

THE OVERDIAGNOSIS OF POST-TRAUMATIC STRESS DISORDER IN EMPLOYMENT LITIGATION

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Post-traumatic stress disorder (PTSD) is a psychiatric disorder that can occur after experiencing or witnessing of a life-threatening event such as military combat, natural disasters, terrorist incidents, serious accidents and personal attacks such as a rape. In the last few years, however, PTSD diagnoses are appearing with increasing regularity in employment lawsuits, and often in cases where such a diagnosis is clearly inappropriate. Typically, PTSD is misdiagnosed in harassment suits in which there may be allegations of egregious and inappropriate conduct in the workplace, but which lack any evidence of a physical assault, threat to life, or the possibility of serious injury. In some instances, however, PTSD is diagnosed in wrongful discharge and employment discrimination claims in which the only allegations of harm are job termination, and/or the denial of a sought after position or employment benefit.

Even in those cases that involve a traumatic event such as a personal assault, however, relevant data indicates that PTSD is not an inevitable outcome, and that only a relatively small proportion of individuals exposed to such an event will actually develop PTSD symptomatology. From the medical perspective, PTSD has an estimated prevalence of 1 to 9 percent in the general population, with somewhat higher rates in women of 12 to 14 percent.¹ The likelihood of developing PTSD is far greater, however, for women who experience a sexual assault such as a rape or an attempted rape.² This occurs despite observations that well over half of all Americans (60.7 percent of men and 51.2 percent of women) report having been exposed to at least one significantly traumatic event in their lives.³

From these statistics it is clear that: 1) only a relatively small fraction of people exposed to a traumatic event will subsequently develop PTSD; and 2) by inference from these data, PTSD is likely overdiagnosed in litigation in general. These epidemiologic patterns and statistics also strongly suggest that factors other than purely clinical considerations may influence the prevalence of PTSD diagnoses in employment litigation.

In fact, PTSD is a diagnosis that lends itself easily to potential abuse in employment litigation, in which the causes of alleged emotional distress are often less tangible than in other types of lawsuits. Specifically, unlike other diagnoses in the Diagnostic and Statistical Manual of Mental Disorders (DSM)⁴, PTSD contains within its very nomenclature and its DSM diagnostic criteria a necessary causative trauma. This can create the impression in a jury of a relatively straightforward relationship between alleged workplace misconduct and purportedly resulting distress, and psychiatric symptomatology. Therefore, because this diagnostic system provides the semblance of a medically sanctioned expression of proximate cause, PTSD is a frequent diagnosis by plaintiffs' attorneys through their experts.

An early and accurate diagnosis of any emotional damages claim, however, should be crucially important to both defendants and plaintiffs. This is so because causes for reported emotional distress may be uncovered in the course of litigation other than those related to the claimant's workplace experiences. This distress, in turn, may be more amenable to resolution and recovery than the distress presumably related to the claimant's workplace experiences. In this vein, and

from the defense perspective, if it can be shown at trial that a testifying forensic expert has misdiagnosed PTSD, doubt can be cast on the overall validity of a plaintiff's claims of emotional distress. Furthermore, a clearly overreaching diagnosis of PTSD can also raise the specter of malingering or symptom exaggeration in a potential juror's mind.⁵

Finally, while PTSD, perhaps because of its strong connection with Vietnam veterans and with military combat in general, often resonates sympathetically with jurors, a testifying forensic expert's conflation of relatively minor stressors such as name-calling, off-color jokes, and even propositions by unappealing coworkers with the experiences of the victims of combat terrorist attacks, torture, and violent personal assaults can have the opposite effect, and actually diminish the value of an otherwise valid claim of emotional distress. Such conflation is a disservice to plaintiffs and defendants alike.

The DSM-IV-TR Diagnostic Criteria

The DSM-IV-TR sets forth the diagnostic criteria for PTSD, which are divided into six categories, or diagnostic criteria. In order to diagnose PTSD, the individual with the disorder must satisfy the following criteria:

1. The person has experienced, witnessed or been confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others and the person's response involved fear, helplessness or horror.
2. The traumatic event is persistently

re-experienced in at least one of the following ways:

- Recurrent and intrusive distressing recollection of the event.
- Recurrent distressing dreams of the event.
- Acting or feeling as though the event were recurring (including flashbacks when waking or intoxicated).
- Intense psychological stress at exposure to events that symbolize or resemble an aspect of the event.

