

Staying on Track: Differentiating Between Genuine and False PTSD Claims in Railroad Litigation

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**Staying on Track:
Differentiating Between Genuine and False
PTSD Claims in Railroad Litigation**

Staying on Track:

**Differentiating Between Genuine and
False PTSD Claims in Railroad Litigation –
Including Both Individual and Mass Torts**

<http://www.fpamed.com/staying-track-ptsd-aar/>

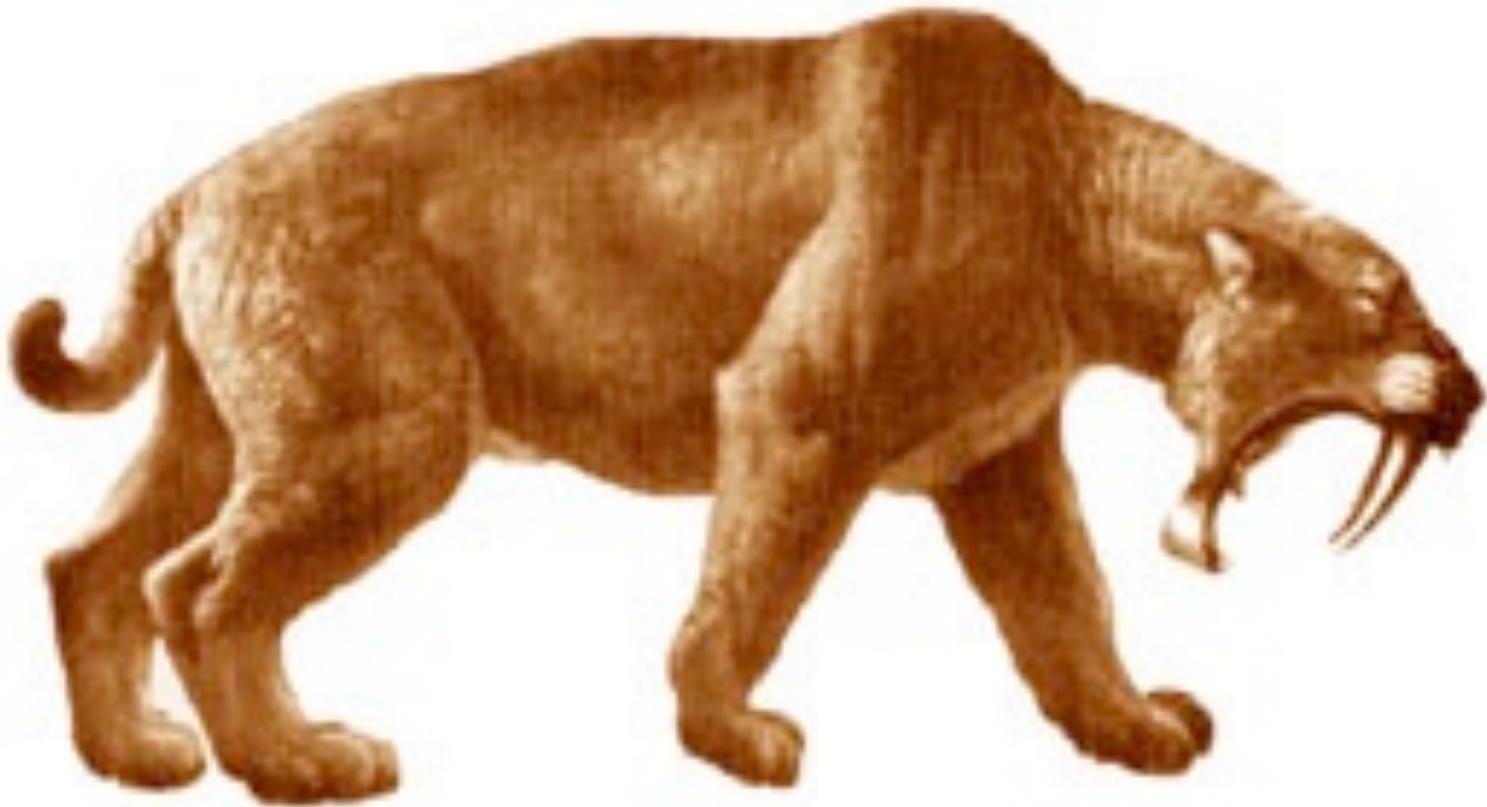
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Staying On Track – Key Issues

- PTSD: What It Is...and What It Is Not
- New DSM-5 criteria for PTSD
- How forensic psychiatrists and psychologists evaluate emotional distress claims
- Assessment Issues unique to mass torts
- Key differences between independent forensic psychiatric and psychological experts and treating psychiatrists and psychologists
- Psychological testing

- Q&A
- ***LOTS OF PICTURES...and some sounds...***

PTSD What It Is, and What It Is Not



Stress: What Is It?

