EVALUATING AND DEFENDING CLAIMS FOR EMOTIONAL AND NEUROPSYCHOLOGICAL DAMAGES

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I. LEGAL BASIS FOR EMOTIONAL DAMAGES

A. Emotional distress in the absence of contemporaneous physical injury.

1. *Schultz v. Barberton Glass Co.*,(1983) 4 Ohio St. 3d 131.
   (a) First case which allowed such recovery in negligence actions.
   (b) Requires serious emotional distress.
   (c) Court stated that danger of fictitious claims was no greater than in physical injury situations.
      (I) Suggested, but did not require, expert testimony to aid the fact-finder.

2. *Paugh v. Hanks*, (1983) 6 Ohio St. 3d 72
   (a) Allowed recovery for bystander to a dangerous event.
      (I) Implied that the bystander had to appreciate the danger, or be in the "zone of danger".
      (ii) Required injuries to be serious and reasonably foreseeable.
   (b) Did not require ensuing physical manifestations of emotional injury, but said such manifestations are evidence of emotional harm.
   (c) Required emotional distress which was "severe and debilitating." Normally constituted person would be unable to adequately cope.

3. *Durris v. Grange Mutual*, (1989) 46 Ohio St. 3d 84
   (a) Held that the person claiming emotional distress had to be in the area of the accident, see the accident or sensorially perceive it.
      (I) Being informed of an injury to a loved one will not give rise to a claim.

4. *Criswell v. Hospital*, (Cuyahoga Co. 1989) 49 Ohio App. 3d 163
   (a) Held that no cause of action is stated in the absence of the perception of real physical danger.
   (b) Misdiagnosis of a medical condition which puts patient in no physical danger is not actionable.

5. *Hawley v. Dresser Industries*, (S.D. Ohio 1990) 737 F. Supp 445
   (a) No cause of action is stated for negligent infliction of emotional distress in employment termination case.
   (b) Consistent with Criswell in the requirement of some physical danger.

6. *Yeager v. Local Union 20*, (1983) 6 Ohio St. 3d 369
   (a) Allowed recovery for intentional or reckless infliction of serious emotional distress.
   (b) Required extreme and outrageous conduct.
   (c) Ohio was last state to recognize the claim.

B. Emotional distress with contemporaneous physical injury.

1. *Binns v. Fredendall*, (1987) 32 Ohio St. 3d 244
   (a) If the plaintiff has contemporaneous physical injury, the emotional distress need not be severe and debilitating.
   (b) One can recover for emotional distress arising out of the death or injury of another, if the plaintiff is directly involved and contemporaneously injured in the same motor vehicle accident with the deceased or injured person.
      (I) Expanded the "zone of danger" concept.
      (ii) Distinguished between mental anguish suffered in the accident and mental anguish from the loss of a loved one which is compensable in a wrongful death case.

C. Emotional Distress and Workers' Compensation

1. *McCrone v. Bank One Corporation*, (2005) 107 Ohio St.3d 272
   (a) Purely emotional distress with no accompanying physical injury is not compensable through workers' compensation.
   (b) Injured worker can sue employer for negligence as a tort case.

2. See also, *Bunger v. Lawson*, (2001) 91 Ohio St.3d 38

II. DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS. FOURTH EDITION, TEXT REVISION. (DSM-IV-TR)

A. DSM-IV-TR is a manual of currently recognized mental disorders. It sets up standard detailed diagnostic criteria and provides opportunities to make differential diagnoses.

B. DSM-IV-TR is divided into five "Axes." These Axes provide a complete approach to assessing mental problems.

1. Axes I and II comprise detailed criteria for all mental disorders, developmental disorders and personality disorders.

2. Axis III describes physical disorders with emotional overtones.

3. Axis IV describes severity of psychosocial stressors (puts life events on a scale from no stress to catastrophic).
   (a) Attempts to explain development of a new mental disorder, recurrence of a prior mental disorder or exacerbation of an already existing disorder.

4. Axis V provides a global assessment of functioning (GAF).
   (a) GAF scales allows the clinician to indicate his or her overall judgment of person's function from 1 (suicidal) to 90 (No or minimal symptoms).

III. SPECIFIC ALLEGATIONS OF EMOTIONAL DAMAGE

A. Post Traumatic Stress Disorder (PTSD)

1. Most common allegation of emotional injury.

2. Requires an event which is outside the range of usual human experience and which provides a subjective belief that the patient or someone else is in danger of death or serious bodily harm.