3. Persistent avoidance of stimuli associated with the trauma or numbing of general responsiveness (not present before the event) as indicated by at least three of the following:

- Efforts to avoid thoughts or feeling associated with the event.
- Efforts to avoid activities or situations which arouse recollections of the event.
- Inability to recall an important aspect of the event (psychogenic amnesia).
- Markedly diminished interest in significant activities, such as hobby or leisure time activity.
- Feeling of detachment or estrangement from others.
- Restricted range of affect, *e.g.*, inability to experience emotions such as feelings of love.
- Sense of a foreshortened future such as not expecting to have a career, more children or a long life.

4. Persistent symptoms of increased arousal (not present before the event) as indicated by at least two of the following:

- Difficulty in falling and staying asleep.

- Irritability or outbursts of anger.
- Difficulty concentrating.
- Hypervigilance.
- Exaggerated startle response.
- Physiological reactivity on exposure to events that resemble an aspect of the event, *e.g.* breaking into a sweat or palpitations.

5. Criteria 2, 3, and 4 must be present for at least one month after the traumatic event.

6. The traumatic event caused clinically significant distress or dysfunction in the individual's social, occupational, and family functioning or in other important areas of functioning.

Of these six criteria, criterion 1, also known as the gateway criterion,⁶ is often the most important and therefore the criterion most often misinterpreted by both lawyers and forensic experts.⁷ Specifically, an individual cannot be diagnosed as suffering from PTSD without meeting criterion 1, which requires both exposure to a traumatic incident and a traumatic stress response to that event. More precisely, the event in question must have caused extreme fear and the perception of absolute helplessness.

The DSM-IV-TR cites military combat, physical attack, kidnapping and terrorism as some examples of the types of traumatic events from which PTSD may develop. While highly traumatic incidents such as a violent personal assault can and do occur in the workplace, incidents such as job termination, offensive utterances, inappropriate horseplay, and/or interpersonal conflicts do not generally qualify as criterion 1 stressors.⁸

In an attempt to circumvent the requirement that a PTSD triggering stressor be life threatening and severe, some forensic experts seek to justify a PTSD diagnosis by claiming *cumulative stressor PTSD*. This theory suggests that

while a series of relatively minor incidents might not individually qualify for a PTSD diagnoses, the cumulative weight and *kindling* (in a neurologic sense) of such stressors might qualify as a traumatic event sufficient to cause PTSD.

While this theory might be relevant to employees such as police officers, emergency workers and fire personnel who regularly witness death and serious injury, it is not accepted as clinically or scientifically valid to explain the cumulative effects of relatively minor stressors such as off-color jokes, horseplay and inappropriate sexual propositions in the workplace; these stressors generally do not involve the threat of death or serious injury.⁹

In addition, even if exposed to a traumatic stressor, an individual must have symptoms consistent with PTSD's other criteria to be properly diagnosed as having PTSD, according to the DSM-IV-TR. In addition to criterion 1, which may be considered the entrance requirements for this diagnosis, the DSM-IV-TR articulates three broad behavioral and symptomatic categories of PTSD symptomatology: re-experiencing, avoidance/numbing, and increased arousal. PTSD may only be diagnosed if one symptom of re-experiencing, three symptoms of avoidance/numbing, and two symptoms of increased arousal are present. If a person has five symptoms, for example, but all are in the hyper-arousal category, the diagnostic criteria have not been met and that individual cannot properly be diagnosed as having PTSD.

Under criterion 2, an individual must experience at least one form of re-experiencing phenomena. These often take the form of either flashbacks or recurrent nightmares. Most important for these symptoms, the re-experiencing of these phenomena must be recurrent, intrusive, and extremely distressing. Merely thinking about or anxiously reflecting about a traumatic event is not sufficient. The more numbing or disassociative the quality of the re-experiencing phenomena described by the

claimant, the more solidly he or she satisfies criterion 2 for PTSD.