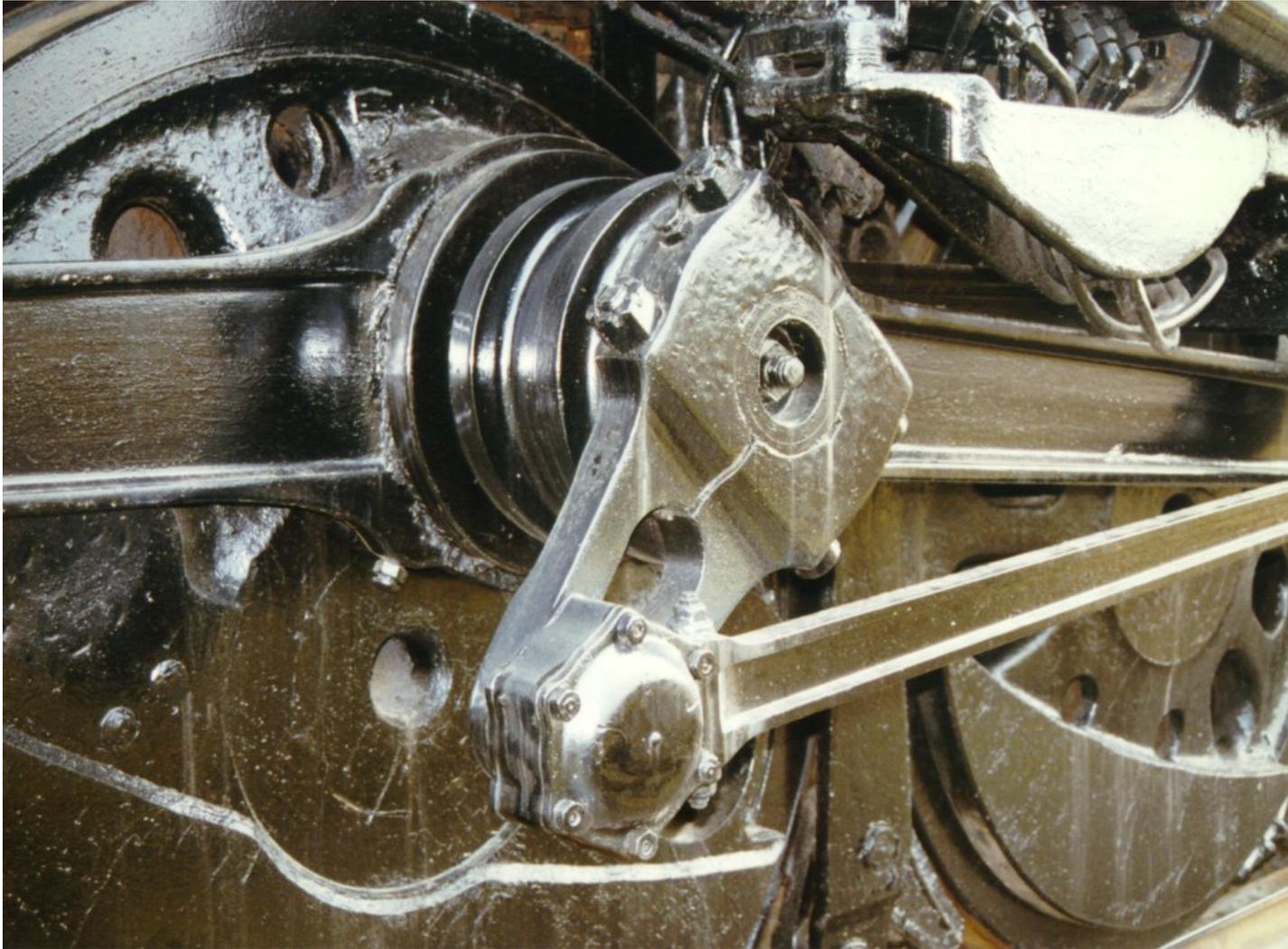
Engineering:

*Stress = A Force Which Deforms Physical
Bodies*

Biology & Medicine:

