

Asbestos Exposure and Psychic Injury—A Review of 48 Claims

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Asbestos exposure has been a common occupational risk resulting in much litigation. Where pulmonary dysfunction has been minimal or even absent, psychic injury has been made an element in claimed damages. Analysis of psychiatric and psychologic claims in 48 cases reveals that diagnoses often do not conform to professional standards, are based on insufficient data sampling, lack adequate overall history as well as medical history, and do not comport with the standard of probability usually required for litigation. The group studied was elderly (mean age—62.6), mostly retired (71%), with some significant medical illnesses (18% on medical retirement). None were retired for pulmonary reasons. As expected, conflict in opinion between the opposing professional medical participants was frequent. Commonly the patients did not substantiate the complaints reported in the medico-legal reports; some ridiculed statements made on their behalf. Many psychological reports reflected simplistic or erroneous concepts of medicine or ignored relevant medical data. This study indicates that in this group claims of psychic injury due to asbestos exposure have little justification and supports the view that the current system of utilization of expert opinions is not reliable or in conformity with reasonable professional standards. Correspondingly, these claims did not result in augmented awards.

Asbestos exposure has resulted in a massive explosion of litigation. In many cases, parenchymal lung disease and pulmonary disability are clearly related to asbestosis, as are mesothelioma and increased rate of lung cancer. Employees, present and retired, have been encouraged to seek litigation through an apparently well organized referral system. When clear-cut impairing pulmonary pathology is not present, other bases for claims of damages have been sought. One increasingly popular claim where physical damage is absent or minimal, is that of psychic injury.

Psychic injury can, of course, be exaggerated.^{1,2} Many psychiatric disorders are easier to mimic than other diseases; lack of relevant test procedures and reliance on history create problems as do the short superficial examinations characteristic of many forensic reviews.³ Some treating professionals attempt to please their patients, clients, or customers and thus also have dubious objectivity. Further, referral systems are so structured that people are sent for professional care and evaluations to those who are likely to reflect a given or predictable point of view.

This article explores these issues in relation to asbestos exposure. Here 48

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cases of claimants are reviewed, all of whom were examined by me for attorneys representing defendant companies. Certainly, the possibility of my bias must be considered by the reader. However, I have attempted to focus on the medical data so that the reader can judge the merits of the various contentions.

Generally, the examinees had at least some exposure to asbestos in the course of their work, some for many decades. An overall issue was a claim of failure to warn and its role in the resultant injury. Whether or not injury resulted from this exposure in a legal sense requires a professional conclusion of a relationship based on reasonable medical or scientific certainty. Theoretically, the burden to demonstrate this falls on a claimant. Therefore, examiners should not speculate but should be required to meet this standard of at least probability in their opinions.

The Group Studied

Forty-eight individuals were referred for psychiatric evaluation (47 male, 1 female). The female was the wife of a man who died of lung cancer that may have been asbestos related, and she in turn had a claim both of asbestosis and mental injury. The group was somewhat elderly with a mean age of 62.6—with a low age of 39 and a high age of 79. The distribution by age is shown in Table 1. Thus, 77 percent were 60 and over.

Thirty-four were retired. A number retired at age 62 or in response to financial incentive by their employers for early retirement. Most worked for refineries and chemical plants and had rel-

Table 1
Age Distribution of Group Studied

Age	n (N = 48)	%
65 or over	25	52
60-64	12	25
55-59	2	4
50-54	7	15
49 and under	2	4

atively high incomes as skilled blue collar workers: apparently many had incomes in the \$30,000 to \$45,000 range while working, and only a few had financial difficulties, mostly related to the care of disabled adult children. Some seen soon after the 500 point drop in the stock market in 1987 displayed little concern.

Of the 34, six retired on the basis of medical disability. These were based on the following causes: cardiac—four, back injury—one, and psychiatric—one. Curiously, but not unexpectedly, none had been retired for pulmonary dysfunction. The man retired for psychiatric reasons had an injury (described below) with possible concussion and organic brain syndrome with severe depression, many hospitalizations, and treatment with electro-convulsive therapy (ECT—10 treatments) with no period of function following the injury.

