| Asthma                    | Hyperventilation                          |
| Aspirin intolerance       | Metabolic alkalosis                       |
| Brucellosis               | Polyneuritis                              |
| Collagen-vascular disease | Polyradiculitis (Guillain-Barre Syndrome) |
| Demyelinating disease     | Pulmonary embolus                         |
| Fasting hypoglycemia      | Vitamin B12 deficiency                    |
| Hypercortisolism          |   |

*The diagnosis of panic disorder can only be made when it cannot be established that an organic factor initiated and maintained the disturbance.* (reference 7, p. 433)

**Q: Is the plaintiff taking any *medications or substances* that may cause periods of intense anxiety and panic, such as:**

- |            |              |                 |
|------------|--------------|-----------------|
| ADALAT     | AMBIEN       | ANDRODERM PATCH |
| ADRENALINE | AMERGE       | ANSAID          |
| AEROBID    | AMPHETAMINES | APRESOLINE      |
| ALPHGAN    | AMYTAL       | ARTHROTEC       |
| ALTACE     | ANAFRANIL    | ASENDIN         |

*SYMPTOM**DEPOSITION QUESTIONS***General  
Questions***(continued)*

|                |                  |                |
|----------------|------------------|----------------|
| AUGMENTIN      | LAMICTAL         | PULMICORT      |
| AVAPRO         | LESCOL           | QUESTRAN       |
| AVONEX         | LEVAQUIN         | RELAFEN        |
| AXID           | LORCET           | REMERON        |
| BUTICAPS       | LOTENSIN         | REVIA          |
| CATAPRES       | LOTREL           | RISPERDAL      |
| CELEBREX       | LOZOL            | SE-AP-ES       |
| CELEXA         | LUDIOMIL         | SEROQUEL       |
| CLARITAN-D     | LUVOX            | SERTRALINE     |
| CLARITIN       | MARCAINE         | SERZONE        |
| CLOMID         | MAVIK            | SINEMET        |
| CLOZARIL       | MAXAIR-AUTOHALER | SONATA         |
| COGNEX         | MAXALT           | SPORANOX       |
| COMBIPRES      | MAXIDE           | ST. JOHNS WORT |
| COZAAR         | MIRAPEX          | STADOL         |
| CYCLOSPORIN    | NARDIL           | SULAR          |
| CYTOTEC        | NEMBUTAL         | SURMONTIL      |
| DEPROL         | NEURONTIN        | SYMMETREL      |
| DESOXYN        | NOLUDAR          | TAGAMET        |
| DILAUDID       | NORCO            | TESTODERM      |
| DIOVAN         | NOREPHEDRINE     | TIMOPTIC       |
| DORAL          | NOROXIN          | TOFRANIL       |
| DURACT         | NORPLANT-SYSTEM  | TRENTAL        |
| DURAGESIC      | NORPRAMIN        | TRILEPTAL      |
| DURAVENT       | NORVASC          | TRINALIN       |
| EFFEXOR        | OXYCONTIN        | TROVAN         |
| ELAVIL         | PAMELOR          | ULTRAM         |
| ELDEPRYL       | PARLODEL         | UNIVASC        |
| ENDEP          | PARNATE          | VALIUM         |
| EQUAGESIC      | PEPCID           | VANTIN         |
| ESTRATEST      | PERMAX           | VIAGRA         |
| ETRAFON        | PHENERGAN-VC-    | VICODIN        |
| EXCELON        | CODEINE          | VICOPROFEN     |
| FLEXERIL       | PHENOBARBITAL    | VIOXX          |
| FLOXIN         | PHENYL-          | VIVACTIL       |
| GOODY HEADACHE | PROPANOLAMINE    | VOLTAREN       |
| POWDER         | PLAVIX           | WELLBUTRIN     |
| HALDOL         | PLENDIL          | ZANAFLEX       |
| HISTUSSIN      | PONDIMIN         | ZIAC           |
| HYTRIN         | PRAVACHOL        | ZOCOR          |
| HYZAAR         | PREVACID         | ZOFRAN         |
| IMDUR          | PRILOSEC         | ZOLOFT         |
| INAPSINE       | PROAMATINE       | ZOMIG          |
| INDOCIN        | PROPULSID        | ZYPREXA        |
| INSULIN        | PROSOM           | ZYRTEC         |
| K-LYTE         | PROTONIX         |                |

*SYMPTOM*

*DEPOSITION QUESTIONS*

**Palpitations, Accelerated Heart Rate**

- Q:** Describe the plaintiff's palpitations or accelerated heart rate.

---

- Q:** When and how often does the plaintiff experience palpitations or accelerated heart rate?

---

- Q:** Does the plaintiff have a history of palpitations or accelerated heart rate before the injury in question?

---

- Q:** Does the plaintiff have a history of any *medical or psychological conditions* that may cause palpitations or accelerated heart rate?  
*The witness may indicate the possibility of the following medical or psychological conditions: please refer to the sections pertaining to these conditions for further questions*

**TABLE 5.5-2.**

|                         |                       |
|-------------------------|-----------------------|
| Conversion disorder     | Mitral valve prolapse |
| Coronary artery disease | Porphyria             |
| Hypoglycemia            | Somatization disorder |
| Menopausal distress     |                       |

- Q:** Did you rule out *stressors or other conditions* not attributable to a mental disorder as a cause of the plaintiff's palpitations or accelerated heart rate?  
*If the witness indicates the possibility of a life stressor or other condition, see the section on other life-stressors for further questions.*

---

- Q:** Did you rule out *sinoatrial tachycardia* as a cause of the plaintiff's palpitations or accelerated heart rate?  
 Sinoatrial tachycardia occurs in many healthy persons and may be a normal family trait. For the adult over eighteen, it is usually defined as a **sustained increased heart rate** of 100 beats or more per minute. (reference 2, p. 302)

---

- Q:** Did you rule out a *physically stressful schedule* as a cause of the plaintiff's palpitations or accelerated heart rate?  
**Heart pounding, palpitations, and tachycardia** are often associated with indigestion, overexertion, a specific emotion, or fatigue. Other symptoms may include fullness in the neck, shortness of breath, nervousness, dizziness, and apprehension. (reference 2, pp. 302, 304)

---

- Q:** Did you rule out an *adjustment disorder with anxiety* as a cause of the plaintiff's palpitations or accelerated heart rate?  
 An adjustment disorder is a transient over-reaction to stress that usually occurs within 90 days and remits within six months. The adjustment disorder with anxiety

## SYMPTOM

## DEPOSITION QUESTIONS

**Palpitations,  
Accelerated  
Heart Rate**

(continued)

is characterized by symptoms of nervousness, worry, jitteriness, and motor tension. **Accelerated heart rate** may be a component of the anxiety. (reference 7, p. 680; reference 4, pp. 1098-1099)

*If the witness indicates the possibility of an adjustment disorder, see the section on adjustment disorders for further questions.*

**Q: Did you rule out *somatoform (psychogenic) pain disorder* as a cause of the plaintiff's palpitations or accelerated heart rate?**

Somatoform pain disorder is characterized by pain as the predominant focus of clinical attention. In addition, psychological factors are judged to have an important role in the onset, severity, exacerbation, or maintenance of the pain. Some of the emotionally caused symptoms may be depression, anxiety, anhedonia (an inability to experience pleasure), insomnia, and irritability. The symptoms may become so severe that the plaintiff feels incapacitated and quits working. (reference 7, p. 485; reference 4, p. 1109)

*If the witness indicates the possibility of a somatoform (psychogenic) pain disorder, see the section on somatoform pain disorder for further questions.*

**Q: Did you rule out a *neuroendocrine disorder*, such as *pheochromocytoma*, as a cause of the plaintiff's palpitations or accelerated heart rate?**

Symptoms of a neuroendocrine disorder include sudden headaches, excessive sweating, and **palpitations**. Often there are associated tremors, weakness, nausea, and epigastric discomfort. The plaintiff may also complain of chest pain, **shortness of breath**, lightheadedness, blurred vision, and flushing. (reference 2, p. 612)

Pheochromocytoma is a tumor of the sympathetic nervous system which specifically causes headaches, lightheadedness, nausea, sweating, trembling, and elevated blood pressure during anxiety attacks. (reference 4, p. 1276)

*If the witness indicates the possibility of pheochromocytoma, see the section on pre-existing medical conditions for further questions.*

**Q: Did you rule out *caffeine consumption or withdrawal* as a cause of the plaintiff's palpitations or accelerated heart rate?**

Characteristic symptoms of *caffeine intoxication* include restlessness, nervousness, excitement, insomnia, flushed face, diuresis, gastrointestinal disturbance, muscle twitching, rambling flow of thought and speech, **tachycardia or cardiac arrhythmia**, periods of inexhaustibility, and psychomotor agitation. When consumed near bedtime, caffeine often disrupts sleep. Symptoms may appear when the plaintiff consumes as little as 250 mg of caffeine per day. The plaintiff that consumes one gram per day usually experiences more severe symptoms. Products which contain caffeine include: coffee, tea, soda, chocolate and weight-loss aids. (reference 7, pp. 231-234; reference 4, p. 1029)

The most common *caffeine withdrawal* symptom is a withdrawal headache. Headaches will occur in about one-third of moderate to high caffeine consumers when their daily intake is stopped. Other withdrawal symptoms include muscle

## SYMPTOM

## DEPOSITION QUESTIONS

**Palpitations,  
Accelerated  
Heart Rate***(continued)*

tension, **anxiety with palpitations**, drowsiness, lethargy, rhinorrhea (runny nose), disinterest in work, irritability, nervousness, mild feelings of depression, yawning, nausea, and fatigue. (reference 4, p. 1029; reference 2, p. 618)

*If the witness indicates the possibility of excess caffeine consumption, see the caffeine consumption chart in Appendix A.*

**Q: Did you rule out cocaine consumption or withdrawal as a cause of the plaintiff's palpitations or accelerated heart rate?**

*Cocaine users* often experience increased energy and confidence or irritability and paranoia with physical aggressiveness. Other behavioral symptoms may include euphoria, hypervigilance, psychomotor agitation, impaired judgment, and impaired social or occupational functioning. Physical symptoms may include **tachycardia**, dilated pupils, elevated blood pressure, perspiration or chills, nausea, vomiting, and hallucinations.

The abrupt *cessation or reduction of cocaine*, after several days use, may cause the plaintiff to feel tired, dysphoric, irritable, depressed, and to crave more of the drug. An anxiety reaction may cause psychomotor agitation, insomnia or hypersomnia, high blood pressure, **tachycardia**, and paranoia. The symptoms may persist for more than a day. (reference 7, p. 245; reference 4, pp. 1008-1009)

**Q: Did you rule out opioid withdrawal as a cause of the plaintiff's palpitations or accelerated heart rate?**

Symptoms of opioid withdrawal may include lacrimation (tearing), rhinorrhea (runny nose), dilated pupils, sweating, diarrhea, yawning, mild hypertension, **tachycardia** (increased heart rate), fever, insomnia, and gooseflesh. Associated features may include restlessness, irritability, depression, tremor, weakness, nausea, vomiting, and muscle or joint pain. These signs, often resembling influenza symptoms, may be precipitated by the abrupt ending of one or two weeks of continuous opioid use. The withdrawal symptoms may last days or weeks. During the final stages of withdrawal, the plaintiff may experience overconcern for bodily discomfort, poor self-image, and a decreased ability to tolerate stress. (reference 7, p. 272; reference 4, pp. 990-991)

**Q: Did you rule out hypochondriasis as a cause of the plaintiff's palpitations or accelerated heart rate?**

The hypochondriac fears or believes that s/he has a serious disease based on their own interpretation of physical symptoms. Medical evaluations do not support the fears of disease. The plaintiff is **preoccupied with** bodily functions such as **heartbeat**, sweating, peristalsis, minor physical abnormalities, or a specific organ such as the heart. Headaches and fatigue are common complaints. (reference 7, p. 504; reference 4, p. 1204)

*If the witness indicates the possibility of hypochondriasis, see the section on pre-existing conditions for further questions.*

## SYMPTOM

## DEPOSITION QUESTIONS

**Palpitations,  
Accelerated  
Heart Rate***(continued)*

**Q: Did you rule out *amphetamine or similarly acting sympathomimetic drug consumption* as a cause of the plaintiff's palpitations or accelerated heart rate?**

Symptoms of amphetamine or similarly acting sympathomimetic drug consumption may include fighting, grandiosity, elation, hypervigilance, psychomotor agitation, impaired judgment, and impaired social or occupational functioning. Physical symptoms may include flushing, difficulty breathing, **tachycardia**, pupil dilation, elevated blood pressure, sweating or chills, nausea, and vomiting. (reference 4, pp. 1007-1008; reference 7, p. 223)

The following drugs may be classified as amphetamines:

Appetite Suppressants (diet pills)

Dextroamphetamines

Ma-huang (ephedra)

(reference 24, pp. 488-489)

Methamphetamines (speed)

Methylphenidates (Ritalin)

(reference 17, p. 586)

**Q: (Female) Did you rule out *premenstrual dysphoric disorder* as a cause of the plaintiff's palpitations or accelerated heart rate?**

Premenstrual dysphoric disorder is characterized by emotional and behavioral symptoms which usually occur during the last week before the menstrual cycle and remit within a few days after menses begins. Symptoms may include tears, sadness, irritability, anger, tension, depression, self-deprecating thoughts, decreased interest in usual activities, fatigability, loss of energy, a subjective sense of difficulty in concentration, changes in appetite, and sleep disturbance. Physical symptoms may also include breast tenderness or swelling, **tachycardia**, sweating, headaches, joint or muscle pain, a sensation of bloating, or weight gain. (reference 7, p. 771; reference 18, p. 1955)

**Q: Did you rule out *porphyria* as a cause of the plaintiff's palpitations or accelerated heart rate?**

Porphyria is an inherited disorder of young to middle-aged adults. It is characterized by episodes of abdominal pain, peripheral neuropathy, weakness, anorexia, nausea, vomiting, **tachycardia**, fever, confusion, depression, and severe anxiety. Mood swings and mental abnormalities are common symptoms. (reference 4, pp. 121, 1276, 1326; reference 9, p. 1156; reference 1, pp. 958, 960)

*If the witness indicates the possibility of porphyria, see the section on pre-existing medical conditions for further questions.*

**Q: Did you rule out *hypoglycemia* as a cause of the plaintiff's palpitations or accelerated heart rate?**

Hypoglycemia is an abnormally low blood sugar level. It often produces personality changes, confusion, dizziness, tremor, anxiety, **tachycardia**, and sweating during acute attacks. Other psychiatric symptoms include fear and dread, depression with fatigue, and agitation with confusion. Hypoglycemia can develop from an insulin

**SYMPTOM****DEPOSITION QUESTIONS****Palpitations,  
Accelerated  
Heart Rate***(continued)*

overdose, insulinoma or islet cell tumor, extensive liver disease, or functional diseases. (reference 2, p. 702; reference 4, pp. 1176-1177; reference 18, pp.1929, 1479.)

*If the witness indicates the possibility of hypoglycemia, see the section on pre-existing medical conditions for further questions.*

**Q: Did you rule out *sedative, hypnotic, or anxiolytic withdrawal* as a cause of the plaintiff's palpitations or accelerated heart rate?**

Withdrawal symptoms develop when the plaintiff reduces or stops the prolonged moderate or heavy use of these substances. Symptoms may include nausea or vomiting; malaise or weakness; autonomic hyperactivity (such as **tachycardia** and sweating); anxiety or irritability; orthostatic hypotension; coarse tremor of the hands, tongue and eyelids; insomnia; and grand mal seizures. (reference 7, p. 284; reference 4, p. 1549)

**Q: Did you rule out *hallucinogen consumption* as the cause of the plaintiff's palpitations or accelerated heart rate?**

Hallucinogen consumption causes changes in perception such as feelings of detachment, illusions, hallucinations, and synesthesia (seeing colors when a loud sound occurs). Behavioral symptoms may include anxiety or depression, ideas of reference, fear of losing one's mind, paranoia, impaired judgment, and impaired social or occupational functioning. Physical symptoms may include dilated pupils, **tachycardia**, sweating, **palpitations**, blurred vision, tremors, and incoordination. Flashbacks of experiences may recur several months or years after hallucinogen use. Many plaintiffs may have gross thought process disturbances. Unlike schizophrenics, they are able to talk in detail about their hallucinations. (reference 7, p. 250; reference 4, p. 874)

**Q: Did you rule out *cannabis (marijuana) consumption* as a cause of the plaintiff's palpitations or accelerated heart rate?**

Cannabis intoxication can occur from marijuana, hashish, or tetrahydrocannabinol (THC). Characteristic symptoms include **tachycardia**, increased appetite, dry mouth, euphoria, anxiety, sensation of slowed time, impaired judgment, and social withdrawal. Inappropriate laughter, panic attacks, and a dysphoric mood may occur. (reference 7, p. 234; reference 4, pp. 1326, 754)

**Q: Did you rule out *masked depression* as a cause of the plaintiff's palpitations or accelerated heart rate?**

The plaintiff with masked depression hides a dysphoric mood with gastrointestinal problems, chronic pain, insomnia, weight loss, and other physical complaints. The elderly experience symptoms of hypertension, **cardiac arrhythmias**, emphysema, diabetes, urinary frequency, dizziness, disturbed bowel functions, and backaches. Masked depression is a common condition frequently missed by physicians. (reference 4, p. 796)

*SYMPTOM*

*DEPOSITION QUESTIONS*

**Palpitations,  
Accelerated  
Heart Rate**

(continued)

**Q: Does the plaintiff have any other *medical conditions* that may cause palpitations or accelerated heart rate (tachycardia), such as:**

|                                  |   |
|----------------------------------|---|
| Acute coronary thrombosis        | Neurocirculatory asthenia               |
| Adrenal gland secretions         | Potassium imbalance                     |
| Anemia                           | Pulmonary disease                       |
| Atrial septal defects            | Pulmonary embolism (thrombolism)        |
| Bradycardia-tachycardia syndrome | Rheumatic fever                         |
| Cardiovascular disease           | Thyrotoxicosis                          |
| Hormonal disorders               | Vagus or sympathetic nerve malfunctions |
| Metabolic disorders              | Various myopathies                      |

**Q: Is the plaintiff taking any *medications or substances* that may cause palpitations or accelerated heart rate (tachycardia), such as:**

|              |               |                 |
|--------------|---------------|-----------------|
| ACCUPRIL     | CAFERGOT      | DITROPAN        |
| ACCUTANE     | CAFERGOT-PB   | DONNATAL        |
| ADALAT       | CALAN         | DORAL           |
| ADAPIN       | CAPOTEN       | DURACT          |
| ADDERALL     | CARDENE       | DURAVENT        |
| ADIPEX       | CARDIZEM      | DYNACIRC        |
| ADRENALINE   | CELEBREX      | ELAVIL          |
| AEROBID      | CELEXA        | ELDEPRYL        |
| ALTACE       | CHLORTRIMETON | EMPIRIN-CODEINE |
| ALUPENT      | CLARITAN-D    | ENDEP           |
| AMBIEN       | CLARITIN      | EQUAGESIC       |
| AMERGE       | CLOMID        | EQUANIL         |
| AMPHETAMINES | CLOZARIL      | ETRAFON         |
| ANAFRANIL    | COGNEX        | EXCELON         |
| ANAPROX      | COLESTID      | FASTIN          |
| ANTABUSE     | COMBIPRES     | FELDENE         |
| APRESOLINE   | COMBIVENT     | FIORICET        |
| ARICEPT      | CONCERTA      | FLEXERIL        |
| ARTANE       | COUMADIN      | FLOMAX          |
| ARTHROTEC    | CYSTOSPAZ     | FLOXIN          |
| ASENDIN      | CYTOMEL       | GUAIFED         |
| ATROVENT     | DALMANE       | GYNERGEN        |
| AVONEX       | DANTRIUM      | HALCION         |
| AXOCET       | DEMEROL       | HALDOL          |
| BELLERGA     | DEPROL        | HISTUSSIN       |
| BENADRYL     | DESOXYN       | HYTRIN          |
| BIPHETAMINE  | DESYREL       | HYZAAR          |
| BRETHINE     | DEXEDRINE     | IMDUR           |
| BRICANYL     | DIBENZYLINE   | IMITREX         |
| BROMFED      | DILACOR       | IMITREX-TABLETS |
| BRONTEX      | DIMETANE      | INAPSINE        |
| BUPRENEX     | DIMETAPP      | INDOCIN         |
| BUSPAR       | DIOVAN        | INSULIN         |

## Panic Attacks and Panic Disorder

*SYMPTOM*

*DEPOSITION QUESTIONS*

**Palpitations,  
Accelerated  
Heart Rate**

(continued)

|                  |               |               |
|------------------|---------------|---------------|
| INTROPIN         | NORPRAMIN     | SERTRALINE    |
| IONAMIN          | NORVASC       | SINEMET       |
| ISUPREL          | NUBAIN        | SINEQUAN      |
| KLONOPIN         | OPTIMINE      | SLO-BID       |
| LAMICTAL         | ORAP          | SLO-PHYLLIN   |
| LANOXIN          | ORNADE        | SOMA          |
| LEVAQUIN         | ORUDIS        | SOMA-COMPOUND |
| LEVO-DROMORAM    | PAMELOR       | SONATA        |
| LEVOTHROID       | PARNATE       | SUDAFED       |
| LEVSIN           | PAXIL         | SURMONTIL     |
| LIBRIUM          | PAXIPAM       | TALECEN       |
| LIMBITROL        | PBZ-SR        | TALWIN-NX     |
| LIORESAL         | PERIACTIN     | TARACTAN      |
| LOPRESSOR        | PERMAX        | TAVIST        |
| LOTENSIN         | PERMITIL      | TEMARIL       |
| LOXITANE         | PHENERGAN-VC- | THEO-DUR      |
| LOZOL            | CODEINE       | THORAZINE     |
| LUDIOMIL         | PHENYL-       | THYROID       |
| LUFYLLIN-GG      | PROPANOLAMINE | TIAZAC        |
| LUVOX            | PLENDIL       | TINDAL        |
| MARCAINE         | POLARIMINE    | TOFRANIL      |
| MAVIK            | PREVACID      | TOPROL-XL     |
| MAXAIR-AUTOHALER | PRILOSEC      | TRENTAL       |
| MAXALT           | PRIMAXIN-IV   | TRIAVIL       |
| MAXIDE           | PRINZIDE      | TRILAFON      |
| MECLIZINE        | PROCAN-SR     | TRILEPTAL     |
| MECLOMEN         | PROCARDIA     | TRINALIN      |
| MEPERGAN         | PROKETAZINE   | TROVAN        |
| MEXITIL          | PROLIXIN      | ULTRAM        |
| MINIPRESS        | PROTONIX      | URECHOLINE    |
| MIRAPEX          | PROVENTIL     | VALTREX       |
| MOBAN            | PROZAC        | VASOTEC       |
| MODURETIC        | QUIDE         | VENTOLIN      |
| MONOPRIL         | QUINAGLUTE    | VERELAN       |
| MORPHINE-SULFATE | REMERON       | VESPRIN       |
| MOTRIN           | RESTORIL      | VIAGRA        |
| NALDECON         | REVIA         | VICOPROFEN    |
| NALFON           | RISPERDAL     | VIOXX         |
| NAPROSYN         | RITALIN       | VIVACTIL      |
| NEO-SYNEPHERINE  | RUFEN         | VOLTAREN      |
| NEURONTIN        | SANOREX       | WELLBUTRIN    |
| NICORETTE        | SANSERT       | WIGRAINE      |
| NIMOTOP          | SE-AP-ES      | XANAX         |
| NOREPHEDRINE     | SELDANE       | ZANAFLEX      |
| NORFLEX          | SERENTIL      | ZANTAC        |
| NORGESIC         | SEREVENT      | ZAROXOLY      |
| NORPACE          | SEROQUEL      | ZEPHREX       |

## Panic Attacks and Panic Disorder

---

*SYMPTOM*                      *DEPOSITION QUESTIONS*

---

**Palpitations,  
Accelerated  
Heart Rate**

ZESTORETIC  
ZESTRIL  
ZIAC

ZITHROMAX  
ZOLOFT  
ZOMIG

ZYBAN  
ZYPREXA  
ZYRTEC

(continued)

**Sweating**

**Q: Describe the plaintiff's sweating.**

---

**Q: When and how often does the plaintiff sweat?**

---

**Q: Does the plaintiff have a history of sweating before the injury in question?**

---

**Q: Does the plaintiff have a history of any *medical or psychological conditions* that may cause sweating?**

*The witness may indicate the possibility of the following medical or psychological conditions: please refer to the sections pertaining to these conditions for further questions.*

**TABLE 5.5-3.**

|                       |                          |
|-----------------------|--------------------------|
| Conversion disorder   | Somatization disorder    |
| Hyperthyroidism       | Somatoform pain disorder |
| Myocardial infarction |                          |

**Q: Did you rule out *stressors or other conditions*, not attributable to a mental disorder, as a cause of the plaintiff's sweating?**

*If the witness indicates the possibility of a life stressor or other condition, see the section on other life-stressors for further questions.*

---

**Q: Did you rule out a *neuroendocrine disorder*, such as pheochromocytoma, as a cause of the plaintiff's sweating?**

Symptoms of a neuroendocrine disorder include sudden headaches, **excessive sweating**, and palpitations. Often there are associated tremors, weakness, nausea, and epigastric discomfort. The plaintiff may also complain of chest pain, shortness of breath, lightheadedness, blurred vision, and flushing. (reference 2, p. 612)

Pheochromocytoma is a tumor of the sympathetic nervous system which specifically causes headaches, lightheadedness, nausea, **sweating**, trembling, and elevated blood pressure during anxiety attacks. (reference 4, p. 1276)

*If the witness indicates the possibility of pheochromocytoma, see the section on pre-existing medical conditions for further questions.*

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## SYMPTOM

## DEPOSITION QUESTIONS

**Sweating***(continued)***Q: Did you rule out *alcohol withdrawal* as a cause of the plaintiff's sweating?**

The reduction or cessation of drinking for at least several days may cause characteristic symptoms: coarse tremor of hands, tongue, or eyelids; nausea or vomiting; malaise or weakness; autonomic hyperactivity (tachycardia, **sweating**, and elevated blood pressure); anxiety, depressed mood or irritability; transient hallucinations or illusions; headache; insomnia; dizziness; fatigue; restlessness; and agitation. (reference 7, p. 212; reference 2, pp. 722, 618; reference 9, pp. 50-54)

**Q: Did you rule out *opioid withdrawal* as a cause of the plaintiff's sweating?**

Symptoms of opioid withdrawal may include lacrimation (tearing), rhinorrhea (runny nose), dilated pupils, **sweating**, diarrhea, yawning, mild hypertension, tachycardia (increased heart rate), fever, insomnia, and gooseflesh. Associated features may include restlessness, irritability, depression, tremor, weakness, nausea, vomiting, and muscle or joint pain. These signs, often resembling influenza symptoms, may be precipitated by the abrupt ending of one or two weeks of continuous opioid use. The withdrawal symptoms may last days or weeks. During the final stages of withdrawal, the plaintiff may experience overconcern for bodily discomfort, poor self-image, and a decreased ability to tolerate stress. (reference 7, p. 272; reference 4, pp. 990-991)

**Q: Did you rule out *infections* as a cause of the plaintiff's sweating?**

|                                  |                                 |
|----------------------------------|---------------------------------|
| Brucellosis                      | Meningitis                      |
| Chronic urinary tract infections | Subacute bacterial endocarditis |
| Infectious mononucleosis         | Syphilis                        |
| Influenza                        | Tuberculosis                    |
| Malaria                          | Viral hepatitis                 |

**Q: (Female) Did you rule out *menopause* as a cause of the plaintiff's sweating?**

Menopausal distress may cause anxiety, fatigue, GI disturbances, urinary frequency, back pain, palpitations, tension, emotional lability, irritability and nervousness, depression, dizziness, insomnia, and **hot flashes**. (reference 4, p. 1173; reference 9, p. 21)

*If the witness indicates the possibility of menopausal distress, see the section on menopause for further questions.*

**Q: Did you rule out *hypochondriasis* as a cause of the plaintiff's sweating?**

The hypochondriac fears or believes that s/he has a serious disease based on their own interpretation of physical symptoms. Medical evaluations do not support the fears of disease. The plaintiff is preoccupied with bodily functions such as heartbeat, **sweating**, peristalsis, minor physical abnormalities, or a specific organ such as the heart. Headaches and fatigue are common complaints. (reference 7, p. 504; reference 4, p. 1204)

*If the witness indicates the possibility of hypochondriasis, see the section on somatoform disorders for further questions.*

## SYMPTOM

## DEPOSITION QUESTIONS

**Sweating***(continued)***Q: Did you rule out cocaine consumption as a cause of the plaintiff's sweating?**

Cocaine users often experience increased energy and confidence or irritability and paranoia with physical aggressiveness. Other behavioral symptoms may include euphoria, hypervigilance, psychomotor agitation, impaired judgment, and impaired social or occupational functioning. Physical symptoms may include tachycardia, dilated pupils, elevated blood pressure, **perspiration** or chills, nausea, vomiting, and hallucinations. (reference 7, p. 245; reference 4, pp. 1008-1009)

**Q: Did you rule out amphetamine or similarly acting sympathomimetic drug consumption or withdrawal as a cause of the plaintiff's sweating?**

Symptoms of amphetamine or similarly acting sympathomimetic *drug consumption* may include fighting, grandiosity, elation, hypervigilance, psychomotor agitation, impaired judgment, and impaired social or occupational functioning. Physical symptoms may include flushing, difficulty breathing, tachycardia, pupil dilation, elevated blood pressure, **sweating** or chills, nausea, and vomiting. (reference 12; reference 4, pp. 1007-1008; reference 7, p. 223)

*Drug withdrawal* symptoms may include a dysphoric mood (depression, irritability, anxiety), fatigue, **sweating**, headaches, insomnia with nightmares, hypersomnia, and psycho-motor agitation. Symptoms begin after the cessation of prolonged drug use (at least two days) and last more than 24 hours. (reference 7, p. 227; reference 4, p. 1008)

The following drugs may be classified as amphetamines:

|                                    |                            |
|------------------------------------|----------------------------|
| Appetite Suppressants (diet pills) | Methamphetamines (speed)   |
| Dextroamphetamines                 | Methylphenidates (Ritalin) |
| Ma-huang (ephedra)                 | (reference 17, p. 586)     |
| (reference 24, pp. 488-489)        |                            |

**Q: (Female) Did you rule out premenstrual dysphoric disorder as a cause of the plaintiff's sweating?**

Premenstrual dysphoric disorder is characterized by emotional and behavioral symptoms which usually occur during the last week before the menstrual cycle and remit within a few days after menses begins. Symptoms may include tears, sadness, irritability, anger, tension, depression, self-deprecating thoughts, decreased interest in usual activities, fatigability, loss of energy, a subjective sense of difficulty in concentration, changes in appetite, and sleep disturbance. Physical symptoms may also include breast tenderness or swelling, tachycardia, **sweating**, headaches, joint or muscle pain, a sensation of bloating, or weight gain. (reference 7, p. 771; reference 18, p. 1955)

**Q: Did you rule out hypoglycemia as a cause of the plaintiff's sweating?**

Hypoglycemia is an abnormally low blood sugar level. It often produces personality changes, confusion, dizziness, tremor, anxiety, tachycardia, and **sweating** during acute attacks. Other psychiatric symptoms include fear and dread, depression with fatigue, and agitation with confusion. Hypoglycemia can develop from an insulin

## SYMPTOM

## DEPOSITION QUESTIONS

**Sweating***(continued)*

overdose, insulinoma or islet cell tumor, extensive liver disease, or functional diseases. (reference 2, p. 702; reference 4, pp. 1176-1177; reference 18, pp. 1929, 1479)

*If the witness indicates the possibility of hypoglycemia, see the section on pre-existing medical conditions for further questions.*

**Q: Did you rule out *sedative, hypnotic, or anxiolytic withdrawal* as a cause of the plaintiff's sweating?**

Withdrawal symptoms develop when the plaintiff reduces or stops the prolonged moderate or heavy use of these substances. Symptoms may include nausea or vomiting; malaise or weakness; autonomic hyperactivity (such as tachycardia and **sweating**); anxiety or irritability; orthostatic hypotension; coarse tremor of the hands, tongue and eyelids; insomnia; and grand mal seizures. (reference 7, p. 284; reference 4, p. 1549)

*Caution: Do not ask the following question if the cause of action involves a head injury or toxic exposure.*

**Q: Did you rule out *neck injury* as a cause of the plaintiff's sweating?**

The plaintiff may develop recurrent unilateral vasodilatory headaches after recovering from an acute injury involving the anterior triangle of the neck. These headaches may also produce pupil dilation, tearing, **sweating**, nausea, vomiting, and photophobia. (reference 2, p. 75)

**Q: Did you rule out *cluster headaches* as a cause of the plaintiff's sweating?**

Cluster headaches are characterized by severe unilateral pain in the eye or temple. They tend to recur in a series of attacks, affecting primarily men. They may last from twenty minutes to two hours and cause severe pain, flushing and **facial sweating**. Sleep-related cluster headaches are severe unilateral headaches that appear intermittently during REM sleep. (reference 4, pp. 1205, 1261; reference 2, p. 70)

**Q: Did you rule out *diseases associated with intermittent fever* as a cause of the plaintiff's sweating, such as:**

Acute osteomyelitis  
Postpartum infections  
Pyelonephritis

**Q: Did you rule out *hallucinogen consumption* as the cause of the plaintiff's sweating?**

Hallucinogen consumption causes changes in perception such as feelings of detachment, illusions, hallucinations, and synesthesia (seeing colors when a loud sound occurs). Behavioral symptoms may include anxiety or depression, ideas of reference, fear of losing one's mind, paranoia, impaired judgment, and impaired social or occupational functioning. Physical symptoms may include dilated pupils, tachycardia, **sweating**, palpitations, blurred vision, tremors, and incoordination. Flashbacks of experiences may recur several months or years after hallucinogen use.

## SYMPTOM

## DEPOSITION QUESTIONS

**Sweating***(continued)*

Many plaintiffs may have gross thought process disturbances. Unlike schizophrenics, they are able to talk in detail about their hallucinations. (reference 7, p. 250; reference 4, p. 874)

**Q: Does the plaintiff have any other *medical conditions* that may cause sweating, such as:**

Acute hemolytic anemia  
Pneumococcal pneumonia

**Q: Is the plaintiff taking any *medications or substances* that may cause sweating, such as:**

|                |                   |                |
|----------------|-------------------|----------------|
| ACCUPRIL       | CLARITIN          | EQUANIL        |
| ACCUTANE       | CLINDEX           | ESKALITH       |
| ADALAT         | CLOZARIL          | ETRAFON        |
| ADAPIN         | COGNEX            | EXCELON        |
| AEROBID        | COMPAZINE         | FELDENE        |
| ALDACTAZIDE    | CORGARD           | FLEXERIL       |
| ALDOMET        | CORTISONE         | HALDOL         |
| ALDORIL        | COUMADIN          | HYDRO-         |
| ALTACE         | CRINONE           | CHLOROTHIAZIDE |
| AMBIEN         | CYCLOSPORIN       | HYDRODIURIL    |
| AMERGE         | CYSTOSPAZ         | HYZAAR         |
| ANAFRANIL      | CYTOMEL           | IMDUR          |
| ANAPROX        | CYTOTEC           | INDERAL        |
| ANSAID         | DALALONE          | INDERIDE       |
| ANTABUSE       | DALMANE           | INDOCIN        |
| APRESOLINE     | DANTRIUM          | INSULIN        |
| ARTHROTEC      | DECADRON          | ISORDIL        |
| ASENDIN        | DELTASONE         | ISUPREL        |
| AXID           | DEMEROL           | KERLONE        |
| BACTRIM        | DEPO-MEDROL       | LAMICTAL       |
| BELLERGA       | DESYREL           | LEVAQUIN       |
| BENTYL         | DIABINESE         | LEVO-DROMORAM  |
| BRETHINE       | DIBENZYLINE       | LEVOTHROID     |
| BRICANYL       | DILACOR           | LEVSIN         |
| BRONTEX        | DILANTIN          | LIBRAX         |
| BUMEX          | DISALCID          | LOMOTIL        |
| BUPRENEX       | DITROPAN          | LOPRESSOR      |
| BUSPAR         | DIURIL            | LOTENSIN       |
| BUTICAPS       | DOLOBID           | LOXITANE IM    |
| CAPOTEN        | DONNATAL          | LOXITANE       |
| CARDURA        | DURACT            | LUDIOMIL       |
| CELEBREX       | DURAGESIC         | W/CODEINE      |
| CELESTON       | EFFEXOR           | LUVOX          |
| CELEXA         | ELDEPRYL          | MACRODANTIN    |
| CHLOR-TRIMETON | EMPIRIN W/CODEINE | MARCAINE       |
| CLARITAN-D     | EQUAGESIC         | MAXALT         |

**SYMPTOM**

**DEPOSITION QUESTIONS**

**Sweating**

(continued)

|                  |               |            |
|------------------|---------------|------------|
| MEBARAL          | PROKETAZINE   | TARACTAN   |
| MECLIZINE        | PROSOM        | TEGRETOL   |
| MEDROL           | PROTONIX      | TENORMIN   |
| MEPERGAN         | PROVERA       | THORAZINE  |
| METHADONE-       | QUIDE         | TIMOPTIC   |
| HYDROCHLORIDE    | QUINAGLUTE    | TINDAL     |
| MINIPRESS        | QUINAMM       | TOFRANIL   |
| MIRAPEX          | RELAFEN       | TOLECTIN   |
| MONOPRIL CAPS    | REMERON       | TOPAMAX    |
| MORPHINE-SULFATE | RISPERDAL     | TORADOL    |
| MOTRIN           | RITALIN       | TRILAFON   |
| NALFON           | ROBAXIN       | TRILEPTAL  |
| NAPROSYN         | ROBAXISAL     | TROVAN     |
| NAVANE           | RUFEN         | ULTRAM     |
| NEMBUTAL         | SANOREX       | UNIVASC    |
| NEURONTIN        | SEPTRA        | URECHOLINE |
| NOLUDAR          | SER-AP-ES     | V-CILLIN K |
| NORPACE          | SEROQUEL      | VERELAN    |
| NORPRAMIN        | SERTRALINE    | VIAGRA     |
| NORVASC          | SERZONE       | VICOPROFEN |
| ORAP             | SINEMET       | VIVACTIL   |
| OXYCONTIN        | SINEQUAN      | WELLBUTRIN |
| PAMELOR          | SOLU-MEDROL   | YOCON      |
| PEDIAZOLE        | SOMA          | ZANAFLEX   |
| PENICILLIN VK    | SOMA COMPOUND | ZANTAC     |
| PERMAX           | SONATA        | ZIAC       |
| PERMITIL         | STELAZINE     | ZOLOFT     |
| PHENERGAN VC     | SUDAFED       | ZOMIG      |
| PHENERGAN-VC-    | SULAR         | ZYBAN      |
| CODEINE          | SUMYCIN       | ZYLOPRIM   |
| PONDIMIN         | TAGAMET       | ZYRTEC     |
| PROCAN SR        | TALECEN       |            |
| PROCARDIA        | TALWIN NX     |            |

**Trembling or Shaking**

- Q:** Describe the plaintiff's trembling or shaking.

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- Q:** When and how often does the plaintiff experience trembling or shaking?

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- Q:** Does the plaintiff have a history of trembling or shaking before the injury in question?

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*SYMPTOM*

*DEPOSITION QUESTIONS*

**Trembling or Shaking**

*(continued)*

**Q: Does the plaintiff have a history of any *medical conditions* that may cause trembling or shaking?**

*The witness may indicate the possibility of the following medical conditions: please refer to the sections pertaining to these medical conditions for further questions.*

**TABLE 5.5-4.**

|  |                                     |
|--|-------------------------------------|
| Addison's disease                      | Hepatic encephalopathy              |
| Arteriovenous malformations            | Hypotension                         |
| Combined systems disease               | Multiple sclerosis                  |
| Cortical basal ganglionic degeneration | Parkinson's disease                 |
| Drug-induced Parkinson's               | Subacute sclerosing panencephalitis |
| Essential tremor                       | Syphilis                            |
| Epilepsy                               | Toxic-induced Parkinson's disease   |

**Q: Did you rule out *stressors or other conditions* not attributable to a mental disorder as a cause of the plaintiff's trembling or shaking?**

*If the witness indicates the possibility of a life stressor or other condition, see the section on other life-stressors for further questions.*

**Q: Did you rule out *essential tremor* as a cause of the plaintiff's trembling or shaking?**

Essential tremor may be identified by a **tremor of the hands, head**, and least frequently, the voice. It typically begins before age 25 and persists throughout life gradually spreading to other parts of the body. There is a strong familial incidence. Physical or social disability may result. (reference 9, pp. 2073-2074)

**Q: Did you rule out a *conversion disorder* as a cause of the plaintiff's trembling or shaking?**

A conversion disorder is characterized by the presence of symptoms or deficits affecting **voluntary motor or sensory function** that suggest a neurological or other general medical condition. Psychological factors are judged to be associated with the symptom or deficit and the symptoms are not intentionally feigned or produced. Conversion symptoms are defense mechanisms that change the unconscious emotional conflict into a physical disability that often symbolizes the nature of the conflict. (reference 12, p. 315; reference 2, pp. 625, 630; reference 7, p. 492)

*If the witness indicates the possibility of a conversion disorder, see the section on conversion disorder for further questions.*

**Q: Did you rule out a *somatization disorder* (psychosomatic) as a cause of the plaintiff's trembling or shaking?**

The plaintiff with a somatization disorder has many physical complaints for several years. S/he sees multiple physicians only to discover no physical cause for the

## SYMPTOM

## DEPOSITION QUESTIONS

**Trembling or Shaking***(continued)*

symptoms. The plaintiff often has exaggerated and vague complaints focusing on either organs or types of symptoms such as **pseudoneurologic or conversion symptoms**, gastrointestinal, female reproductive, psychosexual, pain, and cardiopulmonary symptoms. Anxiety, depression, suicide attempts, social withdrawal, and work or interpersonal relationship difficulties are common. (reference 7, p. 485; reference 4, pp. 389, 940)

*If the witness indicates the possibility of a somatization disorder, see the section on somatoform disorders for further questions.*

**Q: Did you rule out *opioid withdrawal* as a cause of the plaintiff's trembling or shaking?**

Symptoms of opioid withdrawal may include lacrimation (tearing), rhinorrhea (runny nose), dilated pupils, sweating, diarrhea, yawning, mild hypertension, tachycardia (increased heart rate), fever, insomnia, and gooseflesh. Associated features may include restlessness, irritability, depression, **tremor**, weakness, nausea, vomiting, and muscle or joint pain. These signs, often resembling influenza symptoms, may be precipitated by the abrupt ending of one or two weeks of continuous opioid use. The withdrawal symptoms may last days or weeks. During the final stages of withdrawal, the plaintiff may experience overconcern for bodily discomfort, poor self-image, and a decreased ability to tolerate stress. (reference 7, p. 272; reference 4, pp. 990-991)

**Q: Did you rule out *hallucinogen consumption* as the cause of the plaintiff's trembling or shaking?**

Hallucinogen consumption causes changes in perception such as feelings of detachment, illusions, hallucinations, and synesthesia (seeing colors when a loud sound occurs). Behavioral symptoms may include anxiety or depression, ideas of reference, fear of losing one's mind, paranoia, impaired judgment, and impaired social or occupational functioning. Physical symptoms may include dilated pupils, tachycardia, sweating, palpitations, blurred vision, **tremors**, and incoordination. Flashbacks of experiences may recur several months or years after hallucinogen use. Many plaintiffs may have gross thought process disturbances. Unlike schizophrenics, they are able to talk in detail about their hallucinations. (reference 7, p. 250; reference 4, p. 874)

**Q: Did you rule out *inhalant intoxication* as a cause of the plaintiff's trembling or shaking?**

Following inhalant (toxic substance) use, the plaintiff may experience behavioral and physical changes. Behavioral changes may include belligerence, assaultiveness, apathy, impaired judgment, and impaired social or occupational functioning. Physical signs may include dizziness, nystagmus, slurred speech, unsteady gait, lethargy, depressed reflexes, **tremor**, psychomotor weakness, blurred vision or diplopia, stupor or coma, and euphoria. (reference 7, p. 259)

## SYMPTOM

## DEPOSITION QUESTIONS

**Trembling or Shaking***(continued)*

**Q: Did you rule out *sedative, hypnotic, or anxiolytic withdrawal* as a cause of the plaintiff's trembling or shaking?**

Withdrawal symptoms develop when the plaintiff reduces or stops the prolonged moderate or heavy use of these substances. Symptoms may include nausea or vomiting; malaise or weakness; autonomic hyperactivity (such as tachycardia and sweating); anxiety or irritability; orthostatic hypotension; **coarse tremor of the hands, tongue and eyelids**; insomnia; and grand mal seizures. (reference 7, p. 284; reference 4, p. 1549)

**Q: Did you rule out *alcohol consumption or withdrawal* as a cause of the plaintiff's trembling or shaking?**

*Alcohol intoxication* may cause aggressiveness, impaired judgment and attention, irritability, euphoria, depression, emotional lability, and impaired social or occupational functioning. Physical symptoms may include slurred speech, incoordination, unsteady gait, nystagmus, occasional dizziness, and flushed face. Heavy alcohol consumption may cause abnormal sleep patterns. The plaintiff often falls asleep quickly but wakes up earlier and earlier with uncomfortable feelings. Chronic alcoholics may have irregular, unsteady, and slow **tremulous movements**. (reference 7, p. 212; reference 4, p. 67; reference 9, p. 52)

The *reduction or cessation* of drinking for at least several days may cause characteristic symptoms: **coarse tremor of hands, tongue, or eyelids**; nausea or vomiting; malaise or weakness; autonomic hyperactivity (tachycardia, sweating, and elevated blood pressure); anxiety, depressed mood or irritability; transient hallucinations or illusions; headache; insomnia; dizziness; fatigue; restlessness; and agitation. (reference 7, p. 215; reference 2, pp. 722, 618; reference 9, pp. 50-54)

**Q: Did you rule out *ecstasy use* as a cause for the plaintiff's trembling or shaking?**

MDMA (methylenedioxymethamphetamine) use can sometimes result in severe dehydration or exhaustion, or other adverse effects such as nausea, hallucinations, chills, sweating, increases in body temperature, **tremors**, involuntary teeth clenching, muscle cramping, and blurred vision. MDMA users have also reported after-effects such as anxiety, paranoia, and depression. An MDMA overdose is characterized by high blood pressure, faintness, panic attacks, and, in more severe cases, loss of consciousness, seizures, and a drastic rise in body temperatures to 105-106 degrees Fahrenheit. MDMA overdoses can be fatal, as they may result in heart failure or extreme heat stroke. (reference 20)

**Q: Did you rule out *Parkinson's disease* as a cause of the plaintiff's trembling or shaking?**

Parkinsonism is a common neurologic condition characterized by **tremors at rest**. It is a prominent cause of disability. (reference 9, pp. 2070-2073)

*If the witness indicates the possibility of Parkinson's disease, see the section on pre-existing medical conditions for questions.*

## SYMPTOM

## DEPOSITION QUESTIONS

**Trembling or Shaking***(continued)***Q: Did you rule out *metabolic brain disease* as a cause of the plaintiff's trembling or shaking?**

The plaintiff with a metabolic brain disease is inattentive, perplexed, preoccupied, and unable to concentrate. Changes in mental abilities, alertness, awareness, and perception are common. Characteristic physical symptoms include **tremor, asterixis**, (flapping tremor of the extremities), and multifocal myoclonus (sudden gross muscle contractions). (reference 9, pp. 1974-1975)

**Q: Did you rule out *epilepsy* (seizure disorder) as a cause of the plaintiff's trembling or shaking?**

During epileptic seizures, or convulsive attacks, the plaintiff may experience a loss of consciousness and motor control (**jerking of all extremities**). No obvious cause can be found in most plaintiffs with the disorder. However, it may be associated with such conditions as hyperpyrexia, CNS infections, metabolic disturbances, toxic agents, brain defects and lesions, or withdrawal from alcohol, hypnotics, and tranquilizers. (reference 1, pp. 1311-1322; reference 4, p. 153)

*If the witness indicates the possibility of epilepsy, see the section on pre-existing medical conditions for further questions.*

**Q: Did you rule out *hypoglycemia* as a cause of the plaintiff's trembling or shaking?**

Hypoglycemia is an abnormally low blood sugar level. It often produces personality changes, confusion, dizziness, **tremor**, anxiety, tachycardia, and sweating during acute attacks. Other psychiatric symptoms include fear and dread, depression with fatigue, and agitation with confusion. Hypoglycemia can develop from an insulin overdose, insulinoma or islet cell tumor, extensive liver disease, or functional diseases. (reference 2, p. 702; reference 4, pp. 1176-1177)

*If the witness indicates the possibility of hypoglycemia, see the section on pre-existing medical conditions for further questions.*

**Q: Did you rule out a *neuroendocrine disorder*, such as *pheochromocytoma*, as a cause of the plaintiff's trembling or shaking?**

Symptoms of a neuroendocrine disorder include sudden headaches, excessive sweating, and palpitations. Often there are associated **tremors**, weakness, nausea, and epigastric discomfort. The plaintiff may also complain of chest pain, shortness of breath, lightheadedness, blurred vision, and flushing. (reference 2, p. 612)

Pheochromocytoma is a tumor of the sympathetic nervous system which specifically causes headaches, lightheadedness, nausea, sweating, **trembling**, and elevated blood pressure during anxiety attacks. (reference 4, p. 1276)

*If the witness indicates the possibility of pheochromocytoma, see the section on pre-existing medical conditions for further questions.*

## SYMPTOM

## DEPOSITION QUESTIONS

**Trembling or Shaking***(continued)***Q: Did you rule out *multiple sclerosis* as a cause of the plaintiff's trembling or shaking?**

Multiple sclerosis is a common disease of young adults. The disease causes a disorder of the optic nerves, spinal cord, and brain. Symptoms may include depression, apathy, lack of judgement, inattention, **tremor**, vertigo, incoordination, weakness, fatigue, dysarthria (speech impairment), and urinary frequency or hesitancy. (reference 4, p. 1276; reference 1, pp. 1354-1356)

*If the witness indicates the possibility of multiple sclerosis, see the section on MS for further questions.*

**Q: Did you rule out *nocturnal myoclonus* as a cause of the plaintiff's trembling or shaking?**

**Rhythmic muscle twitches** and involuntary movements of the extremities disrupt the plaintiff's sleep. The disorder usually begins during late middle age and in the elderly. (reference 9, pp. 1988-1989)

**Q: Did you rule out *early onset of Wilson's disease* as a cause of the plaintiff's trembling or shaking?**

Wilson's disease is characterized by brain degeneration. Defective copper excretion causes an accumulation of copper in the liver, brain and other tissues. Symptoms may include **tremor exaggerated with movement**, difficulty speaking and swallowing, incoordination, personality changes, explosive anger, abdominal pain, diarrhea, nausea and vomiting, memory loss, and dementia. (reference 9, pp. 1158-1159)

*If the witness indicates the possibility of Wilson's disease, see the section on pre-existing medical conditions for further questions.*

**Q: Did you rule out *early signs of chorea* as a cause of the plaintiff's trembling or shaking?**

Chorea is characterized by irregular, jerky, and varied involuntary movements when the plaintiff is at rest. It may include **twitching movements** of the tongue, face, and lower extremities. Chorea is a symptom of Huntington's disease and Sydenham's chorea. (reference 2, p.685)

**Q: Did you rule out *Shy-Dragger syndrome* as a cause of the plaintiff's trembling or shaking?**

Shy-Dragger syndrome (primary orthostatic hypotension) is a degeneration of preganglionic sympathetic neurons. Symptoms may include **tremor, ataxia** (incoordination of voluntary muscles), rigidity, impotence, atonicity of the urinary bladder, and impaired sweating in the lower part of the body. (reference 10, p. 1099; reference 2, p. 701)

*SYMPTOM*

*DEPOSITION QUESTIONS*

**Trembling or Shaking**

*(continued)*

**Q: Did you rule out *lithium use* as a cause of the plaintiff's trembling or shaking?**

Lithium and the tricyclics are often given as medication for depression. **Tremor** is one of the most common side effects. Other symptoms may include nausea, diarrhea, polyuria (the passage of an excessive quantity of urine), polydipsia (excessive thirst), and weight gain. Toxic effects may include **gross tremor**, increased deep tendon reflexes, persistent headaches, vomiting, mental confusion progressing to stupor, seizures, or cardiac arrhythmias. (reference 1, pp. 1460-1461)

**Q: Did you rule out a *brain tumor* as a cause of the plaintiff's trembling or shaking?**

Brain tumors occur in the skull, brain, or membrane covering the brain or spinal cord. Symptoms vary depending on the size of the tumor and rate of growth. The plaintiff may experience anxiety, dementia, irritability, dizziness, fatigue, headache, vomiting, **tremor**, hyperthermia (high body temperature), and changes in appetite and personality. (reference 4, pp. 139, 834-835, 855, 860, 1276; reference 9, pp. 2161-2164; reference 1, pp. 1351, 1296)

*If the witness indicates the possibility of a brain tumor, see the section on medical conditions for further questions.*

**Caution: Do not ask the following question if the cause of action involves a head injury or toxic exposure.**

**Q: Did you rule out any head injuries or other conditions leading to *organic brain syndrome* as a cause of the plaintiff's trembling or shaking?**

Organic brain syndrome is a term for the symptoms produced by *head injury*, toxic exposure, hypoxia (oxygen deficiency), anoxia (extreme oxygen deficiency in tissues) or other causes. Common symptoms of head injuries include vertigo, syncope (faint) lightheadedness, **trembling**, impaired concentration and memory, easy fatigability, irritability, lack of energy, depression, anxiety, phobia, a lowered tolerance for alcohol, and headaches. Symptoms may appear days or weeks after the injury but usually appear within 24 hours. (reference 2, pp. 75, 111)

**Q: Did you rule out *infections* as a cause of the plaintiff's trembling or shaking?**

- |                                  |                                 |
|----------------------------------|---------------------------------|
| Brucellosis                      | Meningitis                      |
| Chronic urinary tract infections | Subacute bacterial endocarditis |
| Infectious mononucleosis         | Syphilis                        |
| Influenza                        | Tuberculosis                    |
| Malaria                          | Viral hepatitis                 |

**Q: Did you rule out *caffeine consumption* as a cause of the plaintiff's trembling or shaking?**

Characteristic symptoms of caffeine intoxication include restlessness, nervousness, excitement, insomnia, flushed face, diuresis, gastrointestinal disturbance, **muscle twitching**, rambling flow of thought and speech, tachycardia or cardiac arrhythmia, periods of inexhaustibility, and psychomotor agitation. When consumed near

*SYMPTOM*

*DEPOSITION QUESTIONS*

**Trembling or Shaking**

*(continued)*

bedtime, caffeine often disrupts sleep. Symptoms may appear when the plaintiff consumes as little as 250 mg of caffeine per day. The plaintiff that consumes one gram per day usually experiences more severe symptoms. Products which contain caffeine include: coffee, tea, soda, chocolate and weight-loss aids. (reference 7, pp. 231-234; reference 4, p. 1029)

*If the witness indicates the possibility of excess caffeine consumption, see the caffeine consumption chart in Appendix A.*

**Q: Did you rule out amphetamine or similarly acting sympathomimetic drug consumption or withdrawal as a cause of the plaintiff's trembling or shaking?**

Symptoms of amphetamine or similarly acting sympathomimetic *drug consumption* may include fighting, grandiosity, elation, hypervigilance, **psychomotor agitation**, impaired judgment, and impaired social or occupational functioning. Physical symptoms may include flushing, difficulty breathing, tachycardia, pupil dilation, elevated blood pressure, sweating or chills, nausea, and vomiting. (reference 12; reference 4, pp. 1007-1008; reference 7, p. 223)

*Drug withdrawal* symptoms may include a dysphoric mood (depression, irritability, anxiety), fatigue, sweating, headaches, insomnia with nightmares, hypersomnia, and **psychomotor agitation**. Symptoms begin after the cessation of prolonged drug use (at least two days) and last more than 24 hours. (reference 7, p. 227; reference 4, p. 1008)

The following drugs may be classified as amphetamines:

- |                                    |                            |
|------------------------------------|----------------------------|
| Appetite Suppressants (diet pills) | Methamphetamines (speed)   |
| Dextroamphetamines                 | Methylphenidates (Ritalin) |
| Ma-huang (ephedra)                 | (reference 17, p. 586)     |
| (reference 24, pp. 488-489)        |                            |

**Q: Does the plaintiff have any other medical conditions that may cause trembling or shaking, such as:**

- |                                  |                              |
|----------------------------------|------------------------------|
| Benign essential familial tremor | Sydenham chorea              |
| Chorea                           | Thyrotoxicosis               |
| Dystonia                         | Tics                         |
| Myoclonic activity               | Tremors of brain stem origin |

**Q: Is the plaintiff taking any medications or substances that may cause the trembling or shaking, such as:**

- |           |              |              |
|-----------|--------------|--------------|
| ADALAT    | AMBIEN       | ASENDIN      |
| ADDERALL  | AMPHETAMINES | ATARAX       |
| ADIPEX    | ANAFRANIL    | ATROVENT     |
| AKINETONE | ANSAID       | AVAPRO       |
| ALDOMET   | APRESOLINE   | BENADRYL     |
| ALDORIL   | ARICEPT      | BETHANECHOL- |
| ALTACE    | ARTANE       | CHLORIDE     |
| ALUPENT   | ARTHROTEC    | BIPHETAMINE  |

**SYMPTOM****DEPOSITION QUESTIONS****Trembling or Shaking***(continued)*

|               |                  |               |
|---------------|------------------|---------------|
| BRETHINE      | ISUPREL          | PROTONIX      |
| BRICANYL      | KERLONE          | PROVENTIL     |
| BUPRENEX      | KLONOPIN         | RELAFEN       |
| CARDIZEM      | LESCOL           | REMERON       |
| CARDURA       | LEVAQUIN         | RESTORIL      |
| CELEXA        | LIBRAX           | RISPERDAL     |
| CENTRAX       | LIMBITROL        | RONDEC DM     |
| CHLORTRIMETON | LIORESAL         | SANOREX       |
| CIPRO         | LITHIUM CITRATE  | SER-AP-ES     |
| CLARITAN-D    | LOTREL           | SERAX         |
| CLARITIN      | LUDIOMIL         | SERENTIL      |
| CLOZARIL      | LUVOX            | SEREVENT      |
| COGENTIN      | MARPLAN          | SEROQUEL      |
| COGNEX        | MAXALT           | SERTRALINE    |
| COMBIVENT     | MEPERGAN         | SERZONE       |
| COMPAZINE     | MESANTOIN        | SINEMET       |
| COZAAR        | MEXITIL          | SLO-PHYLLIN   |
| CRINONE       | MIRAPEX          | SOMA          |
| DEMEROL       | MOBAN            | SOMA-COMPOUND |
| DEPAKENE      | MONOPRIL         | SONATA        |
| DEPAKOTE      | MORPHINE-SULFATE | SPORANOX      |
| DESOXYN       | NALDECON         | STADOL        |
| DESYREL       | NALFON           | STELAZINE     |
| DEXEDRINE     | NARDIL           | SUDAFED       |
| DILANTIN      | NAVANE           | SULAR         |
| DIMETANE      | NEURONTIN        | SURMONTIL     |
| DORAL         | NOREPHEDRINE     | SYMMETREL     |
| DURACT        | NORPRAMIN        | TALECEN       |
| DURAGESIC     | NORVASC          | TALWIN NX     |
| DURAVENT      | OPTIMINE         | TAVIST        |
| EFFEXOR       | ORAP             | TEGRETOL      |
| ELAVIL        | ORNADE           | TEMARIL       |
| ELDEPRYL      | OXYCONTIN        | THEO-DUR      |
| ENDEP         | PAMELOR          | THORAZINE     |
| ESKALITH      | PBZ-SR           | TIAZAC        |
| ETRAFON       | PERIACTIN        | TINDAL        |
| EXCELON       | PERMAX           | TOFRANIL      |
| FASTIN        | PERMITIL         | TORECAN       |
| FIORICET      | PHENERGAN VC     | TRANCOPAL     |
| FLEXERIL      | W/CODEINE        | TRIAVIL       |
| FLOXIN        | PHENYLPROPANOLA  | TRILAFON      |
| GABITRIL      | MINE             | TRILEPTAL     |
| HISTUSSIN     | POLARIMINE       | TRINALIN      |
| HYZAAR        | PRAVACHOL        | TROVAN        |
| IMDUR         | PRIMAXIN-IV      | ULTRAM        |
| INDOCIN       | PROCARDIA        | VALIUM        |
| IONAMIN       | PROSOM           | VENTOLIN      |

## Panic Attacks and Panic Disorder

*SYMPTOM*

*DEPOSITION QUESTIONS*

**Trembling or Shaking**

*(continued)*

|            |            |         |
|------------|------------|---------|
| VIAGRA     | XANAX      | ZOCOR   |
| VICOPROFEN | YOCON      | ZOLOFT  |
| VISTARIL   | ZANAFLEX   | ZYBAN   |
| VIVACTIL   | ZESTORETIC | ZYPREXA |
| WELLBUTRIN | ZIAC       | ZYRTEC  |

**Shortness of Breath, Smothering Sensations**

**Q:** Describe the plaintiff's shortness of breath or smothering sensations.

**Q:** When and how often does the plaintiff experience a shortness of breath or smothering sensations?

**Q:** Does the plaintiff have a history of shortness of breath before the injury in question?

**Q:** Does the plaintiff have a history of any *medical or psychological conditions* that may cause shortness of breath or smothering sensations?

*The witness may indicate the possibility of the following medical or psychological conditions: please refer to the sections pertaining to these conditions for further questions.*

**TABLE 5.5-5.**

|                                       |                       |
|---------------------------------------|-----------------------|
| Asthma                                | Hyperthyroidism       |
| Chronic obstructive pulmonary disease | Mitral valve prolapse |
| Conversion disorder                   | Parkinson's disease   |
| Coronary artery disease               | Pheochromocytoma      |

**Q:** Did you rule out *stressors or other conditions* not attributable to a mental disorder as a cause of the plaintiff's shortness of breath or smothering sensations?

*If the witness indicates the possibility of a life stressor or other condition, see the section on other life-stressors for further questions.*

**Q:** Did you rule out a *physically stressful schedule* as a cause of the plaintiff's shortness of breath or smothering sensations?

Heart pounding, palpitations, and tachycardia are often associated with indigestion, overexertion, a specific emotion, or fatigue. Other symptoms may include fullness in the neck, **shortness of breath**, nervousness, dizziness, and apprehension. (reference 2, pp. 302, 304)

**Q:** Did you rule out a *somatization disorder (psychosomatic)* as a cause of the plaintiff's shortness of breath or smothering sensations?

The plaintiff with a somatization disorder has many physical complaints for several years. S/he sees multiple physicians only to discover no physical cause for the

## SYMPTOM

## DEPOSITION QUESTIONS

**Shortness of  
Breath,  
Smothering  
Sensations**

*(continued)*

symptoms. The plaintiff often has exaggerated and vague complaints focusing on either organs or types of symptoms such as pseudoneurologic or conversion symptoms, gastrointestinal, female reproductive, psychosexual, pain, and cardiopulmonary symptoms. Anxiety, depression, suicide attempts, social withdrawal, and work or interpersonal relationship difficulties are common.

**Shortness of breath** may be a component of the plaintiff's anxiety. (reference 7, p. 486; reference 4, pp. 389, 940)

*If the witness indicates the possibility of a somatization disorder, see the section on somatoform disorders for further questions.*

**Q: Did you rule out *asthma* as a cause of the plaintiff's shortness of breath or smothering sensations?**

Asthma is a chronic and episodic illness, characterized by widespread narrowing of the tracheobronchial tree. Symptoms include coughing, wheezing, chest tightness and **dyspnea (shortness of breath)**. Nocturnal symptoms and exacerbations are common. Psychiatric forces may affect the clinical expression of asthma in several ways: altered awareness of airway resistance, suggestibility to airway constriction, and comorbidity with panic disorder and depression. (reference 18, pp. 1803-1804)

**Q: Did you rule out *chronic obstructive pulmonary disease (COPD)* as a cause of the plaintiff's shortness of breath or smothering sensations?**

COPD manifests itself in two ways: chronic bronchitis and emphysema. Smoking is the single greatest risk factor and most important cause of chronic obstructive pulmonary disease. COPD affects more than 16 million Americans. Symptoms of COPD include hypoxemia (deficient oxygenation in the blood), bronchial symptoms, and **dyspnea (shortness of breath)** upon exertion. Psychiatric issues affect many facets of the course of COPD. As for asthma, prevalence rates for both panic disorder and anxiety disorders are increased among COPD patients. (reference 18, pp. 1805-1806)

**Q: Did you rule out *psychogenic dyspnea* as a cause of the plaintiff's shortness of breath or smothering sensations?**

Plaintiffs with chronic **psychogenic breathlessness** may be depressed or have a reactive depression to stress. Others may have a depressive psychosis with associated symptoms of anorexia, weight loss, early morning awakening, psychomotor retardation, and daytime mood variations. They may complain of **smothering or being unable to breath**, feeling lightheaded, dizzy, or numb in the extremities and around the mouth. (reference 2, p. 342)

*Defense counsel should note that some plaintiffs with this disorder desire financial compensation and may be malingering.*

**Q: Did you rule out a *neuroendocrine disorder*, such as *pheochromocytoma*, as a cause of the plaintiff's shortness of breath or smothering sensations?**

Symptoms of a neuroendocrine disorder include sudden headaches, excessive sweating, and palpitations. Often there are associated tremors, weakness, nausea,

## SYMPTOM

## DEPOSITION QUESTIONS

**Shortness of  
Breath,  
Smothering  
Sensations**

(continued)

and epigastric discomfort. The plaintiff may also complain of chest pain, **shortness of breath**, lightheadedness, blurred vision, and flushing. (reference 2, p. 612)

Pheochromocytoma is a tumor of the sympathetic nervous system which specifically causes headaches, lightheadedness, nausea, sweating, trembling, and elevated blood pressure during anxiety attacks. (reference 4, p. 1276)

*If the witness indicates the possibility of a neuroendocrine disorder, see the section on pre-existing medical conditions for further questions.*

**Q: Did you rule out *hyperventilation* as a cause of the plaintiff's shortness of breath or smothering sensations?**

Hyperventilation is abnormal, **rapid, deep breathing** usually due to anxiety. Exercise and strong emotion causes hyperventilation or it can begin spontaneously. Symptoms may include lightheadedness, faintness, ringing in the ears, weakness, blurring of vision, and tingling around the mouth or in the extremities. (reference 2, p. 613)

**Q: Did you rule out an *airway obstruction* as a cause of the plaintiff's shortness of breath or smothering sensations?**

*Types of airway obstructions may include:* (reference 1, p. 514)

A foreign body

Blocking by the tongue

Blood

Inflammation, neoplasm, constriction, or air passage trauma

Mucus

Spasm or edema of the vocal cords

**Q: Did you rule out an *allergic reaction* as a cause of the plaintiff's shortness of breath or smothering sensations?**

Allergic rhinitis is seasonal or perennial inflammatory disease of the nasal membranes. Symptoms may include sneezing; a stuffy and itching nose; postnasal drainage; and itching eyes. The plaintiff with allergies may feel generally ill, **short of breath**, and uncomfortable, tired, weak, despondent, irritable, and uninterested in eating. (reference 9, pp. 1867-1868)

**Q: Did you rule out *sleep apnea* as a cause of the plaintiff's shortness of breath or smothering sensations?**

Sleep apnea is the **cessation or suspension of breathing during sleep**, causing the plaintiff to awaken periodically throughout the night. These hesitations may cause sleep disturbance but the plaintiff's main complaint may be excessive daytime drowsiness. (reference 4, pp. 132, 1252)

*SYMPTOM*

*DEPOSITION QUESTIONS*

**Shortness of  
Breath,  
Smothering  
Sensations**  
*(continued)*

**Q: Does the plaintiff have any other *medical conditions* that may cause shortness of breath or smothering sensations, such as:**

- |                                     |  |
|-------------------------------------|--|
| Acute infectious bronchitis         | Midbrain lesions                                 |
| Acute respiratory distress syndrome | Myasthenia gravis                                |
| Asthma                              | Obesity  |
| Brain stem lesions                  | Obstruction above/below the tracheal bifurcation |
| Bronchiolitis                       | Pneumococcal pneumonia                           |
| Chronic asthmatic bronchitis        | Pontine lesions                                  |
| Chronic emphysema                   | Pulmonary embolism (thromboembolism)             |
| Cystic fibrosis                     | Pulmonary fibrosis                               |
| Kyphoscoliosis                      | Respiratory muscle illness                       |
| Medullary lesions                   |  |

**Q: Is the plaintiff taking any *medications or substances* that may cause shortness of breath or smothering sensations, such as:**

- |            |                  |             |
|------------|------------------|-------------|
| ACCUPRIL   | DILACOR          | LOTENSIN    |
| ADALAT     | DIOVAN           | MACRODANTIN |
| AEROBID    | DOLOBID          | MAVIK       |
| ALTACE     | DURACT           | MAXALT      |
| AMBIEN     | DURAGESIC        | MAXIDE      |
| ANAFRANIL  | DYNACIRC         | MECLIZINE   |
| ANAPROX    | EFFEXOR          | MEGACE      |
| ANSAID     | ELDEPRYL         | METHERGIE   |
| ANTABUSE   | ESTROGEN PATCH   | MEXITIL     |
| APRESOLINE | FELDENE          | MINIPRESS   |
| ARICEPT    | FIORICET         | MIRAPEX     |
| ARTHROTEC  | FIORINAL-CODEINE | MODURETIC   |
| ATROVENT   | FLEXERIL         | MONOPRIL    |
| AVAPRO     | FLOXIN           | NALFON      |
| AVONEX     | GUAIFED          | NAPROSYN    |
| AXOCET     | HYDRO-           | NEURONTIN   |
| CARBATROL  | CHLOROTHIAZIDE   | NICORETTE   |
| CARDENE    | HYTRIN           | NOROXIN     |
| CIPRO      | HYZAAR           | NORPACE     |
| CLARITAN-D | IMDUR            | NORVASC     |
| CLARITIN   | INDOCIN          | NOVOLIN     |
| CLOMID     | INTROPIN         | NUBAIN      |
| CLOZARIL   | K-LYTE           | ORUDIS      |
| COGNEX     | KERLONE          | OXYCONTIN   |
| COLESTID   | KLONOPIN         | PARLODEL    |
| COMBIVENT  | LESCOL           | PAXIL       |
| COUMADIN   | LEVAQUIN         | PERMAX      |
| COZAAR     | LIORESAL         | PHENAPHEN   |
| CYTOTEC    | LIPITOR          | W/CODEINE   |
| DALMANE    | LOMOTIL          | PLAVIX      |
| DESYREL    | LOPRESSOR        | PLENDIL     |

## Panic Attacks and Panic Disorder

*SYMPTOM*

*DEPOSITION QUESTIONS*

**Shortness of  
Breath,  
Smothering  
Sensations**

*(continued)*

|               |                   |              |
|---------------|-------------------|--------------|
| PRAVACHOL     | SONATA            | UNIVASC      |
| PREVACID      | STADOL            | VALIUM       |
| PRIMAXIN-IV   | SULAR             | VALTREX      |
| PRINZIDE      | SULINDAC          | VANCOCIN-HCL |
| PROCARDIA     | SYMMETREL         | VASOTEC      |
| PROSOM        | TEGRETOL          | VERELAN      |
| PROTONIX      | TENORMIN          | VIAGRA       |
| QUESTRAN      | TIAZAC            | VICODIN      |
| REMERON       | TIMOPTIC          | VICOPROFEN   |
| REVIA         | TOPROL-XL         | VIOXX        |
| RHINOCORT     | TORADOL           | VOLTAREN     |
| RISPERDAL     | TRENTAL           | ZEPHREX      |
| SER-AP-ES     | TRILEPTAL         | ZESTORETIC   |
| SEREVENT      | TROVAN            | ZESTRIL      |
| SINEMET       | TYLENOL W/CODEINE | ZIAC         |
| SOMA COMPOUND | ULTRAM            | ZOCOR        |

**Choking**

**Q: Describe the plaintiff's choking.**

---

**Q: When and how often does the plaintiff choke?**

---

**Q: Does the plaintiff have a history of choking, other than during panic attacks, before the injury in question?**

---

**Q: Does the plaintiff have a history of *chronic obstructive pulmonary disease* as a cause of the plaintiff's choking?**

COPD manifests itself in two ways; chronic bronchitis and emphysema. Smoking is the single greatest risk factor and most important cause of chronic obstructive pulmonary disease. COPD affects more than 16 million Americans. Symptoms of COPD include hypoxemia (deficient oxygenation in the blood), bronchial symptoms, and dyspnea (shortness of breath) upon exertion. Psychiatric issues affect many facets of the course of COPD. As for asthma, prevalence rates for both panic disorder and anxiety disorders are increased among COPD patients. (reference 18, pp. 1805-1806)

*If the witness indicates the possibility of chronic obstructive pulmonary disease, see the section on pre-existing medical conditions for further questions.*

---

**Q: Did you rule out a *childhood overanxious disorder* as a cause of the plaintiff's choking?**

A child with an overanxious disorder has excessive or unrealistic anxiety or worry for at least six months. S/he tends to be self-conscious and worried about future events and past behavior. Symptoms may include feeling a **lump in the throat**, headaches, gastrointestinal distress, shortness of breath, nausea, dizziness, difficulty falling asleep, nervousness, and other bodily discomforts. The disorder occurs most often in families where there is an unusual emphasis on high achievement. An

## SYMPTOM

## DEPOSITION QUESTIONS

**Choking***(continued)*

overanxious disorder may be accompanied by other phobias. It can persist into adult life as an anxiety disorder, such as a generalized anxiety disorder or a social phobia. (reference 7, p. 472; reference 4, pp.1752-1754)

*Defense counsel should obtain the plaintiff's early school and health records to look for evidence of this disorder.*

**Q: Did you rule out a *somatization disorder* (psychosomatic) as a cause of the plaintiff's choking?**

The plaintiff with a somatization disorder has many physical complaints for several years. S/he sees multiple physicians only to discover no physical cause for the symptoms. The plaintiff often has exaggerated and vague complaints such as **difficulty swallowing** that focus on either organs or types of symptoms such as pseudoneurologic or conversion symptoms, gastrointestinal, female reproductive, psychosexual, pain, and cardiopulmonary symptoms. Anxiety, depression, suicide attempts, social withdrawal, and work or interpersonal relationship difficulties are common. (reference 7, p. 486; reference 4, pp. 389, 940)

*If the witness indicates the possibility of a somatization disorder, see the section on somatoform disorders for further questions.*

**Q: Did you rule out *acute laryngitis* as a cause of the plaintiff's choking?**

Symptoms of acute laryngitis may include an inflammation of the upper or lower respiratory tract, hoarseness, cough, sore throat, and **painful swallowing**. (reference 2, p. 322)

**Q: Did you rule out a *conversion disorder* as a cause of the plaintiff's choking?**

A conversion disorder is characterized by the presence of symptoms or deficits affecting voluntary motor or sensory function that suggest a neurological or other general medical condition. Psychological factors are judged to be associated with the symptom or deficit and the symptoms are not intentionally feigned or produced. Conversion symptoms are defense mechanisms that change the unconscious emotional conflict into a physical disability that often symbolizes the nature of the conflict. (reference 12, p. 315; reference 2, pp. 625, 630; reference 7, p. 492. )

*If the witness indicates the possibility of a conversion disorder, see the section on conversion disorder for further questions.*

**Q: Did you rule out an *airway obstruction* as a cause of the plaintiff's choking?**

*Types of airway obstructions may include:* (reference 1, p. 514)

A foreign body

Blocking by the tongue

Blood

Inflammation, neoplasm, constriction, or air passage trauma

Mucus

Spasm or edema of the vocal cords

*SYMPTOM*

*DEPOSITION QUESTIONS*

**Choking**

(continued)

**Q: Did you rule out an allergic reaction as a cause of the plaintiff's choking?**

Allergic rhinitis is seasonal or perennial inflammatory disease of the nasal membranes. Symptoms may include sneezing; a stuffy and itching nose; **postnasal drainage**; and itching eyes. The plaintiff with allergies may feel generally ill and uncomfortable, tired, weak, despondent, irritable, and uninterested in eating. (reference 9. pp. 1867, 1868)

**Q: Did you rule out early onset of Wilson's disease as a cause of the plaintiff's choking?**

Wilson's disease is characterized by brain degeneration. Defective copper excretion causes an accumulation of copper in the liver, brain and other tissues. Symptoms may include tremor exaggerated with movement, **difficulty speaking and swallowing**, incoordination, personality changes, explosive anger, abdominal pain, diarrhea, nausea and vomiting, memory loss and dementia. (reference 9, pp. 1158-1159)

*If the witness indicates the possibility of Wilson's disease, see the section on pre-existing medical conditions for further questions.*

**Q: Does the plaintiff have any other medical conditions that may cause choking, such as:**

- |                              |  |
|------------------------------|--|
| Asthma                       | Cystic fibrosis (mucoviscidosis)           |
| Chronic asthmatic bronchitis | Emphysema                                  |
| Chronic emphysema            | Obstruction below the tracheal bifurcation |
| Chronic bronchitis           |  |

**Chest Pain or Discomfort**

**Q: Describe the plaintiff's chest pain or discomfort.**

**Q: When and how often does the plaintiff experience chest pain or discomfort?**

**Q: Does the plaintiff have a history of chest pain or discomfort before the injury in question?**

**Q: Does the plaintiff have a history of any medical conditions that may cause chest pain or discomfort?**

**TABLE 5.5-6.**

|                         |                        |
|-------------------------|------------------------|
| Coronary artery disease | Pericarditis           |
| Lung disease            | Pulmonary embolism     |
| Mitral valve prolapse   | (reference 23, p. 382) |
| Multiple sclerosis      |                        |

**Q: Did you rule out somatoform (psychogenic) pain disorder as a cause of the plaintiff's chest pain or discomfort?**

Somatoform (psychogenic) pain disorder and psychogenic cardiac nondisease are both disorders characterized by intense and sustained physical symptoms and pain. **Cardiac pain** may include an accelerated heart rate, palpitations, dizziness, and sweating. These emotionally caused symptoms may be associated with depression,

## SYMPTOM

## DEPOSITION QUESTIONS

**Chest Pain or Discomfort***(continued)*

anxiety, anhedonia (an inability to experience pleasure), insomnia, and irritability. The symptoms may become so severe that the plaintiff feels incapacitated and quits working. (reference 7, pp. 498-503; reference 4, p. 1109)

*If the witness indicates the possibility of a somatoform (psychogenic) pain disorder, see the section on somatoform pain disorder for further questions.*

**Q: Did you rule out an *adjustment disorder with physical complaints* as a cause of the plaintiff's chest pain or discomfort?**

An adjustment disorder is a transient over-reaction to stress that usually occurs within 90 days and remits within six months. The adjustment disorder with physical complaints is characterized by symptoms of fatigue, headache, backache, or other **aches and pains**. This condition is diagnosed as Adjustment Disorder Unspecified. (reference 7, pp. 679-680)

*If the witness indicates the possibility of an adjustment disorder, see the section on adjustment disorders for further questions.*

**Q: Did you rule out *hypochondriasis* as a cause of the plaintiff's chest pain or discomfort?**

The hypochondriac fears or believes that s/he has a serious disease based on their own interpretation of physical symptoms. Medical evaluations do not support the fears of disease. The plaintiff is preoccupied with bodily functions such as heartbeat, sweating, **peristalsis**, minor physical abnormalities, or a specific organ such as the heart. Headaches and fatigue are common complaints. (reference 7, pp. 504-507; reference 4, p. 1204)

*If the witness indicates the possibility of hypochondriasis, see the section on hypochondriasis for further questions.*

**Q: Did you rule out a *somatization disorder (psychosomatic)* as a cause of the plaintiff's chest pain or discomfort?**

The plaintiff with a somatization disorder has many physical complaints for several years. S/he sees multiple physicians only to discover no physical cause for the symptoms. The plaintiff often has exaggerated and vague complaints focusing on either organs or types of symptoms such as pseudoneurologic or conversion symptoms, gastrointestinal, female reproductive, psychosexual pain, and **cardiopulmonary symptoms**. Anxiety, depression, suicide attempts, social withdrawal, and work or interpersonal relationship difficulties are common. (reference 7, pp. 486-490; reference 4, pp. 389, 940)

*If the witness indicates the possibility of a somatization disorder, see the section on somatoform disorder for further questions.*

**Q: Did you rule out the onset of a *muscle disease* as a cause of the plaintiff's chest pain or discomfort?**

Muscle diseases often begin with pain as the primary or only symptom. (reference 4, p. 155)

*SYMPTOM*

*DEPOSITION QUESTIONS*

**Chest Pain or Discomfort**

*(continued)*

**Q: Did you rule out a *new exercise program or work involving physical labor* as a cause of the plaintiff's chest pain or discomfort?**

Vigorous exercise of untrained or deconditioned muscles may result in muscle aches and pain. (reference 9, pp. 2198-2199)

**Q: Did you rule out *niacin deficiency (B complex)* as a cause of the plaintiff's chest pain or discomfort?**

Niacin is one of the B complex vitamins essential for the normal carbohydrate metabolism of yeast cells and animal tissues. As the body's level of niacin decreases, the plaintiff may initially experience a burning tongue after eating hot or spicy foods. Symptoms are often more severe in the spring and fall and may be associated with mild anorexia, fatigue, nervousness, irritability, alternating periods of constipation and diarrhea, or **burning sensations in the epigastrium** (upper and middle abdomen). (reference 2, pp. 121-123)

**Q: Did you rule out a *neuroendocrine disorder, such as pheochromocytoma*, as a cause of the plaintiff's chest pain or discomfort?**

Symptoms of a neuroendocrine disorder include sudden headaches, excessive sweating, and palpitations. Often there are associated tremors, weakness, nausea, and epigastric discomfort. The plaintiff may also complain of **chest pain**, shortness of breath, lightheadedness, blurred vision, and flushing. (reference 2, p. 612)

Pheochromocytoma is a tumor of the sympathetic nervous system which specifically causes headaches, lightheadedness, nausea, sweating, trembling, and elevated blood pressure during anxiety attacks. (reference 4, p. 1276)

*If the witness indicates the possibility of pheochromocytoma, see the section on pre-existing medical conditions for further questions.*

**Q: Does the plaintiff have any other *medical conditions* that may cause chest pain and discomfort, such as:**

- |                                  |   |
|----------------------------------|---|
| Acute myocardial infarction pain | Thoracic pain (from cervical spondylosis) |
| Angina pectoris                  | Mediastinal lymphadenopathy               |
| Aortic pain                      | Mediastinal pain                          |
| Broncholithiasis                 | Myalgia                                   |
| Bronchoesophageal fistula        | Paroxysmal atrial tachycardia (PAT)       |
| Coronary blood flow restriction  | Pericardial pain                          |
| Diaphragmatic pain               | Pleural pain                              |
| Dorsal root injury               | Precordial ache                           |
| Esophageal pain                  | Sickle-cell anemia                        |
| Hiatal hernia                    | Tracheobronchial pain                     |
| Idiopathic breast pain           | Traction diverticula of the esophagus     |
| Intercostal nerve                |   |

*SYMPTOM*

*DEPOSITION QUESTIONS*

**Chest Pain or Discomfort**

(continued)

**Q:** Is the plaintiff taking any *medications or substances* that may cause chest pain or discomfort, such as:

- |             |                |                |
|-------------|----------------|----------------|
| ACCUPRIL    | DIPYRIDOLE     | NEURONTIN      |
| ACCUTANE    | DOLOBID        | NITRO-DUR      |
| ADALAT      | DURACT         | NITROGLYCERINE |
| AEROBID     | DURAGESIC      | NITROSTAT      |
| ALDOMET     | EFFEXOR        | NOROXIN        |
| ALDORIL     | ELDEPRYL       | NORPACE        |
| ALTACE      | ESKALITH       | NORVASC        |
| AMBIEN      | ESTROGEN PATCH | OMNICEF        |
| ANAFRANIL   | EXCELON        | ORAP           |
| ANSAID      | FELDENE        | ORNADE         |
| APRESOLINE  | FLOMAX         | OXYCONTIN      |
| ARICEPT     | FLOVENT        | PAXIL          |
| ATACAND     | FLOXIN         | PERMAX         |
| ATROVENT    | GEODON         | PERSANTINE     |
| AVAPRO      | GLYBURIDE      | PLAVIX         |
| AVONEX      | GOODY HEADACHE | PLENDIL        |
| AXID        | POWDER         | PONDIMIN       |
| BENADRYL    | HYTRIN         | PRAVACHOL      |
| BUMEX       | HYZAAR         | PREVACID       |
| CAPOTEN     | IMDUR          | PRILOSEC       |
| CARDENE     | IMITREX        | PRIMAXIN-IV    |
| CARDIZEM    | INDERAL        | PRINIVIL       |
| CARDURA     | INDOCIN        | PRINZIDE       |
| CELEBREX    | ISORDIL        | PROCARDIA      |
| CELEXA      | KERLONE        | PROSOM         |
| CIPRO       | KLONOPIN       | PROTONIX       |
| CLARITAN-D  | LEVAQUIN       | PROVENTIL      |
| CLARITIN    | LEVOTHROID     | PROZAC         |
| CLOMID      | LICTAL         | REMERON        |
| CLOZARIL    | LIORESAL       | RISPERDAL      |
| COGNEX      | LIPITOR        | RITALIN        |
| COLESTID    | LOTENSIN       | SE-AP-ES       |
| COMBIVENT   | LOTREL         | SEREVENT       |
| CONCERTA    | LOVENOX        | SEROQUEL       |
| CORGARD     | LUVOX          | SERTRALINE     |
| COZAAR      | MACROBID       | SERZONE        |
| CYCLOSPORIN | MACRODANTIN    | SONATA         |
| CYTOMEL     | MAVIK          | SORBITRATE     |
| CYTOTEC     | MAXALT         | TENCET         |
| DALMANE     | MAXIDE         | TEQUIN         |
| DEPACON     | MEXITIL        | THYROID        |
| DESYREL     | MIRAPEX        | TIAZAC         |
| DETROL      | MODURETIC      | TIMENTIN       |
| DILACOR     | MONOPRIL       | TIMOPTIC       |
| DIOVAN      | NASONEX        | TOLECTIN       |

## Panic Attacks and Panic Disorder

*SYMPTOM*

*DEPOSITION QUESTIONS*

**Chest Pain or Discomfort**

*(continued)*

|                 |            |           |
|-----------------|------------|-----------|
| TOPAX           | VASOTEC    | ZIAC      |
| TOPROL-XL       | VENTOLIN   | ZITHROMAX |
| TRANSDERM-NITRO | VERELAN    | ZOFRAN    |
| TRENTAL         | VIAGRA     | ZOLOFT    |
| TRILEPTAL       | VIOXX      | ZOMIG     |
| TRINALIN        | ZANAFLEX   | ZYBAN     |
| TROVAN          | ZAROXOLYN  | ZYPREXA   |
| VALIUM          | ZEBETA     | ZYRTEC    |
| VANCOGIN-HCL    | ZESTORETIC |           |
| VANTIN          | ZESTRIL    |           |

**Nausea, Abdominal Distress**

**Q:** Describe the plaintiff's nausea or abdominal distress.

**Q:** When and how often does the plaintiff experience nausea or abdominal distress?

**Q:** Does the plaintiff have a history of nausea or abdominal distress before the injury in question?

**Q:** Does the plaintiff have a history of any *medical conditions* that may cause nausea or abdominal distress?

*The witness may indicate the possibility of the following medical conditions: please refer to the sections pertaining to these medical conditions for further questions.*

**TABLE 5.5-7.**

|                         |                       |
|-------------------------|-----------------------|
| Addison's disease       | Meningitis            |
| Coronary artery disease | Myocardial infarction |
| Hepatitis B             | Syphilis              |
| Hyperthyroidism         | Uremic encephalopathy |

**Q:** Did you rule out *stressors or other conditions* not attributable to a mental disorder as a cause of the plaintiff's nausea or abdominal distress?

*If the witness indicates the possibility of a life stressor or other condition, see the section on other life-stressors for further questions.*

## SYMPTOM

## DEPOSITION QUESTIONS

**Nausea,  
Abdominal  
Distress**

(continued)

**Q: Did you rule out *migraine headaches* as a cause of the plaintiff's nausea or abdominal distress?**

A classic migraine (vascular) headache may be accompanied by visual disturbances, sensory motor or speech disturbances, **nausea or vomiting**, and emotional changes. On rare occasions, the plaintiff may experience depersonalization or derealization. Migraine headaches may be precipitated by: (reference 4, p. 1204; reference 2, pp. 65-66)

- Birth control pills
- Emotional conflicts or stress
- Fluctuating estrogen levels in women
- Food:
  - Monosodium glutamate (Chinese restaurant syndrome)
  - Phenylethylamine-containing foods
  - Tyramine-containing foods (cheese or other fermented dairy products and chocolate)

**Q: Did you rule out *motion sickness* as a cause of the plaintiff's nausea or abdominal distress?**

The plaintiff that is susceptible to motion sickness may experience anorexia, **nausea and vomiting** during or following transportation by most any moving vehicle. As the symptoms develop, the plaintiff may experience profound apathy, salivation, and sweating. (reference 2, p. 371)

**Q: Did you rule out *niacin deficiency (B complex)* as a cause of the plaintiff's nausea or abdominal distress?**

Niacin is one of the B complex vitamins essential for the normal carbohydrate metabolism of yeast cells and animal tissues. As the body's level of niacin decreases, the plaintiff may initially experience a burning tongue after eating hot or spicy foods. Symptoms are often more severe in the spring and fall and may be associated with mild anorexia, fatigue, nervousness, irritability, alternating periods of constipation and diarrhea, or **burning sensations in the epigastrium** (upper and middle abdomen). (reference 2, pp. 121-123)

**Q: Did you rule out a *neuroendocrine disorder*, such as *pheochromocytoma*, as a cause of the plaintiff's nausea or abdominal distress?**

Symptoms of a neuroendocrine disorder include sudden headaches, excessive sweating, and palpitations. Often there are associated tremors, weakness, **nausea, and epigastric discomfort**. The plaintiff may also complain of chest pain, shortness of breath, lightheadedness, blurred vision, and flushing. (reference 2, p. 612)

Pheochromocytoma is a tumor of the sympathetic nervous system which specifically causes headaches, lightheadedness, **nausea**, sweating, trembling, and elevated blood pressure during anxiety attacks. (reference 4, p. 1276)

*If the witness indicates the possibility of pheochromocytoma, see the section on pre-existing medical conditions for further questions.*

## SYMPTOM

## DEPOSITION QUESTIONS

**Nausea,  
Abdominal  
Distress**

(continued)

**Q: Did you rule out *muscle contraction headaches* as a cause of the plaintiff's nausea or abdominal distress?**

Chronic muscle contraction headaches may produce **nausea, vomiting**, lightheadedness, difficulty in falling asleep, restless sleep with frequent awakenings, loss of energy, impaired memory and concentration, and symptoms of depression. (reference 2, pp. 72-73; reference 4, p. 1204)

*If the witness indicates the possibility of muscle contraction headaches, see the section on pre-existing medical conditions for further questions.*

**Q: Did you rule out *alcohol withdrawal* as a cause of the plaintiff's nausea or abdominal distress?**

The reduction or cessation of drinking for at least several days may cause characteristic symptoms: coarse tremor of hands, tongue, or eyelids; **nausea or vomiting**; malaise or weakness; autonomic hyperactivity (tachycardia, sweating, and elevated blood pressure); anxiety, depressed mood or irritability; transient hallucinations or illusions; headache; insomnia; dizziness; fatigue; restlessness; and agitation. (reference 7, p. 212; reference 2, pp. 722, 618; reference 9, pp. 50-54)

**Q: (Female) Did you rule out *pregnancy* as a cause of the plaintiff's nausea or abdominal distress?**

**Nausea and vomiting** often occur in the first trimester. (reference 2, p. 370)

**Q: Did you rule out *opioid withdrawal* as a cause of the plaintiff's nausea or other abdominal distress?**

Symptoms of opioid withdrawal may include lacrimation (tearing), rhinorrhea (runny nose), dilated pupils, sweating, diarrhea, yawning, mild hypertension, tachycardia (increased heart rate), fever, insomnia, and gooseflesh. Associated features may include restlessness, irritability, depression, tremor, weakness, **nausea, vomiting**, and muscle or joint pain. These signs, often resembling influenza symptoms, may be precipitated by the abrupt ending of one or two weeks of continuous opioid use. The withdrawal symptoms may last days or weeks. During the final stages of withdrawal, the plaintiff may experience overconcern for bodily discomfort, poor self-image, and a decreased ability to tolerate stress. (reference 7, p. 272; reference 4, pp. 990-991)

**Q: Did you rule out a *somatization disorder (psychosomatic)* as a cause of the plaintiff's nausea or abdominal distress?**

The plaintiff with a somatization disorder has many physical complaints for several years. S/he sees multiple physicians only to discover no physical cause for the symptoms. The plaintiff often has exaggerated and vague complaints focusing on either organs or types of symptoms such as pseudoneurologic or conversion symptoms, **gastrointestinal**, female reproductive, psychosexual, pain, and

**SYMPTOM****DEPOSITION QUESTIONS**

**Nausea,  
Abdominal  
Distress**  
(continued)

cardiopulmonary symptoms. Anxiety, depression, suicide attempts, social withdrawal, and work or interpersonal relationship difficulties are common. (reference 7, p. 486; reference 4, pp. 389, 940)

*If the witness indicates the possibility of a somatization disorder, see the section on somatoform disorders for further questions.*

**Q: Did you rule out *amphetamine or similarly acting sympathomimetic drug consumption* as a cause of the plaintiff's nausea or abdominal distress?**

Symptoms of amphetamine or similarly acting sympathomimetic drug consumption may include fighting, grandiosity, elation, hypervigilance, psychomotor agitation, impaired judgment, and impaired social or occupational functioning. Physical symptoms may include flushing, difficulty breathing, tachycardia, pupil dilation, elevated blood pressure, sweating or chills, **nausea and vomiting**. (reference 4, pp. 1007-1008; reference 7, p. 223)

The following drugs may be classified as amphetamines:

|                                    |                            |
|------------------------------------|----------------------------|
| Appetite Suppressants (diet pills) | Methamphetamines (speed)   |
| Dextroamphetamines                 | Methylphenidates (Ritalin) |
| Ma-huang (ephedra)                 | (reference 17, p. 586)     |
| (reference 24, pp. 488-489)        |                            |

**Q: Did you rule out *sedative, hypnotic, or anxiolytic withdrawal* as a cause of the plaintiff's nausea or abdominal distress?**

Withdrawal symptoms develop when the plaintiff reduces or stops the prolonged moderate or heavy use of these substances. Symptoms may include **nausea or vomiting**; malaise or weakness; autonomic hyperactivity (such as tachycardia and sweating); anxiety or irritability; orthostatic hypotension; coarse tremor of the hands, tongue and eyelids; insomnia; and grand mal seizures. (reference 7, p. 284; reference 4, p. 1549)

**Q: Did you rule out *ecstasy use* as a cause for the plaintiff's nausea or abdominal distress?**

MDMA (methylenedioxymethamphetamine) use can sometimes result in severe dehydration or exhaustion, or other adverse effects such as **nausea**, hallucinations, chills, sweating, increases in body temperature, tremors, involuntary teeth clenching, muscle cramping, and blurred vision. MDMA users have also reported after-effects such as anxiety, paranoia, and depression. An MDMA overdose is characterized by high blood pressure, faintness, panic attacks, and, in more severe cases, loss of consciousness, seizures, and a drastic rise in body temperatures to 105-106 degrees Fahrenheit. MDMA overdoses can be fatal, as they may result in heart failure or extreme heat stroke. (reference 20)

## SYMPTOM

## DEPOSITION QUESTIONS

**Nausea,  
Abdominal  
Distress**

(continued)

**Q: Did you rule out *cocaine consumption* as a cause of the plaintiff's nausea or abdominal distress?**

Cocaine users often experience increased energy and confidence or irritability and paranoia with physical aggressiveness. Other behavioral symptoms may include euphoria, hypervigilance, psychomotor agitation, impaired judgment, and impaired social or occupational functioning. Physical symptoms may include tachycardia, dilated pupils, elevated blood pressure, perspiration or chills, **nausea, vomiting**, and hallucinations. (reference 7, p. 241; reference 4, pp. 1008-1009)

**Q: Did you rule out *caffeine consumption* as a cause of the plaintiff's nausea or abdominal distress?**

Characteristic symptoms of caffeine intoxication include restlessness, nervousness, excitement, insomnia, flushed face, diuresis, **gastrointestinal disturbance**, muscle twitching, rambling flow of thought and speech, tachycardia or cardiac arrhythmia, periods of in exhaustibility, and psychomotor agitation. When consumed near bedtime, caffeine often disrupts sleep. Symptoms may appear when the plaintiff consumes as little as 250 mg of caffeine per day. The plaintiff that consumes one gram per day usually experiences more severe symptoms. Products which contain caffeine include: coffee, tea, soda, chocolate and weight-loss aids. (reference 7, pp. 231-234; reference 4, p. 1029)

*If the witness indicates the possibility of excess caffeine consumption, see the caffeine consumption chart in Appendix A.*

**Q: Did you rule out *porphyria* as a cause of the plaintiff's nausea or abdominal distress?**

Porphyria is an inherited disorder of young and middle-aged adults. It is characterized by episodes of **abdominal pain**, peripheral neuropathy, weakness, anorexia, **nausea, vomiting**, tachycardia, fever, confusion, depression, and severe anxiety. Mood swings and mental abnormalities are common symptoms. (reference 4, pp. 121, 1276, 1326; reference 9, p. 1156; reference 1, pp. 958, 960)

*If the witness indicates the possibility of porphyria, see the section on pre-existing medical conditions for further questions.*

**Q: Did you rule out *lithium use* as a cause of the plaintiff's nausea or abdominal distress?**

Lithium and the tricyclics are often given as medication for depression. Tremor is one of the most common side effects. Other symptoms may include **nausea**, diarrhea, polyuria (the passage of an excessive quantity of urine), polydipsia (excessive thirst), and weight gain. Toxic effects may include gross tremor, increased deep tendon reflexes, persistent headaches, **vomiting**, mental confusion progressing to stupor, seizures, or cardiac arrhythmias. (reference 1, pp. 1460-1461)

*SYMPTOM*

*DEPOSITION QUESTIONS*

**Nausea,  
Abdominal  
Distress**  
(continued)

**Q: Did you rule out *masked depression* as a cause of the plaintiff's nausea or abdominal distress?**

The plaintiff with masked depression hides a dysphoric mood with **gastrointestinal problems**, chronic pain, insomnia, weight loss, and other physical complaints. Masked depression is a common condition frequently missed by physicians. (reference 4, p. 796)

**Q: Did you rule out a *childhood separation anxiety disorder* as a cause of the plaintiff's nausea or abdominal distress?**

A childhood separation anxiety disorder begins before the age of eighteen. For many years after the disorder's onset, the adult plaintiff may experience recurrences of the excessive anxiety when separated from significant people or familiar places. Associated symptoms include excessive worry about possible harm to loved ones, avoidance of being alone, nightmares, temper outbursts or uneasy tension, sweating hands, headaches, **stomachaches, nausea and vomiting**. (reference 7, p. 121; reference 4, pp. 887, 1747-1750; reference 1, p. 1864)

*Defense counsel should obtain the plaintiff's early school and health records to look for evidence of this disorder.*

**Q: Did you rule out *pancreatic carcinoma* as a cause of the plaintiff's nausea or abdominal distress?**

Pancreatic carcinoma is a cancer of the pancreas that causes a decrease in enzymes, lipids, glucagens, and insulin. Symptoms may include **abdominal pain** radiating to the back, weight loss, anorexia, weakness, **diarrhea, vomiting**, depression, irritability, and a sense of doom without guilt. (reference 1, p. 751; reference 4, p. 1276; reference 9, pp. 777-779; reference 2, p. 425)

*If the witness indicates the possibility of pancreatic carcinoma, see the section on pre-existing medical conditions for further questions.*

**Q: Did you rule out *infections* as a cause of the plaintiff's nausea or abdominal distress, such as:**

|                                  |                                 |
|----------------------------------|---------------------------------|
| Brucellosis                      | Meningitis                      |
| Chronic urinary tract infections | Subacute bacterial endocarditis |
| Infectious mononucleosis         | Syphilis                        |
| Influenza                        | Tuberculosis                    |
| Malaria                          | Viral hepatitis                 |

**Q: Does the plaintiff have any other *medical conditions* that may also cause nausea or abdominal distress, such as:**

|                           |                                  |
|---------------------------|----------------------------------|
| Abdominal lymphadenopathy | Angle-closure glaucoma           |
| Acute appendicitis        | Cholecystitis                    |
| Acute gastroenteritis     | Diabetic ketoacidosis            |
| Acute pyelonephritis      | Enzyme deficiency                |
| After vagotomy            | Febrile infectious disease       |
| Alcoholic hepatitis       | Gastrointestinal tract disorders |

## Panic Attacks and Panic Disorder

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**SYMPTOM**

**DEPOSITION QUESTIONS**

---

**Nausea,  
Abdominal  
Distress**

(continued)

|  |  |
|--|--|
| Hyperparathyroidism                                  | Neurasthenia   |
| Incomplete bowel obstruction                         | Neuromuscular disorders                                |
| Inflammation of the bowel                            | Niacin deficiency                                      |
| Intestinal flu                                       | Peptic ulcer   |
| Intra-abdominal disorders                            | Pneumococcal pneumonia                                 |
| Irritable bowel syndrome                             | Pseudotumor cerebri (benign intracranial hypertension) |
| Local otitic infection                               | Regional enteritis                                     |
| Malabsorption of fats, carbohydrates, or water       | Salmonellosis  |
| Mechanical obstruction of the gastrointestinal tract | Traveler's diarrhea                                    |
| Meniere's disease                                    | Ulcerative colitis                                     |
|  | Uremia   |

---

**Q: Is the plaintiff taking any medications or substances that may cause nausea, or abdominal distress, such as:**

|              |                      |                 |
|--------------|----------------------|-----------------|
| ACCOLATE     | ATROVENT             | CECLOR          |
| ACCUPRIL     | AUGMENTIN            | CEFTIN          |
| ACROMYCIN-V  | AVAPRO               | CEFZIL          |
| ADALAT       | AVONEX               | CELEBREX        |
| ADAPIN       | AXOCET               | CELESTON        |
| AEROBID      | AZULFIDINE           | CELEXA          |
| AKINETONE    | BACTRIM              | CELONTIN        |
| ALDACTAZIDE  | BACTROBAN            | CHLORAL-HYDRATE |
| ALDOMET      | BECONASE             | CHLORTRIMETON   |
| ALDORIL      | BENADRYL             | CILOXIN         |
| ALLEGRA      | BENTYL               | CIPRO           |
| ALTACE       | BETHANECHOL-CHLORIDE | CLARITAN-D      |
| ALUPENT      | BIAXIN               | CLARITIN        |
| AMBIEN       | BRETHINE             | CLEOCIN         |
| AMCILL       | BRICANYL             | CLIMARA         |
| AMERGE       | BROMFED              | CLINDEX         |
| AMOXYCILLIN  | BRONTEX              | CLINORIL        |
| AMOXIL       | BUMEX                | CLOMID          |
| AMPHETAMINES | BUPRENEX             | CLOXACILLIN     |
| AMPICILLIN   | BUSPAR               | CLOZARIL        |
| AMYTAL       | BUTAZOLIDIN          | CODEINE         |
| ANAFRANIL    | BUTICAPS             | COGENTIN        |
| ANAPROX      | CAFERGOT             | COGNEX          |
| ANSAID       | CAFERGOT-PB          | COLBENAMID      |
| ANTABUSE     | CALAN                | COLESTID        |
| ANTIVERT     | CARAFATE             | COMBIPRES       |
| APRESOLINE   | CARAFATE-TOO         | COMBIVENT       |
| ARICEPT      | CARBATROL            | COMPAZINE       |
| ARTANE       | CARDENE              | CONCERTA        |
| ARTHROTEC    | CATAPRES             | CORGARD         |
| ASENDIN      | CAVERJECT            | CORTISONE       |
| ATIVAN       |                      | COUMADIN        |

## Panic Attacks and Panic Disorder

*SYMPTOM*

*DEPOSITION QUESTIONS*

**Nausea,  
Abdominal  
Distress**  
*(continued)*

|                 |                  |                 |
|-----------------|------------------|-----------------|
| COZAAR          | E-MYCIN          | HISTUSSIN       |
| CRINONE         | ECOTRIN          | HYDERGINE       |
| CYCRIN          | EDECIN           | HYDRO-          |
| CYLERT          | EES              | CHLOROTHIAZIDE  |
| CYTOTEC         | EFFEXOR          | HYDRODIURIL     |
| DALALONE        | ELAVIL           | HYGROTON        |
| DALMANE         | ELDEPRYL         | HYTRIN          |
| DANTRIUM        | EMPIRIN-CODEINE  | HYZAAR          |
| DARVOCET-N      | ENDEP            | ILOSONE         |
| DARVON-COMPOUND | ENDURON          | IMDUR           |
| DAYPRO          | ENTEXLA          | IMMODIUM        |
| DECADRON        | EQUAGESIC        | INAPSINE        |
| DELTASONE       | EQUANIL          | INDERAL         |
| DEMADEX         | ERGOMAR          | INDERIDE        |
| DEMEROL         | ERYC             | INDOCIN         |
| DEPAKENE        | ERYTHOMYCIN      | INTROPIN        |
| DEPAKOTE        | ESGIC            | ISORDIL         |
| DEPO-MEDROL     | ESIDRIX          | K-DUR           |
| DEPO-PROVERA    | ESKALITH         | K-LYTE          |
| DEPROL          | ESTRACE          | K-TAB           |
| DESOGEN         | ESTRATAB         | KEFLEX          |
| DESOXYN         | ESTRATEST        | KEFZOL          |
| DESYREL         | ESTROGEN PATCH   | KERLONE         |
| DETROL          | ETRAFON          | KLONOPIN        |
| DIABETA         | EXCELON          | KLOTRIX         |
| DIABINESE       | FAMVIR           | LAMISIL         |
| DIAMOX          | FELBATOL         | LANOXIN         |
| DIFLUCAN        | FELDENE          | LASIX           |
| DILACOR         | FIORICET         | LESCOL          |
| DILANTIN        | FIORINAL         | LEVAQUIN        |
| DILAUDID        | FIORINAL-CODEINE | LEVO-DROMORAM   |
| DIMETANE        | FLAGYL           | LEVOTHROID      |
| DIMETAPP        | FLOMAX           | LEVSIN          |
| DIOVAN          | FLOXIN           | LIBRAX          |
| DIPYRIDAMOLE    | FLOVENT          | LIBRIUM         |
| DITROPAN        | FLOXIN           | LIMBITROL       |
| DIURIL          | FORTAZ           | LIORESAL        |
| DOLOBID         | FOSAMAX          | LIPITOR         |
| DONNATAL        | GABITRIL         | LITHIUM-CITRATE |
| DORAL           | GLUCOPHAGE       | LO/OVRAL        |
| DULCOLAX        | GLUCOTROL        | LODINE          |
| DURACT          | GUAIFED          | LOMOTIL         |
| DURAGESIC       | GYNE-LOTRIMIN    | LOPID           |
| DURAVENT        | GYNERGEN         | LOPRESSOR       |
| DURICEF         | HABITROL         | LORABID         |
| DYAZIDE         | HALCION          | LORCET          |
| DYNACIRC        | HALDOL           | LOTENSIN        |

*SYMPTOM**DEPOSITION QUESTIONS***Nausea,  
Abdominal  
Distress***(continued)*

|                             |                 |                          |
|-----------------------------|-----------------|--------------------------|
| LOTREL                      | NASACORT        | PERMAX                   |
| LOVENOX                     | NASONEX         | PERMITIL                 |
| LOZOL                       | NAVANE          | PERSANTINE               |
| LUDIOMIL                    | NEMBUTAL        | PHENAPHEN-CODEINE        |
| LUFYLLIN-GG                 | NEURONTIN       | PHENERGAN                |
| LUVOX                       | NICORETTE       | PHENERGAN-VC-<br>CODEINE |
| MACROBID                    | NITRO-BID       | PHENOBARBITAL            |
| MACRODANTIN                 | NITRO-DUR       | PLACIDYL                 |
| MARCAINE                    | NITROSTAT       | PLAQUENIL                |
| MAVIK                       | NIZORAL         | PLENDIL                  |
| MAXAIR-AUTOHALER            | NOLUDAR         | POLARIMINE               |
| MAXALT                      | NOLVADEX        | POLYCILLIN               |
| MAXIDE                      | NORCO           | POLYMOX                  |
| MEBARAL                     | NORDETTE        | PONDIMIN                 |
| MECLIZINE                   | NORFLEX         | PRAVACHOL                |
| MECLOMEN                    | NORGESIC        | PRECOSE                  |
| MEDROL                      | NORINYL         | PREMARIN                 |
| MEGACE                      | NOROXIN         | PREMPHASE                |
| MELLARIL                    | NORPACE         | PREMPRO                  |
| MEPERGAN                    | NORPLANT-SYSTEM | PRILOSEC                 |
| MESANTOIN                   | NORPRAMIN       | PRIMAXIN                 |
| METHADONE-<br>HYDROCHLORIDE | NORVASC         | PRIMAXIN-IV              |
| METHERGIE                   | NUBAIN          | PRINIVIL                 |
| METHOTREXATE                | NYSTANTIN       | PRINZIDE                 |
| METRONIDAZOLE               | OGEN            | PROAMATINE               |
| MEVACOR                     | OMNICEF         | PROCAN-SR                |
| MEXITIL                     | OPTIMINE        | PROCARDIA                |
| MICRO-K                     | ORAP            | PROKETAZINE              |
| MICRONASW                   | ORINASE         | PROLIXIN                 |
| MICRONOR                    | ORTHO-NOVUM     | PROPULSID                |
| MILONTIN                    | ORTHO-CEPT      | PROSOM                   |
| MINIPRESS                   | ORTHOCYCLEN     | PROTONIX                 |
| MINOCIN                     | ORTHOEST        | PROVENTIL                |
| MIRAPEX                     | OXYCONTIN       | PROVERA                  |
| MOBAN                       | PAMELOR         | PULMICORT                |
| MOBIC                       | PARLODEL        | QUESTRAN                 |
| MODURETIC                   | PARNATE         | QUINAMM                  |
| MONOPRIL                    | PATANOL         | REGLAN                   |
| MORPHINE-SULFATE            | PAXIPAM         | RELAFEN                  |
| MOTRIN                      | PBZ-SR          | REMERON                  |
| MYCELEX TROCHES             | PEDIAZOLE       | REVIA                    |
| MYCOSTATIN                  | PENICILLIN-VK   | REZULIN                  |
| MYSOLINE                    | PEPCID          | RIFAMATE                 |
| NALDECON                    | PERCOCET        | RISPERDAL                |
| NALFON                      | PERCODAN        | RITALIN                  |
| NAPROSYN                    | PERI-COLACE     | ROBAXIN                  |
|                             | PERIACTIN       |                          |

## Panic Attacks and Panic Disorder

*SYMPTOM*

*DEPOSITION QUESTIONS*

**Nausea,  
Abdominal  
Distress**  
*(continued)*

|                 |                 |               |
|-----------------|-----------------|---------------|
| ROBAXISAL       | TALWIN-NX       | URECHOLINE    |
| ROCALTROL       | TAVIST          | V-CILLIN-K    |
| RONDEC-DM       | TEGRETOL        | VALIUM        |
| ROXICET         | TEMARIL         | VANCENASE     |
| RUFEN           | TENORETIC       | VANCOCIN-HCL  |
| SALFLEX         | TENORMIN        | VANTIN        |
| SANOREX         | TESSALON        | VASOTEC       |
| SANSERT         | TESTODERM       | VENTOLIN      |
| SE-AP-ES        | TETRACYCLINE    | VERELAN       |
| SECONAL-SODIUM  | THEO-DUR        | VESPRIN       |
| SELDANE         | THORAZINE       | VIAGRA        |
| SEPTRA          | TIAZAC          | VIBRAMYCIN    |
| SERAX           | TICLID          | VICODIN       |
| SERENTIL        | TIGAN           | VICOPROFEN    |
| SEREVENT        | TIMENTIN        | VIOXX         |
| SEROQUEL        | TIMOPTIC        | VISTARIL-     |
| SERTRALINE      | TINDAL          | INTRAMUSCULAR |
| SERZONE         | TOFRANIL        | VIVACTIL      |
| SINEMET         | TOLECTIN        | VOLTAREN      |
| SINEQUAN        | TOLINASE        | WELLBUTRIN    |
| SKELAXIN        | TOPROL-XL       | WIGRAINE      |
| SLO-BID         | TORADOL         | WYGESIC       |
| SLO-PHYLLIN     | TORECAN         | XANAX         |
| SLOW-K          | TRANCOPAL       | YOCON         |
| SOLU-MEDROL     | TRANDATE        | ZANTAC        |
| SOMA            | TRANSDERM-NITRO | ZARONTIN      |
| SOMA-COMPOUND   | TRANSDERM-SCOP  | ZAROXOLY      |
| SONATA          | TRIAVIL         | ZEPHREX       |
| SORBITRATE      | TRILAFON        | ZESTORETIC    |
| SPORANOX        | TRILEPTAL       | ZESTRIL       |
| ST. JOHN'S WORT | TRILISATE       | ZIAC          |
| STADOL          | TRIMPEX         | ZITHROMAX     |
| STELAZINE       | TRINALIN        | ZOFRAN        |
| SUDAFED         | TRIPHASIL       | ZOLOFT        |
| SULINDAC        | TROVAN          | ZOMIG         |
| SUMYCIN         | TUINAL          | ZOVIRAX       |
| SUPRAX          | TUSSI-ORGANIDIN | ZYLOPRIM      |
| SURMONTIL       | TYLENOL-CODEINE | ZYPREXA       |
| SYMMETREL       | TYLOX           | ZYRTEC        |
| SYNALGOS-DC     | ULTRAM          |               |
| TALECEN         | UNIVASC         |               |

**SYMPTOM**

**DEPOSITION QUESTIONS**

**Dizziness,  
Unsteady  
Feelings,  
Faintness**

**Q:** Describe the plaintiff's dizziness, unsteady feelings, or faintness.

**Q:** When and how often does the plaintiff experience dizziness, unsteady feelings, or faintness?

**Q:** Does the plaintiff have a history of dizziness, unsteady feelings, or faintness before the injury in question?

There are a number of hereditary or familial labyrinthine degenerative diseases of the ear in which **vertigo** (sensation or illusion of motion) occurs. (reference 2, p. 718)

**Q:** Does the plaintiff have a history of any *medical conditions* that may cause dizziness, unsteady feelings, or faintness?

*If the witness indicates the possibility of the following medical conditions, see the section on pre-existing medical conditions for further questions.*

**TABLE 5.5-8.**

|              |                    |
|--------------|--------------------|
| Hypertension | Meningitis         |
| Hypoglycemia | Multiple sclerosis |
| Hypotension  | Polycythemia       |

**Q:** Did you rule out *stressors or other conditions not attributable to a mental disorder* as a cause of the plaintiff's dizziness, unsteady feelings, or faintness?

*If the witness indicates the possibility of a life stressor or other condition, see the section on other life-stressors for further questions.*

**Q:** Did you rule out a *labyrinthine or vestibular disease* as a cause of the plaintiff's dizziness, unsteady feelings, or faintness?

There are a number of labyrinthine or vestibular diseases of the ear in which **vertigo** occurs. (reference 2, p. 718)

**Q:** Did you rule out a *physically stressful schedule* as a cause of the plaintiff's dizziness, unsteady feelings, or faintness?

Heart pounding, palpitations, and tachycardia are often associated with indigestion, overexertion, a specific emotion, or fatigue. Other symptoms may include fullness in the neck, shortness of breath, nervousness, **dizziness**, and apprehension. (reference 2, pp. 302, 304)

**Caution:** Do not ask the following question if the cause of action involves a head injury or toxic exposure.

**Q:** Did you rule out any *head injuries or other conditions leading to organic brain syndrome* as a cause of the plaintiff's dizziness, unsteady feelings, or faintness?

Organic brain syndrome is a term for the symptoms produced by head injury, toxic exposure, hypoxia (oxygen deficiency), anoxia (extreme oxygen deficiency) in

## SYMPTOM

## DEPOSITION QUESTIONS

**Dizziness,  
Unsteady  
Feelings,  
Faintness***(continued)*

tissues) or other causes. Common symptoms of head injuries include **vertigo**, **syncope (faint)**, **lightheadedness**, impaired concentration and memory, easy fatigability, irritability, lack of energy, depression, anxiety, phobia, a lowered tolerance for alcohol, and headaches. Symptoms may appear days or weeks after the injury but usually appear within 24 hours. (reference 2, pp. 75, 111)

**Q: Did you rule out *hyperventilation* as a cause of the plaintiff's dizziness, unsteady feelings, or faintness?**

Hyperventilation is abnormal, rapid, deep breathing usually due to anxiety. Exercise and strong emotion causes hyperventilation or it can begin spontaneously. Symptoms may include **lightheadedness**, **faintness**, ringing in the ears, weakness, blurring of vision, and tingling around the mouth or in the extremities. (reference 2, p. 613)

**Q: Did you rule out an *adjustment disorder with anxiety* as a cause of the plaintiff's dizziness, unsteady feelings, or faintness?**

An adjustment disorder is a transient over-reaction to stress that usually occurs within 90 days and remits within six months. The adjustment disorder with anxiety is characterized by symptoms of nervousness, worry, jitteriness, and motor tension. **Dizziness** may be a part of the anxiety symptoms. (reference 7, p. 679; reference 4, pp. 1098-1099)

*If the witness indicates the possibility of an adjustment disorder, see the section on adjustment disorder for further questions.*

**Q: Did you rule out a *neuroendocrine disorder, such as pheochromocytoma*, as a cause of the plaintiff's dizziness, unsteady feelings, or faintness?**

Symptoms of a neuroendocrine disorder include sudden headaches, excessive sweating, and palpitations. Often there are associated tremors, weakness, nausea, and epigastric discomfort. The plaintiff may also complain of chest pain, shortness of breath, **lightheadedness**, blurred vision, and flushing. (reference 2, p. 612)

Pheochromocytoma is a tumor of the sympathetic nervous system which specifically causes headaches, **lightheadedness**, nausea, sweating, trembling, and elevated blood pressure during anxiety attacks. (reference 4, p. 1276)

*If the witness indicates the possibility of pheochromocytoma, see the section on pre-existing medical conditions for further questions.*

**Q: Did you rule out *malinger* as a cause of the plaintiff's dizziness, unsteady feelings, or faintness?**

Malingering may be associated with attempts to avoid work or evade legal responsibilities. Plaintiff complaints may include **vertigo** (illusion of movement), weakness, loss of consciousness, seizures, headaches, visual impairment, and loss of skin sensation. (reference 4, p. 1863)

*If the witness indicates the possibility of malingering, see the section on malingering for further questions.*

## SYMPTOM

## DEPOSITION QUESTIONS

**Dizziness,  
Unsteady  
Feelings,  
Faintness**  
(continued)

**Q: Did you rule out *Meniere's syndrome* as a cause of the plaintiff's dizziness, unsteady feelings, or faintness?**

Meniere's syndrome is sometimes confused with acute anxiety. The most common symptom is **dizziness**. Associated symptoms include nystagmus (tremulous movement of the eyeballs), deafness, and other signs of middle-ear disease. (reference 4, p. 893)

**Q: Did you rule out *anemia* as a cause of the plaintiff's dizziness, unsteady feelings, or faintness?**

**Vertigo**, pounding headaches, **fainting**, dimness of vision, tinnitus (a ringing in one or both ears), irritability, restlessness, inability to concentrate, lethargy, fatigue, drowsiness, GI complaints, are common symptoms of anemia. (reference 2, pp. 566-571)

*If the witness indicates the possibility of an anemia, see the section on medical conditions for further questions.*

**Q: Did you rule out *alcohol consumption or withdrawal* as a cause of the plaintiff's dizziness, unsteady feelings, or faintness?**

*Alcohol intoxication* may cause aggressiveness, impaired judgment and attention, irritability, euphoria, depression, emotional lability, and impaired social or occupational functioning. Physical symptoms may include slurred speech, incoordination, unsteady gait, nystagmus, **occasional dizziness**, and flushed face. Heavy alcohol consumption may cause abnormal sleep patterns. The plaintiff often falls asleep quickly but wakes up earlier and earlier with uncomfortable feelings. Chronic alcoholics may have irregular, unsteady, and slow tremulous movements. (reference 7, p. 212; reference 4, p. 67; reference 9, p. 52)

The *reduction or cessation* of drinking for at least several days may cause characteristic symptoms: coarse tremor of hands, tongue, or eyelids; nausea or vomiting; malaise or weakness; autonomic hyperactivity (tachycardia, sweating, and elevated blood pressure); anxiety, depressed mood or irritability; transient hallucinations or illusions; headache; insomnia; **dizziness**; fatigue; restlessness; and agitation. (reference 7, p. 215; reference 2, pp. 722, 618; reference 9, pp. 50-54)

**Q: Did you rule out a *somatization disorder* (psychosomatic) as a cause of the plaintiff's dizziness, unsteady feelings, or faintness?**

The plaintiff with a somatization disorder has many physical complaints for several years. S/he sees multiple physicians only to discover no physical cause for the symptoms. The plaintiff often has exaggerated and vague complaints focusing on either organs or types of symptoms such as **pseudoneurologic** or conversion symptoms, gastrointestinal, female reproductive, psychosexual, pain, and cardiopulmonary symptoms. Anxiety, depression, suicide attempts, social withdrawal, and work or interpersonal relationship difficulties are common. (reference 7, p. 485; reference 4, pp. 389, 940)

*If the witness indicates the possibility of a somatization disorder, see the section on somatoform disorders for further questions.*

## SYMPTOM

## DEPOSITION QUESTIONS

**Dizziness,  
Unsteady  
Feelings,  
Faintness***(continued)***Q: Did you rule out *inhalant intoxication* as a cause of the plaintiff's dizziness, unsteady feelings, or faintness?**

Following inhalant (toxic substance) use, the plaintiff may experience behavioral and physical changes. Behavioral changes may include belligerence, assaultiveness, apathy, impaired judgment, and impaired social or occupational functioning. Physical signs may include **dizziness**, nystagmus, slurred speech, unsteady gait, lethargy, depressed reflexes, tremor, psychomotor weakness, blurred vision or diplopia, stupor or coma, and euphoria. (reference 7, p. 259)

**Q: (Female) Did you rule out *menopause* as a cause of the plaintiff's dizziness, unsteady feelings, or faintness?**

Menopausal distress may cause anxiety, fatigue, GI disturbances, urinary frequency, back pain, palpitations, tension, emotional lability, irritability and nervousness, depression, **dizziness**, insomnia, and hot flashes. (reference 4, p. 1173; reference 9, p. 21)

*If the witness indicates the possibility of menopausal distress, see the section on medical conditions for further questions.*

**Q: Did you rule out a *brain tumor* as a cause of the plaintiff's dizziness, unsteady feelings, or faintness?**

Brain tumors occur in the skull, brain, or membrane covering the brain or spinal cord. Symptoms vary depending on the size of the tumor and rate of growth. The plaintiff may experience anxiety, dementia, irritability, **dizziness**, fatigue, headache, vomiting, hyperthermia (high body temperature), and changes in appetite and personality. (reference 4, pp. 139, 834-835, 855, 860, 1276; reference 9, pp. 2161-2164; reference 1, pp. 1351, 1296)

*If the witness indicates the possibility of a brain tumor, see the section on medical conditions for further questions.*

**Q: Did you rule out a *depersonalization disorder* (or *depersonalization neurosis*) as a cause of the plaintiff's dizziness, unsteady feelings, or faintness?**

The plaintiff with this disorder has very stressful recurrences of depersonalization. S/he may feel detached from mind, body and reality. Associated symptoms may include **dizziness**, depression, obsessive rumination, somatic concerns, anxiety, fear of going insane, and difficulty with a sense of time and recall. (reference 7, p. 530)

**Q: Did you rule out an *adjustment disorder* as a cause of the plaintiff's dizziness, unsteady feelings, or faintness?**

An adjustment disorder is a transient over-reaction to stress that usually occurs within 90 days and remits within six months. The adjustment disorder with physical complaints is characterized by symptoms of **faintness**, fatigue, headache, backache, or other aches and pains. This condition is diagnosed as adjustment disorder unspecified. (reference 7, p. 679)

*If the witness indicates the possibility of an adjustment disorder, see the section on adjustment disorder for further questions.*

*SYMPTOM*

*DEPOSITION QUESTIONS*

**Dizziness,  
Unsteady  
Feelings,  
Faintness**  
*(continued)*

**Q: Did you rule out *hypochondriasis* as a cause of the plaintiff's dizziness, unsteady feelings, or faintness?**

The hypochondriac fears or believes that s/he has a serious disease based on their own interpretation of physical symptoms. Medical evaluations do not support the fears of disease. The plaintiff is preoccupied with bodily functions such as heartbeat, sweating, peristalsis, minor physical abnormalities, or a specific organ such as the heart. Headaches, **dizziness**, and fatigue are common complaints. (reference 7, p. 504; reference 4, p.1204)

*If the witness indicates the possibility of hypochondriasis, see the section on hypochondriasis for further questions.*

**Q: Did you rule out *infections* as a cause of the plaintiff's dizziness, unsteady feelings, or faintness?**

|                                  |                                 |
|----------------------------------|---------------------------------|
| Brucellosis                      | Meningitis                      |
| Chronic urinary tract infections | Subacute bacterial endocarditis |
| Infectious mononucleosis         | Syphilis                        |
| Influenza                        | Tuberculosis                    |
| Malaria                          | Viral hepatitis                 |

**Q: Does the plaintiff have any other *medical conditions* that may cause dizziness, unsteady feelings, or faintness, such as:**

|                                 |                                    |
|---------------------------------|------------------------------------|
| Brain stem vascular disease     | Nutritional diseases               |
| Cerebellar-pontine-angle lesion | Occular dizziness                  |
| Cervical spine disturbances     | Pseudotumor cerebri                |
| Demyelinative diseases          | (benign intracranial hypertension) |
| Friedreich's ataxia             | Tumors of the vestibular nerve     |
| Infectious diseases             | Vestibular neuritis                |
| Neoplastic diseases             | (epidemic vestibular neuritis)     |

*Diseases of the ear that may cause dizziness or unsteady feelings:*

|  |                              |
|--|------------------------------|
| <b><i>External Ear:</i></b>            | <b><i>Labyrinth:</i></b>     |
| Acoustic trauma                        | Congenital syphilis          |
| Cerumen or foreign bodies in the canal | Fistula                      |
| Otitis externa                         | German measles               |
| Temporomandibular joint syndrome       | Granuloma                    |
| Tympanic perforation                   | Herpes zoster oticus         |
|  | Herpes simplex               |
| <b><i>Middle Ear:</i></b>              | Meniere's disease            |
| Carcinoma                              | Mumps                        |
| Chronic or acute infections            | Otosclerosis                 |
| Eustachian tube malfunction            | Paget's disease              |
| Glomus tumor                           | Trauma by middle ear surgery |
| Infection                              |                              |

*SYMPTOM*

*DEPOSITION QUESTIONS*

**Dizziness,  
Unsteady  
Feelings,  
Faintness**  
*(continued)*

**Q:** Is the plaintiff taking any *medications or substances* that may cause dizziness, unsteady feelings, or faintness, such as:

- |              |                 |                  |
|--------------|-----------------|------------------|
| ACCOLATE     | CARDURA         | DILANTIN         |
| ACCUPRIL     | CEFTIN          | DILAUDID         |
| ACCUTANE     | CEFZIL          | DIMETANE         |
| ADALAT       | CELEBREX        | DIMETAPP         |
| ADAPIN       | CELEXA          | DIOVAN           |
| ADDERALL     | CELONTIN        | DIPYRIDAMOLE     |
| ADIPEX       | CENTRAX         | DITROPAN         |
| AEROBID      | CHLORAL-HYDRATE | DIURIL           |
| ALDACTAZIDE  | CHLORTRIMETON   | DOLOBID          |
| ALDOMET      | CIPRO           | DONNATAL         |
| ALDORIL      | CLARITAN-D      | DORAL            |
| ALTACE       | CLARITIN        | DURACT           |
| AMBIEN       | CLIMARA         | DURAGESIC        |
| AMERGE       | CLINORIL        | DYAZIDE          |
| AMYTAL       | CLOZARIL        | DYNACIRC         |
| ANAFRANIL    | CODEINE         | EFFEXOR          |
| ANAPROX      | COGNEX          | ELAVIL           |
| ANSAID       | COLBENAMID      | EMPIRIN-CODEINE  |
| ANTIVERT     | COLESTID        | ENDEP            |
| APRESOLINE   | COMBIPRES       | ENDURON          |
| ARICEPT      | COMBIVENT       | EQUAGESIC        |
| ARTANE       | COMPAZINE       | EQUANIL          |
| ARTHROTEC    | CONCERTA        | ESGIC            |
| ASENDIN      | CORGARD         | ESIDRIX          |
| ATIVAN       | COUMADIN        | ESKALITH         |
| ATROVENT     | COZAAR          | ESTRACE          |
| AUGMENTIN    | CYCRIN          | ESTRATAB         |
| AVAPRO       | CYLERT          | ESTRATEST        |
| AVONEX       | DALMANE         | ESTROGEN PATCH   |
| AXID         | DANTRIUM        | ETRAFON          |
| AXOCET       | DARVOCET-N      | EXCELON          |
| BACTROBAN    | DARVON-COMPOUND | FAMVIR           |
| BENADRYL     | DECADRON        | FASTIN           |
| BIPHETAMINE  | DELTASONE       | FELDENE          |
| BRICANYL     | DEMADEX         | FIORICET         |
| BRONTEX      | DEMEROL         | FIORINAL         |
| BUMEX        | DEPAKENE        | FIORINAL-CODEINE |
| BUPRENEX     | DEPAKOTE        | FLAGYL           |
| BUSPAR       | DEPO-PROVERA    | FLEXERIL         |
| BUTICAPS     | DEPROL          | FLOMAX           |
| CALAN        | DESOGEN         | FLONASE          |
| CARAFATE     | DESOXYN         | FLOVENT          |
| CARAFATE-TOO | DESYREL         | FLOXIN           |
| CARBATROL    | DETROL          | FORTAZ           |
| CARDENE      | DEXEDRINE       | FOSAMAX          |

**SYMPTOM****DEPOSITION QUESTIONS****Dizziness,  
Unsteady  
Feelings,  
Faintness***(continued)*

|                          |                             |                   |
|--------------------------|-----------------------------|-------------------|
| GABITRIL                 | LOZOL                       | NORGESIC          |
| GLUCOTROL                | LUDIOMIL                    | NORINYL           |
| GUAIFED                  | LUVOX                       | NOROXIN           |
| HABITROL                 | MACROBID                    | NORPACE           |
| HALCION                  | MACRODANTIN                 | NORPLANT-SYSTEM   |
| HISTUSSIN                | MARCAINE                    | NORPRAMIN         |
| HYDERGINE                | MARPLAN                     | NORVASC           |
| HYDRO-<br>CHLOROTHIAZIDE | MAVIK                       | NUBAIN            |
| HYDRODIURIL              | MAXAIR-AUTOHALER            | OCUFLOX           |
| HYGROTON                 | MAXALT                      | OGEN              |
| HYTRIN                   | MAXIDE                      | OMNICEF           |
| HYZAAR                   | MEBARAL                     | OPTIMINE          |
| IMDUR                    | MECLIZINE                   | ORAP              |
| IMITREX                  | MECLOMEN                    | ORNADE            |
| IMITREX-TABLETS          | MEPERGAN                    | ORTH-NOVUM        |
| IMMODIUM                 | MESANTOIN                   | ORTHO-CEPT        |
| INAPSINE                 | METHADONE-<br>HYDROCHLORIDE | ORTHO CYCLEN      |
| INDERIDE                 | METHERGIE                   | ORTHOEST          |
| INDOCIN                  | METHOTREXATE                | ORUDIS            |
| IONAMIN                  | MEVACOR                     | OXYCONTIN         |
| ISORDIL                  | MEXITIL                     | PAMELOR           |
| KEFLEX                   | MICRONOR                    | PARAFON-FORTE     |
| KEFTAB                   | MIDRIN                      | PARLODEL          |
| KERLONE                  | MILONTIN                    | PARNATE           |
| LAMICTAL                 | MINIPRESS                   | PAXIPAM           |
| LASIX                    | MIRAPEX                     | PBZ-SR            |
| LESCOL                   | MOBIC                       | PEPCID            |
| LEVAQUIN                 | MODURETIC                   | PERCOCET          |
| LEVO-DROMORAM            | MONOPRIL                    | PERCODAN          |
| LEVSIN                   | MORPHINE-SULFATE            | PERIACTIN         |
| LIBRAX                   | MOTRIN                      | PERMAX            |
| LIDODERM PATCH           | NALDECON                    | PERMITIL          |
| LIMBITROL                | NALFON                      | PERSANTINE        |
| LIORESAL                 | NAPROSYN                    | PHENAPHEN-CODEINE |
| LIPITOR                  | NARDIL                      | PHENERGAN         |
| LITHIUM-CITRATE          | NEMBUTAL                    | PHENOBARBITAL     |
| LO/OVRAL                 | NICORETTE                   | PINDOLOL          |
| LODINE                   | NIMOTOP                     | PLACIDYL          |
| LOMOTIL                  | NITRO-BID                   | PLAQUENIL         |
| LOPID                    | NITROSTAT                   | PLAVIX            |
| LOPRESSOR                | NIZORIL                     | PLENDIL           |
| LORABID                  | NOLUDAR                     | POLARIMINE        |
| LORCET                   | NOLVADEX                    | PONDIMIN          |
| LOTENSIN                 | NORCO                       | PRAVACHOL         |
| LOTREL                   | NORDETTE                    | PREMARIN          |
| LOXITANE                 | NORFLEX                     | PREMPHASE         |
|                          |                             | PREMPRO           |

## Panic Attacks and Panic Disorder

*SYMPTOM*

*DEPOSITION QUESTIONS*

**Dizziness,  
Unsteady  
Feelings,  
Faintness**  
*(continued)*

|               |                 |                 |
|---------------|-----------------|-----------------|
| PREVACID      | SORBITRATE      | TRINALIN        |
| PRIMAXIN-IV   | SPORANOX        | TRIPHASIL       |
| PRINIVIL      | STADOL          | TROVAN          |
| PRINZIDE      | STELAZINE       | TUSSI-ORGANIDIN |
| PROAMATINE    | SUDAFED         | TYLENOL-CODEINE |
| PROCARDIA     | SULINDAC        | TYLOX           |
| PROSOM        | SUMYCIN         | ULTRAM          |
| PROTONIX      | SUPRAX          | URISED          |
| PROVENTIL     | SURMONTIL       | VANCOCIN-HCI    |
| PROVERA       | SYMMETREL       | VANTIN          |
| QUESTRAN      | SYNALGOS-DC     | VASOTEC         |
| QUIDE         | TAGAMET         | VENTOLIN        |
| REGLAN        | TALECEN         | VERELAN         |
| RELAFEN       | TALWIN-NX       | VIAGRA          |
| REMERON       | TARACTAN        | VICODIN         |
| RESTORIL      | TAVIST          | VICOPROFEN      |
| REVIA         | TEGRETOL        | VIVACTIL        |
| REZULIN       | TEMARIL         | VOLTAREN        |
| RIFAMATE      | TENORMIN        | WELLBUTRIN      |
| RISPERDAL     | TESSALON        | WYGESIC         |
| RITALIN       | TIAZAC          | XANAX           |
| ROBAXIN       | TICLID          | XYLOCAINE       |
| ROBAXISAL     | TIGAN           | YOCON           |
| RONDEC-DM     | TIMOPTIC        | ZANAFLEX        |
| ROXICET       | TINDAL          | ZANTAC          |
| RUFEN         | TOFRANIL        | ZARONTIN        |
| SANOREX       | TOLECTIN        | ZAROXOLY        |
| SANSERT       | TOLINASE        | ZEPHREX         |
| SE-AP-ES      | TOPROL-XL       | ZESTORETIC      |
| SERAX         | TORADOL         | ZESTRIL         |
| SERENTIL      | TORECAN         | ZITHROMAX       |
| SEROQUEL      | TRANCOPAL       | ZOCOR           |
| SERTRALINE    | TRANDATE        | ZOFRAN          |
| SERZONE       | TRANSDERM-NITRO | ZOLOFT          |
| SINEMET       | TRANSDERM-SCOP  | ZOMIG           |
| SINEQUAN      | TRANXENE        | ZOVIRAX         |
| SINGULAIR     | TRENTAL         | ZYBAN           |
| SKELAXIN      | TRIAVIL         | ZYLOPRIM        |
| SOMA          | TRILAFON        | ZYPREXA         |
| SOMA-COMPOUND | TRILEPTAL       | ZYRTEC          |
| SONATA        | TRILISATE       |                 |

**Depersonalization, Q:** Describe the plaintiff's feelings of depersonalization or derealization.  
**Derealization**

**Q:** When and how often does the plaintiff have feelings of depersonalization or derealization?

## Panic Attacks and Panic Disorder

*SYMPTOM*

*DEPOSITION QUESTIONS*

**Depersonalization, Derealization**

*(continued)*

**Q:** Has the plaintiff remained close to other important people in their life?

**Q:** How has the plaintiff's relationship to others changed since the injury?

**Q:** Does the plaintiff have a history of depersonalization or derealization feelings before the injury in question?

**Q:** Does the plaintiff have a history of any *medical or psychological conditions* that may cause feelings of depersonalization or derealization?