Stress = A Process Within the Human Body

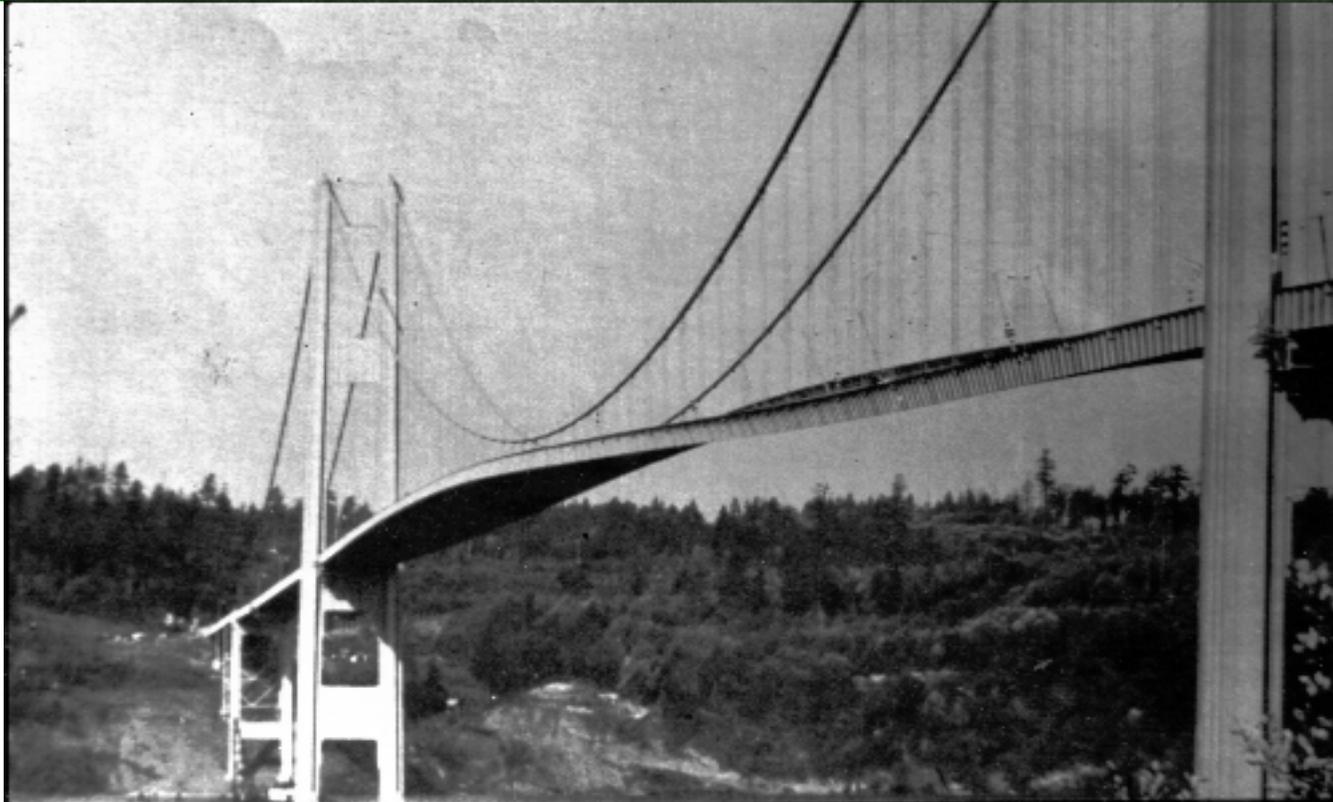
Stress: Mechanical



Stress: Structural



Stress & Structural Failure



1940 Tacoma Narrows Bridge Disaster:

Slender, elegant and graceful, the Tacoma Narrows Bridge stretched like a steel ribbon across Puget Sound in 1940. The third longest suspension span in the world opened on July 1st. Only four months later, the great span's short life ended in disaster. "Galloping Gertie," collapsed in a windstorm on November 7, 1940.

Mechanical Stress Causes Structural Failure

**GALE CAUSES
BRIDGE
TO SWAY**

PTSD: Overwhelming *Emotional Stress* Causes Mental Collapse....



**(THE SILENT
SCREAM OF
WAR...)**

PTSD: Overwhelming *Emotional Stress* Causes Mental Collapse...



Shell Shocked
US Soldier,
1968, Battle
of Hue, Viet
Nam War

DON MCCULLIN/HAMILTONS GALLERY

PTSD: “A rose called by any other name....”

- **“PTSD”** – label first used in Viet Nam War.
 - “silver lining” of war:
 - Billions \$’s spend on PTSD research since Viet Nam War.
 - Same for TBI since Iraq War.
- **“War Neurosis”** – WWII.
- **“Shell Shock”** – WWI.
- **“*Railway Spine*”** – 19th Century Train Accidents.

“Railway Spine”

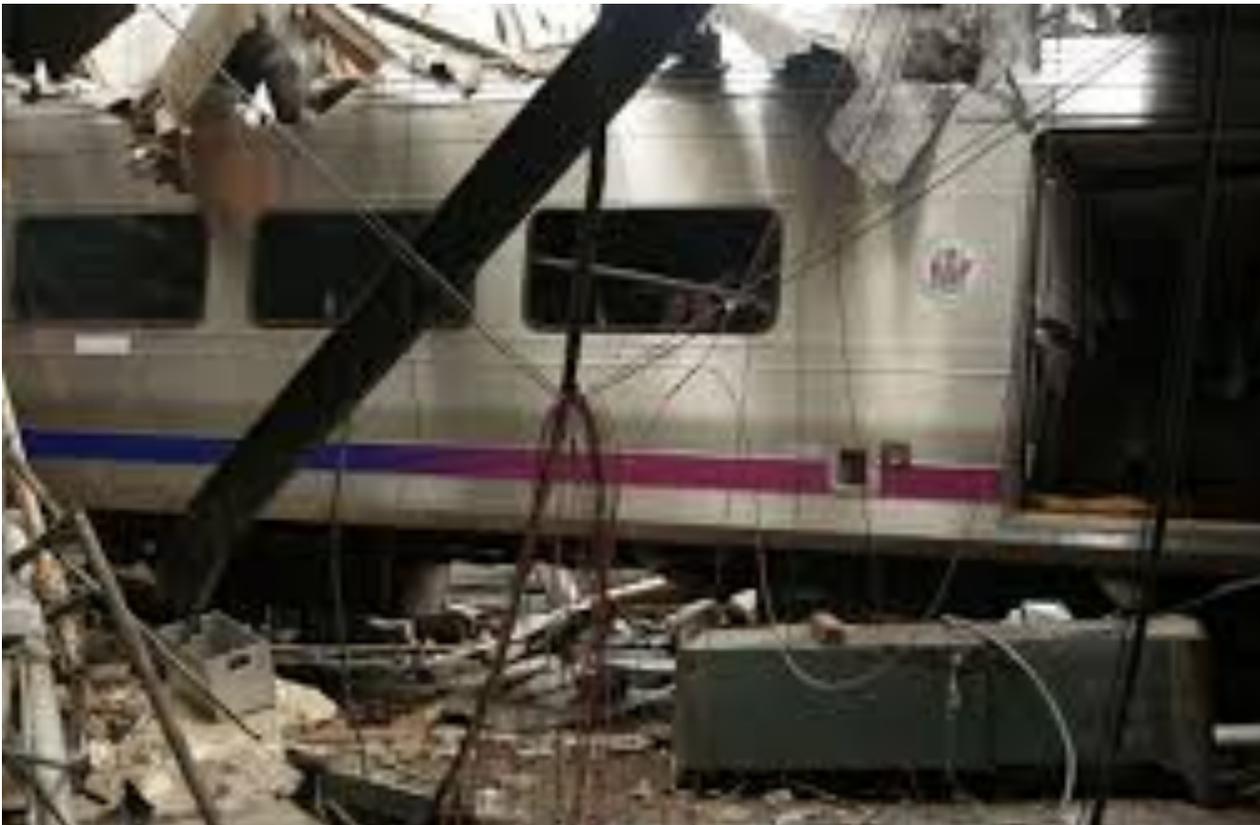


Montparnasse Derailment

1895 train wreck at
Gare Montparnasse,
Paris, France.