3. Symptoms include persistent re-experience of the trauma, emotional numbing or avoidance of activities which gave rise to the trauma, and symptoms of increased arousal (sleep disturbance, concentration difficulties, easily startled.)

4. Often is used as a diagnosis in patients with pre-existing anxiety or depressive disorders.

B. Generalized Anxiety Disorder (GAD)

1. *Unrealistic* or *excessive* anxiety or worry about *two or more* life circumstances.
   (a) Plaintiff's experts often blame a single event (the injury), ignoring the requirement of two life circumstances.

2. Diagnosis of the disorder requires ruling out other related disorders.
   (a) Cannot make diagnosis if the anxiety only occurs during episodes of other disorders.
   (b) Often, patient has organic disorders which can pose as GAD such as hyperthyroid or caffeine intoxication.

3. Patient must have at least six out of eighteen classic symptoms relating to:
   (a) Motor Tension.
      (I) e.g., trembling, twitching, aches
   (b) Autonomic hyperactivity.
      (I) e.g., shortness of breath, dry mouth, dizziness, nausea.
   (c) Hypervigilance.
      (I) e.g., irritability, "on edge", sleep disorders.

C. Phobias

1. Usually not associated with trauma.

2. Literature indicates that they usually develop in early childhood.

3. They rarely result in marked impairment.

D. Panic Disorder

1. Discrete periods of intense fear or discomfort which are unexpected and not triggered by situations where the patient was the focus of others' attention.

2. Frequency of attacks - four in four weeks or one attack followed by a month of persistent fear of another attack.

3. Patient experiences at least four out of thirteen physical symptoms.

4. No organic basis for the symptoms.

5. As with phobias, patient usually has long history of anxiety, fearfulness, dependency and separation anxiety.
   (a) Panic attacks often manifest in children in a school phobia - school records should be obtained.

E. Dysthymia (Depressive Neurosis)

1. Characterized by depressed mood, most of the day, more days than not, for at least two years. Never without the depression for more than two months.

2. In addition to depression, patient shows symptoms such as poor appetite, insomnia low energy, low self-esteem.

3. Contrast with major depressive episode.

4. Patients frequently have pre-existing personality disorder(s) such as borderline histrionic, narcissistic, avoidant or dependent.
   (a) By definition, personality disorders are fixed by adolescence or young adulthood. Are not trauma related.

F. Major Depression/Major Depressive Event

1. Characterized by depressed mood, diminished interest in pleasure, fatigue, changes in weight, thoughts of death, sleep disorders, self-esteem problems.

2. Degrees of depression:
   (a) Mild - few symptoms.
   (b) Moderate - symptoms and impairment between mild and severe.
   (c) Severe - without psychotic features - several symptoms, with marked interference with occupational functioning, social activities or relationships.
   (d) Severe, with psychotic features - delusions or hallucinations.

3. Many patients have a familial history of depression or personal history of depression. anxiety and personality disorders.

4. Often, endocrine disorders and other illnesses are associated with depression.

5. Some medication, especially anti-hypertensive (high blood pressure) drugs can cause a depressed mood.

IV. NEUROPSYCHOLOGICAL CLAIMS OF HEAD INJURY

A. Typically, patients with minor head trauma present claims for disability far exceeding the expected effect.

1. Often plaintiff has gotten an unfavorable report from neurologist or neurosurgeon.

B. Use of Experts
1. Forensic psychologist/psychiatrist/neuropsychologist
   (a) Primary use is help in interpreting testing, review of literature and review of records, attacking plaintiff's expert's diagnosis and help with expert deposition.

2. Careful consideration should be given to an independent interview or examination, and calling your expert at trial.

(a) Caveat - if plaintiff is referred for an interview under Civ.R.35 and your expert gives an unfavorable report, failure to call the expert at trial can be subject to comment by plaintiff's counsel.

C. Neuropsychologists specialize in substantiating disability from seemingly minor head trauma.

1. Basic tenet of neuropsychology is that discrete, devastating brain damage can be missed by traditional examinations and tests.

D. Neuropsychologists administer a battery of tests designed to measure cognitive skills, memory, executive functions, dexterity and mental function.

E. Defenses to neuropsychologist testimony include:

1. Claimed injury is far beyond expected effect of trauma.

2. No loss of consciousness or other hallmarks of real head injury.

3. Plaintiff's long term symptoms and behaviors do not fit the pattern of the sequelae of real brain injury.
(a) e.g., Plaintiff has continued to work, conduct family matters, etc.