Other Medical Conditions

Four examinees had retired on cardiac disability. A number of others had had myocardial infarcts, hypertension, arrhythmias, angina pectoris, enlarged hearts, or congestive failure—a total of 14. For practical purposes, there was almost no functional cardiac disability in this group, even in the small group

who had retired for this reason. One person had had a bypass operation. None expressed concern about their cardiac states, even though several had had significant past problems.

One had a history of stroke but this was not verified, and no confirmatory record was available. One had a history of right frontal intracerebral hemorrhage with a 16-day hospitalization and good recovery. This occurred six weeks before the individual was seen by a psychologist who made no mention of this, various cardiac problems, and past orthopedic injuries, including a concussion, in his report. This claimant also had had a malignant colon polyp removed 3.5 years earlier.

Several had experienced head and back injuries: one had previously been diagnosed as having Parkinson's disease; there was also one questionable seizure disorder, one severe Meniere's disease, and one possible post-traumatic encephalopathy. Four had had prostate surgery. One individual with squamous cell carcinoma of the neck had extensive neck surgery and radiation therapy. There were known indications of an alcohol problem in five. One had had a lumbar sympathectomy for peripheral vascular disease.

In no case was a diagnosis of organic brain disease due to aging made by the claimant's examiner. However, in my examinations, five showed organic brain changes, compatible with a primary degenerative dementia or Alzheimer's disease (average age 65.4).

Pulmonary Evaluations

Summarizing the pulmonary conditions is difficult: clearly conflicting in-

formation about pathology or functional restrictions was common. Some generalizations can be made. As a group, the individuals showed an almost total absence of functional impairment. Most, despite their age, were quite active and did not complain of any symptoms: only a few complained of shortness of breath under certain circumstances; most reported a lifestyle with much physical activity. In one unusual case the patient's doctor reported pleural thickening and increased interstitial markings. At a medical school work-up two years later, the patient reported that he could walk 10 flights of stairs without stopping and could walk 20 city blocks without resting. At the time of this work-up, his chest x-ray was normal as were pulmonary function tests.

Practically all of the claimants did show at least pleural thickening, though in a few cases even here there was disagreement. Fifteen showed pleural plaques with a few cases described as calcified. A number showed interstitial changes, vascular markings, peribronchial scarring, or some parenchymal changes. For practical purposes, clearcut parenchyma changes were not described. Spirometry in several cases reportedly showed small airway disease. Pulmonary function tests were almost all normal; some showed minimal findings. The terms, chronic obstructive pulmonary disease or obstructive restrictive impairment, were used in six cases. In some, the defense doctors attributed the findings to infectious processes in contrast to the claimant's doctors who felt the cause was asbestos exposure.

Several had had various other pulmonary diagnoses over the years—chronic bronchitis, bronchiectasis, chronic interstitial pneumonitis, and atelectasis with “suspected infection.” One person had had an aspergilloma with bronchiectasis and pneumothorax with a right upper lobectomy. Two years later this person had a bilateral pneumonia. In another case, the person was hospitalized with a fibrotic pleuritis “secondary to infection” with a resultant right thoracotomy. The issue of smoking was one for the pulmonologists to argue about, and at times they did.

Prior Psychiatric or Psychologic Treatment

Few of the group evaluated for litigation purposes actually required psychiatric evaluation or treatment. These six individuals will be briefly considered.

1. The most severely disabled was a man who was in an explosion four years earlier where he may have been unconscious and suffered inhalation or chemical bronchitis. He had a number of diagnoses during his seven hospitalizations and numerous consultations— anxiety neurosis, post-traumatic depression with paranoid episodes, syncope, dizziness, fainting, blackouts and numerous other symptoms, and possible hysterical neurological symptoms. He did have pleural plaques. One forensic psychiatrist made a diagnosis of cerebral concussion, post-concussion syndrome, and severe traumatic anxiety psychoneurosis—apparently in evaluation for a workmen’s compensation claim. Subsequently the patient had three psychi-

atric hospitalizations for (1) depressive psychosis, (2) organic brain syndrome and depressive psychosis, and (3) organic brain syndrome and depression with possible convulsive disorder. He had a 50-pound weight loss and no sexual activity since the explosion. In general, he was impaired since his accident and unable to function despite ECT, medication, and psychotherapy. The pertinent psychiatric report was one in which the examiner stated the trauma could not have produced such a profound, persistent, and unresponsive depression, that the patient was hospitalized after he found that he had asbestosis and the “psychic pressures brought on by that knowledge not the pleural thickening, probably triggered the depression which caused the patient’s profound disability.”