Modern Day “Railway Spine”

**September 29, 2016 Hoboken Station, NJ
Train Crash...**



“Railway Spine”

“*Railway spine*” was a nineteenth-century diagnosis for the post-traumatic symptoms of passengers involved in [railroad accidents](#).

[John Eric Erichsen](#)'s classic book, *On Railway and Other Injuries of the Nervous System* was the *first full length medical study of the condition “railway spine”* - often known as "Erichsen's disease". Railway collisions were a frequent occurrence in the early 19th century. Exacerbating the problem was the fact that railway cars were flimsy, wooden structures with no protection for the occupants.

Soon a group of people started coming forward who **claimed that they had been injured in train crashes, but had no obvious evidence of injury**. The railroads rejected these claims as fake.

The nature of *symptoms caused by “railway spine”* was *hotly debated* in the late **19th century**, notably at the meetings of the (Austrian) Imperial Society of Physicians in Vienna, 1886. Germany's leading neurologist, [Hermann Oppenheim](#), **claimed that all *railway spine symptoms were due to physical damage to the spine or brain.***

French and British scholars, notably [Jean-Martin Charcot](#) and Herbert

Page, insisted that some *symptoms could be caused by [hysteria](#) (now **known as [conversion disorder](#)**).*

What Is Not PTSD?

The probability of an event causing PTSD in any particular individual, is only *partially* related to the *severity of the stressor*.

Thus, *Not Every Big, Bad, Traumatic Event Causes PTSD....*

What Is Not PTSD?

Actual Examples of Bad experiences that did NOT cause PTSD:

- After a board meeting, a secretary ate a left-over pastry *contaminated with rat feces*...she **alleged in litigation that she could never work in an office again!** Hers was a truly disgusting experience...but it DID NOT CAUSE PTSD.
- **A supervisor's unwelcome explicit sexual overtures** to a supervisee were offensive & unwelcome & even UNLAWFUL...but they DID NOT CAUSE PTSD.

What Is Not PTSD

- In fact, a majority of people who experience a traumatic and stressful event ***DO NOT DEVELOP PTSD!***
- According to multiple research studies, as many as 40% - 50% of women who are violently raped ***DO NOT DEVELOP PTSD****
- ***WHY???***

* Breslau, Kessler, et al., "Trauma & PTSD in the community," *Arch. Gen Psychiatry*, Vol.55, July 1998, p.626

WHY?

Resiliency

vs.

Vulnerability Factors

(This is not an appellate case!)

What Is “Resiliency?”

USSC. Justice Potter Stewart 1964 in *Jacobellis v. Ohio* (obscenity case): “I know it when I see it!”



PTSD Vulnerability Factors

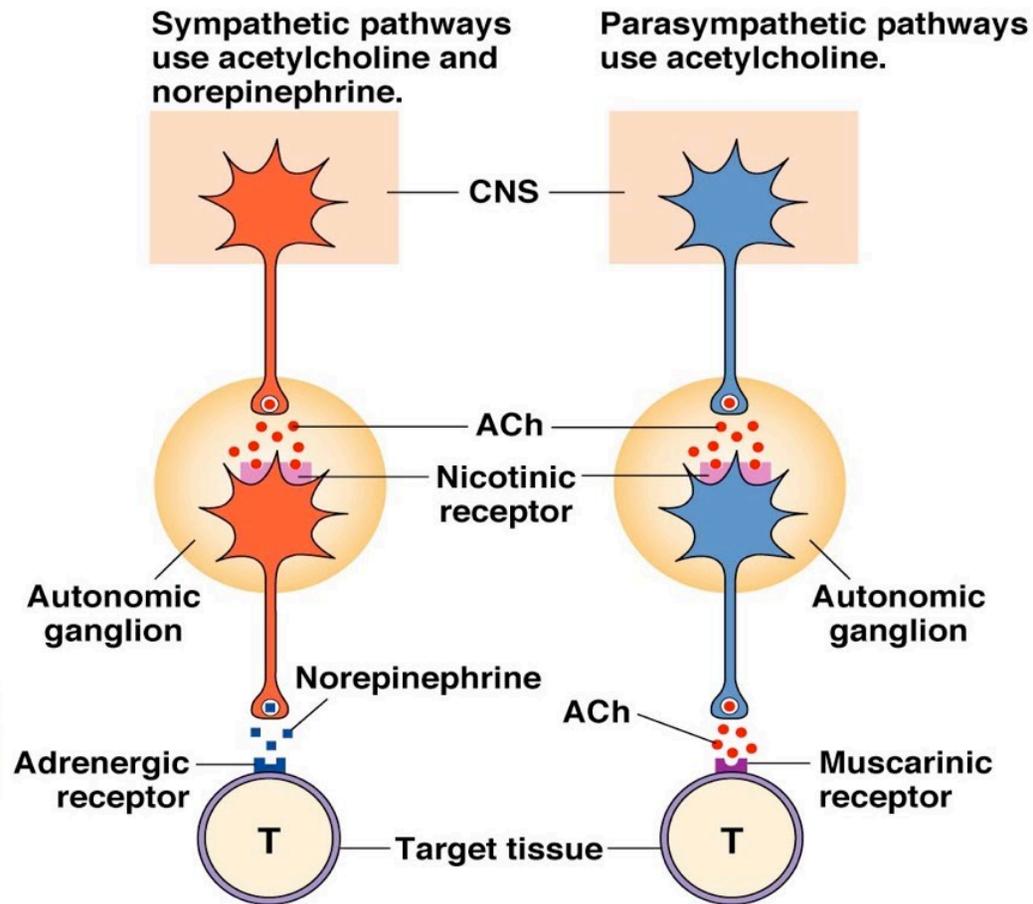
PTSD Risk Factors:*

- prior trauma
- prior psychiatric history
- family psychiatric history
- peritraumatic dissociation
- acute stress symptoms
- the nature of the biological response
- **autonomic** hyperarousal

*Mcfarlane, A., "Posttraumatic stress disorder: A model of longitudinal course and the roles of risk factors," *J. Clin. Psychiatry*, 61, Suppl. 5:15-20, Jan 2000.

