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FORENSIC PSYCHIATRY

USE OF EXPERTS

Forensic psychiatry seeks to determine what is objectively true about a plaintiff's diagnosis and possible injury, using neurocognitive and psychological testing, interviewing, and a review of documentary data, Michael L. Fox and Mark I. Levy say in this BNA Insight.

The authors—one an attorney, the other a forensic psychiatrist—offer a primer on the use of forensic psychiatric evidence in catastrophic injury and mass tort claims, including advice on the practical, legal and ethical issues that arise in these cases.

The Use of Forensic Psychiatry in Catastrophic Injury and Multi-Party Litigation

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Catastrophic accidents often lead to claims for severe emotional distress including allegations of post-traumatic stress disorder ("PTSD"). Similarly, allegations of acute neuropsychological disorders and fear of cancer can follow environmental releases and toxic exposures. So, too, with product liability claims and even claims from entire "classes" of individual employees. A single incident or condition may produce thousands of claims.

The many challenges to defending these claims include limited access to plaintiffs, privacy issues, and treating physicians who often advocate for their patients, relying almost exclusively on their patients' *subjective* reports of their experiences and symptoms, rather than on objectively verifiable data.

In contrast, forensic psychiatry seeks to determine what is *objectively* true about the plaintiff's diagnosis and possible injury, using neurocognitive and psychological testing, in-depth interviewing, and a careful and detailed review of all available relevant documentary data. This article discusses the definition and unique characteristics of forensic psychiatry (in contrast to clinical psychiatry), the effective use of forensic psychiatric expertise in catastrophic injury and mass tort claims, and the practical, legal and ethical issues that frequently arise in these cases.

Definition of Forensic Psychiatry and Credentials

Forensic Psychiatry is a medical subspecialty of psychiatry. Its focus is the interface between the law and behavioral medicine. Like the law, forensic psychiatry is divided into various sections.

According to the sole credentialing body for psychiatry and forensic psychiatry, the American Board of Psychiatry and Neurology ("ABPN"):

> Forensic psychiatry is a subspecialty that involves having psychiatric focus on interrelationships with civil, criminal and administrative law, evaluation and specialized treatment of individuals involved with the legal system, incarcerated in jails, prisons, and forensic psychiatry hospitals.

The ABPN offers subspecialty board certification in this field. However, in order to even be eligible to take the forensic psychiatry board examination, a candidate must have completed a four-year residency in psychiatry, been examined and certified in psychiatry by the ABPN, and then completed a rigorous one-year, full-time, accredited post-residency fellowship in forensic psychiatry.

At this time, less than six percent of the approximately 35,000 board-certified or board-eligible psychiatrists within the United States are also board-certified in forensic psychiatry. Of this total, only a tiny group of several hundred individuals are board certified in Adult, Child & Adolescent Psychiatry and Forensic Psychiatry.

Despite the clear paths to receiving training and obtaining credentials in forensic psychiatry, many psychiatrists who are neither forensically trained nor board-certified in forensic psychiatry continue to offer themselves to litigators as forensic psychiatric ''experts.''

Too often, such untrained ''experts'' do not have a clear understanding of the significant role distinctions between functioning as a treating clinician on the one hand, and providing independent forensic psychiatric opinion on the other, and they often unwittingly slip into the clinician's role of advocate, as if their relationship to the plaintiff examinee is identical to their relationship to a patient whom they are treating. As a result, it is crucial that any attorney who is retaining, or cross-examining, a forensic psychiatric expert understands the important differences between the role of a treating psychiatric clinician versus an independent, forensic psychiatric expert.

Treating Clinician v. Independent Forensic Psychiatric Expert: Wearing Two Hats

The opinions of a forensic psychiatrist must be firmly grounded in thorough clinical training combined with substantial experience. Nevertheless, the roles of psychiatric clinicians and forensic psychiatric experts are widely disparate.

