

Personal injury evaluations in motor vehicle accident cases

BY PHILIP H. WITT, PH.D., ABPP
AND STEVEN E. WEITZ, PH.D.

This article discusses the legal context of psychological evaluations in personal injury cases. The authors then delineate the main principles of performing such evaluations, including methods of determining pre-incident adjustment, evaluating malingering, and considering both pre-existing psychological problems and concurrent stressors. The article uses motor vehicle accident (MVA) cases as a focus of the discussion, pointing out similarities and differences between such physical stressor cases and social stressor cases, such as workplace discrimination or harassment.

Psychological evaluations in personal injury cases derive generally from the law of torts—civil wrongs other than contract violations. In tort cases, four elements must be established before the plaintiff can obtain compensation (see Walfish, 2006):

AUTHORS' NOTE: Reprints can be obtained from Philip H. Witt, Ph.D., Associates in Psychological Services, P.A., 25 N. Doughty Avenue, Somerville, NJ 08876; phwitt@optonline.net

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1. A duty or obligation must be owed to the plaintiff by the defendant.
2. The defendant must have shown dereliction of this duty or obligation through commission or omission.
3. The plaintiff must show evidence of damage or injury that results in a decline in functioning from an earlier point in time.
4. The decline in functioning must have been caused by the defendant's dereliction of duty, thus constituting a proximate cause of the decline in functioning.

An individual who has performed acts that meet the above four criteria has performed what is referred to as tortious conduct. In fact, tortious conduct has been broadly construed (Melton, Petril, Poythress & Slobogin, 1997, p. 363): "Tortious conduct may result from intentional conduct, from negligent conduct, or in some instances from conduct in which the actor's motivation is not at issue and for which strict liability is imposed."

The first two elements are usually referred to as liability elements. That is, did the defendant do wrong. The plaintiff must first establish that the defendant was responsible in some way to the plaintiff and violated that obligation or responsibility. The question of liability is a factual and legal question that is beyond the purview of the mental health evaluator. Whether liability is present is decided by the judge (in a bench trial) or the jury.

The last two elements refer to damages. That is, did the wrongful act(s) by the defendant cause psychological damage, sometimes referred to as "emotional distress" or "pain and suffering." If the court finds that a defendant was liable and that the tortious act caused psychological damage, then the psychological damage, or psychological injury, is compensable. The plaintiff then recovers monetary damages to compensate for the psychological injury. It is the assessment of psychological damages in motor vehicle accident (MVA) cases that will be the focus of the present article.

There are many forms of personal injury evaluations, each with different issues. Any action or omission in which a duty is owed to the plaintiff can potentially result in psychological damage. Aside from MVAs, issues relevant to personal injury evaluations can include:

- Slip-and-fall cases, in which the plaintiff claims psychological effects, such as chronic pain that results in psychological depression.
- Sexual assault, after which the plaintiff reports anxiety, depression, or post-traumatic stress disorder (PTSD).
- Work related discrimination or harassment, based on any protected class, such as race or sex, after which the plaintiff claims emotional distress.
- Physical assault, after which the plaintiff reports psychological symptoms.
- Malpractice by a professional, resulting in a claim of emotional damages.

This list is only partial. The potential list of situations that could result in claims of psychological damages is quite broad. For our purposes, the list can be divided into two general classes: Situations that involve physical injury and situations involving no physical injury. Situations involving physical injury are in some ways easier for a mental health expert to evaluate. In such cases, there is not usually a dispute over whether an incident occurred. For example, in an MVA case, there is typically agreement that an MVA occurred and that the plaintiff and defendant were involved in the MVA. There may well be a dispute about whose responsibility the MVA was or the actual extent of any physical and psychological injuries, but at least there is agreement that the accident occurred.

In personal injury cases involving social stressors, such as harassment or discrimination, there may be a factual dispute over whether the alleged stressor even occurred. The individual alleged to have discriminated against or harassed

the plaintiff may well deny that such acts ever took place. Consequently, psychological evaluations for such social stressors frequently present a more uncertain picture.