Autonomic Nervous System - ANS

The Autonomic Nervous System



PTSD: *DSM-5* Diagnostic Criteria

DIAGNOSTIC AND STATISTICAL
MANUAL OF
MENTAL DISORDERS

FIFTH EDITION

DSM-5

Summary of *DSM-5* PTSD Diagnostic Criteria

- A. Exposure to actual or threatened death, serious injury, or sexual violence.**
- B. Presence of one (or more) intrusion symptoms associated with the traumatic event(s).**
- C. Persistent avoidance of stimuli associated with the traumatic event(s), beginning after the traumatic event(s) occurred.**
- D. Negative alterations in cognitions and mood associated with the traumatic event(s), beginning or worsening after the traumatic event(s).**
- E. Marked alterations in arousal and reactivity associated with the traumatic event(s).**

Summary of *DSM-5* PTSD Diagnostic Criteria

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

G. Functional Impairment: The disturbance causes *clinically significant distress or impairment in social, occupational, or other important areas of functioning.*

H. The disturbance is not attributable to the physiological effects of a substance (e.g., medication, alcohol) or another medical condition

PTSD Co-Morbidities

In the majority of cases, PTSD is accompanied by another condition:

- **Major Depression and/or**
- **An Anxiety Disorder and/or**
- **Substance Abuse.**

Changed PTSD Criteria: Differences Between *DSM-IV(TR)* & *DSM-5*

- ***DSM-5*** criteria for **PTSD** differ significantly from the *DSM-IV (TR)* criteria, e.g.:
 - The **stressor criterion (Criterion A)** is more **explicit** with regard to events that qualify as “traumatic” experiences.
 - “Exposure to actual or threatened death, serious injury, or sexual violence.”
 - Also, *DSM-IV(TR)* Criterion A2 (**subjective reaction**) has been eliminated.

Changed PTSD Criteria: Differences Between *DSM-IV(TR)* & *DSM-5*

- Whereas **there were three major symptom clusters in *DSM-IV(TR)***

- reexperiencing,
- avoidance/numbing,
- and arousal

there are now **four symptom clusters in *DSM-5***, because the **avoidance/numbing cluster is divided into two distinct clusters:**

- **avoidance** and
- **persistent negative alterations in cognitions and mood**. This latter category, which retains most of the *DSM-IV* numbing symptoms, also includes new or reconceptualized symptoms, such as **persistent negative emotional states**.

Changed PTSD Criteria: Differences Between *DSM-IV(TR)* & *DSM-5*

The final cluster—alterations in arousal and reactivity—retains most of the DSM-IV arousal symptoms. It also includes irritable behavior or angry outbursts and reckless or self-destructive behavior.

PTSD is now developmentally sensitive in that diagnostic thresholds have been lowered for children and adolescents.

Furthermore, separate criteria have been added for children age 6 years or younger with this disorder.

What PTSD Is: Full *DSM-5* Diagnostic Criteria

Diagnostic Criteria

309.81 (F43.10)

Posttraumatic Stress Disorder

A. Exposure to actual or threatened death, serious injury, or sexual violence in one (or more) of the following ways:

- 1 Directly experiencing the traumatic event(s).
- 2 Witnessing, in person, the event(s) as it occurred to others.
- 3 Learning that the traumatic event(s) occurred to a close family member or close friend. In cases of actual or threatened death of a family member or friend, the event(s) must have been violent or accidental.
- 4 Experiencing repeated or extreme exposure to aversive details of the traumatic event(s) (e.g., first responders collecting human remains; police officers repeatedly exposed to details of child abuse).

What PTSD Is: Full *DSM-5* Diagnostic Criteria

B. Presence of one (or more) of the following intrusion symptoms associated with the traumatic event(s), beginning after the traumatic event(s) occurred:

- 1 Recurrent, involuntary, and intrusive distressing memories of the traumatic event(s).
- 2 Recurrent distressing dreams in which the content and/or affect of the dream are related to the traumatic event(s).
- 3 Dissociative reactions (e.g., flashbacks) in which the individual feels or acts as if the traumatic event(s) were recurring. (Such reactions may occur on a continuum, with the most extreme expression being a complete loss of awareness of present surroundings.)

What PTSD Is: Full *DSM-5* Diagnostic Criteria

- 4 Intense or prolonged psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event(s).
- 5 Marked physiological reactions to internal or external cues that symbolize or resemble an aspect of the traumatic event(s).

What PTSD Is: Full *DSM-5* Diagnostic Criteria

C. Persistent avoidance of stimuli associated with the traumatic event(s), beginning after the traumatic event(s) occurred, as evidenced by one or both of the following:

- 1 Avoidance of or efforts to avoid distressing memories, thoughts, or feelings about or closely associated with the traumatic event(s).
- 2 Avoidance of or efforts to avoid external reminders (people, places, conversations, activities, objects, situations) that arouse distressing memories, thoughts, or feelings about or closely associated with the traumatic event(s).