My examination showed regression and depression (tearful, childlike, dependent, tremulous, hesitant). Diagnosis was major depression and personality change compatible with post-traumatic encephalopathy. The plaintiff’s attorney liked this defense report so much that he used it in obtaining an ample settlement for his client in the separate case claiming injury from the explosion. Here there was no question as to psychiatric disability—only its possible relation to asbestos exposure.

2. A 60-year-old man had been in weekly psychotherapy for 1.25 years with a psychologist and had been on imipramine. The treating psychologist noted a wide variety of symptoms, including agoraphobia, anxiety, and depression. He noted that the patient

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had a concern about a lung condition that may be related to asbestosis and that was a contributing factor "to the stress he was experiencing." A neuropsychiatrist supported this opinion but acknowledged "underlying" problems. Other records indicated obesity, a history of hypertension, Meniere's disease, deafness, and suprapubic prostatectomy. He also had an enlarged heart and hyperuricemia. He was seen at a prominent clinic where his Meniere's disease was reviewed as well as his psychologic symptoms; there was no reference to a pulmonary condition (the only pulmonary finding at issue was claimed pleural thickening according to the plaintiff's internist who saw him for the report for the litigation). He had had Meniere's for 10 years and had dizziness, tinnitus, and unsteadiness. His retirement at age 59.5 was not a medical one. Current mental status was good: no phobic symptoms or symptoms referable to pulmonary dysfunction were noted. Possible early organicity was suggested. He was primarily concerned about his Meniere's and cardiac status ("abnormal heartbeat"). My diagnosis was adjustment disorder with mixed emotional features, primarily depression in a person with preexisting personality problems.

3. A third man, 69, had been treated a number of years earlier by a psychiatrist with an antidepressant (phenothiazine and tricyclic antidepressant combined). He related this to his marital conflict, the long separations (3 years and 1.5–2 years), his wife's seeing other men, and their ultimate divorce. There

was no mention of this in the report of the psychologist. The only pulmonary reference was pleural thickening.

4. Especially interesting was the case of another 69-year-old man who had seen a psychiatrist for at least eight years. Though there was limited information, the patient had been injured in an accident (17 years earlier, he had a chronic back problem, with an ultimate laminectomy). Psychiatric diagnosis was post-traumatic stress disorder (reports were prepared for another earlier litigation). The psychologist in the current asbestos litigation made no reference to this diagnosis, prior litigation and prolonged prior treatment. He stated that the Minnesota Multiphasic Personality Inventory indicated concern over bodily health, though it was "normal." The psychologist indicated that the asbestosis was potentially lethal and "his assessment is indicative of some alteration and displacement away from comfort and contentment. Because of the rather pernicious, chronic, and progressive nature of his disease, it is felt that the personality changes caused by his disorder will be, in turn, chronic and permanent." (This psychologist has invoked a post-traumatic stress disorder in eight of the nine cases reported in this series; his lack of reference to this previously diagnosed condition is quite striking here).

The patient has a history of back injury and was on Social Security disability for several years for that reason; he had an enlarged heart, arteriosclerotic heart disease, and atrial fibrillation. Interstitial lung findings by one examiner were related to chronic congestive fail-

ure. A recent stress was his wife's Alzheimer's disease. His treating doctors attributed his dyspnea to his cardiac condition. When seen by me, he did show evidence of a chronic mild depression but with good functioning and a positive philosophical outlook.

The internist who evaluated him to support his litigation claim reported calcium-containing pleural thickening and an enlarged heart. Acknowledgment of congestive heart failure as a cause of interstitial markings was made—"but in my experience this is highly unlikely in a person with this clinical history and is probably due to pulmonary asbestosis." Spirometry suggested small airway disease, and pulmonary function tests done elsewhere were normal.

5. One 67-year-old man previously had psychotherapy for six months after the death of his father-in-law.

6. A 39-year-old man had a long-standing drinking problem from his 20s until three years earlier when he participated in an alcohol rehabilitation program.

Thus, of 48 cases only six had had any psychiatric or psychologic treatment or review for therapeutic purposes—none of which could be related to a lung condition.