However, in either case—social stressor or physical injury—the basic principles of the psychological evaluation remain the same. First, the evaluator must determine whether some perceptible change in psychological functioning occurred at the time of or soon after the alleged improper acts by the defendant. Even if a clear change in adjustment occurred, if the court determines that the defendant is not liable—that is, did no wrong—then the finding regarding damages will be moot.

Second, the evaluator must determine whether the change in psychological functioning was caused by the tortious act, specifically whether the tortious act was the “proximate cause” of the psychological injury. As Melton et al. (1997, p. 371) note, “The concept of proximate cause is elusive. The traditional method of determining whether one event is the proximate cause of another is to ask whether one could ‘reasonably foresee’ that the former would lead to the latter.” Proximate suggests that the cause must be near or recent in time to the result.

Personal injury evaluations in general present unique challenges. The evaluator is attempting to retrospectively reconstruct the plaintiff’s mental condition before, during, and after a stressful event or series of events. Although an assessment of current psychological functioning is important, the main thrust of the evaluation is on discerning whether a change in mental adjustment occurred at some time in the past and whether this changed mental adjustment was caused by some event also from some time in the past. In some cases, such as when an adult claims emotional damages due to childhood sexual abuse, the alleged causative event or events may actually be decades in the past. Fortunately, in MVA cases, the alleged causative event is more recent, but nonetheless, the analysis is to a large extent historical.

Preparing for the interview

Ideally, prior to interviewing the plaintiff, the evaluator should review the records in the case. In any given case, these records may be as brief as just two pages of an MVA accident report or as extensive as a carton of various historical and contemporaneous records. By reviewing the records before interviewing the plaintiff, the evaluator can determine areas to explore further during the interview. The records may include:

- **Mental health treatment records:** It is important to know if the plaintiff was in psychotherapy or receiving psychotropic drugs prior to the MVA. One way of determining a baseline of pre-MVA adjustment is to review mental health treatment records. The clearest case occurs when no mental health treatment occurred prior to the MVA, but mental health treatment was needed after the MVA—suggesting a change in adjustment at the time of the MVA. However, even if the plaintiff had mental health treatment prior to the MVA, it is useful to know what the diagnosis was and to attempt to determine from the records any indication of the plaintiff's level of adjustment prior to the MVA. Similarly, any mental health records after the MVA, if available, should be reviewed in detail to determine the plaintiff's level of adjustment since the MVA. In addition, if the actual treatment notes are available (and legible), it is useful to get a sense of what issues the plaintiff has been discussing in treatment. At times, the treatment records reflect a variety of concerns and stressors, none having any relation to the MVA.
- **Medical records:** Even if the evaluator is not a medical professional, medical records can be useful. For example, the emergency room records immediately after the MVA might indicate the emotional state of the plaintiff at that time. The plaintiff's emotional state around the time of the accident is relevant in determining whether PTSD is present. Also, ongoing medical treatment records sometimes reflect the emotional state of the patient, so such records can be a useful source of contemporaneous information.
- **Work and school records:** If the psychological injury that the plaintiff reports is severe, one would expect to see adjustment changes reflected in work or school records. It is important to

assess work and school functioning prior to the MVA, again to obtain an estimate of baseline functioning.

- **Mental health evaluation records:** It is not common for a plaintiff to have a psychological or psychiatric evaluation prior to the MVA. However, there are circumstances in which such a prior evaluation is available, for instance, if the plaintiff had previously been psychiatrically hospitalized or screened at a crisis center prior to the MVA. Some plaintiffs may have been evaluated by Child Study Teams in their academic careers. If such prior psychiatric or psychological evaluations are available, they can provide useful information about pre-MVA adjustment.
- **Plaintiff deposition transcripts:** We never cease to be impressed by the thoroughness of attorneys taking depositions. Consequently, if the plaintiff has been deposed, it is helpful to review the deposition transcript. If the plaintiff's deposition is scheduled to be taken, the mental health evaluator may wish to delay the evaluation until after the plaintiff's deposition, to be able to review the deposition transcript prior to the evaluation.