*The witness may indicate the possibility of the following medical or psychological conditions: please refer to the sections pertaining to these medical conditions for further questions.*

**TABLE 5.5-9.**

|                                |                             |
|--------------------------------|-----------------------------|
| Delusional (paranoid) disorder | Schizophrenia               |
| Postpartum disorder            | Schizophrenia-paranoid type |

**Q:** Did you rule out any signs, symptoms, or history of *hysteria* as a cause of the plaintiff's feelings of depersonalization or derealization?

A plaintiff with hysteria is prone to phobias, **dissociative states, fugues**, and amnesia. Depression, suicidal tendencies and medication dependence are common. (reference 2, p. 633)

**Q:** Did you rule out a *histrionic personality disorder* as a cause of the plaintiff's feelings of depersonalization or derealization?

The histrionic plaintiff is self-centered, dramatic, emotionally excessive, shallow, and exhibits considerable mood instability. S/he is often uncomfortable when not the center of attention and will seek reassurance, approval, or praise from others. The plaintiff may complain of poor health, weakness, headaches, or **feelings of depersonalization**. While an over-concern with physical attractiveness and an inappropriate sexually seductive appearance or behavior is common, plaintiffs with this disorder often have troubled interpersonal relationships and can be sexually naive or unresponsive. (reference 7, pp. 711-714; reference 4, p. 586)

*If the witness indicates the possibility of a histrionic personality disorder or other maladaptive personality traits, see the section on pre-existing personality disorders for further questions.*

**Q:** Did you rule out a *schizotypal personality disorder* as a cause of the plaintiff's feelings of depersonalization or derealization?

A schizotypal personality has **oddities of thinking, perception**, communication, and behavior that resemble schizophrenia. The plaintiff may experience anxiety, depression, and other dysphoric moods that disrupt concentration and the ability to function socially or at work. S/he may have few close friends except for immediate family. (reference 7, pp. 697-701)

## SYMPTOM

## DEPOSITION QUESTIONS

**Depersonalization,  
Derealization***(continued)*

**Q: Did you rule out a *depersonalization disorder* (or *depersonalization neurosis*) as a cause of the plaintiff's feelings of depersonalization or derealization?**

The plaintiff with this disorder has very stressful **recurrences of depersonalization**. They may **feel detached from mind, body and reality**. Associated symptoms may include dizziness, depression, obsessive rumination, somatic concerns, anxiety, fear of going insane, and difficulty with a sense of time and recall (reference 7, p. 530)

**Q: Did you rule out a *seizure* as a cause of the plaintiff's feelings of depersonalization or derealization?**

Seizures (temporal lobe epilepsy) produce the same behaviors as sleepwalking but may occur during the day. During the epileptic attacks, the plaintiff is **unresponsive to environmental stimuli**. Involuntary and repetitious motor movements, such as swallowing and rubbing the hands, are common symptoms. (reference 2, p. 2153)

*If the witness indicates the possibility of seizures, see the section on pre-existing medical conditions for further questions.*

**Q: Did you rule out a *dissociative identity disorder* (formerly known as *multiple personality disorder*) as a cause of the plaintiff's feelings of depersonalization or derealization?**

Dissociative identity disorder is characterized by **two or more distinct personalities** or personality states. The transition from one person to another are often sudden and may be triggered by psychosocial stress or social and environmental stimuli. The disorder is chronic, although personality switches may become less frequent with time. (reference 7, p. 526)

**Q: Did you rule out a *dissociative fugue* (formerly *psychogenic fugue*) as a cause of the plaintiff's feelings of depersonalization or derealization?**

Dissociative fugue is characterized by sudden, unexpected travel away from home or work. **The plaintiff assumes a new identity** and is unable to recall any previous identity. While recovery is rapid and recurrences rare, the plaintiff is often perplexed and disoriented. (reference 7, p. 523 )

**Q: Did you rule out *dissociative amnesia* (formerly *psychogenic amnesia*) as a cause of the plaintiff's feelings of depersonalization or derealization?**

The plaintiff with this disorder has a sudden **inability to recall important personal information**. During the amnesia, perplexity, disorientation, and purposeless wandering may occur. Termination is abrupt and recovery is complete. (reference 7, p. 520 )

**Q: Did you rule out *Ganser's syndrome* as a cause of the plaintiff's feelings of depersonalization or derealization?**

Ganser's syndrome is characterized by giving approximate answers to questions. It may be associated with amnesia, disorientation, perceptual disturbances, **fugue**, and conversion symptoms.

## SYMPTOM

## DEPOSITION QUESTIONS

**Depersonalization, Q: Did you rule out *hallucinogen consumption* as the cause of the plaintiff's Derealization feelings of depersonalization or derealization?***(continued)*

Hallucinogen consumption causes changes in perception such as **feelings of detachment**, illusions, hallucinations, and synesthesia (seeing colors when a loud sound occurs). Behavioral symptoms may include anxiety or depression, ideas of reference, fear of losing one's mind, paranoia, impaired judgment, and impaired social or occupational functioning. Physical symptoms may include dilated pupils, tachycardia, sweating, palpitations, blurred vision, tremors, and incoordination. Flashbacks of experiences may recur several months or years after hallucinogen use. Many plaintiffs may have gross thought process disturbances. Unlike schizophrenics, they are able to talk in detail about their hallucinations. (reference 7, p. 250; reference 4, p. 874)

**Q: Did you rule out *migraine headaches* as a cause of the plaintiff's feelings of depersonalization or derealization?**

A classic migraine (vascular) headache may be accompanied by visual disturbances, sensory motor or speech disturbances, nausea or vomiting, and emotional changes. On rare occasions, the plaintiff may experience **depersonalization or derealization**. Migraine headaches may be precipitated by: (reference 2, pp. 65-66)

- Birth control pills
- Emotional conflicts or stress
- Fluctuating estrogen levels in women
- Food:
  - Monosodium glutamate (Chinese restaurant syndrome)
  - Phenylethylamine-containing foods
  - Tyramine-containing foods (cheese or other fermented dairy products and chocolate)

**Q: Did you rule out a *trance state* as a cause of the plaintiff's feelings of depersonalization or derealization?**

A trance state is an **altered state of consciousness** with diminished ability to respond to the environment or to stimuli.

**Q: Did you rule out *depressive pseudodementia* as a cause of the plaintiff's feelings of depersonalization or derealization?**

Cognitive disturbances seen in severe major depressive episodes are usually referred to as depressive pseudodementia. Treatment for the depression can restore both mood and memory to normal. Anxiety, irritability, a loss of social skills, and **memory gaps for specific periods or events** are characteristic symptoms. (reference 4, pp. 150-151; reference 18, p. 809)

**Q: Did you rule out *cannabis (marijuana) consumption* as a cause of the plaintiff's feelings of depersonalization or derealization?**

Cannabis intoxication can occur from marijuana, hashish, or tetrahydrocannabinol (THC). Characteristic symptoms include tachycardia, increased appetite, dry mouth,

*SYMPTOM*

*DEPOSITION QUESTIONS*

**Depersonalization,  
Derealization**

*(continued)*

euphoria, anxiety, **sensation of slowed time**, impaired judgment, and social withdrawal. Inappropriate laughter, panic attacks, and a dysphoric mood may occur. (reference 7, p. 234; reference 4, pp. 1326, 754)

**Q: Does the plaintiff have any other *medical conditions* that may cause feelings of depersonalization or derealization such as temporal lobe seizures?**

**Q: Is the plaintiff taking any *medications or substances* that may cause feelings of depersonalization or derealization, such as**

|           |           |           |
|-----------|-----------|-----------|
| AMBIEN    | DURAGESIC | OXYCONTIN |
| ANAFRANIL | EXCELON   | PAXIL     |
| AVONEX    | INDOCIN   | PROZAC    |
| BUPRENEX  | LAMICTAL  | REMERON   |
| CARDURA   | LUVOX     | SONATA    |
| CELEXA    | MAXALT    | ZANAFLEX  |
| CIPRO     | NEURONTIN | ZYBAN     |
| DEPROL    | NORVASC   | ZYRTEC    |

**Fear of  
Going Crazy**

**Q: Describe the plaintiff's fear of going crazy or doing something uncontrolled.**

**Q: When and how often does the plaintiff fear going crazy or doing something uncontrolled?**

**Q: Does the plaintiff have a history of fearing going crazy or doing something uncontrolled before the injury in question?**

**Q: Does the plaintiff have a history of *familial mental illness*?**

**Q: Did you rule out an *obsessive-compulsive disorder* as a cause of the plaintiff's fear of going crazy or doing something uncontrolled?**

The obsessive-compulsive plaintiff has persistent unwanted and **uncontrolled thoughts or impulses** that may be characterized by violence, contamination, or doubt. These obsessions often cause the plaintiff to feel anxious. The plaintiff's repeated compulsive behaviors are **attempts to control the impulses** and the accompanying anxiety. Other symptoms may include an exclusive devotion to work or productivity, depression, anxiety, and restlessness. (reference 4, pp. 910-911; reference 7, pp. 456-463)

*If the witness indicates the possibility of an obsessive-compulsive disorder, see the section on obsessive-compulsive disorder for further questions. Note: In addition to the obsessive compulsive disorder, there is an obsessive-compulsive personality disorder. The personality disorder does not have true obsessions and compulsions, but has a clear pattern of perfectionism and rigidity.*

## SYMPTOM

## DEPOSITION QUESTIONS

**Fear of Going Crazy***(continued)*

**Q: Did you rule out *hallucinogen consumption* as the cause of the plaintiff's fear of going crazy or doing something uncontrolled?**

Hallucinogen consumption causes changes in perception such as feelings of detachment, illusions, hallucinations, and synesthesia (seeing colors when a loud sound occurs). Behavioral symptoms may include anxiety or depression, ideas of reference, **fear of losing one's mind**, paranoia, impaired judgment, and impaired social or occupational functioning. Physical symptoms may include dilated pupils, tachycardia, sweating, palpitations, blurred vision, tremors, and incoordination. Flashbacks of experiences may recur several months or years after hallucinogen use. Many plaintiffs may have gross thought process disturbances. Unlike schizophrenics they are able to talk in detail about their hallucinations. (reference 7, p. 252; reference 4, p. 874)

**Q: Did you rule out a *depersonalization disorder* (or *depersonalization neurosis*) as a cause of the plaintiff's fear of going crazy or doing something uncontrolled?**

The plaintiff with this disorder has very stressful recurrences of depersonalization. S/he may feel detached from mind, body and reality. Associated symptoms may include dizziness, depression, obsessive rumination, somatic concerns, anxiety, **fear of going insane**, and difficulty with a sense of time and recall. (reference 7, pp. 530-532)

**Q: (Female) Did you rule out a *postpartum disorder* as a cause of the plaintiff's fear of going crazy or doing something uncontrolled?**

Postpartum disorders are associated with pregnancy and the period after birth. Symptoms may include insomnia, restlessness, fatigue, depression, irritability, headaches, and lability of mood. Later in the postpartum period, the plaintiff may become suspicious, confused or **incoherent, irrational**, excessively concerned over trivialities, and refuse food. Depressed women may experience an overconcern for the baby, guilt, or feelings of inadequacy. **Hallucinations**, infanticide, and suicide are infrequent occurrences. (reference 4, pp. 1238-1241; reference 1, p. 1720)

**Fear of Death**

**Q: Describe the plaintiff's fear of death.**

**Q: When and how often does the plaintiff fear death?**

**Q: Does the plaintiff have a history of fearing death before the injury in question?**

*SYMPTOM*

*DEPOSITION QUESTIONS*

**Fear of Death**  
(continued)

**Q: Does the plaintiff have a history of any *medical conditions* that may cause the fear of death?**

*The witness may indicate the possibility of the following medical conditions: please refer to the sections pertaining to these medical conditions for further questions.*

**TABLE 5.5-10.**

|                           |                      |
|---------------------------|----------------------|
| Coronary artery disease   | Pheochromocytoma     |
| Creutzfeldt-Jakob disease | Pancreatic carcinoma |
| Huntington's disease      | Parkinson's disease  |
| Mitral valve prolapse     |                      |

**Q: Does the plaintiff have a *disease, disorder, or other condition* that may be the basis for a legitimate fear of dying?**

**Q: Did you rule out a past history of *heart attack* as a cause of the plaintiff's fear of dying?**

Despondency is almost a universal response to heart attack. Even without complications, the plaintiff may feel a sense of loss, and vulnerable to further injury. Weakness and tiredness are the most distressing symptoms of the depression. The plaintiff may also experience insomnia, daytime hypersomnia, and practical worries. Complications cause the plaintiff's **despondency and hopelessness** to be intensified. (reference 4, pp. 1156-1157)

*If the witness indicates the possibility of a recent heart attack, see the section on medical conditions for further questions.*

**Numbness,  
Tingling  
Sensations**

**Q: Describe the plaintiff's numbness or tingling sensations (paresthesias).**

**Q: When and how often does the plaintiff experience numbness and tingling sensations?**

**Q: Does the plaintiff have a history of numbness or tingling sensations (paresthesias) before the injury in question?**

**Q: Does the plaintiff have any history of a peripheral nerve injury or disorder?**

**Q: Does the plaintiff have any *neurological disease* that may cause numbness or tingling sensations?**

*SYMPTOM*

*DEPOSITION QUESTIONS*

**Numbness,  
Tingling  
Sensations**  
(continued)

**Q: Does the plaintiff have a history of any *medical or psychological conditions* that may cause numbness and tingling sensations?**

*The witness may indicate the possibility of the following medical or psychological conditions: please refer to the sections pertaining to these medical conditions for further questions.*

**TABLE 5.5-11.**

|                          |                       |
|--------------------------|-----------------------|
| Brain tumor              | Parkinson's disease   |
| Combined systems disease | Pernicious anemia     |
| Hypochondriasis          | Somatization disorder |
| Multiple sclerosis       | Syphilis              |

**Q: Did you rule out a *conversion disorder* as a cause of the plaintiff's numbness or tingling sensations?**

A conversion disorder is characterized by the presence of **symptoms or deficits affecting** voluntary motor or **sensory function** that suggest a neurological or other general medical condition. Psychological factors are judged to be associated with the symptom or deficit and the symptoms are not intentionally feigned or produced. Conversion symptoms are defense mechanisms that change the unconscious emotional conflict into a physical disability that often symbolizes the nature of the conflict. (reference 12, p. 315; reference 2, pp. 625, 630; reference 7, p. 492)

*If the witness indicates the possibility of a conversion disorder, see the section on conversion disorder for further questions.*

**Q: Did you rule out *hyperventilation* as a cause of the plaintiff's numbness or tingling sensations?**

Hyperventilation is abnormal, rapid, deep breathing usually due to anxiety. Exercise and strong emotion causes hyperventilation or it can begin spontaneously. Symptoms may include lightheadedness, faintness, ringing in the ears, weakness, blurring of vision, and **tingling around the mouth or in the extremities**. (reference 2, p. 613)

**Q: Did you rule out *malingering* as a cause of the plaintiff's numbness or tingling sensations?**

Malingering may be associated with attempts to avoid work or evade legal responsibilities. The plaintiff's complaints may include vertigo (illusion of movement), weakness, loss of consciousness, seizures, headaches, visual impairment, and **loss of skin sensation**. (reference 4, p. 1863)

*If the witness indicates the possibility of malingering, see the section on malingering for further questions.*

## SYMPTOM

## DEPOSITION QUESTIONS

**Numbness,  
Tingling  
Sensations**

(continued)

**Q: Did you rule out *hypothyroidism* as a cause of the plaintiff's numbness or tingling sensations?**

Hypothyroidism results from inadequate synthesis of thyroid hormone. Hypothyroidism can produce psychiatric, as well as physical symptoms. The most notable psychiatric symptoms include depression, lethargy, poor concentration, impaired memory, apathy, and syncope. The numerous physical symptoms are: cold intolerance, constipation, muscle cramps, **paresthesias**, menstrual disorders, dyspnea, dizziness, reduced hearing, poor appetite, weight gain, brittle and thinning hair, and bradycardia (slowed heart action). Panic attacks are associated with endocrinological disorders including hypothyroidism and hyperthyroidism. (reference 18, pp. 743, 1810-1812, 1928)

*If the witness indicates the possibility of hypothyroidism, see the section on pre-existing medical conditions for further questions.*

**Q: Did you rule out *porphyria* as a cause of the plaintiff's numbness or tingling sensations?**

Porphyria is an inherited disorder of young to middle-aged adults. It is characterized by episodes of abdominal pain, peripheral neuropathy, weakness, anorexia, nausea, **paresthesia**, vomiting, tachycardia, fever, confusion, depression, and severe anxiety. Mood swings and mental abnormalities are common symptoms. (reference 4, pp. 121, 1276, 1326; reference 9, p. 1156; reference 1, pp. 958, 960)

*If the witness indicates the possibility of porphyria, see the section on pre-existing medical conditions for further questions.*

**Q: Is the plaintiff taking any *medications or substances* that may cause numbness or tingling sensations, such as:**

|                 |             |                  |
|-----------------|-------------|------------------|
| ACCUTANE        | BUTAZOLIDIN | DIAMOX           |
| ADALAT          | CARBATROL   | DILACOR          |
| ADAPIN          | CARDIZEM    | DIOVAN           |
| AEROBID         | CELEBREX    | DURACT           |
| ALTACE          | CELEXA      | DURAGESIC        |
| AMBIEN          | CIPRO       | DYNACIRC         |
| AMERGE          | CLARITAN-D  | EFFEXOR          |
| ANAFRANIL       | CLARITIN    | ELAVIL           |
| ANDRODERM PATCH | CLINORIL    | ELDEPRYL         |
| APRESOLINE      | CLOMID      | ENDEP            |
| ARICEPT         | CLOZARIL    | ENDURON          |
| ARTHROTEC       | COGENTIN    | ERGOMAR          |
| ASENDIN         | COGNEX      | ESIDRIX          |
| AVAPRO          | COMBIPRES   | ESTRATEST        |
| AVONEX          | COMBIVENT   | ESTROGEN PATCH   |
| AXOCET          | COZAAR      | ETRAFON          |
| BELLERGA        | DALALONE    | EXCELON          |
| BENADRYL        | DEPROL      | FAMVIR           |
| BUPRENEX        | DESYREL     | FIORICET         |
| BUSPAR          | DETROL      | FIORINAL-CODEINE |

*SYMPTOM**DEPOSITION QUESTIONS***Numbness,  
Tingling  
Sensations***(continued)*

|                          |                 |            |
|--------------------------|-----------------|------------|
| FLAGYL                   | NEURONTIN       | SULAR      |
| FLEXERIL                 | NOROXIN         | SULINDAC   |
| FORTAZ                   | NORPACE         | SURMONTIL  |
| GABITRIL                 | NORPLANT-SYSTEM | TALECEN    |
| GYNERGEN                 | NORPRAMIN       | TALWIN-NX  |
| HALCION                  | NORVASC         | TAPAZOLE   |
| HYDRO-<br>CHLOROTHIAZIDE | NUBAIN          | TEGRETOL   |
| HYTRIN                   | OPTIMINE        | TENORETIC  |
| HYZAAR                   | ORUDIS          | TESSALON   |
| IMDUR                    | OXYCONTIN       | TESTODERM  |
| IMITREX                  | PAMELOR         | TIAZAC     |
| IMITREX-TABLETS          | PBZ-SR          | TIMOPTIC   |
| INDERAL                  | PEPCID          | TINDAL     |
| INDERIDE                 | PERIACTIN       | TOFRANIL   |
| INDOCIN                  | PERMAX          | TORADOL    |
| INSULIN                  | PERMITIL        | TRANDATE   |
| K-LYTE                   | PLACIDYL        | TRIAVIL    |
| KERLONE                  | PLAVIX          | TRILAFON   |
| LESCOL                   | PLENDIL         | TRINALIN   |
| LIDODERM PATCH           | PRAVACHOL       | TROVAN     |
| LIMBITROL                | PREVACID        | ULTRAM     |
| LIORESAL                 | PRILOSEC        | VASOTEC    |
| LIPITOR                  | PRIMAXIN-IV     | VERELAN    |
| LODINE                   | PRINIVIL        | VIAGRA     |
| LOMOTIL                  | PRINZIDE        | VICOPROFEN |
| LOPID                    | PROAMATINE      | VIOXX      |
| LOTENSIN                 | PROSOM          | VIVACTIL   |
| LOZOL                    | PROTONIX        | WIGRAINE   |
| LUDIOMIL                 | PROZAC          | XYLOCAINE  |
| MARCAINE                 | QUESTRAN        | ZANAFLEX   |
| MAVIK                    | RELAFEN         | ZAROXOLY   |
| MAXAIR-AUTOHALER         | REMERON         | ZESTORETIC |
| MAXIDE                   | RIFAMATE        | ZIAC       |
| MECLOMEN                 | SANOREX         | ZOCOR      |
| MEXITIL                  | SE-AP-ES        | ZOLOFT     |
| MINIPRESS                | SEROQUEL        | ZOMIG      |
| MIRAPEX                  | SERTRALINE      | ZOVIRAX    |
| MODURETIC                | SERZONE         | ZYBAN      |
| MONOPRIL                 | SINEMET         | ZYLOPRIM   |
| MORPHINE-SULFATE         | SINEQUAN        | ZYRTEC     |
| MOTRIN                   | SONATA          |            |
|                          | STADOL          |            |

*SYMPTOM*

*DEPOSITION QUESTIONS*

**Flushes,  
Chills**

**Q: Describe the plaintiff's flushes or chills.**

**Q: When and how often does the plaintiff experience the flushes or chills?**

**Q: Does the plaintiff have a history of flushes or chills before the injury in question?**

**Q: Did you rule out *ecstasy use* as a cause for the plaintiff's flushes or chills?**

MDMA (methylenedioxyamphetamine) use can sometimes result in severe dehydration or exhaustion, or other adverse effects such as nausea, hallucinations, **chills**, sweating, increases in body temperature, tremors, involuntary teeth clenching, muscle cramping, and blurred vision. MDMA users have also reported after-effects such as anxiety, paranoia, and depression. An MDMA overdose is characterized by high blood pressure, faintness, panic attacks, and, in more severe cases, loss of consciousness, seizures, and a drastic rise in body temperatures to 105-106 degrees Fahrenheit. MDMA overdoses can be fatal, as they may result in heart failure or extreme heat stroke. (reference 20)

**Q: Does the plaintiff have a history of any *medical conditions* that may cause flushes or chills associated with fever?**

*The witness may indicate the possibility of the following medical conditions: please refer to the sections pertaining to these medical conditions for further questions.*

**TABLE 5.5-12.**

|                             |                       |
|-----------------------------|-----------------------|
| Arteriovenous malformations | Myocardial infarction |
| Hypertension                | Rheumatoid arthritis  |
| Meningitis                  | Syphilis              |

**Q: Did you rule out a *neuroendocrine disorder*, such as *pheochromocytoma*, as a cause of the plaintiff's flushes or chills?**

Symptoms of a neuroendocrine disorder include sudden headaches, excessive sweating, and palpitations. Often there are associated tremors, weakness, nausea, and epigastric discomfort. The plaintiff may also complain of chest pain, shortness of breath, lightheadedness, blurred vision, and **flushing**. (reference 2, p. 612)

Pheochromocytoma is a tumor of the sympathetic nervous system which specifically causes headaches, lightheadedness, nausea, sweating, trembling, and elevated blood pressure during anxiety attacks. (reference 4, p. 1276)

*If the witness indicates the possibility of pheochromocytoma, see the section on pre-existing medical conditions for further questions.*

## SYMPTOM

## DEPOSITION QUESTIONS

**Flushes,  
Chills***(continued)***Q: Did you rule out *caffeine consumption* as a cause of the plaintiff's flushes or chills?**

Characteristic symptoms of caffeine intoxication include restlessness, nervousness, excitement, insomnia, **flushed face**, diuresis, gastrointestinal disturbance, muscle twitching, rambling flow of thought and speech, tachycardia or cardiac arrhythmia, periods of inexhaustibility, and psychomotor agitation. When consumed near bedtime, caffeine often disrupts sleep. Symptoms may appear when the plaintiff consumes as little as 250 mg of caffeine per day. The plaintiff that consumes one gram per day usually experiences more severe symptoms. (reference 7, pp. 231-234; reference 4, p. 1029)

*See caffeine consumption and symptom chart in Appendix A for further details.*

**Q: Did you rule out *cluster headaches* as a cause of the plaintiff's flushes or chills?**

Cluster headaches are characterized by severe unilateral pain in the eye or temple. They tend to recur in a series of attacks, affecting primarily men. They may last from twenty minutes to two hours and cause severe pain, **flushing and facial sweating**. Sleep-related cluster headaches are severe unilateral headaches that appear intermittently during REM sleep. (reference 4, pp. 1205, 1261; reference 2, p. 70)

**Q: Did you rule out *cocaine consumption* as a cause of the plaintiff's flushes or chills?**

Cocaine users often experience increased energy and confidence or irritability and paranoia with physical aggressiveness. Other behavioral symptoms may include euphoria, hypervigilance, psychomotor agitation, impaired judgment, and impaired social or occupational functioning. Physical symptoms may include tachycardia, dilated pupils, elevated blood pressure, **perspiration or chills**, nausea, vomiting, and hallucinations. (reference 7, pp. 241-245; reference 4, pp. 1008-1009)

**Q: Did you rule out *alcohol consumption* as a cause of the plaintiff's flushes or chills?**

Alcohol intoxication may cause aggressiveness, impaired judgment and attention, irritability, euphoria, depression, emotional lability, and impaired social or occupational functioning. Physical symptoms may include slurred speech, incoordination, unsteady gait, nystagmus, occasional dizziness, and **flushed face**. Heavy alcohol consumption may cause abnormal sleep patterns. The plaintiff often falls asleep quickly but wakes up earlier and earlier with uncomfortable feelings. Chronic alcoholics may have irregular, unsteady, and slow tremulous movements. (reference 7, pp. 212-215; reference 4, p. 67; reference 9, p. 52)

## SYMPTOM

## DEPOSITION QUESTIONS

**Flushes,  
Chills***(continued)***Q: (Female) Did you rule out *menopause* as a cause of the plaintiff's flushes or chills?**

Menopausal distress may cause anxiety, fatigue, GI disturbances, urinary frequency, back pain, palpitations, tension, emotional lability, irritability and nervousness, depression, dizziness, insomnia, and **hot flashes**. (reference 4, p. 1173; reference 9, p. 21)

*If the witness indicates the possibility of menopausal distress, see the section on medical conditions for further questions.*

**Q: Did you rule out *amphetamine or similarly acting sympathomimetic drug consumption or withdrawal* as a cause of the plaintiff's flushes or chills?**

Symptoms of amphetamine or similarly acting sympathomimetic *drug consumption* may include fighting, grandiosity, elation, hypervigilance, psychomotor agitation, impaired judgment, and impaired social or occupational functioning. Physical symptoms may include **flushing**, difficulty breathing, tachycardia, pupil dilation, elevated blood pressure, sweating or **chills**, nausea, and vomiting. (reference 12; reference 4, pp. 1007-1008; reference 7, p. 223-227)

*Drug withdrawal* symptoms may include a dysphoric mood (depression, irritability, anxiety), fatigue, **sweating**, headaches, insomnia with nightmares, hypersomnia, and psychomotor agitation. Symptoms begin after the cessation of prolonged drug use (at least two days) and last more than 24 hours. (reference 7, pp. 227-228; reference 4, p. 1008)

The following drugs may be classified as amphetamines:

|                                    |                            |
|------------------------------------|----------------------------|
| Appetite Suppressants (diet pills) | Methamphetamines (speed)   |
| Dextroamphetamines                 | Methylphenidates (Ritalin) |
| Ma-huang (ephedra)                 | (reference 17, p. 586)     |
| (reference 24, pp. 488-489)        |                            |

**Q: Did you rule out *opioid consumption and withdrawal* as a cause of the plaintiff's flushes or chills?**

*Opioid intoxication* is characterized by euphoria, **flushing**, itching skin, miosis, drowsiness, decreased respiratory rate and depth, hypotension, bradycardia, and decreased body temperature. The initial euphoria is often followed by apathy, unpleasant mood, psychomotor retardation, impaired judgment, and impaired social or occupational functioning. While dependence on opiates is less common than on alcohol or tobacco, it has been estimated that fifteen percent of males and nine percent of females have used an opiate (non-medical) during their lifetime. (reference 7, pp. 269-272; reference 4, pp. 987-988)

Symptoms of *opioid withdrawal* may include lacrimation (tearing), rhinorrhea (runny nose), dilated pupils, **sweating**, diarrhea, yawning, mild hypertension, tachycardia (increased heart rate), fever, insomnia, and **gooseflesh**. Associated features may include restlessness, irritability, depression, tremor, weakness, nausea, vomiting, and muscle or joint pain. These signs, often resembling influenza symptoms, may be precipitated by the abrupt ending of one or two weeks of

## SYMPTOM

## DEPOSITION QUESTIONS

**Flushes,  
Chills***(continued)*

continuous opioid use. The withdrawal symptoms may last days or weeks. During the final stages of withdrawal, the plaintiff may experience overconcern for bodily discomfort, poor self-image, and a decreased ability to tolerate stress. (reference 7, pp. 272-273; reference 4, pp. 990-991)

**Q: Did you rule out *infections* as a cause of the plaintiff's flushes or chills?**

(reference 2, p. 617)

|                                  |                                 |
|----------------------------------|---------------------------------|
| Brucellosis                      | Meningitis                      |
| Chronic urinary tract infections | Subacute bacterial endocarditis |
| Infectious mononucleosis         | Syphilis                        |
| Influenza                        | Tuberculosis                    |
| Malaria                          | Viral hepatitis                 |

**Q: Is the plaintiff taking any *medications or substances* that may cause flushes (hot flashes) or chills?**

*The pyretics are groups or classes that may cause flushes (hot flashes) or chills.*

|               |                          |                           |
|---------------|--------------------------|---------------------------|
| ADALAT        | CYCLOSPORIN              | LUVOX                     |
| ADAPIN        | DALMAN                   | MACROBID                  |
| AEROBID       | DANTRIUM                 | MACRODANTIN               |
| AMERGE        | DEMEROL                  | MAXALT                    |
| AMPHETINES    | DEPACON                  | MEPERGAN                  |
| ANADROL       | DEPROL                   | METHOTREXATE              |
| ANAFRANIL     | DIMETANE                 | MODURETIC                 |
| ANAPROX       | DIPYRIDAMOLE             | MOTRIN                    |
| ANSAID        | DOLOBID                  | NAPROSYN                  |
| APRESOLINE    | DURACT                   | NITRO-BID                 |
| ARICEPT       | EDECRIN                  | NITRO-DUR                 |
| AVAPRO        | ELDEPRYL                 | NITROSTAT                 |
| AVELOX        | EQUAGESIC                | NIZORAL                   |
| AVONEX        | EQUANIL                  | NOROXIN                   |
| BACTRIM       | EXCELON                  | NORPRAMIN                 |
| BELLERGA      | FLOXIN                   | NORVASC                   |
| BENADRYL      | GEODON                   | NUBAIN                    |
| BUPRENEX      | GLYBURIDE                | OPTIMINE                  |
| CAPOTEN       | GOODY HEADACHE<br>POWDER | OXYCONTIN                 |
| CARDIZEM      | HEPARIN                  | PAMELOR                   |
| CARDURA       | IMDUR                    | PAXIL                     |
| CELEBREX      | INAPSINE                 | PBZ-SR                    |
| CELEXA        | INDOCIN                  | PEDIAZOLE                 |
| CHLORTRIMETON | ISORDIL                  | PERIACTIN                 |
| CIPRO         | ISUPREL                  | PERMAX                    |
| CLOMID        | LESCOL                   | PERSANTINE                |
| CLOXACILLIN   | LODINE                   | PHENERGAN VC<br>W/CODEINE |
| CLOZARIL      | LOMOTIL                  | POLARIMINE                |
| COGNEX        | LUDIOMIL                 | PONDIMIN                  |
| CRINONE       |                          |                           |

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*SYMPTOM*

*DEPOSITION QUESTIONS*

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**Flushes,  
Chills**

*(continued)*

|            |                 |              |
|------------|-----------------|--------------|
| PRAVACHOL  | SINEQUAN        | TRILEPTAL    |
| PROATINE   | SLO-PHYLLIN     | TRINALIN     |
| PROCARDIA  | SOMA            | TROVAN       |
| PROSOM     | SONATA          | TYLENOL      |
| PROTONIX   | SORBITRATE      | V-CILLIN K   |
| PROVENTIL  | SULAR           | VANCOCIN-HCL |
| PROZAC     | SURMONTIL       | VENTOLIN     |
| QUINAGLUTE | TALECEN         | VIAGRA       |
| QUINAMM    | TALWIN-NX       | VIOXX        |
| REMERON    | TAVIST          | VIVACTIL     |
| RE VIA     | TEGRETOL        | WELLBUTRIN   |
| ROBAXIN    | TENCET          | ZAROXOLYN    |
| RUFEN      | TEQUIN          | ZESTORETIC   |
| SE-AP-ES   | TERAZOL         | ZESTRIL      |
| SEPTRA     | THEO-DUR        | ZOCOR        |
| SEROQUEL   | TIMENTIN        | ZOLOFT       |
| SERTRALINE | TOFRANIL        | ZYBAN        |
| SERZONE    | TRANCOPAL       |              |
| SINEMET    | TRANSDERM-NITRO |              |



## **SECTION 5.5A: DIRECT CHALLENGE TO THE DIAGNOSIS OR CLAIMS OF PANIC DISORDER WITH AGORAPHOBIA**

### **INTRODUCTION**

Agoraphobia is the fear of being in places where escape is impossible. The plaintiff typically refuses to leave his or her home after a traumatic event. With time, the fear generalizes to a complete fear of leaving the home. Many plaintiffs claiming phobia or agoraphobia have an early history of childhood fears, including school phobia. However, onset is more common from adolescence to mid thirties, and the course may wax or wane from that time.

Defense counsel should obtain the plaintiff's mental health, school, and occupational records. Also, counsel needs to identify the plaintiff's claimed panic symptoms by using the deposition questions in Chapters 1 and 4. Section 5.5A provides questions to challenge the accuracy of that diagnosis.

***Challenging the Plaintiff's Diagnosis of a Panic Disorder With Agoraphobia*****TABLE 5.5A-1.*****Diagnostic criteria for 300.21: Panic Disorder with Agoraphobia*****A. Both (1) and (2):**

- (1) recurrent unexpected Panic Attacks
- (2) at least one of the attacks has been followed by 1 month (or more) of one (or more) of the following:
  - (a) persistent concern about having additional attacks
  - (b) worry about the implications of the attack or its consequences (e.g., losing control, having a heart attack, "going crazy")
  - (c) a significant change in behavior related to the attacks

**B. The presence of Agoraphobia**

**C.** The Panic Attacks 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., hyperthyroidism).

**D.** The Panic Attacks are not better accounted for by another mental disorder, such as Social Phobia or social anxiety disorder (e.g., occurring on exposure to feared social situations), Specific Phobia (e.g., on exposure to a specific phobic situation), Obsessive-Compulsive Disorder (e.g., on exposure to dirt in someone with an obsession about contamination), Posttraumatic Stress Disorder (e.g., in response to stimuli associated with a severe stressor), or Separation Anxiety Disorder (e.g., in response to being away from home or close relatives).

***Criteria for Agoraphobia***

**Note:** Agoraphobia is not a codable disorder. Code the specific disorder in which the Agoraphobia occurs (e.g., 300.21 Panic Disorder With Agoraphobia or 300.22 Agoraphobia Without History of Panic Disorder ).

**A.** Anxiety about being in places or situations from which escape might be difficult (or embarrassing) or in which help may not be available in the event of having an unexpected or situationally predisposed Panic Attack or panic-like symptoms. Agoraphobic fears typically involve characteristic clusters of situations that include being outside the home alone; being in a crowd or standing in a line; being on a bridge; and traveling in a bus, train, or automobile.

**Note:** Consider the diagnosis of Specific Phobia if the avoidance is limited to one or only a few specific situations, or Social Phobia or social anxiety disorder if the avoidance is limited to social situations.

**B.** The situations are avoided (e.g., travel is restricted) or else are endured with marked distress or with anxiety about having a Panic Attack or panic-like symptoms, or require the presence of a companion.



**SYMPTOM****DEPOSITION QUESTIONS****General Questions***(continued)*

**Q: Are the plaintiff's panic attacks becoming less severe?**

**Q: Did you rule out *social phobia* (also known as social anxiety disorder) as a cause of the plaintiff's distress associated with leaving home?**

The primary feature of social phobia is a marked and persistent **fear of social or performance situations** in which embarrassment may occur. These fears interfere significantly with the plaintiff's normal routine, occupation, academic or social activities. (reference 7, pp. 450-456)

**Q: Did you rule out *specific phobia* (formerly simple phobia) as a cause of the plaintiff's distress with leaving home?**

A phobic disorder is characterized by the presence of irrational or exaggerated **fears of a** clearly discernible object, **situation**, or bodily function. The situation or object of the fear is not inherently dangerous or an appropriate source of anxiety. The plaintiff may have symptoms of panic, sweating, tachycardia, shakiness, and difficulty breathing. S/he either avoids the object of the phobia or endures the situation with intense anxiety. There is also a marked distress about having the irrational fear. (reference 7, pp. 443-449; reference 4, pp. 899-900)

*If the witness indicates the possibility of a specific phobia, see the section on phobias for further questions.*

**Q: Did you rule out an *avoidant personality disorder* as a cause of the plaintiff's fear of leaving home?**

The avoidant personality has a pervasive pattern of social inhibition, feelings of inadequacy, and hypersensitivity to negative evaluation that begins by early adulthood. **Avoidant personality disorder and panic disorder with agoraphobia often co-occur.** The avoidant plaintiff is often socially uncomfortable and timid, exaggerates potential difficulties or dangers, is easily hurt, and fears negative comments. While greatly desiring companionship, the plaintiff has few close friends and is unwilling to get involved with others without certainty of being liked. The plaintiff may become depressed, anxious, and angry. This disorder is diagnosed only after the behavior has persisted for many years and the plaintiff is at least 20 years old. (reference 7, pp. 718-721; reference 4, pp. 981-982, 1752)

*If the witness indicates the possibility of an avoidant personality disorder, see the section on avoidant personality disorder for further questions.*

## **SECTION 5.6: DIRECT CHALLENGE TO THE DIAGNOSIS OF DYSTHYMIC DISORDER CLAIMS**

### **INTRODUCTION**

Dysthymic Disorder is a chronic, low-grade depression that must be observed for at least a *two year period*. There is an early onset, beginning in childhood or adolescence, with a persistent, intermittent course. Often the plaintiff's dysthymic level of depression, is imbedded in a pre-existing personality disorder not related to the injury in question. For example, the plaintiff may have a histrionic personality, compulsive, negativistic, sadistic or dependent personality.

Defense counsel should obtain a list of the plaintiff's alleged dysthymic symptoms by using the deposition questions in Chapters 1 and 4. Section 5.6 provides questions to challenge the accuracy of that diagnosis.

***Challenging the Plaintiff's Diagnosis of a Dysthymic Disorder*****TABLE 5.6-1.*****Diagnostic Criteria for 300.4: 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 (see section 5.7) 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.

## Challenging the Plaintiff's Diagnosis of a Dysthymic Disorder

TABLE 5.6-1. (CONTINUED)

Specify if:

**Early Onset:** if onset is before age 21 years

**Late Onset:** if onset is age 21 years or older

Specify (for most recent 2 years of Dysthymic Disorder):

**With Atypical Features**

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### SYMPTOM

### DEPOSITION QUESTIONS

#### Note: Familial Pattern

**There may be a familial pattern. Dysthymic Disorder is more common among first-degree biological relatives of people with Major Depressive Disorder than among the general population.**

#### General Questions

**Q: Describe the plaintiff's mood.**

The plaintiff's mood must be depressed (irritable in children or adolescents). (criterion A)

**Q: How often is the plaintiff depressed?**

The plaintiff must be depressed most of the day for a majority of days over a period of *at least two years* (one year for children and adolescents). (criterion A)

**Q: Describe the plaintiff's depressive symptoms.**

The witness must indicate the presence of at least two symptoms of dysthymic disorder. (criterion B)

**Q: Has the plaintiff had periods of time without symptoms?**

The witness must indicate that for two years, the plaintiff has never been without the depression most days for more than two months at a time. (criterion C)

**Q: Has the plaintiff had a major depressive episode while experiencing dysthymic disorder?**

The plaintiff must not have experienced a major depressive episode. (criterion D)

**Q: Does the plaintiff have a history of being depressed before the injury in question?**

*SYMPTOM*

*DEPOSITION QUESTIONS*

**General Questions**

*(continued)*

**DEFENSE THEORY—TWO YEARS REQUIRED: The Dysthymic Disorder must be observed for at least two years before diagnosis.**

**Q: Does the plaintiff have a history of any *medical or psychological conditions that may cause a depressed mood*?**

*The witness may indicate the possibility of the following medical or psychological conditions: please refer to the sections pertaining to these medical conditions for further questions.*

**TABLE 5.6-2.**

|                                       |   |
|---------------------------------------|---|
| Alzheimer's disease                   | Multiple sclerosis                        |
| Anemia                                | Myocardial infarction                     |
| Antisocial personality disorder       | Obsessive compulsive personality disorder |
| Borderline personality disorder       | Pancreatic carcinoma                      |
| Brain tumors                          | Parkinson's disease                       |
| Chronic obstructive pulmonary disease | Passive aggressive personality disorder   |
| Creutzfeldt-Jakob disease             | Pernicious anemia                         |
| Cushing's syndrome                    | Porphyria                                 |
| Hepatitis B                           | Schizophrenia                             |
| Huntington's disease                  | Somatization disorder                     |
| Hypoglycemia                          | Syphilis                                  |
| Hypothyroidism                        | Systemic lupus erythematosus              |
| Infectious mononucleosis              |   |
| Menopausal distress                   |   |

**Q: Has the plaintiff had a cerebrovascular accident?**

**Q: Did you rule out a *delusional disorder* as a cause of the plaintiff's depressed mood?**

If the plaintiff has symptoms of a chronic psychotic disorder, such as a delusional disorder, the diagnosis of Dysthymic Disorder cannot be made. (criterion F)

**Q: Has the plaintiff had a *manic, mixed, or hypomanic episode*?**

In order for a diagnosis of dysthymic disorder, the plaintiff must not have had a manic, mixed, or hypomanic episode. (criterion E)

*A manic episode* is a period during which the predominant mood is either elevated, expansive, or irritable. Associated manic symptoms include a true reduction in the need for sleep and sleep onset insomnia. The plaintiff may have difficulty falling asleep but wake up refreshed after 2-4 hours.

*Hypomanic episodes* are mood disturbances severe enough to cause marked impairment in social or occupational functioning or to require hospitalization.

**SYMPTOM****DEPOSITION QUESTIONS****General Questions***(continued)*

A *mixed episode* is characterized by a period of time (lasting at least one week) in which the criteria are met both for a manic episode and for a major depressive episode nearly every day. (reference 4, p. 1251; reference 7, p. 365)

**Q: Did you rule out a *bipolar disorder* as a cause of the plaintiff's depressed mood?**

A bipolar disorder has a circular pattern of high and low emotional states (*mania and depression*). During the *manic episodes*, the plaintiff may feel grandiose, have a decreased need for sleep, and decreased emotional capacity, experience a surge of ideas and conversation, and may be easily distracted or pleased. It is often thought that the manic high represents an escape from inner depression and pain. While the plaintiff is extremely active, s/he is often fragmented and unable to finish projects. The plaintiff typically does not realize that s/he is ill.

During *major depressive episodes* the plaintiff may be **depressed** for at least two weeks. The plaintiff may experience an appetite disturbance, weight change, sleep disturbance, psychomotor agitation or retardation, decreased energy and emotional capacity, feelings of worthlessness, difficulty thinking or concentrating, and recurrent thoughts of death or suicide. (reference 4, pp. 408-409, 761; reference 7, pp. 382-391)

**Q: Did you rule out *cyclothymic disorder* as a cause of the plaintiff's depressed mood?**

Cyclothymic disorder is a chronic, fluctuating mood involving numerous periods of hypomanic symptoms and **numerous periods of depressive symptoms**. The symptoms are not severe enough to meet the criteria for a major depressive or manic episode. The plaintiff may have impaired social and occupational functioning. Cyclothymic disorder usually begins in adolescence or early adult life. (reference 7, p. 398; reference 4, pp. 760-761, 804)

**Q: Did you rule out a *schizoaffective disorder* as a cause of the plaintiff's depressed mood?**

This group of disorders is characterized by a mixture of schizophrenic and affective or major depressive and manic syndrome. (reference 12)

**Caution: Do not ask the following question if the cause of action involves a head injury or toxic exposure.**

**Q: Did you rule out any head injuries or other conditions leading to *organic brain syndrome* as a cause of the plaintiff's depressed mood?**

Organic brain syndrome is a term for the symptoms produced by head injury, toxic exposure, hypoxia (oxygen deficiency), anoxia (extreme oxygen deficiency in tissues) or other causes. Common symptoms of head injuries include vertigo, syncope (faint) lightheadedness, impaired concentration and memory, easy fatigability, irritability, lack of energy, **depression**, anxiety, phobia, a lowered tolerance for alcohol, and headaches. Symptoms may appear days or weeks after the injury but usually appear within 24 hours. (reference 2, pp. 75, 111)

**SYMPTOM****DEPOSITION QUESTIONS****General Questions***(continued)*

*Note: The following question is to be asked if the plaintiff has experienced the loss of a family member or a close friend during the past two years.*

**Q: Did you rule out bereavement as a cause of the plaintiff's depressed mood?**

Mourning is a normal grief reaction to a loss, such as the death of a loved one. The plaintiff may **feel depressed and dejected**, have diminished interest in the outside world, a decreased capacity to love, and an inhibition of activity. People tend to feel as if all their energy is taken up with thoughts and memories of the loss. Fatigue and weariness are characteristic symptoms. Sighing, feeling empty, disinterested, listless, eating more or less than normal, losing weight, and having trouble sleeping are common experiences. (reference 4, pp. 1286-1293; reference 7, p. 740; reference 2, p. 617)

**Q: Did you rule out an adjustment disorder with depressed mood as a cause of the plaintiff's depressed mood?**

This adjustment disorder is accompanied by **depression**, tearfulness, sleep disturbance, and feelings of hopelessness to a stressor. It is important to note that an adjustment disorder is a transient over-reaction to stress and should remit within six months. (reference 7, p. 679)

*If the witness indicates the possibility of an adjustment disorder with depressed mood, see the section on adjustment disorders for further questions.*

**DEFENSE THEORY—DIFFERENTIAL DIAGNOSIS: The Dysthymic Disorder criteria is very similar to the research criteria for the Depressive Personality Disorder. However, The Depressive Personality Disorder would have existed BEFORE the cause of action. Defense counsel is referred to the DSM-IV-TR (reference 7, page 788) for further details regarding the Depressive Personality Disorder.**

**Q: Did you rule out hallucinogen consumption as the cause of the plaintiff's depressed mood?**

Hallucinogen consumption causes perceptual changes such as feelings of detachment, illusions, hallucinations, and synesthesia (seeing colors when a loud sound occurs). Behavioral symptoms may include anxiety or **depression**, ideas of reference, fear of losing one's mind, paranoia, impaired judgment, and impaired social or occupational functioning. Physical symptoms may include dilated pupils, tachycardia, sweating, palpitations, blurred vision, tremors, and incoordination. Flashbacks of experiences may recur several months or years after hallucinogen use. Many plaintiffs may have gross thought process disturbances. Unlike schizophrenics, they are able to talk in detail about their hallucinations. (reference 7, p. 250; reference 4, p. 874)

**SYMPTOM****DEPOSITION QUESTIONS****General Questions***(continued)***Q: Did you rule out *ecstasy use* as a cause for the plaintiff's depressed mood?**

MDMA (Methylenedioxyamphetamine) use can sometimes result in severe dehydration or exhaustion, or other adverse effects such as nausea, hallucinations, chills, sweating, increases in body temperature, tremors, involuntary teeth clenching, muscle cramping, and blurred vision. MDMA users have also reported after-effects such as anxiety, paranoia, and **depression**. An MDMA overdose is characterized by high blood pressure, faintness, panic attacks, and, in more severe cases, loss of consciousness, seizures, and a drastic rise in body temperatures to 105-106 degrees Fahrenheit. MDMA overdoses can be fatal, as they may result in heart failure or extreme heat stroke. (reference 20)

**Q: Did you rule out *vascular dementia* as a cause of the plaintiff's depressed mood?**

Vascular dementia is caused by cerebrovascular disease (disease of the brain's blood supply or blood vessels) that quickly produces an irregular deterioration in intellectual functioning. The resulting dementia involves disturbances in memory, abstract thinking, judgment, impulse control, and personality. Combined with **depression**, the dementia often causes many cognitive symptoms. (reference 7, p. 147)

**Q: Did you rule out early symptoms of *dementia of the Alzheimer's type* as a cause of the plaintiff's depressed mood?**

This primary degenerative dementia is caused by Alzheimer's disease. The plaintiff's intellectual abilities, personality, and behavior progressively deteriorate. **Depressive symptoms** may complicate the condition. (reference 7, p. 154)

*Age at onset: Senile onset (after age 65) is much more common than pre-senile onset. Few cases develop before the age of 49.*

**Q: Did you rule out *HIV-associated dementia or HIV-associated mild neurocognitive disorder* as a cause of the plaintiff's depressed mood?**

HIV dementia is a severe cognitive disorder that interfere's substantially with work, home life and social activities. Symptoms of mild neurocognitive disorder associated with HIV infection include difficulty concentrating, unusual fatigability with demanding mental tasks, **feeling slowed down** and memory difficulties. Problem solving , abstract reasoning, and motor performance may also be affected. (reference 18, pp. 308-316; reference 7, p. 163)

**Q: Did you rule out *hypothyroidism* as a cause of the plaintiff's depressed mood?**

Hypothyroidism results from inadequate synthesis of thyroid hormone. Hypothyroidism can produce psychiatric, as well as physical symptoms. The most notable psychiatric symptoms include **depression**, lethargy, poor concentration, impaired memory, apathy, and syncope. The numerous physical symptoms are: cold intolerance, constipation, muscle cramps, paresthesias, menstrual disorders, dyspnea, dizziness, reduced hearing, poor appetite, weight gain, brittle and thinning hair, and bradycardia (slowed heart action). Panic attacks are associated with endocrinological

## SYMPTOM

## DEPOSITION QUESTIONS

**General Questions***(continued)*

disorders including hypothyroidism and hyperthyroidism. (reference 18, pp. 743, 1810-1812, 1928)

*If the witness indicates the possibility of hypothyroidism, see the section on pre-existing medical conditions for further questions.*

**Q: Did you rule out Addison's disease as a cause of the plaintiff's depressed mood?**

Addison's disease develops slowly as the adrenal cortex decreases functioning. The plaintiff experiences significant personality and behavioral changes from the reduced level of the steroidal hormones normally produced by the gland. Advance stages of Addison's disease produce **symptoms of depression**, a lack of physical and emotional responsiveness, mild mental disorders, and recent memory loss. (reference 4, pp. 134, 1170-1171, 1276)

*If the witness indicates the possibility of Addison's disease, see the section on pre-existing medical conditions for further questions.*

**Q: Did you rule out long-term treatment with the adrenal cortical steroids or ACTH as a cause of the plaintiff's depressed mood?**

Plaintiffs with a long-term history of adrenal cortical steroid or ACTH treatment commonly develop major mental disturbances. While taking the drugs, they may experience euphoria, severe mania, **severe depression**, delirium, paresthesia (abnormal tightness or tingling around a limb or trunk), insomnia, restlessness, or agitation. Symptoms usually disappear when the drugs are reduced or discontinued. (reference 4, p. 876)

**Q: Did you rule out an avoidant personality disorder as a cause of the plaintiff's depressed mood?**

The avoidant plaintiff is characterized by social discomfort, fear of negative evaluation, and timidity along with a great desire for companionship and guarantees of uncritical acceptance. The plaintiff may be easily hurt by disapproval, exaggerate potential difficulties or dangers, and fear being embarrassed or hurt by others. These people may have few close friends, are unwilling to get involved with others without certainty of being liked, and avoid social situations. Associated symptoms may include **depression**, anxiety and anger. The disorder is diagnosed only after the behavior has persisted for many years and the plaintiff is at least 20 years old. (reference 7, p. 718; reference 4, pp. 981-982, 1752)

*If the witness indicates the possibility of an avoidant personality disorder or other maladaptive personality traits, see the section on pre-existing personality disorders for further questions.*

**Q: Did you rule out anti-ulcer drugs as a cause of the plaintiff's depressed mood?**

Anti-ulcer drugs inhibit gastric acid secretion. Adverse drug reactions of confusion and **depression** can occur when the plaintiff also has renal (kidney) insufficiency, an organic brain syndrome, or when the anti-ulcer drugs are taken in combination with other drugs that slow metabolism. Cimetidine and Tagamet are examples.

*SYMPTOM*

*DEPOSITION QUESTIONS*

**General Questions**

*(continued)*

*Caution: Do not ask the following question if the cause of action involves a head injury or toxic exposure.*

**Q: Did you rule out a mood disorder due to a general medical condition as a cause of the plaintiff's depressed mood?**

The essential feature of a mood disorder due to a general medical condition is a prominent and persistent disturbance in mood that is judged to be due to the direct physiological effects of a general medical condition such as HIV, thyroid disorders, stroke, Parkinson's, metabolic conditions, endocrine disorders, autoimmune, cancer, viral and other infectious conditions. (reference 7, p. 401)

*If the witness indicates the possibility of an organic mood syndrome with depression, see the section on organic disorders for further questions.*

**Q: Is the plaintiff taking any medications or substances that cause the depressed mood, such as antihypertensive medications?**

Other drugs may include:

- |                 |              |                 |
|-----------------|--------------|-----------------|
| ACCUPRIL        | CELEBREX     | DESYREL         |
| ACCUTANE        | CELEXA       | DEXEDRINE       |
| ADALAT          | CELONTIN     | DILAUDID        |
| ADAPIN          | CIPRO        | DIMETAPP        |
| AEROBID         | CLARITAN-D   | DOLOBID         |
| ALDOMET         | CLARITIN     | DORAL           |
| ALDORIL         | CLIMARA      | DURACT          |
| ALTACE          | CLINORIL     | DURAGESIC       |
| AMBIEN          | CLOZARIL     | DURAVENT        |
| AMYTAL          | CODEINE      | DYNACIRC        |
| ANAFRANIL       | COGENTIN     | EFFEXOR         |
| ANAPROX         | COGNEX       | ELDEPRYL        |
| ANDRODERM PATCH | COMBIPRES    | EMPIRIN-CODEINE |
| ANSAID          | CORGARD      | ENDEP           |
| APRESOLINE      | COUMADIN     | ESGIC           |
| ARICEPT         | COZAAR       | ESTRACE         |
| ARTHROTEC       | CRINONE      | ESTRATAB        |
| ASENDIN         | CYCRIN       | ESTRATEST       |
| ATIVAN          | CYLERT       | ETRAFON         |
| AVAPRO          | CYTOTEC      | EXCELON         |
| AXOCET          | DALMANE      | FELDENE         |
| AZULFIDINE      | DANTRIUM     | FIORICET        |
| BACTRIM         | DAYPRO       | FLAGYL          |
| BIPHETAMINE     | DECADRON     | FLEXERIL        |
| BRONTEX         | DEMEROL      | FLOXIN          |
| BUPRENEX        | DEPAKENE     | GABITRIL        |
| BUSPAR          | DEPAKOTE     | HALCION         |
| BUTICAPS        | DEPO-PROVERA | HALDOL          |
| CALAN           | DEPROL       | HISMANAL        |
| CARBATROL       | DESOGEN      | HISTUSSIN       |
| CATAPRES        | DESOXYN      | HYDERGINE       |

**SYMPTOM****DEPOSITION QUESTIONS****General Questions***(continued)*

|                  |                   |                |
|------------------|-------------------|----------------|
| HYTRIN           | NALFON            | PROCAN-SR      |
| HYZAAR           | NAPROSYN          | PROSOM         |
| IMDUR            | NARDIL            | PROTONIX       |
| INAPSINE         | NEMBUTAL          | PROVERA        |
| INDERAL          | NEURONTIN         | PULMICORT      |
| INDERIDE         | NIZORAL           | REDUX          |
| INDOCIN          | NOLUDAR           | REGLAN         |
| KERLONE          | NOLVADEX          | RELAFEN        |
| KLONOPIN         | NORCO             | REMERON        |
| LAMICTAL         | NORDETTE          | REVIA          |
| LESCOL           | NORINYL           | RISPERDAL      |
| LEVAQUIN         | NOROXIN           | ROBAXIN        |
| LEVO-DROMORAM    | NORPACE           | RUFEN          |
| LIBRAX           | NORPLANT-SYSTEM   | SANOREX        |
| LIDODERM PATCH   | NORPRAMIN         | SE-AP-ES       |
| LIMBITROL        | NORVASC           | SECONAL-SODIUM |
| LIORESAL         | NUBAIN            | SEPTRA         |
| LIPITOR          | OGEN              | SEROQUEL       |
| LO-OVRAL         | ORAP              | SERTRALINE     |
| LODINE           | ORTH-NOVUM        | SERZONE        |
| LOMOTIL          | ORTHO-CEPT        | SINEMET        |
| LOPID            | ORTHOCYCLEN       | SINEQUAN       |
| LOPRESSOR        | ORTHOEST          | SOMA           |
| LORCET           | ORUDIS            | SOMA-COMPOUND  |
| LOZOL            | OXYCONTIN         | SONATA         |
| LUDIOMIL         | PAMELOR           | SPORANOX       |
| LUVOX            | PARLODEL          | SULAR          |
| MACROBID         | PARNATE           | SULINDAC       |
| MARCAINE         | PAXIL             | SURMONTIL      |
| MARPLAN          | PAXIPAM           | SYMMETREL      |
| MAVIK            | PEDIAZOLE         | TAGAMET        |
| MAXAIR-AUTOHALER | PEPCID            | TALECEN        |
| MAXALT           | PERMAX            | TALWIN-NX      |
| MAXIDE           | PHENAPHEN-CODEINE | TEGRETOL       |
| MEBARAL          | PHENERGAN-VC-     | TENORETIC      |
| MECLOMEN         | CODEINE           | TENORMIN       |
| MELLARIL         | PHENOBARBITAL     | TESTODERM      |
| MEPERGAN         | PLAVIX            | TIAZAC         |
| MESANTOIN        | PLENDIL           | TIGAN          |
| MINIPRESS        | PONDIMIN          | TIMOPTIC       |
| MIRAPEX          | PRAVACHOL         | TOFRANIL       |
| MOBAN            | PREMARIN          | TOLECTIN       |
| MODURETIC        | PREMPHASE         | TOPAMAX        |
| MONOPRIL         | PREMPRO           | TOPROL-XL      |
| MORPHINE-SULFATE | PREVACID          | TORADOL        |
| MOTRIN           | PRILOSEC          | TRANCOPAL      |
| NALDECON         | PRINZIDE          | TRANDATE       |

## Dysthymic Disorder

**SYMPTOM**

**DEPOSITION QUESTIONS**

**General Questions**  
(continued)

|                 |            |            |
|-----------------|------------|------------|
| TRANXENE        | VASOTEC    | ZANTAC     |
| TRENTAL         | VIAGRA     | ZARONTIN   |
| TRIAVIL         | VICODIN    | ZESTORETIC |
| TRILAFON        | VICOPROFEN | ZESTRIL    |
| TRINALIN        | VIOXX      | ZIAC       |
| TRIPHASIL       | VIVACTIL   | ZOCOR      |
| TROVAN          | VOLTAREN   | ZOMIG      |
| TUINAL          | XANAX      | ZYBAN      |
| TYLENOL-CODEINE | XYLOCAINE  | ZYLOPRIM   |
| VALIUM          | ZANAFLEX   | ZYRTEC     |

**Poor Appetite, Overeating**

- Q: Describe the plaintiff's poor appetite or overeating.**

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- Q: When and how often does the plaintiff eat?**

---

- Q: What are the plaintiff's eating habits between meals?**

---

- Q: Is the plaintiff taking appetite suppressants?**

---

- Q: Is the plaintiff taking appetite stimulants?**

---

- Q: Does the plaintiff have a history of having a poor appetite or overeating before the injury in question?**

---

- Q: Does the plaintiff have an adolescent history of an eating disorder?**

---

- Q: Does the plaintiff have a history of any *medical or psychological conditions* that may cause a poor appetite or overeating?**  
*The witness may indicate the possibility of the following medical or psychological conditions: please refer to the sections pertaining to these medical conditions for further questions.*

**TABLE 5.6-3.**

|                                 |                              |
|---------------------------------|------------------------------|
| Addison's disease               | Pernicious anemia            |
| Alzheimer's disease             | Porphyria                    |
| Anemia                          | Syphilis                     |
| Borderline personality disorder | Systemic lupus erythematosus |
| Hepatitis B                     | Uremic encephalopathy        |
| Hypothyroidism                  |                              |

## SYMPTOM

## DEPOSITION QUESTIONS

**Poor Appetite,  
Overeating***(continued)***Q: Did you rule out *motion sickness* as a cause of the plaintiff's poor appetite or overeating?**

The plaintiff that is susceptible to motion sickness may experience **anorexia**, nausea and vomiting during or following transportation by most any moving vehicle. As the symptoms develop, the plaintiff may experience profound apathy, salivation, and sweating. (reference 2, p. 371)

**Q: Did you rule out *anorexia nervosa* as a cause of the plaintiff's poor appetite or overeating?**

The anorexic plaintiff weighs fifteen percent less than the minimal weight normal for his or her age and height. S/he **refuses to maintain body weight** and has a distorted body image. Other symptoms may include depressed feelings, crying spells, sleep disturbance, obsessive rumination, obsessive compulsive behavior, anxiety, and occasional suicidal thoughts. Many anorexic adolescents have delayed psychosexual development. Adults with the disorder often have a decreased interest in sex. (reference 7, p. 583; reference 1, pp. 1904-1905; reference 4, pp. 1145, 1731)

**Q: Did you rule out *bulimia nervosa* as a cause of the plaintiff's poor appetite or overeating?**

Bulimia nervosa features recurrent episodes of **binge eating**. The plaintiff usually feels a lack of control over eating and may use self-induced vomiting, laxatives, diuretics, **strict dieting, fasting**, or vigorous exercise to prevent weight gain. **Eating binges** may be planned or secret. This behavior must continue at least two times a week for three months. Associated symptoms may include a depressed mood and self-deprecating thoughts. (reference 7, p. 589)

**Q: Did you rule out *riboflavin deficiency (aribo flavinosis)* as a cause of the plaintiff's poor appetite or overeating?**

Riboflavin is one of the B complex vitamins essential for the normal carbohydrate metabolism of yeast cells and animal tissues. Initial oral symptoms include a mild burning sensation in the tongue, oral lesions, and buccal mucosa of the cheeks. Other symptoms are sore and cracking lips, burning and itching eyes, **loss of appetite**, weakness, and irritability. (reference 2, pp. 121, 124-125)

**Q: Did you rule out *rheumatoid arthritis* as a cause of the plaintiff's poor appetite or overeating?**

Rheumatoid arthritis is a progressive disease that causes long-lasting pain in the joints and muscles. Associated symptoms of severe rheumatoid arthritis may include depression, fatigue, **weight loss, anorexia**, pale skin, and weakness. (reference 4, pp. 1185, 1189, 1194; reference 9, p. 1913)

*If the witness indicates the possibility of rheumatoid arthritis, see the section on pre-existing medical conditions for further questions.*

**SYMPTOM****DEPOSITION QUESTIONS****Poor Appetite,  
Overeating***(continued)***Q: (Female) Did you rule out *premenstrual dysphoric disorder* as a cause of the plaintiff's poor appetite or overeating?**

Premenstrual dysphoric disorder is characterized by emotional and behavioral symptoms which usually occur during the last week before the menstrual cycle and remit within a few days after menses begins. Symptoms may include tears, sadness, irritability, anger, tension, depression, self-deprecating thoughts, decreased interest in usual activities, fatigability, loss of energy, a subjective sense of difficulty in concentration, **changes in appetite**, and sleep disturbance. Physical symptoms may also include breast tenderness or swelling, tachycardia, sweating, headaches, joint or muscle pain, a sensation of bloating, or **weight gain**. (reference 7, pp. 771-774; reference 18, pp. 1955)

**Q: Did you rule out *masked depression* as a cause of the plaintiff's poor appetite or overeating?**

The plaintiff with masked depression hides a dysphoric mood with gastrointestinal problems, chronic pain, insomnia, **weight loss**, and other physical complaints. Masked depression is a common condition frequently missed by physicians. (reference 4, p. 796)

**Q: Did you rule out *Cushing's disease (hyperadrenalism)* as a cause of the plaintiff's poor appetite or overeating?**

Plaintiffs often experience emotional changes before physical signs of the disease appear. Depression is the most common symptom. Other psychological symptoms include irritability, anxiety, confusion, insomnia, and impaired memory or concentration. Some of the characteristic physical signs include an **increased appetite**, weakness, buffalo hump, truncal and facial obesity, heightened facial color, and abdominal striae (stripes). (reference 4, pp. 1171-1172)

*If the witness indicates the possibility of Cushing's disease, see the section on pre-existing medical conditions for further questions.*

**Q: (Adolescent males) Did you rule out *Kleine-Levin syndrome* as a cause of the plaintiff's poor appetite or overeating?**

The Kleine-Levin syndrome most often occurs in adolescent males and is characterized by two-week episodes of excessive sleep and **overeating**. The condition usually remits in adulthood. (reference 9, pp. 1988-1989)

**Q: Did you rule out *hyperthyroidism* as a cause of the plaintiff's poor appetite or overeating?**

Hyperthyroidism, or thyrotoxicosis, results from overproduction of thyroid hormone by the thyroid gland. The most common cause is Graves' disease. The signs and symptoms of hyperthyroidism include both physical and psychiatric complaints. Psychiatric features include nervousness, fatigue, insomnia, mood lability, and dysphoria. There may be a heightened activity level. Cognitive symptoms include a short attention span, impaired recent memory, and an exaggerated startle response.

## SYMPTOM

## DEPOSITION QUESTIONS

**Poor Appetite,  
Overeating***(continued)*

Physical signs and symptoms of hyperthyroidism include increased pulse, arrhythmias (irregular heart rhythm), elevated blood pressure, fine tremor, heat intolerance, excessive sweating, **increased appetite, weight loss**, palpitations (abnormal rapid beating of heart), tachycardia (rapid heart beat), frequent bowel movements, menstrual irregularities, and muscle weakness. Panic attacks are associated with endocrinological disorders including hyperthyroidism, as well as hypothyroidism. (reference 18, pp. 743, 1809-1810, 1928)

*If the witness indicates the possibility of hyperthyroidism, see the section on pre-existing medical conditions for further questions.*

**Q: Did you rule out *viral infections* as a cause of the plaintiff's poor appetite or overeating?**

Viral illnesses, such as infectious hepatitis, mononucleosis, and influenza, may produce significant depressive symptoms in the plaintiff. The plaintiff may experience the depressive symptoms for days or weeks after the illness. These self-limited illnesses may cause the plaintiff symptoms of suicidal ideation, **loss of appetite**, libido, and fatigue. The symptoms, however, are brief and related to the viral illness. (reference 4, pp. 876, 1275)

**Q: (Female) Did you rule out *pregnancy* as a cause of the plaintiff's poor appetite or overeating?**

Nausea, vomiting, and **change in appetite** often occur in the first trimester and may continue throughout the pregnancy. (reference 2, p. 370)

**Q: Did you rule out *lithium* as a cause of the plaintiff's poor appetite or overeating?**

Lithium and the tricyclics are often given as medication for depression. Tremor is one of the most common side effects. Other symptoms may include nausea, diarrhea, polyuria (the passage of an excessive quantity of urine), polydipsia (excessive thirst), and **weight gain**. Toxic effects may include gross tremor, increased deep tendon reflexes, persistent headaches, vomiting, mental confusion progressing to stupor, seizures, or cardiac arrhythmias. (reference 1, pp. 1460-1461)

**Q: Did you rule out an *allergic reaction* as a cause of the plaintiff's poor appetite?**

Allergic rhinitis is seasonal or perennial inflammatory disease of the nasal membranes. Symptoms may include sneezing, a stuffy and itching nose, postnasal drainage, and itching eyes, palate, pharynx, and conjunctivae. The plaintiff with allergies may feel generally ill and uncomfortable, tired, weak, despondent, irritable, and **uninterested in eating**. (reference 9, pp. 1867-1868)

*SYMPTOM*

*DEPOSITION QUESTIONS*

**Poor Appetite, Overeating**

*(continued)*

**Q: Did you rule out *pancreatic carcinoma* as a cause of the plaintiffs poor appetite?**

Pancreatic carcinoma is a cancer of the pancreas that causes a decrease in enzymes, lipids, glucagens, and insulin. Symptoms may include abdominal pain radiating to the back, **weight loss, anorexia**, weakness, diarrhea, vomiting, depression, irritability, and a sense of doom without guilt. (reference 1, p. 751; reference 4, p. 1276; reference 9, pp. 777-779; reference 2, p. 425)

*If the witness indicates the possibility of pancreatic carcinoma, see the section on pre-existing medical conditions for further questions.*

**Q: Did you rule out *cannabis (marijuana) consumption* as a cause of the plaintiff's overeating?**

Cannabis intoxication can occur from marijuana, hashish, or tetrahydrocannabinol (THC). Characteristic symptoms include tachycardia, **increased appetite**, dry mouth, euphoria, anxiety, sensation of slowed time, impaired judgment, and social withdrawal. Inappropriate laughter, panic attacks, and a dysphoric mood may occur. (reference 7, p. 234; reference 4, pp. 1326, 754)

**Q: Did you rule out *nicotine withdrawal* as a cause of the plaintiff's overeating?**

Nicotine withdrawal symptoms include a strong craving for nicotine, anxiety, irritability, frustration or anger, impaired attention, coughing, headaches, insomnia, a mental preoccupation with actions associated with tobacco use, restlessness, drowsiness, gastrointestinal disturbances, an **increased appetite, and weight gain**. The symptoms appear within 24 hours after the cessation or reduction in the use of cigarettes, cigars, pipes, chewing tobacco, or nicotine gum. The plaintiff experiences a decrease in the intensity of the symptoms with time. (reference 7, p. 264; reference 4, pp. 1031-1032)

**Q: Is the plaintiff taking any *medications or substances* that cause poor appetite or overeating, such as:**

- |                 |               |            |
|-----------------|---------------|------------|
| ACROMYCIN-V     | ASENDIN       | CLINORIL   |
| ADAPIN          | AVONEX        | CLOZARIL   |
| ADDERALL        | AZULFIDINE    | COGNEX     |
| AEROBID         | BACTRIM       | COLBENAMID |
| ALDACTAZIDE     | BENADRYL      | COLESTID   |
| ALDOMET         | CARBATROL     | COMBIPRES  |
| ALDORIL         | CARDURA       | COMPAZINE  |
| ALTACE          | CATAPRES      | CONCERTA   |
| AMBIEN          | CELEBREX      | CORGARD    |
| ANADROL         | CELEXA        | CORTISONE  |
| ANAFRANIL       | CELONTIN      | COZAAR     |
| ANDRODERM PATCH | CENTRAX       | CRINONE    |
| ANSAID          | CHLORTRIMETON | CYLERT     |
| APRESOLINE      | CIPRO         | CYTOTEC    |
| ARICEPT         | CLARITAN-D    | CYTOXAN    |
| ARTHROTEC       | CLARITIN      | DALALONE   |

**Dysthymic Disorder****SYMPTOM****DEPOSITION QUESTIONS****Poor Appetite,  
Overeating***(continued)*

|                |                  |             |
|----------------|------------------|-------------|
| DANTRIUM       | KERLONE          | OMNICEF     |
| DAYPRO         | KLONOPIN         | OPTIMINE    |
| DECADRON       | LAMICTAL         | ORAP        |
| DELTASONE      | LANOXIN          | ORNADE      |
| DEPAKENE       | LASIX            | ORTHO-CEPT  |
| DEPAKOTE       | LESCOL           | OXYCONTIN   |
| DESYREL        | LEVAQUIN         | PAMELOR     |
| DETROL         | LIMBITROL        | PARLODEL    |
| DEXEDRINE      | LIORESAL         | PARNATE     |
| DIABINESE      | LIPITOR          | PAXIL       |
| DILACOR        | LITHIUM-CITRATE  | PAXIPAM     |
| DIMETANE       | LODINE           | PBZ-SR      |
| DIMETAPP       | LORABID          | PEPCID      |
| DIOVAN         | LOXITANE         | PERIACTIN   |
| DIURIL         | LOZOL            | PERMAX      |
| DOLOBID        | LUDIOMIL         | PERMITIL    |
| DORAL          | LUVOX            | PLAQUENIL   |
| DURACT         | MACRODANTIN      | POLARIMINE  |
| DURAGESIC      | MARPLAN          | PRAVACHOL   |
| EDECRIN        | MAXAIR-AUTOHALER | PREMPHASE   |
| ELAVIL         | MAXALT           | PREMPRO     |
| ELDEPRYL       | MAXIDE           | PREVACID    |
| ENDEP          | MECLOMEN         | PRILOSEC    |
| ENDURON        | MEGACE           | PRINZIDE    |
| ERYC           | MESANTOIN        | PROCAN-SR   |
| ESIDRIX        | METHADONE-       | PROKETAZINE |
| ESKALITH       | HYDROCHLORIDE    | PROLIXIN    |
| ESTRATEST      | METHOTREXATE     | PROSOM      |
| ESTROGEN PATCH | METRONIDAZOLE    | PROTONIX    |
| ETRAFON        | MICRONOR         | PROZAC      |
| EXCELON        | MILONTIN         | PULMICORT   |
| FAMVIR         | MINOCIN          | QUESTRAN    |
| FELBATOL       | MIRAPEX          | QUIDE       |
| FELDENE        | MODURETIC        | RELAFEN     |
| FLAGYL         | MONOPRIL         | REMERON     |
| FLEXERIL       | MORPHINE-SULFATE | RESTORIL    |
| FLOXIN         | MYSOLINE         | REVIA       |
| GLUCOPHAGE     | NALDECON         | RIFAMATE    |
| HALCION        | NALFON           | RISPERDAL   |
| HALDOL         | NAVANE           | RITALIN     |
| HYDRODIURIL    | NEURONTIN        | ROCALTROL   |
| HYGROTON       | NOLVADEX         | RONDEC-DM   |
| HYTRIN         | NOROXIN          | SE-AP-ES    |
| HYZAAR         | NORPACE          | SELDANE     |
| INDERIDE       | NORPLANT-SYSTEM  | SEPTRA      |
| INDOCIN        | NORPRAMIN        | SEROQUEL    |
| KEFZOL         | NORVASC          | SERTRALINE  |

## Dysthymic Disorder

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**SYMPTOM**

**DEPOSITION QUESTIONS**

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**Poor Appetite,  
Overeating**

*(continued)*

|                 |              |            |
|-----------------|--------------|------------|
| SERZONE         | TETRACYCLINE | VIBRAMYCIN |
| SINEMET         | THORAZINE    | VICOPROFEN |
| SINEQUAN        | TIAZAC       | VIOXX      |
| SONATA          | TICLID       | VIVACTIL   |
| SPORANOX        | TIMOPTIC     | WELLBUTRIN |
| ST. JOHN'S WORT | TINDAL       | XANAX      |
| STADOL          | TOFRANIL     | ZARONTIN   |
| STELAZINE       | TOLECTIN     | ZAROXOLY   |
| SULAR           | TOPAMAX      | ZESTORETIC |
| SULINDAC        | TORECAN      | ZESTRIL    |
| SUMYCIN         | TRENTAL      | ZIAC       |
| SURMONTIL       | TRIAVIL      | ZOCOR      |
| SYMMETREL       | TRILAFON     | ZOLOFT     |
| TALECEN         | TRILEPTAL    | ZOMIG      |
| TALWIN-NX       | TRILISATE    | ZOVIRAX    |
| TARACTAN        | TRINALIN     | ZYBAN      |
| TAVIST          | TROVAN       | ZYLOPRIM   |
| TEGRETOL        | ULTRAM       | ZYPREXA    |
| TEMARIL         | VASOTEC      | ZYRTEC     |
| TENORETIC       | VESPRIN      |            |

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**Insomnia,  
Hypersomnia**

- Q: Describe the plaintiff's insomnia or hypersomnia (excessive sleep).**

---

- Q: When and how often does the plaintiff experience insomnia or hypersomnia?**

---

- Q: Does the plaintiff sleep or take naps during the day?**

---

- Q: What are the plaintiff's pre-bedtime patterns? (eating, exercise, alcohol consumption, etc.)**

---

- Q: Does the plaintiff have a history of *insomnia or hypersomnia* before the injury in question?**

Insomnia may be persistent from childhood or early adolescence into adulthood.  
(reference 4, p. 1253)

---

*SYMPTOM*

*DEPOSITION QUESTIONS*

**Insomnia,  
Hypersomnia**

*(continued)*

**Q: Does the plaintiff have a history of any *medical or psychological conditions* that may cause insomnia or hypersomnia?**

*The witness may indicate the possibility of the following medical or psychological conditions: please refer to the sections pertaining to these medical conditions for further questions.*

**TABLE 5.6-4.**

|                           |                                     |
|---------------------------|-------------------------------------|
| Alzheimer's disease       | Hepatic encephalopathy              |
| Brain tumors              | Manic episodes                      |
| Creutzfeldt-Jakob disease | Postpartum disorder                 |
| Depressive disorders      | Subacute sclerosing panencephalitis |
| Epilepsy                  | Somatoform pain disorder            |

**Q: Did you rule out a *childhood overanxious disorder* as a cause of the plaintiff's insomnia or hypersomnia?**

Children with an overanxious disorder have excessive or unrealistic anxiety or worry for at least six months. They tend to be self-conscious and worried about future events and past behavior. Symptoms may include feeling a lump in the throat, headaches, gastrointestinal distress, shortness of breath, nausea, dizziness, **difficulty falling asleep**, nervousness, and other bodily discomforts. The disorder occurs most often in families where there is an unusual emphasis on high achievement. An overanxious disorder may be accompanied by other phobias. It can persist into adult life as an anxiety disorder, such as a generalized anxiety disorder or a social phobia. (reference 7, p. 472; reference 4, pp. 1752-1754)

*Defense counsel should obtain the plaintiff's early school and health records to look for evidence of this disorder.*

**Q: Did you rule out *stressors or other conditions* not attributable to a mental disorder as a cause of the plaintiff's insomnia or hypersomnia?**

*If the witness indicates the possibility of a life stressor or other condition, see the section on other life-stressors for further questions.*

**Q: Did you rule out *sedative, hypnotic, or anxiolytic withdrawal* as a cause of the plaintiff's insomnia or hypersomnia?**

Withdrawal symptoms develop when the plaintiff reduces or stops the prolonged moderate or heavy use of these substances. Symptoms may include nausea or vomiting; malaise or weakness; autonomic hyperactivity (such as tachycardia and sweating); anxiety or irritability; orthostatic hypotension; coarse tremor of the hands, tongue and eyelids; **insomnia**; and grand mal seizures. (reference 7, p. 284; reference 4, p. 1549)

## SYMPTOM

## DEPOSITION QUESTIONS

**Insomnia,  
Hypersomnia***(continued)***Q: Did you rule out *rebound insomnia* as a cause of the plaintiff's insomnia or hypersomnia?**

Rebound insomnia is a worsening of sleep following intermediate term use of drugs, such as: (reference 9, pp. 1988-1989)

Temazepam (Restoril)

Triazolam (Halcion)

**Q: Did you rule out *sleep apnea* as a cause of the plaintiff's insomnia or hypersomnia?**

Sleep apnea is the cessation or suspension of breathing during sleep. These hesitations may cause the plaintiff to **awaken periodically throughout the night**. The most common complaint of plaintiffs with this disorder is excessive daytime drowsiness. (reference 4, pp. 132, 1252)

**Q: (Obese plaintiff) Did you rule out an *obstructive sleep apnea* as a cause of the plaintiff's insomnia or hypersomnia?**

Obesity, sometimes combined with a physical defect, may lead to pulmonary failure or upper airway narrowing. The obstruction causes **repeated awakenings** during the night and a cycle of night and day episodes of awakenings and drowsiness. Weight reduction can be an effective treatment. (reference 1, p. 1321)

**Q: Did you rule out *restless leg syndrome* as a cause of the plaintiff's insomnia or hypersomnia?**

Restlessness and an uncomfortable or painful crawling sensation in the muscles and bones of the lower legs are signs of the restless leg syndrome. The symptoms usually occur at night, **disturbing sleep**, or when the plaintiff is resting. There is no known cause of the syndrome. (reference 4, pp. 132, 1253)

**Q: Did you rule out *nocturnal myoclonus* as a cause of the plaintiff's insomnia or hypersomnia?**

Rhythmic muscle twitches and involuntary movements of the extremities **disrupt the plaintiff's sleep**. The disorder usually begins during late middle age and in the elderly. (reference 9, pp. 1988-1989)

**Q: Did you rule out *self-imposed chaotic sleep schedules* as a cause of the plaintiff's insomnia or hypersomnia?**

Frequently changing sleep-wake schedules can cause **insomnia** and daytime somnolence (drowsiness). This condition is becoming more prevalent and occurs in plaintiffs that fly frequently or that repeatedly change their work schedule.

**Q: Did you rule out *alcohol consumption or withdrawal* as a cause of the plaintiff's insomnia or hypersomnia?**

*Alcohol intoxication* may cause aggressiveness, impaired judgment and attention, irritability, euphoria, depression, emotional lability, and impaired social or

## SYMPTOM

## DEPOSITION QUESTIONS

**Insomnia,  
Hypersomnia***(continued)*

occupational functioning. Physical symptoms may include slurred speech, incoordination, unsteady gait, nystagmus, occasional dizziness, and flushed face. Heavy alcohol consumption may cause **abnormal sleep patterns**. The plaintiff often falls asleep quickly but wakes up earlier and earlier with uncomfortable feelings. Chronic alcoholics may have irregular, unsteady, and slow tremulous movements. (reference 7, p. 212; reference 4, p. 67; reference 9, p. 52)

The *reduction or cessation of drinking* for at least several days may cause characteristic symptoms: coarse tremor of hands, tongue, or eyelids; nausea or vomiting; malaise or weakness; autonomic hyperactivity (tachycardia, sweating, and elevated blood pressure); anxiety, depressed mood or irritability; transient hallucinations or illusions; headache; **insomnia**; dizziness; fatigue; restlessness; and agitation. (reference 7, 215; reference 2, pp. 722, 618; reference 9, pp. 50-54)

**Q: Did you rule out the onset of psychosis or schizophrenia as a cause of the plaintiff's insomnia or hypersomnia?**

The schizophrenic or pre-psychotic plaintiff will have increasing incidence and severity of nightmares and other **sleep difficulties** often caused by guilt, anxiety or both. If it increases in severity, the plaintiff may develop a psychotic state within a few weeks. (reference 4, pp. 67, 1252)

**Q: Did you rule out amphetamine or similarly acting sympathomimetic drug withdrawal as a cause of the plaintiff's insomnia or hypersomnia?**

Drug withdrawal symptoms may include a dysphoric mood (depression, irritability, anxiety), fatigue, sweating, headaches, **insomnia with nightmares, hypersomnia**, and psychomotor agitation. Symptoms begin after the cessation of prolonged drug use (at least two days) and last more than 24 hours. (reference 7, p. 223; reference 4, p. 1008)

The following drugs may be classified as amphetamines:

|                                    |                            |
|------------------------------------|----------------------------|
| Appetite Suppressants (diet pills) | Methamphetamines (speed)   |
| Dextroamphetamines                 | Methylphenidates (Ritalin) |
| Ma-huang (ephedra)                 | (reference 17, p. 586)     |
| (reference 24, pp. 488-489)        |                            |

**Q: Did you rule out cocaine withdrawal as a cause of the plaintiff's insomnia or hypersomnia?**

The abrupt cessation or reduction of cocaine after several days use, may cause the plaintiff to feel tired, dysphoric, irritable, depressed, and to crave more of the drug. An anxiety reaction may cause psychomotor agitation, **insomnia or hypersomnia**, high blood pressure, tachycardia, and paranoia. The symptoms may persist for more than a day. (reference 7, p. 245; reference 4, pp. 1008-1009)

## SYMPTOM

## DEPOSITION QUESTIONS

**Insomnia,  
Hypersomnia***(continued)***Q: Did you rule out *cyclothymic disorder* as a cause of the plaintiff's insomnia or hypersomnia?**

Cyclothymic disorder is a chronic, fluctuating mood involving numerous periods of **hypomanic symptoms** and numerous periods of **depressive symptoms**. The symptoms are not severe enough to meet the criteria for a major depressive or manic episode. The plaintiff may have impaired social and occupational functioning. Cyclothymic disorder usually begins in adolescence or early adult life. (reference 7, p. 398; reference 4, pp. 760-761, 804)

**Q: (Female) Did you rule out *premenstrual dysphoric disorder* as a cause of the plaintiff's insomnia or hypersomnia?**

Premenstrual dysphoric disorder is characterized by emotional and behavioral symptoms which usually occur during the last week before the menstrual cycle and remit within a few days after menses begins. Symptoms may include tears, sadness, irritability, anger, tension, depression, self-deprecating thoughts, decreased interest in usual activities, fatigability, loss of energy, a subjective sense of difficulty in concentration, changes in appetite, and **sleep disturbance**. Physical symptoms may also include breast tenderness or swelling, tachycardia, sweating, headaches, joint or muscle pain, a sensation of bloating, or weight gain. (reference 7, pp. 771-774; reference 18, pp. 1955)

**Q: Did you rule out *opioid withdrawal* as a cause of the plaintiff's insomnia or hypersomnia?**

Symptoms of opioid withdrawal may include lacrimation (tearing), rhinorrhea (runny nose), dilated pupils, sweating, diarrhea, yawning, mild hypertension, tachycardia (increased heart rate), fever, **insomnia**, and gooseflesh. Associated features may include restlessness, irritability, depression, tremor, weakness, nausea, vomiting, and muscle or joint pain. These signs, often resembling influenza symptoms, may be precipitated by the abrupt ending of one or two weeks of continuous opioid use. The withdrawal symptoms may last days or weeks. During the final stages of withdrawal, the plaintiff may experience overconcern for bodily discomfort, poor self-image, and a decreased ability to tolerate stress. (reference 7, p. 272; reference 4, pp. 990-991)

**Q: Did you rule out a recent *heart attack* as a cause of the plaintiff's insomnia or hypersomnia?**

Despondency is almost a universal response to heart attack. Even without complications, the plaintiff may feel a sense of loss and vulnerable to further injury. Weakness and tiredness are the single most distressing symptoms of the depression. The plaintiff may also experience **insomnia**, **daytime hypersomnia**, and practical worries. Complications cause the plaintiff's despondency and hopelessness to be intensified. (reference 4, pp. 1156-1157)

*If the witness indicates the possibility of a recent heart attack, see the section on medical conditions for further questions.*

## SYMPTOM

## DEPOSITION QUESTIONS

**Insomnia,  
Hypersomnia***(continued)***Q: Did you rule out *nicotine withdrawal* as a cause of the plaintiff's insomnia or hypersomnia?**

Nicotine withdrawal symptoms include a strong craving for nicotine, anxiety, irritability, frustration or anger, impaired attention, coughing, headaches, **insomnia**, a mental preoccupation with actions associated with tobacco use, restlessness, drowsiness, gastrointestinal disturbances, an increased appetite, and weight gain. The symptoms appear within 24 hours after the cessation or reduction in the use of cigarettes, cigars, pipes, chewing tobacco, or nicotine gum. The plaintiff experiences a decrease in the intensity of the symptoms with time. (reference 7, p. 264; reference 4, pp. 1031-1032)

**Q: Does the plaintiff have any *central nervous system or non-central nervous system conditions* that may cause insomnia or hypersomnia such as:*****CNS conditions:***

Degenerative conditions

Neoplasms

***Non-CNS conditions:***

Endocrine diseases

Metabolic diseases

**Q: Did you rule out *nightmares* as a cause of the plaintiff's insomnia or hypersomnia?**

Nightmares (dream anxiety attacks) cause the plaintiff to **awaken from REM sleep** with a detailed account of a disturbing dream. S/he may feel anxious and experience autonomic arousal. Nightmares may occur frequently in the more susceptible plaintiff that is stressed, fatigued, or who has consumed alcohol. (reference 4, p. 1260; reference 7, p. 631 reference 1, p. 1321)

**Q: Did you rule out *night terrors* as a cause of the plaintiff's insomnia or hypersomnia?**

Night terrors cause the plaintiff to **awaken with a sense of intense terror** from a single frightening image not associated with a dream. The plaintiff usually falls asleep and forgets the episode. These occurrences seldom require specific treatment. (reference 4, p. 1260)

**Q: Did you rule out *transient or situational insomnia* as a cause of the plaintiff's insomnia or hypersomnia?**

Transient and situational insomnia: A brief period of insomnia is often associated with anxiety from such things as an upcoming event (e.g., exams or job interviews), a recently anxiety provoking experience, or a grief, loss, or almost any life change. (reference 4, p. 1250)

**Q: Did you rule out *pain or discomfort* as a cause of the plaintiff's insomnia or hypersomnia?**

Almost any medical, toxic, or environmental condition associated with pain and discomfort can produce insomnia.

**SYMPTOM****DEPOSITION QUESTIONS****Insomnia,  
Hypersomnia***(continued)***Q: Did you rule out *habit insomnia* as a cause of the plaintiff's insomnia or hypersomnia?**

Habit insomnia is a conditioned reflex. The plaintiff associates going to bed with restlessness and wakefulness, rather than with sleep. (reference 4, p. 1251)

**Q: Did you rule out *age* as a cause of the plaintiff's insomnia or hypersomnia?**

The number of awakenings per night and the amount of time awake during the night increases gradually with age. These changes may be distressing enough for the plaintiff to seek treatment. (reference 4, p. 1261; reference 1, pp. 1321-1322)

**Q: Did you rule out *masked depression* as a cause of the plaintiff's insomnia or hypersomnia?**

The plaintiff with masked depression hides a dysphoric mood with gastrointestinal problems, chronic pain, weight loss, and other physical complaints. Masked depression is a common condition frequently missed by physicians. (reference 4, p. 796)

**Q: Did you rule out *manic or hypomanic episodes* as a cause of the plaintiff's insomnia or hypersomnia?**

A *manic episode* is a period during which the predominant mood is either elevated, expansive, or irritable. Manic symptoms include a true reduction in the need for sleep. The plaintiff may have **difficulty falling asleep** but often wakes up refreshed after two to four hours of rest.

*Hypomanic episodes* are mood disturbances severe enough to require hospitalization or to greatly impair social and occupational functioning. (reference 4, p. 1251; reference 7, p. 365)

**Q: Did you rule out *somatoform (psychogenic) pain disorder* as a cause of the plaintiff's insomnia or hypersomnia?**

Somatoform pain disorder is characterized by pain as the predominant focus of clinical attention. In addition, psychological factors are judged to have an important role in the onset, severity, exacerbation, or maintenance of the pain. Some of the emotionally caused symptoms may be depression, anxiety, anhedonia (an inability to experience pleasure), **insomnia**, and irritability. The symptoms may become so severe that the plaintiff feels incapacitated and quits working. (reference 7, p.498; reference 4, p. 1109)

*If the witness indicates the possibility of a somatoform (psychogenic) pain disorder, see the section on somatoform pain disorder for further questions.*

**Q: Did you rule out an *adjustment disorder with anxiety* as a cause of the plaintiff's insomnia or hypersomnia?**

An adjustment disorder is a transient over-reaction to stress that usually occurs within 90 days and remits within six months. The adjustment disorder with anxiety is characterized by symptoms of nervousness, worry, jitteriness, and motor tension.

## SYMPTOM

## DEPOSITION QUESTIONS

**Insomnia,  
Hypersomnia***(continued)*

**Insomnia** may be a component of the anxiety. (reference 7, p. 680; reference 4, pp. 1098-1099)

*If the witness indicates the possibility of an adjustment disorder, see the section on adjustment disorders for further questions.*

**Q: Did you rule out *Cushing's disease (hyperadrenalism)* as a cause of the plaintiff's insomnia or hypersomnia?**

Plaintiffs often experience emotional changes before physical signs of the disease appear. Depression is the most common symptom. Other psychological symptoms include irritability, anxiety, confusion, **insomnia**, and impaired memory or concentration. Some of the characteristic physical signs include an increased appetite, weakness, buffalo hump, truncal and facial obesity, heightened facial color, and abdominal striae (stripes). (reference 4, pp. 1171-1172)

*If the witness indicates the possibility of Cushing's syndrome, see the section on pre-existing medical conditions for further questions.*

**Q: Did you rule out *generalized anxiety disorder* as a cause of the plaintiff's insomnia or hypersomnia?**

A generalized anxiety disorder is a persistent anxiety that lasts at least six months. The plaintiff has an excessive anxiety about two or more life circumstances. S/he may be anxious about harm coming to a child or having financial difficulties when there is no apparent reason to worry. Symptoms include muscle tension, restlessness or feeling keyed up, fatigue, difficulty concentrating or mind going blank, **sleep disturbance**, and irritability. (reference 7, p. 472)

*If the witness indicates the possibility of a generalized anxiety disorder, see the section on GAD for further questions.*

**Q: (Female) Did you rule out *menopausal distress* as a cause of the plaintiff's insomnia or hypersomnia?**

Menopausal distress may cause anxiety, fatigue, GI disturbances, urinary frequency, back pain, palpitations, tension, emotional lability, irritability and nervousness, depression, dizziness, **insomnia**, and hot flashes. (reference 4, p. 1173; reference 9, p. 21)

*If the witness indicates the possibility of menopausal distress, see the section on medical conditions for further questions.*

**Q: Did you rule out *muscle contraction headaches* as a cause of the plaintiff's insomnia or hypersomnia?**

Chronic muscle contraction headaches may produce nausea, vomiting, lightheadedness, **difficulty in falling asleep**, restless sleep with frequent awakenings, loss of energy, impaired memory and concentration, and symptoms of depression. (reference 2, pp. 72-73; reference 4, p. 1204)

*If the witness indicates the possibility of headaches, see the section on medical conditions for further questions.*

*SYMPTOM*

*DEPOSITION QUESTIONS*

**Insomnia,  
Hypersomnia**

(continued)

**Q: Did you rule out *caffeine consumption or withdrawal* as a cause of the plaintiff's insomnia or hypersomnia?**

Characteristic symptoms of *caffeine intoxication* include restlessness, nervousness, excitement, **insomnia**, flushed face, diuresis, gastrointestinal disturbance, muscle twitching, rambling flow of thought and speech, tachycardia or cardiac arrhythmia, periods of inexhaustibility, and psychomotor agitation. When consumed near bedtime, **caffeine often disrupts sleep**. Symptoms may appear when the plaintiff consumes as little as 250 mg of caffeine per day. The plaintiff that consumes one gram per day usually experiences more severe symptoms. Products which contain caffeine include: coffee, tea, soda, chocolate and weight-loss aids. (reference 7, pp. 231-234; reference 4, p. 1029)

The most common *caffeine withdrawal* symptom is a withdrawal headache. Headaches will occur in about one-third of moderate to high caffeine consumers when their daily intake is stopped. Other withdrawal symptoms include muscle tension, anxiety, drowsiness, lethargy, rhinorrhea (runny nose), disinterest in work, irritability, nervousness, mild feelings of depression, yawning, nausea, and fatigue. (reference 4, p. 1029; reference 2, p. 618)

*See caffeine consumption and symptom chart in Appendix A for further details.*

**Q: Did you rule out a *nightmare disorder* as a cause of the plaintiff's insomnia or hypersomnia?**

The plaintiff **awakens from sleep at least three times a week** with a detailed account of a recurring nightmare. The nightmares may be long, lifelike, and often involve threats of survival or self-esteem. The dream anxieties occur more frequently with mental stress, physical fatigue, or changes in sleep environment. The disorder usually begins before age of twenty. In most cases a major stressful life event precedes the onset of the disorder. (reference 7, p. 631)

**Q: (Adolescent males) Did you rule out *Kleine-Levin syndrome* as a cause of the plaintiff's insomnia or hypersomnia?**

The Kleine-Levin syndrome most often occurs in adolescent males and is characterized by two-week episodes of **excessive sleep** and overeating. The condition usually remits in adulthood. (reference 9, pp. 1988-1989)

**Q: Did you rule out *infections* as a cause of the plaintiff's insomnia or hypersomnia, such as: (reference 2, p. 617)**

- |                                  |                                 |
|----------------------------------|---------------------------------|
| Brucellosis                      | Meningitis                      |
| Chronic urinary tract infections | Subacute bacterial endocarditis |
| Infectious mononucleosis         | Syphilis                        |
| Influenza                        | Tuberculosis                    |
| Malaria                          | Viral hepatitis                 |

*SYMPTOM*

*DEPOSITION QUESTIONS*

**Insomnia,  
Hypersomnia**

*(continued)*

**Q: Did you rule out any cessation of medications or substances that may cause the plaintiff's insomnia or hypersomnia, such as:**

|                           |                      |
|---------------------------|----------------------|
| Antidepressant medication | Opioids              |
| Benzodiazepines           | Phenothiazines       |
| Hypnotics                 | Sedating tricyclics  |
| Marijuana                 | Tranquilizing agents |

**Q: Does the plaintiff have any other medical conditions that may cause insomnia or hypersomnia, such as:**

|                                 |  |
|---------------------------------|--|
| Abnormal swallowing             | Male hypoandrogen secretion            |
| Asthma                          | Metabolic and pulmonary failures       |
| Brain stem and thalamic lesions | Narcolepsy                             |
| Cluster headaches               | Pickwickian syndrome                   |
| Diseases producing fever        | Pulmonary insufficiencies              |
| Emphysema                       | Sleep-related myoclonus                |
| Gastroesophageal reflux         | Sleep-related painful erections (male) |
| Lethargic encephalitis          |  |

**Q: Is the plaintiff taking any medications or substances that may cause insomnia or hypersomnia?**

*Drugs that may cause insomnia:*

|              |                 |              |
|--------------|-----------------|--------------|
| ACUTANE      | BUSPAR          | COZAAR       |
| ADALAT       | BUTICAPS        | CYCRIN       |
| ADAPIN       | CAFFEINE        | CYLERT       |
| ADDERALL     | CARAFATE-TOO    | DALMANE      |
| ADIPEX       | CARDIZEM        | DANTRIUM     |
| AEROBID      | CATAPRES        | DECADRON     |
| ALTACE       | CEFZIL          | DEPO-PROVERA |
| AMBIEN       | CELEBREX        | DEPROL       |
| AMPHETAMINES | CELEXA          | DESOXYN      |
| AMYTAL       | CELONTIN        | DESYREL      |
| ANAFRANIL    | CHLORAL-HYDRATE | DEXEDRINE    |
| ANAPROX      | CHLORTRIMETON   | DILACOR      |
| ANSAID       | CIPRO           | DILANTIN     |
| ARICEPT      | CLARITAN-D      | DIMETANE     |
| ARTHROTEC    | CLARITIN        | DIOVAN       |
| ASENDIN      | CLINDEX         | DITROPAN     |
| ATROVENT     | CLINORIL        | DOLOBID      |
| AUGMENTIN    | CLOZARIL        | DONNATAL     |
| AZULFIDINE   | COGNEX          | DORAL        |
| BACTRIM      | COLESTID        | DURACT       |
| BELLERGA     | COMBIPRES       | DURAVENT     |
| BENADRYL     | COMBIVENT       | DYNACIRC     |
| BENTYL       | COMPAZINE       | EFFEXOR      |
| BIPHETAMINE  | CONCERTA        | ELAVIL       |

## Dysthymic Disorder

*SYMPTOM*

*DEPOSITION QUESTIONS*

**Insomnia,  
Hypersomnia**

(continued)

|                  |                  |                |
|------------------|------------------|----------------|
| ELDEPRYL         | MEBARAL          | PRILOSEC       |
| ENDEP            | MECLOMEN         | PRINZIDE       |
| ENTEXLA          | METHADONE-       | PROAMATINE     |
| EPHEDRA          | HYDROCHLORIDE    | PROKETAZINE    |
| ETRAFON          | MIRAPEX          | PROPULSID      |
| EXCELON          | MODURETIC        | PROSOM         |
| FASTIN           | MONOPRIL         | PROTONIX       |
| FELBATOL         | MORPHINE-SULFATE | PROVENTIL      |
| FELDENE          | MOTRIN           | PROVERA        |
| FLAGYL           | NALDECON         | PULMICORT      |
| FLEXERIL         | NALFON           | REDUX          |
| FLOMAX           | NAPROSYN         | REGLAN         |
| FLOXIN           | NAVANE           | RELAFEN        |
| GABITRIL         | NEMBUTAL         | REMERON        |
| HABITROL         | NEURONTIN        | RESTORIL       |
| HALCION          | NICORETTE        | REVIA          |
| HALDOL           | NOLUDAR          | RISPERDAL      |
| HISTUSSIN        | NOREPHEDRINE     | RITALIN        |
| HYTRIN           | NOROXIN          | RONDEC-DM      |
| HYZAAR           | NORPACE          | RUFEN          |
| IMDUR            | NORPRAMIN        | SANOREX        |
| INDERAL          | NORVASC          | SANSERT        |
| INDERIDE         | OMNICEF          | SECONAL-ELIXIR |
| INDOCIN          | OPTIMINE         | SECONAL-SODIUM |
| IONAMIN          | ORAP             | SELDANE        |
| KERLONE          | ORNADE           | SEPTRA         |
| KLONOPIN         | ORUDIS           | SEREVENT       |
| LESCOL           | OXYCONTIN        | SEROQUEL       |
| LEVAQUIN         | PAMELOR          | SERTRALINE     |
| LEVO-DROMORAM    | PARLODEL         | SERZONE        |
| LEVOTHROID       | PARNATE          | SINEMET        |
| LEVSIN           | PBZ-SR           | SLO-BID        |
| LIORESAL         | PEDIAZOLE        | SLO-PHYLLIN    |
| LIPITOR          | PEPCID           | SOMA           |
| LODINE           | PERIACTIN        | SOMA-COMPOUND  |
| LOPRESSOR        | PERMAX           | SONATA         |
| LOTENSIN         | PERMITIL         | SPORANOX       |
| LOTREL           | PHENOBARBITAL    | STADOL         |
| LOZOL            | PHENYL-          | SULAR          |
| LUDIOMIL         | PROPANOLAMINE    | SULINDAC       |
| LUFYLLIN-GG      | PLACIDYL         | SURMONTIL      |
| LUVOX            | PLAVIX           | SYMMETREL      |
| MARPLAN          | PLENDIL          | TALECEN        |
| MAVIK            | POLARIMINE       | TALWIN-NX      |
| MAXAIR-AUTOHALER | PONDIMIN         | TAVIST         |
| MAXALT           | PREMPHASE        | TEMARIL        |
| MAXIDE           | PREMPRO          | THEO-DUR       |

## Dysthymic Disorder

**SYMPTOM**

**DEPOSITION QUESTIONS**

**Insomnia,  
Hypersomnia**

*(continued)*

|           |            |            |
|-----------|------------|------------|
| THORAZINE | TROVAN     | XANAX      |
| TIAZAC    | TUINAL     | ZANTAC     |
| TIMOPTIC  | VALIUM     | ZAROXOLY   |
| TINDAL    | VANTIN     | ZESTORETIC |
| TOFRANIL  | VASOTEC    | ZESTRIL    |
| TOPAMAX   | VENTOLIN   | ZOCOR      |
| TOPROL-XL | VERELAN    | ZOLOFT     |
| TORADOL   | VIAGRA     | ZOMIG      |
| TRANXENE  | VICOPROFEN | ZYBAN      |
| TRIAVIL   | VIOXX      | ZYLOPRIM   |
| TRILAFON  | VIVACTIL   | ZYPREXA    |
| TRILEPTAL | VOLTAREN   | ZYRTEC     |
| TRINALIN  | WELLBUTRIN |            |

*Drugs that may cause hypersomnia:*

|                  |                   |                  |
|------------------|-------------------|------------------|
| AMOXAPINE        | FLUNARIZINE       | PIRIBEDIL        |
| ANTIHISTAMINES   | INDORAMIN         | TRAZODONE        |
| BENZODIAZEPINES  | KETOTIFEN         | VALPROATE SODIUM |
| BUTORPHANOL      | LUVOX             | ZESTORETIC       |
| CHLORPHENTERMINE | MAXALT            | ZESTRIL          |
| CLONIDINE        | METHYLDOPA        |                  |
| FENFLURAMINE     | NEUROLEPTIC AGENT |                  |

**Low Energy,  
Fatigue**

**Q: Describe the plaintiff's low energy or fatigue.**

**Q: Does the plaintiff have a history of low energy or fatigue before the injury in question?**

**Q: When and how often does the plaintiff experience the loss of energy or fatigue?**

**Q: Does the plaintiff have a history of any *medical or psychological conditions* that may cause low energy or fatigue?**

*The witness may indicate the possibility of the following medical conditions: please refer to the sections pertaining to these medical conditions for further questions.*

**TABLE 5.6-5.**

|                                       |                       |
|---------------------------------------|-----------------------|
| Addison's disease                     | Depressive disorders  |
| Bipolar disorder                      | Hepatitis B           |
| Brain tumors                          | Hypertension          |
| Chronic fatigue syndrome              | Hyperthyroidism       |
| Chronic obstructive pulmonary disease | Hypoglycemia          |
| Combined systems disease              | Hypothyroidism        |
| Creutzfeldt-Jakob disease             | Menopausal distress   |
| Cushing's syndrome                    | Mitral valve prolapse |

**SYMPTOM**

**DEPOSITION QUESTIONS**

**Low Energy,  
Fatigue**  
(continued)

TABLE 5.6-5. (continued)

|                      |                              |
|----------------------|------------------------------|
| Multiple sclerosis   | Porphyria                    |
| Pancreatic carcinoma | Postpartum disorder          |
| Pernicious anemia    | Systemic lupus erythematosus |
| Polycythemia         | Uremic encephalopathy        |

**Q: Did you rule out *insomnia disorders* as a cause of the plaintiff's low energy or fatigue?**

Insomnia disorders cause sleep disturbance. The plaintiff may be tired after an adequate sleep (non-restorative sleep). This pattern lasts for at least a month with the sleep difficulties occurring at least three times a week. The disorder may be severe enough to cause **daytime fatigue**, irritability, or an impaired memory and concentration. (reference 7, p. 599; reference 2, p. 601)

**Q: Did you rule out *sleep apnea* as a cause of the plaintiff's low energy or fatigue?**

Sleep apnea is the cessation or suspension of breathing during sleep. These hesitations may cause the plaintiff to awaken periodically throughout the night. The most common complaint of plaintiff's with this disorder is **excessive daytime drowsiness**. (reference 4, pp. 132, 1252)

**Q: Did you rule out *chronic fatigue syndrome* as a cause of the plaintiff's low energy or fatigue?**

Chronic fatigue syndrome presents with six months or more of **severe, debilitating fatigue** accompanied by myalgia, headaches, pharyngitis, low-grade fever, cognitive complaints, gastrointestinal symptoms, and tender lymph nodes. There is a high rate (15-54%) of depressive disorders among patients with chronic fatigue syndrome. Persons most likely to be plagued by persistent fatigue after an acute viral illness are patients with pre-existing or co-morbid psychiatric problems. Chronic fatigue syndrome is considered to be a special class of mood disorder with somatic symptoms. (reference 18, pp. 1531-1532)

**Q: Did you rule out *sedative, hypnotic, or anxiolytic consumption or withdrawal* as a cause of the plaintiff's low energy or fatigue?**

Sedative, hypnotic, or anxiolytic *drug consumption* can cause behavioral and physical changes. Behavioral symptoms may include disinhibition of sexual or aggressive impulses, mood lability, impaired judgment, and impaired social or occupational functioning. Physical symptoms may include slurred speech, incoordination, unsteady gait, **fatigue**, and impaired memory or attention span. Sedative drugs and minor tranquilizers cause impairment on many behavioral tasks. They may also improve some plaintiff's work or social functioning by reducing severe anxiety. The effects of two or more drugs, such as sedatives and alcohol, may cause significant behavioral impairment. (reference 7, p. 284; reference 4, p. 1548)

**SYMPTOM****DEPOSITION QUESTIONS****Low Energy,  
Fatigue***(continued)*

*Withdrawal symptoms* develop when the plaintiff reduces or stops the prolonged moderate or heavy use of these substances. Symptoms may include nausea or vomiting; **malaise or weakness**; autonomic hyperactivity (such as tachycardia and sweating); anxiety or irritability; orthostatic hypotension; coarse tremor of the hands, tongue and eyelids; insomnia; and grand mal seizures. (reference 7, p. 284; reference 4, p. 1549)

**Q: Did you rule out *hypothyroidism* as a cause of the plaintiff's low energy or fatigue?**

Hypothyroidism results from inadequate synthesis of thyroid hormone. Hypothyroidism can produce psychiatric, as well as physical symptoms. The most notable psychiatric symptoms include depression, **lethargy**, poor concentration, impaired memory, apathy, and syncope. The numerous physical symptoms are: cold intolerance, constipation, muscle cramps, paresthesias, menstrual disorders, dyspnea, dizziness, reduced hearing, poor appetite, weight gain, brittle and thinning hair, and bradycardia (slowed heart action). Panic attacks are associated with endocrinological disorders including hypothyroidism and hyperthyroidism. (reference 18, pp. 743, 1810-1812, 1928)

**Q: Did you rule out *amphetamine or similarly acting sympathomimetic drug withdrawal* as a cause of the plaintiff's low energy or fatigue?**

Drug withdrawal symptoms may include a dysphoric mood (depression, irritability, anxiety), **fatigue**, sweating, headaches, insomnia with nightmares, hypersomnia, and psychomotor agitation. Symptoms begin after the cessation of prolonged drug use (at least two days) and last more than 24 hours. (reference 7, p. 223; reference 4, p. 1008)

The following drugs may be classified as amphetamines:

|                                    |                            |
|------------------------------------|----------------------------|
| Appetite Suppressants (diet pills) | Methamphetamines (speed)   |
| Dextroamphetamines                 | Methylphenidates (Ritalin) |
| Ma-huang (ephedra)                 | (reference 17, p. 586)     |
| (reference 24, pp. 488-489)        |                            |

**Q: (Female) Did you rule out *premenstrual dysphoric disorder* as a cause of the plaintiff's low energy or fatigue?**

Premenstrual dysphoric disorder is characterized by emotional and behavioral symptoms which usually occur during the last week before the menstrual cycle and remit within a few days after menses begins. Symptoms may include tears, sadness, irritability, anger, tension, depression, self-deprecating thoughts, decreased interest in usual activities, **fatigability, loss of energy**, a subjective sense of difficulty in concentration, changes in appetite, and sleep disturbance. Physical symptoms may also include breast tenderness or swelling, tachycardia, sweating, headaches, joint or muscle pain, a sensation of bloating, or weight gain. (reference 7, pp. 771-774; reference 18, p. 1955)

## SYMPTOM

## DEPOSITION QUESTIONS

**Low Energy,  
Fatigue***(continued)***Q: Did you rule out *hypoglycemia* as a cause of the plaintiff's low energy or fatigue?**

Hypoglycemia is an abnormally low blood sugar level. It often produces personality changes, **tiredness**, confusion, dizziness, tremor, anxiety, tachycardia, and sweating during acute attacks. Other psychiatric symptoms include fear and dread, **depression with fatigue**, and agitation with confusion. Hypoglycemia can develop from an insulin overdose, insulinoma or islet cell tumor, extensive liver disease, or functional diseases. (reference 2, p. 702; reference 4, pp. 1176-1177; reference 18, pp. 1929 and 1479 )

*If the witness indicates the possibility of hypoglycemia, see the section on pre-existing medical conditions for further questions.*

**Q: Did you rule out a *histrionic personality disorder* as a cause of the plaintiff's low energy or fatigue?**

The histrionic plaintiff is self-centered, dramatic, emotionally excessive, shallow, and exhibits considerable mood instability. S/he is often uncomfortable when not the center of attention and seeks reassurance, approval, or praise from others. The plaintiff may complain of poor health, **weakness**, headaches, or feelings of depersonalization. While an over-concern with physical attractiveness and an inappropriate sexually seductive appearance or behavior is common, plaintiffs with this disorder often have troubled interpersonal relationships and can be sexually naive or unresponsive. (reference 7, p. 711; reference 4, p. 586)

*If the witness indicates the possibility of a histrionic personality disorder or other maladaptive personality traits, see the section on pre-existing personality disorders for further questions.*

**Q: Did you rule out *HIV-associated dementia or HIV-associated mild neurocognitive disorder* or as a cause of the plaintiff's low energy or fatigue?**

HIV dementia is a severe cognitive disorder that interfere's substantially with work, home life and social activities. Symptoms of mild neurocognitive disorder associated with HIV infection include difficulty concentrating, **unusual fatigability with demanding mental tasks, feeling slowed down** and memory difficulties. Problem solving , abstract reasoning, and motor performance may also be affected. (reference 18, pp. 308-316; reference 7, p. 163)

**Q: Did you rule out *metabolic alkalosis* as a cause of the plaintiff's low energy or fatigue?**

Metabolic alkalosis is an increased blood PH that may cause symptoms of edginess, **weakness**, muscle cramps and postural hypotension (a drop in blood pressure when standing). (reference 2, p. 761)

## SYMPTOM

## DEPOSITION QUESTIONS

**Low Energy,  
Fatigue***(continued)***Q: Did you rule out *niacin deficiency (B complex)* as a cause of the plaintiff's low energy or fatigue?**

Niacin is one of the B complex vitamins essential for the normal carbohydrate metabolism of yeast cells and animal tissues. As the body's level of niacin decreases, the plaintiff may initially experience a burning tongue after eating hot or spicy foods. Symptoms are often more severe in the spring and fall and may be associated with mild anorexia, **fatigue**, nervousness, irritability, alternating periods of constipation and diarrhea, or burning sensations in the epigastrium (upper and middle abdomen). (reference 2, pp. 121-123)

**Q: Did you rule out *riboflavin deficiency (ariboflavinosis)* as a cause of the plaintiff's low energy or fatigue?**

Riboflavin is one of the B complex vitamins essential for the normal carbohydrate metabolism of yeast cells and animal tissues. Initial oral symptoms include a mild burning sensation in the tongue, oral lesions, and buccal mucosa of the cheeks. Other symptoms are sore and cracking lips, burning and itching eyes, loss of appetite, **weakness**, and irritability. (reference 2, pp. 121, 124-125)

**Q: Did you rule out *alcohol withdrawal* as a cause of the plaintiff's low energy or fatigue?**

The reduction or cessation of drinking for at least several days may cause characteristic symptoms: coarse tremor of hands, tongue, or eyelids; nausea or vomiting; **malaise or weakness**; autonomic hyperactivity (tachycardia, sweating, and elevated blood pressure); anxiety, depressed mood or irritability; transient hallucinations or illusions; headache; insomnia; dizziness; **fatigue**; restlessness; and agitation. (reference 7, p. 212; reference 2, pp. 722, 618; reference 9, pp. 50-54)

**Q: Did you rule out *opioid consumption or withdrawal* as a cause of the plaintiff's low energy or fatigue?**

*Opioid intoxication* is characterized by euphoria, flushing, itching skin, miosis, drowsiness, decreased respiratory rate and depth, hypotension, bradycardia, and decreased body temperature. The initial euphoria is often followed by **apathy**, unpleasant mood, **psychomotor retardation**, impaired judgment, and impaired social or occupational functioning. While dependence on opioids is less common than on alcohol or tobacco, it has been estimated that fifteen percent of males and nine percent of females have used an opioid (nonmedical) during their lifetime. (reference 7, pp. 269-272; reference 4, pp. 987-988)

Symptoms of *opioid withdrawal* may include lacrimation (tearing), rhinorrhea (runny nose), dilated pupils, sweating, diarrhea, yawning, mild hypertension, tachycardia (increased heart rate), fever, insomnia, and gooseflesh. Associated features may include restlessness, irritability, depression, tremor, **weakness**, nausea, vomiting, and muscle or joint pain. These signs, often resembling influenza symptoms, may be precipitated by the abrupt ending of one or two weeks of continuous opioid use. The withdrawal symptoms may last days or weeks. During

## SYMPTOM

## DEPOSITION QUESTIONS

**Low Energy,  
Fatigue***(continued)*

the final stages of withdrawal, the plaintiff may experience overconcern for bodily discomfort, poor self-image, and a decreased ability to tolerate stress. (reference 7, pp. 272-273; reference 4, pp. 990-991)

**Q: Did you rule out *caffeine withdrawal* as a cause of the plaintiff's low energy or fatigue?**

The most common caffeine withdrawal symptom is a withdrawal headache. Headaches will occur in about one-third of moderate to high caffeine consumers when their daily intake is stopped. Other withdrawal symptoms include muscle tension, anxiety, drowsiness, **lethargy**, rhinorrhea (runny nose), disinterest in work, irritability, nervousness, mild feelings of depression, yawning, nausea, and **fatigue**. (reference 4, p. 1029; reference 2, p. 618)

*See caffeine consumption and symptom chart in Appendix A for further details.*

**Q: Did you rule out a *bipolar disorder* as a cause of the plaintiff's low energy or fatigue?**

A bipolar disorder has a circular pattern of high and low emotional states (*mania and depression*). During the *manic episodes*, the plaintiff may feel grandiose, have a decreased need for sleep, and decreased emotional capacity, experience a surge of ideas and conversation, and may be easily distracted or pleased. It is often thought that the manic high represents an escape from inner depression and pain. While the plaintiff is extremely active, s/he is often fragmented and unable to finish projects. The plaintiff typically does not realize that s/he is ill.