Because flashbacks and nightmares are self-reported, however, particular attention should be paid to signs of malingering when assessing this criterion. Evidence of false symptom reporting, or faking,¹⁰ may include previous exposure to and experience with PTSD and its symptomatology; evidence of—even if unintentional—in the form of leading questions during a forensic interview; nightmares that consistently relive the traumatic event in exact detail over several months without any change in the content of such dreams; and questions regarding whether the forensic examiner performed any psychological tests to address the issue of malingering, whether such tests validated the claimant's self-report of such symptoms, and whether symptomatology reported or revealed in testing is validated from any other source (e.g. collateral history from family members).¹¹

Likewise, under criterion 3 an individual must experience three symptoms of persistent avoidance or generalized numbing. A person suffering from PTSD frequently makes deliberate efforts to avoid thoughts, feelings or conversations about the traumatic event and to avoid activities, situations, or people who arouse recollections of that event. This avoidance of reminders may include amnesia regarding an important aspect of the traumatic event. Diminished responsiveness to the external world, referred to as psychic numbing or emotional anesthesia, usually begins soon after the traumatic event.¹²

The individual may complain of having markedly diminished interest or participation in previously enjoyed activities, of feeling detached or estranged from other people, or of having markedly reduced ability to feel emotions (especially those associated with intimacy, tenderness, and sexuality). The individual may also have a sense of a foreshortened future (e.g., not expecting to have a career, marriage, children, or a normal life span). These PTSD symptoms are also capable of being self-reported,

and should be explored indirectly, and verified through the deposition of the plaintiff and any witness that he or she offers to corroborate his or her claim of emotional distress. The forensic mental health evaluator should also explore these issues during the forensic interview/examination, as they may have occurred both before and after the purported traumatic stressor.¹³

Under criterion 4, an individual must experience at least two forms of increased arousal. Generally, an individual who suffers from PTSD has persistent symptoms of anxiety or increased arousal that were not present before the trauma. These symptoms may include difficulty falling or staying asleep (which may be due to recurrent nightmares during which the traumatic event is relived), hypervigilance, and exaggerated startle response. Some individuals report irritability or outbursts of anger, or difficulty concentrating or completing tasks. Again, these symptoms should be explored during the claimant's deposition, and in the deposition of any witnesses offered to support a claim of emotional distress, and in questions directed to the forensic examiner regarding what steps he or she took to independently verify these symptoms. As with criterion 3 symptomatology, the forensic mental health evaluator should also address these symptoms in the course of the forensic interview/examination.¹⁴

Finally, criteria 5 and 6 relate to the duration of the symptoms and the level of functional impairment necessary for a proper diagnosis of PTSD according to the DSM-IV-TR. Generally, one month is the minimum time that symptomatology must be present to support a PTSD diagnosis.

Criterion 6 addresses the level of functional impairment necessary to support a proper PTSD diagnosis. It requires significant impairment in social, occupational and other important areas of functioning. Therefore, one of the key elements in examining any forensic PTSD diagnosis is the reported score in the level of the global assessment functioning (GAF) scale (Axis V of the DSM-IV-TR)

and how this compares to the individual's level of functioning prior to the alleged traumatic event. The GAF scale describes a continuum of level of functioning, presented on a scale of one to 100, with a lower rating indicating decreased functioning.

Extreme importance should be placed on the steps that any forensic examiner takes to independently determine an individual's pre-trauma level of functioning; examiners who only rely upon the claimant's self-reporting of diminished functioning can often be impeached with third party or other collateral evidence to the contrary. In addition, exaggerated descriptions of pre-trauma functioning are often indicative of malingering¹⁵ and should be treated as a proverbial red flag in this context.

