Litigating Psychiatric Injuries

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My Background

- Fellow of RANZCP since 1997 with experience in adult psychiatry, neuropsychiatry and psychotherapy
- Masters of Science in Behavioural Economics, London School of Economics
- Current PhD researcher at University of Sydney Business School
- Owner/Manager of Professional Opinions and Behaviour
- Chief Medical Officer: Allianz Life and Zurich Life (psychiatry)
- Various statutory appointments and advisory positions

What We Will Cover

- Why do experts disagree?
- Endogeneity and the Nature of Psychiatry
- The assessment and diagnosis under DSM-5 of Major Depression, PTSD, Adjustment Disorders, ‘illness behaviour’ and Burnout (that has recently been upgraded in ICD-11).
- Functional overlay – the psychological component of a physical injury.
- What documents or information should be provided to a psychiatrist to assist with assessments.
- Some issues of malingering or exaggeration in relation to psychiatric issues.

Why Do Mental Health Experts Disagree?

- They are not experts (does any psychiatric evidence reach the Daubert standard?)
- The Nature of Psychiatry
- The Endogeneity Problem
- Intentional or unintentional bias in attitudes, beliefs and interests
  - Philosophical differences: positivist vs interpretivism
  - Confirmation bias
  - Selection bias
  - Conflicts (contingency, signaling and duty)
- Methodology (checklists, open-closed questions, incorporation of evidence)
- Irreducible uncertainty about the world and complex problems
- Working with different sets of information.
- Failures of reasoning (e.g. double counting physical symptoms, accounting for all evidence)

The Nature of Psychiatry

	Mental Health	**Physical Conditions**
Assumptions	Interpretivism	Positivism
Nature of reality	Socially constructed	Objective, tangible
Goals of Research	Understanding, weak prediction	Explanation, strong prediction
Subject/Researcher relationship	Interactive, cooperative, participative	Rigid separation
Desired information	What some people think and do; what kinds of problems they are confronted with.	How many people think and do a certain thing or have a specific problem.

Endogeneity

What is **endogeneity** and why is it a problem?

In one instance, **simultaneity**, X causes Y and Y causes X. In psychiatry this is a large problem that is often not solved in individual cases. Did person A's depression cause interpersonal difficulties in the workplace or did the workplace cause interpersonal difficulties (or some mixture of both).

In another, an **omitted variable bias**, there are matters that we are unaware of that explain the outcome such as stressors impacting an applicant.

In the third instance, we have difficulties with **measurement errors**. The DSM/ICD systems are open to interpretation, the person being assessed may be biased due to their condition or other factors. The definitions are in flux.

What do Psychiatric Disorders Have in Common?

- An alteration in thoughts, feelings and behaviour
- The alteration is impactful clinically or at least one sphere of life
- Organised by dominating features e.g. depression, stressor-based,
- Previously distinguished between state and trait, DSM 5 dispensed with that concept.
- Diagnoses are polythetic, meaning that two people with the same diagnosis may look completely different.
- Diagnoses consider political, social and economic factors
- There is no objective measure, all pencil and paper tests are just a measure of alignment to the construct

Depression

- Typically a recurrent mental health condition characterized by a depressed mood together with several commonly occurring features.
- Epidemiology says that recurrence is high.
- In the literature, durations vary. Even without treatment, naturalistic observations show that most people recover within 2 years.
- Respond well to medication (although high placebo). ECT most effective. Magnetic therapy has mixed evidence.
- Most often insidious onset. Individuals are not good at knowing when the depression started. Typically 6 months of symptoms before diagnosis.
- Because of the cognitive distortions and other risk factors, causality is complicated.

Posttraumatic Stress Disorder

- The most serious of the stressor-induced psychiatric disorders. Acute Stress Disorder being the briefer form (<1 month).
- Stressor criteria deliberately weakened over time, sensitive to social and political justice issues.
- Was initially an overwhelming stressor such as torture or dismemberment to reflect the horrors of the Vietnam war, now includes exposure to trauma on social media “if it is work related”, an arbitrary cut off. Every emergency worker will satisfy the stressor criterion.
- Intrusive recollections; Avoidance; Negative alterations in cognition or mood; Alterations in arousal and reactivity. Greater than one month.
- Even with an objective stressor, the balance of symptoms are not falsifiable.
- PCL is a self-reported checklist. No internal validity scales. Problems with validating it in non-clinical settings.