During *major depressive episodes* the plaintiff may be depressed for at least two weeks. The plaintiff may experience an appetite disturbance, weight change, sleep disturbance, psychomotor agitation or retardation, **decreased energy** and emotional capacity, feelings of worthlessness, difficulty thinking or concentrating, and recurrent thoughts of death or suicide. (reference 4, pp. 408-409, 761; reference 7, pp. 382-391)

**Q: Did you rule out an *adjustment disorder* as a cause of the plaintiff's low energy or fatigue?**

An adjustment disorder is a transient over-reaction to stress that usually occurs within 90 days and remits within six months. The adjustment disorder may be characterized by symptoms of **fatigue**, headache, backache, or other aches and pains (reference 7, p. 679)

*If the witness indicates the possibility of an adjustment disorder, see the section on adjustment disorders for further questions.*

**SYMPTOM****DEPOSITION QUESTIONS****Low Energy,  
Fatigue***(continued)***Q: Did you rule out *muscle contraction headaches* as a cause of the plaintiff's low energy or fatigue?**

Chronic muscle contraction headaches may produce nausea, vomiting, lightheadedness, difficulty in falling asleep, restless sleep with frequent awakenings, **loss of energy**, impaired memory and concentration, and symptoms of depression. (reference 2, pp. 72-73; reference 4, p. 1204)

*If the witness indicates the possibility of headaches, see the section on medical conditions for further questions.*

**Q: Did you rule out *hyperthyroidism* as a cause of plaintiff's low energy or fatigue?**

Hyperthyroidism, or thyrotoxicosis, results from overproduction of thyroid hormone by the thyroid gland. The most common cause is Graves' disease. The signs and symptoms of hyperthyroidism include both physical and psychiatric complaints. Psychiatric features include nervousness, **fatigue**, insomnia, mood lability, and dysphoria. There may be a heightened activity level. Cognitive symptoms include a short attention span, impaired recent memory, and an exaggerated startle response.

Physical signs and symptoms of hyperthyroidism include increased pulse, arrhythmias (irregular heart rhythm), elevated blood pressure, fine tremor, heat intolerance, excessive sweating, increased appetite, weight loss, palpitations (abnormal rapid beating of heart), tachycardia (rapid heart beat), frequent bowel movements, menstrual irregularities, and muscle weakness. Panic attacks are associated with endocrinological disorders including hyperthyroidism, as well as hypothyroidism. (reference 18, pp. 743, 1809-1810, 1928)

**Q: Did you rule out *mitral valve prolapse (MVP)* as a cause of the plaintiff's low energy or fatigue?**

Mitral valve prolapse (MVP) is a common and sometimes serious congenital ballooning of a heart valve often associated with arrhythmias of the heart. MVP and panic attacks share many common symptoms including chest pain, palpitation, dyspnea, **weakness, fatigue**, dizziness, syncope (a faint), and anxiety. (reference 4, pp. 1149, 1551)

*If the witness indicates the possibility of mitral valve prolapse, see the section on pre-existing medical conditions for further questions.*

**Q: Did you rule out *infections* as a cause of the plaintiff's low energy or fatigue, such as:**

|                                  |                                 |
|----------------------------------|---------------------------------|
| Brucellosis                      | Meningitis                      |
| Chronic urinary tract infections | Subacute bacterial endocarditis |
| HIV                              | Syphilis                        |
| Infectious mononucleosis         | Tuberculosis                    |
| Influenza                        | Viral hepatitis                 |
| Malaria                          |                                 |

## SYMPTOM

## DEPOSITION QUESTIONS

**Low Energy,  
Fatigue***(continued)***Q: Did you rule out a *neuroendocrine disorder* as a cause of the plaintiff's low energy or fatigue?**

Symptoms of a neuroendocrine disorder include sudden headaches, excessive sweating, and palpitations. Often there are associated tremors, **weakness**, nausea, and epigastric discomfort. The plaintiff may also complain of chest pain, shortness of breath, lightheadedness, blurred vision, and flushing. (reference 2, p. 612)

**Q: Did you rule out *anemia* as a cause of the plaintiff's low energy or fatigue?**

Vertigo, pounding headaches, fainting, dimness of vision, tinnitus (a ringing in one or both ears), irritability, restlessness, inability to concentrate, **lethargy, fatigue**, drowsiness, and GI complaints are common symptoms of anemia. (reference 2, pp. 566-571)

*If the witness indicates the possibility of anemia, see the section on pre-existing medical conditions for further questions.*

**Q: Did you rule out a recent *heart attack* as a cause of the plaintiff's low energy or fatigue?**

Despondency is almost a universal response to heart attack. Even without complications, the plaintiff may feel a sense of loss and vulnerable to further injury. **Weakness and tiredness** are the single most distressing symptoms of the depression. The plaintiff may also experience insomnia, daytime hypersomnia, and practical worries. Complications cause the plaintiff's despondency and hopelessness to be intensified. (reference 4, pp. 1156-1157)

*If the witness indicates the possibility of a recent heart attack, see the section on medical conditions for further questions.*

**Q: Did you rule out an *allergic reaction* as a cause of the plaintiff's low energy or fatigue?**

Allergic rhinitis is seasonal or perennial inflammatory disease of the nasal membranes. Symptoms may include sneezing; a stuffy and itching nose; postnasal drainage; and itching eyes. The plaintiff with allergies may feel generally ill and uncomfortable, **tired, weak, despondent**, irritable, and uninterested in eating. (reference 9, pp. 1867-1868)

**Q: Did you rule out *rheumatoid arthritis* as a cause of the plaintiff's low energy or fatigue?**

Rheumatoid arthritis is a progressive disease that causes long-lasting pain in the joints and muscles. Associated symptoms of severe rheumatoid arthritis may include depression, **fatigue**, weight loss, anorexia, pale skin, and weakness. (reference 4, pp. 1185, 1189, 1194; reference 9, p. 1913)

*If the witness indicates the possibility of rheumatoid arthritis, see the section on pre-existing medical conditions for further questions.*

*SYMPTOM*

*DEPOSITION QUESTIONS*

**Low Energy, Fatigue**

*(continued)*

**Q: Did you rule out *hyperventilation* as a cause of the plaintiff's low energy or fatigue?**

Hyperventilation is abnormal, rapid, deep breathing usually due to anxiety. Exercise and strong emotions may cause hyperventilation, or it can begin spontaneously. Symptoms may include lightheadedness, faintness, ringing in the ears, **weakness**, blurring of vision, and tingling around the mouth or in the extremities. (reference 2, p. 613)

**Q: Did you rule out other *nutritional deficiencies or electrolyte disturbances* as a cause of the plaintiff's low energy or fatigue, such as: (reference 2, p. 618)**

|            |             |
|------------|-------------|
| Folate     | Thiamine    |
| Iron       | Vitamin B12 |
| Pyridoxine |             |

**Q: Did you rule out *loneliness* as a cause of the plaintiff's low energy or fatigue?**

Loneliness and aimlessness are the most pronounced symptoms for six to nine months following the death of a loved one. During this time, the plaintiff's **activity level is very low, they feel dead to new stimuli** and may experience the more severe forms of loneliness, estrangement and alienation. (reference 4, p. 128)

**Q: Did you rule out *sleep deprivation* for any reason as a cause of the plaintiff's low energy or fatigue?**

Sleep deprivation from any cause such as anxiety, sleep apnea, narcolepsy, nocturnal myoclonus, and drug-induced deprivation of REM sleep will result in **fatigue**. (reference 2, p 618)

**Q: Does the plaintiff have any *other medical conditions* that may cause low energy or fatigue, such as:**

|                                 |  |
|---------------------------------|--|
| Acute infectious bronchitis     | Endocrine disorders                                    |
| Anticancer chemotherapy         | Hepatitis  |
| CO2 retention                   | Local peripheral motor neuropathy or radiculopathy     |
| Cancer                          | Male hypoandrogen secretion                            |
| Central nervous system disease  | Metabolic and pulmonary failures                       |
| Chronic renal and liver disease | Myasthenia gravis                                      |
| Chronic pyelonephritis          | Neurologic disorders                                   |
| Congestive heart failure        | Panhypopituitarism                                     |
| Dehydration                     | Pseudotumor cerebri (benign intracranial hypertension) |
| Diabetes                        |  |
| Disseminated malignancy         |  |

**SYMPTOM****DEPOSITION QUESTIONS****Low Energy,  
Fatigue***(continued)***Q:** Is the plaintiff taking any *medications or substances* that may cause low energy or fatigue, such as:

|                 |                 |                  |
|-----------------|-----------------|------------------|
| ACCUPRIL        | CELEXA          | DURAVENT         |
| ACCUTANE        | CELONTIN        | DYNACIRC         |
| ADALAT          | CENTRAX         | EDECIN           |
| ADAPIN          | CHLORAL-HYDRATE | ELAVIL           |
| AEROBID         | CHLORTRIMETON   | ELDEPRYL         |
| AKINETONE       | CIPRO           | EMPIRIN-CODEINE  |
| ALDACTAZIDE     | CLARITAN-D      | ENDEP            |
| ALDACTONE       | CLINDEX         | EQUAGESIC        |
| ALLEGRA         | CLOZARIL        | EQUANIL          |
| ALTACE          | CODEINE         | ESGIC            |
| AMBIEN          | COGNEX          | ESKALITH         |
| AMERGE          | COLESTID        | ETRAFON          |
| ANAFRANIL       | COMBIPRES       | FAMVIR           |
| ANAPROX         | COMBIVENT       | FIORICET         |
| ANDRODERM PATCH | COMPAZINE       | FIORINAL-CODEINE |
| ANTABUSE        | CONCERTA        | FLEXERIL         |
| ANTIVERT        | CORGARD         | FLOXIN           |
| ARICEPT         | COUMADIN        | GABITRIL         |
| ARTANE          | COZAAR          | GLUCOTROL        |
| ARTHROTEC       | CRINONE         | GUAIFED          |
| ASENDIN         | CYCRIN          | HALCION          |
| ATARAX          | CYLERT          | HALDOL           |
| AVANDIA         | CYSTOSPAZ       | HISTUSSIN        |
| AVAPRO          | CYTOTEC         | HUMULIN          |
| AXID            | DALMANE         | HYDRO-           |
| AXOCET          | DANTRIUM        | CHLOROTHIAZIDE   |
| AZULFIDINE      | DEPAKOTE        | HYZAAR           |
| BACTRIM         | DEPO-PROVERA    | IMDUR            |
| BELLERGA        | DEPROL          | IMITREX          |
| BENADRYL        | DESOXYN         | IMMODIUM         |
| BENTYL          | DESYREL         | INAPSINE         |
| BIPHETAMINE     | DETROL          | INDERAL          |
| BRETHINE        | DEXEDRINE       | INDERIDE         |
| BRICANYL        | DIAMOX          | INDOCIN          |
| BROMFED         | DIBENZYLINE     | INSULIN          |
| BUMEX           | DILAUDID        | KEFLEX           |
| BUPRENEX        | DIMETANE        | KEFTAB           |
| BUSPAR          | DIMETAPP        | KERLONE          |
| BUTAZOLIDIN     | DISALCID        | KLONOPIN         |
| CAFERGOT-PB     | DITROPAN        | LAMISIL          |
| CALAN           | DOLOBID         | LESCOL           |
| CARBATROL       | DONNATAL        | LEVAQUIN         |
| CARDURA         | DORAL           | LEVSIN           |
| CELEBREX        | DRAMAMINE       | LIBRIUM          |

**SYMPTOM****DEPOSITION QUESTIONS****Low Energy,  
Fatigue***(continued)*

|                  |                |                 |
|------------------|----------------|-----------------|
| LIDODERM PATCH   | PAMELOR        | SINEQUAN        |
| LIMBITROL        | PARAFON-FORTE  | SINGULAIR       |
| LIORESAL         | PARLODEL       | SKELAXIN        |
| LITHIUM-CITRATE  | PARNATE        | SOMA            |
| LOMOTIL          | PAXIPAM        | SOMA-COMPOUND   |
| LOPID            | PBZ-SR         | SPORANOX        |
| LORCET           | PERIACTIN      | ST. JOHN'S WORT |
| LOTENSIN         | PERMITIL       | STELAZINE       |
| LOTREL           | PHENERGAN      | SURMONTIL       |
| LOXITANE         | PINDOLOL       | SYMMETREL       |
| LOZOL            | PLAVIX         | SYNALGOS-DC     |
| LUDIOMIL         | POLARIMINE     | TAPAZOLE        |
| MACROBID         | PONDIMIN       | TARACTAN        |
| MACRODANTIN      | PRAVACHOL      | TAVIST          |
| MARPLAN          | PREMPHASE      | TEGRETOL        |
| MAVIK            | PREMPRO        | TELDRIN         |
| MAXAIR-AUTOHALER | PRILOSEC       | TEMARIL         |
| MAXALT           | PRINIVIL       | TENORMIN        |
| MAXIDE           | PRINZIDE       | THORAZINE       |
| MECLOMEN         | PROKETAZINE    | TIGAN           |
| MELLARIL         | PROLIXIN       | TIMOPTIC        |
| MESANTOIN        | PROVENTIL      | TINDAL          |
| METHOTREXATE     | PROVERA        | TOFRANIL        |
| MEXITIL          | QUESTRAN       | TOLECTIN        |
| MILONTIN         | QUIDE          | TOLINASE        |
| MINIPRESS        | REGLAN         | TOPAMAX         |
| MOBAN            | RELAFEN        | TORADOL         |
| MODURETIC        | RESTORIL       | TORECAN         |
| MONOPRIL         | REVIA          | TRANCOPAL       |
| MYSOLINE         | RIFAMATE       | TRANDATE        |
| NALDECON         | RISPERDAL      | TRANSDERM-SCOP  |
| NALFON           | RITALIN        | TRANXENE        |
| NAPROSYN         | ROBAXIN        | TRIAVIL         |
| NARDIL           | ROBAXISAL      | TRILAFON        |
| NAVANE           | RONDEC-DM      | TRILEPTAL       |
| NEURONTIN        | RYNATAN        | TRILISATE       |
| NOLUDAR          | SANOREX        | TRINALIN        |
| NORCO            | SANSERT        | TROVAN          |
| NORFLEX          | SE-AP-ES       | TUINAL          |
| NORGESIC         | SECONAL-SODIUM | TUSSI-ORGANIDIN |
| NORPACE          | SELDANE        | TYLENOL         |
| NORPLANT-SYSTEM  | SEPTRA         | UNIVASC         |
| NORPRAMIN        | SERAX          | VALIUM          |
| NORVASC          | SERENTIL       | VANTIN          |
| OPTIMINE         | SEREVENT       | VASOTEC         |
| ORAP             | SERTRALINE     | VENTOLIN        |
| ORNADE           | SINEMET        | VERELAN         |

## Dysthymic Disorder

**SYMPTOM**

**DEPOSITION QUESTIONS**

**Low Energy,  
Fatigue**  
*(continued)*

|                            |            |           |
|----------------------------|------------|-----------|
| VESPRIN                    | WELLBUTRIN | ZITHROMAX |
| VICODIN                    | XANAX      | ZOFRAN    |
| VISTARIL                   | XYLOCAINE  | ZOLOFT    |
| VISTARIL-<br>INTRAMUSCULAR | ZARONTIN   | ZOVIRAX   |
| VIVACTIL                   | ZAROXOLY   | ZYRTEC    |
| VOLTAREN                   | ZEPHREX    |           |
|                            | ZESTORETIC |           |

**Low  
Self-esteem**

**Q: Describe the plaintiff's low self-esteem.**

Low self-esteem, lack of self-confidence, self-reproach, poor concentration and indecisiveness, hopelessness, and helplessness are characteristic psychological symptoms of depression. (reference 1, p. 1453)

**Q: When and how does the plaintiff's low self-esteem manifest itself?**

**Q: Does the plaintiff have a history of low self-esteem before the injury in question?**

Before individuals can establish a loving bond with others, they must possess a self-love or self-esteem, a normal narcissism. Small children lose self-esteem when they lose love. They gain self-esteem when they regain love. An adult who has not achieved normal narcissism or who does not have adequate self-esteem, is trapped in an unending search for love and acceptance. (reference 4, p. 576)

**Q: Does the plaintiff have a history of any *medical or psychological conditions* that may cause low self-esteem?**

*The witness may indicate the possibility of the following medical or psychological conditions: please refer to the sections pertaining to these conditions for further questions.*

**TABLE 5.6-6.**

|                                 |                     |
|---------------------------------|---------------------|
| Antisocial personality disorder | Pernicious anemia   |
| Avoidant personality disorder   | Postpartum disorder |
| Depressive disorders            | Wilson's disease    |
| Paranoid personality disorder   |                     |

**Q: Did you rule out an *identity problem* as a cause of the plaintiff's low self-esteem?**

The plaintiff with an identity problem may experience an uncertainty about identity, long-term goals, career choices, friendship patterns, sexual behavior, religious identification, value systems, and group loyalties. Associated symptoms may include mild anxiety, depression, **self-doubt**, doubt about the future, and impaired social functioning or work performance. The plaintiff may be unable to make decisions, may feel empty or isolated, have a distorted time perspective, and may feel negative or hostile toward others. The disorder is most common for late adolescents, but also occurs in young adults and in middle age when earlier life decisions are questioned. (reference 7, p. 741; reference 4, pp.1762-1765)

## SYMPTOM

## DEPOSITION QUESTIONS

**Low  
Self-esteem***(continued)***Q: Did you rule out *attention-deficit hyperactivity disorder (ADHD)* as a cause of the plaintiff's low self-esteem?**

The essential characteristics of ADHD include inattention, impulsiveness, and hyperactivity. ADHD is usually diagnosed during elementary school years, and can persist throughout childhood. Persons diagnosed with ADHD have a higher prevalence of mood and anxiety disorders, learning disorders, substance-related disorders and the potential for the development of an antisocial personality disorder. Approximately one-third of the children diagnosed with ADHD show some signs of the disorder in adulthood. Associated symptoms may include **low self-esteem**, mood lability, low frustration tolerance, and temper outbursts. (reference 7, pp. 85-93)

**Q: Did you rule out *school failure* as cause of the plaintiff's low self-esteem?**

Feelings of anger, frustration, shame, **loss of self-respect**, and helplessness are emotions that most often accompany school failure. These feelings have a damaging effect on self-esteem, future performance and expectations for success. (reference 4, p. 1872)

**Q: (Female) Did you rule out *premenstrual dysphoric disorder* as a cause of the plaintiff's low self-esteem?**

Premenstrual dysphoric disorder is characterized by emotional and behavioral symptoms which usually occur during the last week before the menstrual cycle and remit within a few days after menses begins. Symptoms may include tears, sadness, irritability, anger, tension, depression, **self-deprecating thoughts**, decreased interest in usual activities, fatigability, loss of energy, a subjective sense of difficulty in concentration, changes in appetite, and sleep disturbance. Physical symptoms may also include breast tenderness or swelling, tachycardia, sweating, headaches, joint or muscle pain, a sensation of bloating, or weight gain. (reference 7, pp. 771-774; reference 18, p. 1955)

**Q: Did you rule out a *borderline personality disorder* as a cause of the plaintiff's low self-esteem?**

A borderline personality disorder is characterized by **unstable** interpersonal relationships, behavior, mood, and **self-image**. The plaintiff may experience temporary mood shifts including depression, irritability, and anxiety. S/he may also have chronic feelings of emptiness or boredom, inappropriate anger, and recurrent suicidal thoughts. Social contrariness and a generally pessimistic outlook often accompany the disorder. Premature death may result from suicide.(reference 7, p. 706)

*If the witness indicates the possibility of a borderline personality disorder or other maladaptive personality traits, see the section on pre-existing personality disorders for further questions.*

**Q: Did you rule out a *negativistic (passive aggressive) personality disorder*, as a cause of the plaintiff's low self-esteem?**

A negativistic (passive aggressive) personality passively resists both the demands of work and society. S/he may express this through procrastination, dawdling, stubbornness, intentional inefficiency, and forgetfulness. The plaintiff may be sulky,

## Dysthymic Disorder

**SYMPTOM**

**DEPOSITION QUESTIONS**

**Low Self-esteem**

(continued)

irritable, or argumentative. Associated symptoms include dependency, **lack of self-confidence**, and a pessimism for the future with no sense of responsibility for their problems. (reference 7, p. 789; reference 4, p. 985)

*If the witness indicates the possibility of a negativistic (passive aggressive) personality disorder or other maladaptive traits, see the section on pre-existing personality disorders for further questions.*

**Q: Did you rule out bulimia nervosa as a cause of the plaintiff's low self-esteem?**

Bulimia nervosa features recurrent episodes of binge eating. The plaintiff usually feels a lack of control over eating and may use self-induced vomiting, laxatives, diuretics, strict dieting, fasting, or vigorous exercise to prevent weight gain. Eating binges may be planned or secret. This behavior must continue at least two times a week for three months. Associated symptoms may include a depressed mood and **self-deprecating thoughts**. (reference 7, p. 589)

**Q: Does the plaintiff have any other medical conditions that may cause low self-esteem, such as a disfiguring disorder including a skin condition?**

**Poor Concentration**

**Q: Describe the plaintiff's poor concentration or difficulty making decisions.**

**Q: When and how often does the plaintiff experience poor concentration or difficulty making decisions?**

**Q: Does the plaintiff have a history of poor concentration or difficulty making decisions before the injury in question?**

**Q: Does the plaintiff have a history of any medical or psychological conditions that may cause poor concentration or difficulty making decisions?**

*The witness may indicate the possibility of the following medical or psychological conditions: please refer to the sections pertaining to these conditions for further questions.*

**TABLE 5.6-7.**

|                         |                               |
|-------------------------|-------------------------------|
| Alzheimer's disease     | Hypothyroidism                |
| Brain tumor             | Multiple sclerosis            |
| Combined system disease | Parkinson's disease           |
| Cushing's disease       | Pernicious anemia             |
| Epilepsy                | Polycythemia                  |
| Hepatic encephalopathy  | Porphyria                     |
| Huntington's disease    | Postpartum disorder           |
| Hypertension            | Schizoid personality disorder |
| Hyperthyroidism         | Schizophrenia                 |
| Hypochondriasis         | Somatoform pain disorder      |
| Hypoglycemia            | Systemic lupus erythematosus  |
| Hypotension             | Uremic encephalopathy         |

## SYMPTOM

## DEPOSITION QUESTIONS

**Poor Concentration***(continued)*

**Q: Describe the *work or home environment* where poor concentration has been observed.**

A disorganized or chaotic environment may be the cause of the inability to concentrate.

**Q: Did you rule out *hypothyroidism* as a cause of the plaintiff's poor concentration and difficulty making decisions?**

Hypothyroidism results from inadequate synthesis of thyroid hormone. Hypothyroidism can produce psychiatric, as well as physical symptoms. The most notable psychiatric symptoms include depression, lethargy, **poor concentration, impaired memory**, apathy, and syncope. The numerous physical symptoms are: cold intolerance, constipation, muscle cramps, paresthesias, menstrual disorders, dyspnea, dizziness, reduced hearing, poor appetite, weight gain, brittle and thinning hair, and bradycardia (slowed heart action). Panic attacks are associated with endocrinological disorders including hypothyroidism and hyperthyroidism. (reference 18, pp. 743, 1810-1812, 1928)

**Q: Did you rule out *attention-deficit hyperactivity disorder (ADHD)* as a cause of the plaintiff's poor concentration and difficulty making decisions?**

The essential characteristics of ADHD include **inattention**, impulsiveness, and hyperactivity. ADHD is usually diagnosed during elementary school years, and can persist throughout childhood. Persons diagnosed with ADHD have a higher prevalence of mood and anxiety disorders, learning disorders, substance-related disorders and the potential for the development of an antisocial personality disorder. Approximately one-third of the children diagnosed with ADHD show some signs of the disorder in adulthood. Associated symptoms may include low self-esteem, mood lability, low frustration tolerance, and temper outbursts. (reference 7, pp. 85-93)

**Q: Did you rule out *dissociative amnesia* (formerly psychogenic amnesia) as a cause of the plaintiff's poor concentration or difficulty making decisions?**

The plaintiff with this disorder has a sudden **inability to recall important personal information**. During the amnesia, perplexity, disorientation, and purposeless wandering may occur. Termination is abrupt and recovery is complete. (reference 7, p. 520)

**Q: Did you rule out a *dependent personality disorder* as a cause of the plaintiff's poor concentration or difficulty in making decisions?**

The dependent personality disorder is featured by a continuous pattern of dependent and submissive behavior beginning by early adulthood. Symptomatic behaviors include the **inability to make decisions alone**, fear of being rejected, difficulty doing projects alone, doing demeaning or unpleasant tasks to be liked, feeling

**SYMPTOM****DEPOSITION QUESTIONS****Poor Concentration***(continued)*

uncomfortable or helpless when alone, feeling devastated or helpless when close relationships end, fearing abandonment, and being easily hurt by criticism or disapproval. (reference 7, p. 721)

*If the witness indicates a dependent personality disorder or other maladaptive personality traits, see the section on pre-existing personality disorders for further questions.*

**Q: Did you rule out a bipolar disorder as a cause of the plaintiff's poor concentration or difficulty in making decisions?**

A bipolar disorder has a circular pattern of high and low emotional states (*mania and depression*). During the *manic episodes*, the plaintiff may feel grandiose, have a decreased need for sleep, and decreased emotional capacity, experience a surge of ideas and conversation, and may be easily distracted or pleased. It is often thought that the manic high represents an escape from inner depression and pain. While the plaintiff is extremely active, s/he is often **fragmented and unable to finish projects**. The plaintiff typically does not realize that s/he is ill.

During *major depressive episodes* the plaintiff may be depressed for at least two weeks. The plaintiff may experience an appetite disturbance, weight change, sleep disturbance, psychomotor agitation or retardation, decreased energy and emotional capacity, feelings of worthlessness, **difficulty thinking or concentrating**, and recurrent thoughts of death or suicide. (reference 4, pp. 408-409, 761; reference 7, pp. 382-391)

**Q: Did you rule out an obsessive compulsive disorder as a cause of the plaintiff's poor concentration or difficulty making decisions?**

The obsessive compulsive plaintiff has **persistent unwanted and uncontrolled thoughts** or impulses that may be characterized by violence, contamination, or doubt. These obsessions often cause the plaintiff to feel anxious. The plaintiff's repeated compulsive behaviors are attempts to control the impulses and the accompanying anxiety. Other symptoms may include an exclusive devotion to work or productivity, depression, anxiety, and restlessness. (reference 4, pp. 910-911; reference 7, p. 456)

*Note: In addition to the obsessive compulsive disorder, there is an obsessive compulsive personality disorder. The personality disorder does not have true obsessions and compulsions, but has a clear pattern of perfectionism and rigidity.*

**Q: Did you rule out alcohol consumption as a cause of the plaintiff's poor concentration or difficulty making decisions?**

Alcohol intoxication may cause aggressiveness, **impaired judgment and attention**, irritability, euphoria, depression, emotional lability, and impaired social or occupational functioning. Physical symptoms may include slurred speech, incoordination, unsteady gait, nystagmus, occasional dizziness, and flushed face.

## SYMPTOM

## DEPOSITION QUESTIONS

**Poor Concentration***(continued)*

Heavy alcohol consumption may cause abnormal sleep patterns. The plaintiff often falls asleep quickly but wakes up earlier and earlier with uncomfortable feelings. Chronic alcoholics may have irregular, unsteady, and slow tremulous movements. (reference 7, p. 212; reference 4, p. 67; reference 9, p. 52)

**Q: Did you rule out *hyperthyroidism* as a cause of plaintiff's poor concentration or difficulty making decisions?**

Hyperthyroidism, or thyrotoxicosis, results from overproduction of thyroid hormone by the thyroid gland. The most common cause is Graves' disease. The signs and symptoms of hyperthyroidism include both physical and psychiatric complaints. Psychiatric features include nervousness, fatigue, insomnia, mood lability, and dysphoria. There may be a heightened activity level. Cognitive symptoms include a **short attention span, impaired recent memory**, and an exaggerated startle response.

Physical signs and symptoms of hyperthyroidism include increased pulse, arrhythmias (irregular heart rhythm), elevated blood pressure, fine tremor, heat intolerance, excessive sweating, increased appetite, weight loss, palpitations (abnormal rapid beating of heart), tachycardia (rapid heart beat), frequent bowel movements, menstrual irregularities, and muscle weakness. Panic attacks are associated with endocrinological disorders including hyperthyroidism, as well as hypothyroidism. (reference 18, pp. 743, 1809-1810, 1928)

**Q: Did you rule out *cocaine consumption or withdrawal* as a cause of the plaintiff's poor concentration or difficulty making decisions?**

*Cocaine users* often experience increased energy and confidence or irritability and paranoia with physical aggressiveness. Other behavioral symptoms may include euphoria, hypervigilance, psychomotor agitation, **impaired judgment**, and impaired social or occupational functioning. Physical symptoms may include tachycardia, dilated pupils, elevated blood pressure, perspiration or chills, nausea, vomiting, and hallucinations.

The abrupt *cessation or reduction* of cocaine, after several days use, may cause the plaintiff to feel tired, dysphoric, irritable, depressed, **unable to concentrate**, and to crave more of the drug. An anxiety reaction may cause psychomotor agitation, insomnia or hypersomnia, high blood pressure, tachycardia, and paranoia. The symptoms may persist for more than a day. (reference 7, p. 245; reference 4, pp. 1008-1009)

**Q: Did you rule out *amphetamine or similarly acting sympathomimetic drug consumption* as a cause of the plaintiff's poor concentration or difficulty making decisions?**

Symptoms of amphetamine or similarly acting sympathomimetic drug consumption may include fighting, grandiosity, elation, hypervigilance, psychomotor agitation, **impaired judgment**, and impaired social or occupational functioning. Physical symptoms may include flushing, difficulty breathing, tachycardia, pupil dilation, elevated blood pressure, sweating or chills, nausea, and vomiting. (reference 4, pp. 1007-1008; reference 7, p. 223)

**SYMPTOM****DEPOSITION QUESTIONS****Poor  
Concentration***(continued)*

The following drugs may be classified as amphetamines:

|                                    |                            |
|------------------------------------|----------------------------|
| Appetite Suppressants (diet pills) | Methamphetamines (speed)   |
| Dextroamphetamines                 | Methylphenidates (Ritalin) |
| Ma-huang (ephedra)                 | (reference 17, p. 586)     |
| (reference 24, pp. 488-489)        |                            |

**Q: Did you rule out *generalized anxiety disorder* as a cause of the plaintiff's poor concentration or difficulty making decisions?**

A generalized anxiety disorder is a persistent anxiety that lasts at least six months. The plaintiff has an excessive anxiety about two or more life circumstances. S/he may be anxious about harm coming to a child or having financial difficulties when there is no apparent reason to worry. Symptoms include muscle tension, fatigue, restlessness or feeling keyed up, **difficulty concentrating**, sleep disturbance, and irritability. (reference 7, p. 472)

*If the witness indicates the possibility of a generalized anxiety disorder, see the section on GAD for further questions.*

**Q: Did you rule out *HIV-associated dementia or HIV-associated mild neurocognitive disorder* or as a cause of the plaintiff's poor concentration or difficulty making decisions?**

HIV dementia is a severe cognitive disorder that interfere's substantially with work, home life and social activities. Symptoms of mild neurocognitive disorder associated with HIV infection include **difficulty concentrating**, unusual fatigability with demanding mental tasks, feeling slowed down and memory difficulties. Problem solving , abstract reasoning, and motor performance may also be affected. (reference 18, pp. 308-316; reference 7, p. 163)

**Q: (Female) Did you rule out *premenstrual dysphoric disorder* as a cause of the plaintiff's poor concentration or difficulty making decisions?**

Premenstrual dysphoric disorder is characterized by emotional and behavioral symptoms which usually occur during the last week before the menstrual cycle and remit within a few days after menses begins. Symptoms may include tears, sadness, irritability, anger, tension, depression, self-deprecating thoughts, decreased interest in usual activities, fatigability, loss of energy, a subjective sense of **difficulty in concentration**, changes in appetite, and sleep disturbance. Physical symptoms may also include breast tenderness or swelling, tachycardia, sweating, headaches, joint or muscle pain, a sensation of bloating, or weight gain. (reference 7, pp. 771-774; reference 18, p. 1955)

## SYMPTOM

## DEPOSITION QUESTIONS

**Poor Concentration***(continued)*

**Q: Did you rule out *muscle contraction headaches* as a cause of the plaintiff's poor concentration or difficulty making decisions?**

Chronic muscle contraction headaches may produce nausea, vomiting, lightheadedness, difficulty in falling asleep, restless sleep with frequent awakenings, loss of energy, **impaired memory and concentration**, and symptoms of depression. (reference 2, pp. 72-73; reference 4, p. 1204)

**Q: Did you rule out *migraine headaches* as a cause of the plaintiff's poor concentration or difficulty making decisions?**

A classic migraine (vascular) headache may be accompanied by visual disturbances, sensory motor or speech disturbances, nausea or vomiting, **difficulty concentrating**, and emotional changes. On rare occasions, the plaintiff may experience depersonalization or derealization and difficulty concentrating. Migraine headaches may be precipitated by: (reference 4, p. 1204; reference 2, pp. 65-66)

- Birth control pills
- Emotional conflicts or stress
- Fluctuating estrogen levels in women
- Food:
  - Monosodium glutamate (Chinese restaurant syndrome)
  - Phenylethylamine-containing foods
  - Tyramine-containing foods (cheese or other fermented dairy products and chocolate)

**Q: Did you rule out *sedative, hypnotic, or anxiolytic consumption* as a cause of the plaintiff's poor concentration or difficulty making decisions?**

Sedative, hypnotic, or anxiolytic drug consumption can cause behavioral and physical changes. Behavioral symptoms may include disinhibition of sexual or aggressive impulses, mood lability, **impaired judgment**, and impaired social or occupational functioning. Physical symptoms may include slurred speech, incoordination, unsteady gait, and **impaired memory or attention span**. Sedative drugs and minor tranquilizers cause impairment on many behavioral tasks. They may also improve some plaintiff's work or social functioning by reducing severe anxiety. The effects of two or more drugs, such as sedatives and alcohol, may cause significant behavioral impairment. (reference 7, p. 284; reference 4, p. 1548)

**Q: Did you rule out *opioid consumption* as a cause of the plaintiff's poor concentration or difficulty making decisions?**

Opioid intoxication is characterized by euphoria, flushing, itching skin, miosis, drowsiness, decreased respiratory rate and depth, hypotension, bradycardia, and decreased body temperature. The initial euphoria is often followed by apathy, unpleasant mood, psychomotor retardation, **impaired judgment**, and impaired social or occupational functioning. While dependence on opioids is less common than on alcohol or tobacco, it has been estimated that fifteen percent of males and nine percent of females have used an opioid (nonmedical) during their lifetime. (reference 7, p. 269; reference 4, pp. 987-988)

## SYMPTOM

## DEPOSITION QUESTIONS

**Poor Concentration***(continued)***Q: Did you rule out *anemia* as a cause of the plaintiff's poor concentration or difficulty making decisions?**

Vertigo, pounding headaches, fainting, dimness of vision, tinnitus (a ringing in one or both ears), irritability, restlessness, **inability to concentrate**, lethargy, fatigue, drowsiness and GI complaints are common symptoms of anemia. (reference 2, pp. 566-571)

*If the witness indicates the possibility of an anemia, see the section on pre-existing medical conditions for further questions.*

**Q: Did you rule out a *schizotypal personality disorder* as a cause of the plaintiff's poor concentration or difficulty making decisions?**

A schizotypal personality has **oddities of thinking, perception**, communication, and behavior that resemble schizophrenia. The plaintiff may experience anxiety, depression, and other **dysphoric moods that disrupt concentration** and the ability to function socially or at work. S/he may have few close friends except for immediate family. (reference 7, p. 697)

*If the witness indicates the possibility of a schizotypal personality disorder or other maladaptive personality traits, see the section on pre-existing personality disorders for further questions.*

**Q: Did you rule out *lithium use* as a cause of the plaintiff's poor concentration or difficulty making decisions?**

Lithium and the tricyclics are often given as medication for depression. Tremor is one of the most common side effects. Other symptoms may include nausea, diarrhea, polyuria (the passage of an excessive quantity of urine), polydipsia (excessive thirst), and weight gain. Toxic effects may include gross tremor, increased deep tendon reflexes, persistent headaches, vomiting, **mental confusion progressing to stupor**, seizures, or cardiac arrhythmias. (reference 1, pp. 1460-1461)

**Q: Did you rule out *insomnia disorders* as a cause of the plaintiff's poor concentration or difficulty making decisions?**

Insomnia disorders cause sleep disturbance. The plaintiff may be tired after an adequate sleep (non-restorative sleep). This pattern lasts for at least a month with the sleep difficulties occurring at least three times a week. The disorder may be severe enough to cause daytime fatigue, irritability, or an **impaired memory and concentration**. (reference 7, p. 599; reference 2, p. 601)

**Q: Did you rule out *hallucinogen consumption* as the cause of the plaintiff's poor concentration or difficulty making decisions?**

Hallucinogen consumption causes perceptual changes such as feelings of detachment, illusions, hallucinations, and synesthesia (seeing colors when a loud sound occurs). Behavioral symptoms may include anxiety or depression, ideas of reference, fear of losing one's mind, paranoia, **impaired judgment**, and impaired social or occupational functioning. Physical symptoms may include dilated pupils, tachycardia, sweating, palpitations, blurred vision, tremors, and incoordination.

**SYMPTOM****DEPOSITION QUESTIONS****Poor Concentration***(continued)*

Flashbacks of experiences may recur several months or years after hallucinogen use. Many plaintiffs may have **gross thought process disturbances**. Unlike schizophrenics, they are able to talk in detail about their hallucinations. (reference 7, p. 250; reference 4, p. 874)

**Q: Did you rule out *cannabis (marijuana) consumption* as a cause of the plaintiff's poor concentration or difficulty making decisions?**

Cannabis intoxication can occur from marijuana, hashish, or tetrahydrocannabinol (THC). Characteristic symptoms include tachycardia, increased appetite, dry mouth, euphoria, anxiety, sensation of slowed time, **impaired judgment**, and social withdrawal. Inappropriate laughter, panic attacks and a dysphoric mood may occur. (reference 7, p. 234)

**Q: Did you rule out a *negativistic (passive aggressive) personality disorder*, as a cause of the plaintiff's poor concentration or difficulty making decisions?**

A negativistic (passive aggressive) personality passively resists both the demands of work and society. S/he may express this through procrastination, dawdling, stubbornness, intentional inefficiency, and **forgetfulness**. The plaintiff may be sulky, irritable, or argumentative. Associated symptoms include dependency, lack of self-confidence, and a pessimism for the future with no sense of responsibility for their problems. (reference 7, p. 789; reference 4, p. 985)

**Q: Did you rule out *nicotine withdrawal* as a cause of the plaintiff's poor concentration or difficulty making decisions?**

Nicotine withdrawal symptoms include a strong craving for nicotine, anxiety, irritability, frustration or anger, **impaired attention**, coughing, headaches, insomnia, a mental preoccupation with actions associated with tobacco use, restlessness, drowsiness, gastrointestinal disturbances, an increased appetite, and weight gain. The symptoms appear within 24 hours after the cessation or reduction in the use of cigarettes, cigars, pipes, chewing tobacco, or nicotine gum. The plaintiff experiences a decrease in the intensity of the symptoms with time. (reference 7, p. 264; reference 4, pp. 1031-1032)

**Q: Did you rule out *transient global amnesia* as a cause of the plaintiff's poor concentration or difficulty making decisions?**

Transient global amnesia is characterized by the **loss of the ability to recall recent events** or to record new memories. The distant past is easily remembered.

**Q: Does the plaintiff have any *other medical conditions* that may cause poor concentration or difficulty making decisions, such as:**

|                                  |                        |
|----------------------------------|------------------------|
| Central nervous system disease   | Vascular disorders     |
| Metabolic and pulmonary failures | Vitamin B12 deficiency |

## Dysthymic Disorder

**SYMPTOM**

**DEPOSITION QUESTIONS**

**Poor Concentration**

*(continued)*

**Q:** Is the plaintiff taking any *medications or substances* that may cause poor concentration or difficulty making decisions, such as:

|            |            |            |
|------------|------------|------------|
| ARTHROTEC  | ETRAFON    | TIMOPTIC   |
| ASENDIN    | EXCELON    | TRIAVIL    |
| BUSPAR     | GABITRIL   | TRILEPTAL  |
| CARDURA    | HABITROL   | TROVAN     |
| CELEXA     | IMDUR      | ULTRAM     |
| CLARITAN-D | KERLONE    | VIVACTIL   |
| CLARITIN   | LEVAQUIN   | WELLBUTRIN |
| CODEINE    | LIMBITROL  | ZARONTIN   |
| CYCLOSPORN | PAXIL      | ZEBETA     |
| DEPROL     | RESTORIL   | ZIAC       |
| DESYREL    | RISPERDAL  | ZOLOFT     |
| ELAVIL     | SERTRALINE | ZYRTEC     |
| ENDEP      | SERZONE    |            |

**Feelings of Hopelessness**

**Q:** Describe the plaintiff's feelings of hopelessness.

**Q:** Does the plaintiff have a history of hopeless feelings before the injury in question?

**Q:** Does the plaintiff have a history of any *medical or psychological conditions* that may cause feelings of hopelessness?

*The witness may indicate the possibility of the following medical or psychological conditions: please refer to the sections pertaining to these conditions for further questions.*

**TABLE 5.6-8.**

|                                       |                       |
|---------------------------------------|-----------------------|
| Addison's disease                     | Hypothyroidism        |
| Borderline personality disorder       | Myocardial infarction |
| Chronic obstructive pulmonary disease | Pancreatic carcinoma  |
| Coronary artery disease               | Postpartum disorder   |
| Creutzfeldt-Jakob disease             | Depressive disorders  |
| Cushing's disease                     | Schizophrenia         |
| Huntington's disease                  | Wilson's disease      |
| Hypoglycemia                          |                       |

**Q:** Did you rule out an *identity problem* as a cause of the plaintiff's feelings of hopelessness?

The plaintiff with an identity problem may experience an uncertainty about identity, long-term goals, career choices, friendship patterns, sexual behavior, religious identification, value systems, and group loyalties. Associated symptoms may include mild anxiety, depression, **self-doubt**, **doubt about the future**, and impaired social

## SYMPTOM

## DEPOSITION QUESTIONS

**Feelings of Hopelessness***(continued)*

functioning or work performance. The plaintiff may be unable to make decisions, **may feel empty or isolated**, have a distorted time perspective, and may feel negative or hostile toward others. The disorder is most common for late adolescents, but also occurs in young adults and in middle age when earlier life decisions are questioned. (reference 7, p. 741; reference 4, pp. 1762-1765)

**Q: Did you rule out *learned helplessness* as a cause of the plaintiff's feelings of hopelessness?**

The plaintiff feels a loss of control, becomes passive, depressed, and withdraws from social support. When trauma has become ingrained, the plaintiff often develops a **chronic sense of helplessness and victimization** and is constantly looking for the trauma's return. (reference 8, pp. 8-9, 219-222)

**Q: Did you rule out a recent *heart attack* as a cause of the plaintiff's feelings of hopelessness?**

Despondency is almost a universal response to heart attack. Even without complications, the plaintiff may feel a sense of loss and vulnerable to further injury. Weakness and tiredness are the single most distressing symptoms of the depression. The plaintiff may also experience insomnia, daytime hypersomnia, and practical worries. Complications cause the plaintiff's **despondency and hopelessness** to be intensified. (reference 4, pp. 1156-1157)

*If the witness indicates the possibility of a recent heart attack, see the section on medical conditions for further questions.*

**Q: Did you rule out a *borderline personality disorder* as a cause of the plaintiff's feelings of hopelessness?**

A borderline personality disorder is characterized by unstable interpersonal relationships, behavior, mood, and self-image. The plaintiff may experience temporary mood shifts including depression, irritability, and anxiety. S/he may also have **chronic feelings of emptiness** or boredom, inappropriate anger, and recurrent suicidal thoughts. Social contrariness and a generally **pessimistic outlook** often accompany the disorder. Premature death may result from suicide. (reference 7, p. 706)

*If the witness indicates the possibility of a borderline personality disorder or other maladaptive personality traits, see the section on pre-existing personality disorders for further questions.*

**Q: Did you rule out a *negativistic (passive aggressive) personality disorder*, as a cause of the plaintiff's feelings of hopelessness?**

A negativistic (passive aggressive) personality passively resists both the demands of work and society. S/he may express this through procrastination, dawdling, stubbornness, intentional inefficiency, and forgetfulness. The plaintiff may be sulky, irritable, or argumentative. Associated symptoms include dependency, lack of self-confidence, and a **pessimism for the future** with no sense of responsibility for their problems. (reference 7, p. 789; reference 4, p. 985)

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*SYMPTOM*

*DEPOSITION QUESTIONS*

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**Feelings of  
Hopelessness**

*(continued)*

**Q: Did you rule out a *bipolar disorder* as a cause of the plaintiff's feelings of hopelessness?**

A bipolar disorder has a circular pattern of high and low emotional states (*mania and depression*). During the *manic episodes*, the plaintiff may feel grandiose, have a decreased need for sleep, and decreased emotional capacity, experience a surge of ideas and conversation, and may be easily distracted or pleased. It is often thought that the manic high represents an escape from inner depression and pain. While the plaintiff is extremely active, s/he is often fragmented and unable to finish projects. The plaintiff typically does not realize that s/he is ill.

During *major depressive episodes* the plaintiff may be depressed for at least two weeks. The plaintiff may experience an appetite disturbance, weight change, sleep disturbance, psychomotor agitation or retardation, decreased energy and emotional capacity, **feelings of worthlessness**, difficulty thinking or concentrating, and **recurrent thoughts of death or suicide**. (reference 4, pp. 408-409, 761; reference 7, pp. 382-391)



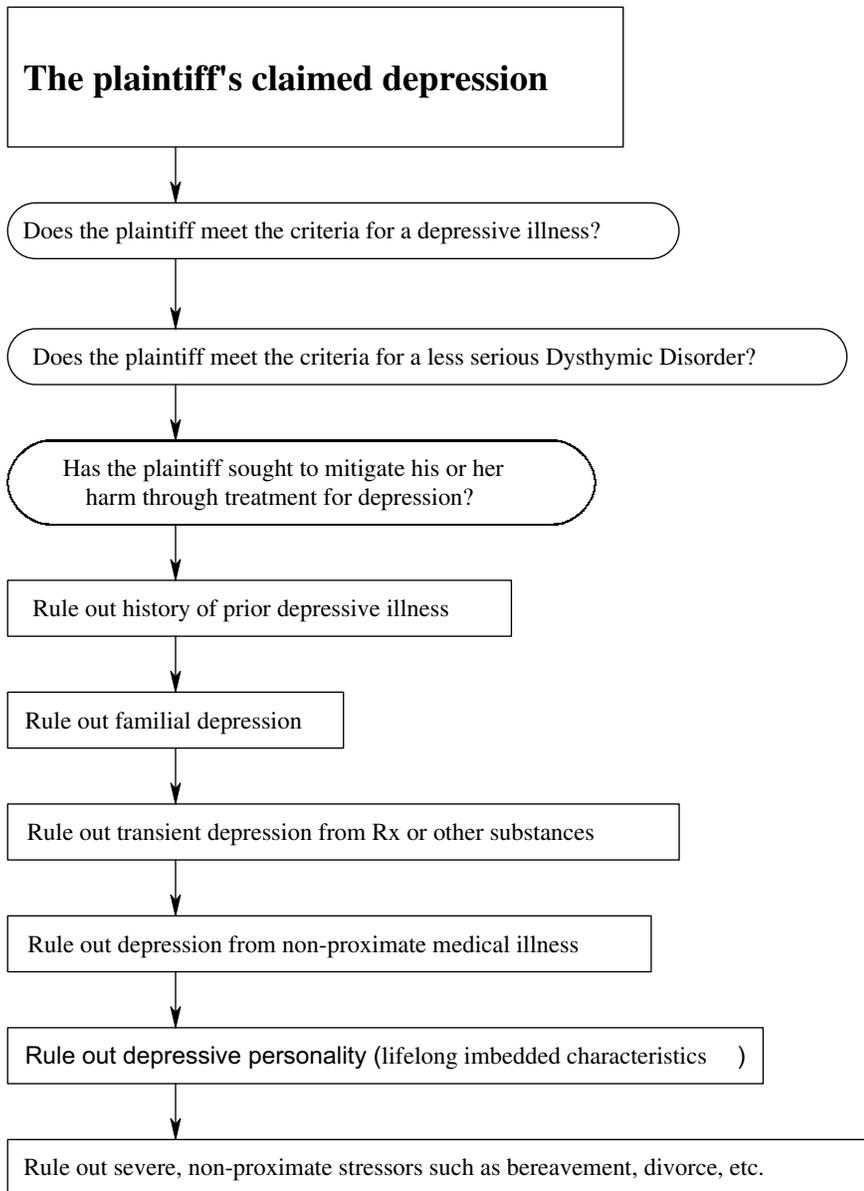
## **SECTION 5.7: DIRECT CHALLENGE TO THE DIAGNOSIS OF MAJOR DEPRESSIVE DISORDER CLAIMS (Formerly Major Depression)**

### **INTRODUCTION**

Plaintiffs are often misdiagnosed with reactive depression from the injury in question. Many plaintiffs with major depressive disorder have a psychiatric history of anxiety, depressive illness, long term pathology or familial patterns of depression. Other plaintiffs may be experiencing depression from the transient effects of medications, endocrine disorders, or other illnesses.

Defense counsel should obtain a list of the plaintiff's claimed major depressive symptoms by using the deposition questions in Chapters 1 and 4. Section 5.7 provides questions to challenge the accuracy of that diagnosis. Questions are provided for each depressive symptom.

## If the Plaintiff Claims a Proximately Related Depression



Depression is a common and varied mental illness. Most plaintiffs claim to suffer from chronic depression but very few expert witnesses take a complete clinical history and conduct a differential diagnosis to determine the cause of the depressive illness. The above chart represents a framework for the analysis and defense of plaintiff's claim of proximately related depression.

### DEFENSE NOTE

Many claims of head injury and other types of organic brain syndrome are accompanied by an additional claim of depression. Defense counsel should note that depression can be the basis for a pseudo dementia. In other words, the plaintiff's claimed cognitive loss may actually be related to a treatable depression.

Challenging the Plaintiff's Diagnosis of a Major Depressive Disorder

TABLE 5.7-1.

Diagnostic criteria for 296.2x Major Depressive Disorder, Single Episode

- A. Presence of a single Major Depressive Episode (See criteria below).
- B. The Major Depressive Episode is not better accounted for by Schizoaffective Disorder and is not superimposed on Schizophrenia, Schizophreniform Disorder, Delusional Disorder, or Psychotic Disorder Not Otherwise Specified.
- C. There has never been a Manic Episode, a Mixed Episode, or a Hypomanic Episode. **Note:** This exclusion does not apply if all of the manic-like, mixed-like, or hypomanic-like episodes are substance or treatment induced or are due to the direct physiological effects of a general medical condition.

If the full criteria are currently met for a Major Depressive Episode, specify its current clinical status and/or features:

- Mild; Moderate; Severe Without Psychotic Features/ Severe With Psychotic Features**
- Chronic**
- With Catatonic Features**
- With Melancholic Features**
- With Atypical Features**
- With Postpartum Onset**

If the full criteria are not currently met for a Major Depressive Episode, specify the current clinical status of the Major Depressive Disorder or features of the most recent episode:

- In Partial Remission, In Full Remission**
- Chronic**
- With Catatonic Features**
- With Melancholic Features**
- With Atypical Features**
- With Postpartum Onset**

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**Challenging the Plaintiff's Diagnosis of a Major Depressive Disorder**


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TABLE 5.7-2.

**Criteria for Major Depressive Episode**

**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.

**Note:** Do not include symptoms that are clearly due to a general medical condition, or mood-incongruent delusions or hallucinations.

- (1) depressed mood most of the day, nearly every day, as indicated by either subjective report (e.g., feels sad or empty) or observation made by others (e.g., appears tearful). **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 (as indicated by either subjective account or observation made by others)
- (3) significant weight loss when not dieting or weight gain (e.g., a change of more than 5% of body weight in a month), 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 (observable by others, not merely subjective feelings of restlessness or being slowed down)
- (6) fatigue or loss of energy nearly every day
- (7) feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick)
- (8) diminished ability to think or concentrate, or indecisiveness, nearly every day (either by subjective account or as observed by others)
- (9) recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide

**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 (e.g., a drug of abuse, a medication) or a general medical condition (e.g., hypothyroidism).

**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.

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*SYMPTOM*

*DEPOSITION QUESTIONS*

**Note:  
Familial  
Pattern**

**Major Depressive Disorder is 1.5-3 times more common among first-degree biological relatives of persons with this disorder than among the general population.**

**General  
Questions**

**Q: Describe the plaintiff's depressed mood or loss of interest or pleasure in activities.**

**Q: Is this mood a change from the plaintiff's previous functioning?** (criterion A)

**Q: When and how often does the plaintiff experience these symptoms?**

Major depression requires a markedly diminished interest or pleasure in most all activities or a depressed mood most of the day, nearly every day for at least a two week period. (criterion A)

**Q: Describe any other symptoms the plaintiff has experienced with the depression.**

The plaintiff must indicate at least five other symptoms that occur with the depression. The symptoms cannot be due to a physical condition, mood-incongruent delusions or hallucinations, incoherence, or a marked loosening of associations. (criterion A for major depressive episode)

**Q: Does the plaintiff have any other Axis I diagnoses such as schizoaffective disorder or schizophrenia?**

The Major Depressive Episode cannot be better accounted for by Schizoaffective Disorder and is not superimposed on Schizophrenia, Schizophreniform Disorder, Delusional Disorder, or Psychotic Disorder Not Otherwise Specified. (criterion B)

*If the witness indicates the presence of any of these disorders, see the pertinent section for further information.*

**Note:** The following five disorders are a group of psychotic conditions that often begin in adolescence or young adulthood. They are characterized by fundamental alterations in concept formations, a misinterpretation of reality, and associated affective, behavioral, and intellectual disturbances.

**Schizoaffective disorder:** This disorder is defined by a period of illness in which there is a major depressive, manic, or mixed episode concurrent with symptoms that meet criterion A for schizophrenia. (reference 7, p. 319)

**Schizophrenia:** Anhedonia (loss of pleasure) is a common distressing symptom of schizophrenia. The plaintiff with schizophrenia often becomes incapable of experiencing any pleasant emotion. The feeling of being emotionally barren, hopeless, and empty may lead to suicide. (reference 4, p. 690)

**Schizophreniform disorder:** The symptoms of this disorder are identical to schizophrenia, except the symptoms persist for less than six months. (reference 7, p. 298)

## SYMPTOM

## DEPOSITION QUESTIONS

**General Questions***(continued)*

**Delusional disorder:** This disorder is characterized by delusions or beliefs held despite evidence and knowledge to the contrary. Symptoms persist for at least one month. (reference 7, p. 323)

**Brief psychotic disorder:** (mixed or not otherwise specified) These conditions involve disturbances of sudden onset of psychotic symptoms such as delusions, hallucinations, disorganized speech, or grossly disorganized or catatonic behavior. The episode lasts at least one day but less than one month. (reference 7, p. 329)

---

**Q: Has the plaintiff ever had a manic episode, mixed episode, or hypomanic episode as would be seen in a bipolar disorder?**

For the diagnosis of major depressive disorder, there cannot have been a manic episode, a mixed episode, or a hypomanic episode. (criterion C)

*If the witness indicates a manic episode, the diagnosis of bipolar disorder may be more appropriate. See the section on bipolar disorder for further information.*

---

**Q: Does the plaintiff have a history of delusions or hallucinations?**

Symptoms related to a general medical condition, mood-incongruent delusions or hallucinations are not included in the symptom requirements for a major depressive episode. (criterion A)

---

**Q: Did you rule out an organic factor as the cause of the plaintiff's depressed mood?**

In order to be diagnosed with a major depressive disorder, the possibility of an organic cause of the symptoms must be eliminated.

---

**Q: Has the plaintiff recently experienced the death of a loved one?**

Symptoms cannot be better accounted for by the presence of bereavement. (criterion E for major depressive episode)

Mourning is a normal grief reaction to a loss, such as the death of a loved one. The plaintiff may feel depressed and dejected, have diminished interest in the outside world, a decreased capacity to love, and an inhibition of activity. People tend to feel as if all their energy is taken up with thoughts and memories of the loss. Fatigue and weariness are characteristic symptoms. Sighing, feeling empty, disinterested, listless, eating more or less than normal, losing weight, and having trouble sleeping are common experiences. (reference 4, pp. 1286-1293; reference 7, pp. 740-741; reference 2, p. 617)

---

**Q: Are the major depressive episodes becoming less severe?**

---

**SYMPTOM**

**DEPOSITION QUESTIONS**

**General Questions**

(continued)

**Q: Does the plaintiff have a history of *melancholic type behaviors* before the injury in question?**

**TABLE 5.7-3.**

|   |
|---|
| <p><b>Criteria for Melancholic Features Specifier</b><br/>(a specifier for major depressive disorder)</p> <p><b>A.</b> Either of the following, occurring during the most severe period of the current episode:</p> <ul style="list-style-type: none"> <li>(1) loss of pleasure in all, or almost all, activities</li> <li>(2) lack of reactivity to usually pleasurable stimuli</li> </ul> <p><b>B.</b> Three (or more) of the following:</p> <ul style="list-style-type: none"> <li>(1) distinct quality of depressed mood</li> <li>(2) depression regularly worse in the morning</li> <li>(3) early morning awakening (at least two hours before usual time of awakening)</li> <li>(4) marked psychomotor retardation or agitation</li> <li>(5) significant anorexia or weight loss</li> <li>(6) excessive or inappropriate guilt</li> </ul> |
|---|

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**Q: Do the plaintiff's depressive symptoms appear seasonally?**

The plaintiff, for example, may experience a depression every year between the beginning of October and the end of November. Seasonal depressions should not be diagnosed if the depression is associated with an obvious seasonally related stressor such as regular unemployment every winter.

*If the witness indicates that the plaintiff may have a seasonal depression, the symptoms may be unrelated to the injury in question. Defense counsel should ask the questions below.*

**TABLE 5.7-4.**

|   |
|---|
| <p><b>Criteria for Seasonal Pattern Specifier</b><br/><i>Specify if:</i></p> <p><b>With Seasonal Pattern</b></p> <p><b>A.</b> There has been a regular temporal relationship between the onset of Major Depressive Episodes in Bipolar I or Bipolar II Disorder or Major Depressive Disorder, Recurrent, and a particular time of the year ( e.g., regular appearance of the Major Depressive Episode in the fall or winter).</p> |
|---|

*SYMPTOM*

*DEPOSITION QUESTIONS*

**General Questions**  
(continued)

**TABLE 5.7-4.** (continued)

|   |
|---|
| <p><b>Note:</b> Do not include cases in which there is an obvious effect of seasonal-related psychosocial stressors ( e.g., regularly being unemployed every winter).</p> <p><b>B.</b> Full remissions (or a change from depression to mania or hypomania) also occur at a characteristic time of the year (e.g., depression disappears in the spring).</p> <p><b>C.</b> In the last two years, two Major Depressive Episodes have occurred that demonstrate the temporal seasonal relationships defined in Criteria A and B, and no nonseasonal Major Depressive Episodes have occurred during that same period.</p> <p><b>D.</b> Seasonal Major Depressive Episodes (as described above) substantially outnumber the nonseasonal Major Depressive Episodes that may have occurred over the individual's lifetime.</p> |
|---|

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**Q: Does the plaintiff experience full remissions seasonally?** (criterion B)

**Q: How many years has the plaintiff been experiencing the seasonal depressions?** (criterion A)

**Q: Has the plaintiff experienced any nonseasonal episodes of depression and remission?** (criterion D)

**Depressed Mood**

**Q: Describe the plaintiff's depressed mood.**

**Q: When and how often is the plaintiff depressed?**

**Q: Does the plaintiff have a history of depressed mood before the injury in question?**  
Some people only have a single major depressive episode and return to normal functioning. Approximately half of the people who have a major depressive episode, however, may eventually have another major depression. Periods of major depression can recur after many years of normal functioning, can occur in clusters, or may gradually become more frequent with age. The first major depressive episode usually occurs in the mid-twenties. (reference 7, p. 369; reference 4, p. 762)

**Q: Does the plaintiff have a history of any medical or psychological conditions that may cause a depressed mood?**

*The witness may indicate the possibility of the following medical or psychological conditions: please refer to the sections pertaining to these conditions for further questions.*

**SYMPTOM**

**DEPOSITION QUESTIONS**

**Depressed Mood**

(continued)

**TABLE 5.7-5.**

|  |   |
|--|---|
| Alzheimer's disease                      | Hypothyroidism                            |
| Anemia                                   | Infectious mononucleosis                  |
| Antisocial personality disorder          | Irritable bowel syndrome                  |
| Asthma                                   | Limbic lobe lesions                       |
| Attention-deficit hyperactivity disorder | Menopausal distress                       |
| Bipolar disorder                         | Multiple sclerosis                        |
| Borderline personality disorder          | Myocardial infarction                     |
| Brain tumor                              | Narcissistic personality disorder         |
| Bulimia                                  | Obsessive-compulsive personality disorder |
| Chronic fatigue syndrome                 | Pancreatic carcinoma                      |
| Chronic obstructive pulmonary disease    | Paranoid personality disorder             |
| Chronic pain                             | Parkinson's disease                       |
| Creutzfeldt-Jakob disease                | Passive aggressive personality disorder   |
| Cushing's syndrome                       | Pernicious anemia                         |
| Fibromyalgia                             | Porphyria                                 |
| Frontal lobe lesions                     | Premenstrual dysphoric disorder           |
| Heart attack                             | Schizophrenia                             |
| Hepatitis B                              | Somatization disorder                     |
| Histrionic personality disorder          | Spinal cord injury                        |
| HIV infections                           | Syphilis                                  |
| Huntington's disease                     | Systemic lupus erythematosus              |
| Hypoglycemia                             |   |
| Hypoparathyroidism                       |   |

**Q: Did you rule out any genetic or family tendencies as a cause of the plaintiff's depressive episodes?**

A family history of depression may double or triple the risk of depression for the plaintiff. (reference 4, p. 768)

Major depressive disorder is 1.5 to 3 times more common among first-degree biological relatives of persons with this disorder than among the general population. (reference 7, p. 373)

**Q: Did you rule out dysthymic disorder (depression) as a cause of the plaintiff's depressed mood?**

Dysthymic disorder is characterized by chronic depressive symptoms less severe than major depression. Always **feeling despondent or melancholy**, the plaintiff believes that depression is part of their personality. Other symptoms may include a poor appetite or overeating, insomnia or hypersomnia, low energy or fatigue, low self-esteem, poor concentration, difficulty making decisions, and **feelings of hopelessness**. The disorder may begin in childhood for both sexes, but is more common in adult females. (reference 7, p. 376; reference 4, pp.803-804)

*If the witness indicates the possibility of dysthymic disorder, see the section on dysthymic disorder for further questions.*

## SYMPTOM

## DEPOSITION QUESTIONS

**Depressed  
Mood***(continued)*

*Caution: Do not ask the following question if the cause of action involves a closed head injury.*

**Q: Did you rule out mood disorder due to a general medical condition (i.e. organic brain syndrome) as a cause of the plaintiff's depressed mood?**

The essential feature of a mood disorder due to a general medical condition is a prominent and **persistent disturbance in mood** that is judged to be due to the direct physiological effects of a general medical condition such as HIV, thyroid disorders, stroke, Parkinson's disease, metabolic conditions, endocrine disorders, autoimmune disorders, cancer, viral and other infectious conditions. (reference 7, p. 401)

**Q: Did you rule out a schizoaffective disorder as a cause of the plaintiff's depressed mood?**

This group of disorders is characterized by a mixture of schizophrenic and affective or **major depressive** and manic **syndromes**. (reference 12)

**Q: Did you rule out cyclothymic disorder as a cause of the plaintiff's depressed mood?**

Cyclothymic disorder is a chronic, fluctuating mood involving numerous periods of hypomanic symptoms and **numerous periods of depressive symptoms**. The symptoms are not severe enough to meet the criteria for a major depressive or manic episode. The plaintiff may have impaired social and occupational functioning. Cyclothymic disorder usually begins in adolescence or early adulthood. (reference 7, p. 398; reference 4, pp. 760-761, 804)

**Q: Did you rule out early onset of dementia of the Alzheimer's type as a cause of the plaintiff's depressed mood?**

This primary degenerative dementia is caused by Alzheimer's disease. The plaintiff's intellectual abilities, personality, and behavior progressively deteriorate. **Depressive symptoms** may complicate the condition. (reference 7, p. 154)

*Age at onset: Senile onset (after age 65) is much more common than pre-senile onset. Few cases develop before the age of 49.*

**Q: Did you rule out an adjustment disorder with depressed mood as a cause of the plaintiff's depressed mood?**

This adjustment disorder is accompanied by **depression**, tearfulness, sleep disturbance, and feelings of hopelessness to a stressor. It is important to note that an adjustment disorder is a transient over-reaction to stress and should remit within six months. (reference 7, p. 679)

*If the witness indicates the possibility of an adjustment disorder with depressed mood, see the section on adjustment disorders for further questions.*

## SYMPTOM

## DEPOSITION QUESTIONS

**Depressed Mood***(continued)***Q: Did you rule out a *pre-existing or familial bipolar disorder* as a cause of the plaintiff's depressed mood?**

A bipolar disorder has a circular pattern of high and low emotional states (*mania and depression*). During the *manic episodes*, the plaintiff may feel grandiose, have a decreased need for sleep, and decreased emotional capacity, experience a surge of ideas and conversation, and may be easily distracted or pleased. It is often thought that the manic high represents an escape from inner depression and pain. While the plaintiff is extremely active, s/he is often fragmented and unable to finish projects. The plaintiff typically does not realize that s/he is ill.

During *major depressive episodes* the plaintiff may be **depressed for at least two weeks**. The plaintiff may experience an appetite disturbance, weight change, sleep disturbance, psychomotor agitation or retardation, decreased energy and emotional capacity, feelings of worthlessness, difficulty thinking or concentrating, and recurrent thoughts of death or suicide. (reference 4, pp. 408-409, 761; reference 7, pp. 382-391)

*If the witness indicates that the plaintiff has a history of manic or hypomanic episodes along with the depression, the plaintiff may not have a major depressive disorder, but may have a bipolar disorder.*

**Q: Did you rule out *vascular dementia (formerly multi-infarct dementia)* as a cause of the plaintiff's depressed mood?**

Vascular dementia is caused by cerebrovascular disease (disease of the brain's blood supply or blood vessels) that quickly produces an irregular deterioration in intellectual functioning. The resulting dementia involves disturbances in memory, abstract thinking, judgment, impulse control, and personality. Combined with **depression**, the dementia often causes **many depressive symptoms**. (reference 7, p. 147)

**Q: Did you rule out *HIV-associated dementia or HIV-associated mild neurocognitive disorder* or as a cause of the plaintiff's depressed mood?**

HIV dementia is a severe cognitive disorder that interferes substantially with work, home life and social activities. Symptoms of mild neurocognitive disorder associated with HIV infection include difficulty concentrating, unusual fatigability with demanding mental tasks, **feeling slowed down** and memory difficulties. Problem solving, abstract reasoning, and motor performance may also be affected. (reference 18, pp. 308-316; reference 7, p. 163)

**Q: Did you rule out *hyperthyroidism* as a cause of plaintiff's depressed mood?**

Hyperthyroidism, or thyrotoxicosis, results from overproduction of thyroid hormone by the thyroid gland. The most common cause is Graves' disease. The signs and symptoms of hyperthyroidism include both physical and psychiatric complaints. Psychiatric features include nervousness, fatigue, insomnia, mood lability, and **dysphoria**. There may be a heightened activity level. Cognitive symptoms include a short attention span, impaired recent memory, and an exaggerated startle response.

## SYMPTOM

## DEPOSITION QUESTIONS

**Depressed Mood***(continued)*

Physical signs and symptoms of hyperthyroidism include increased pulse, arrhythmias (irregular heart rhythm), elevated blood pressure, fine tremor, heat intolerance, excessive sweating, increased appetite, weight loss, palpitations (abnormal rapid beating of heart), tachycardia (rapid heart beat), frequent bowel movements, menstrual irregularities, and muscle weakness. Panic attacks are associated with endocrinological disorders including hyperthyroidism, as well as hypothyroidism. (reference 18, pp. 743, 1809-1810, 1928)

*If the witness indicates the possibility of hyperthyroidism, see the section on pre-existing medical conditions for further questions.*

**Q: Did you rule out *hypothyroidism* as a cause of the plaintiff's depressed mood?**

Hypothyroidism results from inadequate synthesis of thyroid hormone.

Hypothyroidism can produce psychiatric, as well as physical symptoms. The most notable psychiatric symptoms include **depression**, lethargy, poor concentration, impaired memory, apathy, and syncope. The numerous physical symptoms are: cold intolerance, constipation, muscle cramps, paresthesias, menstrual disorders, dyspnea, dizziness, reduced hearing, poor appetite, weight gain, brittle and thinning hair, and bradycardia (slowed heart action). Panic attacks are associated with endocrinological disorders including hypothyroidism and hyperthyroidism. (reference 18, pp. 743, 1810-1812, 1928)

*If the witness indicates the possibility of hypothyroidism, see the section on pre-existing medical conditions for further questions.*

**Q: Did you rule out *viral infections* as a cause of the depressed mood?**

Viral illnesses, such as infectious hepatitis, mononucleosis, and influenza, may produce **significant depressive symptoms** in the plaintiff. The plaintiff may commonly experience the depressive symptoms for days or weeks after the illness. These self-limited illnesses may result in suicidal ideation, loss of appetite, libido, and fatigue. The symptoms, however, are brief and related to the viral illness. (reference 4, pp. 876, 1275)

**Q: (Female) Did you rule out a *postpartum-onset episode* as a cause of the plaintiff's depressed mood?**

If a major depressive episode, manic or mixed episode occurs within four weeks following childbirth, it would be diagnosed as a mood disorder with postpartum-onset. Symptoms that are common in postpartum-onset episodes include **fluctuations in mood** and preoccupation with infant well-being, the intensity of which may range from over-concern to frank delusions. (reference 4, pp. 1238-124; reference 1, p. 1720; reference 7, pp. 422-423)

*If the witness indicates the possibility of a postpartum-onset episode, see the section on medical conditions for further questions.*

*SYMPTOM*

*DEPOSITION QUESTIONS*

**Depressed Mood**

*(continued)*

**Q: Did you rule out *antisocial personality disorder* as a cause of the plaintiff's depressed mood?**

The antisocial plaintiff may have a life time history of irresponsible and antisocial behavior. Childhood behaviors may include lying, stealing, truancy, vandalism, initiating fights, running away from home, and physical cruelty. Adolescents may also become abusers of tobacco, alcohol, and other drugs, or engage in early sexual activity. Adults with antisocial personalities fail to conform to social norms with respect to lawful behavior. They may be unable to keep a job, friendship, or sexual relationship. The plaintiff shows no remorse or guilt when hurting or mistreating others. Frequently this disorder is accompanied by signs of personal distress, tension, an inability to tolerate boredom, **depression**, a conviction that others are hostile, and suicidal attempts. (reference 7, p. 701; reference 4, pp. 1865, 1868-1869)

*If the witness indicates the possibility of an antisocial personality disorder or other maladaptive personality traits, see the section on pre-existing personality disorders for further questions.*

**Q: Did you rule out a *borderline personality disorder* as a cause of the plaintiff's depressed mood?**

A borderline personality disorder is characterized by unstable interpersonal relationships, behavior, mood, and self-image. The plaintiff may experience temporary mood shifts including **depression**, irritability, and anxiety. They may also have chronic feelings of emptiness or boredom, inappropriate anger, and recurrent suicidal thoughts. Social contrariness and a generally pessimistic outlook often accompany the disorder. Premature death may result from suicide. (reference 7, p. 706)

**NOTE: The following questions pertain to depression that may have its onset with drug use / abuse.**

**TABLE 5.7-6.**

|   |
|---|
| <p><b><i>Diagnostic criteria for Substance-Induced Mood Disorder</i></b></p> <p><b>A.</b> A prominent and persistent disturbance in mood predominates in the clinical picture and is characterized by either (or both) of the following:</p> <ul style="list-style-type: none"> <li>(1) depressed mood or markedly diminished interest or pleasure in all, or almost all, activities</li> <li>(2) elevated, expansive, or irritable mood</li> </ul> <p><b>B.</b> There is evidence from the history, physical examination, or laboratory findings of either (1) or (2):</p> <ul style="list-style-type: none"> <li>(1) the symptoms in Criterion A developed during, or within a month of, Substance Intoxication or Withdrawal</li> <li>(2) medication use is etiologically related to the disturbance</li> </ul> <p><b>C.</b> The disturbance is not better accounted for by a Mood Disorder that is not substance induced. Evidence that the symptoms are better accounted for by a Mood Disorder that is not substance induced might include the following: the</p> |
|---|

## SYMPTOM

## DEPOSITION QUESTIONS

**Depressed  
Mood***(continued)*TABLE 5.7-6. *(continued)*

symptoms precede the onset of the substance use (or medication use); the symptoms persist for a substantial period of time (e.g., about a month) after the cessation of acute withdrawal or severe intoxication or are substantially in excess of what would be expected given the type or amount of the substance used or the duration of use; or there is other evidence that suggests the existence of an independent non-substance-induced Mood Disorder (e.g., a history of recurrent Major Depressive Episodes).

- D. The disturbance does not occur exclusively during the course of a delirium.
- E. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

**Note:** This diagnosis should be made instead of a diagnosis of Substance Intoxication or Substance Withdrawal only when the mood symptoms are in excess of those usually associated with the intoxication or withdrawal syndrome and when the symptoms are sufficiently severe to warrant independent clinical attention.

*Code* [Specific Substance]-Induced Mood Disorder:

- 291.89 Alcohol;
- 292.84 Amphetamine [or Amphetamine-Like Substance];
- 292.84 Cocaine;
- 292.84 Hallucinogen;
- 292.84 Inhalant;
- 292.84 Opioid;
- 292.84 Phencyclidine [or Phencyclidine-Like Substance];
- 292.84 Sedative, Hypnotic, or Anxiolytic;
- 292.84 Other [or Unknown] Substance

*Specify type:*

**With Depressive Features:** if the predominant mood is depressed

**With Manic Features:** if the predominant mood is elevated, euphoric, or irritable

**With Mixed Features:** if symptoms of both mania and depression are present and neither predominates

*Specify if:*

**With Onset During Intoxication:** if the criteria are met for intoxication with the substance and the symptoms develop during the intoxication syndrome

**With Onset During Withdrawal:** if criteria are met for Withdrawal from the substance and the symptoms develop during, or shortly after, a withdrawal syndrome

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SYMPTOM

DEPOSITION QUESTIONS

Depressed Mood

(continued)

Q: Did you rule out alcohol consumption or withdrawal as a cause of the plaintiff's depressed mood?

Alcohol intoxication may cause aggressiveness, impaired judgment and attention, irritability, euphoria, depression, emotional lability, and impaired social or occupational functioning. Physical symptoms may include slurred speech, incoordination, unsteady gait, nystagmus, occasional dizziness, and flushed face. Heavy alcohol consumption may cause abnormal sleep patterns. The plaintiff often falls asleep quickly but wakes up earlier and earlier with uncomfortable feelings. Chronic alcoholics may have irregular, unsteady, and slow tremulous movements. (reference 7, pp. 128-129; reference 4, p. 67; reference 9, p. 52)

The reduction or cessation of drinking for at least several days may cause characteristic symptoms: coarse tremor of hands, tongue, or eyelids; nausea or vomiting; malaise or weakness; autonomic hyperactivity (tachycardia, sweating, and elevated blood pressure); anxiety, depressed mood or irritability; transient hallucinations or illusions; headache; insomnia; dizziness; fatigue; restlessness; and agitation. (reference 7, pp. 129-130; reference 2, pp. 722, 618; reference 9, pp. 50-54)

Q: Did you rule out amphetamine or similarly acting sympathomimetic drug consumption or withdrawal as a cause of the plaintiff's depressed mood?

Symptoms of amphetamine or similarly acting sympathomimetic drug consumption may include fighting, grandiosity, elation, hypervigilance, psychomotor agitation, impaired judgment, and impaired social or occupational functioning. Physical symptoms may include flushing, difficulty breathing, tachycardia, pupil dilation, elevated blood pressure, sweating or chills, nausea, and vomiting. (reference 4, pp. 1007-1008; reference 7, p. 223)

Drug withdrawal symptoms may include a dysphoric mood (depression, irritability, anxiety), fatigue, sweating, headaches, insomnia with nightmares, hypersomnia, and psychomotor agitation. Symptoms begin after the cessation of prolonged drug use (at least two days) and last more than 24 hours. (reference 7, p. 227; reference 4, p. 1008)

The following drugs may be classified as amphetamines:

- |                                    |                            |
|------------------------------------|----------------------------|
| Appetite Suppressants (diet pills) | Methamphetamines (speed)   |
| Dextroamphetamines                 | Methylphenidates (Ritalin) |
| Ma-huang (ephedra)                 | (reference 17, p. 586)     |
| (reference 24, pp. 488-489)        |                            |

Q: Did you rule out cocaine consumption or withdrawal as a cause of the plaintiff's depressed mood?

Cocaine users often experience increased energy and confidence or irritability and paranoia with physical aggressiveness. Other behavioral symptoms may include euphoria, hypervigilance, psychomotor agitation, impaired judgment, and impaired social or occupational functioning. Physical symptoms may include tachycardia,

## SYMPTOM

## DEPOSITION QUESTIONS

**Depressed Mood***(continued)*

dilated pupils, elevated blood pressure, perspiration or chills, nausea, vomiting, and hallucinations.

The abrupt *cessation or reduction of cocaine*, after several days use, may cause the plaintiff to feel tired, **dysphoric**, irritable, **depressed**, and to crave more of the drug. An anxiety reaction may cause psychomotor agitation, insomnia or hypersomnia, high blood pressure, tachycardia, and paranoia. The symptoms may persist for more than a day. (reference 7, pp. 141-143; reference 4, pp. 1008-1009)

**Q: Did you rule out *hallucinogen consumption* as the cause of the plaintiff's depressed mood?**

Hallucinogen consumption causes changes in perception such as feelings of detachment, illusions, hallucinations, and synesthesia (seeing colors when a loud sound occurs). Behavioral symptoms may include anxiety or **depression**, ideas of reference, fear of losing one's mind, paranoia, impaired judgment, and impaired social or occupational functioning. Physical symptoms may include dilated pupils, tachycardia, sweating, palpitations, blurred vision, tremors, and incoordination. Flashbacks of experiences may recur several months or years after hallucinogen use. Many plaintiffs may have gross thought process disturbances. Unlike schizophrenics, they are able to talk in detail about their hallucinations. (reference 7, p. 250; reference 4, p. 874)

**Q: Did you rule out *inhalant intoxication* as a cause of the plaintiff's depressed mood?**

Following inhalant (toxic substance) use, the plaintiff may experience behavioral and physical changes. Behavioral changes may include belligerence, assaultiveness, apathy, impaired judgment, and impaired social or occupational functioning. Physical signs may include dizziness, nystagmus, slurred speech, unsteady gait, **lethargy**, **depressed reflexes**, tremor, **psychomotor weakness**, blurred vision or diplopia, stupor or coma, and euphoria. (reference 7, p. 259)

**Q: Did you rule out *opioid consumption or withdrawal* as a cause of the plaintiff's depressed mood?**

*Opioid intoxication* is characterized by euphoria, flushing, itching skin, miosis, drowsiness, decreased respiratory rate and depth, hypotension, bradycardia, and decreased body temperature. The initial euphoria is often followed by apathy, **unpleasant mood**, psychomotor retardation, impaired judgment, and impaired social or occupational functioning. While dependence on opioids is less common than on alcohol or tobacco, it has been estimated that fifteen percent of males and nine percent of females have used an opioid (nonmedical) during their lifetime. (reference 7, p. 269; reference 4, pp. 987-988)

Symptoms of *opioid withdrawal* may include lacrimation (tearing), rhinorrhea (runny nose), dilated pupils, sweating, diarrhea, yawning, mild hypertension, tachycardia (increased heart rate), fever, insomnia, and gooseflesh. Associated features may include restlessness, irritability, **depression**, tremor, weakness, nausea, vomiting, and muscle or joint pain. These signs, often resembling influenza

## SYMPTOM

## DEPOSITION QUESTIONS

**Depressed  
Mood***(continued)*

symptoms, may be precipitated by the abrupt ending of one or two weeks of continuous opioid use. The withdrawal symptoms may last days or weeks. During the final stages of withdrawal, the plaintiff may experience over-concern for bodily discomfort, poor self-image, and a decreased ability to tolerate stress. (reference 7, p. 269; reference 4, pp. 990-991)

**Q: Did you rule out *phencyclidine (PCP)* or similarly acting arylcyclohexylamine consumption as a cause of the plaintiff's depressed mood?**

Symptoms begin within one hour if PCP is taken orally or within five minutes if smoked, inhaled, or taken intravenously. PCP causes very unpredictable behavior within a short period of time. The user can be social and sympathetic one minute then become hostile and negative the next. The most common symptoms are **depression** and anxiety. Other symptoms may include psychomotor agitation, impaired judgment, impaired social or occupational functioning, increased blood pressure or heart rate, numbness to pain, ataxia (incoordination of voluntary muscles), dysarthria (impaired speech), muscle rigidity, seizures, and hyperacusis (painful sensitivity to sounds). After a four to six hour high, the plaintiff may feel **depressed**, irritable, paranoid, belligerent, assaultive, irrational, suicidal, or homicidal. It may take 24-48 hours to completely recover from the drug's effects.

**Mood disorders** may develop shortly after use and are characterized by feelings of self-reproach, guilt, fearfulness, excessive talking, difficulty sleeping, and thoughts that they have destroyed their brains or driven themselves crazy. (reference 7, p. 278; reference 4, pp. 1012-1014)

**Q: Did you rule out *sedative, hypnotic, or anxiolytic consumption or withdrawal* as a cause of the plaintiff's depressed mood?**

Sedative, hypnotic, or anxiolytic *drug consumption* can cause behavioral and physical changes. Behavioral symptoms may include disinhibition of sexual or aggressive impulses, **mood lability**, impaired judgment, and impaired social or occupational functioning. Physical symptoms may include slurred speech, incoordination, unsteady gait, psychomotor retardation, and impaired memory or attention span. Sedative drugs and minor tranquilizers cause impairment on many behavioral tasks. They may also improve some plaintiffs work or social functioning by reducing severe anxiety. The effects of two or more drugs, such as sedatives and alcohol, may cause significant behavioral impairment. (reference 7, p. 284; reference 4, p. 1548)

*Withdrawal symptoms* develop when the plaintiff reduces or stops the prolonged moderate or heavy use of these substances. Symptoms may include nausea or vomiting; malaise or weakness; autonomic hyperactivity (such as tachycardia and sweating); anxiety or irritability; orthostatic hypotension; coarse tremor of the hands, tongue and eyelids; insomnia; and grand mal seizures. (reference 7, p. 287; reference 4, p. 1549)

*SYMPTOM*

*DEPOSITION QUESTIONS*

**Depressed Mood**

(continued)

**Q: Did you rule out *long-term treatment with the adrenal cortical steroids or ACTH* as a cause of the plaintiff's depressed mood?**

Plaintiffs with a long-term history of adrenal cortical steroid or ACTH treatment commonly develop major mental disturbances. While taking the drugs, they may experience euphoria, severe mania, **severe depression**, delirium, paresthesia (abnormal tightness or tingling around a limb or trunk), insomnia, restlessness, or agitation. Symptoms usually disappear when the drugs are reduced or discontinued. (reference 4, p. 876)

**Q: Did you rule out *ecstasy use* as a cause for the plaintiff's depressed mood?**

MDMA (methylenedioxymethamphetamine) use can sometimes result in severe dehydration or exhaustion, or other adverse effects such as nausea, hallucinations, chills, sweating, increases in body temperature, tremors, involuntary teeth clenching, muscle cramping, and blurred vision. MDMA users have also reported after-effects such as anxiety, paranoia, and **depression**. An MDMA overdose is characterized by high blood pressure, faintness, panic attacks, and, in more severe cases, loss of consciousness, seizures, and a drastic rise in body temperatures to 105-106 degrees Fahrenheit. MDMA overdoses can be fatal, as they may result in heart failure or extreme heat stroke. (reference 20)

**Q: Does the plaintiff have any other *medical conditions* that may cause a depressed mood, such as:**

|  |                                 |
|--|---------------------------------|
| Cerebrovascular accidents                  | Hyper and hypoadrenocorticalism |
| Endocrine disorders                        | Hemispheric strokes             |
| Epstein-Barr virus following mononucleosis |                                 |

**Q: Is the plaintiff taking any *medications or substances* that may cause a depressed mood?**

Antihypertensive medications are a particular class of drugs that may cause a depressed mood. Other drugs include:

|                 |             |            |
|-----------------|-------------|------------|
| ACCUPRIL        | ANSAID      | BUSPAR     |
| ACCUTANE        | ANTABUSE    | BUTICAPS   |
| ADALAT          | APRESOLINE  | CALAN      |
| ADAPIN          | ARICEPT     | CARBATROL  |
| AEROBID         | ARTHROTEC   | CATAPRES   |
| ALDOMET         | ASENDIN     | CELEBREX   |
| ALDORIL         | ATIVAN      | CELEXA     |
| ALPHGAN         | AVAPRO      | CELONTIN   |
| ALTACE          | AXOCET      | CENESTIN   |
| AMBIEN          | AZULFIDINE  | CIPRO      |
| AMYTAL          | BACTRIM     | CLARITAN-D |
| ANAFRANIL       | BIPHETAMINE | CLARITIN   |
| ANAPROX         | BRONTEX     | CLIMARA    |
| ANDRODERM PATCH | BUPRENEX    | CLINORIL   |

# Major Depressive Disorder

**SYMPTOM**

**DEPOSITION QUESTIONS**

**Depressed  
Mood**

(continued)

|                 |                  |                   |
|-----------------|------------------|-------------------|
| CLOZARIL        | FLAGYL           | MESANTOIN         |
| CODEINE         | FLEXERIL         | MINIPRESS         |
| COGENTIN        | FLOXIN           | MIRAPEX           |
| COGNEX          | GABITRIL         | MOBAN             |
| COMBIPRES       | HALCION          | MODURETIC         |
| CONCERTA        | HALDOL           | MONOPRIL          |
| CORGARD         | HISMANAL         | MORPHINE-SULFATE  |
| COUMADIN        | HISTUSSIN        | MOTRIN            |
| COZAAR          | HYDERGINE        | NALDECON          |
| CRINONE         | HYTRIN           | NALFON            |
| CYCRIN          | HYZAAR           | NAPROSYN          |
| CYLERT          | IMDUR            | NARDIL            |
| CYTOTEC         | INAPSINE         | NEMBUTAL          |
| DALMANE         | INDERAL          | NEURONTIN         |
| DANTRIUM        | INDERIDE         | NIZORAL           |
| DAYPRO          | INDOCIN          | NOLUDAR           |
| DECADRON        | KERLONE          | NOLVADEX          |
| DEMEROL         | KLONOPIN         | NORCO             |
| DEPAKENE        | LAMICTAL         | NORDETTE          |
| DEPAKOTE        | LESCOL           | NORINYL           |
| DEPO-PROVERA    | LEVAQUIN         | NOROXIN           |
| DEPROL          | LEVO-DROMORAM    | NORPACE           |
| DESOGEN         | LIBRAX           | NORPLANT-SYSTEM   |
| DESOXYN         | LIDODERM PATCH   | NORPRAMIN         |
| DESYREL         | LIMBITROL        | NORVASC           |
| DEXEDRINE       | LIRESAL          | NUBAIN            |
| DILAUDID        | LIPITOR          | OGEN              |
| DIMETAPP        | LO/OVRAL         | ORAP              |
| DOLOBID         | LODINE           | ORTHO-NOVUM       |
| DORAL           | LOMOTIL          | ORTHO-CEPT        |
| DURACT          | LOPID            | ORTHO-NOVUM       |
| DURAGESIC       | LOPRESSOR        | ORTHO-CYCLEN      |
| DURAVENT        | LORCET           | ORTHOEST          |
| DYNACIRC        | LOZOL            | ORUDIS            |
| EFFEXOR         | LUDIOMIL         | OXYCONTIN         |
| ELAVIL          | LUVOX            | PAMELOR           |
| ELDEPRYL        | MACROBID         | PARLODEL          |
| EMPIRIN-CODEINE | MARCAINE         | PARNATE           |
| ENDEP           | MARPLAN          | PAXIL             |
| ESGIC           | MAVIK            | PAXIPAM           |
| ESTRACE         | MAXAIR-AUTOHALER | PEDIAZOLE         |
| ESTRATAB        | MAXALT           | PEPCID            |
| ESTRATEST       | MAXIDE           | PERMAX            |
| ETRAFON         | MEBARAL          | PHENAPHEN-CODEINE |
| EXCELON         | MECLOMEN         | PHENERGAN-VC-     |
| FELDENE         | MELLARIL         | CODEINE           |
| FIORICET        | MEPERGAN         | PHENOBARBITAL     |

## Major Depressive Disorder

*SYMPTOM*

*DEPOSITION QUESTIONS*

**Depressed Mood**

*(continued)*

|                |                 |                 |
|----------------|-----------------|-----------------|
| PLAVIX         | SERZONE         | TRENTAL         |
| PLENDIL        | SINEMET         | TRIAVIL         |
| PONDIMIN       | SINEQUAN        | TRILAFON        |
| PRAVACHOL      | SOMA            | TRINALIN        |
| PREMARIN       | SOMA COMPOUND   | TRIPHASIL       |
| PREMPHASE      | SONATA          | TROVAN          |
| PREMPRO        | SPORANOX        | TUINAL          |
| PREVACID       | ST. JOHN'S WORT | TYLENOL-CODEINE |
| PRILOSEC       | SULAR           | VALIUM          |
| PRINZIDE       | SULINDAC        | VASOTEC         |
| PROCAN SR      | SURMONTIL       | VIAGRA          |
| PROSOM         | SYMMETREL       | VICODIN         |
| PROTONIX       | TAGAMET         | VICOPROFEN      |
| PROVERA        | TALECEN         | VIOXX           |
| PROZAC         | TALWIN NX       | VIVACTIL        |
| PULMICORT      | TEGRETOL        | VOLTAREN        |
| REDUX          | TENORETIC       | WELLBUTRIN      |
| REGLAN         | TENORMIN        | XANAX           |
| RELAFEN        | TESTODERM       | XYLOCAINE       |
| REMERON        | TIAZAC          | ZANAFLEX        |
| REVIA          | TIGAN           | ZANTAC          |
| RISPERDAL      | TIMOPTIC        | ZARONTIN        |
| RITALIN        | TOFRANIL        | ZESTORETIC      |
| ROBAXIN        | TOFRANIL-PM     | ZESTRIL         |
| RUFEN          | TOLECTIN        | ZIAC            |
| SANOREX        | TOPAMAX         | ZOCOR           |
| SE-AP-ES       | TOPROL-XL       | ZOLOFT          |
| SECONAL-SODIUM | TORADOL         | ZOMIG           |
| SEPTRA         | TRANCOPAL       | ZYBAN           |
| SEROQUEL       | TRANDATE        | ZYLOPRIM        |
| SERTRALINE     | TRANXENE        | ZYRTEC          |

**Diminished Interest or Pleasure**

- Q:** Describe the plaintiff's diminished interest or pleasure in activities.

---

- Q:** When and how often does the plaintiff experience a diminished interest or pleasure in activities?

---

- Q:** What specific activities was the plaintiff involved in before the injury?

---

- Q:** What is the extent of involvement in those activities now?

---

- Q:** How has the plaintiff expressed disinterest in these activities?

---

- Q:** Is the plaintiff showing new interest in other areas?

---

*SYMPTOM*

*DEPOSITION QUESTIONS*

**Diminished Interest or Pleasure**

*(continued)*

- Q: What is the plaintiff's explanation for this change in interest?**

---

- Q: Does the plaintiff have a history of diminished interest or pleasure in activities?**

---

- Q: Does the plaintiff have a history of any *medical or psychological conditions* that may cause a markedly diminished interest or pleasure in activities?**  
*The witness may indicate the possibility of the following medical or psychological conditions: please refer to the sections pertaining to these conditions for further questions.*

**TABLE 5.7-7.**

|                                 |                               |
|---------------------------------|-------------------------------|
| Addison's disease               | Pancreatic carcinoma          |
| Antisocial personality disorder | Pernicious anemia             |
| Avoidant personality disorder   | Postpartum disorder           |
| Brain tumors                    | Rheumatoid arthritis          |
| Coronary artery disease         | Schizoid personality disorder |
| Menopausal distress             | Systemic lupus erythematosus  |
| Multiple sclerosis              |                               |

*Note: The following question is to be asked if the plaintiff has experienced the loss of a family member or a close friend during the past two years.*

- Q: Did you rule out *bereavement* as a cause of the plaintiff's diminished interest or pleasure in activities?**  
 Mourning is a normal grief reaction to a loss, such as the death of a loved one. The plaintiff may feel depressed and dejected, have **diminished interest** in the outside world, a decreased capacity to love, and an **inhibition of activity**. People tend to feel as if all their energy is taken up with thoughts and memories of the loss. Fatigue and weariness are characteristic symptoms. Sighing, feeling empty, disinterested, listless, eating more or less than normal, losing weight, and having trouble sleeping are common experiences. (reference 4, pp. 1286-1293; reference 7, pp. 740-741; reference 2, p. 617)

---

- Q: Did you rule out a *negativistic (passive aggressive) personality disorder* as a cause of the plaintiff's diminished interest or pleasure in activities?**  
 A negativistic (passive aggressive) personality passively resists both the demands of work and society. S/he may express this through procrastination, dawdling, stubbornness, intentional inefficiency, and forgetfulness. The plaintiff may be sulky, irritable, or argumentative. Associated symptoms include dependency, lack of self-confidence, and a **pessimism for the future** with no sense of responsibility for their problems. (reference 7, p. 789; reference 4, p. 985)  
*If the witness indicates the presence of negativistic (passive aggressive) personality disorder or other maladaptive personality traits, see the section on pre-existing personality disorders for further questions.*

## SYMPTOM

## DEPOSITION QUESTIONS

## Diminished Interest or Pleasure

(continued)

**Q: Did you rule out a *borderline personality* as a cause of the plaintiff's diminished interest or pleasure in activities?**

A borderline personality disorder is characterized by unstable interpersonal relationships, behavior, mood, and self-image. The plaintiff may experience temporary mood shifts including depression, irritability, and anxiety. They may also have **chronic feelings of emptiness or boredom**, inappropriate anger, and recurrent suicidal thoughts. Social contrariness and a generally pessimistic outlook often accompany the disorder. Premature death may result from suicide. (reference 7, p. 706)

**Q: Did you rule out a *depersonalization disorder* as a cause of the plaintiff's diminished interest or pleasure in activities?**

The plaintiff with this disorder has very stressful recurrences of depersonalization. They may feel detached from mind, body and reality. Associated symptoms may include dizziness, **depression**, obsessive rumination, somatic concerns, anxiety, fear of going insane, and difficulty with a sense of time and recall (reference 7, p. 530)

**Q: Did you rule out *alcohol consumption* as a cause of the plaintiff's diminished interest or pleasure in activities?**

Alcohol intoxication may cause aggressiveness, impaired judgment and attention, irritability, euphoria, depression, **emotional lability, and impaired social or occupational functioning**. Physical symptoms may include slurred speech, incoordination, unsteady gait, nystagmus, occasional dizziness, and flushed face. Heavy alcohol consumption may cause abnormal sleep patterns. The plaintiff often falls asleep quickly but wakes up earlier and earlier with uncomfortable feelings. Chronic alcoholics may have irregular, unsteady, and slow tremulous movements. (reference 7, p. 214; reference 4, p. 67; reference 9, p. 52)

**Q: Did you rule out *cannabis (marijuana) consumption* as a cause of the plaintiff's diminished interest or pleasure in activities?**

Cannabis intoxication can occur from marijuana, hashish, or tetrahydrocannabinol (THC). Characteristic symptoms include tachycardia, increased appetite, dry mouth, euphoria, anxiety, sensation of slowed time, impaired judgment, and **social withdrawal**. Inappropriate laughter, panic attacks, and a dysphoric mood may occur. (reference 7, p. 234; reference 4, pp. 1326, 754)

**Q: (Female) Did you rule out *premenstrual dysphoric disorder* as a cause of the plaintiff's diminished interest or pleasure in activities?**

Premenstrual dysphoric disorder is characterized by emotional and behavioral symptoms which usually occur during the last week before the menstrual cycle and remit within a few days after menses begins. Symptoms may include tears, sadness, irritability, anger, tension, depression, self-deprecating thoughts, **decreased interest in usual activities**, fatigability, loss of energy, a subjective sense of difficulty in concentration, changes in appetite, and sleep disturbance. Physical symptoms may

**SYMPTOM**

**DEPOSITION QUESTIONS**

**Diminished Interest or Pleasure**

(continued)

also include breast tenderness or swelling, tachycardia, sweating, headaches, joint or muscle pain, a sensation of bloating, or weight gain. (reference 7, pp. 771-774; reference 18, p. 1955)

**Q: Did you rule out undetected, early onset of dementia of the Alzheimer's type as a cause of the plaintiff's diminished interest or pleasure in activities?**

This primary degenerative dementia is caused by Alzheimer's disease. The plaintiff's intellectual abilities, personality, **pleasure in activities, and behavior progressively deteriorate**. Depressive symptoms may complicate the condition. (reference 7, p. 154)

*Age at onset: Senile onset (after age 65) is much more common than pre-senile onset. Few cases develop before the age of 49.*

**Q: Did you rule out vascular dementia (formerly multi-infarct dementia) as a cause of the plaintiff's diminished interest or pleasure in activities?**

Vascular dementia is caused by cerebrovascular disease (disease of the brain's blood supply or blood vessels) that quickly produces an irregular deterioration in intellectual functioning. The resulting dementia involves disturbances in memory, abstract thinking, judgment, impulse control, and personality. Combined with **depression**, the dementia often causes many cognitive symptoms. (reference 7, p. 147)

**Q: Did you rule out HIV-associated dementia or HIV-associated mild neurocognitive disorder as a cause of the plaintiff's diminished interest or pleasures in activities?**

HIV dementia is a severe cognitive disorder that interferes substantially with work, home life and social activities. Symptoms of mild neurocognitive disorder associated with HIV infection include difficulty concentrating, **unusual fatigability** with demanding mental tasks, **feeling slowed down** and memory difficulties. Problem solving, abstract reasoning, and motor performance may also be affected. (reference 18, pp. 308-316; reference 7, p. 163)

**Q: Did you rule out infections as a cause of the plaintiff's diminished interest or pleasure in activities, such as:** (reference 2, p. 617)

- |                                  |                                 |
|----------------------------------|---------------------------------|
| Brucellosis                      | Meningitis                      |
| Chronic urinary tract infections | Subacute bacterial endocarditis |
| Infectious mononucleosis         | Syphilis                        |
| Influenza                        | Tuberculosis                    |
| Malaria                          | Viral hepatitis                 |

**Change in Weight or Appetite**

**Q: Describe the plaintiff's significant change in weight or appetite.**

**Q: When and how often does the plaintiff eat?**

**Q: What are the plaintiff's eating habits between meals?**

*SYMPTOM*

*DEPOSITION QUESTIONS*

**Change in Weight or Appetite**

(continued)

**Q:** Is the plaintiff taking appetite suppressants?

**Q:** Does the plaintiff have a history of weight or appetite fluctuation?

**Q:** Does the plaintiff have a history of any *medical or psychological conditions that may cause a significant change in weight or appetite?*

*The witness may indicate the possibility of the following medical or psychological conditions: please refer to the sections pertaining to these conditions for further questions.*

**TABLE 5.7-8.**

|                                       |                              |
|---------------------------------------|------------------------------|
| Alzheimer's disease                   | Pancreatic carcinoma         |
| Anemia                                | Pernicious anemia            |
| Brain tumor                           | Porphyria                    |
| Chronic obstructive pulmonary disease | Syphilis                     |
| Conversion disorder                   | Systemic lupus erythematosus |
| Creutzfeldt-Jakob disease             | Uremic encephalopathy        |
| Hepatitis B                           |                              |

**Q:** Did you rule out *lithium use* as a cause of the plaintiff's change in weight or appetite?

Lithium and the tricyclics are often given as medication for depression. Tremor is one of the most common side effects. Other symptoms may include nausea, diarrhea, polyuria (the passage of an excessive quantity of urine), polydipsia (excessive thirst), and **weight gain**. Toxic effects may include gross tremor, increased deep tendon reflexes, persistent headaches, vomiting, mental confusion progressing to stupor, seizures, or cardiac arrhythmias. (reference 1, pp. 1460-1461)

**Q:** Did you rule out *anorexia nervosa* as a cause of the plaintiff's change in weight or appetite?

The anorexic plaintiff weighs fifteen percent less than the minimal weight normal for his or her age and height. S/he **refuses to maintain body weight** and has a distorted body image. Other symptoms may include depressed feelings, crying spells, sleep disturbance, obsessive rumination, obsessive compulsive behavior, anxiety, and occasional suicidal thoughts. Many anorexic adolescents have delayed psychosexual development. Adults with the disorder often have a decreased interest in sex. (reference 7, p. 583; reference 1, pp. 1904-1905; reference 4, pp. 1145, 1731)

**Q:** Did you rule out *bulimia nervosa* as a cause of the plaintiff's change in weight or appetite?

Bulimia nervosa features recurrent episodes of **binge eating**, a rapid consumption of a large amount of food in a discrete period of time. The plaintiff will have feelings of lack of control over eating and use self-induced vomiting, laxatives, diuretics, **strict dieting or fasting**, or vigorous exercise in order to prevent weight gain. Eating binges may be planned or done secretly and efforts are made to continue the

## SYMPTOM

## DEPOSITION QUESTIONS

**Change in Weight or Appetite**

(continued)

binge once eating has begun. This must continue at least two times a week for three months. Associated symptoms may include depressive moods and self-deprecating thoughts. (reference 7, p. 589)

**Q: Did you rule out a *borderline personality disorder* as a cause of the plaintiff's change in weight or appetite?**

A borderline personality disorder is characterized by unstable interpersonal relationships, behavior, mood, and self-image. The plaintiff may experience temporary mood shifts including depression, irritability, and anxiety. S/he may also have chronic feelings of emptiness or boredom, inappropriate anger, **binge eating**, and recurrent suicidal thoughts. Social contrariness and a generally pessimistic outlook often accompany the disorder. Premature death may result from suicide. (reference 7, p. 706)

*If the witness indicates the possibility of a borderline personality disorder or other maladaptive personality traits, see the section on pre-existing personality disorders for further questions.*

**Q: Did you rule out *cannabis (marijuana) consumption* as a cause of the plaintiff's change in weight or appetite?**

Cannabis intoxication can occur from marijuana, hashish, or tetrahydrocannabinol (THC). Characteristic symptoms include tachycardia, **increased appetite**, dry mouth, euphoria, anxiety, sensation of slowed time, impaired judgment, and social withdrawal. Inappropriate laughter, panic attacks, and a dysphoric mood may occur. (reference 7, p. 234; reference 4, pp. 1326, 754)

**Q: (Female) Did you rule out *premenstrual dysphoric disorder* as a cause of the plaintiff's change in weight or appetite?**

Premenstrual dysphoric disorder is characterized by emotional and behavioral symptoms which usually occur during the last week before the menstrual cycle and remit within a few days after menses begins. Symptoms may include tears, sadness, irritability, anger, tension, depression, self-deprecating thoughts, decreased interest in usual activities, fatigability, loss of energy, a subjective sense of difficulty in concentration, **changes in appetite**, and sleep disturbance. Physical symptoms may also include breast tenderness or swelling, tachycardia, sweating, headaches, joint or muscle pain, a sensation of bloating, or **weight gain**. (reference 7, pp. 771-774; reference 18, p. 1955)

**Q: Did you rule out a *bipolar disorder* as a cause of the plaintiff's change in weight or appetite?**

A bipolar disorder has a circular pattern of high and low emotional states (*mania and depression*). During the *manic episodes*, the plaintiff may feel grandiose, have a decreased need for sleep, and decreased emotional capacity, experience a surge of ideas and conversation, and may be easily distracted or pleased. It is often thought that the manic high represents an escape from inner depression and pain. While the plaintiff is extremely active, s/he is often fragmented and unable to finish projects. The plaintiff typically does not realize that s/he is ill.

## SYMPTOM

## DEPOSITION QUESTIONS

**Change in Weight or Appetite**

(continued)

During *major depressive episodes* the plaintiff may be depressed for at least two weeks. The plaintiff may experience an **appetite disturbance, weight change**, sleep disturbance, psychomotor agitation or retardation, decreased energy and emotional capacity, feelings of worthlessness, difficulty thinking or concentrating, and recurrent thoughts of death or suicide. (reference 4, pp. 408-409, 761; reference 7, pp. 382-391)

**Q: Did you rule out *masked depression* as a cause of the plaintiff's change in weight or appetite?**

Masked depression is a depressive state in which the dysphoric mood is covered or masked by gastrointestinal problems, chronic pain, insomnia, **weight loss**, or other bodily complaints. Masked depression is common and can be easily missed by physicians. (reference 4 p. 796)

**Q: Did you rule out early onset of *Cushing's disease* (hyperadrenalism) as a cause of the plaintiff's change in weight or appetite?**

Plaintiffs often experience emotional changes before physical signs of the disease appear. Depression is the most common symptom. Other psychological symptoms include irritability, anxiety, confusion, insomnia, and impaired memory or concentration. Some of the characteristic physical signs include an **increased appetite**, weakness, buffalo hump, truncal and facial obesity, heightened facial color, and abdominal striae (stripes). (reference 4, pp. 1171-1172)

*If the witness indicates the possibility of Cushing's syndrome, see the section on pre-existing medical conditions for further questions.*

**Q: (Male adolescent) Did you rule out *Kleine-Levin syndrome* as a cause of the plaintiff's change in weight or appetite?**

The Kleine-Levin syndrome, occurring primarily in adolescent males, is characterized by episodes of excessive sleep and **overeating**, lasting up to several weeks. The condition usually remits in adulthood. (reference 9, pp. 1988-1989)

**Q: Did you rule out *dysthymic disorder* (depression) as a cause of the plaintiff's change in weight or appetite?**

Dysthymic disorder is characterized by chronic depressive symptoms less severe than major depression. Always feeling despondent or melancholy, the plaintiff believes that depression is part of their personality. Other symptoms may include a **poor appetite or overeating**, insomnia or hypersomnia, low energy or fatigue, low self-esteem, poor concentration, difficulty making decisions, and feelings of hopelessness. The disorder may begin in childhood for both sexes, but is more common in adult females. (reference 7, p. 376; reference 4, pp.803-804)

*Note: An admission by the witness that the plaintiff has dysthymic disorder is important, because dysthymic disorder is not as severe as major depression. If the witness indicates the possibility of dysthymic disorder, see the section on dysthymic disorder for further questions.*

## SYMPTOM

## DEPOSITION QUESTIONS

**Change in Weight or Appetite**  
(continued)

**Q: (Female) Did you rule out unreported pregnancy as a cause of the plaintiff's change in weight or appetite?**

Mild nausea, vomiting, and **weight or appetite change** are common symptoms during the first four months of pregnancy. (reference 2, p. 370)

**Q: Did you rule out an allergic reaction as a cause of the plaintiff's change in weight or appetite?**

Allergic rhinitis is an inflammatory disease of the nasal membranes. Symptoms may include sneezing, itching of the nose, a stuffy nose and postnasal drainage. The plaintiff with allergies generally feels ill or uncomfortable and **may not be interested in eating**. Other common symptoms may include fatigue, malaise, and irritability. Symptoms may be seasonal or perennial when due to nonseasonal allergens. (reference 9, pp. 1867-1868)

**Q: Did you rule out rheumatoid arthritis as a cause of the plaintiff's change in weight or appetite?**

Rheumatoid arthritis is a progressive disease that causes long-lasting pain in the joints and muscles. Associated symptoms of severe rheumatoid arthritis may include depression, fatigue, **weight loss, anorexia**, pale skin, and weakness. (reference 4, pp. 1185, 1189, 1194; reference 9, p. 1913)

*If the witness indicates the possibility of rheumatoid arthritis, see the section on pre-existing medical conditions for further questions.*

**Q: Did you rule out hyperthyroidism as a cause of the plaintiff's change in weight or appetite?**

Hyperthyroidism, or thyrotoxicosis, results from overproduction of thyroid hormone by the thyroid gland. The most common cause is Graves' disease. The signs and symptoms of hyperthyroidism include both physical and psychiatric complaints. Psychiatric features include nervousness, fatigue, insomnia, mood lability, and dysphoria. There may be a heightened activity level. Cognitive symptoms include a short attention span, impaired recent memory, and an exaggerated startle response.

Physical signs and symptoms of hyperthyroidism include increased pulse, arrhythmias (irregular heart rhythm), elevated blood pressure, fine tremor, heat intolerance, excessive sweating, **increased appetite, weight loss**, palpitations (abnormal rapid beating of heart), tachycardia (rapid heart beat), frequent bowel movements, menstrual irregularities, and muscle weakness. Panic attacks are associated with endocrinological disorders including hyperthyroidism, as well as hypothyroidism. (reference 18, pp. 743, 1809-1810, 1928)

*If the witness indicates the possibility of hyperthyroidism, see the section on pre-existing medical conditions for further questions.*

## SYMPTOM

## DEPOSITION QUESTIONS

## Change in Weight or Appetite

(continued)

**Q: Did you rule out *hypothyroidism* as a cause of the plaintiff's change in weight or appetite?**

Hypothyroidism results from inadequate synthesis of thyroid hormone. Hypothyroidism can produce psychiatric, as well as physical symptoms. The most notable psychiatric symptoms include depression, lethargy, poor concentration, impaired memory, apathy, and syncope. The numerous physical symptoms are: cold intolerance, constipation, muscle cramps, paresthesias, menstrual disorders, dyspnea, dizziness, reduced hearing, **poor appetite, weight gain**, brittle and thinning hair, and bradycardia (slowed heart action). Panic attacks are associated with endocrinological disorders including hypothyroidism and hyperthyroidism. (reference 18, pp. 743, 1810-1812, 1928)

*If the witness indicates the possibility of hypothyroidism, see the section on pre-existing medical conditions for further questions.*

**Q: Did you rule out *viral infections* as a cause of the plaintiff's change in weight or appetite?**

Viral illnesses, such as infectious hepatitis, mononucleosis, and influenza, may produce significant depressive symptoms in the plaintiff. The plaintiff may commonly experience the depressive symptoms for days or weeks after the illness. These self-limited illnesses may include suicidal ideation, **loss of appetite**, libido, and fatigue. The symptoms, however, are brief and related to the viral illness. (reference 4, pp. 876, 1275)

**Q: Did you rule out *Addison's disease* as a cause of the plaintiff's change in weight or appetite?**

Addison's disease develops slowly as the adrenal cortex decreases functioning. The plaintiff experiences significant personality and behavioral changes from the reduced level of the steroidal hormones normally produced by the gland. Advance stages of Addison's disease produce symptoms of depression, **weight and appetite change**, a lack of physical and emotional responsiveness, mild mental disorders, and recent memory loss. (reference 4, pp. 134, 1170-1171, 1276)

*If the witness indicates the possibility of Addison's disease, see the section on pre-existing medical conditions for further questions.*

**Q: Did you rule out *nicotine withdrawal* as a cause of the plaintiff's change in weight or appetite?**

Nicotine withdrawal symptoms include a strong craving for nicotine, anxiety, irritability, frustration or anger, impaired attention, coughing, headaches, insomnia, a mental preoccupation with actions associated with tobacco use, restlessness, drowsiness, gastrointestinal disturbances, **an increased appetite, and weight gain**. The symptoms appear within 24 hours after the cessation or reduction in the use of cigarettes, cigars, pipes, chewing tobacco, or nicotine gum. The plaintiff experiences a decrease in the intensity of the symptoms with time. (reference 7, p. 264; reference 4, pp. 1031-1032)

*SYMPTOM*

*DEPOSITION QUESTIONS*

**Change in Weight or Appetite**

(continued)

**Q:** Is the plaintiff taking any *medications or substances* that may cause a change in weight or appetite, such as:

- |                 |                 |                  |
|-----------------|-----------------|------------------|
| ACCUTANE        | DELTASONE       | LOXITANE         |
| ADALAT          | DEPAKENE        | LOXITANE C       |
| ADAPIN          | DEPAKOTE        | LOXITANE IM      |
| ADDERALL        | DEPO-PROVERA    | LOZOL            |
| ADIPEX          | DESOGEN         | LUDIOMIL         |
| AEROBID         | DESYREL         | LUVOX            |
| ALDOMET         | DETROL          | MARPLAN          |
| ALDORIL         | DEXEDRINE       | MAXAIR-AUTOHALER |
| ALTACE          | DIAMOX          | MAXALT           |
| AMBIEN          | DILACOR         | MAXIDE           |
| ANADROL         | DURACT          | MECLIZINE        |
| ANAFRANIL       | EFFEXOR         | MEGACE           |
| ANDRODERM PATCH | ELAVIL          | MESANTOIN        |
| ANSAID          | ELDEPRYL        | MICRONOR         |
| ARICEPT         | ENDEP           | MIRAPEX          |
| ARTHROTEC       | ESKALITH        | MOBAN            |
| ASENDIN         | ESTRACE         | MODURETIC        |
| ATIVAN          | ESTRATAB        | MONOPRIL         |
| AVONEX          | ESTRATEST       | MOTRIN           |
| BUPRENEX        | ESTROGEN PATCH  | NAVANE           |
| CARDURA         | ETRAFON         | NEURONTIN        |
| CATAPRES        | EXCELON         | NOLVADEX         |
| CELEBREX        | FASTIN          | NORDETTE         |
| CELEXA          | FELDENE         | NOREPHEDRINE     |
| CELONTIN        | FLEXERIL        | NORINYL          |
| CENTRAX         | FLOXIN          | NORPACE          |
| CLARITAN-D      | HYDRO-          | NORPLANT-SYSTEM  |
| CLARITIN        | CHLOROTHIAZIDE  | NORPRAMIN        |
| CLIMARA         | HYTRIN          | NORVASC          |
| CLONOPIN        | IMMODIUM        | OGEN             |
| CLOZARIL        | INDOCIN         | ORAP             |
| COGNEX          | IONAMIN         | ORTHO-CEPT       |
| COMBIPRES       | KERLONE         | ORTHO-NOVUM      |
| COMPAZINE       | KLONOPIN        | ORTHOCYCLEN      |
| CONCERTA        | LAMICTAL        | ORTHOEST         |
| CORGARD         | LEVAQUIN        | OXYCONTIN        |
| CORTISONE       | LEVOTHROID      | PAMELOR          |
| CRINONE         | LIMBITROL       | PAXIL            |
| CYCLOSPORIN     | LIORESAL        | PAXIPAM          |
| CYCRIN          | LIPITOR         | PERMAX           |
| CYLERT          | LITHIUM CITRATE | PERMITIL         |
| CYTOTEC         | LO/OVRAL        | PONDIMIN         |
| DALALONE        | LOMOTIL         | PREMARIN         |
| DECADRON        | LOPID           | PREMPHASE        |

## Major Depressive Disorder

**SYMPTOM**

**DEPOSITION QUESTIONS**

**Change in Weight or Appetite**

(continued)

|             |           |            |
|-------------|-----------|------------|
| PREMPRO     | SINEMET   | TRILISATE  |
| PREVACID    | SINEQUAN  | TRIPHASIL  |
| PRILOSEC    | SONATA    | TROVAN     |
| PROKETAZINE | SPORANOX  | ULTRAM     |
| PROLIXIN    | STELAZINE | UNIVASC    |
| PROSOM      | SUDAFED   | VANTIN     |
| PROTONIX    | SULAR     | VESPRIN    |
| PROVERA     | SURMONTIL | VICOPROFEN |
| PROZAC      | SYNTHROID | VIOXX      |
| PULMICORT   | TARACTAN  | VIVACTIL   |
| QUESTRAN    | TEMARIL   | VOLTAREN   |
| QUIDE       | THORAZINE | WELLBUTRIN |
| RELAFEN     | THYROID   | XANAX      |
| REMERON     | TIAZAC    | ZANAFLEX   |
| REVIA       | TIMOPTIC  | ZESTORETIC |
| RISPERDAL   | TINDAL    | ZESTRIL    |
| RITALIN     | TOFRANIL  | ZIAC       |
| ROCALTROL   | TOLECTIN  | ZOLOFT     |
| RUFEN       | TOPAMAX   | ZOMIG      |
| SANOREX     | TORECAN   | ZYBAN      |
| SE-AP-ES    | TRENTAL   | ZYPREXA    |
| SEROQUEL    | TRIAVIL   | ZYRTEC     |
| SERTRALINE  | TRILAFON  |            |
| SERZONE     | TRILEPTAL |            |

**Insomnia, Hypersomnia**

- Q: Describe the plaintiff's insomnia or hypersomnia (excessive sleep).**

---

- Q: When and how often does the plaintiff have insomnia or hypersomnia?**

---

- Q: Does the plaintiff sleep or take naps during the day?**

---

- Q: What are the plaintiff's pre-bedtime patterns?** (eating, exercise, alcohol consumption, etc.)

---

- Q: Does the plaintiff have a history of insomnia or hypersomnia before the injury in question?**  
 Insomnia may be persistent from childhood or early adolescence into adulthood. (reference 4, p. 1253)

---

- Q: Does the plaintiff have a history of any medical or psychological conditions that may cause a insomnia or hypersomnia?**  
 The witness may indicate the possibility of the following medical conditions: please refer to the sections pertaining to these medical conditions for further questions.

*SYMPTOM*

*DEPOSITION QUESTIONS*

**Insomnia,  
Hypersomnia**  
*(continued)*

**TABLE 5.7-9.**

|                           |                                     |
|---------------------------|-------------------------------------|
| Alzheimer's disease       | Hepatic encephalopathy              |
| Brain tumor               | Manic episodes                      |
| Coronary artery disease   | Meningitis                          |
| Creutzfeldt-Jakob disease | Postpartum disorder                 |
| Depressive disorders      | Somatoform pain disorder            |
| Epilepsy                  | Subacute sclerosing panencephalitis |

**Q: Did you rule out a *nightmare disorder* as a cause of the plaintiff's insomnia or hypersomnia?**

The plaintiff **awakens from sleep at least three times a week** with a detailed account of a recurring nightmare. The nightmares may be long, lifelike, and often involve threats of survival or self-esteem. The dream anxieties occur more frequently with mental stress, physical fatigue, or changes in sleep environment. The disorder usually begins before age of twenty. In most cases a major stressful life event precedes the onset of the disorder. (reference 7, p. 631)

**Q: Did you rule out *caffeine consumption or withdrawal* as a cause of the plaintiff's insomnia or hypersomnia?**

Characteristic symptoms of *caffeine intoxication* include restlessness, nervousness, excitement, **insomnia**, flushed face, diuresis, gastrointestinal disturbance, muscle twitching, rambling flow of thought and speech, tachycardia or cardiac arrhythmia, periods of inexhaustibility, and psychomotor agitation. When consumed near bedtime, **caffeine often disrupts sleep**. Symptoms may appear when the plaintiff consumes as little as 250 mg of caffeine per day. The plaintiff that consumes one gram per day usually experiences more severe symptoms. Products which contain caffeine include: coffee, tea, soda, chocolate and weight-loss aids. (reference 7, pp. 231-234; reference 4, p. 1029)

The most common *caffeine withdrawal symptom* is a withdrawal headache. Headaches will occur in about one-third of moderate to high caffeine consumers when their daily intake is stopped. Other withdrawal symptoms include muscle tension, anxiety, drowsiness, lethargy, rhinorrhea (runny nose), disinterest in work, irritability, nervousness, mild feelings of depression, yawning, nausea, and fatigue. (reference 4, p. 1029; reference 2, p. 618)

*See caffeine consumption and symptom chart in Appendix A for further details.*

**Q: Did you rule out *other life difficulties or stressors* as a cause of the plaintiff's insomnia or hypersomnia?**

**Insomnia** may be caused by life stressors such as marital difficulties, problems at work, guilt over sexual conflicts, or concerns about health. (reference 1, p. 1322)

*If the witness indicates the possibility of another life stressor, see the section on other life-stressors for further questions.*

## SYMPTOM

## DEPOSITION QUESTIONS

**Insomnia,  
Hypersomnia***(continued)*

**Q: Did you rule out *sedative, hypnotic, or anxiolytic withdrawal* as a cause of the plaintiff's insomnia or hypersomnia?**

Withdrawal symptoms develop when the plaintiff reduces or stops the prolonged moderate or heavy use of these substances. Symptoms may include nausea or vomiting; malaise or weakness; autonomic hyperactivity (such as tachycardia and sweating); anxiety or irritability; orthostatic hypotension; coarse tremor of the hands, tongue and eyelids; **insomnia**; and grand mal seizures. (reference 7, p. 284; reference 4, p. 1549)

**Q: Did you rule out *nightmares* as a cause of the plaintiff's insomnia or hypersomnia?**

Nightmares (dream anxiety attacks) cause the plaintiff to **awaken from REM sleep** with a detailed account of a disturbing dream. S/he may feel anxious and experience autonomic arousal. Nightmares may occur frequently in the more susceptible plaintiff that is stressed, fatigued, or who has consumed alcohol. (reference 4, p. 1260; reference 1, p. 1321)

**Q: Did you rule out *night terrors* as a cause of the plaintiff's insomnia or hypersomnia?**

Night terrors cause the plaintiff to **awaken with a sense of intense terror** from a single frightening image not associated with a dream. The plaintiff usually falls asleep and forgets the episode. These occurrences seldom require specific treatment. (reference 4, p. 1260)

**Q: Did you rule out *rebound insomnia* as a cause of the plaintiff's insomnia or hypersomnia?**

Rebound insomnia is a worsening of sleep following intermediate term use of drugs, such as: (reference 9, pp. 1988-1989)

Temazepam (Restoril)

Triazolam (Halcion)

**Q: Did you rule out *habit insomnia* as a cause of the plaintiff's insomnia or hypersomnia?**

Habit insomnia is a conditioned reflex. The plaintiff associates going to bed with restlessness and wakefulness, rather than with sleep. (reference 4, p. 1251)

**Q: Did you rule out *age* as a cause of the plaintiff's insomnia or hypersomnia?**

The number of awakenings per night and the amount of time awake during the night increases gradually with age. These changes may be distressing enough for the plaintiff to seek treatment. (reference 4, p. 1261; reference 1, pp. 1321-1322)

---

*SYMPTOM*

*DEPOSITION QUESTIONS*

---

**Insomnia,  
Hypersomnia**

*(continued)*

**Q: Did you rule out *transient or situational insomnia* as a cause of the plaintiff's insomnia or hypersomnia?**

Transient and situational insomnia is a brief period of insomnia that is often associated with anxiety or related to grief, loss, or almost any life change. (reference 4, p. 1250)

---

**Q: Did you rule out *pain or discomfort* as a cause of the plaintiff's insomnia or hypersomnia?**

Almost any medical, toxic, or environmental condition associated with pain and discomfort can produce **insomnia**.

---

**Q: Did you rule out *sleep apnea* as a cause of the plaintiff's insomnia or hypersomnia?**

Sleep apnea is the cessation or suspension of breathing during sleep. These hesitations may **cause the plaintiff to awaken periodically throughout the night**. The most common complaint of plaintiffs with this disorder is excessive daytime drowsiness. (reference 4, pp. 132, 1252)

---

**Q: Did you rule out *restless leg syndrome* as a cause of the plaintiff's insomnia or hypersomnia?**

Restlessness and an uncomfortable or painful crawling sensation in the muscles and bones of the lower legs are signs of the restless leg syndrome. The symptoms usually occur at night, **disturbing sleep**, or when the plaintiff is resting. There is no known cause of the syndrome. (reference 4, pp. 132, 1253)

---

**Q: Did you rule out *nocturnal myoclonus (muscle twitching)* as a cause of the plaintiff's insomnia or hypersomnia?**

Rhythmic muscle twitches and involuntary movements of the extremities **disrupt the plaintiff's sleep**. The disorder usually begins during late middle age and in the elderly. (reference 9, pp. 1988-1989)

---

**Q: Did you rule out any *work shift change* as a cause of the plaintiff's insomnia or hypersomnia?**

Work shift changes cause sleep-wake symptoms that begin immediately when the work period is scheduled during the night. Symptoms are usually worse the first few days. Some plaintiffs experience **disrupted sleep-wake patterns** for a long time after the shift change. (reference 4, p. 1259)

---

**Q: Did you rule out *self-imposed chaotic sleep schedules* as a cause of the plaintiff's insomnia or hypersomnia?**

Frequently changing sleep-wake schedules causes sleep **insomnia** and daytime somnolence (drowsiness). This condition is becoming more prevalent and occurs in plaintiffs that fly frequently or that repeatedly change their work schedule.

---

## SYMPTOM

## DEPOSITION QUESTIONS

**Insomnia,  
Hypersomnia***(continued)***Q: Did you rule out *somatoform (psychogenic) pain disorder* as a cause of the plaintiff's insomnia or hypersomnia?**

Somatoform pain disorder is characterized by pain as the predominant focus of clinical attention. In addition, psychological factors are judged to have an important role in the onset, severity, exacerbation, or maintenance of the pain. Some of the emotionally caused symptoms may be depression, anxiety, anhedonia (an inability to experience pleasure), **insomnia**, and irritability. The symptoms may become so severe that the plaintiff feels incapacitated and quits working. (reference 7, pp. 498-503; reference 4, p. 1109)

*If the witness indicates the possibility of a somatoform (psychogenic) pain disorder, see the section on somatoform pain disorder for further questions.*

**Q: Did you rule out *masked depression* as a cause of the plaintiff's insomnia or hypersomnia?**

The plaintiff with masked depression hides a dysphoric mood with gastrointestinal problems, chronic pain, **insomnia**, weight loss, and other physical complaints. Masked depression is a common condition frequently missed by physicians. (reference 4, p. 796)

**Q: Did you rule out a *bipolar disorder* as a cause of the plaintiff's insomnia or hypersomnia?**

A bipolar disorder has a circular pattern of high and low emotional states (*mania and depression*). During the *manic episodes*, the plaintiff may feel grandiose, have a **decreased need for sleep**, and decreased emotional capacity, experience a surge of ideas and conversation, and may be easily distracted or pleased. It is often thought that the manic high represents an escape from inner depression and pain. While the plaintiff is extremely active, s/he is often fragmented and unable to finish projects. The plaintiff typically does not realize that s/he is ill.

