The Forensic Examination
The Forensic Examination
A Handbook for the Mental Health Professional
This book prepares the mental health professional to use psychiatric skills when looking for and collecting data in a forensic examination and then apply sound clinical judgment in evaluating that data and presenting the information gathered through a systematic examination.

Based on the experience accumulated in the forensic mental health field, and using the studies conducted as well as the narrative reports prepared as a model, this forensic psychiatric handbook can be read as a practical primer for those mental health professionals (MHPs) interested in using psychiatric and psychological understanding in the courtroom. This is a completely new “game” with its own rules and methods.

We anticipate mental health professionals finding the concepts introduced in this book immediately helpful for use in their practices. This book presents important topics concerning human behavior and mental disorders, in a light and evocative style that brings forth recollections of past and present medicolegal cases in which mental aspects were or should have been prominent.

As you read the cases presented, you become comfortable with the standards of psychiatric and psychotherapeutic practice. You now know what is expected from the expert witness, and how to communicate with the attorney what is at stake, to consider the legal criteria to adhere to, and how to present the basis of our opinions.

We identify strategies for approaching “other” experts’ reports and displaying contradictions. This helps understand the basis (science or advocacy) of the opposing views on the issues at hand.

We demonstrate, with illustrations, how apparently average cases become unique, compelling, and of significant importance to attorneys representing clients, in which mental functioning is of essence.

Psychiatric aspects considered by jurors, judges, and arbitrators should have now the same clarity we expect from X-rays in orthopedic incidents.

This book answers the following questions: How to understand the concept of an adequately “greased” mind? What turns the functioning mind into a troubled mind? How to assess for the predisposing, determining, and triggering factors, when assessing psychic damage?

Psychiatric aspects of legal cases are pointed out, as well as the legal criteria for the mental health practitioner to consider in the forensic work. Through these pages,
the mental health professional will grasp why, when, and how to use the forensic psychiatric work, knowing the scope, depth, and limits of its contribution.

Some of the topics in the vignettes included are forensic psychiatric examinations concerning employment matters: sexual harassment and bullying, discrimination, workers’ compensation, disability evaluations; stalking, PTSD and other psychiatric disorders of legal import in diverse settings, competence, criminal and civil (to write, amend, execute a will; to manage financial and personal affairs).

There are many ways to reach the goal of being and feeling competent working in this specialized forensic field. Objectivity is paramount though not enough. Besides honesty, clinical knowledge and the application of the scientific method are the key ingredients to become an expert.

Early in our career, forensic psychiatry did not come across as an attractive one. Mental health sciences started with the search of how a person’s feeling, thinking, and behaving came together to produce a specific manifestation: a symptom, a sign, a disease, an action, or a particular style of relating to others. We looked for what were the mental tools needed to create those feelings, thoughts, and behaviors, as well as when and how they formed. Lastly, we strived to understand why they expressed themselves at the time they did. Once we harden the scientific and clinical foundations required to develop into a psychiatrist, we can become an expert witness and comfortably sail across the subspecialty (forensics).

During our initial days in the practice of clinical psychiatry, the day came when an attorney requested that we examine her client involved in an accident that caused him (personal injury) physical as well as psychological damage (the latter reflected as a psychiatric disorder and/or “pain and suffering”). I was asked to assess for the presence and extent of mental illness or problems, and if present, to ascertain if this was the first time it appeared, was a significant aggravation, exaggeration, or reenactment of a mental illness that appeared and healed many years ago. Finally, we were to assess if the mental illness complained of was linked (proximately related) to the accident at issue.

We recognized that this examination was not like any other we had customarily done until then. We were not expected to provide any treatment or clinical advice to the person being examined, and the concerns for confidentiality were greatly modified. We were expected to focus on certain issues of value for the attorney, and we were going to be paid by that attorney, who was our “client,” rather than by the person sitting before me (examinee) that was the attorney’s client. At the end of the study, we were expected to prepare a report of our findings and mail it to the lawyer, with the description of and the clinical bases of such findings. All this is at first very different and confusing, for we were used to only seeing and treating “patients,” maintaining secret what we learned from them, and advocating for their wellbeing. All these rules go through many transformations when applied to the forensic field.

In this distinctive subspecialty, we must train and adhere to being objective, neutral, inquisitive, and to position ourselves at equal distance from the forces creating feelings, thoughts, and actions. This proved to be the tool that facilitated our learning this new forensic skill. Crucial was to learn that – as Robert Simon, M.D. said – the forensic mental health professional “is not the engine, but a hood ornament, in
the vehicle of litigation,” and it provided enough support to walk firmly into this shared field that anticipates from us to state what is clinically and scientifically evident and relevant, in a language appropriate for an audience taken to be psychologically unskilled. We do not mean this volume to be an encyclopedic survey of the field; therefore, vast areas of importance will be included.

There is an increasing number of individuals that had been examined in forensic studies that started legal actions and succeeded in malpractice suits against mental health professionals who conducted independent medical examinations (IMEs), largely due to poor quality of the studies and misinterpretation of their legal duties in this context. Judicial immunity for expert witness is no longer sacred and it is eroding due to the unscientific methods used by some mental health professionals that perform these studies without proper restraint, and dispassionate style, using bias and advocacy in their conclusions. Lack of neutrality makes for subjective opinions. We are to uphold the medical mandate to “first of all, do no harm” (primum non nocere) to the examinee, and if we find a clinical situation in need of urgent action, we are required to use proper skill and care to report such finding without delay.

The responsibility “not to harm” the examinee applies with the same rigor expected of a treating physician interested in doing well for the patient. In carrying out an IME, professional malpractice, or more, may and do happen (e.g., failure to recognize a psychiatric emergency, careless infliction of undue psychological pain, not keeping the findings confidential from those not immediately involved with the case, and negligently publicizing the undisguised personal psychiatric history of a forensic examinee, or engaging in the treatment of the forensic evaluatee), setting the stage for malpractice litigation against, and/or board sanctions against the mental health professionals.

Purposely, the main source of learning in this volume is the presentation of case material to demonstrate the process and how to arrive at an opinion, “within a reasonable degree of professional probability.”

We present the topics in two sections: informative and illustrative, addressing the needs of every mental health professional doing, or interested in doing independent psychiatric examinations. They are commonly called IME (independent medical examination), so, in the interest of shortness, we refer to them as such.

The IME, which also comprises the evaluation and analysis of the data collected during the examination, applies to both, the civil and criminal arenas, and are requested by attorneys (plaintiff, defense, or prosecutor), and the court (judges). Insurance companies also call for the investigation of psychiatric disability claims (workers’ compensation) and claims of psychiatric ailments as a result of mishaps or crimes. As well, professional review boards that investigate reports of (ethical) misconduct or attitudes and practices that may place the community at risk, and employers that seek to determine the mental health status and fitness for duty determination of their employees, are all sources of need for this type of service.

The first section of this volume clarifies the basic concepts intrinsic to this forensic branch of mental health. It is organized in chapters that describe aspects of the vastness of this field, the possibilities for, and responsibilities that the mental health
professional needs to focus on, to be a skillful investigative expert first, and then a successful communicator expert witness.

We highlight the difference between clinical and forensic roles, advocacy and science, ethical and legal aspects, and those found by the courts as objectionable and even actionable. Most of these actions are due to poor quality of the investigation and misunderstanding of their legal duties in this field. To limit liability in this context, practical suggestions follow. Becoming acquainted with legal “terms of art” such as burden of proof and standards of care are essential for a good outcome.

We describe the process of proper handling of a forensic or independent psychiatric examination: from the initial contact with the attorney or other proper source, via telephone, letter, or e-mail, to the sequence of subsequent professional steps. This process comprises unique aspects of common situations, such as the initial contact made by the client (meaning the attorney, or the individual to be examined, acting as her/his own attorney: pro se) in contrast to the first contact of a prospective patient. The distinction between the essential definitions of clinical patient and forensic examinee, or client of the attorney-our-client, is emphasized. A particular aspect that applies to forensic social workers distinguishes between the clinical and forensic “client.”

The next step in the examination process takes us to combing the records (collateral sources of information), recognizing and extracting what to select as relevant from the present and/or absent clinical material. We detail the painstaking task of sorting out the relevance of summaries, process notes, and progress notes as reported by the treating mental health professional. This applies not only to office records, normally written by one person, but also to hospital stuff observations, with the benefit of the input of many professionals from different vantage points.

We explain the initial interview, eliminating sources of bias from the outset; how to approach the examination; what to communicate to the evaluee; and how to anticipate potential pitfalls from the initial contact.

Finally, we discuss the preparation of the forensic report. This includes the following headings: introduction, standards, and review of collateral sources of information, interview with the examinee, examinee’s account of her/his present situation, mental status examination (now “or” then), diagnosis (if warranted), and forensic opinion, including its bases.

Still within the first section of this book, we address the crucial aspect of establishing the forensic question(s) to be considered, according to legal criteria, which is of help to the jurist looking for a legal decision. This is emphasized using examples.

The second section introduces vignettes illustrating the steps previously presented in section one. Here we depict, with examples, “bad” and “good” reports from studies performed on the same examinee.

We present condensed definitions of clinical and legal topics in each case, for example, what constitutes psychiatric malpractice, how to assess for pain and suffering in medical malpractice, sexual harassment, how to conduct a suicide and violence risk assessment, et cetera. The case examples have a brief prologue
addressing the clinical issues (such as diagnosis), legal criteria and how the attorney (advocate) presents the case to us, as well as procedural aspects to pay particular attention to, while preparing our opinions, for example, Is the claim of rape in a mentally handicapped individual, enough to sustain a case? Is the claim of “mental instability” in a financially solvent retired elder that engages in controversial ventures, enough to establish incompetence? Does confirmed sexual harassment always lead to psychiatric disorder? Does a psychiatric condition preclude the custody of a child? Is competency to stand trial altered by dementia? Does dementia contradict competence to write or amend a “will”? Can sexually deviant behavior, as well as other unlawful deeds, be explained by the person’s life events and its consequences on the mind, and amount to a diminish responsibility or even temporary insanity, in a court of law?

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Part I

Introductory Concepts to the Field
Definitions and Explanations

Attorney
When a person trained and licensed to practice law, meaning a lawyer, represents clients in legal matters (both in and out of court) and gives legal advice, that lawyer is called an attorney.

Collateral sources of information
All material (legal, medical, psychological, police) collected to enhance the knowledge of an examinee.

Criminal trial
An examination of a claim of an unlawful action done with malicious intent, involving the offering of a testimony before a tribunal (court).

Doctor (medical)
Professional that provides medical care or treatment.

Patient:
One under medical care.

Therapy:
Treatment.

Psychotherapist:
One that provides psychological care or treatment.

Evaluation
The act of considering what was examined in order to judge its value, quality, importance, extent, or condition.

Examination
The act or process of inspecting or testing for evidence of disease or abnormality.

“An expert witness should distinguish between what he knows as an expert and what he may believe as a layman. His role is to contribute the insight of a specialty. He is not an advocate; that is the role of counsel. Nor is he the ultimate trier of the facts; that is the role of the jury or the judge, as the case may be. The trier of the facts may be misled if the expert goes beyond what he can contribute as an expert….” In re Hyett, 61 N.J. 518 (1972) 296 A.2d306 [Supreme Court of New Jersey]
Examinee (also evaluatee) A person, plaintiff, or defendant that is examined.

Expert A person who is very knowledgeable or highly skilled, trained, or experienced.

Expert witness An individual permitted to present opinion in court on matters of fact that are beyond the expertise of ordinary citizens. A qualified forensic examiner that can state and explain, in an understandable and credible manner, the clinical data, the opinion, and the basis for it, to a judge and jury.

Fact-finding process The series of steps taken by the forensic MHP that lead to an expert opinion based on the evidence (i.e., clinical signs fitting in with a specific diagnostic criteria) gathered.

Federal rules of evidence According to the Uniform Rules of Evidence Act, these are instructions on how to decide on admissibility of expert opinion. See Appendix A.

Forensic MHP (psychiatrist, psychologist, psychiatric social worker, psychiatric registered nurse) The professional that is qualified to be called upon and apply knowledge of mental/brain functioning in a court of law in order to assist an attorney and, ultimately the court, in the establishment of legal decisions.

Forensic Relating to or dealing with the application of scientific knowledge to legal problems.

IME Independent medical, psychiatric, or psychological examination. A mental health assessment conducted by a qualified MHP not involved in the treatment of the individual, at the request of a third party.

Junk science Opinions that are based on evidence that falls below the standards of science.

Lunacy An old-fashion term that evolved into what is now known as psychosis.

Science A method that, when applied, will lead to scientific knowledge.

Scientific method It is open, public, repeatable, and its conclusions are based upon evidence.

Sign Objectively detected by observations and tests – what the doctor observes.

Standard of care The MHP is required to exercise, in examining, diagnosing, and treating, that reasonable degree of knowledge, skill, and care which is ordinarily had and used by other members of his profession in similar circumstances. A MHP must act as a reasonable clinician under comparable circumstances.

Statute An act of legislature to enact or prescribe conduct, to define crimes, and in general to promote public welfare.
Symptom Reported as subjectively experienced – what the patient reports.
Testify The making of a statement under oath.
Testimony Statement made by a witness, under oath, in a legal proceeding.

Introduction

Judges have grown weary of “hired guns,” whose opinions are based on weak standards and whose reports state the obvious. A forensic expert should be able to limit the testimony to the disputed aspects of the case and the particular area of expertise he possesses. Judges report their being attentive to the expert’s presentation of facts and brief explanations of key issues because they favor an educational approach.

When attorneys, judges, and jurors need to understand the past or present mental state of an individual, as well as projecting that mental functioning into the future (depending on the case and the particular aspect that needs to be decided), a forensic mental health professional (MHP) is called upon to describe such state of mind. The forensic MHP also is hired to provide the opinion, and its foundation, that helps the law continue in the search for a fair legal decision to a dispute.

A Brief History of Forensic Psychiatry

Despite popular thought, the history of forensic mental health is rich and extensive. It is packed with legal cases in which human behavior and the mental state that fueled it became under legal scrutiny. Cases discussed and settled by the US Supreme Court and other highest state courts came to be known as “Landmark,” setting the standard on how to consider the psychological perspective in the court of law.

The law became used to recognize the fact that not all human behavior is the product of “free will.” A knowledgeable MHP is now called to shed light on the behavioral outcome of abnormal mental processes. He/she presents such findings in the form of opinions based on the application of scientific knowledge contained in a forensic psychiatric examination. The independent medical examination (IME) also comprises the evaluation of the data collected during the examination.

The first recorded example of forensic testimony in a criminal trial took place at the trial of Earl Ferrers in 1760, in which Dr. John Monro, in Bethlem, England, testified by teaching the court about “lunacy.” Dr. Monro enlightened the jury by using the concept of “irresistible impulse,” referring to the inability to curb one’s urge to act. Despite his explanations, the House of Lords found Ferrers guilty. This trial marked the beginning of experts acting as educators (expert witnesses) in the courtroom.

For this courtroom education to occur, a set of rules was created to give guidelines allowing the “teachings” of a MHP to be accepted as evidence in the courtroom. This collection of rules was titled “The Federal Rules of Evidence.” Among them, Rule 701 describes how a treating clinician can testify only as “lay or fact witness.” In this case, a fact witness is a witness who testifies on the facts that he or she observed.
while providing mental healthcare, without going beyond that description. He or she will report only on what transpired during the treatment situation, giving no expert opinion on the circumstances (legal implication) of the specific individual.

The Task and Responsibility of the Mental Health Professional

The MHP performing an IME needs to avail himself of records (e.g., psychological, medical, police, and legal) that confirm or refute the examinee’s narrative, as well as question data that the examinee did not reveal to the MHP. It is vital to clearly differentiate between the forensic and the treating roles and responsibilities of the expert’s practice.

Forensic MHPs are asked to determine all sorts of psychological circumstances, including whether mental illness or disability was, is, or will still be present.

An extensive knowledge of mental health is but one of the many important ingredients of being an expert witness. Disconnected from other factors, the mere knowledge of mental health will play a limited role in the establishment of a legal decision. The expert should help the trier of fact differentiate between objective (clinical signs of disease) and subjective (reported subjective symptoms), and the weight each has in court. This expert, as well, should know how to apply this information to specific clinical matters under legal scrutiny. It is essential to have enough clinical experience and up-to-date knowledge of the field of practice so as to feel at ease using and describing the current standards of care in any particular case.

It is important to be familiar with the “Federal Rules of Evidence,” Article VII: Opinions and Expert Testimony (701–706, Appendix) that regulates the expert’s participation in the fact-finding process.

The limits imposed by Rule 701 refer to the area of attention and scope of the clinician’s practice, which falls outside the legal issues playing a role in his patient’s life. The confidentiality of the treatment process imposes restrictions to gain access to other (collateral) sources of information, as well as impedes divulging data that was obtained in confidence during treatment. Similarly, the clinician needs to cultivate and adhere to his main interest, namely, establishing and maintaining a trusting and working (therapeutic) relationship with his patient. The patient may be hesitant at first to confide in and share information with the psychiatrist/therapist, beyond the reporting of symptoms. The therapist’s job is to safeguard the treatment setting that fosters the development of the psychotherapeutic process. This process may eventually bring about the fertile ground for mental health to occur. The clinician attributes the patient’s first reluctance to relate and be truthful, to the inner workings of that patient’s mind.

Boundary Considerations for the Expert

To be prepared to convey scientific knowledge in an expert opinion, one should know the boundaries imposed by each professional role: the treating and the forensic mental health professional.
Expert witnesses draw from many supplementary sources for information to reach an opinion about a specific case. Only after thorough and extensive study of the case in point should a professional offer his or her expert testimony in court in the form of an opinion followed by the bases for that opinion. The law expects the professional to base the testimony on his/her day-to-day acceptable clinical practice in order to arrive at an opinion. For example, the focus of the practice for a marriage and family therapist is typically on relationship problems between married individuals and among parents and their children, not the diagnosis of mental illness.

This presents a problem in that a professional may provide in court an “expert” testimony that involves more advocacy and personal bias than knowledge or expertise based on medical (psychiatric) science. It should not be inferred that clinical MHPs are typically not as rigorous as forensic MHP in their methods when they work. Both, the clinical and forensic experts, have two different goals while performing their professional tasks.

To treat somebody, clinicians are involved, in their advocating role, in a doctor-/therapist-patient relationship offering support, advice, confrontation, clarification, interpretation, and/or medication within an emotionally tolerant setting. This clinician, if testifying in court, can appear unfocused when trying to put forth his opinion as a forensic expert, because his or her work with the patient is not meant to withstand the diligence and rigor of legal scrutiny. It may also ruin the treatment process, by doing away with the essentials of the doctor/patient relationship.

As treatment providers, MHPs are advocates for their patient, working on helping their patients to achieve their goals. Clinicians do not routinely use collateral sources of information other than to access their patients’ current medical [and laboratory] records and, if the clinical presentation requires it, also their past recorded psychiatric information. Clinicians routinely have limited access and use of collateral sources of information. The clinician learns about the psychiatric patient by observing his mind/brain in action and in his interactions with the therapist. Legal documents are not reviewed, and accessibility to patient’s medical and psychological records from other doctors usually reaches the therapist’s office after the treatment is under way. The primary objective of a clinician is to establish a doctor/patient working relationship and use it to treat, alleviate, cure, and prevent relapse in his suffering patient. A forensic MHP cares, above all, to understand, describe, and explain the mental state of the examinee, at specific times, concerning his or her involvement in a specific legal proceeding.

Comparing Roles of the Mental Health Professional from Clinic/Office to Courtroom

The main difference between the job of a clinician and that of a forensic expert (expert witness) is that the clinician limits his involvement to the treatment room, while the forensic expert uses that same treatment room exclusively as an examination room and then spreads out his practice into the courtroom. Another vital distinction lies in the different handling of confidential information by the psychiatric
clinician and the forensic psychiatrist. Whereas confidentiality is essential to the doctor/patient relationship and for the mental health treatment to proceed, it is not upheld in the forensic psychiatric examination to the same extent, and the examinee ought to understand and appreciate the context in which her communications occur.

The clinical (treating) MHP relies heavily on the patient’s reported symptoms (in contrast to signs found during the examination) – what the patient feels or describes feeling. As the patient’s helper, the clinician accepts such descriptions (symptoms) as valid and present, as she proceeds with the examination, evaluation, diagnostic, and treatment process. This process consists of learning more about the condition that brings the patient to the office, diagnosing the psychiatric illness, then eliminating those symptoms, and possibly curing or controlling the disease. The mental health clinician starts out believing his or her patient’s clinical descriptions and also believes the patient’s reported intention to get well. From the outset, the clinician sets out to diagnose and treat the patient’s mental illness. In an effort to reach this goal, there is a pro-patient stance, and for the patient’s welfare, the confidentiality rule is adhered to. The doctor/patient relationship in a forensic setting is significantly altered.

The individual in a forensic setting is referred to as “examinee” rather than “patient” because he or she is not receiving treatment. The expert is typically not allotted a large amount of time to reach a scientific opinion about the patient’s psychiatric condition. This contrasts greatly to the procedure of a clinician, who discovers new information about his or her patient, practically every visit over long periods of time. With the short amount of time assigned to the forensic MHP, the study of direct (the individual himself) information cannot be the only substantial source informing a scientific opinion; scrupulous review of indirect sources of information, when available, is not only strongly suggested but required in order to draw a probable psychiatric opinion in the amount of time available.

Expert witnesses are asked to help ascertain all sorts of psychological circumstances, including the presence of a mental disorder and its cause and its influence on mental functioning. Performing clinical work, mental health practitioners must adhere to the ethical principles for that practice (e.g., non-maleficence, beneficence, and autonomy) while committed to follow the legal requirements, e.g., confidentiality, as “mandated reporters.” In the pursuit of treatment, clinicians do not ordinarily pay close attention to state statutes, legal criteria such as burdens of proof, rules of evidence, and the like. They adhere to the standards of care and clinical and ethical guidelines within the mental health specialty they practice. These are concepts that belong to the forensic subspecialty adding to the vast knowledge of mental health and applying it to a particular legal issue.

We must clearly see the difference in roles between a forensic expert and a treating clinician. The latter needs and ordinarily has time to establish a doctor/patient relationship; he also has time to develop and pursue treatment goals. The forensic expert knows it is not her place to impart treatment; moreover, it is objectionable for her to establish a bond with the examinee, or to relate to the examinee as if he were a patient, which interferes with the forensic role. The forensic expert’s role is only to “get in, obtained clinical information and get out” and determine, for example, if
a mental disorder or defect plays a specific role in a particular legal action. If the opinion of the forensic MHP is that the mental state of the examinee ought to be taken into account, another job for the expert may be to opine on its cause, if it is possible to determine. In the forensic role, the neutrality and objectivity of the MHP are essential for him or her, to be an acceptable link in the fact-finding process. His neutral stance is expected to exist in the attitude and demeanor with the examinee. He is just expected to advocate for his or her opinion within the facts obtained and considered.

On the other hand, the Federal Rule of Evidence 702 (Testimony by Experts) establishes that:

If scientific, technical, or other specialized knowledge will assist the trier of fact to understand the evidence or to determine a fact in issue, a witness qualified as an expert by knowledge, skill, experience, training, or education, may testify thereto in the form of an opinion or otherwise if (1) the testimony is based upon sufficient facts or data, (2) the testimony is the product of reliable principles and methods, and (3) the witness has applied the principles and methods reliably to the facts of the case.

This is how the court defines the expert witness participation in the understanding of a case or claim. Adhering to this rule, the expert can opine about that which helps the trier of fact, jury or judge, rule on a case. Basically, if an expert speaks in court correctly using current scientific evidence to back up her or his conclusions, the testimony is acceptable under “702.”

Forensic Psychiatry as an Ever-Evolving Practice

The aspect referring to “reliable principles and methods” is the one most revised according to new, tested, validated, dependable, acceptable, and most importantly, relevant knowledge (medical art and science) added to our profession. “The practice of medicine is an art based on science,” said William Osler. This definition does not change; what change is what we take to be “reliable principles and methods.” As the findings of science evolve, what was once testable and reliable may now be considered obsolete and substituted for new scientific methods. As science develops so does better grasping.

The decision if an expert testimony is admissible or not depends on how well the expert uses scientific knowledge, methods, and standards of care to help understand more elusive concepts that are the focus of the legal inquiry. We do this while controlling against speculation and bias.

Before the Federal Rule of Evidence 702 was presented to the scientific and legal communities, the standard for admissibility of expert testimony was known as the “general acceptance standard.” It was first set forth in 1923, as a result of Frye vs. United States. It is known as the “Frye test” and states that a scientific principle is admissible as evidence only after gaining a general acceptance in the field to which it belongs. After the creation of the Federal Rule of Evidence 702, the US Supreme Court unanimously decided that it supersedes Frye’s general acceptance test because
it pursues scientific knowledge with more rigor and allows the judge to decide on
the relevance of the scientific information provided.

In Daubert vs. Merrell Dow Pharmaceuticals, Inc., the US Supreme Court ruled
in 1993 that under the Federal Rules of Evidence, Frye’s general acceptance stan-
dard was not enough to rule out biased testimony and so a new standard was created.
Called the “Daubert test” of evidence admissibility (also known as “Relevant
Analysis”), it allows trial judges to examine the expert evidence during pretrial,
making for a closer inspection than the Frye test had permitted. It is designed to
keep bias, often presented in the form of untested “science,” out of the courtroom,
where convincing but unscientific experts could mislead the jury. Because of this
strong rule, the judge acts as a “gatekeeper” to what gets to the jury, weeding out
“junk science.” The Daubert Court revised Rule 702 to require that an expert’s tes-
timony must amount to “scientific knowledge” in order to be admissible as evidence
to a case.

The “Relevant Analysis” (Daubert test) was adopted for the federal courts,
replacing Frye. Many states’ courts switched from Frye to Daubert, based upon the
Federal Rule of Evidence 702. The goal is to provide judges with an important tool
for preventing the introduction of conjecture and “junk science” under the facade of
expert testimony.

The court involved in the Daubert case interpreted this rule to impose judges to
base admissibility of expert testimony on the reliability and relevance of scientific
principles. As part of the decision, four factors must be addressed in determining the
soundness of the methodology applied by the expert:

1. Whether the theory or technique used has been tested
2. Whether this theory or technique has been subjected to peer review and
   publication
3. The known or potential rate of error or the existence of standards
4. Whether the theory or technique used has been generally accepted

Additionally, in 1999, the Supreme Court decision of Kumho Tire Co. Ltd, v.
Carmichael extended the “Daubert” ruling to testimony based on the expert’s expe-
rience in the field at issue, giving the court more discretion to evaluate expert’s tes-
timony and adding that Daubert applies not only to scientific knowledge but to
“technical” (knowledge acquired by experience) and “other specialized” (not
defined by the law) knowledge as well.

Fundamentally, forensic MHP effort comes down to the application of the ever-
growing methods, increasingly greater precision, and rising ability [of the MHP] to
show the truth or falseness of psychiatric afflictions in the courtroom. In essence,
the field is constantly evolving.
## Definitions and Explanations

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
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<tbody>
<tr>
<td><strong>Administrative law</strong></td>
<td>A law created by regulatory agencies by way of rules, regulations, orders, and decisions.</td>
</tr>
<tr>
<td><strong>Adversarial proceeding</strong></td>
<td>A hearing involving a controversy between two opposing parties, the outcome of which is expected to be favorable only to one of the parties.</td>
</tr>
<tr>
<td><strong>American Medical Association</strong></td>
<td>The organization that groups physicians in the United States.</td>
</tr>
<tr>
<td><strong>Appeal</strong></td>
<td>A request to a higher court to review and reverse the decision of a lower court. No new evidence is introduced and is set to assess for error in applying the law.</td>
</tr>
<tr>
<td><strong>Civil law</strong></td>
<td>Relates to disputes between citizens regarding compensations for misdeeds. It provides all citizens with an accessible and written collection of the laws which apply to them and which judges must follow.</td>
</tr>
<tr>
<td><strong>Criminal law</strong></td>
<td>Body of law that is concerned with a legal action (prosecution), for the purpose of punishment, involving the state (government) and its people.</td>
</tr>
<tr>
<td><strong>Defendant</strong></td>
<td>A person against whom an action is brought.</td>
</tr>
<tr>
<td><strong>Ethical</strong></td>
<td>Relates to the discipline that attempts to understand the nature of morality, to define right and wrong, conforming to professional standards of conduct.</td>
</tr>
<tr>
<td><strong>Indictment</strong></td>
<td>A written charge by a grand jury or prosecutor of a criminal offense.</td>
</tr>
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</table>

“There is no appeal to a court above that of reason.” – Sigmund Freud
<table>
<thead>
<tr>
<th>Term</th>
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<tbody>
<tr>
<td>Jury</td>
<td>A group composed of the peers of the parties or a cross section of the community called upon and sworn, to decide on the facts in issue at trial.</td>
</tr>
<tr>
<td>Litigation</td>
<td>A lawsuit, a dispute under the scrutiny of a court of law.</td>
</tr>
<tr>
<td>MCMI-III</td>
<td>Millon Clinical Multiaxial Inventory (psychological testing), third edition.</td>
</tr>
<tr>
<td>MMPI-2</td>
<td>Minnesota Multiphasic Personality Inventory, Restructured Form (psychological testing), second edition. There is a newer version: MMPI-2-RF (Restructured Form), out in 2008, updating the previous 1989 version.</td>
</tr>
<tr>
<td>Plaintiff</td>
<td>A person who initiates a civil lawsuit.</td>
</tr>
<tr>
<td>Psychiatric</td>
<td>Dealing with cases of mental disorders.</td>
</tr>
<tr>
<td>Psychiatry</td>
<td>One of the branches of medicine, involved in the diagnosis and treatment of mental disorders, using methods that include psychotherapy, medication, electroconvulsive treatment, and magnetic and electric brain stimulation.</td>
</tr>
<tr>
<td>Psychology</td>
<td>Professional discipline concerned with the structuring and functioning of mental processes and its normal and abnormal manifestations. Clinically, it engages in psychotherapeutic modalities and also in the outlining of psychological profiles via testing instruments.</td>
</tr>
<tr>
<td>Reasonable degree of medical/psychiatric/psychological probability</td>
<td>Legal term that refers to the amount of confidence that the expert’s opinion carries. This is measured as the opinion being “more likely than not” to be right (generally accepted at least at 51% of confidence). This legal standard is known as the “burden of proof” referred to as “preponderance of the evidence.”</td>
</tr>
<tr>
<td>Res ipsa loquitur</td>
<td>A Latin phrase which means “the thing speaks for itself.” This is applied to tort claims that, as a matter of law, do not have to be explained beyond the obvious facts.</td>
</tr>
<tr>
<td>Review board</td>
<td>A panel of members of an occupation/profession that oversees the good functioning of its members to safeguard the community and reports to its licensing board.</td>
</tr>
<tr>
<td>Warrant</td>
<td>A written order from a court or official directing the doing of a certain act, especially one directing the arrest of a person.</td>
</tr>
</tbody>
</table>
**Workers’ compensation acts**

Statutes that in general establish liability of an employer (without regard to the fault or negligence of the employer) for injuries or sickness that arise out of and in the course of employment.

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**Introduction**

Mental health providers (MHPs) work diligently, yet delicately, walking on the thin line between psychology, psychiatry, and the law. The MHP must utilize all of his or her knowledge of mental health and mental disorder to draw a well thought-out conclusion on the mental status of the evaluee while adhering to the strict procedures and terminology of the law.

Working on the borderline between mental health and the law makes it imperative not only to know the mental health field well but also to be acquainted with basic legal concepts.

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**Definitions, Concepts, and Basic Legal Terminologies**

The judicial process in the United States follows the *adversarial* system, which relies heavily on juries. This is in contrast to the other major court process, the inquisitorial system, adhered to by many countries, and which does not rely primarily on juries. This presents the MHP with particular challenges of how to address jurors.

Within the judicial processes lie two different types of cases, civil and criminal. A civil case refers to a matter involving a dispute between two individuals. The terms used in civil law are *plaintiff* and *defendant* (the order written on legal forms is always *Plaintiff* vs. *Defendant*). A civil case involves disputes between citizens or between citizens and institutions. In this form of trial, the objective is to make the person “whole” again [by ending his or her mental ailment] through financial means if psychiatric or psychological treatment did not suffice.

Instead, a criminal case is defined as a dispute between the government and its citizen, e.g., *State* (community) vs. *Defendant* (a person against whom a warrant is issued or an indictment is found). The purpose of this type of trial is to establish if the defendant is guilty of a crime and, if so, to assign punishment.

There are two other types of proceedings: administrative courts and review board. Administrative courts relate to workers’ compensation cases and review board committees relate to ethical complaints.

Experts may be called in for each of these types of cases to help the judge or jury (trier of fact) understand complex psychological issues that are, primarily (i.e., state of mind when an action was carried out) or secondarily (i.e., state of mind formed after an action), a core issue of litigation.
“Matters of fact” are the particulars of the case to be looked upon by the jury or judge in trial courts. The expert witness sits in to define and explain certain facts that the jury or judge needs to reflect on but is unskilled to tackle without such teaching. The jury/judge is the trier of fact, by considering the evidence in the adversarial process and then applying the law to those facts.

“Matters of law” are the legal basis used to resolve a case and are decided only by the judge. Only issues of law can be appealed to higher courts, e.g., wrong application of a legal principle and inadequate assistance of counsel. As well, only the judge’s decisions can be appealed, not the jury’s.

Why is it important for some individuals, other than the attorneys, to be present in the courtroom? Fact witnesses are called in to give firsthand accounts of what they observed in a case, helping with their testimonies to inform the jury. Relatives, friends, and acquaintances of the person on trial are asked to give background information on the defendant for the trier of fact to have a better understanding of who is the person on trial. Expert witnesses, like a forensic MHP, are called in to provide the jury with evidence obtained in an objective (scientific) manner and to explain how it contributes to the understanding of the case. This evidence, the psychological state of an examinee, may be otherwise unattainable and unclear through the work of a lawyer.

The Scope of a Forensic Mental Health Professional as an Expert Witness

An expert witness is one who is able to obtain the precise information; consider the standards, guidelines, and current knowledge and practice; and break it down into understandable, unbiased pieces of evidence, which can help moving the legal process along in the courtroom. Unlike the forensic MHP, the treating MHP (clinician) is an advocate for his or her patient turned litigant, due to the treatment relationship formed.

The essential job of any expert in the courtroom is to teach. In a summary fashion, the expert witness is there to describe and explain the application of what is known about normal or abnormal psychology to the jury.

Is there evidence to accept or reject issues such as psychological trauma (i.e., post-traumatic stress disorder), psychosis, dementia, psychiatric disability, wrongful death, malpractice and patient neglect, insanity evaluations, or competency and undue influence issues concerning one’s “will”?

The forensic expert is called upon to opine on controversial issues and state it within a reasonable degree of medical/psychiatric or psychological probability. Nowhere is this more poignant than when the case comes across as so controversial that the outcome may very well be described as a “flip of a coin.” This can occur in either criminal or civil matters. The forensic expert is not needed, however, when the case at hand follows a more clear-cut, res ipsa loquitur path.

Expert witnesses are admitted to testify in courts because they have special knowledge that is greater than that of the average person in the role of trier of fact (judge or jury). The forensic MHP ought to be able to explain psychiatric views in
simpler terms and pictures and create a clearer understanding and impression of the inner functioning of the mind.

**Expectations of and for the Forensic MHP Inside the Courtroom**

Even with modest experience in courtroom protocol, the forensic MHP knows significantly more about mental health than others in the courtroom. When testifying, it is expected to state the circumstances surrounding our participation in the case: the initial contact, the initial question, and the evolution of our study of the case, including everything we used and did to arrive at our opinion. Moreover, one should speak about his or her findings and conclusions without complex and unnecessary technical words. One has to remember to keep things as simple as possible while describing and explaining; the goal is to be understood and helpful to the trier of fact.

Trying to impress the jurors with fancy words and elaborate explanations will only bore and irritate them because they will not be able to understand the mental health issues that are important to decide a case. The expert may be seen as pompous, and therefore insecure. He must assume that the jurors will not adopt his or her opinion blindly, that he is a tool to be used in court to look into and make sense of the particulars of a case.

Jurors consider the expert’s opinion valuable not because they are impressed with him or her, but because they understood, appreciated, and were able to reason logically with the testimony the expert witness offered. When the juror learns about an otherwise obscure psychological topic, he will use what he learned to reach a legal decision.

Adequate preparation will make the contents of one’s testimony important; a strong presentation will allow it to be heard; and a classy presence will make it convincing. – Liptak et al.

Forensic MHPs are, above all, MHPs and, as such, are bound by the strict ethical principles established either by the American Medical Association or by the professional societies where the MHPs belong.

Ethics refer to what is morally and professionally “right.” Ethically, the forensic MHP is expected to be honest, thorough, and above all, follow the scientific method to arrive at an expert opinion.

**Cautionary Considerations When Presenting Examination Findings**

Exams are based on thorough reviews of collateral sources of information and direct examinations (face-to-face interviews) of the examinee. An exception is when the MHP performs a psychological autopsy, since the examinee is now deceased. The use of psychometric (psychological) testing may also be of help.
Psychometric instruments (psychological tests) are often helpful additional data to consider in the forensic arena. This is because most tools were standardized on “patients” who were in the early phases of assessment for psychiatric or psychotherapeutic treatment. These psychological charts rely strongly on the honesty of the individual tested. Respondents who do not belong to this “normative” population [of patients in early stages of treatment] or who have relatively recently taken the tests (e.g., MCMI-3) for nonclinical purposes may score distorted results. Likewise, in the introduction to the MMPI-2 test result, we read:

This report contains computer generated statements. These represent preliminary hypotheses requiring further study through other aspects of psychological evaluations, including clinical interviews, behavioral observations, referral reasons, background information, psychosocial history, current circumstances, recent stressors, physical condition, and other test results.

Psychological testing estimates accuracy of conclusions (sensitivity), none is definite, and alone is an inadequate means (validity and specificity) to detect and then reach (reliable) forensic conclusions. These instruments do not tell us about the time of presentation of the symptoms reported (Is it occurring now or has it occurred in the past?), are not definitive when it comes to assess intention to mislead with the answers, and do not tell us if the test was conducted (context) in a hospital setting, mental health professional’s office, while incarcerated, home, or place of work of the individual tested or if it was administered to a patient or an examinee.

Also, computer interpretation of tests facilitates the use of testing by underqualified evaluators and increases the likelihood of misinterpretation. Psychological testing can be an advantage and the opposite.

Conclusions and Perspectives

To work as an expert witness in the mental health profession can be an exciting source of satisfaction. It is important to have a solid grasp of the foundational aspects that govern the role of MHP within this specialized context. For most, this capacity will fall outside of the training traditionally received in medical or graduate school settings; however, this need not impede one’s abilities to excel in the forensic field. There is no need to have a fluent understanding of the complexities of law to allow one to act as a forensic MHP and expert witness. It is essential to have a confident understanding of the limitations of the role the MHP plays as an expert witness. To this end, knowing the basics of the type of case one may be involved in, the roles of the parties involved, and an adequate working definition of the legal details are sufficient to prepare and present a careful forensic examination. Perhaps one of the most difficult parts is to creatively and coherently link the data gathered from the examinations, testimony, and collateral sources of information together in a report that clearly addresses the question(s) at hand. It is with this aspect in mind that attention turns next to the forensic medical examination in the text ahead.
Performing an Independent Medical Examination: From Initial Contact to Report Preparation

Definitions and Explanations

**Competence**
Legal term used to indicate that a person has the capacity to perform a specific action, i.e., prepare a will or consent to treatment.

**Deposition**
A written record of oral testimony, in the form of questions and answers, made before a public officer, for use in a lawsuit. They are used for the purpose of the discovery of information, or for the purpose of being read as evidence at a trial, or both.

**Discovery**
In civil cases, methods of discovery include depositions and interrogations. In criminal cases, the defendant may request information held by the prosecution, which may help the defense.

**Determining factors**
Life events that harden personality characteristics into a more or less rigid pattern.

**Predisposing factors**
Early conditions that form the basis for the development of later traits. Also considered within “genetic” factors.

**Premorbid**
Refers to a [mental] disorder that was present before a specific event took place.

**Pro se**
Lat. For himself; in one’s own behalf, or being his own attorney.

**Retaining attorney**
Attorney that engages the forensic services.

**Triggering factors**
Causes for the appearance of new and disturbed feeling, thinking, or behaving. According to the intensity of the trigger, it may or may not follow an exaggerated or distorted version of the habitual functioning.

“Psychiatrists practicing in a forensic role enhance the honesty and objectivity of their work by basing their forensic opinions, forensic reports and forensic testimony on all available data.” – Ethics Guidelines for the Practice of Forensic Psychiatry; American Academy of Psychiatry and the Law

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Introduction and Overview to the Independent Medical Examination

For the treating doctor to explain in court the type, magnitude, and origin of the symptoms described by the patient, based on the date of an incident, proves very risky. The danger is that the clinical picture presented to the clinician may not be accurate. The forensic expert’s job is to determine that the examinee’s mental state actually reflects the psychological difficulty he reports.

For example, a man describes symptoms of post-traumatic stress disorder (PTSD) and attributes them to his having been in the towers on “9/11.” He stands to receive monetary benefits from some agency. The problem is that, without proper assessment, the mental health professional (MHP) may conclude that “this is so”; after all, these attacks evoked “unbelievable” horror in all of us. The MHP may not learn, for some time, that, even though the man may indeed be afflicted with PTSD which originated from the examinee’s involvement in the Vietnam War decades ago, for which he had received appropriate psychiatric help, he may be receiving benefits for a psychiatric disorder that may have only been, at worst, minimally exacerbated by the terrorist attacks of 2001. Obviously, this individual knows how PTSD manifests itself and would be able to list its symptoms. This example emphasizes the importance of a meticulous examination, consideration of alternative lines of exploration, and subject to inquiry of what one takes to be evident.

The work of a mental health professional should be as meticulous and comprehensive as possible. To end his or her hard work, the forensic MHP prepares a special (narrative) report to qualify and quantify his or her scientific findings. These findings are presented in a methodical document that states all or some of the following data, according to the specific issue(s) to address in the study: who retained the expert; the purpose of the examination; the question(s) to assess; the material reviewed, if applicable; when, where, and for how long the examination took place; the content of the face-to-face interview; the examination of the current and past mental state; diagnosis; and the forensic psychiatric opinion and its basis. The report should stand alone and contain the information needed and used to arrive at the opinion; the reader should not need to go to outside sources to understand it. The opinion(s) should be based on material described in the early sections of the body of the report. Such a report is commonly referred to as independent medical examination or “IME.”

Important Considerations for the MHP Conducting the IME

The word “independent” essentially indicates that the examiner is neutral, pricing the time he or she took to complete the study, rather than charging for his or her opinion. The examinee is neither a patient nor a client of the forensic MHP. The examinee is the attorney’s client, or the insured of an insurance company requesting the IME. In these instances, the attorney and insurance company becomes the expert’s client. An IME is basically an investigation that calls for honesty and
careful adherence to details and scientific rigor. One must be careful to watch for and exclude partisanship or advocacy.

There is one situation in which the examinee is also the client, and this is when the one requesting the IME acts “pro se.” If the expert’s opinion supports his or her grievance, such a person generally follows through by searching for an attorney to more properly carry out a legal action.

Owing to the fact that the forensic MHP performs an IME, and it is a procedure within the practice of mental health, he or she is obligated to adhere to the principle of not causing harm to the examinee while conducting the examination, among other ethical principles to follow. The expert must also make sure to report found signs of a psychiatric disorder that could prove to become a substantial risk of danger to the examinee or a third party.

Legal Aspects of the IME

The IME applies to both, the civil and criminal settings, and is generally requested by attorneys (plaintiff, prosecutor, and defense), or the court (judges). Insurance companies also call for the investigation of psychiatric disability claims (i.e., workers’ compensation) and claims of psychiatric ailments as a result of mishaps or crimes, as well as professional review boards that investigate reports of ethical misconduct or practices that may place the community at risk, and employers that seek to determine the mental health status of their employees are sources of need for this type of service.

An IME is a relatively long process that commonly starts with the initial call from an attorney (representing a client involved in litigation) desiring to learn more about some psychological issue or functioning that might be afflicting his or her client. On the other hand, the initial contact may come from a defense attorney trying to determine if there is merit to the plaintiff or government’s grievance.

Every case that the forensic expert will work on stems from a specific question that the attorney needs to address (usually pertaining to the mental status of his client (examinee)). This question will keep the expert focused throughout the entire process of the IME. Oftentimes, the specific question to be answered comes about as a result of the initial conversation between the forensic MHP and the attorney.

It is recommended, during that initial contact with the attorney, to spend time building a working relationship while patiently listening to the facts of the case as the attorney sees them from their perspective as an advocate. It is essential to participate with the attorney in the formulation of the specific question(s) for the forensic MHP to address and use scientific curiosity to this task. For example, the attorney that needs to know if his or her client is competent concerning some particular purpose may be reminded that it is not necessary to establish that the client is or was afflicted by a mental disorder (i.e., dementia or psychosis). A disordered mental state does not necessarily mean incompetence. This is one example of the difference between legal (competency) and clinical (mental illness) concepts, and the MHP’s role is as a link between these two fields.
Once the expert knows what is expected of him or her, he or she needs to set an agreement on the hourly cost of performing the study. It is based on the time needed to complete the work, and never on the opinion that the attorney is looking for. In other words, the expert charges for his or her time, and not for his or her expert opinion. This is the only way the MHP can comfortably embark in the time-consuming task of conducting an IME. It is important to request from the attorney, and to state it in the IME report, that all available records on the matter at hand be provided to the expert. This is particularly helpful when, later on in court, the MHP is asked to comment on aspects of the records that may appear to contradict the expert’s opinion and that the MHP never had the opportunity to review and integrate in the study, opinion, and report.

The independent medical (psychiatric) examination is a tool that the legal system, insurance companies, and the like rely on when the purpose is to evaluate the mental status of a litigant, examinee, insured, defendant, or plaintiff; to explain and opine on the mental status of the individual in relation to a specific issue, such as competence to carry on a particular task; or to plan before acting in an unlawful manner. The examiner’s role is that of a knowledgeable helper. Because of its objectivity, the forensic expert becomes an instrument used to decide a case involving mental health questions. It is different than a regular clinical psychiatric examination because while the clinical evaluation aims at diagnosing and treating an individual, the IME intends to answer precise questions pertaining to particular legal matters. For example, while a clinical psychiatric examination is set to diagnose and treat a psychiatrically ill or psychiatrically disabled individual, an IME is solely used to determine whether psychiatric disease, disability, or pain and suffering is present and caused by a certain event or process, such as an accident, harassment, discrimination, bullying, wrongful acts, et cetera.

Scope and Limitations

There is no treatment that necessarily follows an IME, although whether mental health treatment is needed could be one of the questions asked to the examiner by the attorney. The issue is to determine whether the mental state of the litigant should be considered a key element to understand and make a legal decision. The responsibilities of the clinician and forensic expert are clearly different. Their roles frame the relationship between the patient and therapist on the one hand, and that of examinee and examiner on the other, and it makes it unworkable for these two processes to alternate between the clinical and forensic.

When it is time to perform an independent mental examination, attorneys sometimes overlook who is best qualified to conduct it. Going with the treating therapist as a source of a psychiatric or psychological report seems to save time and also be economically advantageous for the attorney. Here, he or she is unable to differentiate between clinical and forensic specialists. The mistake is made when the attorney expects the therapist to be objective in all aspects of his narrative report about his patient.
The therapist (the patient’s healer) is naturally expected to be biased in favor of his patient, since his role is to support, care, and trust (through the building of a long-term doctor/patient relationship/alliance) for his or her patient, whereas the forensic MHP, as examiner, is free from this clinical professional duty.

The IME report is an elaborate procedure that pulls together legal and clinical information from many different sources. These sources appear to the MHP as a compilation of indirect or third-party descriptions in an effort to enhance the knowledge needed to address the question to answer with objectivity and precision. The aim is to digest all the presented data with the intention of bridging the gap between mental health and law. This “bridging” is done in the form of an expert opinion.

An expert opinion aims at answering a specific psychological question, attentive to legal standards and state or federal statutes that govern the preparation, presentation, and, ultimately, admissibility in court of such a report to use and help justice to be served. The forensic expert does not know what psychological question must be answered until his or her first conversation with an attorney.

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**Practical Approaches to the Process**

First, the attorney calls the MHP and says along the lines of, “I have ‘this’ case in which ‘this’ happened. I would like you to tell me if the behavior of this specific person matches a known psychiatric ailment and whether it was indeed caused by this specific event.” The attorney also points out that the law expects the MHP to use certain legal standards and not others. For example, the MHP cannot directly state that the individual on trial is “insane” or that an individual is guilty. The expert must provide scientific evidence of the defendant’s mental functioning at the time of committing a wrongful act, helping the jury make that ultimate decision. In civil matters, for example, the law states that the forensic expert must show that a specific set of criteria was tested in the study of whether an individual was mentally functionally competent to carry out a specific undertaking.

Oftentimes, after presenting the situation of the case at hand, the MHP begins to bounce ideas back and forth with the attorney until they both arrive at a specific question for the expert to look into. It is then that the MHP decides to continue on with the case or to decline participating in the case, based on whatever reasons the MHP decides (e.g., lack of expertise on that specific issue, or not enough time to complete the assignment). Likewise, it may be the attorney that decides that this expert is not the right one for the case. If the MHP chooses to take on the case, then the expert must ask to receive all the information pertaining to the case. Once the MHP receives all the relevant information, and, if working on retainer, the check from the attorney, he or she begins to work on the case.

After the review of all the collateral sources of information, the forensic expert decides to examine the litigant or other individuals that may be able to inform on the study at hand. Special cases concern psychological autopsies, where the legal issue concerns the mental state linked to the actions of an individual who is no longer alive.
If the MHP calls for an interview (which is preferable), then the attorney, the expert’s client, should be able to make his or the opposing counsel’s client, the examinee, available for a psychiatric or psychological examination at the expert’s office. If the situation calls for an interview away from the expert’s office, then it is expected that the attorney make arrangements and pay for the time and expenses involved in this step of the process. Many find it helpful to audiotape (and/or videotape) the examination and directly use the examinee’s responses (answers and comments), in the IME report.

After meeting with the examinee, the MHP discusses the findings with the requesting attorney and then prepares a report, if the attorney requests it. Usually this is the case when the opinion reached coincides with the expectation of the retaining attorney. If the expert’s opinion differs from the one the attorney hoped for, the study comes to an end and the MHP stops working on that case. A cessation from working on the case, however, still entails the MHP to receive payment for the work done on the case.

**Integrity of the Report and Follow-Up Steps**

An opinion by the expert should be clearly based on the information gathered and detailed in the IME report. The IME report must include a section citing all the sources of the opinion and its bases. It should also include what information the MHP took from each source that contributed to the foundation of the expert’s opinion. Attorneys should not have the need to review the sources cited in the report to be able to understand what is written in it. The expert’s report should stand alone.

After writing the IME report, the first assignment of the MHP is concluded. Then, there is the waiting for the next possible steps to occur: review of new material about the case and preparation of an “addendum” report to the original report, deposition by the opposing counsel, and/or a testimony at trial. This “waiting” may be as short as a few weeks or as long as a few years. For this reason, it is useful to have adequate storage room available in one’s office, or to arrange for the attorney to store it for the MHP. The forensic expert must keep all original material created during his work and keep organized notes so as to easily retrieve and refresh one’s working knowledge and in-depth understanding of the case.

The proper submission of the IME report consists of presenting it only to the retaining attorney, and to no one else. Also, it is the standard of forensic practice to provide no advice or comments to the examinee about the opinions reached of his or her case. Coldly stated, the examinee is the object of the study.

The legal professional has the need to make his/her arguments as sound and compelling as possible. This need brought about the separation between clinical and forensic mental health work. Thus, the MHP that goes to court is now either a factual (clinical) or expert (forensic) witness, but not both. The expert goes to court to digest, analyze, interpret, clarify, and help the trier of fact (judge/juror) make the legal decisions through understanding if and how the mental state of the litigant plays a role in the case to decide.
General Directions for Formulating the IME

Once the forensic psychiatric examination and subsequent evaluation is concluded, the expert’s new task involves showing his or her findings in a document. The IME report must contain all the elements of the case and sufficient information about the examinee so that the report may clearly and understandably explore, describe, and explain. One should not need to look beyond the IME report to understand the opinions and how they came to be. For the MHP to prepare the IME report, he or she needs to create the outline of the report. This outline, as a skeleton, is commonly organized as follows:

- **Title**: Independent Psychiatric (or Psychological) Examination, or Forensic Psychiatric (or Psychological) Examination, or Evaluative Psychiatric (Psychological) Examination. It is also referred to as Psychiatric- (or Neuropsychiatric- Psychological-) Legal Examination.

- **Identifying Information of the Examinee**: This consists, relevant to the case, of the following: name, type of case (e.g., competence, guardianship, best interest, fitness, testamentary capacity), docket number (in civil cases) or indictment number (in criminal cases), date of birth, date of loss (i.e., accident, initial disability claim, or assault), date of examination, and date of report.

- **Introduction**: This section introduces the case of study and describes the steps of engagement; the circumstances involving the initial contact with the retaining party (e.g., mail, telephone, email); a brief summary of the case, as related by the attorney; the question(s) for the MHP to address; the financial agreement (retainer contract) between the MHP and attorney; and the MHP request for all pertinent records for us to receive.

- **Review of Collateral Sources of Information**: The expert should first name all the collateral documents that he or she studied. Then the expert should spend time writing down all pertinent information (concerning the particular area of expertise) that was collected from each collateral source. All collected information should be appropriately written down under the corresponding collateral document number in the IME report. All pertinent information used by the expert contributing to the expert’s opinion should be included next.

- **Interview with the Examinee**: The MHP describes the circumstances of the meeting: when, where, and for how long they met. The MHP should mention the time of day (early in the morning, midday, or [late] in the evening), and how the examinee arrived at the office: Did they drive? Did they get lost? Did they arrive on time? How are they dressed? How do they look? How is their posture? How is their speech? These simple, even trivial, questions and others like them may play a crucial role in understanding the examinee’s predicament and are necessary in completing a careful examination.

- **Examinee’s Account of the Present Situation**: The forensic expert must take down what was told and how it was told. He or she must conduct an interview that combines structured and unstructured approaches, meaning, to provide enough guidance to collect the information needed and to encourage enough
freedom of expression to gain access to the examinee’s relating style and state of mind. This consists of factual data concerning the present and past while also listening for any changes in the mode of communicating thought, emotions, and actions. This is the bulk of the direct source of information – the opportunity for the MHP to test what he or she learned from studying the collateral (indirect) sources of information. According to the need of each case, the MHP records data from childhood on, including how it felt like for the examinee to grow up at home. Some cases require the MHP to focus on being able to describe the examinee’s present dilemma as an expression and outcome of past adverse circumstances. The MHP must ask and learn about the examinee’s family, educational, employment, military, legal, and substance use history. This is also important when studying for the presence of premorbid and/or preexisting conditions. The MHP must know if, for example, in claims of PTSD, predisposing, determining, and triggering factors come together to produce this psychiatric ailment.

- **Mental Status Examination**: The MHP must consider this step only if necessary for the case to be understood. Situations in which it may not be needed include studies concerning state of mind at a previous time of commission of a wrongful act (“insanity” evaluation), a probate on an executed “Last Will and Testament,” and the like. The mental status examination helps the MHP study the presence or absence of psychological infirmity (psychic damage) as a result of an event (e.g., assault, harassment, accident).

- **Psychiatric Diagnosis**: This is used only in cases when it is warranted, as when assessing current psychic damage. Psychiatric diagnosis may not be relevant when assessing for civil and criminal competence. In these forensic examinations, the expert looks for the presence of specific criteria that defines a particular function or competence.
  - For example, the defendant is not competent to stand trial when he cannot understand the charges against him, what a trial is about, or how to productively communicate with his attorney and participate in his own defense. If found to be incompetent to stand trial, the diagnosis may be essential, when trying to determine if the defendant’s mental functioning could be restored and thus proceed to trial.

- **Forensic Psychiatric/Psychological Opinion**: In this section, the MHP states his opinion. The “burden of proof” is set as “within a reasonable degree of psychiatric/psychological probability/certainty” in which the opinion is expressed with more that 50% confidence (most likely than not) – as when addressing cases of professional negligence. Immediately following our opinion is the explanation of the bases for that opinion. Here, the MHP enumerates the points revealed throughout the study that sustain his or her opinion(s). The MHP must also mention the limitations, if any, that were encountered that may weaken his or her opinion.
Part II

A Primer of Forensic Cases and Reports
Wrongful Death: Medical Malpractice and the Suicide of a Patient

Definitions and Explanations

**Burden of Proof**
The duty of a party to substantiate an allegation. There are three distinct legal burdens of proof: (1) *preponderance of the evidence*, legal phrase or term of art that denotes more than 50% certainty and is the one used in malpractice cases; (2) *clear and convincing evidence*, which demands approximately 75% certainty and is used on decision concerning civil limitations of liberties, e.g., termination of parental rights, civil commitment, end-of-life decisions concerning the infirmed, and competence to prepare a will; and (3) *beyond reasonable doubt*, used in the criminal arena, a decision that carries close to 100% certainty that a crime was committed.