Factors Leading to the Overdiagnosis of PTSD

Beyond the issue of whether a claimant's forensic expert faithfully relied upon the general parameters necessary for a multi-axial diagnosis of PTSD, it is also crucially important that the forensic examiner do a thorough examination of the plaintiff's previous psychiatric and medical history, not rely solely upon the plaintiff's subjective reporting of symptoms without considering and comparing those self-reports with additional medical records and third-party information, and not otherwise be biased as an advocate for the claimant, as is often the case, for example, when a treating professional is asked to provide an expert forensic assessment and opinion.¹⁶ The key here is that the testifying expert not only interview the plaintiff, but also review records, perform standardized and non-standardized tests, and rely upon objective—or at least well accepted—guidelines in diagnosing PTSD.

For example, it is not unusual for individuals who initially present with PTSD-like symptoms to have underlying personality disorders that were present long before the issues in the litigation arose.¹⁷ Such personality disorder may have caused the plaintiff to misperceive

and/or have unusually severe responses to perceived (rather than actual) stressors in the workplace. The presence of such a disorder obviously goes to issues such as causation and the extent of damages for which an employer may be held liable.

Evidence of such pre-existing disorders may often be available only in records reflecting the plaintiff's past developmental and psychological/psychiatric history and overall level of functioning prior to the alleged stress-producing incident or incidents in the workplace. Such evidence can only be gleaned from detailed review of medical, employment, military, educational, personal, and related records, and from obtaining a detailed personal, medical/psychiatric, family, educational, employment, social, criminal, and related history, including inquiry into such potentially volatile topics as childhood emotional, sexual, and physical abuse.¹⁷

While not exhaustive, at a minimum the following issues should be explored in scrutinizing a questionable PTSD diagnosis:

1. Does the claim of PTSD meet the DSM-IV-TR diagnostic criteria for this disorder?
2. Is the traumatic stressor that is alleged to have caused PTSD of sufficient severity to meet the severity criteria for this disorder (*i.e.* the two "A" DSM-IV-TR diagnostic criteria)?
3. What is the pre-incident/traumatic event psychiatric history of the plaintiff?
4. Is the PTSD diagnosis based exclusively on the subjective reporting of symptoms by the plaintiff?
5. What is the plaintiff's current level of functional impairment, if any?

In addition, while some overlap may be found, consideration should also be given to whether potential misdiagnoses of PTSD result from:

1. Failure to separate unusual or excessive distress following an

adverse workplace incident or incidents from a symptomatology attributable to a preexisting mental disorder.

2. Application of fewer Diagnostic Criteria to a given claimant than are required to meet the DSM-IV-TR diagnostic definition.
3. Failure to consider the contribution of earlier, unrelated traumatic events to the subject's psychiatric symptomatology or illness, resulting in the false attribution of current pathology and symptomatology to the traumatic event being litigated.
4. Failure to uncover pre-existing psychopathology or formal psychiatric diagnoses and/or treatment.
5. Failure to identify a positive family history of mental disorder that may point to another etiology or contributing factors to a claimant's reported workplace-related psychiatric symptomatology.
6. Failure to consider a different diagnosis for the claimant's reported psychiatric symptomatology.

Finally, a detailed inquiry should be made as to whether the particular forensic examiner in question has any bias in favor of confirming victimization.¹⁹ This may include inquiry and investigation concerning whether the forensic examiner has previously diagnosed conditions other than PTSD in employment law related suits, in particular in harassment cases; whether the examiner is a member of any professional associations that advocate a particular ideology or professional viewpoint with respect to victimization; whether a review of the expert's relevant publications, lectures, etc., reflects a bias of the expert; and whether questions about the forensic examiner's experiences with employment law issues, the number of times that he or she has testified for plaintiffs and defendants, and/or courts in these types of cases reflect a bias of the expert.²⁰

Challenges to the Admissibility of PTSD Testimony

A faulty PTSD diagnosis may be excluded as unreliable because, among other reasons, the forensic examiner offered lacks the experience or training to make the diagnosis, has not followed the appropriate diagnostic protocols, or has failed to conduct a differential diagnosis. Specifically, both New Jersey and federal courts require that an expert witness be suitably qualified and possessed of sufficient specialized knowledge to render an expert opinion and explain the basis of that opinion.²¹

While most forensic psychologists and psychiatrists will generally possess the requisite credentials to be able to render a PTSD diagnosis, other mental health care professionals such as marriage counselors, family therapists, socialworkers and other masters-level practitioners may not be so qualified, and their ability to render a PTSD diagnosis can be challenged on that basis.²² Even the testimony of some doctoral-level psychologists and psychiatrists whose work experiences or areas of specialization demonstrate that they lack any personal experience diagnosing and treating PTSD may be challenged on the basis that they are not qualified to render a PTSD diagnosis.

