The Clinician's Corner
by
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I was extremely honored when the Litigation Counsel of America asked me if I would be interested in contributing a monthly column related to mental and emotional injury claims, as well as addressing fraud and malingering issues, in personal injury litigation. Why me? Because I am quite experienced in the evaluation and review of such claims, and lecture and write frequently on these topics. Why would these topics be important? For various reasons, psychiatric disability claims rose 200% in the 1990's alone. The cost of worker's compensation insurance has risen 50% in just the past three years. What could be contributing to these rises? How about fraud and malingering? An interesting study published in 2002 by Mittenberg, Patton, Canyock and Condit, titled "Base Rates of Malingering and Symptom Exaggeration," found that malingering is actually quite common in psychological and neuropsychological claims. These authors, in reviewing published studies on fraud and malingering, reported that 41.24% of mild head injury claims were malingered. In fact, they reported the following base rates of malingering: "Fibromyalgia and chronic fatigue claims-38.61%; pain and somatoform disorders-33.51%; neurotoxic disorders-29.49%; depressive disorders-16.08%." Mittenberg and his colleagues found that when you looked at malingering and symptom exaggeration by referral type, 30.43% of personal injury claims and 32.73% of disability or worker's compensation, were malingered. The essential fact for the litigator to remember is that about 30% of claims for compensation for psychological and neuropsychological injuries involved fraudulent exaggeration and malingering.

It's not just patients or claimants who malinger and commit fraud. In an article titled, "Mental Health Care Fraud: No Petty Crime," published by the Citizens' Commission on Human Rights, they reported that the U.S. General Accounting Office estimates that health care fraud alone costs up to 100 billion dollars each year. Of this estimated rate, the mental health care industry's contribution adds up to 40 billion dollars. You can compare that to the FBI report that the Nation's total losses from street crime in 2002 were only 18 billion. Clearly, claims of mental injury present problematic issues for the claimant, his/her treatment provider, and/or their expert. One of the factors that contribute to the rise of psychological and neuropsychological injury claims (or as often referred to as mental and emotional injury claims) is that they are based upon the subjective self-report of the patient and/or claimant. This self-report can be subject to exaggeration, outright fabrication, and/or misattribution of previous symptoms and disorders to a compensable event. This latter type of malingering is called False Imputation, in that someone falsely relates pre-existing symptoms and disorders to a subsequent compensable event. This type of malingering is often difficult for the non-skilled clinician or treatment provider to identify. Additionally, individuals with claims for compensation can certainly easily research their alleged disorder, and even convince themselves they have those symptoms when they may not. If one would enter the words "Posttraumatic Stress Disorder" in an internet search engine,

one would be surprised at the hits that one would get including some that identify the symptoms to report for that disorder to be compensable under the Veterans Administration or Social Security Administration. Distortions in self-reported symptoms are common and difficult for even sophisticated psychological and neuropsychological tests to appropriately identify. It takes the systematic discovery of all treatment records, pharmaceutical records, employment records, and injury records to properly identify the malingered claim.

The rise of psychological and neuropsychological injury claims actually followed the admission of Posttraumatic Stress Disorder (PTSD) as an official diagnosis in the *Diagnostic and Statistical Manual of Mental Disorders, Third Edition* (DSM-III) in 1980. DSM-III also presented an Index of Suspicion of Malingering that same year. This diagnosis of PTSD was included but not without controversy and political maneuvering. The official diagnoses found in the DSM's, which date back to the original DSM in 1952, are selected by committees whose personal and professional interest has a bearing on diagnoses selected for inclusion. In any event, Posttraumatic Stress Disorder was included in 1980 and was originally defined as a disorder that followed experiences outside the realm of usual human experience, but has since involved instances in which the stressor was witnessed or learned about, and not necessarily directly experienced. PTSD claims have risen ever since 1980. In 2006, the Veterans Administration had concern about their rising cost of disability associated with Posttraumatic Stress Disorder. This cost, by 2005, had risen to 4.3 billion dollars from a 1999 level of 1.7 billion dollars. According to the Veterans Administration this rise is not attributable to Middle Eastern combat veterans returning from Iraq, but were attributable to remaining Vietnam veterans. The Veterans Administration suggested that perhaps things other than PTSD were contributing to the claim and has put together a task force to investigate these areas.

Certainly other issues have affected the diagnosis of psychological and neuropsychological conditions, including discussions of mild traumatic brain injury and Posttraumatic Stress Disorder claims in such forums as the Association of Trial Lawyers of America (since renamed American Association for Justice), monograph, *Trial*, which in 2000 was entitled "Proving Invisible Injuries." This monograph advised attorneys how to "build" such claims. Often mental and emotional injuries are brought forth to enhance the value of an individual's claim and may, or may not, actually be present. Experts not well versed in providing forensic evaluations often take the patient's self-report that they have experienced some type of symptoms, and then assuming a temporal relationship to another a compensable event subsequently establishes that as the causal event. They then render an incident specific diagnosis. Many experts rendering such quick diagnoses and attributing them to a compensable event often fail to adequately evaluate for premorbid conditions, such as other psychiatric conditions. A study by the National Institute of Mental Health in 1993 found that 28.1% of the adult population had diagnosable psychiatric and/or substance abuse disorders. Essentially this means that 1-out-3 adults in our country

would have a pre-existing psychiatric condition unrelated to any compensable event and likely not even exacerbated by it. Since most psychiatric symptoms are not heterogenous to a specific disorder but homogenous to all of them, this allows great error in diagnosis. Past research has readily established that naive subjects can report those symptoms necessary to receive diagnoses of Posttraumatic Stress Disorder, Depression, and Mild Traumatic Brain Injury. In view of the problems with exaggeration and malingering, organizations such as the National Academy of Neuropsychologists have come out with a position paper stating that as part of all neuropsychological batteries, testing for motivation and malingering should always be included. This has been in direct reaction to the abuse of neuropsychological evaluations in mild traumatic brain injury related cases.

In these cases, whether you call them psychiatric; mental and emotional injury claims; psychological injury claims; or neuropsychological injury claims, they all have one thing in common. They need careful and proper evaluation in order to determine the actual value of the injury and even the validity of the alleged injury. Certainly in cases in which an injury has occurred, a person has a right to be made whole. But, in the absence of an actual injury, they do not have the right to fabricate claims that allege compensable injury and demand financial reimbursement that is not warranted.

This monthly column will be devoted to various topics related to such claims. Topics anticipated being covered will be evaluating such issues as sexual harassment claims; mild traumatic brain injury claims; evaluating for malingering; evaluating psychological and neuropsychological tests; and expert issues. Readers with ideas for columns are invited to contact this writer, drpricephd@aol.com, with ideas or suggestions for columns. This writer will attempt to be very responsive to those requests and/or suggestions.