Not infrequently, psychiatric experts and the attorneys who retain them do not appreciate the significant differences between these two roles. The testifying psychiatrist may wear either the hat of a treating clinician or that of an independent expert, but *never* both at once. Why is that? ***The roles of a treating clinician and forensic psychiatric expert differ markedly in their mission, method and ethical duty.***

Like all treating physicians, the treating psychiatrist in accordance with the Hippocratic Oath accepts as his or her ***mission*** *the alleviation of (emotional) suffering,* regardless of its cause.

The ***method*** of the treating clinician is to rely almost exclusively upon the patient's individual account of his or her subjective experience.

For example, when treating symptoms of depression and anxiety in an adult patient who reports that his father beat him when he was a child, the treating clinician accepts the patient's report as a factual statement of his *subjective* reality, without attempting to determine the *objective* accuracy of the patient's self-reported memory by, for example, interviewing family members or reviewing old medical records in order to determine the accuracy of the patient's claim.

Furthermore, there is an implicit treatment contract between doctors and their patients: Patients seek treatment from doctors primarily to alleviate their suffering and facilitate their recovery, not primarily to position themselves for compensation via litigation for alleged injuries. In contrast to patients, however, litigants generally have more complex and nuanced motivations.

With the infrequent exception of when there is a genuine diagnostic uncertainty possibly delaying critical treatment decisions, for example, when a child or adult is being evaluated for learning difficulties, or when a patient appears to be cognitively impaired from head trauma or a degenerative brain disease, treating psychiatrists do *not* generally request psychological testing of their patients.

Finally, treating psychiatrists, like all physicians, are under an ***ethical duty*** in accordance with their Hippocratic Oath to act in what they regard as the best interest of their patient and to ''first do no harm (primum non nocere).'' Generally, physicians align themselves with their patients' goals and objectives, as long as they are safe and reasonable. Consequently, treating physicians are inclined to accommodate the wishes of their patients, unless they believe that doing so might harm them.

Attorneys must understand the important differences between the role of a treating psychiatric clinician and an independent, forensic psychiatric expert.

Therefore, when a patient requests a letter excusing him or her from work, or claims to be disabled, perhaps due to having experienced an acutely distressing event, most treating psychiatric physicians are inclined to accede to their patient's request unless there are specific factors that alert the doctor's skepticism (such as a pattern of ''drug seeking'' behavior).

Accordingly, when treating doctors are asked to testify in litigation on their patient's behalf, they appropriately *advocate* for whatever they believe to be in their patient's best interest. Treating doctors generally do not approach testimony on behalf of a patient with the same professional skeptical scrutiny that typically characterizes a forensic psychiatric expert's opinion.

The primary reason for this advocacy is that treating psychiatrists usually accept and rely upon their patients' self-reporting of their experience. Thus, the treating doctor's diagnostic conclusions and prognostic conclusions offered to the trier of fact may unwittingly be colored by the litigating patient's wishes and selective revelations, without reflecting an evidence-based, objective medical opinion.

For example, it is common for treating doctors to testify inaccurately about causation, simply memorializing what they have been told by their patient. This error is

  EXER ISSN 1536-1896

usually unwitting because they simply lack the wide array of data available to the forensic psychiatric expert, which would provide them with a broader perspective on the various options for causation and free them from the confines of ''proximate cause,'' which is an artificial contrivance of the law.

In fact, most conditions of emotional distress are over-determined, the result of multiple influences along a chain of causation. What is proximate and what is remote is usually in the eye of the beholder. Thus, treating clinicians may uncritically accept their patient's self-serving reports, including allegations of discrimination, employer retaliation and/or wrongful termination when, more often than not, there are multiple causes for events.

This is simply because the treating doctor usually has no objective means by which to weigh the relevant factors and evaluate the patient's attributions of causation. Although the patient's allegations may or may not ultimately be found to be accurate by the trier of fact, the treating psychiatrist usually has insufficient information with which to reach a truly independent judgment about causation.