If a proposed expert possesses the requisite training and experience to render a PTSD diagnoses, his or her testimony must employ reliable criteria in order to be admissible.²³ This is particularly true in New Jersey where the procedure underlying an expert opinion must have either gained general acceptance in the relevant professional or scientific community, or have been commonly deemed admissible in other judicial forums to be considered admissible. Presently, the DSM-IV-TR provides the most generally accepted diagnostic system for the mental health professions in the United States and Canada.²⁴ Therefore, PTSD diagnoses that rely upon idiosyncratic, subjective and/or personal bases, and symptomatology or criteria not found in the DSM-IV-TR, may be subject to challenge on the grounds that they are not based upon generally recognized scientific or professional

principles or requirements, and are therefore not reliable. In particular, treating mental health care professionals often develop personalized views of what constitutes PTSD that bear no reasonable relationship to actual DSM-IV-TR criteria. This is particularly true with respect to criterion I, the requirement that alleged distress be the result of a seriously traumatic incident and produce a severely traumatic stress response.

Finally, any forensic mental health examination must assess whether there are alternative cause for the plaintiff's alleged mental health condition; this is the underlying principle for the concept of "differential diagnosis" in medicine.²⁵ Courts have routinely rejected opinions in which a testifying forensic examiner has failed to develop and articulate any differential diagnoses, even under the more liberal *Daubert* standard employed in federal courts. For example, in *In Re Paoli Railroad Yard PCB Litigation*,²⁶ the Third Circuit stated, ". . . that all of the experts agree that at the core of differential diagnosis is a requirement that experts at least consider alternative causes; this almost has to be true of any technique that tries to find a cause of something." The circuit court further went on to explain:

Defendants' experts explained that a reliable differential diagnosis generally requires a physical examination of the patient, a review of medical records, taking a medical history and conducting of laboratory tests, and always requires careful consideration of alternative causes. We agree with the defendants that performance of physical examinations, taking of medical histories and employment of reliable laboratory tests all provide significant evidence of a reliable differential diagnosis, and that their absence makes it much less likely that a differential diagnosis is reliable.²⁷

Therefore, if a testifying forensic examiner does not conduct an independent inquiry into alternative causation, but merely endorses a plaintiff's self-reporting of emotional symptoms and difficulties, this is not reliable scientific testimony and it should be excluded under either the federal *Daubert* or the New Jersey *Frye* standards governing the admissibility of expert testimony.²⁸

A Caveat for the Employment Law Practitioner and His/Her Forensic Mental Health Evaluator

In all of the editions of the DSM since the DSM-III (1980),²⁹ a "Cautionary Statement" emphasizing the clinical (in contrast to forensic) nature and scope of the DSM has been published. That statement in the current DSM-IV-TR³⁰ in part, notes that:

The clinical and scientific considerations involved in categorization of these conditions as mental disorders may not be wholly relevant to legal judgments, for example, that take into account such issues as individual responsibility, disability determination, and competency. (Page xxxvii).

While this statement makes clear that DSM-IV-TR is not a legal treatise, it should be emphasized that the DSM-IV-TR is widely used and accepted in the United States and Canada, and therefore necessarily provides an important basis for medicolegal assessments and activities in the mental health professions in those countries. Analogously, while textbooks, professional journals, and other such treatises in such scientific disciplines as engineering, aeronautical science, environmental science, medicine, and meteorology may not be *legal* or *forensic* treatises *per se*, they nevertheless provide important input into legal and forensic activities, and are regularly relied upon when a court exercises its gate-keeping function to assess the reliability of expert testimony. The DSM-IV-TR contributes to the mental health sciences in a similar

way, even though it is not itself a *legal treatise*.

