WHAT IS A TEVIS CLAIM AND WHAT DOES IT MEAN FOR MY DIVORCE?

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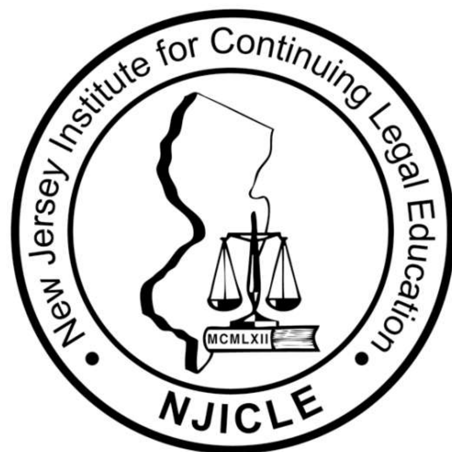

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Moderator

Honorable Lisa F. Chrystal, PJFP (Ret.)
Brach Eichler, LLC
(Roseland)

Speakers

Raj Gadhok, Esq.
Mandelbaum Barrett P.C.
(Roseland)

Eileen A. Kohutis, Ph.D.
Forensic and Clinical Psychologist
(Livingston)

Ronald G. Lieberman, Esq.
Certified by the Supreme Court of New Jersey as a Matrimonial Law Attorney
Rigden Lieberman, LLC
(Moorestown)

Cynthia W. Lischick, Ph.D., LPC, DVS
Main Street Counseling
(Allentown)

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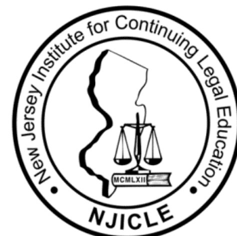

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Table of Contents

	Page
"The Eggshell and Crumbling Skull Plaintiff: Psychological and Legal Considerations for Assessment" Eileen A. Kohutis Shawn McCall	1
Rosenblatt v. Stripto, et al.	17
About the Panelists…	35

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The Eggshell and Crumbling Skull Plaintiff: Psychological and Legal Considerations for Assessment

Eileen A. Kohutis[1] · **Shawn McCall**[2]

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Abstract
Forensic psychologists are called to assist judges and juries to understand the nature and extent of how particular psychological injuries manifest themselves for individual victims and how injuries impact the victims' lives. In order to be most helpful, psychologists need to understand the legal frameworks, concepts, and rules by which tort claims are made and compensated. The psychologist's work is particularly difficult and useful—when there is an interaction between old and new injuries and conditions, which invokes the legal concepts of eggshell skull, crumbling skull, and eggshell psyche. This article first provides a primer of the relevant legal concepts about which the forensic psychologist must be aware so that psychological data, observations, and interpretations may be presented in a way that is familiar and accessible to the legal audience. The article then proceeds to provide an evaluative framework to approach the difficult task of describing psychological injuries and explaining if and how new and old injuries and conditions effect the victim's life and functioning. In particular, the article discusses somatic symptom disorders, factitious disorders, and malingering.

Keywords Eggshell · Skull · Psyche · Psychological · Crumbling

Personal injury cases often have psychological and financial dimensions as well as physical ones, and claims of emotional distress present challenges for the forensic mental health evaluators who must ensure both that valid complaints are compensated and that fraudulent ones are not. In particular in this paper, we will discuss the so-called eggshell skull plaintiff and related terms and offer some guiding principles for evaluating whether in these types of cases harm has been legitimately caused by another's person's wrongful actions.

The Legal Context

In most such cases, one person (the *plaintiff* or *complainant*) claims that he or she has been harmed by another (the *defendant*). It is the plaintiff's obligation to demonstrate that the damage (psychological or physical) had been due to the defendant's intent to do harm, negligence in avoiding harm, or some other failure of responsibility (Ruths et al., 2013). The focus in civil cases is on establishing whether or not the defendant is indeed responsible for the harm that was done and ensuring that the plaintiff is compensated accordingly (Young, 2007). When the claim is for emotional damage, a forensic mental health evaluator is usually asked to assess if, and to what extent, the plaintiff's emotional situation is related to a specific event (the *index event*).

When the plaintiff has been relatively healthy in the past, this assessment is less complicated. However, when the plaintiff is discovered to have a previous physical or psychological condition that has been exacerbated by the defendant's actions, the psychological evaluation become considerably more complicated.

Who Is Responsible for What?

The Thin Skull Rule. The first complication has to do with allocation of responsibility when preexisting conditions exist. In such cases, "the key legal question is the extent to which the pre-existing condition, versus the event of contention [that is, the index event], caused

✉ Shawn McCall
shawn@shawnmccall.com

Eileen A. Kohutis
eakohutis@gmail.com

[1] Private Practice, 2 W. Northfield Road Suite 209, Livingston, NJ 07039, USA

[2] Private Practice, 3041 Mission St. Suite 3001, San Francisco, CA 94110, USA

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the subsequent ailments" (Koch et al., 2006, p. 18). The *thin skull rule*, also called the *eggshell plaintiff rule*, addresses this issue. It refers to a universally accepted principle of American tort law that "the defendant takes his plaintiff as he finds him" (Calandrillo, 2006). It applies in cases when a person is psychologically vulnerable or functionally compromised, even if he or she had been manifesting no signs or symptoms of this vulnerability before the index event, and it takes into account the likelihood that an already-compromised plaintiff may be more inclined to experience emotional distress than someone less inclined (Koch, Douglas, Nicholls, & O'Neill, 2006).

As historically formulated, "the wrong-doer is liable for all injuries resulting directly from the wrongful act, whether they could or could not have been foreseen by him." (Vosburg v. Putney, 1891). This is a critical distinction because the law of tort usually holds that a plaintiff is only liable for those damages that are foreseeable to result from her acts (Fowler v. Harper, 1932; Palsgraf v. Long Island R.R., 1928). Thus, eggshell skull rules allow for recovery of the plaintiff's injuries beyond what may normally be considered reasonably foreseeable (Benn v. Thomas, 1994; Calandrillo & Buehler, 2013). Alternatively, the eggshell skull rule may be understood as lowering the threshold to recovery, such that, in the absence of the rule, if a defendant's tortious behavior would not be expected to cause injury to an ordinary, reasonable person, then the plaintiff would be barred from recovery. However, in practice, an eggshell skull plaintiff has been found to be entitled to recover for tortious behavior below that which would be expected to cause injury to an ordinary, reasonable person (Packard v. Whitten, 1971).

It is important to understand that the eggshell skull rule was originally formulated in and applied to only physical injuries (Calandrillo & Buehler, 2013; Loomis, 2007). In some—but not all—jurisdictions, it has been extended to psychological injuries as well (Calandrillo & Buehler, 2013; Yoshikawa v. Yu, 1996). Therefore, a practitioner must be cognizant of the recognized jurisprudence in his or her jurisdiction, that is applicable to this issue which is consistent with APA's forensic specialty guidelines (American Psychological Association, 2013).

A preexisting condition, therefore, does not, per se, prevent a plaintiff from seeking compensation for an injury or for psychological damages (Vallano, 2013). It applies even in circumstances in which the complainant had been asymptomatic prior to the index event. However, the evaluator in this case must determine the extent to which the plaintiff's situation can be attributed to the defendant's actions. Under the thin skull principle, Smith (2010) noted:

> a defendant is liable for all harm caused by its conduct even if the degree of harm experienced by the plaintiff was not foreseeable due to a preexisting (but perhaps latent) vulnerability or condition of the plaintiff. Thus, a defendant is liable for aggravation of a preexisting injury regardless of whether such aggravation was itself foreseeable. Even in cases where the thin skull rule applies, however, the defendant is liable only for the extent of the exacerbation of the preexisting condition and not the entirety of the plaintiff's injury (pp. 760–761).