During *major depressive episodes* the plaintiff may be depressed for at least two weeks. The plaintiff may experience an appetite disturbance, weight change, **sleep disturbance**, psychomotor agitation or retardation, decreased energy and emotional capacity, feelings of worthlessness, difficulty thinking or concentrating, and recurrent thoughts of death or suicide. (reference 4, pp. 408-409, 761; reference 7, pp. 382-391)

**Q: Did you rule out *cyclothymic disorder* as a cause of the plaintiff's insomnia or hypersomnia?**

Cyclothymic disorder is a chronic, fluctuating mood involving numerous periods of hypomanic symptoms and numerous periods of depressive symptoms. The symptoms are not severe enough to meet the criteria for a major depressive or manic episode. The plaintiff may have impaired social and occupational functioning. Cyclothymic disorder usually begins in adolescence or early adult life. (reference 7, p. 398; reference 4, pp. 760-761, 804)

## SYMPTOM

## DEPOSITION QUESTIONS

**Insomnia,  
Hypersomnia***(continued)***Q: Did you rule out the onset of psychosis or schizophrenia as a cause of the plaintiff's insomnia or hypersomnia?**

The plaintiff who is pre-psychotic or schizophrenic will have an increasing incidence and severity of nightmares and other **sleep difficulties**. These are often caused by guilt, anxiety or both. If it increases in severity, the plaintiff may develop a psychotic state within a few weeks. (reference 4, pp. 67, 1252)

**Q: Did you rule out alcohol consumption or withdrawal as a cause of the plaintiff's insomnia or hypersomnia?**

*Alcohol intoxication* may cause aggressiveness, impaired judgment and attention, irritability, euphoria, depression, emotional lability, and impaired social or occupational functioning. Physical symptoms may include slurred speech, incoordination, unsteady gait, nystagmus, occasional dizziness, and flushed face. Heavy alcohol consumption may cause **abnormal sleep patterns**. The plaintiff often falls asleep quickly but wakes up earlier and earlier with uncomfortable feelings. Chronic alcoholics may have irregular, unsteady, and slow tremulous movements. (reference 7, pp. 128-129; reference 4, p. 67; reference 9, p. 52)

The *reduction or cessation* of drinking for at least several days may cause characteristic symptoms: coarse tremor of hands, tongue, or eyelids; nausea or vomiting; malaise or weakness; autonomic hyperactivity (tachycardia, sweating, and elevated blood pressure); anxiety, depressed mood or irritability; transient hallucinations or illusions; headache; **insomnia**; dizziness; fatigue; restlessness; and agitation. (reference 7, pp. 129-130; reference 2, pp. 722, 618; reference 9, pp. 50-54)

**Q: (Female) Did you rule out menopause as a cause of the plaintiff's insomnia or hypersomnia?**

Menopausal distress may cause anxiety, fatigue, GI disturbances, urinary frequency, back pain, palpitations, tension, emotional lability, irritability and nervousness, depression, dizziness, **insomnia**, and hot flashes. (reference 4, p. 1173; reference 9, p. 21)

*If the witness indicates the possibility of menopausal distress, see the section on medical conditions for further questions.*

**Q: Did you rule out muscle contraction headaches as a cause of the plaintiff's insomnia or hypersomnia?**

Chronic muscle contraction headaches may produce nausea, vomiting, lightheadedness, **difficulty in falling asleep, restless sleep with frequent awakenings**, loss of energy, impaired memory and concentration, and symptoms of depression. (reference 2, pp. 72-73; reference 4, p. 1204)

*If the witness indicates the possibility of headaches, see the section on medical conditions for further questions*

## SYMPTOM

## DEPOSITION QUESTIONS

**Insomnia,  
Hypersomnia***(continued)***Q: Did you rule out cocaine consumption or withdrawal as a cause of the plaintiff's insomnia or hypersomnia?**

*Cocaine users* often experience increased energy and confidence or irritability and paranoia with physical aggressiveness. Other behavioral symptoms may include euphoria, hypervigilance, **reduced need to sleep**, psychomotor agitation, impaired judgment, and impaired social or occupational functioning. Physical symptoms may include tachycardia, dilated pupils, elevated blood pressure, perspiration or chills, nausea, vomiting, and hallucinations.

The abrupt *cessation or reduction of cocaine*, after several days use, may cause the plaintiff to feel tired, dysphoric, irritable, depressed, and to crave more of the drug. An anxiety reaction may cause psychomotor agitation, **insomnia or hypersomnia**, high blood pressure, tachycardia, and paranoia. The symptoms may persist for more than a day. (reference 7, pp. 141-143; reference 4, pp. 1008-1009)

**Q: (Female) Did you rule out premenstrual dysphoric disorder as a cause of the plaintiff's insomnia or hypersomnia?**

Premenstrual dysphoric disorder is characterized by emotional and behavioral symptoms which usually occur during the last week before the menstrual cycle and remit within a few days after menses begins. Symptoms may include tears, sadness, irritability, anger, tension, depression, self-deprecating thoughts, decreased interest in usual activities, fatigability, loss of energy, a subjective sense of difficulty in concentration, changes in appetite, and **sleep disturbance**. Physical symptoms may also include breast tenderness or swelling, tachycardia, sweating, headaches, joint or muscle pain, a sensation of bloating, or weight gain. (reference 7, pp. 771-774; reference 18, p. 1955)

**Q: Did you rule out amphetamine or similarly acting sympathomimetic drug withdrawal as a cause of the plaintiff's insomnia or hypersomnia?**

Drug withdrawal symptoms may include a dysphoric mood (depression, irritability, anxiety), fatigue, sweating, headaches, **insomnia with nightmares, hypersomnia**, and psychomotor agitation. Symptoms begin after the cessation of prolonged drug use (at least two days) and last more than 24 hours. (reference 7, p. 223; reference 4, p. 1008)

The following drugs may be classified as amphetamines:

|                                    |                            |
|------------------------------------|----------------------------|
| Appetite Suppressants (diet pills) | Methamphetamines (speed)   |
| Dextroamphetamines                 | Methylphenidates (Ritalin) |
| Ma-huang (ephedra)                 | (reference 17, p. 586)     |
| (reference 24, pp. 488-489)        |                            |

## SYMPTOM

## DEPOSITION QUESTIONS

**Insomnia,  
Hypersomnia***(continued)***Q: Did you rule out treatment with the *adrenal cortical steroids or ACTH* as a cause of the plaintiff's insomnia or hypersomnia?**

Plaintiffs with a history of adrenal cortical steroid or ACTH treatment commonly develop major mental disturbances. While taking the drugs, they may experience euphoria, severe mania, severe depression, delirium, paresthesia (abnormal tightness or tingling around a limb or trunk), **insomnia**, restlessness, or agitation. Symptoms usually disappear when the drugs are reduced or discontinued. (reference 4, p. 876)

**Q: Did you rule out *dysthymic disorder (depression)* as a cause of the plaintiff's insomnia or hypersomnia?**

Dysthymic disorder is characterized by chronic depressive symptoms less severe than major depression. Always feeling despondent or melancholy, the plaintiff believes that depression is part of their personality. Other symptoms may include a poor appetite or overeating, **insomnia or hypersomnia**, low energy or fatigue, low self-esteem, poor concentration, difficulty making decisions, and feelings of hopelessness. The disorder may begin in childhood for both sexes, but is more common in adult females. (reference 7, pp. 376-381; reference 4, pp. 803-804)

*Note: An admission by the witness that the plaintiff has dysthymic disorder is important because dysthymic disorder is not as severe as major depression. If the witness indicates the possibility of dysthymic disorder, see the appropriate section for further questions.*

**Q: Did you rule out *generalized anxiety disorder* as a cause of the plaintiff's insomnia or hypersomnia?**

A generalized anxiety disorder is a persistent anxiety that lasts at least six months. The plaintiff has an excessive anxiety about two or more life circumstances. They may be anxious about harm coming to a child or having financial difficulties when there is no apparent reason to worry. Symptoms include muscle tension, restlessness or feeling on edge or keyed up, fatigue, difficulty concentrating, **sleep disturbance**, and irritability. (reference 7, p. 472)

*If the witness indicates the possibility of a generalized anxiety disorder, see the section on GAD for further questions.*

**Q: Did you rule out *nicotine withdrawal* as a cause of the plaintiff's insomnia or hypersomnia?**

Nicotine withdrawal symptoms include a strong craving for nicotine, anxiety, irritability, frustration or anger, impaired attention, coughing, headaches, **insomnia**, a mental preoccupation with actions associated with tobacco use, restlessness, drowsiness, gastrointestinal disturbances, an increased appetite, and weight gain. The symptoms appear within 24 hours after the cessation or reduction in the use of cigarettes, cigars, pipes, chewing tobacco, or nicotine gum. The plaintiff experiences a decrease in the intensity of the symptoms with time. (reference 7, p. 264; reference 4, pp. 1031-1032)

*SYMPTOM*

*DEPOSITION QUESTIONS*

**Insomnia,  
Hypersomnia**

(continued)

**Q: Did you rule out *infections* as a cause of the plaintiff's insomnia or hypersomnia, such as: (reference 2, p. 617)**

|                                  |                                 |
|----------------------------------|---------------------------------|
| Brucellosis                      | Meningitis                      |
| Chronic urinary tract infections | Subacute bacterial endocarditis |
| Infectious mononucleosis         | Syphilis                        |
| Influenza                        | Tuberculosis                    |
| Malaria                          | Viral hepatitis                 |

**Q: Did you rule out the *cessation of medications or substances* as a cause of the plaintiff's insomnia or hypersomnia, such as:**

|                           |                      |
|---------------------------|----------------------|
| Antidepressant medication | Phenothiazines       |
| Benzodiazepines           | Sedatives            |
| Hypnotics                 | Sedating tricyclics  |
| Marijuana                 | Tranquilizing agents |
| Opioids                   |                      |

**Q: Does the plaintiff have any *other medical conditions* that may cause insomnia or hypersomnia, such as:**

|                                 |  |
|---------------------------------|--|
| Abnormal swallowing             | Lethargic encephalitis                 |
| Asthma                          | Male hypoandrogen secretion            |
| Brain stem and thalamic lesions | Metabolic and pulmonary failures       |
| Cardiovascular symptoms         | Narcolepsy                             |
| Cluster headaches               | Pickwickian syndrome                   |
| Diseases producing fever        | Pulmonary insufficiency                |
| Emphysema                       | Sleep-related myoclonus                |
| Gastroesophageal reflux         | Sleep-related painful erections (male) |

**Q: Is the plaintiff taking any *medications or substances* that may cause insomnia or hypersomnia, such as:**

|              |              |                 |
|--------------|--------------|-----------------|
| ACCUTANE     | ASENDIN      | CELEBREX        |
| ADALAT       | ATROVENT     | CELEXA          |
| ADAPIN       | AUGMENTIN    | CELONTIN        |
| ADDERALL     | AZULFIDINE   | CHLORAL-HYDRATE |
| ADIPEX       | BACTRIM      | CHLORTRIMETON   |
| AEROBID      | BELLERGAL    | CIPRO           |
| ALTACE       | BENADRYL     | CLARITAN-D      |
| AMBIEN       | BENTYL       | CLARITIN        |
| AMPHETAMINES | BIPHETAMINE  | CLINDEX         |
| AMYTAL       | BUSPAR       | CLINORIL        |
| ANAFRANIL    | BUTICAPS     | CLOZARIL        |
| ANAPROX      | CARAFATE-TOO | COGNEX          |
| ANSAID       | CARDIZEM     | COLESTID        |
| ARICEPT      | CATAPRES     | COMBIPRES       |
| ARTHROTEC    | CEFZIL       | COMBIVENT       |

**SYMPTOM****DEPOSITION QUESTIONS****Insomnia,  
Hypersomnia***(continued)*

|              |                             |                          |
|--------------|-----------------------------|--------------------------|
| COMPAZINE    | INDERIDE                    | OMNICEF                  |
| CONCERTA     | INDOCIN                     | OPTIMINE                 |
| COZAAR       | IONAMIN                     | ORAP                     |
| CYCRIN       | KERLONE                     | ORNADE                   |
| CYLERT       | KLONOPIN                    | ORUDIS                   |
| DALMANE      | LESCOL                      | OXYCONTIN                |
| DANTRIUM     | LEVAQUIN                    | PAMELOR                  |
| DECADRON     | LEVO-DROMORAM               | PARLODEL                 |
| DEPO-PROVERA | LEVOTHROID                  | PARNATE                  |
| DEPROL       | LEVSIN                      | PBZ-SR                   |
| DESOXYN      | LIORESAL                    | PEDIAZOLE                |
| DESYREL      | LIPITOR                     | PEPCID                   |
| DEXEDRINE    | LODINE                      | PERIACTIN                |
| DILACOR      | LOPRESSOR                   | PERMAX                   |
| DILANTIN     | LOTENSIN                    | PERMITIL                 |
| DIMETANE     | LOTREL                      | PHENOBARBITAL            |
| DIOVAN       | LOZOL                       | PHENYL-<br>PROPANOLAMINE |
| DITROPAN     | LUDIOMIL                    | PLACIDYL                 |
| DOLOBID      | LUFYLLIN-GG                 | PLAVIX                   |
| DONNATAL     | LUVOX                       | PLENDIL                  |
| DORAL        | MARPLAN                     | POLARIMINE               |
| DURACT       | MAVIK                       | PONDIMIN                 |
| DURAVENT     | MAXAIR-AUTOHALER            | PREMPHASE                |
| DYNACIRC     | MAXALT                      | PREMPRO                  |
| EFFEXOR      | MAXIDE                      | PRIOSEC                  |
| ELAVIL       | MEBARAL                     | PRINZIDE                 |
| ELDEPRYL     | MECLOMEN                    | PROAMATINE               |
| ENDEP        | METHADONE-<br>HYDROCHLORIDE | PROKETAZINE              |
| ENTEXLA      | MIRAPEX                     | PROPULSID                |
| ETRAFON      | MODURETIC                   | PROSOM                   |
| EXCELON      | MONOPRIL                    | PROTONIX                 |
| FASTIN       | MORPHINE-SULFATE            | PROVENTIL                |
| FELBATOL     | MOTRIN                      | PROVERA                  |
| FELDENE      | NALDECON                    | PULMICORT                |
| FLAGYL       | NALFON                      | REDUX                    |
| FLEXERIL     | NAPROSYN                    | REGLAN                   |
| FLOMAX       | NAVANE                      | RELAFEN                  |
| FLOXIN       | NEMBUTAL                    | REMERON                  |
| GABITRIL     | NEURONTIN                   | RESTORIL                 |
| HABITROL     | NICORETTE                   | REVIA                    |
| HALCION      | NOLUDAR                     | RISPERDAL                |
| HALDOL       | NOREPHEDRINE                | RITALIN                  |
| HISTUSSIN    | NOROXIN                     | RONDEC-DM                |
| HYTRIN       | NORPACE                     | RUFEN                    |
| HYZAAR       | NORPRAMIN                   | SANOREX                  |
| IMDUR        | NORVASC                     | SANSERT                  |
| INDERAL      |                             |                          |

# Major Depressive Disorder

**SYMPTOM**

**DEPOSITION QUESTIONS**

**Insomnia,  
Hypersomnia**

*(continued)*

|                |           |            |
|----------------|-----------|------------|
| SECONAL-ELIXIR | TALWIN-NX | VASOTEC    |
| SECONAL-SODIUM | TAVIST    | VENTOLIN   |
| SELDANE        | TEMARIL   | VERELAN    |
| SEPTRA         | THEO-DUR  | VIAGRA     |
| SEREVENT       | THORAZINE | VICOPROFEN |
| SEROQUEL       | TIAZAC    | VIOXX      |
| SERTRALINE     | TIMOPTIC  | VIVACTIL   |
| SERZONE        | TINDAL    | VOLTAREN   |
| SINEMET        | TOFRANIL  | WELLBUTRIN |
| SLO-BID        | TOPAMAX   | XANAX      |
| SLO-PHYLLIN    | TOPROL-XL | ZANTAC     |
| SOMA           | TORADOL   | ZAROXOLY   |
| SOMA-COMPOUND  | TRANXENE  | ZESTORETIC |
| SONATA         | TRIAVIL   | ZESTRIL    |
| SPORANOX       | TRILAFON  | ZOCOR      |
| STADOL         | TRILEPTAL | ZOLOFT     |
| SULAR          | TRINALIN  | ZOMIG      |
| SULINDAC       | TROVAN    | ZYBAN      |
| SURMONTIL      | TUINAL    | ZYLOPRIM   |
| SYMMETREL      | VALIUM    | ZYPREXA    |
| TALECEN        | VANTIN    | ZYRTEC     |

**Drugs that may cause hypersomnia:**

|                  |             |                   |
|------------------|-------------|-------------------|
| AMOXAPINE        | FLUNARIZINE | NEUROLEPTIC AGENT |
| ANTIHISTAMINES   | INDORAMIN   | PIRIBEDIL         |
| BENZODIAZEPINES  | KETOTIFEN   | TRAZODONE         |
| BUTORPHANOL      | FUMARATE    | VALPROATE SODIUM  |
| CHLORPHENTERMINE | LUVOX       | ZESTORETIC        |
| CLONIDINE        | MAXALT      | ZESTRIL           |
| FENFLURAMINE     | METHYLDOPA  |                   |

**Psychomotor  
Agitation,  
Retardation**

- Q:** Describe the plaintiff's psychomotor agitation or retardation.

---

- Q:** When and how often does the plaintiff experience psychomotor agitation or retardation?

---

- Q:** Does the plaintiff have a history of psychomotor agitation or retardation before the injury in question?

---

- Q:** Does the plaintiff have a history of any *medical or psychological conditions* that may cause psychomotor agitation or retardation?

*The witness may indicate the possibility of the following medical or psychological conditions: please refer to the sections pertaining to these conditions for further questions.*

*SYMPTOM*

*DEPOSITION QUESTIONS*

**Psychomotor  
Agitation,  
Retardation**  
*(continued)*

**TABLE 5.7-10.**

|                        |                             |
|------------------------|-----------------------------|
| Alzheimer's disease    | Parkinson's disease         |
| Brain tumor            | Pheochromocytoma            |
| Cushing's syndrome     | Schizophrenia-paranoid type |
| Hepatic encephalopathy | Syphilis                    |
| Hypothyroidism         | Wilson's disease            |
| Huntington's disease   |                             |

**Q: Did you rule out *attention-deficit hyperactivity disorder (ADHD)* as a cause of the plaintiff's psychomotor agitation or retardation?**

The essential characteristics of ADHD include inattention, **impulsiveness, and hyperactivity**. ADHD is usually diagnosed during elementary school years, and can persist throughout childhood. Persons diagnosed with ADHD have a higher prevalence of mood and anxiety disorders, learning disorders, substance-related disorders and the potential for the development of an antisocial personality disorder. Approximately one-third of the children diagnosed with ADHD show some signs of the disorder in adulthood. Associated symptoms may include low self-esteem, mood lability, low frustration tolerance, and temper outbursts. (reference 7, pp. 85-93)

**Q: Did you rule out an *adjustment disorder with anxiety* as a cause of the plaintiff's psychomotor agitation or retardation?**

An adjustment disorder is a transient over-reaction to stress that usually occurs within 90 days and remits within six months. The adjustment disorder with anxiety is characterized by symptoms of nervousness, worry, **jitteriness, and motor tension**. (reference 7, p. 680; reference 4, pp. 1098-1099)

*If the witness indicates the possibility of an adjustment disorder, see the section on adjustment disorders for further questions.*

**Q: Did you rule out an *obsessive-compulsive disorder* as a cause of the plaintiff's psychomotor agitation or retardation?**

The obsessive-compulsive plaintiff has persistent unwanted and uncontrolled thoughts or impulses that may be characterized by violence, contamination, or doubt. These obsessions often cause the plaintiff to feel anxious. The plaintiff's repeated compulsive behaviors are attempts to control the impulses and the accompanying anxiety. Other symptoms may include an exclusive devotion to work or productivity, depression, anxiety, and **restlessness**. (reference 4, pp. 910-911; reference 7, p. 456)

*If the witness indicates the possibility of an obsessive-compulsive disorder, see the section on obsessive-compulsive disorder for further questions.*

**Note:** *In addition to the obsessive-compulsive disorder, there is an obsessive-compulsive personality disorder. The personality disorder does not have true obsessions and compulsions, but has a clear pattern of perfectionism and rigidity. If*

## SYMPTOM

## DEPOSITION QUESTIONS

**Psychomotor  
Agitation,  
Retardation**

(continued)

*the witness indicates the possibility of an obsessive-compulsive personality disorder or other maladaptive personality traits, see the section on pre-existing psychological conditions for further questions.*

**Q: Did you rule out a *paranoid personality disorder* as a cause of the plaintiff's psychomotor agitation or retardation?**

The paranoid plaintiff has a history of unwarranted suspicion and mistrust of others. Often expecting to be exploited or harmed, s/he may be excessively sensitive, jealous, **hypervigilant, and tense**. The plaintiff may find it difficult to relax or forgive, and is argumentative when threatened by innocent remarks or events. His or her mood is often humorless, cold and unemotional. These plaintiffs rarely seek help because of a tendency to be moralistic, grandiose, and extrapunitive. (reference 7, p. 690; reference 4, pp. 748-753)

**Q: Did you rule out *anemia* as a cause of the plaintiff's psychomotor agitation or retardation?**

Vertigo, pounding headaches, fainting, dimness of vision, tinnitus (a ringing in one or both ears), irritability, **restlessness**, inability to concentrate, lethargy, fatigue, drowsiness, GI complaints, and congestive heart failure are common symptoms of anemia. (reference 2, pp. 566-571)

*If the witness indicates the possibility of anemia, see the section on pre-existing medical conditions for further questions.*

**Q: Did you rule out *caffeine consumption or withdrawal* as a cause of the plaintiff's psychomotor agitation or retardation?**

Characteristic symptoms of *caffeine intoxication* include **restlessness**, nervousness, excitement, insomnia, flushed face, diuresis, gastrointestinal disturbance, muscle twitching, rambling flow of thought and speech, tachycardia or cardiac arrhythmia, periods of inexhaustibility, and **psychomotor agitation**. When consumed near bedtime, caffeine often disrupts sleep. Symptoms may appear when the plaintiff consumes as little as 250 mg of caffeine per day. The plaintiff that consumes one gram per day usually experiences more severe symptoms. Products which contain caffeine include: coffee, tea, soda, chocolate and weight-loss aids. (reference 7, p. 231; reference 4, p. 1029)

The most common *caffeine withdrawal* symptom is a withdrawal headache. Headaches will occur in about one-third of moderate to high caffeine consumers when their daily intake is stopped. Other withdrawal symptoms include **muscle tension**, anxiety, drowsiness, lethargy, rhinorrhea (runny nose), disinterest in work, irritability, nervousness, mild feelings of depression, yawning, nausea, and fatigue. (reference 4, p. 1029; reference 2, p. 618)

*See caffeine consumption and symptom chart in Appendix A for further details.*

*SYMPTOM*

*DEPOSITION QUESTIONS*

**Psychomotor Agitation, Retardation**

(continued)

**Q: Did you rule out *amphetamine or similarly acting sympathomimetic drug consumption or withdrawal* as a cause of the plaintiff's psychomotor agitation or retardation?**

Symptoms of amphetamine or similarly acting sympathomimetic *drug consumption* may include fighting, grandiosity, elation, hypervigilance, **psychomotor agitation**, impaired judgment, and impaired social or occupational functioning. Physical symptoms may include flushing, difficulty breathing, tachycardia, pupil dilation, elevated blood pressure, sweating or chills, nausea, and vomiting. (reference 4, pp. 1007-1008; reference 7, p. 223)

*Drug withdrawal* symptoms may include a dysphoric mood (depression, irritability, anxiety), fatigue, sweating, headaches, insomnia with nightmares, hypersomnia, and **psychomotor agitation**. Symptoms begin after the cessation of prolonged drug use (at least two days) and last more than 24 hours. (reference 7, p. 227; reference 4, p. 1008)

The following drugs may be classified as amphetamines:

- |                                    |                            |
|------------------------------------|----------------------------|
| Appetite Suppressants (diet pills) | Methamphetamines (speed)   |
| Dextroamphetamines                 | Methylphenidates (Ritalin) |
| Ma-huang (ephedra)                 | (reference 17, p. 586)     |
| (reference 24, pp. 488-489)        |                            |

**Q: Did you rule out *alcohol withdrawal* as a cause of the plaintiff's psychomotor agitation or retardation?**

The reduction or cessation of drinking for at least several days may cause characteristic symptoms: coarse tremor of hands, tongue, or eyelids; nausea or vomiting; malaise or weakness; autonomic hyperactivity (tachycardia, sweating, and elevated blood pressure); anxiety, depressed mood or irritability; transient hallucinations or illusions; headache; insomnia; dizziness; fatigue; **restlessness; and agitation**. (reference 7, pp. 129-130; reference 2, pp. 722, 618; reference 9, pp. 50-54)

**Q: Did you rule out *cocaine consumption or withdrawal* as a cause of the plaintiff's psychomotor agitation or retardation?**

*Cocaine users* often experience increased energy and confidence or irritability and paranoia with physical aggressiveness. Other behavioral symptoms may include euphoria, hypervigilance, **psychomotor agitation**, impaired judgment, and impaired social or occupational functioning. Physical symptoms may include tachycardia, dilated pupils, elevated blood pressure, perspiration or chills, nausea, vomiting, and hallucinations.

The abrupt *cessation or reduction of cocaine*, after several days use, may cause the plaintiff to feel tired, dysphoric, irritable, depressed, and to crave more of the drug. An anxiety reaction may cause **psychomotor agitation**, insomnia or hypersomnia, high blood pressure, tachycardia, and paranoia. The symptoms may persist for more than a day. (reference 7, pp. 141-143; reference 4, pp. 1008-1009)

## SYMPTOM

## DEPOSITION QUESTIONS

**Psychomotor  
Agitation,  
Retardation**

(continued)

**Q: Did you rule out *sedative, hypnotic, or anxiolytic consumption or withdrawal* as a cause of the plaintiff's psychomotor agitation or retardation?**

Sedative, hypnotic, or anxiolytic *drug consumption* can cause behavioral and physical changes. Behavioral symptoms may include disinhibition of sexual or aggressive impulses, mood lability, impaired judgment, and impaired social or occupational functioning. Physical symptoms may include slurred speech, incoordination, unsteady gait, **psychomotor retardation**, and impaired memory or attention span. Sedative drugs and minor tranquilizers cause impairment on many behavioral tasks. They may also improve some plaintiffs work or social functioning by reducing severe anxiety. The effects of two or more drugs, such as sedatives and alcohol, may cause significant behavioral impairment. (reference 7, p. 284; reference 4, p. 1548)

*Withdrawal symptoms* develop when the plaintiff reduces or stops the prolonged moderate or heavy use of these substances. Symptoms may include nausea or vomiting; malaise or weakness; autonomic hyperactivity (such as tachycardia and sweating); anxiety or irritability; orthostatic hypotension; coarse tremor of the hands, tongue and eyelids; insomnia; and grand mal seizures. (reference 7, p. 287; reference 4, p. 1549)

**Q: Did you rule out *opioid consumption or withdrawal* as a cause of the plaintiff's psychomotor agitation or retardation?**

*Opioid intoxication* is characterized by euphoria, flushing, itching skin, miosis, drowsiness, decreased respiratory rate and depth, hypotension, bradycardia, and decreased body temperature. The initial euphoria is often followed by apathy, unpleasant mood, **psychomotor retardation**, impaired judgment, and impaired social or occupational functioning. While dependence on opioids is less common than on alcohol or tobacco, it has been estimated that fifteen percent of males and nine percent of females have used an opioid (nonmedical) during their lifetime. (reference 7, p. 269; reference 4, pp. 987-988)

Symptoms of *opioid withdrawal* may include lacrimation (tearing), rhinorrhea (runny nose), dilated pupils, sweating, diarrhea, yawning, mild hypertension, tachycardia (increased heart rate), fever, insomnia, and gooseflesh. Associated features may include **restlessness**, irritability, depression, tremor, weakness, nausea, vomiting, and muscle or joint pain. These signs, often resembling influenza symptoms, may be precipitated by the abrupt ending of one or two weeks of continuous opioid use. The withdrawal symptoms may last days or weeks. During the final stages of withdrawal, the plaintiff may experience overconcern for bodily discomfort, poor self-image, and a decreased ability to tolerate stress. (reference 7, p. 269; reference 4, pp. 990-991)

**Q: Did you rule out a *bipolar disorder* as a cause of the plaintiff's psychomotor agitation or retardation?**

A bipolar disorder has a circular pattern of high and low emotional states (*mania and depression*). During the *manic episodes*, the plaintiff may feel grandiose, have a decreased need for sleep, and decreased emotional capacity, experience a surge of ideas and conversation, and may be easily distracted or pleased. It is often thought

## SYMPTOM

## DEPOSITION QUESTIONS

**Psychomotor  
Agitation,  
Retardation***(continued)*

that the manic high represents an escape from inner depression and pain. While the plaintiff is extremely active, s/he is often fragmented and unable to finish projects. The plaintiff typically does not realize that s/he is ill.

During *major depressive episodes* the plaintiff may be depressed for at least two weeks. The plaintiff may experience an appetite disturbance, weight change, sleep disturbance, **psychomotor agitation or retardation**, decreased energy and emotional capacity, feelings of worthlessness, difficulty thinking or concentrating, and recurrent thoughts of death or suicide. (reference 4, pp. 408-409, 761; reference 7, pp. 382-391)

**Q: Did you rule out *cyclothymic disorder* as a cause of the plaintiff's psychomotor agitation or retardation?**

Cyclothymic disorder is a chronic, fluctuating mood involving numerous periods of hypomanic symptoms and numerous periods of depressive symptoms. The symptoms are not severe enough to meet the criteria for a major depressive or manic episode. The plaintiff may have impaired social and occupational functioning. Cyclothymic disorder usually begins in adolescence or early adult life. (reference 7, p. 398; reference 4, pp. 760-761, 804)

**Q: Did you rule out a *borderline personality disorder* as a cause of the plaintiff's psychomotor agitation or retardation?**

A borderline personality disorder is characterized by unstable interpersonal relationships, behavior, mood, and self-image. The plaintiff may experience temporary mood shifts including depression, irritability, **agitation**, and anxiety. S/he may also have chronic feelings of emptiness or boredom, inappropriate anger, and recurrent suicidal thoughts. Social contrariness and a generally pessimistic outlook often accompany the disorder. Premature death may result from suicide. (reference 7, p. 706)

*If the witness indicates the possibility of a borderline personality disorder or other maladaptive personality traits, see the section on pre-existing personality disorders for further questions.*

**Q: Did you rule out long-term treatment with the *adrenal cortical steroids* or *ACTH* as a cause of the plaintiff's psychomotor agitation or retardation?**

Plaintiffs with a long-term history of adrenal cortical steroid or ACTH treatment commonly develop major mental disturbances. While taking the drugs, they may experience euphoria, severe mania, severe depression, delirium, paresthesia (abnormal tightness or tingling around a limb or trunk), insomnia, **restlessness or agitation**. Symptoms usually disappear when the drugs are reduced or discontinued. (reference 4, p. 876)

**Q: Did you rule out *Addison's disease* as a cause of the plaintiff's psychomotor agitation or retardation?**

Addison's disease is caused by a diminished functioning of the adrenal glands. The decreased levels of corticosteroids may cause symptoms of apathy, fatigue,

## SYMPTOM

## DEPOSITION QUESTIONS

**Psychomotor  
Agitation,  
Retardation**

(continued)

weakness, lack of initiative, seclusiveness, irritability, negativism, depression, poverty of thought, anorexia, weight loss, and hypotension. As the disease progresses, a depressed mood and **psychomotor retardation** may become severe. (reference 4, p. 1171)

*If the witness indicates the possibility of Addison's disease, see the section on pre-existing medical conditions for further questions.*

**Q: Did you rule out *hyperthyroidism* as a cause of the plaintiff's psychomotor agitation or retardation?**

Hyperthyroidism, or thyrotoxicosis, results from overproduction of thyroid hormone by the thyroid gland. The most common cause is Graves' disease. The signs and symptoms of hyperthyroidism include both physical and psychiatric complaints. Psychiatric features include nervousness, fatigue, insomnia, mood lability, and dysphoria. There may be a **heightened activity level**. Cognitive symptoms include a short attention span, impaired recent memory, and an exaggerated startle response.

Physical signs and symptoms of hyperthyroidism include increased pulse, arrhythmias (irregular heart rhythm), elevated blood pressure, fine tremor, heat intolerance, excessive sweating, increased appetite, weight loss, palpitations (abnormal rapid beating of heart), tachycardia (rapid heart beat), frequent bowel movements, menstrual irregularities, and muscle weakness. Panic attacks are associated with endocrinological disorders including hyperthyroidism, as well as hypothyroidism. (reference 18, pp. 743, 1809-1810, 1928)

*If the witness indicates the possibility of hyperthyroidism, see the section on pre-existing medical conditions for further questions.*

**Q: Did you rule out *generalized anxiety disorder* as a cause of the plaintiff's psychomotor agitation or retardation?**

A generalized anxiety disorder is a persistent anxiety, worry and distress about two or more life circumstances for at least six months. Symptoms may include muscle tension, **restlessness or feeling keyed up**, fatigue, difficulty concentrating, sleep disturbance, and irritability. (reference 7, p. 472)

*If the witness indicates the possibility of a generalized anxiety disorder, see the section on GAD for further questions.*

**Q: Did you rule out *nicotine withdrawal* as a cause of the plaintiff's psychomotor agitation or retardation?**

Nicotine withdrawal symptoms include a strong craving for nicotine, anxiety, irritability, frustration or anger, impaired attention, coughing, headaches, insomnia, a mental preoccupation with actions associated with tobacco use, **restlessness**, drowsiness, gastrointestinal disturbances, an increased appetite, and weight gain. The symptoms appear within 24 hours after the cessation or reduction in the use of cigarettes, cigars, pipes, chewing tobacco, or nicotine gum. The plaintiff also experiences a decrease in the intensity of the symptoms with time. (reference 7, p. 264; reference 4, pp. 1031-1032)

*SYMPTOM*

*DEPOSITION QUESTIONS*

**Psychomotor Agitation, Retardation**

(continued)

**Q: Did you rule out *infections* as a cause of the plaintiff's psychomotor agitation or retardation, such as:** (reference 2, p. 617)

- |                                  |                                 |
|----------------------------------|---------------------------------|
| Brucellosis                      | Meningitis                      |
| Chronic urinary tract infections | Subacute bacterial endocarditis |
| Infectious mononucleosis         | Syphilis                        |
| Influenza                        | Tuberculosis                    |
| Malaria                          | Viral hepatitis                 |

**Q: Is the plaintiff taking any *medications or substances* that may cause psychomotor agitation or retardation, such as:**

- |                 |         |
|-----------------|---------|
| AMERGE          | PAXIPAM |
| AMPHETAMINES    | SERZONE |
| ESKALITH        | SONATA  |
| LITHIUM-CITRATE |         |

**Fatigue or Loss of Energy**

**Q: Describe the plaintiff's fatigue or loss of energy.**

**Q: When and how often does the plaintiff experience fatigue or loss of energy?**

**Q: Does the plaintiff have a history of fatigue or low energy?**

**Q: Does the plaintiff have a history of any *medical or psychological conditions* that may cause fatigue or loss of energy?**

*The witness may indicate the possibility of the following medical conditions: please refer to the sections pertaining to these medical conditions for further questions.*

**TABLE 5.7-11.**

|                                       |  |
|---------------------------------------|--|
| Addison's disease                     | Hypothyroidism   |
| Bipolar disorder                      | Infectious mononucleosis                               |
| Brain tumor                           | Meningitis   |
| Chronic fatigue syndrome              | Menopausal distress                                    |
| Chronic obstructive pulmonary disease | Mitral valve prolapse                                  |
| Combined systems disease              | Multiple sclerosis                                     |
| Creutzfeldt-Jakob disease             | Negativistic (passive aggressive) personality disorder |
| Cushing's disease                     | Pancreatic carcinoma                                   |
| Depressive disorders                  | Pernicious anemia                                      |
| Epilepsy                              | Polycythemia   |
| Hepatic encephalopathy                | Postpartum disorder                                    |
| Hepatitis B                           | Syphilis   |
| Hypoglycemia                          | Systemic lupus erythematosus                           |
| Hypertension                          | Uremic encephalopathy                                  |
| Hyperthyroidism                       |  |

## SYMPTOM

## DEPOSITION QUESTIONS

**Fatigue or  
Loss of Energy***(continued)*

**Q: Did you rule out *sleep deprivation*, for any reason, as the cause of the plaintiff's fatigue or loss of energy?**

Sleep deprivation from any cause such as anxiety, sleep apnea, narcolepsy, nocturnal myoclonus, and drug-induced deprivation of REM sleep will result in **fatigue**. (reference 2, p. 618)

**Q: Did you rule out *sleep apnea* as a cause of the plaintiff's fatigue or loss of energy?**

Sleep apnea is the cessation or suspension of breathing during sleep. These hesitations may cause the plaintiff to awaken periodically throughout the night. The most common complaint of plaintiffs with this disorder is excessive daytime drowsiness, and **fatigue**. (reference 4, pp. 132, 1252)

**Q: Did you rule out a *histrionic personality disorder* as a cause of the plaintiff's fatigue or loss of energy?**

The histrionic plaintiff is self-centered, dramatic, emotionally excessive, shallow, and exhibits considerable mood instability. S/he is often uncomfortable when not the center of attention and will seek reassurance, approval, or praise from others. The plaintiff may complain of poor health, **weakness**, headaches, or feelings of depersonalization. While an over-concern with physical attractiveness and an inappropriate sexually seductive appearance or behavior is common, plaintiffs with this disorder often have troubled interpersonal relationships and can be sexually naive or unresponsive. (reference 7, p. 711; reference 4, p. 586)

*If the witness indicates the possibility of a histrionic personality disorder, see the section on pre-existing personality disorders for further questions.*

**Q: Did you rule out *depressive episodes of a bipolar disorder* as a cause of the plaintiff's fatigue or loss of energy?**

During major depressive episodes the plaintiff may be depressed for at least two weeks. The plaintiff may experience an appetite disturbance, weight change, sleep disturbance, psychomotor agitation or retardation, **decreased energy** and emotional capacity, feelings of worthlessness, difficulty thinking or concentrating, and recurrent thoughts of death or suicide. (reference 4, pp. 408-409, 761; reference 7, pp. 382-391)

**Q: Did you rule out *metabolic alkalosis* as a cause of the plaintiff's fatigue or loss of energy?**

Metabolic alkalosis, caused by disease, produces **symptoms of weakness**, muscle cramps and postural hypotension (a drop in blood pressure when standing). (reference 2, p. 761)

---

*SYMPTOM*

*DEPOSITION QUESTIONS*

---

**Fatigue or  
Loss of Energy**

*(continued)*

**Q: Did you rule out *niacin deficiency (B complex)* as a cause of the plaintiff's fatigue or loss of energy?**

Niacin is one of the B complex vitamins essential for the normal carbohydrate metabolism of yeast cells and animal tissues. As the body's level of niacin decreases, the plaintiff may initially experience a burning tongue after eating hot or spicy foods. Symptoms are often more severe in the spring and fall and may be associated with mild anorexia, **fatigue**, nervousness, irritability, alternating periods of constipation, diarrhea, and burning sensations in the epigastrium (upper and middle abdomen). (reference 2, pp.121-123)

---

**Q: Did you rule out *chronic fatigue syndrome* as a cause of the plaintiff's fatigue or loss of energy?**

Chronic fatigue syndrome presents with six months or more of **severe, debilitating fatigue** accompanied by myalgia, headaches, pharyngitis, low-grade fever, cognitive complaints, gastrointestinal symptoms, and tender lymph nodes. There is a high rate (15-54%) of depressive disorders among patients with chronic fatigue syndrome. Persons most likely to be plagued by persistent fatigue after an acute viral illness are patients with pre-existing or co-morbid psychiatric problems. Chronic fatigue syndrome is considered to be a special class of mood disorder with somatic symptoms. (reference 18, pp. 1531-1532)

---

**Q: Did you rule out *infections* as a cause of the plaintiff's fatigue or loss of energy, such as:** (reference 2, p. 617)

- |                                  |                                 |
|----------------------------------|---------------------------------|
| Brucellosis                      | Meningitis                      |
| Chronic urinary tract infections | Subacute bacterial endocarditis |
| Infectious mononucleosis         | Syphilis                        |
| Influenza                        | Tuberculosis                    |
| Malaria                          | Viral hepatitis                 |

---

**Q: Did you rule out *mitral valve prolapse (MVP)* as a cause of the plaintiff's fatigue or loss of energy?**

Mitral valve prolapse (MVP) is a common and sometimes serious congenital ballooning of a heart valve often associated with arrhythmias of the heart. MVP and panic attacks share many common symptoms including chest pain, palpitation, dyspnea, weakness, **fatigue**, dizziness, syncope (a faint), and anxiety. (reference 4, pp. 1149, 1551)

*It the witness indicates the possibility of mitral valve prolapse, see the section on pre-existing medical conditions for further questions.*

---

## SYMPTOM

## DEPOSITION QUESTIONS

**Fatigue or  
Loss of Energy***(continued)***Q: Did you rule out *heart disease* as a cause of the plaintiff's fatigue or loss of energy?**

Fatigue may be caused when body tissues do not receive sufficient nutrients and oxygen. A diseased heart is often unable to pump adequately for the lungs to oxygenate the blood. **Lethargy and fatigue** may be the result of heart diseases such as: (reference 2, pp. 617-618)

Congestive heart failure

Ischemic heart disease

Chronic atrial fibrillation

Valvular heart disease

Chronic obstructive or restrictive  
pulmonary disease

*If the witness indicates the possibility of heart disease, see the section on medical conditions for further questions.*

**Q: Did you rule out *caffeine withdrawal* as a cause of the plaintiff's fatigue or loss of energy?**

The most common caffeine withdrawal symptom is a withdrawal headache. Headaches will occur in about one-third of moderate to high caffeine consumers when their daily intake is stopped. Other withdrawal symptoms include muscle tension, anxiety, **drowsiness, lethargy**, rhinorrhea (runny nose), disinterest in work, irritability, nervousness, mild feelings of depression, yawning, nausea, and fatigue. (reference 4, p. 1029; reference 2, p. 618)

*See caffeine and symptom chart in Appendix A for further details.*

**Q: Did you rule out *alcohol withdrawal* as a cause of the plaintiff's fatigue or loss of energy?**

The reduction or cessation of drinking for at least several days may cause characteristic symptoms: coarse tremor of hands, tongue, or eyelids; nausea or vomiting; **malaise or weakness**; autonomic hyperactivity (tachycardia, sweating, and elevated blood pressure); anxiety, depressed mood or irritability; transient hallucinations or illusions; headache; insomnia; dizziness; **fatigue**; restlessness; and agitation. (reference 7, p. 212; reference 2, pp. 722, 618; reference 9, pp. 50-54)

**Q: Did you rule out *hypoglycemia* as a cause of the plaintiff's fatigue or loss of energy?**

Hypoglycemia is an abnormally low blood sugar level. It often produces personality changes, **tiredness**, confusion, dizziness, tremor, anxiety, tachycardia, and sweating during acute attacks. Other psychiatric symptoms include fear and dread, **depression with fatigue**, and agitation with confusion. Hypoglycemia can develop from an insulin overdose, insulinoma or islet cell tumor, extensive liver disease, or functional diseases. (reference 2, p. 702; reference 4, pp. 1176-1177; reference 18, pp. 1929 and 1479 )

*If the witness indicates the possibility of hypoglycemia, see the section on pre-existing medical conditions for further questions.*

**SYMPTOM**

**DEPOSITION QUESTIONS**

**Fatigue or Loss of Energy**

(continued)

**Q: Did you rule out *amphetamine or similarly acting sympathomimetic drug withdrawal* as a cause of the plaintiff's fatigue or loss of energy?**

Drug withdrawal symptoms may include a dysphoric mood (depression, irritability, anxiety), **fatigue**, sweating, headaches, insomnia with nightmares, hypersomnia, and psychomotor agitation. Symptoms begin after the cessation of prolonged drug use (at least two days) and last more than 24 hours. (reference 7, p. 223; reference 4, p. 1008)

The following drugs may be classified as amphetamines:

- |                                    |                            |
|------------------------------------|----------------------------|
| Appetite Suppressants (diet pills) | Methamphetamines (speed)   |
| Dextroamphetamines                 | Methylphenidates (Ritalin) |
| Ma-huang (ephedra)                 | (reference 17, p. 586)     |
| (reference 24, pp. 488-489)        |                            |

**Q: Did you rule out *sedative, hypnotic, or anxiolytic consumption* as a cause of the plaintiff's fatigue or loss of energy?**

Sedative, hypnotic, or anxiolytic drug consumption can cause behavioral and physical changes. Behavioral symptoms may include disinhibition of sexual or aggressive impulses, mood lability, impaired judgment, and impaired social or occupational functioning. Physical symptoms may include slurred speech, incoordination, **fatigue**, unsteady gait, and impaired memory or attention span. Sedative drugs and minor tranquilizers cause impairment on many behavioral tasks. They may also improve some plaintiffs work or social functioning by reducing severe anxiety. The effects of two or more drugs, such as sedatives and alcohol, may cause significant behavioral impairment. (reference 7, p. 284; reference 4, p. 1548)

**Q: Did you rule out *opioid consumption* as a cause of the plaintiff's fatigue or loss of energy?**

Opioid intoxication is characterized by euphoria, flushing, itching skin, miosis, drowsiness, decreased respiratory rate and depth, hypotension, bradycardia, and decreased body temperature. The initial euphoria is often followed by apathy, unpleasant mood, psychomotor retardation, impaired judgment, and impaired social or occupational functioning. While dependence on opioids is less common than on alcohol or tobacco, it has been estimated that fifteen percent of males and nine percent of females have used an opioid (nonmedical) during their lifetime. (reference 7, pp. 151-152; reference 4, pp. 987-988)

**Q: Did you rule out *cocaine withdrawal* as a cause of the plaintiff's fatigue or loss of energy?**

The abrupt cessation or reduction of cocaine, after several days use, may cause the plaintiff to **feel tired**, dysphoric, irritable, depressed, and to crave more of the drug. An anxiety reaction may cause psychomotor agitation, insomnia or hypersomnia, high blood pressure, tachycardia, and paranoia. The symptoms may persist for more than a day. (reference 7, pp. 141-143; reference 4, pp. 1008-1009)

## SYMPTOM

## DEPOSITION QUESTIONS

**Fatigue or  
Loss of Energy***(continued)***Q: (Female) Did you rule out *premenstrual dysphoric disorder* as a cause of the plaintiff's fatigue or loss of energy?**

Premenstrual dysphoric disorder is characterized by emotional and behavioral symptoms which usually occur during the last week before the menstrual cycle and remit within a few days after menses begins. Symptoms may include tears, sadness, irritability, anger, tension, depression, self-deprecating thoughts, decreased interest in usual activities, **fatigability, loss of energy**, a subjective sense of difficulty in concentration, changes in appetite, and sleep disturbance. Physical symptoms may also include breast tenderness or swelling, tachycardia, sweating, headaches, joint or muscle pain, a sensation of bloating, or weight gain. (reference 7, pp. 771-774; reference 18, p. 1955)

**Q: Did you rule out *inhalant intoxication* as a cause of the plaintiff's fatigue or loss of energy?**

Following inhalant (toxic substance) use, the plaintiff may experience behavioral and physical changes. Behavioral changes may include belligerence, assaultiveness, apathy, impaired judgment, and impaired social or occupational functioning. Physical signs may include dizziness, nystagmus, slurred speech, unsteady gait, **lethargy**, depressed reflexes, tremor, psychomotor weakness, blurred vision or diplopia, stupor or coma, and euphoria. (reference 7, p. 259)

**Q: Did you rule out *cyclothymic disorder* as a cause of the plaintiff's fatigue or loss of energy?**

Cyclothymic disorder is a chronic, fluctuating mood involving numerous periods of hypomanic symptoms and numerous **periods of depressive symptoms**. The symptoms are not severe enough to meet the criteria for a major depressive or manic episode. The plaintiff may have impaired social and occupational functioning. Cyclothymic disorder usually begins in adolescence or early adult life. (reference 7, p. 398; reference 4, pp. 760-761, 804)

**Q: Did you rule out an *allergic reaction* as a cause of the plaintiff's fatigue or loss of energy?**

Allergic rhinitis is seasonal or perennial inflammatory disease of the nasal membranes. Symptoms may include sneezing; a stuffy and itching nose; postnasal drainage; and itching eyes. The plaintiff with allergies may feel ill and uncomfortable, **tired, weak**, despondent, irritable, and uninterested in eating. (reference 9, pp. 1867-1868)

**Q: Did you rule out *anemia* as a cause of the plaintiff's fatigue or loss of energy?**

Vertigo, pounding headaches, fainting, dimness of vision, tinnitus (a ringing in one or both ears), irritability, restlessness, inability to concentrate, **lethargy, fatigue**, drowsiness, GI complaints, and congestive heart failure are common symptoms of anemia. (reference 2, pp. 566-571)

*If the witness indicates the possibility of an anemia, see the section on pre-existing medical conditions for further questions.*

## SYMPTOM

## DEPOSITION QUESTIONS

**Fatigue or  
Loss of Energy***(continued)***Q: Did you rule out *dysthymic disorder* (depression) as a cause of the plaintiff's fatigue or loss of energy?**

Dysthymic disorder is characterized by chronic depressive symptoms less severe than major depression. Always feeling despondent or melancholy, the plaintiff believes that depression is part of their personality. Other symptoms may include a poor appetite or overeating, insomnia or hypersomnia, **low energy or fatigue**, low self-esteem, poor concentration, difficulty making decisions, and feelings of hopelessness. The disorder may begin in childhood for both sexes, but is more common in adult females. (reference 7, pp. 376-381; reference 4, pp.803-804)

*Note: An admission by the witness that the plaintiff has dysthymic disorder is important, because dysthymic disorder is not as severe as major depression. If the witness indicates the possibility of dysthymic disorder, see this section for further questions.*

**Q: Did you rule out *rheumatoid arthritis* as a cause of the plaintiff's fatigue or loss of energy?**

Rheumatoid arthritis is a progressive disease that causes long-lasting pain in the joints and muscles. Associated symptoms of severe rheumatoid arthritis may include depression, **fatigue**, weight loss, anorexia, pale skin, and **weakness**. (reference 4, pp. 1185, 1189, 1194; reference 9, p. 1913)

*If the witness indicates the possibility of rheumatoid arthritis, see the section on pre-existing medical conditions for further questions.*

**Q: Did you rule out *hypothyroidism* as a cause of the plaintiff's fatigue or loss of energy?**

Hypothyroidism results from inadequate synthesis of thyroid hormone. Hypothyroidism can produce psychiatric, as well as physical symptoms. The most notable psychiatric symptoms include depression, **lethargy**, poor concentration, impaired memory, apathy, and syncope. The numerous physical symptoms are: cold intolerance, constipation, muscle cramps, paresthesias, menstrual disorders, dyspnea, dizziness, reduced hearing, poor appetite, weight gain, brittle and thinning hair, and bradycardia (slowed heart action). Panic attacks are associated with endocrinological disorders including hypothyroidism and hyperthyroidism. (reference 18, pp. 743, 1810-1812, 1928)

*If the witness indicates the possibility of hypothyroidism, see the section on pre-existing medical conditions for further questions.*

**Q: Did you rule out *viral infections* as a cause of the plaintiff's fatigue or loss of energy?**

Viral illnesses, such as infectious hepatitis, mononucleosis, and influenza, may produce significant depressive symptoms in the plaintiff. The plaintiff may commonly experience the depressive symptoms for days or weeks after the illness. These self-limited illnesses may lead to suicidal ideation, loss of appetite, libido, and **fatigue**. The symptoms, however, are brief and related to the viral illness. (reference 4, pp. 876, 1275)

## SYMPTOM

## DEPOSITION QUESTIONS

**Fatigue or  
Loss of Energy***(continued)***Q: (Female) Did you rule out a *postpartum-onset episode* as a cause of the plaintiff's fatigue or loss of energy?**

If a major depressive episode, manic or mixed episode occurs within four weeks following childbirth, it would be diagnosed as a mood disorder with postpartum onset. Symptoms that are common in postpartum-onset episodes include fluctuations in mood and preoccupation with infant well-being, the intensity of which may range from over-concern to frank delusions. (reference 4, pp. 1238-1241; reference 1, p. 1720; reference 7, pp. 422-423)

*If the witness indicates the possibility of a postpartum disorder, see the section on medical conditions for further questions.*

**Q: Did you rule out *Addison's disease* as a cause of the plaintiff's fatigue or loss of energy?**

Addison's disease is caused by a diminished functioning of the adrenal glands. The decreased levels of corticosteroids may cause symptoms of apathy, **fatigue**, **weakness**, lack of initiative, seclusiveness, irritability, negativism, depression, poverty of thought, anorexia, weight loss, and hypotension. As the disease progresses, a depressed mood and psychomotor retardation may become severe. (reference 4, p. 1171)

*If the witness indicates the possibility of Addison's disease, see the section on pre-existing medical conditions for further questions.*

**Caution: Do not ask the following question if the cause of action involves a head injury or toxic exposure.**

**Q: Did you rule out any head injuries or other conditions leading to *organic brain syndrome* as a cause of the plaintiff's fatigue or loss of energy?**

Organic brain syndrome is a term for the symptoms produced by head injury, toxic exposure, hypoxia (oxygen deficiency), anoxia (extreme oxygen deficiency in tissues) or other causes. Common symptoms of head injuries include vertigo, syncope (faint), lightheadedness, impaired concentration and memory, **easy fatigability**, irritability, **lack of energy**, depression, anxiety, phobia, a lowered tolerance for alcohol, and headaches. Symptoms may appear days or weeks after the injury but usually appear within 24 hours. (reference 2, pp. 75, 111)

**Q: Did you rule out *generalized anxiety disorder* as a cause of the plaintiff's fatigue or loss of energy?**

A generalized anxiety disorder is a persistent anxiety, worry and distress about two or more life circumstances for at least one month. Symptoms may include muscle tension, restlessness or feeling keyed up, **fatigue**, difficulty concentrating, sleep disturbance, and irritability. (reference 7, p. 472)

*If the witness indicates the possibility of a generalized anxiety disorder, see the section on GAD for further questions.*

*SYMPTOM*

*DEPOSITION QUESTIONS*

**Fatigue or Loss of Energy**

(continued)

**Q: Did you rule out *nutritional deficiencies or electrolyte disturbances* as a cause of the plaintiff's fatigue or loss of energy, such as:**

|            |             |
|------------|-------------|
| Folate     | Thiamine    |
| Iron       | Vitamin B12 |
| Pyridoxine |             |

**Q: Did you rule out any *other medical conditions* that may cause the plaintiff's fatigue or loss of energy, such as:**

|                                 |  |
|---------------------------------|--|
| Acute infectious bronchitis     | Hepatitis  |
| Anticancer chemotherapy         | Hypertension                                       |
| Cancer                          | Local peripheral motor neuropathy or radiculopathy |
| Central nervous system disease  | Neurologic disorders                               |
| Chronic pyelonephritis          | Male hypoandrogen secretion                        |
| Chronic renal and liver disease | Metabolic and pulmonary failures                   |
| CO <sub>2</sub> retention       | Myasthenia gravis                                  |
| Congestive heart failure        | Panhypopituitarism                                 |
| Dehydration                     | Pseudotumor cerebri benign intracranial            |
| Diabetes                        | Uremic encephalopathy                              |
| Disseminated malignancy         |  |
| Endocrine disorders             |  |

**Q: Is the plaintiff taking any *medications or substances* that may cause fatigue or loss of energy, such as:**

|                 |               |                   |
|-----------------|---------------|-------------------|
| ACCUPRIL        | BUMEX         | DANTRIUM          |
| ACCUTANE        | BUPRENEX      | DEPO-PROVERA      |
| ADALAT          | BUSPAR        | DESOXYN           |
| ADAPIN          | CALAN         | DESYREL           |
| AEROBID         | CARBATROL     | DETROL            |
| ALLEGRA         | CARDURA       | DEXEDRINE         |
| ALTACE          | CATAPRES      | DIBENZYLINE       |
| AMBIEN          | CELEBREX      | DIMETANE          |
| AMERGE          | CELEXA        | DOLOBID           |
| ANAFRANIL       | CENTRAX       | DORAL             |
| ANAPROX         | CHLORTRIMETON | DYNACIRC          |
| ANDRODERM PATCH | CLOZARIL      | EDECRIN           |
| ANTABUSE        | COGNEX        | ELAVIL            |
| ARICEPT         | COLESTID      | ELDEPRYL          |
| ARTHROTEC       | COMBIPRES     | EMPIRIN W/CODEINE |
| ASENDIN         | COMBIVENT     | ENDEP             |
| AVANDIA         | CORGARD       | ESKALITH          |
| AVAPRO          | COUMADIN      | FAMVIR            |
| AXOCET          | COZAAR        | FELDENE           |
| BACTRIM         | CRINONE       | FIORICET          |
| BENADRYL        | CYCRIN        | FIORINAL-CODEINE  |
| BIPHETAMINE     | CYTOTEC       | FLEXERIL          |

**SYMPTOM****DEPOSITION QUESTIONS****Fatigue or****Loss of Energy***(continued)*

|                          |                           |                 |
|--------------------------|---------------------------|-----------------|
| FLOXIN                   | MODURETIC                 | SERTRALINE      |
| GABITRIL                 | MONOPRIL                  | SINEMET         |
| HALCION                  | MYSOLINE                  | SINEQUAN        |
| HUMULIN                  | NALFON                    | SINGULAIR       |
| HYDRO-<br>CHLOROTHIAZIDE | NAPROSYN                  | SPORANOX        |
| HYZAAR                   | NARDIL                    | ST. JOHN'S WORT |
| IMDUR                    | NAVANE                    | STELAZINE       |
| IMITREX                  | NEURONTIN                 | SURMONTIL       |
| IMMODIUM                 | NORPACE                   | SYMMETREL       |
| INDERAL                  | NORPLANT-SYSTEM           | TAVIST          |
| INDERIDE                 | NORPRAMIN                 | TEGRETOL        |
| INDOCIN                  | NORVASC                   | TEMARIL         |
| INSULIN                  | OPTIMINE                  | TENORMIN        |
| K-LYTE                   | PAMELOR                   | TIMOPTIC        |
| KEFLEX                   | PARAFON FORTE             | TOFRANIL        |
| KEFTAB                   | PARLODEL                  | TOLINASE        |
| KERLONE                  | PAXIPAM                   | TOPAMAX         |
| LAMISIL                  | PBZ-SR                    | TRANDATE        |
| LESCOL                   | PERIACTIN                 | TRANXENE        |
| LEVAQUIN                 | PHENERGAN VC<br>W/CODEINE | TRIAVIL         |
| LIMBITROL                | PLAVIX                    | TRILEPTAL       |
| LIORESAL                 | POLARAMINE                | TRINALIN        |
| LITHIUM CITRATE          | PONDIMIN                  | TROVAN          |
| LOPID                    | PRAVACHOL                 | VALIUM          |
| LOPRESSOR                | PREMPHASE                 | VANTIN          |
| LOTENSIN                 | PREMPRO                   | VASOTEC         |
| LOTREL                   | PRILOSEC                  | VERELAN         |
| LOZOL                    | PRINIVIL                  | VIVACTIL        |
| LUDIOMIL                 | PRINZIDE                  | WELLBUTRIN      |
| MACRODANTIN              | PROVERA                   | XANAX           |
| MARPLAN                  | QUESTRAN                  | ZANTAC          |
| MAXAIR-AUTOHALER         | REGLAN                    | ZARONTIN        |
| MAXALT                   | RELAFEN                   | ZAROXOLYN       |
| MAXIDE                   | REVIA                     | ZESTORETIC      |
| MECLOMEN                 | RIFAMATE                  | ZITHROMAX       |
| MESANTOIN                | RISPERDAL                 | ZOFRAN          |
| METHOTREXATE             | SELDANE                   | ZOLOFT          |
| MEXITIL                  | SEPTRA                    | ZOVIRAX         |
| MINIPRESS                | SEREVENT                  | ZYLOPRIM        |
|                          |                           | ZYRTEC          |

**SYMPTOM**

**DEPOSITION QUESTIONS**

**Feelings of Worthlessness or Guilt**

- Q: Describe the plaintiff's feelings of worthlessness or guilt.**  
 Low self-esteem, lack of self-confidence and self-reproach, along with poor concentration and indecisiveness, hopelessness and helplessness are characteristic psychologic symptoms of depression. (reference 1, pp. 1453)

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- Q: When and how often does the plaintiff feel worthless or have guilt feelings?**

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- Q: Do you know if the plaintiff is experiencing guilt from an action (unrelated to the injury in question) felt to be wrong, or from worrying that his or her action will be discovered?**

---

- Q: Does the plaintiff have a history of feeling worthless or guilty before the injury in question?**

---

- Q: Does the plaintiff have a history of any *medical or psychological conditions* that may cause feelings of worthlessness or guilt?**  
*The witness may indicate the possibility of the following medical or psychological conditions: please refer to the sections pertaining to these conditions for further questions.*

**TABLE 5.7-12.**

|                                |  |
|--------------------------------|--|
| Avoidant personality disorder  | Negativistic (passive aggressive) personality disorder |
| Delusional (paranoid) disorder |  |
| Dependent personality disorder | Pernicious anemia                                      |
| Hepatitis B                    | Postpartum disorder                                    |

- Q: Did you rule out an *identity problem* as a cause of the plaintiff's feelings of worthlessness or guilt?**  
 The plaintiff with an identity disorder or problem may experience an uncertainty about identity, long-term goals, career choices, friendship patterns, sexual behavior, religious identification, value systems, and group loyalties. Associated symptoms may include mild anxiety, depression, **self-doubt, doubt about the future**, and impaired social functioning or work performance. The plaintiff may be unable to make decisions, may feel empty or isolated, have a distorted time perspective, and may feel negative or hostile toward others. The disorder is most common for late adolescents, but also occurs in young adults and in middle age when earlier life decisions are questioned. (reference 7, p. 741; reference 4, pp. 1762-1765)

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- Q: Did you rule out *school failure* as a cause of the plaintiff's feelings of worthlessness or guilt?**  
 Feelings of anger, frustration, **shame, loss of self-respect**, and helplessness are emotions that most often accompany school failures. They have an emotionally and cognitively **damaging effect on self-esteem**, disabling future performance and clouding expectations for success. (reference 4, p. 1872)

## SYMPTOM

## DEPOSITION QUESTIONS

## Feelings of Worthlessness or Guilt

(continued)

**Q: Did you rule out a recent *heart attack* as a cause of the plaintiff's feelings of worthlessness or guilt?**

**Despondency** is almost a universal response to heart attack. Even without complications, the plaintiff may feel a sense of loss and vulnerability to further injury. Weakness and tiredness are the single most distressing symptoms of the depression. The plaintiff may also experience insomnia, daytime hypersomnia, and practical worries. Complications cause the plaintiff's **despondency and hopelessness** to be intensified. (reference 4, pp. 1156-1157)

*If the witness indicates the possibility of a recent heart attack, see the section on medical conditions for further questions.*

**Q: (Female) Did you rule out *premenstrual dysphoric disorder* as a cause of the plaintiff's feelings of worthlessness or guilt?**

Premenstrual dysphoric disorder is characterized by emotional and behavioral symptoms which usually occur during the last week before the menstrual cycle and remit within a few days after menses begins. Symptoms may include tears, sadness, irritability, anger, tension, depression, **self-deprecating thoughts**, decreased interest in usual activities, fatigability, loss of energy, a subjective sense of difficulty in concentration, changes in appetite, and sleep disturbance. Physical symptoms may also include breast tenderness or swelling, tachycardia, sweating, headaches, joint or muscle pain, a sensation of bloating, or weight gain. (reference 7, pp. 771-774; reference 18, p. 1955)

**Q: Did you rule out *depressive episodes of a bipolar disorder* as a cause of the plaintiff's feelings of worthlessness or guilt?**

During major depressive episodes the plaintiff may be depressed for at least two weeks. The plaintiff may experience an appetite disturbance, weight change, sleep disturbance, psychomotor agitation or retardation, decreased energy and emotional capacity, **feelings of worthlessness**, difficulty thinking or concentrating, and recurrent thoughts of death or suicide. (reference 4, pp. 408-409, 761; reference 7, pp. 382-391)

**Q: Did you rule out a *borderline personality disorder* as a cause of the plaintiff's feelings of worthlessness or guilt?**

A borderline personality disorder is characterized by unstable interpersonal relationships, behavior, mood, and self-image. The plaintiff may experience temporary mood shifts including depression, irritability, and anxiety. S/he may also have chronic **feelings of emptiness** or boredom, inappropriate anger, and recurrent suicidal thoughts. Social contrariness and a generally pessimistic outlook often accompany the disorder. Premature death may result from suicide. (reference 7, p. 706)

*If the witness indicates the possibility of a borderline personality disorder or other maladaptive personality traits, see the section on pre-existing personality disorders for further questions.*

## SYMPTOM

## DEPOSITION QUESTIONS

**Feelings of  
Worthlessness  
or Guilt**

(continued)

**Q: Did you rule out *attention-deficit hyperactivity disorder (ADHD)* as a cause of the plaintiff's feelings of worthlessness or guilt?**

The essential characteristics of ADHD include inattention, impulsiveness, and hyperactivity. ADHD is usually diagnosed during elementary school years, and can persist throughout childhood. Persons diagnosed with ADHD have a higher prevalence of mood and anxiety disorders, learning disorders, substance-related disorders and the potential for the development of an antisocial personality disorder. Approximately one-third of the children diagnosed with ADHD show some signs of the disorder in adulthood. Associated symptoms may include **low self-esteem**, mood lability, low frustration tolerance, and temper outbursts. (reference 7, pp. 85-93)

**Q: Did you rule out an *adjustment disorder with depressed mood* as a cause of the plaintiff's feelings of worthlessness or guilt?**

This adjustment disorder is accompanied by depression, tearfulness, sleep disturbance, **feeling worthless**, and feelings of hopelessness to a stressor. Easy fatigability is often a component of the depression. It is important to note that an adjustment disorder is a transient over-reaction to stress and should remit within six months. (reference 7, p. 680)

*If the witness indicates the possibility of an adjustment disorder with depressed mood, see the section on adjustment disorders for further questions.*

**Q: Did you rule out *anorexia nervosa* as a cause of the plaintiff's feelings of worthlessness or guilt?**

The anorexic plaintiff weighs fifteen percent less than the minimal weight normal for his or her age and height. S/he refuses to maintain body weight and has a distorted body image. Other symptoms may include **depressed feelings**, crying spells, sleep disturbance, obsessive rumination, obsessive compulsive behavior, anxiety, and occasional suicidal thoughts. Many anorexic adolescents have delayed psychosexual development. Adults with the disorder often have a decreased interest in sex. (reference 7, p. 583; reference 1, pp. 1904-1905; reference 4, pp. 1145, 1731)

**Q: Did you rule out *dysthymic disorder (depression)* as a cause of the plaintiff's feelings of worthlessness or guilt?**

Dysthymic disorder is characterized by **chronic depressive symptoms** less severe than major depression. Always feeling despondent or melancholy, the plaintiff believes that depression is part of their personality. Other symptoms may include a poor appetite or overeating, insomnia or hypersomnia, low energy or fatigue, **low self-esteem**, poor concentration, difficulty making decisions, and feelings of hopelessness. The disorder may begin in childhood for both sexes, but is more common in adult females. (reference 7, pp. 376-381; reference 4, pp. 803-804)

*Note: An admission by the witness that the plaintiff has dysthymic disorder is important, because dysthymic disorder is not as severe as major depression. If the witness indicates the possibility of dysthymic disorder, see this section for further questions.*

*SYMPTOM*

*DEPOSITION QUESTIONS*

**Diminished Ability to Think or Concentrate**

**Q:** Describe the plaintiff's diminished ability to think, concentrate, or make decisions.

**Q:** When and how often does the plaintiff experience the diminished ability to think, concentrate, or make decisions?

**Q:** Does the plaintiff have a prior history of having a diminished ability to think, concentrate, or make a decision?

**Q:** Does the plaintiff have a history of any *medical or psychological conditions* that may cause diminished ability to think, concentrate or make decisions?

*The witness may indicate the possibility of the following medical or psychological conditions: please refer to the sections pertaining to these conditions for further questions.*

**TABLE 5.7-13.**

|                           |   |
|---------------------------|---|
| Addison's disease         | Multiple sclerosis                        |
| Alzheimer's disease       | Narcissistic personality disorder         |
| Brain tumor               | Obsessive-compulsive personality disorder |
| Combined systems disease  | Pernicious anemia                         |
| Creutzfeldt-Jakob disease | Polycythemia                              |
| Cushing's syndrome        | Porphyria                                 |
| Epilepsy                  | Postpartum disorder                       |
| Hepatic encephalopathy    | Schizoid personality disorder             |
| Huntington's disease      | Schizophrenia                             |
| Hypertension              | Somatiform pain disorder                  |
| Hypoglycemia              | Subacute sclerosing panencephalitis       |
| Hypotension               | Syphilis                                  |
| Hypothyroidism            | Systemic lupus erythematosus              |
| Meningitis                |   |

**Q:** Did you rule out *attention-deficit hyperactivity disorder (ADHD)* as a cause of the plaintiff's diminished ability to think, concentrate, or make decisions?

The essential characteristics of ADHD include inattention, impulsiveness, and hyperactivity. ADHD is usually diagnosed during elementary school years, and can persist throughout childhood. Persons diagnosed with ADHD have a higher prevalence of mood and anxiety disorders, **learning disorders**, substance-related disorders and the potential for the development of an antisocial personality disorder. Approximately one-third of the children diagnosed with ADHD show some signs of the disorder in adulthood. Associated symptoms may include low self-esteem, mood lability, low frustration tolerance, and temper outbursts. (reference 7, pp. 85-93)

## SYMPTOM

## DEPOSITION QUESTIONS

**Diminished Ability to Think or Concentrate**

(continued)

**Q: Did you rule out the *work or home environment* as a cause of the plaintiff's diminished ability to think, concentrate, or make decisions?**

A disorganized or chaotic environment may be a cause of the plaintiff's **inability to concentrate**.

**Q: Did you rule out *chronic fatigue syndrome* as a cause of the plaintiff's diminished ability to think, concentrate, or make decisions?**

Chronic fatigue syndrome presents with six months or more of severe, debilitating fatigue accompanied by myalgia, headaches, pharyngitis, low-grade fever, **cognitive complaints**, gastrointestinal symptoms, and tender lymph nodes. There is a high rate (15-54%) of depressive disorders among patients with chronic fatigue syndrome. Persons most likely to be plagued by persistent fatigue after an acute viral illness are patients with pre-existing or co-morbid psychiatric problems. Chronic fatigue syndrome is considered to be a special class of mood disorder with somatic symptoms. (reference 18, pp. 1531-1532)

**Q: Did you rule out *nicotine withdrawal* as a cause of the plaintiff's diminished ability to think, concentrate, or make decisions?**

Nicotine withdrawal symptoms include a strong craving for nicotine, anxiety, irritability, frustration or anger, **impaired attention**, coughing, headaches, insomnia, a mental preoccupation with actions associated with tobacco use, restlessness, drowsiness, gastrointestinal disturbances, an increased appetite, and weight gain. The symptoms appear within 24 hours after the cessation or reduction in the use of cigarettes, cigars, pipes, chewing tobacco, or nicotine gum. The plaintiff experiences a decrease in the intensity of the symptoms with time. (reference 7, p. 264; reference 4, pp. 1031-1032)

**Q: Did you rule out a *bipolar disorder* as a cause of the plaintiff's diminished ability to think, concentrate, or make decisions?**

A bipolar disorder has a circular pattern of high and low emotional states (*mania and depression*). During the *manic episodes*, the plaintiff may feel grandiose, have a decreased need for sleep, and decreased emotional capacity, experience a surge of ideas and conversation, and **may be easily distracted** or pleased. It is often thought that the manic high represents an escape from inner depression and pain. While the plaintiff is extremely active, s/he is **often fragmented and unable to finish projects**. The plaintiff typically does not realize that s/he is ill.

During *major depressive episodes* the plaintiff may be depressed for at least two weeks. The plaintiff may experience an appetite disturbance, weight change, sleep disturbance, psychomotor agitation or retardation, decreased energy and emotional capacity, feelings of worthlessness, **difficulty thinking or concentrating**, and recurrent thoughts of death or suicide. (reference 4, pp. 408-409, 761; reference 7, pp. 382-391)

## SYMPTOM

## DEPOSITION QUESTIONS

**Diminished Ability to Think or Concentrate**  
(continued)

**Q: Did you rule out an *obsessive-compulsive disorder* as a cause of the plaintiff's diminished ability to think, concentrate, or make decisions?**

The obsessive-compulsive plaintiff has **persistent unwanted and uncontrolled thoughts or impulses** that may be characterized by violence, contamination, or doubt. These obsessions often cause the plaintiff to feel anxious. The plaintiff's repeated compulsive behaviors are attempts to control the impulses and the accompanying anxiety. Other symptoms may include an exclusive devotion to work or productivity, depression, anxiety, and restlessness. (reference 4, pp. 910-911; reference 7, p. 456)

*If the witness indicates the possibility of an obsessive-compulsive disorder, see the section on pre-existing psychological conditions for further questions.*

***Note:** In addition to the obsessive-compulsive disorder, there is an obsessive-compulsive personality disorder. The personality disorder does not have true obsessions and compulsions, but has a clear pattern of perfectionism and rigidity. If the witness indicates the possibility of an obsessive-compulsive personality disorder, see this section for further questions.*

**Q: Did you rule out *cannabis (marijuana) consumption* as a cause of the plaintiff's diminished ability to think, concentrate, or make decisions?**

Cannabis intoxication can occur from marijuana, hashish, or tetrahydrocannabinol (THC). Characteristic symptoms include tachycardia, increased appetite, dry mouth, euphoria, anxiety, sensation of slowed time, **impaired judgment**, and social withdrawal. Inappropriate laughter, panic attacks, and a dysphoric mood may occur. (reference 7, p. 234; reference 4, pp. 1326, 754)

**Q: Did you rule out *HIV-associated dementia or HIV-associated mild neurocognitive disorder* as a cause of the plaintiff's ability to think, concentrate, or make decisions?**

HIV dementia is a severe cognitive disorder that interferes substantially with work, home life and social activities. Symptoms of mild neurocognitive disorder associated with HIV infection include **difficulty concentrating**, unusual fatigability with demanding mental tasks, feeling slowed down and memory difficulties. **Problem solving, abstract reasoning**, and motor performance **may also be affected**. (reference 18, pp. 308-316; reference 7, p. 163)

**Q: Did you rule out *vascular dementia (formerly multi-infarct dementia)* as a cause of the plaintiff's diminished ability to think, concentrate, or make decisions?**

Vascular dementia is caused by cerebrovascular disease (disease of the brain's blood supply or blood vessels) that quickly produces an **irregular deterioration in intellectual functioning**. The resulting dementia involves **disturbances in memory, abstract thinking, judgment**, impulse control, and personality. Combined with depression, the dementia often causes many cognitive symptoms. (reference 7, p. 147)

*SYMPTOM*

*DEPOSITION QUESTIONS*

**Diminished Ability to Think or Concentrate**  
*(continued)*

**Q: Did you rule out early onset of dementia of the Alzheimer's type as a cause of the plaintiff's diminished ability to think, concentrate, or make decisions?**

This primary degenerative dementia is caused by Alzheimer's disease. The plaintiff's **intellectual abilities**, personality, and behavior **progressively deteriorate**.

Depressive symptoms may complicate the condition. (reference 7, p. 154)

*Age at onset: Senile onset (after age 65) is much more common than pre-senile onset. Few cases develop before the age of 49.*

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*Caution: Do not ask the following question if the cause of action involves a head injury or toxic exposure.*

**Q: Did you rule out any head injuries or other conditions leading to organic brain syndrome as a cause of the plaintiff's diminished ability to think, concentrate, or make decisions?**

Organic brain syndrome is a term for the symptoms produced by head injury, toxic exposure, hypoxia (oxygen deficiency), anoxia (extreme oxygen deficiency in tissues) or other causes. Common symptoms of head injuries include vertigo, syncope (faint), lightheadedness, **impaired concentration and memory**, easy fatigability, irritability, lack of energy, depression, anxiety, phobia, a lowered tolerance for alcohol, and headaches. Symptoms may appear days or weeks after the injury but usually appear within 24 hours. (reference 2, pp. 75, 111)

---

**Q: Did you rule out anemia as a cause of the plaintiff's diminished ability to think, concentrate, or make decisions?**

Vertigo, pounding headaches, fainting, dimness of vision, tinnitus (a ringing in one or both ears), irritability, restlessness, **inability to concentrate**, lethargy, fatigue, drowsiness, and GI complaints, are common symptoms of anemia. (reference 2, pp. 566-571)

*If the witness indicates the possibility of anemia, see the section on pre-existing medical conditions for further questions.*

---

**Q: Did you rule out muscle contraction headaches as a cause of the plaintiff's diminished ability to think, concentrate, or make decisions?**

Chronic muscle contraction headaches may produce nausea, vomiting, lightheadedness, difficulty in falling asleep, restless sleep with frequent awakenings, loss of energy, **impaired memory and concentration**, and symptoms of depression. (reference 2, pp. 72-73; reference 4, p. 1204)

---

**Q: Did you rule out migraine headaches as a cause of the plaintiff's diminished ability to think, concentrate, or make decisions?**

A classic migraine headache may be accompanied by visual disturbances, sensory motor or speech disturbances, nausea or vomiting, **poor concentration**, and sometimes emotional changes. On rare occasions the plaintiff may experience depersonalization or derealization.

## SYMPTOM

## DEPOSITION QUESTIONS

**Diminished  
Ability to  
Think or  
Concentrate**

(continued)

Migraine (or vascular) headaches may often be precipitated by: (reference 4, p. 1205; reference 2, pp. 65-66)

- Birth control pills
- Emotional conflicts or psychological stress
- Fluctuating estrogen levels in women
- Food:
  - Monosodium glutamate (Chinese restaurant syndrome)
  - Phenylethylamine-containing foods
  - Tyramine-containing foods (cheese or other fermented dairy products and chocolate)

**Q: Did you rule out *alcohol consumption* as a cause of the plaintiff's diminished ability to think, concentrate or make decisions?**

Alcohol intoxication may cause aggressiveness, **impaired judgment and attention**, irritability, euphoria, depression, emotional lability, and impaired social or occupational functioning. Physical symptoms may include slurred speech, incoordination, unsteady gait, nystagmus, occasional dizziness, and flushed face. Heavy alcohol consumption may cause abnormal sleep patterns. The plaintiff often falls asleep quickly but wakes up earlier and earlier with uncomfortable feelings. Chronic alcoholics may have irregular, unsteady, and slow tremulous movements. (reference 7, pp. 128-129; reference 4, p. 67; reference 9, p. 52)

**Q: Did you rule out *amphetamine or similarly acting sympathomimetic drug consumption* as a cause of the plaintiff's diminished ability to think, concentrate, or make decisions?**

Symptoms of amphetamine or similarly acting sympathomimetic drug consumption may include fighting, grandiosity, elation, hypervigilance, psychomotor agitation, **impaired judgment**, and impaired social or occupational functioning. Physical symptoms may include flushing, difficulty breathing, tachycardia, pupil dilation, elevated blood pressure, sweating or chills, nausea, and vomiting. (reference 4, pp. 1007-1008; reference 7, p. 223)

The following drugs may be classified as amphetamines:

- |                                    |                            |
|------------------------------------|----------------------------|
| Appetite Suppressants (diet pills) | Methamphetamines (speed)   |
| Dextroamphetamines                 | Methylphenidates (Ritalin) |
| Ma-huang (ephedra)                 | (reference 17, p. 586)     |
| (reference 24, pp. 488-489)        |                            |

**Q: Did you rule out *caffeine withdrawal* as a cause of the plaintiff's diminished ability to think, concentrate, or make decisions?**

The most common caffeine withdrawal symptom is a withdrawal headache. Headaches will occur in about one-third of moderate to high caffeine consumers when their daily intake is stopped. Other withdrawal symptoms include muscle tension, anxiety, drowsiness, lethargy, rhinorrhea (runny nose), **disinterest in work**, irritability, nervousness, mild feelings of depression, yawning, nausea, and fatigue. (reference 4, p. 1029; reference 2, p. 618)

See *caffeine consumption and symptom chart* in Appendix A for further details.

## SYMPTOM

## DEPOSITION QUESTIONS

**Diminished Ability to Think or Concentrate**  
(continued)

**Q: Did you rule out *primary insomnia* as a cause of the plaintiff's diminished ability to think, concentrate or make decisions?**

Primary insomnia involves difficulty initiating or maintaining sleep or experiencing non-restorative sleep. This pattern lasts for at least a month. The disorder may be severe enough to cause daytime fatigue, irritability, or an **impaired memory and concentration**. (reference 7, p. 599-604; reference 2, p. 601)

**Q: Did you rule out *inhalant intoxication* as a cause of the plaintiff's diminished ability to think, concentrate, or make decisions?**

Following inhalant (toxic substance) use, the plaintiff may experience behavioral and physical changes. Behavioral changes may include belligerence, assaultiveness, apathy, **impaired judgment**, and impaired social or occupational functioning. Physical signs may include dizziness, nystagmus, slurred speech, unsteady gait, lethargy, depressed reflexes, tremor, psychomotor weakness, blurred vision or diplopia, stupor or coma, and euphoria. (reference 7, p. 259)

**Q: Did you rule out *sedative, hypnotic, or anxiolytic consumption* as a cause of the plaintiff's diminished ability to think, concentrate, or make decisions?**

Sedative, hypnotic, or anxiolytic drug consumption can cause behavioral and physical changes. Behavioral symptoms may include disinhibition of sexual or aggressive impulses, mood lability, **impaired judgment**, and impaired social or occupational functioning. Physical symptoms may include slurred speech, incoordination, unsteady gait, and **impaired memory or attention span**. Sedative drugs and minor tranquilizers cause impairment on many behavioral tasks. They may also improve some plaintiffs work or social functioning by reducing severe anxiety. The effects of two or more drugs, such as sedatives and alcohol, may cause significant behavioral impairment. (reference 7, p. 284; reference 4 p. 1548)

**Q: (Female) Did you rule out *premenstrual dysphoric disorder* as a cause of the plaintiff's diminished ability to think, concentrate, or make decisions?**

Premenstrual dysphoric disorder is characterized by emotional and behavioral symptoms which usually occur during the last week before the menstrual cycle and remit within a few days after menses begins. Symptoms may include tears, sadness, irritability, anger, tension, depression, self-deprecating thoughts, decreased interest in usual activities, fatigability, loss of energy, **a subjective sense of difficulty in concentration**, changes in appetite, and sleep disturbance. Physical symptoms may also include breast tenderness or swelling, tachycardia, sweating, headaches, joint or muscle pain, a sensation of bloating, or weight gain. (reference 7, pp. 771-774; reference 18, p. 1955)

**Q: Did you rule out *cocaine consumption* as a cause of the plaintiff's diminished ability to think, concentrate, or make decisions?**

Cocaine users often experience increased energy and confidence or irritability and paranoia with physical aggressiveness. Other behavioral symptoms may include euphoria, hypervigilance, psychomotor agitation, **impaired judgment**, and impaired

## SYMPTOM

## DEPOSITION QUESTIONS

**Diminished  
Ability to  
Think or  
Concentrate**  
(continued)

social or occupational functioning. Physical symptoms may include tachycardia, dilated pupils, elevated blood pressure, perspiration or chills, nausea, vomiting, and hallucinations. (reference 7, pp. 141-143; reference 4, pp. 1008-1009)

**Q: Did you rule out a *dependent personality disorder* as a cause of the plaintiff's diminished ability to think, concentrate, or make decisions?**

The dependent personality disorder is featured by a continuous pattern of dependent and submissive behavior beginning by early adulthood. Symptomatic behaviors include the **inability to make decisions alone**, fear of being rejected, difficulty doing projects alone, doing demeaning or unpleasant tasks to be liked, feeling uncomfortable or helpless when alone, feeling devastated or helpless when close relationships end, fearing abandonment, and being easily hurt by criticism and disapproval. (reference 7, p. 721)

*If the witness indicates the possibility of a dependent personality disorder, see the section on pre-existing personality disorders for further questions.*

**Q: Did you rule out *dysthymic disorder* (depression) as a cause of the plaintiff's diminished ability to think, concentrate, or make decisions?**

Dysthymic disorder is characterized by chronic depressive symptoms less severe than major depression. Always feeling despondent or melancholy, the plaintiff believes that depression is part of their personality. Other symptoms may include a poor appetite or overeating, insomnia or hypersomnia, low energy or fatigue, low self-esteem, **poor concentration, difficulty making decisions**, and feelings of hopelessness. The disorder may begin in childhood for both sexes, but is more common in adult females. (reference 7, pp. 376-381; reference 4, pp. 803-804)

*Note: An admission by the witness that the plaintiff has dysthymic disorder is important because dysthymic disorder is not as severe as major depression. If the witness indicates the possibility of dysthymic disorder, see this section for further questions.*

**Q: Did you rule out a *schizotypal personality disorder* as a cause of the plaintiff's diminished ability to think, concentrate, or make decisions?**

A schizotypal personality has **oddities of thinking, perception**, communication, and behavior that resemble schizophrenia. The plaintiff may experience anxiety, depression, and other dysphoric moods that **disrupt concentration** and the ability to function socially or at work. S/he may have few close friends except for immediate family. (reference 7, p. 697)

*If the witness indicates the possibility of a schizotypal personality disorder, see the section on pre-existing personality disorders for further questions.*

**Q: Did you rule out *hypothyroidism* as a cause of the plaintiff's diminished ability to think, concentrate, or make decisions?**

Hypothyroidism results from inadequate synthesis of thyroid hormone. Hypothyroidism can produce psychiatric, as well as physical symptoms. The most notable psychiatric symptoms include depression, lethargy, **poor concentration**,

## SYMPTOM

## DEPOSITION QUESTIONS

**Diminished  
Ability to  
Think or  
Concentrate**

(continued)

**impaired memory**, apathy, and syncope. The numerous physical symptoms are: cold intolerance, constipation, muscle cramps, paresthesias, menstrual disorders, dyspnea, dizziness, reduced hearing, poor appetite, weight gain, brittle and thinning hair, and bradycardia (slowed heart action). Panic attacks are associated with endocrinological disorders including hypothyroidism and hyperthyroidism. (reference 18, pp. 743, 1810-1812, 1928)

*If the witness indicates the possibility of hypothyroidism, see the section on pre-existing medical conditions for further questions.*

**Q: Did you rule out *hallucinogen consumption* as a cause of the plaintiff's diminished ability to think, concentrate or make decisions?**

Hallucinogen consumption causes changes in perception such as feelings of detachment, illusions, hallucinations, and synesthesia (seeing colors when a loud sound occurs). Behavioral symptoms may include anxiety or depression, ideas of reference, fear of losing one's mind, paranoia, **impaired judgment**, and impaired social or occupational functioning. Physical symptoms may include dilated pupils, tachycardia, sweating, palpitations, blurred vision, tremors, and incoordination. Flashbacks of experiences may recur several months or years after hallucinogen use. Many plaintiffs may have gross thought process disturbances. Unlike schizophrenics, they are able to talk in detail about their hallucinations. (reference 7, p. 250; reference 4, p. 874)

**Q: Did you rule out *generalized anxiety disorder* as a cause of the plaintiff's diminished ability to think, concentrate, or make decisions?**

A generalized anxiety disorder is a persistent anxiety, worry and distress about two or more life circumstances for at least one month. Symptoms may include muscle tension, restlessness or feeling keyed up, fatigue, **difficulty concentrating**, sleep disturbance, and irritability. (reference 7, p. 472)

*If the witness indicates the possibility of a generalized anxiety disorder, see the section on GAD for further questions.*

**Q: Did you rule out *hypoglycemia* as a cause of the plaintiff's diminished ability to think, concentrate or make decisions?**

Hypoglycemia is an abnormally low blood sugar level. It often produces personality changes, tiredness, **confusion**, dizziness, tremor, anxiety, tachycardia, and sweating during acute attacks. Other psychiatric symptoms include fear and dread, depression with fatigue, and **agitation with confusion**. Hypoglycemia can develop from an insulin overdose, insulinoma or islet cell tumor, extensive liver disease, or functional diseases. (reference 2, p. 702; reference 4, pp. 1176-1177; reference 18, pp. 1929 and 1479 )

*If the witness indicates the possibility of hypoglycemia, see the section on pre-existing medical conditions for further questions.*

*SYMPTOM*

*DEPOSITION QUESTIONS*

**Diminished Ability to Think or Concentrate**  
(continued)

**Q: Did you rule out *infections* as a cause of the plaintiff's diminished ability to think, concentrate, or make decisions, such as: (reference 2, p. 617)**

|                                  |                                 |
|----------------------------------|---------------------------------|
| Brucellosis                      | Meningitis                      |
| Chronic urinary tract infections | Subacute bacterial endocarditis |
| Infectious mononucleosis         | Syphilis                        |
| Influenza                        | Tuberculosis                    |
| Malaria                          | Viral hepatitis                 |

**Q: Does the plaintiff have any *other medical conditions* that may cause a diminished ability to think, concentrate, or make decisions, such as:**

Central nervous system disease  
Metabolic and pulmonary failures  
Vascular disorders

**Q: Is the plaintiff taking any *medications or substances* that may cause a diminished ability to think, concentrate, or make decisions, such as:**

|                 |               |                 |
|-----------------|---------------|-----------------|
| ADALAT          | CEFZIL        | EMPIRIN-CODEINE |
| AKINETONE       | CELEXA        | ENDEP           |
| ALDACTAZIDE     | CELONTIN      | ESGIC           |
| ALDACTONE       | CENTRAX       | ESKALITH        |
| AMBIEN          | CHLORTRIMETON | ETRAFON         |
| AMERGE          | CLARITAN-D    | EXCELON         |
| AMPHETAMINES    | CLARITIN      | FELDENE         |
| AMYTAL          | CLINDEX       | FIORICET        |
| ANAFRANIL       | CLOZARIL      | FLAGYL          |
| ANDRODERM PATCH | CODEINE       | FLEXERIL        |
| ANSAID          | COGNEX        | FLOXIN          |
| ANTABUSE        | COZAAR        | GABITRIL        |
| ARTANE          | CYCLOSPORIN   | HALCION         |
| ARTHROTEC       | DALMANE       | HALDOL          |
| ASENDIN         | DANTRIUM      | HYDERGINE       |
| AUGMENTIN       | DAYPRO        | HYZAAR          |
| AVONEX          | DESOXYN       | IMDUR           |
| AXID            | DESYREL       | INDOCIN         |
| AXOCET          | DIAMOX        | INSULIN         |
| BENADRYL        | DILANTIN      | K-LYTE          |
| BENTYL          | DIMETANE      | KEFTAB          |
| BUPRENEX        | DISALCID      | KERLONE         |
| BUSPAR          | DOLOBID       | KLONOPIN        |
| BUTAZOLIDIN     | DORAL         | LEVAQUIN        |
| BUTICAPS        | DURACT        | LEVO-DROMORAM   |
| CARBATROL       | DURAGESIC     | LEVSIN          |
| CARDENE         | EDECIN        | LIBRAX          |
| CARDIZEM        | ELAVIL        | LIBRIUM         |
| CARDURA         | ELDEPRYL      | LIDODERM PATCH  |

# Major Depressive Disorder

*SYMPTOM*

*DEPOSITION QUESTIONS*

**Diminished Ability to Think or Concentrate**  
(continued)

|                  |                      |                |
|------------------|----------------------|----------------|
| LIMBITROL        | PERMAX               | TAVIST         |
| LIORESAL         | PERMITIL             | TEGRETOL       |
| LITHIUM-CITRATE  | PHENERGAN-VC-CODEINE | TESSALON       |
| LODINE           | PHENOBARBITAL        | TIMOPTIC       |
| LOPRESSOR        | POLARIMINE           | TINDAL         |
| LUDIOMIL         | PONDIMIN             | TOFRANIL       |
| MACROBID         | PREVACID             | TOPROL-XL      |
| MARPLAN          | PRILOSEC             | TORECAN        |
| MAXAIR-AUTOHALER | PRIMAXIN-IV          | TRANCOPAL      |
| MAXALT           | PRINZIDE             | TRANSDERM-SCOP |
| MEBARAL          | PROAMATINE           | TRANXENE       |
| MECLIZINE        | PROCAN-SR            | TRENTAL        |
| MELLARIL         | PROSOM               | TRIAVIL        |
| MEXITIL          | PROTONIX             | TRILAFON       |
| MIRAPEX          | QUINAGLUTE           | TRILEPTAL      |
| MODURETIC        | QUINAMM              | TRILISATE      |
| MONOPRIL         | RELAFEN              | TRINALIN       |
| MOTRIN           | REMERON              | TROVAN         |
| NALFON           | RESTORIL             | ULTRAM         |
| NEMBUTAL         | REVIA                | VALIUM         |
| NEURONTIN        | RIFAMATE             | VALTREX        |
| NICORETTE        | RUFEN                | VASOTEC        |
| NOLUDAR          | SEROQUEL             | VERELAN        |
| NORFLEX          | SERZONE              | VICOPROFEN     |
| NORGESIC         | SINEMET              | VIVACTIL       |
| NOROXIN          | SINEQUAN             | WELLBUTRIN     |
| NORPRAMIN        | SOMA-COMPOUND        | XANAX          |
| NUBAIN           | SONATA               | XYLOCAINE      |
| OPTIMINE         | STADOL               | ZANTAC         |
| ORUDIS           | SULAR                | ZESTORETIC     |
| PAMELOR          | SURMONTIL            | ZESTRIL        |
| PARLODEL         | SYMMETREL            | ZOVIRAX        |
| PAXIPAM          | TAGAMET              | ZYBAN          |
| PBZ-SR           | TALECEN              | ZYLOPRIM       |
| PEPCID           | TALWIN-NX            | ZYRTEC         |
| PERIACTIN        |                      |                |

**Thoughts of Death or Suicide**

**Q: Describe the plaintiff's recurrent thoughts of death or suicidal ideation.**

**Q: Does the plaintiff have a history of thinking about death or suicide?**

Any person with a history of previous suicide attempts should be considered at increased risk. One out of three or four who attempt suicide has a history of previous behavior. A family history of psychosis and suicide, evidence of substance abuse, a history of inpatient treatment for suicidal depression, or a chaotic home situation combined with feelings of hopelessness, may lead to increased risk of suicide. (reference 4, pp. 795, 808, and 1318)

## SYMPTOM

## DEPOSITION QUESTIONS

## Thoughts of Death or Suicide

(continued)

*Defense counsel should note that single, depressed men over the age of 60 who live alone, have no religious affiliation, and that drink are at the greatest risk of suicide. If the plaintiff has also experienced tension, anxiety, agitation, and insomnia, s/he is especially at risk. (reference 4, p. 795)*

**Q: Does the plaintiff participate in self-endangering behavior?**

Some presumably suicidal plaintiffs take part in dangerous activities. Self-endangering behavior is common but difficult to prove that it is suicidal. The plaintiff often has rational reasons and circumstances to account for harmful behavior. Alcohol consumption and self-medication is a common form of overdose without outward suicidal intent. Other types of self-endangering behavior may include risky occupations or reckless actions, significant omissions (e.g., forgetting to take insulin), significant excesses (e.g., a hunger strike or crash diet), or counter-therapeutic behavior. (reference 4, p. 1280)

**Q: Is the plaintiff experiencing other life stressors?**

An accumulation of stressful life events has been shown to correlate positively with depression, neurosis, acute episodes of schizophrenia, and **suicide attempts**, even though the magnitude of the correlation is small. Examples of stressful life events most important in suicide are heavy drinking, friction with spouse or lover, job troubles, hyperactivity divorce or separation, financial difficulties, drinking just prior to suicide, and feelings of disgrace. (reference 4, pp. 1200, 1313)

*If the witness indicates the possibility of other life stressors, see the section on other life-stressors for further questions.*

**Q: Does the plaintiff have suicidal risk factors, such as:** (reference 4, p. 795)

- (1) experiencing a long episode of depression
- (2) taking hypnotic drugs for more than one year
- (3) displaying psychomotor retardation and self-neglect
- (4) making suicidal gestures or comments

**Other clinical features usually associated with increased suicidal risk are:** (reference 4, p. 824).

- (1) a personal history of suicidal attempts
- (2) an intense suicidal drive
- (3) a history of acting out as the main expression of anxiety
- (4) a lack of family or social support
- (5) significant losses
- (6) hostility
- (7) intense guilt
- (8) anhedonia (loss of pleasure)
- (9) bipolar tendencies switching rapidly from manic to depressed phase
- (10) well-established refractoriness to previous treatments

*SYMPTOM*

*DEPOSITION QUESTIONS*

**Thoughts of Death or Suicide**  
(continued)

**Q: Does the plaintiff have a history of any *medical or psychological conditions* that may cause recurrent thoughts of death or suicidal ideation?**

*The witness may indicate the possibility of the following medical or psychological conditions: please refer to the sections pertaining to these conditions for further questions.*

**TABLE 5.7-14.**

|                                 |                       |
|---------------------------------|-----------------------|
| Bipolar disorder                | Pancreatic carcinoma  |
| Borderline personality disorder | Panic disorders       |
| Cushing's disease               | Schizophrenia         |
| Histrionic personality disorder | Somatization disorder |
| Huntington's disease            |                       |

**Q: Did you rule out a *schizoaffective disorder* as a cause of the plaintiff's recurrent thoughts of death or suicidal ideation?**

Schizoaffective disorders are characterized by a mixture of schizophrenic and affective or major depressive and manic syndromes. These disorders may include **suicide ideation**. (reference 7, p. 319)

**Q: Did you rule out a recent *heart attack* as a cause of the plaintiff's recurrent thoughts of death or suicidal ideation?**

Despondency is almost a universal response to heart attack. Even without complications, the plaintiff may feel a sense of loss and vulnerable to further injury. Weakness and tiredness are the single most distressing symptoms of the depression. The plaintiff may also experience insomnia, daytime hypersomnia, and practical worries. Complications cause the plaintiff's **despondency and hopelessness** to be intensified. (reference 4, pp. 1156-1157)

*If the witness indicates the possibility of a recent heart attack, see the section on pre-existing medical conditions for further questions.*

**Q: Did you rule out a *borderline personality disorder* as a cause of the plaintiff's recurrent thoughts of death or suicidal ideation?**

A borderline personality disorder is characterized by unstable interpersonal relationships, behavior, mood, and self-image. The plaintiff may experience temporary mood shifts including depression, irritability, and anxiety. S/he may also have chronic feelings of emptiness or boredom, inappropriate anger, and **recurrent suicidal thoughts**. Social contrariness and a generally pessimistic outlook often accompany the disorder. **Premature death may result from suicide**. (reference 7, p. 706)

*If the witness indicates the possibility of a borderline personality disorder see the section on pre-existing personality disorders for further questions.*

## SYMPTOM

## DEPOSITION QUESTIONS

Thoughts of  
Death or  
Suicide*(continued)***Q: Did you rule out *anorexia nervosa* as a cause of the plaintiff's recurrent thoughts of death or suicidal ideation?**

The anorexic plaintiff weighs fifteen percent less than the minimal weight normal for his or her age and height. S/he refuses to maintain body weight and has a distorted body image. Other symptoms may include depressed feelings, crying spells, sleep disturbance, obsessive rumination, obsessive compulsive behavior, anxiety, and **occasional suicidal thoughts**. Many anorexic adolescents have delayed psychosexual development. Adults with the disorder often have a decreased interest in sex. (reference 7, p. 583; reference 1, pp. 1904-1905; reference 4, pp. 1145, 1731)

**Q: (Female) Did you rule out a *postpartum-onset episode* as a cause of the plaintiff's recurrent thoughts of death or suicide ideation?**

If a major depressive episode, manic or mixed episode occurs within four weeks following childbirth, it would be diagnosed as a mood disorder with postpartum onset. Symptoms that are common in postpartum-onset episodes include **fluctuations in mood**, and preoccupation with infant well-being, the intensity of which may range from over-concern to frank delusions. (reference 4, pp. 1238-1241; reference 1, p. 1720; reference 7, pp. 422-423)

*If the witness indicates the possibility of a postpartum disorder, see the section on medical conditions for further questions.*

**Q: Did you rule out *antisocial personality disorder* as a cause of the plaintiff's recurrent thoughts of death or suicidal ideation?**

The antisocial plaintiff may have a lifetime history of irresponsible and antisocial behavior. Childhood behaviors may include lying, stealing, truancy, vandalism, initiating fights, running away from home, and physical cruelty. Adolescents may also become abusers of tobacco, alcohol, and other drugs, or engage in early sexual activity. Adults with antisocial personalities tend to be irritable, aggressive, reckless, and promiscuous. They may be unable to keep a job, friendship, or sexual relationship. The plaintiff shows no remorse or guilt when hurting or mistreating others. Frequently this disorder is accompanied by signs of personal distress, tension, an inability to tolerate boredom, depression, a conviction that others are hostile, and **suicidal attempts**. (reference 7, p. 701; reference 4, pp. 1865, 1868-1869)

*If the witness indicates the possibility of an antisocial personality disorder, see the section on pre-existing personality disorders for further questions.*

**Q: Does the plaintiff have any *other medical conditions* that may cause recurrent thoughts of death or suicidal ideation, such as cancer?**

---

*SYMPTOM*

*DEPOSITION QUESTIONS*

---

**Thoughts of  
Death or  
Suicide**

*(continued)*

**Q:** Is the plaintiff taking any *medications or substances* that may cause recurrent thoughts of death or suicidal ideation, such as:

- |          |               |          |
|----------|---------------|----------|
| AMBIEN   | LAMICTAL      | SINEMET  |
| AVONEX   | LEVO-DROMORAM | TOPAMAX  |
| CELEXA   | LUVOX         | ULTRAM   |
| CELONTIN | MIRAPEX       | ZANAFLEX |
| COGNEX   | NEURONTIN     | ZARONTIN |
| EFFEXOR  | NIZORAL       | ZYBAN    |
| EXCELON  | RE VIA        |          |
| FLOXIN   | SEROQUEL      |          |

*Plaintiff's Diagnosis*

**Major Depressive Disorder**

---

*SYMPTOM*

*DEPOSITION QUESTIONS*

---

## **SECTION 5.8: CHALLENGING THE DIAGNOSIS OF ADJUSTMENT DISORDER CLAIMS**

### **INTRODUCTION**

The diagnosis of an adjustment disorder is frequently a positive factor in the defense of damages. This condition is an intense over-reaction and has a short-term prognosis. The symptoms are expected to remit within six months. Alternate stressors should also be considered for the basis of the adjustment disorder. However, even if the injury in question is the basis for the disorder, the diagnosis gives defense counsel the opportunity to argue that:

- 1) The plaintiff's reaction is in excess of what would be expected given the nature of the stressor;
- 2) The condition is not permanent or even long-lasting. It has gone into remission and is no longer disabling.

Adjustment disorders are individual instances of over-reaction. If the plaintiff has a history of over-reaction, the proper diagnosis may be an AXIS II personality disorder. Often in cases of litigation, the symptoms are kept alive by the very presence of the litigation. Following the resolution of litigation, symptoms often abate.

Defense counsel should obtain a list of the plaintiff's claimed adjustment disorder symptoms by using the deposition questions in Chapters 1 and 4. Section 5.8 provides questions to challenge the accuracy of that diagnosis.

---

***Challenging the Plaintiff's Diagnosis of an Adjustment Disorder***


---

**TABLE 5.8-1.*****Diagnostic criteria for Adjustment Disorders***

- A.** The development of emotional or behavioral symptoms in response to an identifiable stressor(s) occurring within 3 months of the onset of the stressor(s).
- B.** These symptoms or behaviors are clinically significant as evidenced by either of the following:
  - (1) marked distress that is in excess of what would be expected from exposure to the stressor
  - (2) significant impairment in social or occupational (academic) functioning
- C.** The stress-related disturbance does not meet the criteria for another specific Axis I disorder and is not merely an exacerbation of a preexisting Axis I or Axis II disorder.
- D.** The symptoms do not represent Bereavement.
- E.** Once the stressor (or its consequences) has terminated, the symptoms do not persist for more than an additional 6 months.

*Specify if:***Acute:** if the disturbance lasts less than 6 months**Chronic:** if the disturbance lasts for 6 months or longer

Adjustment Disorders are coded based on the subtype, which is selected according to the predominant symptoms. The specific stressor(s) can be specified on Axis IV.

**309.0 With Depressed Mood****309.24 With Anxiety****309.28 With Mixed Anxiety and Depressed Mood****309.3 With Disturbance of Conduct****309.4 With Mixed Disturbance of Emotions and Conduct****309.9 Unspecified**

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*SYMPTOM*

*DEPOSITION QUESTIONS*

**General Questions**

- Q: Did you or any other mental health professional in this case diagnose an adjustment disorder?**
- 
- Q: Did you observe and record the plaintiff's symptoms within 90 days of the injury in question? (criterion A)**
- 
- Q: Are the symptoms or behaviors clinically significant?**  
Symptoms must cause marked distress or significant impairment in social or occupational (or academic) functioning. (criterion B)
- 
- Q: Are the symptoms due to the loss of a loved one?**  
Symptoms cannot be due to the presence of bereavement. (criterion D)
- 
- Q: Did the plaintiff's symptoms remit within the required six months? (criterion E)**
- 
- Q: Was the diagnosis an *adjustment disorder with anxiety*?**  
This category should be used when the predominant manifestation is nervousness, worry, and jitteriness.
- 
- Q: Was the diagnosis an *adjustment disorder with depressed mood*?**  
This category should be used when the predominant manifestation is depressed mood, tearfulness, and feelings of hopelessness.
- 
- Q: Why do you believe that the plaintiff overreacted to a stressor?**
- 
- Q: Did you rule out a pre-existing Axis II personality disorder as the cause of the plaintiff's maladaptive reaction?**  
*If the witness indicates the possibility of a personality disorder, see the section on pre-existing personality disorders for further questions.*
- 
- Q: What do you believe is the precipitating stressor?**
- 
- Q: Did you rule out other *stressors* in the plaintiff's life as a cause of the plaintiff's emotional distress?**  
*If the witness indicates the possibility of other stressors, see the section on other life-stressors for further questions.*
- 
- Q: How did you separate the effects of these stressors from plaintiff's current claim?**
- 
- Q: Does the plaintiff have a history of maladaptive overreactions to other life stressors?**
- 
- Q: Has the plaintiff adapted to the stressor?**



---

# CHAPTER 6

## Examining The Plaintiff's Pre-existing Level of Functioning

---

### SECTION

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---

# CHAPTER 6

## EXAMINING THE PLAINTIFF'S PRE-EXISTING LEVEL OF FUNCTIONING

### INTRODUCTION

Discovery of the plaintiff's pre-morbid level of functioning is essential in the defense of injury claims. Without this information, all of the plaintiff's current symptomatology will be attributed to the cause of action. Each plaintiff's history can vary significantly regarding their mental health, their physical health, personality pathology and life stressors.

The plaintiff may have a pre-existing clinical mental disorder and the symptoms and behaviors associated with that disorder may be misdiagnosed as symptoms resulting directly from the injury claim. Discovery of prior mental health records or pharmacy records may show that the plaintiff's current symptoms are a continuation of a pre-existing clinical mental disorder.

There are eleven personality disorders, each with its own constellation of maladaptive behaviors. The plaintiff may have a life-long, pre-existing personality disorder or traits of a personality disorder that accounts for their current behavior and symptom presentation. Anxiety and depression for instance, may be an embedded characteristic of the plaintiff's personality and not a trauma-related condition. Plaintiffs' experts often fail to make the diagnosis of an Axis II personality disorder.

Many medical illnesses can produce neurologic, psychologic and behavioral symptoms, and in some cases these are the first symptoms to appear. A pre-existing medical illness may be the basis for plaintiff's current level of functioning and not the injury claim.

Divorce, a death in the family, physical abuse, substance abuse, academic and occupational problems are "stressors" which may have pre-existed the injury claim and can have a negative effect on the plaintiff's level of functioning. These stressors may be overlooked as the basis for plaintiff's symptoms.

Symptom presentation is often culture specific. An 'ataque de nervios' may not be linked to a particular DSM-IV diagnostic category, and will be misdiagnosed when the plaintiffs' experts are unfamiliar with this culture-bound syndrome.

Defense counsel should obtain a list of the plaintiff's claimed symptoms by referring to the deposition questions in Chapters 1 and 4. The following sections provide questions to challenge the accuracy of the plaintiff's current diagnosis.

## **SECTION 6.0: EXAMINING THE PLAINTIFF'S PRE-EXISTING LEVEL OF FUNCTIONING**

### **INTRODUCTION**

There are more than 200 clinical mental disorders. Many plaintiffs claiming emotional harm have a history of mental illness such as bipolar disorder, pain disorder or obsessive-compulsive disorder. The plaintiff's current symptoms may be caused by a pre-existing clinical mental disorder and not the result of the claimed psychological injury.

Discovery of any and all prior treatment records and the treating psychiatrist's or psychologist's clinical notes is essential. To avoid the egg-shell skull theory, defense counsel must show that the plaintiff's current symptoms and behaviors are merely a recurrence of a pre-existing mental disorder. Information regarding other life stressors and the plaintiff's medications prior to the injury in question are also important. Many medications have strong transient side-effects that may contribute to the plaintiff's symptoms, and will remit when the drugs are discontinued.

Defense counsel should obtain a list of the plaintiff's claimed psychiatric symptoms by using the deposition questions in Chapters 1 and 4. Section 6.1 provides questions to determine the plaintiff's pre-existing level of functioning. Questions are provided for each of the following pre-existing clinical mental disorders.

### **SECTION 6.1: PRE-EXISTING CLINICAL MENTAL DISORDERS**

- |                           |                                   |
|---------------------------|-----------------------------------|
| (1) Conversion Disorder   | (6) Schizophrenia                 |
| (2) Somatization Disorder | (7) Schizophrenia-Paranoid Type   |
| (3) Pain Disorder         | (8) Delusional Disorder           |
| (4) Hypochondriasis       | (9) Obsessive-Compulsive Disorder |
| (5) Bipolar Disorder      |                                   |

# The Plaintiff's Pre-Existing Clinical Mental Disorders

---

## DISORDER

## DEPOSITION QUESTIONS

---

### Conversion Disorder

*A Somatoform Disorder*

See Section 8.4 for additional information.

**Profile:** A conversion disorder is a disturbance of bodily functioning that does not conform to current concepts of the anatomy and physiology of the central and the peripheral nervous system. It typically occurs in a setting of stress and produces considerable dysfunction.

The plaintiff with conversion disorder typically expresses concepts *physically* rather than *verbally*. Shortness of breath may come from a memory or fantasy of smothering. Vomiting may represent disgust. A female plaintiff may experience a false pregnancy due to a desire or fear of pregnancy. The wide variety of conversion symptoms may include motor symptoms or deficits such as impaired coordination or balance, paralysis or localized weakness, aphonia (loss of voice), difficulty swallowing or a sensation of a lump in the throat, and urinary retention. Sensory symptoms or deficits include a loss of touch or pain sensation, double vision, blindness, deafness, and hallucinations. Symptoms may also include seizures or convulsions. Conversion symptoms may begin in adolescence or early adulthood, appearing briefly during a time of stress or persisting for months and years. A chronic conversion disorder may cause the plaintiff to become socially or occupationally impaired. (reference 2, pp. 625-646; reference 7, pp. 492-498)

**DISCOVER YOUR DEFENSE:** Discover all prior employment and military records to look for periods of psychosomatic impairment, as well as indications of a dependent or histrionic personality disorder. The presence of a dependent or histrionic personality disorder increases the plaintiff's vulnerability to conversion symptoms.

**TABLE 6.1-1.**

***Diagnostic criteria for 300.11 Conversion Disorder***

- A.** One or more symptoms or deficits affecting voluntary motor or sensory function that suggest a neurological or other general medical condition.
- B.** Psychological factors are judged to be associated with the symptom or deficit because the initiation or exacerbation of the symptom or deficit is preceded by conflicts or other stressors.
- C.** The symptom or deficit is not intentionally produced or feigned (as in Factitious Disorder or Malingering).
- D.** The symptom or deficit cannot, after appropriate investigation, be fully explained by a general medical condition, or by the direct effects of a substance, or as a culturally sanctioned behavior or experience.
- E.** The symptom or deficit causes clinically significant distress or impairment in social, occupational, or other important areas of functioning or warrants medical evaluation.

# The Plaintiff's Pre-Existing Clinical Mental Disorders

DISORDER

DEPOSITION QUESTIONS

## Conversion Disorder

(continued)

TABLE 6.1-1. (continued)

F. The symptom or deficit is not limited to pain or sexual dysfunction, does not occur exclusively during the course of Somatization Disorder, and is not better accounted for by another mental disorder.

Specify type of symptom or deficit:

- With Motor Symptom or Deficit
- With Sensory Symptom or Deficit
- With Seizures or Convulsions
- With Mixed Presentation

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**NOTE: If the plaintiff has been diagnosed with a conversion disorder, consider asking the expert witness the following questions:**

**Q: What are the indications that the plaintiff has a conversion disorder?**

**Q: Did historic events in the plaintiff's life contribute to the conversion disorder?**

Life events that may contribute to the development of conversion symptoms include physical conditions, exposure to other people with real physical or conversion symptoms, and extreme psychosocial stress (frequently not related to the injury in question).

**Q: What symptoms and behaviors prompted you to diagnose or suspect a conversion disorder?**

**Q: Did you inquire about (name symptom)?** (e.g., the plaintiff's loss of pain)

**Q: What were your sources of information about the (symptom)?**

**Q: Do you agree that the conversion disorder represents a deep psychological need to be disabled?**

**Q: Do you agree that the presence of a conversion disorder may rule out the existence of actual physical injury?**

# The Plaintiff's Pre-Existing Clinical Mental Disorders

DISORDER

DEPOSITION QUESTIONS

## Somatization Disorder

*A Somatoform Disorder*

**Profile:** The plaintiff with a somatization disorder has recurring, multiple, clinically significant somatic (bodily) complaints. A somatic complaint is considered to be clinically significant if it results in medical treatment (taking medication) or causes significant impairment in social, occupational, or other important areas of functioning. Visits to physicians do not reveal a medical cause for the physical symptoms, usually because they are the result of emotional conflicts. The plaintiff is often unable to precisely describe their symptoms, which may range from pain in various sites to dysfunction of a body system. There may also be gastrointestinal complaints and sexual or reproductive complaints. Finally, there is at least one symptom that suggests a neurological condition (impaired coordination or balance, seizures, etc.). Like conversion disorder, the symptoms in somatization disorder are not intentionally produced, but they are linked to psychological factors. Anxiety, depression, social withdrawal and difficulties with work and interpersonal relationships are common. Symptoms usually begin in adolescence, when unresolved emotional conflicts result in the first physical reaction. (reference 7, pp. 486-490; reference 4, pp. 389, 940)

**DISCOVER YOUR DEFENSE:** Discovery of the plaintiff's prior medical records may show many doctor visits and medical procedures, which may help confirm the diagnosis of a somatization disorder.

**TABLE 6.1-2.**

### *Diagnostic criteria for 300.81 Somatization Disorder*

- A.** A history of many physical complaints beginning before age 30 years that occur over a period of several years and result in treatment being sought or significant impairment in social, occupational, or other important areas of functioning.
- B.** Each of the following criteria must have been met, with individual symptoms occurring at any time during the course of the disturbance:
  - (1) *four pain symptoms:* a history of pain related to at least four different sites or functions (e.g., head, abdomen, back, joints, extremities, chest, rectum, during menstruation, during sexual intercourse, or during urination)
  - (2) *two gastrointestinal symptoms:* a history of at least two gastrointestinal symptoms other than pain (e.g., nausea, bloating, vomiting other than during pregnancy, diarrhea, or intolerance of several different foods)
  - (3) *one sexual symptom:* a history of at least one sexual or reproductive symptom other than pain (e.g., sexual indifference, erectile or ejaculatory dysfunction, irregular menses, excessive menstrual bleeding, vomiting throughout pregnancy)
  - (4) *one pseudoneurological symptom:* a history of at least one symptom or deficit suggesting a neurological condition not limited to pain (conversion) symptoms such as impaired coordination or balance,

# The Plaintiff's Pre-Existing Clinical Mental Disorders

DISORDER

DEPOSITION QUESTIONS

## Somatization Disorder

(continued)

TABLE 6.1-2. (continued)

paralysis or localized weakness, difficulty swallowing or lump in throat, aphonia, urinary retention, hallucinations, loss of touch or pain sensation, double vision, blindness, deafness, seizures; dissociative symptoms such as amnesia; or loss of consciousness other than fainting)

**C.** Either (1) or (2):

- (1) after appropriate investigation, each of the symptoms in Criterion B cannot be fully explained by a known general medical condition or the direct effects of a substance (e.g., a drug of abuse, a medication)
- (2) when there is a related general medical condition, the physical complaints or resulting social or occupational impairment are in excess of what would be expected from the history, physical examination, or laboratory findings

**D.** The symptoms are not intentionally produced or feigned (as in Factitious Disorder or Malingering).

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**NOTE: If the plaintiff has been diagnosed with somatization disorder, consider asking the expert witness the following questions:**

**Q: What are the indications that the plaintiff has a somatization disorder?**

**Q: Did historic events in the plaintiff's life contribute to the somatization disorder?**

Familial and environmental factors contribute to the increased incidence of the disorder.

**Q: At what age did it begin?**

Symptoms must begin before the age of 30. (criterion A)

**Q: What symptoms and behaviors prompted you to diagnose or suspect a somatization disorder?**

**Q: Did you inquire about (name symptom)?** (e.g., the plaintiff's vomiting)

**Q: What were your sources of information about the (symptom)?**

**Q: Are the plaintiff's current symptoms caused by or related to a pre-existing somatization disorder?**

**Q: Would you agree that a somatization disorder may be the basis for the plaintiff's symptoms and behaviors?**

# The Plaintiff's Pre-Existing Clinical Mental Disorders

---

## DISORDER

## DEPOSITION QUESTIONS

---

### **Pain Disorder**

*A Somatoform  
Disorder*

See Section 8.5 for additional information.

**Profile:** The plaintiff with a somatoform pain disorder (formerly known as psychogenic pain disorder) is preoccupied with severe and prolonged pain which has no physical origin. The pain is associated with psychological factors which often have a role in the onset, severity, exacerbation, or maintenance of the pain. The pain may also be linked to stressors, such as a significant change in relationships, a need to avoid an obligation, or a need for additional support from others. The plaintiff often visits multiple physicians, uses medicines excessively, or asks for surgery in seeking relief from the pain. Associated symptoms may include depression, anhedonia (loss of pleasure) and insomnia. Females appear to experience certain chronic pain conditions, particularly migraine, and tension-type headaches and musculoskeletal pain, more often than do males. The plaintiff may become socially or occupationally incapacitated and unresponsive or antagonistic toward traditional therapy treatment. (reference 7, pp. 498-503; reference 4, p. 937)

**DISCOVER YOUR DEFENSE:** Discover plaintiff's prior pharmacy records for pain medications, particularly for chronic headache and back pain.

**TABLE 6.1-3.**

***Diagnostic criteria for (Somatoform) Pain Disorder***

- A.** Pain in one or more anatomical sites is the predominant focus of the clinical presentation and is of sufficient severity to warrant clinical attention.
- B.** The pain causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.
- C.** Psychological factors are judged to have an important role in the onset, severity, exacerbation, or maintenance of the pain.
- D.** The symptom or deficit is not intentionally produced or feigned (as Factitious Disorder or Malingering).
- E.** The pain is not better accounted for by a Mood, Anxiety, or Psychotic Disorder and does not meet criteria for Dyspareunia.

*Code as follows:*

**307.80 Pain Disorder Associated With Psychological Factors:** psychological factors are judged to have the major role in the onset, severity, exacerbation, or maintenance of the pain. (If a general medical condition is present, it does not have a major role in the onset, severity, exacerbation, or maintenance of the pain.) This type of Pain Disorder is not diagnosed if criteria are also met for Somatization Disorder.

# The Plaintiff's Pre-Existing Clinical Mental Disorders

DISORDER

DEPOSITION QUESTIONS

## Pain Disorder

(continued)

TABLE 6.1-3. (continued)

Specify if:

**Acute:** duration of less than 6 months

**Chronic:** duration of 6 months or longer

**307.89 Pain Disorder Associated With Both Psychological Factors and a General Medical Condition:** both psychological factors and a general medical condition are judged to have important roles in the onset, severity, exacerbation, or maintenance of the pain. The associated general medical condition or anatomical site of the pain is coded on Axis III.

Specify if:

**Acute:** duration of less than 6 months

**Chronic:** duration of 6 months or longer

**Pain Disorder Associated With a General Medical Condition:** a general medical condition has a major role in the onset, severity, exacerbation, or maintenance of the pain. (If psychological factors are present, they are not judged to have a major role in the onset, severity, exacerbation, or maintenance of the pain.) The diagnostic code for the pain is selected based on the associated general medical condition if one has been established or on the anatomical location of the pain if the underlying general medical condition is not yet clearly established.

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**NOTE: If the plaintiff has been diagnosed with a somatoform pain disorder, consider asking the expert witness the following questions:**

**Q: What are the indications that the plaintiff has a somatoform pain disorder?**

**Q: Did historic events in the plaintiff's life contribute to the somatoform pain disorder?**

A somatoform pain disorder may be precipitated by physical trauma, working at an early age, holding physically strenuous or very routine jobs, or being a workaholic.

**Q: Does the plaintiff's reported pain conform with known neurological patterns (neurological distribution within the body)?**

**Q: What symptoms and behaviors prompted you to diagnose or suspect a somatoform pain disorder?**

## The Plaintiff's Pre-Existing Clinical Mental Disorders

---

*DISORDER*

*DEPOSITION QUESTIONS*

---

**Pain Disorder**  
*(continued)*

- Q:** Did you inquire about (name symptom)? (e.g., the plaintiff's preoccupation with pain)
- 
- Q:** What were your sources of information about the (symptom)?
- 
- Q:** Are the plaintiff's current symptoms and behaviors caused by or related to a somatoform pain disorder?
- 
- Q:** Would you agree that a somatoform pain disorder may be the basis for the plaintiff's symptoms and behaviors?

# The Plaintiff's Pre-Existing Clinical Mental Disorders

---

## DISORDER

## DEPOSITION QUESTIONS

---

### Hypochondriasis

*A Somatoform Disorder*

**Profile:** Fearing serious disease, the hypochondriacal plaintiff is preoccupied with bodily functions and minor physical abnormalities. Medical examinations do not support the plaintiff's fears or interpretation of physical symptoms. The plaintiff believes s/he is not getting proper care and develops a lifetime pattern of visits to multiple doctors and clinics. The hypochondriacal plaintiff is skillful at using medical terms to describe diseases in vivid detail. Other symptoms of the disorder may include anxiety, depression, and obsessive-compulsive behavior. The disorder can become so severe that the plaintiff becomes bedridden. The plaintiff often goes untreated because s/he refuses mental health care. (reference 7, pp. 504-507; reference 4, pp. 1204, 941)

Like conversion disorder and other somatoform disorders, hypochondriasis is characterized by *unconscious manipulation* of symptoms. Contrast this to the factitious disorder and malingering where symptom manipulation is intentional.

**DISCOVER YOUR DEFENSE:** Defense counsel should consider a credit check of the plaintiff for multiple unpaid health care services.

**TABLE 6.1-4.**

***Diagnostic criteria for 300.7 Hypochondriasis***

- A.** Preoccupation with fears of having, or the idea that one has, a serious disease based on the person's misinterpretation of bodily symptoms.
- B.** The preoccupation persists despite appropriate medical evaluation and reassurance.
- C.** The belief in Criterion A is not of delusional intensity (as in Delusional Disorder, Somatic Type) and is not restricted to a circumscribed concern about appearance (as in Body Dysmorphic Disorder).
- D.** The preoccupation causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.
- E.** The duration of the disturbance is at least 6 months.
- F.** The preoccupation is not better accounted for by Generalized Anxiety Disorder, Obsessive-Compulsive Disorder, Panic Disorder, a Major Depressive Episode, Separation Anxiety, or another Somatoform Disorder.

*Specify if:*

**With Poor Insight:** if, for most of the time during the current episode, the person does not recognize that the concern about having a serious illness is excessive or unreasonable

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## The Plaintiff's Pre-Existing Clinical Mental Disorders

---

*DISORDER*

*DEPOSITION QUESTIONS*

---

**Hypochondriasis** NOTE: If the plaintiff has been diagnosed with hypochondriasis, consider asking  
(continued) the expert witness the following questions:

**Q:** What symptoms and behaviors prompted you to diagnose or suspect hypochondriasis?

---

**Q:** Did you inquire about (name symptom)? (e.g., the plaintiff's preoccupation with the fear of disease)

---

**Q:** What were your sources of information about the (symptom)?

---

**Q:** Do you agree that hypochondriasis is a long-term, pre-existing condition that may rule out actual organic injury?

---

**Q:** Are the plaintiff's current symptoms and behaviors caused by or related to hypochondriasis?

# The Plaintiff's Pre-Existing Clinical Mental Disorders

---

## DISORDER

## DEPOSITION QUESTIONS

---

### **Bipolar Disorder**

*A Mood Disorder*

**Profile:** A bipolar disorder has a circular pattern of high and low emotional states (*mania and depression*). During the *manic episodes*, the plaintiff may feel grandiose, have a decreased need for sleep, and decreased emotional capacity, experience a surge of ideas and conversation, and may be easily distracted or pleased. It is often thought that the manic high represents an escape from inner depression and pain. While the plaintiff is extremely active, s/he is often fragmented and unable to finish projects. The plaintiff typically does not realize that s/he is ill.

During *major depressive episodes* the plaintiff may be depressed for at least two weeks. The plaintiff may experience an appetite disturbance, weight change, sleep disturbance, psychomotor agitation or retardation, decreased energy and emotional capacity, feelings of worthlessness, difficulty thinking or concentrating, and recurrent thoughts of death or suicide.

**DISCOVER YOUR DEFENSE:** Discovery of the plaintiff's family history is important. There is an increased risk of a bipolar disorder in the plaintiff whose first-degree biological relatives have a mood disorder.

**TABLE 6.1-5.**

***Diagnostic criteria for 296.7 Bipolar I Disorder, Most Recent Episode Unspecified***

- A.** Criteria, except for duration, are currently (or most recently) met for a Manic, a Hypomanic, a Mixed, or a Major Depressive Episode.
- B.** There has previously been at least one Manic Episode or Mixed Episode.
- C.** The mood symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.
- D.** The mood symptoms in Criteria A and B are not better accounted for by Schizoaffective Disorder and are not superimposed on Schizophrenia, Schizophreniform Disorder, Delusional Disorder, or Psychotic Disorder Not Otherwise Specified.
- E.** The mood symptoms in Criteria A and B are not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication, or other treatment) or a general medical condition (e.g., hyperthyroidism).

*Specify:*

**Longitudinal Course Specifiers** (With and Without Interepisode Recovery)

**With Seasonal Pattern** (applies only to the pattern of Major Depressive Episodes)

**With Rapid Cycling**

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# The Plaintiff's Pre-Existing Clinical Mental Disorders

DISORDER

DEPOSITION QUESTIONS

## Bipolar Disorder

(continued)

**NOTE: If the plaintiff has been diagnosed with a bipolar disorder, consider asking the expert witness the following questions:**

**Q: What symptoms and behaviors prompted you to diagnose or suspect bipolar disorder?**

---

**Q: Describe the plaintiff's manic episodes.**

---

**Q: Describe the plaintiff's depressive episodes.**

---

**Q: Is there a family history of bipolar disorder or other mood disorder?**

---

**Q: How old was the plaintiff when s/he began to exhibit symptoms of bipolar disorder?**

Average age of onset is 20 for both men and women. If the first manic episode or onset occurs after the age of 40, the clinician should consider that the symptoms are more likely due to a general medical condition (i.e. thyroid dysfunction). (reference 7, pp. 385-386)

---

**Q: Do you agree that bipolar disorder is a recurrent disorder?**

More than 90% of individuals who have a single manic episode will go on to have future episodes. (reference 7, p. 386)

---

**Q: Do the plaintiff's symptoms of bipolar disorder interfere with their social or occupational functioning?**

About 60% of bipolar individuals experience chronic interpersonal and occupational difficulties during and between acute episodes.