What PTSD Is: Full *DSM-5* Diagnostic Criteria

D. Negative alterations in cognitions and mood associated with the traumatic event(s), beginning or worsening after the traumatic event(s) occurred, as evidenced by two (or more) of the following:

- 1 Inability to remember an important aspect of the traumatic event(s) (typically due to dissociative amnesia and not to other factors such as head injury, alcohol, or drugs).
- 2 Persistent and exaggerated negative beliefs or expectations about oneself, others, or the world (e.g., “I am bad,” “No one can be trusted,” “The world is completely dangerous,” “My whole nervous system is permanently ruined”).
- 3 Persistent, distorted cognitions about the cause or consequences of the traumatic event(s) that lead the individual to blame himself/herself or others.

What PTSD Is: Full *DSM-5* Diagnostic Criteria

- 4 Persistent negative emotional state (e.g., fear, horror, anger, guilt, or shame).
- 5 Markedly diminished interest or participation in significant activities.
- 6 Feelings of detachment or estrangement from others.
- 7 Persistent inability to experience positive emotions (e.g., inability to experience happiness, satisfaction, or loving feelings).

What PTSD Is: Full *DSM-5* Diagnostic Criteria

E. Marked alterations in arousal and reactivity associated with the traumatic event(s), beginning or worsening after the traumatic event(s) occurred, as evidenced by two (or more) of the following:

- 1 Irritable behavior and angry outbursts (with little or no provocation) typically expressed as verbal or physical aggression toward people or objects.
- 2 Reckless or self-destructive behavior.
- 3 Hypervigilance.
- 4 Exaggerated startle response.
- 5 Problems with concentration.
- 6 Sleep disturbance (e.g., difficulty falling or staying asleep or restless sleep).

What PTSD Is: Full *DSM-5* Diagnostic Criteria

- F. Duration of the disturbance (Criteria B, C, D, and E) is more than 1 month.
- G. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.
- H. The disturbance is not attributable to the physiological effects of a substance (e.g., medication, alcohol) or another medical condition

What PTSD Is: Full *DSM-5* Diagnostic Criteria

Specify whether:

With dissociative symptoms:

- 1 **Depersonalization:** Persistent or recurrent experiences of feeling detached from, and as if one were an outside observer of, one's mental processes or body (e.g., feeling as though one were in a dream; feeling a sense of unreality of self or body or of time moving slowly).
- 2 **Derealization:** Persistent or recurrent experiences of unreality of surroundings (e.g., the world around the individual is experienced as unreal, dreamlike, distant, or distorted).

What PTSD Is: Full *DSM-5* Diagnostic Criteria

Specify if:

With delayed expression: If the full diagnostic criteria are not met until at least 6 months after the event (although the onset and expression of some symptoms may be immediate).

Cases Involving Emotional Injuries

- Refinery explosion
- Airplane or **train crash**
- Chemical spill
- Toxic exposure
- Serious injury
- Assault
- Harassment
- Discrimination

Emotional Injuries

- **Pain & Suffering**
- **Annoyance & Discomfort**
- **Emotional Distress**
- **Fear of Cancer**

Emotional Distress

Emotional distress includes suffering, anguish, fright, horror, nervousness, grief, anxiety, worry, shock, humiliation, and shame. **Serious emotional distress** exists *if an ordinary, reasonable person would be unable to cope* with it.

CACI 1620 (NIED)

Severe Emotional Distress

“Severe emotional distress” is not mild or brief; it must be *so substantial or long lasting that no reasonable person in a civilized society should be expected to bear it.* Plaintiff is not required to prove physical injury to recover damages for severe emotional distress.

CACI 1604 (IIED)

Forensic Psychiatry

An Independent Forensic Psychiatric Expert

**differs from
a Treating Psychiatrist or Psychologist
in the following important respects:**

On Wearing Two Hats:

The Profound Differences Between Treaters and Forensic Psychiatric Experts



Mission, Method & Ethical Duty: Treating Clinician vs. Forensic Expert

TREATING CLINICIAN:

Mission: To alleviate suffering (Hippocratic Oath)

Method: Relies almost exclusively on patient's self-report of *subjective* reality.

Ethical Duty: To the patient (Hippocratic Oath) – *advocates* for patient's best interests

Mission, Method & Ethical Duty: Treating Clinician vs. Forensic Expert

INDEPENDENT FORENSIC PSYCHIATRIC EXPERT:

Mission: To determine what is *objectively* true

Method: Reviews **all** medical/legal/employment documents **AND** performs objective (neuro)psych testing **AND** conducts detailed psychiatric IME interview exam

Ethical Duty: Provides evidence-based opinions to the trier of fact

Description of Forensic Psychiatric IME

Components:

- 1. Psychological (& Neuropsych if indicated) Testing Assessment:**

- 2. Psychiatric Examination:**

Description:

- Precedes Psychiatric Examination
 - Psych (4 - 6 hours)
 - Neuropsych (6 - 8 hours)
-
- Detailed Psychiatric History (4 – 6 hours)
 - Including developmental, medical, psychiatric, medication, substance use, relationship, educational, employment, legal (civil & criminal), military histories & history of event.