4. There are other apparent causes for plaintiffs symptoms and behaviors that have not been ruled out.
(a) e.g., Depression, money problems, life stressors, job problems, pre-existing mental or personality disorders.

5. Plaintiff's neuropsychological tests have been improperly administered, scored or interpreted.
(a) Requires expert assistance.

V. PSYCHOLOGICAL TESTING

A. Minnesota Multiphasic Personality Inventory .-2 (MMPI-2)

1. True/False test consisting of 567 questions.

2. Questions correspond to ten clinical scales and four validity scales.
(a) Clinical scales:
(I) Hyprocondriasis (Hs) - Scale 1;
(ii) Depression (D) - Scale 2;

(iii) Hysteria (Hy) - Scale 3;
(iv) Psychopathic deviate (Pd) - Scale 4;
(v) Masculinity-Femininity (Mf) - Scale 5;
(vi) Paranoia (Pa) - Scale 6;
(vii) Psychasthenia (Obsessive-Compulsive) (Pt) - Scale 7;
(viii) Schizophrenia (Sc) - Scale 8;
(ix) Hypomania (manic) (Ma) - Scale 9; and
(x) Social introversion (Si) - Scale 0

(b) Validity scales:

(I) Question scale - (?) These are unanswered questions. Test takers are encouraged to answer all questions, so an excessive score suggests evasiveness or indecisiveness.

(ii) Lie scale (L) - These are questions most people would answer true (I get angry sometimes). An excessive score might indicate someone who wants to lie to make himself look good.

(iii) Infrequency scale (F) - Questions most people answer false. A high score here might indicate a "random" test-taker, carelessness, confusion or lying to make oneself look bad.

(iv) Correction scale (K) - High score reflects guardedness or defensiveness in responding to psychopathology.

3. Generally regarded as the best measure of one's psychological makeup.

B. Wechsler Adult Intelligence Scales III (WAIS III)

1. Attempts to measure intelligence through use of ten subtests:
(a) information;
(b) comprehension;
(c) arithmetic;
(d) similarities;
(e) vocabulary;
(f) block design;
(g) picture completion;
(h) picture arrangement;
(I) object assembly; and
(j) digit symbol.

2. Plaintiff's performance may or may not be consistent with disability, impairment or brain injury.

C. Millon Clinical Personality Inventory

1. Another personality measure (see MMPI)
2. Outmoded - rarely used.

VI. PRE-EXISTING CLINICAL MENTAL DISORDERS

A. Conversion Disorder -

1. One form of psychosomatic impairment.

2. Patient "convert" bad mental experiences into physical ailments.

3. Conversion disorders include unconscious manipulation of physical symptoms.
   (a) Exacerbation of the symptom occurs near the time of a stressor.
      (I) Stressor is related to a psychological conflict or need and often not the injury.

4. Have you ever seen a diagnosis of Chronic Pain Disorder -
   (a) No Chronic Pain Disorder in DSM IV-TR.

B. Somatization Disorder

1. Patient *believes* he/she is sickly. Spends inordinate amount of time searching for a medical cause for the physical symptoms.

2. Symptoms begin before age 30. Most common in adolescent women.

3. Physical symptoms are varied, most often gastrointestinal, cardiopulmonary, sexual and orthopedic.

4. Often leads to drug abuse, suicidal ideation.

C. Somatoform Pain Disorder (aka Psychogenic Pain Disorder)

1. Similar to Somatization.

2. Patient is pre-occupied with pain for at least six months.

3. Physical exam either:
   (a) Reveals no organic reason for pain or;

(b) If there is an organic reason, the complaints and impairment are grossly in excess of what would be expected from physical findings.

4. Disorder is often diagnosed in people who are workaholics, have had physical trauma, or who hold strenuous or routine jobs.

5. Most frequent onset is ages 30's-40's.
   (a) Often person is incapacitated.
   (b) Twice as common in females as in males.

6. *Hypochondriasis* is a similar disorder.
   (a) Involves a pre-occupation with the fear of having or belief that one has a serious disease, without medical support.
   (b) Duration of at least six months.

D. Schizophrenia/Schizophrenia-Paranoid Type/Delusional Disorder

1. All three are psychotic disorders.

2. Involves delusions and hallucinations.

E. Obsessive Compulsive Disorder

1. Persistent unwanted and uncontrolled thoughts and impulses.
   (a) May be violent thoughts.

2. Compulsive behaviors are attempts to control the impulses.
   (a) Behavior examples are obsessive devotion to work, rigid perfectionism and hand-washing.