---

**Q: Would you agree that the plaintiff's current symptoms and behaviors are related to a pre-existing bipolar disorder?**

# The Plaintiff's Pre-Existing Clinical Mental Disorders

---

## DISORDER

## DEPOSITION QUESTIONS

---

### Schizophrenia

#### *A Thought Disorder*

**Profile:** Schizophrenia is classified as a thought disorder. The unmedicated person with schizophrenia may have difficulty at work, in social situations, and living alone. The most common characteristics of schizophrenia (and other psychotic disorders) are delusions and hallucinations. Typical mental disturbances include a change in content and form of thought, perceptions, sense of self, volition (determination to act), relationship to the external world, and psychomotor behavior. The plaintiff may experience depersonalization, derealization, and incoherent associations. Grossly inappropriate emotions or catatonic behaviors may occur. Associated symptoms may include confusion, disorientation, memory impairment, depression, anxiety, anger, and suicide attempts. The onset of Schizophrenia typically occurs between the late teens and the mid-30s. However, the modal age at onset for men is between 18 and 25 years, and for women between 25 years and their mid-30s. (reference 7, pp. 298-313; reference 4, pp. 631, 635, 669)

While the onset of schizophrenia may be abrupt or insidious, the majority of individuals display some type of prodromal phase with the gradual development of a variety of signs and symptoms. Some individuals display exacerbations and remissions, whereas others remain chronically ill. If the plaintiff is predisposed to schizophrenia, the disorder may be triggered by a stressful event such as the use of drugs (alcohol, ecstasy, amphetamines, and cannabis), extreme physical harm, and rape.

**DISCOVER YOUR DEFENSE:** Defense counsel should discover the plaintiff's school and work records to look for the early signs of this disorder. Schizophrenia is generally accepted in the psychological community as a genetically based condition. In fact, a first degree biological relative of an individual with schizophrenia, has a risk 10 times greater than the general population for the development of schizophrenia. The initial onset of this disorder most likely pre-existed the cause of action.

**TABLE 6.1- 6.**

#### *Diagnostic criteria for Schizophrenia*

**A. Characteristic symptoms:** Two (or more) of the following, each present for a significant portion of time during a one month period (or less if successfully treated):

- (1) delusions
- (2) hallucinations
- (3) disorganized speech (e.g., frequent derailment or incoherence)
- (4) grossly disorganized or catatonic behavior
- (5) negative symptoms, i.e., affective flattening, alogia, (poverty of speech) or avolition (unable to act or decide)

**Note:** Only one Criterion A symptom is required if delusions are bizarre or hallucinations consist of a voice keeping up a running commentary on the person's behavior or thoughts, or two or more voices conversing with each other.

# The Plaintiff's Pre-Existing Clinical Mental Disorders

DISORDER

DEPOSITION QUESTIONS

## Schizophrenia

(continued)

TABLE 6.1- 6. (continued)

- B. Social / occupational dysfunction:** For a significant portion of the time since the onset of the disturbance, one or more major areas of functioning such as work, interpersonal relations, or self-care are markedly below the level achieved prior to the onset (or when the onset is in childhood or adolescence, failure to achieve expected level of interpersonal, academic, or occupational achievement).
- C. Duration:** Continuous signs of the disturbance persist for at least 6 months. This 6-month period must include at least 1 month of symptoms (or less if successfully treated) that meet Criterion A (i.e., active-phase symptoms) and may include periods of prodromal or residual symptoms. During these prodromal or residual periods, the signs of the disturbance may be manifested by only negative symptoms or two or more symptoms listed in Criterion A present in an attenuated form (e.g., odd beliefs, unusual perceptual experiences).
- D. Schizoaffective and Mood Disorder exclusion:** Schizoaffective Disorder and Mood Disorder With Psychotic Features have been ruled out because either (1) no Major Depressive, Manic, or Mixed Episodes have occurred concurrently with the active-phase symptoms; or (2) if mood episodes have occurred during active-phase symptoms, their total duration has been brief relative to the duration of the active and residual periods.
- E. Substance / general medical condition exclusion:** 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.
- F. Relationship to a Pervasive Developmental Disorder:** If there is a history of Autistic Disorder or another Pervasive Developmental Disorder, the additional diagnosis of Schizophrenia is made only if prominent delusions or hallucinations are also present for at least a month (or less if successfully treated).

# The Plaintiff's Pre-Existing Clinical Mental Disorders

DISORDER

DEPOSITION QUESTIONS

## Schizophrenia

(continued)

TABLE 6.1- 6. (continued)

*Classification of longitudinal course (can be applied only after at least 1 year has elapsed since the initial onset of active-phase symptoms):*

**Episodic With Interepisode Residual Symptoms** (episodes are defined by the reemergence of prominent psychotic symptoms); also *specify if: With Prominent Negative Symptoms*

**Episodic With No Interepisode Residual Symptoms**

**Continuous** (prominent psychotic symptoms are present throughout the period of observation); also *specify if: With Prominent Negative Symptoms*

**Single Episode In Partial Remission; also specify if: With Prominent Negative Symptoms**

**Single Episode In Full Remission**

**Other or Unspecified Pattern**

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**NOTE: If the plaintiff has been diagnosed with schizophrenia, consider asking the expert witness the following questions:**

**Q: What are the clinical indications that the plaintiff has schizophrenia?**

**Q: Did historic events in the plaintiff's life contribute to the schizophrenia?**

Both genetics and environmental factors can play a role in the onset of this illness. Is the witness aware of plaintiff's family and social history?

**Q: What symptoms and behaviors prompted you to diagnose or suspect schizophrenia?**

There is no one symptom or behavior, but rather a constellation of "positive" and "negative" signs which help to confirm the diagnosis of schizophrenia. The "positive" symptoms appear to reflect an excess or distortion of normal functions, whereas the "negative" symptoms appear to reflect a diminution or loss of normal functions.

**Q: Did you inquire about (name symptom)? (e.g., the plaintiff's delusions)**

**Q: What were your sources of information about the (symptom)?**

**Q: Are the plaintiff's current symptoms and behaviors caused by or related to schizophrenia?**

# The Plaintiff's Pre-Existing Clinical Mental Disorders

---

## DISORDER

## DEPOSITION QUESTIONS

---

### Schizophrenia- Paranoid Type *A Thought Disorder*

A subtype of schizophrenia defined by the most prominent symptomatology.

**Profile:** The paranoid schizophrenic plaintiff is known for experiencing delusions, along with frequent auditory hallucinations related to a single theme. The plaintiff may be anxious, suspicious, tense, guarded, reserved, hostile, aggressive, or violent. High mental capabilities in areas not invaded by delusions allow the plaintiff to successfully cover up other symptoms of the disorder. Paranoid schizophrenic persons may function well socially and are able to live independently more often than other types of individuals with schizophrenia. There may be preservation of cognitive functioning and affect. Onset of the disorder usually occurs in later life. (reference 7, pp. 313-314; reference 4, pp. 694-697)

**DISCOVER YOUR DEFENSE:** Defense counsel should discover plaintiff's pre-morbid medical history and pharmacy records for prior use of anti-psychotic medications. (e.g., Haldol, Loxitane, Moban, Thorazine, Tindal, Proketazine, Prolixin, Permitil, Trilafon, Compazine, Stelazine, Serentil, Mellaril, Navane, etc.) This may indicate a pre-morbid history of a psychotic disorder.

**TABLE 6.1-7.**

***Diagnostic criteria for 295.30 Paranoid Type***

A type of Schizophrenia in which the following criteria are met:

- A.** Preoccupation with one or more delusions or frequent auditory hallucinations.
- B.** None of the following is prominent: disorganized speech, disorganized or catatonic behavior, or flat or inappropriate affect.

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**NOTE: If the plaintiff has been diagnosed with a paranoid type of schizophrenia, consider asking the expert witness the following questions:**

**Q: What are the clinical indications that the plaintiff has a Schizophrenia-Paranoid Type?**

---

**Q: Did historic events in the plaintiff's life contribute to the paranoid schizophrenia?**  
Schizophrenic disorders, while genetically based, may also be impacted by environmental factors. (reference 7, p. 309)

---

**Q: Did you inquire about (name symptom)?** (e.g., the plaintiff's preoccupation with delusions)

---

**Q: What were your sources of information about the (symptom)?**

---

**Q: Are the plaintiff's current symptoms and behaviors caused by or related to schizophrenia-paranoid type?**

# The Plaintiff's Pre-Existing Clinical Mental Disorders

---

## DISORDER

## DEPOSITION QUESTIONS

---

### Delusional Disorder

*A Thought Disorder*

**Profile:** The delusional plaintiff has persistent, non-bizarre delusions. The delusions have common themes and may be classified by the following types: *erotomantic type* (a delusion that one is loved by another, a stranger or famous person), *grandiose type* (a delusion of possessing a great talent or insight which goes unrecognized), *jealousy type* (a delusion the spouse or lover is unfaithful, without due cause), *persecutory type* (a delusion that s/he is being conspired against, cheated, lied to, poisoned), and *somatic type* (a delusion that involves bodily functions or sensations such as concern that they emit a foul odor; that there is an infestation of insects on or in the skin; or that they have an internal parasite).

This psychotic disorder may range in onset from adolescence to late in life. Work may not be impaired, but the person with these delusions often has social and marital problems. (reference 7, pp. 323-329)

**DISCOVER YOUR DEFENSE:** Discovery of plaintiff's marital and work histories may show delusional behaviors prior to the injury in question.

**TABLE 6.1-8.**

***Diagnostic criteria for 297.1 Delusional Disorder***

- A.** Nonbizarre delusions (i.e., involving situations that occur in real life, such as being followed, poisoned, infected, loved at a distance, or deceived by spouse or lover, or having a disease) of at least 1 month's duration.
- B.** Criterion A for Schizophrenia has never been met. **Note:** Tactile and olfactory hallucinations may be present in Delusional Disorder if they are related to the delusional theme.
- C.** Apart from the impact of the delusion(s) or its ramifications, functioning is not markedly impaired and behavior is not obviously odd or bizarre.
- D.** If mood episodes have occurred concurrently with delusions, their total duration has been brief relative to the duration of the delusional periods.
- E.** 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.

# The Plaintiff's Pre-Existing Clinical Mental Disorders

DISORDER

DEPOSITION QUESTIONS

## Delusional Disorder

(continued)

TABLE 6.1-8. (continued)

Specify type (the following types are assigned based on the predominant delusional theme):

**Erotomaniac Type:** delusions that another person, usually of higher status, is in love with the individual

**Grandiose Type:** delusions of inflated worth, power, knowledge, identity, or special relationship to a deity or famous person

**Jealous Type:** delusions that the individual's sexual partner is unfaithful

**Persecutory Type:** delusions that the person (or someone to whom the person is close) is being malevolently treated in some way

**Somatic Type:** delusions that the person has some physical defect or general medical condition

**Mixed Type:** delusions characteristic of more than one of the above types but no one theme predominates

**Unspecified Type**

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**NOTE: If the plaintiff has been diagnosed with delusional disorder, consider asking the expert witness the following questions:**

**Q: What are the indications that the plaintiff has a delusional disorder?**

**Q: Did historic events in the plaintiff's life contribute to the delusional disorder?**

Severely stressful, early life events may contribute to the development of the disorder.

**Q: What symptoms and behaviors prompted you to diagnose or suspect a delusional disorder?**

**Q: Did you inquire about (name symptom)?** (e.g., the plaintiff's delusions)

**Q: What were your sources of information about the (symptom)?**

**Q: Are the plaintiff's current symptoms and behaviors caused by or related to a delusional disorder?**

# The Plaintiff's Pre-Existing Clinical Mental Disorders

---

## DISORDER

## DEPOSITION QUESTIONS

---

### Obsessive-Compulsive Disorder

*An Anxiety Disorder*

**Profile:** The obsessive-compulsive plaintiff has persistent unwanted and uncontrolled thoughts or impulses that may represent violence, contamination, or doubt. These obsessions often cause the plaintiff to feel anxious. The plaintiff's repeated compulsive behaviors are attempts to control the impulses and the accompanying anxiety. The plaintiff recognizes that their obsessions and compulsions are absurd or irrational. S/he may continually try to resist the thoughts and behaviors. Symptoms may include an obsessive devotion to work and productivity, rigid perfectionism, and depression. Individuals with OCD tend to be secretive about their symptoms and avoid disclosing them. However, they are able to work and earn a living despite marked limitations in their social and emotional lives. The disorder usually begins in adolescence or young adulthood. (reference 4, pp. 904-917; reference 7, pp. 456-463; reference 2, p. 607)

**DISCOVER YOUR DEFENSE:** Discovery of plaintiff's prior pharmacy records may show medications to control the obsessive-compulsive behaviors. There may also be psychiatric records related to the treatment of this disorder.

**TABLE 6.1-9.**

***Diagnostic criteria for 300.3 Obsessive-Compulsive Disorder***

**A.** Either obsessions or compulsions:

*Obsessions as defined by (1), (2), (3), and (4):*

- (1) recurrent and persistent thoughts, impulses, or images that are experienced, at some time during the disturbance, as intrusive and inappropriate and that cause marked anxiety or distress
- (2) the thoughts, impulses, or images are not simply excessive worries about real-life problems
- (3) the person attempts to ignore or suppress such thoughts, impulses, or images, or to neutralize them with some other thought or action
- (4) the person recognizes that the obsessional thoughts, impulses, or images are a product of his or her own mind (not imposed from without as in thought insertion)

*Compulsions as defined by (1) and (2):*

- (1) repetitive behaviors (e.g., hand washing, ordering, checking) or mental acts (e.g., praying, counting, repeating words silently) that the person feels driven to perform in response to an obsession, or according to rules that must be applied rigidly
- (2) the behaviors or mental acts are aimed at preventing or reducing distress or preventing some dreaded event or situation; however, these behaviors or mental acts either are not connected in a realistic way with what they are designed to neutralize or prevent or are clearly excessive

# The Plaintiff's Pre-Existing Clinical Mental Disorders

DISORDER

DEPOSITION QUESTIONS

## Obsessive-Compulsive Disorder

(continued)

TABLE 6.1-9. (continued)

**B.** At some point during the course of the disorder, the person has recognized that the obsessions or compulsions are excessive or unreasonable.

**Note:** This does not apply to children.

**C.** The obsessions or compulsions cause marked distress, are time consuming (take more than 1 hour a day), or significantly interfere with the person's normal routine, occupational (or academic) functioning, or usual social activities or relationships.

**D.** If another Axis I disorder is present, the content of the obsessions or compulsions is not restricted to it (e.g., preoccupation with food in the presence of an Eating Disorder; hair pulling in the presence of Trichotillomania; concern with appearance in the presence of Body Dysmorphic Disorder; preoccupation with drugs in the presence of a Substance Use Disorder; preoccupation with having a serious illness in the presence of Hypochondriasis; preoccupation with sexual urges or fantasies in the presence of a Paraphilia; or guilty ruminations in the presence of Major Depressive Disorder).

**E.** 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.

*Specify if:*

**With Poor Insight:** if, for most of the time during the current episode, the person does not recognize that the obsessions and compulsions are excessive or unreasonable

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**NOTE: If the plaintiff has been diagnosed with an obsessive-compulsive disorder, consider asking the expert witness the following questions:**

**Q: What are the indications that the plaintiff has an obsessive-compulsive disorder?**

**Q: What symptoms and behaviors prompted you to diagnose or suspect an obsessive-compulsive disorder?**

**Q: Did you inquire about (name symptom)?** (e.g., the plaintiff's recurrent or persistent ideas, thoughts, impulses, or images)

**Q: What were your sources of information about the (symptom)?**

**Q: Are the plaintiff's current symptoms and behaviors caused by or related to an obsessive-compulsive disorder?**

## **SECTION 6.2: EXAMINING THE PLAINTIFF'S PRE-EXISTING (LIFE-LONG) PERSONALITY DISORDERS**

### **INTRODUCTION**

Personality is formed between childhood and young adulthood. As each person grows and develops, his or her life experiences, physical health, social environment, and genetic traits form the "persona" or personality. These personality traits then become the life-long manner in which the individual perceives and deals with his or her environment, other persons, and self-image. Only when personality traits are inflexible and maladaptive and cause significant functional impairment do they constitute a Personality Disorder. This maladaptive pattern is stable and of long duration, and its onset can be traced back at least to adolescence.

Eleven distinct Personality Disorders have been identified (see chart), and the prevalence rate (for each disorder) within the general population ranges from 1%-3% percent. Many plaintiffs may have a personality disorder (or traits of one or more personality disorders). Frequently, it is the characteristics of the personality disorder that drive the plaintiff's symptoms and behaviors, and may be the basis of the litigation. The plaintiff's psychological or psychiatric witness rarely admits the existence of these non-proximate conditions because such an admission would cloud the Axis I diagnosis (which is likely being attributed to the cause of action).

Defense counsel should obtain a list of the plaintiff's claimed symptoms by using the deposition questions in Chapters 1 and 4. Section 6.2 provides the diagnostic criteria for each personality disorder and questions to show that the plaintiff's symptoms and behaviors may be part of a pre-existing personality disorder complex. The DSM-IV-TR classifies Personality Disorders in the following manner:

# The Plaintiff's Pre-Existing Personality Disorders

---

## *Examining The Plaintiff's Pre-existing Personality Disorders*

---

### ***CLUSTER A: ODD OR ECCENTRIC BEHAVIOR***

Paranoid Personality Disorder  
Schizoid Personality Disorder  
Schizotypal Personality Disorder

### ***CLUSTER B: DRAMATIC, EMOTIONAL, OR ERRATIC BEHAVIOR***

Antisocial Personality Disorder  
Borderline Personality Disorder  
Histrionic Personality Disorder  
Narcissistic Personality Disorder

### ***CLUSTER C: ANXIOUS OR FEARFUL BEHAVIOR***

Avoidant Personality Disorder  
Dependent Personality Disorder  
Obsessive-Compulsive Personality Disorder  
  
Personality Disorder Not Otherwise Specified\*

\* This category is for disorders of personality functioning that do not meet criteria for any specific Personality Disorder.

**NOTE:** Individuals frequently present with co-occurring Personality Disorders from different clusters.

**NOTE:** The Passive Aggressive Personality Disorder (Negativistic Personality Disorder) formerly in Cluster C, has been moved to Appendix B of the DSM-IV-TR. The section is entitled "Criteria Sets and Axes Provided for Further Study". There is another personality disorder, Depressive Personality Disorder, which is also being considered for inclusion in the next edition of the DSM.

# The Plaintiff's Pre-Existing Personality Disorders

DISORDER

DEPOSITION QUESTIONS

## Paranoid Personality Disorder

### CLUSTER A: ODD OR ECCENTRIC BEHAVIOR

**Profile:** The paranoid plaintiff has a history of unwarranted suspicion and mistrust of others. S/he may be excessively sensitive, pathologically jealous, hypervigilant, tense, and argumentative. It is common for the paranoid plaintiff's mood to be humorless, unforgiving, cold, and unemotional. The paranoid plaintiff typically feels inadequate and expects to be exploited or harmed by others. S/he may act egocentric, moralistic and extrapunitive. Leaders of cults or fringe groups are often of the paranoid personality type. This disorder is more commonly diagnosed in males and the plaintiff with this disorder is often litigious. If the plaintiff has been involved in an auto accident, s/he may consider themselves the object of an injustice and search for evidence to support their delusions. (reference 7, pp. 690-694; reference 4, pp. 748-753)

TABLE 6.2-1.

#### *Diagnostic criteria for 301.0 Paranoid Personality Disorder*

- A.** A pervasive distrust and suspiciousness of others such that their motives are interpreted as malevolent, beginning by early adulthood and present in a variety of contexts, as indicated by four (or more) of the following:
- (1) suspects, without sufficient basis, that others are exploiting, harming, or deceiving him or her
  - (2) is preoccupied with unjustified doubts about the loyalty or trustworthiness of friends or associates
  - (3) is reluctant to confide in others because of unwarranted fear that the information will be used maliciously against him or her
  - (4) reads hidden demeaning or threatening meanings into benign remarks or events
  - (5) persistently bears grudges, i.e., is unforgiving of insults, injuries, or slights
  - (6) perceives attacks on his or her character or reputation that are not apparent to others and is quick to react angrily or to counterattack
  - (7) has recurrent suspicions, without justification, regarding fidelity of spouse or sexual partner
- B.** Does not occur exclusively during the course of Schizophrenia, a Mood Disorder With Psychotic Features, or another Psychotic Disorder and is not due to the direct physiological effects of a general medical condition.

**NOTE:** If criteria are met prior to the onset of Schizophrenia, add "Premorbid," e.g., "Paranoid Personality Disorder (Premorbid)."

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# The Plaintiff's Pre-Existing Personality Disorders

*DISORDER*

*DEPOSITION QUESTIONS*

## **Paranoid Personality Disorder**

*(continued)*

**NOTE:** If the plaintiff has been diagnosed with a paranoid personality disorder or traits of that disorder, consider asking the expert witness the following questions:

- Q:** What are the indications that the plaintiff has a paranoid personality disorder?  
\_\_\_\_\_
- Q:** What symptoms and behaviors prompted you to diagnose or suspect a paranoid personality disorder?  
\_\_\_\_\_
- Q:** Did you inquire about (name symptom)? (e.g., the plaintiff's expectations of harm by others)  
\_\_\_\_\_
- Q:** What were the sources of your information?  
\_\_\_\_\_
- Q:** Would you agree that the development of plaintiff's paranoid personality disorder or traits of that disorder pre-dated the cause of action?  
\_\_\_\_\_
- Q:** Would you agree that many of the plaintiff's symptoms and behaviors may be due to a paranoid personality disorder or traits of that disorder?

# The Plaintiff's Pre-Existing Personality Disorders

DISORDER

DEPOSITION QUESTIONS

## Schizoid Personality Disorder

**Profile:** The schizoid plaintiff is introverted, withdrawn, and prefers to be alone. S/he tends to be indifferent to social relationships and has few close friends outside the family (first-degree relatives). Appearing cold and aloof to others, the plaintiff's emotions and expressions are bland and unresponsive to praise, criticism or comment. The plaintiff is unable to express aggression or anger, lacks goals or direction, is indecisive, self-absorbed, and absentminded. Often beginning in childhood or early adolescence, the disorder is found slightly more often in males. (reference 7, pp. 694-697; reference 4, pp. 1741-1743)

**TABLE 6.2-2.**

### ***Diagnostic criteria for 301.20 Schizoid Personality Disorder***

**A.** A pervasive pattern of detachment from social relationships and a restricted range of expression of emotions in interpersonal settings, beginning by early adulthood and present in a variety of contexts, as indicated by four (or more) of the following:

- (1) neither desires nor enjoys close relationships, including being part of a family
- (2) almost always chooses solitary activities
- (3) has little, if any, interest in having sexual experiences with another person
- (4) takes pleasure in few, if any, activities
- (5) lacks close friends or confidants other than first-degree relatives
- (6) appears indifferent to the praise or criticism of others
- (7) shows emotional coldness, detachment, or flat affect

**B.** Does not occur exclusively during the course of Schizophrenia, a Mood Disorder With Psychotic Features, another Psychotic Disorder, or a Pervasive Developmental Disorder and is not due to the direct physiological effects of a general medical condition.

**Note:** If criteria are met prior to the onset of Schizophrenia, add "Premorbid," e.g., "Schizoid Personality Disorder (Premorbid)."

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**NOTE: If the plaintiff has been diagnosed with a schizoid personality disorder or traits of that disorder, consider asking the expert witness the following questions:**

**Q: What are the indications that the plaintiff has a schizoid personality disorder?**

## The Plaintiff's Pre-Existing Personality Disorders

---

*DISORDER*

*DEPOSITION QUESTIONS*

---

**Schizoid  
Personality  
Disorder**

*(continued)*

**Q:** What symptoms and behaviors prompted you to diagnose or suspect a schizoid personality disorder?

---

**Q:** Did you inquire about (name symptom)? (e.g., the plaintiff's decreased need for close relationships)

---

**Q:** What were the sources of your information? (e.g., psychological testing)

---

**Q:** Would you agree that the development of the plaintiff's schizoid personality disorder or traits of that disorder pre-dated the cause of action?

---

**Q:** Would you agree that many of the plaintiff's symptoms and behaviors may be due to the presence of a schizoid personality disorder or traits of that disorder?

# The Plaintiff's Pre-Existing Personality Disorders

DISORDER

DEPOSITION QUESTIONS

## Schizotypal Personality Disorder

**Profile:** The schizotypal plaintiff may have odd patterns of thinking, perceptions, communication, and behavior that suggest schizophrenia but are not severe enough to meet the criteria. Thought disturbances may include paranoid ideation, suspiciousness, ideas of reference, odd beliefs and speech. S/he may believe in clairvoyance, telepathy, or superstitions. The plaintiff may appear eccentric and unkempt; they may talk to themselves or respond to others inappropriately; and they may be unable to have relations outside the immediate family. Approximately three percent of the population may have this disorder. Work and social impairment are common. (reference 7, pp. 697-701)

**TABLE 6.2-3.**

### *Diagnostic criteria for 301.22 Schizotypal Personality Disorder*

- A.** A pervasive pattern of social and interpersonal deficits marked by acute discomfort with, and reduced capacity for, close relationships as well as by cognitive or perceptual distortions and eccentricities of behavior, beginning by early adulthood and present in a variety of contexts, as indicated by five (or more) of the following:
- (1) ideas of reference (excluding delusions of reference)
  - (2) odd beliefs or magical thinking that influences behavior and is inconsistent with subcultural norms (e.g., superstitiousness, belief in clairvoyance, telepathy, or "sixth sense"; in children and adolescents, bizarre fantasies or preoccupations)
  - (3) unusual perceptual experiences, including bodily illusions
  - (4) odd thinking and speech (e.g., vague, circumstantial, metaphorical, overelaborate, or stereotyped)
  - (5) suspiciousness or paranoid ideation
  - (6) inappropriate or constricted affect
  - (7) behavior or appearance that is odd, eccentric, or peculiar
  - (8) lack of close friends or confidants other than first-degree relatives
  - (9) excessive social anxiety that does not diminish with familiarity and tends to be associated with paranoid fears rather than negative judgments about self
- B.** Does not occur exclusively during the course of Schizophrenia, a Mood Disorder With Psychotic Features, another Psychotic Disorder, or a Pervasive Developmental Disorder.

**Note:** If criteria are met prior to the onset of Schizophrenia, add "Premorbid," e.g., "Schizotypal Personality Disorder (Premorbid)."

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# The Plaintiff's Pre-Existing Personality Disorders

*DISORDER*

*DEPOSITION QUESTIONS*

## **Schizotypal Personality Disorder**

*(continued)*

**NOTE: If the plaintiff has been diagnosed with a schizotypal personality disorder or traits of that disorder, consider asking the expert witness the following questions:**

- Q: What are the indications that the plaintiff has a schizotypal personality disorder?**
- 
- Q: Did historic events in the plaintiff's life contribute to the schizotypal personality disorder?**  
The disorder is more likely to appear in families of a schizophrenic.
- 
- Q: What symptoms and behaviors prompted you to diagnose or suspect a schizotypal personality disorder?**
- 
- Q: Did you inquire about (name symptom)?** (e.g., the plaintiff's ideas of reference)
- 
- Q: What were the sources of your information?**
- 
- Q: Would you agree that the onset of plaintiff's schizotypal personality disorder or traits of that disorder pre-dated the cause of action?**
- 
- Q: Would you agree that many of the plaintiff's current symptoms and behaviors may be due to a schizotypal personality disorder or traits of that disorder?**

# The Plaintiff's Pre-Existing Personality Disorders

DISORDER

DEPOSITION QUESTIONS

## CLUSTER B: DRAMATIC, EMOTIONAL, OR ERRATIC BEHAVIOR

### Antisocial Personality Disorder

**Profile:** The antisocial plaintiff may have a lifetime history of irresponsible and antisocial behavior. Childhood behaviors may include lying, stealing, truancy, vandalism, initiating fights, running away from home, and physical cruelty. Adolescents may also become abusers of tobacco, alcohol, and other drugs, or engage in early sexual activity. Adults with antisocial personalities fail to conform to social norms with respect to lawful behavior. They may be unable to keep a job, friendship, or sexual relationship. The antisocial plaintiff shows no remorse or guilt when hurting or mistreating others. Frequently this disorder is accompanied by signs of personal distress, tension, an inability to tolerate boredom, depression, a conviction that others are hostile, and suicidal attempts. Three percent of males and one percent of females in the general population, have an antisocial personality disorder. **Malingering should be strongly suspected when the plaintiff appears to have an antisocial personality disorder.** Also, there is a major degree of overlap between antisociality and substance-use disorders. (reference 7, pp. 701, 739; reference 4, pp. 1865, 1868-1869)

TABLE 6.2-4.

#### *Diagnostic criteria for 301.7 Antisocial Personality Disorder*

- A. There is a pervasive pattern of disregard for and violation of the rights of others occurring since age 15 years, as indicated by three (or more) of the following:
- (1) failure to conform to social norms with respect to lawful behaviors as indicated by repeatedly performing acts that are grounds for arrest
  - (2) deceitfulness, as indicated by repeated lying, use of aliases, or conning others for personal profit or pleasure
  - (3) impulsivity or failure to plan ahead
  - (4) irritability and aggressiveness, as indicated by repeated physical fights or assaults
  - (5) reckless disregard for safety of self or others
  - (6) consistent irresponsibility, as indicated by repeated failure to sustain consistent work behavior or honor financial obligations
  - (7) lack of remorse, as indicated by being indifferent to or rationalizing having hurt, mistreated, or stolen from another

# The Plaintiff's Pre-Existing Personality Disorders

DISORDER

DEPOSITION QUESTIONS

## Antisocial Personality Disorder

(continued)

TABLE 6.2-4. (continued)

- |   |
|---|
| <p><b>B.</b> The individual is at least age 18 years.</p> <p><b>C.</b> There is evidence of Conduct Disorder with onset before age 15 years.</p> <p><b>D.</b> The occurrence of antisocial behavior is not exclusively during the course of Schizophrenia or a Manic Episode.</p> |
|---|

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**NOTE:** If the plaintiff has been diagnosed with an antisocial personality disorder or traits of that disorder, consider asking the expert witness the following questions:

**Q:** What are the indications that the plaintiff has an antisocial personality disorder?

---

**Q:** Did historic events in the plaintiff's life contribute to an antisocial personality disorder?

Some childhood events may influence the development of antisocial behavior; child abuse, removal from home, growing up without both parents, and inconsistent parental discipline. Familial patterns of antisocial behavior, social class, and pre-puberty disorders (attention-deficit hyperactivity disorder or conduct disorder) may also be factors in the development of antisocial personalities.

---

**Q:** What symptoms and behaviors prompted you to diagnose or suspect antisocial personality behavior?

---

**Q:** Did you inquire about (name symptom)? (e.g., the plaintiff's attendance in school?)

---

**Q:** What were the sources of your information?

---

**Q:** Would you agree that the onset of plaintiff's antisocial personality disorder or traits of that disorder pre-dated the cause of action?

---

**Q:** Would you agree that many of the plaintiff's current symptoms and behaviors may be due to the presence of an antisocial personality disorder or traits of that disorder?

# The Plaintiff's Pre-Existing Personality Disorders

## DISORDER

## DEPOSITION QUESTIONS

### Borderline Personality Disorder

**Profile:** A borderline personality disorder is characterized by unstable interpersonal relationships, behavior, mood, and self-image. The borderline plaintiff may experience temporary mood shifts including depression, irritability, and anxiety. The borderline plaintiff typically engages in behavior that is potentially self-damaging such as binge eating, casual sex, substance abuse, reckless driving, and overspending. They may also have chronic feelings of emptiness or boredom, inappropriate anger, and recurrent suicidal thoughts and gestures. Social contrariness and a generally pessimistic outlook often accompany the disorder. The borderline plaintiff often has a sense of entitlement or exception when it comes to observing rules and there may be a history of lawsuits. The borderline plaintiff may exhibit an intense *generalized anxiety* or an overwhelming *panic disorder* during more intense periods of anxiety. Other Axis I co-morbid disorders observed in the borderline personality are *mood disorders*, *substance-related disorders*, *posttraumatic stress disorder*, and *attention deficit / hyperactivity disorder*. Premature death may result from suicide. (reference 7, pp. 706-710)

TABLE 6.2-5.

#### **Diagnostic criteria for 301.83    *Borderline Personality Disorder***

A pervasive pattern of instability of interpersonal relationships, self-image, and affects, and marked impulsivity beginning by early adulthood and present in a variety of contexts, as indicated by five (or more) of the following:

- (1) frantic efforts to avoid real or imagined abandonment. **Note:** Do not include suicidal or self-mutilating behavior.
- (2) a pattern of unstable and intense interpersonal relationships characterized by alternating between extremes of idealization and devaluation
- (3) identity disturbance: markedly and persistently unstable self-image or sense of self
- (4) impulsivity in at least two areas that are potentially self-damaging (e.g., spending, sex, substance abuse, reckless driving, binge eating). **Note:** Do not include suicidal or self-mutilating behavior.
- (5) recurrent suicidal behavior, gestures, or threats, or self-mutilating behavior
- (6) affective instability due to a marked reactivity of mood (e.g., intense episodic dysphoria, irritability, or anxiety usually lasting a few hours and only rarely more than a few days)
- (7) chronic feelings of emptiness
- (8) inappropriate, intense anger or difficulty controlling anger (e.g., frequent displays of temper, constant anger, recurrent physical fights)
- (9) transient, stress-related paranoid ideation or severe dissociative symptoms

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# The Plaintiff's Pre-Existing Personality Disorders

---

*DISORDER*

*DEPOSITION QUESTIONS*

---

**Borderline  
Personality  
Disorder**

*(continued)*

**NOTE: If the plaintiff has been diagnosed with a borderline personality disorder or traits of that disorder, consider asking the expert witness the following questions:**

**Q: What are the indications that the plaintiff has a borderline personality disorder?**

---

**Q: What symptoms and behaviors prompted you to diagnose or suspect a borderline personality disorder?**

---

**Q: Did you inquire about (name symptom)? (e.g., interpersonal relationships)**

---

**Q: What were the sources of your information?**

---

**Q: Would you agree that the onset of the borderline personality disorder or traits of that disorder, pre-dated the cause of action?**

---

**Q: Would you agree that the plaintiff's current symptoms and behaviors may be due to the presence of a borderline personality disorder or traits of that disorder?**

# The Plaintiff's Pre-Existing Personality Disorders

---

## DISORDER

## DEPOSITION QUESTIONS

---

### Histrionic Personality Disorder

**Profile:** The essential feature of a histrionic personality disorder is pervasive and excessive emotionality and attention-seeking behavior. The pattern begins by early adulthood and is present in a variety of contexts. S/he is often uncomfortable when not the center of attention and will seek needed reassurance, approval, and praise from others. While an over-concern with physical attractiveness and inappropriate sexually seductive appearance and behavior are common, the plaintiff with this disorder may have difficulty with close relationships or may be sexually naive and unresponsive. They have a high degree of suggestibility and their opinions and feelings are easily influenced by others. They may be overly trusting, especially of strong authority figures whom they see as magically solving their problems. Histrionic personalities openly and dramatically *exhibit conversion symptoms*, as well as *hypochondriacal and somatization symptoms* as instruments for attracting attention and nurture. *Factitiously created symptoms and psychogenic pains* are another form of stimulation for the histrionic. (reference 7, pp. 711-714; reference 4, p. 586)

**TABLE 6.2-6.**

***Diagnostic criteria for 301.50 Histrionic Personality Disorder***

A pervasive pattern of excessive emotionality and attention seeking, beginning by early adulthood and present in a variety of contexts, as indicated by five (or more) of the following:

- (1) is uncomfortable in situations in which he or she is not the center of attention
- (2) interaction with others is often characterized by inappropriate sexually seductive or provocative behavior
- (3) displays rapidly shifting and shallow expression of emotions
- (4) consistently uses physical appearance to draw attention to self
- (5) has a style of speech that is excessively impressionistic and lacking in detail
- (6) shows self-dramatization, theatricality, and exaggerated expression of emotion
- (7) is suggestible, i.e., easily influenced by others or circumstances
- (8) considers relationships to be more intimate than they actually are

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**NOTE: If the plaintiff has been diagnosed with a histrionic personality disorder or traits of that disorder, consider asking the following questions:**

**Q: What are the indications that the plaintiff has a histrionic personality disorder?**

---

## The Plaintiff's Pre-Existing Personality Disorders

---

*DISORDER*

*DEPOSITION QUESTIONS*

---

**Histrionic  
Personality  
Disorder**

*(continued)*

- Q:** What symptoms and behaviors prompted you to diagnose or suspect a histrionic personality disorder?
- 
- Q:** Did you inquire about (name symptom)? (e.g., the plaintiff's demands for reassurance, approval, or praise)
- 
- Q:** What were the sources of your information?
- 
- Q:** Could the plaintiff's chronic medical complaints and visits to physicians be attention-seeking behavior?
- 
- Q:** Would you agree that the onset of a histrionic personality disorder or traits of that disorder pre-dated the cause of action?
- 
- Q:** Would you agree that the plaintiff's current symptoms and behaviors may be due to the presence of a histrionic personality disorder or traits of that disorder?

# The Plaintiff's Pre-Existing Personality Disorders

---

## DISORDER

## DEPOSITION QUESTIONS

---

### Narcissistic Personality Disorder

**Profile:** A narcissistic plaintiff, constantly seeking attention and admiration, has a grandiose sense of self-importance. S/he exaggerates accomplishments, talents, and achievements. The narcissistic plaintiff is preoccupied with self, feels special, unique, entitled, expects preferential treatment, and lacks empathy or feelings for others. The disorder is relatively common and often is accompanied by a depressed mood, interpersonal difficulties, and unrealistic goals. Work achievements may be enhanced because of the plaintiff's continuing need for success. Fifty to seventy-five percent of those diagnosed with a narcissistic personality disorder are male. *Dysthymic disorder* is the most common Axis I disorder seen among narcissists. They may exhibit *hypochondriacal symptoms* following embarrassment or defeat. (reference 7, pp. 714-717; reference 4, p. 966)

**TABLE 6.2-7.**

***Diagnostic criteria for 301.81 Narcissistic Personality Disorder***

A pervasive pattern of grandiosity (in fantasy or behavior), need for admiration, and lack of empathy, beginning by early adulthood and present in a variety of contexts, as indicated by five (or more) of the following:

- (1) has a grandiose sense of self-importance (e.g., exaggerates achievements and talents, expects to be recognized as superior without commensurate achievements)
- (2) is preoccupied with fantasies of unlimited success, power, brilliance, beauty, or ideal love
- (3) believes that he or she is "special" and unique and can only be understood by, or should associate with, other special or high-status people (or institutions)
- (4) requires excessive admiration
- (5) has a sense of entitlement, i.e., unreasonable expectations of especially favorable treatment or automatic compliance with his or her expectations
- (6) is interpersonally exploitative, i.e., takes advantage of others to achieve his or her own ends
- (7) lacks empathy: is unwilling to recognize or identify with the feelings and needs of others
- (8) is often envious of others or believes that others are envious of him or her
- (9) shows arrogant, haughty behaviors or attitudes

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# The Plaintiff's Pre-Existing Personality Disorders

---

## DISORDER

## DEPOSITION QUESTIONS

---

### **Narcissistic Personality Disorder**

*(continued)*

**NOTE: If the plaintiff is diagnosed with a narcissistic personality disorder or traits of that disorder, consider asking the expert witness the following questions:**

- Q: What are the indications that the plaintiff has a narcissistic personality disorder?**  
\_\_\_\_\_
- Q: What symptoms and behaviors prompted you to diagnose or suspect a narcissistic personality disorder?**  
\_\_\_\_\_
- Q: Are the plaintiff's symptoms and behaviors caused by a narcissistic personality disorder?**  
A "narcissistic injury" can be caused by any challenge to the narcissistic plaintiff's exaggerated sense of entitlement and "special" status.  
\_\_\_\_\_
- Q: Did you inquire about (name symptom)?** (e.g., the plaintiff's reaction to criticism)  
\_\_\_\_\_
- Q: What were the sources of your information?**  
\_\_\_\_\_
- Q: Would you agree that the onset of the plaintiff's narcissistic personality disorder or traits of that disorder pre-dated the cause of action?**  
\_\_\_\_\_
- Q: Would you agree that the plaintiff's current symptoms and behaviors may be due to a narcissistic personality disorder or traits of that disorder?**

# The Plaintiff's Pre-Existing Personality Disorders

DISORDER

DEPOSITION QUESTIONS

## CLUSTER C: ANXIOUS OR FEARFUL BEHAVIOR

### Avoidant Personality Disorder

**Profile:** The avoidant plaintiff is socially uncomfortable and timid, fears embarrassment and criticism, and is easily hurt by others. S/he greatly desires companionship and guarantees of uncritical acceptance. The avoidant plaintiff usually exaggerates potential difficulties or dangers, and avoids doing anything outside usual activities. Having few close friends, s/he is unwilling to get involved with others without certainty of being liked. Work performance may be impaired when interpersonal involvement is necessary. Associated symptoms may include *depression, anxiety*, anger, and phobias, especially *social phobia*. Avoidant disorder often starts in infancy or childhood with shyness, isolation, and fear of strangers. Avoidant personality disorder often *co-occurs with panic disorder with agoraphobia*. (reference 7, pp. 718-721; reference 4, pp. 981-982, 1752)

**TABLE 6.2-8.**

#### ***Diagnostic criteria for 301.82 Avoidant Personality Disorder***

A pervasive pattern of social inhibition, feelings of inadequacy, and hypersensitivity to negative evaluation, beginning by early adulthood and present in a variety of contexts, as indicated by four (or more) of the following:

- (1) avoids occupational activities that involve significant interpersonal contact, because of fears of criticism, disapproval, or rejection
- (2) is unwilling to get involved with people unless certain of being liked
- (3) shows restraint within intimate relationships because of the fear of being shamed or ridiculed
- (4) is preoccupied with being criticized or rejected in social situations
- (5) is inhibited in new interpersonal situations because of feelings of inadequacy
- (6) views self as socially inept, personally unappealing, or inferior to others
- (7) is unusually reluctant to take personal risks or to engage in any new activities because they may prove embarrassing

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**NOTE: If the plaintiff has been diagnosed with avoidant personality disorder or traits of that disorder, consider asking the expert witness the following questions:**

**Q: What are the indications that the plaintiff has an avoidant personality disorder?**

# The Plaintiff's Pre-Existing Personality Disorders

---

*DISORDER*

*DEPOSITION QUESTIONS*

---

**Avoidant  
Personality  
Disorder**

*(continued)*

**Q: Did historic events in the plaintiff's life contribute to an avoidant personality disorder?**

Life events that may contribute to the development of this disorder include a disfiguring illness or an avoidant disorder of childhood or adolescence.

---

**Q: What symptoms and behaviors prompted you to diagnose or suspect an avoidant personality disorder?**

---

**Q: Did you inquire about (name symptom)?** (e.g., the plaintiff's reaction to criticism or disapproval)

---

**Q: What were the sources of your information?**

---

**Q: Would you agree that the onset of plaintiff's avoidant personality disorder or traits of that disorder pre-dated the cause of action?**

---

**Q: Would you agree that the plaintiff's current symptoms and behaviors may be due to an avoidant personality disorder or traits of that disorder?**

# The Plaintiff's Pre-Existing Personality Disorders

DISORDER

DEPOSITION QUESTIONS

## Dependent Personality Disorder

**Profile:** The dependent plaintiff is characterized by having a continuous pattern of dependent, submissive behavior and fears of separation. Personality characteristics include the lack of self-confidence, an inability to make decisions or do projects alone, feeling uncomfortable or helpless when alone, feeling devastated when a close relationship ends, fearing abandonment and being easily hurt by criticism and disapproval. The dependent plaintiff may do demeaning or unpleasant tasks just to be liked. The disorder is common in both males and females, however in clinical settings, this disorder has been diagnosed more frequently in females. Dependent personalities are extremely vulnerable to *anxiety disorders*, and new responsibilities may give rise to *panic anxiety attacks*. Somatoform disorders, such as *conversion symptoms*, particularly numbness in hands or feet, are a way of displaying their helplessness. They are also disposed to *factitious disorders* (assuming the role of the patient). (reference 7, pp. 721-725; reference 4, p. 967)

**TABLE 6.2-9.**

### ***Diagnostic criteria for 301.6 Dependent Personality Disorder***

A pervasive and excessive need to be taken care of that leads to submissive and clinging behavior and fears of separation, beginning by early adulthood and present in a variety of contexts, as indicated by five (or more) of the following:

- (1) has difficulty making everyday decisions without an excessive amount of advice and reassurance from others
- (2) needs others to assume responsibility for most major areas of his or her life
- (3) has difficulty expressing disagreement with others because of fear of loss of support or approval. **Note:** Do not include realistic fears of retribution.
- (4) has difficulty initiating projects or doing things on his or her own (because of a lack of self-confidence in judgment or abilities rather than a lack of motivation or energy)
- (5) goes to excessive lengths to obtain nurturance and support from others, to the point of volunteering to do things that are unpleasant
- (6) feels uncomfortable or helpless when alone because of exaggerated fears of being unable to care for himself or herself
- (7) urgently seeks another relationship as a source of care and support when a close relationship ends
- (8) is unrealistically preoccupied with fears of being left to take care of himself or herself

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# The Plaintiff's Pre-Existing Personality Disorders

*DISORDER*

*DEPOSITION QUESTIONS*

## **Dependent Personality Disorder**

*(continued)*

**NOTE: If the plaintiff has been diagnosed with a dependent personality disorder or traits of that disorder, consider asking the expert witness the following questions:**

- Q: What are the indications that the plaintiff has a dependent personality disorder?**
- 
- Q: Did historic events in the plaintiff's life contribute to the dependent personality disorder?**  
Life events that may contribute to the development of this disorder include a chronic illness or a separation anxiety disorder.
- 
- Q: What symptoms and behaviors prompted you to diagnose or suspect a dependent personality disorder?**
- 
- Q: Did you inquire about (name symptom)?** (e.g., the plaintiff's inability to make everyday decisions without advice or reassurance from others)
- 
- Q: What were the sources of your information?**
- 
- Q: Would you agree that the onset of plaintiff's dependent personality disorder or traits of that disorder pre-dated the cause of action?**
- 
- Q: Would you agree that the plaintiff's current symptoms and behaviors are due to a dependent personality disorder or traits of that disorder?**

# The Plaintiff's Pre-Existing Personality Disorders

DISORDER

DEPOSITION QUESTIONS

## Obsessive-Compulsive Personality Disorder

**Profile:** The essential feature of obsessive-compulsive personality disorder is a preoccupation with orderliness, perfectionism, and mental and interpersonal control, at the expense of flexibility, openness, and efficiency. The obsessive-compulsive plaintiff's high standards may cause an inability to complete tasks or to gain satisfaction from accomplishments. An excessive devotion to work and productivity is often combined with inefficiency due to an over-concern with details, lists, and organization.

Compulsive personalities tend to be indecisive, moralistic, judgmental, and unable to express feelings or give compliments. Associated symptoms may include *depression*, a need for control, and extreme sensitivity to criticism. When the disorder is mild, the compulsive plaintiff may be capable of high levels of achievement. Compulsives are among the most frequent candidates for *generalized anxiety disorders*. They also employ *conversion disorders and hypochondriacal symptoms* to camouflage their perceived short-comings. (reference 7, pp. 725-729; reference 1, p. 1410)

In an *obsessive-compulsive disorder* (an AXIS I Clinical Mental Disorder) there are, by definition, true obsessions and compulsions which are not present in an *obsessive-compulsive personality disorder* (an AXIS II Personality Disorder). If the expert witness indicates the possibility of an *obsessive-compulsive disorder*, see the section on this condition for further questions.

**TABLE 6.2-10.**

### **Diagnostic criteria for 301.4 Obsessive-Compulsive Personality Disorder**

A pervasive pattern of preoccupation with orderliness, perfectionism, and mental and interpersonal control, at the expense of flexibility, openness, and efficiency, beginning by early adulthood and present in a variety of contexts, as indicated by four (or more) of the following:

- (1) is preoccupied with details, rules, lists, order, organization, or schedules to the extent that the major point of the activity is lost
- (2) shows perfectionism that interferes with task completion (e.g., is unable to complete a project because his or her own overly strict standards are not met)
- (3) is excessively devoted to work and productivity to the exclusion of leisure activities and friendships (not accounted for by obvious economic necessity)
- (4) is overconscientious, scrupulous, and inflexible about matters of morality, ethics, or values (not accounted for by cultural or religious identification)
- (5) is unable to discard worn-out or worthless objects even when they have no sentimental value
- (6) is reluctant to delegate tasks or to work with others unless they submit to exactly his or her way of doing things

# The Plaintiff's Pre-Existing Personality Disorders

DISORDER

DEPOSITION QUESTIONS

## Obsessive-Compulsive Personality Disorder (continued)

TABLE 6.2-10. (continued)

- |   |
|---|
| <p>(7) adopts a miserly spending style toward both self and others; money is viewed as something to be hoarded for future catastrophes</p> <p>(8) shows rigidity and stubbornness</p> |
|---|

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**NOTE: If the plaintiff has been diagnosed with an obsessive-compulsive personality disorder or traits of that disorder, consider asking the expert witness the following questions:**

**Q: What are the indications that the plaintiff has an obsessive-compulsive personality disorder?**

---

**Q: Did historic events in the plaintiff's life contribute to an obsessive-compulsive personality disorder?**

The disorder tends to occur more frequently among families with a history of the disorder.

---

**Q: What symptoms and behaviors prompted you to diagnose or suspect an obsessive-compulsive personality disorder?**

---

**Q: Did you inquire about (name symptom)?** (e.g., the plaintiff's perfectionism)

---

**Q: What were the sources of your information?**

---

**Q: Would you agree that the onset of plaintiff's obsessive-compulsive personality disorder or traits of that disorder pre-dated the cause of action?**

---

**Q: Would you agree that the plaintiff's current symptoms and behaviors may be due to an obsessive-compulsive personality disorder or traits of that disorder?**

## **SECTION 6.3: EXAMINING THE PLAINTIFF'S PRE-EXISTING MEDICAL CONDITIONS**

### **INTRODUCTION**

Many communicable diseases, endocrine disorders, and other medical conditions *have accompanying psychological symptoms*. While some symptom causes are unknown, others are the result of changes within the brain metabolism brought on by disease. Therefore, discovery of the plaintiff's entire medical history is essential. Evidence of any prior illness must be examined thoroughly in order to find a relationship with the current claimed symptoms.

Defense counsel should obtain a list of all pre-existing medical conditions by using the deposition questions in Chapters 1 and 4 and by discovery of historical records. Section 6.3 provides questions to investigate the relationship between the pre-existing medical conditions and the post-accident diagnoses.

**NOTE:** Many plaintiffs have medical illnesses or conditions that have not been detected or diagnosed. It is possible that the claimed mental symptoms are actually caused by an undiscovered medical condition.

#### **A. PRE-EXISTING MEDICAL CONDITIONS**

- |   |                                   |
|---|-----------------------------------|
| (1) Addison's Disease                     | (18) Meningitis                   |
| (2) Anemia                                | (19) Menopausal Distress          |
| (3) Arteriovenous Malformation            | (20) Mitral Valve Prolapse        |
| (4) Brain Tumors                          | (21) Multiple Sclerosis           |
| (5) Chronic Obstructive Pulmonary Disease | (22) Myocardial Infarction        |
| (6) Combined Systems Disease              | (23) Pancreatic Carcinoma         |
| (7) Coronary Artery Disease               | (24) Parkinson's Disease          |
| (8) Cushing's Syndrome                    | (25) Pernicious Anemia            |
| (9) Epilepsy                              | (26) Pheochromocytoma             |
| (10) Hepatic Encephalopathy               | (27) Polycythemia                 |
| (11) Hepatitis B                          | (28) Porphyria                    |
| (12) Hypertension                         | (29) Postpartum Disorder          |
| (13) Hyperthyroidism                      | (30) Rheumatoid Arthritis         |
| (14) Hypoglycemia                         | (31) Syphilis                     |
| (15) Hypotension                          | (32) Systemic Lupus Erythematosus |
| (16) Hypothyroidism                       | (33) Uremic Encephalopathy        |
| (17) Infectious Mononucleosis             | (34) Wilson's Disease             |

#### **B. UNDIAGNOSED, EARLY STAGES OF SEVERE DISEASE**

- |                                |  |
|--------------------------------|--|
| (35) Alzheimer's Disease       | (37) Huntington's Disease                |
| (36) Creutzfeldt-Jakob Disease | (38) Subacute Sclerosing Panencephalitis |

# The Plaintiff's Pre-Existing Medical Conditions

DISORDER

DEPOSITION QUESTIONS

## A. PRE-EXISTING MEDICAL CONDITIONS

### Addison's Disease

**Profile:** Addison's disease (adrenal cortical insufficiency) develops slowly as the adrenal cortex (part of the adrenal gland) decreases functioning. The plaintiff experiences significant personality and behavioral changes from the reduced level of the steroidal hormones normally produced by the gland. Advanced stages of Addison's disease produce symptoms of depression, a lack of physical and emotional responsiveness, mild mental disorders, and recent memory loss. An Addisonian crisis results from an acute reduction in steroidal hormone levels. Early signs of a crisis may include weakness, nausea, vomiting, abdominal pain and apathy. Later symptoms may consist of hallucinations, delusions, psychosis, stupor and coma. Hypotension (low blood pressure) may bring on shock and death. Tuberculosis was believed to be the main cause of the disease. However, a spontaneous reduction in the size of the adrenal cortex appears to be the most common cause. (reference 4, pp. 134, 1170-1171, 1276)

Defense counsel should obtain prior medical records including blood tests in any case with a history of Addison's disease. An endocrinologist or internal medicine specialist should be retained to study the case records.

#### Q: What are the psychological symptoms of *Addison's disease*?

|   |                                |
|---|--------------------------------|
| Apathy  | Negativism                     |
| Apprehension                                  | Personality changes            |
| Depression                                    | Poverty of thought             |
| Irritability                                  | Recent memory loss             |
| Lack of initiative                            | Seclusion                      |
| Lack of physical and emotional responsiveness | Suspicion                      |
|   | Toxic psychosis with confusion |

#### Q: What are the physical symptoms of *Addison's disease*?

|                                  |   |
|----------------------------------|---|
| Abdominal distress               | Hypotension (low blood pressure)        |
| Anorexia                         | Progressive asthenia (loss of strength) |
| Convulsions                      | Tremors                                 |
| Diffuse pigmentation of the skin | Weakness                                |
| Fatigue                          | Weight loss                             |

#### Q: What are the behavioral symptoms of *Addison's disease*?

Generalized behavioral changes may be experienced.

## The Plaintiff's Pre-Existing Medical Conditions

---

DISORDER

DEPOSITION QUESTIONS

---

**Addison's  
Disease**

*(continued)*

**Q: What processes are used to screen for *Addison's disease*?**

*Early diagnosis:*

ACTH (adrenocorticotrophic hormone) response showing a diminished reserve of adrenaline

*Advanced diagnosis:*

Low serum levels of sodium chloride and bicarbonate

High levels of serum potassium

Low adrenal steroid levels in a 24-hour urine collection

Diffuse high-amplitude slow activity on an electroencephalogram

---

**Q: What problems are encountered in screening for *Addison's disease*?**

The plaintiff's despondency may cause a misdiagnosis of depression. Usually a correct diagnosis cannot be made until later in the disease when the physical signs become distinct or there is an Addisonian crisis.

---

**Q: Are the plaintiff's current physical, psychological or behavioral symptoms caused by *Addison's disease*?**

# The Plaintiff's Pre-Existing Medical Conditions

---

## DISORDER

## DEPOSITION QUESTIONS

---

### Anemia

**Profile:** Anemia is one of the most frequent and significant worldwide health problems. It is a reduction in the volume of red blood cells that carry oxygen to body organs and tissues. The plaintiff's symptoms will depend upon the severity, duration, and type of the anemia. (reference 9, pp. 870, 872, 874; reference 2, p. 566; reference 1, p. 1063)

See the sections on pernicious anemia and combined systems disease for additional related questions.

**Q: What are the psychological symptoms of anemia?**

|            |                |
|------------|----------------|
| Apathy     | Irritability   |
| Depression | Loss of libido |

---

**Q: What are the physical symptoms of anemia?**

|  |  |
|--|--|
| Amenorrhea<br>(absence of menstrual periods) | Intermittent constipation and diarrhea |
| Anorexia                                     | Jaundice                               |
| Congestive heart failure                     | Lassitude                              |
| Drowsiness                                   | Skin pallor (abnormal pale appearance) |
| Exercise intolerance                         | Splenomegaly (enlarged spleen)         |
| Fatigue                                      | Spots before the eyes                  |
| GI complaints                                | Tinnitus (ringing in one or both ears) |
| Headache                                     | Vertigo                                |
|  | Weakness                               |

---

**Q: What are the behavioral symptoms of anemia?**

|                                |                                  |
|--------------------------------|----------------------------------|
| Bizarre behavior               | Lack of interest in surroundings |
| Diminished enthusiasm for work | Restlessness                     |

---

**Q: What processes are used to screen for anemia?**

|   |                                       |
|---|---------------------------------------|
| Complete blood count (or hemogram)        | Examination of at least one stool for |
| Examination of the peripheral blood smear | occult blood                          |
|   | Reticulocyte count                    |

---

**Q: What problems are encountered in screening for anemia?**

The occurrence of anemia symptoms tends to vary greatly depending on the plaintiff's physical activity, physical conditioning, and circulatory adequacy. It is possible for a plaintiff to have severe anemia without symptoms.

---

**Q: Are the plaintiff's current physical, psychological or behavioral symptoms caused by anemia?**

# The Plaintiff's Pre-Existing Medical Conditions

---

## DISORDER

## DEPOSITION QUESTIONS

---

### Arteriovenous Malformations

**Profile:** Arteriovenous malformations are tangled masses of dilated arteries and veins. These congenital defects are usually located within the largest part of the brain (cerebrum). They range in size from barely detectable lesions, to huge networks occupying an entire lobe of the brain or one cerebral hemisphere. These tangled masses often bleed and cause further symptoms from parenchymal or subarachnoid hemorrhaging. The plaintiff experiences physical symptoms rather than psychological changes. (reference 4, pp. 114, 139; reference 1, pp. 1374, 1333; reference 9, p. 2104)

**Q: What are the physical symptoms of arteriovenous malformations?**

|  |   |
|--|---|
| Bruit (a murmur or other sound related to circulation) | Loss of neurologic function below the level of the hemorrhage |
| Fever  | Migraine headaches on the same side                           |
| Focal epilepsy   | Nuchal rigidity (stiffness of the neck)                       |
| Focal neurologic sensory-motor deficits                | Seizures  |
| Hemorrhages  | Sudden head pains   |

---

**Q: What processes are used to screen for arteriovenous malformations?**

Diagnosis may be made when a "bag of worms" appears on a myelogram (with the needle removed and the plaintiff supine). This test can be confirmed by selective arteriography. A CT scan generally outlines malformations greater than 1.5 cm in diameter. Regional cerebral blood flow (RCBF) testing may also detect the malformations.

---

**Q: Are the plaintiff's current physical symptoms caused by arteriovenous malformations?**

# The Plaintiff's Pre-Existing Medical Conditions

DISORDER

DEPOSITION QUESTIONS

## Brain Tumors

**Profile:** Brain tumors are benign or malignant space-occupying lesions that develop in the skull, the brain, or the membrane covering the brain or spinal cord (meninges). The symptoms vary with size and rate of tumor growth, but show a gradual increase of pressure within the brain. Symptoms may include vomiting, and swelling of the optic disk. Other symptoms may depend upon the plaintiff's genetic makeup, intelligence, and premorbid personality. Brain tumors occur in adults of both sexes. (reference 4, pp. 139, 834-835, 855, 860, 1276; reference 9, pp. 2161-2164; reference 1, pp. 1351, 1296)

**Q: What are the psychological symptoms of a *brain tumor*?**

|                           |                         |
|---------------------------|-------------------------|
| Anxiety                   | Inertia (sluggishness)  |
| Clouding of consciousness | Irritability            |
| Dementia                  | Memory impairment       |
| Depression                | Personality changes     |
| Emotional lability        | Progressive dysfunction |
| Forgetfulness             |                         |

**Q: What are the physical symptoms of a *brain tumor*?**

|   |  |
|---|--|
| Aphasia (impaired language use)         | Hyperthermia (high body temperature)     |
| Bradycardia (slow heart rate)           | Hypothermia (low body temperature)       |
| Changes in appetite                     | Lethargy                                 |
| Convulsions                             | Numbness                                 |
| Dizziness                               | Papilledema (swelling of the optic disk) |
| Drowsiness                              | Projectile vomiting                      |
| Fatigue                                 | Seizures                                 |
| Fever                                   | Tremor                                   |
| Headache (more in morning than evening) | Visual changes                           |
| Hypertension (high blood pressure)      | Weakness                                 |

**Q: What are the behavioral symptoms of a *brain tumor*?**

|                   |           |
|-------------------|-----------|
| Impaired judgment | Tiredness |
| Self-criticism    |           |

**Q: What processes are used to screen for a *brain tumor*?**

|             |                                     |
|-------------|-------------------------------------|
| Arteriogram | Skull x-rays                        |
| CT scan     | WAIS-R or WAIS III                  |
| EEG         | (Wechsler Adult Intelligence Scale) |
| MRI         |                                     |

**Q: What problems are encountered in screening for a *brain tumor*?**

The plaintiff may or may not experience early symptoms depending upon tumor location and density.

**Q: Are the plaintiff's current psychological, physical or behavioral symptoms caused by a *brain tumor*?**

# The Plaintiff's Pre-Existing Medical Conditions

---

## DISORDER

## DEPOSITION QUESTIONS

---

### Chronic Obstructive Pulmonary Disease

**Profile:** Chronic obstructive pulmonary disease (COPD) is a major cause of disability and death, affecting more than 16 million Americans. The disease results from a combination of chronic obstructive bronchitis (acute inflammation of the bronchi) and pulmonary emphysema. Both of these disorders are closely associated with smoking. The most common symptom is the slow, progressive and insidious onset of dyspnea (shortness of breath). Other symptoms may include a cough, wheezing, recurrent respiratory infections, hypoxemia (deficient oxygenation in the blood), weakness, weight loss, and periods of severe depression or anxiety. (reference 9, pp. 399-403; reference 1, pp. 628-635; reference 18, pp. 1805-1806)

**Q: What are the psychological symptoms of *chronic obstructive pulmonary disease*?**

|            |                                    |
|------------|------------------------------------|
| Anxiety    | Increased risk of a panic disorder |
| Depression | Lack of libido                     |

---

**Q: What are the physical symptoms of *chronic obstructive pulmonary disease*?**

Physical symptoms are variable and depend on the stage of the disease. They may include:

|  |                                  |
|--|----------------------------------|
| Cough  | Recurrent respiratory infections |
| Cyanosis (bluish discoloration of the skin or membranes) | Sputum                           |
| Edema (swelling)   | Stooped posture                  |
| Dyspnea  | Weakness                         |
| Labored breathing  | Weight loss                      |
| Obstructive sleep apnea                                  | Wheezing                         |

---

**Q: What are the neurologic symptoms of *chronic obstructive pulmonary disease*?**

Decreases in:

|  |                                  |
|--|----------------------------------|
| Alertness  | Perceptual-motor learning skills |
| Motor speed and strength of intact verbal intellectual abilities | Problem-solving                  |
|  | Psychomotor speed                |

---

**Q: What processes are used to screen for *chronic obstructive pulmonary disease*?**

The most characteristic feature of COPD is a persistent reduction in forced expiratory flow rates. Three criteria may be used for diagnosing COPD:

- (1) Slowing of forced expiration;
  - (2) Expiratory slowing must persist despite therapy;
  - (3) Specific diseases that may cause the symptoms must be excluded.
- 

**Q: What problems are encountered in screening for *chronic obstructive pulmonary disease*?**

Symptoms are variable. Early physical examinations may be normal except for the slowing of forced expiration.

---

**Q: Are the plaintiff's current physical, psychological, or neurologic symptoms caused by *chronic obstructive pulmonary disease*?**

# The Plaintiff's Pre-Existing Medical Conditions

DISORDER

DEPOSITION QUESTIONS

## Combined Systems Disease

**Profile:** Combined systems disease (subacute combined degeneration of the spinal cord) is a result of cobalamin or folate deficiency (megaloblastic anemia). Combined systems disease designates a spinal cord disorder marked by the insidious beginning and gradual progression of demyelination, initially of the dorsal and later the lateral columns. The gradual degeneration (over 10-15 years) of the spinal cord causes a variety of physical, mental, and emotional changes. The plaintiff may experience peripheral tingling or prickling sensation in the extremities, weakness, leg stiffness, unsteadiness, lethargy, fatigue, and irritability. Delirium or confusion, spastic voluntary muscle incoordination, and postural hypotension (low blood pressure when standing) may be symptoms of the advanced disease. Neurologic symptoms usually appear before other physical signs. Vegetarians are particularly susceptible to this disorder when both animal protein and dairy products are excluded from the diet. Alcoholism also contributes to the onset of this disease. (reference 1, pp. 1374, 1078; reference 2, p. 613; reference 23, pp. 864-865)

Defense counsel should look for the triad of anemia, back pain, and mental symptoms.

### Q: What are the psychological symptoms of *combined systems disease*?

|   |                    |
|---|--------------------|
| Acute confusional state   | Listlessness       |
| Apprehensiveness  | Mania              |
| Delirium  | Mild depression    |
| Delusions   | Panic attacks      |
| Depression  | Paranoia           |
| General mental deterioration including loss of cognitive skills | Personality change |
| Hallucinations  | Psychosis          |
| Irritability  | Slow mentation     |
|   | Suicide            |

### Q: What are the physical and neurological symptoms of *combined systems disease*?

|                                   |   |
|-----------------------------------|---|
| Abnormal smell or taste           | Lethargy  |
| Abnormal gait                     | Lhermitte's sign  |
| Ataxia                            | Memory loss   |
| Babinski's sign                   | Obtundation (reduced sensitivity)                           |
| Decreased reflexes                | Paresthesias  |
| Decreased muscle strength         | Postural hypotension (lowered blood pressure upon standing) |
| Decreased vision or optic atrophy | Romberg's sign  |
| Disorientation                    | Spastic ataxia (voluntary muscle incoordination)            |
| Fatigue                           | Spasticity  |
| Impaired position sense           | Unsteadiness  |
| Impaired vibration sense          | Urinary or fecal incontinence                               |
| Impaired touch or pain perception | Urinary urgency or nocturia                                 |
| Impotence                         | Weakness  |
| Increased reflexes                |   |
| Insomnia                          |   |
| Leg stiffness                     |   |

# The Plaintiff's Pre-Existing Medical Conditions

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DISORDER

DEPOSITION QUESTIONS

---

**Combined  
Systems  
Disease**  
(continued)

**Q: What processes are used to screen for *combined systems disease*?**

If drugs are excluded as a cause, the differential diagnosis of megaloblastic anemia in adults is limited to the task of distinguishing between cobalamin deficiency and folate deficiency. Distinguishing between cobalamin and folate deficiency is important because treatment of cobalamin deficiency with folate does not relieve the neuropsychiatric abnormalities.

*Initial tests:*

- (1) Serum cobalamin (normal, 200-900pg/mL)
- (2) Serum folate (normal, 2.5-20 ng/mL)

*Follow-up:*

- (1) Serum cobalamin less than 350pg/mL or
- (2) Serum folate less than 5 ng/mL or  
    Serious unexplained hematologic or neuropsychiatric abnormalities are very suggestive of cobalamin or folate deficiency

*Follow-up tests:*

- (1) Serum methylmalonic acid (normal, 70-270 nmol) – elevated in cobalamin deficiency
- (2) Serum homocysteine (normal, 5-16 umol) – elevated in cobalamin and folate deficiency

---

**Q: What problems are encountered when screening for *combined systems disease*?**

Disease onset is gradual causing a variety of physical complaints. For an accurate diagnosis, combined systems disease needs to be differentiated from compressive cord lesions, multiple sclerosis, and other anemias.

---

**Q: Are the plaintiff's current physical, neurological, or psychological symptoms caused by *combined systems disease*?**

# The Plaintiff's Pre-Existing Medical Conditions

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DISORDER

DEPOSITION QUESTIONS

---

## Coronary Artery Disease

**Profile:** Coronary artery disease has been linked with several major risk factors; elevated cholesterol, hypertension (high blood pressure), smoking, a family history of heart disease, diabetes, obesity, and type A behavior (the excessively competitive or hostile plaintiff). Coronary artery disease often leads to heart attack, hospitalization, and physical or mental complications upon arriving home. Despondency is a common response to heart attack. The plaintiff feels a sense of loss, damage, and vulnerability to further injury. (reference 4, pp. 1148-1149, 1154-1157, 893; reference 1, p. 387)

**Q: What are the psychological symptoms of coronary artery disease?**

***Before a heart attack:***

Anxiety  
Avoidance

***After a heart attack:***

Anxiety  
Depression  
Despondency  
Hopelessness  
Situational apprehension  
Vulnerability

---

**Q: What are the physical symptoms of coronary artery disease?**

***Before a heart attack:***

Chest pain  
Dyspnea (shortness of breath)  
Indigestion  
Palpitations  
Tachycardia

***After a heart attack:***

Daytime hypersomnia (sleepiness)  
Early morning awakening  
Easy fatigability  
Weakness

---

**Q: What are the behavioral symptoms of coronary artery disease?**

***Before heart attack:***

Personality traits are often associated with coronary artery disease and type A behavior. The type A plaintiff is characterized by feeling a time urgency (e.g. knee jerking, tense posture, rapid body movements, excessive forehead and upper lip sweating, walking and eating fast), and competitive hostility (hostile laugh, clenched fist, explosive voice, use of obscenities, irritation and rage over past events, distrust of motives, impatience).

***After a heart attack:***

The dysphoria and "vegetative signs" can become, for some plaintiffs, a major affective disorder (depression).

---

**Q: What processes are used to screen for coronary artery disease?**

Coronary angiography  
EKG

Radioisotope scan evaluation

---

## The Plaintiff's Pre-Existing Medical Conditions

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*DISORDER*

*DEPOSITION QUESTIONS*

---

**Coronary  
Artery Disease**

*(continued)*

**Q: What problems are encountered in screening for *coronary artery disease*?**

Most problems occur in differentiating coronary or cardiovascular disorders from anxiety disorders. A differential diagnosis can be difficult because the symptoms are few in number, short in duration, and changing in nature (often being absent at the time of the physical exam).

---

**Q: Are the plaintiff's current physical, psychological, or behavioral symptoms caused by *coronary artery disease*?**

# The Plaintiff's Pre-Existing Medical Conditions

DISORDER

DEPOSITION QUESTIONS

## Cushing's Syndrome

**Profile:** Cushing's syndrome (hyperadrenalism) is due to an excess of the adrenocortical hormone cortisol. The hormonal excess may be caused by an overactive adrenal cortex or excessive treatment with adrenal cortical hormones. The plaintiff with Cushing's syndrome may have characteristic changes in appearance including trunk and facial obesity, abdominal striae (stripes), heightened facial color, buffalo hump, bruising, fat alteration, increased hair growth, and weight gain. Depression is common, ranging in severity from crying spells to suicide attempts. (reference 4, pp. 1276, 1171-1172, 545; reference 9, pp. 1264-1265; reference 1, p. 1022; reference 2, pp. 272, 609)

**Q: What are the psychological symptoms of *Cushing's syndrome*?**

|                                 |                                |
|---------------------------------|--------------------------------|
| Agitation                       | Impaired memory                |
| Anxiety                         | (short-term memory loss)       |
| Confusion                       | Irritability                   |
| Depression                      | Loss of libido (sexual desire) |
| Difficulty concentrating        | Paranoid psychosis             |
| Disorientation                  | Psychiatric disturbances       |
| Elated mood or manic excitement | Thought disorders with somatic |
| Emotional lability              | (bodily) delusions             |

**Q: What are the physical symptoms of *Cushing's syndrome*?**

|  |  |
|--|--|
| Abdominal striae (stripes)   | Increased appetite                     |
| Buffalo hump (a deposit of adipose tissue between the shoulder blades) | Insomnia                               |
| Easy bruising  | Muscle wasting                         |
| Easy fatigability  | Osteoporosis                           |
| Fat alteration   | Renal calculi                          |
| Fragile skin   | Susceptibility to infection            |
| Glucose intolerance  | Truncal and facial obesity (moon face) |
| Heightened facial color  | Weakness                               |
| Hypertension   | Weight gain                            |

The male plaintiff may become impotent and the female may become susceptible to amenorrhea (absence of menstruation), hirsutism (growth of hair in unusual places and in unusual amounts) and acne.

**Q: What processes are used to screen for *Cushing's syndrome*?**

Cushing's syndrome can usually be determined from a physical exam. Laboratory tests include a 24-hour urine cortisol test and an overnight dexamethasone suppression test (DST).

## The Plaintiff's Pre-Existing Medical Conditions

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DISORDER

DEPOSITION QUESTIONS

---

### Cushing's Syndrome

*(continued)*

**Q:** What problems are encountered in screening for *Cushing's syndrome*?

Mental changes may precede the physical symptoms. Behavioral symptoms differ based on the origin of excess cortisol. *Severe manifestations of the disease cause an organic mental disorder that may resemble other organic, toxic or metabolic conditions.*

Fifteen to twenty-five percent of the plaintiffs with Cushing's disease have symptoms of paranoia and hallucinations that resemble schizophrenia.

---

**Q:** Are the plaintiff's current physical or psychological symptoms caused by *Cushing's syndrome*?

# The Plaintiff's Pre-Existing Medical Conditions

DISORDER

DEPOSITION QUESTIONS

---

## Epilepsy

**Profile:** Epilepsy (seizure disorder) is a brain disorder characterized by recurring hyperactive brain functioning that causes epileptic seizures. The seizures are transient episodes of impaired consciousness, motor and sensory disturbances, involuntary movements, and psychic or sensory experiences. Epilepsy is often classified into two categories. The first category includes partial seizures (focal or localized), while the second involves generalized seizures (convulsive or non-convulsive). Epilepsy is often caused by a cerebral lesion combined with a genetic predisposition. The condition usually begins in early childhood but can appear at any age. Approximately 0.5 percent of the population in the United States have active seizures, three percent have had recurrent seizures, and nine percent have experienced at least one seizure during their lifetime. (reference 4, p. 134; reference 9, pp. 2149-2151)

**Q: What are the psychological symptoms of *epilepsy*?**

***Partial Seizures:***

Alteration of consciousness  
Amnesia  
Illusions  
Fear  
Forced laughing  
Forced thinking  
Hallucinations  
Psychomotor manifestations

***Generalized Seizures:***

Alteration of consciousness  
Loss of consciousness

---

**Q: What are the physical symptoms of *epilepsy*?**

***Partial Seizures:***

Auras of taste or smell  
(premonitory sensations of a seizure)  
Focal clonic movements  
Impaired speech  
Lip or tongue movements  
Localized motor seizures  
Localized pain  
Loss of tone and strength  
Turning of head, eyes, and body

***Generalized Seizures:***

Aura of peculiar visceral  
(internal) sensations  
Incontinence (involuntary evacuation  
of feces or urine)  
Tongue biting

***After seizures:***

Drowsiness  
Muscle aches and pains

---

**Q: What processes are used to screen for *epilepsy*?**

|  |                                       |
|--|---------------------------------------|
| Blood count                              | Lumbar Puncture                       |
| CT scan                                  | MRI                                   |
| EEG (the most important diagnostic test) | Serum calcium                         |
| Laboratory studies                       | Urinalysis (to screen for drug abuse) |

---

**Q: Are the plaintiff's current physical or psychological symptoms caused by *epilepsy*?**

# The Plaintiff's Pre-Existing Medical Conditions

DISORDER

DEPOSITION QUESTIONS

## Hepatic Encephalopathy

**Profile:** Hepatic encephalopathy (portal-systemic encephalopathy or hepatic coma) is a disease of the liver that causes impaired mental functioning leading to stupor or coma. The liver normally metabolizes and detoxifies digestive products. In hepatic disease, these products go into circulation before being detoxified. The toxic effect of these substances on the brain causes personality and mental symptoms, including delirium. Personality disturbance is often the first symptom of any disease affecting the brain. The metabolic or toxic encephalopathies are easily mistaken for psychosis or neurosis. (reference 1, pp. 816-817; reference 9, p. 121)

**Q: What are the psychological symptoms of *hepatic encephalopathy*?**

|              |                        |
|--------------|------------------------|
| Agitation    | Impaired consciousness |
| Altered mood | Impaired judgment      |
| Coma         | Mania                  |
| Confusion    | Stupor                 |

**Q: What are the physical symptoms of *hepatic encephalopathy*?**

|                             |                                     |
|-----------------------------|-------------------------------------|
| Drowsiness                  | Slowed speech                       |
| Flapping tremor (asterixis) | Sluggish movement                   |
| Sleep pattern changes       | Sweet breath odor (fetor hepaticus) |

**Q: What are the behavioral symptoms of *hepatic encephalopathy*?**

The behavioral effects of hepatic encephalopathy include inappropriate behavior.

**Q: What processes are used to screen for *hepatic encephalopathy*?**

|  |  |
|--|--|
| A clinical judgment based on existing symptoms | EEG showing slow-wave activity<br>Laboratory tests |
|--|--|

**Q: What problems are encountered in screening for *hepatic encephalopathy*?**

Laboratory tests and other clinical data only roughly correlate with liver function tests and mental status.

**Q: Are the plaintiff's physical, psychological, or behavioral symptoms caused by *hepatic encephalopathy*?**

# The Plaintiff's Pre-Existing Medical Conditions

DISORDER

DEPOSITION QUESTIONS

## Hepatitis B

**Profile:** Hepatitis B (liver inflammation) is a virus associated with many liver diseases. The virus is contracted in a manner similar to HIV, but is more common and infectious. About one-third of those who have the virus may have no symptoms. Another third may suffer from flu-like symptoms, such as fatigue and loss of appetite. The remaining third become seriously ill and develop jaundice (the yellowing of the skin and whites of the eyes and a darkening of the urine). Ninety percent of those infected eliminate the virus within six months, but remain infectious until the virus is gone. The remaining five to ten percent become chronic carriers and may eventually die from cirrhosis or liver cancer. This chronic active hepatitis is a disabling, exhaustive, and often fatal disease. (reference 1, pp. 837-840)

**Q: What are the psychological symptoms of hepatitis B?**

The psychological symptoms of hepatitis B may include depression and malaise.

**Q: What are the physical symptoms of hepatitis B?**

Symptoms vary from minor flu-like symptoms to fatal liver failure. They may also include:

|                           |            |
|---------------------------|------------|
| Abdominal pain            | Exhaustion |
| Anorexia                  | Fatigue    |
| Back pain                 | Fever      |
| Dark brown urine          | Jaundice   |
| Enlarged and tender liver | Nausea     |

**Q: What processes are used to screen for hepatitis B?**

Hepatitis B may be diagnosed by identifying HBsAg (hepatitis B, surface antigen) in serum.

**Q: What problems are encountered in screening for hepatitis B?**

The disease is difficult to diagnose because the first symptoms resemble a mild flu.

**Q: Are the plaintiff's current physical or psychological symptoms caused by hepatitis B?**

# The Plaintiff's Pre-Existing Medical Conditions

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## DISORDER

## DEPOSITION QUESTIONS

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### Hypertension

**Profile:** Hypertension (high blood pressure) has been associated with emotional and physical stress, personality type, diet, obesity, alcohol, life changes, traumatic events, social conditions, and environmental variables. Most symptoms are the result of the complications from chronic and untreated high blood pressure. A blood pressure of 160/95mm or more (affecting eighteen percent of the population) is a leading cause of death and the main cause of heart disease and stroke. Thirty-eight percent of the population has a blood pressure of 140/90mm or more. Over a twenty year period, this group has twice the risk factor for cardiovascular disease than those with a lower blood pressure. Other symptoms of hypertension include fatigue, dizziness, irritability, brain damage, confusion, flushed face, headaches, nervousness, and retinal changes. Vascular dementia seems to be directly related to severe, sustained hypertension. (reference 4, pp. 1118, 139, 1136, 1153-1154, 859; reference 1, pp. 391-392, 192)

Defense counsel should search for a familial pattern of hypertension or medical records containing a history of antihypertensive drug prescriptions. Many antihypertensive medications cause depression.

**Q: What are the psychological symptoms of *hypertension*?**

Confusion  
Dementia

Irritability  
Nervousness

---

**Q: What are the physical symptoms that can be caused by *hypertension*?**

Brain damage  
Dizziness  
Edema (swelling)  
Epistaxis (nosebleed)

Fatigue  
Flushed face  
Headaches  
Retinal changes

---

**Q: What processes are used to screen for *hypertension*?**

Blood pressure readings on two or three separate days  
Complete blood count  
History and physical exam  
Routine urinalysis  
(with microscopic examination)

Serum triglycerides  
Serum levels – BUN and or creatinine, potassium, cholesterol, uric acid, glucose, HDL cholesterol

---

**Q: What problems are encountered in screening for *hypertension*?**

Hypertension is usually asymptomatic until complications develop in vital organs.

---

**Q: Are the plaintiff's current physical or psychological symptoms caused by *hypertension*?**

# The Plaintiff's Pre-Existing Medical Conditions

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## DISORDER

## DEPOSITION QUESTIONS

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### Hyperthyroidism

**Profile:** Hyperthyroidism (thyrotoxicosis) occurs when there is an excess of the thyroid hormone being secreted into the body. Mental symptoms, similar to those caused by generalized anxiety, may be the first early signs of the disease. The plaintiff with hyperthyroidism will experience a persistent anxiety unrelated to life events, wake up anxious, and will need to continuously move. A thyroid storm (thyrotoxic crisis) is characterized by an abrupt onset of muscle weakness, extreme restlessness with wide emotional swings, tachycardia, confusion, psychosis, coma and death. Graves' disease and diffuse toxic goiter are the most common causes of hyperthyroidism. In some cases the disease can have a psychosomatic (pertaining to the mind and body) basis. (reference 4, pp. 856, 876, 1109, 1176-1177, 1276; reference 2, pp. 609, 702, 851; reference 1, pp. 1002-1003; reference 18, pp. 743, 1809-1810, 1928)

**Q: What are the psychological symptoms of *hyperthyroidism*?**

|                              |                          |
|------------------------------|--------------------------|
| Anxiety                      | Impaired intelligence    |
| Depression                   | Impaired recent memory   |
| Distraction                  | Inability to concentrate |
| Edginess                     | Nervousness              |
| Emotional lability           | Panic attacks            |
| Euphoria                     | Short attention span     |
| Exaggerated startle response | Tension                  |
| Hyperexcitability            |                          |

---

**Q: What are the physical symptoms of *hyperthyroidism*?**

|   |                                     |
|---|-------------------------------------|
| Arrhythmias (irregular heart rhythm)                        | Ocular signs                        |
| Dyspnea (shortness of breath)                               | (lid lag, protruding eyes, tearing) |
| Elevated blood pressure                                     | Palpitations                        |
| Goiter (enlargement of the thyroid gland)                   | Sweating                            |
| Heat intolerance  | Tachycardia                         |
| Increased appetite  | Tremors                             |
| Increased pulse   | Vitiligo                            |
| Menstrual irregularity                                      | (loss of melanin skin pigmentation) |
| More frequent bowel movements                               | Vomiting                            |
| Muscle weakness   | Weight Loss                         |
| Night terrors (sometimes misdiagnosed as a symptom of PTSD) |                                     |

---

**Q: What are the behavioral symptoms of *hyperthyroidism*?**

While experiencing great fatigue and exhaustion, the plaintiff may still feel driven. Other symptoms may include crying spells, hyperactive or grandiose behavior, and inappropriate temper outburst.

---

## The Plaintiff's Pre-Existing Medical Conditions

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DISORDER

DEPOSITION QUESTIONS

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**Hyperthyroidism Q:** What processes are used to screen for *hyperthyroidism*?

(continued)

Clinical signs of the syndrome may include a widened pulse pressure, enlarged gland, fine tremor of the fingers and tongue, muscle wasting, fine silky hair, and warm, moist skin. Diagnostic tests may include elevated serum thyroxine levels and high T3 and T4 serum levels.

---

**Q:** What problems are encountered in screening for *hyperthyroidism*?

The rapid onset of symptoms may resemble an anxiety or panic attack. Other symptoms resemble the hypomanic plaintiff or the plaintiff with a generalized anxiety disorder.

Elderly plaintiffs with apathetic thyrotoxicosis have symptoms of weight loss, muscular wasting, cardiovascular abnormalities with atrial fibrillation, apathy, depression, and cognitive losses often mistaken in diagnosis for senility.

---

**Q:** Are the plaintiff's current physical, psychological or behavioral symptoms caused by *hyperthyroidism*?

# The Plaintiff's Pre-Existing Medical Conditions

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## DISORDER

## DEPOSITION QUESTIONS

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### Hypoglycemia

**Profile:** Hypoglycemia is a below normal blood glucose level. When the plaintiff's blood glucose goes below a critical point, s/he may experience weakness, hunger, nervousness, tremor, palpitations, headaches, confusion, sweating, faintness, personality changes, and sometimes convulsions. Hypoglycemia may be caused by a reaction to a meal, specific nutrients, drugs (including alcohol), fasting, or a psychosomatic disorder. Hypoglycemia or insulin shock may also occur when too much insulin or too little food is taken by a plaintiff with diabetes. The disorder can occur equally in adults of both sexes. (reference 4, pp. 133, 1109, 1176-1177, 1276; reference 1, pp. 1047, 1052-1054, 1292; reference 2, pp. 610, 702; reference 18, pp. 1929,1479)

**Q: What are the psychological symptoms of hypoglycemia?**

|            |                    |
|------------|--------------------|
| Agitation  | Fear and dread     |
| Anxiety    | Irritability       |
| Confusion  | Nervousness        |
| Depression | Personality change |

---

**Q: What are the physical symptoms of hypoglycemia?**

|                     |                     |
|---------------------|---------------------|
| Abdominal pain      | Pale and moist skin |
| Dizziness           | Perspiration        |
| Fainting            | Shortness of breath |
| Fatigue             | Sweating            |
| Headache            | Tachycardia         |
| Heart palpitations  | Tremor              |
| Hunger              | Visual disturbances |
| Lightheadedness     | Weakness            |
| Nausea and vomiting |                     |

Central nervous system symptoms may progress to a loss of consciousness, convulsions, and coma.

---

**Q: What processes are used to screen for hypoglycemia?**

Hypoglycemia can be diagnosed by laboratory tests for low plasma glucose. Observing the plaintiff's reduction of symptoms after taking sugar or other food may also identify the presence of hypoglycemia.

---

**Q: What problems are encountered in screening for hypoglycemia?**

The early symptoms of hypoglycemia resemble a generalized anxiety disorder, panic attacks, or severe alcoholism. When it is known that the plaintiff has diabetes, the diagnosis is not difficult.

---

**Q: Are the plaintiff's current physical or psychological symptoms caused by hypoglycemia?**

# The Plaintiff's Pre-Existing Medical Conditions

---

DISORDER

DEPOSITION QUESTIONS

---

## Hypotension

**Profile:** Hypotension is an abnormally low blood pressure that may be caused by drugs (narcotics, sedatives, or diuretics) or by disease of the autonomic (involuntary) nervous system. Orthostatic hypotension is a drop in blood pressure resulting from an acute blood loss, standing a long time, or rising rapidly to stand. Both systolic (top number) and diastolic (bottom number) pressures will fall with little or no pulse alteration. A systolic pressure of 90 is considered to be the minimum normal pressure for a healthy adult. (reference 1, p. 509; reference 9, p. 1984; reference 2, p. 658)

Defense counsel should look for the use of antihypertensive agents, antidepressants, phenothiazines, and sedatives. These drugs accentuate the plaintiff's tendencies toward hypotension.

**Q: What are the psychological symptoms of *hypotension*?**

Confusion  
Delirium

Giddiness

---

**Q: What are the physical symptoms of *hypotension*?**

Dizziness  
Faintness  
Falling

Staggering  
Tremulousness

---

**Q: What processes are used to screen for *hypotension*?**

Blood pressure tests

---

**Q: Are the plaintiff's current physical or psychological symptoms caused by *hypotension*?**

# The Plaintiff's Pre-Existing Medical Conditions

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## DISORDER

## DEPOSITION QUESTIONS

---

### Hypothyroidism

**Profile:** Hypothyroidism (myxedema) is caused by an insufficient amount of the thyroid hormone. The amount of thyroid insufficiency typically determines the plaintiff's symptoms. Common physical manifestations include a puffy face, dry skin, and cold intolerance. Mental disturbances may consist of a personality change, depression, lethargy, irritability, and anxiety. These symptoms can develop so slowly and insidiously that even those closest to the plaintiff may not be aware of its onset. Hypothyroidism is common in adults, especially females over 40. The disorder usually results from efforts to control hyperthyroidism through surgery or the administration of radioactive iodine. (reference 4, pp. 1276, 1169-1170; reference 9, pp. 1288-1290; reference 18, pp. 743, 1810-1812, 1928)

**Q: What are the psychological symptoms of *hypothyroidism*?**

|                 |                         |
|-----------------|-------------------------|
| Anxiety         | Lethargy                |
| Apathy          | Panic attacks           |
| Depression      | Poor concentration      |
| Despair         | Premonitions of doom    |
| Hallucinations  | Slowed mental processes |
| Impaired memory | Somatic delusions       |
| Irritability    | Suicidal thoughts       |

---

**Q: What are the physical symptoms of *hypothyroidism*?**

|                                 |                                   |
|---------------------------------|-----------------------------------|
| Anorexia                        | Infertility                       |
| Arthralgia                      | Irregular menstruation            |
| Bradycardia (slowed heart rate) | Low pulse rate                    |
| Cold intolerance                | Lowered body temperature          |
| Constipation                    | Muscle cramps                     |
| Decreased sweating              | Numbness and tingling in fingers  |
| Dizziness                       | Poor appetite                     |
| Dry coarse skin and hair        | Puffy face                        |
| Dyspnea                         | Slow, low-pitched hoarse voice    |
| Enlarged heart                  | Stiff and aching muscles          |
| Fatigue                         | Swelling of hands and extremities |
| Headache                        | Syncope                           |
| Hearing loss                    | Weakness                          |
| Impotence                       | Weight gain                       |

---

**Q: What processes are used to screen for *hypothyroidism*?**

A blood test that measures the plaintiff's TSH serum levels (a reduced free T4 index) is the best indicator of hypothyroidism.

---

**Q: What problems may be encountered in screening for *hypothyroidism*?**

The "myxedema madness" that sometimes occurs with hypothyroidism may resemble schizophrenia, cerebrovascular insufficiency, or senile dementia. The plaintiff is mentally alert even during delusional or paranoid behaviors.

---

**Q: Are the plaintiff's current physical or psychological symptoms caused by *hypothyroidism*?**

## The Plaintiff's Pre-Existing Medical Conditions

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DISORDER

DEPOSITION QUESTIONS

---

### Infectious Mononucleosis

**Profile:** Infectious mononucleosis is an acute infection often referred to as glandular fever, kissing disease, or Pfeiffer's disease. Associated with the Epstein-Barr virus, the plaintiff may acquire the disease through contact with contaminated saliva, contaminated eating and drinking utensils, or from a blood transfusion. After five to seven weeks (for young adults), symptoms of malaise, fatigue, headache, and chills may appear. The disease is self-limited and usually the most acute symptoms begin to subside in four to six weeks. Fatigue may continue for many months after the recovery period. Current research indicates that the Epstein-Barr virus may cause symptoms of anxiety and depression many years after the occurrence of infectious mononucleosis. (reference 9, pp. 1719-1721; reference 1, pp. 202-203)

**Q: What are the psychological symptoms of *infectious mononucleosis* (mono)?**

|            |         |
|------------|---------|
| Anxiety    | Malaise |
| Depression |         |

---

**Q: What are the physical symptoms of *infectious mononucleosis*?**

|   |                             |
|---|-----------------------------|
| Chills                                      | Lymphocytosis with abnormal |
| Fatigue                                     | lymphocytes                 |
| Fever                                       | Rash                        |
| Headache                                    | Sore throat                 |
| Lymphadenopathy<br>(lymph node enlargement) | Splenomegaly                |

---

**Q: What processes are used to screen for *infectious mononucleosis*?**

Infectious mononucleosis may be diagnosed by the plaintiff's symptoms and characteristic blood abnormalities (heterophile and EBV antibody titer). An elevated white blood cell count generally occurs during the second and third week of the disease.

---

**Q: Are the plaintiff's physical or psychological symptoms caused by *infectious mononucleosis* or the residual Epstein-Barr syndrome?**

# The Plaintiff's Pre-Existing Medical Conditions

DISORDER

DEPOSITION QUESTIONS

---

## Meningitis

**Profile:** Meningitis is an inflammation of the membranes of the brain or spinal cord. The meningitides are named by either the causative agent (viral meningitis, tuberculous meningitis, pneumococcal meningitis) or by symptom characteristics (acute, chronic).

**Viral meningitis** (aseptic meningitis) is a benign self-limited illness usually caused by mumps. It may last from three days to two weeks, although persistent symptoms of fatigue, lightheadedness, and general asthenia (loss of strength) may last for months.

**Acute meningitis** (purulent) is characterized by the sudden onset of a headache, nausea, vomiting or loss of consciousness. The plaintiff has a high fever and nuchal rigidity (stiff neck). The disease usually occurs before the age of ten. If an acute meningitis is diagnosed late or occurs in the elderly, it may be fatal.

**Chronic meningitis** is characterized by the gradual onset of a headache, stiff neck, malaise, and fever. (reference 12, p. 822; reference 4, pp. 123-124, 205, 721; reference 1, pp. 1339-1346; reference 9, p. 2122)

**Q: What are the psychological symptoms of meningitis?**

|          |         |
|----------|---------|
| Delirium | Malaise |
| Dementia |         |

---

**Q: What are the physical symptoms of meningitis?**

|                |                                     |
|----------------|-------------------------------------|
| Abdominal pain | Leg signs                           |
| Dizziness      | (Kernig's, Lasegue's, Brudzinski's) |
| Drowsiness     | Lightheadedness                     |
| Fatigue        | Nausea and vomiting                 |
| Fever          | Stiff neck                          |
| Headache       |                                     |

---

**Q: What processes are used to screen for meningitis?**

Diagnosis requires a CSF (cerebrospinal fluid) examination.

---

**Q: What problems are encountered in screening for meningitis?**

All the symptoms of meningitis may occur without disease. The widespread use of antibiotics to treat respiratory infections may partially reverse or hide meningitis symptoms.

---

**Q: Are the plaintiff's current physical or psychological symptoms caused by meningitis?**

# The Plaintiff's Pre-Existing Medical Conditions

DISORDER

DEPOSITION QUESTIONS

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## Menopausal Distress

**Profile:** Menopause occurs after approximately a one years absence of the menstrual cycle. The physical and psychological symptoms are quite variable with each woman regarding age of onset, severity of symptoms and the duration of symptoms. Generally, menses tapers off during a two to five year span, between the ages of 40 and 55. However, menopause can also occur following the surgical removal of the ovaries. The severity of physical and mental symptoms appears to be related to the rate of hormone withdrawal, amount of hormone depletion, the physical ability to withstand the aging process, overall health and level of activity, sociocultural background, and current adaptation to aging and role changes. Some plaintiffs who previously had low self-esteem and low life satisfaction may experience more serious psychological difficulties. (reference 4, pp. 1173-1174; reference 2, pp. 610-611; reference 1, pp. 1680-1681; reference 9, p. 21)

**Q: What are the psychological symptoms of *menopause*?**

|                    |              |
|--------------------|--------------|
| Anxiety            | Irritability |
| Depression         | Lassitude    |
| Emotional lability | Tension      |

---

**Q: What are the physical symptoms of *menopause*?**

|                 |                                    |
|-----------------|------------------------------------|
| Back pain       | Lacrimation (tearing)              |
| Dizziness       | Nervousness                        |
| Fatigue         | Night sweats                       |
| Flushes         | Numbness and tingling              |
| GI disturbances | Palpitations                       |
| Hot flashes     | Urinary frequency and incontinence |
| Insomnia        |                                    |

---

**Q: Are the plaintiff's current physical or psychological symptoms caused by the onset of *menopause*?**

# The Plaintiff's Pre-Existing Medical Conditions

DISORDER

DEPOSITION QUESTIONS

## Mitral Valve Prolapse

**Profile:** Mitral valve prolapse (MVP) is a common and sometimes serious congenital ballooning of a heart valve. Most plaintiffs with MVP have no signs of the disorder. Others may have symptoms that resemble anxiety and panic attacks such as arrhythmias (abnormal heart beat), chest pain, palpitations, dyspnea (shortness of breath), weakness, fatigue, dizziness, syncope (a faint), and anxiety. Five percent of the population are affected by this condition. Mitral valve prolapse may be viewed as either an associated condition or a cause of anxiety and panic. (reference 4, pp. 1148-1149, 1551; reference 1, p. 526; reference 18, p. 1799)

**Q: What are the psychological symptoms of *mitral valve prolapse*?**

Anxiety  
Fatigue

Panic

**Q: What are the physical symptoms of *mitral valve prolapse*?**

Arrhythmias (an alteration in rhythm of the heartbeat either in time or force)  
Chest pain  
Dizziness  
Dyspnea (shortness of breath)

Fatigue  
Palpitations  
Syncope (loss of consciousness due to reduced blood flow to the brain)  
Weakness

**Q: What processes are used to screen for *mitral valve prolapse*?**

A physical examination will reveal arrhythmias of the heart, the presence of a midsystolic click, and a systolic murmur. The diagnosis can be confirmed by echocardiography.

**Q: What problems are encountered in screening for *mitral valve prolapse*?**

In panic disorder, mitral valve prolapse is detected in 10 to 25 percent of patients studied with echocardiography. However, prolapse also occurs in a substantial portion of the population without panic disorder, and the nature of the relationship remains uncertain. The subjective experience of valve prolapse (fluttering, chest pressure) may trigger panic sensations. MVP is not only linked with panic disorder, but also with other disorders and autonomic instability.

**Q: Are the plaintiff's current physical or psychological symptoms caused by *mitral valve prolapse*?**

# The Plaintiff's Pre-Existing Medical Conditions

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## DISORDER

## DEPOSITION QUESTIONS

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### Multiple Sclerosis

**Profile:** Multiple sclerosis, (a demyelinating disease), affects 250,000 to 350,000 persons in the United States. Twice as many women as men are affected by the disease. Eight-five percent of the cases are diagnosed between age 20 and 50. Initial symptoms may include weakness, paresthesia (tingling, burning, tightness of limbs or trunk), visual loss, incoordination, vertigo, and sphincter impairment. MS is a slow progressive disease of the optic nerves, spinal cord, and brain. It produces a variety of symptoms due to the randomly distributed MS lesions. Some of the early neurological signs resemble hysteria or a conversion disorder. The course of multiple sclerosis is just as variable and unpredictable as the presenting symptoms (see types of MS below). Seventy percent of the MS patients experience some stability or remission of symptoms after the onset of the disease. Over time, there is usually a decreased rate of recovery, increased disability, and death (often after 35 years of disease symptoms). (reference 4, p. 1276; reference 2, p. 613; reference 9, pp. 2143, 2145; reference 1, p. 1355; reference 18, pp. 299-307, 882-883)

**Q: What are the psychological symptoms of *multiple sclerosis*?**

|  |   |
|--|---|
| Apathy   | Euphoria  |
| Changes in intellectual functioning<br>(deficits in problem-solving, and<br>speed of information processing) | Inattention   |
| Bipolar disorder   | Lack of judgment  |
| Depressive syndromes   | Memory difficulties<br>( <i>most frequent complaint</i> ) |
| Delirium   | Nonaffective psychosis                                    |
| Dementia   | Pathological laughing or weeping                          |
| Emotional lability (impressions of hysteria)   | Personality changes                                       |

---

**Q: What are the physical symptoms of *multiple sclerosis*?**

|   |   |
|---|---|
| Abnormalities in the cerebrospinal fluid                      | Pain in the face, extremities, or trunk                         |
| Babinski signs (extension of big toe<br>when foot is stroked) | Paresthesia (tingling, burning, tightness<br>of limbs or trunk) |
| Dysarthria (speech impairment)                                | Scanning speech   |
| Fatigue ( <i>most common and<br/>debilitating complaint</i> ) | Spasticity  |
| Hearing loss  | Tremor  |
| Hesitancy or retention  | Unilateral visual loss  |
| Incontinence  | Urinary frequency   |
| Incoordination  | Vertigo   |
| Nystagmus (oscillation of the eyeballs)                       | Weakness  |

---

**Q: What are the behavioral symptoms of *multiple sclerosis*?**

|                        |                |
|------------------------|----------------|
| Forced laughter        | Sudden weeping |
| Inappropriate behavior |                |

---

## The Plaintiff's Pre-Existing Medical Conditions

---

DISORDER

DEPOSITION QUESTIONS

---

### Multiple Sclerosis

(continued)

**Q: What are the cognitive changes or symptoms of *multiple sclerosis*?**

Ten percent of patients with MS develop subcortical dementia, and more than 40% demonstrate cognitive impairment. Learning, memory, and executive control are most commonly affected, and impairments of these functions are usually associated with reduced perceptual-motor speed, psychomotor slowing, and attentional difficulties. Many of the problems with learning and memory found in MS patients may be attributed to attentional factors.

---

**Q: What type of *multiple sclerosis* does the plaintiff have?**

MS may present in several ways. The first stage or pattern is rather benign, with a few mild early exacerbations, complete or nearly complete remissions, and minimal or no disability. Another type, known as relapsing-remitting MS, is characterized by more frequent early exacerbations and less complete remissions, but with long periods of stability and some disability. Chronic-relapsing MS is characterized by fewer remissions as the disease progresses and increasing (cumulative) disability. Finally, chronic-progressive MS, usually has an insidious onset and steady progression of symptoms. These descriptions have limitations because a relapsing-remitting course may occur for several years followed by a chronic-progressive illness. Also, no universal agreement has been reached about the definition of relapse or remission. (reference 21, pp. 804-825)

---

**Q: What processes are used to screen for *multiple sclerosis*?**

Magnetic resonance imaging (MRI) has greatly increased the precision of diagnosing multiple sclerosis. The most frequent sites of multiple sclerosis lesions occur in the optic nerves, the long tracts of the spinal cord, and the periventricular white matter. However, white matter changes that occur with MS also occur in other neurological conditions. Therefore, confirmation of an MS diagnosis by clinical and other laboratory measures is essential.

The most useful laboratory tests are visual or somatosensory evoked potentials and analysis of  $\gamma$ -globulin and myelin basic protein in the cerebrospinal fluid. In multiple sclerosis patients sensory evoked potentials are slowed or absent and  $\gamma$ -globulin and myelin basic protein levels are elevated.

---

**Q: What problems are encountered in screening for *multiple sclerosis*?**

None of the laboratory measures are specific for multiple sclerosis and not all multiple sclerosis patients show any or all of these changes. Early neurological symptoms can often resemble hysteria or a conversion disorder.

---

**Q: Are the plaintiff's current physical, psychological, cognitive, or behavioral symptoms caused by *multiple sclerosis*?**

# The Plaintiff's Pre-Existing Medical Conditions

---

## DISORDER

## DEPOSITION QUESTIONS

---

### Myocardial Infarction (MI)

**Profile:** Myocardial infarction (MI) is an area of dead heart muscle tissue caused by an inadequate blood flow. The blood supply to the heart may be reduced by an obstruction or constriction of the arteries, heart valve disease, heart failure, or other mechanical disturbance. The ability of the heart to continue functioning is directly related to the amount of tissue damage. This condition is characterized by moderate to severe chest pain and arrhythmias (an alteration in rhythm of the heartbeat either in time or force). (reference 1, pp. 494-497; reference 2, pp. 151, 371; reference 4, p. 141)

**Q: What are the psychological symptoms of myocardial infarction?**

|                    |                         |
|--------------------|-------------------------|
| Anxiety            | Depression              |
| Confusional states | Sense of impending doom |

---

**Q: What are the physical symptoms of myocardial infarction?**

Early symptoms of acute MI are a deep visceral pain or aching pressure radiating to the back, jaw, or left arm.

|  |           |
|--|-----------|
| Arrhythmia                             | Pale skin |
| Bradycardia                            | Syncope   |
| Diaphoresis (increase in perspiration) | Vomiting  |
| Hypertension                           |           |

---

**Q: What processes are used to screen for myocardial infarction?**

The amount of cardiac damage can be determined by the plaintiff's symptoms, ECG abnormalities, and a rise in the serum activity of the enzymes released from the myocardial (heart muscle tissue) cells.

---

**Q: What problems are encountered in screening for myocardial infarction?**

Symptoms may be very mild, unrecognized, or silent. The plaintiff may first interpret the pain as indigestion.

---

**Q: Are the plaintiff's current physical or psychological symptoms caused by myocardial infarction or other related heart disease?**

## The Plaintiff's Pre-Existing Medical Conditions

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DISORDER

DEPOSITION QUESTIONS

---

### Pancreatic Carcinoma

**Profile:** Pancreatic carcinoma is a fatal disease that develops slowly and insidiously. It is the second most common tumor of the digestive system and the fourth most common cause of cancer death. Frequently, the first clinical manifestation of occult pancreatic carcinoma is the onset of a major depressive disorder. One of the few physical signs of pancreatic carcinoma is pain in the upper or right abdomen that radiates to the back. The pain may be accompanied by weakness, weight loss, pruritus, jaundice, and frequently, hyperglycemia. The disease occurs more frequently in males (3:1) than females. (reference 4, p. 1276; reference 1, p. 751; reference 9, pp. 777-779; reference 2, p. 425; reference 18, p. 868)

**Q: What are the psychological symptoms of *pancreatic carcinoma*?**

|                              |                          |
|------------------------------|--------------------------|
| Depressive disorder          | Psychiatric disturbances |
| Loss of drive and motivation | Sense of doom            |
| Malaise                      |                          |

---

**Q: What are the physical symptoms of *pancreatic carcinoma*?**

|                                |                  |
|--------------------------------|------------------|
| Anemia                         | Thrombophlebitis |
| Anorexia                       | Vomiting         |
| Diarrhea                       | Weakness         |
| Dull epigastric abdominal pain | Weight loss      |
| Jaundice                       |                  |

---

**Q: What processes are used to screen for *pancreatic carcinoma*?**

Tests to detect pancreatic cancer include ultrasonography, CT, retrograde pancreatography, arteriography, and pancreatic function testing.

---

**Q: What problems are encountered in screening for *pancreatic carcinoma*?**

There are only a few characteristic signs of the disease. Symptoms develop slowly and insidiously, sometimes resembling symptoms of depression, a gastric ulcer or cancer, other intra-abdominal malignancies, or chronic pancreatitis.

---

**Q: Are the plaintiff's current physical or psychological symptoms caused by *pancreatic carcinoma*?**

# The Plaintiff's Pre-Existing Medical Conditions

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## DISORDER

## DEPOSITION QUESTIONS

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### Parkinson's Disease

**Profile:** Parkinson's disease has characteristic symptoms of tremor or bradykinesia (slowness and poverty of movement). Changed gait, posture, and facial expression appear as the disease progresses. Plaintiffs often experience personality changes, depression, and dementia. The plaintiff will also become more passive, dependent, fearful, and indecisive. Parkinson's disease is not fatal, but complications include pneumonia, urinary tract infections, and ulcers. Disability seldom occurs until ten or fifteen years after onset. The disease occurs in about one percent of those over 50 years of age and tends to affect more males than females. (reference 4, pp. 118-119, 147; reference 9, pp. 2070-2071; reference 1, pp. 1359-1360)

**NOTE (1)** Secondary or acquired Parkinsonism can result from encephalitis or exposure to toxins such as manganese, carbon monoxide or psychotropic drugs.

**NOTE (2)** Early tremor of Parkinsonism may be misdiagnosed as nervousness, especially when the plaintiff is under emotional stress.

**NOTE (3)** Slowness and poverty of movement, speech, and facial expression may be misdiagnosed as depression or withdrawal.

#### Q: What are the psychological symptoms of Parkinson's disease?

|   |                                   |
|---|-----------------------------------|
| Anhedonia   | Depressive disorder               |
| Anxiety   | (most common psychiatric symptom) |
| Apathy  | Emotional lability                |
| Cognitive impairment<br>(ranging from mild to severe)               | Fearfulness                       |
| Delirium  | Hallucinations                    |
| Delusions   | Indecisiveness                    |
| (medications lower the threshold for<br>delusions & hallucinations) | Irritability                      |
| Dementia (common in geriatric patients)                             | Memory deficits                   |
|   | Slowed information processing     |

---

#### Q: What are the physical symptoms of Parkinson's disease?

|  |   |
|--|---|
| Appetite disturbance   | Psychomotor retardation   |
| Bradykinesia<br>(slowness and poverty of movement)*            | Rigidity*   |
| Choking  | Shuffling, small steps, festination<br>(a tendency to accelerate) |
| Difficulty swallowing  | Sleep disturbance<br>(vivid dreams and nightmares)                |
| Gait hesitation  | Soft voice  |
| Masked face  | Resting tremor*   |
| Pain, tingling, numbness, burning on the<br>side with symptoms | Unsteadiness  |
| Postural instability<br>(loss of postural reflexes)*           | <b>* cardinal clinical sign</b>                                   |

---

## The Plaintiff's Pre-Existing Medical Conditions

---

DISORDER

DEPOSITION QUESTIONS

---

### Parkinson's Disease

(continued)

**Q: What are the behavioral symptoms of *Parkinson's disease*?**

Dependency

Passiveness

Obsessive-compulsive behaviors

Spontaneous laughing or crying

---

**Q: What processes are used to screen for *Parkinson's disease*?**

Diagnosis is made primarily based on clinical symptoms. An early diagnosis of the disease is difficult. An MRI may reveal thinning of the low signal band produced by the substantia nigra, but the usefulness of this finding for early diagnosis is limited. However, the diagnosis of several secondary causes of Parkinsonism may be assisted by MRI.

---

**Q: What problems are encountered in screening for *Parkinson's disease*?**

There is no specific test that can identify the disease.

---

**Q: Are the plaintiff's current physical, psychological or behavioral symptoms caused by *Parkinson's disease*?**

# The Plaintiff's Pre-Existing Medical Conditions

DISORDER

DEPOSITION QUESTIONS

## Pernicious Anemia

**Profile:** Pernicious anemia (Addisonian anemia) is a potentially fatal disease that results from a lack of Vitamin B12. The disease develops slowly over several months and is often accompanied by degeneration of the posterior and lateral columns of the spinal cord. While a burning tongue (glossitis) may be an early sign of the disease, other symptoms can easily be mistaken for depression. Pernicious anemia often leads to combined systems disease and occurs most frequently in females aged 40 to 60. Vitamin B12 is found in meat and other animal protein foods. (reference 4, p. 1276; reference 1, pp. 1077-1079; reference 2, pp. 576, 570)

Defense counsel should investigate any incidences of anemia in plaintiff's history. An internal medicine specialist or neurologist should be retained to determine if the plaintiff's claimed mental or physical symptoms are actually due to a pre-existing anemia.

**Q: What are the psychological symptoms of *pernicious anemia*?**

*Many of these symptoms only occur in the older anemic patient.*

|            |                                  |
|------------|----------------------------------|
| Agitation  | Feelings of worthlessness        |
| Anxiety    | Guilt                            |
| Apathy     | Irritability                     |
| Confusion  | Mania                            |
| Delirium   | Memory loss                      |
| Delusions  | Paranoia (megaloblastic madness) |
| Depression | Personality changes              |

**Q: What are the physical symptoms of *pernicious anemia*?**

|   |  |
|---|--|
| Abdominal pain  | Glossitis (burning of the tongue)      |
| Anorexia  | Intermittent constipation and diarrhea |
| Ataxia (incoordination of involuntary muscles, e.g., walking) | Lemon-yellow skin pallor               |
| Brain damage  | Loss of vibratory sense                |
| Difficulty in walking   | Smooth beefy-red tongue                |
| Extremity paresthesia   | Weakness                               |
| Fatigue   | Weight loss                            |

**Q: What processes are used to screen for *pernicious anemia*?**

Laboratory tests that can establish a B12 deficiency and pernicious anemia include a serum Vitamin B12 assay with either microbiologic or radioisotopic methods. These tests are effective later in the disease.

**Q: What problems are encountered in screening for *pernicious anemia*?**

Early diagnosis is difficult. Pernicious anemia has few early symptoms and an early blood test may give no indication of the disease. Later symptoms can be mistaken for depression.

**Q: Are the plaintiff's current physical or psychological symptoms caused by *pernicious anemia*?**

# The Plaintiff's Pre-Existing Medical Conditions

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## DISORDER

## DEPOSITION QUESTIONS

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### **Pheochromocytoma**

**Profile:** Pheochromocytoma is a tumor of the sympathetic nervous system. The tumor typically causes either sustained or fluctuating hypertension (high blood pressure). The plaintiff may have spontaneous attacks of hypertension or attacks precipitated by physical exertion, pressure on the abdomen, or emotional stress. Frequency and duration of the hypertensive episodes are different for each person but can be severe enough to cause death. Common associated symptoms include headaches, palpitations, and diaphoresis (perspiration). These symptoms occur with the variations in blood pressure. The disease occurs in adults of both sexes. (reference 4, p. 1276; reference 2, p. 612; reference 9, pp. 1410, 274)

**Q: What are the psychological symptoms of *pheochromocytoma*?**

|              |                                |
|--------------|--------------------------------|
| Anxiety      | Inability to function during a |
| Apprehension | hypertensive attack            |
| Fear         | Panic attacks                  |

---

**Q: What are the physical symptoms of *pheochromocytoma*?**

|  |                      |
|--|----------------------|
| Agitation                              | Hypertension         |
| Blurred vision                         | Lightheadedness      |
| Chest pain                             | Nausea               |
| Elevated blood pressure during attacks | Palpitations         |
| Epigastric discomfort                  | Postural hypotension |
| Excessive sweating                     | Shortness of breath  |
| Flushing                               | Skin color changes   |
| Glycosuria (sugar in the urine)        | Trembling            |
| Headaches                              | Weakness             |
| Hypermetabolism                        |                      |

---

**Q: What processes are used to screen for *pheochromocytoma*?**

A diagnosis of pheochromocytoma is based upon clinical examination and confirmation with biochemical tests, such as:

- CT of the abdomen (to locate catecholamine-secreting tumors)
- Plasma levels of catecholamines
- Radiographic studies
- Fluorometric measurements of unconjugated catecholamines
- Spectrophotometric measurements of total metanephrines
- Urine collection (24-hour) to measure catecholamines and metabolites

---

**Q: What problems are encountered in screening for *pheochromocytoma*?**

Intermittent normal blood pressure and symptoms resembling anxiety or panic attacks make the disease difficult to diagnose.

---

**Q: Are the plaintiff's current physical or psychological symptoms caused by *pheochromocytoma*?**

# The Plaintiff's Pre-Existing Medical Conditions

DISORDER

DEPOSITION QUESTIONS

---

## Polycythemia

**Profile:** Polycythemia is a chronic life-threatening disease involving bone marrow. It is characterized by an increase in red blood mass and hemoglobin concentration. The result is an impaired blood flow, hypervolemia (greater than normal volume of blood), increased cardiac output, and hyperviscosity (abnormally high resistance to flow). These increases are responsible for most of the symptoms of polycythemia. The plaintiff may also experience fatigue, decreased efficiency, difficulty concentrating, headaches, drowsiness, forgetfulness, and vertigo. The disorder affects about seven million people, mostly males. The average age of onset is 60 years old. Survival time with treatment is about thirteen years. (reference 1, pp. 1106-1109; reference 2, p. 831)

**Q: What are the psychological symptoms of *polycythemia*?**

Difficulty concentrating

Forgetfulness

---

**Q: What are the physical symptoms of *polycythemia*?**

Abdominal discomfort

Headaches

Dizziness

Night sweats

Drowsiness

Paresthesias

Erythremia

Vertigo

(flushed, slightly cyanotic appearance) Visual symptoms

Fatigue

Weight loss

---

**Q: What are the behavioral symptoms of *polycythemia*?**

Decreased efficiency

---

**Q: What processes are used to screen for *polycythemia*?**

Minimal criteria for diagnosis are an elevated red blood count mass, a SaO<sub>2</sub> (type of arterial blood gas) above 92 percent, and an enlarged spleen.

---

**Q: Are the plaintiff's current physical, psychological or behavioral symptoms caused by *polycythemia*?**

# The Plaintiff's Pre-Existing Medical Conditions

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## DISORDER

## DEPOSITION QUESTIONS

---

### Porphyria

**Profile:** Porphyria (acute intermittent type) is an inherited metabolic disorder that may be suddenly precipitated by drugs and substances such as barbiturates, alcohol, tranquilizers, and oral contraceptives. The plaintiff may have attacks of abdominal pain, central nervous system symptoms, mental and emotional changes, and convulsions. The sudden and acute onset of symptoms resemble anxiety attacks or conversion reactions. This metabolic malfunctioning causes increased quantities of porphyrins in the blood, tissues, feces, and urine. Prolonged and acute increases in the porphyrins may result in death. Disease treatment partially involves instructing the plaintiff to avoid any known precipitating factors. Porphyria occurs most often in females aged twenty to forty. (reference 4, pp. 1276, 121, 1326; reference 9, p. 1156; reference 1, pp. 958, 960)

**Q: What are the psychological symptoms of *porphyria*?**

|  |   |
|--|---|
| Depression                                       | Mood swings                                     |
| Mental abnormalities<br>(confusion to psychosis) | Organic brain syndrome<br>Sudden severe anxiety |

---

**Q: What are the physical symptoms of *porphyria*?**

|                           |                      |
|---------------------------|----------------------|
| Anorexia                  | Paresthesia          |
| Constipation              | Postural hypotension |
| Low grade fever           | Tachycardia          |
| Nausea                    | Vomiting             |
| Pain                      | Weakness             |
| Pain (leg and lower back) |                      |

---

**Q: What are the behavioral symptoms of *porphyria*?**

|                              |                                      |
|------------------------------|--------------------------------------|
| Angry or emotional outbursts | Extremes of excitement or withdrawal |
|------------------------------|--------------------------------------|

---

**Q: What processes are used to screen for *porphyria*?**

Porphyria is diagnosed by finding specific abnormal porphyrin in the urine or abnormal blood enzymes characteristic of defective heme production. Urinary PBG is elevated during acute attacks and while symptoms persist.

---

**Q: What problems are encountered in screening for *porphyria*?**

The plaintiff's symptoms may often resemble conversion reactions or anxiety/panic attacks. Routine laboratory tests may be inconclusive.

---

**Q: Are the plaintiff's current physical, psychological or behavioral symptoms caused by *porphyria*?**

# The Plaintiff's Pre-Existing Medical Conditions

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## DISORDER

## DEPOSITION QUESTIONS

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### Postpartum Mood Disorder

**Profile:** During the postpartum period, up to 85 percent of women experience some type of mood disturbance. For most women the symptoms are transient and relatively mild. However, some women (10-15%) experience a more disabling and persistent form of mood disturbance, a postpartum depression. Postpartum mood disorders are typically divided into three categories: (1) postpartum blues, (2) nonpsychotic postpartum depression, and (3) puerperal psychosis. Factors predisposing to depression at that time include the rapid change in hormonal functioning which includes the abrupt withdrawal of estrogen and progesterone, decreasing serum cortisol concentration, changes in thyroid function, and the psychological and circadian stress of a newborn infant. (reference 18, pp. 1276-1277, 1949)

**Postpartum blues:** Within the first week following childbirth, thirty to eight-five percent of new mothers experience mood lability, tearfulness, insomnia and anxiety.

**Nonpsychotic postpartum depression:** Within the first two to three months following childbirth, ten to fifteen percent of new mothers experience depressed mood, excessive anxiety and insomnia. Ambivalent or negative feelings toward the infant are often reported. Twenty-six percent of adolescent mothers develop a postpartum depression.

**Puerperal psychosis:** Within the first two to four weeks following childbirth, 0.1 to 0.2 percent of new mothers experience a more significant mood disturbance, including agitation and irritability, severe anxiety, obsessions, depressed mood or euphoria, delusions, depersonalization and disorganized behavior. Profound dysfunction may result and suicidal ideation is frequently reported.

**Q: What are the psychological symptoms of a *postpartum mood disorder*?**

|                       |                         |
|-----------------------|-------------------------|
| Anhedonia             | Helplessness            |
| Anxiety               | Identity fragmentation  |
| Agitation             | Impaired memory         |
| Confusion             | Impaired judgment       |
| Delirium              | Intermittent depression |
| Delusions             | Irritability            |
| Depersonalization     | Mood swings             |
| Disorganized behavior | Psychotic depression    |
| Euphoria              | Tearfulness             |
| Functional psychosis  | Time disorientation     |

---

**Q: What are the physical symptoms of a *postpartum mood disorder*?**

|          |                    |
|----------|--------------------|
| Fatigue  | Restlessness       |
| Headache | Somatic complaints |
| Insomnia |                    |

---

**Q: What are the behavioral symptoms of a *postpartum mood disorder*?**

|                 |                                |
|-----------------|--------------------------------|
| Crying spells   | Obsessive-compulsive behaviors |
| Distractibility |                                |

---

## The Plaintiff's Pre-Existing Medical Conditions

---

DISORDER

DEPOSITION QUESTIONS

---

### Postpartum Mood Disorder

(continued)

**Q: What processes are used to screen for a *postpartum mood disorder*?**

Severe postpartum depression and psychosis are easily recognized. However, milder or more insidious forms of depressive illness are frequently missed. Various medical illnesses mimic psychiatric illness during the postpartum period. Hypothyroidism is relatively common in women after delivery and may cause a constellation of symptoms resembling major depressive disorder. A blood test that measures the TSH serum levels will provide evidence of a hypothyroid condition.

---

**Q: What problems are encountered in screening for a *postpartum mood disorder*?**

Hypothyroidism, Cushing's syndrome, and folate deficiency have depressive or psychotic symptoms similar to postpartum disorders and are not uncommon diseases following pregnancy. Women with prior histories of schizophrenia or a manic-depressive disorder are more apt to have recurrences with pregnancy. Also, psychiatric illness may emerge for the first time during the postpartum period, e.g., schizophrenia or schizoaffective disorder, making it difficult to distinguish from puerperal psychosis.

---

**Q: Are the plaintiff's current physical, psychological or behavioral symptoms caused by *postpartum mood disorder*?**

# The Plaintiff's Pre-Existing Medical Conditions

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## DISORDER

## DEPOSITION QUESTIONS

---

### Rheumatoid Arthritis

**Profile:** Rheumatoid arthritis is a systemic, chronic, inflammatory, progressive disease of unknown origin. Psychological and environmental stress factors are thought to play a role in the cause and severity of the disease. The plaintiff will experience inflammation of the joints and connected areas, crippling deformity, and a lack of productivity. The disease occurs more often in females than males and more frequently with advancing age. (reference 4, pp. 1185, 1189, 1194; reference 9, p. 1913; reference 18, pp. 1828-1829)

Defense counsel should examine the plaintiff's medical and familial history for prior evidence of this disease. Many plaintiffs suffer from chronic rheumatoid arthritis.

**Q: What are the psychological symptoms of *rheumatoid arthritis*?**

Depression

Malaise

---

**Q: What are the physical symptoms of *rheumatoid arthritis*?**

Anorexia

Joint pain and inflammation

Early morning joint stiffness

Pale and clammy skin of the extremities

Fatigue

Weakness

Fever

Weight loss

Functional impairment and deformity

---

**Q: What processes are used to screen for *rheumatoid arthritis*?**

No single test offers explicit confirmation of rheumatoid arthritis. However, rheumatoid factors are found in seventy percent of those afflicted with the disease.

The American College of Rheumatology requires the presence of four of the following symptoms to be present to confirm the diagnosis of rheumatoid arthritis:

- (1) morning stiffness
  - (2) arthritis of three or more joint areas
  - (3) arthritis of the hand joints
  - (4) symmetrical arthritis
  - (5) rheumatoid nodules
  - (6) serum rheumatoid factor
  - (7) typical radiographic changes
- 

**Q: What problems are encountered in screening for *rheumatoid arthritis*?**

Rheumatoid arthritis has a highly variable clinical course, appearing suddenly or slowly over weeks and months. The plaintiff sometimes wakes up in the morning with acute generalized rheumatoid arthritis. The more sudden onset may be confused with acute myositis (inflammation of the muscle), viral syndromes, or septic arthritis.

---

**Q: Are the plaintiff's current physical or psychological symptoms caused by *rheumatoid arthritis*?**

# The Plaintiff's Pre-Existing Medical Conditions

DISORDER

DEPOSITION QUESTIONS

## Syphilis

**Profile:** Syphilis is a chronic disease usually contracted from another person through sexual contact. Pain and progressive dementia with agitation, expansiveness, or depression are common symptoms. Syphilis is caused by "treponema pallidum" spirochetes. It is easily treated with the administration of six to nine million units of penicillin over a two to three week period. If left untreated, the plaintiff may experience periods of active symptoms and years of a latent stage, which can last for the rest of the plaintiff's life. In about 30 percent of those not treated, the disease will affect the heart, central nervous system and brain. (reference 1, pp. 1616-1621; reference 9, pp. 1650-1654; reference 4, p. 127; reference 18, pp. 340, 744)

**Q: What are the psychological symptoms of syphilis?**

|   |            |
|---|------------|
| Agitation                                 | Depression |
| Dementia (seen in parietic neurosyphilis) | Malaise    |

**Q: What are the physical symptoms of syphilis?**

|   |  |
|---|--|
| Albuminuria<br>(presence of albumin in the urine)   | Jaundice                                       |
| Anemia  | Lesions  |
| Anorexia (absence of appetite)                      | Nausea   |
| Ataxia<br>(incoordination of voluntary muscles)     | Neck stiffness                                 |
| Chancre<br>(painless, clean-based, indurated ulcer) | Pain   |
| Enlarged lymph nodes                                | Paresis (weakness)                             |
| Fatigue   | Paresthesias<br>(tingling, burning, tightness) |
| Fever   | Patchy hair loss                               |
| Headaches   | Rashes   |
|   | Slurred speech                                 |
|   | Tremors  |

**Q: What processes are used to screen for syphilis?**

The rapid plasma reagin test (RPR) or Venereal Disease Research Laboratories (VDRL) test is the most common screening test for syphilis. Positive results on these tests are followed up with fluorescent treponemal antibody absorption (FTA-ABS) tests. The test that is diagnostic of tertiary or CNS syphilis is the CSF VDRL. A positive CSF VDRL is typically associated with other CSF findings such as abnormal CSF protein and white blood cell counts.

Other screening tests include:

|   |                        |
|---|------------------------|
| Darkfield examination of<br>fluids from lesions | Radiologic examination |
| CSF (cerebrospinal fluid) tests                 | Serologic tests        |
|   | Thorough physical exam |

## The Plaintiff's Pre-Existing Medical Conditions

---

*DISORDER*

*DEPOSITION QUESTIONS*

---

### **Syphilis**

*(continued)*

**Q: What problems are encountered in screening for *syphilis*?**

Symptoms of the disease's second stage resemble pityriasis rosea, infectious mononucleosis and infectious hepatitis. During the latent stage there are no clinical signs of syphilis and the cerebrospinal fluid is normal.