For example, a psychiatric patient may be classified as 50% disabled due to depression and receiving Social Security Disability payments. She also manages to hold a part-time job as a psychologist and effectively function as a spouse and parent. At an annual physical examination, her bloodwork reveals that she has high cholesterol, and she is negligently prescribed a course of statins by her physician, who both failed to consider the patient's depressive condition and failed to inform the patient of the potential side effects of the medication. After the patient becomes severely depressed, loses her job, is psychiatrically hospitalized, and requires 2 years or more to recover, the plaintiff may still be able to recover for the difference in impairment caused by the physician's malpractice above and beyond the 50% that she was already disabled. She cannot recover for the preexisting condition that predisposes her to further depression because that would result in double recovery from both the Social Security Administration and the defendant. However, according to the eggshell skull rule, she can recover for damages of the aggravated condition, and the preexisting condition does not preclude, or bar, her from recovery.

A related concept is the so-called *crumbling skull rule* (Young, 2007 p. 62). This concept and the distinction from the eggshell skull rule are perhaps best described by the Canadian Supreme Court:

> The "crumbling skull" doctrine is an awkward label for a fairly simple idea. It is named after the well-known "thin skull" rule, which makes the tortfeasor liable for the plaintiff's injuries even if the injuries are unexpectedly severe owing to a pre-existing condition. The tortfeasor must take his or her victim as the tortfeasor finds the victim, and is therefore liable even though the plaintiff's losses are more dramatic than they would be for the average person.
>
> The so-called "crumbling skull" rule simply recognizes that the pre-existing condition was inherent in the plaintiff's "original position." The defendant need not put the plaintiff in a position better than his or her original position. The defendant is liable for the injuries caused, even if they are extreme, but need not compensate the plaintiff for any debili-

> tating effects of the pre-existing condition which the plaintiff would have experienced anyway. The defendant is liable for the additional damage but not the pre-existing damage….Likewise, if there is a measurable risk that the pre-existing condition would have detrimentally affected the plaintiff in the future, regardless of the defendant's negligence, then this can be taken into account in reducing the overall award….This is consistent with the general rule that the plaintiff must be returned to the position he would have been in, with all of its attendant risks and shortcomings, and not a better position. (Athey v. Leonati, [1996] 3 S.C.R. 458 at para. 34–35).

In the case of psychological damage, as is explored herein, consider a professional ballet dancer with a projected career of 10 years who is suffering from the progressing symptoms of Huntington's disease which is threatening her ability to perform theatrically. She likely has only a few performances left and her promising career is cut drastically short by a negligent event. In the index event, she suffers psychological trauma from an overhead stage light nearly landing directly on her; after which, she is unable to even take a single step onto the stage. The plaintiff would be unlikely to recover loss of income from performances—though other damages may be recoverable—because the Huntington's disease, which was not the plaintiff's fault, has already effectively removed her ability to earn by performance.

While other aspects of the damages from the index event may be compensable, she would not be able to recover for that employment which was already essentially lost to her due to her crumbling skull condition of Huntington's disease. Should she have just received the diagnosis and would still be reasonably expected to gainfully perform for another four years, then the dancer may be able to recover damages pursuant to the index event if she would be unable to perform. However, she would only be able to recover for the first 4 years of the remaining 10 years of her predicted career because the disease has already stricken the last six years. Justice would not be served by forcing the defendant to pay for those last six years that the plaintiff's career that, sadly, the plaintiff would not be able to realize due to the Huntington's.

Preexisting Circumstances

Inherent in the eggshell skull, eggshell psyche, and crumbling skull concepts is that there are some circumstance that makes the plaintiff more vulnerable in some ways than the average, ordinary, or reasonable person. It is important to understand that the underlying vulnerability to the tortfeasor's action, or lack thereof, may take the form of either an injury or a condition (Calandrillo & Buehler, 2013).

With a focus on psychological injury, a plaintiff with a managed mental health condition at the time of the index event who subsequently experiences resurgence or relapse of psychiatric symptoms may be able to recover damages. Recovery may also be possible when the index event is a physical injury that exacerbates a prior mental health condition that results in renewed psychological symptoms and distress (Miley v. Landry; 1991).

Regarding a preexisting condition, a plaintiff may have a feature of his or her body that makes the plaintiff more susceptible to injury, such as diabetes or a degenerative spinal condition. Moreover, the condition does not have to be known to the plaintiff at the time of the injury. As it applies to forensic psychological inquiry, one may be able support expression or aggravation of a latent psychological predisposition, of schizophrenia for example, by investigating the prior presence of prodromal indicators of the subsequently expressed mental illness (Bota, Sagduyu, & Munro, 2005).

This means, as Kane (2007) has pointed out, that the assessor must first "evaluate, to the degree possible, the preinjury status of the individual, the additional problems associated with the current trauma index event, and the affect [sic] of the current trauma on the individual's ability to function" (p. 350). It is up to the evaluator to consider whether and to what extent any preexisting conditions do or do not account for the complainant's current state and to recognize that some pre- and post-index event disorders may co-exist in the absence of a causal relationship.

Causation

A critical aspect of establishing a defendant's liability to the plaintiff is proving that the plaintiff's action, or inaction, caused the injury that resulted in defendant's damages. This element of causation has two prongs: actual and legal causation (Moore, 2019).

In a three-car collision, the middle car may be the actual cause of the damage to the front car even though the middle car was actually at a safe following distance from the front car. However, when the rear car had been speeding and collided with the middle car, the middle car was propelled into the front car. Thus, while the middle car is the actual cause of the front car's damage, the driver of the front car would not likely be able to sustain a claim against the middle driver because the middle driver was not the legal cause of the front auto's damages; rather, the rear driver is the legal cause of the front driver's damage.

Establishing actual causation generally derives from a description of the events that allows the finder of fact—be it judge or jury—to rationally, or logically, conclude that the plaintiff's injury and related damages had been caused by the defendant. Perhaps best described by Lord Wright of the English court actual "[c]ausation is to be understood as the man in the street, and not as either the scientist or the metaphysician would understand it" (Yorkshire Dale Steamship Co v Minister of War Transport, 1942). Some of the tests of actual, or factual, causation include the "but for" test as well as the substantial factor test (Weigand, 2019). An exploration of how the 'but for' test of actual causation relates to the task of the forensic evaluator follows.

The "But For" Test

The "but for" test asks: "But for the [tortious] act, would the injuries have resulted?" (Koch, 2006). Specifically, when there is a preexisting condition, is it likely that the plaintiff would be in a similar situation (that is, that preexisting but inactive vulnerabilities would have appeared, or that an active condition would have worsened) had the index event not happened (Iezzi et al., 2013).

The thin skull rule and the "but for" test apply straightforwardly in situations where a vulnerable plaintiff had been manifesting no clinical signs or functional limitations prior to the index event, but *after* the index event demonstrates changes in level of functioning that could reasonably be attributed to it. However, when a plaintiff who was manifesting psychological vulnerabilities and functional limitations even before the index event claims that the event is responsible for subsequent deterioration, the evaluation of post-injury changes may be more complicated (Iezzi et al., 2013, p. 158).

Specifically, when the plaintiff had once shown evidence of vulnerability but was not manifesting it at the time of the index event, the thin skull rule and the "but for" test apply, and changes in health and functioning are attributed not to the pre-event condition but to the index event. However, when the person *had* been manifesting signs of a psychological or physical condition prior to the event, then changes in function and symptom presentation after the event need to be scrutinized carefully, and this is where an evaluator has to be knowledgeable: not only about the complainant's own case but also about the course of conditions like the complainant's. The evaluator must attempt to ascertain what factors potentially caused the changes, taking into account the possibility that other than the index event, or other precipitants, might be responsible for or otherwise contributed to the complainant's condition. For example, a woman has a prior history of depression, but it's been latent for years. And then her husband files for divorce and she gets hit by a young man joy-riding. The woman is very upset and becomes depressed and anxious. The evaluator still needs to assess how much her renewed depression is related to the accident and how much is due to the husband leaving her—even though she did not have an active preexisting condition.