3. Depression and anxiety result from knowledge that obsession is unhealthy.

VII. PRE-EXISTING PERSONALITY DISORDERS

A. These disorders are generally recognizable by late adolescence/early adulthood and are characteristic of adult life.

1. Personality disorder drives the person's behavior and may be the real reason underlying the psychological claims in litigation.

B. Paranoid/Schizo/Schizotypal/Obsessive Compulsive Personality Disorders

1. These are disorders which track the mental disorders listed above.

C. Borderline Personality Disorder

1. Characterized by mood swings, inappropriate anger.

2. Often shows self-damaging "binge" behavior in areas such as sex, spending, eating, substance use.

3. This patient feels a sense of entitlement or exception from rules.
   (a) Often have a history of litigation or claims.

4. These people border on the psychotic

D. Histrionic Personality Disorder

1. Patient is self-centered, dramatic, emotionally excessive and shallow.

2. Uncomfortable when not the center of attention.
   (a) Seeks assurance, approval and praise.
      (I) Sometimes inappropriately sexually seductive.

3. Often complains of poor health, weakness, headaches.

4. Histrionic patients often dramatize injuries received in accidents.

E. Narcissistic Personality Disorder

1. Constantly seeks attention, is grandiose and self important.

2. Exaggerates accomplishments and talents.
   (a) Expects preferential treatment.

3. Often is accompanied by depressed mood, interpersonal difficulties and unrealistic goals.

F. Avoidant Personality Disorder

1. Pervasive pattern of social discomfort, timidity.

2. Easily hurt by criticism.

3. Exaggerates difficulties or dangers.

4. Avoids interpersonal involvement in work situations.

G. Dependent Personality Disorder

1. Continuous pattern of dependent/submissive behavior.

2. Lack of self-confidence, fears abandonment.

H. Passive-Aggressive Personality Disorder

1. Quietly resists demands for adequate performance.
   (a) Procrastinates, dabbles, stubborn, intentional inefficiency.
   (b) Patient may do poorly or fail to cooperate in physical therapy.
   (c) Sulky, irritable argumentative.

2. Patient often shows dependency, substance abuse.

L. Malingering

1. Technically not a mental disorder.

2. Essential feature is intentional production of false or grossly exaggerated physical or psychological symptoms.
   (a) Patient is motivated by incentives such as avoiding military service, compensation, avoiding work, evading criminal charges.
   (b) Therapist will look for referral of patient by lawyer, marked discrepancy between objective findings and claimed stress or disability, lack of cooperation and presence of antisocial personality disorder.
   (c) Malingering differs from conversion or somatoform disorders because of the *intentional* production of symptoms.

VIII. MEDICATION'S EFFECTS ON MENTAL STATE

A. There is growing evidence that drugs, including tranquilizers, anti-depressants (Prozac) and anti-hypertensives can cause anxiety, depression, poor memory and mental problems.

B. All evidence of medications during patient's life must be carefully discovered.

1. Information should be reviewed by expert for evidence of side effects and possible substance abuse.

C. Consult Physician's Desk Reference (PDR) for side effect information and contraindications.

IX. PROCURING RECORDS

A. HIPAA

1. Standards for Electronic Transactions Rule, 45 C.F.R. Parts 160, 162 and 164 (Transaction Rule)
   (a) Facilitates uniformity in health care transactions.

2. Health Insurance Reform: Security Standards 45 C.F.R. Part 164 Subpart C (Security Rule)
   (a) Ensures health information stored electronically is protected from unauthorized computer access.

3. Standards for Privacy of Individually Identifiable Health Information 45 C.F.R. Parts 160 and 164 (Privacy Rule)
   (a) Ensures that protected health information ("PHI") is adequately secured and protected from inadvertent or unauthorized disclosure.

4. Obtaining Protected Health Information
   (a) In order to obtain PHI from a Covered Entity, a requesting party must first
      (I) Obtain detailed authorization from the patient or subject of the PHI.

      (ii) Obtain a court order which complies with the Privacy Rules.
      (iii) A subpoena alone for PHI is no longer sufficient.
      (iv) When obtaining PHI pursuant to a subpoena, advise in writing the party whose PHI you will be seeking. Attach a copy of your letter to the subpoena so the Covered Entity will be aware of your compliance.

5. The HIPAA Compliant Authorization
   (a) In order to be compliant with the requirements of HIPAA and the Privacy Rule, an authorization must be written in "plain English" and contain the following elements:
      (I) Specific description of the PHI to be disclosed. The phrase "any and all" may no longer be sufficient. 45 C.F.R. 164.508 (c)(1)(I).