Interviewing the plaintiff

The clinical interview of a plaintiff has historically formed the core of psychological or psychiatric evaluations in personal injury cases. At the outset of the interview, the evaluator should make clear the limits of confidentiality. An evaluation in a personal injury case does not establish a traditional doctor-patient treatment relationship, with the confidentiality that such a relationship implies. To the contrary, the evaluator needs to make clear to the plaintiff that the specific purpose of the evaluation is to provide an opinion for the purpose of the lawsuit and that no treatment will be offered. In a like manner, a written release of information should be obtained from the examinee indicating that either the plaintiff's attorney or the defense attorney will be receiving a written report of the evaluation. In fact, a number of commentators have suggested that treating doctors should avoid offering expert opinions because of the inherent

role conflict between treatment, on the one hand, and forensic evaluation, on the other hand (for example, Greenberg & Shuman, 1997). Although a treating doctor can provide information regarding the course of treatment and the patient's progress, ideally a nontreating professional should be retained to provide a forensic evaluation of the plaintiff.

The interview then needs to address the following areas:

- **Mental status examination***: What is the plaintiff's mental functioning during the interview session? How alert and responsive is the plaintiff? What level of physical pain, if any, does the plaintiff report? Are there evident impairments of cognition or mood? What is the plaintiff's physical presentation, including irregularities of gait? Is there any suicidal ideation or intent?
- **Medication history**: What medications, especially psychotropic or pain management medications, has the plaintiff taken?
- **Symptom history**: What is the plaintiff's history of psychological symptoms? Here, the evaluator is most concerned with symptoms reflecting anxiety and depression, given that these are the most common areas of psychological disturbance after an MVA. One specific form of anxiety disorder of relevance is PTSD, and the evaluator should inquire about symptoms that reflect the PTSD diagnostic criteria.

Interviewing collaterals

Telephone or (on occasion) in-person interviews of collateral sources can be useful in corroborating the plaintiff's symptom and adjustment history. The ideal collateral is a professional, such as a treating psychotherapist, who knew the plaintiff before, during, and after the MVA. If the treating professional had contact with the plaintiff both before and after the MVA, then one can inquire regarding changes in adjustment at or soon after the MVA.

It is frequently the case that, however, that a treating professional is not available to interview. In that case, the

evaluator can interview friends, family members, or coworkers (depending on circumstances and availability). Again, the ideal person to interview is one with a long history with the plaintiff—someone who has known the plaintiff before the MVA. With friends and family members, one must bear in mind the possibility that the collateral source will be aligned with the plaintiff and therefore will slant his or her report to support the plaintiff's position. Therefore, the evaluator should treat such collateral informants as only one source of information, to be compared to the results of other aspects of the evaluation. Nonetheless, such collateral sources can be useful if they have a long history with the plaintiff.

Psychological testing

Psychological testing of an MVA plaintiff can be helpful in three ways. First, some psychological tests, such as the Millon Clinical Multiaxial Inventory-III (MCMI-III,) (Millon, 1997) have been developed specifically to assess Diagnostic and Statistical Manual (DSM) Axis II disorder, that is, personality disorders. Personality disorders are enduring maladaptive patterns that impair the individual's ability to function effectively. If such a personality disorder exists in a plaintiff, it would be likely to manifest itself prior to the MVA and thus constitute a significant pre-existing condition. Such a pre-existing condition, if present, would likely have resulted in pre-MVA psychological difficulties, which in some cases make it more difficult to ascertain a distinct change in adjustment due to the MVA. However, even here, the evaluator should be cautious in drawing inferences from the MCMI-III results regarding historical levels of personality functioning. As Butcher and Miller (2006, p. 146) note: "There are no foolproof ways of detecting premorbid personality or preinjury functioning with only present time measurement."