The Substantial Factor Test

The but for test only accounts for one tortfeasor for obviously logical reasons. If something would not have happened except for the occurrence of some other event, then there can only be one possible cause. However, sometimes there can be more than one possible cause, wherein each cause is enough to have resulted in the plaintiff's injury. Consider a woman who suffers from depression, agoraphobia, and paranoia after being sexually harassed by three different managers at her workplace, such that each of the managers had made sexual advances towards the plaintiff. Each of the managers also threatened her that if she told anyone that she would be terminated as well as if she did not provide each with sexual gratification, then not only she would not be promoted but also she would be demoted at the next performance review. In such a scenario, each of the manager's behaviors would, on its own, presumably be of sufficient severity to cause the plaintiff's distress in isolation from the other managers' behaviors. In this way, but-for causation cannot be established because the plaintiff's distress and damages cannot be attributed to a single tortfeasor in the manner demanded by the but for test. This paves the way for the substantial factor test, otherwise called the multiple sufficient causes test (Lester, 1987; Weigand, 2019).

Proximate Cause

As previously mentioned, there is a second category of causation, which is the legal cause of the plaintiff's injury. "Traditionally, it is said that the proximate cause concept selects from among all actual causes the legally responsible causes by invoking policy considerations. But whether something is a causally relevant factor in producing some outcome may be nonnormative through and through." (Fumerton & Kress, 2001). Though there are a number of tests of proximate cause, the foreseeability test is the most well known (Moore, 2019). The foreseeability test asks whether an ordinary, reasonable, and prudent person in the defendant's position would have been able to predict that the plaintiff's injury might have been a possible outcome of the defendant's behavior, be it action or inaction. It is important to note that foreseeability is both an inclusive and exclusive concept in that it both defines what the defendant knew or should have known to establish liability as well as what was beyond the deliberation of the defendant, which places a limitation upon the defendant's liability.

Injury

Common to all causes of action in tort (intentional, negligence, strict liability) is that the plaintiff must prove that the defendant's behavior through action or inaction caused the plaintiff's injury. As such, the forensic evaluation will be best positioned to be useful to the trier of fact by identifying and describing the injury and effects of the injury as well as discussing the attribution of causation when possible and supported by the gathered data. With forensic psychological evaluations, the injury is less tangible than physical ones, such as a severed hand from an industrial accident. Psychological injuries are more covert and less readily ascertainable. In that way, they are more akin to the medical damages from long-term exposure to asbestos (JM Products Corporation v Superior Court of Contra Costa County, 1980) or, more recent and ongoing, residential chemicals (Roundup Products Liability Litigation, MDL 2741, U.S. District Court, Northern District of California).

A useful report will carefully and accurately describe the index event, the symptoms of the injury, and the functional ways that the plaintiff's life is impacted by the injury. The type and severity of the impact on the plaintiff's life and well-being will serve as the basis for calculating damages, and damages cannot be calculated if the injury description is vague or otherwise unclear. Given that the resultant damages from the injury will have a monetary value attributed to them, it will not generally be within the purview of the psychologist to appraise the value of the damages. Just as it not up to the psychologist to establish either the defendant's duty to the plaintiff or the defendant's breach of said duty in a negligence action, the psychologist should primarily focus on explaining the injury and secondarily describing causality only to the degree possible given the fact set. The psychologist should focus on her role in the case, which is describing to the Court the plaintiff's injury and its psychological consequences, including prognostically into the future, aside from potentially the origin of the injury; however, valuation of the injury and the injury's financial implications is likely outside of the purview of the forensic evaluator. The careful description of the event of issue, its psychological consequences, and all relevant considerations is the forensic psychologist's charge.

Forensic Symptom Evaluation: Three Categories

The "but for" test means that the forensic evaluator must make the best determination possible of how much of the plaintiff's distress is attributable to the defendant's actions. Sometimes the injury alleged by the complainant can be documented concretely in a doctor's office or a medical laboratory. Sometimes it cannot, however, and this is especially true of alleged emotional damage. This is the second complication in such evaluations. The evaluator must sometimes assess elusive symptoms in the context of the patient's past history and current state as well as the known course of the alleged condition. Furthermore, and this is the third complication in such cases, the evaluator must keep in mind the possibility, and when forensically necessary, whether the plaintiff's complaint is truthful and not willfully malingered.

We will not discuss here the clear-cut medical and surgical conditions that can be tracked by concrete laboratory, radiological, and other test results, and limit the paper to three situations that exist on the border between the physical and the psychological and present the greatest challenges to forensic mental health evaluators. The first is *somatic symptom disorder* (*SSD*), which challenges the evaluator's skill in assessing physical complaints. The other two are *factitious disorder* and *malingering*, which are distinct from each other but which are hard often to distinguish from the SSDs and require assessment of the honesty as well as the symptoms of the plaintiff.

SSD and factitious disorder both fall under the *DSM-5's* new diagnostic category *Somatic Symptoms and Related Disorders* (SSRD) (*Diagnostic and Statistical Manual of Mental Disorders* 5; American Psychiatric Association, 2013). The SSRD category consists of seven disorders, but we will discuss only the two mentioned above: *somatic symptom disorder (SSD)* and *factitious disorder.* The third condition under discussion, *malingering*, has no listing of its own in the *DSM*-5, for reasons which we will discuss below, or even a place in the index. However, it is an important factor in the differential diagnosis of the other two, and is, in fact, mentioned in DSM-5 under the "Differential Diagnosis" section of factitious disorder.

SSD and factitious disorder have in common with each other (and with the other diagnoses in the SSRD category) that they include both physical and psychiatric symptoms, and that the physical symptoms are accompanied by substantial distress and impairment. They differ, however, in one important area—the matter of intent. People with SSD are not intentionally trying to be, or to look, ill. They believe that they have a physical ailment that has not yet been diagnosed, and are both physically uncomfortable and psychologically fearful about what it might portend. People who present with factitious disorders, on the other hand, know they are not ill even while they present themselves as such. So do malingerers; the distinction between those latter two categories is that the incentive for falsification in the factitious disorders is internal and psychological, compared to external and concrete in the second.

Persons who present with factitious disorders seek the attention and concern they reap in the patient role, while malingerers are after external gain, such as financial compensation or the avoidance of jail time. No such internal or external incentives are in play in SSDs.

Somatic Symptom Disorder: Somatizing and Medically Unexplained Symptoms

Somatizing is the expression of psychological distress through physical symptoms; SSD patients experience emotional discomfort as physical symptoms that they attribute, often fearfully, to physical illness, and for which they then seek medical treatment (Lipowski, 1988). These symptoms may be "inferred from the patients' reports … or from behavior that is under motor control," but they "cannot be objectively verified" (Merten & Merckelbach, 2013, p. 125). In some cases, physicians can find no physical cause for them; in others, the descriptions by the patient do not correspond with whatever physical findings *are* present (Klaus et al., 2013; Swanson, Hamilton, & Feldman, 2010). Such *medically unexplained symptoms* (MUS) are common and salient in somatizing—any part of the body may be the locus of a medically unexplained complaint (Klaus et al., 2013)—and fall in *DSM-5* under the SSD category (Dimsdale et al., 2013). It is important to note, however, that persons who somatize may still have co-existing physical conditions (Lipowski, 1988), and also that some "real" physical conditions are difficult and slow of diagnosis. MUS rekindle age-old debates about mind–body dualism—the extent to which mind and body are distinct entities (Klaus et al., 2013).