**Contributory negligence**
Legal defense in civil law describing a situation where the plaintiff has, through her own negligence, caused or contributed to the injury suffered sustained, e.g., jaywalking and on the phone when hit by a driver who is driving carelessly.

**Damage**
Harm or injury resulting from a violation of a legal right. There are three major categories of *damages* in tort law for which financial reward is ordered: (1) actual, to compensate expenses for medical treatments and loss of wages; (2) compensatory, to compensate for pain and suffering; and (3) punitive or exemplary, usually paid for intentional torts where malice can be shown.

“Evidence is the bones of an opinion.” – *Mark Twain*
Informed Consent

Legal phrase indicating that a person understands and appreciates the facts and implications of an action. The individual needs to be in possession of all of her faculties, without an impairment of judgment at the time of consenting. In medicine, it establishes that the patient is attentive concerning the illness, the treatment proposed, the benefits and risks, the options, and the possible outcome if untreated.

Proximate or Direct Cause

The active cause that sets in motion a chain of events that brings about a result, without the intervention of any other source (Dictionary of Legal Terms; Third Edition, 1998, Barron’s).

Psychological Autopsy

Analysis of a death from physical, psychological, and social perspectives, reconstructing the lifestyle of the deceased, his motivations, relationships, and factors that took him to his death.

Introduction to a “Wrongful Death” Case

A wrongful death lawsuit claims that the death of a person was caused by the conduct of another person, regardless of the defendant’s conduct being negligent or intentional. This type of lawsuit seeks to resolve the injustice of death and demands monetary compensation for the surviving loved ones.

The person might have died as a result of an automobile accident, work accident, violent act, defective equipment or medication, or medical, including psychiatric or psychological negligent care. One of the types of wrongful death claims results from negligent medical practice or medical malpractice, causing the death of a patient.

In a typical wrongful death case, the attorney seeks to obtain damages for the victim’s family which may include medical, hospital, and burial expenses, past and future monetary losses such as loss of financial support and service, and compensation for pain and suffering.

A MHP is called upon to determine if psychiatric or psychological malpractice occurred, also presented as an assessment of whether there had been a deviation of the professional standard of care and of its proximate connection to the damage. Additionally, one may be asked to determine if pain and suffering occurred in the loved one, and if it resulted in the development of a full-blown psychiatric disorder.

Negligence and Other Relevant Medicolegal Concepts

When approaching a psychiatric malpractice case, consider that the basic concept underlying a psychiatric/psychological malpractice action is that of negligence, defined as the mental health professional having done something that he should not
have done (acts of commission) or not having done something that he should have
done (acts of omission), which leads to patient injury.

The therapist must act as any prudent or reasonable clinician would act, under
comparable circumstances. According to the standard of care, the mental health
professional is required to exercise, in diagnosis and treatment, that reasonable
degree of knowledge, care, and skill which is ordinarily had and used by other mem-
ers of his profession in similar circumstances. Responsibility is not excused if,
because of ignorance or carelessness, the act injures the patient. If he fails to exer-
cise such reasonable care (a legal duty), his care conduct will be labeled as negli-
gent, and he is liable for personal injuries directly caused by such act of negligence.

The law of psychiatric malpractice (tort law, a civil wrong) is the law of negli-
gence applied to mental health professionals. There are two types of error that the
mental health professional is responsible for:

1. Error of fact: which comes about when there is a failure to gather clinically use-
ful data, i.e., past psychiatric records, current medical records, history of suicide
attempts or violence, risk assessments, etc. Disregarding this clinical informa-
tion contributes to an improper assessment, diagnosis, treatment, and outcome.
2. Error of judgment: which is not generally actionable, providing that the mental
health practitioner acted in good faith, applied himself to obtain necessary infor-
mation (facts), and demonstrated adequate reasoning with it.

The plaintiff, who is by now a “former” patient, has the burden of proof by pre-
ponderance of the evidence that what is known as the “4 Ds” in medical malpractice
occurred: (1) there must be a duty to care (doctor/patient or therapist/client relation-
ship); (2) there must be a dereliction or deviation of that demonstrable duty (breach
of duty, e.g., abandonment, “errors of fact,” breach of confidentiality); (3) the breach
of duty must have caused actual harm to the patient, for which damages resulted;
and (4) the deviation of the standard of care must be a direct cause of the damage or
injury. Each criterion needs to be confirmed to stand legal scrutiny. At the end, it
usually comes down to deciding if and demonstrating how that deviation was the
proximate cause of the damage.

Particular Territories for the Forensic MHP with Cases of Suicide

There exist two critical areas of clinical focus1: First, we have to consider the foreseeability of suicide potential. Courts rarely find liability if there is no clear suicidal risk, since it is extremely difficult to predict suicide. Second, once the risk is recognized, precautions should be taken to prevent suicide. The failure to do an adequate assessment of suicide risk is a common basis for lawsuits.

1 P. Resnick, MD course on “Legal and Ethical Issues in Mental Health”. 6/27/04.
There are two types of factors to keep in mind with respect to risk. We must assess both: (a) **chronic factors**, which are long term and therefore mostly close to a prompt clinical change and are also called static factors, and (b) **acute factors**, or dynamic factors, which are recent and generally amenable to fast change. Chronic factors include previous suicide attempt(s) (most significant factor); family history of suicide; being male, which is three times more likely to commit suicide than females; white race; unmarried status; living alone; lack of social support; alcohol/non-prescription substance abuse; medical illness (people with chronic illness commit suicide more often than those with terminal illness); unemployment (worse if recent); fall in social or economic status; rejection by spouse or lover; anniversary of important losses; freedom from responsibility for children under age 18; and impulsivity (signs include reckless driving and promiscuity).

**Acute factors** linked to suicide include severe anxiety (unpleasant emotion related to the idea that something bad is about to happen), restlessness (the physical manifestation of anxiety), anxious ruminations, global insomnia, psychosis with delusions of poverty or doom, and recent alcohol abuse (half of suicides show alcohol in their bodies).

If there is a suicidal plan, ask about the specificity of the plan, including preparation (e.g., suicidal note, final acts in anticipation of death like insurance policies, wills); assess the availability of a lethal method even if there is no specific plan and whether there has been any rehearsal or experimental action.

Also, assess what the patient understands to be a “positive” meaning of suicide and death. This includes such aspects as rebirth, reunion with a dead love one, identification with a dead family member, or a solution to one’s insufferable problems. The risk increases if death takes on a positive meaning, and this inevitably breaks the therapeutic alliance. Do not rely on “no-suicide contracts.” It gives the mental health practitioner a false sense of reassurance; yet, it is significant if the patient refused to do it.

Psychiatrists should question close relatives of suicide-prone patients about suicidal communication. Patients tell family members about their wish to die much more often than they tell clinicians. Psychiatric hospital admission is regularly required if the risk factors are numerous and intense. Follow-up visits must be frequent when the risk exists, and family members should be acquainted with this particular clinical problem and, if warranted, be supported by the mental health practitioner.

The conditions most often linked to suicide are affective illness: mostly major depressive disorder, depressive and mixed states of bipolar disorder, schizophrenia (the presence of mood-congruent delusions increases the likelihood of suicide), borderline personality disorder, narcissistic personality disorder, antisocial personality disorder, and alcohol and other substance use disorder.

Although there is no clear line of demarcation, based on our clinical exploration of the chronic (static) and acute (dynamic) factors, it is important to specify that in our judgment the risk is minimal or mild, moderate (psychiatric action must be taken), or severe. Lastly, keep in mind that the standard of care exists for the assessment of suicidal risk, but not for the prediction of suicide.
Considerations for the Following Cases

I will address one other significant aspect for the forensic MHP to address: suicide risk assessment vis-à-vis medical and psychiatric malpractice. These cases concern the treatment and disposition of a non-hospitalized patient and a hospitalized patient.

We should keep in mind that liability is more likely to be found in inpatients and those prematurely discharged patients than outpatients. Simply stated, this is because while the patient is hospitalized, the staff has total and round-the-clock access to the patient’s actions and review of the treatment protocol and its result. The failure to do an adequate assessment of suicide risk is a common basis for suits. The most successful method of suicide in psychiatric units is hanging, while the most common method in general units is jumping out.

On the other hand, the risk of suicide is greatest during the week after hospital admission, within the month immediately after discharge, and, in general, during the early stages of recovery from a mental illness.

In the hospital setting, inquire about suicide only after rapport is established to increase the chance of getting honest answers. The psychiatric staff should routinely question close relatives of suicide-prone patients about suicidal communication. Often, in completed suicides, the spouses and close relatives were told about it, as opposed to a small fraction of clinicians.

During the treatment of a hospitalized patient, it is essential to make frequent risk assessments and to write the reasons to discontinue suicide checks, and reasons to justify privileges. A patient without a clinical reason for being better (e.g., still having inadequate working relationship with the psychiatrist, not enough time for the medication to be effective, the outside stressful situation has not gotten better) can look improved when they decide that the solution to their despair is suicide.

Before discharge, the clinician should know the reason for the patient to feel distraught. Also, one must consider home safety (e.g., stored pills, firearms) with the patient and the family. Follow-up visits should be frequent after hospital discharge. The patient’s family should be acquainted with this particular problem and, if possible, be supported by the mental health professional.

In these particular types of cases, the clinician ought to check in with the patient by telephone periodically between sessions. Generally, courts do not find liability for an error in judgment when evaluating suicide potential, if it is based on adequate suicide risk assessment.

Document your reasoning based on clinical data collected during the visit. In the hospital, know and follow your hospital policy. Never alter a medical record after a suicide. Correctly dated “late entries” are reasonable. It is advisable, when in doubt, for the psychiatrist to obtain consultation.

In the vignette that follows, paying attention to the details of the many different facets of how the case was handled, the outcome weighs heavily in support of the expert’s opinion.
Case 4a: Psychiatric Office Visit and the Suicide of a Patient

Diagnostic categories considered in the case (4a) illustrated below, according to the DSM-5, are:

Unspecified Schizophrenia Spectrum and Other Psychotic Disorder, (298.9): This category includes psychotic symptomatology (e.g., delusions, hallucinations, disorganized speech, grossly disorganized or catatonic behavior) about which there is inadequate information to make a specific diagnosis and that cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Major Depressive Disorder, Recurrent, with Mood-Congruent Psychotic Features, (296.34): This category describes a serious condition afflicting a person during the prior two weeks, with a change in her functioning. This patient has depressed mood most of the day, including loss of interest and pleasure in all, or almost all activities, marked changes in sleep and appetite, fatigue, feelings of worthlessness, hopelessness, and helplessness, and recurrent thoughts of death and suicide. Also, the delusions and hallucinations found in this disorder are entirely consistent with the person’s depressive themes.

The attorney for Mrs. Yung’s state described to me the possibility of this being a medical (psychiatric) malpractice (liability) case. He described a Korean woman in her 1950s, living in this country for some 12 years. She had prior psychiatric history in her country of origin, including hospitalization for depression and suicidal thinking. The attorney added that her daughter, at this time, recognizing her mom’s psychiatric ailment, took her to a Korean-speaking psychiatrist. Some hours after leaving the psychiatrist’s office, this woman committed suicide by jumping off from the top of a five-story building.

Collateral sources of information were used to conduct a psychological autopsy. Close attention to details to assess suicidal risk helped reach the expert’s opinion. At around the time of the hospitalization in her native country, her husband had migrated to the United States. Some 6 years later, the family reunited in America.

Mrs. Yung’s daughter presently described her mother as sleeping too much and persistently depressed. Her mom was diabetic and had problems sticking to the proper diet. At home, Mrs. Yung had become “extremely nervous, and shaky.” She expressed the belief that others were watching her and that the TV portrayed strange and threatening images and was detecting that people in the street despised her.

Her daughter took Mrs. Yung to Dr. Chu and observed part of the interview. She recalled the doctor asking her mother if she had any thought of suicide. Dr. Chu’s records contained forms that the psychiatrist filled out with information from her patient.

The notes read: “Significant risk factors: Suicide, yes… drown myself...” Other symptoms were “voices...thoughts broadcasting...paranoia.”

Mrs. Yung was not taking any medication. Those days, Mrs. Yung was going through the process of divorce. No inquiry about marital strife or any prior history of suicidal intent was noted in the medical record. The patient had recently stopped going to work, and there was no adequate home caretaking from family or friends. The daughter reported that her mom was visibly shaking in the doctor’s office.
The mental status exam recorded that Mrs. Yung was a woman with psychomotor retardation and flat affect. Dr. Chu reported her mood in two words written in Korean, meaning: “I don’t know.” I also read, “at times appears to be responding to unseen stimuli (hallucinations)...thought blocking and decreased productivity...thinks a lot about World Trade Center attack; also of drowning.”

Her concentration and recent/remote memory were compromised. Her judgment was described as “patient came” and insight as “wants treatment.”

Dr. Chu recognized the patient was thinking of suicide and having a plan to carry it out, describing the patient as a woman with history of psychotic disorder, 13 years ago, and the return of psychotic symptoms, 3 months ago. The diagnoses are unspecified schizophrenia spectrum and other psychotic disorder and rule-out schizophrenia, paranoid type. The sources of stress are psychosis and divorce from husband. Dr. Chu prescribed a month supply of risperidone 1 mg twice daily, haloperidol 5 mg twice daily (both antipsychotics), and benztropine 1 mg twice daily (to alleviate possible muscular adverse reactions of the antipsychotics) and to return to his office in 12 days. The psychiatrist signed a 3-week off work, disability form.

At the morgue, she arrived with three vials of medications prescribed by Dr. Chu, each with one less tablets than prescribed. Toxicology analysis was negative.

Dr. Chu deviated from the accepted standard of psychiatric care.

Dr. Chu failed to hospitalize her patient to treat her acute and modifiable suicide risk factors. Mrs. Yung had no constant care by family or aide and not much support from her husband, and her daughter and son-in-law were busy at work during the day. Dr. Chu did not write in the chart that she inquired about family support and that her daughter or son-in-law was going to look after her. Dr. Chu did not see the clinical need to have her patient constantly supervised, despite the ominous clinical presentation.

Dr. Chu did not provide or prescribe any type of psychotherapeutic intervention, other than the use of medications, in a person beset by an overwhelmed mind, due to psychosis, depression, and the imminent separation from her husband. She did not inquire about the effects on Mrs. Yung of the current divorce proceedings.

Dr. Chu did not obtain information about the reason for prior hospitalization and did not conduct the study of prior suicidal history or the content of her delusions and hallucinations. Dr. Chu found that Mrs. Yung’s concentration and memory were impaired, and yet, the psychiatrist left her on her own to “pull herself together.” The patient was fearful, overwhelmed, and totally psychologically resourceless. She appeared only to be saying that she wanted her extreme affliction to end. Her judgment was severely compromised by her inability to reason. Her family, not Mrs. Yung, made the emergency call to Dr. Chu. She was not competent to participate in an “informed consent” decision.

The patient was severely impaired due to serious symptomatology. A month’s supply of psychiatric medications given to a person who is unable to take care of herself and is psychotic and with active suicidal thoughts indicates a lack of appreciation of the seriousness of the current crisis. There was a need to create a therapeutic protocol requiring aggressive interventions: immediate hospitalization,
constant observation, the use of psychiatric medication, and supportive psychotherapeutic techniques.

The goal of a suicide risk assessment is not to predict suicide but to identify modifiable risk factors to become the focus of therapeutic interventions. Mrs. Yung had a history of depression with suicidal ideation requiring hospitalization in her native country, occurring around the time when her husband left her. She was found by Dr. Chu to suffer from “serious” psychiatric symptoms including hallucinations, paranoid delusions, thought blocking and unproductive thinking rendering her incapable of reasoning, flat affect, insomnia, decreased appetite, poor judgment, tearfulness, suicidal ideation, and a conscious plan to end her life.

Mrs. Yung was thinking “a lot” about the WTC attack. It primarily signifies death by violent means. Mrs. Yung felt under siege without mental resources to restore balance. Suicidal psychotic patients utilize more violent methods of ending their lives. Depressive symptoms in schizophrenia are the strongest predictors of suicidal behavior, as is prior attempts of suicide; severity of psychotic symptoms, particularly hallucinations; thought insertion/broadcast; and significant recent life stressors and poor social support.

Suicide risk assessment is a process, not an event. In a patient like Mrs. Yung, it cannot be performed on an outpatient basis, with no available support (distant husband and busy children), no friends, and a second psychiatric visit scheduled for 2 weeks later.

Case 4a: Opposing Forensic Expert Opinion – Psychiatric Office Visit and the Suicide of a Patient

It is this expert’s opinion that Dr. Chu did not deviate from a reasonable standard of care in her treatment of Mrs. Yung.

The expert opined that it was very impressive that Dr. Chu made herself available on such short notice, on an emergency basis. He also stated that since she was squeezing the patient into her schedule, she only had a limited amount of time to evaluate Mrs. Yung. The doctor was seeing her with a minimum of collateral information. Mrs. Yung’s daughter, who brought her to the appointment, knew little of her mother’s psychiatric past, except from what her mother had told her.

Another point this expert makes is that Mrs. Yung’s suicide attempt was 20 years earlier, in Korea, without any attempts in the interval. He also states that although Mrs. Yung told her psychiatrist that she had thoughts of drowning herself, there was not necessarily a plan to do so. He points out that drowning oneself is a difficult task. He later emphasizes that Mrs. Yung stated that she would not drown herself, even though she thought about it.

The expert argues that Mrs. Yung had a sufficient support system at home. He claims that her daughter and son-in-law had known that she had deteriorated psychiatrically and needed to be watched closely. He also holds that since her son-in-law had a flexible work schedule, he was available to watch Mrs. Yung. He claims that many patients kill themselves, even while on an inpatient basis.
The expert asserts that the reason why Dr. Chu did not look into Mrs. Yung’s divorce proceedings, prior hospitalizations, suicide history, or the content of her delusions was because she had a limited amount of time with the patient. He also mentions that no extensive history could have been obtained due to her condition.

The expert notes “there is no basis for the assumption that the divorce was a stressor for the decedent.” However, on another part of his report, he also mentioned that Dr. Chu rated “divorce” as one of the top four stressors in the psychiatric record.

The expert also states that psychiatrists know that certain patients will kill themselves, despite the psychiatrist’s best efforts. He recognizes that once someone makes up his/her mind, he/she views mental health professionals as adversaries.

The expert claims that Mrs. Yung was not honest about her intentions to kill herself when she spoke with Dr. Chu. He also claims that her daughter might have known that Mrs. Yung was going to kill herself by jumping of a tall building (contributory negligence). He based that opinion on the fact that when she was looking for her mother, one of the places she drove by was the street where the building was located.

Case 4b: Nonpsychiatric Hospitalization and the Suicide of a Discharged Patient

Walking down the stairs, at home, Mr. Penn – age 61 – fractured his right arm and sprained the muscles on his right leg. He also struck his head and was momentarily unconscious. He was hospitalized, under the care of an internist, an orthopedist, a neurologist, a rehab therapist, and also a psychiatrist. In the aftermath of the fall, he developed acute and severe depression. He was discharged 1 week later, with no psychiatric referral, and 4 days later he committed suicide by hanging himself.

In the emergency room, he was also found to be slow, somewhat confused and disoriented to time and place. There was a history of poorly controlled blood pressure, on irbesartan (antihypertensive) and atorvastatin (cholesterol-reducing). The hospital record had entries from the internist, neurologist, orthopedist, and all other staff involved in his care, but there were no psychiatric notes, even though a psychiatrist examined him to assess and treat his depression.

The patient started rehab therapy. The “order sheet” shows that the psychiatrist was contacted for a consultation about the patient’s depression. The internist did not fill out a consultation form for psychiatry, as he did, as per hospital policy, with the other consultations: neurology, orthopedist, and physical therapy. The purpose of the consultation form, filled out by the treating physician, is to direct the consultant (psychiatrist, in this instance) to place the findings and recommendations on the form. This was not done by the psychiatrist.

Notes by the nurse, internist, and rehabilitation therapist reported Mr. Penn as anxious and depressed. The internist prescribed lorazepam (antianxiety). The nurse noted that the patient was “very anxious, crying.” She also wrote that the patient’s emotional state was a barrier to learning about his current needs for rehab treatment. Three days after admission, the internist wrote “very depressed” and prescribed
paroxetine (antidepressant) and zaleplon (hypnotic). The internist did not acknowledge in the patient’s chart that a psychiatric consult was performed, as he had done with other specialists’ medical entries. Some days later, the internist writes that his patient was clear for discharge, within 1 week of admission, if cleared by neurology and orthopedics; also, “Patient would like to go home.”

His discharge plans included treatment with occupational therapy in 3 days, with the internist in 2 weeks, and with the orthopedist in 3 weeks. It did not include psychiatric medications or a follow-up appointment. The patient was prematurely discharged home, at his own request. Two hours prior to discharge, the patient had to be given lorazepam. He was released on anticoagulant, antihypertensive, and antacid, but not psychiatric medication. The final diagnoses are right arm fracture, post-concussion disorder, hypertension, and anxiety and depression. The internist made sure that his patient had specific prescriptions and appointments for rehabilitation therapy and orthopedics, as well as internal medicine, to treat his hypertension and high cholesterol.

His family reported that he told his daughters, in the hospital, that he wanted to die and that they communicated this, in the hospital, to the internist. Also, the internist told the family that he did not want his patient to take antidepressants to avoid drowsiness and lethargy, interfering with physical therapy. Mr. Penn was discharged on Friday. He felt depressed during the weekend. Sunday was his birthday, and he did not want to celebrate it.

On Monday morning he was taken to physical therapy, still feeling depressed. While at the hospital, the rehab therapist was apprised of his serious psychiatric condition. Patient was told to contact the psychiatrist he saw in the hospital.

From home, in the early afternoon, his wife reported that she called the psychiatrist but was unable to reach him. The internist did not return her call, either. At night, the psychiatrist, according to the family, told the wife that she should call back when they had the money to pay for the treatment. On Tuesday morning he was found dead (hung).

On page 12 of his deposition, the psychiatrist said that his obligation was to see the patient only once for a consultation. He also mentioned that he dictated that consultation, although the hospital records did not contain such. He added that he did not need to take notes about his patients because of his good memory, but did not recall the day he first met Mr. Penn, or when he spoke with the internist that requested the consult.

When he examined the patient, there were three people in the room (his girlfriend and two daughters). The doctor did not speak with them. While deposed, the psychiatrist stated, “...patient was a little tense and a little... I cannot say upset but he was thinking more... depressed... he was a little upset.” He also stated that the patient denied having suicidal ideation. His approach was: “We give antidepressants and wait and see how they work.” No psychotherapy was delivered or offered, and no involvement of the family in the treatment was provided.

The psychiatrist recognized the sudden loss of bearings and self-esteem regulation when one is confronted with such a massive loss of ability to function. “I don’t have doubt that the patient was depressed.” He knew that the patient turned “more
upset” when discussing his physical condition. Antianxiety, hypnotic, and antidepressant medications were prescribed right before he examined him.

The psychiatrist did not write medical notes in the patient’s chart because “I don’t like to write. I hate it.” He said that he did not think the patient’s clinical condition merited his consultation be immediately posted in the medical chart. There are no records of psychiatric visits to his patient. He also said that his subsequent visits to his patient were brief, “possibly two minutes.” The reason for that was that he did not think it was clinically necessary to follow him up.

The psychiatrist did not consider his visit(s) to Mr. Penn “official,” despite happening while “doing rounds.” He emphasized that he had no obligation to post clinical notes in the chart. He thought that his patient’s request to be discharged sooner meant that he was better. That was “the only change,” in an otherwise severely depressed patient. He did not review the hospital progress notes after the initial visit with his patient “because it appeared to be an ‘organic’ problem and this does not belong to me.” The psychiatric clinician decided that the overall clinical condition was not of psychiatric value and did not read the entries stating “Patient is very depressed.”

The psychiatrist told the internist that the patient “is okay to go home.” He said that it would have been sufficient for him to hear his patient saying that he was not suicidal to discharge him home. During the deposition, the psychiatrist said that he gave his name and telephone number to the patient’s family for a follow-up with him “if they needed it…to call me.”

The psychiatrist also mentioned that he received a call from a woman telling him that his patient was actively suicidal and that he told “the woman” to take Mr. Penn to the office or to a hospital. He did not write this in the record, nor did he follow up to assess the result of his intervention. He left it up to the family to find the way to deal with the crisis. He did not identify this woman, ask any question to clarify his patient’s condition, or talk to his patient. He did not get in touch with Mr. Penn after the woman’s phone call to him.

The psychiatrist did not read the hospital chart or else he would have learned that his patient was sleeping at night only because he was taking hypnotics; also, he appeared calm because he was taking sedatives and he had just started antidepressants.

According to the standards of care, once the psychiatrist assumes the duty of caring for a patient, this cannot be interrupted until the patient is well or, if still ill, under the care of another MHP. It is also standard to make the clinical findings of a hospital consultation immediately available, particularly when the severity of the patient’s condition warrants urgent attention. The psychiatrist never checked the medical record, throughout his patient’s hospitalization, to find in the chart the consultation that he said he dictated. He did not write clinical notes to apprise the medical staff of his clinical opinion and assure adequate patient care.

In his deposition, the psychiatrist said he thought that a normal dictation could take up to 3 days to reach the medical record and should have known that it is faster to request it “stat.” He should have written his psychiatric findings, diagnosis, and treatment recommendations for the referring physician and the rest of the medical
staff to have access of the clinical data without delay. It was his obligation to perform follow-up visits in the hospital and after discharge unless Mr. Penn had an appointment set up with a different psychiatrist.

During the examination, the psychiatrist did not include the three family members present at his patient’s bedside, and he did not ask these relatives to leave the room for him to perform the clinical study in a private and conducive fashion. He should have included the family members present in the room with his patient in the psychiatric assessment of his patient. He did not initiate a psychotherapeutic process, nor engage any family member in it either.

The psychiatrist observed his patient being tense (restless, anxious, impatient, depressed, and irritable). He noticed that the patient was ruminating (“thinking more”), depressed, and wanting to leave the hospital while still quite ill. In fact, the psychiatrist mentioned in his deposition that he expected the mental condition to worsen, but he took no measure to care for his patient.

The psychiatrist did not inquire about depressive symptoms or suicidal thoughts, plans, or gestures in the past and substance use and/or abuse in the past or present. These are significant factors in the suicide risk assessment of a patient, crucial on someone presenting with the clinical characteristics of Mr. Penn.

The psychiatrist effectively stated that the patient worsened while under his care; all his symptoms persisted, with the additional request for premature discharge, indicating helplessness and hopelessness. Psychiatric help in the hospital was not forthcoming. We expect a patient that resolves to end his life to deny suicidal thoughts.

The psychiatrist did not read the medical records prior to examining his patient. He was not aware that the patient was suffering from intense emotional pain, as per the hospital staff. It was noted: “Patient is very depressed, insomnia, and restlessness.”

The psychiatrist showed inadequate clinical skill by not asking the female caller to put his patient on the phone to clarify his clinical status.

Standard of care exists for the assessment of suicide risk, not for the prediction of suicide. The goal of a suicide risk assessment is not to predict suicide but to identify modifiable risk factors that can be the focus of therapeutic interventions.

Some of the obvious risk factors in this case included being a 61-year-old male, with a sudden onset of, and likely lingering, major functional physical limitations concerning his main occupation (carpenter). This alone set him at an acute risk. The patient was currently unemployed and financially strained. It is commonplace to see how hard it is for men in these conditions to establish or join support groups. An important holiday was coming up right after discharge from the hospital (his birthday). While hospitalized, the patient showed signs of severe anxiety, insomnia, and anxious ruminations fueling his depression.

The psychiatrist never acknowledged suicide risk because he did not assess for it. This is most significant since the doctor had control of the clinical situation, being hospitalized, with total access to his patient, medical records, and relatives readily available and present at the bedside.
Rapport between doctor and patient was never established. This would have increased the likelihood of a clinically meaningful assessment and honest answers. The doctor never knew how ill his patient was.

The majority of patients in the hospital deny suicidal ideation within hours of completed suicide. The risk of suicide is greatest during the 1st week after hospital admission (this patient was too weak and impaired to carry out in the hospital any complex act on his own) and the month immediately after discharge, as well as during the first stages of recovery from a mental illness.

Once the patient loses hope and his goal is to die, the psychiatrist’s role changes from being an ally to being an adversary, since the therapist’s goal is to prevent suicide. The majority of persons who commit suicide communicate their intention mostly to their relatives. The psychiatrist excluded his relatives from any treatment effort.

Follow-up visits should be frequent after discharge. The patient should be checked in by telephone periodically between sessions. In this case there was none. There was no psychiatric treatment prescribed at discharge. The hospital did not readmit him 3 days after his discharge but referred him to his psychiatrist on an outpatient basis.

The patient felt physically and psychologically resourceless. He wanted his extreme affliction to end. His judgment was severely compromised by his total sense of helplessness and hopelessness. The hospital doctors effectively abandoned his patient. On the morning before the suicide, a visit to the hospital resulted in Mr. Penn’s being referred back to the psychiatrist. The family then tried to connect with both, the internist and the MHP, to improve his patient’s severe condition. Mr. Penn died the following morning.

The opinion, within a reasonable degree of medical probability, was that the treatment provided by the psychiatrist and internist departed from accepted standards of medical/psychiatric care and was proximately related to his death.

Case 4b: Opposing Forensic Expert Opinion – Nonpsychiatric Hospitalization and the Suicide of a Discharged Patient

“It is my opinion within reasonable medical certainty that the psychiatrist did not deviate from a reasonable standard of care in his treatment of Mr. Penn. The internist ordered lorazepam, paroxetine, and zaleplon. Clearly she was not reluctant to treat her patient’s depression.”

In a progress note, the internist made a diagnosis of “depression” for the first time. She stated, “Patient feels very depressed.” She stated that antidepressants have already been started. She wrote an order for a consultation by the psychiatrist.

The expert indicates that the psychiatrist said he reviewed the chart and spoke to one of the nurses before seeing the patient. The nurse told him that Mr. Penn did not seem sad. Although quiet, he was eating and sleeping adequately. In his answers to interrogatories, the psychiatrist stated that he spoke with family members who stated that Mr. Penn had not expressed any suicide ideas to them; and this occurred
while the patient was still in the hospital. In his deposition, Mr. Penn’s son claimed
he did not speak with the psychiatrist. He did not speak to any of his father’s physi-
cians in the emergency room.

The psychiatrist did not see evidence that the patient presented with a suicide risk
when he performed the consultation. Mr. Penn’s son stated that his father told him
that he was depressed and had experienced a panic attack. “Jokingly, he mentioned
something suicidal.” His father made a reference to shooting himself. Mr. Penn
denied depression, but the psychiatrist opined that he was moderately depressed due
to his fall and its aftermath. He dictated his consultation, which for unknown rea-
sons never showed up in the chart. Although he saw the patient a few more times, he
did not dictate any subsequent notes or bill for these subsequent hospital visits. He
billed only for the first consultation.

The expert commented that according to the psychiatrist, his patient wanted to go
home. He told the internist that Mr. Penn could be discharged as long as he contin-
ued on the paroxetine. Mr. Penn was advised to contact the psychiatrist for an
appointment in the office post-discharge. This indicates that the patient’s state of
mind did not represent a psychiatric emergency.

This expert was also of the opinion that Mr. Penn was not a private patient of the
psychiatrist. The doctor had never seen him previously on an outpatient basis, and
Mr. Penn had never had a psychiatric treatment prior to this hospital admission.

The expert wrote, “In my experience, patients frequently decide to follow up
with a different psychiatrist upon discharge. This is even more likely to happen in a
non-emergency situation, as exemplified by this case. In my opinion, it takes time
for a depression to improve. There is no indication that the patient was ‘very
depressed’ at this time. I have found that patients who are referred to as ‘very
depressed’ by a primary care physician are often labeled as mildly or moderately
depressed by an experienced psychiatrist.”

This expert further notes, “From the psychiatric viewpoint, the only reason to
keep the patient in the hospital would have been if he were imminently suicidal. The
fact that Mr. Penn was not ordered on a one-to-one suicide watch suggests that there
was no concern that he was imminently suicidal. The Webster’s Unabridged
Dictionary states that the word ‘imminent’ is defined as ‘about to take place or hap-
pen.’ In my opinion, this would mean that the patient was a high suicide risk in the
next few minutes or hours. A psychiatrist could not be expected to predict that Mr.
Penn would be a high suicide risk four days post discharge.”

In this expert’s report, it further stated, “Mr. Penn’s son stated in his deposition
that his father mentioned suicide about five times during the weekend after the dis-
charge from the hospital. Amazingly, he did not become concerned about his father’s
safety until the Sunday of that weekend. In my opinion, Mr. Penn’s son contributed
to his father’s death by assuming the role of psychiatrist in this situation. His failure
to take his father seriously contributed to the psychiatrist’s opinion. Patients view
even their family and mental health professionals as adversaries once they have
made the decision to kill themselves. It is not unusual for a patient to lie about or
downplay their suicidal intention. This is the probable basis for the patient’s talking
‘in a joking way.’"
The expert explains, “The ‘standard of care’ refers to that degree of knowledge and skill which is ordinarily possessed and exercised by other psychiatrists when diagnosing and treating patients under similar circumstances. This concept of the ‘standard of care’ is often misunderstood by physicians. It is not a standard of excellence. In his deposition, the psychiatrist stated that he believed that he had 15 or 16 patients in the hospital during the time that Mr. Penn was at the hospital. In this setting, psychiatrists tend to adopt a medical model of treatment and rely on medications rather than psychotherapy. This approach is consistent with what has happened in American psychiatry in the last 20 years.”

Finally, the expert noted, “I believe that this is an example of the ‘hindsight bias’ which often occurs in malpractice litigation in which a negative outcome, such as a suicide, has occurred. The plaintiff’s expert looks at the information available at the time of the actual treatment and erroneously concludes that it was clearly foreseeable that there would be a bad outcome. The decision about malpractice must be based on the data available to the psychiatrist. Only in retrospect was Mr. Penn an emergency. In this case, the psychiatrist was serving as a consultant. He did not have to see Mr. Penn continuously after his first consultation. The psychiatrist’s lack of written documentation is a deviation from the standard of care. However, no one has ever died from poor record keeping.”
Definitions and Explanations

Etiology  Source or origin of psychiatric disorder
Reckless  Conscious disregard for consequence

Infliction of Emotional Distress

Non-intentional infliction of emotional distress refers to damage cases by negligence, in which the unintentional action or inaction of someone caused a mental health harm which, if permanent, extended beyond the maximum improvement achieved through psychological and psychiatric treatments.

Intentional infliction of emotional distress (intentional tort) is a legal concept that considers the “mental injury” created as a result of an intentional, malevolent, unrestrained, and immoral conduct. For this claim to succeed, the plaintiff has to demonstrate that:

1. The defendant acted intentionally or recklessly.
2. The conduct was “extreme and outrageous.”
3. The conduct caused the emotional distress.
4. The emotional distress is severe.

Once it is determined, by confession or evidence, that intentional infliction of emotional (psychological) distress has happened, there is usually the question of “Illness is the experience of living through disease. If disease talk measures the body, illness talk tells of the fear and frustration of being inside a body that is breaking down. Illness begins where medicine leaves off, where I recognize that what is happening to my body is not some set of measures. […] Disease talk charts the progression of certain measures. Illness talk is a story about moving from a perfectly comfortable body to one that forces me to ask: What’s happening to? Not it, but me”. – Arthur Frank

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A. M. Goldwaser, E. L. Goldwaser, The Forensic Examination,
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what type, how much, if it limits the functioning of the plaintiff/victim, and whether it is likely to be permanent.

**Case 5a: Sexual Predator in a Coach-Student Relationship**

I was hired to determine if Julie Smith was psychologically afflicted by her romantic/sexual relationship with Coach Franklin, her high school marching band coach, and if confirmed, what the diagnosis, etiology, and treatment were recommended. She became involved with him at age 14 while he’s in his late 50s. Their affair lasted a year and a half.

I met with Julie 4 years after the relationship had ended. She informed me that she was taking lamotrigine for bipolar disorder, as diagnosed by her psychiatrist.

I determined that Julie had been psychologically damaged as a result of the sexually abusive attitude and behavior that her marching band coach inflicted on her, from the time he lured her to become sexually involved with him until the time he was incarcerated.

Julie’s relationship with Coach Franklin started during her freshman year of high school, when he started making sexual jokes in class. Their sexual relationship began when he asked her to stay after school to help him prepare for the band performance. When he had her alone in the room, he shifted to a serious sexual nature, asking if Julie “wanted to touch it.” He took her to the back of the room, and it was then they shared their first kiss. He warned her not to tell anyone since he was risking everything to be with her.

Some months into the relationship, a student happened upon them kissing in a classroom. State Child Welfare Support Agency was called and both Julie and Coach Franklin were questioned about the event. Both of them denied any involvement and presented it as a misinterpretation on the part of the student that saw them together; and no further action was taken.

Some months later, the teacher’s wife caught them in the Franklins’ home. Julie and her friend had been invited over to Coach Franklin’s house for a marching band barbeque. Since Julie had become friendly with Coach Franklin’s daughter, she spent the night at their house. While everyone was asleep, Coach Franklin came downstairs to where Julie was sleeping and had sex with her. His wife walked in while they were engaging in sexual intercourse.

The coach’s wife did not tell anyone about what she had witnessed until 5 months later. She reported to her husband’s supervisor at the school that he had become too close with Julie. The supervisor told her that he did not want to get involved. Later, Mrs. Franklin went to Julie’s parents. Julie responded with suicide threats. Her parents did not take legal action since Julie had attempted suicide 1 year earlier, but they forbade Julie from seeing the coach.

The affair continued in secret for another several months, until Julie’s parents caught her out with the coach. They took legal action. Julie sank into a depression and began to “cut herself,” a behavior that she had been struggling with for years.
She believed that she and her coach were in love. Julie was hospitalized for 2 weeks for her own safety. She started therapy and antidepressant medication.

Julie’s younger brother suffered from a mild form of autism. This was a very upsetting situation for her family and Julie in particular. Julie stated that she wished that she had been afflicted with the syndrome rather than her brother. Coach Franklin succeeded in isolating Julie from them.

After this “relationship” ended, Julie described problems handling anger, which she said she did not experience before this relationship. Julie had to constantly remind herself that the coach did not love her, in order to cope with the situation. She felt that she missed out on a large part of her adolescence because of him.

She had flashbacks of their sexual experiences and feared that Coach Franklin would look for her once he got out of prison. Julie also reported trust issues. She had difficulty telling people about herself or believing what others say.

After the affair, Julie entered into a relationship with a woman, not much older than her, and began to identify herself as “gay.” She felt more comfortable with a woman. She learned to replace cutting herself with running when feeling down and stressed. She also described herself as a private and secretive young woman, who was constantly looking over her shoulder. Feeling safe this way, her lack of academic achievement became more pronounced.

I concluded that Julie Smith suffered from adjustment disorder with mixed anxiety and depressed mood, chronic. Her condition was permanent. The stressor that Julie was psychologically responding to was repetitive sexual exploitation, based on the coach’s position of power. Julie experienced impairment in personal, family, and social functioning. After the affair, Julie learned to “play it safe” as an effort to limit her exposure to exploitation. She also exhibited weariness, irritability, and impatience; she did not feel safe in unstructured environments.

Julie’s time with her coach was made to feel right, loved, accepted, and in a world with no blemishes, providing that she devalue and stop caring for the world she came from. The coach became the sole supplier of all her needs as long as she submitted to and wanted to be his object of sexual exploitation.

Julie needed her school to provide her with a safe environment where she could study and meet people her age. Her marching band coach preyed on her, having identified her as vulnerable due to her age and emotional conflicts. He isolated her from friends, parents, and psychotherapist. He controlled her, taught her to lie, and became her only source of self-esteem regulation. Her sense of freedom became reduced.

By being in a homosexual relationship, Julie was avoiding confronting the state of mind created by her coach. I recommended that Julie continues psychiatric and psychotherapeutic treatments, focused on helping her deal with this situation and improve functioning by developing new and adaptive mechanisms to the ordeal. I also recommended family therapy to mend their bonds needed to continue processing the unfortunate situation that unfolded.
Post-traumatic Stress Disorder

Definitions and Explanations

**Cerebral palsy**
A term that describes a group of chronic disorders impairing control of movement that appear in the first few years of life and generally do not worsen over time. The disorders are caused by faulty development of or damage to motor areas in the brain that disrupts the brain’s ability to control movement and posture. Symptoms of cerebral palsy include difficulty with fine motor tasks (such as writing or using scissors), difficulty maintaining balance or walking, and involuntary movements.

**Endocrine**
Hormonal; relative to the endocrine system.

**Esotropia**
A form of strabismus where one or both of the eyes turn inward.

**Otorrhea**
Discharge of pus from the ear.

**Symbiotic relationship**
The interdependent condition of the infant child and her mother, acting thereby as the child’s protector or “buffer,” since she lacks an independent capacity for self-preservation (A glossary of Psychoanalytic Terms and Concepts; The American Psychoanalytic Association, 1968).

Introduction to the Legal Aspects of Post-traumatic Stress Disorder

Perhaps more than any other psychiatric disorders, post-traumatic stress disorder (PTSD) has influenced and been influenced by the law. In civil law, the PTSD diagnosis establishes the assertion that an external event can serve as a direct cause of a mental disorder. In criminal law, PTSD is unique among other mental disorders, and it is called upon by the defense.
PTSD has been officially used since 1988, when introduced in the Diagnostic and Statistical Manual of Mental Disorders, third edition (DSM-III). It then became a bona fide psychiatric disorder. It is quite limiting to the individual suffering from it. I call it “The Humpty-Dumpty Affliction” in that “he sat on a wall and had a great fall, and no one could put him together again.” PTSD is a serious, debilitating, and chronic condition that is often overlooked. It is not created at will, and it is beyond one’s control.

I refer to an illness that is essentially described by its symptoms, meaning the description of the person’s subjective experiences. The mental health expert’s job during the forensic psychiatric investigation (or independent medical examination, IME) is to confront the presence or absence of signs (objective findings) and thus corroborate or refute the diagnosis of PTSD. These signs connect our direct observation during the examination with that of others’ found while reviewing collateral sources describing the examinee’s different levels of functioning.

The possibility of PTSD being feigned (malingered) must always be considered. Since the specific criteria of PTSD are easily accessible to any interested person, it would not be too difficult for him/her to report the symptoms the examiner looks for, thus challenging the forensic psychiatrist to produce data that will withstand scientific and legal scrutiny.

Few personal injury cases reach the courts without an expressed or implied allegation of malingering, having as primary motivation, financial gain, and then sympathy and social support.

### Psychological Distress Following Traumatic Events

Many recognize the physical pain after an accident or injury, yet few realize that what goes on in the mind can be just as, if not more, devastating as car crash, a mishap at work, a fall (the physical wounds are often clear), a bad back, a sore neck, etc., but there is more: the mental component.

This sudden, unexpected, and violent assault of one’s sense of integrity and continuity can interrupt the sense of well-being. PTSD is seldom recognized but is commonly concurrent with personal injury. Patients often undergo test after test and take medications that do not improve their condition. If not recognized, these patients sometimes have surgery that does not heal their pain. Eventually, many with PTSD start feeling neglected because doctors, even attorneys, do not know what to do for them.

By understanding the full dimension of a client’s trauma, psychological as well as physical, an attorney can address the legal factor well-armed. PTSD, when present, broadens the range of vision of what is damaged.

Depressive and anxiety symptoms are part of PTSD, as of adjustment disorder, and the like. The accident or traumatic event triggers a cycle and often people’s minds become totally immersed in their mishaps and pain. There is no more order to life. People become irritable, dysthymic, dependent, scared, disoriented, detached, and paralyzed either physically and/or emotionally.
The Importance of Individualized Assessment

Not all people who experience upset need treatment. Depending on the pre-trauma personality characteristics and the nature and magnitude of the event, with the help of family and friends, many find they can move on and get better. Others, however, need professional help to recover and move in a positive direction. It is not always the severity of the accident that determines whether one develops PTSD; rather, it is the meaning the person attaches to the experience, and the personality characteristics that the individual has when confronted with the mishap. Everyone brings into a trauma-producing situation (triggering situation), predisposing and determining aspects, also called premorbid personality. It is impossible, beforehand, to determine who will absorb the psychological effects of trauma and move on with their lives.

Many PTSD patients have difficulty talking about their trauma, which makes it hard for the disorder to be detected. Sufferers also have repeated episodes in which they re-experience the traumatic event. They have trouble concentrating because of this. They lose interest in activities and become socially withdrawn. People with PTSD avoid daily situations that remind them of the accident. Irritability, sleep disturbances, and restlessness are also part of the disorder.

This condition is treatable. The results are better if these symptoms are approached early on by the clinician. The goal is to help the patient recover to a premorbid level of functioning, by working through the trauma and pain, develop new and better adaptive mechanisms, and resolve the resulting grief.

Case 6a: Work-Related Accident – Loss of Limb While Operating a Machine

The accident took place 3.5 years before the attorney requested a forensic psychiatric evaluation; and aftertreatments and deposition of plaintiff were completed.

The question that still concerned the plaintiff’s attorney was whether Mr. Oré was then and is currently psychologically afflicted after the accident that occurred while he was working as a welder at a construction site. As a result of the accident, Mr. Oré’s right forearm, below the elbow, was severed.

Mr. Oré was 17 years old when the accident occurred. He had been diligent and hardworking, rapidly moving from stockpiling to welder in 1 year. He had migrated from the countryside of Chile to the United States, just days before being hired by the construction company, without prior experience or command of the language.

Throughout his orthopedic treatments, Mr. Oré came across as a quiet, reserved, and cooperative young man that did not seem to require psychological help. On the other hand, at the site of the bloody incident, all those involved and concerned, including ambulance, fire, and police personnel, needed crisis intervention of some form.

The examination with me revealed a person that remained seated in the same position through the 3-h interview. This lack of flexibility, spontaneity, and overall
stilted demeanor conveyed a gentle, albeit afflicted, and impoverished relating style. Mr. Oré suffered from PTSD, major depressive disorder, and pain disorder. He depicted the “emotional anesthesia” described in cases of PTSD, characterized by a feeling of detachment or estrangement while maintaining intact his ability to test reality.

Mr. Oré had seen himself as attractive, assertive, young, energetic, driven, and able to start over. His actions before the accident attested to this. He lost it all. The clinically significant distress and impairment in his personal, social, and occupational life were prominent and well documented.

His occupation changed from being a productive worker and a family-oriented adolescent (he lived with his cousin and financially supported his mother and younger siblings in his native country) to being a full-time patient, without possibility of cure and only limited physical improvement.

Mr. Oré was right handed. That hand defined this manual laborer. Without his dominant hand, he saw himself becoming an insignificant person, useless, and hopeless. He lost the most important organizational apparatus (the right hand of a right-handed man) designed for him to achieve adaptation and progress, indispensable to carrying out specialized activities.

It was essential to describe the “phantom limb” phenomenon affecting him. It refers to the network of nerves in a large and specific area of the brain still generating messages about the missing body parts despite the absence of stimulus-driven input (right hand). This continues throughout life. It evokes images in the mind that tease and prevent Mr. Oré from psychologically working through the loss.

Mr. Oré’s nonreflective persona, coupled with his disconcerted attitude and depressive symptomatology (as described in the body of the narrative report), curtailed his ability to express emotional content (phenomenon also known as alexithymia); this accounted for his reserved stance and explained the absence of seeking out psychiatric help. It became clear why Mr. Oré appeared to be currently free of psychological ailment to the untrained eye.

Case 6b: Rape of a Woman with Cognitive Impairment

On her way back home from the workshop she attended daily, Ms. Thomas, 27 years old, was raped by the house’s maintenance worker, in the elevator of the building where she lived with her mother.

Some 2 weeks later, Ms. Thomas disclosed the assault to her elderly, still active but fragile mother, a diabetic woman, convalescing from a stroke.

There was no evidence of the sexual attack itself, other than Ms. Thomas not being a virgin, whereas in all prior gynecological exams (due to endocrine deficiency) she appeared not to have had sexual intercourse.

The case for her attorney surfaced as somewhat muddled since Ms. Thomas was “not all that vocal,” per reports; and so she seemed to be calm, young, attractive, well mannered, and, above all, “doing well.”
Ms. Thomas had said that she would like to go back to “work” (the workshop) where she had been going for years, performing repetitive manual labor and chores like gluing small boxes together. Her social life involved two fellow female “workers,” with whom she only met with at work. After the rape, she interrupted the attendance, received psychotherapy and was prescribed paroxetine (antidepressant) and ziprasidone (antipsychotic also used to curb agitation), and then resumed work. Months later, Ms. Thomas stopped going to work because her mother could no longer escort her downstairs to the van and greet her in the street at the end of the day, as she had started doing after the sexual assault.

A review of all existing records, including medical, gynecologic, psychiatric, and deposition transcripts pointed at Ms. Thomas being emotionally afflicted by the sexual attack. Her demanding responses of taking frequent showers, and becoming restless and aloof, gave way some 8 months later to her resuming attendance at the workshop, until her mother put an end to this routine. Ms. Thomas’ life again changed dramatically.

Using an audiotape interview (also of the mother and sister), it was possible to memorialize the responses. Her ability to recall, concentrate, and think logically was adequate as well.

Taking into consideration the limits imposed by her cognitive impairment, her mental status exam revealed signs and symptoms commonly seen in individuals subjected to extremely dangerous, traumatic, humiliating life experiences. Ms. Thomas had never complained of any untoward event against her. She appeared to be a truthful and accurate informant. She did not appear to be fabricating any of her history. According to her mother, Ms. Thomas loved to shop and buy clothes. The opinion was that Ms. Thomas had been and was currently affected by the event. It was central to point out that “mental retardation” (a term riddled throughout the records) was not a psychiatric disorder and that Ms. Thomas had been living to her fullest intellectual potential, emotionally well-adapted, and “in touch”. Her sexuality and sense of femininity had not been hindered by her cognitive impairment but by the sexual attack she endured.

Routine activities and predictability of her surroundings are essential to maintain her mental stability. It was documented that her mother had been her “coach” since she was 5 years old. In fact, it was because her mother did such a good job teaching Ms. Thomas; that mom had been hired to work for a nationally recognized group dealing with the intellectually disabled. Her mother was totally invested in the safety and well-being of Ms. Thomas, contributing significantly to her social and support network.

Ms. Thomas had fewer resources to deal with the trauma than the average person. She was minimally verbal yet able to react and express herself when she was sensitively brought into the subject. Her responses were those typically seen in individuals subjected to submit by force, including the threat of imminent death.

Describing the special bond that Ms. Thomas and her mother had was crucial. The mother successfully invested long and laborious years loving, educating, and protecting her daughter. In the process, a “symbiotic” relationship developed between them. Her mother was the umbrella to keep Ms. Thomas free of danger. The rape affected
her mother in powerful and meaningful ways separately than it did her daughter. They both mentally regressed, and the functional capacity of the mother, which fueled that of Ms. Thomas, weakened and neither felt safe any longer. Ms. Thomas became a recluse, shattering her personal, social, and occupational life.

**Case 6b: Opposing Forensic Expert Opinion – Rape of a Woman with Cognitive Impairment**

The examiner found that Ms. Thomas was being truthful during his deposition with her and, furthermore, she could appreciate the meaning of truth-telling and the importance of such during their “conversation.” She did not know why she was in the (deposition) room, but her recall of past events, school days, year of graduation from the “School for Handicapped Children”, sequence of daily events from schooling to working, and what her first job entailed “working with rods.” Ms. Thomas also said that her mother was her friend and that she went on the bus to lunch with her “friend Cynthia.” She was able to provide her full address, age, and telephone number.

The examiner took from her deposition her description of the occurrence: “the maintenance man took my pants off and put his penis in vagina.” She said that it happened in the elevator of her apartment and that his name was Charlie. He grabbed her arm, she stated, and took her black leather book bag. Moreover, she described he was wearing a uniform of brown pants and a beige shirt. She said that he raped her in the elevator. She noted that she had bruises on her back, but no cuts or broken bones. She told her mother and sister Beth. Beth took her to the hospital and therapist. She took sertraline (Ms. Thomas said “Paxil”). The man in the elevator was a skinny guy who rode a bicycle in the parking lot. She also said that she took a van to go to work.

The examiner noted that 3.5 years after the reported event, Ms. Thomas still lived in the same housing project and the man she accused of raping her was still at work in the development. Yet, she did not appear to be emotionally upset when she talked about seeing him. Ms. Thomas told the examiner that she thought about the rape a lot and that she still felt “nervous and dizzy” but was not able to elaborate on these symptoms.

She only spoke when spoken to and then responded in brief phrases. The examiner noted that her cognition appeared seriously compromised. It was further mentioned that Ms. Thomas’ ability to concentrate and recall memory appeared to be poor. He added that her language production was meager, her logical thinking was impaired, and her affect and mood were normal and appropriate. He also found no evidence of sociopathic thinking or behavior.

As it related to her complaint, the examiner found “PTSD, by history, generally now resolved, not clinically apparent,” as a psychosocial stressor, noted, “occasional occurrences of memories about her rape, by history, mild.” Lastly, the examiner added that “Ms. Thomas sustained no permanent psychiatric condition or disability, relative to the reported rape.”
Case 6c: Victim of Police Brutality

Questions: Does José Ríos suffer from post-traumatic stress disorder as a result of the event that took place on February 29, 1998? Is Mr. Ríos currently psychologically afflicted as a result of the event of February 29, 1998? If so, what is his diagnosis, treatment recommended, the cost for same and prognosis?

It is reported that, on February 29, 1998, Mr. Ríos was driving home from a bar when he noticed a car blocking his path. Moments after having honked at the car, two men dressed in dark civilian clothing came at him, forced him out of his car, restrained him, beat him, and then drove him home with not an explanation but a warning to “Go home and shut the fuck up.” After being contacted by the defense attorney representing one of the two men, later determined to be police officers, I reviewed all of the pertinent information so that I may be able to determine whether José Ríos suffered from PTSD as a result of this event.

Promptly arriving at my office, Mr. Ríos requested that I conduct the meeting in Spanish, to which I agreed. With clarity, he was able to depict to me the sequence of events with vivid descriptions of that February day 3 years earlier. He was driving down a street coming from a bar when he honked at a car that was blocking his path. Moments later, two men dressed in dark clothing, one holding a gun pointed at him, yelled, “What’s up, motherfucker?” After forcing Mr. Ríos out of the car, the two men threw him on the ground, handcuffed him, and beat him. Finally, Mr. Ríos realized the two men were police officers but still had no idea why they were beating him. Mr. Ríos thought quickly and blurted out the name of the sheriff he knew and the police officers brought him into their car and finally drove him home with a warning “Go home and shut the fuck up.”

Shortly after arriving home, he explained to his fiancée what had happened that night. They dropped off their son at his mother-in-law’s and made a stop at the police station on their way to the hospital. He retold his experience to the police over the phone from the hospital where the lacerations on his hand were sutured. The hospital records indicated that there were “two one-inch lacerations to the dorsum of the right hand, swollen, and tender.” Now there is only slight scarring. He said the doctors “did a very good job and his hand is fully functional.” The hospital also reports that they located multiple body abrasions, but his mental status exam was unremarkable, and there were no signs of anxiety or agitation.

However, Mr. Ríos said to me that his hand was only a minimal part of his sufferings. “I couldn’t sleep for several days… I was scared when in the street… I am vigilant when I go to a bar…” Almost 5 months after the incidence, Mr. Ríos started to see Dr. Perez for treatment twice a month with supportive psychotherapy only. Dr. Perez reported that Mr. Ríos was well connected to his surroundings, and his occupational functioning has not been affected. He clinically diagnosed Mr. Ríos as having phobias to policemen, and the psychiatric diagnosis was PTSD directly caused by the event of February 1998. He then prescribed clonazepam (mild sedative) and psychotherapy based on a brief encounter of 20–30 min approximately once a month. Mr. Ríos had a total of 19 visits to Dr. Perez over a time period of 16 months.
Mr. Ríos told me that his visits to Dr. Perez were good but not as comforting as traveling to Perú every holiday season. He is also very family-oriented. His two children both live with their mothers, but he spends all his free time “visiting them and doing sports with them.” When I asked him for the reason of the divorce from one, and the breakup from his second relationship, he just said “Personal problems… there were very personal problems that made us split… we are best friends… but due to an impasse, we are not together…” However, he mentioned that he did currently date other women and went out often.