Second, psychological testing allows an assessment of current symptoms that is structured and standardized. The individual's test responses are compared with either (or both) a clinical or a nonclinical sample. In this way, the evaluator can determine whether, for example, the plaintiff reports significant present levels of anxiety, depression, or PTSD symptoms.

Third, objective psychological tests can assist in determining whether the plaintiff is malingering, that is, faking or exaggerating psychological symptoms. Objective personality tests such as the MCMI-III (Millon, 1997), Minnesota Multiphasic Personality Inventory-2 (MMPI-2) (Butcher, Dahlstrom, Graham, Tellegen & Kaemmer, 1989), and Personality Assessment Inventory (PAI) (Morey, 1991) have what are referred to as validity scales. These scales indicate the attitude with which the individual took the test. For example, a pattern of validity scale elevations could indicate that the plaintiff endorsed symptoms to a degree that would be unusual even in a severely disturbed clinical sample—an improbably severe symptom pattern. Such a response pattern in and of itself would not necessarily indicate that a plaintiff is malingering, but such a pattern would at least raise that possibility.

In addition, there have been tests developed specifically to assess malingering of mental health symptoms, most prominently the Structured Interview of Reported Symptoms (SIRS) (Rogers, Bagby & Dickens, 1992) and the Structured Inventory of Malingered Symptomatology (SIMS) (Widows & Smith, 2005). These tests survey a wide range of symptoms, some of which are unusual even in a clinical population—for example, rare symptoms, absurd symptoms, or improbable symptom combinations. Both tests were developed using simulation studies in which normal individuals are encouraged to “fake bad” on the test, and their reported symptom patterns are contrasted with normal or clinical individuals who respond without such “fake bad”

instructions. However, the evaluator should not make a conclusion regarding malingering solely by using even a test specifically designed to assess malingering. As always, such information should be considered within the context of corroborating information.

Special issues

In MVA personal injury evaluations, there are a number of distinct issues. Although we have touched on some of these issues above, we will review them in more detail here, providing some case examples.

Obtaining a baseline The evaluator should make an estimate of the plaintiff's baseline function prior to the MVA. The best sources of information are those that were obtained contemporaneously prior to the MVA (not reconstructed from the plaintiff's recollection). Such information includes prior treatment records or psychological evaluations, prior medical records, and historical work or educational records. This historical information can then be compared to information regarding functioning from after the MVA.

One assessment difficulty occurs in cases in which the plaintiff's pre-MVA adjustment was poor. In such cases, even if liability is clearly established, it may not be possible to credibly assert damages.

Case 1

Background The plaintiff was a 17-year-old boy who was struck while walking to school. The liability of the driver of the auto was clearly established. The boy sustained soft tissue injuries. He reported that he was anxious and depressed after the accident, emotions he attributed to the accident. Prior to the MVA the boy had been psychiatrically hospitalized on three occasions for suicidal gestures, including attempted overdose with

prescription drugs. He had prior diagnoses of bipolar mood disorder and major depressive disorder.

Analysis Although there was no doubt about the liability borne by the driver of the auto, the plaintiff's pre-MVA adjustment was so poor that it was not possible to conclude that the MVA worsened his adjustment.