Somatizers and people with MUS make frequent medical appointments and tend not to be reassured when the ensuing tests and procedures indicate no cause for further evaluation. Typical examples of MUS are dizziness, fatigue, pain, malaise, and abdominal pain, all of which are common and ordinary bodily sensations that most people experience at one time or another and tend not to worry too much about. And in fact, most MUS are transient (Creed, 2016). In people who somatize, however, symptoms may be misinterpreted as indicators of a serious illness; they may also arise in the context of an anxiety or depressive disorder that the patient does not recognize as causative.

The factors that contribute to the development of MUS have not yet been defined, but it seems clear that both physical and psychological factors play a role (Young, 2008). This makes the physical symptoms of an SSRD more difficult to assess than symptoms with obvious medical explanations. When the complainant's physical symptoms cannot be interpreted with the usual medical tools, it is up to the evaluator to consider the possibility that they are psychological manifestations and assess them as such (Hamilton & Kouchi, 2018). This does not mean they should be discounted, and when they are a function of somatization, they may appear more prominently than otherwise; as Young stated, "somatizers are prone to symptom exaggeration" (Young, 2014, p. 527). This, however, is another complicating factor for evaluators. Complainants in personal injury cases may exaggerate their symptoms for a variety of reasons, some of which may relate to factors outside of the complainant's awareness, such as childhood trauma. Nevertheless, the forensic evaluator's task requires parsing out any preexisting dispositions or symptoms, symptoms attributable to the index event, and symptom exaggeration. In such cases, the exaggeration is unconscious (Young, 2007), and *DSM-5* makes clear that a diagnosis of SSD implies no intent to deceive (APA, 2013).

Factitious Disorders

In the differential diagnosis of factitious disorder and malingering, however, the question of deception takes center stage. Both of these may look at first like SSD, in that the medical complaints cannot be documented or explained, and there may be apparent overlap with depression or anxiety. But they must be carefully distinguished both from SSD and from each other. In both factitious disorder and malingering, the production and presentation of symptoms is conscious, deliberate, and under the patient's control. However, these are two distinct presentations.

Factitious disorders are included in the SSRD category because the patient presents with somatic symptoms and with "medical disease conviction" (APA, 2013). The primary gain in factitious disorder is the relief of psychological distress, which the patient achieves by securing the role of patient and eliciting medical attention through the intentional exaggeration, feigning, or production of the symptoms of a disease. The fabricated illness may be psychological, physical, or both. For instance, dissociative identity disorder and posttraumatic stress disorder are psychological conditions that may be fabricated. Wounds that do not heal, chronic dysregulation of blood glucose and insulin levels, rashes, burns, seizures, and paralysis are just a few of the physical complaints with which persons with factitious disorders may present (Hamilton et al., 2008). Perhaps the disorder, or diagnosable condition, that most precisely both straddles the physical and psychological as well as defines the difference being just on the physical side of the divide is chronic pain syndrome (CPS). The *ICD-10* (*International Classification of Diseases 10th Edition*, World Health Organization, 1992) recognizes CPS in diagnosis code G89.4 with the definition of: chronic pain associated with significant psychosocial dysfunction. Conversely, the current iteration of the psychiatric diagnostic manual has eliminated CPS as a psychiatric problem, per se, though the authors do provide some guidance for workarounds, including SSRD or

psychological factors affecting other medical conditions. Nevertheless, the essence of CPS is that there is a patient who is experiencing pain, is relatedly suffering impairment in some domain of functioning, and the pain is not better explained by another medical condition.

It has been recognized that repetitive stress movements may later be associated with the complaints of chronic pain. Consider an assembly like worker who, for the past year, has been expressing complaints of upper body pain that increases throughout her shift, which becomes pronounced in her wrists and hands during the latter half of the shift. The pain in the extremities was the initial complaint, which has worsened over time, and the more generalized upper body pain emerged during the past six months. She experiences these symptoms on her days off also, though not to the degree that she does on work days. After a year of complaints, she is sent for a medical assessment. During the examination, she is determined to suffer from degenerative disk disease (DDD) in its early stages. DDD affects the spinal column and is, generally, a qualifying condition in order to be classified as disabled. There is no apparent physical condition that would be a substrate for the extremity pain. Herein, the evaluator would need to be able to describe the additional impairment, if any, that the patient experiences from the CPS secondary to repetitive stress movements beyond the impairment that is caused by DDD. Further consideration may also explore whether the injury pursuant to CPS is sufficiently independent from that experienced by DDD in order to make a determination that the crumbling skull condition of DDD should not truncate any award of the CPS. This would be because the CPS would cause injury beyond that which would be explained by DDD even as the DDD progresses.

People who present with factitious disorder tend to give inaccurate histories and strive to maintain the sick role (Hamilton et al., 2008). For example, a patient may consult a physician for “intractable diarrhea” and be given the appropriate medication. The diarrhea does not abate, however, and the puzzled physician orders tests to determine its origin. The tests are negative, but the diarrhea continues—because the patient, unknown to the physician, is taking laxatives. The patient knows there is no physical illness, but act as if there was in order to secure the role of patient. People who report factitious disorders to elicit caretaking from others tend to cooperate with diagnostic evaluations and comply with the treatment recommendations made by health care providers (Singh, Avasthi, & Grover, 2007). In the face of these interventions, however, they will continue to maintain their symptoms by whatever means necessary in order to ensure their access to medical attention. This lack of response to appropriate intervention is a clue to factitious disorder.

Prevalence estimates for factitious disorders range between 0.05 and 2.0%; they are fairly uncommon (Fleige et al., 2007; Gieler & Eckhardt-Henn, 2004). They do raise for the evaluator, though, the question of whether the plaintiff’s presenting symptoms are, in fact, the result of the defendant’s activity, or deliberately motivated by a need for attention and concern.

Malingering

In malingering, the incentive is external rather than psychological. Per *DSM-5*, “Malingering is differentiated from factitious disorder by the intentional reporting of symptoms *for gain* (e.g., money, time off from work). In contrast, the diagnosis of factitious disorder requires the absence of obvious rewards” (p. 326; emphasis added).

Malingerers are not courting medical attention. Their actions—attempts to deceive the evaluator with claims of impairment; failure to cooperate with assessment; exaggeration or invention of symptoms—are undertaken in the service of an external goal, such as a larger financial settlement in a personal injury case (Bass & Halligan, 2014). In their efforts to secure a desirable diagnosis, malingerers behave in the way that they think a person with that condition would behave, and they report the symptoms that they think a person with that condition would report. However, their mimicry does not always accord with the way the target disorder really presents clinically, and, in fact, it is just such inconsistent responses that alert forensic evaluators to the possibility of malingering.

Both factitious disorders and malingering tend to be episodic, situation-specific, and dependent on the complainant’s involvement with a legal, medical, or social field (Bass & Halligan, 2014). Therefore, when MUS are part of a patient’s presentation, factitious disorders and malingering must be carefully ruled out, especially when external gain is at issue. Misdiagnosis may raise both financial and legal problems (Bass & Halligan, 2014), and it is a risk that must be taken seriously. The question confronting the evaluator, obviously, is as follows: What reliable and valid procedures can be used to arrive at a defensible diagnosis or determination of ill intent?

Assessment

The job description of a forensic psychologist does not include determining the physical status of the evaluee. However, the evaluator has a fundamental responsibility to assess whether the subject’s portrayal of his or her symptoms (physical and psychological) and history

is accurate: that is, whether that person's condition has been represented as it is, or whether it has been distorted by conscious and intentional exaggeration. For instance, a sudden drop in credit card use might suggest that the subject is too depressed or anxious, to engage in ordinary activities, or whether there has there been a change or an increase in spending. Reviewing such information before meeting with the subject is useful; it may flag an issue that needs to be investigated, and certainly it will help to focus the interview.