Conclusion

From the legal perspective, all parties benefit when forensic examiners render credible and accurate diagnoses of PTSD claimants. From a plaintiff's attorney's perspective, finding out for the first time at trial that PTSD was grossly misdiagnosed can be devastating. Specifically, such a plaintiff's attorney may have significantly overvalued a case based upon the expectation that PTSD will be a highly compensated injury. Conversely, an accurate PTSD diagnosis permits defense attorneys to approach their clients about fairly compensating the truly injured. A continuation of the present practice in employment litigation, however, of diagnosing PTSD in situations where such claims clearly have no merit, will, over time, result in the label of PTSD bearing no reasonable relationship to the actual disorder.³¹

From the clinical and scientific perspective of the employment attorney's forensic examiner, the rigorous and careful evaluation of claimants in employment law matters, using the principles articulated in this article and elsewhere,³² will give a valid, credible, and realistic assessment of those claimants, clinically and scientifically supportable, and useful to attorneys and the court. From the broader clinical and epidemiologic perspectives, such an approach will avoid the pitfall of false positives and resulting overdiagnosis.³³ ■

Endnotes

1. The National Comorbidity Survey (NCS), conducted between Sept. 1990 and Feb. 1992, was comprised of interviews of a representative national sample of 8,098 Americans aged 15 to 54 years, found that the estimated lifetime prevalence of PTSD among adult Americans is 7.8percent, with women (10.4percent) twice as likely as men (5percent) to have PTSD at some point in their lives. This represents a