---

**Q: Are the plaintiff's current physical or psychological symptoms caused by *syphilis*?**

# The Plaintiff's Pre-Existing Medical Conditions

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## DISORDER

## DEPOSITION QUESTIONS

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### Systemic Lupus Erythematosus (SLE)

**Profile:** Systemic lupus erythematosus (SLE) is a connective tissue disease of unclear etiology, characterized by recurrent episodes of destructive inflammation in many different organ systems including the skin, joints, kidneys, blood vessels, and central nervous system. The plaintiff with this disease may experience depression, confusion, psychosis, personality and physical changes. SLE is thought to result from dysregulation of the immune system, which results in production of antibodies against the self. Females between the ages of fifteen and twenty-five are afflicted with the disorder more than other groups. (reference 4, pp. 1276, 114, 1211; reference 9, pp. 1924-1928; reference 1, pp. 1207-1209; reference 18, pp. 1831, 744)

**Q: What are the psychological symptoms of systemic lupus erythematosus?**

Neuropsychiatric complications occur when there is direct involvement of the central nervous system. Lupus causes small vessel vasculitis in the brain. Microhemorrhages and microinfarcts are common pathological findings at autopsy. Cognitive impairment, psychotic symptoms, and behavioral abnormalities can be observed in lupus cerebritis patients.

|                                 |                    |
|---------------------------------|--------------------|
| Anxiety                         | Personality change |
| Confusion                       | Psychotic symptoms |
| Depression                      | Seizures           |
| Florid delirium                 | Thought disorders  |
| Marked behavioral abnormalities |                    |

---

**Q: What are the physical symptoms of systemic lupus erythematosus?**

The American Rheumatism Association developed criteria for the diagnosis of lupus. A person is said to have the disease if four of the following symptoms are or have been present:

- (1) malar rash
- (2) discoid rash
- (3) photosensitivity
- (4) oral ulcers
- (5) arthritis
- (6) serositis (pleuritis or pericarditis)
- (7) renal disorder
- (8) neurological disorders (seizures or psychosis)
- (9) hematological disorder (anemia, leukopenia, thrombocytopenia)
- (10) immunological disorder
- (11) abnormal titer of antinuclear antibody

Other physical symptoms may also include:

|                                    |  |
|------------------------------------|--|
| Alopecia (loss of hair)            | Migraine headaches                     |
| Anemia                             | Nephritis (inflammation of the kidney) |
| Anorexia                           | Stroke                                 |
| Fatigue                            | Vasculitis (inflammation of a vessel)  |
| Fever                              | Weight loss                            |
| Hypertension (high blood pressure) |  |

---

## The Plaintiff's Pre-Existing Medical Conditions

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DISORDER

DEPOSITION QUESTIONS

---

**Systemic Lupus  
Erythematosus  
(SLE)**

*(continued)*

**Q: What processes screen for *systemic lupus erythematosus*?**

Laboratory tests for lupus include the lupus prep and tests for serum antinuclear and antideoxyribonucleic acid (DNA) antibodies. Seventy to ninety percent of the plaintiffs with SLE will have a positive SLE cell test some time during the disease. Careful evaluation and long-term observation are necessary for an accurate diagnosis. Histologic (tissue) changes in the spleen and kidney may show SLE disease.

---

**Q: What are the difficulties in screening for *systemic lupus erythematosus*?**

Systemic lupus erythematosus is unpredictable. The disease develops slowly over years and has periods of remission. There is no one symptom or test that definitely identifies the disease. A plaintiff may have all the described physical or mental signs and not have the disease. A plaintiff with SLE may have no symptoms or signs. Also, the psychological signs of the disease can be mistaken for the symptoms of schizophrenia or steroid psychosis.

---

**Q: Are the plaintiff's current physical or psychological symptoms caused by *systemic lupus erythematosus*?**

# The Plaintiff's Pre-Existing Medical Conditions

DISORDER

DEPOSITION QUESTIONS

## Uremic Encephalopathy

**Profile:** Uremic encephalopathy (kidney disease) occurs when the kidney is no longer able to carry out excretory functions. *Chronic uremic encephalopathy* may be accompanied by the slow development of dementia, changes in level of consciousness, and the characteristic symptoms of kidney failure. The disease resembles a metabolic encephalopathy. Both are easily misdiagnosed for psychosis or neurosis. The plaintiff can recover if the uremia is treated. *Progressive uremic encephalopathy* (dialysis dementia) occurs in the plaintiff with chronic uremia that has been treated with dialysis for at least three years. The plaintiff will experience speech abnormalities and dementia. Death usually results from dialysis complications. (reference 4, pp. 856-857; reference 9, pp. 488-489)

Defense counsel should look for plaintiff's use of medications containing aluminum, such as antacids. Aluminum may also be found in dialysate fluid. New evidence suggests that progressive uremic encephalopathy may be caused by aluminum toxicity.

**Q: What are the psychological symptoms of *uremic encephalopathy*?**

Dementia

Impaired concentration

**Q: What are the physical symptoms of *uremic encephalopathy*?**

Abdominal pain

Fatigue

Anemia

Nausea and vomiting

Asthenia

Weight loss

**Q: What processes are used to screen for *uremic encephalopathy*?**

- (1) A urinalysis may show protein or other abnormalities. An abnormal urinalysis may occur 6 months to 10 or more years before symptoms appear.
- (2) Creatinine levels progressively increase.
- (3) BUN is progressively increased.
- (4) Creatinine clearance progressively decreases.
- (5) Potassium test may show elevated levels.
- (6) Arterial blood gas and blood chemistry analysis may show metabolic acidosis.

**Q: What problems are encountered in screening for *uremic encephalopathy*?**

Chronic uremic encephalopathy clinically resembles metabolic encephalopathy, including the ability to recover.

**Q: Are the plaintiff's current physical or psychological symptoms caused by *uremic encephalopathy*?**

# The Plaintiff's Pre-Existing Medical Conditions

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## DISORDER

## DEPOSITION QUESTIONS

---

### Wilson's Disease

**Profile:** Wilson's disease (hepatolenticular degeneration) is an autosomal recessive disorder of copper metabolism that becomes symptomatic in the second to third decades of life. It is a relatively rare familial disease that causes dementia and motor dysfunction. A defective copper metabolism produces excessive copper deposits in tissues of the cornea, kidneys, liver, and brain. The accumulation of copper within the body tissue causes the disease symptoms and degenerative changes in the brain. The plaintiff with Wilson's disease often feels demoralized, depressed, apprehensive, and misunderstood. It is a treatable cause of dementia, although most plaintiffs will first seek treatment because of motor dysfunction. (reference 4, pp. 118, 155, 861, 1276; reference 2, pp. 424, 581, 613, 849, 758; reference 1, pp. 913-914; reference 9, pp. 832, 1158-1159; reference 18, p. 744)

**Q: What are the psychological symptoms of Wilson's disease?**

|  |                                   |
|--|-----------------------------------|
| Abnormal mental states progressing to coma and death | Impaired intellectual functioning |
| Dementia   | Memory loss                       |
| Explosive anger                                      | Personality changes               |
| Feeling demoralized                                  | Psychosis                         |
|  | Sudden mood swings                |

---

**Q: What are the physical symptoms of Wilson's disease?**

*Early symptoms may include:*

|  |          |
|--|----------|
| Cirrhosis                              | Rigidity |
| Evidence of abnormal copper metabolism | Tremor   |
| Gait disturbance                       |          |

*Other symptoms may include:*

|   |                   |
|---|-------------------|
| Abdominal pain  | Liver dysfunction |
| Brain damage  | Movement disorder |
| Diarrhea  | Nausea            |
| Diffuse myalgia (pain in muscles)   | Renal dysfunction |
| Distinctive lunule  | Tremor            |
| Extrapyramidal symptoms   | Vomiting          |
| Fever   |                   |
| Hemolysis (destruction of red blood cells; results in escape of hemoglobin) |                   |

---

**Q: What are the behavioral symptoms of Wilson's disease?**

|               |                             |
|---------------|-----------------------------|
| Combativeness | Schizophrenic-like behavior |
|---------------|-----------------------------|

---

**Q: What processes are used to screen for Wilson's disease?**

High copper output in urine, amino aciduria and low ceruloplasmin (the copper-carrying plasma protein) will confirm a clinical diagnosis. Also, Kayser-Fleischer rings adjacent to the cornea can be seen during a slit-lamp examination.

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## The Plaintiff's Pre-Existing Medical Conditions

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*DISORDER*

*DEPOSITION QUESTIONS*

---

**Wilson's  
Disease**

*(continued)*

**Q:** What problems are encountered in screening for *Wilson's disease*?

The first unusual symptoms of the disease often cause a misdiagnosis of hysteria or hypochondriasis. Other symptoms resemble late adolescent temper outbursts and incorrigibility or schizophrenia.

---

**Q:** Are the plaintiff's current physical, psychological or behavioral symptoms caused by *Wilson's disease*?

# The Plaintiff's Pre-Existing Medical Conditions

DISORDER

DEPOSITION QUESTIONS

## B. UNDIAGNOSED, EARLY STAGES OF SEVERE DISEASE

### Alzheimer's Disease

(Dementia of the Alzheimer's type)

**Profile:** Alzheimer's disease is a cortical degenerative disease, which causes a progressive atrophy of the cerebral cortex. The hallmark of dementia is memory impairment and initially short-term memory is most affected. The deterioration of other intellectual functions slowly progresses to an advanced stage of impairment within two or three years. The plaintiff may also experience a reduction in emotions, increased anxiety, and physical or neurological symptoms later in the course of the illness. Alzheimer's disease is the most common form of dementia and is responsible for over half of all dementia cases. Rarely appearing in young adults, its frequency increases with age. By age 65, five percent of the population have the disease and by age 80, twenty percent are afflicted. A genetic link with the disease is suspected, but the cause is primarily unknown. There is no treatment, but new drugs are on the market and more are being developed in an attempt to slow the progression of the disease (cognitive decline). (reference 4, pp. 117, 844; reference 1, p. 1306; reference 9, pp. 27, 1999-2000; reference 18, pp. 884, 3068)

#### Q: What are the psychological symptoms of Alzheimer's disease?

|            |                    |
|------------|--------------------|
| Apathy     | Disorientation     |
| Agitation  | Flattened emotions |
| Amnesia    | Hallucinations     |
| Anxiety    | Hostility          |
| Confusion  | Irritability       |
| Delusions  | Paranoia           |
| Dementia   | Withdrawn          |
| Depression |                    |

#### Q: What are the physical symptoms of Alzheimer's disease?

|   |                     |
|---|---------------------|
| Agnosia (inability to recognize objects)                | Insomnia            |
| Aphasia (impaired speech)                               | Language impairment |
| Apraxia (impaired motor function)                       | Reduced appetite    |
| Dyspraxia (difficulty performing coordinated movements) | Restlessness        |

#### Q: What processes are used to screen for Alzheimer's disease?

Diagnosis is usually from clinical symptoms and the gradual exclusion of other causes with laboratory tests.

#### Q: What problems are encountered in screening for Alzheimer's disease?

Pre-senile and senile-onset dementias resemble most characteristics of Alzheimer's disease. No specific laboratory test can diagnose the disease.

#### Q: Are the plaintiff's physical or psychological symptoms caused by an undiagnosed Alzheimer's disease?

# The Plaintiff's Pre-Existing Medical Conditions

DISORDER

DEPOSITION QUESTIONS

## Creutzfeldt-Jakob Disease (CJD)

**Profile:** Creutzfeldt-Jakob disease (CJD) is a progressive disease of the cortex, basal ganglia, and spinal cord that develops in middle-aged and elderly adults. Recent research indicates a variant of CJD may occur from a diet consisting of meat contaminated with bovine spongiform encephalopathy (BSE). This condition is also known as mad cow disease. Dementia is often the first symptom of the illness and may be accompanied by self-neglect, apathy, irritability, and myoclonic (abrupt and irregular jerking) seizures. The plaintiff experiences a rapid development of dementia with daily and weekly signs of mental deterioration. The disease usually affects a healthy adult in mid-life and rapidly reduces them to a state of helplessness or death in less than a year. No known treatment exists. (reference 9, pp. 2001, 2136; reference 4, pp. 126; reference 1, pp. 220-221; reference 21, pp. 170-171)

**Q: What are the psychological symptoms of *Creutzfeldt-Jakob disease*?**

|                        |                                |
|------------------------|--------------------------------|
| Anxiety                | Impaired judgment              |
| Apathy                 | Insomnia                       |
| Delusions              | Irritability                   |
| Dementia               | Memory loss                    |
| Depression             | Nervousness                    |
| Emotional fluctuations | Periodic loss of consciousness |
| Hallucinations         | Unusual behavior               |

**Q: What are the physical symptoms of *Creutzfeldt-Jakob disease*?**

|  |                                      |
|--|--------------------------------------|
| Aphasia (impaired speech)  | Headache                             |
| Ataxia<br>(incoordination of voluntary muscles)                  | Loss of appetite                     |
| Cerebellar dysfunction   | Muscle wasting                       |
| Coordination disturbance   | Myoclonic jerks                      |
| Cortical blindness   | Rigidity                             |
| Dysarthria   | Seizures                             |
| Easy fatigability  | Slowness of movement                 |
| Fasciculations (incoordinate contraction<br>of skeletal muscles) | Somnolence (drowsiness)              |
| Involuntary movements  | Tremors                              |
|  | Visual disturbance and abnormalities |
|  | Weakness and stiffness of limbs      |

**Q: What are the behavioral symptoms of *Creutzfeldt-Jakob disease*?**

Self-neglect

# The Plaintiff's Pre-Existing Medical Conditions

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DISORDER

DEPOSITION QUESTIONS

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**Creutzfeldt-  
Jakob Disease  
(CJD)**

*(continued)*

**Q: What processes are used to screen for *Creutzfeldt-Jakob disease*?**

Examination of visual fields show areas of blindness that the person may not realize are present. There is loss of coordination related to visual-spatial perception changes and changes in the cerebellum, the area of the brain that controls coordination (cerebellar ataxia).

An EEG (electroencephalogram, a reading of electrical activity of the brain) shows characteristic changes indicating Creutzfeldt-Jacob disease, if the symptoms have been present for at least 3 months.

Though not diagnostic, presence of the 14-3-3 protein in the spinal fluid (obtained by lumbar puncture, "spinal tap") is highly suggestive of the disease, when accompanied by other characteristic symptoms.

---

**Q: What problems are encountered in screening for *Creutzfeldt-Jakob disease*?**

The behavioral symptoms of the disease may resemble a functional psychiatric disorder.

---

**Q: Are the plaintiff's current physical, psychological or behavioral symptoms caused by an undiagnosed *Creutzfeldt -Jakob disease*?**

# The Plaintiff's Pre-Existing Medical Conditions

DISORDER

DEPOSITION QUESTIONS

## Huntington's Disease (HD)

**Profile:** Huntington's disease is an inherited (autosomal dominant) degenerative disease of the brain. First symptoms are usually dementia, emotional and psychiatric disturbances, with memory loss and difficulty in anticipating or planning future events. Neuropsychological changes may precede motor changes (rapid, irregular, asymmetrical jerks of the extremities). However, the chorea (movement disorder) and mental changes can also occur simultaneously. Plaintiffs with the disease may have repeated episodes of severe depression and psychoses sometime during the illness. Huntington's disease usually begins between the ages of 30 and 50, but is not uncommon in a younger person (10% of cases are juvenile HD). The plaintiff often survives fifteen to twenty years after disease onset. Suicide rates are high (ten percent) because of severe depression and the slow progression of symptoms without cure. (reference 4, pp. 40, 87, 117-118, 865; reference 1, pp. 1362-1363; reference 9, p. 2001; reference 20, p. 2085; reference 21, p. 698))

Defense counsel should look for family incidence of the disease. The child of each effected parent will have a 50 percent risk of inheriting the gene.

### Q: What are the psychological symptoms of *Huntington's disease*?

|                             |                              |
|-----------------------------|------------------------------|
| Agitation                   | Impulsiveness                |
| Apathy                      | Inertia                      |
| Confusion                   | Loss of recent memory        |
| Delusions                   | Mania                        |
| Dementia                    | Paranoia                     |
| Depression                  | Personality changes          |
| Hallucinations              | Psychosis                    |
| Hostility                   | Schizophrenic-like delusions |
| Impaired judgment           | Social withdrawal            |
| Impaired mental functioning |                              |

### Q: What are the physical symptoms of *Huntington's disease*?

|  |  |
|--|--|
| Ataxia<br>(incoordination of voluntary muscles)  | Chorea (involuntary, jerky movements)      |
| Dysarthria<br>(difficulty in articulating words) | Fidgety<br>(irregular, hesitant, unsteady) |
| Dysphagia (difficulty in swallowing)             | Seizures                                   |
| Clumsiness                                       |  |

### Q: What are the behavioral symptoms of *Huntington's disease*?

Violent behavior

## The Plaintiff's Pre-Existing Medical Conditions

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DISORDER

DEPOSITION QUESTIONS

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### Huntington's Disease (HD)

(continued)

**Q: What processes are used to screen for *Huntington's disease*?**

Huntington's disease can be readily diagnosed in an adult with the clinical triad of chorea, dementia and personality disorder, and a positive family history of the disease. Difficulty arises when there is no family history of the disease, or the family history is unknown.

- (1) Diffuse abnormalities can be seen in an EEG.
- (2) CT scans will show enlarged ventricles with the characteristic butterfly appearance of the lateral ventricles, as a result of the degeneration of the caudate nucleus.
- (3) PET scans using fluorodeoxyglucose will show a hypometabolism in the caudate and the putamen in affected patients.

---

**Q: What problems are encountered in screening for *Huntington's disease*?**

Huntington's disease is difficult to diagnose because of the variability of the symptoms and the tendency of families to deny its presence. Other conditions in which choreic movements are a major symptom must be excluded e.g., Sydenham chorea, and tardive dyskinesia. Some plaintiffs may only experience the mental changes. If apathy and inertia are the primary symptoms, the plaintiff may be diagnosed as having a mood disorder. Periodic episodes of psychotic illness may resemble schizophrenia.

---

**Q: Are the plaintiff's current physical, psychological or behavioral symptoms caused by an undiagnosed *Huntington's disease*?**

# The Plaintiff's Pre-Existing Medical Conditions

DISORDER

DEPOSITION QUESTIONS

## Subacute Sclerosing Panencephalitis (SSPE, Dawson Disease)

**Profile:** Subacute sclerosing panencephalitis (SSPE) is a disease caused by a defective measles virus characterized by progressive dementia, incoordination, ataxia, myoclonic jerks, and other focal neurologic signs. The illness typically begins in childhood or adolescence and progresses to decerebration (causing the cerebrum to be nonfunctional), coma, and death within one to three years. Within weeks of onset, the plaintiff may experience intellectual deterioration, convulsive seizures, changes in speech, and motor abnormalities. Other initial symptoms may include failing school work, forgetfulness, temper outburst, distractibility, sleeplessness, and hallucinations. (reference 4, p. 126; reference 1, pp. 181, 218-219; reference 21, pp. 164-165; reference 23, pp. 2137-2138)

**Q: What are the psychological symptoms of *subacute sclerosing panencephalitis*?**

|                |                            |
|----------------|----------------------------|
| Distraction    | Intellectual deterioration |
| Hallucinations | Temper outbursts           |

**Q: What are the physical symptoms of *subacute sclerosing panencephalitis*?**

|                     |                     |
|---------------------|---------------------|
| Ataxia              | Incoordination      |
| Changes in speech   | Loss of speech      |
| Chorea              | Motor abnormalities |
| Convulsive seizures | Myoclonic jerks     |
| Dystonic posturing  |                     |

**Q: What are the behavioral symptoms of *subacute sclerosing panencephalitis*?**

Sleeplessness

**Q: What processes are used to screen for *subacute sclerosing panencephalitis*?**

Patients usually have a history of measles within the first 2 years of life.

- (1) Clinical diagnosis is established with EEG findings that show a widespread abnormality of the cortical activity with a "burst suppression" pattern of high-amplitude slow wave (or spike and slow wave) complexes occurring at a rate of every 4 to 20 seconds synchronous with or independent of the myoclonic jerks.
- (2) An elevated CSF (cerebrospinal fluid)  $\gamma$ -globulin.
- (3) Elevated levels of measles virus antibody can be found in serum and cerebral spinal fluid.
- (4) CT scan may show cortical atrophy and focal or multifocal low-density lesions of the white matter.

**Q: What problems are encountered in screening for *subacute sclerosing panencephalitis*?**

Measles virus may also cause a subacute encephalitis, and the prominence of cognitive and motor dysfunction resembles that of SSPE.

Progressive rubella panencephalitis is a rare disorder resembling SSPE but caused by the rubella virus. The course of the illness is also similar to SSPE.

**Q: Are the plaintiff's current physical, psychological or behavioral symptoms caused by an undiagnosed *subacute sclerosing panencephalitis*?**

## SECTION 6.4: THE PLAINTIFF'S OTHER LIFE STRESSORS

### INTRODUCTION

Stress is caused by an inability to handle incoming stimuli. It is a cumulative process. The effects of other life stressors in the plaintiff's life are often not discovered or measured by the plaintiff's expert witness.

In a recent case, the plaintiff missed psychotherapy for one month. The treating psychiatrist's clinical notes did not mention the reason for the patient's absence. Other notes, discovered from the files of her orthopedist, revealed that the plaintiff's mother died during this period. When questioned in deposition, the psychiatrist stated that he knew of the death but did not consider it important enough to record in his notes. The failure to recognize the importance of this event by the witness indicated bias for the plaintiff. The psychiatrist willingly manipulated his records to make the injury in question appear to be the only major stressor in the plaintiff's life.

Defense counsel should obtain a list of the plaintiff's alternate causes of stress, by using the deposition questions in Chapters 1 and 4. Section 6.4 provides questions to challenge the plaintiff's claim that the injury in question is their *only* life stressor.

## The Plaintiff's Other Life Stressors

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DISORDER

DEPOSITION QUESTIONS

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### A. ADDITIONAL CONDITIONS THAT MAY BE A FOCUS OF CLINICAL ATTENTION

The following life conditions are referred to as V Codes in the DSM-IV-TR. They are not mental disorders, but they are often related to mental disorders in one of the following ways: 1) the problem is the focus of diagnosis or treatment and the individual has no mental disorder; 2) the individual has a mental disorder but it is unrelated to the problem; 3) the individual has a mental disorder that is related to the problem, but the problem is sufficiently severe to warrant independent clinical attention.

Plaintiff's expert witnesses frequently fail to list these conditions in their diagnosis. Such conditions would dilute their claim of the plaintiff's proximately caused psychological injury.

---

### V65.2 Malingering

**Profile:** The malingering plaintiff has subjective complaints that are not based on objective or measurable facts. S/he intentionally produces or grossly exaggerates physical or psychological symptoms. Such exaggerations are motivated by external incentives such as avoiding military service; avoiding work; obtaining financial compensation; evading criminal prosecution; obtaining drugs; or securing better living conditions. At times, the malingering behavior may represent adaptive behavior (e.g., feigning illness while a captive of the enemy during wartime). This category should be considered when the plaintiff's malingering is apparently not caused by a factitious disorder (no external incentive), conversion disorder, other somatoform disorders (internal incentives), or any other mental disorder. (reference 7, p. 739)

**Malingering is a very important topic in the litigation setting, particularly in personal injury cases where secondary gain may be prominent. Counsel may refer to section 8.1 for additional questions and information on malingering.**

**Defense counsel should consider the possibility of malingering if any of the following situations occur:**

1. The plaintiff is referred by an attorney to a clinician for examination.
2. There is a marked discrepancy between the objective findings of the physician and the subjective complaints of the plaintiff.
3. The plaintiff is resistant to treatment or is uncooperative during the diagnostic evaluation.
4. The presence of antisocial personality disorder.

*(If the witness indicates the possibility of an antisocial personality disorder, see the section on pre-existing personality disorders for further questions)*

---

**Q: Did you rule out the V Code diagnosis of *malingering* as the cause of the plaintiff's symptoms and behaviors?**

---

**Q: Has the plaintiff presented with inconsistent complaints or symptoms, which are out of proportion to the objective medical evidence in this case?**

---

**Q: Does the plaintiff have any obvious secondary gain?**

---

## The Plaintiff's Other Life Stressors

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DISORDER

DEPOSITION QUESTIONS

---

V65.2

### Malingering

(continued)

**Q: What are the most common psychiatric conditions that are *malingered*?**

The most common psychiatric conditions that are intentionally produced by plaintiffs include:

- (1) amnesia
- (2) mental retardation
- (3) organic impairment
- (4) posttraumatic residual (i.e. post-concussion syndrome)
- (5) psychosis

---

**Q: Is there a foolproof method to distinguish between *malingering* and a true illness or conversion disorder?**

Even for experienced clinicians, it is sometimes difficult to distinguish between malingering and a true illness or a somatoform, factitious, or conversion disorder. This is especially true when the malingerer has high intellectual functioning (as most do), and has acquired information about a particular illness or injury and can produce symptoms consistent with that condition.

---

**Q: Is *malingering* commonly seen in neurological or litigation settings?**

Plaintiffs with a long list of subjectively reported symptoms stemming from a relatively minor accident are frequently seen in neurological settings. In litigious settings, the estimated incidence of malingering is around 10-20%, but may actually be higher due to under-reporting by health care practitioners.

---

**Q: To the best of your knowledge, has the plaintiff ever been involved in previous litigation?**

The malingerer may have a prior history of litigation or observed a family member or friend in a litigious context. In addition, a successful malingerer's behavior has been reinforced (usually through monetary compensation) and will occur repeatedly as often as society rewards the malingerer.

---

**Q: Has the plaintiff ever been diagnosed with factitious disorder?**

In factitious disorder (like malingering) there is also symptom simulation and exaggeration but the motivation is an internal one (compared to external) and the desired effect is to be placed in the "sick role". In the DSM IV-TR, the disorder can be specified by three subtypes: with predominantly physical signs and symptoms, with predominantly psychological signs and symptoms, and with physical and psychological signs and symptoms.

---

**Q: Has the plaintiff ever been diagnosed with an antisocial personality disorder?**

Malingeringers are able to effectively lie and manipulate without remorse and many have a history of criminal behavior. These characteristics are typical of antisocial personality disorder. The overall prevalence of antisocial personality disorder in community samples is about 3% in males and 1% in females.

---

## The Plaintiff's Other Life Stressors

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DISORDER

DEPOSITION QUESTIONS

---

### V65.2

#### Malingering

(continued)

*The following questions should be asked of testifying neuropsychologists:*

**Q: Was the plaintiff given any neuropsychological tests to detect *malingering*?**

In litigation, evidence submitted to support the plaintiff's diagnosis of brain injury is often the plaintiff's own subjective complaints. Neuropsychological testing is helpful in comparing the plaintiff's actual level of cognitive functioning to the plaintiff's reported level of functioning. Commonly used tests to detect malingering are: (1) Test of Memory and Malingering (TOMM); (2) The Minnesota Multiphasic Personality Inventory (MMPI-2); (3) The Rey 15 Item Test; and (4) forced choice tests.

---

**Q: Was the plaintiff given the Rey 15 Item Test?**

The Rey 15 item test is a commonly used neuropsychological test designed to detect malingering. It is based on the belief that persons faking a brain injury will perform more poorly than those with severe brain injury. A card is presented to the patient with 5 rows of 3 stimuli organized sequentially. The patient only has to remember a few concepts and those who cannot should be considered for malingering. Typically malingerers don't perform as well as patients with legitimate injuries and they do not display the common errors made by truly brain injured patients.

---

**Q: Was the plaintiff given the Minnesota Multiphasic Personality Inventory (MMPI-2)?**

The MMPI-2 is the most widely used personality test and it consists of 567 items in the form of statements which must be answered as true or false. There are three scales used for validity, the "L" (lie) scale, the "F" (faking) scale, and the "K" (defensiveness) scale. These are used to assess a variety of things including malingering.

---

**Q: Do the results of the Minnesota Multiphasic Personality Inventory (MMPI-2) indicate the plaintiff was malingering or attempting to place him/herself in a bad light?**

Elevated F scores may be considered evidence of malingering and suggest unusual and contradictory ways of answering the items on the test. *However, the F scale can fail at detecting malingering in cases of personal injury because some questions require the patient to admit things that malingerers try to avoid admitting.*

---

### V62.3

#### Academic Problem

**Profile:** This category should be considered when the plaintiff's academic problem does not appear to be caused by a specific mental disorder or developmental disorder. The primary focus of treatment is the plaintiff's academic problems, which may include failing grades, significant under-achievement, or generally poor academic performance (in a person who otherwise displays adequate intellectual functioning). (reference 7, p. 741)

**Q: Did you rule out the V Code diagnosis of *academic problems* as the cause of the plaintiff's symptoms and behaviors?**

---

## The Plaintiff's Other Life Stressors

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### DISORDER

### DEPOSITION QUESTIONS

---

#### **V71.01 Adult Antisocial Behavior**

**Profile:** This category should be considered when the plaintiff's antisocial behavior is not apparently caused by the presence of a conduct disorder, antisocial personality disorder, impulse-control disorder, or other mental disorder. Treatment or attention is focused directly on the behavior. Plaintiffs with antisocial behaviors may be professional thieves, racketeers, or drug dealers. (reference 7, p. 740)

**Q: Did you rule out the V Code diagnosis of *adult antisocial behavior* as the cause of the plaintiff's symptoms and behaviors?**

---

#### **V62.89 Borderline Intellectual Functioning**

**Profile:** This category should be considered when the focus of clinical attention is associated with borderline intellectual functioning. This is defined as an IQ in the 71-84 range. This diagnosis should not be confused with being mentally retarded (an IQ of 70 or below). A misdiagnosis may cause an incorrect assessment of potential adaptive functioning. (reference 7, p. 740)

**Q: Did you rule out the V Code diagnosis of *borderline intellectual functioning* as the cause of the plaintiff's symptoms and behaviors?**

---

#### **V71.02 Child or Adolescent Antisocial Behavior**

**Profile:** This category should be considered when the plaintiff's (childhood or adolescent) antisocial behavior is apparently not caused by a conduct disorder, an impulse-control disorder, or other mental disorder. Treatment or attention is focused directly on the antisocial behavior. This behavior may include isolated antisocial acts displayed by the child or adolescent. (reference 7, p. 740)

**Q: Did you rule out the V Code diagnosis of *childhood or adolescent antisocial behavior* as the cause of the plaintiff's symptoms and behaviors?**

---

#### **V62.81 Relational Problem**

**Profile:** This category should be considered when significant impairment in functioning occurs between family members such as a parent-child relational problem, partner relational problem, sibling relational problem, relational problem related to a mental disorder or general medical condition, and relational problem not otherwise specified (NOS). Relational problems should be considered when the plaintiff has interpersonal problems or patterns of interaction that are associated with clinically significant impairment in functioning. Treatment or attention is focused directly on the interpersonal problem which may include difficulties in interpersonal relationships as well as difficulties with co-workers. (reference 7, pp. 736-737)

**Q: Did you rule out the V Code diagnosis of *relational problem* as the cause of the plaintiff's symptoms and behaviors?**

---

**Q: Did you rule out the V Code diagnosis of *partner relational problem* as the cause of the plaintiff's symptoms and behaviors?**

---

**Q: Did you rule out the V Code diagnosis of *parent-child relational problem* as the cause of the plaintiff's symptoms and behaviors?**

---

## The Plaintiff's Other Life Stressors

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### DISORDER

### DEPOSITION QUESTIONS

---

#### V15.81 Noncompliance With Treatment

**Profile:** This category should be considered when the focus of clinical attention is noncompliance with an important aspect of the treatment for a mental disorder or a general medical condition. The reasons for noncompliance may include discomfort resulting from treatment (medication side-effect), expense of treatment, decisions based on personal value judgments or religious or cultural beliefs about the advantages and disadvantages of the proposed treatment, maladaptive personality traits or coping styles (denial of illness) or the presence of a mental disorder (schizophrenia, avoidant personality disorder). (reference 7, p. 739)

**Q: Did you rule out the V Code diagnosis of *noncompliance with treatment* as the cause of the plaintiff's symptoms and behaviors?**

---

#### V62.2 Occupational Problem

**Profile:** This category should be considered when the plaintiff's occupational problems are apparently not caused by a mental disorder. Treatment or attention is focused directly on the plaintiff's occupational problems which may include dissatisfaction and uncertainty about career choices. (reference 7, p. 741)

**Q: Did you rule out the V Code diagnosis of *occupational problems* as the cause of the plaintiff's symptoms and behaviors?**

---

#### V62.89 Phase of Life Problem

**Profile:** This category should be considered when the focus of clinical attention is a problem associated with a particular developmental phase or some other life circumstance that is not due to a mental disorder. Examples include entering school, leaving parental control, changes in marriage, divorce, career, or retirement. (reference 7, p. 742)

**Q: Did you rule out the V Code diagnosis of *phase of life problem* as the cause of the plaintiff's symptoms and behaviors?**

---

#### 780.9 Age-Related Cognitive Decline

**Profile:** This category should be considered when the focus of clinical attention is an objectively identified decline in cognitive functioning consequent to the aging process that is within normal limits given the person's age. Individuals with this condition may report problems remembering names or appointments or may experience difficulty in solving complex problems.

**Q: Did you rule out the condition of an *age-related cognitive decline* as the cause of the plaintiff's symptoms and behaviors?**

---

#### V62.82 Bereavement

**Profile:** This category can be used when the focus of clinical attention is a reaction to the death of a loved one. As part of their reaction to the loss, some grieving individuals present with symptoms characteristic of a Major Depressive Episode (e.g., feelings of sadness and associated symptoms such as insomnia, poor appetite, and weight loss). The bereaved individual typically regards the depressed mood as "normal," although the person may seek professional help for relief of associated symptoms such as insomnia or anorexia. The duration and expression of "normal" bereavement varies considerably among different cultural groups. The diagnosis of Major Depressive Disorder is generally not given unless the symptoms are still present two months after the loss. However, the presence of certain symptoms that are not characteristic of a "normal" grief reaction may be helpful in differentiating bereavement from a Major Depressive Episode.

## The Plaintiff's Other Life Stressors

---

DISORDER

DEPOSITION QUESTIONS

---

### V62.82 Bereavement

(continued)

The following symptoms are not characteristic of the normal grief reaction and may indicate a Major Depressive Episode:

1. guilt about things other than actions taken or not taken by the survivor at the time of the death
2. thoughts of death other than the survivor feeling that he or she would be better off dead or should have died with the deceased person
3. morbid preoccupation with worthlessness
4. marked psychomotor retardation
5. prolonged and marked functional impairment
6. hallucinatory experiences other than thinking that he or she hears the voice of, or transiently sees the image of, the deceased person

**Q: Did you rule out the V Code diagnosis of *bereavement* as the cause of the plaintiff's symptoms and behaviors?**

---

### 313.82 Identity Problem

**Profile:** This category can be used when the focus of clinical attention is uncertainty about multiple issues relating to identity such as long-term goals, career choice, friendship patterns, sexual orientation and behavior, moral values, and group loyalties.

**Q: Did you rule out the V Code diagnosis of an *identity problem* as the cause of the plaintiff's symptoms and behaviors?**

---

### V62.89 Religious or Spiritual Problem

**Profile:** This category can be used when the focus of clinical attention is a religious or spiritual problem. Examples include distressing experiences that involve loss or questioning of faith, problems associated with conversion to a new faith, or questioning of spiritual values that may not necessarily be related to an organized church or religious institution.

**Q: Did you rule out the V Code diagnosis of *religious or spiritual problem* as the cause of the plaintiff's symptoms and behaviors?**

---

### V62.4 Acculturation Problem

**Profile:** This category can be used when the focus of clinical attention is a problem involving adjustment to a different culture (e.g., following migration).

**Q: Did you rule out the V Code diagnosis of *acculturation problem* as the cause of the plaintiff's symptoms and behaviors?**

---

## The Plaintiff's Other Life Stressors

### B. SOCIAL STRESSOR CHART

Defense counsel should determine if the stressor was present before or after the cause of action and if the stressor currently exists.

**TABLE 6.4-1. STRESS CHECK LIST**

| Category  | Before | After | Present |
|---|--------|-------|---------|
| <b><i>I. SPOUSE</i></b>                                 |        |       |         |
| Suicide of spouse                                       |        |       |         |
| Death of spouse (other causes)                          |        |       |         |
| Divorce   |        |       |         |
| Marital separation                                      |        |       |         |
| Marital reconciliation                                  |        |       |         |
| Sex difficulties  |        |       |         |
| Marriage  |        |       |         |
| Change in number of arguments with spouse               |        |       |         |
| Spouse begins or stops work                             |        |       |         |
| <b><i>II. CHILDREN/FAMILY</i></b>                       |        |       |         |
| Death of child  |        |       |         |
| Death of a close family member                          |        |       |         |
| Child leaving home                                      |        |       |         |
| Birth of child  |        |       |         |
| Change in health of family member                       |        |       |         |
| Trouble with in-laws                                    |        |       |         |
| <b><i>III. INTERPERSONAL</i></b>                        |        |       |         |
| Death of a close friend                                 |        |       |         |
| Break up with boyfriend/girlfriend                      |        |       |         |
| Change in number of arguments with boyfriend/girlfriend |        |       |         |

*(continued)*

## The Plaintiff's Other Life Stressors

**TABLE 6.4-1. STRESS CHECK LIST** (continued)

| Category  | Before | After | Present |
|---|--------|-------|---------|
| <b>III. INTERPERSONAL</b> (continued)                   |        |       |         |
| Sexual difficulties with boyfriend/girlfriend           |        |       |         |
| Change in living arrangements with boyfriend/girlfriend |        |       |         |
| Change in social activities                             |        |       |         |
| <b>IV. PHYSICAL</b>                                     |        |       |         |
| Rape  |        |       |         |
| Miscarriage   |        |       |         |
| Physical illness (serious) diagnosed                    |        |       |         |
| Personal injury or illness                              |        |       |         |
| Pregnancy   |        |       |         |
| Revision of personal habits                             |        |       |         |
| Change in recreation                                    |        |       |         |
| <b>V. HOME</b>  |        |       |         |
| Leaving home  |        |       |         |
| Change in residence                                     |        |       |         |
| Change in living conditions                             |        |       |         |
| Change in eating habits                                 |        |       |         |
| Change in sleeping habits                               |        |       |         |
| Change in number of family get-togethers                |        |       |         |
| <b>VI. SCHOOL</b>                                       |        |       |         |
| Failing/low grades in school                            |        |       |         |
| Change in schools                                       |        |       |         |
| Begin or end school                                     |        |       |         |
| <b>VII. WORK</b>  |        |       |         |
| Fired from work place                                   |        |       |         |
| Laid off  |        |       |         |

(continued)

## The Plaintiff's Other Life Stressors

**TABLE 6.4-1. STRESS CHECK LIST** (continued)

| Category                               | Before | After | Present |
|--|--------|-------|---------|
| <b>VII. WORK</b> (continued)           |        |       |         |
| Trouble with boss or co-workers        |        |       |         |
| Career change                          |        |       |         |
| Change in hours or conditions          |        |       |         |
| Change in responsibilities             |        |       |         |
| <b>VIII. FINANCIAL</b>                 |        |       |         |
| Bankruptcy                             |        |       |         |
| Foreclosure of mortgage or loan        |        |       |         |
| Change in financial state              |        |       |         |
| Loan (personal, car)                   |        |       |         |
| Mortgage                               |        |       |         |
| <b>IX. OTHER</b>                       |        |       |         |
| Natural disaster (earthquake, tornado) |        |       |         |
| Christmas/Holidays                     |        |       |         |
| Jail term/arrest                       |        |       |         |
| Minor violations of the law            |        |       |         |
| Retirement                             |        |       |         |
| Vacation                               |        |       |         |
| Change in church activities            |        |       |         |
| Outstanding personal achievement       |        |       |         |

## SECTION 6.5: CULTURE-BOUND SYNDROMES

### INTRODUCTION

The term culture-bound syndrome refers to recurrent, locality-specific patterns of aberrant behavior and troubling experiences. The syndrome or constellation of symptoms and problems may or may not be linked to a particular DSM-IV diagnostic category. Culture-bound syndromes are generally limited to specific societies or culture areas and are localized, folk, diagnostic categories that frame coherent meanings for certain repetitive, patterned, and troubling sets of experiences and observations. (reference 7, pp. 898-903)

It should be noted that all industrialized societies include distinctive subcultures and diverse immigrant groups, who may present with culture-bound syndromes. **This is an area that is often overlooked by clinicians as well as forensic experts.** Though there are quite a few culture-bound syndromes studied and acknowledged in clinical practice in North America, the most common culture-bound syndromes encountered in litigation encompass two ethnic groups: Asian and Latin cultures. This may be an oversimplification of an important group of disorders. Therefore, if a plaintiff presents with symptoms that appear consistent with a **culture-bound syndrome**, additional information should be obtained, as well as an independent medical examination by an expert from that area.

Defense counsel should obtain a list of the plaintiff's symptoms by using the deposition questions in Chapters 1 and 4. Section 6.5 provides a brief description of the most prominent culture-bound syndromes. Section 6.5 also provides questions to determine if plaintiff's expert witness considered these syndromes before making their diagnosis.

# The Plaintiff's Culture-Bound Syndromes

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## DISORDER

## DESCRIPTIONS OF CULTURE BOUND SYNDROMES

---

### A. Latin Culture-Bound Syndromes

#### **ataque de nervios**

An idiom of distress principally reported among Latinos from the Caribbean but recognized among many Latin American and Latin Mediterranean groups. Commonly reported symptoms include uncontrollable shouting, attacks of crying, trembling, heat in the chest rising into the head, and verbal or physical aggression. Dissociative experiences, seizure-like or fainting episodes, and suicidal gestures are prominent in some attacks but absent in others. A general feature of an ataque de nervios is a sense of being out of control. Ataques de nervios frequently occurs as a direct result of a stressful event relating to the family (e.g., news of the death of a close relative, a separation or divorce from a spouse, conflicts with a spouse or children, or witnessing an accident involving a family member). People may experience amnesia for what occurred during the ataque de nervios, but they otherwise return rapidly to their usual level of functioning. Although descriptions of some ataques de nervios most closely fit with the DSM-IV description of Panic Attacks, the association of most ataques with a precipitating event and the frequent absence of the hallmark symptoms of acute fear or apprehension distinguish them from Panic Disorder. Ataques span the range from normal expressions of distress not associated with having a mental disorder to symptom presentations associated with the diagnoses of Anxiety, Mood, Dissociative, or Somatoform Disorders.

---

#### **bilis and colera**

*also referred to as muina*

The underlying cause of these syndromes is thought to be strongly experienced anger or rage. Anger is viewed among many Latino groups as a particularly powerful emotion that can have direct effects on the body and can exacerbate existing symptoms. The major effect of anger is to disturb core body balances (which are understood as a balance between hot and cold valences in the body and between the material and spiritual aspects of the body). Symptoms can include acute nervous tension, headache, trembling, screaming, stomach disturbances, and, in more severe cases, loss of consciousness. Chronic fatigue may result from the acute episode.

---

#### **falling-out blacking-out**

These episodes occur primarily in southern United States and Caribbean groups. They are characterized by a sudden collapse, which sometimes occurs without warning but sometimes is preceded by feelings of dizziness or "swimming" in the head. The individual's eyes are usually open but the person claims an inability to see. The person usually hears and understands what is occurring around him or her but feels powerless to move. This may correspond to a diagnosis of Conversion Disorder or a Dissociative Disorder.

---

#### **locura**

A term used by Latinos in the United States and Latin America to refer to a severe form of chronic psychosis. The condition is attributed to an inherited vulnerability, to the effect of multiple life difficulties, or to a combination of both factors. Symptoms exhibited by persons with locura include incoherence, agitation, auditory and visual hallucinations, inability to follow rules of social interaction, unpredictability, and possible violence.

---

# The Plaintiff's Culture-Bound Syndromes

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## DISORDER

---

## DESCRIPTIONS OF CULTURE BOUND SYNDROMES

---

### **nervios**

A common idiom of distress among Latinos in the United States and Latin America. A number of other ethnic groups have related, though often somewhat distinctive, ideas of "nerves" (such as *nevra* among Greeks in North America). *Nervios* refers both to a general state of vulnerability to stressful life experiences and to a syndrome brought on by difficult life circumstances. The term *nervios* includes a wide range of symptoms of emotional distress, somatic disturbance, and inability to function. Common symptoms include headaches and "brain aches," irritability, stomach disturbances, sleep difficulties, nervousness, easy tearfulness, inability to concentrate, trembling, tingling sensations, and *mareos* (dizziness with occasional vertigo-like exacerbations). *Nervios* tends to be an ongoing problem, although variable in the degree of disability manifested. *Nervios* is a very broad syndrome that spans the range from cases free of a mental disorder to presentations resembling Adjustment, Anxiety, Depressive, Dissociative, Somatoform, or Psychotic Disorders. Differential diagnosis will depend on the constellation of symptoms experienced, the kind of social events that are associated with the onset and progress of *nervios*, and the level of disability experienced.

---

## B. Asian Culture-Bound Syndromes

### **shenjing shuairuo** (*"neurasthenia"*)

In China, a condition characterized by physical and mental fatigue, dizziness, headaches, other pains, concentration difficulties, sleep disturbance, and memory loss. Other symptoms include gastrointestinal problems, sexual dysfunction, irritability, excitability, and various signs suggesting disturbance of the autonomic nervous system. In many cases, the symptoms would meet the criteria for a DSM-IV Mood or Anxiety Disorder. This diagnosis is included in the Chinese Classification of Mental Disorders, Second Edition (CCMD-2).

### **shen-k'uei** (Taiwan) **shenkui** (China)

A Chinese folk label describing marked anxiety or panic symptoms with accompanying somatic complaints for which no physical cause can be demonstrated. Symptoms include dizziness, backache, fatigability, general weakness, insomnia, frequent dreams, and complaints of sexual dysfunction (such as premature ejaculation and impotence). Symptoms are attributed to excessive semen loss from frequent intercourse, masturbation, nocturnal emission, or passing of "white turbid urine" believed to contain semen. Excessive semen loss is feared because of the belief that it represents the loss of one's vital essence and can thereby be life threatening.

### **shin-byung**

A Korean folk label for a syndrome in which initial phases are characterized by anxiety and somatic complaints (general weakness, dizziness, fear, anorexia, insomnia, gastrointestinal problems), with subsequent dissociation and possession by ancestral spirits.

# The Plaintiff's Culture-Bound Syndromes

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## *DEPOSITION QUESTIONS*

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(See References 7 and 18, for additional information and syndromes)

### **General Questions**

**Q: Is the plaintiff indigenous to an area other than North America?**

---

**Q: How long has the plaintiff been in the United States?**

---

**Q: Did you follow the outline for cultural formulation found in Appendix I of the DSM-IV-TR?**

The outline for cultural formulation is included in the appendix of the DSM-IV-TR to assist clinicians in systematically evaluating and reporting the impact of the individual's cultural context.

---

**Q: Describe the cultural identity of the individual.**

---

**Q: Is the plaintiff fully assimilated in the U.S. culture or does s/he remain bicultural?**

---

**Q: What language does the plaintiff speak?**

---

**Q: Does the plaintiff have a local support system?**

---

**Q: At any time, did the plaintiff's cultural background affect your diagnosis and treatment? If so, how?**

---

**Q: Is the plaintiff exhibiting any behaviors which may be representative of a culture-bound syndrome?**

---

**Q: Could the plaintiff's symptoms be due to the presence of an unrecognized culture-bound syndrome?**

---

**Q: Does the examiner speak the plaintiff's native language or have experience in the plaintiff's native country or region?**

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# CHAPTER 7

## Challenging Claims of Head Injury and Organic Brain Syndrome

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## **CHAPTER 7**

# **CHALLENGING CLAIMS OF HEAD INJURY AND ORGANIC BRAIN SYNDROME**

## **INTRODUCTION**

Claims of organic brain syndrome from head injury and toxic exposure must be examined closely by the defense counsel. Analysis of these cases is essential because:

- (1) There are many cases of manipulated symptoms related to organic brain syndrome.
- (2) These claims provide a foundation for treatment protocols that are very costly and may show little or no improvement in the plaintiff's condition.
- (3) There may be a number of alternate causes for plaintiff's neurologic complaints.

The purpose of this chapter is to prepare defense counsel to depose plaintiff's expert witnesses that have diagnosed organic brain syndrome. Although there are an alarming number of real head injuries each year, defense counsel must be able to recognize spurious head injury claims.

The following is a list of "indicators" of a possible spurious head injury claim.

- (1) The claimed injury is far beyond the expected effect of the trauma;
- (2) There is no loss of consciousness or other hallmarks of real head injury;
- (3) The plaintiff's long-term symptoms and behaviors do not fit the pattern of the sequelae of real organic brain syndrome;
- (4) There are other apparent causes for the plaintiff's symptoms and behaviors that have not been ruled out;
- (5) The plaintiff's neuropsychological tests have been improperly administered, scored, or interpreted.

Defense counsel should obtain a list of the plaintiff's claimed symptoms by referring to the deposition questions in Chapters 1 and 4. The following sections provide questions to challenge the accuracy of the plaintiff's current diagnosis.

## SECTION 7.1: CHALLENGING THE NEUROPSYCHOLOGICAL EVIDENCE

### DEFENSE THEORIES:

- (1) **The plaintiff's neuropsychological test performance may be influenced by non-organic variables which cannot be controlled for during testing, e.g., pain, fatigue, transient side-effects of medication, depression, anxiety, and motivation.**
- (2) **Neuropsychological testing may be able to identify some of the plaintiff's cognitive deficits, however, the tests cannot identify the etiology of those deficits.**
- (3) **The most common error made by plaintiff's neuropsychologist is the over-interpretation of test findings.**

## INTRODUCTION

Neuropsychology is a subspecialty of psychology that attempts to understand the relationship between behavior and brain functioning. Neuropsychology is recognized by the American Psychological Association as a specialty, with board certification through the American Board of Professional Psychology. (reference 18, p. 689) Ideally, a neuropsychological evaluation includes a thorough clinical evaluation followed by tests that are well-validated, reliable, standardized, and normed. These aspects of the evaluation help quantify behavioral or neurological changes that may have resulted from a brain injury or other central nervous system disturbance. In most cases, a plaintiff is referred for neuropsychological testing in order to determine their cognitive status and perhaps, their prognosis for future functioning. These evaluations are typically used by the plaintiff as proof of damages, related to a proximately caused brain injury. However, there are many flaws in the evaluation process, including problems with test protocol and selection of tests, administration of the tests, interpretation of the data, and the examiner's conclusions and diagnoses. The information contained in section 7.1 can be used to challenge the plaintiff's neuropsychological evaluation and expert witness testimony.

In order to effectively question the plaintiff's neuropsychologist, it is important to discover all clinical evaluations, test evaluations, raw test data, handwritten notes, and diagnostic conclusions. Unfortunately, some neuropsychologists are reluctant to give up this information, citing ethical dilemmas. For example, some psychological and neuropsychological tests include practice sensitive items. The scores on these items can be changed by practice or preview. Many of these and other psychological tests are protected by licensing agreements between the publisher of the test and the individual psychologist that uses the test materials. In many cases, the psychologist will refuse to release or hand-over the test questions because of the requirements of these arrangements. Psychologists also believe that the individual test questions will be taken out of context and ridiculed because, taken individually, they may not appear to be related to any valid scientific purpose.

# Neuropsychological Testing

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## *Challenging the Neuropsychological Evidence*

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*The defense counsel is committed to the production of evidence for evaluation by the court, particularly the trier of fact. Ethical and legal dilemmas may arise from this situation:*

1. Which, if any, materials must be retained as confidential by the psychologist or neuropsychologist?
2. Are the opinions of the neuropsychological witness based on the data provided by the use of these items?
3. Can the administration of these test items change from test to test or between neuropsychologists?
4. Would "good men differ" on the use, protocol, administration or findings of these test components?
5. Does the "reading" or interpretation of these items differ in value or importance from other items commonly examined such as x-rays?
6. Should the neuropsychologist be required to produce these items?
7. Can the neuropsychologist be required to produce these items?
8. What effect does the license agreement have on the issue before the court?
9. Will the jury arrive at a more thoroughly informed decision by seeing these items (probative value)?
10. Would exposure of these items before a jury and courtroom observers actually cause test changes in later tests given to any of these individuals? Is a separate harm created? Who is actually harmed?
11. Have the particular items in question ever been revealed to the public in other ways, such as scientific research articles or text?
12. Does the defense counsel's duty to represent his client also give him or her an ethical responsibility to seek all evidence that has possible probative value?
13. Does the court of jurisdiction have the authority to weigh and determine these legal problems?
14. Will a motion to exclude the testimony of plaintiff's witness be accepted by the court because of witness failure to produce the sensitive test items?

**NOTE:** *A court order to produce the "protected," practice sensitive items may cause the plaintiff's witness to withdraw from the case or be barred from testimony for his or her failure to comply with the order. Defense counsel should be aware of these issues during the discovery phase of any case in which neuropsychological evidence is being presented by the plaintiff.*

# Neuropsychological Testing

---

## DEPOSITION QUESTIONS

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### General Questions

#### GENERAL QUESTIONS FOR THE NEUROPSYCHOLOGIST:

- Q: Was the plaintiff referred to you for neuropsychological assessment?**  
\_\_\_\_\_
- Q: Was the plaintiff referred to you by his/her attorney?**  
If not, who referred the plaintiff to you?  
\_\_\_\_\_
- Q: Describe your education.**  
\_\_\_\_\_
- Q: Describe your training specific to the administration of neuropsychological tests.**  
\_\_\_\_\_
- Q: Are you board certified in neuropsychology?**  
\_\_\_\_\_
- Q: Describe your forensic experience.**  
\_\_\_\_\_
- Q: How many times have you testified in court?**  
\_\_\_\_\_
- Q: What percentage of your work is for plaintiffs?**  
\_\_\_\_\_
- Q: What is the purpose of neuropsychological testing?**  
Neuropsychological testing is conducted for research purposes, to aid in diagnosis, to evaluate treatment efficacy, or to provide information for a legal matter. The purpose for the testing often determines what questions should be addressed and particularly what areas of testing to concentrate on (reference 31, p. 110). Typically in injury claims, the question to be answered is whether the plaintiff's medical, psychological, and social functioning has been altered.  
\_\_\_\_\_
- Q: What does neuropsychological testing attempt to assess?**  
In general, neuropsychological tests are administered to estimate a plaintiff's attention, concentration, verbal capacity, memory and executive functioning. Executive functioning includes problem-solving skills, abstract thinking, planning and reasoning abilities. (reference 33, p. 527)  
\_\_\_\_\_
- Q: When was the plaintiff's neuropsychological testing conducted?**  
In cases of trauma, neuropsychological testing should not be given during the acute or postacute stages. During this time the plaintiff may be experiencing rapid changes including fatigue and depression which can result in poor performance. Generally, 3-6 months post-trauma is sufficient for restoration of stamina and mental capabilities. (reference 31, p. 116) At that time, a baseline of performance may be obtained.  
\_\_\_\_\_
- Q: What time of day were the tests conducted and how long did they take?**  
Often, full neuropsychological batteries take many hours to complete. A full day of testing may result in fatigue for an otherwise healthy person, not to mention a person possibly suffering from physical, emotional, and other difficulties. Fatigue may have adversely affected the test results.  
\_\_\_\_\_

# Neuropsychological Testing

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## DEPOSITION QUESTIONS

---

### General Questions

(continued)

**Q: Did you conduct a clinical interview of the plaintiff at the time of testing?**

---

**Q: Who conducted the actual testing?**

---

**Q: Were any of the neuropsychological tests administered by technicians?**

(1) If so, who was that person?

(2) What are his or her qualifications?

Neuropsychologists will often use a technician to assist with the administration of the tests for reasons of time and cost. However, as a result, the neuropsychologist does not become familiar with the plaintiff and cannot identify testing errors or provide firsthand descriptions of test behaviors. Most technicians do not record the plaintiff's responses and their observations are limited by lack of training and experience. This can lead to restricted data and the findings of the tests can be questioned. (reference 31, pp. 130-131)

---

**Q: Describe your test protocol or procedures.**

---

**Q: How many times have you tested persons with the plaintiff's claimed injury?**

---

**Q: Who came to the test sessions with the plaintiff?**

---

**Q: Did the plaintiff take any of the tests home to complete?**

Taking the test home may invalidate the results. Having a family member help the plaintiff with the test may also invalidate the results.

---

**Q: How many times did you test the plaintiff?**

The ideal neuropsychological test protocol would be baseline testing at six months post-trauma, a second testing at one year post-trauma and a third testing at a year and half post-trauma. Most persons with valid head injury have a dramatic recovery curve that will be evidenced over this period of time. Full recovery may take 28 months. The plaintiff's pattern of recovery may be revealing. If there is a significant delay in the reporting of cognitive complaints this may be due to a subdural hematoma, or it may be due to a non-organic depressive pseudodementia, or medication side-effects.

---

**Q: How are neuropsychological test deficits measured?**

There are two types of standards against which a plaintiff's performance can be measured. The first, **comparison standard**, is normative (based on average performances) and derived from an appropriate population and the second, **individual standard**, is the plaintiff's history or prior level of functioning. Comparison standards should not be used unless the skills being measured can be performed by all intact adults without variability of age, sex, education or general mentality. Therefore a neuropsychological test evaluating vocabulary level should not use a comparison standard because it is based on varying social class and education level. Rather an individual standard (based on premorbid information) should be utilized to clearly demonstrate a deficit or rate of change in an individual. (reference 31, pp. 98-101)

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# Neuropsychological Testing

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## DEPOSITION QUESTIONS

---

### General Questions

(continued)

**Q: How do you select the appropriate tests for each patient?**

The test selection process is an important step in the neuropsychological evaluation, and the following factors should be considered: (reference 31, pp. 119-121)

- (1) **Examination goals**  
(assess competency, executive function, rehabilitation etc.)
  - (2) **Validity and reliability**
  - (3) **Sensitivity and specificity**
  - (4) **Parallel forms**  
(for retesting to show deterioration or improvement)
  - (5) **Time and cost**  
(should be kept at essential minimums)
  - (6) **Nonstandardized assessment techniques**  
(should only be used for research)
- 

**Q: How were the tests selected for this particular plaintiff?**

---

**Q: List and describe each of the tests that you administered.**

---

**Q: List all of the components of each test administered, such as:**

- (1) Questions or other stimulus items
  - (2) Answer sheets and forms
  - (3) Notes of the test administrator
  - (4) Published test norms and administrative instructions
  - (5) Scoring and interpretation of materials
  - (6) Impairment rating systems
- 

**Q: Could the testing have been conducted without the use or existence of any of these items?**

---

**Q: Did you rely on all of these items to reach your final conclusions in this case?**

---

**Q: Have each of these items been submitted for discovery and examination?**

**If not, why not?**

*Defense counsel should ask the witness to produce them for the court at this time.*

---

**Q: Is each test that you administered described in psychological literature?**

---

**Q: Have you read reviews of the tests in the Mental Measurement Yearbook?**

---

**Q: Have there been journal articles published that criticize the validity or reliability of any of the components of the tests that you administered in this case?**

---

# Neuropsychological Testing

---

## DEPOSITION QUESTIONS

---

### General Questions

(continued)

**Q: Can the etiology of an injury be determined from neuropsychological testing?**

A neuropsychological test score alone cannot and should not be used to identify the cause of a disturbance. Testing only provides the examiner with bits of data in the form of a score which when compared and combined with other scores can result in trends or patterns of behavior or deficit. These can then be used to consider various problems and methods of treatment. In short, the only fact which can be discovered upon neuropsychological testing is that a score is above or below the normal population or the individual's level of premorbid functioning. (reference 38)

---

**Q: Did you identify any moderating or confounding factors that would have influenced the plaintiff's performance?**

Performance on tests can be influenced by a number of transient or situational factors. An experienced neuropsychologist should be able to identify relevant factors that might undermine or contribute to poor test performance. (reference 18, p. 695).

---

**Q: What are some factors, other than brain damage, that can influence a plaintiff's performance on neuropsychological tests?**

Low test scores can be attributed to a number of things besides trauma. Some factors which may contribute to poor performance are listed below: (reference 38)

- (1) **Original endowment** (pre-morbid IQ, learning disorders)
- (2) **Environment** (education, occupation, life experiences)
- (3) **Motivation** (effort applied during testing)
- (4) **Physical health** (pain, fatigue, arthritis, peripheral nerve damage)
- (5) **Psychological distress**
- (6) **Psychiatric disorders** (depression, anxiety, etc.)
- (7) **Medications** (anticonvulsants, psychotropics, etc.)
- (8) **Errors in scoring** (failing to control for age, ethnicity, etc.)
- (9) **Errors in interpretation** (over-interpreting the results)
- (10) **Qualifications and expertise of the neuropsychologist**

Other factors that may potentially influence performance include: (reference 18, p. 695)

|                       |                       |
|-----------------------|-----------------------|
| acute illness         | impaired hearing      |
| aging                 | impaired vision       |
| alcohol use           | psychiatric disorders |
| illicit substance use | significant stressors |

---

**Q: Are neuropsychological tests objective?**

Neuropsychological tests are under the control of a single examiner, subject to their predispositions, thereby ruling out any claim of objectivity. It is the neuropsychologists that interpret the results (at their discretion) and their motivations must be considered. (reference 38, p. 1130) In addition, some of the test questions are not objective and hardly seem to address the issue of brain injury (for example, how far is it from Florida to Hawaii?).

*Most tests also allow manipulation by the plaintiffs. This often goes undetected because few tests offer reliable built-in validity scales to assure the plaintiff is not "cheating."*

---

# Neuropsychological Testing

---

## DEPOSITION QUESTIONS

---

### General Questions

(continued)

**Q: When analyzing the results of neuropsychological testing, did you rely solely on the quantitative test scores in forming your opinions in this case?**

The potential for *interpretive error* when relying solely on test scores is real. The evaluation of test scores (quantitative data) combined with direct observation (qualitative data) of the plaintiff is necessary for understanding the plaintiff's level of cognitive functioning. In other words, how a plaintiff solved a problem and the circumstances of the examination are just as important, if not more so, than the test scores themselves. (reference 31, pp. 149-150) Multiple studies have found that test scores alone often fail to discriminate between schizophrenic and brain damaged patients.

---

**Q: Was the plaintiff attentive at the time of the testing? How did you measure the plaintiff's attentiveness?**

Inattention is a common symptom or complaint from persons undergoing neuropsychologic evaluation. The inattentive plaintiff can complicate the testing process in that they will routinely fail tests of memory or other tests requiring attention and concentration. Caution should be used when interpreting tests results from a seemingly inattentive plaintiff.

---

**Q: How did you control for plaintiff's *inattention* in testing?**

Many symptoms of a head trauma must be controlled for in order to fairly assess the plaintiff's cognitive abilities. Attention deficits, reduced auditory span, and distractibility can all combine to obscure the cognitive ability of the plaintiff. What may seem to be a memory disorder on neuropsychological testing, can in fact be due to attention deficit, fatigue, lack of motivation, depression and frustration.

---

**Q: What were the normative groups in the tests that you administered?**

- (1) Does the plaintiff belong to the population used to develop the test norms?
  - (2) Is the plaintiff fluent in the language of the population used to develop the test norms?
  - (3) Is the plaintiff's ethnic and social group the same as the group used to develop the test norms?
- 

**Q: What are the weaknesses, if any, of the tests that you administered?**

---

**Q: Read your notes from the clinical interview into the record.**

---

**Q: What do you know about the plaintiff's premorbid history?**

In order to demonstrate that the plaintiff's cognitive functioning declined as a result of the trauma, an estimation of their premorbid functioning is required. This is typically done through clinical evaluation, discovery of educational and occupational records, as well as performance on tests that are minimally affected by brain injury (fund of information and vocabulary). *Impairment is then defined based on statistically significant deviations from this premorbid functioning.* (reference 18, p. 695)

---

**Q: What documents were given to you regarding the plaintiff's premorbid history?**

---

# Neuropsychological Testing

---

## DEPOSITION QUESTIONS

---

### General Questions

(continued)

- Q:** Did you review the plaintiff's school records?  
\_\_\_\_\_
- Q:** Describe the plaintiff's academic performance history.  
\_\_\_\_\_
- Q:** Are you aware of any childhood learning disorders or problems?  
\_\_\_\_\_
- Q:** What is the plaintiff's medical history?  
\_\_\_\_\_
- Q:** What is the plaintiff's psychological history?  
\_\_\_\_\_
- Q:** What is the plaintiff's legal history?  
\_\_\_\_\_
- Q:** What is the plaintiff's social history (marriages, dependents, family of origin, siblings)?  
\_\_\_\_\_
- Q:** Is English the plaintiff's first language?  
\_\_\_\_\_
- Q:** Is the plaintiff from another country?  
If so, how long has he/she been in this country?  
\_\_\_\_\_
- Q:** Does the plaintiff have a history of head injury before the injury in question?  
\_\_\_\_\_
- Q:** Does the plaintiff have a history of any other medical or neurological condition?  
(e.g., birth trauma, serious childhood illness, high fevers, stroke, heart condition, diabetes, degenerative diseases, etc.)  
\_\_\_\_\_
- Q:** Did you perform a clinical examination or in any other way conduct a differential diagnosis for the following disorders (conditions that may mimic head injury):
- Degenerative diseases of the central nervous system:*
- |                     |                                |
|---------------------|--------------------------------|
| Alzheimer's disease | Progressive supranuclear palsy |
| Huntington's chorea | Senile dementia                |
| Parkinson's disease | Simple cortical atrophy        |
| Pick's disease      |                                |
- Vascular disorders:*
- |                                  |                         |
|----------------------------------|-------------------------|
| Arteriovenous malformation       | Cranial arteritis       |
| Binswanger's disease             | Multi-infarct dementia  |
| Carotid artery occlusive disease | Subarachnoid hemorrhage |
| Cerebral embolism                |                         |

# Neuropsychological Testing

---

## DEPOSITION QUESTIONS

---

### General Questions

(continued)

#### *Metabolic, endocrine, and nutritional disorders:*

|  |  |
|--|--|
| Avitaminosis:<br>cyanocobalamine, folate, nicotinic acid, thiamine   | Hepatic, renal or pulmonary failure<br>Hepatolenticular degeneration (Wilson's disease)                      |
| Chronic disorders of electrolyte metabolism:<br>hypercalcemia, hypocalcemia, hyponatremia, hypernatremia, hypokalemia            | Hypoxia or anoxia of any origin<br>Paget's disease<br>Porphyria<br>Remote effects of carcinoma and lymphomas |
| Dialysis dementia  | Vitamin intoxication:<br>vitamins A and D  |
| Endocrinopathies:<br>Addison's disease, Cushing's syndrome, hyperinsulinism, hypothyroidism, hypopituitarism, hypoparathyroidism |  |

#### *Intracranial space-occupying lesions:*

|                           |                               |
|---------------------------|-------------------------------|
| Aneurysm                  | Lymphoma and leukemia         |
| Chronic subdural hematoma | Neoplasm, benign or malignant |
| Chronic abscess           | Parasitic cyst                |
| Colloid cyst              | Tuberculoma                   |

#### *Earlier head trauma:*

##### *Epilepsy:*

##### *Infections:*

|                           |                                |
|---------------------------|--------------------------------|
| Brucellosis               | Meningitis of any cause        |
| Creutzfeldt-Jakob disease | Multifocal leukoencephalopathy |
| Encephalitis of any cause | Syphilis                       |
| HIV                       |                                |

##### *Intoxication:*

|                 |   |
|-----------------|---|
| Alcohol         | Heavy metals:<br>mercury, lead, arsenic, thallium |
| Carbon monoxide | Medical drugs, such as barbiturates               |

#### *Normal-pressure hydrocephalus:*

##### *Heat stroke:*

##### *Electric injury:*

##### *Disorders of the hematopoietic system:*

|           |                                     |
|-----------|-------------------------------------|
| Erythemia | Thrombotic thrombocytopenia purpura |
|-----------|-------------------------------------|

##### *Miscellaneous diseases of unknown origin:*

|                    |             |
|--------------------|-------------|
| Histiocytosis X    | Sarcoidosis |
| Multiple sclerosis |             |

# Neuropsychological Testing

---

## DEPOSITION QUESTIONS

---

### General Questions

(continued)

**Q: Did you know that the person being tested was in litigation at the time of testing?**

---

**Q: What non-test behaviors did you observe?**

---

**Q: Did you establish a premorbid baseline of academic or intellectual functioning for this plaintiff? How did you arrive at this estimation?**

In order to assess the severity of an injury and relate it to a loss or decline in future functioning, one must know the plaintiff's pre-injury level of functioning and medical history. Prior drug and alcohol abuse, head injuries, personality disorders, and criminal activity are all important factors and without this information the impact of a relatively minor head injury may be overestimated by the examiner. Often the plaintiff will recall their pre-injury situations as better than they really were, in which case it is helpful to have unbiased persons to verify information.

---

**Q: Did you interview other persons about this plaintiff?**

---

**Q: Did you review the records of other health care professionals in this case?**

---

**Q: Did you administer a test of reading comprehension?**

What is the plaintiff's level of reading comprehension?

*A 6th grade reading level or above is required for many neuropsychological test results to be valid.*

---

**Q: Was the plaintiff on any medication at the time of testing?**

Many plaintiffs who are referred for a neuropsychological evaluation are taking prescription medication or are self-medicating with over the counter medicine. Whatever the reason for the medication (mood or sleep disturbance, anxiety, tension, cold symptoms), the examiner should discover or inquire about these drugs prior to testing. ***Most neuropsychological tests are sensitive to the transient side-effects of medications.***

---

***NOTE: If the plaintiff is over sixty, ask the following question.***

**Q: Is the plaintiff taking any medication which could cause cognitive decline?**

The acute use of benzodiazepines has been associated with negative performance on memory, attention, and psychomotor performances. At least one study of persons aged 60-70 years old who were chronic users demonstrated a statistically significant risk for a decline in cognitive functioning as measured by the Mini Mental Status Exam, Digit Symbol Substitution Test, and Part B of the Trail Making Test. Tests for attention seemed to be particularly affected. These differences were not accounted for by age, sex, education, alcohol or tobacco use, or use of other psychotropic medication other than benzodiazepines. The authors concluded that long-term use of benzodiazepines may be associated with accelerated cognitive decline in this group. (reference 36, pp. 285-293)

---

# Neuropsychological Testing

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## DEPOSITION QUESTIONS

---

### General Questions

(continued)

**Q:** What prescribed or over-the-counter medications had the plaintiff *taken* during the 72 hour period prior to your testing?

---

**Q:** What prescribed or over-the-counter medications did the plaintiff *discontinue* in the 72 hour period prior to your testing?

---

**Q:** Did the plaintiff use *street drugs* during the 72 hour period prior to testing?

---

**Q:** Did the plaintiff *withdraw from street drugs* during the 72 hour period prior to testing?

---

**Q:** Did you consider the effects of the plaintiff's medication on test performance?

Many drugs can react to produce behavior that will significantly affect neuropsychological findings. In fact, these drugs may even be responsible for the behavior changes that warrant neuropsychological assessment. Medication may influence cognitive functioning in many ways and the interaction of multiple drugs with medical and psychiatric disorders is a complex issue.

Prescription drug use is often overlooked by psychologists even though the effects on performance are well known. The use of all medications should be noted before testing to prevent inaccurate explanations for poor performance.

---

*NOTE: Ask the following questions for each medication taken by the plaintiff at the time of testing:*

**Q:** Who prescribed this drug and what was the dosage?

---

**Q:** Was the drug in the therapeutic level at the time of testing? (blood level)

---

**Q:** Could the drug have been at a toxic level at the time of testing?

---

**Q:** What are the side-effects and adverse reactions listed in the current issue of the Physician's Desk Reference (PDR) or in documentation provided by the drug manufacturer?

---

**Q:** Are there any published interactions between the drugs that the plaintiff was taking at the time of testing?

Poly-drug use can produce poor neuropsychological test scores in the absence of brain injury.

---

**Q:** Does the plaintiff, in the past or present, *habitually use illicit drugs*?

Hallucinogens, inhalants, opioids, amphetamines, cocaine, ecstasy and PCP all produce cognitive and behavioral changes which could be mistaken for a trauma-induced organic disorder.

---

# Neuropsychological Testing

---

## DEPOSITION QUESTIONS

---

### General Questions

(continued)

**Q: Does the plaintiff have a *history of chronic alcohol use*?**

There is substantial evidence showing that alcoholism causes brain damage, and **on neuropsychological tests it is difficult to differentiate this from a traumatic brain injury**. Studies in which groups of alcoholic plaintiffs underwent routine CT scanning, have demonstrated an incidence of brain atrophy in as high as 50% of all alcoholic patients scanned. If neuropsychological testing is performed on plaintiffs with demonstrable cortical atrophy, functional deficits that accompany the structural abnormality can sometimes be observed. The range of neuropsychologic deficits runs from minimal cognitive deficits to a profound organic brain syndrome secondary to the alcoholism. (reference 37)

---

**Q: Did you identify *clinical depression in the plaintiff*?**

If so, was this through an objective measure of depression such as the Beck Depression Inventory or Scale 2 (depression) on the MMPI-2?

---

**Q: Is it possible that any neuropsychological deficits in this plaintiff, are related to *depressive pseudodementia (treatable and reversible) and not an organically based cognitive loss*?**

Depressive pseudodementia is a cognitive disturbance due to a severe depressive episode. The plaintiff may appear to be demented, however, there is an underlying depression that is treatable and with appropriate medication the dementia-like behaviors are frequently reversible.

---

**Q: Did you identify *clinical levels of anxiety in the plaintiff*?**

If so, was this through an objective measure of anxiety such as the Beck Anxiety Inventory or Scale 3 (hysteria) on the MMPI-2?

---

**Q: How did you control for the effects of the plaintiff's *psychiatric problems*?**

Depression and anxiety can contribute to poor test taking. The examiner will often overlook or underestimate the effects of various psychiatric problems on neuropsychological testing. Many neuropsychological tests are sensitive to depression and anxiety.

---

**Q: How did you control for the effects of the plaintiff's *chronic pain*?**

Chronic pain can lead to inattention, depression, anxiety, emotional lability, distraction and fatigue. For a valid evaluation, the examiner must consider the effects of pain on neuropsychological test results.

---

**Q: How did you control for the effects of other *significant life stressors on plaintiff's test performance*?**

Stress can result in depression and cognitive dysfunction, as well as lower the threshold for pain. The neuropsychologist is unable to control for the effects that stress may have had on the tests.

---

# Neuropsychological Testing

---

## DEPOSITION QUESTIONS

---

### General Questions

(continued)

**Q: Did you administer a *personality inventory*?**

A complete neuropsychological battery should always include a personality inventory such as the Minnesota Multiphasic Personality Inventory (MMPI). This is essential to determine the plaintiff's level of functioning prior to and on the day of testing. The MMPI has built in validity scales which are useful in detecting malingering, motivation, test taking attitude, and pre-existing pathology. In addition, the MMPI provides information regarding various personality traits such as depression, anxiety, self-esteem, abnormal thinking, introversion/extroversion, nervousness, and aggression.

---

**Q: Were there any *abnormal or invalid scales* on the plaintiff's personality test?**

---

**Q: Did you diagnose an *Axis II personality disorder or traits of a personality disorder* in the plaintiff?**

---

**Q: What methods did you use to control for the presence of *malingering*?**

Impaired performance can be faked or embellished as a function of either conscious or unconscious factors. A responsible evaluation should explore alternative explanations for a phenomenon including malingering / emotional embellishment as well as medical explanations. Common tests given to detect malingering include the Rey 15 Item Memory Test, Validity Indicator Profile, Hiscock Forced Choice Test, and Test of Memory and Malingering (TOMM).

There is no study demonstrating that adequate performance on one or more tests of malingering guarantees full motivation on the rest of the neuropsychological tests. (reference 35, p. 62)

*For additional information and questions on malingering, please refer to section 8.1.*

---

**Q: What methods did you use to control for the *presence of a factitious disorder*?**

A factitious disorder is the intentional manipulation of symptoms to receive care or remain in the patient role.

---

**Q: Did you rely on any *subjectively reported data* to arrive at your conclusions?**

The Daubert standards for admissibility of evidence discourages conclusions that rely on subjectively reported data. Daubert also questions whether the conclusions rely on the examiner's subjective interpretation of test results, as is often required by many neuropsychological tests. (reference 35, p. 62)

---

**Q: Did you rule out a *pre-existing seizure disorder* as a cause of the plaintiff's poor test performance?**

Focal seizures will typically involve just one side of the brain. In such cases, the seizure-prone plaintiff is likely to display a pattern of test performance like that of plaintiff's with similar lesions who are not troubled by seizures.

Left hemisphere epileptic foci tend to be associated with impaired verbal functions, including verbal memory, with some compromise in abstract reasoning and slowed right hand finger tapping.

# Neuropsychological Testing

---

## DEPOSITION QUESTIONS

---

### General Questions

(continued)

Plaintiff's with right hemisphere foci are likely to display slowed left hand finger tapping and the visuoperceptual, visual memory, and constructional disabilities that tend to occur with right hemisphere lesions.

In one study, patients with right temporal foci were found to make an abnormal number of errors in general, and perseverative errors in particular, on the Wisconsin Card Sorting Test. (reference 31, pp. 314-315)

---

**Q: Did you rule out *dementia* as a reason for the plaintiff's poor test performance?**

---

**Q: Did you rule out *age or stress related cognitive decline* as a cause of memory, attention or concentration problems?**

---

**Q: Did you use the *multiaxial assessment system* to report the plaintiff's disorders, conditions and level of functioning?**

The Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association, outlines a five part assessment system to be used in evaluating patients. The diagnostic manual and multiaxial system are accepted and used by a majority of mental health care professionals in the United States. The multiaxial system consists of five areas that clinicians should examine to fully understand, diagnose and treat their patients. **Without the use of these guidelines, clinicians tend to look at only a narrow band of the client's behavior and make incomplete and incorrect judgments regarding diagnosis and treatment.**

---

**Q: Did you administer a fixed (standard) test battery or a flexible test battery?**

Fixed or standard batteries often used in neuropsychological evaluation include the Halstead-Reitan Neuropsychological Battery and the Luria Nebraska Neuropsychological Battery. The administration of non-standard or flexible test batteries has been challenged in Federal Court because they do not fulfill the requirements of the Daubert rules of evidence.

From: *Behavioral Sciences and the Law, Vol. 14, 315-322 (1996)*. In *Chapple v. Ganger, 851 F. Supp. 1481 (E.D. Wash, 1994)*, the Daubert Standard was applied for the very first time to the use of fixed (standardized) versus flexible (nonstandardized) neuropsychological test batteries in the federal court. In this personal injury case, the Chapple court gave far greater weight to the results obtained from a fixed battery than to the results obtained from two flexible neuropsychological test batteries.

Significantly, under the Daubert standard the District Judge noted the lack of medical and scientific evidence to support the conclusions made by the Plaintiffs' two expert witnesses, a psychologist and a neuropsychologist, even though each had administered a comprehensive and flexible neuropsychological test battery and had based their conclusions on the test results. The judge accepted as scientific evidence the objective test results obtained from the fixed Halstead-Reitan Neuropsychological Test Battery for Older Children administered by the Defendants' expert witness Dr. Ralph Reitan and also accepted his scientific expert testimony which was closely derived from these data. Applying the Daubert standard to the neuropsychological test results and opinions of the expert witnesses, the District Judge held that the entire reasoning process and not simply part of the reasoning process upon which the expert witness derives a conclusion must reflect scientific methodology.

# Neuropsychological Testing

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## DEPOSITION QUESTIONS

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### General Questions

(continued)

Regarding the neuropsychological batteries themselves, the Chapple court accepted as scientific evidence the fixed or standardized battery results (e.g., the HRB results) and only admitted results obtained from some of the individual tests found within the two flexible nonstandardized batteries offered by the Plaintiffs; although, both of the flexible batteries in their entirety were used by the Plaintiffs' two expert witnesses to form their diagnoses. The court did not expressly state its reason for exclusion although it appears that a battery, as such, must meet adequate test construction standards, as suggested in the APA's Standard for Educational and Psychological Testing, in order to satisfy the stated Daubert requirements of scientific validity, reliability, methodology, and procedure.

---

**Q: Did you consider that *inherent statistical weaknesses* in the tests may account for some of the plaintiff's test performance?**

Many of the tests used in forensic neuropsychological evaluations have statistical problems that weaken their reliability and validity.

---

**Q: Do a few scores below the expected norm necessarily indicate impaired intellectual functioning?**

It is perfectly normal to have a few scores below the plaintiff's expected level of cognitive functioning. In fact, most persons have neuropsychological limitations. When the neuropsychologists overinterpret test scores to show impairment, the real issue of actual impairment due to injury is obscured.

---

*NOTE: In cases where the plaintiff is diagnosed with DAI (diffuse axonal injury).*

**Q: Were any of the foundation studies regarding diffuse axonal injury (DAI) conducted on primates?**

The primate studies at the University of Pennsylvania were halted due to animal cruelty concerns. Many jurisdictions do not permit the use of animal model studies to prove human injury.

---

*NOTE: Use caution with the following question(s) if the neuropsychological test results indicate organic deficits.*

**Q: Are the results of the neuropsychological testing consistent with the plaintiff's subjective complaints?**

---

**Q: Do the results of the plaintiff's neuropsychological testing indicate or support a diagnosis of brain injury?**

While neuropsychological tests are useful in detecting impaired mental functioning, it is important to remember that *these tests do not measure brain damage*. Rather, they may provide information about a possible underlying brain disorder and interpretations other than brain damage may exist. Therefore, even if the testing detected brain dysfunction, the tests are not sophisticated enough to determine the cause of the brain dysfunction. (reference 35, p. 25)

---

# Neuropsychological Testing

---

## DEPOSITION QUESTIONS

---

### General Questions

(continued)

**Q: Have the plaintiff's neuropsychological test deficits been corroborated by objective or scientifically verifiable tests such as CT scan or MRI?**

According to the Daubert rules of evidence, a neuropsychologist must be able to cite scientific evidence proving general causation and correlation of damages to focal areas of brain damage seen by a method other than neuropsychological examination. (reference 35, p. 25)

---

**Q: Is it your opinion that a neuropsychologist can predict a person's "real world" functioning from the results of neuropsychological tests?**

Many experts feel that a neuropsychological evaluation is more telling than a neurological exam in identifying subtle cognitive dysfunction. However, the Mayo Clinic conducted a study which attempted to judge "real world" functioning following brain injury. The study concluded that the ability to predict "real world" functioning following brain injury (via neuropsychological testing) was no better than chance, and usually far worse. (reference 35, p. 25)

---

**Q: What are some *common interpretive errors* made by neuropsychologists?**

Intentional or not, even the most experienced neuropsychologists are prone to make errors when interpreting test results. Some common interpretive errors are as follows: (reference 31, pp. 151-152)

- (1) **Overgeneralization** – The tendency for neuropsychologists to overgeneralize their findings from one group to another is commonplace. "If this, then that" is often a fallacy of logic.
- (2) **False negatives/positives** – The absence of low scores in actual brain damaged plaintiffs can occur with inappropriate examination.
- (3) **Confirmatory bias** – The examiner seeks evidence supporting the known outcome rather than exploring contradictory evidence.
- (4) **Over and under-interpretation** – It must be considered that one single, seemingly important finding could just be a mistake and may not deserve a lot of weight.
- (5) **Under-use of base rates** – Frequently relying on signs or conditions as diagnostic indicators while ignoring base rates will always produce more errors. Base rates are often neglected and in traumatic brain injury (TBI) cases this can lead to inappropriate diagnoses. Often the symptoms seen in TBI (variable attention, imperfect memory, variable mood and motivation) are common in the general population as well.

## **SECTION 7.2: PERSONALITY CHANGE DUE TO A GENERAL MEDICAL CONDITION**

**DEFENSE THEORY: The plaintiff's personality change is due to a medical condition unrelated to the cause of action OR the personality pathology pre-existed the cause of action.**

### **INTRODUCTION**

Often the first sign of an undiagnosed medical condition may be a persistent personality disturbance, manifested by mood instability, poor impulse control, outbursts of aggression or rage, marked apathy, suspiciousness, or paranoid thoughts.

A number of neurological and other general medical conditions may cause personality changes. Medical conditions which are most likely to cause a personality change include central nervous system neoplasms, head trauma, cerebrovascular disease, Huntington's disease, epilepsy, infectious conditions (HIV), endocrine conditions, and autoimmune conditions. Chronic general medical conditions associated with pain and disability can also be associated with changes in personality. In order to determine if a general medical condition is the basis of plaintiff's personality change, results from a physical examination as well as laboratory findings must be included in the clinical evaluation.

# Personality Change Due to a General Medical Condition

---

## DEPOSITION QUESTIONS

---

**TABLE 7.2-1.**

**Diagnostic criteria 310.1 Personality Change Due to...[Indicate the General Medical Condition]**

- A.** A persistent personality disturbance that represents a change from the individual's previous characteristic personality pattern. (In children, the disturbance involves a marked deviation from normal development or a significant change in the child's usual behavior patterns lasting at least 1 year).
- B.** There is evidence from the history, physical examination, or laboratory findings that the disturbance is the direct physiological consequence of a general medical condition.
- C.** The disturbance is not better accounted for by another mental disorder (including other Mental Disorders Due to a General Medical Condition).
- D.** The disturbance does not occur exclusively during the course of a delirium and does not meet criteria for a dementia.
- E.** The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

**Specify type:**

- Labile Type:** if the predominant feature is affective lability
- Disinhibited Type:** if the predominant feature is poor impulse control as evidenced by sexual indiscretions, etc.
- Aggressive Type:** if the predominant feature is aggressive behavior
- Apathetic Type:** if the predominant feature is marked apathy and indifference
- Paranoid Type:** if the predominant feature is suspiciousness or paranoid ideation
- Other Type:** if the predominant feature is not one of the above, e.g., personality change associated with a seizure disorder
- Combined Type:** if more than one feature predominates in the clinical picture
- Unspecified Type:**

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# Personality Change Due to a General Medical Condition

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## DEPOSITION QUESTIONS

---

**TABLE 7.2-2.**

| <i>Personality Changes Due to a General Medical Condition</i>   | <i>Evaluation Methods</i>   |
|---|---|
| Episodes of crying<br>Outbursts of belligerence<br>Poor impulse control<br>Shifts of mood and emotions<br>Socially inappropriate behavior | History<br>Physical exam<br>Psychological testing<br>Neuropsychological testing<br>EEG<br>CT scan |
| Apathy<br>Indifference<br>Lack of concern for own environment<br>Loss of interest in usual activities                                     | MRI scan<br>PET scan<br>Blood tests<br>Other  |
| Inability to predict effects of behavior<br>Unconcern for consequences of behavior  |   |
| Decreased libido<br>Hyper-religiosity<br>Outbursts of anger, rage<br>Verbosity in speech and writing<br>Irritability                      |   |
| Paranoid ideation<br>Suspiciousness   |   |

### General Questions

**Q:** Describe the plaintiff's personality disturbance.

---

**Q:** Is the plaintiff's personality change constant or confined to specific situations?

---

**Q:** When did the plaintiff first experience a personality change?

---

**Q:** How long has the plaintiff been experiencing a personality change?

---

**Q:** Did you obtain information about the plaintiff's premorbid functioning?

---

**Q:** Was there evidence of a pre-existing personality pathology?

---

**Q:** Is the plaintiff's current behavior different from premorbid patterns?

---

**Q:** To what do you attribute this change?

---

# Personality Change Due to a General Medical Condition

---

## DEPOSITION QUESTIONS

---

### General Questions

(continued)

**Caution:** *Do not ask the following questions if the cause of action involves a closed head injury, electrical injury or toxic exposure.*

**Q: Did the plaintiff have a head injury?**

Closed head injuries are a common cause of changes in personality. (reference 18, p. 921)

---

**Q: What evaluation methods were used to determine the cause of plaintiff's personality disturbance?**

---

**Q: Did you rule out a *brain tumor* as a cause of the plaintiff's personality disturbance?**

Brain tumors occur in the skull, brain, or membrane covering the brain or spinal cord. Symptoms vary depending on the size of the tumor and rate of growth. The plaintiff may experience anxiety, dementia, irritability, dizziness, fatigue, headache, vomiting, hyperthermia (high body temperature), and **changes in appetite and personality**. (reference 4, pp. 139, 834-835, 855, 860, 1276; reference 9, pp. 2161-2164, reference 1, pp. 1351, 1296)

*If the witness indicates the possibility of a brain tumor, see the section on pre-existing medical conditions for further questions.*

---

**Q: Did you rule out *cerebrovascular disease* as a cause of the plaintiff's personality disturbance?**

---

**Q: Did you rule out *multiple sclerosis* as a cause of the plaintiff's personality disturbance?**

Multiple sclerosis is a common disease of young adults. The disease causes a disorder of the optic nerves, spinal cord, and brain. Symptoms may include depression, **personality change**, apathy, lack of judgement, inattention, tremor, vertigo, incoordination, weakness, fatigue, dysarthria, (speech impairment), and urinary frequency or hesitancy. (reference 4, p. 1276; reference 1, pp. 1354-1356)

*If the witness indicates the possibility of multiple sclerosis, see the section on pre-existing medical conditions for further questions.*

---

**Q: Did you rule out a family history of *Huntington's disease* or other genetic disorder as a cause of the plaintiff's personality disturbance?**

Huntington's disease is an inherited degenerative disease of the brain. First symptoms are usually **personality or psychological changes** with memory loss and difficulty in anticipating or planning future events. Dementia can develop months or years before the characteristic chorea. (reference 4, pp. 40, 87, 117-118, 865; reference 1, pp. 1362-1363; reference 9, p. 2001)

*If the witness indicates the possibility of Huntington's disease, see the section on pre-existing medical conditions for further questions.*

---

# Personality Change Due to a General Medical Condition

---

## DEPOSITION QUESTIONS

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### General Questions

(continued)

**Q: Did you rule out *epilepsy* as a cause of the plaintiff's personality disturbance?**

Epilepsy is a brain disorder characterized by recurring hyperactive brain functioning that causes epileptic seizures. The disorder is often the result of a cerebral lesion combined with a genetic predisposition. Epilepsy usually begins in early childhood but can appear at any age. **Personality disturbances**, amnesia, and psychosis are frequently encountered in the plaintiff with epilepsy. (reference 4, pp. 134, 877; reference 9, pp. 2149-2151)

*If the witness indicates the possibility of epilepsy, see the section on pre-existing medical conditions for further questions.*

---

**Q: Did you rule out *Addison's disease* as a cause of the plaintiff's personality disturbance?**

Addison's disease develops slowly as the adrenal cortex decreases functioning. The plaintiff experiences significant **personality and behavioral changes** from the reduced level of the steroidal hormones normally produced by the gland. Advance stages of Addison's disease produce symptoms of depression, a lack of physical and emotional responsiveness, mild mental disorders, and recent memory loss. (reference 4, pp. 134, 1170-1171, 1276)

*If the witness indicates the possibility of Addison's disease, see the section on pre-existing medical conditions for further questions.*

---

**Q: Did you rule out *encephalitis* as a cause of the plaintiff's personality disturbance?**

Encephalitis is an inflammatory disease of the brain. Most plaintiffs acquire the disease as a complication of a viral infection such as measles, chicken pox, or rubella. This disease may develop five to ten days following the virus and is characterized by a perivascular demyelination (loss of the protective sheath around the vessels) of the brain. Symptoms include **personality disruptions**, amnesia, cognitive impairment, and symptoms resembling psychosis. Death rates from the disease are high. (reference 4, pp. 155, 872; reference 1, pp. 1342-1344)

---

**Q: Did you rule out the onset of *hypoglycemia* as a cause of the plaintiff's personality disturbance?**

Hypoglycemia is an abnormally low blood sugar level. It often produces **personality changes**, tiredness, confusion, dizziness, tremor, anxiety, tachycardia, and sweating during acute attacks. Other psychiatric symptoms include fear and dread, depression with fatigue, and agitation with confusion. Hypoglycemia can develop from an insulin overdose, insulinoma or islet cell tumor, extensive liver disease, or functional diseases. (reference 2, p. 702; reference 4, pp. 1176-1177; reference 18, pp. 1929, 1479 )

*If the witness indicates the possibility of hypoglycemia, see the section on pre-existing medical conditions for further questions.*

---

# Personality Change Due to a General Medical Condition

---

## DEPOSITION QUESTIONS

---

### General Questions

(continued)

**Q: Did you rule out *systemic lupus erythematosus* as a cause of the plaintiff's personality disturbance?**

Systemic lupus erythematosus (SLE) causes inflammation in body organs such as the kidneys; the tissue surrounding the heart, lungs, thoracic cavity and blood vessels. The plaintiff may become depressed, confused, and have other thought disorders and **personality change**. Physical symptoms may include anorexia, fatigue, fever, migraine headaches, and weight loss. (reference 9, pp. 1924-1928; reference 1, pp. 1207-1209)

*If the witness indicates the possibility of systemic lupus erythematosus, see the section on pre-existing medical conditions for further questions.*

---

**Q: Did you rule out *Wilson's disease* as a cause of the plaintiff's personality disturbance?**

Wilson's disease is characterized by brain degeneration. Defective copper excretion causes an accumulation of copper in the liver, brain and other tissues. Symptoms may include tremor exaggerated with movement, difficulty speaking and swallowing, incoordination, **personality changes**, explosive anger, abdominal pain, diarrhea, nausea and vomiting, and dementia. (reference 9, pp. 1158-1159)

*If the witness indicates the possibility of Wilson's disease, see the section on pre-existing medical conditions for further questions.*

---

**Q: Did you rule out *psychoactive substance use / abuse* as a cause of the plaintiff's personality disturbance?**

Psychoactive substance use often causes **personality disturbance**. The plaintiff may not necessarily be dependent on the drug, but typically uses the drug periodically despite knowing the problems caused by its use. Nine substances should be considered:

Alcohol  
Amphetamine or similarly acting sympathomimetics  
Cannabis  
Cocaine/crack  
Ecstasy (MDMA)  
Hallucinogens  
Inhalants  
Opioids  
Sedatives, hypnotics, or anxiolytics

*Defense counsel should refer to the questions on the following pages for further information about the symptoms of substance use, including personality changes.*

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# Personality Change Due to a General Medical Condition

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## DEPOSITION QUESTIONS

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### General Questions

(continued)

**Q: Did you rule out *alcohol consumption* as a cause of the plaintiff's personality disturbance?**

Alcohol intoxication may cause aggressiveness, impaired judgement and attention, irritability, euphoria, depression, emotional lability, **personality disturbance**, and impaired social or occupational functioning. Physical symptoms may include slurred speech, incoordination, unsteady gait, nystagmus, occasional dizziness, and flushed face. Heavy alcohol consumption may cause abnormal sleep patterns. The plaintiff often falls asleep quickly but wakes up earlier and earlier with uncomfortable feelings. Chronic alcoholics may have irregular, unsteady, and slow tremulous movements. (reference 7, pp. 128-129; reference 4, p. 67; reference 9, p. 52)

---

**Q: Did you rule out *amphetamine or similarly acting sympathomimetic drug consumption* as a cause of the plaintiff's personality disturbance?**

Symptoms of amphetamine or similarly acting sympathomimetic drug consumption may include fighting, grandiosity, elation, hypervigilance, psychomotor agitation, impaired judgement, **personality change**, and impaired social or occupational functioning. Physical symptoms may include flushing, difficulty breathing, tachycardia, pupil dilation, elevated blood pressure, sweating or chills, nausea, and vomiting. (reference 4, pp. 1007-1008; reference 7, pp. 223-227)

---

**Q: Did you rule out *cannabis (marijuana) consumption* as a cause of the plaintiff's personality disturbance?**

Cannabis intoxication can occur from marijuana, hashish, or tetrahydrocannabinol (THC). Characteristic symptoms include tachycardia, increased appetite, dry mouth, euphoria, anxiety, sensation of slowed time, impaired judgement, and social withdrawal. Inappropriate laughter, panic attacks, and a dysphoric mood may occur. (reference 7, pp. 236-241; reference 4, pp. 1326, 754)

---

**Q: Did you rule out *cocaine consumption* as a cause of the plaintiff's personality disturbance?**

Cocaine users often experience increased energy and confidence or irritability and paranoia with physical aggressiveness. Other **behavioral symptoms** may include euphoria, hypervigilance, psychomotor agitation, impaired judgement, and impaired social or occupational functioning. Physical symptoms may include tachycardia, dilated pupils, elevated blood pressure, perspiration or chills, nausea, vomiting, and hallucinations. (reference 7, pp. 241-245; reference 4, pp. 1008-1009)

---

**Q: Did you rule out *inhalant intoxication* as a cause of the plaintiff's personality disturbance?**

Following inhalant (toxic substance) use, the plaintiff may experience **behavioral** and physical **changes**. Behavioral changes may include belligerence, assaultiveness, apathy, impaired judgement, and impaired social or occupational functioning. Physical signs may include dizziness, nystagmus, slurred speech, unsteady gait, lethargy, depressed reflexes, tremor, psychomotor weakness, blurred vision or diplopia, stupor or coma, and euphoria. (reference 7, pp. 259-260)

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# Personality Change Due to a General Medical Condition

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## DEPOSITION QUESTIONS

---

### General Questions

(continued)

**Q: Did you rule out *opioid consumption* as a cause of the plaintiff's personality disturbance?**

Opioid intoxication is characterized by euphoria, flushing, itching skin, miosis, drowsiness, decreased respiratory rate and depth, hypotension, bradycardia, and decreased body temperature. The **initial euphoria** is often **followed by apathy**, unpleasant mood, psychomotor retardation, impaired judgement, and impaired social or occupational functioning. While dependence on opiates is less common than on alcohol or tobacco, it has been estimated that fifteen percent of males and nine percent of females have used an opiate (nonmedical) during their lifetime. (reference 7, pp. 269-272; reference 4, pp. 987-988)

---

**Q: Did you rule out *sedative, hypnotic, or anxiolytic consumption* as a cause of the plaintiff's personality disturbance?**

Sedative, hypnotic, or anxiolytic drug consumption cause **behavioral** and physical **changes**. Behavioral symptoms many include disinhibition of sexual or aggressive impulses, mood lability, impaired judgement, and impaired social or occupational functioning. Physical symptoms may include slurred speech, incoordination, unsteady gait, and impaired memory or attention span. Sedative drugs and minor tranquilizers cause impairment on many behavioral tasks. They may also improve some plaintiff's work or social functioning by reducing severe anxiety. The effects of two or more drugs, such as sedatives and alcohol, may cause significant behavioral impairment. (reference 7, pp. 284-287; reference 4, p. 1548)

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**Q: Did you rule out *ecstasy use* as a cause of the plaintiff's personality disturbance?**

Disturbing evidence is emerging that the increasingly popular drug ecstasy can be linked to users suffering long-term brain damage. University of Adelaide (Australia) researchers have found that ecstasy taken on a few occasions could cause severe damage to brain cells, with the potential to cause future memory loss or psychological problems. In 1998, the National Institute of Mental Health conducted a study of a small group of habitual MDMA users who had abstained from use for approximately 2-3 weeks. The study revealed that the abstinent users suffered damage to the neurons in the brain that transmit serotonin, an important biochemical involved in a variety of critical functions including learning, sleep, and integration of emotion. The results of the study indicate that recreational MDMA users may be at risk of **developing permanent brain damage** that may manifest itself in the form of depression, anxiety, memory loss, and **other neuropsychiatric disorders**. (reference 34)

---

**Q: Is the plaintiff taking any other *prescribed medications or substances* that may cause a personality disturbance?**

|          |               |           |
|----------|---------------|-----------|
| AMBIEN   | ELDEPRYL      | PERMAX    |
| BONTRIL  | EXCELON       | TIAZAC    |
| DECADRON | LAMICTAL      | TOPAMAX   |
| DEPACON  | LEVO-DROMORAM | TRILEPTAL |
| DESOPYN  | NALFON        | ZYPREXA   |

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# Personality Change Due to a General Medical Condition

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## DEPOSITION QUESTIONS

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### General Questions

(continued)

**Q:** Does the plaintiff have any other *medical conditions* that may cause a personality disturbance, such as:

|   |   |
|---|---|
| Binswanger's disease  | Hypokalemia<br>(deficiency of potassium in the blood) |
| Brucellosis   | Hyponatremia<br>(abnormally low blood salt levels)    |
| Carotid artery occlusive disease                            | Hypoparathyroidism                                    |
| Cerebral embolism   | Hypopituitarism                                       |
| Chronic subdural hematoma                                   | Hypoxia<br>(oxygen deficiency in the brain tissue)    |
| Chronic abscess   | Lymphoma and leukemia                                 |
| Colloid cyst  | Multifocal leukoencephalopathy                        |
| Cranial arteritis   | Neoplasm, benign or malignant                         |
| Electrolyte metabolism disorders                            | Normal pressure hydrocephalus                         |
| Encephalitis  | Paget's disease                                       |
| Endocrine disorders<br>(thyroid and adrenocortical disease) | Progressive supranuclear palsy                        |
| Erythemia   | Pulmonary failure                                     |
| Heat stroke   | Remote effects of carcinoma and<br>lymphomas          |
| Hypercalcemia<br>(abnormally high blood calcium levels)     | Renal failure   |
| Hyperinsulinism   | Sarcoidosis   |
| Hypernatremia<br>(abnormally high blood salt levels)        | Simple cortical atrophy                               |
| Hypocalcemia<br>(abnormally low blood calcium levels)       | Thrombotic thrombocytopenic purpura                   |
|   | Tuberculoma   |



## SECTION 7.3: ALTERNATE CAUSES OF THE PLAINTIFF'S DEMENTIA

**DEFENSE THEORY: The plaintiff's loss of intellectual and cognitive ability may be caused by factors other than the injury in question.**

### INTRODUCTION

Dementia describes the deterioration or loss of intellectual faculties, reasoning power, memory, and volition due to an organic brain disease. There are many organic causes of dementia and they are listed according to presumed etiology: Dementia of the Alzheimer's Type, Vascular Dementia, Dementia Due to Other General Medical Conditions (e.g., human immunodeficiency virus [HIV] disease, head trauma, Parkinson's disease, Huntington's disease, Creutzfeldt-Jakob), Substance-Induced Persisting Dementia (i.e., due to a drug of abuse, a medication, or toxic exposure), Dementia Due to Multiple Etiologies, or Dementia Not Otherwise Specified (if the etiology is indeterminate).

The essential feature of a dementia is the development of multiple cognitive deficits that include memory impairment and at least one of the following cognitive disturbances: **aphasia** (unable to use or comprehend words), **apraxia** (loss of coordinated movements), **agnosia** (inability to recognize familiar objects), or a **disturbance in executive functioning**. The cognitive deficits must be sufficiently severe to cause impairment in occupational or social functioning and must represent a decline from a previously higher level of functioning.

**Note:** In the DSM-IV-TR, Cognitive Disorder NOS (Not Otherwise Specified) is included in the chapter with dementia and delirium. This diagnosis is given for presentations that are characterized by cognitive dysfunction presumed to be due to either a general medical condition or substance use that do not meet criteria for any of the disorders listed elsewhere in this section. Cognitive Disorder NOS is frequently diagnosed by neuropsychologists. Many of the same questions that apply to dementia may also be asked when there is a diagnosis of Cognitive Disorder NOS.

# Alternate Causes of the Plaintiff's Dementia

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## DEPOSITION QUESTIONS

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**TABLE 7.3-1.**

| <b>Clinical Characteristics Used In Distinguishing Dementia From Depressive Pseudodementia*</b>   |  |
|---|--|
| <b>Dementia</b>   | <b>Pseudodementia *</b>  |
| <ul style="list-style-type: none"> <li>• Attention and concentration impaired</li> <li>• Behavioral disability equals cognitive loss</li> <li>• Cognitive loss precedes depression</li> <li>• Consistently poor performance</li> <li>• Insidious onset</li> <li>• “Near miss” answers frequent</li> <li>• Often evasive, angry, or sarcastic when pressed for answers, or tries hard to answer correctly but just misses</li> <li>• Often neglected, sloppy; manner facetious or apathetic and indifferent; catastrophic reaction may be evoked; emotional expression often labile and superficial</li> <li>• Orientation impaired</li> <li>• Patient <i>minimizes</i> cognitive loss</li> <li>• Patient minimizes or denies cognitive deficits, tries to conceal them by circumstantially, perseveration, changing topic of conversation</li> <li>• Recent memory loss exceeds remote</li> <li>• Restless sleep and early morning awakening <i>rare</i></li> <li>• Thoughts of death and dying</li> <li>• Usually globally impaired and consistently poor</li> <li>• Worse at night</li> </ul> | <ul style="list-style-type: none"> <li>• Attention and concentration preserved</li> <li>• Behavior better than cognitive loss would predict</li> <li>• Depression precedes cognitive loss</li> <li>• Variable Performance</li> <li>• Acute onset</li> <li>• Often slow, “I don’t know” answers frequent</li> <li>• Facial expression sad, worried; manner retarded or agitated, never facetious or euphoric; bemoans or ridicules own impaired performance but no true catastrophic reaction</li> <li>• Orientation impaired</li> <li>• Patient exaggerates cognitive loss</li> <li>• Patient complains vocally of memory impairment and poor intellectual performance, exaggerates and dwells on these deficits</li> <li>• Equal loss of recent / remote memory</li> <li>• Restless sleep and early morning awakening common</li> <li>• Suicidal thoughts more common</li> <li>• Often confined to memory impairment; if globally impaired, it is because patient refuses to make effort</li> <li>• No diurnal variation</li> </ul> |

\*A treatable, reversible loss of cognitive ability.

# Alternate Causes of the Plaintiff's Dementia

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## DEPOSITION QUESTIONS

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### General Questions

**Q: Describe the symptoms of the plaintiff's dementia.**

Dementia is characterized by confusion, disorientation, apathy, and stupor of varying degrees.

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**Q: What type of dementia did you diagnose in the plaintiff?**

---

**Q: When did the plaintiff first experience dementia?**

---

**Q: Did the plaintiff have signs of dementia before the injury in question?**

---

**Q: Do the plaintiff's symptoms of dementia interfere with functioning?**

The cognitive deficits must be sufficiently severe to cause impairment in occupational or social functioning and must represent a decline from a previously higher level of functioning.

---

**Q: Did you rule out an episode of *delirium* as a cause for the plaintiff's symptoms of dementia or cognitive decline?**

Memory impairment occurs in both delirium and dementia. Delirium is also characterized by a reduced ability to maintain and shift attention appropriately. The clinical course can help to differentiate between delirium and dementia. Typically, symptoms in delirium fluctuate and symptoms in dementia are relatively stable. A diagnosis of a dementia should not be made if the cognitive deficits occur exclusively during the course of a delirium. (reference 7, p. 136)

---

**Q: What tests did you use to determine the presence of dementia?**

Memory may be formally tested by asking the person to register, retain, recall, and recognize information. The ability to learn new information may be assessed by asking the individual to learn a list of words. The individual is requested to repeat the words (registration), to recall the information after a delay of several minutes (retention, recall), and to recognize the words from a multiple list (recognition). (reference 7, p. 147)

---

**Q: Did you perform any *objective diagnostic tests* to confirm or rule out dementia?**

Neuroimaging may aid in the differential diagnosis of dementia. Computed tomography (CT) or magnetic resonance imaging (MRI) may reveal cerebral atrophy, focal brain lesions (cortical strokes, tumors, subdural hematomas), hydrocephalus, or periventricular ischemic brain injury. Functional imaging procedures such as positron-emission tomography (PET) or single photon emission computed tomography (SPECT) are not routinely used in the evaluation of dementia, but may provide useful differential diagnostic information (e.g., parietal lobe changes in Alzheimer's disease or frontal lobe alterations in frontal lobe degenerations) in individuals without evidence of structural changes on CT or MRI scans.

---

# Alternate Causes of the Plaintiff's Dementia

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## DEPOSITION QUESTIONS

---

### General Questions

(continued)

**Q: Did you rule out an *early onset of Alzheimer's disease* as a cause of the plaintiff's dementia?**

Alzheimer's disease causes a **progressive deterioration of the brain** and personality. The first major symptoms are usually amnesia (forgetfulness), visuomotor coordination, and abstract thought. Early stages of the disease may resemble the affective disorders, confusing diagnosis and treatment. Dementia then slowly progresses to an advanced stage of impairment within two or three years. (reference 4, pp.117, 844; reference 9, pp. 27, 1999-2000)

*If the witness indicates the possibility of Alzheimer's disease, see the section on pre-existing medical conditions for further questions.*

---

**Q: Did you rule out *Pick's disease* as a cause of the plaintiff's dementia?**

Pick's disease causes a **deterioration of the brain's frontal lobe**. The disease is characterized by erratic and impulsive behaviors that progress to profound deterioration and death within two to five years. (reference 15, pp. 508-509)

---

**Q: (Elderly plaintiff) Did you rule out *senile dementia* as a cause of the plaintiff's dementia?**

Senile dementia is a progressive disease of the elderly characterized by the **loss of memory** and impaired intellectual abilities.

---

**Q: Did you rule out a *familial history of Huntington's disease or other genetic disorders* as a cause of the plaintiff's dementia?**

Huntington's disease is an inherited degenerative disease of the brain. First symptoms are usually personality or psychological changes with memory loss and difficulty in anticipating or planning future events. **Dementia** can develop months or years before the characteristic chorea. (reference 4, pp. 40, 87, 117-118, 965; reference 1, pp. 1362-1363; reference 9, p. 2001)

*If the witness indicates the possibility of Huntington's disease, see the section on pre-existing medical conditions for further questions.*

---

**Q: Did you rule out *vascular dementia (formerly multi-infarct dementia)* as a cause of the plaintiff's dementia?**

Vascular dementia (formerly multi-infarct dementia) is caused by cerebrovascular disease (disease of the brain's blood supply or blood vessels) that quickly produces an irregular **deterioration in intellectual functioning**. The resulting dementia involves disturbances in memory, abstract thinking, judgement, impulse control, and personality. (reference 7, p. 158)

---

## Alternate Causes of the Plaintiff's Dementia

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### DEPOSITION QUESTIONS

---

#### General Questions

(continued)

**Q: Did you rule out the onset of Parkinson's disease as a cause of the plaintiff's dementia?**

Parkinson's disease has characteristic symptoms of tremor or bradykinesia (slowness and poverty of movement). Changed gait, posture, and facial expression appear as the disease progresses. Plaintiffs often experience personality changes, depression, and **dementia**. Disability usually occurs ten to fifteen years after disease onset. (reference 4, pp. 118-119, 147; reference 9, pp. 2070-2071; reference 1, pp. 1359-1360)

*If the witness indicates the possibility of Parkinson's disease, see the section on pre-existing medical conditions for further questions.*

---

**Q: Did you rule out hepatic encephalopathy as a cause of the plaintiff's dementia?**

Hepatic encephalopathy is a disease of the liver that causes impaired mental functioning leading to stupor and coma. The liver normally metabolizes and detoxifies digestive products. In hepatic disease these products go into circulation before being detoxified. The toxic effects of these substances cause personality and **mental symptoms, including delirium**. (reference 1, pp. 816-817; reference 9, p. 121)

*If the witness indicates the possibility of hepatic encephalopathy, see the section on pre-existing medical conditions for further questions.*

---

*Note: The following question is only for plaintiffs with concurrent kidney disease.*

**Q: Did you rule out renal dialysis dementia as a cause of the plaintiff's dementia?**

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**Q: Did you rule out hypothyroidism as a cause of the plaintiff's dementia?**

Hypothyroidism results from inadequate synthesis of thyroid hormone. Hypothyroidism can produce psychiatric, as well as physical symptoms. The most notable psychiatric symptoms include depression, lethargy, **poor concentration, impaired memory**, apathy, and syncope. The numerous physical symptoms are: cold intolerance, constipation, muscle cramps, paresthesias, menstrual disorders, dyspnea, dizziness, reduced hearing, poor appetite, weight gain, brittle and thinning hair, and bradycardia (slowed heart action). Panic attacks are associated with endocrinological disorders including hypothyroidism and hyperthyroidism. (reference 18, pp. 743, 1810-1812, 1928)

*If the witness indicates the possibility of hypothyroidism, see the section on pre-existing medical conditions for further questions.*

---

**Q: Did you rule out heavy concentrations of carbon monoxide as a cause of the plaintiff's dementia?**

Sources of exposure may include occupational and residential locations.

---

## Alternate Causes of the Plaintiff's Dementia

---

### DEPOSITION QUESTIONS

---

#### General Questions

(continued)

**Q: Did you rule out Addison's disease as a cause of the plaintiff's dementia?**

Addison's disease develops slowly as the adrenal cortex decreases functioning. The plaintiff experiences significant personality and behavioral changes from the reduced level of the steroidal hormones normally produced by the gland. Advanced stages of Addison's disease produce symptoms of depression, a lack of physical and emotional responsiveness, **mild mental disorders, and recent memory loss**. (reference 4, pp. 134, 1170-1171, 1276)

*If the witness indicates the possibility of Addison's disease, see the section on pre-existing medical conditions for further questions.*

---

**Q: Did you rule out Cushing's syndrome as a cause of the plaintiff's dementia?**

Plaintiffs often experience emotional changes before physical signs of the disease appear. Depression is the most common symptom. Other psychological symptoms include irritability, anxiety, **confusion**, insomnia, and **impaired memory or concentration**. Some of the characteristic physical signs include an increased appetite, weakness, buffalo hump, truncal and facial obesity, heightened facial color, and abdominal striae (stripes). (reference 4, pp. 1171-1172)

*If the witness indicates the possibility of Cushing's syndrome, see the section on pre-existing medical conditions for further questions.*

---

**Q: Did you rule out Wilson's disease as a cause of the plaintiff's dementia?**

Wilson's disease is characterized by brain degeneration. Defective copper excretion causes an accumulation of copper in the liver, brain and other tissues. Symptoms may include tremor exaggerated with movement, difficulty speaking and swallowing, incoordination, personality changes, explosive anger, abdominal pain, diarrhea, nausea and vomiting, and **dementia**. (reference 9, pp. 1158-1159)

*If the witness indicates the possibility of Wilson's disease, see the section on pre-existing medical conditions for further questions.*

---

**Q: Did you rule out porphyria as a cause of the plaintiff's dementia?**

Porphyria is an inherited disorder of young to middle-aged adults. It is characterized by episodes of abdominal pain, peripheral neuropathy, weakness, anorexia, nausea, vomiting, tachycardia, fever, confusion, depression, and severe anxiety. Mood swings and **mental abnormalities** are common symptoms. (reference 4, pp. 121, 1276, 1326; reference 9, p. 1156; reference 1, pp. 958, 960)

*If the witness indicates the possibility of porphyria, see the section on pre-existing medical conditions for further questions.*

---

**Q: Did you rule out avitaminosis as a cause of the plaintiff's dementia?**

Avitaminosis is any disease resulting from a vitamin deficiency. Deficiencies in cyanocobalamine, folate, nicotinic acid, and thiamine may result in dementia.

---

**Q: Did you rule out vitamin intoxication from vitamins A and D as a cause of the plaintiff's dementia?**

---

## Alternate Causes of the Plaintiff's Dementia

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### DEPOSITION QUESTIONS

---

#### General Questions

(continued)

**Q: Did you rule out an *undiagnosed brain tumor* as a cause of the plaintiff's dementia?**

Brain tumors occur in the skull, brain, or membrane covering the brain or spinal cord. Symptoms vary depending on the location, size, and rate of growth. The plaintiff may experience anxiety, **dementia**, irritability, dizziness, fatigue, headache, vomiting, hyperthermia (high body temperature), and changes in appetite and personality. (reference 4, pp. 139, 834-835, 855, 860, 1276; reference 9, pp. 2161-2164; reference 1, pp. 1351, 1296)

*If the witness indicates the possibility of a brain tumor, see the section on pre-existing medical conditions for further questions.*

---

**Q: Did you rule out *epilepsy* as a cause of the plaintiff's dementia?**

Epilepsy is a brain disorder characterized by recurrent hyperactive brain functioning that causes epileptic seizures. The disorder is often the result of a cerebral lesion combined with a genetic predisposition. Epilepsy usually begins in early childhood but can appear at any age. Personality disturbances, **amnesia**, and psychosis are frequently encountered in the plaintiff with epilepsy. (reference 4, pp. 134, 877; reference 9, pp. 2149-2151)

*If the witness indicates the possibility of epilepsy, see the section on pre-existing medical conditions for further questions.*

---

**Q: Did you rule out *meningitis* as a cause of the plaintiff's dementia?**

Meningitis is an inflammation of the membranes of the brain or spinal cord that may cause **dementia**, delirium, and malaise. The meningitides are named by either the causative agent (viral meningitis, tuberculous meningitis, pneumococcal meningitis) or by symptom characteristics (acute, chronic). (reference 12, p. 822; reference 4, pp. 123-124, 205, 721; reference 1, pp. 1339-13346; reference 9, p. 2122)

*If the witness indicates the possibility of meningitis, see the section on pre-existing medical conditions for further questions.*

---

**Q: Did you rule out *syphilis* as a cause of the plaintiff's dementia?**

Syphilis is a chronic disease usually contracted during sexual contact with another infected person. It is easily treated with penicillin. If the disease is not treated, the plaintiff may experience periods of active symptoms, including **dementia**, and years of latency. (reference 1, pp. 1616-1621; reference 9, pp. 1650-1654; reference 4, p. 127)

*If the witness indicates the possibility of syphilis, see the section on pre-existing medical conditions for further questions.*

---

## Alternate Causes of the Plaintiff's Dementia

---

### DEPOSITION QUESTIONS

---

#### General Questions

(continued)

**Q: Did you rule out *Wernicke-Korsakoff syndrome* as a cause of the plaintiff's dementia?**

The Wernicke-Korsakoff syndrome is a disorder due to a thiamine deficiency. It occurs most often in chronic alcoholics and plaintiff's that have most of their caloric intake from alcohol. The Wernicke's encephalopathy is a neuropsychiatric emergency, which is manifested by confusion, ataxia, and eye-movement abnormalities. The plaintiff must be treated immediately with large doses of thiamine to prevent an alcohol-persisting amnesic disorder from developing. Korsakoff's syndrome often follows an acute episode of Wernicke's encephalopathy.

Korsakoff's syndrome occurs when some areas of the brain are severely damaged. Characteristic symptoms include a **memory impairment for new information and events** since the onset of the illness. The plaintiff typically fabricates imaginary or confused experiences for those s/he cannot remember (confabulation). Emotional symptoms include apathy, blandness, or mild euphoria. In alcoholism, destruction of the brain is often irreversible. (reference 4, pp. 870-872; reference 7, p.178)

---

**Q: Did you rule out *multiple sclerosis* as a cause of the plaintiff's dementia?**

Multiple sclerosis is a common disease of young adults. The disease causes a disorder of the optic nerves, spinal cord, and brain. Symptoms may include depression, **changes in intellectual functioning**, apathy, lack of judgement, inattention, tremor, vertigo, incoordination, weakness, fatigue, dysarthria (speech impairment), and urinary frequency or hesitancy. (reference 4, p. 1276; reference 1, pp. 1354-1356)

*If the witness indicates the possibility of multiple sclerosis, see the section on pre-existing medical conditions for further questions.*

---

**Q: Did you rule out *heavy metal toxicity* as a cause of the plaintiff's dementia?**

Mercury, lead, arsenic, thallium and other substances may cause dementia.

---

**Q: Did you rule out *dementia associated with HIV infection* as a cause of the plaintiff's dementia?**

Dementia that is associated with direct HIV infection of the central nervous system is typically characterized by forgetfulness, slowness, **poor concentration, and difficulties with problem solving**. Behavioral manifestations most commonly include apathy and social withdrawal, and occasionally these may be accompanied by **delirium**, delusions, or hallucinations. Tremor, impaired rapid repetitive movements, imbalance, ataxia, hypertonia, generalized hyperreflexia, positive frontal release signs, and impaired pursuit and saccadic eye movements may be present on physical examination. (reference 7, p. 163)

---

**Q: Did you rule out *substance intoxication or withdrawal* as a cause of the plaintiff's dementia?**

Multiple **cognitive deficits** can occur in the context of substance use and are diagnosed as substance intoxication or substance withdrawal. If the dementia results from the persisting effects of a substance (i.e., a drug of abuse, a medication, or toxic exposure), then substance-induced persisting dementia is diagnosed. (reference 7, pp. 199-209 )

---

# Alternate Causes of the Plaintiff's Dementia

---

## DEPOSITION QUESTIONS

---

### General Questions

(continued)

**Q: Did you rule out *mental retardation* as a cause of the plaintiff's dementia?**

Mental retardation is characterized by significantly **subaverage general intellectual functioning**, with concurrent impairments in adaptive functioning and with an onset before age 18 years. Mental retardation is not necessarily associated with memory impairment. In contrast, the age at onset of dementia is usually late in life. (reference 7, pp. 41-49)

---

**Q: Did you rule out *schizophrenia* as a cause of the plaintiff's dementia?**

Schizophrenia can also be associated with **multiple cognitive impairments** and a decline in functioning, but schizophrenia is unlike dementia in its generally earlier age at onset, its characteristic symptom pattern, and the absence of a specific etiological general medical condition or substance. Typically, the cognitive impairment associated with schizophrenia is less severe than that seen in dementia. (reference 7, pp. 298-316)

*If the witness indicates the possibility of schizophrenia, see the section on pre-existing clinical mental disorders for further questions.*

---

**Q: Did you rule out the *presence of depression* as a cause of the plaintiff's dementia?**

Major depressive disorder may be associated with complaints of **memory impairment, difficulty thinking and concentrating, and an overall reduction in intellectual abilities**. Individuals sometimes perform poorly on mental status examinations and neuropsychological testing. Particularly in elderly persons, it is often difficult to determine whether cognitive symptoms are better accounted for by a dementia or by a major depressive episode. (reference 7, pp. 369-376)

---

**Q: Did you rule out *malingered and the factitious disorder* as causes of the plaintiff's dementia?**

Dementia must be distinguished from malingering and factitious disorder. The patterns of cognitive deficits presented in malingering and factitious disorder are usually not consistent over time and are not characteristic of those typically seen in dementia. For example, individuals presenting with factitious disorder or malingering may perform calculations while keeping score during a card game, but then claim to be unable to perform similar calculations during a mental status examination. (reference 7, pp. 739, 513-517)

*If the witness indicates the possibility of malingering or factitious disorder, see Chapter 8, sections 8.1 and 8.2 for further questions.*

---

**Q: Did you rule out *age-related cognitive decline* as a cause of the plaintiff's dementia?**

Dementia must be distinguished from the normal decline in cognitive functioning that occurs with aging (as in age-related cognitive decline). The diagnosis of dementia is warranted only if there is demonstrable evidence of **greater memory and other cognitive impairment** than would be expected due to normal aging processes and the symptoms cause impairment in social or occupational functioning. (reference 7, p. 740)

---

# Alternate Causes of the Plaintiff's Dementia

---

## DEPOSITION QUESTIONS

---

### General Questions

(continued)

**Q: Did you rule out other causes of dementia including:** (reference 18, p. 895)

**Tumor:**

Primary cerebral \*  
Metastatic \*

**Trauma:**

Hematomas \*  
Posttraumatic dementia \*

**Infection (chronic)**

Syphilis \*  
Creutzfeldt-Jakob disease +  
AIDS dementia complex ++

**Cardiac / vascular**

Single infarction \*  
Multiple infarction +  
Large infarction  
Lacunar infarction  
Binswanger's disease  
Hemodynamic type \*

**Congenital / hereditary**

Huntington's disease ++  
Metachromatic leukodystrophy ++

**Primary psychiatric**

Pseudodementia ++

**Physiological**

Epilepsy \*  
Normal pressure hydrocephalus \*

**Metabolic**

Vitamin deficiencies \*  
Chronic metabolic disturbances \*  
Chronic anoxic states \*  
Chronic endocrinopathies \*

**Degenerative dementias**

Alzheimer's disease +  
Pick's disease (dementia of frontal lobe) +  
Parkinson's disease \*  
Progressive supranuclear palsy ++  
Idiopathic cerebral ferrocalsinosis (Fahr's disease) ++  
Wilson's disease \*

**Demyelinating**

Multiple sclerosis ++

# Alternate Causes of the Plaintiff's Dementia

---

## DEPOSITION QUESTIONS

---

### General Questions

*(continued)*

### Drugs and toxins

Alcohol \*

Heavy metals \*

Carbon monoxide poisoning \*

Medications \*

Irradiation \*

---

\* Variable or mixed pattern

+ Predominantly cortical pattern

++ Predominantly subcortical pattern



## SECTION 7.4: ALTERNATE CAUSES OF THE PLAINTIFF'S AMNESIA, CONCENTRATION AND MEMORY PROBLEMS

**DEFENSE THEORY: The plaintiff's amnesia, loss of concentration, and loss of memory may be caused by factors other than the injury in question.**

### INTRODUCTION

Amnestic disorders are syndromes in which short-term and long-term memory is impaired within a state of normal consciousness. An amnestic disorder is also characterized by memory impairment in the absence of other significant accompanying cognitive impairments. Memory functions are divided into three stages: registration, retention, and recall. **Registration** refers to the capacity to add new material to memory. *Anterograde amnesia* is the inability to register or learn new information from a specific event onward; it typically follows head trauma, states of cerebral physiological imbalance, or drug effects. **Retention** is the ability to hold memories in storage. **Recall** is the capacity to return previously stored memories to consciousness. *Retrograde amnesia* is an impairment in recalling memories that were established before a traumatic event, extending backwards in time. Amnestic disorders are listed in the DSM-IV-TR according to presumed etiology: Amnestic Disorder Due to a General Medical Condition, Substance-Induced Persisting Amnestic Disorder, or Amnestic Disorder Not Otherwise Specified.

The presumed etiology of the amnestic disorder determines the diagnosis. If it is judged that the memory disturbance is a consequence of the direct physiological effects of a general medical condition (including head trauma), then amnestic disorder due to a general medical condition is diagnosed. If the memory disturbance results from the persisting effects of a substance (i.e., a drug of abuse, a medication, or toxic exposure), then substance-induced persisting amnestic disorder is diagnosed. When both a substance (e.g., alcohol) and a general medical condition (e.g., head trauma) have had an etiological role in the development of the memory disturbance, both diagnoses are given. If it is not possible to establish a specific etiology (i.e., dissociative, substance induced, or due to a general medical condition), amnestic disorder not otherwise specified, is diagnosed.

# Amnesia, Concentration, and Memory Problems

SYMPTOM

DEPOSITION QUESTIONS

## Amnesia

TABLE 7.4-1.

**Diagnostic criteria for 294.0 Amnestic Disorder Due to . . . [Indicate the General Medical Condition]**

- A.** The development of memory impairment as manifested by impairment in the ability to learn new information or the inability to recall previously learned information.
- B.** The memory disturbance causes significant impairment in social or occupational functioning and represents a significant decline from a previous level of functioning.
- C.** The memory disturbance does not occur exclusively during the course of a delirium or a dementia.
- D.** There is evidence from the history, physical examination, or laboratory findings that the disturbance is the direct physiological consequence of a general medical condition (including physical trauma).

*Specify if:*

**Transient:** if memory impairment lasts for 1 month or less

**Chronic:** if memory impairment lasts for more than 1 month

**Coding note:** Include the name of the general medical condition on Axis I, e.g., 294.0 Amnestic Disorder Due to Head Trauma; also code the general medical condition on Axis III.

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**Q: Describe the plaintiff's amnesia.**

**Q: When and how often does the plaintiff have amnesia?**

**Q: Does the plaintiff have a history of amnesia?**

# Amnesia, Concentration, and Memory Problems

---

## SYMPTOM

## DEPOSITION QUESTIONS

---

### Amnesia

(continued)

**Q: How did you determine the presence of amnesia?**

- (1) Mental status examination?
- (2) Psychological testing?