An essential part of making such a determination is the administration of psychological tests. Subjects in forensic settings may display very different behaviors and motivations than they do in clinical ones, and evaluators must remain aware of this. As Greenberg and Schuman (1997) pointed out in their classic paper on the differing roles of therapists and forensic evaluators, the goal of assessment in a therapeutic setting is diagnosis and treatment; the goal in a forensic setting is to answer a specific psycho-legal question, which may have major financial implications for one or another of the contesting parties.

The Eggshell Plaintiff

What happens, then, in a so-called eggshell plaintiff or crumbling skull case? As we have seen, a preexisting injury or condition does not lessen the legitimacy of a complainant's new claim. In fact, previous vulnerability may increase the costs required to restore the complainant to the preinjury state. When genuine emotional distress has been triggered by an index event, the victim is due appropriate compensation and treatment; a person who claims distress untruthfully is not. Therefore, as already described, a crucial aspect of the evaluation of alleged emotional distress is assessment of its validity, and, as we have endeavored to show, this is a knotty problem for assessors, especially when the evaluee presents with a complex medical or psychiatric history. To that end, an evaluator must identify her or his conclusions regarding the validity of the evaluee's claims at some point in the report.

As in any psycho-legal assessment, the psychological evaluator must address the particular question that is the reason for the referral. Once deliberate deception has been ruled out, the evaluator has an ethical obligation to review all the relevant, reliable data to reach conclusions about causation with a reasonable degree of psychological certainty (Young, 2007), and to keep in mind that the final report may have significant financial, and sometimes emotional, repercussions for one or both parties. For all these reasons, it is important that evaluators collect detailed information not only about the complainant's present diagnosis but also about any previous or current functional limitations that may have been caused or exacerbated by the index event. We offer that such an assessment may incorporate incidental investigation tools, such as interviews and psychological testing in forms of performance validity testing and symptom validity testing.

Incidental Investigation

The following are classic techniques for conducting investigation and inquiry:

Interviews: The interviewer will conduct a comprehensive interview of past history, including of interpersonal relationships, employment, physical and mental health history, legal involvement, as well as the evaluee's assessment of current status and any perceived changes since the index event. The interview will also involve detailed inquiry into the index event and any associated changes in response to it. The interview should include a request for the names of some collateral contacts: friends, family members, or coworkers who can report what they have observed about how the event of issue has affected the subject. The evaluator will be formulating opinions and hypotheses in response to the subject's story, and can take the opportunity of the interview to consider what psychological tests would be most likely to confirm or disconfirm them, or any other questions that have been left unanswered by the subject's own report. Inconsistencies between different records and in verbal reports by subjects in interview can provide valuable information toward determining the truth value of a subject's condition.

Collateral Sources of Information: In situations involving injury, sound evaluation procedures include comparing postinjury functioning with preinjury, or premorbid, functioning. Sadly, formal assessments of premorbid functioning are rarely available (Franzen et al., 1997). Nevertheless, there are a number of sources of information upon which to form a comparison that can be found in peoples' lives. For example, friends, family, co-workers and others may be able to describe a plaintiff's depressogenic speech and behaviors before and after the index event in order to inform the evaluation. Similarly, these contacts may be able to describe differences in the plaintiff's risk-taking, anger management, or disordered thinking. Perhaps a plaintiff becomes more easily frustrated, drinks more alcohol, uses more marijuana, is more forgetful, is less able to follow directions, is more prone to get distracted, is more willing to take risks, or is more lethargic following the index event. Moreover, behavioral patterns may either emerge or disappear after an index event.

Therefore, the evaluator will inquire as to the complainant's background and education, and explore all relevant social, family, and occupational history. The complainant's

medical and psychiatric histories, legal history, and any history of substance abuse will also be investigated, as will details about current and previous levels of functioning in daily life. Changes in financial behavior may be considered. The evaluator will also look for objective documentation of the subject's day-to-day situation. Pharmacy and medical records should be reviewed, as should any relevant legal proceedings, employers' records, and treatment reports by past and current health care providers. The evaluator might contact significant others, such as work supervisors, who have been in a position to observe the complainant, including work performance, over time.

Additionally in the case of a known, preexisting injury, there may be examination and treatment records that can provide useful comparative information with which the evaluator can describe the impact of the index event upon the plaintiff's functioning. Even without formal testing, treatment providers may be able to describe that episodes of emotional dysregulation may last longer or be more severe after the index event than before. Given the role that self-medication with substance use can have in mental health, premorbid substance use may cover psychological symptoms that are unable to be contained and reach expression after the index event. Treatment notes may indicate if there have been changes in critical risk variables concerning the plaintiff's mental health. Furthermore, given that chronic mental health conditions often have uneven treatment trajectories, the assessor should evaluate changes in the broad patterns of the trajectory after the index event as compared to before.

Analysis and Synthesis of Corroborative and Disconfirmatory Data Points: Here, too, however, these are not one-sided considerations; even in the absence of deliberate deception, the evaluator must keep an open mind in the consideration of collateral material. Certainly, some complainants exaggerate their symptoms in the hope of greater compensation, but it is not uncommon for a person who had experienced a traumatic stressor in the past to report feeling more stressed by an event than a person who has not experienced a prior stressor (Gold & Stejskal, 2011). It is also true, and less generally recognized, that when damage has developed over time, or in the context of a preexisting condition, the complainant may not be fully aware of the extent to which he or she has actually been compromised (Ruths et al., 2013). Finally, some complainants do not have the insight or self-awareness to recognize the extent of their own injuries for intellectual or other reasons; some need to experience, and portray, themselves as "healthy, cooperative, and resilient rather than fragile, accusatory, or depressed" (Goodman-Delahunty & Foote, 1995, p. 190), and so may misrepresent, willfully or otherwise, the extent of the injury. Often, it is not until after the evaluation interview and the examination of the background sources that the evaluator even learns that the eggshell plaintiff has a history of previous trauma or illness.

The inevitability of such competing interpretations is why evaluators must strive to develop an independent perspective on the subject's past and present life, and why collateral and contextual material is essential in assessing personal injury claims in eggshell cases. Without it, evaluators cannot give the trier of fact the crucial guidance they need in their deliberations about the origin of the complainant's injury, its extent, and the degree to which the defendant is responsible.

Ethically, a forensic evaluation should produce similar results regardless of whether the psychologist is retained by the plaintiff or the defendant. In that vein, it may be beneficial to the trier to fact to include and explain data that supports that the index event resulted in the injury as well as to include and explain data that supports that the index event did not lead to the injury in that all cases are likely to have some good supporting and nonsupporting data. By proactively exploring both positions, the evaluator may establish credibility and professionalism with the court, which may be particularly useful if opposing counsel retains their own retained or rebuttal expert that will be potentially engaged simply to discredit the evaluator's conclusions.

Psychological Testing Measures

Psychological measures of personality and trauma may conceptually be considered the category of testing tools most analogous to the collateral sources of information of the incidental investigation tools.

Personality Tests

Here are some of the tests that are especially useful in forensic evaluations; the ones chosen in any instance will depend on the specifics of the complainant's case. Personality tests provide information about a person's traits and behaviors and are standardized, and most psychologists will administer one as part of a forensic evaluation. The three most frequently used in forensic and clinical settings are the Minnesota Multiphasic Personality Inventory-2 (MMPI-2; Butcher et al., 2001), the Minnesota Multiphasic Personality Inventory-2 Restructured Form (MMPI-2 RF; Ben-Porath & Tellegen, 2008/2011), and the Personality Assessment Inventory (PAI; Morey, 1991, 2007). They each have empirical underpinnings, and provide robust norms against which to consider subjects' responses. They also have validity scales built into them that can provide clues to any attempts to game the answers, either positively or negatively. Instruments that assess personality traits and behaviors may also be administered, such as and the Rorschach Inkblot Test

(Meyer et al., 2011), but there has been some controversy in the scientific literature regarding its use in forensic evaluations (Garb et al., 2005; Meyer et al., 2011 for discussions). The Rorschach Performance Assessment System (R-PAS) has endeavored to address prior limitations (Erard, 2012). Because different tests measure different personality constructs, more than one personality measure may be administered. The MMPI-2 and the PAI, for example, both assess depression, but with attention to different aspects of it, and PAI measures borderline personality traits specifically while the MMPI-2 does not address them directly.