After the incident with the police officers, Mr. Ríos bought a house in the town where the incident took place and became a landlord. He considers himself a workaholic. In addition to his work as a handyman, he cleans professional and commercial spaces. “I’m always busy”; he added, “yet, whenever I have a free moment, I run to be with my children.”

I asked him how else he was affected by the February 1998 event. To this, he responded, “The other day… I was coming from a cleaning job… a police officer stopped me on the road… it was related to my not having stopped at the ‘yield’ sign… I had stopped but he didn’t see that because I was behind three other cars… he gave me a break, ‘Just be careful’, and let me go… I always respected the police, but I never felt afraid of them.” He continued to explain that he has had nightmares after the event, “The other day, I had a very bad nightmare… I felt they were attacking me… they were taking me out of the car… a rehashing of what happened to me… they happen when I’m in the street and don’t feel safe… then I go home and I have a nightmare.”

It was my opinion that José Ríos did not suffer from PTSD, which is characterized by the re-experiencing of an extremely traumatic event. This would affect his personal relationships, social life, and work. Features of this disorder would include insomnia, jumpiness, hyper-vigilance, emotional paralysis, denial, shame, silence, and disturbed appetite. Mr. Ríos did not change any aspects of his life. While he would be expected to have reduced ability to feel emotions such as intimacy, tenderness, and sexuality, he still goes out to bars, gets together with his friends to play soccer, and dates women. He was also able to maintain healthy relationships with his children and their mothers.

Instead of being numbed, silent, and “running away” from the event, his first action the night of the incident was to inform his fiancé of the occurrence. His response may have been intense fear but not helplessness or horror. Soon after telling her, he was able to report the incident to the police at the hospital. Although the policemen that reportedly assaulted him warned him of keeping quiet, he soon retold the story to many people, including the authority.

His behavior during our meeting was outgoing, friendly and open, vivid, and cooperative. He did not seem to have markedly diminished interest on participating in significant activities. He also did not avoid the activities, places, or people that arose recollections of the trauma. Instead, he accepted the event and moved on to becoming the landlord of an apartment and accepted new responsibilities.

Mr. Ríos did not show signs of a phobic disorder, either. In fact, he had been stopped by a police officer for a moving violation that took place almost in front of
Mr. Ríos was bitter about the event. He received no formal apology or explanation by the police department. However, he was not suffering from a psychiatric disorder.

Case 6d: Work-Related Accident – Burn Injury from Explosion

I was hired to ascertain whether Mr. Gould suffers from PTSD, as a result of being burned in an engine explosion during his job working with engines on a freight ship.

I determined within a reasonable degree of medical probability that Mr. Gould’s descriptions of his suffering from this event are not consistent with any recognized clinical pattern of a psychiatric disorder. The diagnosis of PTSD was not found at the time of my evaluation of the examinee.

Four months after the mishap, Mr. Gould started seeing a psychiatrist once monthly. It took place in connection to a worker’s compensation claim, at the advice of his attorney. Claimant reported to the psychiatrist that he had flashbacks to the accident, as well as crying spells, sleeplessness, and waking up in a sweat. He also stated that he was on guard all the time and was unable to enjoy activities he typically would, among them, sexual relations. Taken at face value, the psychiatrist diagnosed anxiety disorder and started treating him. During psychiatric treatment, on at least two separate treatment visits, Mr. Gould said that his sexual problems were due to back pain.

At my examination of Mr. Gould, 16 months after the mishap, he walked in using a cane. He informed me that he had limitation in his left index finger and thumb. He also stated that “after a lumbar fusion, an MRI, and a disco-gram” his sciatic nerve bothered him. “I was blown backwards into a sink, in the engine room… and uh… I guess my disc got hurt… and my left knee also got hurt.” When I pointed out that he was not taking any medication for pain, he informed me that he had not been doing so for the last 7 months in order to not mix them with what his psychiatrist was giving him. According to the records, he had been prescribed innumerable types and amounts of analgesics.

I asked Mr. Gould to relate to me the event. He informed me that he was in the engine room doing his job of servicing the engines when the accident happened. He was reading and recording the temperature of the engines when he heard a cylinder rattling like there was something wrong. When he went over to check on it, he was standing directly in front of the cylinder that exploded and caught fire. The explosion burned his hair and arms, which he used to protect his face. He got out of the room and made sure to close the door tightly behind him as to not let the fire “breathe” and spread. He then alerted the crew on how to properly extinguish the fire. He asked for ice and water for his burns before he was transported to the hospital.

Mr. Gould told me, “The burns were very painful… and bad… I can close my eyes any time of the day or night and see that explosion.” He went on to tell me
how he was not simply worried about himself but the seven other people onboard as well. He also told me that they were very grateful to him for saving a $25 million vessel.

Mr. Gould showed great fondness of his co-workers and even that he missed them. He informed me of his intention of reconnecting with them after the litigation was over. He also stated “I always figure that I stay with [the company]… is the best company I’ve ever worked with.” He again informed me of his desire to return to work after the litigation concluded. “I’d love to… I’d give it a try… on my boat… or some other vessel.”

Mr. Gould informed me that he was going ahead with the plan to marry his girlfriend of 2 years. He felt that he “taught her things” and that he was a positive influence in her life. He also informed me that he no longer drank alcohol, stating, “It’s more fun being sober… you can remember everything.”

Mr. Gould cannot remember why he started seeing a psychiatrist. He also told me that he did not know how many tablets of medication he had taken the morning of our meeting, informing me that it was whatever his girlfriend has given him. He also blamed his sexual problems not just on his back but on the medications as well. However, he told me that his psychiatrist told him that the medication would not affect his sexual life. Also, Mr. Gould did not remember his psychiatrist ordering the necessary blood tests in relation to the medication. He later informed me that if he had the desire to engage in sexual relations, he did not take his medications. He simply took the medication because his doctor told him to.

Mr. Gould said that at the end of this litigation he wanted, “To go on with my life… to go back to work… to do my thing… to upgrade my license to become a Chief Engineer… and not to take pills every five minutes… build my house… I have two ponds that need dire attention… and I can’t even do that because of this crap (litigation).”

My opinion that Mr. Gould did not suffer from PTSD was founded on many reasons. Mr. Gould did not exhibit any emotional symptoms or behavioral signs that he was suffering from PTSD. His response to the event was one of intense fear, but not helplessness or horror. Rather, he remained lucid, attentive, and resourceful throughout the incident. He was able to take care of the emergency, alert the crew, and save the vessel.

Mr. Gould missed his job and wished to go back working as soon as the litigation was over. He also did not change any aspect of his lifestyle in any substantial manner, nor did he exhibit any phobic behavior. He never behaved in a manner indicating avoidance of the stimuli associated with the trauma. He did not come across as frail, hesitant, easily overwhelmed, anxious, or fearful as individuals suffering from PTSD do. Instead he was poised, determined to resume his occupation and to excel in it. Mr. Gould was also able to talk to me about the occurrence. He was able to vividly describe the sequence of events. I found that despite his psychiatrist’s diagnosis, treatment, and prognosis, Mr. Gould has no need to take psychiatric medications or for intensive psychotherapy.

Mr. Gould was planning to marry his girlfriend, in accordance with longstanding plans. He did not believe that there was impairment in the functioning of his
hands, since he was planning on resuming his position and taking on additional responsibilities.

No depressed or anxious mood was reported nor diminished pleasure in his daily activities. I did not observe any signs of fatigue, sluggishness, or lack of energy, which one would expect in a case of disturbed sleep. Nor did Mr. Gould have any difficult sustaining attention and concentration throughout the interview, which lasted approximately 3 h. There were also no feelings of worthlessness reported; rather he took pride in his activities.

Mr. Gould informed me that prior to the accident, he preferred to work at night. Being awake at night did not constitute insomnia but went along with his somewhat aloof lifestyle, which was also displayed by his father and brothers. I talked in depth with him about his family.

Despite Mr. Gould’s complaints of pain, he was not taking any medications for it. His posture, attitude, and demeanor reflected no somatic or neuropathic pain whatsoever. He also told me that he selected which medications to take and when, in order to engage in sexual relationships. He later told me that he did not know what he was taking nor for what purposes. His sexual functioning was not compromised by mental impairment. He also planned to discontinue psychiatric visits and medications after the litigation was completed. He reported that he was taking the medications “to do the right thing,” rather than to treat an afflicted state of mind stemming from the accident.

Mr. Gould told me that he wanted to be with his “crew,” performing the same job, aboard the same vessel, after the litigation was concluded. He was not afraid of ship engines. In fact, he reported loving his job, wanting to learn more, and being promoted as an engineer. He pointed out that certain activities and occupations have risks that he was willing and ready to accept.

Case 6d: Opposing Forensic Expert Opinion – Work-Related Accident (Burn Injury from Explosion)

One year prior to examining Mr. Gould, he had an IME. The MHP who saw him noticed that he drove 45 miles to the office, was accompanied by his girlfriend, and displayed no involuntary movement or gait disturbance. He was not using a cane as aide to his walking. He was able to carry on with everyday activities. While at work, one of the machines he looked after exploded in front of him. He was hospitalized in the burn unit for 16 days, but no surgery was needed.

Mr. Gould told the examiner that he had intrusive recollections of the explosion that kept him awake and turned him anxious and tearful. He added that he was hesitant, on guard, less lively, and not able to enjoy sexual intimacy.

Mr. Gould mentioned that he had received two DUI (driving under the influence of alcohol) many years prior and was in jail four times for reports of domestic violence. There was also a childhood history of witnessing a great deal of violence in the house. His parents became divorced when he was 10 years of age. He did not finish high school and had been employed since age 15. At 25 years old, he was
involved in a motor vehicle accident with his ATV (all-terrain vehicle), as a result of which he lost consciousness and was hospitalized for 3 days. He hurt his neck, shoulder, and face, including a broken nose.

According to the examiner, his mental status exam was positive only for depressed mood. The examiner made the diagnoses of anxiety disorder NOS and alcohol abuse noncontinuous, with a GAF of 50 and a past year GAF of 75. Mr. Gould was recommended cognitive-behavioral therapy and sertraline (antidepressant). He was also prescribed supportive therapy, a hypnotic, a sedative, and Cialis (for erectile dysfunction). He was also prescribed Seroquel (antipsychotic) because of the report of insomnia and nightmares and lithium carbonate for a possible bipolar disorder.

The psychiatric opinion was that all this was work-related and recommended cognitive-behavioral therapy, along with medications. This doctor took Mr. Gould as his patient.

Case 6e: Child Falling from Second Floor Window

Alice is 8 years old. Three years ago, she fell from the window of her bedroom on the second floor of a building where the family lived. She landed on the concrete sidewalk.

Alice sustained multiple injuries, including a broken forearm and a laceration of the chin. The mother could only speak Russian and thus was unable to communicate with medical personnel. Alice complained of pain in the wrist, chin, and hip. It is reported that she remained conscious during the incident. It is written that the mother tried to take a hold of her daughter prior to the fall but could not grab Alice in time. She will have permanent scarring on some areas of her body, most prominent on the lip and chin.

Child Protective Services indicated there was no neglect of the children (Alice was the oldest of three) and the parents were alert and responsive. Nothing remarkable was found in her developmental history; she was described as “active and tomboyish.” The incident happened in the summer; half a year later (in school), it is reported that she was sent home because she was feeling “scared.”

During this academic year, Alice’s performance in school was indicated as “Substandard: She does not remain on tasks, does not follow directions, is reluctant to attempt new assignments, seems limited in her memory skills, and requires repeated drill and practice... fights with other students, getting easily upset and showing little interaction with classmates and adults in the classroom. Alice avoids situations, assignments, and other responsibilities in class. She tends to not participate in class, due to her apparent shyness. She frequently looks unhappy.”

Testing shows developmental lags in mental (nonverbal) maturity and fine motor coordination, oral language, reading comprehension, visual motor integration, and mathematical reasoning ability. She was placed in full-time special education.

The parents placed Alice into a different school system at 8 years old. She had already been classified as “learning disabled” and displayed “signs of what may
be “selective mutism” that may be a result of high levels of anxiety resulting in extreme shyness.”

The mother stated that Alice is forgetful and frightened in school. She added that Alice suffers from headaches, restless sleep, and wakes up with anxiety often. Mom added that aside from being enrolled in special education, her daughter had no academic problems. The father stated that Alice is afflicted by headaches and nervousness. “She does not have enough patience to play with other kids, and she wants to be alone.”

During my examination, the father said that he, the mother, and Alice had come to see me “To learn what is wrong with our daughter... she’s forgetful. She has nightmares often... she has a bad temper.” The mother added “It’s a constant thing, she has a bad temper and she is forgetful... the teacher explains to her the homework... when she gets home she forgets... then she gets frustrated... and she often gets tantrums about this... the teacher gave Alice a list of work to do and a schedule about when to do it... she forgets how to do it, even after she was explained, in detail, the work ahead... it’s so frustrating for her, and for me... it should be easy for her to get 100, but she gets 61... she is a very confused child.”

The mother continued, “Alice’s teachers (all four of them) said that she is not supposed to forget as much as she does and that she is not oriented to time, not being able to differentiate between ‘today’ and ‘tomorrow’.”

The parents told me she was not in any form of treatment since no one ever indicated the need for it. Before her accident, it was said that Alice behaved like a normal child, having friends of different ethnicities. The parents stated that their girl had never been unruly.

When the child began kindergarten (the academic year after her fall), she had problems with easy homework assignments; “we learned that she would put her head down whenever the teacher talked to her... her hands over her face... the teacher told us that Alice appeared distracted, fearful, absent-minded, and staring at the wall... she appeared scared of the children making fun of her.” The parents were very self-conscious about how they would look as parents if people knew about the accident, and because of this, they never mentioned the accident to anyone (for a while, not even his teacher), stopped going to Church, and retreated from their own friends into their home.

“Alice became all too sensitive now. Before the incident she was feisty, fearless, and always running around. Now, she does not mix well with other children, she is afraid of getting hit.” She is now afraid of windows and is very moody. The parents informed me that she never wants to leave the apartment and often spaces out, even staring into the mirror.

The family never once talked about the incident, in order not to “bother” her. They did not want her to become upset about it. The mother said, “I don’t want her to get upset... I don’t want her to remember it.”

I was informed that Alice used to like going with her dad to the grocery store, which her father owned. “Now she is very serious with the customers, she does not joke around with people any longer.” The father described that he some nights had
to shake Alice to wake her up from a nightmare. She frequently asked when her
scars would fade and was too fearful at school to participate in athletics.

I first met with the parents, alone with me and an interpreter. The parents then left
the room and Alice came in for me to examine her. Her command of English was
such that no interpreter was needed in the room with us. She sat on the floor next to
me, with a winter jacket on (zipped up to her lips, as to cover/hide the scars from
view) despite the temperature in the examining room being comfortable. Upon my
inquiry about the fall, she took off her jacket and allowed me to see her scarring.

Alice told me that she learned to say, “My little brother pushed me off the bicy-
cle,” when asked by anyone about the scars on her face. She had thought that keep-
ing silent about the traumatic event was in the best interest of the family. She did not
have positive memories about the hospital. She became animated when describing
to me her favorite cartoon characters.

Alice showed a depressed and anxious mood and an overall reserved attitude.
Her memory and attention/concentration, though loosely tested, appeared adequate.
The examination was conducted in a quiet and controlled environment that did not
reflect the distractions and frustrations of everyday living. Her intelligence appeared
to be average. Alice recognized that the accident was hurtful to her and that its sig-
nificance was still present today. It was my opinion, with a reasonable degree of
medical probability, that Alice was currently suffering from PTSD and post-concussion
disorder.

Alice was trustingly and playfully acting within the confines of her home. She
was not being defiant. She was suddenly confronted with death. Her parents are not
reflective people. They tried to hide from the incident and forget about it. An event
of this magnitude cannot be forgotten and must be confronted. Alice does not know
how to handle it and has succumbed to her fright. Her responses to mundane situa-
tions are typical of individuals subjected to the overwhelming threat of imminent
disaster.

PTSD is characterized by the re-experiencing of an extremely traumatic event.
The individual experiences increased arousal and avoidance to stimuli associated
with the event. She experiences shame, denial, insomnia, hyper-vigilance (state of
being constantly on guard), silence, and numbing. The individual cannot adequately
perceive the outside world and adapt to it. It affects personal relationships and aca-
demic and social life.

The parents feel a great deal of shame in their parental abilities and their loss of
protective control over Alice. The family retreated into their house and stopped all
social activities, making sure Alice told people that she fell off her bicycle, further
suppressing the possibility of working through the trauma. Alice has a sleep distur-
bance, physical scarring, and an inability to relax and talk about the experience.
Since the tragic event is uppermost in their minds, Alice is mostly quiet, also dem-
onstrating a diminished responsiveness to the external world (numbing). She felt
detached from others and had lost interest in all activities she used to find exciting
and enjoyable.

The school found her to be limited in all aspects of functioning interpersonally,
socially, and academically. Alice could no longer participate in school life. She was
described as being avoidant, moody, inattentive, and unhappy, all symptoms of PTSD. Alice was not handicapped before the fall; she did not experience any event that would interfere with her development. After the fall, for the first time, her pediatrician noted Alice becoming fearful. She went from active, playful, and exploring to shy, anxious, and hiding. She could no longer explore the world personally, socially, and academically. She was constantly re-experiencing the trauma, in every room containing a window: At home she sat on the floor, same as she did in my office – away from the window.

She is also afflicted by post-concussion disorder. Symptoms and signs include irritability, depression, anxiety, forgetfulness, inattentiveness, explosiveness, and sleep disturbance following head injury.

The continuous presence of the stimuli associated with the event did not allow Alice to recognize the event as a “thing of the past,” and she would continue to act as if the event were about to occur. Another reminder of the tragic accident is the persistence of facial scarring. Common to this family relating style, she tried to avoid dealing with the psychological effects of his fall, which in turn made her condition worsen. Treatment was recommended for all, Alice, and her parents.

Case 6f: Physical Assault – Robbery-Kidnapping

The following issues were presented to me for consideration:

1. Was Moon Ha psychiatrically afflicted by the events of March 14, 2004–March 15, 2004?
2. If Ms. Ha has been psychiatrically injured by those events, provide an opinion regarding the past and present psychiatric diagnosis, treatment, and prognosis of such condition(s).

The attorney called, identified herself as the attorney of Moon Ha, and briefly described the alleged events of March 14–15, 2004, involving her client. She provided me with a brief account of the incident in which Ms. Ha was assaulted and kidnapped by a male individual, stranger to her.

The attorney requested that I review medical and legal records, then examine her client, and lastly produce a forensic psychiatric report stating my opinion in connection to the questions stated above. I agreed to the procedure and requested that he provide me with all the records pertinent to this case.

I reviewed the “complaint,” “plaintiff’s answers to Form A interrogatories,” police department investigation report, building safety expert report, treating psychiatrist’s report and treatment notes, deposition transcript of Moon Ha, telephone conversation with Ms. Ha’s psychotherapist, and report of forensic psychiatric examination.

The assault started at 9:30 p.m. and went on for hours afterward, in which Moon Ha was allegedly further threatened and kidnapped by her assailant.
It is said that on the night of March 14, 2004, a man unknown to Ms. Ha and not a resident entered the building after her through an unsecured door and then stepped into the elevator with her. He attacked her by grabbing her and pointing a knife at her chest and neck. His first purported intention was to rob her of her valuables. He threatened to kill her if she did not comply with his commands. The assailant then forced her out of the elevator, through the apartment building, into the parking area in the back of the building.

He proceeded to force Ms. Ha into the trunk of her own automobile. At this time the man stabbed her in the face, including her eye. He then drove away, stopped to pick up others, and smoked marijuana in the car. It is said that he continued terrorizing Ms. Ha with the threats of imminent injury and death for approximately 3 h.

The culprit drove her about the area and into New City for approximately 3 h, all the while smoking marijuana and picking up friends. After approximately 3 h being held prisoner in the car’s dark trunk, Ms. Ha was able to escape when the car was briefly parked.

The MHP described her mental status as being moderately depressed and anxious. Her affect was restricted. Her cognitive functioning was poor. He diagnosed PTSD, acute; and her GAF (Global Assessment of Functioning) was severely impaired in all areas. He recommended psychotherapy and medications, to alleviate her symptoms and improve her level of functioning.

In treatment, the doctor described no significant change in her symptomatology, and the condition became chronic. He prescribed sertraline (antidepressant), 150 mg daily, and alprazolam (mild sedative/antianxiety), 0.25 mg daily. He emphasized this patient being afraid of being attacked and having other symptoms of the disorder, including an emotional numbness, flashbacks, and nightmares. Ms. Ha had “Missed appointments... also difficult to establish a psychotherapeutic relationship. Medications (sertraline) produced adverse reactions, i.e. diarrhea... she has been anxious and socially isolated, and she has poor sleep and... eating poorly... working full time. Her assailant is in jail... re-experienced the symptoms. Medications: sertraline and alprazolam... Looked for an apartment building in which she didn’t have to take an elevator. She is afraid to take the elevator…”

The report by the treating MHP continues, “She feels a dread when she opens the trunk of the car. She feels fearful if she has to stop at a traffic light. She does not want to go out after dark... easily awakened. Goes out to and from work only, no socialization... at work it is hard to concentrate and perform. Complaint filed against her. She feels distrustful of others and fears they may have other agenda... overly anxious at work... does not go out... she is not in a relationship. She remains depressed, hyper vigilant and afraid. Medication increased… stays in, does not want to drive. Tries to leave work early (gets dark earlier)... Fearfulness in the street, when walking home from a parking space.”

After 1 year of the event, “minimal improvement” was reported or noticed by psychiatrist. “Described flashbacks and feeling easily bewildered and vulnerable... Missed appointments because of her fear of being in the darkness of the night. At work she remains isolated, avoids dealing with customers. She still has dreams and flashbacks. Medications changed to sertraline; still has anxiety, panic and avoidance
behavior, she is disturbed. Not much psychotherapy yet, also taking alprazolam and zolpidem (hypnotic)… avoidant behavior… venlafaxine (anti-depressant) started, stop sertraline… she does not have much of other activities (other than work)… no significant change. She continues to function on much the same way… easily upset and feels irritable. Sleep disturbed.”

In her deposition Ms. Ha said that she came to the United States because she wanted to study American culture and language. She was here first from 1991 to 1993. After finishing high school in Kansas, she went back to Taiwan for 1 year, where she worked to save money, came back to America, and continue her studies, which she did, until 1999, when she was graduated from state college, with a degree in international studies. She had decided to stay in this country.

Ms. Ha found a job as an administrative assistant, where she worked from 10 to 99 to the day of the assault. Five months later she resumed her employment in a different trading company. She added that she was hired for showroom sales. She was found to be unqualified for the task at hand, so she was transferred to a receptionist job; “Because I really couldn’t help customers… just I couldn’t talk to people whom I don’t know.” Later she explained, “It was not due to language problems, since it was a Chinese company and the customers were Chinese and Korean and I am easily able to communicate with the costumers… in the showroom they displayed like knives and things. I was kind of afraid to touch those. That’s why like I really couldn’t sell.”

Ms. Ha described the inadequacies and defects regarding the entrance doors to the building where she lived on the day of the assault. On that day, she stayed at work long after 6 p.m., to socialize with co-workers. She described her assailant as a “big male … black.” She was not nervous, since she thought he was visiting a friend. Ms. Ha turned edgy when depicting the sudden, unexpected, and violent attack she sustained from behind by this man with a knife at her neck.

Ms. Ha mentioned him ordering her, “Don’t say anything, nothing to lose... and he’ll kill me any time... I couldn’t move... so I was like I could say nothing, but I tried to let the person (someone passing by) know something happened to me... but he just kept telling me, don’t scream, don’t say nothing, he’ll kill me.” She described the parking lot in the back of the building. “It’s dark, you couldn’t see anything. He took me there and looking for something in my bag... and touching my body a little bit… in a sexual kind of way... he told me to open the trunk... and he pushed me into the trunk. When he pushed me, the knife slashed my eye and face... he told me to get in. But I really couldn’t move... because I was so afraid... so he pushed me.” Ms. Ha was in that trunk for “about 3 hours… Just he’s telling (someone on the cell phone, while in the car) like he got a car and got me in the trunk still alive. It’s a game so that time, you know, I was like sure he’s going to kill me, and then he started driving and picking up... people... and after smelling the marihuana.”

Ms. Ha talked about recalling at some point that there was a lever to pull from the inside of the trunk where she was trapped, to push the back seat forward. “I wrote a letter to my parents... in the trunk.” Right after she escaped, she asked for help. “I tried to explain, but I really couldn’t talk.” At this point, and noticing that Ms. Ha was emotionally exhausted, the deposing attorney asked her, “Do you want to stop?”
Ms. Ha then replied affirmatively, although she had not asked for any break or special consideration. In fact, she’d say, “I’m sorry.”

The note read: “Dad and mom, I’m sorry. I appreciate what you did to me.”

Ms. Ha mentioned that she “just start keep crying and crying;” when she met the police. “I was in panic and couldn’t talk… my eyes were injured, so they decide to take me to the hospital… I thought like I’m going to lose the vision in the left eye… some material from the knife is inside of the eye. It’s still there… I really don’t want to have surgery. That’s why I stopped going there (to the ophthalmologist). But I still have to put eye drops every night, otherwise I get sties easily.”

Ms. Ha said that ever since the assault and injury to her eye, she had stopped wearing contact lenses. “It’s bothering me and makes me cry. It hurts. I’m kind of afraid to put the contact in the eye because it has a scar and a cut and material is inside still… I just keep putting the antibacterial… itching and pain.”

Ms. Ha feels responsible (guilty) for not getting better and turning her psychotherapist “upset.” Ms. Ha describes having crying spells, feeling angry.

The reports of Ms. Ha read, “I can’t really control myself. I usually stay home by myself. I don’t go out; especially at night time. I can’t. Even I have to go to work; I have to pay so much attention to people because I can’t really trust them. I always imagine like anybody is going to attack me, kill me. If I opened the trunk and I get something from the trunk, I feel like somebody is going to push me. If I see a knife, somebody’s going to take the knife to kill me. I just dream about the attack. Like the next attack somebody’s going to kill me… (I) stay home… they don’t know (coworkers) what happened to me. I cannot talk. I don’t talk.”

I had the opportunity of speaking with her psychotherapist who told me that she had been working with Moon Ha for more than 1 year to treat symptoms of PTSD and major depression. To date the therapist did not find much relief in Ms. Ha. He is of the opinion that the medications were not helping to correct her condition. The therapist described his patient as having decreased appetite and loss of weight. She was for the most part withdrawn and kept herself isolated, with limited outings, going from her apartment to work and back to her apartment. She refused to socialize with friends and felt totally debilitated. She used to be vivacious, proactive, and communicative; instead now “she is a wreck… she is plagued with fear of men, black men especially; she doesn’t want to meet new people and is only good as a receptionist, even though she was prepared to do much more.”

I met with Ms. Ha for 3 h. With her consent, the entire meeting was audiotaped. “I was kidnapped… it’s really tough to talk… when I got home from work, I walked from the parking lot to the apartment. There was a guy in the building… I felt nothing of it… I went to the elevator… he went into the elevator with me… he put a knife on my throat and said, ‘I will kill you.’ First he asked me for money… he then took me to my car. He asked me for the key… he put me inside… his knife cut my left eye and face… not deep on my face… he put me in the trunk. He took my cell phone… he started driving. He called up his friend and said that he got me and I was alive, he referred to me as a bitch.” Ms. Ha was hesitant to pronounce the word “bitch.” She explained to me, after some probing, that it is a “bad word… bad meaning about a
woman... I don’t use that word... the dictionary defines it as a woman that fools around, or... like a stupid woman.”

Ms. Ha went on telling me, “He said, ‘This is a game’ “I thought that he was going to kill me... especially when he said: ‘She’s still alive.’”

The examinee told me that the intruder said, “‘Don’t say anything.’ He had a knife on my throat... I couldn’t think of anything... my mind went blank... I didn’t do anything. I didn’t feel anything for a while... I don’t really remember... I was so afraid... I couldn’t move... he was so strong. He had his arm around my chest... he then didn’t ask for anything... only to be quiet... he then asked me for money. He took my purse from my back... there was no money, or not much... he asked me for the key of my car... we were still inside the building, by the stairs, on the way to the back of the building he touched me... a little bit... in the pockets of my jacket... when we were outside in the parking lot, it was dark out there... he touched me... more, on my hips and thighs, both of them... then he took my keys... I felt he was going to rape me and then kill me... my mind just went blank... My body was all shaky and everything... he then put me in the trunk... it was dark; I couldn’t see anything... my eye hurt... I was scared... he was going to kill me.”

Ms. Ha reflected on her inability to ask the man to let her go, “I couldn’t talk... He picked up people in the car... I wrote a letter to my parents. I don’t remember how I did that... I love you, I’m sorry, I was going to die before them, thank you (for helping me grow up).” She deduced that she took a piece of paper from her purse. “I do not know how I wrote it. There was some light coming from the tail lights... I must have put it (the paper) in my jacket.” Before she exited from the car, she had to take her jacket off, since a piece of it was entrapped by the trunk lock. “The car stopped... somebody got out of it. Then all of them got out of the car. I was waiting for a while... I was so afraid to do it... I pulled the lever and pushed forward the back of the seat. I got out of the car. I tried to run away but my legs were shaking so badly. I couldn’t walk, so I hid behind a car. Then I walked away, but always afraid they would come to get me any time. I went to a house. The lights were on... I asked for help. The people didn’t open the door, so I asked for help, to call the police... there was blood on my face... then he let me in... I was crying and crying... I couldn’t talk to the police... they took me to the station and then I went to the emergency room. I still have some material from the knife inside my eye. The eye doctor finally told me that it will be in my eye forever.”

Ms. Ha described the difficulties she still experiences with the injured eye: sty, pink eye, and inability to wear contact lenses ever again, having to use eye drops or cream on the affected eye. She added that she used to wear contact lenses to feel more attractive, replacing her eyeglasses.

“I had to stay in my house... I was afraid of staying in my own apartment. I didn’t want to see people except my roommate... not to go out of the building... fear for being attacked again... thinking about that all the time... where should I hide... even now, if I’m home and hear something, any noise, a door that opens outside... when I take a shower, I have to make sure all doors are locked.”

“I didn’t go back to work (after the assault). I couldn’t go out of my apartment. I was too afraid to go out. I told my boss that I needed a long vacation. I explained
what happened; the company was small. He said he couldn’t wait. He said that he had to hire another person... I just needed more time.”

Ms. Ha lived on savings and help from her roommate, from then on. “It was (the assault) on TV in China, people knew what happened to me... my friends knew about it. I was afraid people will come and ask me about it. I wanted to avoid all of them. My brother came to see me after the accident.”

Her family still lived in the same small town at the countryside of Taiwan. “My parents always worked... I was always with my little brother. My grandfather has a company. All the family works there. I took my brother to school and then walked together to the company to have dinner. My parents didn’t have much time to be with us.” She described spending little leisure time with her parents or being helped with her homework; in fact, she helped her brother with his. She had learned to be self-sufficient, which also made it more difficult to ask for and avail herself of help from others. She anticipated being misunderstood.

Ms. Ha spoke about past relationships. The examinee started dating (first boyfriend) when she was 16 years old and in high school in Kansas. She had been involved, in college, in romantic relationships. She had sexual relations for the first time at age 17 while in high school. She remained sexually active with her boyfriends. The most recent one lasted for some 6 months. His name was Tony, an Italian young man. They ended their relationship a few weeks before the event here described. “He was my girlfriend’s friend’s roommate.” Ms. Ha told me that since the assault, “I just don’t feel like having a boyfriend. Being alone is the only way I feel comfortable. I have no interest in being with other people.”

“I wanted to come to America; my parents wanted me to stay in China. They had agreed at last... I wanted to learn English and the American culture... to work for the United Nations, on International issues.”

Ms. Ha told me that after finishing high school, she went to China for 1 year, worked to save money, and then came back to the United States to start college. She completed her studies in 4 years. After the first semester, she moved off campus, with other students. All the while, she met Chinese, American, and people from other countries, with whom she socialized. She went to clubs, restaurants, and outings to the urban area. She always felt at ease with people, moving in new and diverse environments.

Now instead, she describes that the sight of a man near her, especially a black man, causes her to shake and to fear being attacked. “I know it’s crazy. If his hand is in his pocket, I fear he’ll grab something... and do something. I don’t really feel safe.”

Ms. Ha works as a receptionist. She was hired as showroom sales representative. “They were not satisfied with my work. I couldn’t sell things, or talk to customers, so they changed my position. I couldn’t talk to strangers. I used to be a ‘people person’. I would talk to anybody.” Ms. Ha added that even when a car gets close to her, she feels uncomfortable and “…like running away from that area.” She felt that people walking behind her would grab or “kill me.” Ms. Ha denied prior psychiatric history.
About therapy, “I wasn’t ready to talk to people... with my therapist; it took a while to feel comfortable. He understood. He was not pushy, tries to help me. He gets frustrated at times... I make him upset.” Ms. Ha told me that she was currently seeing the therapist on a twice-weekly basis and her psychiatrist once every 4–6 weeks. She still felt resourceless.

Ms. Ha told me that at night, in the dark, “I always think about this... regardless of not wanting... any noise makes me think of it.” She stated that she woke up often with the expectation of an imminent attack, and at times, currently, she was woken up by a nightmare in which, “I see myself dying, I’m tired all the time, during the day.”

The examinee denied having suicidal ideations but described having a distinct sense of a foreshortened future, being unable to plan ahead. “I can’t see what I am going to do 3 years from now. Looking at the mirror, I don’t see myself, but someone else. I see my face, my hand, but... it’s weird, crazy... at the same time they are not mine.”

Ms. Ha told me that her appetite was decreased, “When I get upset I can’t eat. I lost 15 pounds.” She added that she took many days off from work, due to headaches, rashes, feeling sickly often, and having developed allergies she did not have before, i.e., to animals including dogs and cats. She described not being able to feel excited by anything. “I often try hard not to cry. I believe that (during the assault) not crying saved me from the man that took me... at work I go to the bathroom to cry. It happens while driving. Any noise at home brings back memories.”

Ms. Ha was a formally dressed and well-groomed, attractive, petite, slender, young adult woman, who appeared her stated age. She wore her long, straight, dark hair, neatly hanging loose, a black shirt, a knee-length dark colored skirt, and knee-high brown boots. She was cooperative. There was psychomotor retardation noticed.

Throughout our entire meeting, lasting 3 h, Ms. Ha remained in the same seated position, leaning forward close to the edge of the chair, not once sitting back. Her legs were kept tightly closed and at no time did she cross her legs, all the while crossing her arms and “hugging” her purse. She appeared demure. This lack of flexibility, spontaneity, and overall stilted demeanor conveyed a gentle and somewhat pleasant, albeit afflicted, and impoverished relating style. There were no abnormal gestures or mannerisms noticed.

Her affect was moderately constricted, but not intense, marked by a great deal of restraint. It was appropriate to the situation and ideation. Her mood was depressed, anxious, worried, and bitter, with a saddened facial expression. Speech was clear, coherent, not pressured, and relevant. She was easily understood and had a fairly good command of the English language, with Chinese being her mother tongue. Ms. Ha was oriented, and her memory, attention, and concentration were adequate. These assessments were performed in a quiet and controlled environment, which did not reflect the distractions and frustrations of everyday living. Therefore, difficulties might have been underestimated.

There was no gross deficit of judgment. She appeared of average intelligence. Ms. Ha recognized that her emotional balance was shattered ever since the event of
March 4 and needed psychiatric help to improve. Nonetheless, she transmitted a sense of futility regarding being able to overcome her condition.

My opinion, within a reasonable degree of medical certainty, was that Ms. Ha was afflicted by PTSD, chronic, and major depressive disorder, moderate, chronic; and both disorders were proximately related to the traumatic episode here described.

Ms. Ha was suddenly, unexpectedly, and fiercely assaulted in the night by a man, armed with a weapon, which later on was used to injure her. She did not react with violence and was not threatening to her attacker; she was indeed cooperative. She was forced to participate in her own violation.

Because Ms. Ha is a “doer,” rather than a reflective, introspective person, she has tried to deal with the horror she was forced to endure, in the best way she knew how: by not talking about it, by hiding it, by hiding from it, and by trying to forget it. Since the stimuli were of such magnitude, it was impossible to handle, thus she succumbed to her fright. Her responses are those classically found in individuals subjected to sustained submission by force, including the threat of imminent death.

PTSD is characterized by the re-experiencing of an extremely traumatic event accompanied by symptoms of increased arousal and by avoidance of stimuli associated with the trauma. It is a psychological (including emotional) reaction to trauma: a painful, shocking experience that overwhelms our mental capacity to react in an adaptive manner to what has just happened. It is a sudden and unexpected assault to one’s sense of physical integrity and continuity, which interrupts the essence of our well-being. After the seism, people feel and behave in a manner concordant with a changed perception of life. What once seemed safe and stable, in a flash, now seems dangerous and unpredictable. One cannot take his/her safety for granted any longer, dreading new assaults. It affects personal relationships, social life, and work.

Other features of PTSD are recurrent memories, shame, insomnia, jumpiness (inability to rest), hyper-vigilance (state of being constantly on guard), avoidance of situations that remind the person of the trauma, and fear that the event will imminently happen again. We also see an initial reaction of paralysis, denial, and silence – as in this case – as an attempt to ensure safety through compliance, which paradoxically protects the assailant. There is a great sense of shame related to their loss of control over their bodies, seen also in situations involving torture and coercion. Physiological changes appear as well: less appetite, sleep disturbance, inability to relax, and inability to talk about the experience.

The diagnosis of PTSD includes the experience of serious injury. Ms. Ha performs at far less than adequate levels of functional capacity, manifesting in avoidance, hyperalertness, and uncertainty about her worth, constantly second-guessing others. There is a diminished responsiveness to the external world, referred to as “psychic numbness” or “emotional anesthesia,” usually starting soon after the traumatic event.

As in this case, the individual complains of having marked diminished interest in previously enjoyed activities and feeling detached and estranged from other people, as well as having markedly reduced ability to feel emotions, especially those associated with intimacy, tenderness, and sexuality.
As described in the documents I reviewed, and based on my examination, Ms. Ha was observed to have impaired affect modulation, dissociative symptoms (i.e., lack of recollection regarding her writing the note to her parents while captive), somatic complaints, feelings of constantly being threatened, and impaired relationships with others.

This is a woman who developed these mental disorders as a consequence of an event in which she was attacked and stabbed with a knife, by a man that, from behind her, suddenly and unexpectedly presented himself with such weapon and proceeded to dehumanize her, ending up closing her off in the trunk of her car.

As it is commonly clinically observed in people subjected to the type of extreme experience as the one afflicting Ms. Ha, the mental apparatus becomes immediately beleaguered. There is a paralysis (repeatedly described by her) of the normal psychological responses. Such a freeze (also described as “psychic numbness”) manifested itself in her using “isolation of affects” (she knew the gravity of the threat but was unable to feel accordingly) and “depersonalization” (a disturbance in the sense of self, experienced as a feeling of unfamiliarity in regard to one’s own body or of its parts). It is a feeling of unreality or strangeness concerning the self and the environment, as in her description of her mind becoming blank, being unable to feel or say anything, and being unable to act in any way other than as a prey.

Ms. Ha’s relating style was dramatically and permanently altered, as if under a spell cast by this larger male, assaulting her from behind; holding a knife on this petite, defenseless woman; and rendering her resourceless over a prolonged period of time while continuing to victimize her, with verbal threats. She is now continually resourceless, always “hiding,” as if constantly subjected to imminent devastating attacks. Ms. Ha’s functioning deteriorated on all levels: personally, socially, and occupationally.

Both of her treating mental health professionals described this woman as impaired and as functioning haphazardly and at a markedly impoverished level, compared with her premorbid level of functioning.

Ms. Ha suffers from major depressive disorder, chronic. Her mood is depressed most of the day, nearly every day; there is a markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day; there is loss of appetite and subsequent weight loss; her sleep is disturbed; there is psychomotor retardation, fatigue, and loss of energy; there are feelings of worthlessness and guilt, as well as indecisiveness. All these symptoms cause clinically significant distress and impairment in her personal, social, and occupational life.

Consistently throughout the records I reviewed and my direct observation of this subject, I found in her an overall sense to minimize her plight, rather than to maximize her affliction.

Ms. Ha has always been a proactive woman. Characterological aspects (her responsive style) molded her to plan ahead and then to execute according to those plans and the foreseeable outcomes. She had been quite skillful in the past to deal with the expected stresses of life in a solid and independent manner. Her sense of internal well-being and stability came mainly from knowing that the external world was predictable and stable.
Many of her psychological solutions to the traumatic event are not adaptive. Ms. Ha has thus far been unable to “absorb” the psychiatric treatment that would help her to be less reactive and more reflective.

Ms. Ha had a basically positive, action-oriented personality, with good solid values, realistic expectations, and future goals. All this has changed now. This condition is permanent. The modest clinical improvement described reflects a poor prognosis. The course is chronic and may wax and wane in intensity. Most often, exacerbation occurs in association with actual or perceived stressful events. Her symptomatology has evolved into a permanent mark in her personality. This traumatic experience, even if treated properly, will leave her vulnerable to stress decompensation in the future.

I recommend that Ms. Ha undergo psychiatric treatment, combining psychiatric medications and supportive, expressive, and rational-emotive behavioral modalities of psychotherapy, aimed at helping her develop new and adaptive mechanisms to the trauma and thus also improving her major depressive disorder. Such treatment should be conducted on a twice-weekly visit, with periodic medication management visits.

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**Case 6f: Opposing Forensic Expert Opinion – Physical Assault (Robbery-Kidnapping)**

Dr. Gill filed a report, called “neuropsychiatric evaluation.” He describes the events, according to Ms. Ha’s narration. He added that approximately 6 months after the assault Ms. Ha “got a new job as a receptionist, which she has at the present time.”

Dr. Gill quoted Ms. Ha, “There was this black guy in the lobby. I didn’t think anything about it. I thought maybe he was just talking on the intercom to a friend. I took out my key; I got my mail and went into the apartment building. He came in with me and got on the elevator with me. I really didn’t think much about it. Suddenly as he went up in the elevator, he put a knife to my throat and my chest. He wanted money. I really didn’t have any. Took me downstairs and out of the building into the parking lot to my car and put me in the trunk. Then he drove around, and I could hear that he had other people in the car, so he was with his friends. I could smell pot. He drove around for about 3 h. Then he parked the car, and he left... he scratched my left eye, and I had a cut on the left side of my face, but that got better and it healed... I took time off from work, but they couldn’t give me any more time, so I quit the job.”

Dr. Gill found out that her parents encouraged her to see a therapist because, “I was staying home a lot, and I was having trouble sleeping. I was afraid that I would be assaulted again.” Dr. Gill states in his report that Ms. Ha told him that all her symptoms improved with time and with treatment. Dr. Gill reviewed the clinical notes of Ms. Ha’s psychiatrist, indicating that she was “not improving from her fears; she remained withdrawn and isolated, hypersensitive, afraid of going into a car and elevator.” This examiner also noted that the diagnosis for which she was
treated was PTSD, chronic. Ms. Ha told Dr. Gill, “I was afraid of being assaulted again; I was staying home a lot, and I was having trouble sleeping.”

Dr. Gill noted that Ms. Ha was currently in treatment, taking medications and receiving psychotherapy, and that her symptoms improved as a result of this ongoing methods; he adds, “Her anxiety and depression are improved with venlafaxine… still complains that it is difficult to make friends, and has occasional stomach cramps… she felt, at first, incompetent because she wasn’t dealing with the situation better; that her life was empty; she had nightmares; felt useless and like a nobody; she was no longer dating.”

Dr. Gill found her mental status totally unremarkable. He described her speech as, “She was talkative with a good level of spontaneous, expressive speech... her tone of voice was lively. She did not sound depressed.” Dr. Gill did not find any level of psychomotor retardation, just that “Ms. Ha was quiet.” Her mood and affect were described as “appropriate and stable,” and he found no signs or symptoms of PTSD. He added that she did not complain of anticipation of misfortune to self or others. He added, “She did not appear to be at all socially withdrawn.”

Dr. Gill was of the opinion that Ms. Ha had no diagnosis on Axis I (major psychiatric diagnosis) and only found on Axis IV (psychosocial and environmental contributors), as current stressors, “Lives alone in the United States, having family in China, not support system and an immigrant status.”

Dr. Gill stated, “There was no particular emotional display when she was describing the incident in question... There are no signs of functional loss secondary to any Neuro-psychiatric illness.” He was of the opinion that Ms. Ha did not need psychiatric treatment, since “maximal medical benefits had already been reached.” Nonetheless he thought that Ms. Ha could benefit from psychotherapy, “in terms of adjusting to living in this country by herself with no support system, and with her family entirely in China.”

Dr. Gill recognized that Ms. Ha was under stress. He nonetheless attributed such stress, without objective findings, to her state of emotional tension due to her living in the United States without her parents and brother (something she had been doing for 9 years) and not to the more recent, extreme, and overwhelming experience of being assaulted at knife point and then tortured for a sustained period of time.

Dr. Gill concluded that Ms. Ha needed psychiatric treatment but to help her deal with her living in this country (something of her choice and her liking) rather than to being brutally attacked.

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**Case 6g: Personality Change – Animal Bite by a Cockroach**

The attorney requested that I conduct an IME on his client, Tim, a mildly mentally handicapped, 13-year-old boy, with a history of developmental delay, ADHD, neuromuscular abnormalities, and in special education. The attorney questioned if Tim had been psychologically afflicted by the cockroach infestation of his residence, particularly in reference to the insects creeping into his body. The question presented to me was whether this child with mental disabilities had the capacity to react
“normally” to what happened to him living under the conditions described and its aftermath.

In preparation for the examination, I reviewed Tim’s (then 7 years old) neurodevelopmental evaluation; pediatrician’s medical records; pediatric ENT (ear, nose, and throat) clinic reports starting when Tim was 6 years old; operative reports at the age of 7 (thrice operated on), 8, and 10; two other doctors’ (ENT) reports; mom’s and Tim’s depositions; and “plaintiff’s answers to interrogatories.”

I first met with his mother, then with Tim alone, and finally with the two together in my examining room. Tim lived with his mother and two half brothers (8 and 13 years his senior) in a roach-infested apartment. When he was 6 years old, “one large roach and three baby roaches were removed from his left ear.” Appropriate medical treatment was provided. Two weeks later, when another cockroach lodged in the same ear, more treatment ensued; this time eggs were also extracted from that ear. Moreover, this ear was found to be infected, and it developed into a chronic condition with severe purulent otorrhoea discharge from the ear, and eventually structural damage resulted. Pain was significant, and “foul-smelling otorrhoea” was also described as “disturbing” to Tim. Tim’s mom mentioned that the doctor placed the insects and eggs on the gauze and showed them to her. Tim had to undergo 21 days of intravenous antibiotic treatment as an attempt to prevent and then to treat the infection in the bone. Tim had to protect the ear from water coming in when showering or bathing. In school he had to sit at a specific place to favor the ear he could still use, to help deal with what was diagnosed as a left conductive hearing loss.

During the next 5 years, Tim underwent five surgical interventions, including structural reconstruction and prosthetic implants to repair anatomical damage in the left internal ear. He was recommended to submit to yet another operation, which he did not want to accept but would not refuse if pressed to submit to the intervention.

During his deposition, Tim mentioned “Cockroaches went in my ear, this one, left one.” Later, he described screaming in pain because of this. Tim told the deposing attorney that he had “A lot (of cockroaches) in my ear” and “bad dreams, about cockroaches, a lot.”

Tim was born at 29 weeks (out of 40-week full-term birth) of gestation; his birth weight was 1 lb 15.5 oz. Many difficulties had to be overcome to eventually discharge him from the hospital, 2 months after birth. Developmental delay ensued. When he was 4 years old, a speech evaluation was requested. ADHD was also diagnosed, and Tim was doing well with dextroamphetamine (central nervous system stimulant). He also received physical therapy. At 6 years of age, he displayed an abnormal gate and was not yet toilet trained. When Tim was 7 months old, he underwent eye surgery to correct bilateral esotropia with good result. His developmental history was positive for an overall delay in gross and fine motor skills. His dexterity was overall compromised. There was also a significant speech delay, but his hearing was found to be normal. His attention span was short; he was highly distractible and very active, but not disruptive or aggressive, with normal
frustration threshold. His diagnosis was “multi-handicapped child, with global delay in onset of language; gross/fine motor skills and cognition; ADHD; and questionable mild cerebral palsy.”

At first, Tim’s mom described her son constantly talking about the occurrences to his brothers and neighbors, as well as about the doctors’ procedures, and having seen the insects on the gauze. At night his sleep was fretful, tossing and turning and waking up with a jump. Eventually Tim would repeatedly ask his mom to insert cotton balls in his ears to prevent cockroaches from crawling into them. To this original and repetitive intrusion, Tim had to endure the medical and surgical treatments, consisting on more invasions into his body. His hearing loss further decreased his chances to learn in school.

The emphasis was on structural reparation of the damage ear, overlooking, on the part of all physicians, the psychological damage these terrifying, painful, and disgusting intrusions caused in Tim. Mother is now hyperalert in looking for one to immediately destroy. Tim is particularly afraid of a roach on the wall, lest it jump on him.

Tim was able to correctly spell his lengthy and complicated last name, as well as his age and phone number. He was able to adequately communicate with me and was aware of the problem and of “The cockroaches… they went in my ear. The doctor had to take them out... I had to call my mother to kill the cockroach... I’m afraid they’ll jump on me... can I ask you a question? The doctors that operated on me... I don’t want another. I’m afraid of it... the anesthesia. I feel like throwing up a lot of stuff... they are six already... I had five operations. I don’t want that... I’m disgusted... I was like 10 years old; it happened years ago... my mother put cotton in my ear too, so they won’t go in my ear... I felt sad, angry, mean... I don’t like them that much... I think they are going to run away from me, because I don’t want them to go in my ear... I don’t want to have another operation, the sixth one already.” All the while, Tim squirmed in the chair while relating the incidents of animal and medical “intrusions.”

Tim added, “In the past I was afraid of the cockroaches, but not now. Whenever I see a cockroach I call my mother to kill it, because I’m afraid it would jump in my ear.” This response was exclusively felt toward cockroaches and not any other insect. Tim was often spraying the kitchen, even though there was no roach to be found. At other times, his mother would smell the roach spray, indicating that he had sprayed the room. In bed, he would often shake the pillow and sheets before resting.

Tim appeared to be a truthful and accurate historian, within the limits of his mental capacity to process data and temporal sequence of events. He did not appear to fabricate any of his history. He did not appear accusatory but instead quite involved, obsessed even, with the reverberations of the tragedy he was forced to withstand. He was still affected by it.

It is perfectly reasonable for anyone to squirm while imagining these events happening. Can a “mentally handicapped” child go through the same psychological upheaval? Can these events significantly obstruct his psychological progress?
careful scrutiny, I was able to expose the elements required to establish that chronic PTSD did exist, evolving in a self-defeating attitude in this child, perceiving the surgical interventions as new editions of unwanted and painful invasions into his body (through the same ear). He had to endure new traumatization, by lying down and withstanding such intrusions. Once the child’s baseline level of functioning and mental capacity to appreciate reality and perceive his environmental stimuli accurately is established, the deviations from his baseline can be noted and qualified according to a psychiatric diagnosis of PTSD.
Definitions and Explanations

**ADA**

Americans with Disabilities Act; federal civil rights legislation that prohibits disability-based discrimination related to employment, public services, public accommodations, and telecommunications.

**Cognitive behavioral therapy**

A form of psychotherapy focused on changing thoughts and behaviors that are related to specific target symptoms, aiming at symptom reduction and improved functioning (American Psychiatric Glossary, 8th Edition, American Psychiatric Publishing Inc.).

**Dysthymic disorder**

One of the depressive disorders, with a chronic course of at least 2 years of sad mood, low self-esteem, brooding about past events, and low interest and energy level, without reaching the scope and intensity found in major depressive disorder (somatic symptoms and recurrent thoughts of death) (DSM-IV-TR, American Psychiatric Association).
Mental impairment  A limitation in functioning due to a mental disability (Handbook on Mental Disability Law – American Bar Association).

Obsessive-compulsive disorder  An anxiety disorder characterized by obsessions, compulsions, or both that are time-consuming and distressing or interfere significantly with normal routine, occupational functioning, usual social activities, or relationships with others (American Psychiatric Glossary, 8th Edition, American Psychiatric Publishing Inc.).

Competency and Disability

A psychiatric ability or disability to function in an occupation is one of the many aspects of “fitness for duty” or “competency” evaluations. It is a determination that falls in between the clinical and legal ability to perform an action. In this particular chapter, it relates to one’s capacity to perform at work. Competence is a legal term that means legally qualified. “Psychiatric disability” refers to the state of being not fully capable of performing all mental functions required of a specific occupation, due to mental disease or defect.

With the enactment of the Americans with Disabilities Act (ADA) in 1990, “mental disability” is defined as a mental impairment that substantially (a) limits one or more of the person’s major life activities, (b) records existence of such an impairment, or (c) being regarded as having such an impairment (covering present, past, and perceived impairments).

We need to have two criteria met in order to be able to carry out the task: (1) knowledge of symptoms and signs of mental disorders, including their severity or intensity, the scope or extent of the compromised areas of functioning, and (2) how they specifically affect employability, partially or totally, and if temporarily or permanently.

Taking the time to be thorough in reviewing the many records the MHP is provided with gives the chance to cross-reference and see if the information matches. A typical point to begin with is understanding the claimant’s job description.

Case 7a: Claim of Mental Disability to Function as an Accountant

An insurance company requested an IME to assess Mr. Todd’s mental state concerning his disability claim. I was asked to assess his diagnosis, if any, his capacity to work, and his need for special accommodations. I was asked to evaluate the appropriateness of the current treatment and whether a better treatment was necessary concerning Mr. Todd’s return to full or part-time work. I was also asked to comment on his reported inability to perform his pre-disability work activities on a part-time basis.
Mr. Todd’s basis for his disability was that he could not perform in a stressful workplace. He had been in psychotherapy for 8 years, since he was confirmed “disabled” for OCD and dysthymic disorder with “obsessive ruminations and depression.” He had been seeing a psychiatrist for 11 years, for the diagnoses of obsessive-compulsive disorder, major depressive disorder, and generalized anxiety disorder. All the clinical reports determined that Mr. Todd was not any better and that he was not able to work, despite the different approaches offered to him: clomipramine, fluvoxamine (anti-OCD), bupropion (antidepressant), CBT, and the like. It was reported, “the symptoms gradually worsened despite intensive psychiatric and psychological treatment.”

Before his disability, Mr. Todd had been successfully working as a business consultant for large companies. There was a report of alcohol and cocaine use post-disability. He would interrupt the psychiatric medications when ingesting these “other” substances. Therapy notes would read, “Continues suffering from the rigidity imposed by OCD… has great difficulty reading… he comes across as narcissistic and grandiose… increasingly depressed and highly anxious… his ability to focus and concentrate is extremely compromised and minimal… it takes the patient several hours to read a small section of the newspaper due to a loose focus on details and repetitive reading of the same information over and over again without benefit of comprehension.” The psychologist described this self-report as evidence of impairment, “The patient presents with a classic symptom picture.” On the other hand, Mr. Todd was able to consult with a legal advisor about financial matters.

Mr. Todd emphasized that he had problems concentrating, focusing, and retaining the information that he read and also that he felt fatigued and a general feeling of tiredness. According to the records, he spent the day relaxing and reading the newspaper, as well as exercising 3 days a week. He visited the local library 3 days a week to learn more about his illness. He stopped by his office three times per week to collect his mail and messages. At home, he watched TV, his appetite was normal, and he played with his children.

The claimant typewrote a two-page letter to the disability company claim specialist, describing feelings of severe anxiety and depression due to having lost a new job, with similar duties. He said that he had trouble meeting assigned deadlines and understanding guidelines. He added that he experienced overwhelming anxiety almost from the start of a new job he took after his disability was agreed on. Lastly, Mr. Todd asked in his letter, “If my claim is considered re-opened, will it result in my pre-disability income being indexed for inflation which I believe occurs late spring each year?”

Mr. Todd met with me for an uninterrupted 3.75 h. He arrived on time, after driving for more than 1 h to my office. He read through a two-page “consent form” and showed understanding of the information in it without any difficulty or assistance. Sometime later, he told me, “I have difficulty reading and retaining… comprehending… I read something and feel I don’t understand what I’m reading… maybe part of my OCD… I need to read slowly and over… a very high percentage of the time… the more anxious I am, the worse it is… these
medications help me… but I took methylphenidate more than it was prescribed… it made me feel good… more energy.”