Psychiatric Assessments in Mass Torts

Types of Mass Torts:

- **Natural Disasters**
- **Man-made Disasters (train or airplane crashes, industrial accidents, etc.)**
- **Toxic Torts**
 - Mold
 - Water Supply Contamination
 - Exposure to Chemicals and/or Radiation
 - Fear of Cancer
- **Discrimination**
- **Product Liability**

Issues Unique to Mass Tort IMEs

- Using a **psychiatric & psychological assessment team** vs. assembling a panel of individual experts *de novo*.
 - **Increased accuracy and credibility of forensic opinions** when population is assessed by a single team of experts.
(e.g. Mrs. Smith is damaged vs. Mr. Jones who is not)
- Screening and examining a **representative sample** vs. entire population.
- “Normal” or **“Bell Curve”** distribution of damages.
- Problems with sampling: **the “Barbell”** effect.

Advantages of a Psychiatric /Psychological Team vs. Law Firm Retaining Separate Experts

1. **Experience** With Mass Tort Population Assessments.
2. **Quality** of Individual Experts.
3. **Cohesion** – Team Used to Working Together.
4. **Collateral Informants** – Each Examined Claimant is a Collateral Informant for Every Other Claimant.
5. **Increased Accuracy and Credibility** of Forensic Opinions When One Population is Assessed by **One Team** of Experts: **Ability to Compare & Contrast Uninjured Claimants With Injured Claimants.**

Screening and Examining a Representative Sample vs. Entire Population

Sampling Issues:

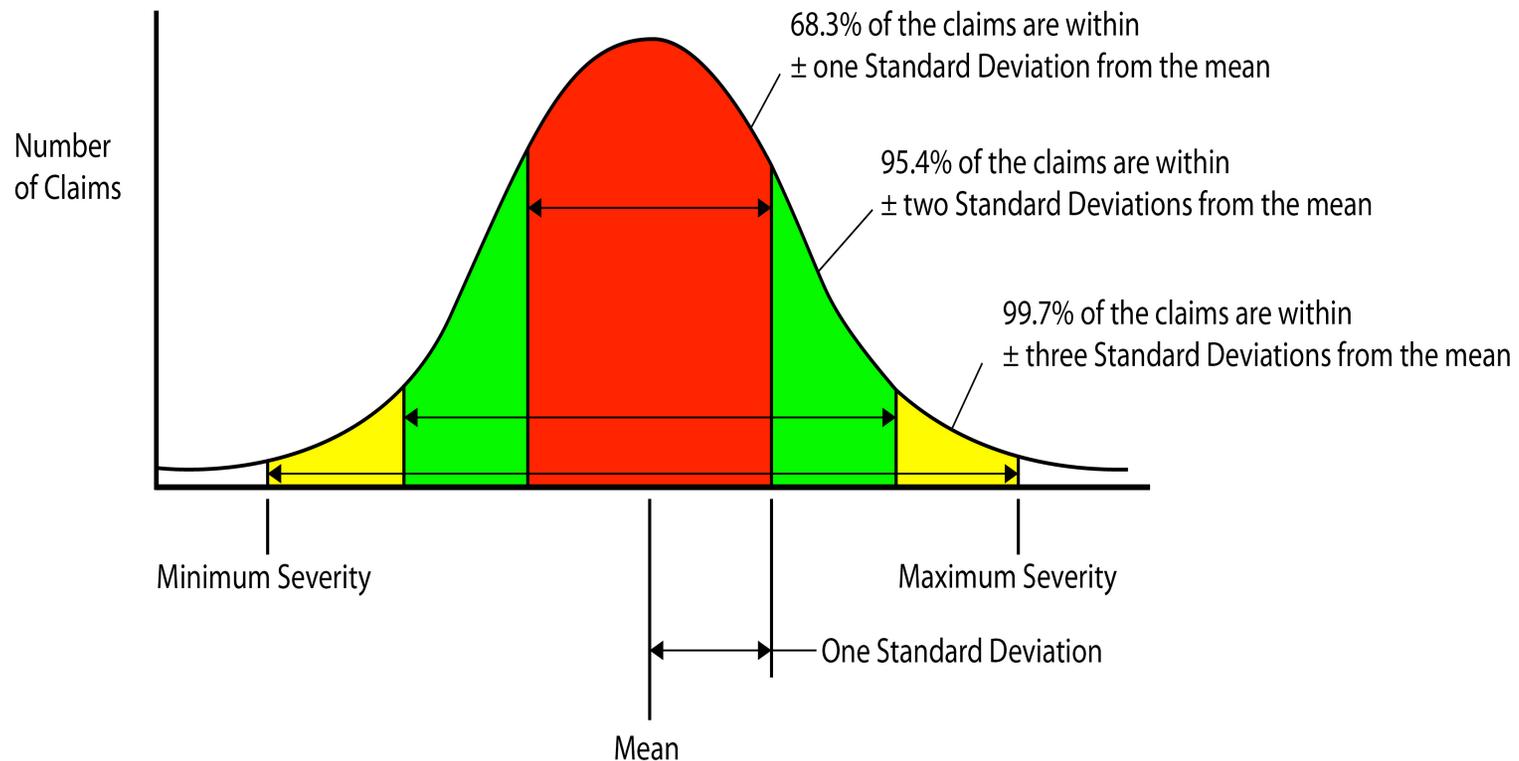
“Bell” Curve

VS.

“Barbell”

Distribution of Damages Produced by a Catastrophic Event:

A Gaussian (Normal) or “Bell” Curve Distribution of Claims



Sampling Problems When “Representative” Plaintiffs Selected by Plaintiff & Defense Counsel

The “Barbell” Effect

Defense counsel:

Minimal or no damages

Plaintiffs’ counsel:

Very significant damages



Psychological Testing

- **All Medical Testing, Including Psychological Testing, Answers a Simple Membership Question...**
- *Based upon the examinee's test data, which group of independently diagnosed individuals does the examinee most closely resemble.*

Psychological Testing for PTSD

- Difference between Clinical and Forensic Applications of Psych Testing
- Different Tests and Test Modalities are Best Practice.
- Importance of Validity Scales Especially in Forensic Cases.
- The Limitations of Self Report Measures such as Beck Depression & Anxiety Scales, etc.