Assess symptom pattern for more than one time period The most common symptoms after an MVA involve chronic pain, depression, and anxiety (especially although not only PTSD symptoms). By the time the evaluator interviews the plaintiff, if the evaluator has had access to extensive records, he or she will have formed hypotheses about which symptom areas are likely to be present in the plaintiff. During the interview, in inquiring about the plaintiff's symptoms we have, we have found it useful to systematically ask the plaintiff about three different times: prior to the MVA, during the first six months after the MVA, and during the most recent six months. Once the evaluator has a general sense of the symptom pattern, during the interview the evaluator can actually review the DSM criteria for these three time periods to determine whether the plaintiff met a diagnosis during each of those periods. In most jurisdictions a diagnosis is not required to recover for psychological damages. In fact, some commentators recommend that evaluators not rely so heavily on diagnoses and focus instead on specific functional impairments that the plaintiff may have suffered (see Greenberg, Shuman & Meyer, 2004). Nonetheless, DSM diagnoses have become the *de facto* standard for offering opinions on psychological injury, and the evaluator can expect to be cross-examined at length about the foundation for any diagnoses offered for the plaintiff. Therefore, the evaluator should exercise care in reaching a diagnosis. Although in treatment, diagnoses are sometimes used casually, without consideration as to whether the patient meets each of the necessary diagnostic criteria, in personal injury evaluations, the evaluator should carefully consider each diagnostic criterion and determine what evidence supports that criterion.

The
special case
of PTSD

Although, as noted above, in many jurisdictions no diagnosis at all is required to compensate for psychological injury, one common diagnosis found in MVA cases is PTSD. PTSD, an anxiety disorder, has five criterion areas: duration, exposure to stressor, intrusive symptoms, avoidance behaviors, and increased arousal/anxiety. PTSD is in many ways ready-made for tort litigation because, unlike other mental health diagnoses, a diagnosis of PTSD requires an external stressor (Melton, et al., 1997). MVAs frequently qualify as a stressor of sufficient magnitude to make a diagnosis of PTSD plausible—involving the experience of helplessness in the presence of a life threatening or physical injury causing event. Many individuals, however, experience such events without developing full-blown PTSD. Blanchard, Hickling, Taylor, Loos, Forneris & Jaccard (1996) found that PTSD cases after MVAs could be predicted in the majority of cases by the presence of: prior major depression, extent of physical injury during the MVA, fear of dying during the accident, and initiation of litigation.

The evaluator should determine which of the PTSD criteria, if any, the plaintiff met before and after the MVA, as well as determining to what extent the plaintiff's symptoms have subsided. The evaluator should be familiar with the diagnostic criteria for PTSD and systematically sample these areas. A number of structured PTSD assessment instruments are available, or the evaluator can rely on the actual diagnostic criteria from the DSM, keeping the book available for reference during the interview.

Although depression is not listed among the diagnostic criteria for PTSD, it frequently accompanies PTSD. PTSD can be a disruptive, disabling disorder; consequently, the functional impairment resulting from PTSD can in itself lead to the development of a secondary depression. In addition, although PTSD is an anxiety disorder whereas depression is not, there is in fact some symptom overlap between the two disorders. Both disorders may involve fatigue, loss of energy, irritability, and sleep disturbance.

Case 2

Background The plaintiff is a 42-year old woman with some pre-MVA history of mild depression. She had been in psychotherapy intermittently for some years, typically with a diagnosis of adjustment disorder with depressed affect. However, her pre-MVA depression had not impaired her ability to get good grades in school or to function effectively at work. After a serious MVA two years before the evaluation, she developed clear symptoms of PTSD. She attempted to avoid driving wherever possible, limited her activities as a result. She had intrusive thoughts of and nightmares about the MVA. Her sleep was disturbed, and she showed a number of other symptoms of increased anxiety. Coincident with her PTSD impairment, she became despondent, feeling as if her life would never improve. During the most recent six months prior to the evaluation, the plaintiff's symptoms had partially remitted. She met fewer, although still some, of the diagnostic criteria for PTSD. She no longer met sufficient PTSD criteria to make that diagnosis. Because her PTSD-related impairment had decreased, she was less depressed.

Analysis In the interview, the evaluator kept the DSM at his side to systematically ask the plaintiff about these symptoms in the three relevant time periods: pre-MVA, during the first six months after the MVA, and during the most recent six months. In this way, the evaluator could give a clear assessment of the lack of any pre-MVA PTSD symptoms, as well as the extent of remission during the most recent six months.