Indeed, several courts have excluded treating doctors' testimony as merely reciting the allegation of the alleged victim under the guise of expert opinion. For example, in *United States v. Whitted*,[1] the Eighth Circuit found the doctor's diagnosis of ''repeated sexual abuse'' to rest solely on his acceptance of the victim's account. In *United States v. Charley*,[2] the 10th Circuit found that a doctor's conclusion of abuse based on the girls' allegations was merely vouching for the credibility of the child complainants. And in *Viterbo v. Dow Chem. Co.*,[3] the Fifth Circuit excluded the opinion of a medical expert who (a) sought to attribute the plaintiff's depression and other ailments to his exposure to a chemical based only on the plaintiff's statements, and (b) was unaware of a family history of depression and hypertension that could have explained the source of the symptoms.

The Mission, Methodology, and Ethical Duty of Independent Forensic Psychiatric Experts Contrast Starkly With Treating Doctors

The ***mission*** of the forensic psychiatric expert is not the alleviation of suffering but rather the determination, as accurately as possible, of what is objectively true, assuming a professionally skeptical point of view and seeking firm evidence to support any conclusions while always considering alternative hypotheses. Therefore, the forensic psychiatric expert vigorously seeks objective data relevant to determining an accurate diagnosis, recommending treatment, and offering opinions about prognosis and causation.

The guiding standard to be achieved is akin to the opinion of a ballistics expert who can state with reasonable scientific probability that a particular bullet was fired by a particular weapon, or was not. Although forensic psychiatrists are clearly cognizant that determining what is objectively true in behavioral medicine is far more complex and nuanced than in ballistic science, this nevertheless remains the gold standard for the opinions of any well-trained, independent forensic psychiatric expert.

The ***method*** of forensic psychiatric analysis is to review *all* available, possibly relevant data, including all medical and legal records from time periods prior and subsequent to the events giving rise to the litigation, collateral information from deposition transcripts, other testimony and declarations of key witnesses, as well as psychological or neurocognitive test data.

Psychological tests are administered, interpreted and reported by an experienced, well-trained, forensic psychologist in civil (and some criminal) matters. In addition to the psychological testing, the forensic psychiatrist conducts an in-depth, detailed, multi-hour interview of the plaintiff.

The psychological test data makes possible a statistical comparison of the individual's functioning to that of other individuals of a similar demographic profile. In fact, all testing in medicine (including blood testing, imaging and psychological testing) answers a simple ''membership'' question, i.e., by statistically comparing the examinee's data derived from a given test instrument to analogous data obtained from a very large population of individuals of similar background to determine whether an individual's pattern of test responses is similar or dissimilar to those of other persons who present with similar symptoms.

Neurocognitive and psychological testing also provides solid, scientific evidence that can be used to form evidence-based opinions about the likely veracity of the plaintiff's claims regarding loss of cognitive functioning or emotional distress, as well as the plaintiff's fitness to function at work, at home, or in legal proceedings. Thus, the ***method*** of forensic psychiatric practice is to assess the examinee's subjective narrative within a much larger context of clinical evidence than is generally available to the treating psychiatrist.

Under Rule 35 of the Federal Rules of Civil Procedure, the court may order a party whose mental condition is in issue to submit to a mental examination by a suitably licensed or certified examiner upon a showing of good cause.[4] Because courts distinguish between emotional distress asserted as an element of damages for other claims such as physical injury or harassment, and independent claims of emotional distress, most cases where mental examinations are allowed involve separate tort claims for emotional distress or an allegation of ongoing severe mental injury or impairment.[5]

Many states have rules similar to Rule 35, although California requires a showing of ''exceptional circumstances'' before ordering the mental examination of a party who stipulates ''that no claim is being made for mental and emotional distress over and above that usually associated with the physical injuries claimed.''[6]

Courts also recognize the importance of testing and often approve their administration as part of court-ordered mental health examination. In *Newman v. San Joaquin Delta Community College*,[7] the defendant community college district's examiner was permitted to conduct some of 26 psychological and neuropsychologi-