(ii) The name and title (if applicable) of the person authorizing PHI disclosure. If the authorization is to be executed by the person's authorized representative, designate the relationship or title of the authorizing individual. To streamline the process, attach a copy of the letter of authority or authorizing document, for example an Executor or Administratrix, or Durable Power of Attorney for Health Care Agent in Fact. 45 C.F.R. 164.508(c)(1)(ii).

(iii) The identity of the person(s) or class of persons to whom the PHI can be disclosed. Keep this broadly defined. 45 C.F.R.164.508(c)(1)(iii).

(iv) Purpose of the disclosure. Keep the reason general; pending litigation or potential litigation will generally be sufficient. 45 C.F.R.164.508(c)(1)(iv).

(v) Termination date or event for the authorization. 45 C.F.R.164.508(c)(1)(v).

(vi) Signature (dated) of the person whose PHI is sought. 45 C.F.R.164.508(c)(1)(vi).

(vii) Statement that the authorization may be revoked, that said revocation must be in writing, any exceptions to the right of revocation, and a description outlining the steps for revocation. 45 C.F.R. 164.508(c)(2)(I). Actions taken in reliance on the authorization prior to revocation will not be affected by the revocation. 45 C.F.R. 164.508(a)(5).

(viii) A statement that treatment, payment, or benefits will be not be affected by consent or refusal to authorize PHI release. 45 C.F.R. 164.508(c)(2)(ii).

(ix) A statement that the PHI is subject to re-disclosure by the requesting party and would no longer be protected under the Privacy Rule. 45 C.F.R. 164.508(c)(2)(iii).

(x) If it is anticipated that PHI will be shared with an expert or other consultant, that user, by name or class, should be set forth on the authorization. Unless specifically provided for by the authorization, the information may not be disclosed to other counsel, staff or an expert. 45 C.F.R. 164.508(c)(2)(iii). Consider including the name of the requestor's law firm, company or agency, and a specific statement that other lawyers, staff and consultants may access the information. Likewise, if it is anticipated the PHI will be further disclosed, such as to a consultant or expert, be sure the release reflects the possibility of re-disclosure and the fact the information received is no longer entitled to the Privacy Rule protections. 45 C.F.R. §164.508(c)(2)(iii).

6. 42 C.F.R. Part 1 - federal restrictions on drug and alcohol treatment records. If authorized by appropriate order of court of competent jurisdiction for good cause records can be obtained. 42 C.F.R. Part 2 § 2.1 (b) (e) and 2.2 (b)(c).

B. Records to obtain:

1. Credit/Loan records.
   (a) Depressed patients often have a history of credit problems.
   (b) Psychosomatic patients often don't pay doctor bills.

2. Driving records.
   (a) Check for previous accidents, history of claims, may lead to medical/psych. records.

3. School records.
   (a) Often there is a history of personality or mental disorders, discipline problems, "acting out", psych. referrals.

4. Employment records.
   (a) Discipline problems, large amounts of sick or leave time, grievances, "job hopping".

5. Income tax records.

6. Insurance records.
   (a) Look for medical history on applications, refusal of insurers to issue a policy, receipt of medical or psych. benefits.

7. Legal records.
   (a) Other suits/claims.
   (b) Domestic relations-divorce, domestic violence, court ordered counseling.

8. Medical records.
   (a) Hospital records - pre & post injury, admission summaries, emergency room, discharge summaries, mediation, *nurses notes.*
   (b) Diagnostic charts, alcohol and drug tests, body chemical results, mediation orders.
   (c) Physician orders, diagnoses, consultation notes, restraint or seclusion orders.
   (d) Occupational and physical therapy notes (look for insight as to patient motivation/co-operation).

(e) Social work/social services reports.
(f) Outpatient records.

9. Military records - discharge, disciplinary, fitness reviews, medical reports, combat experience (for PTSD).

10. Drug/Alcohol Treatment - (watch out for statutory/regulatory restrictions).

11. Private psychological/psychiatric/neuropsychological records.
    (a) Referral letters
    (b) Clinical history, mental status exam, conclusions, diagnosis, prognosis, recommendations, office notes.
    (c) Look for references to the accident in question.
    (d) All tests, including patient participation tests, answer sheets.

12. Plaintiff personal records - diary, calendar, narratives.

13. Pharmacy/prescription records.

GS #835817