The eggshell plaintiff Not everyone who is exposed to a stressor develops a diagnosable mental disorder, PTSD, or otherwise. However, some plaintiffs have pre-existing psychological problems that make them vulnerable to developing more severe disorders if they experience a traumatic event, such as an MVA. Recent research indicates that individuals who have been exposed to prior traumatic events, who have pre-existing difficulties with

anxiety and depression, or who lack social support are more vulnerable to developing PTSD in the face of a traumatic event (for example, Ozer, Best, Lipsev & Weiss, 2003; Walfish, 2006). Unlike the case above, in which a plaintiff's pre-MVA adjustment was so poor as to preclude any opinion about damages, in cases in which pre-existing vulnerabilities were present, it may well be possible to determine if the MVA aggravated the plaintiff's psychological difficulties. Moreover, in some cases in which there were prior adjustment problems or earlier traumas, there may be a period of intervening good adjustment that was disrupted by the MVA.

Case 3

Background The plaintiff was a 30-year old woman who had been sexually abused by an uncle as a child. She experienced depression as a teenager, which the contemporaneous psychological reports from that time attributed to her prior history of sexual abuse. However, she terminated psychological treatment in her late teens. During her 20's, her adjustment was good. She married, completed college with good grades, and experienced no significant emotional difficulties. Her collateral sources described her as happy and productive during her 20's. At age 30, she was involved in a serious MVA, which required initial hospitalization and ongoing physical therapy for chronic pain. She experienced a diagnosable adjustment disorder with depressed affect as well as PTSD during the first six months after the MVA. Both disorders were in partial remission at the time of the evaluation.

Analysis The plaintiff experienced sexual abuse early in life. She had difficulties during her teens with depression. Both these elements predisposed her to later psychological problems, including PTSD. Regardless, she experienced good adjustment during her 20's. This positive adjustment was

disrupted by the MVA and its aftereffects. Consequently, the MVA was the proximate cause of her current distress.

Assessing malingering

A cornerstone of personal injury psychological evaluations is assessing malingering—that is, feigning mental illness or distress. Attorneys for both the plaintiff and the defense want to know whether the plaintiff is credible, whether the plaintiff is reporting symptoms accurately. The mental health evaluator uses a variety of methods to assess malingering.

First, the evaluator looks for convergence among the sources of information. The following questions can provide areas of inquiry:

- Are the symptoms that the plaintiff reports of functional impairment consistent with other sources of information, such as school or work records?
- Do the collateral informants indicate the same change in the plaintiff's adjustment at the time of the MVA as does the plaintiff?
- Is the plaintiff's account of his or her symptoms consistent with the medical or mental health records?
- Did any inconsistencies emerge during the plaintiff's deposition?
- Are any inconsistencies evident within the sources of documentation, such as contradictions between medical and mental health records?

In addition, psychological testing is invaluable in assessing malingering. As previously noted, many standardized objective personality tests, such as the MMPI-2 or PAI have validity scales, and examination of these scales can help determine whether feigning of symptoms is present. Moreover, it is helpful to administer tests specifically designed to assess malingering, such as the SIRS or the SIMS. The use of such malingering-specific tests allows the evaluator to be precise in indicating the degree of similarity of the plaintiff's test response style to the response style of individuals with intentionally faked symptoms.

However, no conclusion regarding malingering should be made on psychological test data alone. Even if the results of the testing are consistent with malingering, there may be alternative explanations. First, the individual may be in an acute emotional crisis, struggling with severe depression. Depression in and of itself, if severe, can color one's perceptions, causing one to describe oneself and one's life in overly negative terms. Second, the individual may be issuing a "cry for help," wishing to ensure that his or her complaints are taken seriously, out of a strong need for nurturance and support from others. Third, the individual may be experiencing real psychological symptoms, but may be exaggerating the extent of these symptoms, rather than fabricating the symptoms from whole cloth. All these possibilities are best determined by comparing the psychological testing results to other sources of information. As Butcher and Miller note (2006, p. 146):

It is not possible to determine, on the basis of the MMPI-2 or any psychological test for that matter, whether a claimant's injuries are actually based on organic conditions or derive from personality factors. It is also not possible, with confidence, to determine on the basis of a psychological test alone whether the patient is malingering.