Psychiatric or Psychologic Examinations Submitted by the Claimant for the Asbestos Litigation

The evaluations on behalf of the plaintiff offered diagnoses in a number of different categories. Where a number of diagnoses were listed or inferred, the

most prominent was utilized as a primary classification. In 15 (more than 30%), no diagnosis could be ascertained. Where a number of diagnoses were offered by different examiners in the same case, the one from the forensic specialist was used.

The diagnoses by the plaintiff's examiners are shown in Table 2. The examiners for the plaintiff were categorized by profession. Where multiple reports were submitted, the profession utilized is that of the forensic specialist who prepared a report or primary report for legal purposes. The examiners were psychologist (Ph.D. or Ed.D.)—38, psychiatrist (M.D.)—six, psychiatrist (D.O.)—two, and no examiner—two (the latter where no supportive report was submitted). Three examiners performed 39 of the 46 evaluations (two did not have any evaluations). One psychologist did 31 examinations (67%), and a psychologist and a psychiatrist each did four (8.7% each). Each seemed to have a diagnostic style. Thus, the examiner who performed 31 contributed most of those with no diagnosis; he also made eight of the nine post-traumatic diagnoses (whether called post-traumatic response,

Table 2
Diagnoses by the Plaintiffs' Examiners

Diagnosis	n
None	15
Post-traumatic disorder	9
Cancer phobia	7
Depression (unspecified)	6
Anxiety	3
Personality change	3
Dysthymic disorder	1
Adjustment disorder	1
Mixed	1
No report submitted	2

post-traumatic disorder, or post-traumatic stress disorder). The psychiatrist diagnosed all four cases as cancerphobia, and the other psychologist three of four as cancer phobia.

Examples of Proffered Opinions

Analyzing each case and presenting in detail the history and the reports of all examiners are not possible. Some sampling is necessary in order to communicate the essence of the conclusions and pertinent information related to the reasonableness of such conclusions. Claims of cancer phobia and post-traumatic disorder will be discussed in other papers.

X, a 60-year-old man was interviewed by the psychologist together with his wife (the report seems to indicate that they were seen together). He purportedly related that since he received a diagnosis of asbestosis three years earlier, he had no sexual desire and he had become impotent, that he became more solitary, that he and his wife led "dual" activities, and that he did little with his wife. His wife reported that the diagnosis came the week that her mother was in a coma that led to her death. She said that since that time, it was "like living with a stranger," that they did not sleep together or go out together, and that she leaves the house to be away from him. She expressed great anger.

The psychologist concluded, "Mr. (X) is an individual who, through occupational exposure to asbestos, has contracted asbestosis. He has responded to this disease with a psychiatric disorder, characterized by depression and agitation. This stressor has produced major

decays in the marital relationship as well as Mr. X's personal adjustment. He and the marriage are clearly in need of psychological intervention."

In my examination, X was somewhat vague about his sexual relationship with his wife. He related, "She claims 5 years ago; that's what she told the psychologist." He indicated that he had no sexual desire. He also indicated that he and his wife rarely talk to each other ("when we have to"). They communicate by notes. He described her as picayune and critical ("I don't need that anymore"). He added, "She says 'you go your way and I'll go mine!'" Asked how long the marital problem existed, he stated, "I've been bickered and badgered for 39 years." They have been married for 39 years.

In this particular case, X did have pulmonary and pleural findings with mild obstructive disease functionally as well as an enlarged heart and hypertension. The defense internist stated that there was moderate restrictive disease with normal airway functioning. The adversarial internists disagreed as to the cause. In addition, there was evidence of an alcohol problem (enlarged liver, elevated liver tests, history of drinking). He liked to travel, garden, and do wood-working. He showed no symptoms psychologically. The attribution of the prime, and apparently only significant, problem-marital conflict, to the pulmonary condition seems at the very least to be simplistic and unmerited and was not atypical of many of the comments in these records.