[1] 11 F.3d 782 (8th Cir.1993).
[2] 189 F.3d 1251 (10th Cir.1999).
[3] 826 F.2d 420 (5th Cir.1987).
[4] Fed. R. Civ. P. 35(a).
[5] *See In re Methyl Tertiary Butyl Ether (''MTBE'') Products Liability Litigation*, 528 F. Supp. 2d 303, 319 (S.D.N.Y. 2007).
[6] Cal. Code Civ. Proc. § 2032.320.
[7] 272 F.R.D. 505 (E.D. Cal. 2011).

cal tests he deemed necessary over the course of two five-hours sessions to the plaintiff-student whose mental condition was in controversy in her ADA action arising from an alleged assault by college police officers.

Similarly, in *Gavin v. Hilton Worldwide, Inc.*,[8] where an employee brought an action against her former employer, alleging failure to accommodate her chronic, severe depression in violation of federal and state law, the court ordered the plaintiff-employee to undergo a mental examination that included the assistance of a clinical psychologist to conduct psychological tests, including the entire Wechsler Adult Intelligence Scale—Fourth Edition (''WAIS–IV''), the Minnesota Multiphasic Personality Inventory-2 (''MMPI-2''), and the Rorschach Inkblot Test.

The forensic psychiatrist's examination should also be without interference or attendance by the plaintiff's attorney or others because, regardless of their good intentions, they may contaminate an examination.[9]

Video recording the examination may not be permitted in some jurisdictions, although courts have recognized that such recording will provide the best evidence of whether the retained expert conducted a fair examination and will also show whether plaintiff engaged in any delay or misconduct.[10] The ***ethical duty*** of the forensic psychiatric expert is only to the trier of fact, consistent with the role of the expert to assist the trier of fact to understand the evidence or determine a fact in issue.[11]

While the forensic psychiatric expert's retention by one side in a civil or criminal dispute may be alleged to indicate that he or she plays the role of an advocate, the opinions proffered must always be evidence-based, which is also the modern standard for all best medical practice. It should be agreed from the outset that the only duty owed by the forensic expert to the retaining attorney is a commitment to professionalism, honesty and a fiduciary duty regarding payment for expert services.

Thus, a party should understand at the time the expert is retained that, after applying the most current scientific principles of data analysis, the expert's conclusions may, or may not, support the retaining attorney's theory of the case.

Finally, the forensic psychiatric expert is expected to explain complex medical and behavioral information to the trier of fact in readily understandable language, without jargon or pretense. Thus, an ability to communicate clearly and directly in both written and spoken contexts is the forensic psychiatrist's most important skill.

Challenges in Assessing Populations of Litigants and Advantages of Employing Cohesive Teams to Conduct These Assessments

When many plaintiffs allege as part of their claim for compensatory damages emotional and other intangible injuries, the very nature of these damages necessarily implicates the subjective differences of each plaintiff's circumstances. This often precludes class certification.[12]

So-called ''Lone Pine'' case management orders may be effective in mass tort cases to assure that plaintiffs claiming emotional distress have prima facie expert support for their claims.[13] Such cases may require the court to order individual mental exams when emotional distress is an element of a plaintiff's claim, even if the plaintiffs have stipulated that they will not support those claims with medical evidence.[14]

There are two basic components to an effective and scientifically sound independent medical evaluation: the psychological (and/or neuropsychological) testing, and the careful and detailed review of all available data including a detailed psychiatric interview examination.

Lone Pine **orders help identify the segment of the population claiming impairment who should then undergo independent psychiatric examinations.**

In one sense, this is no different from the requirements for any competent forensic psychiatric assessment of a plaintiff who puts their mental status at issue, whether the plaintiff is unique or a member of a group of plaintiffs. On the other hand, there are unique dynamics that characterize the psychiatric assessment of a population of litigants. For example, although it is always desirable for a forensic psychiatric defense expert to obtain information from collateral informants in addition to the plaintiff when conducting any forensic psychiatric independent mental examination of an individual plaintiff, this is rarely possible due to predictable objections from plaintiff's counsel.