Clinical Testing

- The Doctor Trusts what the Patient Says.
- Tests that only Measure Symptoms are Helpful for Treatment Planning.
- No Effort made to Evaluate the *Reliability* and *Validity* of the Test Results.
- No Effort to Evaluate Malingering

Forensic Testing

- There is No “Doctor Patient” Relationship.
- There may be Issues of Secondary gain.
- ***Assessment of the Reliability and Validity of the Symptoms is Critical.***
- Patients are often Not Necessarily Reliable Historians.
- Litigants may have More Complex Motivations than Patients.
- Pre-existing Conditions are Frequently Denied.
- Usually the Independent Expert is the First Physician to Look at “the Big Picture.”

Best Practice Testing

- Tests Designed with *Multiple Built In Validity Scales.*
- Tests that *Identify Problems with Bias.*
- Tests That *Identify Many Kinds of Psychological Problems.*
- Tests That *Do Not “Cherry Pick”* One Specific Problem.
- Tests That *Identify Potential Malingering.*

Best Practice Tests

Tests We Use (and why)...

- **Minnesota Multiphasic Personality Inventory (MMPI-2 or MMPI-RF)**
- **Personality Assessment Inventory (PAI)**
- **Rorschach Performance Assessment System (R-PAS)**
- **We look for cross correlation among different tests and employ tests utilizing different modalities.** (analogous to comparing Brain MRI data v Brain CAT Scan data.)

Clinical Endorsement Questionnaires

Tests We Don't Use (and why)...

- **Clinician Administered PTSD Scale (CAPS)**
the “Gold Standard” of the VA
- **Structured Clinical Interview for DSM Disorders (SCID)**
- **PTSD Checklist for DSM-5 (PCL-5)**
- **Posttraumatic Stress Diagnostic Scale**
- **Davidson Trauma Scale (DTS)**

Trauma Specific Tests

- **Trauma Symptom Inventory I & II.**
- **Detailed Assessment of Posttraumatic Stress (DAPS):**
 - Provides a Laundry List of PTSD Symptoms.
 - Limited Validity Scales Triggered by Endorsement of Extreme Items.
 - Flawed Design: Originally Developed Based on Mailed Out Questionnaires.

Problems With Clinical Endorsement Questionnaires

- *“Face Evident”* Questions.
- Allows the Person to *Endorse a Potentially Biased List of Symptoms.*
- Some of the Tests are *Poorly Designed.*
- *The PTSD Checklist Tests Allow Anyone of Average Intelligence to Score Positive for PTSD.*
- There are *Limited Validity Indicators.*
- These Tests Can Be Useful in a Clinical, Practice *BUT NOT FORENSIC PRACTICE.*

Raw Test Data

- Test *raw data is best exchanged directly between psychologists* on each side of a case
- When test data is required by an attorney there should be *a stipulated protective order* which insures that the data will not become part of the public domain and will only be used as needed by counsel and/or their retained experts and all copies will be returned or destroyed at the conclusion of litigation

Retention of Data

- The Psychologist has the *duty to retain all original notes.*
- The Psychologist has the *duty to retain all test data.*
- Destruction of any notes or data is potentially grounds to limit or exclude testimony
- Data must be sufficiently legible that it can be assessed by the opposing psychologist

Test Data vs. Test Manuals

- The ethics code of the American Psychological Association (APA) allows for the exchange of test data.
- ***The ethics code does not allow psychologists to copy or provide copies of test manuals.***
- Any competent psychologist should have access to any test manuals needed
- Test manuals are trade secret and confidential

Repeat Testing

- Every Psychologist Must do their Own Testing.
- They Cannot Rely Solely Upon Testing Done in the Past.
- Even When the Same Test is Used it May Give a Different Result.
- Repeat Testing Helps Assess the Reliability of the Test Results.
- Repeat Testing May Also Show Improvement.

Staying On Track – Audience Questions

How do you differentiate between a diagnosis of PTSD and depression? Are the treatments relatively the same?

Staying On Track – Audience Questions

Do you find that hypnotherapy can be useful in the treatment of PTSD?

Staying On Track – Audience Questions

Does PTSD manifest itself only when the individual is placed in similar circumstances to the triggering event (e.g., sexual assault victim in an intimate setting, soldier around loud war-like noises), or does it increase the individuals' fight or flight response/anxiety levels in any type of somewhat stressful situation (minor traffic accident, big presentation at work, etc.)?

Staying On Track – Audience Questions

Can PTSD remain latent and then manifest weeks, months, or years later?

Staying On Track – Audience Questions

How can you identify the cause(s) of PTSD, particularly if the patient has experienced multiple traumatic events during his or her lifetime?

Staying On Track – Audience Questions

Can testing and diagnosis of PTSD be impacted by having a person's treating provider vs. an independent forensic psychiatrist or other neutral evaluator conduct the testing and diagnose? If so, how and discuss potential issues associated with having a treating provider test/diagnose PTSD.

Staying On Track – Audience Questions

How do you differentiate between a diagnosis of anxiety and PTSD? How are the treatments similar or different?

Staying On Track – Audience Questions

What are some of the factors that correlate to the severity of symptoms experienced by a victim of a traumatic event?

How is it that two people could go through the same event and have dramatically different symptoms?

Staying On Track – Audience Questions

What environmental factors (i.e. stable employment, family life, supportive friends, etc.) impact the efficacy of treatments for PTSD symptoms?