*Defense counsel should determine which characteristics were noted in the plaintiff's evaluation, such as:*

- (1) Temporary inability to recall information
- (2) Amnesia localized in time
- (3) No evidence of brain damage
- (4) Sudden onset of symptoms
- (5) Onset following a physical trauma
- (6) Awareness of the amnesia
- (7) Indifference to the amnesia
- (8) Inconsistency of the amnesia

---

**Q: Did you rule out the onset of Addison's disease as a cause of the plaintiff's amnesia?**

Addison's disease develops slowly as the adrenal cortex decreases functioning. The plaintiff experiences significant personality and behavioral changes from the reduced level of the steroidal hormones normally produced by the gland. Advanced stages of Addison's disease produce symptoms of depression, a lack of physical and emotional responsiveness, mild mental disorders, and **recent memory loss**. (reference 4, pp. 134, 1170-1171, 1276)

*If the witness indicates the possibility of Addison's disease, see the section on pre-existing medical conditions for further questions.*

---

**Q: Did you rule out cannabis (marijuana) use as a cause of the plaintiff's amnesia?**

A cannabis delusional disorder can occur within two hours of marijuana use and remits within six hours. The plaintiff may experience persecutory delusions, marked anxiety, emotional lability, depersonalization, derealization, hallucinations, and **amnesia for the episode**. (reference 7, pp. 236-241; reference 4, pp. 1326, 754)

---

**Q: Did you rule out the onset of Alzheimer's disease as a cause of the plaintiff's amnesia?**

Alzheimer's disease causes a progressive deterioration of the brain and personality. The first major symptoms are usually **amnesia (forgetfulness)**, visuomotor coordination, and abstract thought. Early stages of the disease may resemble affective disorders, confusing diagnosis and treatment. Dementia then slowly progresses to an advanced stage of impairment within two or three years. (reference 4, pp. 117, 844; reference 1, p. 1306; reference 9, pp. 27, 1999-2000)

*If the witness indicates the possibility of Alzheimer's disease, see the section on pre-existing medical conditions for further questions.*

---

**Q: Did you rule out encephalitis as a cause of the plaintiff's amnesia?**

Encephalitis is an inflammatory disease of the brain. Most plaintiffs acquire the disease as a complication of a viral infection such as measles, chicken-pox, or rubella. This

# Amnesia, Concentration, and Memory Problems

---

## SYMPTOM

## DEPOSITION QUESTIONS

---

### Amnesia

(continued)

disease may develop five to ten days following the virus and is characterized by a perivascular demyelination (loss of the protective sheath around the vessels) of the brain. Symptoms include personality disruptions, **amnesia**, cognitive impairment, and symptoms resembling psychosis. Death rates from the disease are high. (reference 4, pp. 155, 872; reference 1, pp. 1342-1344)

---

**Q: Did you rule out a seizure disorder as a cause of the plaintiff's amnesia?**

Epilepsy is a brain disorder characterized by recurring hyperactive brain functioning that causes epileptic seizures. The disorder is often the result of a cerebral lesion combined with a genetic predisposition. Epilepsy usually begins in early childhood but can appear at any age. Personality disturbances, **amnesia**, and psychosis are frequently encountered in the plaintiff with epilepsy. (reference 4, pp. 134, 877; reference 9, pp. 2149-2151)

*If the witness indicates the possibility of epilepsy, see the section on pre-existing medical conditions for further questions.*

---

**Q: Did you rule out signs or symptoms of hysteria as a cause of the plaintiff's amnesia?**

A plaintiff with hysteria is prone to phobias, dissociative states, fugues, and **amnesia**. Depression, suicidal tendencies and medication dependence are common. (reference 2, p. 633)

---

**Q: Did you rule out undiagnosed vascular dementia (formerly multi-infarct dementia) as a cause of the plaintiff's amnesia?**

Vascular dementia (formerly multi-infarct dementia) is caused by cerebrovascular disease (disease of the brain's blood supply or blood vessels) that quickly produces an irregular deterioration in intellectual functioning. The resulting dementia involves **disturbances in memory**, abstract thinking, judgement, impulse control, and personality. Combined with depression, the dementia often causes many cognitive symptoms. (reference 7, p. 158)

---

**Q: Did you rule out transient global amnesia as a cause of the plaintiff's amnesia?**

Transient global amnesia is characterized by the **loss of the ability to recall recent events or to record new memories**. The distant past is easily remembered. Attacks last six to twenty-four hours and can occur at any age, especially in men. Recovery is usually complete. (reference 1, p. 1310)

---

**Q: Did you rule out pernicious anemia as a cause of the plaintiff's amnesia?**

Pernicious anemia results from a lack of vitamin B12. The disease develops slowly causing both physical and mental symptoms. The plaintiff may experience feelings of depression, worthlessness and guilt, irritability, paranoia, and a **loss of memory**. Physical symptoms may include anorexia, abdominal pain, intermittent constipation and diarrhea, weight loss, and weakness. Pernicious anemia often leads to combined systems disease. (reference 4, p. 1276; reference 1, pp. 1077-1079; reference 2, pp. 576, 570)

*If the witness indicates a possibility of pernicious anemia or combined systems disease, see the section on pre-existing medical conditions for further questions.*

---

# Amnesia, Concentration, and Memory Problems

---

## SYMPTOM

## DEPOSITION QUESTIONS

---

### Amnesia

(continued)

**Q: Did you rule out *dementia associated with HIV infection* as a cause of the plaintiff's amnesia?**

Dementia that is associated with direct HIV infection of the central nervous system is typically characterized by **forgetfulness**, slowness, poor concentration, and difficulties with problem solving. Behavioral manifestations most commonly include apathy and social withdrawal, and occasionally these may be accompanied by delirium, delusions, or hallucinations. Tremor, impaired rapid repetitive movements, imbalance, ataxia, hypertonia, generalized hyperreflexia, positive frontal release signs, and impaired pursuit and saccadic eye movements may be present on physical examination. (reference 7, p. 163)

**Q: Did you rule out *dissociative amnesia (formerly psychogenic amnesia)* as a cause of the plaintiff's amnesia?**

The plaintiff with this disorder has a sudden **inability to recall important personal information**. Dissociative amnesia most commonly presents as a retrospectively reported gap or series of gaps in recall for aspects of the individual's life history. These gaps are usually related to traumatic or extremely stressful events. During the amnesia, perplexity, disorientation, and purposeless wandering may occur. Termination is abrupt and recovery is complete. (reference 7, pp. 520-523)

**Q: Did you rule out *depressive pseudodementia* as a cause of the plaintiff's amnesia?**

Cognitive disturbances seen in severe major depressive episodes are usually referred to as depressive pseudodementia. Treatment for the depression can restore both mood and memory to normal. Anxiety, irritability, a loss of social skills, and **memory gaps for specific periods or events** are characteristic symptoms. (reference 4, pp. 150-151; reference 18, p. 809)

**Q: Did you rule out *Ganser's syndrome* as a cause of the plaintiff's amnesia?**

Ganser's syndrome is characterized by giving approximate answers to questions. It may be associated with **amnesia**, disorientation, perceptual disturbance, fugue, and conversion symptoms. (reference 7, p. 533)

**Q: Did you rule out a *passive aggressive (negativistic) personality disorder* as a cause of the plaintiff's amnesia?**

A passive aggressive or negativistic personality passively resists both the demands of work and society. S/he may express this through procrastination, dawdling, stubbornness, intentional inefficiency, and **forgetfulness**. The plaintiff may be sulky, irritable, or argumentative. Associated symptoms include dependency, lack of self-confidence, and a pessimism for the future with no sense of responsibility for their problems. (reference 7, pp. 789-791; reference 4, p. 985)

# Amnesia, Concentration, and Memory Problems

SYMPTOM

DEPOSITION QUESTIONS

## Amnesia

(continued)

TABLE 7.4-2.

**Diagnostic criteria for Substance-Induced Persisting Amnestic Disorder**

- A. The development of memory impairment as manifested by impairment in the ability to learn new information or the inability to recall previously learned information.
- B. The memory disturbance causes significant impairment in social or occupational functioning and represents a significant decline from a previous level of functioning.
- C. The memory disturbance does not occur exclusively during the course of a delirium or a dementia and persists beyond the usual duration of Substance Intoxication or Withdrawal.
- D. There is evidence from the history, physical examination, or laboratory findings that the memory disturbance is etiologically related to the persisting effects of substance use (e.g., a drug of abuse, a medication).

Code [Specific Substance]-Induced Persisting Amnestic Disorder:

(291.1 Alcohol; 292.83 Sedative, Hypnotic, or Anxiolytic; 292.83 Other [or Unknown] Substance)

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**Q: Did you rule out chronic alcohol use as a cause of the plaintiff's amnesia?**

The plaintiff's amnesia may be caused by chronic alcohol use which is diagnosed as an alcohol-induced persisting amnestic disorder. A vitamin deficiency occurs with prolonged, heavy ingestion of alcohol causing neurological disturbances including **memory impairment**. (reference 7, pp. 177-179)

**Q: Did you rule out Wernicke-Korsakoff syndrome as a cause of the plaintiff's amnesia?**

The Wernicke-Korsakoff syndrome is a disorder due to a thiamine deficiency. It occurs most often in chronic alcoholics and plaintiff's that have most of their caloric intake from alcohol. The Wernicke's encephalopathy is a neuropsychiatric emergency, which is manifested by confusion, ataxia, and eye-movement abnormalities. The plaintiff must be treated immediately with large doses of thiamine to prevent an alcohol-persisting amnestic disorder from developing. Korsakoff's syndrome often follows an acute episode of Wernicke's encephalopathy. The Korsakoff's syndrome occurs when some areas of the brain are severely damaged. Characteristic symptoms include a **memory impairment** for new information and events since the onset of the illness. The plaintiff typically fabricates imaginary or

# Amnesia, Concentration, and Memory Problems

---

## SYMPTOM

## DEPOSITION QUESTIONS

---

### Amnesia

(continued)

confused experiences for those s/he cannot remember (confabulation). Emotional symptoms include apathy, blandness, or mild euphoria. In alcoholism, destruction of the brain is often irreversible. (reference 4, pp. 870-872; reference 7, p.178)

---

**Q: Did you rule out *sedative, hypnotic, or anxiolytic use* as a cause of the plaintiff's amnesia?**

Sedative, hypnotic, or anxiolytic drug use can cause behavioral and physical changes. Behavioral symptoms may include disinhibition of sexual or aggressive impulses, mood lability, impaired judgement, and impaired social or occupational functioning. Physical symptoms may include slurred speech, incoordination, unsteady gait, and **impaired memory** or attention span. Sedative drugs and minor tranquilizers cause impairment on many behavioral tasks. They may also improve some plaintiff's work or social functioning by reducing severe anxiety. The effects of two or more drugs, such as sedatives and alcohol, may cause significant behavioral impairment. (reference 7, pp. 284-293; reference 4, p. 1548)

---

**Q: Did you rule out the *effects of a toxin* as a cause of plaintiff's amnesia?**

Toxins reported to evoke symptoms of amnesia include, lead, mercury, carbon monoxide, organophosphate insecticides, and industrial solvents. (reference 7, pp. 178-179)

---

**Q: Does the plaintiff have any other *medical conditions* that may cause amnesia?**

|   |  |
|---|--|
| Anoxic / ischemic encephalopathy or hypoglycemia    | Infarction in the medial thalamic nuclei<br>Ischemia                 |
| Bilateral lesions involving the limbic memory route | Limbic and other paraneoplastic syndromes                            |
| Cerebellar ataxia                                   | Mass lesions involving the limbic system                             |
| Cerebral anoxia                                     | Peripheral neuropathy  |
| Electroconvulsive therapy                           | Posterior cerebral artery and other strokes involving the hippocampi |
| Encephalitides                                      | Ruptured anterior communicating artery aneurysms                     |
| Focal lesions                                       | Stroke   |
| Head injury<br>(not related to the cause of action) | Subarachnoid hemorrhage  |
| Herpes simplex and other infections                 | Surgical intervention  |
| Hypothalamic neoplasms                              | Tumors of the third ventricle and mesial temporal region             |
| Hypoxia   |  |
| Infarction of the posterior cerebral arteries       |  |

---

## Amnesia, Concentration, and Memory Problems

---

### SYMPTOM

### DEPOSITION QUESTIONS

---

#### Amnesia

(continued)

**Q:** Did you rule out the *transient side-effects of medication* as a cause of plaintiff's amnesia?

Medications reported to cause amnesic disorders include anti-convulsants and intrathecal methotrexate. (reference 7, p. 178)

Other medications include:

|            |               |           |
|------------|---------------|-----------|
| ALTACE     | EXCELON       | PROVIGIL  |
| AMBIEN     | GEODON        | PROZAC    |
| ANSAID     | HALCION       | RISPERDAL |
| AVONEX     | KERLONE       | SEROQUEL  |
| CARDIZEM   | LAMICTAL      | SONATA    |
| CARDURA    | LEVO-DROMORAM | SULAR     |
| CELEXA     | LIPITOR       | TIAZAC    |
| CLARITAN-D | LUVOX         | TRILEPTAL |
| CLARITIN   | MIRAPEX       | TROVAN    |
| CLOZARIL   | NEURONTIN     | ULTRAM    |
| COGNEX     | ORUDIS        | ZOMIG     |
| DEPACON    | OXYCONTIN     | ZYBAN     |
| DORAL      | PAXIL         | ZYLOPRIM  |
| DURACT     | PREVACID      | ZYPREXA   |
| DURAGESIC  | PROSOM        | ZYRTEC    |

## Amnesia, Concentration, and Memory Problems

---

*SYMPTOM*

*DEPOSITION QUESTIONS*

---

**Loss of  
Concentration**

**Q: Have you considered that the plaintiff's failure to learn and remember may be caused by an inability to concentrate?**

**Note:** *If the witness admits that a loss of memory may be due to having failed to learn new information (e.g., test data) because of an inability to concentrate, the defense counsel should ask some or all of the following questions.*

---

**Q: Does the plaintiff have a history of any *medical conditions* that may cause an inability to concentrate?**

*If the witness indicates the possibility of any of the following medical conditions, see the section on pre-existing medical conditions for further questions.*

**TABLE 7.4-3.**

|                          |                                     |
|--------------------------|-------------------------------------|
| Addison's disease        | Hypothyroidism                      |
| Combined systems disease | Meningitis                          |
| Cushing's syndrome       | Parkinson's disease                 |
| Epilepsy                 | Pernicious anemia                   |
| Hepatic encephalopathy   | Polycythemia                        |
| Hypertension             | Porphyria                           |
| Hyperthyroidism          | Postpartum disorder                 |
| Hypoglycemia             | Subacute sclerosing panencephalitis |
| Hypotension              | Systemic lupus erythematosus        |

**Q: Did you rule out *attention-deficit hyperactivity disorder* (ADHD) as a cause of the plaintiff's inability to concentrate?**

The essential characteristics of ADHD include **inattention**, impulsiveness, and hyperactivity. ADHD is usually diagnosed during elementary school years, and can persist throughout childhood. Persons diagnosed with ADHD have a higher prevalence of mood and anxiety disorders, learning disorders, substance-related disorders and the potential for the development of an antisocial personality disorder. Approximately one-third of the children diagnosed with ADHD show some signs of the disorder in adulthood. Associated symptoms may include low self-esteem, mood lability, low frustration tolerance, and temper outbursts. (reference 7, pp. 85-93)

---

**Q: Did you rule out *cyclothymic disorder* as a cause of the plaintiff's inability to concentrate?**

Cyclothymic disorder is a chronic, fluctuating mood disorder involving numerous periods of hypomanic symptoms and numerous periods of depressive symptoms. The symptoms are not severe enough to meet the criteria for a major depressive or manic episode. The plaintiff may have impaired social and occupational functioning. Cyclothymic disorder usually begins in adolescence or early adult life. (reference 7, p. 398; reference 4, pp. 760-761, 804)

---

# Amnesia, Concentration, and Memory Problems

---

## SYMPTOM

## DEPOSITION QUESTIONS

---

### Loss of Concentration

(continued)

**Q: Did you rule out a *bipolar disorder* (manic-depressive) a cause of the plaintiff's inability to concentrate?**

A bipolar disorder has a circular pattern of high and low emotional states (*mania and depression*). During the *manic episodes*, the plaintiff may feel grandiose, have a decreased need for sleep, and decreased emotional capacity, experience a surge of ideas and conversation, and may be easily distracted or pleased. It is often thought that the manic high represents an escape from inner depression and pain. While the plaintiff is extremely active, s/he is often **fragmented and unable to finish projects**. The plaintiff typically does not realize that s/he is ill.

During *major depressive episodes* the plaintiff may be depressed for at least two weeks. The plaintiff may experience an appetite disturbance, weight change, sleep disturbance, psychomotor agitation or retardation, decreased energy and emotional capacity, feelings of worthlessness, **difficulty thinking or concentrating**, and recurrent thoughts of death or suicide. (reference 4, pp. 408-409, 761; reference 7, pp. 382-391)

---

**Q: Did you rule out an *obsessive-compulsive disorder* or an *obsessive-compulsive personality disorder* as causes of the plaintiff's inability to concentrate?**

The obsessive-compulsive plaintiff has persistent unwanted and uncontrolled thoughts or impulses that may represent violence, contamination, or doubt. These obsessions often cause the plaintiff to feel anxious. The plaintiff's repeated compulsive behaviors are attempts to control the impulses and the accompanying anxiety. Other symptoms may include an exclusive devotion to work or productivity, depression, anxiety, and restlessness. (reference 4, pp. 910-911; reference 7, pp. 245-247)

*If the witness indicates the possibility of an obsessive-compulsive disorder, see pre-existing clinical mental disorders. If the witness indicates the possibility of an obsessive-compulsive personality disorder, see pre-existing personality disorders for further questions.*

---

**Q: Did you rule out an *adjustment disorder with anxiety* as a cause of the plaintiff's inability to concentrate?**

An adjustment disorder is a transient over-reaction to stress that usually occurs within 90 days and remits within six months. The adjustment disorder with anxious mood is characterized by symptoms of nervousness, worry, jitteriness, and motor tension. The plaintiff may have **difficulty concentrating** as part of the anxiety. (reference 7, pp. 679-683; reference 4, pp. 1098-1099)

*If the witness indicates the possibility of an adjustment disorder, see section 5.8 for further questions.*

---

**Q: Did you rule out *anemia* as a cause of the plaintiff's inability to concentrate?**

Signs and symptoms attributable to anemia include, fatigue, syncope, dyspnea on exertion, decreased exercise capacity, **decreased mental acuity**, tachycardia, angina, postural hypotension, or transient ischemic attack. (reference 23, p. 905)

*If the witness indicates the possibility of anemia, see the section on pre-existing medical conditions for further questions.*

---

# Amnesia, Concentration, and Memory Problems

---

## SYMPTOM

## DEPOSITION QUESTIONS

---

### Loss of Concentration

(continued)

**Q: Did you rule out *polycythemia* as a cause of the plaintiff's inability to concentrate?**

Polycythemia is a chronic life-threatening disease involving the bone marrow. It is characterized by an increase in red blood mass and hemoglobin concentration. The result is an impaired blood flow, hypervolemia (greater than normal volume of blood), increased cardiac output, and hyperviscosity (abnormally high resistance to flow). These increases are responsible for most of the symptoms of the disease that include **impaired concentration**, forgetfulness, fatigue, headaches, and vertigo. (reference 1, pp.1106-1109; reference 2, p. 831)

*If the witness indicates the possibility of polycythemia, see the section on pre-existing medical conditions for further questions.*

---

**Q: Did you rule out *muscle contraction headaches* as a cause of the plaintiff's inability to concentrate?**

Chronic muscle contraction headaches may produce nausea, vomiting, lightheadedness, difficulty in falling asleep, restless sleep with frequent awakening, loss of energy, **impaired memory and concentration**, and symptoms of depression. (reference 2, pp. 72-73; reference 4, p. 1204)

---

**Q: Did you rule out a *schizotypal personality disorder* as a cause of the plaintiff's inability to concentrate?**

The schizotypal personality has oddities of thinking, perception, communication, and behavior that resembles schizophrenia. The plaintiff may experience anxiety, depression, and other dysphoric moods that **disrupt concentration** and the ability to function socially or at work. S/he may have few close friends except for immediate family. (reference 7, pp. 697-701)

*If the witness indicates the possibility of a schizotypal personality disorder, see the section on pre-existing personality disorders for further questions.*

---

**Q: Did you rule out *migraine headaches* as a cause of the plaintiff's inability to concentrate?**

A classic migraine (vascular) headache may be accompanied by visual disturbances, **concentration problems**, sensory motor or speech disturbances, nausea or vomiting, and emotional changes. On rare occasions, the plaintiff may experience depersonalization or derealization. Migraine headaches may be precipitated by: (reference 4, p.1204; reference 2, pp. 65-66)

- Birth control pills
  - Emotional conflicts or stress
  - Fluctuating estrogen levels in women
  - Food:
    - Monosodium glutamate (Chinese restaurant syndrome)
    - Phenylethylamine-containing foods
    - Tyramine-containing foods (cheese or other fermented dairy products and chocolate)
-

# Amnesia, Concentration, and Memory Problems

---

## SYMPTOM

## DEPOSITION QUESTIONS

---

### Loss of Concentration

(continued)

**Q: Did you rule out *excessive caffeine use* as a cause of the plaintiff's inability to concentrate?**

Characteristic symptoms of caffeine intoxication include restlessness, nervousness, excitement, insomnia, flushed face, diuresis, gastrointestinal disturbance, muscle twitching, **rambling flow of thought and speech**, tachycardia or cardiac arrhythmia, periods of inexhaustibility, and psychomotor agitation. When consumed near bedtime, caffeine often disrupts sleep. Symptoms may appear when the plaintiff consumes as little as 250 mg of caffeine per day. The plaintiff that consumes one gram per day usually experiences more severe symptoms. Products which contain caffeine include: coffee, tea, soda, chocolate and weight-loss aids.(reference 7, pp. 231-234; reference 4, p. 1029)

*See caffeine consumption and symptom chart in Appendix A for further details.*

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**Q: (Female) Did you rule out *premenstrual dysphoric disorder* as a cause of the plaintiff's inability to concentrate?**

Premenstrual dysphoric disorder (PMDD) is characterized by emotional and behavioral symptoms which usually occur during the last week before the menstrual cycle and remit within a few days after menses begins. Symptoms may include tears, sadness, irritability, anger, tension, depression, self-deprecating thoughts, decreased interest in usual activities, fatigability, loss of energy, a subjective sense of **difficulty in concentration**, changes in appetite, and sleep disturbance. Physical symptoms may also include breast tenderness or swelling, tachycardia, sweating, headaches, joint or muscle pain, a sensation of bloating, or weight gain. (reference 7, pp. 771-774; reference 18, p. 1955)

---

**Q: Did you rule out *insomnia disorders* as a cause of the plaintiff's inability to concentrate?**

Insomnia disorders cause sleep disturbance. The plaintiff may be tired after an adequate night's sleep (non-restorative sleep). This pattern lasts for at least a month with the sleep difficulties occurring at least three times a week. The disorder may be severe enough to cause daytime fatigue, irritability, or an **impaired memory and concentration**. (reference 7, pp. 597-609; reference 2, p. 601)

---

*Note: The following question is to be asked if the plaintiff has experienced the loss of a family member or a close friend during the past two years.*

**Q: Did you rule out *bereavement* as a cause of the plaintiff's inability to concentrate?**

Mourning is a normal grief reaction to a loss, such as the death of a loved one. The plaintiff may feel depressed and dejected, have diminished interest in the outside world, a decreased capacity to love, and an inhibition of activity. People tend to feel as if all their energy is taken up with thoughts and memories of the loss. Fatigue and weariness are characteristic symptoms. Sighing, feeling empty, disinterested, listless, eating more or less than normal, losing weight, and having trouble sleeping are common experiences. (reference 4, pp. 1286-1293; reference 7, pp. 740-741; reference 2, p. 617)

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# Amnesia, Concentration, and Memory Problems

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## SYMPTOM

## DEPOSITION QUESTIONS

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### Loss of Concentration

(continued)

**Q: Did you rule out *dysthymic disorder* as a cause of the plaintiff's inability to concentrate?**

Dysthymic disorder is characterized by chronic depressive symptoms less severe than major depression. Always feeling despondent or melancholy, the plaintiff believes that depression is part of their personality. Other symptoms may include a poor appetite or overeating, insomnia or hypersomnia, low energy or fatigue, low self-esteem, **poor concentration, difficulty making decisions**, and feelings of hopelessness. The disorder may begin in childhood for both sexes, but is more common in adult females. (reference 7, pp. 376-381; reference 4, pp. 803-804)

---

**Q: Did you rule out *multiple sclerosis* as a cause of the plaintiff's inability to concentrate?**

Multiple sclerosis is a common disease of young adults. The disease causes a disorder of the optic nerves, spinal cord, and brain. Symptoms may include depression, apathy, lack of judgement, **inattention**, tremor, vertigo, incoordination, weakness, fatigue, dysarthria (speech impairment), and urinary frequency or hesitancy. (reference 4, p. 1276; reference 1, pp. 1354-1356)

*If the witness indicates the possibility of multiple sclerosis, see the section on pre-existing medical conditions for further questions.*

---

**Q: Did you rule out *hypothyroidism* as a cause of the plaintiff's inability to concentrate?**

Hypothyroidism results from inadequate synthesis of thyroid hormone. Hypothyroidism can produce psychiatric, as well as physical symptoms. The most notable psychiatric symptoms include depression, lethargy, **poor concentration**, impaired memory, apathy, and syncope. The numerous physical symptoms are: cold intolerance, constipation, muscle cramps, paresthesias, menstrual disorders, dyspnea, dizziness, reduced hearing, poor appetite, weight gain, brittle and thinning hair, and bradycardia (slowed heart action). Panic attacks are associated with endocrinological disorders including hypothyroidism and hyperthyroidism. (reference 18, pp. 743, 1810-1812, 1928)

*If the witness indicates the possibility of hypothyroidism, see the section on pre-existing medical conditions for further questions.*

---

**Q: Did you rule out the onset of a *metabolic brain disease* as a cause of the plaintiff's inability to concentrate?**

The plaintiff with a metabolic brain disease is **inattentive**, perplexed, preoccupied, and **unable to concentrate**. Changes in mental abilities, alertness, awareness, and perception are common. (reference 9, pp. 1974-1975)

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# Amnesia, Concentration, and Memory Problems

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## SYMPTOM

## DEPOSITION QUESTIONS

---

### Loss of Concentration

(continued)

**Q: Did you rule out an *undiagnosed brain tumor* as a cause of the plaintiff's inability to concentrate?**

Brain tumors occur in the skull, brain, or membrane covering the brain or spinal cord. Symptoms vary depending on the size of the tumor and rate of growth. The plaintiff may experience anxiety, **dementia**, irritability, dizziness, fatigue, headache, vomiting, hyperthermia (high body temperature), and changes in appetite and personality. (reference 4, pp. 139, 834-835, 855, 1276; reference 9, pp. 2161-2164; reference 1, pp. 1351, 1296)

*If the witness indicates the possibility of a brain tumor, see the section on pre-existing medical conditions for further questions.*

---

**Q: Did you rule out *hypoglycemia* as a cause of the plaintiff's inability to concentrate?**

Hypoglycemia is an abnormally low blood sugar level. It often produces personality changes, tiredness, **confusion**, dizziness, tremor, anxiety, tachycardia, and sweating during acute attacks. Other psychiatric symptoms include fear and dread, depression with fatigue, and agitation with confusion. Hypoglycemia can develop from an insulin overdose, insulinoma or islet cell tumor, extensive liver disease, or functional diseases. (reference 2, p. 702; reference 4, pp. 1176-1177; reference 18, pp. 1929, 1479)

*If the witness indicates the possibility of hypoglycemia, see the section on pre-existing medical conditions for further questions.*

---

**Q: (Female) Did you rule out *menopausal symptoms* as a cause of the plaintiff's inability to concentrate?**

Menopausal symptoms may cause anxiety, fatigue, GI disturbances, urinary frequency, back pain, palpitation, tension, emotional lability, irritability and nervousness, depression, dizziness, insomnia, and hot flashes. **Difficulty concentrating** may occur as a part of the depression. (reference 4, p. 1173; reference 9, p. 21)

*If the witness indicates the possibility of menopausal distress, see the section on pre-existing medical conditions for further questions.*

---

**Q: Did you rule out the *onset of Cushing's syndrome (hyperadrenalism)* as a cause of the plaintiff's inability to concentrate?**

Plaintiffs often experience emotional changes before physical signs of the disease appear. Depression is the most common symptom. Other psychological symptoms include irritability, anxiety, confusion, insomnia, and **impaired memory or concentration**. Some of the characteristic physical signs include an increased appetite, weakness, buffalo hump, truncal and facial obesity, heightened facial color, and abdominal striae (stripes). (reference 4, pp. 1171-1172)

*If the witness indicates the possibility of Cushing's syndrome, see the section on pre-existing medical conditions for further questions.*

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# Amnesia, Concentration, and Memory Problems

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## SYMPTOM

## DEPOSITION QUESTIONS

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### Loss of Concentration

(continued)

*Caution: Do not ask the following question if the cause of action involves a head injury or toxic exposure.*

**Q: Did you rule out the possibility of a head injury leading to organic brain syndrome as a cause of the plaintiff's inability to concentrate?**

Organic brain syndrome is a term for symptoms produced by head injury, toxic exposures, hypoxia (oxygen deficiency), anoxia (extreme oxygen deficiency in tissues) or other causes. Common symptoms of head injuries include vertigo, lightheadedness, syncope, **impaired concentration** and memory, easy fatigability, irritability, lack of energy, depression, anxiety, phobia, a lowered tolerance for alcohol, and headaches. Symptoms may appear days or weeks after the head injury but usually appear within 24 hours. (reference 2, pp. 75, 111)

---

**Q: Did you rule out infections as a cause of the plaintiff's inability to concentrate?** (reference 2, pp. 617, 450-451)

|                                  |                                 |
|----------------------------------|---------------------------------|
| Brucellosis                      | Postpartum infections           |
| Chronic urinary tract infections | Subacute bacterial endocarditis |
| Infectious mononucleosis         | Syphilis                        |
| Influenza                        | Tuberculosis                    |
| Malaria                          | Viral hepatitis                 |

---

**Q: Is the plaintiff taking any medications or substances that may cause an inability to concentrate, such as:**

|             |            |            |
|-------------|------------|------------|
| ARTHROTEC   | ETRAFON    | TIMOPTIC   |
| ASENDIN     | EXCELON    | TRIAVIL    |
| BUSPAR      | GABITRIL   | TRILEPTAL  |
| CARDURA     | HABITROL   | TROVAN     |
| CELEXA      | IMDUR      | ULTRAM     |
| CLARITAN-D  | KERLONE    | VIVACTIL   |
| CLARITAN    | LEVAQUIN   | WELLBUTRIN |
| CODEINE     | LIMBITROL  | ZARONTIN   |
| CYCLOSPORIN | PAXIL      | ZEBETA     |
| DEPROL      | RESTORIL   | ZIAC       |
| DESYREL     | RISPERDAL  | ZOLOFT     |
| ELAVIL      | SERTRALINE | ZYRTEC     |
| ENDEP       | SERZONE    |            |

# Amnesia, Concentration, and Memory Problems

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## SYMPTOM

## DEPOSITION QUESTIONS

---

### Loss of Memory

These questions pertain to a more generalized type of memory than amnesia (i.e. simple forgetfulness)

**Q: Did you rule out *Lyme disease* as a cause of the plaintiff's memory problems?**

Lyme disease, transmitted by the bite of an infected Ixodes tick, can cause a vast array of neuropsychiatric disorders, ranging from mild mood changes to psychosis and **severe memory loss**. Plaintiff's with Lyme disease will show **impairment in short-term memory**, processing speed, and inattention on neuropsychological tests. Cognitive symptoms include word-finding problems, word-substitutions, new-onset dyslexia, marked inattention and distractibility, difficulty with organization, and the sensation that one's brain is in a fog. Other less common neuropsychiatric aspects associated with Lyme disease include panic attacks, transient paranoia, illusions or hallucinations (visual, olfactory, auditory), anorexia, depersonalization, violent outbursts, obsessive-compulsive disorder, agitated mania and personality change. Because of the multisystem involvement in Lyme disease and the frequent concurrence of anxiety and depression, patients may be mistakenly diagnosed as having a primary psychiatric or a somatoform disorder before Lyme disease is even considered. (reference 18, p. 337)

---

**Q: Did you rule out the *onset of dementia* as a cause of the plaintiff's memory problems?**

**Memory impairment** is a requirement in the diagnosis of dementia, and it is a prominent early symptom. Individuals with dementia become impaired in their ability to learn new material, or they forget previously learned material. Most individuals with dementia have both forms of **memory impairment**, although it is sometimes difficult to demonstrate the loss of previously learned material early in the course of the disorder. (reference 7, p. 147)

---

**Q: Did you rule out the *onset of Alzheimer's disease* as a cause of the plaintiff's memory loss?**

Alzheimer's disease causes a progressive deterioration of the brain and personality. The first major symptoms are usually amnesia (**forgetfulness**), visuomotor coordination, and abstract thought. Early stages of the disease may resemble affective disorders, confusing diagnosis and treatment. Dementia then slowly progresses to an advanced stage of impairment within two or three years. (reference 4, pp. 117, 844; reference 1, p. 1306; reference 9, pp. 27, 1999-2000)

*If the witness indicates the possibility of Alzheimer's disease, see the section on pre-existing medical conditions for further questions.*

---

# Amnesia, Concentration, and Memory Problems

---

## SYMPTOM

## DEPOSITION QUESTIONS

---

### Loss of Memory

(continued)

**Q: Did you rule out *dementia associated with HIV infection* as a cause of the plaintiff's memory loss?**

Dementia that is associated with direct HIV infection of the central nervous system is typically characterized by **forgetfulness**, slowness, poor concentration, and difficulties with problem solving. Behavioral manifestations most commonly include apathy and social withdrawal, and occasionally these may be accompanied by delirium, delusions, or hallucinations. Tremor, impaired rapid repetitive movements, imbalance, ataxia, hypertonia, generalized hyperreflexia, positive frontal release signs, and impaired pursuit and saccadic eye movements may be present on physical examination. (reference 7, p. 163)

**Q: Did you rule out *dissociative amnesia (formerly psychogenic amnesia)* as a cause of the plaintiff's memory loss?**

The plaintiff with this disorder has a sudden **inability to recall important personal information**. Dissociative amnesia most commonly presents as a retrospectively reported gap or series of gaps in recall for aspects of the individual's life history. These gaps are usually related to traumatic or extremely stressful events. During the amnesia, perplexity, disorientation, and purposeless wandering may occur. Termination is abrupt and recovery is complete. (reference 7, pp. 520-523)

**Q: Did you rule out *depressive pseudodementia* as a cause of the plaintiff's memory loss?**

Cognitive disturbances seen in severe major depressive episodes are usually referred to as depressive pseudodementia. Treatment for the depression can restore both mood and memory to normal. Anxiety, irritability, a loss of social skills, and **memory gaps for specific periods or events** are characteristic symptoms. (reference 4, pp. 150-151; reference 18, p. 809)

**Q: Did you rule out *age-related cognitive decline* as a cause of the plaintiff's loss of memory?**

Age-related cognitive decline is classified in the DSM-IV-TR under other conditions that may be a focus of attention. This category can be used when the focus of clinical attention is an objectively identified decline in cognitive functioning consequent to the aging process that is within normal limits given the person's age. Individuals with this condition may report **problems remembering names or appointments** or may experience difficulty in solving complex problems. (reference 7, p. 740)

**Q: Did you rule out a *passive aggressive (negativistic) personality disorder* as a cause of the plaintiff's memory problems?**

A passive aggressive or negativistic personality passively resists both the demands of work and society. S/he may express this through procrastination, dawdling, stubbornness, intentional inefficiency, and **forgetfulness**. The plaintiff may be sulky, irritable, or argumentative. Associated symptoms include dependency, lack of self-confidence, and a pessimism for the future with no sense of responsibility for their problems. (reference 7, pp. 789-791; reference 4, p. 985)

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# Amnesia, Concentration, and Memory Problems

---

## SYMPTOM

## DEPOSITION QUESTIONS

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### Loss of Memory

(continued)

**Q: Did you rule out *Wernicke-Korsakoff syndrome* as a cause of the plaintiff's memory loss?**

The Wernicke-Korsakoff syndrome is a disorder due to a thiamine deficiency. It occurs most often in chronic alcoholics and plaintiff's that have most of their caloric intake from alcohol. The Wernicke's encephalopathy is a neuropsychiatric emergency, which is manifested by confusion, ataxia, and eye-movement abnormalities. The plaintiff must be treated immediately with large doses of thiamine to prevent an alcohol-persisting amnesic disorder from developing. Korsakoff's syndrome often follows an acute episode of Wernicke's encephalopathy.

The Korsakoff syndrome occurs when some areas of the brain are severely damaged. Characteristic symptoms include a **memory impairment** for new information and events since the onset of the illness. The plaintiff typically fabricates imaginary or confused experiences for those s/he cannot remember (confabulation). Emotional symptoms include apathy, blandness, or mild euphoria. In alcoholism, destruction of the brain is often irreversible. (reference 4, pp. 870-872; reference 7, p.178)

---

**Q: Did you rule out *polycythemia* as a cause of the plaintiff's memory loss?**

Polycythemia is a chronic life-threatening disease involving the bone marrow. It is characterized by an increase in red blood mass and hemoglobin concentration. The result is an impaired blood flow, hypervolemia (greater than normal volume of blood), increased cardiac output, and hyperviscosity (abnormally high resistance to flow). These increases are responsible for most of the symptoms of the disease that include impaired concentration, **forgetfulness**, fatigue, headaches, and vertigo. (reference 1, pp.1106-1109; reference 2, p. 831)

*If the witness indicates the possibility of polycythemia, see the section on pre-existing medical conditions for further questions.*

---

**Q: Did you rule out *muscle contraction headaches* as a cause of the plaintiff's memory loss?**

Chronic muscle contraction headaches may produce nausea, vomiting, lightheadedness, difficulty in falling asleep, restless sleep with frequent awakening, loss of energy, **impaired memory** and concentration, and symptoms of depression. (reference 2, pp. 72-73; reference 4, p. 1204)

---

**Q: Did you rule out *hypothyroidism* as a cause of the plaintiff's memory loss?**

Hypothyroidism results from inadequate synthesis of thyroid hormone. Hypothyroidism can produce psychiatric, as well as physical symptoms. The most notable psychiatric symptoms include depression, lethargy, poor concentration, **impaired memory**, apathy, and syncope. The numerous physical symptoms are: cold intolerance, constipation, muscle cramps, paresthesias, menstrual disorders, dyspnea, dizziness, reduced hearing, poor appetite, weight gain, brittle and thinning hair, and bradycardia (slowed heart action). Panic attacks are associated with endocrinological disorders including hypothyroidism and hyperthyroidism. (reference 18, pp. 743, 1810-1812, 1928)

*If the witness indicated the possibility of hypothyroidism, see the section on pre-existing medical conditions for further questions.*

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## Amnesia, Concentration, and Memory Problems

---

### SYMPTOM

### DEPOSITION QUESTIONS

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#### Loss of Memory

(continued)

**Q: Did you rule out the onset of *Cushing's syndrome* (hyperadrenalism) as a cause of the plaintiff's memory loss?**

Plaintiffs often experience emotional changes before physical signs of the disease appear. Depression is the most common symptom. Other psychological symptoms include irritability, anxiety, confusion, insomnia, and **impaired memory** or concentration. Some of the characteristic physical signs include an increased appetite, weakness, buffalo hump, truncal and facial obesity, heightened facial color, and abdominal striae (stripes). (reference 4, pp. 1171-1172)

*If the witness indicates the possibility of Cushing's syndrome, see the section on pre-existing medical conditions for further questions.*

---

**Caution: Do not ask the following question if the cause of action involves a head injury or toxic exposure.**

**Q: Did you rule out the possibility of a head injury leading to organic brain syndrome as a cause of the plaintiff's memory loss?**

Organic brain syndrome is a term for symptoms produced by head injury, toxic exposures, hypoxia (oxygen deficiency), anoxia (extreme oxygen deficiency in tissues) or other causes. Common symptoms of head injuries include vertigo, lightheadedness, syncope, **impaired concentration and memory**, easy fatigability, irritability, lack of energy, depression, anxiety, phobia, a lowered tolerance for alcohol, and headaches. Symptoms may appear days or weeks after the head injury but usually appear within 24 hours. (reference 2, pp. 75, 111)

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**Q: Did you rule out *ecstasy use* as a cause of the plaintiff's memory problems?**

Disturbing evidence is emerging that the increasingly popular drug ecstasy can be linked to users suffering long-term brain damage. University of Adelaide (Australia) researchers have found that ecstasy taken on a few occasions could cause severe damage to brain cells, with the potential to cause future **memory loss** or psychological problems. In 1998, the National Institute of Mental Health conducted a study of a small group of habitual MDMA users who had abstained from use for approximately 2-3 weeks. The study revealed that the abstinent users suffered damage to the neurons in the brain that transmit serotonin, an important biochemical involved in a variety of critical functions including learning, sleep, and integration of emotion. The results of the study indicate that recreational MDMA users may be at risk of developing permanent brain damage that may manifest itself in the form of depression, anxiety, **memory loss**, and other neuropsychiatric disorders. (reference 34)

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# Amnesia, Concentration, and Memory Problems

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## SYMPTOM

## DEPOSITION QUESTIONS

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### Loss of Memory

(continued)

**Q: Did you rule out the onset of *Addison's disease* as a cause of the plaintiff's memory loss?**

Addison's disease develops slowly as the adrenal cortex decreases functioning. The plaintiff experiences significant personality and behavioral changes from the reduced level of the steroidal hormones normally produced by the gland. Advanced stages of Addison's disease produce symptoms of depression, a lack of physical and emotional responsiveness, mild mental disorders, and **recent memory loss**.

(reference 4, pp. 134, 1170-1171, 1276)

*If the witness indicates the possibility of Addison's disease, see the section on pre-existing medical conditions for further questions.*

---

**Q: Did you rule out *undiagnosed vascular dementia* (formerly multi-infarct dementia) as a cause of the plaintiff's memory loss?**

Vascular dementia (formerly multi-infarct dementia) is caused by cerebrovascular disease (disease of the brain's blood supply or blood vessels) that quickly produces an irregular deterioration in intellectual functioning. The resulting dementia involves **disturbances in memory**, abstract thinking, judgement, impulse control, and personality. Combined with depression, the dementia often causes many cognitive symptoms.

(reference 7, p. 158 )

---

**Q: Did you rule out *pernicious anemia* as a cause of the plaintiff's memory loss?**

Pernicious anemia results from a lack of vitamin B12. The disease develops slowly causing both physical and mental symptoms. The plaintiff may experience feelings of depression, worthlessness and guilt, irritability, paranoia, and a **loss of memory**. Physical symptoms may include anorexia, abdominal pain, intermittent constipation and diarrhea, weight loss, and weakness. Pernicious anemia often leads to combined systems disease.

(reference 4, p. 1276; reference 1, pp. 1077-1079; reference 2, pp. 576, 570)

*If the witness indicates a possibility of pernicious anemia or combined systems disease, see the section on pre-existing medical conditions for further questions.*

---

**Q: Did you rule out the *transient side-effects of medication* as a cause of plaintiff's memory loss?**

|           |           |            |
|-----------|-----------|------------|
| ANAFRANIL | LESCOL    | TOPROL-XL  |
| CLOZARIL  | LOPRESSOR | TRANDATE   |
| CORGARD   | LUDIOMIL  | TRANSDERM  |
| COZAAR    | MARPLAN   | VOLTAREN   |
| DESYREL   | MAXALT    | ZEBETA     |
| ELDEPRYL  | MEXITIL   | ZESTORETIC |
| ESKALITH  | MONOPRIL  | ZESTRIL    |
| GABITRIL  | PRAVACHOL | ZIAC       |
| HALCION   | RIFAMATE  | ZOCOR      |
| HYZAAR    | SERZONE   | ZONEGRAN   |
| INDERAL   | TENORETIC | ZYBAN      |
| INDERIDE  | TENORMIN  |            |
| KERLONE   | TIMOPTIC  |            |

## SECTION 7.5: ALTERNATE CAUSES OF THE PLAINTIFF'S HALLUCINATIONS AND DELUSIONS

**DEFENSE THEORY: The plaintiff's hallucinations and delusions may be due to factors other than the injury in question.**

### INTRODUCTION

#### *Hallucinations:*

Hallucinations are sensory experiences in the absence of appropriate stimuli. Hallucinations can affect any sensory system and sometimes occur in several concurrently. Auditory hallucinations are the most common, however visual, gustatory (taste), olfactory (smell) and sensory (touch) hallucinations also occur.

*Simple auditory hallucinations* are more commonly associated with organic psychoses, such as delirium, complex partial seizures, and toxic and metabolic encephalopathies. Auditory hallucinations are classically associated with schizophrenia (seen in 60-90 percent of patients), but are also seen in mood disorders with psychotic features.

*Visual hallucinations* occur in neurological and psychiatric disorders, including toxic disturbances, drug withdrawal, focal central nervous system lesions, migraine headaches, blindness, schizophrenia and psychotic mood disorders. In certain religious subcultures visual hallucinations may be experienced as normal.

*Hypnagogic and hypnopompic hallucinations* are common, predominantly visual hallucinations that occur during the moments immediately before falling asleep and during the transition from sleep to wakefulness, respectively. Both of these types of visual hallucinations occur in normal persons. They can also be characteristic symptoms of narcolepsy (brief attacks of deep sleep).

*Haptic hallucinations* involve touch. Simple haptic hallucinations, such as the feeling that bugs are crawling over one's skin are common in alcohol withdrawal syndromes and in cocaine intoxication.

*Olfactory and gustatory hallucinations*, involving smell and taste respectively, have most often been associated with organic brain disease, particularly uncinuate fits of complex partial seizures.

(reference 15, p. 672; reference 12, p. 587; reference 18, pp. 810-811; reference 23, pp. 2032, 2037, 2177, 2050)

# The Plaintiff's Hallucinations and Delusions

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## *Challenging the Plaintiff's Diagnosis of Hallucinations and Delusions*

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### ***Delusions:***

*Delusions* are fixed, false beliefs, strongly held and immutable in the face of refuting evidence. They cannot be changed by rational argument or a demonstration of relevant facts. The content of delusions is highly influenced by culture. There are three primary types of delusions: *delusional percept*—interpreting a normal perception with a delusional meaning; *delusional mood*—feeling that something uncanny or odd is going on that involves the plaintiff; *delusional memory*—the memory of an event that is clearly delusional.

Delusions occur in schizophrenia, psychotic mood disorders, mania, and depression. (reference 15, p. 669; reference 12, p. 366; reference 18, pp. 800-801)

### ***Classic types of delusions are:***

Delusions of :           persecution; grandeur; influence; doubles; having sinned; erotic attachment; replacement of significant others; disguise

Delusional:             jealousy

Nihilistic delusions

Somatic delusions

Shared delusions

# The Plaintiff's Hallucinations and Delusions

---

## DEPOSITION QUESTIONS

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### General Questions

- Q: What type of hallucinations and delusions did you diagnose in the plaintiff?**  
(reference 15, pp. 472, 478-479)
- 
- Q: When and how often does the plaintiff have hallucinations or delusions?**
- 
- Q: How long has the plaintiff had the hallucinations or delusions?**
- 
- Q: Describe the characteristics of the plaintiff's hallucinations or delusions.**  
Compare the description of plaintiff's hallucinations and / or delusions with those listed above for alternate causes.
- 
- Q: What tests were used to determine if the plaintiff was experiencing hallucinations or delusions?** (reference 4, p. 487; reference 15, pp. 472-481)  
Clinical observation and projective testing may be the most helpful in determining the presence and nature of the plaintiff's hallucinations and delusions. Tests include:  
Minnesota Multiphasic Personality Inventory (MMPI)  
Rorschach Inkblot test  
Thematic Apperception Test (TAT)  
Mental Status Examination
- 
- Q: Did the plaintiff suffer from any *birth trauma*?**
- 
- Q: Did the plaintiff have a *history of head trauma* before the injury in question?**  
Plaintiff's hallucinations may be due to a seizure disorder subsequent to a prior head injury.
- 
- Q: Does the plaintiff have a *history of hallucinations or delusions* before the injury in question?**  
If yes, what was the nature of the hallucinations and the cause of the hallucinations?
- 
- Q: Did you rule out a *seizure disorder* as a cause of the plaintiff's hallucinations or delusions?**  
Temporal lobe seizures are often accompanied by **both visual and auditory hallucinations**. (reference 23, p. 2037)  
*If the witness indicates the possibility that the plaintiff has an epilepsy disorder, see the section on pre-existing medical conditions for further questions.*
-

# The Plaintiff's Hallucinations and Delusions

---

## DEPOSITION QUESTIONS

---

### General Questions

(continued)

**Q: Did you rule out *Lyme disease* as a cause of the plaintiff's hallucinations?**

Lyme disease, transmitted by the bite of an infected Ixodes tick, can cause a vast array of neuropsychiatric disorders, ranging from mild mood changes to psychosis and severe memory loss. Plaintiff's with Lyme disease will show impairment in short-term memory, processing speed, and attention on neuropsychological tests. Cognitive symptoms include word-finding problems, word-substitutions, new-onset dyslexia, marked inattention and distractibility, difficulty with organization, and the sensation that one's brain is in a fog. Other less common neuropsychiatric aspects associated with Lyme disease include panic attacks, transient paranoia, illusions or **hallucinations (visual, olfactory, auditory)**, anorexia, depersonalization, violent outbursts, obsessive-compulsive disorder, agitated mania and personality change. Because of the multisystem involvement in Lyme disease and the frequent concurrence of anxiety and depression, patients may be mistakenly diagnosed as having a primary psychiatric or a somatoform disorder before Lyme disease is even considered. (reference 18, p. 337)

---

**Q: Did you rule out the onset of *psychosis or schizophrenia* as a cause of the plaintiff's hallucinations or delusions?**

The plaintiff with schizophrenia or who is pre-psychotic will have increasing incidence and severity of nightmares and other sleep difficulties often caused by guilt, anxiety or both. If it increases in severity, the plaintiff may develop a psychotic state within a few weeks. **Auditory hallucinations** have been reported in 60-90 percent of persons diagnosed with schizophrenia. (reference 4, pp. 67, 1252; reference 18, pp. 810-811)  
*If the witness indicates the possibility of schizophrenia, see the section on pre-existing clinical mental conditions for further questions.*

---

**Q: Did you rule out *alcohol withdrawal* as a cause of the plaintiff's hallucinations or delusions?**

The reduction or cessation of drinking for at least several days may cause characteristic symptoms: coarse tremor of hands, tongue, or eyelids; nausea or vomiting, malaise or weakness; autonomic hyperactivity (tachycardia, sweating, and elevated blood pressure); anxiety, depressed mood or irritability; **transient hallucinations** or illusions; headache; insomnia; dizziness; fatigue; restlessness; and agitation. (reference 7, pp. 215-216; reference 2, pp. 722, 618; reference 9, pp. 50-54)

---

**Q: Did you rule out a *brain tumor* as a cause of the plaintiff's hallucinations or delusions?**

Brain tumors occur in the skull, brain, or membrane covering the brain or spinal cord. Symptoms vary depending on the size of the tumor and rate of growth. The plaintiff may experience anxiety, dementia, irritability, dizziness, **hallucinations, delusions**, fatigue, headache, vomiting, hyperthermia (high body temperature), and changes in appetite and personality. (reference 4, pp. 139, 834-835, 855, 860, 1276; reference 9, pp. 2161-2164; reference 1, pp. 1351, 1296)

*If the witness indicates the possibility of a brain tumor, see the section on pre-existing medical conditions for further questions.*

# The Plaintiff's Hallucinations and Delusions

---

## DEPOSITION QUESTIONS

---

### General Questions

(continued)

**Q: Did you rule out *infections of the brain* as a cause of the plaintiff's hallucinations or delusions?**

Viral infections of the brain include: brain abscess, venous sinus thrombosis, infectious endocarditis, subdural empyema, cranial epidural abscess, neurosyphilis, acute viral meningitis and encephalitis, and HIV. (reference 23)

---

**Q: Did you rule out *hallucinogen consumption* as the cause of the plaintiff's hallucinations or delusions?**

Hallucinogen consumption causes changes in perception such as feelings of detachment, illusions, **hallucinations**, and synesthesia (seeing colors when a loud sound occurs). Behavioral symptoms may include anxiety or depression, ideas of reference, fear of losing one's mind, paranoia, impaired judgement, and impaired social or occupational functioning. Physical symptoms may include dilated pupils, tachycardia, sweating, palpitations, blurred vision, tremors, and incoordination. Flashbacks of experiences may recur several months or years after hallucinogen use. Many plaintiffs may have gross thought process disturbances. Unlike schizophrenics, they are able to talk in detail about their hallucinations. (reference 7, pp. 252-254; reference 4, p. 874)

---

**Q: Did you rule out *cocaine use* as a cause of the plaintiff's hallucinations or delusions?**

Cocaine users often experience increased energy and confidence or irritability and paranoia with physical aggressiveness. Other behavioral symptoms may include euphoria, hypervigilance, psychomotor agitation, impaired judgement, and impaired social or occupational functioning. Physical symptoms may include tachycardia, dilated pupils, elevated blood pressure, perspiration or chills, nausea, vomiting, and **hallucinations**. (reference 7, pp. 241-245; reference 4, pp. 1008-1009)

---

**Q: Did you rule out *cannabis (marijuana) use* as a cause of the plaintiff's hallucinations or delusions?**

A cannabis delusional disorder occurs within two hours of marijuana use and remits within six hours. The plaintiff may experience **persecutory delusions**, marked anxiety, emotional lability, depersonalization, derealization, **hallucinations**, and amnesia for the episode. (reference 7, pp. 236-241; reference 4, pp. 1326, 754)

---

**Q: Did you rule out *ecstasy use* as a cause of the plaintiff's hallucinations or delusions?**

MDMA use can sometimes result in severe dehydration or exhaustion, or other adverse effects such as nausea, **hallucinations**, chills, sweating, increases in body temperature, tremors, involuntary teeth clenching, muscle cramping, and blurred vision. MDMA users have also reported after-effects such as anxiety, paranoia, and depression. An MDMA overdose is characterized by high blood pressure, faintness, panic attacks, and, in more severe cases, loss of consciousness, seizures, and a drastic rise in body temperatures to 105-106 degrees Fahrenheit. MDMA overdoses can be fatal, as they may result in heart failure or extreme heat stroke. (reference 20)

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# The Plaintiff's Hallucinations and Delusions

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## DEPOSITION QUESTIONS

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### General Questions

(continued)

**Q: Did you rule out *dementia associated with HIV infection* as a cause of the plaintiff's hallucinations or delusions?**

Dementia that is associated with direct HIV infection of the central nervous system is typically characterized by forgetfulness, slowness, poor concentration, and difficulties with problem solving. Behavioral manifestations most commonly include apathy and social withdrawal, and occasionally these may be accompanied by delirium, **delusions, or hallucinations**. Tremor, impaired rapid repetitive movements, imbalance, ataxia, hypertonia, generalized hyperreflexia, positive frontal release signs, and impaired pursuit and saccadic eye movements may be present on physical examination. (reference 7, p. 163)

---

**Q: Did you rule out *other medical or psychological conditions* as a cause of the plaintiff's hallucinations and delusions?**

**Cobalamine deficiency** or pernicious anemia (Vitamin B12) see section 6.3

**Conversion disorder** – Auditory, visual and tactile hallucinations are often reported in persons diagnosed with a conversion disorder. (reference 18, p. 1511)

**Ganser's syndrome** – An uncommon dissociative disorder, hallucinations occur in half the persons diagnosed with this disorder. A precipitating stressor can be litigation and disability claims. (reference 18, pp. 1574- 575)

**Huntington's disease** – A movement disorder characterized by chorea and dementia. Hallucinations and paranoid delusions are most frequent and can develop before the onset of motor symptoms. (reference 18, pp. 292-293)

**Lewy body dementia** – A degenerative dementia with subcortical deficits - Well formed, recurrent visual hallucinations include animals, children and "small people". (reference 23, p. 2046)

**Malingering** – Plaintiffs attempting to malingering psychosis often fake auditory hallucinations. (reference 18, pp. 1904-1905)

**Manic phase of a bipolar disorder** – The plaintiff can be psychotic in the manic phase, with delusions and hallucinations consistent with grandiosity, as well as persecutory delusions. (reference 23, p. 2050)

**Migraine headaches** – Hallucinations precede the headache and may be the dominant aspect of the migrainous attack. The classical hallucination of migraine looks like the jagged top of a fort or wall of a castle. (reference 18, p. 239)

**Narcolepsy** – A disorder of excessive daytime sleepiness which includes hypnagogic hallucinations. (reference 23, p. 2032)

**Parkinson's disease** – Delusions and visual hallucinations occur during dopamine replacement therapy (levodopa - Laradopa). (reference 18, p. 286)

---

# The Plaintiff's Hallucinations and Delusions

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## DEPOSITION QUESTIONS

---

### General Questions

(continued)

**Q:** Is the plaintiff taking *any medications* that may cause hallucinations or delusions, such as:

|                          |               |                |
|--------------------------|---------------|----------------|
| AMERGE                   | HALDOL        | PROVIGIL       |
| AMPHETAMINES             | HISTUSSIN     | PROZAC         |
| AMYTAL                   | INDERAL       | REMERON        |
| ARICEPT                  | INDERIDE      | RESTORIL       |
| ARTANE                   | KEFTAB        | REVIA          |
| AVELOX                   | KERLONE       | RONDEC DM      |
| AZULFIDINE               | KLONOPIN      | RUFEN          |
| BACTRIM                  | LAMICTAL      | SEPTRA         |
| BUPRENEX                 | LIMBITROL     | SEROQUEL       |
| BUTICAPS                 | LIORESAL      | SINEMET        |
| CARBATROL                | LOPRESSOR     | SINEQUAN       |
| CARDIZEM                 | LUDIOMIL      | SONATA         |
| CELONTIN                 | LUVOX         | STADOL         |
| CLOZARIL                 | MARPLAN       | SUDAFED        |
| CODEINE                  | MEBARAL       | SURMONTIL      |
| COMBIPRES                | MECLIZINE     | SYMMETREL      |
| CORGARD                  | MEXITIL       | TAGAMET        |
| CYLERT                   | MINIPRESS     | TALECEN        |
| DALMANE                  | MIRAPEX       | TALWIN NX      |
| DEMEROL                  | MOTRIN        | TEGRETOL       |
| DEPACON                  | NALDECON      | TENORETIC      |
| DESOXYN                  | NEMBUTAL      | TENORMIN       |
| DESYREL                  | NOLUDAR       | TESSALON       |
| DITROPAN                 | NORFLEX       | TIAZAC         |
| DOLOBID                  | NORGESIC      | TIMOPTIC       |
| DURACT                   | NORPRAMIN     | TOFRANIL       |
| DURAGESIC                | NUBAIN        | TRANSDERM-SCOP |
| DURAVENT                 | PAMELOR       | TRIAVIL        |
| EFFEXOR                  | PARLODEL      | TRILISATE      |
| ELAVIL                   | PAXIL         | TRINALIN       |
| ELDERPRYL                | PEDIAZOLE     | ULTRAM         |
| ENDEP                    | PERIACTIN     | VALIUM         |
| ESKALITH                 | PERMAX        | VALTREX        |
| ETRAFON                  | PHENOBARBITAL | VIVACTIL       |
| FELDENE                  | PREVACID      | WELLBUTRIN     |
| FLEXERIL                 | PRILOSEC      | ZANTAC         |
| GOODY HEADACHE<br>POWDER | PROCAN SR     | ZEBETA         |
| HALCION                  | PROSOM        | ZOMIG          |
|                          | PROTONIX      | ZYBAN          |



## SECTION 7.6: ALTERNATE CAUSES OF THE PLAINTIFF'S SEIZURES

**DEFENSE THEORY:** The plaintiff's seizures may be caused by factors other than the injury in question. Medical conditions, drug-induced seizures and neurologic conditions can all produce seizure activity. A detailed, accurate history of the plaintiff's seizure activity is the single most important factor in diagnosis.

### INTRODUCTION

#### *Seizures Defined:*

Seizures are the periodic and excessive discharge of electrical activity from cerebral neurons which can result in loss of consciousness, involuntary movements, abnormal sensory phenomena, increased autonomic activity, and a variety of psychic disturbances. Seizures are a relatively common symptom of brain dysfunction, and they may occur during the course of many acute medical or neurologic illnesses.

#### *Epilepsy Defined:*

Epilepsy is a term applied to a group of chronic conditions whose major clinical manifestation is the occurrence of epileptic seizures - sudden and usually unprovoked attacks of subjective experiential phenomena, altered awareness, involuntary movements, or convulsions. Although a diagnosis of epilepsy requires the presence of seizures, not all seizures imply epilepsy.

(reference 23, p. 2151; reference 10, pp. 338-367)

# Alternate Causes of the Plaintiff's Seizures

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## DEPOSITION QUESTIONS

---

### General Questions

**Q: What type of seizure did you diagnose in the plaintiff?**

In order to accurately determine which type of seizure the plaintiff is experiencing, plaintiff's doctors should have consulted family members (or someone close to the plaintiff) to objectively describe the characteristics of the seizures. (reference 9, p. 2149)

**TABLE 7.6-1.**

**Classification of Epileptic Seizures and Syndromes \***

Classification of seizures

**I. Partial (focal) seizures**

**A. Simple partial seizures** (consciousness not impaired)

1. With motor signs (including jacksonian, versive, and postural)
2. With sensory symptoms (including visual, somatosensory, auditory, olfactory)
3. With psychic symptoms (including dysphasia, hallucinatory, and affective changes)
4. With autonomic symptoms

**B. Complex partial seizures** (consciousness is impaired)

1. Simple partial onset followed by impaired consciousness
2. With impairment of consciousness at onset
3. With automatisms

**C. Partial seizures evolving to secondarily generalized seizures**

**II. Generalized seizures nonfocal origin**

**A. Absence seizures**

**B. Myoclonic seizures; myoclonic jerks** (single or multiple)

**C. Tonic-clonic seizures**

**D. Tonic seizures**

**E. Atonic seizures**

**III. Unclassified epileptic seizures**

**Classification of epileptic syndromes**

**I. Idiopathic epilepsy syndromes** (focal or generalized)

**A. Benign neonatal convulsions**

**B. Benign partial epilepsy of childhood**

**C. Childhood absence epilepsy**

**D. Juvenile myoclonic epilepsy**

**E. Idiopathic epilepsy, otherwise unspecified**

# Alternate Causes of the Plaintiff's Seizures

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## DEPOSITION QUESTIONS

---

### General Questions

(continued)

TABLE 7.6-1. (continued)

|  |
|--|
| <p><b>II.</b> Cryptonic or symptomatic epilepsy syndromes (focal or generalized)</p> <ul style="list-style-type: none"><li><b>A.</b> West's syndrome (infantile spasms)</li><li><b>B.</b> Lennon-Gastaut syndrome</li><li><b>C.</b> Epilepsia partialis continua</li><li><b>D.</b> Temporal lobe epilepsy</li><li><b>E.</b> Frontal lobe epilepsy</li><li><b>F.</b> Post-traumatic epilepsy</li><li><b>G.</b> Other symptomatic epilepsies, otherwise unspecified</li></ul> <p><b>III.</b> Other epilepsy syndromes of uncertain or mixed classification</p> <ul style="list-style-type: none"><li><b>A.</b> Neonatal seizures</li><li><b>B.</b> Febrile seizures</li><li><b>C.</b> Reflex epilepsy</li><li><b>D.</b> Adult nonconvulsive status epilepticus</li><li><b>E.</b> Other unspecified</li></ul> |
|--|

\*International League Against Epilepsy (ILAE)

**Q:** Did your examination of the plaintiff (and family members) include the following questions regarding the history of their seizure activity?

- (1) Date and circumstances of first attack?
- (2) First consistent event in the seizure: Is there an aura? Are initial signs and symptoms focal or lateralizing?
- (3) Subsequent evolution of the seizure, in sequence (seizures are dynamic and evolving e.g., simple partial seizures can evolve into complex partial seizures)
- (4) Postictal manifestations (symptoms and behaviors following a seizure)
- (5) Does the plaintiff have more than one seizure type?
- (6) What is the average rate of occurrence? What is the longest seizure-free interval since onset?
- (7) What precipitates the plaintiff's seizures? (alcohol, sleep deprivation, particular stimuli, stress)
- (8) Is there a pattern to the occurrence of the seizures? (e.g., circadian)
- (9) Has there been a change in characteristics of the seizure?
- (10) Does the plaintiff have a family history of seizures? Does the plaintiff have a neurologic disease that places them at risk for seizures? Cerebral injury?

# Alternate Causes of the Plaintiff's Seizures

## DEPOSITION QUESTIONS

### General Questions

(continued)

**Q:** Did you rule out *alternate causes* of the plaintiff's symptomatic seizure activity?

TABLE 7.6-2.

| Medical conditions  |   |
|---|---|
| <i>Metabolic derangements</i>                               |   |
| Hyponatremia  | (sodium deficiency less than 120 mEq/L)                   |
| Hypernatremia   | (high concentration of sodium greater than 150-155 mEq/L) |
| Hypoglycemia  | (low blood sugar - less than 40 mg/dL)                    |
| Hyperglycemia   | (excess sugar in the blood - greater than 400 mg/dL)      |
| Hyperosmolality   | (bodily fluid with abnormally high osmolarity)            |
| Hypocalcemia  | (deficiency of calcium in the blood)                      |
| Respiratory alkalosis                                       | acute   |
| <i>Drug-induced seizures</i>                                |   |
| Isoniazid, penicillins                                      |   |
| Theophylline, aminophylline                                 |   |
| Lidocaine   |   |
| Meperidine  |   |
| Ketamine, halothan, enflurane, methohexital                 |   |
| Amitriptyline, maprotiline, imipramine, doxepin, fluoxetine |   |
| Haloperidol, trifluoperazine, chlorpromazine                |   |
| Ephedrine, phenylpropanolamine, terbutaline                 |   |
| Methotrexate, BCNU, asparaginase                            |   |
| Cyclosporine  |   |
| Cocaine (crack), phencyclidine, amphetamines                |   |
| Alcohol (withdrawal)  |   |
| <i>Illnesses</i>  |   |
| Eclampsia   |   |
| Hypertensive encephalopathy                                 |   |
| Liver failure   |   |
| Polyarteritis nodosa  |   |
| Porphyria   |   |
| Renal failure   |   |
| Sickle cell disease   |   |
| Syphilis  |   |
| Systemic lupus erythematosus                                |   |
| Thrombotic thrombocytopenic purpura                         |   |
| Whipple's disease   |   |

# Alternate Causes of the Plaintiff's Seizures

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## DEPOSITION QUESTIONS

---

### General Questions (continued)

TABLE 7.6-2. (continued)

**Neurologic conditions**

- Angiitis of the nervous system
- Meningitis
- Encephalitis
- Acute head trauma (impact seizures)
- Stroke
- Brain abscess
- Brain tumor

(Reference 23, p. 2151)

**Q: What tests were used to arrive at the seizure type?**

1. A physical examination discovers systemic diseases responsible for the seizures.
2. A neurologic examination differentiates between partial or generalized seizures.
3. Mental status examinations show specific cognitive deficits.
4. Observations of the seizures reveal necessary details or differential diagnosis.
5. CT scans determine recent onset of seizures.
6. Psychometric testing determines level of attention, performance of verbal and IQ, memory, language, and personality traits.
7. Electroencephalography (EEG) is the most useful test in determining the focus of seizure activity. (reference 9, pp. 2155-2156)

---

**Q: Does the plaintiff have a history of seizures before the injury in question?**

There is a familial incidence of certain types of seizures including absence or petit mal and psychomotor epilepsy. Asymmetry in the size of hands, feet and face may also show the existence of long-standing lesions in the contralateral (opposite side) hemisphere. (reference 10, p. 339)

---

**Q: Did the plaintiff suffer from any birth trauma?**

Many conditions of birth trauma lead to what is loosely termed as "cerebral palsy" and are often associated with seizures. (reference 10, p. 339)

---

**Q: Did you rule out factitious seizures as a cause of the plaintiff's seizures?**

*If the witness indicates the possibility of a factitious disorder, see the section on factitious disorders for further questions.*

---

**Q: Did you rule out infections of the brain as a cause of the plaintiff's seizures?**

Infections such as viral encephalitis, and bacterial and fungal infections in the brain can lead to the development of seizures. (reference 10, p. 341)

---

## Alternate Causes of the Plaintiff's Seizures

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### DEPOSITION QUESTIONS

---

#### General Questions

(continued)

**Q: Did you rule out *neoplasia (tumors) of the nervous system* as a cause of the plaintiff's seizures?**

Primary, metastatic, and slow growing tumors may cause the onset of seizures. (reference 10, p. 341)

*If the witness indicates the possibility of a brain tumor, see the section on pre-existing medical conditions for further questions.*

---

**Q: Did you rule out the effects of an early developmental illness as a cause of the plaintiff's seizures?**

Plaintiff's with developmental defects or viruses may experience seizures: (reference 10, p. 339)

Anoxia  
Rubella

Sturge-Weber disease  
Tuberous Sclerosis

---

**Q: Did you rule out *exposure to toxic substances* as a cause of the plaintiff's seizures, such as:** (reference 10, p. 341)

Atropine  
Corticosteroids  
Insulin  
Lead

Penicillin  
Tricyclic antidepressants  
(lowers the seizure threshold)

---

**Q: Did you rule out *vascular disease* as a cause of the plaintiff's seizures, such as cerebral arteriosclerosis?** (reference 10, p. 341)

---

**Q: Did you rule out *sedative, hypnotic, or anxiolytic withdrawal* as a cause of the plaintiff's seizures?**

Withdrawal symptoms develop when the plaintiff reduces or stops the prolonged moderate or heavy use of these substances. Symptoms may include nausea or vomiting, malaise or weakness; autonomic hyperactivity (such as tachycardia and sweating); anxiety or irritability; orthostatic hypotension; coarse tremor of the hands, tongue and eyelids; insomnia; and **grand mal seizures**. (reference 7, pp. 159-160; reference 4, p. 1549)

---

**Q: Did you rule out *ecstasy use* as a cause for the plaintiff's seizures?**

MDMA use can sometimes result in severe dehydration or exhaustion, or other adverse effects such as nausea, hallucinations, chills, sweating, increases in body temperature, tremors, involuntary teeth clenching, muscle cramping, and blurred vision. MDMA users have also reported after-effects such as anxiety, paranoia, and depression. An MDMA overdose is characterized by high blood pressure, faintness, panic attacks, and, in more severe cases, loss of consciousness, **seizures**, and a drastic rise in body temperatures to 105-106 degrees Fahrenheit. MDMA overdoses can be fatal, as they may result in heart failure or extreme heat stroke. (reference 20)

---

# Alternate Causes of the Plaintiff's Seizures

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## DEPOSITION QUESTIONS

---

### General Questions

(continued)

**Q: Did you rule out *lithium use* as a cause of the plaintiff's seizures?**

Lithium is primarily used as a medication for bipolar disorder. Tremor is one of the most common side-effects. Other side-effects may include nausea, diarrhea, polyuria (the passage of an excessive quantity of urine), polydipsia (excessive thirst), and weight gain. Toxic effects may include gross tremor, increased deep tendon reflexes, persistent headaches, vomiting, mental confusion progressing to stupor, **seizures**, or cardiac arrhythmias. (reference 1, pp. 1460-1461)

---

**Q: Did you rule out *alcohol use or withdrawal* as a cause of the plaintiff's seizures?**

Ethanol can precipitate seizures in any epileptic. Seizures usually occur the morning after a weekend or even a single-day of drinking rather than during inebriation.

“Alcohol-related” seizures, affecting alcoholics not otherwise epileptic, have traditionally been considered a withdrawal phenomenon, occurring usually within 48 hours of the last drink in subjects who have abused ethanol, chronically or in binges, for months or years. Seizures usually occur singly or as a brief cluster; status epilepticus is infrequent. Focal features are present in 25% and do not consistently correlate with evidence of previous head injury or other structural cerebral pathology. (reference 21, p. 969)

---

**Q: Did you rule out *malingering* as a cause of the plaintiff's seizures?**

Malingering may be associated with attempts to avoid work or evade legal responsibilities. Plaintiff complaints may include vertigo (illusion of movement), weakness, loss of consciousness, **manipulated seizures**, headaches, visual impairment, and loss of skin sensation. (reference 4, p. 1863)

*If the witness indicates the possibility of malingering, see the section on malingering for further questions.*

---

**Q: Did you rule out *psychogenic seizure activity*?**

Epileptic seizures are difficult and sometimes impossible to clinically differentiate from similar brief behavioral disturbances of psychological origin, such as hysterical reactions or feelings of detachment. (reference 4, p. 153)

---

**Q: Did you rule out a *conversion disorder* as a cause of the plaintiff's alleged seizure activity?**

A conversion disorder is characterized by the presence of symptoms or deficits affecting voluntary motor or sensory function that suggest a neurological or other general medical condition. Psychological factors are judged to be associated with the symptom or deficit and the symptoms are not intentionally feigned or produced. Conversion symptoms are defense mechanisms that change the unconscious emotional conflict into a physical disability that often symbolizes the nature of the conflict. One of the more common conversion symptoms is **seizures**. (reference 12, p. 315; reference 2, pp. 625, 630; reference 7, pp. 492-498)

*If the witness indicates the possibility of a conversion disorder, see the section on pre-existing mental disorders and section 8.4 for further questions.*

## Alternate Causes of the Plaintiff's Seizures

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### DEPOSITION QUESTIONS

---

#### General Questions

(continued)

**Q:** Are the characteristics of the plaintiff's seizures *bizarre or inconsistent* across episodes?

The following guidelines are useful in differentiating *true organic seizures* from *pseudoseizures* or "*spells*."

- a. Seizures are usually stereotyped and spells are often not stereotyped. (The patient should not faint on one occasion, convulsively shake on another, and smack his lips on another.)
- b. There is a gradual onset of the spell, enough time to sit down, take medicine, or see the floor coming up.
- c. Seizures are not abortable, while spells are abortable or delayable by some tactic.
- d. Seizures are generally accompanied by tonic-clonic activity but spells often consist of pure syncope (without tonic-clonic convulsive activity).
- e. Seizures often result in a fall while spells only occur in the standing position, or on standing up from a lying position.
- f. If the plaintiff was conscious or can recall events s/he has probably not had a true seizure.
- g. If there was purposeful, well-organized, or premeditated behavior during the spell, the plaintiff probably did not have a true seizure.
- h. Seizures are almost always accompanied by postictal confusion, lethargy, or headache. The absence of these objective symptoms suggests a spell or pseudoseizure.
- i. The patient may be having spells if they continue unabated despite adequate anticonvulsant medication. (Anticonvulsants work. If they make no inroads into a plaintiff's spells despite adequate blood levels, you are probably not looking at a seizure disorder.)
- j. If the EEG is normal during a spell, or immediately afterwards, the plaintiff is probably not having true organic seizures.

There are enough exceptions to the above tips to make each one only a guideline, not a firm rule. The simultaneous occurrence of two or more of these, however, markedly raises the improbability of a seizure disorder. Counsel may wish to ask the plaintiff's experts questions pertaining to each of these points. (reference 26, pp. 468-469)

---

## Alternate Causes of the Plaintiff's Seizures

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### DEPOSITION QUESTIONS

---

#### General Questions

(continued)

**Q: Does the plaintiff have any *other medical conditions* that may cause seizures, such as:** (reference 26, pp. 468-469)

**TABLE 7.6-3.**

|                              |                                  |
|------------------------------|----------------------------------|
| Acute hypertension           | Multiple Sclerosis               |
| Anoxia (cerebral)            | Myasthenia gravis                |
| Aortic stenosis              | Myocardial infarction            |
| Arrhythmia                   | Narcolepsy                       |
| Atrial myxoma                | Neurofibromatosis (central form) |
| Basilar artery migraine      | Orthostatic hypotension          |
| Basilar artery TIA           | Periodic paralysis               |
| Carotid artery TIA           | Pick's disease                   |
| Cataplexy                    | Polycythema vera                 |
| Congestive heart failure     | Postinfectious condition         |
| Demyelination                | Postvaccination                  |
| Guillain Barre syndrome      | Recurrent pulmonary emboli       |
| Hematologic hyperviscosity   | Renal failure                    |
| Hepatic failure              | Sinus bradycardia                |
| Hypersensitive carotid sinus | Subaortic stenosis               |
| Hypoxia                      | Temporal arteritis               |
| Malignant brain tumor        | Third ventricular colloid cyst   |
| Medication side-effects      | Trauma - chronic subdural        |
| Meningioma                   | Vasovagal response               |
| Micturition syncope          | Vestibular disturbance           |

**Q: Is the plaintiff taking any *medications or substances* that would cause or contribute to the seizures, such as:**

|             |                |                 |
|-------------|----------------|-----------------|
| ACCUTANE    | DESYREL        | INSULIN         |
| AMYTAL      | DIAMOX         | ISUPREL         |
| ASENDIN     | DIFLUCAN       | KEFTAB          |
| CEFZIL      | DILANTIN       | KLONOPIN        |
| CELONTIN    | ELAVIL         | LAMICTAL        |
| CIPRO       | ENDEP          | LEVAQUIN        |
| CLARITAN-D  | ESKALITH       | LIORESAL        |
| CLARITIN    | ETRAFON        | LITHIUM-CITRATE |
| CLOZARIL    | FLAGYL         | LORABID         |
| CODEINE     | FLOXIN         | LOXITANE        |
| COMBIVIR    | FORTAZ         | LUDIOMIL        |
| CYLERT      | GABITRIL       | MEBARAL         |
| DANTRIUM    | GLYBURIDE      | MECLIZINE       |
| DEPACON     | GOODY HEADACHE | MESANTOIN       |
| DEPAKENE    | POWDER         | METRONIDAZOLE   |
| DEPAKOTE    | GUAIFED        | MEXITIL         |
| DEPO-MEDROL | HALDOL         | MILONTIN        |

# Alternate Causes of the Plaintiff's Seizures

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## DEPOSITION QUESTIONS

---

### General Questions

*(continued)*

|                  |           |           |
|------------------|-----------|-----------|
| MORPHINE-SULFATE | QUIDE     | TOPAMAX   |
| MYSOLINE         | SINEQUAN  | TRANXENE  |
| NALFON           | STELAZINE | TRIAVIL   |
| NAVANE           | SUPRAX    | TRILAFON  |
| NEURONTIN        | SURMONTIL | TRILEPTAL |
| NICORETTE        | TARACTAN  | VALIUM    |
| NORPRAMIN        | TEGRETOL  | VIVACTIL  |
| PAMELOR          | TEMARIL   | XANAX     |
| PERMITIL         | THORAZINE | ZARONTIN  |
| PHENOBARBITAL    | TIMENTIN  | ZEPHREX   |
| PRIMAXIN-IV      | TINDAL    | ZOFRAN    |
| PROKETAZINE      | TOFRANIL  | ZONEGRAN  |

## SECTION 7.7: ALTERNATE CAUSES OF THE PLAINTIFF'S HEADACHES

**DEFENSE THEORY:** The plaintiff's headaches may be caused by factors other than the injury in question. Ninety percent of the population experience a headache of one type or another. Tension headaches are the most common type and migraine is the second most common primary headache disorder.

### INTRODUCTION

#### *Primary Headache Disorders*

Most plaintiffs with recurrent or chronic headaches suffer from a primary headache disorder for which no ominous underlying source can be found.

- (1) **Migraine headache** (There may be a familial pattern)  
There may be prodromal symptoms 24 to 48 hours before a migraine attack. The headache phase consists of 4 to 72 hours of unilateral throbbing head pain of moderate to severe intensity that is worsened by routine physical exertion and associated with nausea, photophobia, and phonophobia. Migraine headaches affect women disproportionately.
  - (1a) **Migraine without an aura** (85% of migraine patients experience this type)
  - (1b) **Migraine with an aura** (15% of migraine patients experience this type)  
Typical aura symptoms include visual disturbance, unilateral paresthesias and or numbness in the hands or face, unilateral weakness, ataxia, bilateral paresthesias, and a decreased level of consciousness.
- (2) **Cluster headache**  
Cluster headaches consist of recurrent episodes of unilateral, orbital, supraorbital, or temporal head pain. It derives its name from the cluster of headaches during a period of time, separated by headache-free periods. The condition is more common in men than women.
- (3) **Tension headache**  
Tension headaches are the most common of the primary headaches, occurring more frequently in women. They occur in episodic and chronic forms. Episodic tension-type headache consists of recurrent attacks of tight, pressing (band-like), bilateral, mild to moderate head pain that lasts from minutes to days. The chronic form occurs at least fifteen days per month.

## Alternate Causes of the Plaintiff's Headaches

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### *Description of Headaches*

---

(4) **Chronic daily headache**

This applies to headaches that occur more than 15 days per month for at least 1 month. This includes cluster headache, hemicrania continua, chronic paroxysmal hemicrania, and chronic tension-type headache. *Chronic daily headache is often associated with overuse of analgesic medications.*

(5) **Other primary headache syndromes**

Chronic paroxysmal hemicrania, hemicrania continua, benign cough headache, exertional / orgasmic headache, and hypnic headaches (rare syndrome of the elderly).

### *Secondary Headache Disorders*

Headache may be the initial complaint in a host of central nervous system and systemic abnormalities. Prominent abnormalities that may result in chronic headache include the following:

(1) **Giant cell arteritis**

This is an inflammatory vasculitis involving branches of the temporal arteries. It affects persons older than 60 years of age.

(2) **Headache associated with *increased* intracranial pressure**

Causes of intracranial pressure include: mass lesion, blockage of cerebrospinal fluid circulation, hemorrhage, hypertensive encephalopathy, venous sinus thrombosis, hyperadrenalism or hypoadrenalism, altitude sickness, tetracycline, and vitamin A intoxication.

(3) **Headache associated with *decreased* intracranial pressure**

Low-pressure headaches occur following lumbar puncture, intracranial surgery, ventricular shunting, trauma, severe dehydration, post-dialysis status, diabetic coma, uremia, or hyperpnea. Low-pressure headaches can also occur spontaneously.

(4) **Substance-induced headaches**

Exposure to a toxic substance may cause headache. Withdrawal from a medication or substance may also produce headaches.

## Alternate Causes of the Plaintiff's Headaches

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### *Description of Headaches*

---

**TABLE 7.7-1.**

| <b>Substances Inducing Headache</b> |   |
|-------------------------------------|---|
| <i>After Acute Exposure</i>         | <i>Following Withdrawal after Chronic Use</i> |
| Alcohol                             | Alcohol                                       |
| Amphotericin B                      | Barbiturates                                  |
| Azithromycin                        | Caffeine                                      |
| Carbon monoxide                     | Ergotamine                                    |
| Cimetidine                          | Opiate analgesics                             |
| Cocaine / crack                     |   |
| Danazol                             |   |
| Diclofenac                          |   |
| Dipyridamole                        |   |
| Estrogen / birth control pills      |   |
| Fluconazole                         |   |
| Indomethacin                        |   |
| Monsodium glutamate                 |   |
| Nifedipine                          |   |
| Nitrates / nitrites                 |   |
| Ondansetron                         |   |
| Phenylethylamine                    |   |
| Ranitidine                          |   |
| Reserpine                           |   |
| Tyramine                            |   |
| Timolol ophthalmic drops            |   |
| Verapamil                           |   |

# Alternate Causes of the Plaintiff's Headaches

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## *Description of Headaches*

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TABLE 7.7-2

### **Secondary Headache Disorders**

#### ***Headaches Associated with Cranial Vascular Abnormalities***

- Subarachnoid hemorrhage
- Intracerebral, epidural, and subdural hematoma
- Unruptured vascular malformation
  - Arteriovenous malformation
  - Saccular aneurysm
- Carotid or vertebral artery dissection
- Carotidynia
- Cerebral intra-arterial occlusion
- Venous thrombosis
- Arterial hypertension

#### ***Headaches Associated with Non-vascular Intracranial Disorders***

- Intracranial neoplasms
- High- and low-pressure headaches
- Inflammatory disorders
  - Temporal (giant cell) arteritis
  - Tolosa-Hunt syndrome
  - Intracranial sarcoidosis
- Intracranial infection
  - Acute meningitis
  - Meningoencephalitis
  - Brain abscess

#### ***Headaches Associated with Systemic Abnormalities***

- Systemic infection, viral, bacterial, treponemal, etc.
- Substance-induced headaches, exposure and withdrawal
- Metabolic disturbance
  - Hypoxia, altitude sickness, sleep apnea (reduced oxygen)
  - Hypercapnia (excess of carbon dioxide in the blood)
  - Hypoglycemia (reduced blood sugar)
  - Dialysis

#### **Head and Face Pain Associated with Disorders of Cranial Nerves**

- Neuralgias
  - Trigeminal neuralgia
  - Glossopharyngeal neuralgia
  - Occipital neuralgia

#### **Herpes zoster**

#### **Head and Face Pain Associated with Disorders of Other Cranial Structures**

- Glaucoma
- Sinusitis
- Temporomandibular joint disease
- Dental pain
- Neck abnormalities

(reference 23, pp. 2066-2072)

# Alternate Causes of the Plaintiff's Headaches

---

## DEPOSITION QUESTIONS

---

### General Questions

**Q: What type of headache syndrome did you diagnose in the plaintiff?**

Defense counsel should ask the following questions for the diagnosis given by the witness.

- (1) What tests did you use to diagnose the plaintiff's headaches?
  - (2) Are these tests conclusive?
- 

**Q: Describe the characteristics of the plaintiff's headaches.**

---

**Q: When and how often does the plaintiff have headaches?**

---

**Q: How long has the plaintiff had headaches?**

---

**Q: Is the plaintiff taking MAO inhibitors for depression?**

While taking MAO inhibitors, the plaintiff typically experiences headaches after ingesting foods containing tyramine (cheddar cheese, red wine). This is due to a sharp rise in blood pressure. (reference 2, p. 77)

---

**Q: Does the plaintiff have a *history of headaches* before the injury in question?**

Sixty percent of all patients who suffer from migraine headaches have a familial history of headaches.

---

**Q: Did you rule out *stressors or other conditions* not attributable to a mental disorder as the cause of the plaintiff's headaches?**

*If the witness indicates the possibility of a life stressor, see the section on Other Life Stressors for additional questions.*

---

**Q: Did you rule out *aneurysms* as a cause of the plaintiff's headaches?**

Aneurysms along the posterior communicating arteries or the internal carotid artery may cause a frontal headache. (reference 2, p. 78)

---

**Q: Did you rule out *excessive sleep* as a cause of the plaintiff's headaches?**

---

**Q: Did you rule out *hypertension* as a cause of the plaintiff's headaches?**

Hypertension (high blood pressure) has been associated with emotional and physical stress, personality type, diet, obesity, alcohol, life changes, traumatic events, social conditions, and environmental variables. Most symptoms, such as **headaches**, are the result of prolonged high blood pressure. (reference 4, pp. 1118, 139, 1153-1154, 859; reference 1, pp. 391-392, 192)

*If the witness indicates the possibility of hypertension, see the section on pre-existing medical conditions for further questions.*

---

# Alternate Causes of the Plaintiff's Headaches

---

## DEPOSITION QUESTIONS

---

### General Questions

(continued)

**Q: Did you rule out *anemia* as a cause of the plaintiff's headaches?**

Vertigo, **pounding headaches**, fainting, dimness of vision, tinnitus (a ringing in one or both ears), irritability, restlessness, inability to concentrate, lethargy, fatigue, drowsiness, GI complaints, and congestive heart failure are common symptoms of anemia. (reference 2, pp. 566-571)

*If the witness indicates the possibility of anemia, see the section on pre-existing medical conditions for further questions.*

---

**Q: (Female) Did you rule out *premenstrual dysphoric disorder* as a cause of the plaintiff's headaches?**

Premenstrual dysphoric disorder (PMDD) is characterized by emotional and behavioral symptoms which usually occur during the last week before the menstrual cycle and remit within a few days after menses begins. Symptoms may include tears, sadness, irritability, anger, tension, depression, self-deprecating thoughts, decreased interest in usual activities, fatigability, loss of energy, a subjective sense of difficulty in concentration, changes in appetite, and sleep disturbance. Physical symptoms may also include breast tenderness or swelling, tachycardia, sweating, **headaches**, joint or muscle pain, a sensation of bloating, or weight gain. (reference 7, pp. 771-774; reference 18, p. 1955)

---

**Q: Did you rule out *polycythemia* as a cause of the plaintiff's headaches?**

Polycythemia is a chronic life-threatening disease involving the bone marrow. It is characterized by an increase in red blood mass and hemoglobin concentration. The result is an impaired blood flow, hypervolemia (greater than normal volume of blood), increased cardiac output, and hyperviscosity (abnormally high resistance to flow). These increases are responsible for most of the symptoms of the disease, such as **headaches**. (reference 1, pp. 1106-1109; reference 2, p. 831)

*If the witness indicates the possibility of polycythemia, see the section on pre-existing medical conditions for further questions.*

---

**Q: Did you rule out *meningitis* as a cause of the plaintiff's headaches?**

Meningitis is an inflammation of the membranes of the brain or spinal cord. The meningitides are named by either the causative agent (viral meningitis, tuberculous meningitis, pneumococcal meningitis) or by symptom characteristics (acute, chronic). **Headaches**, dizziness, and a stiff neck are a few common symptoms. (reference 12, p. 822; reference 4, pp. 123-124, 205, 721; reference 1, pp. 1339-1346; reference 9, p. 2122)

*If the witness indicates the possibility of meningitis, see the section on pre-existing medical conditions for further questions.*

---

**Q: Did you rule out the *cessation of steroid use* as a cause of the plaintiff's headaches?** (reference 2, p. 56; reference 10, p. 323)

---

# Alternate Causes of the Plaintiff's Headaches

---

## DEPOSITION QUESTIONS

---

### General Questions

(continued)

**Q: Did you rule out *arteriovenous malformations* as a cause of the plaintiff's headaches?**

Arteriovenous malformations (AVM) are tangled masses of dilated arteries and veins. These congenital defects are usually located within the largest part of the brain. They range in size from barely detectable lesions up to huge networks occupying an entire lobe or hemisphere of the brain. Symptoms include sudden head pains and **migraine headaches** on the side of the malformations. (reference 4, pp. 114, 139; reference 1, pp. 1374, 1333; reference 9, p. 2104)

*If the witness indicates the possibility of arteriovenous malformations, see the section on pre-existing medical conditions for further questions.*

---

**Q: Did you rule out *eye disease* as a cause of the plaintiff's headaches?**

Eye disease commonly cause headaches or local pain in the eye. (reference 10, p. 337)

---

**Q: Did you rule out *hypoglycemia* as a cause of the plaintiff's headaches?**

Hypoglycemia is an abnormally low blood sugar level. It often produces personality changes and physical symptoms, such as **headaches**. Hypoglycemia can develop from an insulin overdose, insulinoma or islet cell tumor, extensive liver disease, or functional diseases. Hypoglycemic plaintiffs often have headaches three to four hours after a meal due to the dilation of the scalp blood vessels. (reference 2, p. 702; reference 4, pp. 1176-1177)

*If the witness indicates the possibility of hypoglycemia, see the section on pre-existing medical conditions for further questions.*

---

**Q: Did you rule out *certain foods* as a cause of the plaintiff's headaches?**

**Migraine headaches** may be caused by foods that contain phenylethylamine, tyramine (cheese, fermented dairy products, and chocolate), and monosodium glutamate (Chinese restaurant syndrome). **Vascular headaches** may be caused by chemicals, drugs, and foods that have a vasodilator effect, such as: (reference 4, p. 1204; reference 2, p. 77)

|   |               |
|---|---------------|
| Alcohol                                       | Nitrites      |
| Monosodium glutamate (MSG)                    | Nitroglycerin |
| Nitrates in cured meat (ham, hot dogs, bacon) |               |

---

**Q: Did you rule out *painful ophthalmoplegia* as a cause of the plaintiff's headaches?**

Painful ophthalmoplegia is characterized by a boring, **headache-like pain behind the eyes** usually due to a chronic inflammatory lesion. (reference 10, p. 332)

---

**Q: Did you rule out *poor posture* as a cause of the plaintiff's headaches?**

Poor posture results in tension in the muscles of the head and neck and are known as **postural headaches**.

---

## Alternate Causes of the Plaintiff's Headaches

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### DEPOSITION QUESTIONS

---

#### General Questions

(continued)

**Q: Did you rule out *cervical strain* as a cause of the plaintiff's headaches?**

Cervical strains are very common sequelae of motor vehicle accidents. A strain in the cervical region of the neck may cause or contribute to **headaches**. The muscle strain can persist for weeks to months, especially when ongoing legal action is based on the presence of disability. (reference 18, p. 372)

---

**Q: Did you rule out *fatigue* as a cause of the plaintiff's headaches?**

Fatigue can cause an **acute tension-type headache** that responds to analgesic and rest. (reference 18, p. 372)

---

**Q: Did you rule out *excessive exertion* as a cause of the plaintiff's headaches?**

Excessive exertion can cause an **acute tension-type headache** that responds to analgesic and rest. (reference 18, p. 372)

---

**Q: (Female) Did you rule out *pregnancy* as a cause of the plaintiff's headaches?**

A positive relationship has been found between the onset of **migraine headaches** and the change in the endocrine balance that accompanies pregnancy. (reference 2, p. 65; reference 10, p. 323)

---

**Q: Did you rule out a *brain tumor* as a cause of the plaintiff's headaches?**

Brain tumors occur in the skull, brain, or membrane covering the brain or spinal cord. Symptoms vary depending on the size of the tumor and rate of growth. The plaintiff may experience anxiety, dementia, irritability, dizziness, fatigue, **headache**, vomiting, hyperthermia (high body temperature), and changes in appetite and personality. (reference 4, pp. 139, 834-835, 855, 860, 1276; reference 9, pp. 2161-2164; reference 1, pp. 1351, 1296)

*If the witness indicates the possibility of a brain tumor, see the section on pre-existing medical conditions for further questions.*

---

**Q: Did you rule out *pheochromocytoma* as a cause of the plaintiff's headaches?**

Pheochromocytoma is a tumor of the sympathetic nervous system which specifically causes **headaches**, lightheadedness, nausea, sweating, trembling, and elevated blood pressure during anxiety attacks. (reference 4, p. 1276)

*If the witness indicates the possibility of pheochromocytoma, see the section on pre-existing medical conditions for further questions.*

---

**Q: Did you rule out *abscesses* as a cause of the plaintiff's headaches?**

An unruptured brain abscess may cause **headaches** in a manner similar to a brain tumor. (reference 2, p. 78)

---

# Alternate Causes of the Plaintiff's Headaches

---

## DEPOSITION QUESTIONS

---

### General Questions

(continued)

**Q: Did you rule out *infectious diseases* as a cause of the plaintiff's headaches?**

Infectious disease, or any fever producing illness, may cause **headaches** due to an increased cerebral blood flow. Examples include: (reference 2, p. 617; reference 10, p. 336)

|                                  |                                 |
|----------------------------------|---------------------------------|
| Brucellosis                      | Respiratory tract infections    |
| Chronic urinary tract infections | Subacute bacterial endocarditis |
| Colds                            | Syphilis                        |
| Infectious mononucleosis         | Tuberculosis                    |
| Influenza                        | Typhus                          |
| Malaria                          | Viral hepatitis                 |

---

**Q: Did you rule out *vitamin A toxicity* as a cause of the plaintiff's headaches?**

---

**Q: Did you rule out *syphilis* as a cause of the plaintiff's headaches?**

Syphilis is a chronic disease usually contracted from another person through sexual contact. Pain and progressive dementia with agitation, expansiveness, or depression are common symptoms. It can be treated with penicillin. If the disease is not treated, the plaintiff may experience periods of active symptoms and years of latency.

**Headaches** are a common symptom of disease. (reference 1, pp. 1616-1621; reference 9, pp. 1650-1654; reference 4, p. 127)

*If the witness indicates the possibility of syphilis, see the section on pre-existing medical conditions for further questions.*

---

**Q: Did you rule out *hypothyroidism* as a cause of the plaintiff's headaches?**

Hypothyroidism results from an insufficient synthesis of the thyroid hormone. Low hormone levels may cause impaired memory, inattention, depression, despair, suicidal thoughts, crying spells, premonitions of doom and characteristic physical symptoms such as **headaches**. (reference 4, p. 1171)

*If the witness indicates the possibility of hypothyroidism, see the section on pre-existing medical conditions further questions.*

---

**Q: Did you rule out *hypercapnia* as a cause of the plaintiff's headaches?**

Hypercapnia is the retention of carbon dioxide (CO<sub>2</sub>) in the arterial blood. With this condition, cerebral blood flow greatly increases and the plaintiff will complain of **headaches**. The condition may be caused by chronic emphysema, bronchiectasis, pulmonary infection, and the hypoventilation syndrome of extreme obesity (Pickwickian syndrome). (reference 10, p. 336)

---

**Q: Did you rule out *diseases of the nose, paranasal sinuses and throat* as a cause of the plaintiff's headaches?**

Mucous membranes are sensitive to inflammation and pressure caused by tumors and empyemas. The resulting pain may be referred to the frontal or frontotemporal regions as **headaches**. (reference 10, p. 337) Sinusitis may cause facial pain in the context of fever and nasal congestion. (reference 18, p. 372)

---

## Alternate Causes of the Plaintiff's Headaches

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### DEPOSITION QUESTIONS

---

#### General Questions

(continued)

**Q: Did you rule out *diseases or conditions of the mouth* as a cause of the plaintiff's headaches?**

Dental pain, injury to the temporomandibular joint, or malocclusion that forces a person to chew on only one side of the mouth may strain one masseter muscle and produce **unilateral headache**. (reference 18, p. 372)

---

**Q: Did you rule out *malingering* as a cause of the plaintiff's headaches?**

Malingering may be associated with attempts to avoid work or evade legal responsibilities. Avoidance may be accomplished through subjective reports of physical symptoms such as **headaches**. (reference 4, p. 1863)

*If the witness indicates the possibility of malingering, see section 8.1 on malingering for additional questions.*

---

**Q: Did you rule out *caffeine withdrawal* as a cause of the plaintiff's headaches?**

The most common caffeine withdrawal symptom is a **withdrawal headache**. Headaches occur in about one-third of moderate to high caffeine consumers when their daily intake is stopped. (reference 4, p. 1029; reference 2, p. 618)

*See caffeine consumption and symptom chart in Appendix A for further details.*

---

**Q: Did you rule out *conversion disorder* as a cause of the plaintiff's headache pain?**

A conversion disorder is characterized by the presence of symptoms or deficits affecting voluntary motor or sensory function that suggest a neurological or other general medical condition. Psychological factors are judged to be associated with the symptom or deficit and the symptoms are not intentionally feigned or produced. Conversion symptoms are defense mechanisms that change the unconscious emotional conflict into a physical disability that often symbolizes the nature of the conflict.

**Headaches** are a common conversion symptom. A careful history by the witness may reveal recurrent headaches brought on by specific types of situations.

(reference 12, p. 315; reference 2, pp. 625, 630; reference 7, pp. 492-498; reference 4, p. 1204)

*If the witness indicates the possibility of a conversion disorder, see the section on pre-existing mental disorders and section 8.4 for further questions.*

---

**Q: Did you rule out *amphetamine or similarly acting sympathomimetic drug use or withdrawal* as a cause of the plaintiff's headaches?**

Symptoms of amphetamine or similarly acting sympathomimetic *drug consumption* may include fighting, grandiosity, elation, hypervigilance, psychomotor agitation, impaired judgment, and impaired social or occupational functioning. Physical symptoms may include flushing, difficulty breathing, tachycardia, pupil dilation, elevated blood pressure, sweating or chills, nausea, and vomiting. (reference 4, pp. 1007-1008; reference 7, p. 223)

*Drug withdrawal* symptoms may include a dysphoric mood (depression, irritability, anxiety), fatigue, sweating, **headaches**, insomnia with nightmares, hypersomnia, and psychomotor agitation. Symptoms begin after the cessation of prolonged drug use (at least two days) and last more than 24 hours. (reference 7, p. 227; reference 4, p. 1008)

# Alternate Causes of the Plaintiff's Headaches

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## DEPOSITION QUESTIONS

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### General Questions

(continued)

The following drugs may be classified as amphetamines:

|                                    |                            |
|------------------------------------|----------------------------|
| Appetite Suppressants (diet pills) | Methamphetamines (speed)   |
| Dextroamphetamines                 | Methylphenidates (Ritalin) |
| Ma-huang (ephedra)                 | (reference 17, p. 586)     |
| (reference 24, pp. 488-489)        |                            |

---

**Q: Did you rule out the use of marijuana as a cause of the plaintiff's headaches?**

Headaches may be associated with marijuana use. (reference 18, p. 372)

---

**Q: Is the plaintiff taking any medications or substances that may cause headaches, such as:**

|                 |              |                 |
|-----------------|--------------|-----------------|
| ACCOLATE        | AVONEX       | CELONTIN        |
| ACCUPRIL        | AXID         | CENTRAX         |
| ACCUTANE        | AXOCET       | CHLORAL-HYDRATE |
| ACTOS           | AZULFIDINE   | CHLORTRIMETON   |
| ADALAT          | BACTRIM      | CIPRO           |
| ADAPIN          | BACTROBAN    | CLARITAN-D      |
| ADDERALL        | BECONASE     | CLIMARA         |
| ADIPEX          | BELLERGA     | CLINORIL        |
| ADRENALINE      | BENADRYL     | CLOMID          |
| AEROBID         | BENTYL       | CLOZARIL        |
| ALDACTAZIDE     | BETHANECHOL- | COGNEX          |
| ALDACTONE       | CHLORIDE     | COLBENAMID      |
| ALDOMET         | BIAXIN       | COLESTID        |
| ALDORIL         | BIPHETAMINE  | COMBIPATCH      |
| ALORA PATCH     | BONTRIL      | COMBIPRES       |
| ALPHGAN         | BRETHINE     | COMBIVENT       |
| ALTACE          | BRICANYL     | COMPAZINE       |
| AMBIEN          | BRONTEX      | CONCERTA        |
| ANAFRANIL       | BUMEX        | CORGARD         |
| ANAPROX         | BUPRENEX     | CORTISONE       |
| ANDRODERM PATCH | BUSPAR       | COUMADIN        |
| ANSAID          | BUTAZOLIDIN  | COZAAR          |
| ANTABUSE        | BUTICAPS     | CRINONE         |
| APRESOLINE      | CAFERGOT     | CYCLOSPORIN     |
| ARICEPT         | CAFERGOT-PB  | CYCRIN          |
| ARTANE          | CALAN        | CYLERT          |
| ARTHROTEC       | CARAFATE-TOO | CYSTOSPAZ       |
| ASENDIN         | CARBATROL    | CYTOMEL         |
| ATACAND         | CARDENE      | CYTOTEC         |
| ATIVAN          | CEFTIN       | DALALONE        |
| ATROVENT        | CEFZIL       | DALMANE         |
| AVANDIA         | CELEBREX     | DANTRIUM        |
| AVAPRO          | CELESTON     | DARVOCET-N      |
| AVELOX          | CELEXA       | DARVON-COMPOUND |

## Alternate Causes of the Plaintiff's Headaches

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### DEPOSITION QUESTIONS

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#### General Questions

(continued)

|                 |                  |                  |
|-----------------|------------------|------------------|
| DECADRON        | ESTRATEST        | KLONOPIN         |
| DEMADEX         | ESTROGEN PATCH   | LANOXIN          |
| DEMEROL         | ETRAFON          | LASIX            |
| DEPACON         | EXCELON          | LESCOL           |
| DEPAKENE        | FAMVIR           | LEVAQUIN         |
| DEPAKOTE        | FASTIN           | LEVOTHROID       |
| DEPO-MEDROL     | FELBATOL         | LEVSIN           |
| DEPO-PROVERA    | FELDENE          | LIBRAX           |
| DEPROL          | FIORICET         | LIMBITROL        |
| DESOGEN         | FIORINAL         | LIORESAL         |
| DESOXYN         | FIORINAL-CODEINE | LIPITOR          |
| DESYREL         | FLAGYL           | LITHIUM-CITRATE  |
| DETROL          | FLEXERIL         | LO-OVRAL         |
| DEXEDRINE       | FLOMAX           | LOMOTIL          |
| DIFLUCAN        | FLONASE          | LOPID            |
| DILACOR         | FLOXIN           | LOPRESSOR        |
| DILANTIN        | FORTAZ           | LORABID          |
| DIMETANE        | FOSAMAX          | LOTENSIN         |
| DIMETAPP        | GLUCOTROL        | LOTREL           |
| DIOVAN          | GLYBURIDE        | LOZOL            |
| DIPYRIDAMOLE    | GOODY HEADACHE   | LUDIOMIL         |
| DISALCID        | POWDER           | LUFYLLIN-GG      |
| DIURIL          | GUAIFED          | LUVOX            |
| DOLOBID         | GYNERGEN         | MACROBID         |
| DONNATAL        | HABITROL         | MACRODANTIN      |
| DORAL           | HALCION          | MARCAINE         |
| DURACT          | HALDOL           | MARPLAN          |
| DURAGESIC       | HISTUSSIN        | MAXAIR-AUTOHALER |
| DURAVENT        | HUMULIN          | MAXIDE           |
| DYAZIDE         | HYDRO-           | MEBARAL          |
| DYNACIRC        | CHLOROTHIAZIDE   | MECLIZINE        |
| EDECRIN         | HYDRODIURIL      | MECLOMEN         |
| EFFEXOR         | HYGROTON         | MEDROL           |
| ELAVIL          | HYTRIN           | MELLARIL         |
| ELDEPRYL        | HYZAAR           | MEPERGAN         |
| EMPIRIN-CODEINE | IMDUR            | METHADONE-       |
| ENDEP           | INDERIDE         | HYDROCHLORIDE    |
| ENDURON         | INDOCIN          | METHERGIE        |
| ENTEXLA         | INSULIN          | METHOTREXATE     |
| EQUAGESIC       | INTROPIN         | MEVACOR          |
| EQUANIL         | IONAMIN          | MEXITIL          |
| ERGOMAR         | ISOPTO-CARPINE   | MICRONOR         |
| ESGIC           | ISORDIL          | MIDRIN           |
| ESIDRIX         | ISUPREL          | MILONTIN         |
| ESKALITH        | KEFLEX           | MINIPRESS        |
| ESTRACE         | KEFTAB           | MIRAPEX          |
| ESTRATAB        | KERLONE          | MOBIC            |

## Alternate Causes of the Plaintiff's Headaches

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### DEPOSITION QUESTIONS

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#### General Questions

(continued)

|                  |               |                 |
|------------------|---------------|-----------------|
| MODURETIC        | PAXIL         | RITALIN         |
| MONISTAT         | PAXIPAM       | ROBAXIN         |
| MONOPRIL         | PBZ-SR        | ROBAXISAL       |
| MORPHINE-SULFATE | PEDIAZOLE     | ROCALTROL       |
| MOTRIN           | PEPCID        | RONDEC-DM       |
| MUSE             | PERIACTIN     | RUFEN           |
| NALDECON         | PERMAX        | SANOREX         |
| NALFON           | PERMITIL      | SANSERT         |
| NAPROSYN         | PERSANTINE    | SE-AP-ES        |
| NASACORT         | PHENERGAN-VC- | SECONAL-SODIUM  |
| NASALCROM        | CODEINE       | SELDANE         |
| NASONEX          | PLAQUENIL     | SEPTRA          |
| NEMBUTAL         | PLAVIX        | SERAX           |
| NEO-SYNEPHERINE  | PLENDIL       | SEREVENT        |
| NEURONTIN        | POLARIMINE    | SEROQUEL        |
| NITRO-BID        | PONDIMIN      | SERTRALINE      |
| NITRO-DUR        | PRAVACHOL     | SERZONE         |
| NITROSTAT        | PREMARIN      | SINEMET         |
| NIZORAL          | PREMPHASE     | SINEQUAN        |
| NOLUDAR          | PREMPRO       | SINGULAIR       |
| NOLVADEX         | PRIMAXIN-IV   | SKELAXIN        |
| NORDETTE         | PRINIVIL      | SLO-BID         |
| NORFLEX          | PRINZIDE      | SLO-PHYLLIN     |
| NORGESIC         | PROAMATINE    | SOLU-MEDROL     |
| NORINYL          | PROCARDIA     | SOMA            |
| NOROXIN          | PROLIXIN      | SOMA-COMPOUND   |
| NORPACE          | PROPOFOL      | SONATA          |
| NORPLANT-SYSTEM  | PROPULSID     | SORBITRATE      |
| NORPRAMIN        | PROSOM        | SPORANOX        |
| NORVASC          | PROTONIX      | ST. JOHN'S WORT |
| NUBAIN           | PROVENTIL     | STADOL          |
| OGEN             | PROVERA       | STELAZINE       |
| OMNICEF          | PROVIGIL      | SUDAFED         |
| OPTIMINE         | PROZAC        | SULINDAC        |
| ORAP             | PULMICORT     | SUMYCIN         |
| ORINASE          | PYRIDIUM      | SUPRAX          |
| ORNADE           | QUESTRAN      | SURMONTIL       |
| ORTHO-NOVUM      | QUINAGLUTE    | SYMMETREL       |
| ORTHO-CEPT       | QUINAMM       | TAGAMET         |
| ORTHOCYCLEN      | REDUX         | TALECEN         |
| ORTHOEST         | REGLAN        | TALWIN-NX       |
| ORUDIS           | RELAFEN       | TAPAZOLE        |
| OXYCONTIN        | REMERON       | TAVIST          |
| PAMELOR          | REVIA         | TEGRETOL        |
| PARLODEL         | REZULIN       | TEMARIL         |
| PARNATE          | RIFAMATE      | TENORETIC       |
| PATANOL          | RISPERDAL     | TEQUIN          |

## Alternate Causes of the Plaintiff's Headaches

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### DEPOSITION QUESTIONS

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#### General Questions

(continued)

|                 |            |            |
|-----------------|------------|------------|
| TERAZOL         | TRILAFON   | WELLBUTRIN |
| TESSALON        | TRILEPTAL  | WIGRAINE   |
| TESTODERM       | TRILISATE  | WYGESIC    |
| THEO-DUR        | TRINALIN   | XANAX      |
| THYROID         | TRIPHASIL  | XENICAL    |
| TIAZAC          | TRIVIFLOR  | YOCON      |
| TICLID          | TROVAN     | ZARONTIN   |
| TIGAN           | TUINAL     | ZAROXOLY   |
| TIMENTIN        | TYLENOL PM | ZEBETA     |
| TIMOPTIC        | ULTRAM     | ZEPHREX    |
| TINDAL          | URECHOLINE | ZESTORETIC |
| TOFRANIL        | VALIUM     | ZESTRIL    |
| TOLECTIN        | VANCENASE  | ZITHROMAX  |
| TOLINASE        | VANTIN     | ZOFRAN     |
| TOPROL-XL       | VASOTEC    | ZOLOFT     |
| TORADOL         | VENTOLIN   | ZONEGRAN   |
| TORECAN         | VERELAN    | ZOVIRAX    |
| TRANCOPAL       | VESPRIN    | ZYBAN      |
| TRANSDERM-NITRO | VIAGRA     | ZYLOPRIM   |
| TRANSDERM-SCOP  | VICOPROFEN | ZYPREXA    |
| TRANXENE        | VIVACTIL   | ZYRTEC     |
| TRIAVIL         | VOLTAREN   |            |

## SECTION 7.8: ALTERNATE CAUSES OF THE PLAINTIFF'S SYNCOPE, LOSS OF BALANCE, AND FALLING

**DEFENSE THEORY:** The plaintiff's syncope (fainting), loss of balance, and falling may be caused by factors other than the injury in question. Neurological, medical, psychological and situational conditions can produce a syncopal episode.

### INTRODUCTION

*Syncope* is the phenomenon of loss of consciousness associated with loss of postural tone. The episode is caused by a global impairment of blood flow to the brain. Syncope must be differentiated from seizures, which may manifest similarly but have a different pathophysiology and therapy.

*Loss of balance* is generally associated with disorders of motor function. Unsteadiness of gait is a common symptom. When associated with complaints of dizziness or vertigo, disease of the labyrinth, the vestibular nerve, the brain stem, or the cerebellum is a probable cause.

*Falling* may be the result of neurologic disorders, arthritis, musculoskeletal impairments, poor balance, postural instability, cardiac arrhythmias, generalized weakness, orthostatic hypotension, visual impairments, dementia, medications with sedating properties, and hypertensive medications

# The Plaintiff's Syncope, Loss of Balance, and Falling

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## SYMPTOM

## DEPOSITION QUESTIONS

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### Syncope

#### A. SYNCOPE

The most frequent causes of fainting are vasovagal mechanisms, orthostatic hypotension, cardiac arrhythmias, and vertebrobasil artery insufficiency. (reference 4, p. 141)

**Q: What tests were used to determine if the plaintiff was experiencing syncope or fainting?**

Syncope lasts less than one minute and usually no longer than fifteen seconds. Tests for degrees of unconsciousness are imprecise, but include:

Stuporous: The plaintiff responds to vigorous and frequent verbal or noxious stimuli.

Semicomatose: The plaintiff responds to only pain.

Comatose: The plaintiff responds only to deep stimuli or does not respond at all.

---

**Q: Describe the characteristics of the plaintiff's fainting.**

---

**Q: When and how often does the plaintiff faint?**

An overwhelming emotional trauma may cause the plaintiff to faint. This is an extreme example of providing a barrier against the traumatic stimuli. (reference 4, pp. 1322, 573)

---

**Q: How long has the plaintiff experienced episodes of fainting?**

---

**Q: Is the plaintiff experiencing anxiety?**

---

**Q: Did you rule out *other life stressors* as a cause of the plaintiff's fainting?**

*If the witness indicates the possibility of a life stressor or other condition, see the section on Other Life Stressors for further questions.*

---

**Q: Does the plaintiff have a *history of fainting* before the injury in question?**

---

**Q: Did you rule out a *loss of sodium* as a cause of the plaintiff's fainting?**  
(reference 4, p. 141)

---

**Q: Did you rule out any *change in intrathoracic pressure* as a cause of the plaintiff's fainting?**

The plaintiff may faint when there is a change in intrathoracic pressure from coughing (tussive syncope), valsalva maneuver, positive pressure breathing, a pulmonary embolism, or pneumonia. (reference 4, p. 141)

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# The Plaintiff's Syncope, Loss of Balance, and Falling

---

## SYMPTOM

## DEPOSITION QUESTIONS

---

### Syncope

(continued)

**Q: Did you rule out a *conversion disorder* as a cause of the plaintiff's fainting?**

A conversion disorder is characterized by the presence of symptoms or deficits affecting voluntary **motor or sensory function** that suggest a neurological or other general medical condition. Psychological factors are judged to be associated with the symptom or deficit and the symptoms are not intentionally feigned or produced. Conversion symptoms are defense mechanisms that change the unconscious emotional conflict into a physical disability that often symbolizes the nature of the conflict. (reference 12, p. 315; reference 2, pp. 625, 630; reference 7, pp. 492-498) **Fainting may be due to an emotionally charged encounter of unconscious significance.** (reference 4, p. 1322)

*If the witness indicates the possibility of a conversion disorder, see the section on pre-existing mental disorders and section 8.4 for further questions.*

---

**Q: Did you rule out an *hysterical faint* as a cause of the plaintiff's fainting?**

The hysterical faint is a dramatic event. The plaintiff may gracefully sink to the ground and usually not suffer any physical injury. Physical signs remain unchanged. Skin color and EEG are normal. (reference 4, p. 1160)

---

**Q: Did you rule out *hyperventilation* as a cause of the plaintiff's fainting?**

Hyperventilation is abnormal, rapid, deep breathing usually due to anxiety. Exercise and strong emotion causes hyperventilation or it can begin spontaneously. Symptoms may include lightheadedness, **faintness**, ringing in ears, weakness, blurring of vision, and tingling around the mouth or in the extremities. (reference 2, p. 613)

---

**Q: Did you rule out *abdominal epilepsy* as a cause of the plaintiff's fainting?**

Sudden attacks of abdominal pain, transient confusion, **syncope**, headaches, and EEG seizure patterns are the result of abdominal epilepsy. (reference 4, p. 570)

---

**Q: Did you rule out *ecstasy use* as a cause for the plaintiff's fainting or feeling faint?**

MDMA use can sometimes result in severe dehydration or exhaustion, or other adverse effects such as nausea, hallucinations, chills, sweating, increases in body temperature, tremors, involuntary teeth clenching, muscle cramping, and blurred vision. MDMA users have also reported after-effects such as anxiety, paranoia, and depression. An MDMA overdose is characterized by high blood pressure, **faintness**, panic attacks, and, in more severe cases, **loss of consciousness**, seizures, and a drastic rise in body temperatures to 105-106 degrees Fahrenheit. MDMA overdoses can be fatal, as they may result in heart failure or extreme heat stroke. (reference 20)

---

**Q: Did you rule out *vasodepressor or vasovagal attacks* as a cause of the plaintiff's fainting?** (reference 4, p. 1160)

---

# The Plaintiff's Syncope, Loss of Balance, and Falling

---

## SYMPTOM

## DEPOSITION QUESTIONS

---

### Syncope

(continued)

**Q: Did you rule out *anemia* as a cause of the plaintiff's fainting?**

Vertigo, pounding headaches, **fainting**, dimness of vision, tinnitus (a ringing in one or both ears), irritability, restlessness, inability to concentrate, lethargy, fatigue, drowsiness, and GI complaints are common symptoms of anemia. (reference 2, pp. 566-571)

*If the witness indicates the possibility of anemia, see the section on pre-existing medical conditions for further questions.*

---

**Q: Did you rule out *mitral valve prolapse* as a cause if the plaintiff's fainting?**

Mitral valve prolapse (MVP) is a common and sometimes serious congenital ballooning of a heart valve often associated with arrhythmias of the heart. MVP and panic attacks share many common symptoms including chest pain, palpitation, dyspnea, weakness, fatigue, dizziness, **syncope**, and anxiety. (reference 4, pp. 1149, 1551)

*If the witness indicates the possibility of mitral valve prolapse, see the section on pre-existing medical conditions for further questions.*

---

**Q: Did your rule out *undetected myocardial infarction* as a cause of the plaintiff's fainting?**

Myocardial infarction is an area of dead heart muscle tissue caused by an inadequate blood flow. The blood supply to the heart may be reduced by an obstruction or constriction of the arteries, heart valve disease, heart failure, or other mechanical disturbances. Symptoms may include **syncope**. (reference 1, pp. 494-497; reference 2, pp. 151, 371; reference 4, p. 141)

*If the witness indicates the possibility of myocardial infarction, see the section on pre-existing medical conditions for further questions.*

---

**Q: Did you rule out *orthostatic hypotension* as a cause of the plaintiff's fainting or loss of balance?**

Orthostatic hypotension may cause the plaintiff to faint. The disorder may be caused by:

Adrenal insufficiency

Diabetes mellitus

Drugs

Exhaustion

Idiopathic autonomic disease

Malnutrition

Metabolic encephalopathy

Postsympathectomy

Pregnancy

Prolonged bed rest

Prolonged standing

Rapid shift of body position

---

# The Plaintiff's Syncope, Loss of Balance, and Falling

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## SYMPTOM

## DEPOSITION QUESTIONS

---

### Syncope

(continued)

**Q: Does the plaintiff have any *other medical conditions* that may cause fainting or falling, such as:**

|   |                                      |
|---|--------------------------------------|
| Adams-Stokes syndrome                         | Medication-induced fainting          |
| Atrial myxoma                                 | Narcolepsy                           |
| Bradycardia or heart block                    | Paroxysmal cardiac arrhythmias       |
| Cardiac causes of heart failure               | Severe vertigo                       |
| Cardiovascular disease                        | Small cerebral infarct or hemorrhage |
| Carotid sinus reflex (direct cerebral effect) | Subarachnoid hemorrhage              |
| Gait disorders                                | Tachycardia (atrial or ventricular)  |
| Hypertensive encephalopathy                   | Transient ischemic attack            |
| Hypovolemia                                   | Valvular disease                     |
| Hypoxia                                       |                                      |

---

**Q: Is the plaintiff taking any *medications with anticholinergic properties*?**

Orthostatic hypotension with syncope may be experienced by plaintiff's on anticholinergic medication. (reference 4, p. 1322)

---

**Q: Is the plaintiff taking any *medications or substances* that may cause fainting, such as *vasodilator drugs*?**

Other drugs which may cause fainting:

|            |              |                  |
|------------|--------------|------------------|
| ACCUPRIL   | CLARITIN     | FLOXIN           |
| ADALAT     | CLINDEX      | HYZAAR           |
| ADRENALINE | CLINORIL     | IMDUR            |
| ALTACE     | CLOMID       | INDOCIN          |
| AMBIEN     | CLOZARIL     | KERLONE          |
| AMERGE     | COGNEX       | LAMICTAL         |
| AMYTAL     | COZAAR       | LEVAQUIN         |
| ANAFRANIL  | CRINONE      | LIBRIUM          |
| ANTABUSE   | CYTOTEC      | LIMBITROL        |
| ARICEPT    | DEMEROL      | LIORESAL         |
| ARTHROTEC  | DEPROL       | LIPITOR          |
| ASENDIN    | DESYREL      | LODINE           |
| AVAPRO     | DIOVAN       | LOTENSIN         |
| AVONEX     | DIPYRIDAMOLE | LUDIOMIL         |
| BRONTEX    | DOLOBID      | LUVOX            |
| BUTICAPS   | DURACT       | MARCAINE         |
| CARBATROL  | DURAGESIC    | MAVIK            |
| CARDENE    | DYNACIRC     | MAXAIR-AUTOHALER |
| CARDIZEM   | EFFEXOR      | MAXALT           |
| CARDURA    | ELDEPRYL     | MEBARAL          |
| CELEBREX   | EQUAGESIC    | MEPERGAN         |
| CELEXA     | EQUANIL      | METHADONE-       |
| CENTRAX    | EXCELON      | HYDROCHLORIDE    |
| CIPRO      | FLEXERIL     | MEXITIL          |
| CLARITAN-D | FLOMAX       | MINIPRESS        |

## The Plaintiff's Syncope, Loss of Balance, and Falling

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### *SYMPTOM*

### *DEPOSITION QUESTIONS*

---

#### **Syncope**

*(continued)*

|                  |               |            |
|------------------|---------------|------------|
| MIRAPEX          | PRINZIDE      | THIAZAC    |
| MONOPRIL         | PROCARDIA     | TIMOPTIC   |
| MORPHINE-SULFATE | PROKETAZINE   | TOPAMAX    |
| MUSE             | PROSOM        | TOPROL-XL  |
| NAVANE           | PROTONIX      | TRANDATE   |
| NEMBUTAL         | PROVIGIL      | TRILEPTAL  |
| NEURONTIN        | PROZAC        | TROVAN     |
| NOLUDAR          | PULMICORT     | ULTRAM     |
| NORFLEX          | QUESTRAN      | VALIUM     |
| NORGESIC         | QUINAGLUTE    | VANTIN     |
| NORPACE          | QUINAMM       | VASOTEC    |
| NORVASC          | REMERON       | VERELAN    |
| OXYCONTIN        | ROBAXIN       | VIAGRA     |
| PARLODEL         | SE-AP-ES      | VIOXX      |
| PAXIL            | SERAX         | WELLBUTRIN |
| PAXIPAM          | SOMA          | XANAX      |
| PERMAX           | SOMA-COMPOUND | ZANAFLEX   |
| PERSANTINE       | SONATA        | ZAROXOLY   |
| PHENERGAN-VC-    | SULAR         | ZESTORETIC |
| CODEINE          | SULINDAC      | ZESTRIL    |
| PHENOBARBITAL    | TALECEN       | ZIAC       |
| PLACIDYL         | TALWIN-NX     | ZONEGRAN   |
| PLAVIX           | TEGRETOL      | ZYBAN      |
| PLENDIL          | TEMARIL       | ZYRTEC     |
| PREVACID         | TENORETIC     |            |

# The Plaintiff's Syncope, Loss of Balance, and Falling

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## SYMPTOM

## DEPOSITION QUESTIONS

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### Loss of Balance

#### B. LOSS OF BALANCE

Loss of balance includes a sense of movement or disturbance of equilibrium, such as imbalance, unsteadiness, or vertigo.

Defense counsel should note that the loss of balance may be described as dizziness or vertigo. It is common for plaintiffs to use the term dizziness for faintness.

Defense counsel should determine the exact meaning of the words used by the plaintiff to describe his or her symptoms.

**Q: What tests were used to determine the cause of the plaintiff's loss of balance?**

The angiogram may reveal abnormalities that may cause a loss of balance. (reference 4, p. 140)

Other tests include:

Audiometry

Electronystagmography

Caloric test

Radiograph of the skull

---

**Q: Describe the characteristics of the plaintiff's loss of balance.**

---

**Q: When and how often does the plaintiff lose balance?**

---

**Q: How long has the plaintiff experienced a loss of balance?**

---

**Q: Does the plaintiff have a *history of dizziness or ear disease* before the injury in question?**

---

**Q: Did you rule out a *labyrinthine disease or labyrinthitis* as a cause of the plaintiff's loss of balance?**

*Labyrinthine diseases* of the internal ear or obstructions in the external or middle chambers of the ear often cause **dizziness and loss of balance**. *Labyrinthitis* is characterized by sudden episodes of **dizziness or vertigo** that last for minutes or hours. Infections, allergies, vascular disease, trauma, tumor, drugs, and toxins may cause the dysfunction of the labyrinth. Attacks recur with decreasing frequency and severity over a few days or weeks. (reference 4, p. 140)

---

**Q: Does the plaintiff have a history of *central nervous system (CNS) disease* before the injury in question?**

---

**Q: Did you rule out the *onset of a central nervous system (CNS) disease* as a cause of the plaintiff's loss of balance?** (reference 4, p. 140)

---

# The Plaintiff's Syncope, Loss of Balance, and Falling

---

## SYMPTOM

## DEPOSITION QUESTIONS

---

### Loss of Balance

(continued)

**Q: Did you rule out hypoglycemia as a cause of the plaintiff's loss of balance?**

Hypoglycemia is an abnormally low blood sugar level. It often produces personality changes, confusion, **dizziness**, tremor, anxiety, tachycardia, and sweating during acute attacks. Hypoglycemia can develop from an insulin overdose, insulinoma or islet cell tumor, extensive liver disease, or functional diseases. (reference 2, p. 702; reference 4, pp. 1176-1177)

*If the witness indicates the possibility of hypoglycemia, see the section on pre-existing medical conditions for further questions.*

---

**Q: Did you rule out a brain tumor as a cause of the plaintiff's loss of balance?**

Brain tumors may occur in the skull, brain, or membrane covering the brain or spinal cord. Symptoms vary depending on the size of the tumor and rate of growth. The plaintiff may experience anxiety, dementia, irritability, **dizziness**, fatigue, headache, vomiting, hyperthermia (high body temperature), and changes in appetite and personality. (reference 4, pp. 139, 834-835, 855, 860, 1276; reference 9, pp. 2161-2164; reference 1, pp. 1351, 1296)

*If the witness indicates the possibility of a brain tumor, see the section on pre-existing medical conditions for further questions.*

---

**Q: Did you rule out menopausal distress as a cause of the plaintiff's loss of balance?**

Menopause occurs after a years absence of the menstrual cycle. The plaintiff may have few physical or psychological complaints. However, symptoms, such as **dizziness**, can be severe and last for months or years. The severity of symptoms appears to be related to the rate of hormone withdrawal, amount of hormone depletion, the physical ability to withstand the aging process, overall health and level of activity, sociocultural background, and current adaption to aging and role changes. (reference 4, pp. 1173-1174; reference 2, pp. 610-611; reference 1, pp. 1680-1681)

*If the witness indicates the possibility of menopausal distress, see the section on pre-existing medical conditions for further questions.*

---

**Q: Did you rule out hypertension as a cause of the plaintiff's loss of balance?**

Hypertension (high blood pressure) has been associated with emotional and physical stress, personality type, diet, obesity, alcohol, life changes, traumatic events, social conditions, and environmental variables. Most symptoms such as **dizziness**, are the result of prolonged high blood pressure. (reference 4, pp. 1118, 139, 1136, 1153-1154, 859; reference 1, pp. 391-392, 192)

*If the witness indicates the possibility of hypertension, see the section on pre-existing medical conditions for further questions.*

---

# The Plaintiff's Syncope, Loss of Balance, and Falling

---

## SYMPTOM

## DEPOSITION QUESTIONS

---

### Loss of Balance

(continued)

**Q: Did you rule out *early onset of Parkinson's disease* as a cause of the plaintiff's loss of balance?**

Parkinson's disease has characteristic symptoms of tremor, unsteadiness, or bradykinesia (slowness and poverty of movement). **Changed gait, posture**, and facial expression appear as the disease progresses. Plaintiffs often experience personality changes, depression, and dementia. Disability usually occurs ten to fifteen years after disease onset. (reference 4, pp. 118-119, 147; reference 9, pp. 2070-2071; reference 1, pp. 1359-1360)

*If the witness indicates the possibility of Parkinson's disease, see the section on pre-existing medical conditions for further questions.*

---

**Q: Did you rule out *early onset of multiple sclerosis* as a cause of the plaintiff's loss of balance?**

Multiple sclerosis is a common disease of young adults. The disease causes a disorder of the optic nerves, spinal cord, and brain. Symptoms may include depression, apathy, lack of judgement, inattention, tremor, **vertigo, incoordination**, weakness, fatigue, dysarthria (speech impairment), and urinary frequency or hesitancy. (reference 4, p. 1276; reference 1, pp. 1354-1356)

*If the witness indicates the possibility of multiple sclerosis, see the section on pre-existing medical conditions for further questions.*

---

**Q: Does the plaintiff have any *other medical conditions* that may cause loss of balance, such as:**

|  |                     |
|--|---------------------|
| Allergies  | Hypocalcemia        |
| Diseases of the cerebellum or cerebrum             | Hypothyroidism      |
| Diseases of the eighth cranial nerve or brain stem | Meniere's disease   |
| Hematological disease                              | Pellagra            |
| Hyperadrenalism                                    | Systemic infections |
| Hypoadrenalism                                     | Toxic reactions     |

---

**Q: Is the plaintiff taking any *medications* that may cause vertigo or dizziness?**

Almost every medication on the market has the potential to cause **dizziness or vertigo**. Dizziness and vertigo, along with headaches, are the most frequently reported side-effects of prescription medication. Discovery of plaintiff's medication since the cause of action is essential. The Physician's Desk Reference (PDR) will provide the adverse effects for each medication prescribed to the plaintiff.