Claims of marital difficulty or declin-

ing sexual interest related to asbestos exposure were made in several cases without very compelling support. One examiner apparently usually had a short interview and had the patient fill out a symptom check list and a Minnesota Multiphasic Personality Inventory (MMPI). The use of the MMPI in medicolegal situations has long been recognized as fraught with difficulty.⁴ When a true-false fill-in by the examinee describing himself is utilized, reporting of pathology may be questioned, although a normal pattern in a litigation situation usually indicates that the person is reacting reliably. Frequently, access to or use of medical and other personal history was limited, or ignored, and obviously in psychiatric conditions (as well as other medical conditions), history is a major factor in an adequate evaluation.

In a number of the reports, the examinee denied difficulties on the screening devices. The examiner attempted to explain this by pointing out that this was an example of denial. Similarly, when the history was negative, this also could be called denial. Thus, "even though Mr. (A) denies it, this record is indicative of a clinical depression."

A 79-year-old man's main complaint was of his knees (apparently a knee replacement had been recommended). He was also concerned about his eyes (having had recent cataract surgery with bilateral lens implantation). He had no other complaints. Psychiatric examination was quite normal. His forensic internist made a diagnosis of pleural asbestosis. The MMPI was reported as

showing that the patient attempted to "minimize problems." The psychologist commented that occupational exposure to asbestos "has led him to develop asbestosis, which leads to diminished vital capacity and difficulty with breathing. He clearly shows concern over his health and of his physical well-being. However, his concern is not such that it comprises a psychiatric disorder. He must clearly live with the anxiety of having an incurable disease and one that increases his likelihood of fatal mesothelioma." Of interest was a note from a university hospital where he had eye surgery several months earlier (subsequent to the internist's examination noted above) where the patient was described as "a remarkably healthy 78-year-old gentleman without cardiopulmonary or end organ disease."

Often the language was dramatic. In a case of a 61-year-old, retired for nonmedical reasons with no pulmonary function impairment, the psychologist stated, "While Mr. B's illness is irreversible, there is little doubt that his current psychological adjustment to it can be improved No one can remove the sword hanging over his head of decreased vital capacity, probability of early death and cancer."

A 61-year-old man was told by a fellow worker that he should "put in" for asbestosis. His x-ray did show "irregular pulmonary densities," and he was diagnosed by a pulmonologist as having pulmonary asbestosis with normal function tests. The psychologist reported that he was defensive and "his attempt to foster an image of health adjustment is . . .

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transparent” He was described as having depression, moderate distress, presenting a profile often seen after severe physical injury. “He has taken the news of his disease clearly in a traumatic way, and it has produced a negative effect on his adjustment even with his attempt to minimize its impact on him. Because of the chronicity of his disorder and the life-threatening nature that it does present to him, it is clearly felt that his negative adjustment pattern will be chronic and permanent.” The psychologist also stated that he had “collateral hypertension,” implying a relationship to his pulmonary condition that his internist did not note. At my psychiatric examination Mr. D. said that he did not have any problems, that he understood that he had asbestosis and worried about it lately. He did not climb as far “without breathing heavy.” He currently was working as a maintenance man in a school system, was in good health, and had not seen a physician in 2.5 years. A jovial man, he was asked if he were happy-go-lucky: he responded, “I really am.”

A 39-year-old man was diagnosed as having pleural asbestosis with pleural thickening and a probable increase in interstitial markings. Work-up at a university hospital reported an asymptomatic state, normal x-rays, and no pulmonary impairment. The psychologist explained a negative MMPI by stating, “He clearly had a bias (sic!) away from complaint and away from negative report.” He commented further, “Given his history of alcoholism, his father’s asbestosis, as well as his own, the adjust-

ment that (he) is currently utilizing is tenuous and may deteriorate The probability is that his current defense system will not prove satisfactory. Continued care will be required for him to maintain his functional capacity.”

This man was seeing no physician for treatment and has never been on any medicine except disulfiram. He was a foreman overseeing fiberglass installation, worked regularly, and liked to go fishing and hunting.

In one case, the psychologist indicated that the then 68-year-old patient was irritable, snappy, and more argumentative and that relations with his son had become strained. The history from other sources indicated long-standing difficulties with his son who had suffered brain damage following cardiovascular surgery; his son was destructive and abusive at home for many years. In fact, six years earlier, the claimant was beaten by his son and hospitalized for chest injuries (he did not report his information to me). His son was disabled, unemployable, and a chronic financial drain.