He was quite skillful in educating me about the convoluted accounting aspects of his work, his disability income, and the calculation concerning his present income. Mr. Todd explained to me how his disability payment was scheduled and the insurance company’s incentive program for him to go back to work. He also talked about a business venture that failed because of the unscrupulous behavior of the boss. He was quite bitter about it and emphasized that others also saw his boss as “dangerous.” Contrary to Mr. Todd’s portrayal, his psychotherapist wrote to the insurance company that Mr. Todd lost his job because of being psychiatically impaired.

The claimant told me that his children and friends did not presently know that he was disabled or that he was ill. “I view it as a weakness… there is a stigma attached to having a mental illness.” His children thought that he worked from home. “My wife didn’t understand my disability… she had tremendous difficulty in understanding my illness.”

At first, Mr. Todd denied any problems with illegal substances, but then he turned pensive, his voice was low, and his speech was slow. He disclosed, “I apologize… I stand corrected… let me see… mid ‘90s… I started using cocaine… which I ended in ’97… maybe for a couple of years… I wasn’t happy… I tried it once in college… I thought it was a stupid drug… in the ‘90s a friend had it… my wife wasn’t really happy… but it didn’t contribute to our troubled relationship… I stopped it because my wife asked me to… all the doctors knew about it.”

The psychiatric evaluation of Mr. Todd, which included the analysis of the psychiatric and psychotherapeutic records (cited in the report), and the direct examination, did not reveal an incapacitating psychiatric condition. The claimant did not show the objective signs of depression such as furrowed brow, sad face, or slowing of speech or movement. There was no depressed mood described most of the day, and no marked diminished interest or pleasure in his daily present and future activities was reported.

He was actively involved in planning to immediately start a vocational rehabilitation program at a local university and begin participating in his children’s extracurricular activities. Mr. Todd was willing and able to handle the family finances. Moreover, he was also competent in keeping up with their standard of living, despite not going to work. His children, friends, and even neighbors had no inkling that he received disability income or that he suffered from any psychiatric illness.

Despite his stating that he was unable to focus, the letters he wrote to the insurance company’s adjuster were lucid, cogent, focused, and evidencing good and sustained ability to concentrate, containing relevant information and showing no indication of cognitive decline. These letters eloquently illustrated his intact cognitive functions.

There were no feelings of worthlessness reported. At no time did the examinee describe feeling weak, vulnerable, desperate, or destitute. No diminished ability to think, recall, or concentrate was found. He was not indecisive. There were no
cognitive deficits of any type found throughout the entire examination period. Likewise, the neuropsychologist found no abnormality in the testing performed.

It was my opinion that Mr. Todd did not suffer from generalized anxiety disorder. Without appropriate medication, he was able to move about the day without experiencing excessive anxiety and worry. There were no keyed up feelings, by history, or in my presence; he was not fatigued in my office, in spite of our meeting taking place early in the morning, after some 80-min drive; he was not irritable; his mind did not go blank at any point during our meeting; he appeared relaxed during the entire time the meeting lasted.

It was my opinion that the insured did not evidence clinical signs of obsessive-compulsive disorder. His affective tone was different from the hesitant and demurred stance that we clinically observe in individuals afflicted by this condition; in fact, he evidenced quite the opposite relating style: expansive, engaging, witty, and vivacious.

Mr. Todd’s propensity to use mind-altering substances also goes against a diagnosis of obsessive-compulsive disorder. This need of his describes him as an individual that seeks to gratify his impulses to look for pleasure, rather than suffering from uncontrollable thoughts of using these substances or using them to control these obsessive thoughts.

Mr. Todd was a great storyteller: entertaining, vivid, engaging, fluid, expansive, being quite comfortable, calm, and collected while talking about innumerable topics, regardless of emotional ease, pain, or embarrassment. He did not evidence the stilted and worried speech seen in patients suffering from severe and disabling forms of obsessive-compulsive disorder.

Mr. Todd was able to joke, “schmooze,” chuckle, giggle, smile, and bring to our meeting many touches of a good sense of humor that permeated throughout. He was well connected with me and the world. He also was in control of his decisions, able to avail himself of expert advice in the conduction of his financial and business matters. His life style did not change, despite the gloom he reported.

In his last job, which failed after 4 months, he felt quite comfortable working under stress in the same business. He noted, “I work my ass off… I was getting in the office at 7:30 A.M. and getting home at 10:00 P.M…. and then I kept doing more work at home.” Mr. Todd depicts a considerable source of stress such as marital strife, financial hardship, and hiding his disability, which he endures and deals with on a daily basis.

In spite of being described as severely psychologically fragile by his mental health professionals, Mr. Todd is able to struggle alone at home and took to the challenge of the mentally demanding neuropsychological testing, as well as the lengthy meeting with me.

The description of his suffering was not consistent with any recognized major psychiatric disorder or disabling clinical pattern. This is a man suffering from a personality disorder that causes him some distress, and, from time to time, curtails his ability to enjoy his life. I do not see this individual as mentally disabled. It seemed clear that Mr. Todd wanted to maintain and extend the present disability determination, in spite of it not being warranted.
Case 7a: Opposing Forensic Expert Opinion – Claim of Mental Disability to Function as an Accountant

Mr. Todd was referred for neuropsychological IME with the diagnoses: depression, anxiety, and OCD. The examiner was told that Mr. Todd was currently taking escitalopram 20 mg/d and clonazepam 2 mg/p.r.n.

The examiner collected information about the insured’s work activities. He reported becoming increasingly depressed and anxious and with obsessive tendencies and was then unable to work. He added that he was not able to concentrate, make decisions, and “just dealing with people.” He was presently trying to regain total disability benefits and a waiver of his monthly premium.

Mr. Todd provided the examiner with pertinent history. He started seeing a psychiatrist roughly 10 years prior for symptoms of chronic depression, anxiety, and obsessive tendencies. The claimant said, “The symptoms gradually worsened despite intensive psychiatric and psychological treatment.”

The examiner read in the records that the insured was afflicted with “cocaine dependency” even though Mr. Todd denied it. He was also dependent on OxyContin prescribed for lumbar pain relief.

Mr. Todd told the examiner that he could not perform in a stressful workplace. He reported to the neuropsychologist that his reading ability was impaired, that his attention and concentration was reduced, and that he had “marginal decision making and difficulty sequencing events.” He denied compulsiveness and that he only obsessed while emphasizing being depressed.

The examiner covered his medical history, including “chronic anxiety which began sometime in late adolescence”, to which Mr. Todd explained, “I dealt with it.” Mr. Todd graduated from State College with a BA degree in business. He worked in the same field for 22 years. He denied current marital discord and appeared to be in no acute distress.

The claimant was able to establish rapport, and his eye contact was good. He was articulate and an excellent historian, and his memory and orientation were intact. He reported subtle neurovegetative depressive symptoms such as dysphoria, generalized fatigue, and diminished libido. Problem-solving abilities and test-taking rate were grossly intact.

Mr. Todd was referred to, by the examiner, as patient and was found to be accurate, valid, and reliable in his responses. His General Memory Index and Basic Academic Skills Quotient were well within the high average range. His evaluation read, “The neuro-psychological evaluation is essentially unremarkable for neuropsychological alterations.”

The results of the testing showed “normal cognitive processes… Mr. Todd remains independent in all activities of daily living (ADL). He has been able to reside home, operate an automobile, manage daily and monthly finances, parent his children, and socialize with family and friends.”

The examiner also mentioned that Mr. Todd evidenced “agitated depression, anxiety, somatic preoccupation, and unusual thought processes… his response to questions concerning depression are well within the severe ranges of depressive
symptomatology. He was found to have psychasthenia (slow mentation), schizophrenia, and social introversion." 

Because the claimant had not been working for long, the examiner opined that his overall prognosis was guarded. The neuropsychologist did not find Mr. Todd suffering from signs of any psychiatric disorder. GAF (Axis V): 60–65 (some mild symptoms, or some difficulty in occupational functioning, but generally functioning pretty well). “From a pure neurocognitive perspective, there are no work-related restrictions/limitations.”

The examiner then determined that the current treatment appears appropriate and that the medical documentation is consistent with the insured’s reports.

Case 7b: Claim of Onset of Psychiatric Disability During Military Service

According to the DSM-IV-TR, bipolar disorder is characterized by “manic episodes, which are distinct episodes of persistent elevated, expansive, or irritable mood.” It must last for at least 4 days. During this period, the person must present with three or more of the following symptoms to a significant degree:

1. Inflated self-esteem of grandiosity
2. More talkative than usual or pressured speech
3. Decreased need for sleep
4. Subjective experience that thoughts are racing
5. Distractibility
6. Psychomotor agitation
7. Excessive involvement in pleasurable activities that have a high potential for painful consequences (such as unrestrained buying sprees, sexual indiscretions, or foolish business investments)

The episode must cause changes in functioning that are uncharacteristic of the person when not symptomatic. The change must be observable by others.

Manic episodes can be distinguished from hypomanic episodes since they are not severe enough to cause significant impairment in social or occupational functioning or to necessitate hospitalization. There must also not be psychotic features.

A mixed episode is one where the criteria for both a manic and a major depressive episode are met nearly every day during at least a 1-week period. The mood disturbance is severe enough to cause marked impairment in occupational or social functioning.

A mood destabilizer is any environmental factor that disrupts the balance of mood. It may worsen the illness. In 95% of bipolar manic patients, the age of onset is before 25. The age of onset peaks at 18 in men. Violence often occurs during manic/hypomanic periods. It is also possible for recognition of the illness to take years. Substance abuse can worsen the disease and interfere with the diagnosis.
Mr. Thompson (pro se) contacted me asking to study and render an expert opinion about the following psychiatric-legal issue: “Is it as likely as it is not that the acquired psychiatric condition Bipolar Disorder [of Mr. Thompson] had its onset during the active Military Service?” The burden of proof expected in this arena was 50%. This case was to be presented to a veteran administration medical review board. He provided me with a brief account of the issue and requested that I review medical and military records and then examine him and members of his family.

I determined that it was at least as likely as it was not that the acquired psychiatric condition bipolar disorder of Mr. Thompson had its onset during active military service between the years of 1962 and 1964.

I analyzed the academic, military, and medical (psychiatric) records made available to me. These documents cover a span from 1956 to the present and grant me access to the clinical observations of the onset of the bipolar disorder and the many descriptions depicting the progression of this disease. I also spent time interviewing both Mr. Thompson and his wife, first separately, and then jointly.

Records preceding his military service portrayed him as a well-adjusted individual, who was honorable, scholarly, conscientious, courageous, and responsible. Despite having grown up in a conflicted household, Mr. Thompson presented as an unscathed student who received awards, commendations, and leadership roles. He began using alcohol during high school, but this did not hamper his performance. During college he felt great pressure from his family to become a dentist. However, that profession did not inspire him, as he preferred to spend time with nature. His alcohol use was still present at this time.

Influenced by an older cousin, Mr. Thompson joined the military after college. Mr. Thompson completed his preflight training with above average qualifications. His motivation did not fade, but his psychological abilities gave way when he became more afflicted with a psychiatric condition, recognized years later, as bipolar disorder.

The disturbance in mood that is characterized by bipolar disorder, either as mania or depression, must be observable by others. In this case the impairment was not severe enough to necessitate hospitalization; failed training and transfer to less stressful activities became the hallmark, instead. While in the military, his incipient psychiatric features were misinterpreted as academic failure, incompetence, and irresponsibility. His symptoms were not due to substance use and would have presented regardless of alcohol use.

Mr. Thompson’s previous diagnosis of dysthymic disorder was mistaken since it explicitly excludes manic, hypomanic, or mixed episodes. The descriptions provided by his wife (whom he met some months after his military service ended), his brother, and the records provided all confirmed this behavior.

Mr. Thompson was not aware that he was suffering from a psychiatric illness. His thoughts were racing, his sleep was disturbed and non-restorative, and his capacity to concentrate and be attentive was compromised. He used alcohol in an attempt to self-medicate and make his emotional pain bearable.

His mind-set abruptly changed between May and June of 1963. He was no longer able to comply and to be reasonable, studious, or responsible. Manic symptoms had
taken over his functioning and disabled him. As expected of a person experiencing this disorder and clear example of the symptomatology of a manic episode of bipolar disorder, Mr. Thompson bought an expensive sports car that was way beyond his financial means.

During the downswing of the illness, Mr. Thompson was able to produce again, but at a lower level. Without treatment, these periods of euthymia (calmness or even mood) in which he could be productive were short lived. During his stint in the military, Mr. Thompson was transferred several times, resulting in both promotion and demotion, and he was both commended and criticized for his performance.

The description persisted, almost unaltered throughout the years. Alcohol use had no effect on it. Mr. Thompson’s behavior only changed once specific treatment started with medications (mood stabilizers).

During my review of the records I noticed that Mr. Thompson suffered from irritability, suspiciousness, depression, despair, suicidal ideation, and restlessness. All of these symptoms of bipolar disorder, mixed episodes, were recognized by his doctor but wrongly attributed to alcohol use. In 1976, 12 years after his military service, he was hospitalized for assault, which is a well-established feature of untreated bipolar disorder.

A doctor accurately diagnosed Mr. Thompson as suffering from bipolar disorder and alcoholism. However, he did not treat Mr. Thompson for bipolar disorder, focusing only on his alcoholism. He did not offer a mood stabilizer, which in those days was lithium carbonate. Today his clinical presentation is unequivocally diagnosed as bipolar disorder by many psychiatrists that examined and treated him.

**Case 7c: Claim of Spinal Damage and Treatment-Resistant Skin Ulcer**

**Psychiatric disorders to consider:**

*Dysthymic Disorder* – a depressive disorder characterized by a chronic course of at least 2 years duration (seldom without symptoms) with depressive mood and a range of other symptoms that may include feelings of inadequacy; loss of self-esteem, or self-deprecation; feeling of hopelessness or despair; feelings of guilt, brooding about past events or self-pity; low energy and chronic tiredness; being less active or talkative than usual; poor concentration and indecisiveness; and inabilities to enjoy pleasurable activities.

*Borderline Personality Disorder* – characterized by instability of interpersonal relationships, self-image, affects, and control over impulses. Manifestations may include frantic efforts to avoid real or imagined abandonment, unstable and intense relationships that alternate between extremes of idealization and devaluation, repetitive self-mutilation or suicide threats, and inappropriate, intense, or uncontrolled anger.

*Major Depressive Disorder (MDD)* – occurs in a person who has never had an episode of mania and is characterized by significant lowering of the mood and loss
of interest or pleasure in daily activities, plus a range of other symptoms that include significant weight or appetite changes, insomnia or hypersomnia, psychomotor agitation or retardation, fatigue or loss of energy, feelings of worthlessness or excessive and inappropriate guilt, diminished ability to think or concentrate, indecisiveness, and recurrent thoughts of death or suicide. Some patients have only a single episode, whereas others have recurrent episodes of depression.

Conversion Disorder – a somatoform disorder, characterized by a symptom suggestive of a neurological disorder that affects sensation or voluntary major function. The symptom is not consciously or intentionally produced, cannot be explained fully by any known general medical condition, and is severe enough to impair functioning or require medical attention. Commonly seen symptoms are blindness, double vision, deafness, impaired coordination, paralysis, and seizures.

Malingering – 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.

Factitious Disorder – characterized by physical or psychological symptoms that are intentionally feigned or produced in order to assume the sick role. There must be direct evidence as well as no other causes of the symptom to support that it is being intentionally produced. There are no clear external incentives (e.g., financial) to assume the sick role in factious disorder.

Many individuals with factitious disorder have worked in occupations that familiarize them with medical ailments, e.g., nurse, health aide, or EMT (emergency medical technicians). The presence of the following factors may raise the possibility that the illness is factitious: dramatic or atypical presentation; vague and inconsistent details, although possibly plausible on the surface; long medical record with multiple admissions; acceptance, with equanimity, of the discomfort and risk of diagnostic procedures and even surgery; substance abuse, especially of prescribed analgesics and sedatives; and controlling, hostile, angry, or disruptive attitudes and behaviors.

Factious disorder may present in many ways: fabricating complaints, falsifying objective signs, self-inflicting conditions, exaggerating or exacerbating preexisting medical conditions, or any combination of the above.

There is a fluctuating clinical course, including rapid development of complications or a new pathology if the initial workup findings prove negative. A suspicion of factitious disorder is raised when the patient has evidence of self-induced physical signs, a healing wound that keeps reversing the “getting better” process. The mental status examination showed the typical features of factitious disorder: an attitude that started being cooperative with assessment to frank evasiveness regarding details. Mood and affect may be brighter than what would be expected given the patient’s medical state.
Questions to consider:

– Is Mrs. Wayne suffering from major depressive disorder and in need of the medicines being prescribed to her? Is it possible that Mrs. Wayne’s “elusive” physical ailments are linked to an underlying mental disorder?

I was asked to evaluate Mrs. Wayne in accordance to her disability claim and the relevance between that claim and her mental status. Mrs. Wayne was a slender 40-year-old woman who had sustained a lower back injury 6 years earlier while working in a nursing home. Mrs. Wayne had seen mental health professionals for nearly 20 years, and in almost every situation, a different diagnosis was reached, and a different medicine was prescribed.

Psychiatric records indicated that Mrs. Wayne attempted suicide as a teenager three times. At 19 years old, Mrs. Wayne was found by her therapist to be depressed and irritable, with loss of appetite and self-destructive tendencies. At this time she was diagnosed with dysthymic disorder. When new symptoms surfaced, the claimant sought help from a new physician. This attempt at a psychiatric and psychotherapeutic treatment lasted 11 years. Mrs. Wayne had been involved in an abusive relationship since she was 20, which mirrored her relationship with her sexually and physically abusive father. At around this time, she was also diagnosed with borderline personality disorder.

Eight years later, the claimant was diagnosed with major depressive disorder with panic attacks, on top of her two existing diagnoses. She tried many antidepressants but did not stick to any since she developed physical side effects; she was unable to tolerate while on each of them. These problems did not necessarily have a known association with the medication.

In 1992, Mrs. Wayne sustained a back-related injury at the nursing home where she worked, while lifting a patient. She was recommended 2 weeks of bed rest. This event did not cause her depression to worsen, contrary to what was expected. Three months later, the insured’s therapist recorded that Mrs. Wayne “needed anger management.” She told her client to cease all antidepressant medication since her depression was in remission.

A year and a half later, venlafaxine (antidepressant) was prescribed to her. She was later put on a mild sedative, lorazepam. While on both of these prescriptions, she developed recurrent bulimic symptoms. Her life was up and down for the next 3 years. She had several miscarriages and confronted her parents about her less than adequate upbringing. After her marriage, she stopped taking medication because she started complaining about adverse effects. The next month, mirtazapine (antidepressant) was prescribed.

Conversion disorder became a possibility once she claimed to have bowel and bladder problems along with no use of her right leg. Typically, no physical explanations for these occurrences were available, so a psychiatric IME was conducted.

I met with Mrs. Wayne in 2004. She had been in the hospital for 6 months due to a skin infection in her left hip that had persisted for the past year. It was related to a
spinal cord stimulator that had been inserted. Mrs. Wayne was lying on her right side due to this infection. She explained, “A skin graft keeps opening and being infected.”

Mrs. Wayne informed me of her many afflictions. She mentioned surgery related to the spinal cord stimulator, as well as paralysis and sensory loss on her right side. She also explained that she has a total lack of motor capacity on her right side, little movement on the left, and a tremor in her left hand.

She told me that despite all of this, she did not feel hopeless. She was able to do chores around the house and had aspirations of learning how to drive her modified car. She was planning on using leg splints to help her walk, which she was able to do with the help of a cane until 2004.

When questioned about previous surgeries, Mrs. Wayne stated she only ever had surgery on her back. She seemed surprised when I questioned her about a surgery related to a dog bite she had experienced a few years back. She later admitted to an appendectomy as well. She also denied any suicide attempts or trouble with eating disorders.

I can conclude with a reasonable degree of probability that Mrs. Wayne was not suffering from MDD. She did not show objective signs of depression, such as furrowed brow, sad face, or slowing of speech or movement. She was not fatigued or inattentive, nor did she make mention of it on a day-to-day basis. There were no feelings of worthlessness reported, in fact, that she took pride in her home activities.

Mrs. Wayne was suffering from factitious disorder. Mrs. Wayne displayed a bad-tempered, if confronted, and evasive manner and provided a dramatic medical history of questionable veracity. Many patients with this disorder actually induce medical conditions, such as the dermatological one this patient presented. As with many patients with factitious disorder, Mrs. Wayne has worked in occupations that familiarize one with medical ailments.

Her mental status examination showed the typical features of factitious disorder, as described above.

This is a woman who endured severe early-life traumas and as a consequence strong underlying masochistic needs, as seen in her repetitive harmful relationships one after another. This is her regressive way of handling her current highly conflictive marital life, in which she briefly sees her husband; he cares for her, and then goes home; and she sleeps in her own bed, alone, while protected by “caring” authorities. This disorder also is more prominent in individuals with borderline personality disorder, as is Mrs. Wayne’s case.

Since Mrs. Wayne does not want to avail herself of the proper psychiatric treatment to address this serious condition, it stands to reason that she will continue using medical resources to satisfy psychiatric (ill) needs to remain physically damaged. The claimant’s factitious disorder was not a direct result of her reported work-related accident.

Her psychiatric ailment, with all the components that are described since 1993, predated her work-related accident.

I suggested appraising her husband, and, to the extent possible, involve him in the psychiatric approach to be taken. I also recommended a clinical case conference to help the different disciplines understand and create a uniform clinical approach.
Case 7d: Claim of Depression and Fibromyalgia

Major depressive disorder (MDD) according to the DSM-5 manual of the APA is characterized by the presence of five or more of the following symptoms, daily, over a 2-week period:

- Depressed mood most of the day
- Diminished interest or pleasure in all, or almost all, daily activities
- Significant weight loss/gain over a month’s time (over 5% body mass) and marked daily changes in appetite
- Insomnia or hypersomnia nearly every day
- Psychomotor agitation or retardation nearly every day
- Fatigue or loss of energy nearly every day
- Feelings of worthlessness or excessive or inappropriate guilt nearly every day
- Diminished ability to think or concentrate, or indecisiveness, nearly every day
- Recurrent thoughts of death, suicidal ideation (with no specific plan), suicide attempt, or suicide plan

Along with these symptoms, the individual is impaired in his social, occupational, and other important areas of functioning. These symptoms are not due to the effects of a substance or general medical condition.

Fibromyalgia is a chronic syndrome (constellation of signs and symptoms) characterized by diffuse or specific muscle, joint, or bone pain, fatigue, and a wide range of other symptoms. Because the nature of fibromyalgia is not well understood, some physicians believe that it may be psychosomatic or psychogenic; others believe the condition to be rheumatic in pathoetiology.

Ms. Willies, a technician working for a neurology practice, nearing 60 years of age, claims to be afflicted by MDD that was triggered the day of her employment termination, her 2nd year in that company. She believes she was fired after an onset of bilateral carpal tunnel syndrome, a condition that limits the use of her hands and her working abilities. Ms. Willies reports that she has developed insomnia; suicidal ideation; nightmares; anxiety; inability to focus, concentrate, and drive long distances; and loss of appetite (after being fired). These symptoms are typically found in a depressed individual. She also added that she has decreased fine motor abilities. She began seeing a psychiatrist (Dr. Adams) monthly and a psychologist (Dr. Jones) every couple of weeks. I was asked to conduct an IME to determine whether Ms. Willies suffered from a psychiatric disability as a result of MDD.

Prior to the interview, I reviewed many documents for background information on Ms. Willies’ medical and psychiatric history. I read that Dr. Jones and Dr. Adams noted Ms. Willies’ disabilities were not attributed to any psychological affliction. She reported not seeing an MHP for 6 weeks during her reported time of feeling intensely psychiatrically sick. Ms. Willies held many lengthy conversations with the insurance company over many different topics; handwritten complex, lengthy letters concerning her depression, bilateral carpal tunnel syndrome, and fibromyalgia (despite her disclosing a week before she wrote one of the letters that she was “in
too much pain to write”); and kept asking if the start of her psychiatric disability could be set to coincide with the day of her job termination, so funds could be collected earlier.

The insurance company found her employer to act fairly concerning her needs for accommodation. Her claim of disability for depression was equivocal, at best, as per her psychiatrist. She then brought up a second diagnosis, fibromyalgia, as noted from an “expert” in that field. Ms. Willies had mentioned that she contemplated suicide due to depression, despite doctor’s notes not finding a significant risk for suicide.

The claimant also reported that she would often think of jumping “down out of a high-rise building and disappear from this world.” A physician from the social security administration saw this report as critical and labeled her depressed, granting her disability benefits from social security. Ms. Willies used this doctor’s opinion to satisfy her need of proof to the insurance company.

Ms. Willies seemed not to be in a hurry to receive psychiatric treatment; instead, she kept calling the insurance company to secure the disability decision. To that end, she kept reporting feeling down, including that in 2000 she took an overdose of diazepam (sedative), yet, no medical intervention was needed or sought out. Also, Ms. Willies told the insurance company that although she suffered from severe depression, it came second to her fibromyalgia.

She reported to a nurse and a vocational rehabilitation consultant from the disability insurance carrier that she was “just too depressed” from her “hands’ condition” and that she had no motivation to start working again. Despite a couple of different self-reported cases of depression throughout her life (in high school and graduate school), she suddenly became depressed after her job termination.

When she moved to North Carolina, Ms. Willies began seeing Dr. Ruiz, whose clinical impression was that Ms. Willies was euthymic (normal mood), further noting “her daily lifestyle was uninterrupted, and she appeared organized and smiling, although slightly anxious.” Dr. Ruiz said she had a “manipulative, evasive/guarded attitude.”

When learning that her monthly disability checks were in jeopardy, she told Dr. Ruiz that she had developed suicidal ideation. She was also reluctant to any recommended treatment. Paradoxically, Dr. Ruiz also wrote a GAF score of 42, inconsistent with euthymia. He also wrote in the record that she was compliant with the treatment he recommended.

The physician from SSA (Social Security Administration) that interviewed Ms. Willies noted that she was taking many medications (although not one of them was a psychiatric medication). She also described that she had been depressed a few years prior to the present occurrence and took sertraline, felt better, and then stopped the treatment.

The treating psychiatrist ran several tests to view her current state of mind. Nothing remarkable was found, despite her reporting significant psychopathology.

I examined Ms. Willies. Showing up 15 min late for her appointment, Ms. Willies said she had to drive for over an hour to get to my office and ended up getting lost in the proximity to my place of work. I greeted her in the waiting room with a
handshake. Her hand felt frail and had no grip to it. She said her hands were in “lots of pain.” Ms. Willies was under the assumption that I work for her insurance company and that I was told in advance that my opinion should be to find her not disabled. I mentioned that this was not the case.

The claimant provided me with all her identifying information and from the beginning of the meeting kept trying to read from notes she had prepared beforehand. I asked her to postpone doing it until the end of our meeting. The insured went on to describe the six medications she was taking; three were psychiatric drugs: zolpidem (hypnotic), escitalopram, and imipramine (antidepressants). Ms. Willies noted that she took imipramine on the morning of our meeting (against instructions to take it only at night) “for nervousness.”

Describing the situation that triggered her onset of MDD, Ms. Willies said that she had to get surgery for her carpal tunnel syndrome, leaving work for a month. Upon returning, she explained, she was subject of discrimination by colleagues since she now needed help transporting all her equipment. As mentioned earlier, Ms. Willies worked in a neurology office performing skilled technical tasks as an electromyographist (measuring nerve conduction through muscle response to direct stimulation) and used to be completely independent in transporting relatively heavy equipment. The claimant added she was surprised to be fired, stating that it was because she said she needed another operation (and thus, more time off) for her wrist to heal.

In the past, Ms. Willies said that she was thrown from a golf cart in North Carolina and suffered a brain concussion (3 years prior). For emphasis she added that a helicopter took her to a hospital.

About her psychiatric history, Ms. Willies explained that she could have used it but felt ashamed to see a psychiatrist because in her environment it was taboo to do so. “Everyone would think you are going crazy,” she said. The claimant smiled and giggled while talking about this.

Also, she expressed dissatisfaction with her current psychiatrist, saying he provides no advice for her to follow. That is her reason for not feeling it is critical to get psychiatric and/or psychotherapeutic care.

Inquiring about her previous episodes of depression, Ms. Willies responded, “In graduate school … I was very depressed. I didn’t tell anybody... I was also very shy... my grades were very bad.” She stated she was depressed in her last year of high school, but she did not want to seek out psychiatric help. “I didn’t grow up in a very good environment, my family was not supportive.” Details of childhood neglect as well as verbal and physical abuse surfaced.

Ms. Willies was married with two children. She described her husband as self-centered, distant, and unsupportive. Descriptions of marital strife followed. Her husband physically and verbally abused her too. He stopped when she threatened to call the police. She disclosed having suffered a fractured rib by his hand. Ms. Willies said that she occasionally considered suicide, but “my children need me.” Smiling and speaking scornfully, she mentioned that she bought a small condo in North Carolina that she made use of to get away from her husband and “relate to friends down there.” She would currently go out to dinner and sing as a hobby with friends,
although her doctor told her not to sing anymore (due to a recently removed tumor from her vocal cords).

Ms. Willies was casually dressed in “springtime” attire (T-shirt and Capri pants). She carried a designer bag and a diet Snapple with her as she came into the office. Her gait appeared normal. Throughout the interview, no psychomotor agitation or retardation was displayed. As the examination ended, she pointed out that it was difficult and painful to initiate movements, as she stood up to leave. She also took the time to stroll around the room and pointed at various pieces of art that attracted her. Ms. Willies maintained good eye contact throughout the 3-h interview.

Her affect, mood, speech, sensorium, memory, attention, orientation, concentration, and judgment all appeared normal. Her intelligence level appeared average or above average. She did not display significant signs of depression, anxiety, or tension during the interview and spoke clearly and cogently. After the first few minutes of circumspection, Ms. Willies appeared comfortable throughout the remainder of our meeting. She was only interested in the superficial treatment she was currently receiving, which would not have been conducive to the development of a clinically workable psychotherapeutic process, or adequate use of medication management.

It was my opinion, within reasonable degree of probability, that Ms. Willies was neither psychiatrically disabled nor suffering from MDD. She did not describe a depressed mood throughout most of the day, or a diminished interest or pleasure in daily activities. She did not show any objective signs of depression, such as furrowed brow, sad face, or slow speech/movement. She explained to the insurance company how fibromyalgia affects a person especially in the morning (the interview took place in the early morning; she had to wake up a few hours prior and drive for over an hour to my office). She showed no signs of sluggishness or fatigue.

A person suffering from MDD would require intense psychiatric treatment and would find it extremely challenging if not impossible to adapt easily to new environments. Contrary to what Ms. Willies displayed, essentially requiring no intense psychotherapeutic or psychiatric care and demonstrating an ability to switch between 6 months in North Carolina and 6 months in Ohio. There was no psychomotor agitation or retardation during the entire interview. She was attentive and energetic, displaying no signs of worthlessness. She did not feel weak, vulnerable, or desperate. The claimant had no cognitive deficits and was aware of all her choices.

She took pride in her work and would still be working if she was not fired. Ms. Willies was not even thinking of herself as psychiatrically disabled at the time she was terminated. She was bitter, not depressed, and could not overcome her anger toward her employer. Her depression, she said, was second to all her other ailments, including a dismal marital life and a damaged ability to sing (a source of enjoyment for her). Ms. Willies reported two previous occurrences of a depressive situation (high school and graduate school), yet she was still able to perform and graduate without any psychiatric aid.

Her psychologist described her as disabled but provided no clinical documentation for such a clinical opinion. Four months after the onset of her “severe
depression,” she told her psychotherapist that she was the greeter at a large congre-
gational church, was taking a cruise to Cayman with her husband and friends, and
was planning on taking up golf again. Also, Ms. Willies continued playing golf,
played in July with her husband to defend their championship title for the 2nd year,
and in September (after she applied for disability), she began thinking of joining a
golf league in North Carolina, away from her unsupportive husband. Ms. Willies
did not mention any of this to the SSA examiner. She told him, instead, that she
needed help with simple needs like bathing herself (but never mentioned that her
husband is completely unavailable to her). A few days later she took a 6-month
vacation to Texas.

Despite her complaining constantly of pain in her wrists, difficulty gripping, and
physical weakness/stiffness in her hands, she kept playing golf. Seven months after
the reported onset of MDD, she began talking about retiring, rather than becoming
psychiatrically well. Her retirement included moving to North Carolina, away from
her abusive and uncaring husband, and becoming a better golfer.

The claimant had reported being involved in a car accident some years prior, yet
despite her reported memory loss, she was still able to boast her impressive job
performance of “over 1000 electromyography studies per year.”

Ms. Willies initiated and settled a lawsuit against her employer successfully (a
very stressful process), planned a trip to North Carolina and periodic visits to Ohio
for the holidays, planned to join a golf league, played bridge, and started a new
social life down there.

Her reported symptoms started even before her job termination, yet she contin-
ued working up to 60-h weeks successfully. In spite of her reported MDD, she did
not see a psychiatrist for 6 weeks. Ms. Willies planned and carried out many activi-
ties during the months of her reported severe depression. She also complained of
problems with fine motor movements, yet she was able to clearly handwrite exten-
sive letters in small lettering. She was able to put makeup on her eyes and lips when
she met with the insurance company representative.

Many calls that Ms. Willies made to the insurance company were in the morn-
ing. Also, the letters the claimant wrote to the insurance company were very
elaborate, lengthy, and contained structured and organized information. These
letters were written a few months after she claimed MDD, yet they displayed
intact cognitive ability. In her letters she spoke of suicide, but to the psychothera-
pist and the psychiatrist, she did not mention any suicidal ideation. The weight
loss and change in appetite described by Ms. Willies reflected her interest in eat-
ing healthy and losing weight. As I found in the records, she had told different
accounts to different clinicians. Ms. Willies claimed extreme difficulty focusing,
driving, and reading. She drove over an hour to my office, attentively read
through a two-page form describing the exam, and remained focused for the 3 h
our meeting lasted.

The description of her suffering was not consistent with any recognized dis-
abling clinical pattern. This individual was not incapacitated. She appeared to suffer
from a personality disorder that causes some distress which in turn prevents her
from enjoying life from time to time but did not make her mentally disabled.
Case 7e: Claim of PTSD Linked to “9/11”

I was provided with Mr. Flynn’s job description, investigative report from insurance company, and medical and psychological records and asked to conduct an IME to determine if the claimant was afflicted by a psychological condition that prevented him from functioning in his occupation as the actuary and in-house bookkeeper of a company. This young adult man had been growing in his activities for the last 9 years.

Mr. Flynn had been receiving disability benefits since 9/11/01. He worked at one of the WTC Towers. He thrived in this fast-paced environment, to the detriment of his marriage. His activities at the time consisted of visiting with friends, walking, and caring for his son.

Mr. Flynn noted in the claim form that his occupational limitations included anxiety attacks, depression, thoughts of death, shortness of breath, and not being able to function as he used to. The diagnosis by his marital therapist was PTSD. The counselor cited that his client had “traumatic recollection of escaping from WTC; was distracted, disinterested, with flat affect, nightmares, emotional outbursts, inability to concentrate for any length of time, and confusion.” To this, it was then added, “An inability to feel love” and, as a new diagnosis, “Partner Relationship Problems.” He continued working, but not feeling as sharp as he once was prior to the traumatic event.

The therapist stated that their first meeting took place on 10/18/01. He was not in therapy from 2/02 to 11/02. On 9/03, the therapy session related only to his struggles with his wife. A psychiatrist wrote that Mr. Flynn was not compliant with his treatment recommendations and also missed appointments with him. He was prescribed an antidepressant and a hypnotic.

On the month he stopped working, roughly 1.5 years after 9/11, the claimant visited a psychiatrist who diagnosed “PTSD and dysthymic disorder”; he added that “Mr. Flynn could work in a different occupation” and that he was “not interested in returning to the same occupations as before 9/11.” Mr. Flynn also told the psychiatrist that he started seeing the therapist after 9/11, due in whole to this tragic day.

An interview conducted by the insurance company investigator showed no indication of cognitive decline. Furthermore, it was noted, “He (Mr. Flynn) spoke clearly and concisely.” It was found that in the summer 2001, he and his wife started marital therapy, after trying pastoral counseling. His wife moved out the marital residence in August 2001 (1 month before the attacks on the WTC), Mr. Flynn continued in psychotherapy.

On 9/11, Mr. Flynn was on the 35th floor of one of the WTC buildings. After the plane hit the building, and he summoned that it was not safe to stay inside, Mr. Flynn was able to reach the street and walked with a friend, crossing the bridge to Brooklyn. He took a shower in this friend’s home and eventually made it to his own home. “For the next month, I was glued to the TV.” Mr. Flynn preserved the clothing he wore on 9/11 in a bag. “Our boss told us to stay home for a couple of weeks… there was no place to work… I didn’t know if I still had a job… until the
company relocated outside of NYC, where we worked for some months; and then we got back to the City.”

The claimant worked for 1.5 years before filing for disability benefits. He added that he attended funerals of people that were in the building that day. At some point, while separated from his wife, the claimant flew with his son to Orlando to celebrate his father’s birthday. Mr. Flynn dated women until he resumed his marriage. One of the relationships appeared to have become long-lasting, as he described, “It was good, Joan was very warm, she made me feel comfortable... but then she became too demanding... I had to go out with customers and stuff... I had to break it up after a year.” Three months later, he resumed his marital relationship, about 2 years after he and his wife separated (2001–2003). Yet, Mr. Flynn was firm when he said, “Before 9/11 everything was wonderful with my wife.”

Mr. Flynn maintained that 5 years after the destruction of the WTC towers, he was still unable to work, due to PTSD. He was seeing a therapist, every 6 weeks, due to feeling “anxious and also emotionally dead.” Despite reporting insomnia, he would get up at 6 a.m., check on his email, fix his son’s breakfast, and then take him to the bus stop at roughly 8:30 a.m. He continues his daily routine with a 1-h walk, runs errands, and prepares dinner. The claimant helps his son with homework and spends time socializing with friends.

I met with him at 9 a.m., and our interview lasted for 3 h. Mr. Flynn drove to my office. He took time to read a two-page form explaining the procedure. As we talked about its content, it was clear that he fully understood it. Mr. Flynn told me that he had “This constant cough... I was in all that smoke.” He described in detail the occurrence on 9/11. Mr. Flynn was able to recall what was happening to and around himself, as well as others’ reactions. On his way out of his office, he grabbed a bottle with water. He also said that, shortly after the terrorist attacks, he separated from his wife and then their plans for having a second child collapsed. The claimant described himself as having always been abrupt and coarse with his wife and with girlfriends before he met his wife.

Mr. Flynn was able to describe his occupation and define the terms of his trade in a reasonable fashion. He provided examples of business transactions, numbers, and dates, reflecting a lucid, agile, and cogent state of mind. He was able to mention his training and the jobs he went through to arrive at the position he held last. Mr. Flynn worked at the WTC for 2 years before it was destroyed. He recalled that most of the workforce was reluctant to move in to the WTC recalling the terrorist attempt at destroying one of them in 1993.

Mr. Flynn mentioned that two of the workers in his company felt mentally troubled enough that they abruptly decided to leave New York City and moved out of the state, to live in rural areas. Likewise, two female employees decided not to go back to work into a building that overlooked “ground zero.”

He also told me about his growing up at home, with a demanding father that praised work above all, and a series of childhood mischief, including some impulsive and aggressive behavior toward property and even peers, following by attempts at getting away with it.
The claimant told me that at some point after 9/11 his work performance started to decline, having “something like panic attacks,” feeling anxious, and having to withstand the company’s financial burden on his shoulder. He explained that the job obligations increased because they did not have clients’ information backed up properly, outside the premises.

“I couldn’t take it… I left. They gave me an ‘x’ amount of severance money… I couldn’t sleep at night, having bad dreams… I still get depressed sometimes, and angry and explosive. I have trouble talking, responding to people asking me things… people smoking bringing me back to the smoke that day.” Mr. Flynn took a family vacation last year to Costa Rica. He is now involved in landscaping his backyard, “trying to create paradise.” The claimant also mentioned that when his son was born, some 5 years before 9/11, he had started changing his heart about his work habits.

Mr. Flynn mentioned that he does not have much of a sexual interest. “It is as if part of me died.” He added that marital intimacy occurred less often than it used to, “as if I didn’t care about sex… I don’t feel connected to her… with Joan (recent ex-girlfriend) was different… it was good… when we were dating, we were passionate.”

His mental status exam was unremarkable. His affect was not constricted nor intense, and his mood was neutral. He did not display signs of anxiety or depression. Mr. Flynn’s speech was clear, coherent, and relevant. He was spontaneous, fluid, vivacious, articulate, witty, and quite engaging in his relating style. There were no cognitive deficits found throughout the entire 3 h the examination lasted. He was in good control of his decisions and actions. Despite stating that he was not any better, 5 years after the event, he was comfortable with the present treatments.

I found Mr. Flynn not suffering from PTSD, or any other major psychiatric diagnosis. I did not find this man to have an incapacitating psychiatric condition. He did not present the symptomatology of PTSD: his response to the WTC attacks and subsequent collapse of the towers, on 9/11/01, was of intense fear, but not helplessness or horror.

The claimant was lucid and resourceful as he exited the building, with countless other people, carrying a water bottle, able to plan ahead. He acted appropriately and did not panic. He knew all along what to do, how to do it, and where to go to keep himself safe and sound. Moreover, he did all of this in a reasonable, timely, and collected manner, unlike the functioning of a mind that is suddenly resourceless by an overwhelming traumatic event.

Mr. Flynn did not change any aspect of his lifestyle after the event, unlike the subdued and impoverished routine we expect of a patient afflicted by PTSD. He did not come across as frail, hesitant, easily overwhelmed, anxious, and fearful, as those suffering from PTSD are. Instead he was poised and strong-minded. There was no avoidance behavior, a key component criterion of PTSD.

Narrating the occurrence on 9/11 did not elicit intense anxiety or feeling of being overwhelmed and emotionally paralyzed. He did not display numbing of general responsiveness related to the outside world, or restricted range of affect. His
relationship with his son improved; he started dating and enjoying it; he kept working in the same occupation; he took his clients out; he traveled daily to work in Manhattan. Mr. Flynn was “glued” to the TV; kept the clothes he wore that day, as if a trophy; attended to funerals; and related to loved ones of fallen workers. The number of inconsistencies with a clinical diagnosis of PTSD is apparent and warrants a dissenting opinion.

**Case 7e: Opposing Forensic Expert Opinion – Claim of PTSD Linked to “9/11”**

Dr. Lutz was asked to assess the current cognitive and psychological status, as well as his current diagnosis.

As noted in his neuropsychological report, Dr. Lutz conducted no more than a superficial review of Mr. Flynn’s developmental stages, childhood, and family circumstances.

According to the insured’s report, right after 9/11, “His pattern reflects severe psychological disturbance at this time… overwhelmed by anxiety, tension, and depression… marital discord was significant in his current situation.” Mr. Flynn told the examiner that he had become unable to multitask. The MHP noted, “His executive and cognitive skills are generally intact. His speed of information processing, attention and concentration, verbal abstract reasoning, working memory, and verbal memory were all found to be intact.” Some areas that fell within the borderline functioning were interpreted as “psychogenic etiology…psychogenic contribution and a psychogenic pattern were evident.” Dr. Lutz did not inquire and/or consider these findings when reaching an opinion. Similar concern surfaced on the MMPI-2, in which, “on the infrequency backward section of the F scale, his responses were either extreme or exaggerated, resulting in potential validity issues of the response pattern.”

Dr. Lutz concluded, “His pattern reflects rather severe psychological disturbance at this time. Overall, his pattern is consistent with individuals who feel overwhelmed by anxiety, tension, and depression. In addition, his MDS elevation reflects that marital discord likely plays a significant role in his current condition… Analysis of his overall pattern reveals that his impaired scores are due to a combination of PTSD and secondary gain factors.”

Dr. Lutz made the diagnosis of PTSD, chronic. All this was based on Mr. Flynn’s reporting that he socialized less, his concentration was disturbed, and he had nightmares and panic attacks. He told Dr. Lutz that he was afraid of going to Manhattan. During the testing time, the claimant was affable, friendly, agile, and with very good eye contact. There was a normal cognitive mental functioning. The neuropsychologist provided no clinical documentation of such affliction. The neuropsychological testing alone, and in combination with the verbal exchange between examinee and examiner, did not indicate the presence of a psychiatric condition, let alone, a disabling one. The clinical notes from Mr. Flynn’s therapist and psychiatrist stated he was afflicted by PTSD and dysthymic disorder.
The claimant, Mr. Flynn, was also examined by a psychiatrist, Dr. Fox. The insured was able, once again, to provide a detailed account of what happened on 9/11 and his response to it. He omitted telling the examiner that he grabbed a bottle of water, on his way out of his office, and that more than 1 h later, already in the street, he gave it to a woman in need of help.

Likewise, Dr. Fox took it as fact that Mr. Flynn never received any psychological counseling before 9/11, that his mood changed dramatically afterward, and moreover that he then developed marital problems. Dr. Fox did not review collateral sources of information.

Also, Dr. Fox takes as facts the insured’s statements and repeats them in his report, “After the incident in question he was unable to function. He became very angry at his wife... he isolated himself and put up a wall... he had feelings of failure... he has sleeping problems... his nighttime is filled with nightmares... he may talk in his sleep... he has only been in NYC, Manhattan, in one occasion... he doesn’t socialize...” Dr. Fox adds, “He admits to nightmares, flashbacks, phobic avoidance, of the situation, inability to handle any significant stress... hyper reactivity to loud outbursts by others.”

Dr. Fox, rooted on the above reporting, concludes that the claimant continues to suffer from PTSD, which obviously at this point is chronic. “Based on my contact with him, I find no evidence that he can return to the hectic, intermittently loud, and explosive environment that he worked at before.”

Case 7f: Claim of Major Depressive Disorder for Psychiatric Disability

Dr. Jones, a middle-aged, self-employed dentist, claims to be afflicted by MDD. His claim for psychiatric disability states he is unfit to work and does not want to endanger his patients as a result of his present carelessness. His psychiatrist, Dr. Brown, supports his diagnosis, stating that his evaluation showed depression, a lack of motivation, inability to focus and concentrate, insomnia, increased appetite, anxiety, fatigue, loss of interest in daily activities, forgetfulness, decreased motivation and self-confidence, and finally incapability to work. These symptoms are typical of a depressed individual. Dr. Brown decided to treat Dr. Jones’ depression with several drugs and monthly, 30-min, psychotherapy sessions.

Several documents were reviewed that provided background information about this claimant. These included a letter from the insurance company summarizing the case, the disability income and office overhead form, a psychiatric interview by a nurse claims manager, Dr. Jones’ psychiatric records, the psychiatrist’s (Dr. Brown) evaluation form, St. John’s Medical Center’s medical records, laboratory tests, and a report of psychological testing.

These records indicate that Dr. Jones complained of depression in 1998, did not stop working, and did not receive any treatment for his psychological ailment. Dr. Brown made the same diagnosis for his first episode as he did for this current second one, in 2004.
Dr. Jones had been hospitalized in 3/01 for shortness of breath. The ECG (electro-cardiogram) showed normal readings. He was found to be a smoker with blood pressure at 122/80 (unremarkable). In 2002, he was treated with physical therapy after a motor vehicle accident. His blood pressure was taken 35 times (on 35 visits), and it was always within the norm. His chest and heart yielded similar results in terms of normality. However, he currently was prescribed preventative hypertension medication and heart medication. Dr. Jones suffers from diabetes mellitus, and his kidneys seemed somewhat compromised. In 2002, a complaint of sharp shoulder pain caused severe insomnia. For this he was taking zolpidem (hypnotic).

Dr. Jones saw his psychiatrist only once during the first complaint of depression. He did not interrupt his practice of as a dentist, working at times up to 18 h a day. To reiterate, Dr. Jones claims to be presently suffering from a psychiatric disability due to major depressive disorder. His psychiatrist backs up the statement by reporting that his patient is incapable of working because he is mentally distraught as characterized by the symptoms provided by the DSM-5.

Dr. Jones entered my office at 9:00 a.m. for his interview. The examination was audiotaped. He was asked to read and, if in accordance, sign and date a form. The claimant said that he did not remember the date. After a few guesses at different days, he appeared to recall the correct date and wrote it down. He also reported not to remember his office zip code, even though he has worked at the same location for 9 years. After some time, he did recall it correctly. He could not, however, recall his social security number because it had “too many numbers” but provided his correct phone number and birth date.

An hour into the interview, Dr. Jones was asked to narrate the incident that triggered his depression. At that time, he requested a break. It was the only break he took throughout the 3-h interview. He asked if he could go drink some tea but instead went out to the street to smoke his pipe.

Upon his return, Dr. Jones told of what led to his depression, an incident in which two of his three daughters, who also worked for him in the office, were caught by the police taking his prescription slips to obtain narcotics for their friends. He went on to describe his dislike for his wife whom he blamed for their daughters’ problems. Long-standing marital strife was revealed.

Dr. Jones was very spiteful toward his wife and these two daughters. “They are deceitful and rebellious; they do poorly in school and have troubled friends.”

Dr. Jones had always looked down at his wife’s background and felt that she was very soft as a disciplinarian with the children. When the daughters would get in trouble, she would protect them by keeping them secret from her husband. Despite all these family tensions, Dr. Jones had always worked long days, proving to be professionally and financially successful and driven.

He began to bring his daughters to his office so that they could escape from their troubled friends and the drugs and alcohol on the streets he was concerned with exposing them to. One day, he received a call from a pharmacy saying that a few of his prescriptions for Percocet looked suspicious. The police were called to investigate, and they had found the culprits, who turned out to be his daughters.
He did not try to stop the police from taking them into custody. The wife was outraged that he did not protect the girls unconditionally after the crime they committed. Bitter and resentful, he left the house, and soon the wife filed for divorce. He still supported his family financially but closed down his practice 5 months after the occurrence. His lifestyle now consists of daily 2-h walks and frequent luncheons with friends.

He is proud of the family he came from. Talking for quite a while, he listed all six of his siblings and his parents, their jobs, and where they all lived. He visited his siblings, in a distant state, a few months after the incident with his daughters, to spend time away from home. He did this twice, for 2 months each time, in a lapse of 1 year.

Dr. Jones stated that the antidepressant medication did not work. What did work, however, were the trips to see his adored siblings. He felt well rested, laughing, and happy during his 2-month visits. Upon returning to his office, Dr. Jones felt he “lost it all” and became depressed again.

Dr. Jones claimed to have started smoking after his daughters stole the prescriptions. He repeatedly said “No” when I asked, several times, if he had been a smoker before the incident. He began to talk about his insomnia and how his psychological pain kept him awake throughout the night. Dr. Jones stated how he took oxygen to sleep (afflicted with COPD – chronic obstructive pulmonary disease), but when he could not sleep, he would smoke and watch TV.

Despite claiming that the medication did not work, he reported continuing to take the medication to try and improve his emotional state. He added that his appetite was very volatile, fluctuating between hunger and fullness “quickly and randomly.”

During the last 5 min of the interview, a line of inquiry led Dr. Jones to believe that I doubted his disability. He burst into a display of powerful excitement, yelling about how his children had “killed” him. He repeated that his children killed him, while smacking his chest with his fist and raising his voice. Several times he threatened to leave, exploding in dissatisfaction with the examination. During this monologue, he showed anger, irritation, rage, and excitement. He beat his chest soundly. Once this display was over, he did not present any shortness of breath, or physical symptoms of distress of any type.

Throughout the entire 3-h interview, Dr. Jones was focused, awake, and able to answer questions in an orderly manner. He maintained good eye contact. He appeared sluggish from the moment we met in the waiting room, until a few minutes into the examination. No psychomotor agitation or retardation was displayed throughout the interview until the final 5 min, when he appeared very upset.

Although he complained of being distraught, he was comfortably seated in the chair with his legs crossed. During the initial part of our meeting, every now and then, Dr. Jones would cough loudly. As the examination progressed and he became more involved, he stopped coughing. He frequently kept trying to relay the message that he could not work due to depression, lack of concentration, and faulty memory.
His affect, mood, and speech were unremarkable. Bitterness manifested in his feelings for his wife, concerning their long-standing marital strife. His sensorium was also clear. He was oriented to time, person, and place. Recent, remote, and immediate memory was intact. Throughout the interview, he remained attentive and focused. Never was a question asked twice, and only once did he ask to interrupt the 180-min interview. He never became distracted from his thoughts. Dr. Jones’ intelligence level appeared normal or above average.

He was aware of his possibilities and was able to reason. He was not interested in any psychotherapeutic approach to heal his ailments. The only therapy he believed was necessary was spending time with his siblings on a vacation.

My psychiatric opinion was that Dr. Jones did not suffer from major depressive disorder. Except at the beginning and end of the meeting, Dr. Jones did not exhibit objective signs of depression, e.g., furrowed brow, sad face, or slowing of speech/movement.

Previous records contradict descriptions made by Dr. Jones of having a depressed mood most of the day. Rather than MDD, he appears to suffer from a personality disorder.

During the interview, Dr. Jones would say that he was depressed and desperate, but he did not appear to be in either state of emotional unrest. Aside from the beginning and ending of the interview, there was no psychomotor agitation or retardation. Repeatedly, Dr. Jones kept bringing up the message that he was psychiatrically disabled. His behavior at the beginning and end of our meeting seemed to be forced, in order to drive this message home to me.

Dr. Jones had been depressed in the past, with the same symptoms described to me now. Despite this, he never took off from work during that time and recovered from it without psychiatric treatment. Dr. Jones was not cooperative with Dr. Brown’s suggestion for more intense psychiatric treatment either, insisting a good treatment was to be on vacation with his siblings. He does not require the use of psychiatric medication, and his current psychotherapeutic treatment is minimal.

During the time the reported psychiatric conditions afflicted Dr. Jones so severely, he did not need close psychiatric monitoring. Dr. Jones’ mental status exam showed him to be able to perform the duties of his occupation. During the interview, he was not fatigued, inattentive, or indecisive. He could think clearly and speak well and had no cognitive deficits. He did not feel vulnerable or desperate. He was in control of his decisions and well connected to the world. Dr. Jones had no obsessive symptoms and could focus on his thoughts. He showed good communication skills and had no problem talking about various topics, regardless of emotional ease, pain, or embarrassment.

He arrived at the interview early in the morning, after reporting he had a hard and restless night, and showed no sign of fatigue or loss of energy, despite saying he took several sedating psychiatric medications. His insomnia is due to orthopedic ailments and predates by many months the May 2004 occurrence. Paradoxically, in the past Dr. Jones blamed his insomnia on orthopedic problems, for which he took zolpidem (hypnotic), while not on psychiatric ones.
Dr. Jones reported, despite his efforts, a total lack of improvement, against evidence in the records to the contrary. Dr. Jones had always worked under similar psychological strain (he took pride in working well under pressure) from his family. He remained productive even throughout the entire incident with his youngest daughter having to be hospitalized after running away from home, some years prior to May 2004.

He is able to plan and carry out social events, locally, at home, and twice away, in his home state. Dr. Jones was very active during the day: eating with friends at restaurants, 2-h walks, and talking with friends. He had a hired housekeeper who he kept up with and often traveled for relaxation to see his family of origin (whom he was very proud of) and financially supported his immediate family. The insured had the great discipline, physical (and mental) strength, and determination to go on 2-h walks each day. His libido was satisfactory, as described by his psychiatrist. There is no known psychiatric illness that can be cured solely by vacations to see one’s family. Dr. Jones reported no feelings of worthlessness and took great pride in being a member of the dental profession. He maintained good eye contact throughout the meeting.

Dr. Jones was not forthcoming with the psychologist when saying he was taking five psychiatric medications. That was shown to be untrue. He told the psychologist who examined him 2 weeks prior to his meeting with me that he had a bad memory, that he could not think or concentrate, and that he was very distracted. Also, he had told the psychologist that he had no family conflicts before the incident when his daughters stole the prescriptions. This also proved to be totally incorrect. Dr. Jones complained to Dr. Brown in 1998 of having the same symptoms he described in 2004. When he was interviewed by a psychologist in 2005, he denied ever having a history of depression. Dr. Jones repeatedly said that he did not smoke before 2004. This was contrary to a hospital note in 2001 saying that he was a smoker, with symptoms of shortness of breath.

He is bitter and is not ready to “clear the air” with his daughter. He is angry with his wife as well. These feelings are not new (hurt, betrayal, lack of support), and the risk factors for suicide studied during the interview were minimal. Dr. Jones does not suffer from MDD now and has not been psychiatrically disabled for the last 12 months.