Adjustment Disorders

- Catch-all for stressors generally less severe than for PTSD.
- Occur within 3 months of the stressor.
- Time limited to within 6 months of the cessation of the stressor or **its consequences**. In effect in most cases it may be successfully argued to have a long duration.
- No strong evidence that treatment makes much difference.
- Commonly diagnosed, less commonly studied.

Burnout

- An “occupational phenomena” , **not a medical condition.**
- “Burn-out is a **syndrome** conceptualized as resulting from chronic workplace stress that has not been successfully managed. It is characterized by three dimensions:
  - feelings of energy depletion or exhaustion;
  - increased mental distance from one’s job, or feelings of negativism or cynicism related to one's job; and
  - reduced professional efficacy.
- Best understood as a social dynamic specific to work. I would argue that as there is no medical impairment, it could not be an injury.

Functional Overlay

- Rarely used term in the literature
- For practical purposes, is the psychological component of a physical disorder
- Somatic Symptom Disorder: **one or more somatic symptoms** that are **distressing**; **excessive** thoughts, feelings, or behaviours related to the somatic symptoms or associated health concerns; a **persistence** of symptoms.
- It is not falsifiable due to subjectivity in both assessor and examinee. Almost impossible to dispute. Unlike previous version that required intra-psychic conflicts to be identified, this this atheoretical.

Documentation

- Different sets of information has a strong potential to bias opinions and create artificial differences of opinions. This is costly in time and money and adversely impacts the credibility of expert opinion
- In my experience, defendant clients provide much more information.
- Producing 1000 pages of irrelevant documents to experts will signal a lack of focus that may be reciprocated.
- Psychiatrists are looking for relevant history, patterns of conduct, reliable facts. Facts of relevance include prescriptions, medical certificates, diagnoses, contemporaneous stressors.
- GP notes have mixed value; consider PBS record; factual matter more helpful than opinions

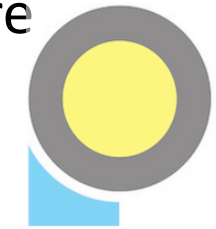
Malingering and Exaggeration

- Malingering is a determination by an arbitrator of fact, not a doctor
- Experts should be able to identify inconsistencies
- Experts should comment on the strength of the evidence and plausibility
- Many pencil and paper tests e.g. DASS, K-10 or Beck inventories are either screening or rating tests and have no internal validity scale, and easily manipulated by a motivated respondent and therefore unhelpful for diagnosis or rating.
- Personality testing scales: MMPI and PAI speak to the likelihood of the presentation based on statistical modelling.
- TOMM does not examine memory, but effort.
- Many other similar tests performed by psychologists.
- They will report that the test performance showed/did not show evidence of exaggeration or poor effort.
- How does one factor this into the balance of evidence?

Observations from Clinical Practice

- Impairment: (WHO) any loss or abnormality of psychological, physiologic, or anatomic structure or function. Diagnoses would fall into this category e.g. Major Depression
- Disability: The Disability Discrimination Act (DDA) defines a disabled person as someone who has a physical or mental impairment that has a substantial and long-term adverse effect on his or her ability to carry out normal day-to-day activities.

- In clinical practice we have individuals with mostly severe impairments e.g. BAD or schizophrenia and mild to moderate disability. Suicide uncommon but not rare. Improvement in the absence of incentives is typical.
- In litigation, we have individuals who usually have mild impairments with severe disability. Suicide is rare. Improvement during litigation is uncommon.



Recommendations

- Treating experts have problems with the expert witness codes as their first duty is to their patients, not the court.
- Contingency payments to both experts and treating doctors should be resisted.
- The minimum level of education, training and experience should be a clinical psychologist.
- Ensuring uniformity of information/agreed facts for experts at the time of examination
- Value of conclaves?

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