Trauma Measures

If a person has been physically or sexually assaulted, or involved in an automobile accident, a trauma measure may be administered. The Clinician-Administered PTSD Scale for *DSM-5* (CAPS-5; Blake et al., 1995) and the Detailed Assessment of Posttraumatic Stress (DAPS; Briere, 2001) assess both current trauma and post-traumatic symptoms, while the Trauma Symptom Inventory-2 (TSI-2; Briere, 2011) measures PTSD alone. Of these three, the CAPS-5 has the most robust validity scales. The MMPI-2 (Scheibe, Bagby, Miller, & Dorian, 2001) and the MMPI-2RF (Selbom, Lee, Ben-Porath, Arbisi, & Gervais, 2012; Wolf et al., 2008) may be useful in assessing the presence or absence of trauma.

Validity Measures

Suppose, for example, that a complainant reports having felt tired, listless, agitated, and unable to concentrate since the index event. The forensic mental health evaluator must determine: first, whether that claim is legitimate or mendacious; second, if legitimate whether or not it is exaggerated; and third, in either of the latter cases, to what extent it is related to the index event. However, simply finding relevant inconsistencies is not enough. Interviewing the complainant and reviewing the associated documents will not fully resolve either of the first two of those questions; and clinical intuition is not reliable in determining whether a person is lying or telling the truth (Drogin et al., 2015).

This is why the statistical validity checks built into certain psychological tests can be helpful in assessing the veracity of complainant's reports of the symptoms and capabilities. The way a person responds to such tests tells the evaluator something about the way that person approaches the evaluation process. Patients who attempt to manipulate test results in one direction or other are likely to do the same elsewhere in their evaluations, so tests that flag manipulation alert the evaluator to look for other warning signs. It is important to note, however, that exaggeration, for instance, does not automatically indicate malingering as it may be related to another phenomena, such as factitious disorder discussed *supra*. While it is obvious that a complainant's performance on testing may be affected by the stakes of the evaluation, especially in a forensic context, it must be evaluated in conjunction with all other available sources of data before it is appropriate to assume deliberate deception; exaggeration may simply indicate that the complainant is feeling overwhelmed and is calling out for help (Young, 2019). The evaluator will need to look further to determine to what extent falsification is being used in pursuit of a damage settlement or other concrete advantage.

For instance, in the case of deliberate deception, the very effort not to succeed on a test, or not to respond truthfully and straightforwardly (*negative response bias*), may in itself expose the attempted deception. Malingerers with misconceptions about how psychiatric disorders appear clinically sometimes describe constellations of symptoms on personality tests that are not reported by authentic psychiatric patients—they may deny hearing voices, for example, while claim to receive messages from white cars with burned-out left headlights. Such attempts to demonstrate impairment are strongly indicative of deception and warrant additional investigation.

PVTs and SVTs

Consider the following examples. A 40-year-old man says he is depressed and that his symptoms are as follows: feeling sad and tearful, difficulty concentrating, disturbed sleep, gets lost in his house, and is incontinent. On a personality test, his scores are normal, and there are no elevations on any scales. But what is unusual is getting lost in his house and being incontinent. It is also unusual that on the personality test his profile is normal because based on what he reported, one would expect some elevations on the Depression scale; so for it to be normal is odd. His symptoms are neither in accord with his reports nor with the test scores. Feeling sad, exhibiting tearfulness, having difficulty concentrating, and experiencing disturbed sleep are signs of depression but getting lost in the house and being incontinent are not—especially in a 40-year-old person. Such a presentation would certainly have the evaluator look more critically for indications of malingering, should there not be a plausible alternative explanation for otherwise inconsistent symptoms.

A 50-year-old woman complains of difficulty concentrating, forgetfulness, and headaches, but when administered the Digit Span subtest of the Weschler series of intelligence tests and a two-alternatives, forced-choice test, which is easy to succeed on, her scores on both of these measures is within the average range for a person her age. This type of presentation would cause the evaluator to consider whether she was malingering.

PVTs

Performance Validity Tests (PVTs), similar to Symptom Validity Tests (SVTs) discussed below, are designed to alert the examiner as to whether the data being collected is valid from the lens of cognitive ability. PVTs assess the validity of the subject's performance on an ability task (Larrabee, 2012; Merten & Merckelbach, 2013). These tests are behavioral measures from which inferences are drawn about performance. For example, although it is expected that patients give their best efforts on cognitive tests, this is not always so (Bigler, 2012). Persons who respond slowly on a test with a timed component will score poorly; for example, they may do so inadvertently out of depression or confusion. But they may do so deliberately if they are seeking to maintain the role of patient, or to collect financial compensation for a personal injury claim.

As another example, people sometimes try to exaggerate impairment by deliberately giving incorrect answers. But in tests where the chance of giving the wrong answer is 50–50, it is expected that the score will be high because of the simplicity of the test and because seriously impaired and brain-damaged persons perform well and are capable of passing these kinds of test (Rogers et al., 2018). Obtaining a score at the chance level of 50%, such as on the TOMM, is problematic and raises a red flag for the possibility of malingering however other factors, such as fatigue, extreme psychopathology, and inattention may also be at play. A score significantly below chance and for the TOMM, according to basic probability statistics, indicates that a score of 17 or less out of 50 is so low that only deliberate feigning makes sense as an interpretation of the result. The evaluator will then need to examine the entire profile of the evaluee—interview data, documents, record review, collateral information, and other test results, including on SVTs and PVTs—to determine whether outright malingering should be attributed to the person. On the other hand, *positive response bias* implies a deliberate overestimation or exaggeration of abilities, as when a person attempts to appear more capable than is actually the case in a guardianship evaluation. Here too, however, there are few absolute criteria. A person who is depressed may have difficulty concentrating and respond slowly and/or poorly on tests or in interviews, which can be mistakenly read as an indicator of negative response bias. This is why collateral and contextual information is so crucial in making determinations of this kind.

Psychological testing, therefore, is useful not only for the hypotheses it generates and specific information it provides but also because it offers normative data against which evaluators can assess clinical findings and so assist in differentiation between authentic symptoms and contrived ones. Some of the measures most commonly used in forensic evaluations have scales built into them to help evaluators assess the subject's *response style* (that is, whether there is an effort to falsely minimize or maximize psychological disturbance). They may help the tester address other aspects of the subject's response as well: Did the subject respond in a direct and forthright manner? Were the subject's answers plausible and consistent? Did they accord with the injuries alleged in the complaint? A skilled evaluator takes advantage of testing as valuable in itself and also as a check against which other sources of information may be measured.

Testing Specifically for Dissimulation: The Test of Memory Malingering (TOMM; Tombaugh, 1996) may be administered when falsification is suspected on other measures of cognitive function. The TOMM is administered in suspected cases of cognitive malingering: that is, when diminished mental capacity is alleged. It is important to develop a further understanding of why a respondent produced "below-chance performance on forced-choice stand-alone measures of effort." (Young, 2014, p. 78).

Embedded Measures: Intelligence tests are also useful when cognitive or memory impairment is claimed; among these are the Wechsler Adult Intelligence Scale-IV (WAIS-IV; Wechsler, 2008), or the Wechsler Memory Scale-4 (WMS-4; Wechsler, 2009). Unlike some other tests mentioned in this discussion, there are no validity scales on these intelligence tests. For instance, Greiffenstein, Baker, and Gola (1994) developed the Reliable Digit Span from the WAIS-R Digit Span subtest, which has been thoroughly validated (Schroeder, Twumasi-Ankrah, Baade & Marshall, 2011). It has established cutoffs that, and if an examinee scores below an established cutoff, it is statistically likely that the examinee was intentionally underperforming. On the WMS-4, the level of chance performance is known on Logical Memory Recognition subtest. Thus while neither Reliable Digit Span or Logical Memory Recognition are validity tests, certain performance profiles on either would spark questions about falsification.