Case 4

Background The plaintiff was in an MVA, since which he has complained of chronic pain in his lower back and neck. Initially, he believed that his pain problems would resolve on their own. Although his pain persisted, he refrained from reporting the accident to his doctors because he feared negative repercussions from his job as a carpenter, which requires significant physical labor. Eventually, when the plaintiff realized that his problems were not resolving but were intensifying instead, he told his doctors about the accident as having been the source of his pain complaints. In reports by both the plaintiff's treating physicians, there are questions regarding the possibility that the plaintiff is exaggerating or

feigning his physical complaints. In the current evaluation, there is some evidence of symptom magnification from the plaintiff's PAI and the SIMS. The plaintiff may indeed be exhibiting some degree of symptom magnification at this time.

Analysis People have a variety of motivations for magnifying their physical and psychological complaints. In the present case, it was the evaluator's opinion that the plaintiff was both desperate enough and despondent enough about his inability to work and to provide for his family that he may have been exaggerating his complaints as a "cry for help." However, both by history and by presentation on interview, as well as by his wife's report, it was the evaluator's opinion that the plaintiff's depressive symptoms were significant and genuine. Furthermore, because the plaintiff and his wife independently reported a pre-MVA high level of physical and psychological functioning that changed rather abruptly after the MVA, it was the evaluator's opinion that the plaintiff's depressive symptoms were a direct result of his work accident and its sequelae. The above case illustrates that although there was likely symptom exaggeration present, there was nonetheless real symptomatology present. Symptom exaggeration does not preclude real, underlying symptoms, and symptom exaggeration is not necessarily always motivated by an attempt to increase damages recovery from the litigation. Moreover, in this case, the abrupt change in adjustment at the time of the MVA established a causal relationship. These conclusions were reached by placing the psychological test results in the context of other sources of information, including corroborating collateral information.

Concurrent stressors In some cases, although a change in adjustment occurs around the time of the MVA, concurrent stressors may be present. These concurrent stressors, if significant, could in themselves impair the plaintiff's psychological adjustment. In some cases, it may not be possible to determine whether the MVA or the concurrent stressors caused the impairment of the plaintiff's adjustment. Whether the effects of the MVA

can be distinguished from the effects of the concurrent stressors may depend on the timing of any symptoms.

Case 5

Background The plaintiff was in a serious MVA, after which she experienced a diagnosable major depressive disorder. However, just after the MVA, her husband of 23 years filed for divorce and moved out of the home. Shortly afterwards, the plaintiff's eldest son physically assaulted her daughter, requiring the intervention of the state's child protection agency.

Analysis In this case, it was not possible to distinguish the effects of the MVA from the severe concurrent stressors in the plaintiff's life. The concurrent stressors—in this case divorce and difficulties with a child—were so severe and so close in time to the MVA that no credible case could be made that the MVA, and not the concurrent stressors, was the cause of her post-MVA depression.

Case 6

Background The plaintiff was involved in a serious MVA, after which she experienced PTSD, after which she also developed a major depressive disorder. She reported that her depression caused her to emotionally withdraw from the marriage, alienating her husband. Consequently, six months after the MVA, her husband moved out of the home and filed for divorce. The plaintiff also indicated that her depression caused her to be unable to work. Her attendance on the job declined, and her work evaluations, which had previously been excellent, became poor. Interviews of collateral sources corroborated the plaintiff's accounts of the timing of events and symptoms after the MVA.