The outcome of this interview showed marital disharmony, compounded by his distress over his daughters’ unlawful behaviors, orthopedic ailments, diabetes mel-litus, diabetic nephropathy, hypercholesterolemia, and COPD. However, he is not psychiatrically disabled. His depression is a boosted sadness due to several ongoing psychosocial stressors. He is not suffering from major depressive disorder, as extracted from the large amount of evidence and inconsistencies in reports with the subjective findings. The description of his suffering is not consistent with any recognized major psychiatric condition or disabling clinical pattern. Dr. Jones is not mentally disabled but, instead, suffers from a personality disorder that prevents him from enjoying his life every now and then.
Case 7f: Opposing Forensic Expert Opinion – Claim of Major Depressive Disorder for Psychiatric Disability

Dr. More was asked to study the insured’s cognitive and emotional status. The claimant told the examiner that he had never seen a psychiatrist for treatment before 2004. He also told the psychologist that he was presently taking all of the following medications: sertraline, bupropion, lorazepam, temazepam, and zolpidem (two anti-depressant agents, one sedating medication, and two hypnotics).

Dr. Jones told Dr. More, “There were no family conflicts prior to his daughters’ stealing his prescriptions.” He added that he could not concentrate or think. Dr. More found, all along, “exaggerated reporting of symptomatology.”

In sum, he found the psychological testing to be invalid in its results, due to the lack of cooperation of the insured. Dr. More referred to Dr. Jones’ answers as “extreme” and “absurd.” Signs of lack of cooperation were abundant.

Dr. More was, nonetheless, of the opinion that Dr. Jones was afflicted with the diagnoses of depressive disorder and personality disorder.
Definitions and Explanations

Abulia
Lack of interest

Aphasia
Impaired ability to use or comprehend (spoken or written) words.

Executive functioning
Capacity to plan, organize, abstract, sequence, and carry out.

Hypomanic episode
A psychopathological state and abnormality of mood falling between normal positive mood and mania. Same but less severe features as in mania, i.e., unrealistic optimism, pressure of speech and activity, and decreased need for sleep. Although it is different from the person’s usual non-depressed mood and is observable to others, it does not cause marked functional impairment or need for hospitalization (American Psychiatric Glossary, 8th Edition, American Psychiatric Publishing Inc.).

Informed consent doctrine
Patients must be told about (1) the nature and purpose of the proposed treatment or procedure, (2) its potential benefits and risks, and (3) the alternative approaches available, including no treatment at all, along with their benefits and risks. It involves the disclosure by a physician to a competent patient that makes a voluntary choice, according to what a reasonable person could understand of these clinical facts.

MMSE
Mini-mental status exam is a quick way to evaluate cognitive function. It is often used to screen for dementia or monitor its progression. Eleven items are scored to a maximum of 30. Twenty-four or over is considered normal.
Introduction to Competency Assessments

There are four functional abilities examined in competency assessments,\(^1\) as it relates to a specific field or function:

1. Ability to *express* a choice or make a decision (i.e., paralyzing ambivalence, frequent reversals)
2. Ability to *understand* information relevant to decision-making (i.e., intellectual and cognitive issues; delusions, delirium, dementia)
3. Ability to *appreciate* the information’s *significance* to one’s own situation (i.e., informed consent)
4. Ability to *reason logically* with the relevant information (i.e., to weigh options)

Based on these four aspects, *incompetence* is a status defined by functional deficits resulting from a mental condition that is sufficiently great, rendering the person currently unable to meet the demands of a specific decision-making situation, weighed in light of its potential consequences.

Testamentary Capacity

The legal standards surrounding testamentary capacity are often considered in cases where decision-making competency is in question. A person possesses testamentary capacity if at the specific time of the preparation and execution of the “last will and testament”:

(a) He/she knows the extent of the estate and assets.
(b) He/she knows the natural heirs of his/her bounty.
(c) He/she understands the nature (definition) of a will.
(d) The decision of how to distribute his/her assets is not made under coercion or manipulation (“undue influence”).

To carry out the assessment of the first three questions, the person has to have the clarity of mind that allows for these processes to be conducted. Clarity of mind refers, in this situation, to adequate “cognitive” ability, defined as the capacity to maintain adequate levels of focus, attention, concentration, memory, abstraction, recognition, and intention.

“The making of a will does not depend upon a sound body, but upon a sound mind.”\(^2\)

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\(^1\) From: “Ethics and Legalities Involved in Competency Determination of the Elderly;” by Raymond Deeney, Esq., Symposium on “Ethics, Pain, and Suffering of Geriatric Patients;” 3/3/05.

The fourth step to prove competence, “undue influence,” refers primarily to heirs having and using the opportunity and disposition to unduly sway a susceptible testator to obtain an unfairly advantageous result to the person who exercises the influence.

Attention should be paid to determine that the will was not hastily executed. In other words, the person benefited was not active in pursuing the drafting and execution of the will, with malicious intent, and did not initiate the process for the preparation of the will. Such a person ought not to be present at the execution, and the changes in the will should be consistent with prior declaration of the testator. The decisions need to be reasonable rather than unnatural in accordance with the testator’s attitudes, views, and family. If a significant change is introduced in the will, this should be reasonably justified.

In cases in which testamentary capacity might be questionable later on, the attorney should take precautions, including taking information from the testator related to assets and relatives. If reasonably expected people to be included in the will are excluded or a major change is presented in the new will, the attorney ought to know the reasons for the changes. This may prompt the attorney to obtain a psychiatric opinion as to competency as close to the date of the execution of the will as possible. It is advantageous to have the witnesses observe both the preliminary conference with the client and the conference immediately prior to execution of the will.

Once again, recordings (audio and/or audio-video) of the proceedings are most valuable to affirm that the testator is able to appreciate both, qualitatively and quantitatively, the impact of the will changes on the individuals affected by such amendment.

Case 8a: Competence to Prepare a Will

An attorney approached me to form an opinion regarding the competency of his client, Mrs. White, who suffered from a reported diagnosis of “Neurocognitive Disorder/DSM-5 (Dementia).”

Neurocognitive Disorders/Dementia is characterized by (a) decline in language, motor, and visual-spatial skills; (b) changes in mood, personality, and executive functioning; (c) decline in goal-oriented behavior; and (d) loss of memory (word retrieval and the naming of objects, learning new words, and recalling old ones).

Many depositions and medical records were reviewed to assess the mental capacity of the late Mrs. White, an elderly woman who had given her house to one of her children in her revised “last will and testament.” The other two children brought about a lawsuit against the child receiving the house, questioning the legitimacy of their mother’s action, which took place some 6 months before her death.

From the records it is noted that her health was adequate until she had a stroke at age 84. As a result of the stroke, her two daughters found her at times to be “confused” and “not feeling like herself… withdrawn… sleeps all day.” Her hospital doctor was treating Mrs. White for multiple and diverse conditions, but her mental status never became the focus of his clinical attention.
A mini-mental status exam (MMSE) was done by the neurologist treating her after the stroke and showed a score of 22/30. With this, along with her not being oriented to “day” and “season” and having decreased concentration and immediate memory recall, the doctor diagnosed her with “subcortical dementia, abulia, and mild aphasia.” Due to many medical ailments, she was on seven medications (although none of which was aimed to treat cognitive decline).

After 6 months and several further visits, a new MMSE was done, and a score of 28/30 was noted. The diagnosis of dementia was ruled out. She was noted to have continued making positive progress. Mrs. White “is doing well…she is significantly better.” Twenty-two months after the stroke, doctors had concluded that she no longer suffered from “aphasia or neglect (abulia).” A little more than 2 years after the stroke occurred, doctors stated that “she has been doing well and has no further symptoms.”

Future checkups showed more physical deterioration, but none are related to those of psychiatric/neurological nature. From the many depositions, two common descriptions were observed. Firstly, her physical vigor was slowly declining. Also, she was able to recognize the people she knew. Her memory decline was adequate for her age.

Individuals stated in several depositions that Mrs. White was able to take care of herself, without the help of her daughter (who inherited the house) for the majority of the time.

An individual with mild neurocognitive disorder/dementia, although will have trouble with new information, may still know her children, the approximate size of her estate, and that she wishes to reward the daughter with whom she is living with a large share of the inheritance.

Mrs. White created her “last will and testament” in 1990. She modified her “will” in 1995. In 1996, her MMSE was normal. From then on, her internist and her neurologist extensively discussed with her the complexities of her multiple medical illnesses. Mrs. White’s responses were appropriate.

It is documented by physicians and friends (including her son-in-law) that Mrs. White was capable (adequate) of taking care of her needs when alone in the house.

The professional opinion, with a reasonable degree of medical certainty, was that Mrs. White had the necessary mental capacity to understand the quality and nature of her actions when she signed over the deed of her house to her daughter.

**Case 8b: Competence to Revise a Will**

Mr. Miller, a successful businessman turned alcoholic, was hospitalized three times during the year of his death, at 60 years old. During his second admission, he prepared his will. He signed it by stamping his fingerprint onto the page (his hand, at the time, had IV fluids going through). It was reported that he was in the presence of three witnesses, his treating physician, and a lawyer. It is said that Mr. Miller had the mental capacity to proceed, without duress or undue influence, and to carry out
the preparation of his will, as reported by the doctor present at the execution of the will.

Mr. Miller had one son from his first marriage and four from his second. All five children were included in the will, but the first child was bestowed next to nothing, as opposed to the rest.

Five months before his death, he was diagnosed at the hospital with pneumonia, left-sided pleural effusions, and chronic liver disease complicated with scleral icterus (yellowing of the eyes), fetor hepaticus (distinct breath odor), ascites (fluid in the lower abdomen) – all signs of liver damage secondary to alcoholism. He was overweight all his life. Laboratory testing showed chronic anemia, abnormal coagulation time, and impaired synthetic liver function. Despite all this, nursing notes described him as alert and oriented, and it is written that neurologically he was found to be within limits.

He was discharged, and readmitted later that month, to a different hospital for alcohol abuse and liver damage. He signed the admission form and needed to be detoxified. He was diagnosed with alcohol disorder and hepatitis B, status post pneumonia. It was also found that Mr. Miller was “depressed, had insomnia, could not concentrate, had poor social judgment, had suspicion of others, and had poor impulse control.” His GAF (Global Assessment of Functioning) was 40, with noted “major impairment in work, family relationships, judgment, thinking, and mood, as well as some impairment in reality testing or communication.”

The record noted that Mr. Miller drank a liter of alcohol every day for years. He complained of anxiety, tremors, nausea, vomiting, insomnia, suspicion, impulsivity, and guardedness. The psychiatric note indicated a lack of family support and that he did not wish to work any longer.

Three months later he was rehospitalized for severe liver disease (for the next 3 weeks). On admission, he was found to be confused and weak and had tremors. His liver problems caused bleeding problems, deemed to be due to alcohol abuse. Mr. Miller was disoriented to time. The day after admission, he began showing signs of severe liver failure, including jaundice, bleeding, enlarged liver and spleen, ascites, and pleural effusions large enough to considerably impact his breathing effort.

Hospital records point out that “the patient shows minimal improvement,” as his lungs’ function worsened and his heart increased in size (likely due to an underlying effusion process as well) during the 1st week in the hospital. He became hypoactive, and his blood pressure dropped. During his 2nd week, he began to slightly improve. His lungs cleared, and he was discharged home with an oxygen tank.

Two months after this, he was back in the hospital for upper gastrointestinal bleeding and congestive heart failure. Mr. Miller was found to have melena (partially digested blood in the feces significant for potential internal bleeding), as well as several bouts of vomiting “fresh” blood. His diagnosis upon death (in the hospital 3 days after admission) was hepatic failure and upper gastrointestinal bleeding. He was found to be lethargic, with severe respiratory distress. The laboratory findings indicated severe liver failure.
Mr. Miller had been showing signs of mental decline long before the execution of his will. In the medical records, he had shown compromised mental functioning months before he created the will. The records show a poor capacity to concentrate, and poor social judgments for over a month, consistent with liver failure in the context of hepatic encephalopathy, although this workup was not considered as per the medical records. He was found to be lethargic and hypoactive; it is said that 4 days prior to the execution of his will, he had shown minimal improvement. He was unable to participate in his treatment and was medicated with Librium for detoxification and sedating purposes, even 9 days after this admission.

The evening of the day in which this patient reportedly executed his will, a tube was inserted on his side (thoracocentesis), to drain a large amount of fluid that prevented his lungs from expanding adequately, compounding an already hypoxic state. That same day the nursing notes read, “7:10 A.M., ‘Patient is awake but hypoactive, also hypotensive (BP: 90/51), with incongruent responses. He is edematous and has pain to the touch of the skin’.” No presence of family members is reported during this day.

When executing his will, he did not have the right frame of mind to reflect on family relationships and financial matters, in regard to the distribution of his assets. The severity of his mental decline, along with the powerful effects of Librium, rendered him unable to institute the decisions that are alleged to have been carried out in his will.

The day before he implemented his will, Mr. Miller was found to be unstable, severely ill, and unable to cooperate with the treatment efforts. He was consistently described as “confused and disoriented.”

It is my professional opinion, with a reasonable degree of medical certainty, that Mr. Miller lacked the necessary mental capacity to execute or revise his “last will and testament.”

Case 8c: Paternal Fitness for Unsupervised Time-Sharing

Parental competence is assessed in fitness for duty cases wherein questions of custody must be addressed in regard to the best interest of the child. A legal standard to uphold in these contexts considers that to have adequate skills to function as a parent, one should be able to (a) look after the physical and emotional welfare of a child (children) and (b) significantly contribute to the child’s (children’s) ability to adapt to social and educational environments.

Mr. Brown is 40 years old and divorced. His attorney requested a psychiatric evaluation regarding his fitness (competence) to function as father to his two young sons.

Reported Diagnosis:

Bipolar Disorder: Major psychiatric disorder characterized by a cyclical or recurrent, pronounced, and persistent alteration of mood between manic and depressive symptoms. In the DSM-I, it is divided in two types: Type I, having manic,
and/or depressive features; or Type II having depressed and/or hypomanic but never truly manic features.

**Substance/Medication-Induced Bipolar or Related Disorder:** In the DSM-5 – a prominent and persistent disturbance in mood characterized by depressed mood or markedly diminished interest or pleasure in all, or almost all, activities and/or elevated, expansive, or irritable mood. To consider this diagnosis, there should be evidence from the history, physical examination, or laboratory findings that the symptoms developed during or soon after exposure to substance intoxication or withdrawal. It causes clinically significant distress or impairment in functioning.

Hospital records from 8 years earlier showed that Mr. Brown was voluntarily hospitalized (2 years prior to divorce) for MDD and suicidal ideation. He and his wife were interviewed, and it was established that Mr. Brown “loves his boys very much… and is very good with his sons… Dad had been living out of town… and came home once for children’s birthday.” During his hospital stay, Mr. Brown’s status became involuntary due to “suicidal thoughts, erratic behavior, suspiciousness, irritability, instability, guardedness, anger, and pressured speech; there was psychomotor agitation, and impaired insight and judgment.” There was a mention of alcohol and marijuana use, as well as crystal methamphetamine and “mini-thin” (a CNS stimulant) all within the year of his hospitalization. At this point, antidepressants were discontinued, and antipsychotics were started, although there was no evidence of psychosis.

After he was ready for discharge, the summary stated that Mr. Brown had “cleared nicely… his depressed mood lifted with ease.” He was released with the diagnosis of “Bipolar Disorder and Personality Disorder NOS with narcissistic and paranoid features” and a recommendation to take psychiatric medications to prevent relapse.

Army medical records indicate no psychiatric abnormality throughout his military career of 4 years. The doctors that examined him wrote that Mr. Brown is a “defensive, rigid, and deceptive individual who attempts to over-control his feeling of resentment and anger…he sees himself as a victim and strongly reacts in an overly controlling fashion towards his sons and a disregard for established visitation.” The doctors noted that Mr. Brown had been dishonest in regard to his use of drugs, denying ever using alcohol, marijuana, or hospitalized for psychiatric reasons. The doctors concluded, “Mr. Brown has serious psychiatric problems, and, without medication, he would have severe difficulties communicating with his ex-wife.” It was also said that without treatment, “it is not safe for him to have unsupervised visitation.”

At the time of divorce, both parents agreed to joint legal custody of the children, with ample time for dad and children to be together. Five years after the divorce, remarried Mom requested a very stringent schedule for Mr. Brown: a supervised 6 h visitation every other Saturday set through the recommendation of a psychologist.

I met with Mr. Brown, who had arrived 15 min before the accorded time, having to travel from a distant state. He provided me with identifying information and described the complex route he took to reach my office. He explained his present
situation, “I’ve been having the children for 3.5 years. I spent every weekend with the boys from Friday afternoon to Sunday evening...up to this year. From then on (without any crisis in their relationship) it was changed to every other Saturday, for six hours, with supervision.” He went on to describe that they usually did homework, played ball, and “father-son things.” When he disagreed with the new schedule, the court became involved. Mom was initially uninterested in the court’s proposal to have each parent psychologically evaluated.

Mr. Brown described his childhood to me. Although never witnessed, he heard his unfaithful father (alcoholic) abusing his mother. Currently Mr. Brown lives back with his mother, working full time at a job he “loved” for the past 3 years. There had not been any citation at work for wrongful acts and added that he actively participated in continuing education required by the company (40 h/year). Mr. Brown had a college degree.

Mr. Brown reported that while in the military, he would call his sons every night and visit every 6 months. He also talked about the time when his oldest son was born. While mom was at work during the day, he stayed home with his son. “I was Mr. Mom,” he added, and that “there was never a complaint put on any record” about his parental skills with his son until he became employed at his father-in-law’s business. “Her father was a total jerk to me,” Mr. Brown said.

When his wife and father-in-law told him to see a mental health professional, he agreed although he did not think he had problems. Mr. Brown said whatever was afflicting him had cleared up without the use of medication given to him and denied ever having bipolar disorder, cyclical periods of depression (days when he would lay in bed not wanting to do anything), or periods of feeling on top of the world. Dad was equivocal in his recollections about feeling suicidal when he was hospitalized in the past. His legal history, as he reports, involves some “speeding tickets” and DWI in college.

My opinion was that Mr. Brown did not suffer from a mental disorder that posed any risk to his children being with him during unsupervised visitations or baseball practices. Likewise, it was my opinion that Mr. Brown was fit to be a parent to his two sons.

Exhibiting good eye contact and being animated and cooperative throughout the interview, Mr. Brown did not display any sign of a psychological disorder. His hospital discharge diagnosis was erroneous. Given an 8-year follow-up, without psychotherapy or any medication, he displayed no signs of bipolar disorder. The doctors wrote that his condition “cleared up nicely” – bipolar disorder does not “clear up nicely.”

The most likely diagnosis that afflicted dad during the hospitalization so many years ago was substance-induced mood disorder, a time-limited mood disturbance due to direct physiological effects of the drugs he was taking. This disorder can present itself with depression and expansive or irritable mood, but not mental confusion. These symptoms can cause clinically significant impairment to the social, occupational, and other areas of functioning. The symptoms are typically due to withdrawal. Since Dad never continued the use of drugs, he never relapsed.
There was never any instance of inadequate care during the 3.5 years of unsupervised visitation. Mr. Brown and his children enjoyed 3 days/week at activities like baseball practice and games coaching his youngest son’s team and assistant coaching his other son’s team. Neither the court nor mom ever questioned his ability to care after liberal joint legal custody was awarded. The new request for change of visitation was just Mom’s preference.

The present evaluation made by the three doctors concluded that there was no sign of inadequate care during the 3.5 years of uninterrupted unsupervised visitation. Even the children said there were no problems with their dad. The three doctors were not able to produce evidence of significant risk to the welfare of his sons, nor did they provide any clinical data to back up the diagnoses they made or the psychiatric treatment they recommended. Lastly, the doctors did not give an opinion as to their understanding why Mr. Brown, for the last 8 years (since hospitalization), had not taken any psychiatric medication, or was not under any type of psychiatric treatment, and no disturbing event was ever described between him and his children.

Case 8c: Opposing Forensic Expert Opinion – Paternal Fitness for Unsupervised Time-Sharing

This psychiatric evaluation report was jointly prepared by a court-appointed psychiatrist and two psychologists concerning “best interest” of the two sons of Mr. Brown. It is said that Mom and Dad were married for 8 years. Their divorce was finalized 3 years later. The physical custody of the children was assigned to Mom, and two consecutive weekends of visitation were granted to Dad.

About Mom, the experts wrote that she was “somewhat naive.” Depicted as a loving, attentive, and devoted mother, the doctors added “...she said she could be a better mother by having more time with her boys.” There was no mention of possible conflicts between her employment outside her home and helping her children grow up. She was found to have “no characterological problems.”

Regarding Dad, the doctors wrote that he was a “somewhat rigid, defensive, and deceptive individual who attempts to overcontrol his feelings of resentment and anger...he had been dishonest in regard to his use of chemicals and that he denied ever the use of alcohol, marijuana, or being hospitalized for psychiatric reasons.”

The doctors used the psychiatric diagnosis provided by the doctor that treated him in the hospital 8 years ago: bipolar disorder. They also took a secondary diagnosis of personality disorder NOS with narcissistic and paranoid features as his current diagnosis as well. According to the experts, the 8-year-old hospital records also indicate that at that time, Dad was prescribed fluphenazine 5 mg/day (anti-psychotic), hydroxyzine 50 mg/day (hypnotic), and divalproex 500 mg/day (mood stabilizer). The opinion of the hospital psychologist 8 years ago was that no diagnosis was possible to be obtained of Dad using psychological testing, since Dad, at that time, was uncooperative. The psychologist referred to possible narcissistic and paranoid traits.
The doctors added that Dad “tends to see himself as a victim and strongly reacts in an overly controlling fashion towards his sons and a disregard for established visitation.” They concluded “Dad has serious psychiatric problems, and, without medication, he would have severe difficulties in communicating with Mom. Additionally, without his continuation of mental health treatment, it is felt that it is not safe for him to have unsupervised visitation with the children.”

Case 8d: Best Interest in Time-Sharing/Visitation

Luisa and William O’Neal are divorced and find it hard to agree on the time-sharing schedule for their 8-year-old son, Eric O’Neal. The current time-share schedule, which Mom approved of, allowed Dad two overnights per week with Eric. William wanted to implement a more stringent schedule for Mom and become the primary custodial parent of Eric.

Both parents met individually with Dr. Park, who intended to find a schedule they could all agree upon. Mom told the psychologist that she did not want the new schedule because “Dad would brainwash Eric against” her. She is also concerned with Dad’s alcohol and illicit drugs history. Dr. Park was aware of his regular attendance to AA meetings. In the meeting with Mr. O’Neal, Dr. Park read a Valentine’s Day card for Dad from his son that said, “I love you more than anything.” Dad explained that his relationship with Luisa ended because of his gout (disease that produces warmth, pain, swelling, and extreme tenderness in a joint, usually a big toe joint, and is commonly brought about by consumption of alcohol). She went out dancing three times a week, and he could not join her. Instead, he assisted Eric on his homework and taught him piano and chess and coached him in sports. He emphasized that although Mom was a caring mother, Eric was not her first priority as Eric was for him. Based on test scores, Dr. Park determined that Eric’s choice was to be with Dad and he should be the primary custodial parent.

It was determined in a substance use disorder evaluation that William’s drug choices included alcohol, oxycodone, and hydrocodone. A urine test was found to be diluted, indicating purposeful adulteration of William’s urine sample. It was determined in medical records from St. Bosco’s Health Hospital that he was recommended to attend AA meetings. Then he was admitted for the second time due to “daily drinking, consuming a gallon of wine a day and taking Percocet, using 5–20 pills a day.” He told Dr. Park that he “retired” from a medical practice due to medical disability for spinal stenosis.

The court ordered that William stop making visits to his son until he can demonstrate that he is not under the influence of drugs or alcohol for a sufficient period of time. A police officer stated that he saw Dad at his house who “appeared to be intoxicated,” and when asked if he had anything to drink, he replied twice, “I think he (Eric) is better off with her (Mom).” William made plans to bring his son on a cruise, to which the court ordered against.

I met with both parents individually and then each parent with Eric. Luisa recounted a certain weekday when she was scheduled to pick her son up in the
evening, “My son called me at noon... I knew something was going on... Dad came
to the door with vomit on his shirt, his cheeks swollen... smelling of alcohol... my
son also says that his dad does not drink... I feel very strongly that he also manipu-
lates our son....” She added that although William says he is the coach of Eric’s
sports teams, he is actually the assistant coach.

Then I met with Mr. O’Neal. He listed all the licenses he received for various
vocational occupations, including ones as a plumber, electrician, real estate agent,
etc. He explained he practiced anesthesiology at the University of Seattle, “I didn’t
like anesthesia anymore... drugs were very tempting, and I got into those... I got
addicted... alcohol, and narcotics, pain killers... in the hospital: morphine,
Demerol....”

Dad explained that he has been getting urine tests at an addiction center, but
when I asked him if that had been going on for all these years, he corrected himself
“...a while back I did 4–5 years of urine... then I stopped... I got surgery... on my
rotator cuff... no, it was on my foot, I had a touch of gout... I have a titanium joint
placed several years ago... I’m sorry, I’m trying to figure that out... let me think for
a moment... When I drink, I drink wine; red wine...doesn’t really matter...” I
pointed out that suffering from gout, red wine tends to activate the ailment and can
tigger or precipitate pain. He assured me that this was not his case.

When I pointed out that according to hospital records, he has been consuming
large amounts of alcohol and narcotics, persistently, and for quite a long time, he
appeared surprised that I knew. After some moments of circumspection, he said,
“no... not to my knowledge.” He showed me records of “negative” urine tests for
the last 10 years. William told me he was not taking any painkiller for the nerve pain
he said he suffered from but instead took a muscle relaxant. I pointed out the incon-
sistency in his recollections versus the medical records. He did not submit urine
tests around the month the police officer found him “to be intoxicated.”

I asked him about his first wife and their daughter. “I told her (first wife) to take
her (daughter) for now...I didn’t have time for her...She (daughter) has a child... she
did not tell me she was putting this child up for adoption... I would’ve taken him
in...of course...” He was hesitant and unclear relating the story. I had to ask many
questions and variations of the same question to obtain this information.

I inquired as to the role he described being proud of on his son’s sports teams.
William noted, “I was his soccer and baseball coach for three years...I’m still his
coach right now....” When I asked him if, being the coach, he had an assistant, to
which he replied that “I’m the assistant...it’s too much work.”

Then I met with Eric alone, later to be joined by Luisa. Eric very clearly told me
of his visitation schedule he had grown quite accustomed to. “She [Mom] takes care
of me and buys me stuff... but my dad plays with me a lot... but... let me think of
what to say....” Eric whispered to himself, as if recalling something previously
rehearsed, and then said aloud, “My mom buys me a lot of things but she doesn’t
spend a lot of time with me... I spend a lot of time with my dad.” He told me he
would like to be with his dad “because he does more stuff... and buys me stuff...
like an ‘I-Pod’...” I don’t know what I would get for Christmas from my mom...he
buys me more... no... she buys me more than he does... but he plays with me a
lot….” I asked him if he knew the reason for him not to go on the cruise with his dad. Eric responded, “Because my mom didn’t let me…she probably wants to be mean to my dad, so he couldn’t take me. My dad told me that he couldn’t take me because of my mom….”

Dad and Eric arrived at my office only a few minutes before the accorded time, where I found them in the waiting room quite involved in a game of chess with many pieces placed away from the initial game position. Dad asked me to meet with him alone first, handed Eric a small football and followed me to the examining room. I asked John about failing the urine test by diluting the sample, and he was taken aback by my knowledge of the event. He told me he would fax me the correction to the failed urine screen lab test but never sent it to me. He also mentioned that he “told him [Eric] to say one thing: the truth” during the meeting.

When I asked Eric to join us, Dad said “Where is the football? Go get it….” When Eric returned with the football, they engaged for a little while in throwing it around. Again, I asked Eric for his understanding of this meeting. He responded that he wanted both parents to have time with him “fair and square…I don’t want them to have any more fights….” Dad intervened to show that he and Eric played a lot together and started quizzing Eric, “What else do we do together?” Eric appeared to have been placed on the spot, “And how do we like the French fries?” When Eric hesitated, Dad helped him by saying, “Well done.” Dad insisted on continuing to interrogate Eric himself. When Eric hesitated, William would “help” him remember his answers. Dad said he taught Eric how to foul the opponent with the elbow in soccer. “If the ref doesn’t call it, you hit him again… we want to beat them….”

William mentioned that Luisa wanted to take their son on vacation. Then he turned to Eric and asked, “Do you want to go?” When Eric said “Sure,” John immediately confronted him, “Are you sure? What did you tell me?” Eric quickly rebutted, “No, because she does not know how to make games with me... Me and my dad always play together in the water…..” Dad added, “Because I’m the shark…..” When I asked Eric about his initial response, he said, “I forgot my answer.” Dad then said “I want to take you on a cruise. Do you want to come?” Eric said “Sure.” Dad asked him if he wanted to go to the ocean. Eric said “No.” Then immediately after William said “With me?,” Eric replied, “Sure, because I like surfing.”

It is in my opinion within a reasonable degree of medical probability that it is in the best interest of Eric O’Neal to maintain the child-parent time-sharing as it was prior to its being restricted for Dad, contingent upon establishing trustable alcohol/opiate abstinence. “Checks and balances” is paramount in the decision. Dad helps with homework, and Mom cooks for Eric. Mom encourages Eric to socialize. Dad has no social life, other than the one he creates around his son and the needs he decided that Eric should have.

Dad comes across as an engaging and friendly man. He feels he needs to be in control of the interaction, and, as seen during my meetings with him, he tried on multiple occasions to turn the table and ask me to reply to his inquiries instead. He misrepresented most of what he said, like being his son’s sports team’s head coach, the reasons for the failed urine screen test, or the fact that inordinate ingestion of wine would not affect his gout (coming from someone with a medical background
and chronic history of the disease). Although William said that he had stopped abusing substances “a long time ago,” he repeatedly relapsed into his dependence. There are many other convoluted stories that he creates to depict him in a better light, such as saying that he retired from the practice of medicine due to medical disability (spinal stenosis) when the truth is that his license was taken from him due to writing illegal prescriptions and using the drugs available to him as an anesthesiologist.

Finally, Dad staged a chess game to demonstrate his devotion to his son. It was clear that throughout the joint meeting with Dad, Eric, and me, Eric had been trained by his father to provide the “right” answers before me.

Case 8d: Opposing Forensic Expert Opinion – Best Interest in Time-Sharing/Visitation

William (“Dad”) told Dr. Park that he wanted to be the primary custodial parent of his son, from Monday through Friday evening, and for Eric to be with Luisa (“Mom”) Saturday and Sunday evenings, adding that he was the “best prepared to provide structure and guidance.”

Mom mentioned that she would like to keep the current schedule where dad is having two overnights per week with their son. She is concerned that if Dad has more time than is presently allowed, he would succeed in “brainwashing” their son against her.

Dr. Park understood that Dad had been sober from alcohol and illicit drugs for the last 4.5 years. He also accepted that dad regularly attended to AA meetings. Some 2 years ago, Eric wrote a letter indicating that he wanted to live with his father. The examiner reviewed other letters, including last year’s Valentine card written to Dad. The psychologist noted that last year Dad had a fractured metatarsal joint (formed by bones between ankle and toes). During the interview, Dad “spoke positively about the child’s mother.”

Dad told the psychologist that, some 8 years ago, he started having problems with alcohol and he left Ohio, where he was taking a “refresher course as part of his residency” and returned to Utah with Luisa. William told the psychologist that he only had one alcoholic relapse, for 2–3 weeks, 9 months ago, after Luisa had left him. He added that he then was voluntarily admitted at St. Bosco’s for a 4-day detoxification program. According to Dad, the doctors told him to “simply return to AA meetings.”

Mr. O’Neal also said to Dr. Park that his problems with Luisa stemmed from his suffering from gout and being unable to accompany her to go out dancing. Dad reported that Mom would go out dancing every Tuesday, Friday, and Saturday.

Dad described being the primary caretaker of son, doing homework with him, as well as teaching him piano and chess, and coaching him in sports. Currently, he picks up Eric daily after school. Mom picks him up from Dad’s house at 6 P.M., from Monday through Thursday, and he then sleeps at Mom’s. On Friday night, Eric sleeps at Dad’s, and Mom takes him from Saturday noon to Sunday at 4 P.M., and then he sleeps in dad’s home on Sunday.
Dad told the examiner that psychiatric treatment did not help him. Instead, AA meetings were what he needed to be “anchored.” He had been in “drug and alcohol rehab three or four times in the past.” William added that a “loss of focus” was the factor responsible for his relapses. Dad mentioned that he was afflicted by multiple medical ailments, including “gout, arthritis, spinal stenosis (back nerve pain), low-thyroid functioning (hypothyroidism), high blood cholesterol (hypercholesterolemia), high blood pressure (hypertension), and asthma.” Dad did not mention here his polysubstance dependence disorder. Despite, he added “his health is good.”

Dr. Park learned about Dad’s legal issues by citing, “He got in trouble for writing illegal prescriptions.” Also of note is his collection of 13 guns. Dad told the psychologist that if his son is not with him, he felt “a loss of purpose and some loneliness.” Yet, William added that he was able to “put his child first.” He was able to say that Mom was demonstrative and loving toward Eric. William volunteered that he did not think that Mom’s priority was their son, whereas in fact, that was what he emphasized about himself.

Dad also mentioned that he handled the discipline with their son. He described being quite understanding and affable with Eric. Dad rated above average in intelligence. The psychologist found the testing results were valid. Dr. Park wrote that William demonstrated wanting to “do things his own way, resist authority, be self-centered, impatient, disregard for others, and having insufficient delay in gratification. He had an elevated addiction proneness scale.” About Mom, Dr. Park found that she was “cooperative and had no evidence of thought disorder.” He added that Mom had two main concerns, which included Dad’s extensive history of polysubstance abuse (“abusing alcohol and pills”) and his attempting to align their son against her.

Dr. Park noted that Mom does not believe Dad can control the abuse of alcohol and narcotics. She is taken to work hard in the housekeeping business, owning a small company with several employees she must manage. She has a stable relationship with another man, who Eric knows and relates to. Mom’s 23-year-old son from a previous relationship lives with her and works at the local marketplace. She also has a 25-year-old daughter, who is married and lives several states away, and works in the gardening industry.

Luisa has another concern that Dad would “…not allow Eric to be his own person. He is being heavily influenced by his father in a negative way.” Dr. Park noticed that Mom “had a tendency to deny psychological problems... and overestimate healthy functioning.” The examiner did not make mention of this same consideration concerning Dad. Neither parent was found to be suffering of a major psychiatric disorder. Dr. Park then met with Eric. He was aware the meeting had to do with deciding “who should keep [him].” Eric told the psychologist that he “did everything with Dad and almost nothing with Mom.” Dr. Park determined, based on his clinical evaluation and a battery of test scores that Eric’s choice was to be with Dad.

The conclusion was that Eric “clearly shows a positive relationship with both parents…and an attitude that lacks respect for Mom, even taking her for granted.” Dr. Park found an inconsistency concerning how low she scored on standardized
testing and her limited command of the English language and her financial and occupational successes. Dr. Park only refers to William’s “past history of drug and alcohol abuse.” The psychologist did not confront him with the inconsistencies describing his past and present polysubstance abuse.

The examiner concluded that Eric should be with Dad as the primary custodial parent, from Sunday through Thursday, as well as one monthly weekend. Mom could have dinner with Eric one or two evenings. Dad should also attend AA meetings and have bimonthly drug screenings.

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**Case 8e: Fitness for Duty in Law Enforcement as a Police Officer**

Fitness or competence needs to be addressed, using *preponderance of the evidence* as the standard of proof and as threshold a measure of *adequacy* or what is the minimum necessary ability to perform that function. It is typically asked in these types of cases to assess an individual’s intellectual level, judgment, motivation for the position sought, team orientation, acceptance of supervision, presence of psychological problems, persistence, self-restraint, stress resistance, and possible biases.

Officer Sanders is a young corrections officer working in a prison. He wants to leave this position to work in the streets of Boston, as a police officer. To become a police officer, it is required to be psychologically evaluated. Officer Sanders had been examined by Dr. Smith at the Law Enforcement Fitness Evaluation Center (LEFEC) and was found to be unfit to function as a police officer.

Seven months earlier, Officer Sanders had been at LEFEC to be evaluated by a psychologist, Dr. Brown. This psychologist noted that Officer Sanders had told her of his arrest history and said that in his late teenage years, he was arrested for shoplifting and again 1 year later for possession of cocaine.

Dr. Brown found Officer Sanders fit to become a correction officer and indicated that he “has a checkered past but seems to have come around and sees the importance of both being serious and responsible.”

Police reports show no driver’s license suspensions, criminal records, restraining orders, or credit problems. The tests taken were the same for both occupations.

Officer Sanders saw me for a “Re-evaluation regarding the last psychological examination I took, this time to become a police officer… the interviewer understood that I am immature based on how I answered some questions… that I need supervision… yet, in my job now… we are under a lot of stress… I’m mature enough to do my job well… my senior officers like the way I work… I don’t have

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*Note in what follows the use of phrases like “He mentioned that...” or “Officer Sanders stated that...” or “The applicant said that he had always been...” rather than “The applicant had always been...” The first group of phrases indicates that the following was reported to the examiner by the examinee, without any corroboration from the former. The second way of starting the sentence implies that the examiner has, at least some evidence of this information being correct.*

*Same psychological procedural testing is used to assess fitness for both occupations: police and corrections officers.*
to be watched all the time… I don’t have to call them all the time for answers to questions… I work independently… they told me they are satisfied with my job… Dr. Smith, the second psychologist that examined me for fitness as a police officer, doesn’t know me.”

Officer Sanders added, “I work in the jail… keeping the inmates under control… it gets stressful maintaining peace between everyone… we are dealing with different personalities… we are right there with the inmates… face to face… a lot of tension… I am able to leave that tension behind when I leave work… it’s not worth bringing it home and still being upset and stressed… If they understand that you are serious, they respect you, and comply… I had seen another officer locking an inmate up to calm down, rather than charging him with not following orders and filing a lot of paperwork. It worked very well… the thing is to do your job well and expect them to do the same.”

Officer Sanders told me that he had always been interested in law enforcement, joining a sort of “boy scout” group for the police in high school. He dropped out of the county college after a couple years to begin working. He mentioned that he tried out several different jobs over 4 years after he left college. He then worked in a restaurant for 5 years, moving from entry level to manager. Eventually he had the desire to stop working and resume his college education to obtain a degree in criminal justice and law enforcement.

He then started to develop a desire to become a police officer. “It’s a good, stable job… with good benefits, a pension, and above all: a future. There is a great deal of diversity in assignments, with many challenges everyday.”

Officer Sanders mentioned that, after taking psychological tests, he first worked in Sudbury, as a correction officer in a juvenile detention center; he then transferred, in the same capacity, to an adult facility, also after a second and new set of psychological tests. He said that he got along well with his fellow correction officers and supervisors; he was never late, and he had never been written up or abused his sick time. Eventually he applied for a position as a police officer.

He described an uneventful childhood, intact family life, and average schooling. He mentioned that he still had many of his childhood friends and that he went on vacations with them. Regarding his two arrests, the officer told me, “I was young and stupid. As I said earlier (about the arrested juveniles he had worked with), ‘Young people react now, and they don’t think of the consequences until later, they don’t think’.”

Recounting more of the arrest, “I had just turned 18… my friend was two years older than me… he took batteries (shoplifting)… the clerk saw him… at that time he had a job… so I told the clerk I did it… so he wouldn’t get in trouble. I didn’t want him to lose his job… I was not working yet… they took me to the police station… I went to court and paid the fine… I was young and stupid… I did not tell my parents right away, for them not to get upset… I handled it by myself… but I did it all wrong… I was scared to tell my parents… I should have told them… from then on, I told them everything… what a mistake I made… it went on my records… I had just turned 18.”
He explained to me that the second arrest occurred when he was “about 20.” He went with a friend to see a band playing in town. The friend “…had a small bit of cocaine… I wanted to try drugs that night. I was an athlete (captain of the varsity football team). I had never done any of this before.” The police were doing a random check and pulled them over. They found the cocaine and brought them to the station. Charges were dismissed since the police did not have probable cause to pull them over.

Presently, the applicant denied the use of illicit drugs and added that he drank alcohol occasionally and socially with friends, never to an excess. He was never pulled over for a DUI. Officer Sanders had no points on his driver’s license. He had received a speeding ticket once while riding one of his three motorcycles. He mentioned that he liked tattoos and had five on his body. In the future he plans to get a tattoo of his children’s names. He has no body piercings.

I inquired about the reasons for Dr. Smith (the examiner that disqualified him) to question the applicant’s abilities as an officer. “I am already in the law enforcement field, so I don’t need to lie… I’m an honest person… I trust people once I know them… I’m not a distrustful person… I’m easy going… I don’t bother anybody… I am not a fighter… I only know how to defend myself.” He recognized that being eager in the examination might have appeared to the psychologist as dishonesty, out of context. “I am physically and mentally strong… I’m quite able to deal with the stress of work… quite well, every day.”

The mental status examination showed nothing remarkable that would indicate a major psychiatric ailment.

It was my opinion, within a reasonable degree of medical probability, that Officer Sanders was fit to fulfill the duties of a police officer. He did not pose a significant risk to the community or police department. I had the added benefit of conducting Officer Sanders’ IME 7 months after Dr. Smith examined him opining unfavorably about his application.

The applicant had never had an order for “retraining” in any job he had undergone. Correction Officer Sanders has demonstrated his capacity for team work: captain of the varsity football team, manager of a restaurant, and officer in a correctional facility. On the contrary, his history is a good one. After 5 years as a manager, he became a correction officer, moving after 6 months from the juvenile arena to the adult one and, after 8 months there, applying to join the police force. He even had accepted a lower salary (transitioning from manager to officer).

Throughout his employment history, Officer Sanders proved to be focused, motivated, practical, fast-learning, perceptive, and having keen judgment. He was also able to incorporate good examples of others into his own work. Officer Sanders’ arrests took place during a very specific and no longer present developmental stage of late adolescence. After accepting responsibility for the two incidents, the officer demonstrated stability, good work ethics, and successful employment.

A closer look at the testing instruments revealed that it was exactly the same package used to decide on his application as a correction officer and as a police officer. The use of this battery of tests was prescribed to assess suitability for the work as a “law enforcement officer.”
Case 8e: Opposing Forensic Expert Opinion – Fitness for Duty in Law Enforcement as a Police Officer

This examination was done by Dr. Smith at the LEFEC. Dr. Smith was asked “to determine the presence, if any, of emotional or intellectual characteristics that would detrimentally affect the applicant’s performance as a police officer.”

The psychologist administered ten different tests and a 35 min interview with Officer Sanders. He noted that Officer Sanders “has had at least three different full time jobs in the last two years.” He added, “There appears to be a tendency for deceptive behavior, and it is emphasized that no assumption of dishonesty can, or should be made from this score, unless supported by other, factual data.” On the other hand, his honesty score was listed as average. Likewise, his overall intellectual functioning was found to be average, with fair judgment and writing ability. He also scored fair concerning his attitudes toward law enforcement and the presence of bias. Officer Sanders’ dishonesty score was average.

The tests also indicated that his work attitude was positive, there was no hint of alcohol/substance abuse, and no gender bias was found. It was noted, “Work history and feelings about doing a good job appear to be generally acceptable.”

Officer Sanders also “scored low in the area of aggression, average on willingness to take orders, accept constructive criticisms, concede responsibility for errors, and ability to integrate as a member of a team. The test results also indicate that the applicant has an inclination to be insightful, compassionate, able to learn from experiences, and assumes a practical attitude towards getting jobs done. Officer Sanders’ psychological test results point toward this candidate having an average public safety and structured organizational profile fit.”

Dr. Smith prepared a summary of 13 aspects that he graded through the psychometric instruments he used. Of the 13, 11 of them were within the norm: overall history associated with success, overall social adjustment history, motivational level, self-discipline/initiative level, freedom from personality problems, freedom from depression, freedom from racial-ethnic bias, control of impulses, vocational attitude, work history, and trust in the integrity/honesty of others. Two aspects were deemed abnormal: apparent candor and consistency/reliability.

The reading of the scores also appropriately disclaims, “Any prediction is only a probability. Other factors must be considered in determining job suitability.” The examiner ranked the applicant as, “Optimistically... poor to low average.”

Dr. Smith indicated that the applicant’s scores reflected “reasonable maturity and acceptance of authority.” It was also noted that Officer Sanders had a long work history and had never been fired from a job. He had no problems with co-workers or supervisors. To this end, it was documented that “In a Police Situations Test... he demonstrated adequate judgment.”

Despite the positive findings on the examination, Dr. Smith did not recommend him for the position of police officer because of the psychologist’s “significant concern” for the arrest history of this candidate when a teenager. Dr. Smith added that a “slightly different version” of the arrest events was given by the officer in a previous testing situation, when he applied for the position of corrections officer. Dr. Smith did
not provide a description of what the “slightly different version” was. He never pro-
vided the dissimilar quotes or comment on the fact that both versions truthfully depict
the same events. Reviewing the records, it became apparent that the officer indeed
provided Dr. Smith, as well as Dr. Brown, with the same stories of his arrest history.

Dr. Smith described a problem area as being his employment history, which he
moved between three jobs in 2 years. Dr. Smith’s testing showed that the officer was
insightful, compassionate, and reliable. The examiner based his rejection on his
own concern about the arrest history of Officer Sanders.

Case 8f: Fitness for Duty and Competency to Function as a Teacher

Fitness for duty is related to competency – being able to perform a particular task or
function. Owing to the fact that fitness for duty is regulated and declared by indi-
vidual states, it is imperative to be aware of the state’s provisions. In this case, the
state has declared an individual fit to perform as a “vocational school teacher” if:

- The teacher is able to work with parents and with the community, has solid and
innovative teaching methods, and has the ability to create a stimulating learning
environment.
- The teacher has the following personal and professional qualities: attendance
and punctuality; personal appearance; voice, speech, and use of English; profes-
sional attitude and professional growth; and resourcefulness and initiative.
- The teacher provides pupil guidance and instruction: effect on character and per-
sonality growth of pupils; control of class; maintenance of wholesome classroom
atmosphere; planning and preparation of work; skill in adapting instruction to
individual needs and capacities; effective use of appropriate methods and tech-
niques; skill in making class lessons interesting to pupils; extent of pupil partici-
pation in the class and school program; evidence of pupil growth in knowledge,
skills, appreciations, and attitudes; and attention to pupil health, safety, and gen-
eral welfare.
- The teacher should be skillful in classroom or shop management: attention to
physical conditions, housekeeping, and appearance of room; care of equipment;
attention to records and reports; and attention to routine matters.
- The teacher should participate in school and community activities: maintenance
of good relations with other teachers and with supervisors, effort to establish and
maintain good relationships with parents, and willingness to accept special
assignments in connection with the school program.

It is the job of the forensic mental health professional to evaluate the examinee,
in this case the teacher, and assess whether or not there is a mental disease or defect
that interferes with the ability to function in the particular occupation given the
aforementioned criteria and standards to uphold. The role of the expert is not to
correct a diagnostic interview but a specific functional capacity assessment.
Also pertinent to this particular case is a concept of labor law regarding “whistle-blowing.” A whistle-blower can be any person that witnesses and reports misconduct by an individual, an organization, or a government entity. Typically, the misconduct involves a violation of any law or regulation. Whistle-blowing cases can involve stock/security fraud, money laundering, health threats, safety violations, tax evasion, malpractice, corporate corruption, and more.

Whistle-blowing cases are designed to hold public entities accountable while protecting and compensating the victim(s) and/or the whistle-blower. Typically, the whistle-blower receives a percentage of the lawsuit settlement funds.

Laws and statute of limitations for whistle-blowing cases vary. For instance:

- Employees or former employees may have up to 300 days to file a discrimination case against their company.
- Environmental whistle-blowers have only 30 days to make a written complaint to the Occupational Safety and Health Administration (OSHA).
- Federal employees complaining of violation of civil rights laws have only 45 days to make a written complaint to their equal employment opportunity (EEO) officer.
- Those reporting false claims against the federal government may have up to 6 years to file a civil lawsuit and may redeem 15–30% of the recovered funds under the US False Claims Act.

Ms. Jenkins has been a renowned and revered teacher in the school district for 22 years. Having started what became a prestigious program to further develop inner-city students interested in pursuing an engineering future, Ms. Jenkins proved over and over to be a valuable asset to the school system, faculty, and students.

Collateral documents from students, principals, superintendents, and other teachers describe and praise Ms. Jenkins with descriptors such as “genius,” “extraordinary,” and “innovative.” “[Ms. Jenkins] spent many of [her] free periods and time after school helping students and teachers, created an impressive atmosphere of rigor and professionalism that pervades [her] classroom” and “excellently prepared and presented lessons.”

Programs providing education and technical experience for minority students were being closed due to the allocation, suspected misappropriation, of the school’s budget elsewhere. Ms. Jenkins was aware of this injustice and was gathering the appropriate information to tell the Bureau of Education the occurrence. Upon realizing what Ms. Jenkins was going to do, the principal of the school ordered her to get a psychological examination by Dr. Witt to determine whether or not she was fit to work. Principal Kingly stated that all the stress of teaching compounded itself too heavily, thus negatively impacting her teaching ability.

Letters of support from former students read, “You have inspired me and many other students… one of the few excellent teachers that I encountered during my high school education… after so many years many of your old students (like me) still remember you, admire you, and give you as an example of the impact a teacher can have to guide, inspire, and ultimately change our lives.” Another former pupil wrote,
“I want to take this opportunity to thank you for your drive and motivation as a teacher. You never hesitated to share your humor, experiences, genius, and strong views. I will always remember and admire you for that… any success or opportunities in my life that comes my way is truly a product of you along with the few extraordinary human beings in my life.”

The town’s mayor presented Ms. Jenkins with a certificate of recognition “For outstanding achievement as a vocational school teacher in our Town’s Public Schools, your work with parents and with the community, your solid and innovative teaching methods, and your ability to create a stimulating learning environment.” Similar commendations were given to her by the school principal like “I thank you for your commitment to our students and our school community. You have made our school shine.”

Dr. Townsend, Medical Director, Town Department of Education, requested that Dr. Witt evaluate Ms. Jenkins, a teacher with 34 years of service. Dr. Townsend describes his encounter with Ms. Jenkins as her being “tense and agitated, with loud and pressured speech, which was self-serving, grandiose, tangential, and in need to be re-focused.” The medical director mentioned in the letter that the teacher “appeared to be somewhat manic, with mood congruent grandiosity and paranoia. Her insight and judgment, as well as her ability to function as a teacher seemed impaired… Please perform a detailed psychological evaluation to determine her current status and whether or not she is capable of providing effective and continuous service as a teacher of architectural design and engineering.”

I met with Ms. Jenkins for 7.5 h divided into two sessions. At my request, Ms. Jenkins agreed to our entire meeting being audiotaped. Ms. Jenkins provided me with identifying information, stating that she was 54 years old, living in Hackensack, divorced, and currently involved in a relationship with a man. Ms. Jenkins told me that she was not taking any medication at the present time and did not suffer from any physical ailment.

She described the program she was enrolled to teach at the High School of Science, located in the “inner city.” She provided details of her functioning as a teacher, having created a highly successful Architectural Design Program for high school students. She was an architect and sculptor. Her curriculum, updated as needed, was always accepted and applauded by the school administration. It called for a flexible interdisciplinary approach that required the purchase of educational materials to enhance the comprehensive learning process that the program covered. She designed, built, and financed, for the most part, the creation of the Architectural Design Program.

She also spoke about the circumstances that caused her to meet with me, using a colorful, expansive, and vivid descriptive style, full of the flair characteristic of accomplished architects, artists, and teachers. During the second meeting, I was able to listen to an audiotaped psychological examination that declared her unfit in which Ms. Jenkins cogently described and explained the present circumstances.

“I often came to the school one or two minutes late, but I was not late for class… two times I got a ‘U’ (unsatisfactory) rating for lateness, the first one some 30 years
ago, and the second one now, 1.5 years ago... The first time I received the ‘U’ rating for lateness, I was not found unfit to teach...."

Based on the documents I reviewed, my direct examination of Ms. Jenkins over a period of 7.5 h, and the standards and criteria set forth by the Board of Education, it is my opinion within a reasonable degree of medical probability that Ms. Jenkins is fit to fulfill the duties of a vocational school teacher in the Jersey City School System.

Her mental status examination revealed no psychiatric signs or symptoms representing a psychiatric ailment. Dr. Witt did not have the advantage of reviewing the letters from her students or the innumerable letters and reports of observations of this teacher’s performance, year in and year out, dating from 1982 to the present.

Without clinical data substantiating the presence of a psychiatric illness, Dr. Witt decided Ms. Jenkins needed psychiatric treatment, including taking medication for a period of 6 months. In fact, Ms. Jenkins’ descriptions of exceptional achievement as a teacher are all backed by those that observed or received her lessons. She has been continuously psychologically stable, productive, successful, and “fit to teach,” since 1982.

The accompanying documents from many sources, including principals, teachers, parents, and students, describe this teacher as an “extraordinary” teacher; “unique”; “spectacular”; “innovative”; “incredibly structured”; “terrific”; “genius”; “shocking”; “excellently prepared and presented lessons”; “inspirational”; “outstanding”; “impressive”; “constantly adding new references to the class”; “helping parents, teachers (with classroom management), and students”; “working tirelessly”; “unequaled”; “a giant”; “the only term that can be used to describe the work shown is spectacular”; “you spent many of your free periods and time after school helping students, and also teachers”; “motivational”; “impressive atmosphere of rigor and professionalism that pervades your classroom”; “truly inspirational”; “students find confidence and thrive in the type of learning environment that I found in your room”; “you have always given a great deal of your free time to encourage your students to participate in additional training”; and “several aspects of your lesson impressed me, like the loud clear voice you used to make your presentation and the attention your students gave you.”

The artistic style that characterizes Ms. Jenkins and that she uses in the classroom is what, through decades, makes teachers, assistant principals, and principals alike rave about this teacher year after year, at least since 1982, without any time of loss of professional functioning.

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**Case 8f: Opposing Forensic Expert Opinion – Fitness for Duty and Competency to Function as a Teacher**

Ms. Jenkins was referred to Dr. Witt by the head of the medical office at the Board of Education, “for a detailed psychological evaluation to determine her current status and whether or not she is capable of providing effective and continuous service as a teacher of architectural design.”
Dr. Witt did not provide the standard/criteria he used to assess Ms. Jenkins’ fitness for duty. Furthermore, Dr. Witt made no indication of the criteria he used to approach his examination. The examiner was provided only with letters from a 2-year period. None of the records from this teacher’s personal file were available to the psychologist, in preparation for his psychological examination of Ms. Jenkins.

Ms. Jenkins’ expansive expressive style of describing herself and her performance in the High School of Science negatively impacted Dr. Witt’s opinion, citing, “She often highlighted her exceptional qualities and achievements….” The examiner was dubious of Ms. Jenkins’ descriptions such as “For a person with my background, it’s like I’m in jail… it’s a crime against the children. I had built a prized architectural program… that’s the tragedy, I’m the only teacher in America that has such a program, for several years I’ve been changing the future of life of these students. I’ve changed the kids’ lives.”

Dr. Witt concluded that the findings of the psychometric tests that she administered to Ms. Jenkins showed, “Ms. Jenkins is currently functioning overall in the high average to superior range.” All the aspects tested fell between the average and superior range, while none fell below average. The worst element found as a result of the testing was the description of Ms. Jenkins as “a not very introspective/insightful” person.

Without having had the benefit of independent corroboration of Ms. Jenkins’ productivity as a teacher, Dr. Witt defined Ms. Jenkins as “nonproductive.” Moreover, the psychologist acknowledges not knowing enough of this teacher’s background to comment on her descriptions of her performance and that she was only to assume Ms. Jenkins suffers from a psychiatric illness. Since Dr. Witt did not avail herself of collateral sources of information to confront what the examinee narrated to her, she referred to it as “her rendition,” thus doubting Ms. Jenkins’s information and concluding that this teacher was not able to function effectively.

The lack of information about Ms. Jenkins’s sustained superior performance led Dr. Witt to mistakenly assume that “Ms. Jenkins was not able to handle teaching pressures, becoming overwhelmed and necessitating leaves from the Board of Education, to lower pressures upon herself and recuperate.”

Again, not having had the benefit of reviewing Ms. Jenkins’ personal file, Dr. Witt mistakenly assumed that this teacher’s “present statements reflect a marked grandiosity and over expansiveness.”

The psychologist mentions that, irrespective of the accuracy of her statements, “her (Ms. Jenkins’) functioning is deteriorating.” Dr. Witt was of the impression that Ms. Jenkins needed periodically “a hiatus from teaching.”

Based on these assumptions, Dr. Witt concluded, “at least for the foreseeable future, Ms. Jenkins does not appear capable of functioning effectively and continuously as a teacher.” Dr. Witt concluded that there was probable danger regarding Ms. Jenkins’ being in a classroom teaching and that in spite of not having found her suffering from a psychiatric condition (and providing no psychiatric diagnosis), Ms. Jenkins needed to take psychiatric medication to become “stable.”