SVTs

SVTs, similar to PVTs discussed above, are designed to alert the examiner as to whether the data being collected is valid from the lens of reported symptoms. They are designed to identify and target unusual reported symptom profiles (Larrabee, 2012). Specifically, SVTs compare reported symptoms with the test reports by other people with the alleged condition, and alert the tester to atypical patterns (Larrabee, 2012; Merten & Merckelbach, 2013). "Symptom validity test assessment may include specific tests, indices, and observations, but need not always include tests designed to assess symptom validity" (Bush, et al., 2005, p. 421). SVTs help to distinguish between credible and noncredible symptom presentation (as opposed to the presence or absence of malingering). "Positive SVTs indicate that a patient's test

profile is probably uninterpretable, but it does not inform clinicians about the cause of this failure" (Merten & Merckelbach, 2013, p. 123). In other words, SVTs look for unusual symptom constellations or configurations, but do not attribute intent to them.

The Inventory of Problems-29 (IOP-29; Giromini, Viglione, Pignolo, & Zennaro, 2018), a newly developed measure, assesses credible cognitive and psychological symptoms. It was developed because many of the popular malingering measures have different cut-offs reported in the literature, and this makes it difficult for the evaluator to know which cut-off to employ in an assessment. The IOP-29 gives a probability score from zero to one, where zero indicates the report is valid and the closer the score approaches one the greater likelihood the report is not valid.

Three commonly administered tests measure malingered psychopathology in persons claiming emotional distress. These are the Structured Interview of Reported Symptoms (SIRS; Rogers, Bagby, & Dickens, 1992) as well as its update: the Structured Interview of Reported Interview-2 (SIRS-2; Rogers, et al. 2010), the Structured inventory of Malingered Symptomatology (SIMS; Widows & Smith, 2005), and the Miller Forensic Assessment of Symptoms Test (M-FAST; Miller 2001). The SIRS is perhaps the most widely used measure of malingered psychopathology. It is a 172-structured interview that enables the evaluator to ask questions in greater detail about specific item with robust reliability and validity (Rogers et al., 1992). It was designed to assess the various response styles of individuals who are feigning or exaggerating psychological symptoms, such as reporting rare or unusual symptoms, inconsistencies between reported and observed symptoms. It has eight major feigning strategies in the primary. Its update, the SIRS-2, is also a 172-structured interview. It has the same primary scales but includes three measures designed to reduce false positive scores. The SIRS-2, however, does not appear to meet the reliability and validity coefficients of its predecessor (Rubenzer 2010; Tylicki et al. 2018).

The SIMS and M-FAST are screening instruments of malingering. The SIMS is a 75-item measure of memory impairment and psychopathology (Widows & Smith, 2005.) The M-FAST is a 25-item measure that is used to assess severe psychopathology (Miller, 2001). The utility of these two screening measures is that scores that exceed the recommended cutoff and are suggestive of malingering and then a more in-depth assessment needs to be undertaken.

Finally, some of the personality measures discussed above, such as the MMPI-2 and PAI, also include various validity scales. Results from the validity scales can help the forensic evaluator to know if the evaluee is exaggerating, underreporting, or even if the response pattern is such an extreme departure that its utility is questionable. Of course, even response profiles that are extremely invalid according to the scoring must be interpreted within the context of the individual examinee, which emphasizes the importance of the collateral sources of data and information previously discussed.

Assessing for Malingering

Of the different types of attempted test manipulation, malingering is the one that has been most researched (Otto, 2008), and it is prevalent enough that prudent forensic mental health evaluator will keep their minds open to the possibility in all types of evaluations. Mittenberg and colleagues (2002) surveyed neuropsychologists who evaluate individuals in personal injury, workers compensation, criminal, and medical or psychiatric cases, and the researchers asked the neuropsychologists to estimate the number of cases of probable falsification of cognitive symptoms they had encountered in the previous year. By their reckoning, about 29% of personal injury cases and 8% of the medical cases involved probable malingering or symptom exaggeration. Probable malingering or symptom exaggeration was estimated to be 35% for claimed fibromyalgia or chronic fatigue syndrome, 31% for claimed chronic pain or somatoform disorder, 15% for claimed depressive disorder, and 14% for claimed anxiety disorder. Other researchers have found that in medico-legal settings, about one third of patients diagnosed with dissociative disorder, pain disorder, or somatoform disorder may be deliberately lowering their scores on evaluative tests, and those patients are likely malingering (Merten & Merckelbach, 2013). Estimates of malingering in patients with chronic pain ranges between 20 and 50% (Greve, et al., 2009). Young (2015) recently estimated that the rate of malingering or problematic presentation to be between 0 and 30%.

In a classic paper, Slick, Sherman, and Iverson (1999) presented a model of malingering based on the congruity (or lack thereof) of test data, observed behavior, and collateral reports in the context of substantial external incentives. They emphasized that evaluators must consider carefully any discrepancies between the evaluee's observed presentation and performance, the data collected in testing, and information from collateral reports or general background information. The less congruence there is among these various sources of information, the greater the likelihood of malingering. If either performance on psychometrically sound tests yields data that is discrepant with reports from collaterals or the observed behavior of the complainant is inconsistent with the reports from the collaterals, and if a substantial external incentive is present, then an indication of possible, probable, or definite malingering should be noted. Then, the evaluator needs to ascertain which category seems most likely or to offer an alternate hypothesis that might explain the complainant's behavior.

Merten and Merckelbach (2013), in a comprehensive article on malingering and SVTs, pointed out that a significant proportion of complainants perform poorly on these tests, and that a claimant's inconsistency raises questions about the validity of the claim. Here, too, evaluators are encouraged to consider malingering, and to place it along the continuum of *possible malingering* to *definite malingering*. But while they include negative response bias in their model of malingering assessment, they note that this is not on its own a sufficient basis for attributing malingering to a complainant, and that "entities such as depression and somatoform syndromes (such as fibromyalgia, chronic fatigue, and pain disorder) may produce" scores that resemble those of malingerers (p. 124). Slick, Sherman, and Iverson (1999) too remind evaluators that there are alternative diagnoses (such as depression) that need to be considered. Malingering should be attributed only when the forensic mental health evaluator is certain of the evidence for it (Merten & Merckelbach, 2013; Rogers, 2008) and when no equally cogent alternative explanation is available.

A person with a somatoform disorder or depression may underperform on SVTs. In a forensic setting, about one third of patients with a somatoform, dissociative, or pain disorder may display a negative response bias (Merten & Merckelbach, 2013). However, somatoform disorders, dissociative disorders, "or other medically unexplained symptoms, mild depression, or posttraumatic stress disorder" are not sufficient to explain failure on SVT. Malingering may coexist with a real mental disorder when there is a substantial financial incentive, and that the symptoms of a somatoform disorder may be created if there is the possibility of a financial gain (Merten & Merckelbach, 2013). Evaluators are likely to make errors in diagnosing MUS, somatization, or dissociative disorders if they do not attempt to exclude malingering (and factitious disorder) as alternate explanations, and such errors are prone to happen in litigating situations where people are seeking external gain (Merten & Merckelbach, 2013).