However, in multi-plaintiff litigation when a cohesive forensic team is assessing an entire population of litigants, each plaintiff is, in fact, a collateral witness to the claims of every other plaintiff. This is a rich source of data for the expert to mine. Another critical scientific fact about the distribution of damages produced by a catastrophic event, is that, like so many other scientific phenomena, this distribution too follows a

[8] 291 F.R.D. 161 (N.D. Cal. 2013).

[9] *See, e.g., Ragge v. MCA/Universal Studios,* 165 F.R.D. 605 (C.D. Cal. 1995) (denying third party observer where examiner did not propose to use unorthodox or potentially harmful techniques in his exam); *Golfland Entertainment Centers, Inc. v. Superior Court*, 108 Cal. App. 4th 739 (2003) (finding mental examination can be recorded but not attended by counsel).

[10] *See, e.g., Schaeffer v. Sequoyah Trading & Transp.*, 273 F.R.D. 662 (D. Kan. 2011) (videotaping ordered over plaintiff's objection).

[11] Fed. R. Evid. 702(a).

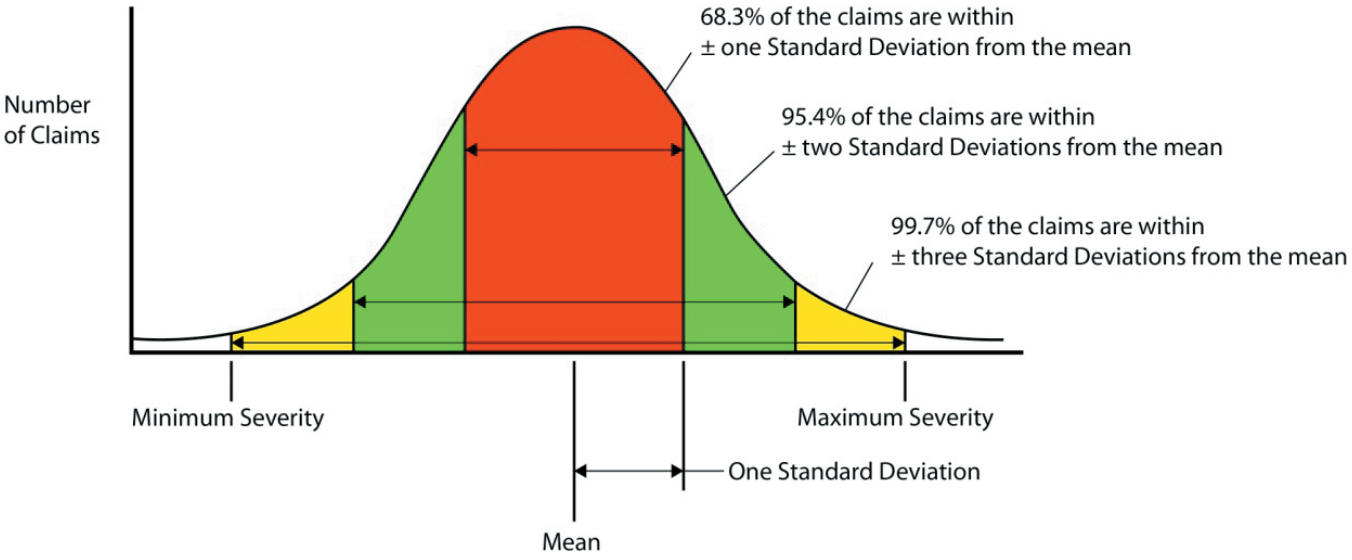
[12] *Steering Committee v. Exxon Mobil Corp.*, 461 F.3d 598 (5th Cir. 2006) (class action seeking emotional distress damages following refinery explosion); *Allison v. Citgo Petroleum Corp.*, 151 F.3d 402 (5th Cir. 1998) (class action seeking emotional distress damages for alleged employment discrimination).