Analysis In this case, slightly different than Case 5, the MVA led to a major depressive disorder. The plaintiff's depression, in turn, led to major life stressors. However, all these difficulties flowed from the initial emotional impact of the MVA. Consequently, the MVA could credibly be considered the proximate cause, despite the presence of other significant stressors. The timing of these additional stressors, although close in time to the MVA, were sufficiently afterwards and clearly caused by the plaintiff's MVA-related psychological impairment, that the MVA was still causative.

Conclusion

Interpreting the information gathered in a psychological evaluation generally, and in an MVA case specifically, involves considering alternative hypotheses. It is the rare case in which one explanation so clearly fits the data that no other explanations are possible. The evaluator must consider the data and systematically determine which explanation best fits.

In personal injury cases involving trauma, such as MVA cases, a reasonable (and classic) analytic structure for considering alternative hypotheses is provided by Ebaugh and Benjamin (as discussed in Melton, et al., 1997, pp. 378-379), which we will paraphrase:

- The trauma was the sole cause of the mental injury. This would occur when there were no signs of disorder before the trauma. The evaluator concludes that the mental disorder would not have occurred at all were it not for the trauma.
- The trauma was the major precipitating factor. For example, there may have been some indication of emotional difficulties prior to the trauma, but the evaluator concludes that but for the MVA, the symptoms would not have occurred at this time.
- The trauma was an aggravating factor. In these cases, emotional difficulties were present before the trauma, but the trauma significantly worsened symptoms of these difficulties.

- The trauma was a minor factor. In these cases, the emotional disorder was well-developed before the trauma, but the trauma to some extent intensified the symptoms.
- The trauma was unrelated to any emotional disorder.

Whether the evaluator wishes to explicitly articulate this structure when communicating in a report or through testimony is a matter of personal style. In any case, the evaluator should be clear in any communications. We recommend the following guidelines for reports and testimony:

- Lay a foundation for any conclusions. There is nothing less helpful than a report in which the facts and inferences that lead to one's conclusions are unarticulated. The goal of the report should be transparency.
- Acknowledge whatever uncertainty is present and indicate how this uncertainty is resolved. In some cases, the evidence is muddy. It is not always possible to reach a firm conclusion regarding causation. If this is true in a given case, the evaluator is better served by acknowledging this in the report, rather than waiting to have such uncertainty revealed later in depositions or trial testimony. It is acceptable to say in a report or testimony that one does not know the answer to a given question.
- Be clear about testing hypotheses. As noted above, an evaluation involves testing alternative hypotheses, perhaps none of which provides a perfect fit with the data. If more than one hypothesis is plausible, the evaluator is best served by considering the evidence for each and indicating how the evidence best supports one or the other.
- Avoid jargon. The goal of a report or testimony is not to demonstrate how intelligent the evaluator is, but rather to communicate findings clearly.
- Address only the issues that the retaining attorney has asked to be addressed (Babitsky, Mangraviti & Todd, 2000). The evaluator should have a clear idea of what issues the retaining attorney wants addressed, and the report should be focused on exactly those issues, no more, no less.
- Avoid statements that make one appear as an advocate. An evaluator who appears to be an advocate for either side will

lose credibility (Babitsky, Mangraviti & Todd, 2000). Such advocacy statements tend to be more common in reports written by treating doctors, who understandably have a patient-doctor bond developed with the plaintiff. Nonetheless, on occasion, advocacy statements are evident in reports by forensic evaluators and should be avoided.

All the above guidelines have one common purpose—to form a foundation for the evaluator’s credibility. In the end, credibility is perhaps the most important characteristic that an evaluator can offer the court. Whether through a report, deposition, or trial testimony, if an evaluator is not credible, then his or her time (and the client’s money) is wasted. In MVA cases, following the above principles will increase the likelihood that the evaluator’s findings will be clear, well-reasoned, and in the end, credible.

Note * A structured interview outline of this area for MVA and chronic pain cases is available from the second author.

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