Dr. Witt also assumed that Ms. Jenkins had episodes of “marked deterioration in functioning and was rapidly decompensating.” Dr. Witt also estimated that Ms. Jenkins needed a 6-month period of psychiatric treatment.
Dr. Witt was of the impression, without presenting clinical evidence, that teaching was a source of stress for Ms. Jenkins. The psychologist added finally, “If returned to a stressful teaching environment, more flagrant disorganization and deterioration would rapidly follow.” Dr. Witt did not provide clinical data to demonstrate such “disorganization and deterioration” of Ms. Jenkins’s mental functioning.

**Case 8g: Fitness/Competence to Consent to Sexual Relations of a Mentally Handicapped Woman**

Some diagnoses to consider heading into this next case are:

- **Mental Retardation, Mild**: Intellectual Disability: IQ functioning level from 50 to 55 to approximately 70. Concurrent defects or impairments in adaptive functioning must be present. They must exist in at least one of the following areas to meet age expectations: communication, self-care, home living, social/interpersonal skills, use of community resources, self-direction, functional academic skills, work, leisure, health, and safety.

- **Learning Disorder/Disability**: A disorder that significantly interferes with academic achievement even though performance on tests measuring each skill is not substantially below that expected given the person’s chronological age, measured intelligence, and age-appropriate education.

- **Personality Disorder**: An enduring pattern of inner experience and behavior that deviates markedly from the expectations of the individual’s culture is pervasive and inflexible, had its onset in adolescence or early adulthood, is stable over time, and leads to distress or impairment.

- **Histrionic Personality Disorder**: A pattern of excessive emotionality and attention-seeking behavior. Must present five or more of the following:
  1. Discomfort when not the center of attention.
  2. Interaction with others is characterized by inappropriate sexually seductive or provocative behavior.
  4. Uses physical appearance to draw attention to self.
  5. Style of speech that is impressionistic and lacking in detail.
  7. Easily influenced by others.
  8. Considers relationships to be more intimate than they actually are.

I was retained to ascertain whether Gloria Mori had the ability to consent to having sexual intercourse. I was also asked to ascertain whether Ms. Mori could form the intent to pursue sexual intercourse with another, as well as knowingly accept the advances for sexual intercourse from another.
Roy Erickson had been charged with the rape of Gloria Mori. The alleged victim claimed that, although a young adult by age, she was not able to consent by reason of mental defect.

Ms. Mori was adopted, along with three siblings. Their father had been killed with a knife in the town square back in their home country, and the children had witnessed it. The mother, an alcoholic with mental problems, had them with her for some time, living on the street and sleeping nights under stalls in the marketplace. The children had reportedly been physically abused and perhaps sexually abused. The children had a hard time adapting to their new environment, having problems both at home and at school. Ms. Mori was found to have chronic ear infections which lead to hearing impairment.

A psychological evaluation was carried out by an expert in vocational rehabilitation matters, a few weeks after the reported rape. He took as fact that Ms. Mori was born with a “complete congenital hearing loss, due to the absence of certain bony structures in the mechanism of hearing.” Ms. Mori presented to the evaluation “Dressed in tight fitting blue jeans and a low-cut blouse.”

She was able to sit quietly and attentively throughout the examination. The results of his testing showed verbal IQ, 66; performance IQ, 78; and full-scale IQ, 69. Without adjusting the verbal component in light of a hearing loss (a commonly practiced means of accounting for such) and subsequent learning disabilities, the expert concluded that the diagnosis was mental retardation, mild (a full-scale IQ of 70 is considered normal). The expert referred to the examinee as “patient,” assuming the position of advocate, presenting a conceivable conflict of interests. He recognized, nonetheless, “she is functioning at a reasonably high level.” His evaluation was clearly designed to assess her functional capacity in work situations.

There was also an evidentiary interview performed close to the time of “disclosure.” It is worth mentioning the background and credentials of Ms. Ritz, according to her resume. She had obtained a bachelor’s degree in social work, and did not pursue a career in psychology, psychotherapy, or forensics, with no formal clinical training.

Ms. Ritz learned that Ms. Mori had gone to stay with her sister and her sister’s family, where her mother also was living, to help them after the birth of their second child. This took place for a lapse of 10 days. Less than a month later, she told her mother that she was no longer a virgin, and a legal procedure ensued. Her mother told the interviewer that Ms. Mori functioned at approximately a 12-year-old age level. She also told her that she was hearing impaired since childhood. Ms. Mori experienced abuse and domestic violence. It is reported that she saw her father being killed with a knife. The extent of their abuse history is unknown.

Ms. Mori described many instances of sexual relationships between her brother-in-law (i.e., the husband of her sister) and her, in the child’s bedroom, the living room, the laundry room, the kitchen, the computer room, his bedroom, and also at a hotel. She said she did not want to say anything in order not to hurt her sister, yet on another part of the interview, she said that she told her sister almost right away of what was happening. Ms. Mori did not describe at any time the experience of
physical pain, humiliation, or any other emotion commonly connected to forced first sexual experiences. Instead she said she felt “stupid, scared.” She then added “the next day I was in love with him.”

Ms. Mori was skillful in calculating distances, concerning traveling time from one point to another. She was also able to describe her being aware of contraceptive methods being used during these sexual encounters and that she was also aware of the possibility of pregnancy as a result of sexual intercourse. She further mentioned that upon her return home to her grandmother’s, she took her car, drove it to a store, selected a pregnancy test kit, purchased it, drove back to her grandmother’s house, read the instructions, performed the test, interpreted the result correctly after waiting “3 minutes” for the result to appear, and found that she was not pregnant.

Ms. Ritz did not question anything Ms. Mori said, taking for granted the veracity of her words. She did not question any of the inconsistencies evident throughout the interview. Ms. Ritz was not aware of the leading questions she was presenting the examinee with.

Ms. Mori’s diary entries read, “My brother-in-law was so good husband and maybe someday I would find someone like him... I saw you first time I saw him and I really love him very much, I don’t know! But it’s pretty stupid I am. I wish I didn’t love my brother-in-law because he had cute body and I wish I can touch him. I can’t touch him, he’s my brother-in-law, it’s really sick I really want to have sex with someone but I don’t know how but I didn’t have sex yet... I wish I can try it! Have sex but I am glad I didn’t do it ... But I can’t wait the rest of my life.”

Ms. Mori is able to independently perform all tasks associated with personal hygiene and personal care. She is able to shop for her own clothing and personal needs, she has learned to cook and can fix meals for the family, and she is able to complete household chores and does not have any physical limitations. She does, however, have some fine motor functioning impairment.

Ms. Mori had been prescribed sertraline for depression, which she refused to take. In 2000 a diagnosis was made of depression, and Ms. Mori was prescribed with Serzone. This medication was changed to sertraline because of sensitivity to the first medication. She was described to be irritable, sullen, and talking angrily at her mother. Ms. Mori’s psychiatrist did not find her to be suffering from an intellectual disability, although he considered it. He registered the IQ tests results in 2001 as “verbal, 60s; performance, 80s; global 70s.”

An educational assessment that took place at the beginning of 2001 determined that Ms. Mori was not found to suffer from any mental handicap. Her scores fell within the limits of normalcy. She was found instead to be suffering from a learning disorder.

In the video interview of Ms. Mori, she did not describe any pain nor emotional correlate or tearfulness about the descriptions. I found no current expressions of fear, disgust, or pain.

She was able to fall asleep with no difficulty during her stay at her sister’s. There was no complaint of insomnia at any time. According to Ms. Mori, her brother-in-law, who she claims initiated the affair, would wake her up to engage in sexual activity.
I did not get to have a first-hand interview with Ms. Mori. From the information presented to me, I determined that this is a woman with a poorly integrated mental apparatus, weighed down with psychological (developmental) limitations, which prevented her from achieving the goals of psychological (emotional) development. This is what mostly interferes with her adaptation. Gloria Mori is a mentally immature individual, not a mentally handicapped one.

What drove her IQ scale down was her verbal difficulties, primarily related to massive early deprivation, overwhelmed with neglect and abuse, English being her second language, and her suffering from a pervasive hearing impairment.

It seems clear that Ms. Mori has a learning disorder. She also seems to suffer from a personality disorder, most likely histrionic personality disorder.

It is my opinion, within a reasonable degree of medical certainty, that Gloria Mori has the ability to consent to having sexual intercourse. It is also my opinion, within a reasonable degree of medical certainty, that Gloria Mori is able to form the intent to pursue sexual intercourse with another, as well as knowingly accept the advances for sexual intercourse from another.

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**Case 8h: Fitness/Competence to Practice Nursing**

Professional boards are charged with the task of reflecting the public interest to make sure the board does not focus on the self-interests of its licensed members and instead oversees and protects the community at large from licensed professionals that conduct their healing practices in an unethical manner or while impaired.

State licensing boards make enormous contributions to their respective profession. From the standpoint of the professional association, licensure laws define their profession, which is critical for third-party reimbursement. It also ensures that people who have not gone through arduous training cannot call themselves professionals, in the present case, registered nurses, (professing to have the knowledge, values, and experience of the members of that specific field), in effect reaping what nurses have sown in terms of reputation. These boards also play an important check on quality. They demonstrate that we take the importance of our services very seriously.5

Andrew Nash, RN, a middle-aged man, is reapplying for his license to practice emergency room pediatric nursing. Five years prior, he voluntarily surrendered his license for 3 years. The State Office of Professional Discipline ordered him to take 60 continuing education credits, stressing patient care and safety, as well as go for a psychiatric evaluation (and comply with treatment if recommended). Mr. Nash practiced nursing in a location that allowed nurses with special qualifications to provide certain medical procedures. The investigative records were available to me. Mr. Nash had been found to use excessive force restraining his pediatric patients during medical procedures, causing in a number of them some physical damage.

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5 Advanced Ethics: The Anatomy of Professional Disciplinary Actions-How to Protect Yourself”; presented by Bryant Welsh, Ph.D., J.D., sponsored by PsyBC. October 9, 2005.
When he reapplied for his license, he had many more than the demanded credits. A psychiatric evaluation was done by Dr. Thomas. Mr. Nash does not think he did anything wrong, nor does he believe he is suffering psychologically. He sees his problems at the hospital as a series of unfortunate events and does not know of anything he could have done differently to prevent them. Dr. Thomas concluded that Mr. Nash “has shown little insight into his role in the events… it is very likely that similar incidents would occur again if he were allowed to handle children.”

Mr. Nash told the psychiatrist of his family, how his father was “an artist and a bum,” his mother was “loving and responsible,” his younger brother did not graduate high school and was jailed for handling illicit drugs, and how Mr. Nash himself attended nine different high schools before graduation.

Mr. Nash described to the psychiatrist that he needed to develop a “game plan of what changes I would make within my nursing practice to show the Board that there would be significant changes that would… guarantee that safe care is being provided.”

I was approached for a second opinion, to assess if he had a mood disorder or “anger management issues” that needed to be treated so he could practice nursing again.

Mr. Nash told me of the incident which led to the revocation of his nursing license. He had a 5-year-old patient. It was reported that while performing some triage work, the patient suffered a fracture of the right femur (thigh bone). “The media misrepresented the whole thing.” There were 13 cases with verified complaints; some of patients’ bones broke during medical treatment, “of which five I didn’t even see.” Injuries included the breaking of a patient’s thumb, another patient’s wrist, etc. He described all these injuries as “accidents in the process of delivering nursing care.”

The nurse described to me the organizational aspects of his pediatric acute care practice, in a large, inner-city hospital. He reported tending to some 30 child patients a day. He mentioned that it was a lot easier, quicker, and less stressful to work with children, compared to adults, adding that these arrangements (seeing large amounts of patients everyday) were typical for a practice like his.

Mr. Nash had a chaotic childhood. His mother conceived Mr. Nash at age 16, and 2 years later, his younger brother was born by a different father. Growing up fatherless, they moved around to different communities numerous times. When he was 16 years old, his mother moved away from the children to manage a fast-food restaurant and bartend/waitress in another town. Mr. Nash took care of his younger brother, cooked for the two of them, and successfully carried out “gigs” as a magician. He described how at 12 years of age, he would take a train across the state to watch a movie, walk through the city, and return home, walk a mile to the dentist with a Medicaid card, and then walk a mile back home. His home was a small room above a tavern.

He had a lot of academic and social difficulties in school, switching from some 13 secondary schools and 4 colleges. Mr. Nash emphasized that, when he focused, he did very well. He was held back 2 years in secondary school, but toward the end, he worked hard to make up for those years and graduate on time. At 16 years old, he
met his current wife, 3 years older than him. She was working as a physician assist-
tant and he as a magician. Encouraged by her, he applied to nursing school and got
in on a full scholarship. To illustrate how focused and driven he was, Mr. Nash
described enrolling in an online brief psychology course and repeatedly testing to
obtain an “A.”

Upon becoming a nurse, he fused the art of magic with the practice of pediat-
ric nursing, adding, “If you do magic for children, they like you.” I inquired as to
the incident that moved the board to get close to revoking his license. He began
telling me that he always followed the protocols set forth by the American
Nursing Association and the State Licensing Board concerning the use of
restraints. It was advised against the parent being present with the child in the
treatment room in these cases, since the tendency was for the child to behave
worse, causing conflict between the authority of the medical professional and the
parent.

Mr. Nash told me that he never thought he needed psychiatric treatment. He
added that he learned how not to be a parent from his childhood experiences and
that his approach to life was “what doesn’t kill me, makes me stronger.” Instead, he
said he read a lot of “self-improvement” and psychology books and felt that he was
a “stable and well-adjusted individual.” He described to me a book he was writing
on “mathematical philosophy, based on the problems of dichotomization in our
society… the wrong of artificially splitting things into twos all the time… instead of
placing emphasis on the spectrum beyond good and bad, for example.” He added,
“I’m not like most people… I grew up by myself… ‘love’ is the most important
thing in my life… there’s no room for negative feelings….”

Mr. Nash went on to talk about love, in detail, as an emotion toward people, as
opposed to a “sine qua non” of a relationship and that anger was a wasted emotion
that he did not have. He described how, if he felt an inkling of hatred, he “would
analyze it and get rid of it… I’m not a yeller… I talk with the person.”

His affect and insight were the only aspects of the mental status examination that
appeared problematic. He gave the impression of someone being interviewed for a
job and did not seem interested in figuring out if psychological problems played a
role in the infliction of pain he is reported to have caused in his patients. He did not
believe he needed any sort of treatment, nor did he think there was any connection
between his troubled childhood, particular relating patterns, and the actions that
caused the physical injuries of his patients. One of his first patients, a child of
5 years of age, died as a result of improper use of anesthesia, followed by a crucial
delay in requesting help while in the hospital setting.

His claiming to not know how his patients were injured indicates a defensive
reaction to compensate for an overwhelming harm to his self-esteem. He talked
about how his tragic past helped him become the good person he is today. Unlike the
rest of his family of origin, he said he was psychologically healthy. As his occupa-
tion as a teenager suggests, he *magically* reinvented himself. He is a firm believer in
the saying “what doesn’t kill you, makes you stronger.”

When it comes to nursing, Mr. Nash appears only in it for the monetary aspect.
He does not view his profession as a “helping” one. He cannot empathize and be
concerned about others, mainly his patients. He lacks the ability to acknowledge his “contributions” to the injuries he was involved in that led to the license suspension.

It is my opinion that Mr. Nash suffers from narcissistic personality disorder (NPD). This disorder is characterized by, according to the DSM-IV-TR, him having a pervasive pattern of grandiosity, need for admiration, and a lack of empathy. Someone with NPD overestimates their abilities, inflates their accomplishments, and loves to boast. They manipulate the standards to fit their practice and feel surprise or anger when the results are contradicting their expectation. These individuals are not tolerant and can yield injurious responses when provoked. Mr. Nash expects total admiration and compliance by all. He fishes for compliments, often using great charm. People with NPD tend to only form relationships if the other person seems likely to advance their purposes. Mr. Nash poses a likely risk of hurting his patients due to his inability to recognize his own aggressive behavior under stressful conditions, while all along being limited to experience empathy, and recognize the plight of another. The “at-risk” population comprised children, impaired adults, and the elderly.

It is possible to help this individual through psychotherapeutic treatment conducted by a skillful professional. Through therapy, he can learn to identify the conflictive forces at the core of his aggressive behavior, particularly when under stress.

Mr. Nash started psychotherapy, and I met with him, at his initiative, some months later. By then, I had discussed the therapeutic process with his treating psychologist. I met with him to assess his fitness to adequately provide direct nursing/medical care to the “unimpaired” adult community. This population excludes the geriatric group and the psychologically and physically infirmed individuals.

As established, Mr. Nash suffered from NPD that limited his capacity to adequately care for a specific sector of the public, namely, children and the vulnerable. However, not all persons with this disorder act in a violent manner, and not all of them respond well to psychological treatment.

Mr. Nash does not pose an imminent danger to unimpaired adults and has no prior history of such behavior to them. Andrew Nash, R.N., has not treated adults in his nursing/health practice, so no record of violent behavior has ever been recorded.

Based on the aforementioned, I find no psychiatric contraindication for Mr. Nash to practice clinical nursing with unimpaired adults, once it is established that he has the adequate nursing knowledge to provide such care. The State Board of Nursing will use this finding as one aspect of the criteria it needs to reach its decision. Eventually he may be permitted to deal with well-child checkups required for school attendance if the board sees fit.
**Introduction to Assessing the Risk of Violence**

Standard of care exists for the assessment of *violence* risk but not for the prediction of violence or dangerousness (this is not a psychiatric diagnosis, it is a legal judgment based on social policy).

Four tasks form the basis of any professionally adequate risk assessment. The MHP must be educated about what information to gather regarding risk, gather it, use it to estimate risk, and, if the clinician is not the ultimate decision-maker, she/he must communicate the information and estimate to those who are responsible for making clinical decisions.

A clinical determination that a patient is dangerous does not necessarily indicate that the person is likely to commit a violent act. Rather it represents a judgment that a patient poses an unacceptable risk of causing harm.

The assessment of a risk of violence is a present-time estimation and, at most, comprises a lapse of a few days or week. Attention is paid to the risk factors for violent behavior. It is important to clinically evaluate if there is current violent ideation; how well planned the threat of violence is; available means of inflicting injury; past history of violence and impulsive behavior with attention to frequency and degree (magnitude) of past injuries to others and self, toward whom, and under what circumstances; substance abuse (i.e., alcohol, illicit drugs); presence of psychiatric disorders (such as schizophrenia, mania, or other psychosis) or other organic (brain) disorders; and non-compliance with psychiatric treatment in the past. Stability of family environment should also be evaluated.¹

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Case 9a: Violence Risk Assessment for a Child with a “Kill List” at School

Question: Does Tim, age 11, pose a significant risk of violence?

Ms. Roa called from Tim’s school district to inform me that he had composed a “kill list” that included schoolmates and teachers. Tim did not describe any specific plan or perform any violent action. In response to this list, he was suspended until a psychiatric evaluation is performed. He started to receive homeschooling.

Several documents were reviewed prior to meeting with the parents and Tim himself. These included a letter from Ms. Roa, an incident report from Tim’s school, his report cards, nurse’s records from his school, all his medical records, the “kill list,” and 12 pages of Tim’s writings and drawings.

Ms. Roa’s letter stated that Tim wrote notes in school of wanting to kill himself as well as others and that Tim showed an inability to control his thoughts with remarks like, “I wish I were dead” and “I wish to go to Heaven and have eternal life.” Upon the discovery of these notes by a schoolmate, an incident report was issued.

His report card for the fourth grade showed As in eight subjects and Bs in two. There were no critical remarks. Throughout the fifth grade, he had received all As and Bs. The third marking period showed As in nine subjects and a B in one subject, with an observation of needing to complete his work on time and to be more observant of school and classroom rules.

The school nurse’s records showed no significant ailments. The hospital’s medical records, where Tim was taken directly from school, showed unremarkable neurological, psychological, and physical examinations. Firstly, the doctor recommended admission, and upon further examination, Tim was recommended to be discharged home, being diagnosed with depression, despite of no clinical documentation for it. There was no history of substance abuse or psychiatric illness.

Tim stated that he liked math and science and would like to find a cure for cancer. He added, “I didn’t want to hurt anybody.” A notebook containing the actual “kill list,” drawings, and writings of Tim showed disturbing images. First, I noticed a list of names that sat under the title “kill list.” Next to it was a list of names under the heading “wish list” consisting of those that he would like to spare, which included his little brother. There were no plans written to kill anybody, including himself. One of Tim’s written narratives ended with him saying, “I will be trying to survive the future.”

Tim’s parents talked about his being a “model student” and that he was studious and liked to draw and read. They said they were “totally surprised” at this event, claiming it was the first time anything of this sort had happened. Two days prior to this event, Tim received a prize from the city for an essay that he had written. The family celebrated.

Aside from receiving only As and Bs throughout his elementary school education, the parents described how he liked to read all sorts of books appropriate for his age level, as well as to draw. “In fact,” they added, “he has books that teach him how
to draw.” Tim’s parents mentioned that Tim had always been a quiet and well-mannered boy and “that no one knows who he is.”

The mother described to me how Tim told her he composed his “kill list” in a moment of rage. He had told his mother a secret that he kept for 3 years and that he had a crush on a girl in his class, Laura. He had told his best friends, Kyle and Sue, about this “love” of his. Kyle and Sue had been telling everyone in his class about his crush and he was very upset, especially at his best friends. On this list were their names, including Laura, which he said was to cover up anyone’s thoughts of him being fond of her.

The parents described how, when angry, Tim would turn “quiet, almost still, and read, write, and/or draw.” Tim was not described as a child who expressed his intense emotions verbally.

Tim’s parents said that, at the hospital, no one explained to them the reason for the initial recommendation for hospitalization. Once home, he began homeschooling until a psychiatric evaluation clarified if he could start attending public school again. Homeschool is about an hour a day. He would spend the remainder of the day at his parents’ antique store. They said, “He is aware of what he did, and also learned about the consequences of it… he regrets it, and never imagined this outcome.”

The parents talked about their marriage. They mentioned that they had a good relationship, and both participated in the upbringing of their two children. They added that Tim never had psychological or physical ailments, and the two brothers were never physically punished for misbehaving. “Swearing is not allowed in the house, and we don’t have cable TV. Both children are expected to study, respect, and clean their rooms. They play together and look up to each other.”

I was informed that a week before Tim created the “kill list,” a robbery took place at the store, while Tim was present. A man held up the store, the father became angry and swore at the man and told his wife to call the police, and the man took a chair, shattered the glass door, and ran away. Tim witnessed this violence. The family never discussed the event at home.

I met with Tim (member of an ethnic minority) after meeting with his parents. He told me that he knew he did something wrong and that “the issue is to correct it… and also learn from my mistakes.” He added that the reasons for placing certain people on his “kill list” were due to small disputes between friends (one girl bosses around his best friend). “I was just mad at them,” he added.

Tim cares deeply for his family and enjoys his new neighborhood because it is quiet. In the town Tim lived before he moved to his current residence, he witnessed two older boys swearing at each other on the playground during school. It quickly escalated into a fight until teachers came to break it up.

Tim was quick to inform me that he took karate (offensive practices) and advanced to a green belt, progressing from “white, to yellow, to orange, to green,” he proudly described. He enjoyed taking an alternate form of practice called aikido (self-defense techniques) over karate and plans on resuming aikido (a defensive form of martial arts) soon.

Tim told me of his passion for reading and that his favorite books were the “Goosebumps” series. “They are not scary, there is no violence, but action... it
doesn’t get you scared… it helps you use your imagination….” He also enjoyed reading books about the revolutionary war. Tim talked at length about his knowledge of the “Underground Railroad.”

When it came to anger, he said his dad deals with it by “working hard and also taking naps,” while his mom “reads a book and plays soft music.” He mentioned that he felt scared during the store burglary incident. It was the first time he saw his father in a rage. He said this occurrence took place 2 weeks prior to the “kill list.” After the robbery, and even the “kill list” incident happened, nobody in the family even so much mentioned it.

Tim was aware that almost everyone at school knew about his “kill list.” He was upset because he realized that people will forever look at him differently, “not as a bad person… but as somebody who needs help.” He did not think of the repercussions that followed.

There were no abnormalities found in his mental status exam. Tim recognized the seriousness of his threat and was aware of the impression it made on all those concerned. He did not suffer from a mental disorder that posed a risk to commit a violent act, nor did he hold a record of previous antisocial behavior or violence to himself or others. He did not suffer from a substance disorder, nor was he impulsive.

Tim had no plan of action to carry out the death of, or violence toward, the people on his list. Despite his list, his conduct was nonthreatening toward all involved.

The boy was living in a secure and stable home environment. His parents held a solid employment history, financial stability, and social network. His relationships with others were never characterized as superficial. He was a sincere, dedicated, and interested boy.

The opinion reached was that Tim did not currently present a likelihood of a risk of violence toward himself or others, although preparing the “kill list” was, in itself, abnormal (indicating a mind in trouble). He appeared to be an intellectually and artistically resourceful boy; however, given the limited communication between him and his family to discuss emotionally charged situations, he was left on his own to sort out intense emotions using inadequate psychological means.

To correct this situation, the recommendation was made that Tim resume his normal schooling at the start of the next academic cycle (it was currently June) and also that he begin psychotherapeutic treatment aimed at developing effective ways of dealing with upsetting emotional states.
Definitions and Explanations

**Actus Reus**  
Unlawful act

**Mens Rea**  
Culpable or guilty mind

**Intent**  
A state of mind in which the person knows and desires the consequence of his act

**Reasonable Person**  
Legal concept referring to a person’s use of adequate attention, knowledge, intelligence, and judgment that society requires of its members for the protection of their own interests and those of others (Dictionary of Legal Terms; Third Edition, 1998, Barron’s)

**Affirmative defense**  
One that serves as a basis for proving some new fact, in which the defendant does not simply deny a charge but offers new evidence to avoid judgment against him/her (Dictionary of Legal Terms; Third Edition, 1998, Barron’s)

Introduction to the Insanity Plea

Two essentials need to be proven present by the government, beyond a reasonable doubt, for an act to be judged as criminal: *actus reus* and *mens rea*. The prosecution’s task is to establish that the defendant had the *intent* to commit the wrongful act, in addition to the act itself.

Insanity is a legal term that does not mean psychosis or mental illness but that may incorporate these concepts into its definition. It specifically considers the state of mind of the defendant at the time the illegal act occurred.

The law defines the elements of the person’s mental state that the prosecution must prove in order to establish intent. Generally, the state has to prove that one of four possible standards of culpability was present at the time the wrongful act took place. The defendant must have acted either purposely, knowingly, recklessly, or
negligently. The former two aspects were previously called “specific intent” and the last two “general intent.”

The highest culpability standard is *purposely*, which means that the person’s conscious object is to engage in such conduct or cause such a result. The second highest is *knowingly*, that is, the person acts with the awareness of the nature of the conduct or is practically certain that the conduct will cause that result. *Recklessly* means that, concerning the result of the action, the person consciously disregards a substantial and unjustifiable risk. The disregard of the risk must represent a gross deviation of the standard of conduct that a reasonable person would observe in the actor’s situation. Finally, gross *negligence* refers to the failure to perceive a substantial and unjustifiable risk that the result will occur or that the circumstance exists.

The Insanity Defense Reform Act of 1984, enacted by Congress in 1984, in response to the verdict in the Hinckley trial and codified at Title 18, US Code, Section 17, states that a person accused of a crime can be judged not guilty by reason of insanity if “the defendant, as a result of a severe mental disease or defect, was unable to appreciate the nature and quality or the wrongfulness of his act(s).” Under these circumstances, the defendant is declared “not guilty by reason of insanity (NGRI).” Insanity is an affirmative defense and has to be proven by the defendant. In some jurisdictions, a second prong (volitional) is added, reading: “and/or must not be able to conform his/her conduct to the requirements of the law.”

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**Case 10a: Assault by a Schizophrenic**

In October 2001, Mr. May was brought to a hospital’s emergency room because he had, for no apparent reason, “gone berserk” and attacked a nurse. He was immediately arrested and charged with aggravated assault. Several documents were reviewed, including police statements and hospital and outpatient psychiatric records, prior to examining Mr. May to decide whether or not he was insane at the time of the criminal act.

Mr. May was taken from a city bus for acting strangely, saying the lights on the bus were flickering in a pattern, telling him that there was a bomb on the bus and how to dismantle it. He also is reported to have said that he made a computer when he was 6 years old and was the CEO of multimedia, but could not give the location of his office. Mr. May had not paid the bus fare. He was hospitalized at around 8:00 AM. He was “confused, talking nonsense, and seeing something on the wall.” The medical documents further noted, “Patient not taking medication… refuses labs… diagnostic impression: Psychotic episode.” His responses to questions were inappropriate: “I’m from the ranch in Texas, President Bush’s.” He then began swaying back and forth, staring at the ceiling. He was behaving very aggressively and refused to give consent for hospital treatment. Mr. May was also accusatory, demanding, and fluttering his eyes constantly. At 9:10 AM, he leaped out of a hospital bed and attacked a nurse who was going to “check him prior to evaluation.” He was placed in four-point leather restraints (wrists and ankles). Later he explained that the reason for attacking the nurse was because, “She’s part of the plot to end the
world.” Further investigation led to Osama Bin Laden paraphernalia plastered all over his disheveled apartment.

Later that night Mr. May became calm and cooperative, denying any feelings of agitation. “He cannot remember anything about the assault. Patient is too psychotic to discuss Consent to Inform Family…he is unable to sign form.” The next morning, although still in restraints, he was reading and eating normally. His brother said there was no history of violence or medication. His father explained that he paid for his living arrangements, to keep him off the streets because he did not have a steady job. He was never reportedly in treatment.

His insight and judgment were severely impaired. With a GAF of 30, he described “9/11” as a stressor. A few days after the assault, he was admitted to a psychiatric hospital, where he was unkempt and behaved in a very guarded and belligerent manner. His speech was monotonous; his mood was agitated and labile. He said that people were laughing at him and was found to have delusions of persecution and grandeur. His thinking was often disorganized, and he was not oriented to time. His attention, concentration, insight, and judgment were poor.

Mr. May was eventually transferred to a forensic unit for further care. He was given medications, and his mental state cleared. As he became more cooperative, he admitted to hearing voices from the devil telling him to join “the cult.” He developed a greater insight and was able to recognize he had a mental problem. He became compliant. He soon was no longer hallucinating or delusional and was able to think logically. Mr. May was cleared for discharge with a diagnosis of schizoaffective disorder. He was required to stay on medication and follow up with a psychiatrist.

Later, Mr. May attended an outpatient treatment. The psychiatrist mentioned that “9/11” affected Mr. May, causing him to become seriously preoccupied with terrorists. He believed the nurse treating him in the hospital was a terrorist, and as a result, he tried to kill her. At that time, his insight was marginal and his judgment was defective. The psychiatrist diagnosed him with schizophrenia, paranoid type.

He was interviewed again a few months later, and although he “seems to be in good shape,” according to the report, with a normal rate of speech and better hygiene, the diagnosis remained the same.

Mr. May showed up promptly to the examination with me. In his late 30s, he had been on psychiatric disability for 9 months. He provided identifying information and current psychiatric medications, which included risperidone (antipsychotic) and Colace (stool softener).

Mr. May said, as he was recounting to me the events of the day of the assault, that on the bus, he had thought there was a bomb, and the only way to disable it was to watch the lights on the bus. “It made perfect sense back then… now it seems perfectly foolish.” When the police came on the bus to arrest him, he claimed to feel relieved and did not resist. He could not recall if the bus incident happened before or after the hospital. To him, the hospital he was taken to “looked like ground zero… there were jackhammers… in the street. The noise did not stop bothering me.”

In the hospital Mr. May claimed to have seen “a man with a beard” who reminded him of a terrorist, “the enemy.” He added, “I was tapping my feet and watching the
lights, as if it were a game of chess... I was looking for black and white players on a chessboard... I didn't know what they were doing to me.” He said he was afraid of the “man with a beard,” yet cooperative at the same time, providing identifying information. “They were moving me from room to room, again according to the game of chess, and according to the lights... she (the nurse) came in and tapped my arm as if to put in an IV. She was in and out, again according to the rules of chess. I heard people asking my name, then quacking like ducks, gibberish... I thought she was going to poison me... that was when I hit her... a voice told me to punch... I was afraid of the man with a beard. I had to do it to protect me, it was all part of a game of chess... they kept moving me from room to room, it was a game of chess... the jackhammers in the street... four men restrained me.”

He went on to describe how he was “tortured.” He was asked for a urine sample, but he did not produce any, so “they passed a hot wire in me... twisting... it was the most painful thing I’ve ever had in life... so painful I fell unconscious... I then woke up in a psychiatric hospital... the chess game was over, no more light, no more duck-quacking. I was clearer, no more restraints... I was taking pills.”

In the psychiatric hospital, he said he felt imprisoned, scared, and uncomfortable. Slowly he realized that people wanted to help him. He did not know why he assaulted the nurse, for he said he had never assaulted anyone before. “I am a very passive man,” he added as he handed me a letter from his father describing dates they could remember about his past psychiatric involvement. In 1996, he was diagnosed with “bipolar/schizophrenia”, but was not told to seek further counseling. The same happened again in 1999. A few times after that, he went to some sessions at a center, with some help, but interrupted it.

Mr. May described how 6 years ago he was living in California when his car was stolen. He had problems with his job and lost his apartment; he left for the east coast and asked his brother for support. He thought he only needed financial help, not psychiatric help.

He reported having a “good childhood” and rich in experiences and ambition. He claimed to be a very good magician in his youth, but now magic made him nervous. He said that he had a stable and productive family whom he related well with. “At 8 years old I had a ‘Compu-kit’. The lights blinked according to the way the wires were connected... I can see now how the mind can play tricks on you.”

Before “9/11” he lost his job as a telemarketer. He was studying the Internet since “9/11,” decoding and sending messages to people. He felt distanced from his family and stressed out. He watched the towers collapse and felt very upset that people would do that. “I was frantically decoding messages and sending them everywhere.”

He added that currently, his sleep and appetite were normal and felt comfortable attending psychiatric treatment. Mr. May’s affect was mildly constricted and intense, appropriate to the situation and ideation. His mood, speech, and judgment were unremarkable. There was no formal thought disorder elicited. He denied current hallucinations and delusions of any type. He denied current or past suicidal ideations. He was oriented to time, person, and place. His ability to recall clearly the events surrounding his assault on the nurse was limited due to the
psychological turmoil he had been under. Otherwise his memory, attention, and concentration were adequate. His intelligence level appeared average, although no psychometric testing was performed. Mr. May recognized that his insight had been lost the day he assaulted the nurse and that he needed continued psychiatric help to remain stable.

The question for me to address is of Mr. May’s sanity at the time of the act for which he was charged with aggravated assault of a nurse in 2001. The opinion, within a reasonable degree of medical probability, was that on that date, Mr. May was afflicted from an acute decompensation of paranoid schizophrenia.

Manifestations of this mental disease include auditory hallucinations (hearing voices), elaborate delusional belief systems (false beliefs about people trying to kill him), having a special capacity to decode messages from terrorists, being closely related to President Bush, the hospital being the stage of terrorist attack, hospital personnel being terrorists in disguise (and alternatively chess pieces), and being able to decipher rules and procedures by following lights on the ceiling of a bus and hospital room. His thinking was illogical and secretive, his affect was flattened and inappropriate, and his behavior was erratic and unpredictable.

His delusions were bizarre and included classical paranoid ideas: he thought he was being attacked by a “class” of people and only he knew how to figure them out. These delusions related to the assumption of his keen intellectual capacity to decode Internet messages and his being a member of President Bush’s staff and family. His auditory hallucinations were of the schizophrenic type. Mr. May’s assault on the nurse is consistent with his perception of being attacked. He had a history of slow but progressive mental decline, lasting over 10 years.

On the day of the assault, it was evident that he was suffering from a psychotic episode and could not comply with any offered treatment or even sign the admission forms. The assault is in response to psychotic symptoms and not due to any use of substances. There is no record of violence in this man.

A psychiatrist confirmed on the day of admission into the hospital that he was suffering from a mental illness that endangered him, others, and/or property. The psychiatrist confirmed that his judgment and capacity to control his behavior and recognize reality were all impaired.

Mr. May’s psychotic behavior fully conformed to his delusions; he did not know the wrongfulness of the act he committed because he truly believed the nurse and other hospital employees were terrorists. He also believed that real people had become chess pieces; among these chess pieces was the nurse, whom he thought was a terrorist instead. He was also receiving specific messages from the lights in the bus and in the hospital rooms he was in.

It is also my opinion that he did not know the wrongfulness of his act, thinking he was acting in self-defense. He acted out of intense fear because of what appeared to him to be a confusing world in which terrorists were killing everybody.

It was not his intention to be violent but to only decode “terrorist” Internet messages and warn other people about their imminent strike. He could not refrain from attacking the nurse because he was convinced that he was the victim of a conspiracy.
in which he was about to be killed by the “terrorist” nurse. Also, he could not stop himself because he felt controlled by voices. Putting all of these pieces together, it is clear that the mind in which Mr. May was operating from did not allow him to act appropriately. In fact, it is likely that the events unfolded due to his psychiatric episode occurring acutely at that time and, furthermore, with the correct treatment, would have been avoided.
Diminished Capacity

When Mental Illness Compromises Judgment

Kleptomania is characterized by (a) recurrent failure to resist impulses to steal objects that are of no personal use or monetary value, (b) rising sense of tension before the theft, and (c) feeling of pleasure or gratification when committing the theft. The individual does not steal in response to hallucinations or delusions, and the theft is not preplanned nor is it done with the collaboration of others. The individual will hoard the objects, give them away, or surreptitiously return them. The kleptomaniac frequently fears apprehension and will avoid committing the theft in plain view of a police officer. The individual may even feel guilt and depressed by the theft. Ironically, kleptomania is associated with compulsive buying as well as mood disorders, anxiety disorders, eating disorders (particularly bulimia), personality disorders, and other impulse control disorders.

Case 11a: Diminished Capacity with Kleptomania

Prior to meeting Ann Witt, I reviewed all data given to me. Her lawyer told me that she has once again been charged with shoplifting. The reason he had called me was because this has been happening regularly and she was found guilty for all shoplifting charges. Now, the attorney wanted to know if his client had a clinical psychiatric diagnosis that prevented her ability to function appropriately in certain situations she was routinely being found guilty in.

At the prime of our meeting, Mrs. Witt stated “I steal.” When I asked her to expand on the statement, she explained “I go to stores and I take things. I am a compulsive thief. I just can’t go to the stores without taking something… sometimes foolish things… anything I can get away with, I guess. Pepper shakers, knickknacks, figurines… I don’t have specific thing I’m going out to take. If I like it, I take it.” Most of the thefts occurred at nighttime; she does not go to the store during the day. She continued to explain that during the act of theft, she feels “queasy, nervous, and
scared” until the moment she leaves the store. However, after the act is accomplished, she feels “happy that [she] didn’t get caught.” She added, “If I don’t steal, I feel rotten… I feel I went there for nothing. I know I need help.”

Mrs. Witt mentioned also that she was aware of the reason of the evaluation. She understood the circumstances that brought her to court. She also mentioned that she is “petrified of going to jail.” She had never tried to outsmart the security guards and was never incarcerated. However, her many charges led to fines and probation. She was even ordered to be sent to jail for 30 days. Mrs. Witt added that she only stole from stores; she did not steal anywhere else including a friend’s house or doctor’s office.

When she resumed to explaining her medical history and present condition, I found out that she had a history of bulimia, eating incessantly, reaching over 300 lb. Due to bulimia, she developed sleep apnea disorder. This is a condition characterized by heavy snoring, with frequent periods of apnea (interruption of breathing). Her bulimia also led to her gastric stapling which reduced her weight to 160.

In addition to bulimia, her first psychiatric diagnosis was agoraphobia and panic disorder. Like bulimia, panic disorder is also another disorder that kleptomania is associated with. She displayed signs of agoraphobia and panic disorder when she was in line at the grocery store with her son. “I went to Shop Rite… as I was getting on line to check out, I felt I was going to pass out. I couldn’t talk,” she described. Agoraphobia is the fear of being in crowded areas that may be difficult or embarrassing to escape from. This explains the reason Mrs. Witt goes to the stores in the nighttime instead of the daytime. The mass of people makes her feel uncomfortable. However, in these cases, agoraphobia may be controlled by the assistance of a companion. “I don’t like being by myself,” she added, “I panic, and I would go back home. I feel like running around like a chicken without its head.”

After performing the examination, it was in my opinion that Ann Witt suffered from kleptomania, panic disorder with agoraphobia, and bulimia nervosa. Mrs. Witt knew that theft was wrong but could not control her impulse to steal. As is typical with kleptomaniacs, she feared apprehension. The objects she stole had no monetary value or use to her. Her condition before, during, and after the theft (feelings of nervousness followed by feelings of gratification and finally feelings of guilt) follow the symptoms of a kleptomaniac. She also has the disorders which kleptomania is associated with. I observed the severity of her conditions, when we learned about the other medical, surgical, and psychiatric conditions that she suffered from.
Introduction to Malingering

Few mental disorder cases reach the courts without an expressed or implied allegation of malingering, having as primary motivation, financial gain, and then sympathy and social support.

*Malingering* is listed in the DSM-5 as the subject of Differential Diagnosis concerning Factitious Disorder; as a condition not attributable to a mental disorder that may become the focus of clinical attention. It is the “intentional production of false or grossly exaggerated physical or psychological symptoms, motivated by external incentives (a recognizable goal), such as... financial compensation” (APA 2000, p. 739).

The clinical presentation is diverse and heterogeneous. It defines a responsive style, rather than an identifiable syndrome, and is characterized by peculiar descriptions of severity, duration, and degree of distress.

In deception, the individual tries his/her best to appear as if describing a current and debilitating clinical entity. The clinical interview is the only viable method of concentrating on motivation.

A malingerer is not a dishonest patient that lies or distorts the past, or a manipulative patient, or the disengaged aloof or defensive patient, or the one that wants badly to be seen as suffering, as a patient. *Malingering only describes the deliberate fabrication or gross exaggeration of symptoms for a recognizable goal.*

There are two main situations in which the diagnosis of malingering can be clearly confirmed: when these persons think they are unobserved and are caught in the act and when they actually confess that they are faking.

An essential third option, and the one that sheds the most light during the examination, consists of the thorough collection of collateral data, including any prior medical and psychiatric records and complete progress notes of the therapist, rather than summary reports. If the clinician *possesses* more factual information about the case than the claimant knows, it helps the examiner to assess the claimant’s veracity.
Case 12a: Malingered Kleptomania Versus Shoplifting

I was asked to examine a woman with an apparent compulsory behavior to steal. Her defense attorney referred his client to me, hoping I would fine her suffering from Kleptomania.

This was a Ukrainian woman, Ms. Kozak, that presented to me in the company of her sister who asked to be present to assist with translating as needed. Ms. Kozak had serious limitations with the English language. I spent 1 h with her, reviewing some material Ms. Kozak brought along and examining her. She was 50 years old, divorced, and working 20 h weekly as a “home attendant” with the Ukrainian elderly. No occupational problems had ever been reported about her.

Ms. Kozak told me that she never had legal problems for stealing or shoplifting before. She lived with, and took care of, her 103-year-old grandfather, who was presently infirmed and bedridden. Twelve days prior, she had started taking Elavil (antidepressant) 25 mg, and lorazepam (mild sedative) 0.5 mg p.r.n., both twice daily, as per a psychiatrist that after that first visit referred her to the local mental health center. There was no history of mental health treatment in this country.

“Sometimes I don’t know what I’m doing… I was with my sister and her mother-in-law, shopping at Wal-Mart.” Ms. Kozak replaced the price tags of three to four items (women’s clothing) with tags indicating lesser price. She added that this was done “in the open… sort of.”

Ms. Kozak told me that she received special education, as her speech was delayed until she was 4–5 years old, due to cognitive and behavioral problems. She would suddenly feel overwhelmed and act bizarrely, thinking that people wanted to poison her. The examinee said that she completed the eighth grade. Also, I was told that when Ms. Kozak was 1 year of age, she became sick with meningitis.

I heard from her that her father had a mental illness, was deaf/mute from birth, and was disabled. Her mother, also a deaf/mute from birth, was diabetic and lived with her sister. Ms. Kozak was the eldest of the four children; only one of them remains in Ukraine. She added that the brother that lives in America does not speak to her since she is “not normal.” She came to the United States 4 years ago and had a son in college. Ms. Kozak mentioned that her grandparents helped her to raise her son.

Encouraged by her sister, Ms. Kozak took a 2-week course and trained to become a home attendant, same as her sister was. Ms. Kozak was working in this capacity for 1.5 years, 4 h per day, for a total of 20 h weekly.

“I don’t go shopping at all now… I have my sister doing it for me… I don’t understand what happened.”

She also mentioned that in her country, she had been the subject of physical abuse by her ex-husband and that on one occasion, she took a knife to attack him, but did not hurt him. She was then hospitalized in a mental institution for several months, some 16 years ago. During her time in the hospital, her husband divorced her, without her knowing about it. I was told that, in total, Ms. Kozak was psychiatrically hospitalized three times.
Ms. Kozak’s sister told me that Ms. Kozak was depressed and added, “Sometimes she loses her memory.” She assured me that her sister had never done anything like what she is charged with doing. The sister also told me that Ms. Kozak does not drive because she is afraid of her getting behind the wheel, due to her nervousness and depression. I was told that, at home, she cried easily and often.

She was casually and comfortably dressed and well groomed. Ms. Kozak appeared her stated age and was courteous and appropriate. Her mood appeared somewhat labile, crying with ease (she was also facing serious, criminal charges). She appeared ashamed of the actions she took and at times would childishly giggle. Furthermore, she was able to provide me with identifying information, knew who the current president was, and was also able to carry out “serial 7s” with some errors, “100-97-94-91-87-84-81-77-74-71-67-64-61.”

Ms. Kozak presented me with photocopies of some “official-looking” documents, written in a Slovak language, and reportedly translated into English by an “official-looking” translation. The material indicated that as far back as 1967 and until 1994 (2 years before she came to this country), she had been found to be totally and permanently disabled with the diagnosis of “schizophrenic dementia.”

The English translation of the documents stated, at the bottom of the page, “This is an accurate translation from the Ukrainian original,” and an identifiable signature appeared below with no typed name next to it. Other pages would read, “The authenticity of the translation is certified,” followed by a different signature with again no typed name next to it.

One of the reportedly “officially translated documents” read on top, “USSR – Department of Health – Hospital for patients with Mental illness” (verbatim). The information included on this document read, “This document is given to Ms. Kovak and certifies that in consequence of hard brain infection illness ‘Meningitis’, that she had go through childhood, she has brain injury that includes partial loss of memory, recurrent headaches, inadequate behavior.”

Despite these “ominous clinical” assertions about her seriously compromised state of mind, Ms. Kovak had not been under psychiatric care until after she was arrested for criminal behavior at the department store. Ms. Kovak was not occupationally disabled and was able to care for the elderly and infirmed, and her mental status did not reveal any of the clinical characteristics observed in individuals afflicted by kleptomania.

As a result of the IME, I was of the opinion, within a reasonable degree of psychiatric probability, that this woman prepared a scam designed to walk off the store with articles of clothing having paid less than the price originally marked for them.

Primer on Traumatic Brain Injury, a Common Complaint in the Malingering

Psychiatric problems, particularly depression and anxiety, have been found to occur commonly in patients suffering from traumatic brain injury (TBI). It is the second most common neurological condition, after migraine headaches. In particular,
closed-head injuries typically result in more diffuse impairments than do open head injuries. Although outside the scope of this book, we will delve into a brief overview of the pathological and physiological underpinnings that govern traumatic brain injury and its symptomatic manifestations. A number of highly credible and reputable sources have helped in compiling the information to follow, and it may behoove the interested reader to learn further on the topic; in particular, we reference a manuscript written by Dr. Slagle, D.O, from 1990 that still remains an important text for TBI, concussion, and their related psychiatric manifestations.1

A concussion refers to the temporary loss or diminution of consciousness or other function due to a blow to the head. Moreover, there need not be any macroscopically observable damage to the gross structure of the brain, although microscopic nerve and blood vessel damage may occur. A contusion refers to the actual bruising of the brain, usually involving some combination of swelling, laceration, and hemorrhage that can be clearly observed. A concussion refers to the altered state of behavior and consciousness that the injury produces, while a contusion is its observable pathophysiological correlate. In closed-head injuries, contusions are most likely to occur in brain regions that lie near bony prominences within the base of the cranial cavity, particularly the frontal and temporal lobes.

In closed-head injury, a blow to the movable head produces a much more severe brain injury than one to a rigidly fixed head, which is one reason for head supports on automobile seats. Nearly all head injuries have some rotational component to the trauma due to the various motions and forces on the brain, via the head’s suspension on the flexible neck.

The rotational acceleration/deceleration injuries, or whiplash events, produce a sudden shifting of the brain within the skull, twisting and turning of the brain, where diffuse microscopic axonal injury occurs, creating stretching and tearing (known as shearing), which pulls apart axons and disrupts cell bodies. A short circuit of the neuronal system ensues. This correlates with loss of consciousness or with a period of feeling stunned, confused, and disoriented. (It also happens in the shaken baby syndrome, where the infant’s brain is damaged by shaking.)

TBI is a traumatically induced physiological disruption of brain function and can be caused by (1) the head being struck, (2) the head striking an object, or (3) the brain undergoing movement in the skull without any direct external trauma to the head. TBI is manifested at least by one of the following:

1. Any period of loss of consciousness
2. Any loss of memory for events immediately before (retrograde amnesia) or after the accident (anterograde amnesia)
3. Any alteration in mental state at the time of the accident (e.g., feeling dazed, disoriented, or confused)
4. Focal neurological deficit(s) that may or may not be transient but where the severity of the injury does not exceed the following: post-traumatic amnesia

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(PTA) not greater than 24 h; after 30 min, an initial Glasgow Coma Scale (GCS) of 13–15 (measuring degree of responsiveness; a score of 13–15, mild TBI with clinically significant findings; 10 or less, severe TBI); and loss of consciousness for 30 min or less

It is important to remember that a person may physically look fine and yet has sustained a TBI that affects his/her memory, day-to-day functioning, and personality. MRI, CT scans, or x-rays of the skull and brain can also be normal. In fact, they cannot tell a physician if the person is awake or asleep and alive or dead. They are not tests of functional impairments. Concussions are characterized by a lack of demonstrable focal neurological deficit and a clinical course of apparent recovery.

TBI patients present with symptoms characteristic of pathology from frontal and temporal areas, grouped into five clusters. These include:

1. **Affective**: apathetic, with little motivation, moodiness, depression, anxiety, and general mood instability.
2. **Behavioral**: restlessness, irritability, and agitation (from out of the blue, with minimal or no provocation, very quickly they become explosive). It is typical that they become remorseful, although not necessarily blaming others but themselves for this behavior and may also feel withdrawn. They have an overall inability to deal with stress.
3. **Somatic**: headaches, dizziness, fatigue, and sleep disturbance.
4. **Cognitive**: disturbed memory, concentration, distractibility and inattentiveness, and lack of spontaneity.
5. **Perceptual**: tinnitus, sensitivity to noise and light also occur.

**Case 12b: Claim of Post-concussion Disorder Secondary to Traumatic Brain Injury Seeking Neurological/Psychiatric Disability to Function at Work**

Mr. Fitz was 46 years old and out of work due to a work-related accident that reportedly incapacitated him, some 8 months ago. His work consists of transporting goods in a truck, including boxes of home appliances, and unloading them at designated sites.

Hospital records where he was taken from the scene describe that while unloading boxes, a box of 20 lb. fell on him, hitting his head and causing loss of consciousness of up to 30 min. In the ER, Mr. Fitz appeared confused and disoriented, his speech was not clear, and he did not recall the event. He was hospitalized. He was prescribed phenytoin (anticonvulsant). Two days later, Mr. Fitz was much improved.

Neuropsychological tests were administered 1.5 and 3 months after the occurrence. The claimant was vague in his responses; he remembered that on the day of the incident, he had driven his truck and that he tried to move away from the falling boxes. He added that he saw bright lights and that his head hurt. Mr. Fitz mentioned that he felt dizzy and with vertigo. Some months later, the claimant was prescribed
sertraline (antidepressant), which he was not consistently taking. He reported being “nervous” at night and with disturbed sleep.

During the neuropsychological tests, some “unusual” fine hand tremor was noted, more pronounced when asked to copy some simple images. He could write his name, but when writing a short sentence, his body would shake. He was able to draw a triangle, which he identified as “pyramid” and had trouble drawing a circle. Mr. Fitz could not complete the alphabet. At some point he turned emotional, looked at his daughter, who was in the room with him, acting as translator, and asked her who she was.

All these aspects were catalogued by the psychologist as histrionic and disproportionate and made her think of malingering. Despite this concern, the examiner reached the opinion that Mr. Fitz was unable to return to work, which included driving his truck on the road and unloading boxes. The psychologist suggested a psychiatric IME be done. Mr. Fitz had two such evaluations performed.

Mr. Fitz’s orthopedist found that he was fit to work in his occupation 10 weeks after the event. A neurologist diagnosed post-concussion syndrome; a CT scan of the head was normal, and an EMG (test to assess the speed of nerve conduction) did not show radiculopathy, a neurologic condition related to an impinged nerve causing pain and impairment in the respective muscle groups involved.

Mr. Fitz had some sketchy psychiatric history. Roughly 15 years ago, he took an overdose of clorazepate (antianxiety) when his romantic partner left him, and he was in some mental health treatment for 6 months. He then moved in with his mother.

A psychiatrist examined him 5 months postaccident. Mr. Fitz explained that the reasons for him not to take sertraline were that it caused stomachache and turned him overactive and it was too costly, as the insurance company was not covering it. He was found to be oriented, but not knowing who the actual president was. He added that he could not live alone since he was forgetful since the accident. He lived with his mother. Mr. Fitz was diagnosed with cognitive disorder, depressive disorder, and possibly PTSD. “Secondary gain” (simulation or exaggeration) issues were mentioned but not considered beyond this point.

During my examination of Mr. Fitz, and as an example of how badly his state of health was, he said that one morning he woke up in the bathtub, with water up to his chest. He also mentioned that many times he did not recall what happened the day before, after he woke up in the morning. He would wake up depressed and nervous. Claimant said that he studied until junior high school. Moments later, he stated that he did not recall his past. He added that those aspects he did remember were retaught to him by his mother, by showing him documents and pictures to help recover his memory; otherwise he had learned about his history anew.

Claimant said that he recently took his mother’s car, without permission, and later on he called her up, being lost somewhere. He mentioned that he was unable to have an intimate life with his girlfriend. Mr. Fitz said that he worked for the same company for 7 years. He then added that his mother had recently read to him all this information. He said that this had been his first accident at work. “I look at the
calendar, daily to remind myself the date,” and repeated that he leaned on his mother to be informed about his past.

The insured said that he spent the day with his computer and music. His recent memory appeared intact. Mr. Fitz mentioned that his girlfriend told him that he had been saving money to move in with her. His hobby was to play the electronic keyboard, compose songs, and transfer them to special electronic files in his computer. He then added that he was relearning to play the piano. Claimant said that he felt depressed and overall slow, including a low appetite and energy level, and that he was disinterested and with little ability to concentrate. His language was coherent and goal-directed. His capacity to understand the questions, appreciate their meaning, and answer them showed an intact cognitive functioning. Mr. Fitz would add to most of his answers comments such as “I had to be reminded of this.”

He met with me at the request of the insurance company that paid his disability benefits. My examination of Mr. Fitz took place 8 months after the accident. Claimant spent 3 uninterrupted hours with me. The examination consisted of structured and unstructured techniques, like questionnaires and open-ended history-gathering questions, respectively.

I had the chance of seeing him, in the waiting room, chatting with a woman whom he came in with while preparing a cup of coffee for himself. I did not notice signs of his being slowed or disheartened. His exchange with the woman was fluid and friendly, and she did not have the need to clarify anything for him.

Once in the examination room, Mr. Fitz gently placed the cup of coffee next to his chair. Later on, he finished drinking his coffee and placed the empty cup in the garbage container. Claimant spelled his name and the street where he lived. He provided his birth date, age, phone, and social security numbers. He told me that he was separated from his wife and that his mother had taught him all this anew. “According to my mother, I am separated since 1980… I don’t remember things… she sits next to me… first my name, next my birth date, my social security number, and so on… my mom works with doctors… she used to be the receptionist at a doctor’s office… now she works at the airport.”

Claimant told me that on two occasions, he lied down in his bed at night, with his pajamas on, and woke up in the bathtub with the water up to his neck. The water did not wake him up, nor his mother, whose bedroom was next to the bathroom. He added that he did not tell his mother about this, in order not to worry her.