## SECTION 7.9: ELECTRICAL INJURY CLAIMS

**DEFENSE THEORY:** The extent of electrical injury is proportional to current, voltage, duration of exposure, location or focus of injury, cellular architecture, and whether the electricity is alternating or direct current. Defense counsel should look for clear evidence of these injury factors, especially when there is a claim of organic brain syndrome.

### INTRODUCTION

The more common cause of electrical injury, alternating current (AC), is more dangerous than direct current (DC) because it can produce tonic muscle contractions and the plaintiff may be unable to release the source of electricity. Cardiac arrest and coma frequently accompany electrocution with alternating current, and these events are most likely to occur at current frequencies of 50 to 60 cycles per second. As frequency increases over 60 cycles per second, tissue damage and the risk of cardiac arrest decrease.

Electricity causes injury by four mechanisms:

- (1) **direct contact** (low-voltage electrical sources produce direct injury at the point of contact. Skin and subcutaneous tissue are most commonly involved)
- (2) **conduction** (high-voltage current causes direct injury at point of contact and causes damage to tissues that conduct the current through the body)
- (3) **arc** (arc burns occur without the source of electricity actually contacting the body surface. Very high voltage is required to produce a charge transfer and extremely high temperatures are produced.)
- (4) **secondary ignition** (burns occur when the electrical source ignites clothing and other flammable materials)

The intensity of electrical flow through the tissues is a function of voltage, resistance of the tissues, and diffusion of the current. The pathway that the current takes is critical; electrical energy disrupts normal neural impulses. Thus, if it should enter the top of the head, the flow of current through the brain may disrupt the normal cardiac and respiratory impulses from the medulla (the mechanism of death in electrocution). An equally strong current entering the lower part of the body and exiting through the foot might induce injury to tissues but not death. If critical neural pathways are not interrupted, the electrical energy may cause damage by generating heat. The current will disperse across the cross-sectional areas through which it flows. Hence in general, the trunk sustains less heat damage than the extremities, which have smaller cross-sectional areas. (reference 23, pp. 68-70)

# Electrical Injury Claims

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## *Challenging the Plaintiff's Diagnosis of Electrical Injury*

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Electric current can damage an individual in three ways:

- (1) by thermal heating of the tissues;
- (2) by deregulating autonomously functioning organ systems, such as the circulatory and respiratory systems;
- (3) by one-time or continuing stimulation of the nerves and striated muscles

In the first case, the result is coagulation necrosis, and in the second case, life-threatening events can occur such as arrhythmia or apnea. In the third case, vigorous nerve stimulation can lead to paralysis and vasospasm. Massive muscle contractions due to nerve stimulation or the direct triggering of striated muscles can cause ruptures, ligamentous tears, fractures and joint dislocations, while prolonged current passing through the thoracic wall may stimulate tetany of the intercostal muscles and diaphragm resulting in asphyxia.

The sequelae of electrical injuries may encompass a full range of symptoms that can vary from insignificant, brief, or mild after-effects, to progressively more severe levels of dysfunction and debilitation. Even though the intensity of dysfunction and magnitude of impairment associated with such injuries may vary dramatically from one victim to another, the resulting symptomology, particularly in its more severe versions, appears to reflect multiple common factors that may collectively be termed Post Electrocutation Syndrome. For instance, progressive neural deterioration is not uncommon in these cases. However, neural deterioration is confined to the pathway that the electrical current took through the body and if the current did not go through the brain, it is unlikely that there will be brain damage.

Brain injury may occur from the direct effects of the electricity on the brain or from secondary injury from the anoxia that may accompany cardiac arrest. Thus, even if the electrical current did not go through the brain, if the cardiovascular system was affected, a lack of oxygen to the brain may occur.

Neurological complications are common sequelae to electrocution and can affect the entire nervous system: brain, spinal cord, and peripheral nerves. Immediate changes may include varying levels of unconsciousness and respiratory or motor paralysis. These changes are usually *transient*. Permanent changes may include cortical encephalopathy (due to hypoxia at the time of the accident), a stroke-like picture, or a striatal syndrome. All of these may develop immediately or within several months after the insult.

Analysis of the medical records is essential to determine the path of the electricity. Often there is no evidence that the electricity passed through the brain or that the plaintiff suffered a loss of consciousness. In these cases, reduced respiration is required to produce the cognitive impairments or other dysfunction often claimed by a plaintiff that sustained an electrical injury.

There are a number of other variables that should be taken into consideration in electrical injury cases. The variables include the age and size of the person, the amount and type of electricity, and environmental conductivity factors including skin moisture and clothing. Current with a potential of 440V or more is considered high voltage, and voltages of 1000V or more may cause massive tissue destruction (and is usually accompanied by entry and exit wounds). (reference 39, pp. 64-65)

# Electrical Injury Claims

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## DEPOSITION QUESTIONS

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### General Questions

**Q: Have you examined or treated other patients who have had electrical injuries?**

**Q: Have you examined or treated patients who have had electrical injuries similar to the plaintiff's (i.e. similar voltage, similar entrance and exit wounds not involving the brain)?**

**Q: Please describe the presumed path of the electricity through the plaintiff.**

The pathway of current through the body determines the nature of the injury. Current traveling from arm to arm or between an arm and a foot is likely to traverse the heart and is more dangerous than current traveling between a leg and the ground. (reference 45, p. 2441)

Lightning flashes over the person, producing little internal tissue damage, but may result in electrical short-circuiting of systems (cardiovascular, respiratory, ect.).

**Q: Did the plaintiff lose consciousness?**

**Q: Did the plaintiff stop breathing?**

**Q: What was the amount and type of voltage experienced by the plaintiff?**

AC (alternating current) is more dangerous than DC (direct current) and the higher the voltage and amperage the greater the likelihood of damage from either type of current. Low-voltage is 110-220 V, and may cause freezing to the circuit. High-voltage, 500-1000 V currents tend to cause deep burns. (reference 45, p. 2441)

**TABLE 7.9-1.**

|  | <b>Direct Current</b>  | <b>Alternating Current</b>      |
|--|------------------------|---------------------------------|
| <i>Threshold for perception of current entering the hand</i> | 5-10 milliamperes (mA) | 1-10 mA at 60 Hz                |
| <i>The let-go current</i>                                    | 75 mA for a 70-kg man  | 15 mA, varying with muscle mass |
| <i>Ventricular fibrillation</i>                              | 300-500 mA             | 60-100 mA at 60 Hz              |

**Q: Was there an entry wound? An exit wound?**

This information is critical in cases of electrical injury because once the entrance wound and exit wound are identified, the destructive path of the electrical burn can be traced. There usually are defined contact wounds, and all tissue in a direct path between them is at risk for thermal injury. The most common entry point is the hand, followed by the head. The most common exit point is the foot. With AC, the site of the entry and exit points cannot be determined. More appropriate terms are "source" and "ground." (reference 45, p. 2441)

Lightning rarely, if ever, produces entry and exit wounds. (reference 45, p. 2442)

# Electrical Injury Claims

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## DEPOSITION QUESTIONS

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### General Questions

(continued)

**Q: Do any objective tests (i.e. MRI, EEG, etc.) identify any neural degeneration, injury, or seizures?**

**Q: Was a baseline assessment conducted in the emergency room or in the initial treating physician's office?**

A baseline assessment in electrical injury cases should include an ECG, cardiac enzymes, a CBC, and urinalysis, especially for myoglobin (a red iron-containing protein pigment in muscles that is similar to hemoglobin). Cardiac monitoring for 12 hours is indicated if there is a suggestion of cardiac damage, arrhythmias, or chest pain. If a loss of consciousness is being claimed, the results of a CT scan or MRI should be available for review. These scans would have been conducted to rule out the possibility of intracranial hemorrhage. (reference 45, pp. 2442-2443)

**Q: Was there any evidence of tissue damage?**

Electric current can damage an individual by thermal heating of the tissues. The result is coagulation necrosis or death of the tissues. Generally, the duration of current flow through the body is directly proportional to the extent of injury because longer exposure breaks tissues down, allowing internal current flow. The current flow produces heat, damaging internal tissues. (reference 45, p. 2441)

**Q: Was there any evidence of cardiac involvement?**

There have been fatal electrical injury cases involving voltage as low as 50 to 60V (probably the result of arrhythmias). One study concluded that initial cardiac evaluation (EKG) and monitoring do not appear to be necessary in persons sustaining household electrical injuries (120 and 240V). Even in the case of high-voltage, significant cardiac complications among immediate survivors of high-voltage electrical injuries are less common than previously suspected. Instead, **transient** arrhythmias predominate.

**Q: Was there any evidence of paralysis?**

Electrical injuries of the extremities may cause paralysis, muscle atrophy, sensory deficit, causalgia, and reflex sympathetic dystrophy (RSD). Limb dystonia has rarely been reported following electrical injury to an extremity, although it may result from cerebral hemisphere electrical trauma.

Neuromuscular tests (EMG/NCS) conducted by a neurologist can determine if the plaintiff's claims of sensory dysfunction such as burning pain, muscle problems, pain, paralysis or other symptoms are related to the electrical injury.

**Q: Was there any evidence of intracranial damage?**

Actual passage of electrical current through the brain causes inflammatory changes in the blood vessels of the meninges and brain tissue. Subarachnoid hemorrhage or thrombosis of blood vessels and infarction would generally follow.

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# Electrical Injury Claims

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## DEPOSITION QUESTIONS

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### General Questions

*(continued)*

**Q: Has the plaintiff experienced any delayed symptoms? Please describe them.**

Progressive disorders may begin after electrical injury and resemble one or another of several syndromes such as Parkinsonism, cerebellar disorders, myelopathy, spinal muscular atrophy, or sensorimotor peripheral neuropathy. (reference 46, p. 463)

The most commonly reported long-term sequelae in lightning strikes are pain syndromes, neuropsychologic damage and sympathetic nervous system damage. Some form of amnesia generally results. (reference 45, p. 2442)

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**Q: Could any of the plaintiff's *physical symptoms* be due to the coincidental occurrence of a non-proximate condition?**

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**Q: Could any of the plaintiff's *psychological symptoms* be due to a pre-existing condition?**

Elements of mood disorders (depression) or anxiety disorders (PTSD) have been reported following electrical injury cases. Frequently, the plaintiff has a pre-existing mood or anxiety disorder that may account for their current symptomatology.

*Refer to Chapter 6 for a list of symptoms associated with a pre-existing mental disorder, personality disorder or medical illness.*



## SECTION 7.10: SELECTED TOXIC EXPOSURE CLAIMS: CARBON MONOXIDE AND TOXIC MOLD

**DEFENSE THEORY:** Many plaintiffs claiming neurologic and psychologic symptoms as a result of a toxic exposure have a prior history which may include: head trauma, drug and substance abuse, prior occupational / environmental toxic exposures, and medical or psychiatric illness. A thorough discovery of the plaintiff's history is essential in these cases.

**DEFENSE THEORY:** Plaintiff's experts often use questionnaires known as toxic screening reviews, examinations or surveys. Many of these instruments are poorly constructed and poorly validated. They are normed on small populations that do not relate to toxic injury plaintiffs and they would not withstand a scientific (Daubert or Frye) challenge. These toxic questionnaires are given to class-action and individual plaintiffs and should raise a red flag for defense counsel.

### INTRODUCTION

Plaintiffs seeking to prove a toxic case must establish both *general* and *specific* causation. *General causation* is the demonstration that a given toxic substance, in the particular location and for a particular duration, can cause the type of illness or injuries alleged. *Specific causation* requires proof that the toxic chemical actually *did* cause the alleged injuries. Establishing either type of causation requires expert testimony, which is subject to exclusion or limitation under the Daubert case, and comparable rules in state courts that still follow the *Frye* line of cases. (Defense counsel is referred to the journal, *For The Defense*, September & October, 2002 issues for the articles by Sheldon Margulies on Specific and General Causation. *For The Defense* is a publication of The Defense Research Institute, Chicago).

Toxic exposure claims are relatively rare, but when they do occur, the nature of the claims require a thorough investigation into the mechanism of injury, the symptoms, and the alleged sequelae. As with electrical injury claims, cases of toxic exposure are difficult and often mismanaged by physicians with no expertise in the area. The following information and questions will focus on carbon monoxide poisoning, the most common claim of toxic (hypoxic) injury, and toxic mold.

# Toxic Exposure Claims

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## Challenging the Plaintiff's Diagnosis of Toxic Exposure

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### Carbon Monoxide

### Carbon Monoxide Introduction

#### I. Current Scientific Information

##### A. General Information

Carbon monoxide (CO) toxicity results from impaired oxygen delivery and utilization, which leads to cellular hypoxia. Areas of poorly developed anastomotic vessels and high metabolic activity (e.g., brain, heart) are particularly susceptible. Carbon monoxide affects several different sites within the body, but the exact contribution of each pathophysiologic effect remains unclear.

The lungs rapidly absorb carbon monoxide, which avidly combines with hemoglobin at 230 to 270 times greater affinity than oxygen. Elimination occurs exclusively through the lungs; the half-life of carboxyhemoglobin (COHb) in room air is 3 to 4 hours depending on minute ventilation. Administration of 100% oxygen shortens the half-life to 30 to 40 minutes. Hyperbaric oxygen (100% oxygen at 2.5 atm) further reduces the half-life to as little as 15 to 20 minutes. About 85% of absorbed CO combines with hemoglobin; the remainder attaches to myoglobin and blood proteins. For average, sedentary, nonsmoking workers maximum allowable exposures (200ppm) produce 0.18 mg/100 mL in blood and carboxyhemoglobin levels of 6.8%.

Perceptible clinical effects occur with a 20-hour exposure to concentrations as low as 0.01% (100 ppm). Carbon monoxide toxicity is increased by numerous factors, including decreased barometric pressure (e.g., high altitude), increased alveolar ventilation (e.g., activity, high metabolic rate) (e.g., children, pets, birds), preexisting cardiovascular and cerebrovascular disease, reduced cardiac output, increased affinity of hemoglobin for CO, anemia, hypovolemia, pulmonary carbon monoxide diffusing capacity, and increased rate of endogenous CO production. (reference 25, pp. 1465-1470)

**TABLE 7.10-1.**

#### Neurologic Signs and Symptoms in CO Exposure:

| <b>Acute exposure</b> | <b>Chronic exposure</b>    |
|-----------------------|----------------------------|
| weakness              | severe headache            |
| fatigue               | nausea                     |
| amnesia               | vomiting                   |
| apathy                | abdominal pain             |
| impulsiveness         | weakness                   |
| distractibility       | fatigue                    |
| incontinence          | intellectual deterioration |
| abnormal reflexes     | dizziness                  |
| abnormal motor exam   | paresthesias               |
| cerebellar findings   | changes in vision          |

# Toxic Exposure Claims

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## DISORDER

## DEPOSITION QUESTIONS

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### Carbon Monoxide *(continued)*

**Q: Have you worked with other patients who have had some type of toxic exposure?**

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**Q: Have you worked with other patients who have had toxic exposure similar to the plaintiff's (i.e. similar substance and severity of exposure)?**

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**Q: Please describe the mechanism of exposure (furnace, occupational exposure, etc.).**

---

**Q: Did the plaintiff lose consciousness?**

If the plaintiff lost consciousness, they may have relapses for several weeks and continue to suffer from headaches, fatigue, loss of memory, difficulty thinking, irrational behavior, and irritability.

---

**Q: Did the plaintiff stop breathing?**

---

**Q: Are there any factors which may increase susceptibility to toxicity?**

Carbon monoxide toxicity is increased by numerous factors, including decreased barometric pressure (e.g., high altitude), increased alveolar ventilation (e.g., activity, high metabolic rate possibly found in children, pets, birds, etc.), preexisting cardiovascular and cerebral vascular disease, reduced cardiac output, increased affinity of hemoglobin for CO, anemia, hypovolemia, pulmonary carbon monoxide diffusing capacity, and increased rate of endogenous CO production. (reference 25, pp. 1465-1470)

---

**Q: How long was the plaintiff exposed to the substance?**

**The time of exposure, the concentration of CO, the activity level of the person breathing the CO, and the person's age, sex, and general health all affect the danger level.** For instance, a concentration of 800 ppm will cause headaches after one hour, but can lead to unconsciousness and death in 2 to 3 hours.

---

**Q: What was the level of exposure?**

Maximum allowable exposure is about 200 ppm, but perceptible clinical effects occur with a 20-hour exposure to concentrations as low as 0.01% (100 ppm). (reference 25, pp. 1465-1470)

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# Toxic Exposure Claims

DISORDER

DEPOSITION QUESTIONS

---

## Carbon Monoxide

(continued)

**Q: What are the severities of the poisoning in this case?**

(reference 25, pp. 1465-1470)

**Mild poisoning:**

- COHb levels less than 30 percent
- No signs or symptoms of impaired cardiovascular or neurologic function
- May complain of headache, nausea or vomiting
- Admission of patients with COHb levels greater than 25%

**Moderate poisoning:**

- COHb levels from 30 to 40 percent
- No signs or symptoms of impaired cardiovascular or neurologic function
- Cardiovascular status should be followed closely even in absence of clear cardiac effects, especially in those patients with underlying heart disease.

**Severe poisoning:**

- COHb levels greater than 40 percent or cardiovascular or neurologic functional impairment at any COHB
  - Cardiovascular functioning monitoring
  - Transport to a hyperbaric oxygen facility
- 

**Q: Did the level of exposure exceed the industrial exposure limits?**

The TLV (threshold limit value) is 35 ppm for an 8-hour workday on a time-weighted average. This level allows for a maximum COHb level of 5% during an 8-hour period assuming normal activity. This TLV is based on an alveolar ventilation of 6L/min and a CO diffusing capacity of 30mL/min/kg. The ceiling concentration to which a worker may be transiently exposed without altering COHb level is 200 ppm. This short-term exposure limit (STEL) implies that a worker would be asymptomatic 15 minutes after cessation of exposure. (reference 25, pp. 1465-1470)

---

**Q: How much exposure to carbon monoxide is dangerous?**

At very high concentrations, carbon monoxide kills in less than five minutes. At very low concentrations, the effects of carbon monoxide may take years to affect the body. The U.S. Occupational Health and Safety limit is 50 parts per million (ppm) for our eight hour averaging time (maximum allowable exposure is much higher). **Carbon monoxide detectors are required to sound an alarm when concentrations are greater than 100 ppm.**

---

**Q: Were the plaintiff's presenting symptoms characteristic of acute carbon monoxide exposure?**

Patients presenting with acute poisoning may display weakness, fatigue, and "amnesic confabulatory state," apathy, impulsiveness, and distractibility. There may be fecal and urinary incontinence. There are often abnormal motor, sensory, and cerebellar findings, including abnormal reflexes. Three percent of those acutely poisoned develop permanent sequelae, including mental deterioration (98%), urinary and fecal incontinence (88%), and gait disturbance (81%). (reference 25, pp. 1465-1470)

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# Toxic Exposure Claims

DISORDER

DEPOSITION QUESTIONS

## Carbon Monoxide

(continued)

**Q: Were the plaintiff's symptoms characteristic of chronic carbon monoxide exposure?**

Chronically poisoned patients typically present with combinations of the following: severe headache, nausea, vomiting, and abdominal pain; weakness and fatigue; insidious intellectual deterioration with decreased cognitive functioning and difficulties thinking, especially at work; dizziness; paresthesias; and changes in vision. In the active stage of poisoning, they may have hypertension, hyperthermia, and cherry skin. One may find homonymous hemianopsia, papilledema, scotoma, and flame-shaped retinal hemorrhages. Red and white blood cell levels may be elevated. Urine is often positive for albumin and glucose. With the resultant decrease of oxygen, patients may complain of new-onset or worsened angina, palpitations, intermittent claudication, and symptoms of COPD. ST depression may be seen on ECG. (reference 25, pp. 1465-1470)

**WARNING:** Forty-three percent of people who suffer chronic poisoning have neurologic sequelae at 3-year follow-up. Of these, about 40% have memory impairment, including amnesic confabulatory states, and retro- and anterograde amnesias. Many have cerebral, cerebellar, and midbrain damage evidenced in findings of akinetic movements, agnosia, apraxia, rigidity, and brisk reflexes. Thirty-three percent have personality changes usually including lethargy, apathy, and fatigue. They may show irritability, verbal aggression, violence, impulsiveness, moodiness, "affective incontinence," severe attention deficits, distractibility, and sexual outbursts. Eleven percent suffer gross neuropsychologic damage. Some persons are psychotic, disoriented, and blind. They may have vestibular dysfunction with poor hearing.

**Q: Are there any diagnostic tests confirming permanent damage?**

Abnormal *EEG* findings are common (diffuse slow waves, low voltage) and parallel the progression of an hypoxic encephalopathy. The predictive value of the EEG is questionable, since a patient with a critically abnormal EEG may completely recover.

The *ECG* is a sensitive test for the presence of myocardial damage in adults. Ischemic changes range from ST depression and T-wave flattening or inversions to ST elevation indicative of myocardial infarction. Dysrhythmias range from frequent premature ventricular contractions to atrial fibrillation and ventricular tachyarrhythmias.

On *MRI*, carbon monoxide poisoning reveals cytotoxic edema and demyelination. White matter and basal ganglia are commonly damaged. These findings are nonspecific and may be associated with barbiturate intoxications, hypoglycemia, cyanide, disulfiram, and hydrogen sulfide poisoning. *MRI* may be more sensitive than *CT* scans in detecting tissue edema caused by demyelination.

Positive computerized axial tomography (*CT*) accurately predicts severe neurologic sequelae within 24 hours (e.g., low-density globus pallidus lesions), but not all patients with neurologic impairment have abnormal *CT* scans. (reference 25, pp. 1465-1470)

# Toxic Exposure Claims

*DISORDER*

*DEPOSITION QUESTIONS*

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## **Carbon Monoxide**

*(continued)*

**Q: What are the health effects of carbon monoxide poisoning?**

Carbon monoxide symptoms are similar to the flu and include headaches, fatigue, nausea, dizziness, confusion, and irritability. Continued exposure can lead to vomiting, loss of consciousness, brain damage, heart irregularity, breathing difficulties, muscle weakness, abortions and even death. Because the symptoms mimic so many illnesses, it is often misdiagnosed. (reference 44)

---

**Q: Was the plaintiff taken to a hyperbaric oxygen chamber following exposure to carbon monoxide?**

Hyperbaric oxygen therapy is indicated in cases of severe exposure. It is beneficial in the following ways: (reference 44)

- Produces a rapid dissociation of CO from hemoglobin (the half-time for elimination of CO is reduced from over 5 hours with air to 23 minutes).
  - Oxygen breathing at 3 atmospheres absolute (ATA) provides immediate delivery of dissolved oxygen in plasma in an adequate amount to support basic tissue metabolism, even when the amount of CO bound to hemoglobin is high.
- 

**Q: What is Hyperbaric Oxygen Therapy?**

Hyperbaric oxygen is a mode of therapy in which the patient breathes 100% oxygen at pressures greater than normal atmospheric (sea level) pressure. In contrast with attempts to force oxygen into tissues by topical applications at levels only slightly higher than atmospheric pressure, hyperbaric oxygen therapy involves the systemic delivery of oxygen at levels 2-3 times greater than atmospheric pressure. (reference 44)

---

**Q: Is the plaintiff a cigarette smoker?**

The average levels of carbon monoxide in a nonsmokers blood is less than 2%. An average smoker (defined as about 1 pack per day) may have levels in the range of 4-5% and a heavy smoker (defined as more than 1 pack per day) may have levels ranging from 8-12%.

---

**Q: Did you consider chronic alcohol use / intoxication as a cause of the plaintiff's symptoms which are being attributed to toxic exposure?**

# Toxic Exposure Claims

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## *Challenging the Plaintiff's Diagnosis of Toxic Exposure*

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### **Toxic Mold**

### **Toxic Mold Introduction**

#### **I. Current Scientific Information**

##### **A. General Information**

Molds are simple, microscopic organisms, and are found virtually everywhere, indoors and out. They can be found on plants, foods, dry leaves and other organic material. Mold spores are tiny and lightweight, allowing them to travel through the air. Mold growths range in color from white to orange and from green to brown and black. When mold is present in large quantities, it can cause allergic symptoms similar to those due to pollen exposure.

Certain molds can produce toxins, called mycotoxins, that the mold uses to inhibit or prevent the growth of other organisms. Mycotoxins are found in both living and dead mold spores. Even after being disinfected, materials permeated with mold must be removed. Dead spores may continue to have allergic and toxic effects. Mycotoxins are generally not volatile – a disturbance is generally required in order to trigger exposure.

Pathogenic mold can cause irritation, rash, illness, or death. The most common species of mold are: *Cladosporium*, *Penicillium*, *Alternaria*, *Aspergillus*, *Mucor* and *Stachybotrys chartarum* (which produces toxins). The unusual species include: *Epicoccum*, *Aspergillus versicolor*, *Aurebasidium* and *Fusarium*.

##### **B. Variations in Mold Species and Individual Reactions**

Mold species vary tremendously in their ability to cause health effects. A similar, almost idiosyncratic, response to mold is found among individuals: some people can withstand substantial exposure to mold, while others are more susceptible. This is one of the reasons that agencies have such difficulty establishing "safe" levels of mold. These uncertainties are compounded by interaction of mold species. One species might not produce particularly toxic reactions standing alone, but might mix with other mold species to create a highly toxic soup.

In view of the impact to different individuals, one thing is clear: the defense team should be particularly sensitive to environments where there are immune-susceptible individuals. Schools, hospitals, and health care facilities immediately come to mind because each environment houses those who potentially have compromised immune systems.

##### **C. Health Effects from Exposure**

All of us are exposed to molds. The health impact, however, is highly specific to the individual. Depending on the type of mold, nature of exposure and individual, an individual may experience: (a) allergic / immunologic reactions; (b) infections; and (c) toxic effects.

# Toxic Exposure Claims

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## *Challenging the Plaintiff's Diagnosis of Toxic Exposure*

---

### **Toxic Mold**

*(continued)*

#### **D. Allergic Reactions**

Perhaps the most common health problems associated with exposure to mold are allergic reactions, which range from mildly uncomfortable to life-threatening illnesses (e.g., severe asthma attack). Common signs or symptoms of an allergic reaction to mold include:

- Watery eyes
- Runny nose and sneezing
- Nasal congestion
- Itching
- Coughing
- Wheezing and impaired breathing
- Headache
- Fatigue

#### **E. Infections**

While not as common as allergies, there are several types of mold-related infections. These include aspergillosis in susceptible people and allergic fungal sinusitis. Other fungi, which grow in soil or are carried by birds (e.g., histoplasmosis), can cause infections but are rare in indoor exposures. The classifications of infections caused by fungi are systemic, opportunistic and dermatophytic.

#### **F. Toxic Reactions**

Toxic reactions from exposure to molds remain one of the least studied and understood areas of human health. This area concerns exposure to toxins on the surface of mold spores, not with the growth of mold in the body. There are few case studies that report that toxic molds (i.e., those containing certain mycotoxins) inside homes can cause unique or rare health conditions such as pulmonary hemorrhage or memory loss.

# Toxic Exposure Claims

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## *Challenging the Plaintiff's Diagnosis of Toxic Exposure*

---

### **Toxic Mold**

(continued)

## **II. Plaintiff's Evidence of Causation**

### **A. Differential Diagnosis**

Similar to other toxic exposure cases, plaintiffs in a mold case must address causation through a differential diagnosis employing three elements:

1. That the mold has the capacity to cause injury.
2. That the plaintiff was exposed to the mold spores.
3. That other potential causes for the plaintiff's injuries have been eliminated.

Applying the Daubert analysis, it is difficult for the plaintiff to prove that mold has the capacity to injure because of the lack of scientific knowledge, the lack of peer review, and the general level (current) of unacceptability within the scientific community.

*There is a great deal of research on the impact of toxic molds in animals. Veterinarians know the effect on horses and donkeys eating moldy hay. Stachybotrys, for example, was first identified as the cause of disease in farm animals in Europe during the 1930's. However, sufficient research has not been done regarding its effects on humans. The first known human morbidity from it was identified in Chicago in 1986, when a family suffered flu symptoms (diarrhea, dermatitis and general fatigue) for five years, until the Stachybotrys was found and removed. Research is advancing in this area given the heightened level of interest from various governmental and private agencies.*

### **B. General Causation**

In a federal case, or in a jurisdiction following the federal rule, the court is required under Daubert and its progeny to be the gatekeeper - to keep out unreliable expert testimony in technical or scientific areas. In this regard, Federal Rule of Evidence 702 charges the trial judge with ensuring that an expert's testimony is relevant and based on a reliable foundation. However, the judge has discretion here, and the following considerations may bear upon her inquiry:

- whether the theory or technique in question can be tested;
- whether it has been subjected to peer review and publication;
- its known or potential error rate (statistical validity); and
- whether it has attracted widespread acceptance within the relevant scientific community.

For jurisdictions following the Frye line of cases, the standard is higher than the federal rule. Frye and its progeny mandate that the techniques or methods used be "generally accepted within the scientific community". (By contrast, FRE 702 identifies this as only one factor to be considered by the court.)

## Toxic Exposure Claims

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### *Challenging the Plaintiff's Diagnosis of Toxic Exposure*

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#### **Toxic Mold**

*(continued)*

Often, plaintiff's experts can demarcate only an association between the exposure and the alleged injury or illness. In 1965, Sir Bradford Hill established specific criteria for evaluating whether a disease was caused by chemical exposure, or merely associated with it:

- (1) strength of association;
- (2) consistency;
- (3) specificity;
- (4) temporality;
- (5) dose response;
- (6) plausibility;
- (7) coherence; and
- (8) experimentation

Using the enumerated criteria (by itself, or to organize expert testimony, a Daubert/Frye motion in limine, motions for summary judgement, or an outline for cross-examination), defense counsel can expertly attack plaintiff's faulty causation assumptions.

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Daubert v. Merrell Dow Pharmaceuticals, Inc., 509 U.S. 579 (1993).

Frye v. United States, 293 F.2d 102 (1923)

See, e.g., Castellow v. Chevron USA, 97 F.Supp.2d 780, 787 (2000).

# Toxic Exposure Claims

## Toxic Mold

(continued)

### III. The Defense of Toxic Mold Cases

#### A. Proximate Cause

Plaintiff's seeking to prove a toxic mold case must establish both general and specific causation. General causation is the demonstration that a given toxic substance, in the particular location and for a particular duration, can cause the type of illness or injuries alleged. Specific causation requires proof that the toxic chemical actually did cause the alleged injuries. Establishing either type of causation requires expert testimony, which is subject to exclusion or limitation under the Daubert case, and comparable rules in state courts that still follow the Frye line of cases.

#### B. Exposure to Mold Does Not Equal Illness

The presence of fungi on building materials, as identified by a visual assessment or by bulk/surface sampling results, does not necessarily mean that people will be exposed to mold or exhibit health effects. In order for humans to be exposed indoors, fungal spores, fragments, or metabolites must be released into the air and inhaled, physically handled (dermal exposure), or ingested.

Whether symptoms develop in people exposed to fungi depends on the nature of the fungal material (e.g., allergenic, toxic, or infectious), the amount of exposure, and the susceptibility of exposed persons. Susceptibility varies with genetic predisposition (e.g., allergic reactions do not always occur in all individuals), age, state of health, and concurrent exposures. For these reasons, and because measurements of exposure are not standardized and biological markers of exposure to fungi are largely unknown, it is difficult to determine "safe" or "unsafe" levels of exposure for people in general. (reference 43, pp. 16-26)

---

**Q: Describe the basis for this claim of exposure:  
when?, where?, how?**

---

**Q: Describe the type of mold involved.**

---

**Q: How was the mold tested and analyzed?**

---

**Q: Describe the plaintiff's physical reaction.**

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**Q: Describe the plaintiff's psychological reaction (cognitive and emotional).**

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**Q: Describe the plaintiff's social reaction (isolation, relocation, etc.).**

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**Q: Describe any past documented or undocumented sensitivity to mold or other foods or substances.**

---

**Q: Describe past treatment for allergies.**

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**Q: Describe plaintiff's past residential history.**

---

## Toxic Exposure Claims

*DISORDER*

*DEPOSITION QUESTIONS*

### **Toxic Mold**

*(continued)*

- Q:** Describe plaintiff's past occupations and locations.
- 
- Q:** Describe the proximate cause linkage between the claimed exposure and the claimed symptoms, behaviors and illnesses.
- 
- Q:** Describe the physical and psychological evaluation techniques (clinical, laboratory, tests, etc).
- 
- Q:** Describe the exact diagnoses resulting from these evaluation techniques.
- 
- Q:** Describe the differential diagnostic technique.
- 
- Q:** What alternate sources of symptoms, behaviors and illnesses were considered and ruled out in the differential diagnostic process?
- 
- Q:** Describe the prescribed treatments and medications.
- 
- Q:** Describe the plaintiff's compliance with treatment.
- 
- Q:** Provide all past medical, psychological and social history records and documentation including occupational, military and litigation histories.
- 
- Q:** List and describe the psychological and neuropsychological tests and questionnaires used in this case.

## **SECTION 7.11: CHALLENGING THE PLAINTIFF'S ELECTRODIAGNOSTIC EVIDENCE**

**DEFENSE THEORY:** In cases where the plaintiff has undergone diagnostic testing, defense counsel should attempt to obtain the actual films or scores and submit them for an independent evaluation. Many times the written report is incorrect or omits important factual data, such as medications taken the day of testing.

**DEFENSE THEORY:** Some scans are still in the research stage and may be challenged on the basis that they do not have the scientific foundation to be admissible.

### **INTRODUCTION**

Tests such as EEG tracings, MR imaging and CT scans are used to identify areas of acute structural and functional damage following brain trauma. Recently, advanced tests such as PET scans, SPECT scans, quantitative EEGs and evoked potentials (EPs) have been used to further delineate functional damage to the brain. These tests are often used by the plaintiff when other diagnostic testing has been negative. However, there are many drawbacks to these newer tests, primarily because they are so new (expensive, little background research, overinterpretation, etc.). The information in section 7.11 may be used to challenge the plaintiff's diagnostic evidence as proof of damages.

# Challenging the Electrodiagnostic Evidence

TEST

DEPOSITION QUESTIONS

---

## A. ELECTROENCEPHALOGRAPHY (EEG)

EEG

**Q: Do the records indicate that the plaintiff had an electroencephalogram (EEG)?**

Electroencephalograms (EEG) measure spontaneous brain electrical activity by electrodes attached to the scalp. It is measured by the frequency and voltage of the signals present and its importance lies in detecting *functional* abnormalities of the brain. With a head injury of any type, there is usually suppression of electrical activity in the brain which returns to normal with recovery. (reference 21, pp. 67, 424)

---

**Q: According to the medical records, when was the electroencephalogram (EEG) administered?**

An electroencephalogram (EEG) done in the 24-48 hour period subsequent to injury can be abnormal even when there has been no actual brain trauma. This may be due to the effects of multiple medications (narcotics, benzodiazepines) and/or alcohol intoxication. Sleep deprivation and anxiety as a result of waiting in the emergency room may also affect the recording. (reference 27, p. 72)

---

**Q: Was the electroencephalogram (EEG) administered by a technician certified by the American Board of Registration in Electrodiagnostic Technology?**

The quality of EEG recording and the evaluation can vary; therefore, standards of practice must be met to ensure accurate interpretation. The technician should be trained in EEG and certified by the American Board of Registration in Electrodiagnostic Technology and participate in ongoing educational activities. The lab should meet standards set by the American EEG Society, and the equipment should be calibrated prior to each use.

---

**Q: Describe some common electroencephalogram (EEG) abnormalities?**

Electroencephalogram (EEG) abnormalities frequently seen are listed below: (reference 21, pp. 67-69)

- (1) *diffuse slowing* – most common, nonspecific findings, present in patients with various diffuse encephalopathies including toxic, metabolic, anoxic and degenerative conditions
  - (2) *focal slowing* – suggests localized parenchymal dysfunction, abnormalities found in about 70% of patients with focal slowing
  - (3) *triphasic waves* – characteristic of either hepatic encephalopathy or toxic-metabolic encephalopathy
  - (4) *epileptiform discharges* – strongly linked with seizure disorders and epilepsy
  - (5) *periodic lateralizing epileptiform discharges* – suggest destructive cerebral lesions
  - (6) *general periodic sharp waves* – commonly seen following cerebral anoxia
-

# Challenging the Electrodiagnostic Evidence

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TEST

DEPOSITION QUESTIONS

---

## EEG

(continued)

**Q: Can the electroencephalogram (EEG) provide a precise diagnosis or etiology of an abnormality?**

Various insults to the brain can result in alterations of electrophysiology. The EEG can rarely provide an exact diagnosis or identify the cause of an abnormality, except perhaps in cases of seizure disorders or delirium and dementia. The EEG is a nonspecific indicator of brain electrophysiology and only provides the examiner with imprecise information on which to base broad assumptions about cerebral function. (reference 33, p. 167)

---

**Q: Are there any disadvantages or limitations to the use of electroencephalograms (EEG)?**

Abnormal EEGs have been found to occur in some control groups, suggesting that the EEG may not be the best diagnostic tool for assessing brain injury. It may also be difficult to evaluate EEGs because the criteria used to characterize normal EEGs are vague. In addition, EEGs must be performed by a licensed, trained technician and even then may be subject to bias during interpretation. Due to its sensitivity, EEG readings may be affected by nearby equipment, or by hypothermia, sedatives, anticonvulsants and anesthetic agents. (reference 28, pp. 87-94)

---

**Q: What are artifacts and what is responsible for their presence?**

Artifacts are features of a diagnostic test which do not occur naturally or are artificially produced. They are the result of muscle or eye blinks, head movement, inaccurate or loose electrode placement, paste bridges, or defective machines. (reference 29)

---

**Q: Are there any factors that can contribute to an abnormal EEG?**

Athletes who have suffered multiple head injuries have a higher incidents of abnormal EEG readings. EEGs can also be affected by the use of sedatives and anticonvulsants, or by hypothermia and anesthetic agents. (reference 28) Age can also affect brain wave frequencies. Typically, brain waves which were slow in youth (theta, beta) speed up, and those that were fast in youth (alpha) slow down, as a result of advanced age. Approximately 30% of persons over age 50 have diffuse slowing of the EEG in either one, or both temporal lobes. Chronic alcoholics display abnormal EEGs which are shown as heightened parietal lobe alpha waves. The likelihood of finding an abnormal EEG can actually be increased by 10% with the use of nasopharyngeal leads (pertaining to the nose and pharynx). (reference 30, pp. 120, 517)

---

**Q: Did you consider the plaintiff's age as a contributing factor in the abnormal EEG?**

Approximately 30% of persons over age 50 have diffuse slowing of the EEG in either one, or both temporal lobes. (reference 31, pp. 252, 289-290)

---

**Q: Did you consider the plaintiff's alcohol use as a contributing factor in the abnormal EEG?**

Chronic alcoholics display abnormal EEGs which are shown as heightened parietal lobe alpha waves. (reference 31, pp. 252, 289-290)

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## Challenging the Electrodiagnostic Evidence

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### TEST

### DEPOSITION QUESTIONS

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#### EEG

(continued)

**Q: Do the records indicate whether the plaintiff was taking any *drugs* subsequent to the injury?**

An abnormal electroencephalogram (EEG) may be attributed to specific individual drugs rather than brain injury. For example, an overdose of psychotropics can produce a slower EEG. At therapeutic doses, benzodiazepines, barbiturates and stimulants can result in increased beta waves, but do not necessarily cause focal or paroxysmal changes. Lithium can bring about paroxysmal EEG changes which can be difficult to separate from those which indicate epilepsy. Chronic cocaine use can also show diffuse EEG slowing as well as brain atrophy on computed tomography (CT) scans. (reference 31, p. 260)

*Medications which will influence or change EEG readings include:*

|           |                 |           |
|-----------|-----------------|-----------|
| ASENDIN   | FLAGYL          | PROLIXIN  |
| BONTRIL   | FLEXERIL        | RITALIN   |
| CLINDEX   | GABITRIL        | SURMONTIL |
| CLOZARIL  | HALCION         | TOFRANIL  |
| DEPROL    | IMITREX-TABLETS | TOPAMAX   |
| DESOXYN   | LIBRIUM         | TRIAVIL   |
| ELAVIL    | LIMBITROL       | TRILEPTAL |
| ENDEP     | LITHIUM-CITRATE | VALIUM    |
| EQUAGESIC | LUDIOMIL        | VESPRIN   |
| EQUANIL   | NOLUDAR         | VIVACTIL  |
| ESKALITH  | NORPRAMIN       |           |
| ETRAFON   | PAMELOR         |           |

---

**Q: Was the plaintiff's electroencephalogram (EEG) normal prior to the claimed injury?**

Recent brain injury can aggravate a preexisting abnormal record. A central nervous system (CNS) infection in the neonatal period or early childhood can also cause a persisting abnormality or dysrhythmia on the EEG. In one study, pre- and post-injury EEGs were examined and it was found that 51% of the patients had an abnormal EEG before the current examination (however the studied population was not normal because the subjects had the pre-injury EEGs for psychiatric or neurologic reasons). (reference 40, pp. 52-53)

---

**Q: Are there any procedures used to elicit abnormal electroencephalogram activity?**

Procedures such as sleep deprivation, hyperventilation, photic stimulation and the use of special leads (nasopharyngeal) can all be used to elicit abnormal activity. Typically these techniques serve to increase sensitivity and enhance abnormal activity. (reference 33, p. 166)

---

*If the EEG was not used in this case:*

**Q: Does the fact that this test (EEG) was not given to the plaintiff, indicate that the plaintiff did not appear to be head injured?**

In many cases involving litigation, diagnostic tests do not appear in the records. This is evidence that the trained medical observers did not believe that a head injury had occurred.

# Challenging the Electrodiagnostic Evidence

TEST

DEPOSITION QUESTIONS

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## B. QUANTITATIVE ELECTROENCEPHALOGRAM (QEEG)

QEEG

**Q: Do the records indicate the use of quantitative electroencephalogram (QEEG)?**

Quantitative electroencephalograms (QEEG) are a relatively new technology with the potential to rapidly analyze large amounts of electrophysiological data. This data is derived from complex electrical brain activity, and the procedure is fairly noninvasive. However, its usage is quite limited. Results from QEEG studies in patients with brain injuries have shown abnormalities that can be due to organic causes, but these findings are nonspecific and require careful clinical interpretation. QEEG is currently not a routine part of the neuropsychological or neuropsychiatric evaluation in brain injury patients, but with careful administration by a trained electroencephalographer in conjunction with a routine EEG, the results may yield information to supplement other diagnostic measures. (reference 30, pp. 119-122)

---

**Q: Were abnormalities found on the quantitative electroencephalogram (QEEG) confirmed by any other diagnostic methods?**

Due to its novelty and high sensitivity, abnormal QEEGs, especially when unconfirmed by routine EEGs or other diagnostic procedures, are not necessarily indicative of brain pathology. The results will show greater significance of dysfunction when combined with additional findings such as neuropsychological testing, anatomic brain imaging and functional brain imaging. (reference 41, pp. E-21-22)

---

**Q: What are artifacts and what is responsible for their presence?**

Artifacts are features of a diagnostic test which do not occur naturally or are artificially produced. They are the result of muscle or eye blinks, head movement, inaccurate or loose electrode placement, paste bridges, or defective machines. (reference 29)

---

**Q: Are there any confounding problems of the quantitative electroencephalogram (QEEG) which result in high rates of false positives?**

The following factors, either alone or in combination, have been proven to result in erroneous diagnoses of abnormalities seen on a QEEG. These abnormalities may mistakenly be attributed to a brain injury. (reference 29)

- (1) *nonspecific diagnoses* – a wide variety of disorders can produce the same EEG changes
  - (2) *lack of standardized methods*
  - (3) *artifacts* – can confuse results and interpretations
  - (4) *medication effects*
  - (5) *incorrect statistical comparisons* – normal control subjects commonly have QEEG "abnormalities" due to statistical chance rather than some pathology
-

## Challenging the Electrodiagnostic Evidence

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### TEST

### DEPOSITION QUESTIONS

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#### QEEG

*(continued)*

**Q: Does drowsiness effect quantitative electroencephalogram (QEEG) results?**

Drowsiness mimics brain damage on the QEEG. The diffuse slow wave activity may be incorrectly read as an abnormality when it is actually due to drowsiness. Routine electrophysiological tests are properly performed when the patient is awake and fully rested. Sleep deprivation can elicit abnormal activity by increasing sensitivity. (reference 33, p. 166)

---

*If the QEEG was not used in this case:*

**Q: Does the fact that this test (QEEG) was not given to the plaintiff, indicate that the plaintiff did not appear to be head injured?**

In many cases involving litigation, diagnostic tests do not appear in the records. This is evidence that the trained medical observers did not believe that a head injury had occurred.

# Challenging the Electrodiagnostic Evidence

TEST

DEPOSITION QUESTIONS

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## C. COMPUTED TOMOGRAPHY (CT) SCANNING

### CT Scanning

**Q: Do the medical records indicate the use of Computed Tomography (CT) Scanning?**

Computed Tomography (CT) Scanning was introduced in the early 1970's and is used to reveal structural abnormalities of the brain. It can show contusions, hemorrhage, edema, brain shifting and detect most skull fractures. It is primarily used to evaluate moderate and severe head injuries, and its role in mild head injury is debatable. CT scanning is based on the passage of multiple intersecting x-ray beams through the head. An electric signal is produced when photons are transmitted and an attached computer calculates the density of the intersecting beams which is then converted from digital to analog form and represented on a television screen. (reference 28, pp. 75-79)

---

**Q: Are there any advantages of Computed Tomography (CT) scan over Magnetic Resonance Imaging (MRI)?**

Computed Tomography (CT) scanning is superior to MRI in diagnosing skull fractures and acute injuries to certain other organ structures. CT detection of intracranial blood such as subarachnoid, parenchymal and epidural hemorrhages is also superior to MRI. CT scanning is noninvasive and more widely available than MRI. The procedure is quicker and cheaper, making it a simple preventative test for evaluation of acute structural abnormalities in the brain. (reference 28, pp. 76-84)

---

**Q: Are there any disadvantages or limitations of Computed Tomography (CT) scanning?**

Computed Tomography (CT) scans, while highly accurate, also have several limitations. Bilateral and unilateral subdural hematomas are undetectable or difficult to diagnose unless there is a shifting in structures. CT scans are not effective in detecting soft tissue abnormalities unless they are calcified. It cannot detect damage at the cellular level, excluding a diagnosis of diffuse axonal injury. Lesions are difficult to identify, particularly the size of the lesion, due to the presence of artifacts. (reference 28, pp. 75-84)

---

**Q: Is it possible to draw conclusions about the function of the brain based on Computed Tomography (CT) scan findings?**

Computed Tomography (CT) scans are only useful in detecting structural abnormalities of the brain. If any conclusions have been drawn with regard to the function of the brain, they should only be considered inferences and not direct evidence of "brain damage". (reference 41, p. E-5)

---

**Q: Is there any degree of interpretive error in analyzing Computed Tomography (CT) scan results?**

In a study of CT scan interpretations by experienced academic neurologists, there was excellent agreement for the presence of stroke or hemorrhage, but poor agreement on the more quantitative judgments such as presence of edema and lesion size. There was also disagreement on whether certain scans were normal or abnormal. (reference 41, pp. E-9-10)

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## Challenging the Electrodiagnostic Evidence

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TEST

DEPOSITION QUESTIONS

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### CT Scanning

*(continued)*

**Q: Are there any other factors which could be responsible for cerebral atrophy or ventricular enlargement found on Computed Tomography (CT) scans?**

Cerebral atrophy and ventricular enlargement can occur as a result of aging, chronic drinking, primary mental illness, corticosteroid use and a variety of other causes. Therefore, any attempt to link cerebral atrophy or ventricular enlargement to a sole incident of alleged brain injury can be questioned, and the finding deemed nonspecific. (reference 41, p. E-10)

---

**Q: Do the records indicate the use of more than one Computed Tomography (CT) scan?**

Successive CT scans should be compared to control for differences in machine/equipment and software, which can be responsible for changes in the results. There is no universally accepted measure of brain atrophy or ventricular enlargement which can be quantitatively compared across machines and institutions. (reference 41, p. E-10)

---

**Q: What are some clinical indications for a computed tomography (CT) scan of the brain?**

CT scanning is fast moving away from its previously limited usage and becoming a primary diagnostic tool in psychiatric illness. The following are a few of the many clinical indicators suggesting a CT scan of the brain: cognitive decline on the mental status exam (MSE), dementias, psychoses, alcohol abuse with possible unreported head trauma, seizure and movement disorders, and focal neurological signs with psychiatric symptoms. (reference 33, p. 208)

# Challenging the Electrodiagnostic Evidence

TEST

DEPOSITION QUESTIONS

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## D. MAGNETIC RESONANCE IMAGING (MRI)

MRI

**Q: Do the medical records indicate the use of Magnetic Resonance Imaging (MRI)?**

Magnetic Resonance Imaging (MRI) is similar to the images produced by Computed Tomography (CT) Scanning, but they are more specific and can analyze tissue characteristics. MRI is based on the fact that there will be different magnetic properties for different tissues. The patient is placed in a cylinder in which a uniform magnetic field is created. The resulting images are based on the proton densities of the tissues. They are converted by a computer from signals occurring when the protons, excited from the energy, return to their normal resting stage. Some MRI abnormalities may only be revealed through follow-up scanning and in some cases of severe head injury, MRI may not indicate any pathology at all. (reference 30, p. 114)

---

**Q: Are there any advantages of Magnetic Resonance Imaging (MRI) over Computed Tomography (CT) scanning or X-rays?**

Magnetic Resonance Imaging (MRI) has been shown to detect lesions not seen on CT scans. In a study designed to compare MRI and CT scans in patients with mild to moderate brain injuries, an MRI revealed lesions in 80% of the cases while CT scans were abnormal in only 20% of the cases. MRI is also superior to the CT scan in diagnosing the following: (reference 30, pp. 110-114)

- (1) soft tissue abnormalities
- (2) brain contusions
- (3) diffuse axonal injuries involving white matter and corpus callosum
- (4) cerebral and intracranial hemorrhages and collections of blood
- (5) shows blood flow or cerebrospinal fluid (CSF) flow
- (6) bone marrow abnormalities
- (7) toxin exposure

MRIs generally have higher resolution with less artifacts than CT scans. Artifacts become problematic when brain areas close to bone (such as the orbital frontal region) are imaged.

---

**Q: Are there any disadvantages or limitations of the Magnetic Resonance Imaging (MRI) technique?**

Magnetic Resonance Imaging (MRI) is still more expensive than CT scans. It is time consuming, sometimes making it difficult to administer to certain people, such as the elderly, critically ill and persons with claustrophobia. MRI should not be used for patients with metallic implants, like pacemakers, cochlear implants and old aneurysm clips. (reference 21, p. 60; reference 28, p. 83)

---

**Q: Is it possible to draw conclusions about the function of the brain based on MRI findings?**

MRI is only useful in detecting structural abnormalities of the brain. If any conclusions have been drawn with regard to the function of the brain, they should only be considered inferences and not direct evidence of "brain damage".

---

## Challenging the Electrodiagnostic Evidence

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TEST

DEPOSITION QUESTIONS

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### MRI

(continued)

**Q: Can age be a factor in the abnormalities found in Magnetic Resonance Imaging (MRI)?**

Subcortical white matter hyperintensities become more common with increasing age, especially in people at risk for cerebrovascular disease. White matter hyperintensities can represent the following:

- (1) infarction (formation of necrotic tissue following cessation of blood supply);
- (2) gliosis (proliferation of neurological tissue in the central nervous system);
- (3) demyelination (removal of myelin sheath of a nerve);
- (4) no pathologic abnormality (if uncorrelated with other diagnostic findings, an abnormality can be regarded as nonspecific)

Currently there is no universally accepted system for quantifying abnormalities of MRI in order to distinguish between normal (due to old age) and pathologic changes. (reference 41, p. E-10)

---

**Q: Do the records indicate the use of any special imaging techniques apart from the routine Magnetic Resonance Imaging (MRI)?**

Some special imaging sequences can be used to show greater detail of an abnormality. It is these images that the plaintiff with alleged brain image will submit. However, in one study of panic disorder, 40% of patients showed temporal lobe abnormalities when special techniques were used, while routine MRI was usually normal. In the same study, 10% of the normal controls showed the same abnormality, which could not be correlated with future findings in surgery or autopsy. (reference 41, pp. E-11-12)

# Challenging the Electrodiagnostic Evidence

TEST

DEPOSITION QUESTIONS

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## E. SINGLE PHOTON EMISSION COMPUTED TOMOGRAPHY (SPECT)

SPECT

**Q: Do the medical records indicate the use of Single Photon Emission Computed Tomography (SPECT)?**

Single photon emission computed tomography (SPECT) scanning measures blood flow in the brain. The underlying theme of SPECT is that when a region of the brain is metabolically active, blood flow to that region will increase as a result of greater metabolic demand. Therefore, low metabolic activity in any area could be due to decreased metabolism or to some form of vascular disease. This procedure is similar to the Positron Emission Tomography (PET) scan in that both are useful in detecting abnormalities not visible with anatomic brain imaging (computed tomography, CT, and magnetic resonance imaging, MRI). (reference 30, p. 115)

---

**Q: Are there any advantages of Single Photon Emission Computed Tomography (SPECT) scanning over Positron Emission Tomography (PET) scanning?**

SPECT scans are not only cheaper but more widely available than PET scans. This is because PET requires sophisticated and expensive equipment to be used by highly trained personnel while the equipment for SPECT is easily obtained and therefore common in most hospitals. SPECT can be especially helpful as an adjunct to information obtained through CT and MRI in diagnosing brain injured patients. (reference 30, pp. 115-117)

---

**Q: Are there any disadvantages or limitations of Single Photon Emission Computed Tomography (SPECT) scans?**

A major limitation of SPECT is the lack of evidence that its use can correctly detect and diagnose classic psychiatric disorders. Many SPECT systems in use have discrepant or little investigational capabilities which prevents this equipment from being a significant diagnostic tool. In comparison with PET scanning, SPECT can reveal information about blood flow only, while PET can measure blood flow and metabolic function. SPECT is also slower and has a lower degree of resolution than PET. (reference 30, p. 117)

---

**Q: Can an abnormality be found on a SPECT scan with a normal CT scan or MRI?**

It is likely that areas of abnormal brain function will be detected with a SPECT in patients who have "minor" TBI and normal CT and MRI studies. However, PET and SPECT are largely clinical research tools at this time. (reference 30, p. 364)

---

**Q: Is there any degree of interpretive error in analyzing Single Photon Emission Computed Tomography (SPECT) scans?**

SPECT can present some interpretive problems even for experienced evaluators. Findings are often pathologically nonspecific and could be associated with a specific test technique. Abnormalities can be seen in patients with primary psychiatric illnesses and often the issue of reversibility is not addressed. (reference 41, p. E-14)

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## Challenging the Electrodiagnostic Evidence

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TEST

DEPOSITION QUESTIONS

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**SPECT**  
(continued)

**Q: Can an abnormality on the Single Photon Emission Computed Tomography (SPECT) scan occur in someone without brain injury?**

Abnormalities have been found on the SPECT scan in individuals who have no prior history of brain injury, yet possess a history of psychiatric disorders. These abnormalities have been seen in individuals with posttraumatic stress disorder (PTSD), somatization disorder, major depression and chronic alcoholism. For this reason, caution should be used when attributing an abnormal SPECT scan to brain injury. In fact, the American Academy of Neurology has decided that there is insufficient evidence that the SPECT scan can accurately diagnose traumatic brain injury (TBI). (reference 33, pp. 525-527)

---

**Q: Can other non-brain injury conditions contribute to an abnormal SPECT scan?**

The pattern of regional cerebral blood flow reported in normal subjects, at least in part, **reflects the condition of the subject at the time**. At present, there are no generally accepted standard conditions for the control or resting state (control for headaches, depression, medical conditions, etc.). However, this is clearly needed prior to using the SPECT scan across all conditions. (reference 32, pp. 438-439)

---

**Q: Was the plaintiff's Single Photon Emission Computed Tomography (SPECT) scan normal prior to the claimed event?**

Due to the low specificity of the SPECT scan, it is difficult to date any abnormality found. In other words, a blood flow abnormality could have pre-existed the cause of action.

---

**Q: Should Single Photon Emission Computed Tomography (SPECT) scan results be used as hard evidence in diagnosing brain injury?**

The SPECT scan, in its present state of the art, should be used strictly as an investigational tool in diagnosing brain injury. Functional imaging results at this level can only contribute to the evaluation of head injury or confirm any findings discovered through other established testing methods. (reference 33, p. 527)

---

**Q: Did you rule out *migraine headache* as a reason for an abnormal Single Photon Emission Computed Tomography (SPECT) scan?**

Migraines often coexist with a number of neurological disorders such as epilepsy and stroke and psychiatric disorders such as depression and anxiety. Changes in blood flow have been documented in certain types of migraines. The actual headache phase of a migraine begins during a period of decreased blood flow. This should be considered as a reason for an abnormal SPECT scan. (reference 33, p. 400)

---

**Q: Does the fact that this test (SPECT) was not given to the plaintiff, indicate that the plaintiff did not appear to be head injured?**

In many cases involving litigation, diagnostic tests do not appear in the records. This is evidence that the trained medical observers did not believe that a head injury had occurred.

---

## Challenging the Electrodiagnostic Evidence

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*TEST*

*DEPOSITION QUESTIONS*

---

**SPECT**

*(continued)*

**Q: Is there extensive research proving the diagnostic value of the SPECT scan?**

It is likely that areas of abnormal brain function will be detected in patients who have "minor" TBI and normal CT and MRI studies. However, PET and SPECT are largely clinical research tools at this time. (reference 30, p. 364)

---

**Q: Are all SPECT systems alike?**

One of the confounding variables in any attempt to consolidate SPECT findings into clinically meaningful protocols is the significant discrepancy between the investigational capabilities of many different SPECT systems presently in use. Although some of the newer machines are getting better, research into their effectiveness is preliminary. (reference 38, pp. 299-300)

# Challenging the Electrodiagnostic Evidence

TEST

DEPOSITION QUESTIONS

## F. PET SCAN

### PET Scan

**Q: Do the medical records indicate the use of the Positron Emission Tomography (PET)?**

Positron Emission Tomography (PET) scanning measures cerebral blood flow (CBF), oxygen utilization, glucose metabolism, or specific neurotransmitter receptor functions. The PET can reveal regional (focal) and global (diffuse) decreases in brain glucose metabolism. This procedure is similar to the Single Photon Emission Computed Tomography (SPECT) scan in that both are useful in detecting abnormalities not visible with anatomic brain imaging (computed tomography, CT, and magnetic resonance imaging, MRI). (reference 30, pp. 117-118)

**Q: Can you delineate glucose abnormalities caused by the plaintiff's alleged brain injury from glucose abnormalities caused by other sources?**

Other sources of abnormality include:

- (1) Anemia
- (2) Chemical hepatitis (hepatic encephalopathy)
- (3) Chronic migraine headache disorder (pre-existing)
- (4) Medication effects

**Q: Can you determine if the abnormalities illustrated in the PET scan existed prior to the cause of action?**

Due to the low specificity of the PET scan, it is difficult to date any abnormality found. In other words, a blood flow abnormality could have pre-existed the cause of action.

**Q: Are there any major faults with the PET scan?**

PET images appear blurry and lack anatomical details needed to identify the area of brain activity. Technical constraints limit the theoretical resolution of PET to less than 4 mm. (reference 33)

**Q: Can an abnormality on a PET scan be caused by psychological conditions?**

Abnormalities on PET have been demonstrated in individuals with psychiatric disorders who have no history of brain injury, including Post-traumatic Stress Disorder, Somatization Disorder, Major Depression, and Chronic Alcoholism— *The American Academy of Neurology has concluded that there currently is insufficient evidence for the use of SPECT to diagnose TBI (traumatic brain injury), and its use in this condition should be considered investigational. With the present state of the art, functional imaging results can only be used as part of an overall evaluation to confirm findings documented elsewhere.*" (reference 33, pp. 525-257)

**Q: Can other non-brain injury conditions contribute to an abnormal PET scan?**

The pattern of blood flow reported in normal subjects, at least in part, reflects the condition of the subject at the time. At present, there are no generally accepted standard conditions for the control or resting state. However, this is clearly needed prior to using the PET scan across all conditions. (reference 32, pp. 438-439)

# Challenging the Electrodiagnostic Evidence

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*TEST*

*DEPOSITION QUESTIONS*

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## **G. MAGNETIC RESONANCE SPECTROSCOPY (MRS)**

**MRS**

**Q: Do the medical records indicate the use of Magnetic Resonance Spectroscopy (MRS)?**

Magnetic Resonance Spectroscopy (MRS) is currently a research technique but promises to be a clinically useful tool in evaluating biochemical changes in the brain. It has the capacity to assess brain pathologies such as dementia, encephalopathy, neonatal hypoxia, tumor growth and ischemia. MRS works by detecting tissue concentrations of certain nuclei which can reveal potential abnormalities in membranes. (reference 33, p. 216)

---

**Q: What are the advantages of using Magnetic Resonance Spectroscopy (MRS)?**

Magnetic Resonance Spectroscopy is known to be a noninvasive and repeatable functional imaging tool. It is beneficial in determining membrane and metabolic abnormalities and may prove useful for longitudinal studies. (reference 33, p. 245)

---

**Q: Are there any disadvantages or limitations of Magnetic Resonance Spectroscopy (MRS)?**

One major limitation of MRS is its relative newness and lack of established applications. It also has limited spatial resolution and is inferior to the Positron Emission Tomography (PET) scan for certain molecules. (reference 33, p. 245)

# Challenging the Electrodiagnostic Evidence

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TEST

DEPOSITION QUESTIONS

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## H. X-RAY

### X-RAY

**Q: Do the records indicate the use of skull X-rays?**

Skull X-rays are frequently used after head trauma to aid in the discovery of depressed skull fractures, hidden intracranial foreign bodies, air in the skull or shifted pineal gland. Early detection of skull fracture is important to decrease the risk of intracranial injury. (reference 28, pp. 70-71)

---

**Q: Do the records indicate the use of spinal X-rays?**

Traumatic lesions and fractures of the spinal cord can go unnoticed after a head injury, making spinal X-rays important. Spinal X-rays can help differentiate between preexisting conditions (spina bifida, scoliosis) and a traumatic pathology. Metabolic and endocrine disorders (osteoporosis) and inflammatory conditions can also be detected by studying bone changes. (reference 28, p. 72)

---

*If X-rays were not used in this case:*

**Q: Does the fact that X-Rays were not used in this case, indicate that the plaintiff did not appear to have a head injury or skull fracture?**

In many cases involving litigation, diagnostic tests do not appear in the records. This is evidence that the trained medical observers did not believe that a head injury had occurred.

# Challenging the Electrodiagnostic Evidence

TEST

DEPOSITION QUESTIONS

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## I. EVOKED POTENTIALS

EP

**Q: Do the records indicate evoked potential (EP) testing?**

Evoked potentials (EP) measure specific brain responses to sensory stimuli. The stimuli can be **visual, auditory or somatosensory**, and they are repeatedly presented to the subject while a computer adds and averages the electrical responses to display a characteristic waveform. Positive and negative peaks are measured in milliseconds and can be early (< 50 msec poststimulus), middle (50-250 msec poststimulus) or late (> 250 msec poststimulus). EP testing is exceptional in that it can provide information on cortical processing occurring by the millisecond. (reference 38, p. 289)

---

**Q: What is the importance of visual evoked potentials (VEPs)?**

Visual evoked potentials (VEPs) can detect asymptomatic optic neuritis and can aid magnetic resonance imaging (MRI) in diagnosing demyelinating disease. They can also assess an infant's visual system where blindness may be suspected. Common stimuli used are reverse checkerboard patterns, sinusoidal gratings and repetitive flashes. These are all variable (size of checks, pattern luminance, repetition rate) and therefore may not show the same patterns across laboratories. (reference 42, p. 19) **In other words, different equipment and laboratories may produce different test responses and this is not, in itself, an indication of pathology.**

---

**Q: What is the importance of brainstem auditory evoked potentials (BAEPs)?**

Brainstem auditory evoked potentials (BAEPs) use a series of clicks as stimuli. The frequency, intensity and duration of the clicks influence the latency and amplitude of the response. Seven waves can be detected, although only I through V are routinely used. The presence of response (beyond wave I) indicates brain stem activity and can then help localize lesions and central nervous system (CNS) dysfunction. (reference 42, p. 20)

---

**Q: What is the importance of somatosensory evoked potentials (SSEPs)?**

Somatosensory evoked potentials (SSEPs) are measured by stimulating the sensory nerves of the extremities. Abnormalities can indicate sensory dysfunction, but interpretation can often be difficult. (reference 42, pp. 20, 103)

---

**Q: Could the plaintiff's somatosensory evoked potential (SSEPs) test results be related to other, non-traumatic causes?**

SSEPs show alterations in the somatosensory pathways which indicate conditions such as focal lesions (strokes, tumors, and cervical spondylosis) and diffuse disease (hereditary system degeneration). (reference 21, pp. 75)

---

**Q: How are normal and abnormal responses characterized?**

A normal range has been established for major responses, and abnormalities are characterized by differences in expected patterns and deviation from normal responses. EPs can show abnormal peaks of latency or amplitude. Latency abnormalities suggest conduction defects like the demyelinating disease multiple sclerosis (MS). Amplitude abnormalities suggest focal dysfunction in the corresponding structure. (reference 4)

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# Challenging the Electrodiagnostic Evidence

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## TEST

## DEPOSITION QUESTIONS

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### EP

(continued)

**Q: Can the etiology of an abnormal evoked potential (EP) be determined?**

When certain symptoms are present with no identifiable cause, EPs can be useful in determining possible underlying dysfunctions (reference 7, pp. 614). In other words, an abnormality in either sensory or brain function can be reasonably inferred from EPs, but a **specific etiology** cannot.

---

**Q: What are some possible changes in the brain which may result in altered evoked potentials (EPs)?**

Changes in carbon dioxide content, intracranial pressure, cerebral blood flow, arterial oxygenation and hypothermia can change or eliminate EPs (reference 11, pp. 97). In addition, direct cortical response is sensitive to anoxia and ischemia and can disappear with decreased blood flow. (reference 12, p. 43)

---

**Q: Did you rule out *schizophrenia* as a cause of the plaintiff's abnormal evoked potentials?**

Studies have shown that schizophrenic patients have reduced suppression of the P50 wave and abnormal P300 potentials. This evidence contributes to the theory that schizophrenic patients have problems filtering internal and external stimuli. While there are some inconsistencies in this data, there is evidence that abnormal evoked potentials may be due to factors besides those considered organic. (reference 33, p. 171)

---

**Q: Are there any disadvantages or limitations to the use of evoked potentials (EPs)?**

The clinical significance of EPs in diagnosing classic psychiatric illnesses (schizophrenia and depression) is still unclear and for now they are considered only research tools. In addition, there are several confounding variables which may result in inconsistent data, such as motivation, level of consciousness, medication and sensory acuity (reference 33, p. 171).

---

**Q: What are artifacts and what is responsible for their presence?**

Artifacts are features of a diagnostic test which do not occur naturally or are artificially produced. They are the result of muscle or eye blinks, head movement, inaccurate or loose electrode placement, paste bridges, or defective machines (reference 29). Middle and late evoked potentials are especially susceptible to experimental artifact. Movement artifacts can also confound the data. (reference 33, p. 171)

---

**Q: Could the use of medical testing equipment in different settings or laboratories, or by different examiners, be the basis for varying scores and results?**

Because of elements such as instrument calibration, incorrect administration, data interpretation and anatomical and physiological factors, there may be differences in test results from one lab to another. *The witness should be asked how s/he controlled for these variances.*

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# CHAPTER 8

## Symptom Manipulation by the Plaintiff

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### SECTION

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# **CHAPTER 8**

## **SYMPTOM MANIPULATION BY THE PLAINTIFF**

### **INTRODUCTION**

Some forms of symptom manipulation imply conscious production of symptoms and complaints usually for some type of secondary gain. The most common types of symptom manipulation seen in forensic cases are Malingering and the Factitious Disorder. In the case of Malingering, the plaintiff intentionally manipulates his or her symptoms for compensation or to avoid military duty or work responsibilities. In the Factitious Disorder, the plaintiff wants to become a patient and receive medical care, attention, and the care of others, such as family members. Another condition that may be included in this category is Ganser's syndrome. This is a less common and less well-known condition. The symptoms resemble those seen in Dissociative Disorders, thus its classification as a Dissociative Disorder NOS.

Another, less common form of manipulation occurs in conditions known as Somatoform Disorders. Somatoform Disorders would best be considered unconscious forms of manipulation, as opposed to the conscious manipulation seen in Malingering and the Factitious Disorder. Somatoform disorders have somatic complaints that suggest a major malady, yet have no demonstrable, physical disorder (hence, the term somatoform). Two of the Somatoform Disorders, the Conversion Disorder and Somatoform Pain Disorder, should be considered when objective etiologies do not coincide with subjective complaints AND when there is no obvious external or secondary gain. An independent psychological and psychiatric examination will provide evidence of these conditions.

Defense counsel should obtain a list of the plaintiff's claimed symptoms by referring to the deposition questions in Chapters 1 and 4. The following sections provide questions to challenge the accuracy of the plaintiff's current diagnosis.

## SECTION 8.1: MALINGERING

**DEFENSE THEORY:** Four elements suggest the plaintiff may be malingering when (1) the plaintiff's attorney refers them for treatment; (2) the plaintiff's complaints of illness are grossly exaggerated, with few objective findings; (3) the plaintiff is uncooperative with treatment and diagnosis; (4) the plaintiff's history and behavior indicate the presence of an antisocial personality disorder.

### INTRODUCTION

The essential feature of Malingering is the intentional production of false or grossly exaggerated physical or psychological symptoms, motivated by external incentives such as avoiding military duty, avoiding work, obtaining financial compensation, evading criminal prosecution, or obtaining drugs. Under some circumstances, Malingering may represent adaptive behavior—for example, feigning illness while a captive of the enemy during wartime.

Malingering differs from Factitious Disorder in that the motivation for the symptom production in Malingering is an *external incentive*, whereas in Factitious Disorder external incentives are absent. Evidence of an intrapsychic need to maintain the sick role suggests Factitious Disorder. Malingering is differentiated from Conversion Disorder and other Somatoform Disorders by the intentional production of symptoms and by the obvious, external incentives associated with it. In Malingering (in contrast to Conversion Disorder), symptom relief is not often obtained by suggestion or hypnosis.

Malingering is not diagnosable as an Axis I mental disorder. Instead, it is found in the DSM IV and DSM IV-TR under the section entitled *Other conditions that may be a focus of clinical attention* (V-codes).

# Malingering

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## DEPOSITION QUESTIONS

---

### General Questions

**Q: What is malingering?**

Malingering is not a mental disorder, it is simply maladaptive behavior. The behavior is produced to obtain money or to avoid responsibility. The distinction between a factitious disorder 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. (reference 7, p. 739)

---

**Q: Did you apply the index of suspicion of *malingering* to this case?**

(reference 7, p. 739; reference 16, p. 331)

There are four factors which should alert the examiner to the possibility of malingering. The four index elements include:

- (1) 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.

Other behavior that suggests malingering is the exaggeration of symptoms, a history of recurrent accidents, a history of litigation or worker's compensation claims, and a poor work history.

---

**Q: Has the plaintiff ever been diagnosed with an antisocial personality disorder?**

Malingers are able to effectively lie and manipulate without remorse and many have a history of criminal behavior. These characteristics are typical of antisocial personality disorder. Approximately 1-3% of the population is diagnosed with antisocial personality disorder.

*If the witness indicates the possibility of an antisocial personality disorder, see the section on pre-existing personality disorders for further questions.*

---

**Q: What are some common motivators for malingering?**

- (1) to avoid criminal responsibility, trial and punishment
  - (2) to avoid military service
  - (3) financial gain - disability insurance, veteran's benefits, worker's compensation, tort damages for alleged psychological injury
  - (4) to move from prison to a hospital
  - (5) admission to a hospital - by the homeless
  - (6) to seek drugs
- 

**Q: What are the most common psychiatric conditions that are malingered?**

- (1) amnesia
  - (2) mental retardation
  - (3) organic impairment
  - (4) posttraumatic residual
  - (5) psychosis
-

# Malingering

---

## DEPOSITION QUESTIONS

---

### General Questions

(continued)

**Q: Is malingering commonly seen in neurological or litigation settings?**

Plaintiffs with a long list of complaints that they claim resulted from a seemingly trivial accident in which there was no loss of consciousness are commonly seen in neurological settings. In litigious settings, the estimated incidence of malingering is around 10-20%, but it may be higher due to under reporting by health care practitioners.

---

**Q: To the best of your knowledge, has the plaintiff ever been involved in previous litigation?**

The malingerer may have a prior history of litigation or been in the position to observe a family member or friend in a litigious context. In addition, a successful malingerer's behavior has been reinforced (usually through monetary compensation) and will occur repeatedly as often as society rewards the malingerer.

---

**Q: Do you routinely look for manipulation of symptoms?**

---

**Q: What tests or methods do you use to look for deception or manipulation of symptoms?**

Neuropsychological tests used to detect malingering:

- (1) Minnesota Multiphasic Personality Inventory (MMPI)
  - (2) Test of Memory and Malingering (TOMM)
  - (3) Validity Indicator Profile (VIP)
  - (4) Rey 15 Item test
- 

**Q: Was the plaintiff given any neuropsychological tests to detect malingering?**

In litigation, evidence submitted to support the plaintiff's diagnosis of brain injury is often the plaintiff's own subjective complaints. Neuropsychological testing is helpful in comparing the plaintiff's actual level of cognitive functioning to the plaintiff's reported level of functioning. Tests designed to detect malingering look at symptom exaggeration, inconsistent response styles, and performance that is worse than control subjects or subjects with true organic injuries.

---

**Q: Was the plaintiff given the Minnesota Multiphasic Personality Inventory (MMPI)?**

The MMPI is the most widely used personality test and it consists of 567 items in the form of statements which must be answered as true or false. There are three scales used for validity, the "L" (lie) scale, the "F" (faking) scale, and the "K" (defensiveness) scale. These are used to assess a variety of things including malingering.

---

**Q: Do the results of the Minnesota Multiphasic Personality Inventory (MMPI) indicate the plaintiff was malingering?**

Elevated "F" scores may be considered evidence of malingering and suggest unusual and contradictory ways of answering test items.

*However, the "F" scale can fail at detecting malingering in cases of personal injury, because some questions require the patient to admit things that malingerers try to avoid admitting.*

---

# Malingering

---

## DEPOSITION QUESTIONS

---

### General Questions

(continued)

**Q: What are the objective or quantitative indicators of *malingering* on the MMPI?**

An elevated score on the “F” scale (a validity scale) may be suggestive of malingering or an attempt to fake bad.

T-scores in a range of 65 to 79 are indicative of persons who:

- may have very deviant social, political, or religious convictions
- may manifest clinically severe neurotic or psychotic disorders if relatively free of psychopathology, are described as:
  - moody
  - restless
  - dissatisfied
  - changeable, unstable
  - curious and complex
  - opinionated
  - opportunistic

T-scores between 80-99 on the “F” scale indicate persons who:

- may be exaggerating symptoms and problems as a plea for help
- may be malingering
- may be resistant to the testing procedure
- may be clearly psychotic

---

**Q: What was the score(s) on the F minus K scales (F-K)?**

Persons who are trying to create the impression of severe psychopathology score higher on the "F" scale than the "K" scale. When the "F" scale raw score minus the "K" scale raw score is greater than 9, a fake-bad profile is likely. The higher the score the greater the likelihood of a fake-bad profile. (reference 47, p. 46)

---

**Q: At what level does the *F minus K scale* indicate manipulation of test answers to you?**

---

**Q: How did you confirm or rule out whether the MMPI data involved an attempt to fake or exaggerate symptoms?**

---

**Q: Was the plaintiff given the Rey 15 Item Test?**

The Rey 15 item test is a commonly used neuropsychological test to detect malingering. It is based on the belief that persons faking a brain injury will perform more poorly than those with severe brain injury. A card is presented to the patient with 5 rows of 3 stimuli organized sequentially. The patient only has to remember a few concepts and those who cannot should be considered for malingering. Typically malingerers don't perform as well as patients with legitimate injuries and they do not display the common errors made by truly brain injured patients.

---

**Q: Did you or any other examiner administer the Wechsler Adult Intelligence Scale revised (WAIS-R) or the WAIS-III?**

---

# Malingering

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## DEPOSITION QUESTIONS

---

### General Questions

(continued)

- Q: What does *wide scatter* indicate?**  
Wide scatter of test answers may indicate answer manipulation.
- 
- Q: Was there *wide scatter* on the plaintiff's subtests?**
- 
- Q: Is *malingering* an important issue in psychotherapy?**
- 
- Q: Is *malingering* an important issue when the patient is a litigant?**
- 
- Q: Did you verify the plaintiff's symptoms or complaints in any way?**
- 
- Q: Who did you talk with to verify the plaintiff's symptoms or complaints?**
- 
- Q: Are you aware of studies showing that children and adults have deceived psychologists and psychiatrists into believing that they have a mental illness, including brain damage?**
- 
- Q: Are you aware of any articles in scientific or professional journals stating that psychiatrists and psychologists have not developed a successful way to detect malingering?**
- 
- Q: Are you aware of studies that show little relationship between the clinician's confidence in his or her opinion regarding malingering and the accuracy of that opinion?**
- 
- Q: Is there a foolproof method to distinguish between malingering and a true illness or conversion disorder?**  
It is extremely difficult to distinguish between malingering and a true illness or a somatoform, factitious, or conversion disorder even for experienced clinicians. This is especially true when the malingerer, has high intellectual functioning and has acquired information about a particular sickness or injury and provides symptoms consistent with that condition.
- 
- Q: Are you familiar with the Rosenhan study on faking mental illness? ("On Being Sane in Insane Places")**  
Professor Rosenhan's study entitled "On Being Sane in Insane Places" included eight normal students as part of a university research project. Each participant went to twelve mental hospitals complaining of voices saying, "empty," "hollow," or "thud." While all other information presented upon admission to the hospitals was within the normal range, they were all diagnosed as schizophrenic. Immediately after admission, the Rosenhan "patients" stopped the simulation of hearing voices. They were kept in the hospital an average of three weeks.

# Malingering

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## DEPOSITION QUESTIONS

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### General Questions

*(continued)*

During that time, none of the examining psychiatrists discovered that the symptoms of schizophrenia were feigned. No further data was gathered by the psychiatrists to validate the diagnosis. In fact, the psychiatrists distorted the information obtained from these patients to fit the diagnosis.

Despite various methodological flaws, this study provides valuable insight on the inability of psychiatrists to distinguish feigned mental illness from actual mental illness.

- 
- Q: Is it possible for a patient to deceive you?**
- 
- Q: Have you ever been deceived by a patient?**
- 
- Q: How did you learn that you were deceived?**
- 
- Q: If someone was successful in deceiving you, you wouldn't know you were deceived, would you?**
- 
- Q: Then, you really wouldn't know how many patients involved in litigation have successfully deceived you?**
- 
- Q: Is it possible that the plaintiff has manipulated his or her symptoms to receive compensation in this case?**

## SECTION 8.2: FACTITIOUS DISORDER

**DEFENSE THEORY:** The factitious disorder is a relatively common basis for the ongoing report of symptoms and behaviors in claims of physical and psychological injury. Although malingering is frequently suspected and investigated, the factitious disorder is rarely the subject of inquiry by defense counsel.

### INTRODUCTION

Factitious Disorders are characterized by physical or psychological symptoms that are intentionally produced or feigned in order to assume the sick role. The judgment that a particular symptom is intentionally produced is made both by direct evidence and by excluding other causes of the symptom. For example, an individual presenting with hematuria is found to have anticoagulants in his possession. The person denies having taken them, but blood studies are consistent with the ingestion of anticoagulants. A reasonable inference, in the absence of evidence that accidental ingestion occurred, is that the individual may have taken the medication intentionally. It should be noted that the presence of factitious symptoms does not preclude the coexistence of true physical or psychological symptoms.

Factitious Disorders are distinguished from acts of Malingering. In Malingering, the individual also produces the symptoms intentionally, but has a goal that is obviously recognizable when the environmental circumstances are known. For example, the intentional production of symptoms to avoid jury duty, standing trial, or avoid serving in the military would be classified as Malingering. Similarly, if an individual who is hospitalized for treatment of a mental disorder simulates an exacerbation of illness to avoid transfer to another, less desirable facility, this would be an act of Malingering. In contrast, in Factitious Disorder, the motivation is a psychological need to assume the sick role, as evidenced by an absence of external incentives for the behavior. Malingering may be considered to be adaptive under certain circumstances (e.g., in hostage situations), but by definition, a diagnosis of a Factitious Disorder always implies psychopathology.

# Factitious Disorder

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## DEPOSITION QUESTIONS

---

TABLE 8.2-1.

**Diagnostic Criteria for Factitious Disorder**

- A. Intentional production or feigning of physical or psychological signs or symptoms.
- B. The motivation for the behavior is to assume the sick role.
- C. External incentives for the behavior (such as economic gain, avoiding legal responsibility, or improving physical well-being, as in Malingering) are absent.

Code based on type:

- 300.16 With Predominantly Psychological Signs and Symptoms:**  
if psychological signs and symptoms predominate in the clinical presentation
- 300.19 With Predominantly Physical Signs and Symptoms:**  
if physical signs and symptoms predominate in the clinical presentation
- 300.19 With Combined Psychological and Physical Signs and Symptoms:**  
if both psychological and physical signs and symptoms are present but neither predominates in the clinical presentation

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### General Questions

**Q: Is there any indication of a purposeful manipulation of symptoms?**

If the witness indicates the possibility of symptom manipulation, defense counsel should ask the following questions to determine if the plaintiff has a factitious disorder or is malingering (a manipulation of symptoms to obtain money or avoid responsibility). See the section on malingering for additional questions.

---

**Q: What procedures did you use to rule out a factitious disorder?**

---

**Q: Did you verify the plaintiff's reported symptoms and behaviors with observations by others?**

---

**Q: Did you give the plaintiff psychological tests?**

Detection of the factitious disorder is primarily from the clinical interview and history. (See Chapter 1)

---

**Q: Did you examine all of the plaintiff's medical history to determine the presence of previous factitious behavior? (e.g., extensive exploratory testing with negative results)**

---

# Factitious Disorder

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## DEPOSITION QUESTIONS

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### General Questions

**Q:** Did you examine nurse's notes from past medical records to determine the presence of previous *factitious behavior*?

---

**Q:** Does the plaintiff have a history of *numerous hospitalizations*?

---

**Q:** Is it possible that any of the plaintiff's symptoms are *factitious*?

---

**Q:** Has the plaintiff ever been diagnosed with *factitious disorder*?

In factitious disorder (like malingering) there is also symptom simulation and exaggeration, but the motivation is an internal one (compared to external) and the desired effect is to be placed in the "sick role". In the DSM IV and DSM IV-TR, the disorder can be specified by three subtypes: with predominantly physical signs and symptoms, with predominantly psychological signs and symptoms, and with physical and psychological signs and symptoms.



## SECTION 8.3: GANSER'S SYNDROME

**DEFENSE THEORY:** Ganser's syndrome appears mainly in high risk head injury cases. The condition usually presents at deposition when the plaintiff answers questions with Ganser pattern responses. This pattern is indicative of a person who wants to prove that he is brain damaged. Knowing that he cannot refuse to answer the deposition questions, he provides a specific pattern of answers. These include, "I don't know" answers to questions that he obviously does know the answer (What is your name? What is your spouse's name? etc.). The second pattern is answering past the point or providing many answers that do not match the question. Ganser plaintiffs appear to have a malingering phenomenon in combination with a mental illness.

### INTRODUCTION

Ganser's syndrome is rather uncommon in the general population. It is a fascinating, yet poorly studied dissociative condition whose exact etiology, classification, and symptom constellation are still debated in the literature. (reference 18, p. 1574) Ganser's syndrome is listed in the DSM-IV and DSM IV-TR under the heading of Dissociative Disorder, not otherwise specified (NOS). In this syndrome, ludicrous approximate answers or responses are made to simple questions or commands, which indicate that the questions are clearly understood and that deliberately incorrect responses are being given. (reference 22) When asked to add two and two, the answer may be five. The sum of three and three may be stated as seven. When asked to point upward, the patient may point down, and then point up when asked to point down. Ganser's syndrome is frequently accompanied by complaints of auditory and visual hallucinations, circumscribed amnesia, and disorientation. The symptoms in this syndrome develop rapidly and usually occur in response to severe environmental stressors, such as facing imprisonment. It is short-lived and requires essentially no active treatment.

# Ganser's Syndrome

---

## DEPOSITION QUESTIONS

---

### General Questions

**Q: What is Ganser's syndrome?**

Ganser's syndrome is characterized by approximate, but incorrect or random verbal responses, disorientation, perceptual disturbances or hallucinations, and fugue and conversion symptoms, with eventual abrupt recovery and amnesia for the episode. The cause of Ganser's syndrome is unknown but researchers have identified three possible causes: 1) direct organic damage from head injury; 2) a psychotic reaction to intolerable stress and a feeling of helplessness; and 3) a hysterical reaction, with compensation as a possible motive.

---

**Q: Does the plaintiff answer questions with approximate answers?**

---

**Q: Does the plaintiff have trouble naming common objects?**

---

**Q: Are there any precipitating stressors which may have led to the onset of Ganser's syndrome?**

---

**Q: Is there any evidence of a comorbid Axis I disorder?**

Research suggests that the majority of patients with Ganser's syndrome have a comorbid mental disorder. In fact, the condition may be a prelude to an acute and severe psychotic episode. (reference 18, p. 1575)

---

**Q: Has the plaintiff been subjected to any recent severe environmental stressor?**

---

**Q: Does the plaintiff stand to gain anything if his claims are accepted?**

---

**Q: Are you familiar with Ganser's syndrome?**

Ganser's syndrome occurs much more often in men than women, the mean age of subjects is 35 years of age and the mean duration of the episode is 1 month. Appropriate treatment will lead to a rapid resolution of the syndrome. (reference 18, p. 1575)

---

**Q: Have you observed, evaluated or tested a person who presented with Ganser-like symptoms?**

Frequently observed Ganser symptoms include amnesia, disorientation or confusion, conversion symptoms, fugue state, and a loss of personal identity. Hallucinations occur in 50% of persons with Ganser's syndrome. These symptoms are also seen in severe head injury cases, and a lack of familiarity with Ganser's syndrome may lead to a misdiagnosis. (reference 18, p. 1575)

## SECTION 8.4: CONVERSION DISORDER

**DEFENSE THEORY:** Once organic causes have been ruled out for the plaintiff's symptoms, the presence of a Conversion Disorder must be considered. The unconscious motivation of the plaintiff with a Conversion Disorder is the strong need to be disabled. Early treatment can prevent the disabilities from becoming permanent. Plaintiffs with a Conversion Disorder often have a history that includes physical or mental abuse.

### INTRODUCTION

The essential feature of Conversion Disorder is the presence of symptoms or deficits affecting voluntary motor or sensory function that suggest a neurological or other general medical condition. Psychological factors are judged to be associated with the symptom or deficit, a judgment based on the observation that the initiation or exacerbation of the symptom or deficit is preceded by conflicts or other stressors. The symptoms are not intentionally produced or feigned, as in Factitious Disorder or Malingering.

Conversion symptoms are related to voluntary motor or sensory functioning and are thus referred to as "pseudoneurological." Motor symptoms or deficits include impaired coordination or balance, paralysis or localized weakness, aphonia, difficulty swallowing or a sensation of a lump in the throat, and urinary retention. Sensory symptoms or deficits include loss of touch or pain sensation, double vision, blindness, deafness, and hallucinations. Symptoms may also include seizures or convulsions.

Traditionally, the term conversion derived from the hypothesis that the individual's somatic symptom represents a symbolic resolution of an unconscious psychological conflict, reducing anxiety and serving to keep the conflict out of awareness ("primary gain"). The individual might also derive "secondary gain" from the conversion symptom—that is, external benefits are obtained or noxious duties or responsibilities are evaded.

Conversion Disorder appears to be more frequent in women than in men. Reported rates of Conversion Disorder have varied widely, ranging from 11/100,000 to 500/100,000 in general population samples. It has been reported in up to 3% of outpatient referrals to mental health clinics.

# Conversion Disorder

---

## DEPOSITION QUESTIONS

---

**TABLE 8.4-1.**

***Diagnostic Criteria for 300.11 Conversion Disorder***

- A.** One or more symptoms or deficits affecting voluntary motor or sensory function that suggest a neurological or other general medical condition.
- B.** Psychological factors are judged to be associated with the symptom or deficit because the initiation or exacerbation of the symptom or deficit is preceded by conflicts or other stressors.
- C.** The symptom or deficit is not intentionally produced or feigned (as in Factitious Disorder or Malingering).
- D.** The symptom or deficit cannot, after appropriate investigation, be fully explained by a general medical condition, or by the direct effects of a substance, or as a culturally sanctioned behavior or experience.
- E.** The symptom or deficit causes clinically significant distress or impairment in social, occupational, or other important areas of functioning or warrants medical evaluation.
- F.** The symptom or deficit is not limited to pain or sexual dysfunction, does not occur exclusively during the course of Somatization Disorder, and is not better accounted for by another mental disorder.

*Specify type of symptom or deficit:*

- With Motor Symptom or Deficit**
- With Sensory Symptom or Deficit**
- With Seizures or Convulsions**
- With Mixed Presentation**

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### General Questions

**Q: Describe the plaintiff's motor symptoms.**

Symptoms or deficits may affect voluntary motor function.

---

**Q: Describe the plaintiff's sensory symptoms.**

Symptoms or deficits may affect voluntary sensory function.

---

**Q: Are there any psychological factors or conditions that could explain the onset of the plaintiff's symptoms?**

In conversion disorder, psychological factors are judged to be associated with the symptom or deficit because the initiation or exacerbation of the symptom or deficit is preceded by conflicts or other stressors. (criterion B)

---

# Conversion Disorder

---

## DEPOSITION QUESTIONS

---

### General Questions

(continued)

- Q: Are the plaintiff's symptoms more frequent or intense during times of stress?**  
Symptoms may be more common following extreme psychosocial stress (e.g., warfare, death, separation, trauma, etc.). In fact, diagnosis is often made when a close temporal relationship between a conflict or stressor and the initiation or exacerbation of a symptom is obvious (if symptoms cannot be explained medically). (reference 7, pp. 492-498)
- 
- Q: Are the plaintiff's symptoms intentionally produced? Is there any identifiable secondary gain?**  
The symptoms or deficits in conversion disorder are not intentionally produced or feigned (as in Factitious Disorder or Malingering). (criterion C)
- 
- Q: Are the plaintiff's symptoms explainable by any identifiable medical condition?**  
The conversion symptom or deficit cannot, after appropriate investigation, be fully explained by a general medical condition. (criterion D)
- 
- Q: Are the plaintiff's symptoms explainable as a medication or drug side-effect?**  
The conversion symptom or deficit cannot, after appropriate investigation, be fully explained by the direct effects of a substance. (criterion D)
- 
- Q: Are the plaintiff's symptoms explainable as a culturally sanctioned behavior or experience?**  
The conversion symptom or deficit cannot, after appropriate investigation, be fully explained as a culturally sanctioned behavior or experience. (criterion D)
- 
- Q: Do the plaintiff's complaints result in clinically significant distress?**  
Conversion symptoms often cause significant distress and impairment in social, occupational, or other important areas of functioning. (criterion E)
- 
- Q: Did you perform a thorough examination and medical investigation in order to rule out Conversion Disorder?**  
A diagnosis of Conversion Disorder can be made if a thorough medical investigation has been performed to rule out a neurological or general medical condition. If there is no identifiable medical etiology for the symptoms, Conversion disorder should be considered.
- 
- Q: Have the plaintiff's symptoms ever appeared to be inconsistent or change over time?**  
Conversion symptoms are often inconsistent. A "paralyzed" extremity will be moved inadvertently while dressing or when attention is directed elsewhere. If placed above the head and released, a "paralyzed" arm will briefly retain its position, then fall to the side, rather than striking the head. A conversion "seizure" will vary from convulsion to convulsion, and paroxysmal activity will not be evident on an EEG. (reference 7, pp. 492-498)
-

# Conversion Disorder

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## DEPOSITION QUESTIONS

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### General Questions

(continued)

**Q: Does the plaintiff show any concern over their condition and current complaints?**

Individuals with conversion symptoms may show "la belle indifference" (i.e., a relative lack of concern about the nature or implications of the symptoms) or may also present in a dramatic or histrionic fashion. Because these individuals are often suggestible, their symptoms may be modified or resolved based on external cues. (reference 7, pp. 492-498)

---

**Q: Does the plaintiff present in a dramatic or histrionic manner?**

(reference 7, pp. 492-498)

---

**Q: Are there any associated laboratory findings?**

No specific laboratory abnormalities are associated with Conversion Disorder. In fact, it is the absence of expected findings that suggests and supports the diagnosis of Conversion Disorder. However, laboratory findings consistent with a general medical condition do not exclude the diagnosis of Conversion Disorder, because it only requires that a symptom not be fully explained by such a condition. (reference 7, pp. 492-498)

---

**Q: Are there any objective abnormalities that might corroborate the plaintiff's claimed symptoms?** (abnormal neurological exam with focal deficits such as abnormal cranial nerves, reflexes, motor, sensory findings)

Symptoms of Conversion Disorder typically do not conform to known anatomical pathways and physiological mechanisms. Thus, expected objective signs (e.g., reflex changes) are rarely present. (reference 7, pp. 492-498)

---

**Q: Does the plaintiff have a history of pseudoneurological symptoms?**

The onset of Conversion Disorder is generally from late childhood to early adulthood, rarely before age 10 years or after age 35 years. A history of unexplained somatic (especially conversion) or dissociative symptoms signifies a greater likelihood that an apparent conversion symptom is not due to a general medical condition. (reference 7, pp. 492-498)

---

**Q: Is there a family history of conversion symptoms?**

Limited data suggest that conversion symptoms are more frequent in relatives of individuals with Conversion Disorder. Increased risk of Conversion Disorder in monozygotic twin pairs but not in dizygotic twin pairs has been reported. (reference 7, pp. 492-498)

## SECTION 8.5: PAIN DISORDER

(also known as Somatoform Pain Disorder)

**DEFENSE THEORY: Comprehensive treatment of plaintiff's pain disorder should include antidepressant medication. Failure to treat the underlying depression in chronic pain cases will significantly delay recovery.**

### INTRODUCTION

The essential feature of Pain Disorder is pain that is the predominant focus of the clinical presentation and is of sufficient severity to warrant clinical attention. The pain causes significant distress or impairment in social, occupational, or other important areas of functioning. Psychological factors are judged to play a significant role in the onset, severity, exacerbation, or maintenance of the pain. The pain is not intentionally produced or feigned as in Factitious Disorder or Malingering.

Examples of impairment resulting from the pain include an inability to work or attend school, frequent use of the health care system, pain that is a major focus of the individual's life, substantial use of analgesics, and relational problems such as marital discord and disruption of the family's normal lifestyle.

Psychological factors which can exacerbate the Pain Disorder may be due to a pre-existing Axis I condition and / or Axis II personality disorder. Evidence of prior psychopathology would help mitigate damages attributed to a proximately caused pain syndrome. Even in the event that these psychological factors do not meet the diagnostic criteria for a clinical mental disorder, an emotional response to a psychosocial stressor is usually transient and rarely results in permanent disability. Pain associated with these reactions may resolve when the stress subsides.

**Note:** This diagnosis should be carefully considered by defense experts. The diagnosis allows for some level of pain attributable to an injury or medical condition, but that which may be out of proportion to the injury due to the presence of psychological factors. **This may mitigate the plaintiff's claim of permanent and proximately caused pain.**

# Pain Disorder

---

## DEPOSITION QUESTIONS

---

TABLE 8.5-1.

***Diagnostic criteria for Pain Disorder***

- A. Pain in one or more anatomical sites is the predominant focus of the clinical presentation and is of sufficient severity to warrant clinical attention.
- B. The pain causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.
- C. Psychological factors are judged to have an important role in the onset, severity, exacerbation, or maintenance of the pain.
- D. The symptom or deficit is not intentionally produced or feigned (as in Factitious Disorder or Malingering).
- E. The pain is not better accounted for by a Mood, Anxiety, or Psychotic Disorder and does not meet criteria for Dyspareunia.

Code as follows:

**307.80 Pain Disorder Associated With Psychological Factors:** psychological factors are judged to have the major role in the onset, severity, exacerbation, or maintenance of the pain. (If a general medical condition is present, it does not have a major role in the onset, severity, exacerbation, or maintenance of the pain.) This type of Pain Disorder is not diagnosed if criteria are also met for Somatization Disorder.

Specify if:

**Acute:** duration of less than 6 months

**Chronic:** duration of 6 months or longer

**307.89 Pain Disorder Associated With Both Psychological Factors and a General Medical Condition:** both psychological factors and a general medical condition are judged to have important roles in the onset, severity, exacerbation, or maintenance of the pain. The associated general medical condition or anatomical site of the pain is coded on Axis III.

Specify if:

**Acute:** duration of less than 6 months

**Chronic:** duration of 6 months or longer

# Pain Disorder

---

## DEPOSITION QUESTIONS

---

**TABLE 8.5-1. (continued)**

**Note:** There is another subtype of Pain Disorder known as Pain Disorder Associated With a General Medical Condition. This subtype of Pain Disorder is not considered a mental disorder and is coded on Axis III. It is listed here to facilitate differential diagnosis. The pain results from a general medical condition, and psychological factors are judged to play either no role or a minimal role in the onset or maintenance of the pain.

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### General Questions

**Q: Describe the plaintiff's pain.**

---

**Q: Does the plaintiff's pain interfere with his or her functioning?**

Pain may severely disrupt various aspects of daily life. Unemployment, disability, and family problems are frequently encountered among individuals with chronic forms of Pain Disorder.

---

**Q: Are there any *psychological factors or conditions* that could explain the onset of the plaintiff's symptoms?**

In Pain Disorder, psychological factors are judged to be associated with the symptom or deficit because the initiation or exacerbation of the symptom or deficit is preceded by conflicts or other stressors. (criterion C)

---

**Q: Are there any *psychosocial stressors or events* that could explain the onset of the plaintiff's symptoms.**

While the answer to this question will likely be the cause of action, a positive response in this regard indicates that the plaintiff's pain is, in part, due to the transient effects of a stressor.

---

**Q: Are the plaintiff's symptoms more *frequent or intense during times of stress*?**

Pain symptoms may be exacerbated following a psychosocial stressor.

---

**Q: Are the plaintiff's symptoms *intentionally produced*? Is there any identifiable secondary gain?**

The symptoms or deficits in Pain Disorder are not intentionally produced or feigned (as in Factitious Disorder or Malingering). (criterion D)

---

**Q: Is the plaintiff's pain better accounted for by a *pre-existing, psychological disorder*?**

Pain Disorder is not diagnosed if the pain is better accounted for by a Mood, Anxiety, or Psychotic Disorder, or if the pain presentation meets criteria for Dyspareunia (painful sexual intercourse). (criterion E)

---

# Pain Disorder

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## DEPOSITION QUESTIONS

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### General Questions

(continued)

**Q: Did you conduct a thorough *medical examination and psychological evaluation* to rule out Pain Disorder?**

Again, this diagnosis should be considered by the defense (and is rarely considered by the plaintiff), as it represents pain that has been confounded by psychological factors (which are usually transient).

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**Q: Have the plaintiff's symptoms ever appeared to be *inconsistent or change over time*?**

Pain symptoms which are psychologically linked, may wax and wane over time, in accordance with various stressors or mood states.

---

**Q: Does the plaintiff present in a *dramatic or histrionic manner*?**

---

**Q: Has the plaintiff become *addicted to a narcotic or any other pain medication*?**

Indications that the plaintiff may be abusing pain medication are:

- (1) Taking more medications than prescribed;
  - (2) Under-reporting actual numbers of medications being used;
  - (3) Telephone calls requesting medications or refills rather than actual office visit;
  - (4) Not accurately reporting to physician(s) the prescribing practice of all other physicians being seen;
  - (5) Failing to report medication use concerns of one physician to other physicians;
  - (6) Receiving the same medication from more than one prescriber, with no evidence that one physician is aware of others prescribing;
  - (7) Pattern of justifying need to take more than prescribed;
  - (8) References to being unable to taper or reduce use;
  - (9) Reference to symptoms consistent with withdrawal symptoms;
  - (10) History of lost, stolen or destroyed medications;
  - (11) Altering prescriptions;
  - (12) Using different pharmacies to fill prescriptions from different physicians;
  - (13) Pattern of switching from one physician to another when the first physician expresses concern about prescription medication use, indicates reluctance or refusal to continue prescribing, or proposes alternate strategies for symptom control;
  - (14) Receiving a prescription for one type of narcotic, then requesting another medication of the same drug class, citing minimal pain relief or negative side-effects;
  - (15) Resistance and noncompliance with non-pharmacologic intervention.
- 

**Q: Does the plaintiff have a *history of alcohol dependence or drug abuse*?**

A history of Substance Dependence or Abuse, whether with an illicit drug or a prescribed medication, increases the risk for the development of pain pill Dependence or Abuse. However, even individuals without a history of Substance Dependence or Abuse are at risk for developing these problems. As many as 25% of individuals who have been prescribed opioids for treatment of chronic pain may become abusive of or dependent on the pain medication.

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# Pain Disorder

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## DEPOSITION QUESTIONS

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### General Questions

(continued)

**Q: Have you reviewed the medical reports of plaintiff's other treating clinicians for their diagnosis, treatment and medications?**

The risk of developing an iatrogenic Substance Dependence can be minimized by ruling out the presence of an underlying, treatable cause for the pain.

- (1) Has the plaintiff been diagnosed with a comorbid mental disorder? If so, are they receiving treatment for that disorder, either psychotherapy or medication?
- (2) Is the plaintiff being prescribed pain medication by several treating clinicians?
- (3) Is the plaintiff alcohol dependent? Treatment for a pain disorder is compromised when the plaintiff abuses alcohol.

---

**Q: Has the plaintiff been prescribed *OxyContin* for pain relief?**

There is emerging data indicating that OxyContin, an opioid agonist and a Scheduled II controlled substance, is a high-risk drug under certain conditions. If the plaintiff is taking this drug, they may develop drug dependence and the risks and side-effects that are associated with OxyContin drug dependence. The transient side-effects of this opioid agonist may be identified, in error, as direct effects of the cause of action.

The Physicians' Desk Reference 2002 lists the adverse side-effects of OxyContin as follows:

**OXYCONTIN** (oxycodone hcl controlled-release) for the management of moderate to severe pain where use of an opioid analgesic is appropriate for more than a few days. **ADVERSE EFFECTS:** respiratory depression, apnea, respiratory arrest, circulatory depression, hypotension, shock, constipation, nausea, somnolence, dizziness, vomiting, pruritus, headaches, dry mouth, sweating, asthenia, nervousness, insomnia, anorexia, abdominal pain, dyspepsia, rash, anxiety, euphoria, dyspnea, postural hypotension, chills, twitching, gastritis, abnormal dreams, thought abnormalities, hiccups, accidental injury, chest pain, facial edema, malaise, neck pain, migraine, syncope, vasodilatation, ST depression, dysphagia, eructation, flatulence, gastrointestinal disorder, increased appetite, stomatitis, lymphadenopathy, dehydration, hyponatremia, peripheral edema, syndrome of inappropriate antidiuretic hormone secretion, thirst, abnormal gait, agitation, amnesia, depersonalization, depression, emotional lability, hallucination, hyperkinesia, hypesthesia, hypotonia, malaise, paresthesia, seizure, speech disorder, stupor, tinnitus, tremor, vertigo, withdrawal syndrome, cough increased, pharyngitis, voice alteration, dry skin, exfoliative dermatitis, abnormal vision, taste perversion, dysuria, hematuria, impotence, polyuria, urinary retention, urination impaired.

---

**Q: Does the plaintiff's pain interfere with his or her sleep?**

Common sleep symptoms in individuals with chronic pain include delayed sleep onset, frequent awakenings, nonrestorative sleep, and decreased sleep time. Sleep Disorders such as obstructive sleep apnea and nocturnal myoclonus occur at higher rates among individuals with chronic pain than in the general population. (reference 7, pp. 498-503)

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# Pain Disorder

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## DEPOSITION QUESTIONS

---

### General Questions

*(continued)*

**Q: Are there any associated laboratory findings to confirm the source of plaintiff's pain?**

Laboratory testing may reveal pathology that is associated with the pain (e.g., finding of a herniated lumbar disc on a magnetic resonance imaging (MRI) scan in an individual with radicular low-back pain). However, often there is no objective medical evidence corroborating the plaintiff's pain.

---

**Q: Are there any positive findings of pain on physical examination?**

The physical examination may reveal pathology that is associated with the pain. Pain Disorder can be associated with many general medical conditions. Among the most common general medical conditions associated with pain are various musculoskeletal conditions (e.g., disc herniation, osteoporosis, osteoarthritis or rheumatoid arthritis, myofascial syndromes), neuropathies (e.g., diabetic neuropathies, postherpetic neuralgia), and malignancies (e.g., metastatic lesions in bone, tumor infiltration of nerves). (reference 7, pp. 498-503)

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**Q: Does the plaintiff have a history of unexplained pain?**

In most cases, the patient's pain has persisted for many years prior to when the individual comes to the attention of the mental health profession. (reference 7, pp. 498-503)

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**Q: Is there a familial history of pain complaints or Pain Disorder?**

Depressive Disorders, Alcohol Dependence, and chronic pain may be more common in the first-degree biological relatives of individuals with chronic Pain Disorder. (reference 7, pp. 498-503)

# APPENDIX



**APPENDIX  
A**

*Caffeine Consumption and Symptom Chart*

| <b>CAFFEINE CONSUMPTION</b>   |                               |
|---|-------------------------------|
| <b>Source</b>   | <b>Milligrams of Caffeine</b> |
| Coffee (6 oz)   | 100 mg                        |
| Cola (12 oz)  | 45 mg                         |
| Tea (6 oz)  | 40 mg                         |
| Medications containing caffeine   | 25-50 mg                      |
| Migraine Medication   | 100-300 mg                    |
| Over-the counter stimulants   | 100-300 mg                    |
| <b>CAFFEINE SYMPTOMS</b>  |                               |
| 250 mg or more per day  |                               |
| Restlessness<br>Nervousness<br>Excitement<br>Insomnia<br>Flushed face<br>Diuresis<br>Gastrointestinal complaints  |                               |
| 1,000 mg (1 gram) or more per day   |                               |
| Muscle twitching<br>Rambling flow of thought / speech<br>Cardiac arrhythmia<br>Inexhaustibility<br>Psychomotor agitation<br>Ringing in the ears<br>Flashes of light |                               |
| 10 grams or more per day  |                               |
| Grand mal seizures<br>Respiratory failure   |                               |

**APPENDIX  
B**

*Transient Drug Side-effects that Are Frequently Claimed as Permanent Effects of Injury*

| <b>Published side-effects of the plaintiff's commonly used drug classes.<br/>These are transient side-effects that will remit when the drug is withdrawn.</b> |                     |                   |         |                 |                            |            |                      |          |
|---|---------------------|-------------------|---------|-----------------|----------------------------|------------|----------------------|----------|
| <b>Rx</b><br><br><b>The drug class<br/>(and prescribed use),<br/>of drugs most often noted<br/>in the plaintiff's medical records.</b>                        | Agitation           | Anger / Hostility | Anxiety | Appetite Change | Confusion / Disorientation | Depression | Dizziness or Vertigo | Headache |
|   | 1. Analgesic (pain) | ●                 | ●       | ●               | ●                          | ●          | ●                    | ●        |
| 2. Anti-inflammatory (musculoskeletal)  | ●                   | ●                 | ●       | ●               | ●                          | ●          | ●                    | ●        |
| 3. Antiarthritic (stiffness and joint pain)   | ●                   | ●                 | ●       | ●               | ●                          | ●          | ●                    | ●        |
| 4. Anticonvulsant (seizures)  | ●                   | ●                 | ●       | ●               | ●                          | ●          | ●                    | ●        |
| 5. Antidepressant (depression and pain)   | ●                   | ●                 | ●       | ●               | ●                          | ●          | ●                    | ●        |
| 6. Antihypertensive (high blood pressure)   | ●                   |                   | ●       | ●               | ●                          | ●          | ●                    | ●        |
| 7. Antipsychotic (thought disorders)  | ●                   | ●                 | ●       | ●               | ●                          | ●          | ●                    | ●        |
| 8. Antianxiety (nervousness, anxiety)   | ●                   | ●                 | ●       | ●               | ●                          | ●          | ●                    | ●        |
| 9. Appetite suppressant (weight loss)   | ●                   |                   |         |                 |                            | ●          | ●                    | ●        |
| 10. Cardiovascular (heart functions & rhythm)   |                     |                   | ●       | ●               | ●                          | ●          | ●                    | ●        |
| 11. Decongestant (allergies)  | ●                   | ●                 |         | ●               | ●                          | ●          | ●                    | ●        |
| 12. Herbal remedies (alternative medications)   |                     |                   |         |                 |                            | ●          | ●                    | ●        |
| 13. Migraine preparation (chronic headache)   | ●                   | ●                 | ●       | ●               | ●                          | ●          | ●                    |          |
| 14. Muscle relaxant (muscle spasm and pain)   | ●                   |                   | ●       |                 | ●                          | ●          | ●                    | ●        |
| 15. Oral Contraceptive (birth control)  |                     |                   |         | ●               |                            |            | ●                    | ●        |
| 16. Sedative / Hypnotic (rest or sleep)   | ●                   | ●                 | ●       | ●               | ●                          | ●          | ●                    | ●        |
| 17. Steroid (inflammation or skin reactions)  |                     |                   | ●       | ●               | ●                          | ●          | ●                    | ●        |
| 18. Vertigo Agents (balance, dizziness & nausea)  | ●                   |                   | ●       |                 | ●                          | ●          | ●                    | ●        |

|   | Impaired Mental Performance | Impaired Physical Performance | Incoordination | Libido Change / Sexual Dysfunction | Insomnia | Irritability | Loss of Concentration | Loss of Memory | Nightmares and Abnormal Dreams | Nervousness | Pain | Syncope (Fainting) | Vision Decrease or change | Weakness / Fatigue / Tiredness |
|---|-----------------------------|-------------------------------|----------------|------------------------------------|----------|--------------|-----------------------|----------------|--------------------------------|-------------|------|--------------------|---------------------------|--------------------------------|
| ● | ●                           | ●                             | ●              | ●                                  | ●        | ●            | ●                     | ●              | ●                              | ●           | ●    | ●                  | ●                         | ●                              |
|   | ●                           | ●                             | ●              | ●                                  | ●        | ●            | ●                     | ●              | ●                              | ●           | ●    | ●                  | ●                         | ●                              |
|   | ●                           | ●                             | ●              | ●                                  | ●        | ●            | ●                     | ●              | ●                              | ●           | ●    | ●                  | ●                         | ●                              |
| ● | ●                           | ●                             | ●              | ●                                  |          | ●            | ●                     | ●              | ●                              | ●           | ●    |                    | ●                         | ●                              |
| ● | ●                           | ●                             | ●              |                                    | ●        | ●            | ●                     | ●              | ●                              | ●           | ●    | ●                  | ●                         | ●                              |
| ● |                             | ●                             | ●              | ●                                  | ●        |              | ●                     | ●              | ●                              | ●           | ●    | ●                  | ●                         | ●                              |
|   |                             | ●                             | ●              | ●                                  | ●        | ●            | ●                     | ●              | ●                              | ●           | ●    | ●                  | ●                         | ●                              |
| ● | ●                           | ●                             | ●              | ●                                  | ●        | ●            | ●                     | ●              | ●                              | ●           | ●    | ●                  | ●                         | ●                              |
|   |                             |                               | ●              |                                    | ●        |              |                       |                |                                |             |      |                    | ●                         |                                |
| ● |                             | ●                             | ●              |                                    | ●        |              | ●                     | ●              | ●                              | ●           | ●    |                    | ●                         | ●                              |
| ● |                             |                               | ●              | ●                                  | ●        | ●            | ●                     | ●              | ●                              |             | ●    | ●                  | ●                         | ●                              |
| ● | ●                           |                               | ●              |                                    |          |              |                       | ●              |                                |             |      |                    |                           | ●                              |
| ● | ●                           | ●                             | ●              | ●                                  | ●        | ●            | ●                     | ●              | ●                              | ●           | ●    | ●                  | ●                         | ●                              |
| ● | ●                           |                               | ●              | ●                                  | ●        |              |                       | ●              | ●                              | ●           | ●    | ●                  | ●                         | ●                              |
| ● |                             |                               |                |                                    | ●        |              |                       | ●              |                                |             |      |                    |                           |                                |
| ● |                             | ●                             | ●              | ●                                  | ●        | ●            | ●                     | ●              | ●                              | ●           | ●    | ●                  | ●                         | ●                              |
|   |                             |                               | ●              |                                    | ●        |              | ●                     | ●              |                                | ●           |      | ●                  |                           | ●                              |
|   | ●                           |                               | ●              |                                    | ●        |              |                       |                |                                | ●           |      |                    | ●                         | ●                              |

## APPENDIX

### C

#### *Medications That May Cause Anxiety*

|                 |                  |               |
|-----------------|------------------|---------------|
| ADALAT          | ETRAFON          | PHENERGAN-VC- |
| ADRENALINE      | EXCELON          | CODEINE       |
| AEROBID         | FLEXERIL         | PHENOBARBITAL |
| ALPHGAN         | FLOXIN           | PHENYL-       |
| ALTACE          | GOODY HEADACHE   | PROPANOLAMINE |
| AMBIEN          | POWDER           | PLAVIX        |
| AMERGE          | HALDOL           | PLENDIL       |
| AMPHETAMINES    | HISTUSSIN        | PONDIMIN      |
| AMYTAL          | HYTRIN           | PRAVACHOL     |
| ANAFRANIL       | HYZAAR           | PREVACID      |
| ANDRODERM PATCH | IMDUR            | PRILOSEC      |
| ANSAID          | INAPSINE         | PROAMATINE    |
| APRESOLINE      | INDOCIN          | PROPULSID     |
| ARTHROTEC       | INSULIN          | PROSOM        |
| ASENDIN         | K-LYTE           | PROTONIX      |
| AUGMENTIN       | LESCOL           | PULMICORT     |
| AVAPRO          | LEVAQUIN         | QUESTRAN      |
| AVONEX          | LORCET           | RELAFEN       |
| AXID            | LOTENSIN         | REMERON       |
| BUTICAPS        | LOTREL           | REVIA         |
| CATAPRES        | LOZOL            | RISPERDAL     |
| CELEBREX        | LUDIOMIL         | SE-AP-ES      |
| CELEXA          | LUVOX            | SEROQUEL      |
| CLARITAN-D      | MARCAINE         | SERTRALINE    |
| CLARITIN        | MAVIK            | SERZONE       |
| CLOMID          | MAXAIR-AUTOHALER | SINEMET       |
| CLOZARIL        | MAXALT           | SONATA        |
| COGNEX          | MAXIDE           | SPORANOX      |
| COMBIPRES       | MIRAPEX          | STADOL        |
| COZAAR          | NARDIL           | SULAR         |
| CYCLOSPORIN     | NEMBUTAL         | SURMONTIL     |
| CYTOTEC         | NEURONTIN        | SYMMETREL     |
| DEPROL          | NOLUDAR          | TAGAMET       |
| DILAUDID        | NORCO            | TESTODERM     |
| DIOVAN          | NOREPHEDRINE     | TIMOPTIC      |
| DORAL           | NOROXIN          | TOFRANIL      |
| DURACT          | NORPLANT-SYSTEM  | TRENTAL       |
| DURAGESIC       | NORPRAMIN        | TRILEPTAL     |
| DURAVENT        | NORVASC          | TRINALIN      |
| EFFEXOR         | OXYCONTIN        | TROVAN        |
| ELAVIL          | PAMELOR          | ULTRAM        |
| ELDEPRYL        | PARLODEL         | UNIVASC       |
| ENDEP           | PARNATE          | VALIUM        |
| EQUAGESIC       | PEPCID           | VANTIN        |
| ESTRATEST       | PERMAX           | VIAGRA        |

## APPENDIX

### C

*(continued)*

#### *Medications That May Cause Anxiety*

VICODIN

VICOPROFEN

VIOXX

VIVACTIL

VOLTAREN

WELLBUTRIN

ZANAFLEX

ZIAC

ZOCOR

ZOFRAN

ZOLOFT

ZOMIG

ZYPREXA

ZYRTEC

## APPENDIX

### D

#### *Medications That May Cause Depression*

|                 |                 |                  |
|-----------------|-----------------|------------------|
| ACCUPRIL        | COUMADIN        | HISTUSSIN        |
| ACCUTANE        | COZAAR          | HYDERGINE        |
| ADALAT          | CRINONE         | HYTRIN           |
| ADAPIN          | CYCRIN          | HYZAAR           |
| AEROBID         | CYLERT          | IMDUR            |
| ALPHGAN         | CYTOTEC         | INAPSINE         |
| ALTACE          | DALMANE         | INDERAL          |
| AMBIEN          | DANTRIUM        | INDERIDE         |
| AMYTAL          | DAYPRO          | INDOCIN          |
| ANAFRANIL       | DECADRON        | KERLONE          |
| ANAPROX         | DEMEROL         | KLONOPIN         |
| ANDRODERM PATCH | DEPAKENE        | LAMICTAL         |
| ANSAID          | DEPAKOTE        | LESCOL           |
| ANTABUSE        | DEPO-PROVERA    | LEVAQUIN         |
| APRESOLINE      | DEPROL          | LEVO-DROMORAM    |
| ARICEPT         | DESOGEN         | LIBRAX           |
| ARTHROTEC       | DESYREL         | LIDODERM PATCH   |
| ASENDIN         | DEXEDRINE       | LIMBITROL        |
| ATIVAN          | DILAUDID        | LIORESAL         |
| AVAPRO          | DIMETAPP        | LIPITOR          |
| AXOCET          | DOLOBID         | LO-OVRAL         |
| AZULFIDINE      | DORAL           | LODINE           |
| BACTRIM         | DURACT          | LOMOTIL          |
| BIPHETAMINE     | DURAGESIC       | LOPID            |
| BRONTEX         | DURAVENT        | LOPRESSOR        |
| BUPRENEX        | DYNACIRC        | LORCET           |
| BUSPAR          | EFFEXOR         | LOZOL            |
| BUTICAPS        | ELAVIL          | LUDIOMIL         |
| CALAN           | ELDEPRYL        | LUVOX            |
| CARBATROL       | EMPIRIN-CODEINE | MACROBID         |
| CATAPRES        | ENDEP           | MARCAINE         |
| CELEBREX        | ESGIC           | MARPLAN          |
| CELEXA          | ESTRACE         | MAVIK            |
| CELONTIN        | ESTRATAB        | MAXAIR-AUTOHALER |
| CENESTIN        | ESTRATEST       | MAXALT           |
| CIPRO           | ETRAFON         | MAXIDE           |
| CLARITAN-D      | EXCELON         | MEBARAL          |
| CLARITIN        | FELDENE         | MECLOMEN         |
| CLIMARA         | FIORICET        | MELLARIL         |
| CLINORIL        | FLAGYL          | MEPERGAN         |
| CLOZARIL        | FLEXERIL        | MESANTOIN        |
| CODEINE         | FLOXIN          | MINIPRESS        |
| COGENTIN        | GABITRIL        | MIRAPEX          |
| COGNEX          | HALCION         | MOBAN            |
| COMBIPRES       | HALDOL          | MODURETIC        |
| CORGARD         | HISMANAL        | MONOPRIL         |

## APPENDIX

### D

(continued)

#### *Medications That May Cause Depression*

|                          |                 |                 |
|--------------------------|-----------------|-----------------|
| MORPHINE-SULFATE         | PREMPHASE       | TIAZAC          |
| MOTRIN                   | PREMPRO         | TIGAN           |
| NALDECON                 | PREVACID        | TIMOPTIC        |
| NALFON                   | PRILOSEC        | TOFRANIL        |
| NAPROSYN                 | PRINZIDE        | TOFRANIL-PM     |
| NARDIL                   | PROCAN-SR       | TOLECTIN        |
| NEMBUTAL                 | PROSOM          | TOPAMAX         |
| NEURONTIN                | PROTONIX        | TOPROL-XL       |
| NIZORAL                  | PROVERA         | TORADOL         |
| NOLUDAR                  | PROZAC          | TRANCOPAL       |
| NOLVADEX                 | PULMICORT       | TRANDATE        |
| NORCO                    | REDUX           | TRANXENE        |
| NORDETTE                 | REGLAN          | TRENTAL         |
| NORINYL                  | RELAFEN         | TRIAVIL         |
| NOROXIN                  | REMERON         | TRILAFON        |
| NORPACE                  | REVIA           | TRINALIN        |
| NORPLANT-SYSTEM          | RISPERDAL       | TRIPHASIL       |
| NORPRAMIN                | RITALIN         | TROVAN          |
| NORVASC                  | ROBAXIN         | TUINAL          |
| NUBAIN                   | RUFEN           | TYLENOL-CODEINE |
| OGEN                     | SANOREX         | VALIUM          |
| ORAP                     | SE-AP-ES        | VASOTEC         |
| ORTHO-NOVUM              | SECONAL-SODIUM  | VIAGRA          |
| ORTHO-CEPT               | SEPTRA          | VICODIN         |
| ORTHOCYCLEN              | SEROQUEL        | VICOPROFEN      |
| ORTHOEST                 | SERTRALINE      | VIOXX           |
| ORUDIS                   | SERZONE         | VIVACTIL        |
| OXYCONTIN                | SINEMET         | VOLTAREN        |
| PAMELOR                  | SINEQUAN        | WELLBUTRIN      |
| PARLODEL                 | SOMA            | XANAX           |
| PARNATE                  | SOMA-COMPOUND   | XYLOCAINE       |
| PAXIL                    | SONATA          | ZANAFLEX        |
| PAXIPAM                  | SPORANOX        | ZANTAC          |
| PEDIAZOLE                | ST. JOHN'S WORT | ZARONTIN        |
| PEPCID                   | SULAR           | ZESTORETIC      |
| PERMAX                   | SULINDAC        | ZESTRIL         |
| PHENAPHEN-CODEINE        | SURMONTIL       | ZIAC            |
| PHENERGAN-VC-<br>CODEINE | SYMMETREL       | ZOCOR           |
| PHENOBARBITAL            | TAGAMET         | ZOLOFT          |
| PLAVIX                   | TALECEN         | ZOMIG           |
| PLENDIL                  | TALWIN-NX       | ZYBAN           |
| PONDIMIN                 | TEGRETOL        | ZYLOPRIM        |
| PRAVACHOL                | TENORETIC       | ZYRTEC          |
| PREMARIN                 | TENORMIN        |                 |
|                          | TESTODERM       |                 |

## APPENDIX

### E

#### *Medications That May Cause Impaired Cognitive Functioning*

|                 |               |            |
|-----------------|---------------|------------|
| AMBIEN          | FLEXERIL      | RISPERDAL  |
| AMYTAL          | GABITRIL      | SERTRALINE |
| ANDRODERM PATCH | HABITROL      | SERZONE    |
| ARTHROTEC       | IMDUR         | SONATA     |
| ASENDIN         | KERLONE       | SULAR      |
| BUSPAR          | LAMICTAL      | TEQUIN     |
| BUTICAPS        | LEVAQUIN      | TIMOPTIC   |
| CARDURA         | LEVO-DROMORAM | TORADOL    |
| CELEXA          | LIMBITROL     | TRIAVIL    |
| CLARITAN-D      | MEBARAL       | TRILEPTAL  |
| CLARITIN        | MIRAPEX       | TROVAN     |
| CODEINE         | NEMBUTAL      | ULTRAM     |
| COGNEX          | NEURONTIN     | VICOPROFEN |
| CYCLOSPORIN     | PAXIL         | VIVACTIL   |
| DEPACON         | PERMAX        | WELLBUTRIN |
| DEPROL          | PHENOBARBITAL | ZANAFLEX   |
| DESYREL         | PREVACID      | ZARONTIN   |
| DILACOR         | PROAMATINE    | ZEBETA     |
| DORAL           | PROSOM        | ZIAC       |
| DURAGESIC       | PROTONIX      | ZOLOFT     |
| ELAVIL          | PROVIGIL      | ZYBAN      |
| ENDEP           | PROZAC        | ZYRTEC     |
| ETRAFON         | REMERON       |            |
| EXCELON         | RESTORIL      |            |

**APPENDIX  
F**

*Medications That May Cause Impaired Memory Functioning*

|                 |               |                |
|-----------------|---------------|----------------|
| AKINETONE       | HALCION       | SERZONE        |
| ALDACTAZIDE     | HALDOL        | SINEMET        |
| ALDACTONE       | HYZAAR        | SOMA-COMPOUND  |
| AMPHETAMINES    | INDERAL       | SYMMETREL      |
| AMYTAL          | INDERIDE      | TAGAMET        |
| ANAFRANIL       | INDOCIN       | TENORETIC      |
| AXID            | K-LYTE        | TENORMIN       |
| AXOCET          | KERLONE       | TESSALON       |
| BUTICAPS        | KLONOPIN      | TIMOPTIC       |
| CELONTIN        | LESCOL        | TOPROL-XL      |
| CENTRAX         | LEVAQUIN      | TRANCOPAL      |
| CHLORTRIMETON   | LEVSIN        | TRANDATE       |
| CLONOPIN        | LOPRESSOR     | TRANSDERM-SCOP |
| CLOZARIL        | LUDIOMIL      | TRANXENE       |
| CORGARD         | MARPLAN       | TRILAFON       |
| COZAAR          | MAXALT        | TRILISATE      |
| DANTRIUM        | MEXITIL       | VOLTAREN       |
| DESOXYN         | MODURETIC     | XANAX          |
| DESYREL         | MONOPRIL      | ZEBETA         |
| DILANTIN        | NOLUDAR       | ZESTORETIC     |
| ELDEPRYL        | NORFLEX       | ZESTRIL        |
| EMPIRIN-CODEINE | NORGESIC      | ZIAC           |
| ESGIC           | NUBAIN        | ZOCOR          |
| ESKALITH        | PBZ-SR        | ZONEGRAN       |
| FELDENE         | PHENOBARBITAL | ZYBAN          |
| FIORICET        | PRAVACHOL     |                |
| FLEXERIL        | PROCAN-SR     |                |
| GABITRIL        | RIFAMATE      |                |



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