[13] *See*, e.g., *In re: Vioxx Products Liability Litigation*, 388 Fed. Appx. 391 (5th Cir. 2010); *see also Avila v. Willits Environmental Remediation Trust,* 633 F.3d 828 (9th Cir. 2011).

[14] *See, e.g., In re Methyl Tertiary Butyl Ether (''MTBE'') Products Liability Litigation,* 528 F. Supp. 2d 303 (S.D.N.Y. 2007).

EXER ISSN 1536-1896

Gaussian (Normal) or Bell distribution curve:



In other words, given a sufficiently large sample, a catastrophic event will cause extreme damage to a very small segment of the population and no damage whatsoever to an equally small group, each about 2.15+ percent of the total population. The overwhelming segment of the population (about 68.3 percent) falls within one standard deviation of the mean of the Bell Curve, i.e., they are neither unscathed nor severely injured. Approximately 13.55 percent of the population are in the second standard deviation on either side of the mean, i.e., the first group has experienced some but only mild damages, and the other has experienced serious but not severe damages. Thus, about 15.7 percent of the population have experienced either none or only minor damages from the event. An equal percentage experienced serious to severe emotional damages. The remainder, almost 70 percent of the population, falls somewhere in the middle of these two groups.

Understandably, in mass tort litigation, most plaintiffs' attorneys want to argue that their particular clients are among the most seriously affected by the damaging event, that is two, three or more standard deviations beyond the mean of damaging effects caused by the event.

However, the unique advantage for the defense of using a team to evaluate the entire affected population is that the forensic psychiatric expert can testify with considerable scientific credibility that while one plaintiff may be injured another probably is not. In other words, it is statistically highly improbable that even a substantial minority of the population would have been severely injured by a given event.

If the selection of test plaintiffs has left the parties without this information, rather than the resulting sample representing a scientifically valid normal distribution curve of damages within the affected population, it would likely resemble an artificial ''barbell'' distribution of plaintiffs who resided outside of two standard deviations on either side of the mean. A genuinely random selection of ''sample'' plaintiffs by the court would produce a far more statistically representative group of ''sample'' plaintiffs whose injuries would have more accurately represented the distribution of damages across the entire population of litigants.

Use of ''Lone Pine'' orders can help to identify the segment of the population claiming (with evidentiary support) mental suffering or impairment which should then undergo independent forensic psychiatric examinations. Test plaintiffs can then be selected to accurately represent the overall population of claimants.

As discussed above, statistically speaking, the same catastrophic event may produce genuine PTSD, or symptoms of mild emotional distress, or even malingered symptoms in different individuals within the affected population. According to the *Diagnostic and Statistical Manual of Mental Disorders*, Fifth Edition (May 2013) (''DSM-5''), the following are the current diagnostic criteria for PTSD in adults and children older than six years of age:

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

1. Directly experiencing the traumatic event(s).

2. Witnessing, in person, the event(s) as it occurred to others.

3. Learning that the traumatic event(s) occurred to a close family member or close friend. In cases of actual or threatened death of a family member or friend, the event(s) must have been violent or accidental.

4. Experiencing repeated or extreme exposure to aversive details of the traumatic event(s) (e.g., first responders collecting human remains; police officers repeatedly exposed to details of child abuse). Note: Criterion A.4 does not apply to exposure through electronic media, television, movies, or pictures, unless this exposure is work related.

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

1. Recurrent, involuntary, and intrusive distressing memories of the traumatic event(s). Note: In children older than 6 years, repetitive play may occur in which themes or aspects of the traumatic event(s) are expressed.

2. Recurrent distressing dreams in which the content and/or affect of the dream are related to the traumatic event(s). Note: In children, there may be frightening dreams without recognizable content.

3. Dissociative reactions (e.g., flashbacks) in which the individual feels or acts as if the traumatic event(s) were recurring. (Such reactions may occur on a continuum, with the most extreme expression being a complete loss of awareness of present surroundings.) Note: In children, trauma-specific reenactment may occur in play.