I mentioned that his birthday, the year of the work-related accident, fell on the day after the 9/11 tragedy in NYC. Without delay, he talked about the amount of dead people as a result of it, “people like me,” he added. “People that did such acts were cowards that did not appreciate life. I heard in the news that the ones behind it were Arabs.”

“Since the accident, I always see a light with lots of shadows… it’s a white light that doesn’t hurt my eyes… it comes from the front of me… I walk through the light and see a lot of things… and I have, like, premonitions… in a dream I saw the disaster at the ‘Twin Towers’ before it happened… people told me it was going to happen… I can see that an accident is about to happen, but not to whom, so I can’t prevent it.”
I then asked Mr. Fitz if he heard voices as he was seeing the white light. “Yes, sometimes… a voice that says ‘Fitzy’, my nickname.” He also described grotesque and bloody images that came up to him and turned him depressed. He did not reflect horror, curiosity, or apprehension during this reporting.

I asked him if when he had a headache, both hands shook. He answered, “Yes… and when I write, even without a headache, my hands shake.”

Mr. Fitz told me that he composed music. From the radio, he taped music on a cassette and then downloaded it into his computer and saved it on “minifiles.” He then figured out the number and type of instruments that played a part in the piece of music. “I memorize all this, and in my mind I figure out each instrument.” Claimant detailed the type and name of the musical instruments and described for me the ones I had no knowledge of and the sound they produced. He appeared quite involved in this subject of his interest.

Mr. Fitz told me that his instrument was the piano. “My mother told me that I used to play it… she gave me sheet music and explained to me how to read it… it took me 3 months to learn the theory of music… my mom told me that I used to make money making musical arrangements for bands.” Claimant introduced everything he said about his past, saying that his mother taught him all about his likes, hobbies, and history. “My mother told me that I used to drink alcohol on weekends… my mother told me that I have a sister, Mary… about my father… my grandmother….”

Mr. Fitz had no problems driving his car, but he said he was afraid of getting lost while driving his truck. He added that sometimes he did not know how to use the steering wheel. “My mom put a map in my car.”

I wanted to visualize the configuration of the different rooms on the second floor of his house, like the bathroom, his mother’s and his own bedroom, and in his bedroom, the situation of the musical and computer components he had. Mr. Fitz got up, came close to me, and on a sheet of paper drew a diagram of the second floor of the house and, in it, the disposition of the equipment in his bedroom that I asked him about. He also drew five horizontal lines (a pentagram) and musical notes on it, also indicating rhythm, tempo, and other elements to create music. We spent 20 min on this task, while he stayed knelt drawing, describing, and explaining on the footrest next to my chair. He did not display any tremor while engrossed on his drawings and writing down numbers.

He was able to describe to me the route he took to come to drive to my office. His mental status was unremarkable, including his affect and mood and his cognitive skills. He did not feel the need for psychiatric or psychological intervention.

A surveillance video tape provided to me depicted him driving alone and using, at the same time, a walkman-type headset.

I did not find him afflicted of any psychiatric disorder, in particular, major depressive disorder and PTSD. Mr. Fitz was simulating memory disturbance. He had said that he lived with his mother due to his forgetfulness, whereas he lived with her since the separation from his daughter’s mother, some 11 years earlier.

He was reluctant to take medications for the symptoms he reported. He endorsed bizarre symptoms and signs created by myself, such as hand tremor when headache...
appear, noticeable only when he was lying in bed, getting lost while driving, and hearing a voice when crossing over the beam of white light. Mr. Fitz said he was not able to multiply “2 × 2,000,” yet able to write down different speeds with which music could be played and calculate elements of music composition.

Mr. Fitz’s description of the disintegration of his self-identity clashes against his relaxed attitude toward it. Claimant said that he was afraid of hurting people while on his truck, but not while driving his car. He also said that he learned a massive amount of information from his mother about himself, his family, his work, and his hobbies. This indicated to me that his ability to memorize, recall, concentrate, learn, be attentive, and maintain focus was grossly intact. The reported amnesia was not consistent with any known medical phenomenon.

Case 12b: Opposing Forensic Expert Opinion – Claim of Post-concussion Disorder Secondary to Traumatic Brain Injury Seeking Neurological/Psychiatric Disability to Function at Work

A neuropsychological IME was conducted 6 weeks after the reported accident. Two neurological exams showed no damage. Dr. Lead described claimant as having, “An ‘unusual’ fine motor tremor which increased as he was asked to copy simple figures. This appears to be histrionic in nature. He was unable to recite the alphabet in his native tongue. He had markedly exaggerated dysfluency. The grasp of the pencil was abnormal, although procedural memory is rarely compromised with his type of injury. At some point during the testing, he looked at his daughter and asked her, ‘Who are you? Who am I?’.”

The psychologist found, “Mr. Fitz’ symptoms are out of proportion to the reported head injury sustained. There is no neurological evidence of any head trauma… the possibility that he is malingering cannot be ruled out given the current evaluation.”

Some 6 weeks later, the same psychologist reexamined the claimant. “I could not find any objective evidence of cognitive disability which would be causally related to his injury. Rather, his behavior was quite histrionic in my opinion and most likely related to his premorbid psychiatric condition.” Dr. Lead also stated that Mr. Fitz would not be capable of returning to work. Dr. Lead asked for a psychiatric IME.

An initial psychiatric IME (by Dr. Zen) was conducted with the help of a language interpreter. Dr. Zen referred to the examinee as “patient” and found that claimant had been prescribed sertraline 50 mg/day, without his compliance, due to reports of stomachaches, overactivity, and high cost. Mr. Fitz told Dr. Zen that sometimes he woke up in different rooms than where he actually went to sleep in. Dr. Zen commented, “He’s hedging…” and, “Here again he is kind of evasive.” When Dr. Zen asked him how long he worked in the company, the insured said that he did not remember, except that the papers he was shown indicated that he worked in that company since 1984. He could perform simple calculations and has fair attention, concentration, comprehension, and recall. It is further noted in the report,
“He talks about his bad past memory… however, his recent memory seems to be normal. His affect was described as labile, he was found to be depressed… and limited insight and judgement.”

Dr. Zen diagnosed depressive disorder, possibly PTSD. He also mentioned the possible secondary gain from presenting as sickly as he did. Dr. Zen declared that he was equivocal about the “problem of secondary gain.” The MHP recommended sertraline 50 mg/day.

A second IME (Dr. Rose) examined, in Mr. Fitz’s native tongue, to determine if he was able to return to work.

Claimant told Dr. Rose that “he gets headaches, neck problems, and cannot recall things from the past, or who he is. When he talked about his family he said, ‘She says she is my mother’, allegedly he sees his girlfriend in her, but has no recollection of their relationship prior to the accident. Complains that he appears in places and doesn’t know where he is, which is inconsistent with his preserved anterograde memory when tested, he also complained that he does not recognize his friends. However, as per his mother, he spends a long time talking on the cellular phone. Mother also complained that claimant is in general more irritable and hyper and sleeps poorly. He was able to tell me his daughters’ names and when I asked him if they were identical twins, he said they looked alike, but when they were little their resemblance was bigger.” Dr. Rose’ report goes on, “Mr. Fitz was able to recall three objects out of three, after five minutes; was able to comment on current events, and was able to spell ‘world’ forward, but not backward. Dr. Rose indicated as a diagnosis, ‘Rule out Dissociative Amnesia, Malingering, and Mood Disorder secondary to Brain Trauma’.” Dr. Rose recommended a rehabilitation program for cognitive problems, group therapy, olanzapine (antipsychotic) and sertraline, and also an EEG (electroencephalogram).
Stalking

**Definition and Explanation**

*Stalking* Persistent, distressing, or threatening behavior consisting of at least two elements: the actor must repeatedly follow the victim and must engage in conduct that annoys or alarms the victims and serves no legitimate purpose.

**Introduction to the Forensic Considerations of Stalking**

Stalking refers to the willful, malicious, and repeated following and harassing of another person that threatens his or her safety. It is referred as *obsessional following*, but unlike an obsession, the most common prohibited act (following) is voluntary, planned, and gratifying to the fervent stalker. It is very common for stalking victims to report flashbacks, nightmares, loss of appetites, depression, and suicidal thoughts. Many come to suffer from adjustment disorders and even post-traumatic stress disorder. These results can be disabling to the victim.

Most stalkers are not violent. Weapons, if an attack does occur, are more often used to assert power and control than to inflict physical harm upon the victim. Homicide is rare, but it does occur in stalking cases from time to time.

A fervent and increasingly intrusive relation, a step prior to stalking, is a repetitive harassment behavior that threatens the victims’ safety.

**Case 13a: Stalking and the Intentional Infliction of Emotional Pain**

Diagnosis to consider: adjustment disorder with mixed anxiety and depressed mood, chronic. This condition is characterized by a psychological response to an identifiable stressor that results in the development of clinically significant
emotional or behavioral symptoms. The symptoms must develop within 3 months of the onset of the stressors. It is also marked by significant impairment in social or occupational functioning. By definition, adjustment disorder must resolve itself within 6 months of the termination of the stressor. The symptoms may persist for a prolonged period of time (longer than 6 months), if they occur from a chronic stressor. The mixed anxiety and depressed mood subtype should be used when the predominant manifestation is a combination of depression and anxiety.

I was asked to consider the following questions: Was Ms. Russo psychologically afflicted by the verbal expressions and demeanor of Mr. Alonso? Is she still affected? What is her diagnosis, treatment recommendation, and estimated cost for this and the prognosis overall?

Mr. Alonso was the building manager and had the right and ability to enter the building apartments and to impose fees and charges against tenants. However, he could not discriminate against others based on gender. Three days after moving into the apartment, Mr. Alonso began to demand that Ms. Russo cook him dinner. He also demanded that she invites him to her apartment. Some months later, he began to remark on her body, telling her that her “tits and ass are looking good.” Mr. Alonso used the security cameras to zoom in on her at the building pool, while she was there in a bikini. He would withhold or alter building privileges as punishment for her not complying with his requests, such as towing her car.

He would also give her detailed accounts of his sexual encounters with other women. He informed her that there were complaints from other tenants about her moaning and multiple sex partners, but no documentation was ever provided.

Ms. Russo made it known to Mr. Alonso that she did not welcome or desire his actions, by telling him “never” or refusing to respond. In September 2003, Ms. Russo formally complained to Mr. Alonso’s boss. She felt offended and harassed. She felt fear, emotional distress, and physical illness. She would have severe pain in her stomach and vomit. However, despite this complaint, Mr. Alonso was not removed from his position, and his presence had a greater negative effect on Ms. Russo. Ms. Russo sustained emotional and psychological distress, harm and embarrassment, and loss of self-esteem and status.

Ms. Russo began to have nightmares and to run from the garage to her apartment. She also dreaded calling the office and facing his comments.

In April, while informing her that he needed to have a key to her apartment in his office to complete some repairs in her apartment due to water damage, he informed her that the “maintenance men were eager to sniff her underwear.” Later that summer, he demanded that Ms. Russo come to his office to get a parking sticker or he would tow her car. He then took the opportunity to demand that she cook him dinner, and when she declined, he told her that he would be “getting laid” later and that she was “looking fat.”

Ms. Russo formally complained about both forms of harassment, abuse of power and sexual harassment, in September. This was after Ms. Russo needed Mr. Alonso to help her solve the problem of water ruining her living room floor. After this point, Ms. Russo began to have nightmares about being assaulted by Mr. Alonso.
Learning that Mr. Alonso was not going to be relieved of his duties, Ms. Russo reacted with intense gastrointestinal symptoms and other psychological concomitant symptoms of anxiety, nightmares, fear, and hyper-vigilance. She has a history of infectious mononucleosis and fibromyalgia. It is stated that her psychological and psychosomatic symptoms developed as a result of the harassment and would not be relieved until Mr. Alonso was removed from the premises. She suffered from fatigue, anergia (lack of energy), muscular and stomach pain, anxiety, and limitation of overall functioning.

Ms. Russo explained to me that Mr. Alonso is no longer allowed to be in contact with her, after she complained to his boss in September. After this, she would hardly see him, but she was afraid of secretly being watched by him. She would have intense fear of him jumping out from behind something and beating or raping her. She explained to me that he made her feel violated and instilled a fear that he could enter her home at any point. She no longer used the pool facilities since he watched her on the security camera.

Ms. Russo’s nightmares were occurring three times a week. She had her cousin sleep over four times during the 6 months prior to our interview. She was more frightened after the complaint was launched than before.

The examinee was 20 years old when she had her first sexual encounter. She mentioned that it had always been an enjoyable experience for her, but during her last relationship, which lasted until August 2003, her sexual interest had declined. Her boyfriend knew about her problems with Mr. Alonso and wrote a letter to her boss on her behalf.

Mr. Russo feels that she has changed due to the stalking. She was once a woman for whom it was easy to ask for help, but she had changed into a frightened person who became very cautious and who tried to “nip problems in the bud.”

She stated that she has difficulty concentrating at work. Despite the fact that she was able to complete her tasks, she would get very lost and distracted. She also reported that she had lost a lot of weight, while this was occurring, and her appetite decreased.

Her sleep was described as disturbed and often non-restorative. She would wake up more than once during the night due to anxiety dreams (nightmares).

Ms. Russo told me that despite the fact that she loved her apartment, she would have to move if Mr. Alonso ended up staying. She added that she was disgusted with Mr. Alonso’s behavior in terms of what he did to her as the manager of her property.

Throughout the entire meeting, the examinee covered her torso with a jacket, even though the room temperature was quite comfortable.

It was my opinion, within a reasonable degree of medical probability, that Ms. Russo suffered from adjustment disorder with mixed anxiety and depressed mood, chronic. It was also my opinion that the aforementioned diagnosis was directly related to the attitude and behavior of Mr. Alonso. This condition referred to a psychological response to an identifiable stressor: the repetitive stalking/harassment that Ms. Russo was subjected to, which resulted in the development of clinical significant emotional and behavioral problems.
The psychological handicap of Mr. Alonso’s actions hindered Ms. Russo to the extent of impairing her ability to take her safety for granted and prevented her from being able to freely express her femininity. Ms. Russo’s symptoms are strong and debilitating. They are intensified now that Ms. Russo and Mr. Alonso do not communicate verbally or visually. She knows he is around, but not seen. She had a constant sense of being watched.

The solution is to completely avert contact between Ms. Russo and Mr. Alonso, which is literally impossible, since he is in charge of the premises where she resides.

Now Ms. Russo does not allow anyone to approach her or be in a position of power and control, which hinders her social functioning and may adversely impact psychiatric treatment efforts.

Ms. Russo’s condition is permanent. I would recommend that Ms. Russo continue psychiatric treatment, combining psychiatric medications and supportive/expressive individual therapy, aimed at helping her deal with the ordeal and its aftermath. This would help her ability to function in social, personal, and occupational settings.
Sexual Harassment

Definition and Explanation

Respondeat superior  Lat.: let the superior reply. Legal expectation that a superior ensures that the employee follows company rules to prevent wrongdoing.

Sexual Harassment Defined and Contextualized to the Forensic MHP

According to the US law, sexual harassment is a form of gender discrimination in employment that is prohibited by Title VII of the Civil Rights Act of 1964. In 1980, the Equal Employment Opportunity Commission (EEOC) issued its final guidelines of sexual harassment: “Unwelcome sexual advances, requests for sexual favors, and other verbal or physical conduct of a sexual nature constitute sexual harassment when (1) submission to such conduct is made either explicitly or implicitly a term or condition of an individual’s employment, (2) submission to or rejection of such contact by an individual is used as a basis for employment decisions affecting such individual, or (3) such conduct has the purpose or effect of unreasonably interfering with an individual’s work performance or creating an intimidating, hostile, or offensive working environment.”

The first two situations described in the EEOC guidelines corresponds to what is called quid pro quo sexual harassment, a form of sexual harassment in which sexual compliance is exchanged, or proposed to be exchanged, for employment or academic opportunity. In quid pro quo behavior, the coercion behind the advances is brought to light by the reprisals that follow a refusal to comply. While quid pro quo harassment requires a difference in power between the perpetrator and victim, the last situation (3) does not. It is called the “hostile environment” sexual harassment.

A less clear, yet more pervasive situation involves persistent behavior that simply makes the work environment unbearable.
In short, sexual harassment has two forms: (1) *quid pro quo* (by manager or supervisor), as in the classic situation when a manager requests sexual favors in exchange for promotion, and (2) hostile work environment, if the harasser is a co-worker. In this type, the standard (*respondeat superior*) is that the employer knew or should have known and did nothing to remedy the situation.

Sexual harassment covers a diverse group of behaviors. It includes remarks of a sexual nature, such as repeated requests for dates, whistles, staring, and sexual propositions not directly linked to employment, as well as unwanted physical contact of a nonsexual nature. The harassment can escalate to sexual propositions linked to job enhancement or job threats, unwanted physical conduct of a sexual nature, and sexual assault.

Perceptions of behavior as sexual harassing differ according to the type of person that experiences it as offensive. It greatly depends on what is called the pre-trauma risk factors explored in earlier chapters.

**What to Expect as the MHP in Cases of Sexual Harassment**

A “reasonable woman” standard is used in sexual harassment cases for both genders, primarily because the sexually blind reasonable person standard tends to be male-biased and to ignore the experiences of women. A victim may choose to submit to the harassment, ignore the behavior, avoid the perpetrator, confront the perpetrator, change jobs or class, report the behavior to a superior or a grievance committee, or seek legal assistance. The last two routes are infrequent because of uncertainty that reporting harassment can help the victims in any way and concern that it can hinder their personal, occupational, or educational progress. There is a sense that while formal action tries to assess the guilt or innocence of the alleged harasser, informal efforts try to put an end to the problem.

The forensic MHP can serve several functions as expert witness in sexual harassment cases. This encompasses evaluation of the presence or absence of preexisting psychological disorders, the psychological injury attributable to the harassment, the relationships between preexisting disorders and posttraumatic symptoms, or the prognosis for future disability and necessity for treatment with some estimate of cost to the plaintiff.

The role of the forensic MHP is to help the attorney prepare for deposition of an adverse expert. This includes reviewing of the adverse expert’s report and notes, consulting with the attorney regarding issues likely to be important, and playing a role in deciding whether plaintiff should attend depositions of the adverse expert.

Above all, the expert witness has to be able to educate the jury by explaining (digesting) what “trauma” is, how it comes to happen, and how it applies or not to the case in question.

The credibility of the plaintiff (even though this is for the jury to determine) can be touched upon based on the study of the underlying personality style, as well as the risk of re-traumatization in the course of litigation. Issues of sincerity relate to
the overall examination of the plaintiff’s social, occupational, and, critically, mental functioning, rather than concentrating on the narrative style of the event(s) reported by the plaintiff. For example, calmness may indicate malingering or, in contrast, a symptom of the plaintiff’s disorder (e.g., dissociation).

The goal is to advocate for one’s expert opinion, rather than for a social cause that repudiates harassment. The forensic psychiatrist may participate in elucidating its occurrence (in ascertaining “Did it happen?”) but mostly, if it indeed happened, whether psychiatric affliction is present or not in its aftermath and its quality and quantity.

Sexual harassment is a destructive behavior that can cause profound psychiatric problems for its victims, who commonly keep quiet about the offense. If it happens in the clinical (medical-psychiatric) setting, it is called sexual misconduct or boundary violation.

Conceptualizing and Defining Medicolegal Respects of Sexual Harassment

Sexual harassment is different from flirtation, flattery, request for a date, and other acceptable behavior occurring within the workplace or the classroom. It lacks the elements of choice and mutuality inherent in a normal relationship. It is also distinct from other forms of harassment that do not involve conduct of a sexual nature.

Harassment may be motivated by race, religion, and politics. In addition, it is distinct from rape. It is a type of sexual coercion that relies on the power of the perpetrator to affect its victim’s economic, occupational, or academic status and does not necessarily involve physical force. It has the potential to affect its victim’s ability to perform on the job or in school, their career opportunities, their personal relationships, their self-esteem, their psychological well-being, and even their physical health.

Victims report a wide array of symptoms, including anger, fear, depression, crying spells, anxiety, irritability, and decline in self-esteem, feelings of humiliation and alienation, and a sense of helplessness ad vulnerability. There are also symptoms of psychological sequelae or somatization, such as headaches, decrease or increase in sleep and appetite, weight loss or gain, and respiratory and urinary symptoms.

The list of the above-reported symptoms needs to be fastidiously and sensibly examined. Moreover, the likelihood of symptoms is directly associated with the quality and severity of the behavior in question and the possible risk factors already present in the victim.

The victim’s initial reactions (“reasonable woman”) to sexual harassment are typified by self-doubt and confusion. They often feel guilty and wonder whether they might have caused and/or encouraged the behavior. They may minimize or deny what has happened, in part because it is frightening to realize that those in positions of authority may be neither just nor trustworthy.
Case 14a: Claim of Sexual Harassment with Quid Pro Quo Producing Significant Psychological Distress

Ms. Peters, during employment, was sexually assaulted by her boss, Mr. Taylor, who is married to Ms. Peters’ manager. Throughout her term of employment, she was constantly bombarded with crude, sexual, and vulgar comments by Mr. Taylor. In fact, Mr. Taylor encouraged all employees to engage in sexual comments toward each other and openly share sexual experiences at staff meetings. Ms. Peters is claiming to be psychiatrically injured by the assault and is still suffering today.

Legal, medical, and psychotherapeutic records were reviewed prior to examining this individual. Mr. Taylor claims that his employee welcomed and voluntarily participated in these sexual experiences. Ms. Peters states that she is in extreme emotional distress and has “suffered (psychological) damages” from Mr. Taylor’s abusive sexual conduct.

About a year prior to the assault, while employed, Ms. Peters had exchanged several emails with Mr. Taylor concerning her affection for Mr. Taylor and his wife and the support they had given to her to overcome life’s problems. She indicated how she loved him “and the last thing I want to have happened is to disappoint you.”

She had attended a meeting with both, Mr. and Mrs. Taylor, to evaluate her job performance and revise her salary. They drank alcohol. Mr. Taylor’s wife left the meeting briefly and Mr. Taylor brought Ms. Peters upstairs, where he pulled her pants down halfway and penetrated her. She did not fight it but rather tried several times to talk him into stopping. He did not conclude because Ms. Peters told him his wife was downstairs, at which point they stopped. She called her roommate, also a co-worker, who came over, talked for a while with Mr. Taylor and his wife (there were many sexual comments by Mr. Taylor [in front of his wife who played along with him]), and then took Ms. Peters out to a bar, where she drank more alcohol to the point of vomiting. Ms. Peters told her roommate what happened, and she took her to the hospital, where a rape-kit was performed, and she began counseling three times a week. Sertraline was prescribed.

Ms. Peters is and has always been at least mildly overweight; she has a history of an eating disorder. Her family never supported her. Growing up fatherless, her mother was a prostitute (with AIDS) who was criminally active and took many different narcotic drugs. She grew up with her aunt and uncle from the ages of 7–17. Another uncle lived with them who had molested her when she was age 13–17 (at 13 she developed depression and an eating disorder).

Currently she says she cannot sleep (after the incident). She feels “very overwhelmed with trauma.” Although she enjoyed her job, she felt betrayed. “It is difficult,” she says, “to concentrate now.” She is emotionally supported by her fiancé and her sister.

During an evaluation, nothing remarkable was found. Despite not finding any abnormality in her psyche, she had an expert report with the opinion that she was suffering from anxiety and depression. She was also described as having insomnia and feelings of hopelessness, helplessness, and inadequacy.
After the incident, Ms. Peters continued working 16-h days, became pregnant 3 months afterward, had bought a new car, and moved to a more spacious apartment.

Ms. Peters showed up to the interview a half-hour late. She discussed her relationship with Mr. Taylor and his wife. She mentioned how she lived with them for 3 months when she first moved across country, until she found a home to settle into. They all grew very close, spending vacations and holidays together. Even after she had moved out she still occasionally spent nights at Mr. Taylor’s home. During all this time, nothing sexual happened.

Ms. Peters described for me the events of the evening that she felt tormented by. The night of the assault, she had gone to Mr. Taylor’s home for a job performance review (all employee reviews were held at their home). His wife made several martinis, and they all discussed her performance for quite some time – alcohol was a “common thing” at Mr. Taylor’s job reviews. After a while, Mr. Taylor began yelling at Ms. Peters over her desire for a raise. She began to cry and tried to leave. His wife convinced her to stay. The review ended late, and since they had been drinking, Ms. Peters intended to stay the night. The wife ran out to a store for soda, and while she was gone, Mr. Taylor advanced on Ms. Peters. She did not physically resist. She tried to convince him to stop, and eventually, after penetration, he did; the whole act was less than 5 min, she reports. When getting dressed he said to her that he was coming back for her later that night. She said, “No, you can’t,” to which he replied, “Yes.”

Despite her feeling comfortable around him and his wife for a long time, she now felt scared and knew she had to leave. She said she had her roommate come to pick her up. When she arrived, the wife was home and the four of them sat and talked for a while. The roommate was subject to several sexual comments by Mr. Taylor, as he played a version of “spin the bottle” with the cordless phone on the table. The wife even took part in a sexual comment which, according to Ms. Peters, made her feel uncomfortable. Ms. Peters and her roommate soon left for home, stopping for a few drinks at a bar on the way.

Ms. Peters said she was scared to tell her roommate what happened because she was new to the area, with not many friends or money. At the bar, she said that she “lost it,” “my boss molested me… my boss molested me….” A man (stranger) walked her to her car with the roommate, and they went to the hospital, where police were called, and a rape-kit was completed. She called her fiancée who came as well.

Mr. Taylor wondered why she never returned to work. Ms. Peters discovered later that the company had no sexual harassment policy. She attended some therapy sessions after the assault, moved in with her fiancée (as planned prior to the incident), and found a new job with a position of equal importance, and although she claimed depression after the assault, she proactively and efficiently was able to accomplish quite a number of things afterward. The fiancée was supportive of her, although neither of them talked about the incident much; he was angry with Mr. Taylor. The two of them got married a week after my examination of her, which took place a year after the event, and some 8 months after becoming pregnant.
Ms. Peters said that it is difficult for her to be physically and emotionally close to her fiancé. She thinks she is “cutting herself off” from him. She finds it “difficult to have sex” primarily because she is “not interested in sex.” She stated that she rarely had sexual relations with her boyfriend and felt guilty about not being emotionally close to him. She mentioned how she rarely told him what she felt because she still had “a lot of hurt and anger.” Ms. Peters went on to say her depression fluctuated periodically. The whole summer after the assault, she felt angry and did not leave her house. “It was so unfair,” she added, “I worked so hard for them...."

The interview was held over a year after the incident, and she said that she still had nightmares most nights about the day of the assault and in the street sometimes sees someone who reminded her of Mr. Taylor and panics (but not often). Ms. Peters advised me that she did not think of the assault every day because “I have to move on with my life.” She is saddened that this will always be a part of her life, and it is difficult to watch TV when topics such as sexual assault are discussed or acted out.

Ms. Peters began talking about her family and her childhood. She talked about her troubled mother and how she grew up with her aunt, uncle, and their children since the age of 7. She described how she was “touched” by her other uncle (who frequently came to visit) between ages 13 and 15 (on the psychological forms, she filled out in the past it said 13–17). She described how while she was asleep at night in her room (only bedroom in the basement) he would come in and “fondle her genitals.” She added that it was very unpleasant, uncomfortable, embarrassing, and made her nervous. She would tell him to go away, but he never listened, and as a result, she began waking up at night in a panic, looking around to see if he was in the room. “I was living in fear.”

During the interview, Ms. Peters said that she never thought she needed psychiatric help as a result of her childhood struggles. She developed, during her teenage years, an eating disorder in which she followed periods of overeating by periods of starvation (which have persisted until present time). She tried more than once to pursue an eating disorder correction program but could never commit to following it. She took Paxil (antidepressant medication), saying it was common for the treatment of eating disorders.

Ms. Peters stated that she didn’t feel disturbed by her uncle’s persistent sexual abuse, but she did feel afflicted by the “assault” from her boss. “It was a bad thing to happen to me... uncomfortable... I was in a quandary over how to approach it with the family.”

There was nothing remarkable in any aspect of the evaluation with regard to her mental state. As a result, I found no psychiatric diagnosis proximately related to the reported sexual assault by Mr. Taylor, and she did not currently suffer from any psychiatric disorder (due to the assault).

Ms. Peters stated that “Now, a year later, things should get better...I don’t think of it every day... I get on with my life... I worked myself up again.” She spontaneously brought up her excitement about getting married to a man who she shared interest, feelings, and support with.

She described how it was common to witness Mr. Taylor and his wife arguing in the workplace. She was not bothered by it and felt nothing significant that Mr.
Taylor constantly bombarded her with sexual comments concerning her sex life. She was familiar with this behavior; he had kissed her while intoxicated, on more than one occasion. The night of the assault, she knew to leave the house if uncomfortable (as she almost did during the review), and she knew when Mr. Taylor was going to proposition her, as he had done several times before. After the assault, she stayed and talked with him and his wife about many sexual matters, including his lewd comments about Ms. Peter’s roommate’s body.

At the bar, she described her boss’s assault to her roommate as “molestation” (word she used to depict her uncle’s actions to her), and not as rape. The “complaint” she filed referred to her being sexually touched, instead of raped or penile penetration. Also, at the bar she met a man who helped her walk from the bar to her car. She was not fearful of him.

In her emails (a year prior to the assault), she appealed to Mr. Taylor as wanting to become close friends with him. She included comments such as “Hey Tom… Tom, you and I have become very close… I love you… love ya, Ms. Peters.” The time she wrote that email was one of apparently great psychological hardships for her. She was taking alprazolam (antianxiety); she had gone through a mental breakdown, had crying spells, and was very unhappy. During this time, she appeared not to be close to Mr. Taylor.

Ms. Peters tried to hide her medical history from me, and until I pointed each ailment out, she said not to remember. During the entire examination, she did not once mention the crude and vulgar comments routinely made by Mr. Taylor. She observed that her eating disorder had not intensified in the last year. She had also advised me that she “put herself through college,” implying having completed it, yet on the records she said that she had “almost” completed an undergraduate degree. Also, until I mentioned the sexual molestation from her uncle, she described to me that she had never experienced an unwelcome sexual touch before. She explained that she thought it was unimportant. Eventually she mentioned that, during those times, she felt intense fear, distrust, disgust, and bitterness.

It is clinically improbable for a woman with her childhood and psychiatric history that without treatment, she could overcome the massive physical and sexual assault and neglect she sustained from birth onward by essential caretakers: mother, father, aunt, and uncles. This same clinical background becomes accountable for the onset of the psychosomatic illnesses, such as eating disorders and other gastrointestinal ailments observed in Ms. Peters.

A month after the assault, she saw her primary physician. She informed her of the assault and the next day called her doctor to have her write and fax a letter stating her diagnosis and why she should leave her job. This brought up a question about her interest in medical documentation (not psychiatric) of the complaint, since she did not follow up on any of the recommended (affordable) psychiatric treatments, even after saying that she was “not feeling good.” She had led her primary physician to believe she was going for psychotherapeutic treatment three times a week. There was a discrepancy about what she told her physician and later as well to the examiner concerning how much of antidepressant medication she took. Yet, she did not take the newly prescribed antidepressant medication. Her
physician also believed that she had no social support since she was new in town. She did not know of the (then) boyfriend or roommate.

Ms. Peters described insomnia, depression, anxiety, and stress as new occurrences (after the assault), yet the same was described by her in the past, long before the assault took place. The examinee’s tragic past and the absence of adequate psychological treatment to work through the neglect she suffered, involuntary servitude, and sexual abuse placed her in harm’s way to repeat the ordeal. She grew up accepting the “normalcy” of being mistreated, abused, disrespected, and abandoned. Ms. Peters labored in a service-oriented company. Due to her past, it was easier for her to assist others, rather than receive it. She was totally functional and able to go on with her life, seeing this occurrence as something typical, “par for the course.”

During the course of her employment, sexual comments were commonplace. Her job performance did not decline, but instead it rapidly excelled. Ms. Peters thrived and grew in her occupation within the work environment, indicating no upheaval or detriment in her occupational, social, and personal functioning, as demonstrated in her own and her boss’ evaluation of her job performance, as well as her establishing a prompt and long-lasting relationship with the man who became her husband and the father of her daughter and enjoying his family’s support, trips, plans, leisure activities, and friends together.

When Ms. Peters ended her work relationship with Mr. Taylor, she had no trouble whatsoever (and without the help of psychiatric treatment) to find a similar type of work and title elsewhere. Ms. Peters chose to omit telling me that she was pregnant and due in about 1–2 months. Less than 1 month after, she stopped working for the Taylors; Ms. Peters moved in together with her then boyfriend, and some 6 weeks later she became engaged to him. She bought a car, found a new job at the same professional level as the previous one, and within 3 months became pregnant.

I found no psychiatric diagnosis proximately related to her employment in general or to the reported sexual assault, here complained of.

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**Case 14a: Opposing Forensic Expert Opinion – Claim of Sexual Harassment with Quid Pro Quo Producing Significant Psychological Distress**

The expert, Dr. Koch, met with Ms. Peters on three occasions, and in the first of them, he administered the MMPI-2.

It is this expert’s opinion that Ms. Peters suffered significant psychological damage, as a result of the sexual assault perpetrated by her boss. The psychologist accepted Ms. Peters’ statement that this repetitive sexual victimization from at least age 13 had no ill-effect on her developing mental apparatus, in spite of her descriptions of having developed, during those years, psychiatric symptoms and signs (behavior) of what was later on diagnosed as an eating disorder that became chronic. Dr. Koch noted that she had been neglected and physically abused by her mother since birth.
Dr. Koch gathered the following timeline: “started work (7/02), sexual assault (9/03), moved into an apartment she rented with boyfriend, bought a car, and started new job (10/03), became engaged (11/03), pregnant (2/04), married (10/04), son’s birth (11/04).”

The expert noticed that, concerning her employment, she placed herself from the outset in a very similar situation to the one she lived through with her aunt and uncle as a child. In fact, she participated in the creation of a family-type relationship with Mr. and Mrs. Taylor, according to her, plagued with “familiar” sexual contents. She described also feeling the same way she felt in early adolescence in the aunt and uncle’s home, “trapped into accepting these behaviors.”

The psychologist also noted that, in the described sexual example on the work-related trip, she excused her boss when he kissed her, “That’s Tom,” using the same reason her aunt used when she was a child that her abusive uncle was neurologically impaired. Tom in the plane was also “neurologically impaired” by alcohol, and both of them drank. Regarding Mr. Taylor’s behavior, Ms. Peters stated, “Everyone laughed it off, including me, ‘That’s Tom’ ... he was never sneaky about it. Tom’s this way.” She accepted it as a fact of her life.

Ms. Peters told the psychologist that she experienced with the Taylor’s the same familiar experiences she had to repeatedly withstand as a teenager in her family’s home. Ms. Peters told the psychologist that she “was not particularly troubled” by Mr. Taylor’s behavior, when “his front brushed up against her back, and she could feel his “body parts” through his clothing.

Ms. Peters told the expert that she was not intoxicated when she left the Taylors’ house. She also said that she was going to sleep over at the Taylors’ because she had too much to drink, and in fact when she went out for drinks, that same night, she left her car behind because she had drunk too much.

Ms. Peters told the psychologist that she “didn’t move across the country with any enthusiasm.” In fact, she reported to me the exact opposite. She told the examiner, “I put up with a lot because I felt trapped and with nowhere to go,” just as when a 13-year-old girl in the house of her adoptive parents, aunt and uncle. Ms. Peters stated that she had been able to be active, proactive, energetic, creative, and productive, working up to 16 h per day, in spite of mentioning that from the start she had been subjected to different and repetitive forms of sexual harassment.

Two weeks after the reported incident, Ms. Peters had gotten a new car and a new apartment.... She had also gotten engaged and started living with her fiancéé. She also looked for and found a new job; in the same field and with the same job description and salary, she had enjoyed working for Mr. Taylor. Some 3 months later, she became pregnant.

Ms. Peters told the psychologist that she did not actively try to stop Mr. Taylor’s advances because, “I was scared,” implying being quite attentive, vigilant, and aware of the current situation. She also said that at that moment she did nothing because, “I was stunned,” meaning her mental apparatus being, for a lapse of time, unaware, not alert, and overwhelmed. These descriptions were contradictory and begged for analysis. She further told Dr. Koch, “I’ve never felt so trapped and so naïve.”
Contrary to what I audiotaped during my examination of Ms. Peters, she told the examiner that she kept relating with her biological mother. Also, contradictory was her saying, “I obsess about what happened… I think a lot about it.”

Ms. Peters told the psychologist that she currently felt the same familiar feelings she experienced back as an adolescent being sexually abused by her uncle, humiliated, embarrassed, alone, and trapped. Ms. Peters told the psychologist, “I don’t see this getting better. It will never go away.” Ms. Peters told me, “I don’t carry it with me... I don’t think of it every day. I get on with my life. I worked myself up again... now I focus on my relationship.”

Dr. Koch was under the impression that Ms. Peters terminated the psychiatric treatment after benefitting from it, following the reported sexual assault. In fact, she quite prematurely interrupted the treatment because she did not find it helpful or necessary.

Dr. Koch notes that the MMPI-2 profile “appears to be an accurate indication of her functioning… one may hypothesize.... Ms. Jones (her, now, married name) appears to be experiencing some adjustment problems.” His descriptions of her character structure reveal a long-standing pattern and not a new occurrence. In fact, Dr. Koch did not evidence any new sign, after the reported rape, as part of his findings, other than the self-reported data.

The examiner found no evidence of psychiatric or psychological impairment of any type, related to the aftermath of the reported sexual assault. The diagnoses presented by Dr. Koch predated by many years the reported rape by her boss.

This expert made the diagnoses: PTSD, with depression, anger, and anxiety, partner relational problems (marital), and severe. Dr. Koch referred to “invasive, sexual harassment.” He referred to Ms. Peters being “deeply traumatized by the reported sexual assault at work… deeply affected by this entire experience… constant thoughts about the sexual harassment and assault… described panic attacks, following her self-report.”

Dr. Koch ends his reporting by stating, “Ms. Peter’s traumatization and other emotional symptoms that she has had during and since her employment… cannot be attributed to any of her childhood experiences, including the eating disorder, conflicted relationship with her mother, and molestation by her uncle. The sexual harassment culminating in sexual assault constituted the proximate cause of traumatization and other emotional symptoms from which she now suffers… she is deeply aware of her need for treatment… she is motivated for and prepared to engage in individual and marital therapy following the conclusion of this litigation.”

Case 14b: Claim of Sexual Harassment and a Hostile Work Environment

Reported Diagnosis: PTSD – according to the DSM-IV-TR manual of the APA, is characterized by the presence of both of the following occurrences:
The traumatic event is re-experienced in one or more of the following ways (for periods longer than 1 month): recurrent and intrusive distressing recollections or dreams of the event, acting or feeling as if the traumatic event was recurring, intense psychological distress, or psychological reactivity at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event.

Symptoms of PTSD include insomnia/hypersomnia, irritability or outburst of anger, difficulty concentrating, hyper-vigilance, and/or an exaggerated startle response. There are also constant efforts to avoid thoughts, feelings, or conversations about the trauma; efforts to avoid places, activities, or people that arouse recollections of the trauma; inability to recall an important aspect of the trauma; diminished interest in significant activities; feelings of detachment from others; restricted range of affect (feelings); and a sense of foreshortened future.

Along with these symptoms, the individual is impaired in his or her social, occupational, and other important areas of functioning. These symptoms are not due to the effects of a substance or general medical condition.

Ms. Lee claims to be suffering from the sexual harassment by Mr. Blum, a co-worker of a company where she was successfully employed. The question to be considered is whether or not Ms. Lee is currently psychiatrically afflicted as a result of the reported sexual harassment of Mr. Blum.

Numerous documents were reviewed prior to the meeting with the plaintiff. These documents included Mr. Mayo’s (her psychotherapist) progress notes (1996–2002); an application for employment (4/99); progress notes from Dr. Pool (her psychiatrist) (2000–2002); a job application with its respective letter of rejection; police department incident reports of harassment (10/2001, 6/2002, and 1/2003); written statement by Ms. Lee; police report of harassment; medical records from two different medical centers; a notice from the state superior court; Mr. Blum’s writings to Ms. Lee (including a poem and a list of pages of songs, a one-page list of harassing events Mr. Blum had imposed on Ms. Lee, seemingly written by Ms. Lee); deposition of the manager of the company; protective order notice of the state superior court; depositions of Ms. Lee and a co-worker; a psychological expert report by Dr. White, as well as his curriculum vitae.

Seen by Mr. Mayo, her psychotherapist, from 1996 to 2002, Ms. Lee gave disturbing details about her husband, family friends, and parents. She began by explaining her relationship with her husband. It is a troublesome one, distant, affectionless, and devoid of fun. She wanted to strengthen her marriage by attending individual and couple therapy sessions. A few months into the sessions, she went on a date with a family friend (their attorney) who, she reported, ended up raping her while intoxicated. He “bit her on her shoulder, chest, and genitals, threw her against the house, and later on the deck where he proceeded to rip her shorts off and penetrate her. She was terrified of the kids waking up
who were sleeping upstairs…. He [then] fell asleep on the back deck until he woke up and drove off.”

She kept this occurrence a secret until she found out she had Herpes and Hepatitis B. Being as she continued to have sexual relations with her husband, she was scared of infecting him as well. For the next 9 months, Ms. Lee and her husband tried to patch things up by attending couples therapy, but it ended in divorce proceedings.

Her childhood was spent in fear and abuse by both her parents. Her mother, using a kitchen knife, cut Ms. Lee’s wrists. On other occasions her father sexually abused her. She grew up distrusting men.

Ms. Lee was a productive and successful woman at work. Another employee, Mr. Blum, much older than her, began to pursue (harass) Ms. Lee with verbal remarks. Although not threatening, she portrayed them as uncomfortable and annoying. Mr. Blum would give her poems he wrote for her, as well as a tape of him singing. After complaining, more than once, to management, Mr. Blum was fired for sexual harassment.

A month after the first complaint, Ms. Lee went to the emergency room complaining of chest pain, palpitations, and shortness of breath. She claimed insomnia and anxiety. Although her mood was found to be anxious, nothing remarkable was noted. She was given a mild sedative to take for 4 days since she “does not appear in any distress.”

In her deposition statement, Ms. Lee talks about how she stopped psychiatric/psychotherapeutic treatment due to an exhaustion of health insurance benefits. She continues to say that her psychiatric problems are due to the verbal harassment of Mr. Blum. Her constantly looking around, afraid of him sneaking up on her, stress at home making sure the children never play alone outside, and not driving anywhere outside of work are all due to Mr. Blum’s actions. She has also complained previously of harassment by a neighbor who has since moved out.

She knows her problems are due to her entire life’s events and not solely to Mr. Blum’s remarks. She states that she is not kept from dating and socializing and is able to sleep well at night. Consequently, she had not missed a day of work in over a year before she quit in fall of 2002 (Mr. Blum was fired in the beginning of the spring of 2002). She had stated that she was the salesperson of the year for her company, winning all the contests they had. In spite of being the top sales representative of her company, she declared that she was afraid at first of telling her manager about Mr. Blum out of fear of losing her own job. Currently she works for a different company, making a higher salary and receiving health benefits as well.

The therapist that interviewed her made no notation about a disturbed state of mind after she had confronted the manager about Mr. Blum’s actions. The only description written to describe the situation was “inappropriate.”

The only psychiatric disorder she was found to suffer from was depression. She complained of chronic migraines, an ongoing problem long before her contact with Mr. Blum. Ms. Lee told her psychotherapist, a year before the reported harassment, that she was still “struggling to keep herself together emotionally.” It is noted that she finds it easier at work, where she’s “busy and can pretend everything is okay.” Also, she did not receive any treatment for the stress created by the actions of Mr.
Blum. Ms. Lee said that she did not trust people. The psychologist read her mistrust as a result of Mr. Blum instilling fear in her mind.

Ms. Lee appeared for the meeting with me as comfortably dressed. Nothing remarkable was found regarding her physical characteristics and gait. She stated that she took Wellbutrin (antidepressant) daily. She then described how Mr. Blum used to harass and “stalk” her constantly in the workplace and how it affected her life. He knew a lot of personal information regarding Ms. Lee’s family, and in turn, she was always afraid of seeing him outside the workplace. She said she told him to stop and complained “plenty of times” to the manager, but she was not relieved.

During the IME with me, Ms. Lee went on to talk about her abusive parents, her mother in particular, as “short, overweight, and alcoholic.” She said her father did not drink. Problems at home hurt her academically. She was a “C” student and could not separate feelings from home with those of school. She was not a popular girl and held one friend from 2nd to 8th grade.

Her husband was “controlling and mean.” Her parents did not support the relationship and forbade them from returning home for any reason. When she brought up the issue of divorce, he told her to go into therapy. He would constantly make rude and demeaning comments toward her, as well as their children. On several occasions he broke things in the house in a display of anger. “He actually terrorized us,” she added.

She also mentioned that she had currently been dating for a year, with a divorced man roughly her age and with three children. It was difficult, she said, for her to trust him. What made it worse, she claimed, was that she was not used to having someone care about her and support her like he did.

During the entire interview, her affect, mood, speech, attention, concentration, memory, thought, and sensorium all appeared to be within normal psychiatric limits. Her judgment and insight were adequate and estimated intelligence level was average.

It was my professional opinion that Ms. Lee did not suffer from any psychiatric ailment proximately related to the events involving Mr. Blum.

Her psychotherapist and psychiatrist did not find (or make note of) her to suffer from PTSD. She was not diagnosed with PTSD by the members of the medical practice where she received the antidepressant medication (Wellbutrin is not primarily used for the pharmacological treatment of PTSD). During the time she reported that the harassment by Mr. Blum was taking place, Ms. Lee interrupted seeing her psychotherapist and her psychiatrist, and although recommended, she never resumed treatment with either.

During her time of employment shared with Mr. Blum, Ms. Lee did not suffer from any functional impairment or social/intimate/personal and occupational decline typically seen in individuals with PTSD. The symptoms she had, shortness of breath, palpitations, migraines, nausea, and vomiting, had been happening long before the reported sexual harassment by Mr. Blum. Despite being reportedly harassed by him, she continued to perform her daily exercise routinely and successfully.

Many traumatic events in Ms. Lee’s life occurred at home. Despite these events happening, she never feared for her life from any of them, did not activate an already
installed security system, and did not take the time to report to the authorities the instances such as the rape on her deck or her neighbor snooping around in her backyard. Ms. Lee did not develop any psychiatric disorder after the rape incident. She kept the clothes (some of them torn) that she was wearing that night, led a normal lifestyle right after the incident, and even hoped for a future with the man that raped her; she had a long-standing “crush” on him. This rape incident occurred while Ms. Lee was attending marital therapy.

Ms. Lee had always been, since long before the complaint of harassment, a woman who did not trust men. Despite this untrustworthiness, she showed a great need to position herself in a situation of needing men to take care of her, to “rescue her,” as in her numerous relationships, being advised of what to do with aspects of her life, including automobile troubles, financial concerns, and insurance matters, and receiving “gifts” from men, like a cell phone, liquor, poems, etc.

Ms. Lee’s anxious arousal, enticing style, and defensive avoidance are issues leading back to her childhood. Her need to stay busy as to not become overwhelmed with painful feelings is an aspect of hers that traces back to long before the relationship with Mr. Blum. She knows how it feels to be traumatized, by men and women; there is no clinical evidence of PTSD due to Mr. Blum’s sexual harassment.

Due to unresolved conflicts with her father, as assumed in psychotherapy, she said she is angry at all men. Ms. Lee had been planning to find another job (to replace the one in which she worked with Mr. Blum) long before the incident with Mr. Blum arose. Her main concern was finding a job with health insurance benefits. She was good at what she puts herself to; she excelled toward the top of the group quickly.

She is highly functional at work and close to a man in a nurturing relationship. She does not receive and does not feel she needs psychiatric treatment, other than Wellbutrin. Her mental status was molded prior to the reported harassing posture of Mr. Blum, her abusive parents, and uncaring ex-husband.

While the reported sexual harassment was taking place, the 9/11 terrorist attacks occurred, but did not affect her in the least (as opposed to someone with PTSD having their trauma reactivated by the terrorist attacks).

While in psychotherapy, Ms. Lee affirmed (11/98) that she could act the role she wanted others to perceive about her. This is a woman who has believed that it was “normal” to be mistreated, neglected, physically and verbally abused, abandoned, and disrespected. She was told by her parents from birth that she should accept and expect “what was coming” to her. Ms. Lee has difficulty accepting help from others (MHP) and forming constructive relationships. It is easier for her to serve others than to ask for help herself.

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**Case 14b: Opposing Forensic Expert Opinion – Claim of Sexual Harassment and a Hostile Work Environment**

Dr. White reviewed the same material I did, conducted a clinical interview, and administered two psychological tests: TSI (Trauma Symptoms Inventory) and MMPI-2.
In his report the examiner explains that the TSI aims at assessing the impact of traumatic events on psychological functioning. It also reflects acute and chronic trauma. The second test was used to assess mental health status. In his report, Dr. White never introduced what he learned from Ms. Lee by prefacing it with: “Ms. Lee states…”

By the time she met with the psychologist, Ms. Lee had been working for a different company for 1.5 years as the “director of sales.” The examiner learned that Ms. Lee had suffered “stormy” developmental years. Her parents had been physically and sexually abusive. She told Dr. White that contrary to what was documented in the psychotherapy notes, after separating from her husband, she befriended a male who showed up at her door one night and sexually assaulted. Because he was intoxicated, she was able to get away from him.

The mental status exam conducted by Dr. White was unremarkable for findings of mental disorder, stating, “no cognitive deficits were found, and her emotional responses were appropriate to context.” He identified a “significant trauma history” but did not place it in a particular time of her life. The examiner found that Ms. Lee’s appetite and her sexual interests were intact, and she also had a significant relationship.

Ms. Lee reported that she had what Dr. White took to be somatic equivalents of stress created by Ms. Blum’s actions. She told the examiner that she needed to visit the hospital because of this. Ms. Lee also started out with, “I would say that…,” when answering to his question concerning the current impact on her of what happened at work. Based on her report of symptoms and attitudes, the examiner concluded that Ms. Lee was afraid of being constantly stalked by Mr. Blum. Also, Dr. White understood that her saying that she did not trust people meant that this was due to the fears that Mr. Blum produced in her. The psychologist was then of the opinion that her list of symptoms and described attitudes corresponded well to the diagnosis of PTSD. He saw proof of this in her depiction of “defensive avoidance” and “anxious arousal” as the two highest clinical scales. “She prefers to stay busy instead of falling prey to painful thoughts.”

Dr. White ended his reports noting, “Ms. Lee is experiencing significant anxiety of a post-traumatic nature….” Dr. White did not consider Ms. Lee’s chaotic household environment while preparing his opinion. He also interpreted her reported emotional reactions as “extreme” and her reported feelings as “helplessness.” Thus, the examiner was of the opinion that Ms. Lee suffered from PTSD that is proximately related to the reported sexual harassment by Mr. Blum.
Case 15a: Assessing Allegation Validity of Sexual Abuse

I was contacted by an attorney to ascertain the reliability of the videotaped examination of a minor, Cynthia, conducted by Detective Lynn Huron, from the prosecutor’s office, concerning the allegation of sexual abuse by her father, on June 1, 1999.

The attorney, representing Dad (defendant), asked me to watch and consider the videotaped interview of this minor, and also the pertinent records and documents concerning the allegation of sexual abuse of this 5-year-old by her father, and provide my opinion. I agreed to the procedure.

Materials reviewed included (1) St. Paul’s Hospital for Children medical records, June 2, 1999; (2) sexual abuse records (SAR), clinical chart, July 23, 1999–December 8, 2000; (3) court transcripts concerning child custody matters, as well as marital council report; (4) videotaped (and written) interview of Cynthia by Detective Lynn Huron, June 5, 1999; (5) sexual assault/under 6; report of Detective Huron, June 4, 1999; and (6) Police Department, investigation report, June 18, 1999.

The report on suspected child abuse states that Cynthia commented, “My coochie is infected because my dad put chocolate stuff on me… he hit my coochie with a little bat… he stuck his finger in my mouth and then in my coochie… I said, ‘Stop it’… he didn’t have any pants on.” Cynthia also said that it happened on several other occasions. Mom added that Cynthia told her that “cream came out of the hole in his privates.”

Cynthia was wearing the same underwear she wore in Dad’s house. She was reportedly quite active and playful in the emergency department, even laughing and joking with the medical and nursing staff. Cynthia’s genital exam did not reveal any abnormality, trauma, or forced entry. Mom said that her daughter told her that her dad placed his finger in her vagina.

The “diagnosis” arrived at was “Child Sexual Abuse.”

Mom said that she and her fiancée picked Cynthia up from Dad’s house at 3:45 PM. Later that night, she disclosed to Mom about the sexual abuse by Dad. Mom
said Cynthia mentioned, “Daddy put his finger in my mouth…then in my coochie. This was the fourth time.”

According to Mom’s report, Cynthia also said to her, “Daddy has a hole in his coochie and white creamy stuff came out.” Cynthia added that it happened every day when she wakes up.

Material obtained from the SAR clinical chart, August 26, 2002–March 25, 2003, noted that Mom told the counseling social worker that her daughter said, “Daddy licked off” her genitalia a chocolate liquid he had applied on it. Mom added that her daughter told her that her father’s penis was erect. Mom also said that Cynthia disclosed to her the sexual abuse when they were in the car on the way to the lake they would frequent and that her fiancée immediately turned the car around and drove them home. Mom said that Cynthia did not know that what happened to her was wrong.

Cynthia “was very cheerful today.” Her mental status exam was unremarkable. The clinical diagnosis that SAR arrived at was “Sexual Abuse of Child (by biological father).” Despite not finding any abnormal psychiatric component, Cynthia was “diagnosed” by the counseling social worker as suffering from PTSD. Cynthia was trusting and accepted directions from adults, was friendly and outgoing, and had good self-esteem. The girl showed “no sign of aggression and no difficulty separating from her mom.”

During her counseling visits, Cynthia spent an hour with the counseling social worker. Her “affect was appropriate and her mood was happy.” Contrary to Mom’s reports, “her play is not aggressive.” She wanted her mom to wait outside. Cynthia reported her mom would pull her hair if she was bad.

Notes from January 7, 2004 stated that she did not return to “counseling” until December 2, 2000, which was her last visit. Cynthia had no symptoms or signs of psychological turmoil. She was very productive and creative during her last visit and feeling very proud of it. The counseling was terminated.

Mom reported Cynthia as clingy, hanging on mom’s legs, and crying. Yet, the opposite was revealed during counseling. Mom reported both that Cynthia would describe monsters and that she has never shown fear of monsters before. Mom also stated that her daughter did not show signs of distress when exposed to situations, places, objects, or people that reminded her of the abuse.

Records of the court hearings and decision concerning child custody matters, as well as Marital Council Report Information Sheet, indicate the presence of a spiteful relationship between Cynthia’s parents.

The videotaped interview of Cynthia and the text of such by Detective Lynn Huron, from the prosecutor’s office, represented Ms. Huron as conducting the meeting as if in a hurry, having the quality of an interrogation rather than an interview. The rapport building stage consisted on the examiner praising Cynthia for her physical appearance. Detective Huron took for granted that this 5-year-old girl was able to read.

Cynthia introduced a curious thought: “I live with a man from next door sometimes,” which called the attention of the examiner but did not pursue it. Detective Huron was not interested in learning about who their neighbor was, when learning that he lived in her home.
Far from feeling any negative emotion toward her dad, Cynthia wanted to be next to him. Cynthia showed no sign of sexual overstimulation. Detective Huron did not ascertain whether this 5-year-old girl appreciated the difference between true and false. And only 2 min into the examination, and in a spontaneous fashion, Cynthia told the investigator, “I’m going to tell you right now what happened.”

Cynthia then said, “My dad put chocolate stuff on my cooch.” She responded to her being asked to elaborate, by saying, “He hit me with the tiny bat next.” She added that their clothes were off. Detective Huron did not ask how it happened that she was naked. She did not ask, at any time, for Cynthia’s feelings, while the sequence Cynthia reported was unfolding. Next, the girl told that her dad licked his hand and inserted in her “cooch.” This last event happened more than once, but Detective Huron did not inquire as to the rate or the frequency. Cynthia went on to say it happened in her dad’s bedroom and on his bed.

Detective Huron then asked the child if she saw any part of Dad’s body that she was not supposed to. To which she replied, “his cooch.” When asked to say more, Cynthia stated, “Chocolate stuff spitted up his cooch.”

All this exchange took place, spontaneously within the first few minutes they were together.

Detective Huron then asked Cynthia to recognize the girl and boy figures. She correctly named the girl’s body parts. Before going over the boy’s, she, of her own accord, sheepishly added, “I’m naked” and “sometimes yes and sometimes no.” Detective Huron did not follow these significant leads but asked Cynthia to follow her agenda, instead.