- small proportion of those who have experienced at least one traumatic event. Specifically, the same survey found that 60.7percent of men and 51.2percent of women reported at least one traumatic event. *See also* Rachel Yehuda & Cheryl M. Wong, "Etiology and Biology of Post Traumatic Stress Disorder: Implications for Treatment," *8 Psychiatric Clinics of N. Am.* 109 (2001).
2. A 1993 study found that 32percent of women who had been raped experienced PTSD. *See* Resnick, H.S., D.G. Kilpatrick, B.S. Dansky, et al. "Prevalence of Civilian Trauma and Posttraumatic Stress Disorder in a Representative Sample of Women," *J. Consult. Clin. Psychol.*, 61: 984-991, 1993.
 3. *See* note 2.
 4. The *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision, or DSM-IV-TR*, published by the American Psychiatric Association, Washington, DC, 2000, is the main diagnostic reference and guidebook for mental health professionals in the United States of America and Canada.
 5. Malingering is the purposeful exaggeration of physical or psychological complaints in order to receive some kind of reward. Rewards typically are money, but may also include drugs, insurance settlement or avoidance of punishment, work, military service, jury duty, etc. (Morrison, J., *DSM-IV-Made Easy: A Clinician's Guide to Diagnosis*, NY: the Guilford Press, 1995).
 6. Robert I. Simon, "Forensic Psychiatric Assessment of PTSD Claimants" (pages 41-90), in Robert I. Simon (Ed.) *Posttraumatic Stress Disorder in Litigation Guidelines for Forensic Assessment* (Second Edition; 2003), Washington, DC: American Psychiatric Publishing, Inc.
 7. James McDonald, Jr., "Posttraumatic Stress Dishonesty," *Employee Relations Law Journal*, 28 (4 Spring), 2004; Robert I. Simon (Ed.) *Posttraumatic Stress Disorder in Litigation Guidelines for Forensic Assessment* (Second Edition, 2003), Washington, DC: American Psychiatric Publishing, Inc.
 8. John S. Mark, "What Constitutes a Stressor? The 'Criterion A' Issue in PTSD" (pages 37-54), in John R.T. Davidson and Edward B. Foa (Eds.), *Posttraumatic Stress Disorder* (1993), Washington, DC: American Psychiatric Publishing, Inc.
 9. *See* note 8.
 10. Jay Ziskin, *Use of the MMPI in Forensic Settings* (1981), Minneapolis, MN: National Computer Systems/Professional Assessment Services, at 4.
 11. Daniel P. Greenfield, Henry L. SanGiacomo and Patrick Westerkamp, "Psychiatric Evaluations in Employment Law," *New Jersey Labor and Employment Law Quarterly*, 25(1): 28-30, Fall 2001.
 12. John Briere, *Psychological Assessment of Adult Posttraumatic States* (1997), Washington, DC: American Psychological Association, at 26, 29.
 13. Sara P. Feldman-Schorrig and James J. McDonald, Jr., "The Role of Forensic Psychiatry in the Defense of Sexual Harassment Cases," *The Journal of Psychiatry and Law*, XX: 5-33, Spring, 1992.
 14. *See* note 11.
 15. Daniel P. Greenfield and Jeffrey A. Brown, "Psychopharmacology" (pages 133 - 142), in David R. Price and Paul R. Lees-Haley (Eds.), *The Insurer's Handbook of Psychological Injury Claims* (1995), Scatthe: Claims Books.
 16. Daniel P. Greenfield and Herman Huber, "Should Doctors Serve as Patients' Expert Witnesses?" *New Jersey Lawyer*, 7 N.J.L., June 8, 1998.
 17. Mark S. Lipian, "Personality Disorders in Employment Litigation" (pages 212-261), in James J. McDonald, Jr. and Francine B. Kulick (Eds.), *Mental and Emotional Injuries in Employment Litigation* (Second Edition; 2001), Washington, DC: BNA Press.
 18. *See* note 11.
 19. Paul R. McHugh and Phillip R. Slavney, *The Perspectives of Psychiatry* (Second Edition; 1998), Baltimore: The Johns Hopkins University Press, at 18-30.
 20. Sara Feldman-Schorrig, "Factitious Sexual Harassment," *Bulletin of the American Academy of Psychiatry and Law*, 24(3): 387-392, 1996.
 21. Ben Bursten, *Psychiatry on Trial. Fact and Fantasy in the Courtroom* (2001), Jefferson, NC: McFarland and Co., Inc., at 14-25.
 22. *See* David Faust, Jay Ziskin, Hames B. Hiers, *Brain Damage Claims: Coping with Neuropsychological Evidence* (1991), Los Angeles: Law and Psychology Press.
 23. Daniel P. Greenfield, John W. Podboy, Marc I. Zimmerman, "Blackouts and Amnestic Phenomena in the Law," *American Journal of Forensic Psychiatry*, 20(1): 19-25.
 24. *See* note 4.
 25. Anthony S. Fanci, Eugene Braunwald, et al. (Eds.), *Harrison's Principles of Internal Medicine* (Fourteenth Edition; 1998), New York: McGraw-Hill, at 3-6.
 26. *See Daubert v. Merrell Dow Pharmaceuticals, Inc.*, 509 US 579 (1993).
 27. 35 F.3d 717, 758-59 (3d Cir. 1994), *cert. denied*, 513 U.S. 1190, 115 S.Ct. 1253, 131 L.Ed.2d 134 (1995).
 28. *Id.*
 29. *See Daubert v. Merrell Dow Pharmaceuticals, Inc.*, 509 US 579 (1993) and *Frye v. U.S.*, 293 F. 1013 (D.C. Cir. 1923).
 30. Daniel P. Greenfield, "Pharmacology and Psychopharmacology" (pages 454-501), in James J. McDonald, Jr., and Francine B. Kulick (Eds.), *Mental and Emotional Injuries in Employment Litigation* (Second Edition; 2001), Washington, DC: BNA Press.
 31. *See* note 4.
 32. *See* note 7.
 33. James J. McDonald and Francine B. Kulick (Eds.), *Mental and Emotional Injuries in Employment Litigation* (Second Edition; 2001), Washington, DC: BNA Press; Robert I. Simon (Ed.), *Posttraumatic Stress Disorder in Litigation. Guidelines for Forensic Assessment* (Second Edition; 2003), Washington, DC: American Psychiatric Publishing, Inc.
 34. Judith Manner and Shira Kramer, *Mansner & Bahn, Epidemiology-An Introductory Text* (Second Edition; 1985), Philadelphia: W.B. Saunders Co., at 217-220.
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