A 66-year-old man with pleural thickening and no other findings was described by the psychologist as chronically tense and anxious, self-deprecating, and socially withdrawn. The psychologist used the expression, “alteration in personality.” As there was no family or other medical history in his report, the psychologist did not note a chronic marital problem since the beginning of their marriage culminating in divorce the same year that he saw the psychologist (after 40 years of marriage). The psychologist did not report the death of the

patient's only son eight years before. The patient started seeing a psychiatrist 15 years earlier and had been on a phenothiazine-tricyclic combination drug for many years. Of his son's death, he said, "his death still bothers me, haunts me." None of this was in the psychologist's report.

Most common was the comment based on one interview of a progressive deterioration that was inevitable. A 68-year-old man had an MMPI in the "normal range, indicating a basically well adjusted individual . . . (He) is adept at making a good first impression." Regarding the patient's concern about his health, the psychologist said, "Due to the chronic and ever-growing nature of his disorder, it is felt that his concerns will be permanent and realistic."

A general tenor was the opinion that lung disease is directly related to the degree of physical disorder, and therefore if the physical disease progresses, a mental disorder must also do so. This is, of course, not a reasonable professional opinion. People with deteriorating physical conditions do not necessarily have any mental disorder, and indeed those in this group who did have significant physical disorders did not demonstrate psychologic dysfunction—one notable exception being the man involved in the explosion.

Discussion

Forty-eight cases involving claims both of asbestosis and related psychic injury have been analyzed. As a group, the claimants demonstrated minimal pul-

monary dysfunction; almost all had some radiological findings supportive of a possible asbestos reaction. Generally, they were referred through channels publicized by coworkers or union for possible litigation purposes. The disparity of professional opinions by internists and pulmonologists suggests that peculiar disparity of opinions is not restricted to psychiatrists and psychologists. Also clear was the fact that many of the examiners did not have access to hospital and other medical records at the time of their evaluations.

The group was consisted generally of elderly white men; the average was 62.6. Thirty-four were retired, six of whom had retired for medical reasons, none related to pulmonary dysfunction. The men were unusual in that they were quite cooperative and made few claims in the interview situation, many stating just that they were sent to be examined. Practically all had good, long work records and high incomes as blue collar skilled workers. Most were of Central European background.

They were a diverse but usually socially active and well adjusted group. The problems described by some were not typical of the group. They were straightforward, blunt, and friendly. Many who did have problems discussed them frankly; those dealt generally with realistic problems of everyday life.

Review of these cases raises a serious question as to the quality of work used in legal claims referable to asbestosis where pulmonary findings are minimal and psychic injury is claimed. Diagnoses seemed to be more characteristic of the

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examiner than of the examinee. Psychologists offered remarks referable to medical issues which were either repetitions of the claimant's forensic pulmonologist or which reflected limited medical sophistication. Often the historical information utilized was grossly inadequate. Significant issues, medical and psychiatric, were omitted from many of the discussions.

Diagnoses were often unclear or not in synchrony with professional standards. One third of the cases had diagnoses of post-traumatic reactions (9) or cancer phobia (7). Analyses of these cases are to be published separately.

Interestingly, psychiatric or psychologic testimony was presented in only one case, that of the woman who claimed to have gotten asbestosis from proximity to her husband. Her case as were the others was based on "failure to warn." One of her allegations was based on survivorship rules and loss of consortium. The second was based on direct injury to her. The jury rejected the claim based on her husband's illness, concluding that there was no proximate cause as warning would have made no difference in the ultimate result. The jury also decided that she had had no physical injury related to asbestosis and that there were thus no damages based on emotional reaction to a physical injury.

Most of the cases were settled for amounts in the \$15,000 to \$30,000 range—perhaps in the nuisance settlement range. Those that went to trial resulted in verdicts of no damages to \$77,000. Verdicts in New Jersey are reportedly somewhat less than elsewhere.

The attorneys for the defense felt that the claims of psychic injury had little merit, played no role in settlement, and did not result in augmented damage awards. Reportedly, plaintiffs' firms have submitted fewer such claims recently as the expenses involved in claiming psychic injury apparently have brought little in return.

This review would support the conclusion that "expert" opinions in support of damage claims for psychic injury after asbestos exposure have little merit from the clinical standpoint and that generally such claims in at least one jurisdiction have met little acceptance.

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