While going over the boy’s body parts, the examiner mistakenly repeated what the girl said, “eyes” as “your eyes,” and from then on Cynthia followed Detective Huron’s suggestive leads and referred to the rest of the male body parts as, “my nose, my mouth, my boobie, my belly button, my coochie.” When the detective reversed the trend she established, the girl followed her influence again.

Cynthia said that Dad poured the “chocolate stuff” on her “cooch” and that she rubbed it in. She also stated, “Dad put his hand on my stomach, and not in my cooch.” She then added that Dad also drew on her body. She could not describe her father’s penis as erect, as she had reportedly told her mother.

The detective asked Cynthia if Dad ever showed her movies that he wasn’t supposed to. Cynthia answered, “Yeah.” She was asked to describe them, and the child talked about “lots of animals that were playing, fighting, and talking too much.”

Reportedly, this examination took place 4 days after the girl first disclosed to anyone about something bad that had happened to her and that person was her mother. Cynthia had already forgotten who she told first about these events.

As the interview was coming to an end, Cynthia denied that her dad told her to touch his body and also denied that she actually touched his body.

Based on my examination of the material, including the videotaped (~25-min-long) examination of Cynthia, it is my opinion, within a reasonable degree of medical probability, that the examination performed by Detective Lynn Huron is not reliable as a source of valid and incriminating information concerning the allegation of child sexual abuse of Cynthia, by her father.
Based on the report of Mom and daughter, and despite lack of evidentiary confirmation, the hospital changed the initial diagnosis of “r/o (rule out) Child Sexual Abuse” to “Child Sexual Abuse.” This took place before the videotaped interview.

One indicator of unreliable interview is presenting leading questions, which promote, at least, inaccuracy in the young examinee’s answer. There was little if any rapport built between Cynthia and Detective Huron. For example, during the anatomical identification section of the interview, Cynthia followed the detective’s lead, when concretely (as children this age are) identified the body parts, including the penis, as her own.

The investigator did not remain objective, skeptical, or open to all information and alternative explanations. She did not pursue crucial details provided by Cynthia, such as the inconsistencies, like “Dad licking off the chocolate stuff…Dad drawing on my body…inserting his finger in my or his mouth…rubbing my cooch…,” and her recall having been so phenomenal for details of the abuse and at the same time not recalling that just some days earlier, she first disclosed to her mom, either at Mom’s house or the lake house.

Detective Benet chose not to follow Cynthia’s leads with inquisitive remarks, for instance, “How did she end up naked? Where does she sleep? How did she end up on Dad’s bed? How did she feel during, after, and when she reportedly narrated the abuse?”

During the entire videotaped interview, Cynthia stayed on facts that could have been learned from other sources. Indeed, she was equivocal on many aspects and extraordinarily clear on others, not expected of a child her age. Detective Huron discouraged emotional expressions that could have proven valuable by adding credibility to her reporting.

Within the first few minutes of the meeting and following Detective Huron’s prompt, Cynthia announced, as if ready to take the exam, that she was about to tell everything the interviewer wanted to know. Cynthia then embarked in sequencing details of abuse, requiring inordinate attention, focus (sequencing), capacity to abstract (reference to having an infection, to dad’s penis resembling a pencil), and recall, not seen in an otherwise naïve, 5-year-old girl. Detective Huron did not use the opportunity to ask about the discrepancy in the narrative. Children this age do not have the capacity to reflect on past experiences, such as, “it happened four times in the past.”

Traumatic memories are not verbal but harbored in emotional turmoil and behavioral manifestations. None of this was evident in Cynthia, as it should have been expected of a sexual abuse that has just occurred. There was no symptom or sign of psychological trauma or even discomfort in this little girl that, according to the mother, knew that something bad had happened to her and even tried to stop her dad from perpetrating sexual abuse. There was no sign of conflict, emotional or physical pain, bitterness, or shame, otherwise typical and expected in these reported circumstances.

The only time during the interview in which Cynthia showed uneasiness was when uttering, “I’m naked,” projecting herself onto the female doll. Detective Huron ignored this significant statement, which Cynthia repeated twice.
This child did not appear to be under any psychological pressure from the descriptions she offered. Cynthia appeared with remarkable recall for details and of the chronological sequence of their evolving, much more developmentally mature than would feasibly be expected at her age and in her situation. Cynthia appeared not to be numbed by the experience she reported or sexually overstimulated by it; again these would be common expressions for many children of her age and who suffered the events she described.

Detective Huron demonstrated bias when announcing some “bad situation…that was not supposed to happen.” She took that Cynthia understood and appreciated the moral meaning of that phrase, despite Cynthia showing a total lack of appreciation, when she described watching a movie with animals depicting their ruckus playing and fighting (perhaps understood by her as bad behavior) as what was “not supposed to happen.” It would have been more conducive to ask Cynthia, “What kind of movies do you and Dad watch together?” The same applies to questions concerning how the “chocolate stuff” got on Cynthia, rather than improperly asking what part of Dad’s body he used to apply the substance.

Detective Huron did not ask Cynthia about attitudes and practices in her Mom’s house, between Mom and her live-in boyfriend/neighbor, regarding privacy, nudity, and sexuality. Detective Huron came to the interview with this girl, with the knowledge that she had been medically diagnosed as having been sexually abused by her dad, without new clinical data to change the presumptive diagnosis of “Rule Out Child Sexual Abuse” to the definitive diagnosis of “Child Sexual Abuse.”

A faulty evaluation may lead to the misdiagnosis of sexual abuse.
Case 16a: Discrimination and Assault Causing PTSD

I was asked to examine the plaintiff and determine, within a reasonable degree of professional probability, whether Mr. Lux suffered from a psychological or psychiatric disorder, as a result of the reported incidents I am about to describe.

I was not asked to determine if the information concerning the events described is accurate. I was not asked to comment on the federal and state laws that protect individuals because of their sexual orientation. Similarly, I was not asked to comment on the approach taken by the authorities of the city of Ancash and the officers of the Local Union 432. I, as expected, excluded my personal view and opinion about the rights of persons based on their sexual orientation.

The attorney requested a forensic psychiatric examination of the records of this case and of Zach Lux and to provide him with a forensic psychiatric report that included my opinion of whether Mr. Lux has been psychologically afflicted (in particular PTSD) by the events and circumstances he reported during the period of May 1998–March 2003 and specifically of July 31, 2001.

Material reviewed before the examination of Mr. Lux included complaint and jury demand; plaintiff’s objections and responses to defendants’ interrogatories; psychotherapy, psychiatric, and psychiatric disability records; cardiology records; psychiatric (IME) report; deposition transcript of Zach Lux, Vol. I-IV, in a 2-month span approximately 23 h of testimony; and letter sent to me by Mr. Lux, after my examination of him, entitled: “Physical and Mental Symptoms.”

Mr. Lux and his male (homosexual) partner, Jon Ray, moved to Ancash 2.5 years before the reported event. They lived next to Local 432 – Brotherhood of Auto Mechanics. The “complaint” states that for nearly 3 years they lived in that house, they were subjected to loud, noisy parties at the Local 432 next door to plaintiffs’ residence. The union members would reportedly get drunk and loud, disturbing the peace and regularly awaking the plaintiffs and the neighbors, before dispersing after 3:00 a.m. It also reads that at some point in time, their neighbors further disturbed their peace by, at least once a week, harassing them due to their sexual orientation,
e.g., ringing their doorbell and fleeing from the scene and also throwing what appeared as used condoms into their property. The plaintiffs added that they complained about this to the Union central office and the police, but to no avail. Plaintiffs further state that on March 23, 2002, some 20 members of the Local 432 threatened them with physical harm, after watching an international soccer game, on television. This took place after Mr. Ray went outside and asked the defendants to be quiet.

According to the complaint, in response, Mr. Ray was told, “you shut the fuck up, you fucking faggot, piece of shit... you want some more condoms?” Others joined in, yelling similarly biased and degrading insults. It is reported that the mechanics became unrestrained, running up and down alongside the plaintiffs’ property, pounding on the walls. The report goes on to describe how the union members jumped onto the plaintiffs’ fence, shaking it, hitting it, and attempting to pull it down, while shouting, “Get the fuck out of here now faggot! We are going to kill you... and your dogs... get the fuck out of Ancash.” Neighbors called the police.

The plaintiff also states that he reasonably believed that he and his partner were in imminent danger of being attacked physically and became emotionally distraught and concerned about their safety and security. They called 911; the police arrived but did not arrest the defendants, despite Mr. Lux insisting that he wanted to press charges. Plaintiff noticed that the police officers, although sympathetic with the plaintiff’s outcry, minimized the reporting of his complaint, “aiding and abetting discrimination and harassment based on sexual orientation.” I read that, since the attacks, there have been several additional incidents of harassment based on discrimination. Plaintiff states that defendants caused property damage and emotional distress, mental anguish, emotional harm, and the physical manifestation of their emotional injuries.

On the registration form for psychotherapy, Mr. Lux wrote, “Bias attack on partner and I.” Mr. Lux noted a past history of social anxiety disorder (fear to be in public places), extreme social isolation, sexual problems, low self-esteem, feelings of guilt, shame, self-hatred, uncertainty about sexual orientation/gender identity, and work stress. He told the therapist that he was distant from his family and also that he felt ambivalent about work. Mr. Lux noted he was a recovered alcoholic, not drinking for over 20 years. He underwent cardiac surgery and was currently taking cardiac medication, also on products to control high blood pressure and high cholesterol. As a preventive, he took aspirin (to facilitate blood flow) and Adderall (mixed amphetamines for mental stimulation). A month after the reported assault, Mr. Lux was not taking antidepressant or antianxiety medications.

One month after the event, Mr. Lux started psychotherapy, which lasted for 1 year. Mr. Lux had been in treatment for major depression with Dr. Goodman, a psychiatrist, for some 20 years.

The psychotherapist diagnosed “Dysthymia and Generalized Anxiety.” He also noted that Mr. Lux functioned at a moderately impaired level, according to what he reported. The progress notes read, “Is involved with the gay community around bias issues... continues to talk about crime... stress in relationship (with Jon)... will consider move... moved forward with law suit (claim of $5M opened 2.5 months after the
event). ‘Am I worth this?’ Moving out of Ancash… client brought newspaper clipping about case… at work, people knew about ‘circumstances’, but they are not supportive… discussed negotiation of work issues and upcoming family reunion… overwhelmed because of new work assignments… tension at home – Grand Jury met… is going to close on his new residence soon. Encouraging Jon to work… feels pressure to stay at the job he doesn’t like… has troubles with Jon… relationship volatile – continues to provide update on case – has plans for Thanksgiving with friends….”

The therapist acknowledged that the psychiatrist added a prescription for a small dose of an SSRI (antidepressant). “Client in mediation for case; it may settle… Zach came with articles about additional harassment and investigations… he states that he ‘wanted to organize a vigil’… client seems stable despite (first) anniversary of event – Jon is working… he filed for psychiatric disability… indicates displeasure with his work environment… will use time to job hunt and to shift his medication… feels that Seattle setting would be more positive/supportive.”

After 25 visits (13 months after the event), Mr. Lux’ therapy ended. “Client kept me posted regarding outcome of lawsuit… often feels unsupported by the gay community. Feels less depressed but continues to isolate… his relationship has been strained by partner’s unemployment and partner’s severe ADD… Client had a depressive relapse (eleven months after the event) and went on disability. Displeasure with work environment, feels that a big city setting would be more positive/supportive.”

The therapist notes, “He’ll continue treatment with his psychiatrist. Mood seems to be improving – will begin job hunting or may return to old job with accommodations… fearful about aging and achievement.” His final diagnosis was “Dysthymia and Generalized Anxiety.” Mr. Lux described, “…being at peace that everything that can be done about the law suit, is done… has begun creative activity movie about the incident… showed me in session – this brought joy… working on movie.”

The psychiatrist noted that she first met with Mr. Lux 19 years before the event. At that time, after he stopped drinking and smoking, anger and depression surfaced and resentment toward Jon for not working. He took antidepressants and stimulants to help him “jump-start” his days. She further mentioned, “From time to time, feeling hopeless and helpless, feeling little purpose in going on living… No suicide plan or attempt… Had many sleeping problems; was unhappy at work.” These symptoms were present long before the event. No mention is made in the clinical notes of problems with the auto mechanics next door.

Mr. Lux’ partner gave him Adderall, mixed amphetamines, which he took at higher than recommended dosages. His psychiatrist kept prescribing it to improve mood, sense of well-being, alertness, and focus at work. He welcomed losing weight while on it. He was also talking Toprol (heart medication) which commonly produces fatigue and dizziness as side effects. All these clinical notes date from before the incident. Mr. Lux also went back to smoking, prior to the event. He reengaged smoking despite being aware of the health problems this was causing him, including shortness of breath, tightness of chest, sense of lack of oxygen, coughing, and complications to his heart condition. He was also taking amphetamines, which may seriously interfere with his cardiovascular functioning.
One month after the event, the psychiatrist notes that Mr. Lux felt “very uncomfortable living next to the Union building, and that he will have to move… distraught, angry, and humiliated.” Mr. Lux stated he couldn’t concentrate on reading anymore. He “reported flashbacks, nightmares, and increased stress since Union incident. Hypnotics and sedatives prescribed. Close on new apartment (seven months after the event). No promotion at work. Feels at times suicidal, but denies intent, extremely depressed; hopeless, and helpless. Grand Jury did not indict the Union mechanics responsible for the event, and patient feels victimized… His father criticized him and put him down in public; mother didn’t protect him.”

Mr. Lux applied for long-term disability due to his reporting impaired sleep, tiredness in the morning, inactivity, increased anxiety, decreased concentration, and forgetfulness. He filled out the form titled “Personal Profile Evaluation,” detailing what he considered to be his psychiatric limitations for which he was disabled. His own psychiatrist endorsed his application (19 months after the event) with the diagnosis of “Major Depressive Disorder, Recurrent, Severe.” She added that Mr. Lux made “many errors in mathematical calculations and he was too severely limited in functioning.” According to the psychiatrist, Mr. Lux was taking an antidepressant, amphetamines, and a product to increase daytime alertness. His psychiatrist also wrote (erroneously), in the form, that she first saw Mr. Lux for treatment 5 months before the Local 432 incident.

Mr. Lux told his cardiologist (2 years before the event) that he had “marked fatigue” and was taking Ritalin to improve it. His heart condition was stable at every checkup.

Mr. Lux underwent 23 h of deposition in four sittings. He was able to provide a thorough and succinct description and explanation of his occupation, to recall names and dates, details of his educational background including the names of schools, and geographical locations. He was also able to pinpoint his prior job locations and description of job duties in different places. He used metaphors and analogies; e.g., “the writing was on the wall.” He worked for 1 year after the incident and decided to stop; he was not fired. Mr. Lux was able to remember and describe the process required to apply for disability and how to use his vacation/sick time. He handled the claim by and for himself; he represented himself. He was also able to spell the name of all his doctors. He identified the medications and described how and why he took them, as he did with the two open-heart surgeries he underwent. The plain-tiff also named and described the medications prescribed by his psychiatrist, to improve his mood and mental alertness.

Mr. Lux recalled the date he moved to Ancash, after living in Europe for several years. He correctly named the jobs, places, and dates he used to be at, throughout the years. At the house in Ancash, next to Local 432, he lived for 3 years, without a written contract forcing him to stay there, passed the 1st year. He said that, as a gay man, his antenna was always out for potential danger zones. He was aware of this from the start of his stay in Ancash, that the mechanics were unpleasant toward him and his partner, noting, “from very, very early on…, gay men and women spend their whole life with their antenna up, waiting…,” and further added, “I remember distinctly very early on there was an incident where
I saw people outside the union building....” Mr. Lux appeared to be able to calmly recount this and other reportedly traumatic events.

He demonstrated having keen recall of Jon telling him (now some 4.5 years earlier) that the person was running toward the Union building, after ringing his doorbell. He also recalled the condoms thrown into his property. During the deposition, Mr. Lux was able to concentrate, focus, detail, be attentive, and orient himself while describing “the south front corner of Local 432 abutted our yard almost... gravel, a strip of gravel punctuated by a few bushes, low bushes... a fence between the yard and the southeast corner of the Union quarters....”

Mr. Lux talked about the times his doorbell was ringed, and the condoms thrown into their property, but he never complained about this to the town police before the event. He did complain about the loud parties late into the night. He read the police reports about their responses. What concerned him the most was that the police never acted upon his complaints of excessive noise and drinking coming from the auto workers.

Mr. Lux described the triggering factor as Jon telling the union members, “Please, shut the hell up.” As soon as Mr. Lux assessed the situation, he called the police, which arrived within 5 min. He did what he reasonably had to do. Mr. Lux described what happened, the different voices he heard, the different actions the auto mechanics took, and the epithets they uttered. That night, he spent 1 h talking with the police, and then he went to bed, to sleep upstairs. Three days later, he went to the police station and gave a statement. He had been very concerned that this incident was going to be glossed over and that nothing would be done. “I was very polite and courteous (with the police), but I did express these reservations.” He added, “We knew that we were living next to a powder keg; these guys could do essentially what they wanted.” He described the union members’ behavior, their parties, and their homophobia.

Mr. Lux described his two heart surgeries, how successful they were, the tests he periodically took to monitor his condition, and that his arteries were “clean as a whistle.” He categorically denied having smoked any cigarette from the time he moved to Ancash and the morning after the incident. Concerning his emphysema, he said that he was totally asymptomatic.

Mr. Lux saw his psychiatrist for the treatment of “depression and feeling that his career was not taking him anywhere”; he experienced “anhedonia” (lack of pleasure on anything one does and used to enjoy), “sort of a loss of pleasure principle,” and a general feeling of lassitude. He talked about his strife, being gay, as a youngster, in the town he grew up in. “Being a despised minority does have an effect on people, you know.” Mr. Lux provided a cogent analysis and reflections concerning homosexuality from historical, sociological, and religious points of view.

Mr. Lux affirmed, “My diagnosis today is Major Depression.” He added that he never suffered from major depression until the event. The lists of symptoms that took him to treat with his psychiatrist include low self-esteem, lack of assertiveness, “being a doormat,” poor verbal skills, stifled creativity, lassitude, lethargy, depression, feeling down, and feeling sad. He waited 4 days for his regular psychiatric appointment to report the event. At that visit, his blood pressure and pulse were unremarkable.
I examined him for 3.5 h. He drove to the office and carried with him files and a cup of coffee. He commented, “I’m unemployed for 18 months. I am on disability for Major Depression.”

I handed him a form titled, “Consent for Forensic Examination by Alberto M. Goldwaser, M.D.” I asked Mr. Lux to read through the two-page form. He read it quietly. He also made one editing correction, on the second page, item #3. I reviewed the key points emphasized in the form, detailing my role in this process, and he then signed it. Despite, he added, “You’ve been hired to undermine whatever medical evidence my attorney will present.”

Mr. Lux told me all about the occurrence, what preceded it, and what followed. “We made it very clear (to the police) that we were filing a complaint. We were never given the opportunity… over the course of the next two weeks… we had not decided, other than filing a criminal complaint, to file a civil law suit. We approached the idea of doing it when it became apparent that nothing was going to happen; and that my suspicions were confirmed. It was obvious that this was going to die on the vine… there was a mob out there banging against our house and threatening to kill us… over and over again… Is this okay? Can you do that? The whole thing of terrorist threats; assault to property; trespassing… they had three people who admitted to doing it… how many people had been interviewed? How many arrests had been made? Two years later… what has been done? Nothing.”

At some point Mr. Lux asked me if I had seen the house. He took out a number of photographs and a blueprint of the property, all lined up on pages covered with a transparent cellophane cover. Mr. Lux stood up, approached me, and pointed and described the layout of their house, the parking lot, and the Union building. He explained, “This is Local 432… this is the door the mechanics always used… this is our house… this is our fence… see the wooden fence goes up there… they got on top of this table and against this chain link fence… this is our little porch… this is the front… this is the side… this is the side… this is the back yard… that wooden fence was shaken… this is where their beer went… this is where they had their BBQs… they were practically on our deck… every weekend… they would park in this parking lot… right next to our living room… we complained to the police… at night in the dark sitting in their cars with the lights on our house… for an hour or so….”

Mr. Lux continued, “And that started a whole series of harassment that went on during the summer… my partner was not working… I was working and gone 10–12 hours a day… some 20 minutes away on the highway….” He showed me a newspaper clip concerning Local 432 reopening, after the event. “Jon finally got help from our local political office… they intervened, and the investigation was taken to the Bias Unit at the State capital.”

I asked Mr. Lux how it felt like living in Ancash. “I lived my life as a gay man… knowing that I was hated… simply because I was gay… people got beaten up… killed… simply because they were gay… so I spend my whole life always on guard… always looking over your shoulder… meanwhile the climate ostensibly changes a bit… the 70s, 80s, and the 90s are all by… and some attention is paid in this country for human rights for the gays to some degree, and other groups… and
then suddenly it happens... out of the blue... when you least expect it... this mob attacks your home... it pulls out the foundation from underneath you and everything just collapsed...."

I asked Mr. Lux how all this affected him. To this, he remarked, "I can’t get rid of it... I get depressed... I also... I didn’t even realize... but I also have manifestations of Post-Traumatic Stress Disorder... I feel tired, there are days I struggle to stay awake... I don’t have the energy (appeared teary-eyed)... I try, I try, and I try... I can’t... I have 4 siblings... they all knew I was gay... they all knew about this... I don’t call them... I can’t pick up the phone to call my 88-year-old mother... she has severe Parkinson’s in the last year... she knows who I am when I talk to her... I didn’t call her in 18 months after this happened... I didn’t call often before, but regularly every few months...."

He said nothing about his psychiatric treatment until I inquired about it. “Oh, yes, I’m seeing a psychiatrist in a town nearby, once weekly. I take medications and also am in cognitive therapy with her.” He took out his phone to get hold of the medication information. “I am so lethargic... I can fall asleep at the drop of a hat, anytime, anywhere; she took me off Adderall because of my heart. I’m taking this beta-blocker... my heart surgeon was adamant about my taking the beta-blocker for the rest of my life. I had heart surgery in May 1999. I had an aneurysm of the ascending aorta, and he put a graft that included the aortic valve and a good segment of the ascending aorta. My blood pressure is fine. I’m very cautious about my heart condition.”

Mr. Lux proceeded, “I take this new antidepressant, since my depression is not being alleviated... I took Cialis (for erectile dysfunction), Adderall was stopped a few months ago, after years of taking it... it sharpened my mind a bit... no side effects from Adderall... I took a small dose of it... I don’t have ADD... Dr. Goodman told me that she would give me a small dose of Adderall... she came up with the idea... you know I can’t prescribe for myself this product... to start up my mind... because of my lethargy and fatigued and poor concentration... this is why I went on disability, because I could not concentrate at work, and I was making mistakes at work.”

I pointed out that he told me that he was taking Adderall for years for the purpose of focusing and increasing his concentration. He explained, “Oh, yeah... I had a history of depression; but by the time the incident with the car mechanics came along I was no longer taking antidepressants. I certainly never had depression as I have it now; incapacitating. I always worked; I had a career.”

I asked Mr. Lux about his report of disability. After a long pause, he said, “I am incapacitated now because my career... I’ve been a fashion designer. It’s a very deadline-oriented, a hard pressure job. I was working 50–60 hours per week and I was doing a very good job. I was a shining star; I had a great deal of energy, focus, and concentration. Now the combination of depression and perhaps post traumatic events... I don’t know... but my concentration became more and more difficult... I began to make mistakes in my drawings and my creative flair was dwindling; I even had a screaming fight with my boss. I had never done that in my life. I started crying in the office, several times in the middle of the day. I sent a nasty email to someone..."
in accounting. One of the chief executives sat in my office and talked to me about it. I began to feel I was going to implode in the office, when everyone was watching; those types of things.”

Mr. Lux told me that he started smoking again. He told me that he did not smoke one cigarette until the day of the reported assault. Mr. Lux said that before the event, he had been on maintenance therapy, once monthly, and not taking any medication. “Before,” he explained, “the depression was not as severe… even though I was taking medication or whatever… I could say I really wasn’t depressed… I don’t even know what triggers these things, but I suddenly feel awful. There are bouts of it; I can spend 4–5 days in bed, wanting to sleep all the time… bouts of it… I stagger into the bathroom… I can sleep all day and all night, when it first comes on. After four to five days… it gradually breaks slowly… I sleep for a couple of hours and wake up… but it’s like being chained to the bed with a rubber band… I sit down on the toilet and… okay; I’ve got to do this and this. And the next thing I know is that I’m in bed again. I don’t care about anything. The same way they come, they go away… two weeks ago I had one. It lasts for four five days, and then it goes. Then, I get up and think how stupid I was. I wasted all that time. During these times, I really don’t care if I live or die. You can pull the plug… you can gas me… you can do whatever you want… I don’t care… what happens to me or to other people… I can’t read… you know I was an avid reader. I have thousands of illustrations and designs… half of which are still in boxes, since we moved… since I can’t get the motivation to finish doing it. I’m trying to make a little library, but as soon as I start, my mind wanders off to something else.”

I asked Mr. Lux what kinds of things distract his attention. After a brief hesitation, he replied, “Initially, the mechanics. But that is not so much anymore… now I can have a blank mind… I can sit there and stare into the space for long periods; and not to think of anything. People do that and it’s enjoyable for them. I can stay in that state for 20 minutes or more… this is when I’m out of these bouts… when I’m in the bouts… just pull a pillow over my eyes and that’s it… I am out… basically unconscious… whether I am awake or not… and the antidepressant does not stop the patterns, you know.”

About his relationship with Jon, Mr. Lux described, “It’s bad… we have never fought like now. It’s awful… about anything… we say nasty things to each other in the last two years… I’d call him ‘a parasite’… Jon has had a period of unemployment… he is pulling himself together… he is working now… it’s been very difficult for him… so, I was the bread-winner… which gives you a certain amount of power… I tell you, I feel sorry for the old fashion 50s housewives… putting up with the one that brings home the paycheck.”

“We love each other… we’re together for almost two dozen years… living in a social setting that encourages us to abandon each other… our society is set up, legally, to keep men and women who are married, together, because divorce is a hassle. Gay men can walk away from it with no problem. Nobody thinks that we can do it, anyways.”

“What I love about Jon? Many, many things. He’s one of the kindest… to me… he loves me deeply. I’m convinced of that. Even though I fought in his face when
I’m angry… he’s kind and generous. He is the most intelligent person I’ve ever met in my life… he’s perceptive… I call him an ‘idiot savant’… he’s the most brilliant person I’ve ever met in my life, but he can’t tie his shoelaces… which can be frustrating…)

Concerning post-traumatic stress disorder, Mr. Lux talked about several unremitting symptoms in his comments, “The hyper-vigilance, combined with this startle reflex… it’s awful… any unexpected noise or whatever… and I jump. Even in my sleep, for heaven’s sake… I overreact to noise. I mean it’s like… it’s an overreaction… and ah… I cannot get the events out of my mind. It keeps coming back, you know… particularly, ‘We will kill you, we will kill you… you fucking faggots… and your dogs!’, all the time, all the time.”

I then asked Mr. Lux to clarify his statement that he never went back to Ancash after he left. “Yes, since we moved to a new place… yes, indeed… I had to go back… I had my cardiologist, dentist, and internist were there… every three or four months I had to go back… I severed my relationships with all these doctors… much to my regret. Periodically, there was some chore I had to do. I went to Ancash to fill out prescriptions; ‘odds and ends’… going for my medical records for the attorneys… I went to pick them up… time and again we would have to drive to Ancash… either Jon and I, or just me alone… it was extremely uncomfortable… these people staring at you…”

Close to the end of our meeting, I asked Mr. Lux if there was anything that I did not ask him or that he thought we should cover. He became pensive for a moment. “Well, I guess I could beat the dead horse and try to convince you that I am depressed and that they’ve given me the diagnosis of Post Traumatic Stress Disorder with a wide list of symptoms that I have. (He retrieved a list from his pocket he carried with him and read aloud) Recurrent nightmares; a lot of them I don’t remember and the frequency varies… I wake up and go right back to sleep.”

I asked Mr. Lux to describe one of the nightmares. As he was having difficulty coming up with one, I suggested to him to tell me the last one he had. “I’m sleeping and wake up and hear my dog, in Ancash; in the living room… he is lying on the floor making an awful honking, cloaking sound… a yellow vile coming out of his mouth. I get a towel, pick him up… and hold him in my arms… later he dies in my arms… in Ancash… right next to the parking lot. It was always one of our fears that after the incident they were going to poison them (the dogs). It was easy to throw something over the fence.”

Mr. Lux’ mental status examination revealed essentially normal findings. He did not display any psychomotor agitation or retardation. I did not detect any abnormal gestures or mannerisms. No fine or gross tremors were observed on any of his limbs. His gait appeared normal, and he was in no obvious physical pain or discomfort. After an initial period of hesitation, Mr. Lux appeared to be more at ease with the interviewing process. Even though he was at times somewhat suspicious and reluctant to provide much information, for most of our meeting, he appeared relaxed, animated, and cooperative.

Mr. Lux was able to remain seated for the duration of the interview, some 210 min. On two occasions, he got up from his chair to show me material that
illustrated his viewpoints. Some 90 min into the examination, he excused himself to go outside and smoke a cigarette. Mr. Lux appeared to be able to relax and be animated. He had good eye contact and was quite connected. During moments of circumspection, he had a message for me to accept, which was that he was at all times depressed, apprehensive, and insecure. He was not friendly, in the belief that I had been hired to contradict other medical findings and opinions. Nonetheless he was able to make lighthearted comments and provide metaphorical examples. His affect was not constricted nor intense. It was appropriate to the situation and to the ideation. Mr. Lux did not describe or display, presently, any debilitating psychiatric symptoms, so no quantifiable alteration of his affect was expected. His mood was for the most part neutral. Mr. Lux displayed no signs of depression or anxiety throughout the entire time our meeting lasted.

Mr. Lux appeared bitter when describing his not having gotten validation and justice concerning the event. His speech was clear, coherent, not pressured, and relevant. He was spontaneous, articulate, fluent, and vivacious. Mr. Lux was quite engaging and productive in his descriptions. There was no formal thought disorder or loosening of associations elicited. Mr. Lux denied hallucinations or delusions of any type. He also denied current suicidal or homicidal ideation. There was no evidence of any symptoms or signs indicating risk of suicide. Mr. Lux was oriented to time, person, and place. The examinee had driven to my office. His recent, remote, and immediate memory was intact, as tested throughout the interviewing period. Likewise, his attention and concentration were intact. Mr. Lux was quite able to participate in a 210-min interview without becoming distracted, inattentive, or losing his concentration. I did not have to repeat any question or bring him back to any subject because of distractibility or inattentiveness. Not once did he lose the thread of his thinking. Mr. Lux was able to calculate in a timely fashion. Estimated intelligence level was average or above. Mr. Lux reported symptoms of a recurrent psychiatric ailment, major depressive disorder. He also mentioned that he was given the diagnosis of post-traumatic stress disorder. He added that he was aware he needed to be in psychiatric treatment. There was no gross deficit of judgment.

I found no psychiatric diagnosis proximately related to Mr. Lux’ reported events of July 31, 2001. He did not show the emotional symptoms or behavioral signs of individuals suffering from post-traumatic stress disorder. PTSD is characterized by the re-experiencing of an extremely traumatic event accompanied by symptoms of increased arousal and by avoidance of stimuli associated with the trauma. It is a psychological (including emotional) reaction to trauma – a painful, shocking experience that overwhelms the mental capacity to react in an adaptive manner to what has just happened. It is a sudden and unexpected assault to one’s sense of physical integrity and continuity, which interrupts the essence of our well-being. After the trauma, people feel and behave in a manner concordant with a changed perception of life. What once seemed safe and stable, in a flash, now seems dangerous and unpredictable. One cannot take his safety for granted any longer, dreading new assaults. It affects personal relationships, social life, and work.

Other features of PTSD are recurrent memories, shame, insomnia, jumpiness (inability to rest), hyper-vigilance (state of being constantly on guard), avoidance of
situations that remind the person of the trauma, and fear that the event will imminently happen again. We also see an initial reaction of mental paralysis, denial, disbelief, and silence – contrary to what we have seen in Mr. Lux’ case – and an attempt to ensure safety through compliance. There is a great sense of shame related to the loss of control over his body and/or property. Physiological changes appear as well, including but not limited to decreased appetite, sleep disturbance, inability to relax, and inability to talk about the experience.

PTSD includes the experience of serious injury. The patient then performs at far less than adequate levels of functional capacity, manifesting in avoidance, hypervigilance, and uncertainty about his worth and constantly second-guessing others.

There is a markedly diminished responsiveness to the external world, referred to as “psychic numbness” or “emotional anesthesia,” usually starting soon after the traumatic event. Contrary to what we observed in Mr. Lux’ case, the individual complains of having markedly diminished interest in previously enjoyed activities, and a new feeling of having become detached and estranged from other people, as well as having markedly reduced ability to feel emotions, especially those associated with intimacy, tenderness, and sexuality. As described in the documents I reviewed and based on my examination of Mr. Lux, he was not observed to have impaired affect modulation, dissociative symptoms (i.e., lack of recollection of what happened before, during, and/or after the reported assault), somatic complaints, feelings of constantly being threatened, and impaired relationships with others.

His response to the reported stressful event was of fear, but not helplessness or horror. Mr. Lux remained lucid, cogent, attentive, and creative throughout the incident and acted in a reasonable manner, summoning and waiting for the police to help. Opposite to what we see in patients suffering from PTSD, immediately following the event of July 31, 2001, Mr. Lux went to his room, laid down, fell asleep, and the next morning started writing the account of what had taken place the previous night. He did not need to be treated by his psychiatrist on an emergency basis. In fact, he was able to wait until his next scheduled appointments 4 days later before disclosing the event. Mr. Lux was looking for justice, not urgent psychiatric help.

Mr. Lux established that he had always suffered from relational problems, which was one of the reasons for him to become an alcoholic and one important reason to feel so depressed when he stopped drinking alcohol. Not only did Mr. Lux not need urgent psychiatric treatment as a result of the event of August 1, 2002, but he also continued performing satisfactorily in his occupation, commuting a distance to get to it, and stayed in the same house for more than 6 months, until he bought a new residence elsewhere.

Mr. Lux did not change any aspect of his lifestyle, unlike the subdued and impoverished routine we expect of a patient suffering from PTSD; he remained well connected to all aspects of his environment. Mr. Lux did not come across as frail, hesitant, easily overwhelmed, anxious, and fearful, as individuals suffering from PTSD often do. Instead he was animated, energized, and at times feisty – expecting and demanding from the police to do its job.
There was no avoidance behavior, which is one component criteria of PTSD. After the incident, Mr. Lux continued living next to Local 432 and going to town for his every need. He followed through all the steps necessary to complain about the incident, including conducting his own research and using the Internet, to learn about proper investigating procedures.

Mr. Lux and Mr. Ray, resourcefully, contacted and met with a government official to obtain the help he needed to carry out his grievance. They also looked for support from the gay community at large. Mr. Lux never restricted his driving around Ancash or any other areas. The dream that Mr. Lux related to the “opposing” examiner (see report below) may very likely represent a triumphant solution to decades of relational strife and secrecy having grown up in a household in which being homosexual was considered aberrant. Mr. Lux noted that his father had put him down in public and his mother failed to protect him.

Contrary to what we find in patients suffering from PTSD, Mr. Lux never behaved in a manner indicating avoidance of stimuli associated with the trauma or a numbing of general responsiveness related to the outside world. Mr. Lux did not evidence restricted range of affect, related to the reported behavior of the auto mechanics.

His psychiatrist made the diagnosis of major depressive disorder, recurrent, severe. Mr. Lux reported to this doctor, 10 years prior to the event, an “underlying resentment at Jon” due to his not contributing financially in the relationship. Depression and anger were reported by Mr. Lux and found by the psychiatrist at that time. The psychiatrist noted that, 1 month before the reported attacks, Mr. Lux’ psychiatric problems were difficult to control, he changed antidepressants, and his patient continued taking Adderall to deal with lassitude.

The bedroom was situated on the opposite side of the Union building. Mr. Lux never related to his doctor that his insomnia was related to the mechanics’ noise. In fact, on the night of the incident, Mr. Lux was awakened by Mr. Ray, not by the “loud” noise the mechanics were making. One month after the event, he told the doctor that he was dieting and making effort to lose weight. His heart condition was stable and his blood pressure well monitored.

Mr. Lux did not avoid the activities, places, or people that arouse recollections of the event. Mr. Lux did not have a sense of foreshortened future; on the contrary, he moved forward in his occupation, became quite involved in the litigation process, and purchased his own home. Following the reported assault incident, Mr. Lux did not evidence any avoidance behavior, his functioning did not decline, there was no distortion in his activity level, and his attention and concentration levels were not compromised by what happened on that day. Importantly, the functional decline expected in patients suffering from PTSD would starkly contrast the functional abilities Mr. Lux reported, and even boasted, about.

Mr. Lux was able to talk to me about the occurrence. He was able to vividly describe the sequence of events. He was able to withstand 23 h of deposition, over a period of four meetings, talking about the events, and related matters, quite able to concentrate, focus, and sustain his attention, without experiencing distractibility or confusion. Mr. Lux did not evidence the presence of intense anxiety, characteristic of PTSD that would otherwise be expected to occur in these recounts and situations.
In the examples that Mr. Lux provided, there was no description of intense anxiety response bordering panic that he recognized as excessive or unreasonable.

Mr. Lux reported, in a poignant fashion, the recognized symptoms and signs of patients suffering from major depressive disorder, recurrent type, as amply demonstrated by his long-term treating psychiatrist, including repeated episodes of periodic bouts of being depressed most of the day, with markedly diminished interest or pleasure in his daily activities, and symptoms and signs of fatigue, sluggishness, and lack of energy during the entire time the depressive episode lasted. Mr. Lux did not currently go through one of those bouts of depression. He did not have difficulty sustaining attention and concentration throughout the interview with me or during his previous statements. Not once did he become distracted. I never had to repeat the question or bring him back to any topic due to distraction.

Our meeting took place in the early morning, yet I observed no sign of fatigue, sluggishness, or lack of energy expected from a person suffering acute decompensation of major depressive disorder, recurrent type. There was no psychomotor agitation or retardation noticed during our entire time together. Mr. Lux was not fatigued or inattentive. There were no feelings of worthlessness reported. In fact, he took pride in his activities, as demonstrated when he “edited” the long form I handed him, for him to read and sign. He did not describe currently feeling weak, vulnerable, desperate, or destitute, at any time. No diminished ability to think, recall, or concentrate was found. He was not indecisive. There were no cognitive deficits of any type found throughout the entire examination period.

Mr. Lux was never particularly concerned about his cardiac ailments. In fact, his condition is stable and according to the medical records and Mr. Lux’ narrative, no new sign of deterioration has been clinically found. Periodic scheduled echocardiograms showed a “well-functioning prosthetic valve.” He showed no preoccupation about his heart condition when he took, without his doctor clinical advising, Adderall, a stimulant taken by his partner to treat his ADD. Mr. Lux kept taking Adderall, in increasing amounts, before the incident, in great excess to the recommended dosage for an individual without heart disease. Mr. Lux showed no indication of concern for his heart condition, or any other physical disorder when, despite his psychiatrist’s warning, he smoked cigarettes before the event, and being also aware of the respiratory problems that the use of cigarettes brought on.

Adderall is a product that is contraindicated in patients afflicted by symptomatic cardiovascular disease, hypertension, and with history of substance abuse. Serious cardiovascular adverse events and sudden death have been reported with misuse and in individuals with cardiovascular disease that take amphetamine and amphetamine derivatives. Adderall is also a potent appetite suppressant, which Mr. Lux welcomed, since he wanted to lose weight, and, in fact, he gladly lost weight way before the incident while ingesting 80 mg/day, exceedingly more than the recommended dosage of Adderall, again, not a medication that was not clinically indicated or prescribed for him. Also, according to his psychiatrist’s record, he resumed smoking long before the reported assault, contradicting Mr. Lux’ assertion that this had not been the case.
Mr. Lux pointed out, on many occasions, during his depositions and the examination with me that he had always been on guard concerning bias against homosexuals. This stemmed from his parents and oldest brother’s prejudice at home, and the painfully demeaning anti-gay experiences as a young adult, in his hometown.

Mr. Lux had already shown, long before the incident, signs of deep dissatisfaction with his career and job, as expressed in treatment to his psychiatrist. He had told his psychiatrist that he wanted to retire due to it. Mr. Lux stayed in the house next to Local 432 for 3 years, even though he had no obligation to do that, since he had no lease agreement of any type to “tie him down” to it. He had the financial means to move out of this place.

No more than 2 weeks after the reported events, the psychiatrist referred to his reaction of the incident, in her clinical notes as “upset” and “uncomfortable.” Neither his psychiatrist nor his psychotherapist found him suffering from PTSD. In fact, the therapist noticed that Mr. Lux did not have any particularly strong reaction to the first anniversary of the reported events of July 31, 2001, as typically clinically found in patients suffering from PTSD. He also reported that Mr. Lux had a history of apprehension of being in public places, social withdrawal, and work stress, unrelated to the event in question.

The psychiatric examination I conducted of Mr. Lux revealed essentially normal findings (a compensated and stable state of mind), with no objective clinical evidence of anxiety, depression, mood disorder, or any other psychiatric condition or disorder, other than by history and records reviewed.

Mr. Lux is bitter about his report of having been insulted and threatened. Furthermore, he resents the fact that no formal apology and explanation were given to him by a member of the union/police department or officials from Ancash. He is not suffering from a major psychiatric disorder stemming from the reported events caused by the auto mechanics and the Ancash officials. As he so lucidly expressed it, it was a cesspool of nepotism.

Mr. Lux appeared disillusioned with our contemporary societal approach to homosexuality and that, as he “always knew it, the same old bias still persists.” Mr. Lux was well connected with me and to the world. He also was in good control of his decisions and actions. He read all the reports about the event, conducted a web search on the subject, and contacted influential people and advocacy groups. A far cry from the avoiding and defeated attitude expected from someone beset with PTSD.

Mr. Lux described “struggling” to stay alert and awake, as every time during relapses of his chronic depressive illness. These descriptions run against the cluster of anxiety-related symptoms seen in patients suffering from PTSD. They described the clinical symptomatology seen in patients suffering from depression. In individuals suffering from anxiety disorders, of which PTSD is one, we see hyperalertness, instead.

Mr. Lux never complained to his psychiatrist, before the incident, about any insufferable mistreatment at the hands of the members of Local 432. The psychiatric records report that, early on in the psychiatric treatment, Mr. Lux manifested a sense of hopelessness, dissatisfaction with his career, and foreshortened future.
The psychological testing that the “opposing” expert administered (see below) showed that Mr. Lux was often contradictory and also exaggerated in his reporting of his suffering. He portrayed himself to the other expert as a well-adapted individual before the event and a totally non-functional person afterward, including having a peculiar medication schedule (taking antidepressant five times daily); resuming smoking cigarettes only after the incident; driving to work at 80 mph; taking Adderall at his psychiatrist’s prescription (in fact, he took it from his partner); stating that he was taking Adderall in small doses (while he was taking doses higher than normally recommended); asserting that his depressive symptoms became of significance after the event; saying that his difficulty with his partner started after the incident, the loss of weight was a surprising and unwelcomed problem, and he was totally disorganized and unable to focus and concentrate for more than two paragraphs (the form I presented for him to read and sign had more than two paragraphs); and his stating that he never went back to Ancash once he left that town, among a host of others.

Mr. Lux was of the mindset, throughout his life, that he was despised as a gay man, by society in general and by the mechanics in particular. Mr. Lux would always take for granted he was hated as a gay man. He added that it was commonplace to expect, from a group of young males, insults about homosexuality. He adapted to this gloomy situation and stayed in the house next to a group of loud and bigoted individuals, reportedly, prone to drunkenness. The auto mechanics would customarily behave, repeatedly, in the same and familiar fashion and hold their BBQs next to Mr. Lux’ backyard.

Forensic Psychiatric Opinion: (a) It is my opinion within a reasonable degree of medical probability that the description of Mr. Lux’ suffering, from April 1997 to February 2002, and in particular by the reported events of July 31, 2001, was not consistent with the clinical patterns found in individuals suffering from post-traumatic stress disorder, related to the period of time here considered. (b) It is my opinion, within a reasonable degree of medical probability, that Mr. Lux does not suffer from any psychiatric disorder proximately related to the reported events of July 31, 2001. He has sustained no permanent psychiatric condition relative to his reported grievance.

The MHP, Dr. Phillips, stated that he was of the opinion that Mr. Lux “has suffered a marked psychological trauma and long-term psychological impairment as a result of reported discrimination and harassment based on sexual orientation as well as retaliation on the part of the Local 432, Ancash Police Department and other defendants in this case.”

The MHP also provides an opinion about deviation from the standards of organizational responsibilities of the town of Ancash, and its Police Department, concerning discrimination, harassment, and retaliation. Dr. Phillips reported that the acts
that caused Mr. Lux “neuropsychiatric impairments” were “threats, intimidation, and invasion of property… before and after the incident.” Furthermore, he was of the opinion that Mr. Lux, having been horrified and helpless, “suffered from Post-Traumatic Stress Disorder with depressive features.”

Dr. Phillips also opined that as a result of the reported events of before and after the incident, Mr. Lux and his partner developed “relational problems.” He added that he was of the opinion that Mr. Lux was also suffering from “Enduring Personality Changes after Catastrophic Experience,” characterized by a loss of his sense of safety in his home and community and loss of faith in society.

Mr. Lux’ cardiac condition, as the MHP commented, was probably aggravated by the events here complained of. Dr. Phillips stated that Mr. Lux told him that he had started smoking after the incident.

The MHP pointed out that the alcohol consumption of the auto mechanics, members of Local 432, was ongoing. He was of the opinion that on the night of the incident, this chronic use of alcohol prompted “the ferocious, highly threatening nature of the harassment of Mr. Lux.”

Dr. Phillips opined that Mr. Lux had “preexisting vulnerability… had experienced the types and degrees of discrimination against homosexuals typical in the United States in recent decades… Mr. Lux had a history of Chronic Depression… treated with psychotherapy and medications… and alcoholism, but was reportedly sober for 20 years.” Dr. Phillips noted that he had a history of a heart ailment and underwent two heart operations.

The psychologist and MHP, Dr. Phillips, stated that Mr. Lux had, all along, felt comfortable in his occupation as executive in a designer’s firm and had a “high level of motivation” and that he never expressed any degree of despair or intent to quit working well before the incident. Mr. Lux kept working for approximately 1 year after the incident, when he decided to stop and apply for disability determination.

The MHP commented that Mr. Lux had become well adapted to “the ever-present, garden-variety bias against gay people.” Dr. Phillips went on to write that he told him that when he moved 7 months after the incident, he lived an “insecure existence, as fugitive.”

After administering a battery of psychological tests to Mr. Lux, Dr. Phillips was of the opinion, “He had the tendency to minimize rather than exaggerate his symptoms.” He described that the testing demonstrated “his presentation of a large number of unusual symptoms is relatively common in personal injury litigation, which indicates that a possible tendency to exaggerate symptoms be considered in the evaluation.” The MHP believed that this contradiction may be explained due to Mr. Lux having (unreported by Mr. Lux) “chronic pain.”

Dr. Phillips further noted in his report that he found Mr. Lux to be “overwhelmed by anxiety, tension, and depression… is functioning at a very low level of efficiency… he is plagued by anxiety and worry, chaos, disorganization, difficulty with concentration, and resulting work impairment, as well as strains in his relationship.”

Dr. Phillips also indicated that Mr. Lux was quite able to pay “careful attention to the content of each item,” during the lengthy time required for the psychological
testing. Contrary to the previous finding, Dr. Phillips listed Mr. Lux’ reporting of being confused, easily distracted, restless, forgetful, unable to express himself (communicating understandably and effectively to others), impaired attention/concentration, disorganization, and nightmares.

Likewise, Dr. Phillips picked some aspects of the test results that confirm his hypotheses and discards other test result findings, from the test he chose to administer to Mr. Lux. The MHP invalidates the test results as wrong when they contradict his impressions and/or Mr. Lux’ descriptions. Some of the tests indicate, “The possibility of multiple diagnoses… Nonetheless, his anxiety and stress are characterized as being within what would be considered the normal range… he does not appear to feel hopeless, and his self-esteem seems largely intact… and well-motivated for mental health treatment… he reports a positive attitude towards the possibility of personal change, the value of therapy, and the importance of personal responsibility.”

Based on Mr. Lux’ responses, the testing instruments presented contradicting conclusions, which Dr. Phillips did in fact note by sharing, “Mr. Lux was found hopeful and with an intact self-esteem on one test result; and hopeless and defeated on another.” Dr. Phillips opined that Mr. Lux could have overcome “the one severe trauma, the incident at issue, as he had overcome other chronic and acute difficulties in his life.”

The MHP did not find, as a result of the psychological testing, that loss of appetite and/or weight was a prominent part of the clinical picture. Mr. Lux had told Dr. Phillips that as a result of his affliction from the incident, he had loss 40 lb.

The MHP mentioned that Mr. Lux reported to him, in the testing situation, that his capacity for sustained concentration is “nearly totally impaired… and mind wandering was a big problem… constant sadness.”

Dr. Phillips stated that Mr. Lux “may currently be too disorganized or be too overwhelmed to participate meaningfully in some form of treatment.” The MHP describes him as displaying a highly organized mind in his office yet described him as being disorganized.

Despite a total lack of symptoms and signs of any significant cardiac deterioration, the MHP proposed that his cardiac condition indicates a poor psychological prognosis in connection with the event, as well as before and after it.

The MHP found that Mr. Lux had a troubled upbringing, including throughout childhood and adolescence. He was afraid of his father and did not get along with his siblings. He described himself as intelligent, but passive, fearful, shy, quiet, and clumsy. Mr. Lux grew up maladjusted and unhappy related to his growing up as a gay teenager. He was afflicted by lifelong emotional problems, manifested by depression and alcoholism.

Dr. Phillips also went on to note Mr. Lux’ resilience. The examiner was of the opinion that the event, before and after, caused such toughness to break. He mentioned that he was quite afflicted in anticipation to their meeting. Mr. Lux told the MHP that he experienced a strong sense of loss and deprivation at being impaired from continuing in that profession. The examiner accepted this report as fact and included it in the expert opinion without any corroborating signs or findings.
The MHP included in his report that Mr. Lux “continued working 50–60 hours a week up to a year after the Union building events. He was also able to negotiate a long commute in difficult traffic, which added to his long hours at work.”

In agreement with my findings, the MHP found that Mr. Lux was quite organized, cogent, and lucid while describing details of his occupation. Likewise, he was able to maintain focus and appropriateness of thinking and emotions while recollecting from his troubled past. The MHP interpreted Mr. Lux being quite appropriate in his description of his leaky valve, without mentioning pain or undue concern.

Then, the MHP described Mr. Lux becoming disorganized when recounting the harassment, taunts, threats, and invasions perpetrated against him and his partner. The description was so vivid that it evoked horror in the examiner, which he made mention of in his report quite expressively. The MHP writes that he noticed that Mr. Lux became “increasingly avoidant and disoriented at this time.” He was found to become disorganized in his narrative.

Mr. Lux informed his evaluator that they and other neighbors had repeatedly reported to the authorities the unruly, antisocial, disturbing behavior of the auto mechanics. He also told Dr. Phillips that after the attack on them by the union members, “we were trapped in the house... we were like prisoners in our own home.” The examinee mentioned that he would go to work on a daily basis, and in fact he did not need to take any time off from his occupation. He told the MHP, “I’m always on the alert now when I go out.”

According to Dr. Phillips’ report, Mr. Lux needed to be supported and reoriented by the MHP after he narrated the incident. He asked him to put in writing and mail to him “some samples of the nightmares.” Dr. Phillips did not explain why Mr. Lux did not come up with at least one nightmare during the examination. The explanation that the examiner provided was due to time limitations and the stress of the examination. In the dream that Mr. Lux prepared for the MHP, he goes to a conservative protestant church, “like those of my youth” with a friend, who sits on the other side of the aisle. A man next to him whispers a homophobic slur. He then confronts the man by getting as close as possible to him and then discharges a yell at him, as powerfully as he can.

The MHP attempts to interpret the dream, without the participation of Mr. Lux. To properly carry out this task, we need a “patient” and his spontaneous associations to the manifest content (the ever-present secondary elaboration) of the dream. The MHP recognized Mr. Lux’ prior history of major depressive disorder, alcoholism (sober since 1985), sexual dysfunction, and anti-gay discrimination and harassment. He started receiving psychiatric treatment some 20 years prior.

Dr. Phillips accepted, as fact, Mr. Lux statement that he had just started smoking again “after the events” and noted, “This behavior is self-destructive in a person with a history of heart disease.” The MHP had read in the medical records of the treating psychiatrist that that was not true and that the “indifference to my own fate” had gone on for a long time before the events.
The MHP knew, based on the psychiatric records, that Mr. Lux had been thinking of retiring long before the incident; however, he chose not to clarify this contradiction and accepted Mr. Lux’ explanation for his interruption of employment and application for financial disability benefits. Dr. Phillips was aware that Mr. Lux was vocal and expressive about the events, seeking support from the gay community. Dr. Phillips concluded that he was of the opinion that the prognosis of his ailment (PTSD) was guarded.
Appendix: Article VII – Opinions and Expert Testimony

**Rule 701. Opinion Testimony by Lay Witnesses**

If the witness is not testifying as an expert, the witness’ testimony in the form of opinions or inferences is limited to those opinions or inferences which are (a) rationally based on the perception of the witness, and (b) helpful to a clear understanding of the witness’ testimony or the determination of a fact in issue, and (c) not based on scientific, technical, or other specialized knowledge within the scope of Rule 702.

**Rule 702. Testimony by Experts**

If scientific, technical, or other specialized knowledge will assist the trier of fact to understand the evidence or to determine a fact in issue, a witness qualified as an expert by knowledge, skill, experience, training, or education, may testify thereto in the form of an opinion or otherwise, if (1) the testimony is based upon sufficient facts or data, (2) the testimony is the product of reliable principles and methods, and (3) the witness has applied the principles and methods reliably to the facts of the case.

**Rule 703. Bases of Opinion Testimony by Experts**

The facts or data in the particular case upon which an expert bases an opinion or inference may be those perceived by or made known to the expert at or before the hearing. If of a type reasonably relied upon by experts in the particular field in forming opinions or inferences upon the subject, the facts or data need not be admissible in evidence in order for the opinion or inference to be admitted. Facts or data that are otherwise inadmissible shall not be disclosed to the jury by the proponent of the opinion or inference unless the court determines that their probative value in assisting the jury to evaluate the expert’s opinion substantially outweighs their prejudicial effect.
Rule 704. Opinion on Ultimate Issue

(a) Except as provided in subdivision (b), testimony in the form of an opinion or inference otherwise admissible is not objectionable because it embraces an ultimate issue to be decided by the trier of fact.

(b) No expert witness testifying with respect to the mental state or condition of a defendant in a criminal case may state an opinion or inference as to whether the defendant did or did not have the mental state or condition constituting an element of the crime charged or of a defense thereto. Such ultimate issues are matters for the trier of fact alone.

Rule 705. Disclosure of Facts or Data Underlying Expert Opinion

The expert may testify in terms of opinion or inference and give reasons therefor without first testifying to the underlying facts or data, unless the court requires otherwise. The expert may in any event be required to disclose the underlying facts or data on cross-examination.

Rule 706. Court Appointed Experts

(a) Appointment:
   The court may on its own motion or on the motion of any party enter an order to show cause why expert witnesses should not be appointed and may request the parties to submit nominations. The court may appoint any expert witnesses agreed upon by the parties and may appoint expert witnesses of its own selection. An expert witness shall not be appointed by the court unless the witness consents to act. A witness so appointed shall be informed of the witness’ duties by the court in writing, a copy of which shall be filed with the clerk or at a conference in which the parties shall have opportunity to participate. A witness so appointed shall advise the parties of the witness’ findings, if any; the witness’ deposition may be taken by any party; the witness may be called to testify by the court or any party. The witness shall be subject to cross-examination by each party, including a party calling the witness.

(b) Compensation:
   Expert witnesses so appointed are entitled to reasonable compensation in whatever sum the court may allow. The compensation thus fixed is payable from funds which may be provided by law in criminal cases and civil actions and proceedings involving just compensation under the fifth amendment. In other civil actions and proceedings, the compensation shall be paid by the parties in such proportion and at such time as the court directs, and thereafter charged in like manner as other costs.
(c) Disclosure of appointment:
   In the exercise of its discretion, the court may authorize disclosure to the jury of
   the fact that the court appointed the expert witness.

(d) Parties’ experts of own selection:
   Nothing in this rule limits the parties in calling expert witnesses of their own
   selection.
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