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

5. Marked physiological reactions to internal or external cues that symbolize or resemble an aspect of the traumatic event(s).

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

1. Avoidance of or efforts to avoid distressing memories, thoughts, or feelings about or closely associated with the traumatic event(s).

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

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

1. Inability to remember an important aspect of the traumatic event(s) (typically due to dissociative amnesia and not to other factors such as head injury, alcohol, or drugs).

2. Persistent and exaggerated negative beliefs or expectations about oneself, others, or the world (e.g., ''I am bad,'' ''No one can be trusted,'' ''The world is completely dangerous,'' ''My whole nervous system is permanently ruined'').

3. Persistent, distorted cognitions about the cause or consequences of the traumatic event(s) that lead the individual to blame himself/herself or others.

4. Persistent negative emotional state (e.g., fear, horror, anger, guilt, or shame).

5. Markedly diminished interest or participation in significant activities.

6. Feelings of detachment or estrangement from others.

7. Persistent inability to experience positive emotions (e.g., inability to experience happiness, satisfaction, or loving feelings).

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

1. Irritable behavior and angry outbursts (with little or no provocation) typically expressed as verbal or physical aggression toward people or objects.

2. Reckless or self-destructive behavior.

3. Hypervigilance.

4. Exaggerated startle response.

5. Problems with concentration.

6. Sleep disturbance (e.g., difficulty falling or staying asleep or restless sleep).

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

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

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

Specify whether:

With dissociative symptoms: The individual's symptoms meet the criteria for posttraumatic stress disorder, and in addition, in response to the stressor, the individual experiences persistent or recurrent symptoms of either of the following:

1. Depersonalization: Persistent or recurrent experiences of feeling detached from, and as if one were an outside observer of, one's mental processes or body (e.g., feeling as though one were in a dream; feeling a sense of unreality of self or body or of time moving slowly).

2. Derealization: Persistent or recurrent experiences of unreality of surroundings (e.g., the world around the individual is experienced as unreal, dreamlike, distant, or distorted).

3. Note: To use this subtype, the dissociative symptoms must not be attributable to the physiological effects of a substance (e.g., blackouts, behavior during alcohol intoxication) or another medical condition (e.g., complex partial seizures).

Specify if:

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

The DSM-5 notes that ''[t]he essential feature'' of PTSD is the development of characteristic symptoms following exposure to one or more traumatic events, although the clinical presentation often varies. It is well established within contemporary research literature that the likelihood of developing PTSD increases with the severity of the stressor.

A driver involved in a minor collision is far less likely to develop PTSD than a victim of a violent crime. However, even among the population of those victims, not all develop PTSD. Why a particular individual develops a serious emotional response to a traumatic event and why another does not has been the focus of increasing scientific study, examining whether vulnerability and resiliency factors affect the likelihood that one will develop PTSD. The point being that the event criterion alone does not establish PTSD, highlighting the need in mass tort and multi-plaintiff litigation to use case management orders and rules of procedure and evidence to differentiate the plaintiffs and evaluate them individu-

  EXER ISSN 1536-1896

ally utilizing the skills of trained forensic psychiatrists and their teams.

Conclusion

Catastrophic events will not cause the same emotional response or injury to occur among all persons who experience the same or similar events. In multi-plaintiff litigation, challenges to class certification and utilization of case management tools such as ''Lone Pine'' orders can help distinguish those plaintiffs seeking to recover for emotional distress rather than garden variety pain and suffering.

Forensic psychiatric examinations including psychological testing early in the process can help validate or disprove plaintiffs' claims and, in mutli-plaintiff actions, better identify the representative subgroup of bellwether plaintiffs. Regardless of whether the action involves one plaintiff, hundreds or thousands, the forensic psychiatrist's mission, methods and duty will help the trier of fact ascertain the relationship, if any at all, between the alleged disorder and defendant's alleged wrongdoing.