Malingering should be considered when a person fails on an SVT or PVT—especially on a series of them—although malingering cannot be assumed from this alone (Merten & Merckelbach, 2013; Young, 2014). The general rule of psychological testing and assessment continues to apply in this narrow analysis, such that both convergent and divergent information derived from different measurement methods should be utilized (Young, 2014, p. 409). Young (2014) provides the Feigned, or Malingered Posttraumatic Stress Disorder Related Disability/Dysfunction (F-PTSDR-D), which is a framework for examining the possible presence of malingered PTSD in forensic psychological assessments (p. 109). Young's framework could be particularly useful in the current context as it goes beyond the previously developed malingered neurocognitive dysfunction (MND) and malingered pain-related dysfunction (MPRD) models to address the psychological injury of PTSD, in particular, in a more robust way than the Rubenzer (2009) models for examining malingered PTSD (p. vi). This system provides specific controls for current areas of controversy and dispute in the field, including but not limited to interpretative biases on the part of the practitioner (p. 445), by enumerating extensive, discrete criteria, as well as interpretative guidance and consideration when professional consideration may be required (p. 133).

Summary

Whether retained by the plaintiff or the defendant, an evaluator owes the court a fair and honest assessment of the complainant, a thoughtful answer to the psycho-legal questions for which the complainant was referred, and the basis for the evaluator's conclusions. This paper deals with some of the challenges that forensic mental health evaluators encounter in fulfilling those obligations, especially in the assessment of so-called eggshell plaintiffs—that is, people with past or latent psychiatric histories. One challenge is to make as certain as possible that the evaluee's complaint has not been fabricated. Although attorneys often believe that they can screen their clients accurately for truthfulness, this is not always the case. Such "unconditional trust in their client" many keep plaintiff attorneys from recognizing a malingering client (Vallano 2013, p. 105). If the complaint has been made in good faith, the second challenge is to discern whether or not it is exaggerated, either in a positive or a negative direction. If so, is the exaggeration deliberate, or is it the inadvertent response of a vulnerable person to stress? Finally, to establish the effect of the index event, the evaluator must compare the subject's past and previous functioning.

When there is a condition that preexists the index event—and especially when the severity of its symptoms whose severity cannot be determined by laboratory tests or other concrete medical measures—the evaluator must look farther afield to determine the course of the complainant's injury and the timing of its development. Well-established tests of robust reliability and validity are an important tool in the evaluator's box. On the one hand, they can suggest trauma, psychopathology, and psychological distress, and on the other hand, they can suggest more problematic presentations or even malingering as elements in a complaint. But they cannot stand alone. Since the effects of some complicating factors (such as MUS, previous trauma, or preexisting anxiety or depression) may wax and wane over time, the report must also take into account all relevant information about the complainant's status before and after the injury. This includes lifestyle information, physician interviews, previous

legal and financial history, pharmacy bills, and so on. Diversity of information enhances accuracy of assessment; the evaluator's net should be cast as widely as possible.

Evaluators must always remember, however, that evidence of a psychiatric history may be misused in courts. It can prejudice judges and fact-finders. It can be used by defendants' attorneys to discredit a plaintiff, or depicted as the exclusive cause of the condition that has brought the plaintiff to court (Smith, 2010). This is why it is so important that forensic mental health evaluators weigh in an impartial manner on any and all data that can reasonably be brought to bear on their conclusions. This includes scrutinizing their own preferred and alternate hypotheses as well as looking carefully at the evidence that both supports and disconfirms them. It is only after all possible explanations for a plaintiff's condition have been carefully considered that an evaluator can ascertain that the eggshell plaintiff has or has not, in whatever degree, been injured by the defendant.

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SUPERIOR COURT OF NEW JERSEY
APPELLATE DIVISION
DOCKET NO. A-0177-15T4

RANDY B. ROSENBLATT,

Plaintiff-Appellant,

v.

VINCENT STRIPTO, ESQ., AND DRAZIN & WARSHAW, P.C., HOWARD BACHMAN, ESQ. AND GOLDSTEIN & BACHMAN, ATTORNEYS AT LAW,

Defendants-Respondents.

Submitted January 18, 2017 – Decided August 2, 2017

Before Judges Ostrer and Vernoia.

On appeal from the Superior Court of New Jersey, Law Division, Monmouth County, Docket No. L-12-13.

Ginsberg & O'Connor, P.C., attorneys for appellant (Gary D. Ginsberg and Stephen P. Burke, Jr., on the brief).

Giordano, Halleran & Ciesla, P.C., attorneys for respondents Vincent Stripto and Drazin & Warshaw, P.C. (Michael J. Canning, of counsel; Mr. Canning and Matthew N. Fiorovanti, on the brief).

Kaufman Dolowich & Voluck, LLP, attorneys for respondents Howard Bachman and Goldstein & Bachman, Attorneys at Law (Iram P. Valentin,

of counsel; Mr. Valentin and David J. Gittines, on the brief).

PER CURIAM

In this attorney malpractice case, we review the trial court's requirement that plaintiff provide expert testimony to establish proximate cause. Plaintiff Randy Rosenblatt sued two of her former divorce attorneys and their respective law firms, Vincent Stripto of Drazin & Warshaw, P.C., and Howard Bachman of Goldstein & Bachman. Plaintiff alleged that the two failed to notify her that she might have a Tevis claim, which negatively affected the outcome of her divorce. The trial court concluded that expert testimony was necessary to prove proximate causation, and eventually granted summary judgment for defendants once it became clear that plaintiff had not offered such testimony.

On appeal, plaintiff challenges the court's evidentiary ruling and the entry of summary judgment. We affirm.

I.

Bachman succeeded Stripto as plaintiff's divorce attorney. Stripto began representing plaintiff in 2000. He filed and then, at plaintiff's request, withdrew complaints on her behalf in 2000, 2001 and 2002. The following year, he filed the complaint that was later amended and ultimately litigated. Stripto also represented plaintiff in a related domestic violence action, which

resulted in a January 2004 final restraining order (FRO) against her husband.

Plaintiff substituted Bachman for Stripto later that year. During Bachman's representation, plaintiff and her husband agreed to binding arbitration of their divorce case. Plaintiff discharged Bachman in 2006 after receiving the arbitration decision.

In November 2007, after consulting with another attorney, plaintiff claimed she discovered for the first time that she had a potential marital tort claim against her husband under Tevis v. Tevis, 79 N.J. 422 (1979).[1] The potential claim related to three altercations in 2002, 2003 and 2004. She alleged that in 2002, her husband grabbed her arm so firmly it left a black and blue mark that lasted a week; in 2003, he pushed her against a wall, causing short-lived pain to her neck and one of her hands (she could not recall which); and in 2004, he butted heads with her in the midst of an argument.

She contended neither Stripto nor Bachman ever informed her that she had a potential tort claim, which was now barred. Plaintiff filed her legal malpractice action on December 28, 2012,

[1] Stripto and his law firm contested this assertion during discovery, stating that another attorney at Drazin & Warshaw explicitly discussed and recommended against filing a Tevis claim. However, for purposes of our review, we assume – as did the trial court – the truth of plaintiff's allegation.

seeking damages that she allegedly would have recovered had the claim been brought. Plaintiff also sought damages for the "severe, temporary and permanent physical and mental injuries requiring medical and psychological care and treatment and will require such care in [the] future." She produced no medical records or expert testimony to support her claim of permanent injury, however.

Although the attorneys did not discuss a potential Tevis claim or file one on plaintiff's behalf, they were aware of the incidents. Stripto referred to them in plaintiff's claim for divorce based on extreme cruelty. The 2004 incident also prompted the domestic violence complaint (although the prior history of domestic violence added only the 2003 incident and did not allege any physical injury from that prior event). Bachman, in turn, relied on the FRO during the arbitration hearings in an attempt to gain sole legal custody of the children.

Both attorneys explained they did not discuss the possibility of a Tevis claim with plaintiff because they did not believe the incidents provided a viable claim for such relief. In particular, they noted plaintiff did not suffer any documented long-term physical or psychiatric injury from the events. Moreover, plaintiff never received medical treatment or medication for any resulting injuries, nor did she seek any psychological or psychiatric treatment for emotional or verbal abuse by her husband.

As a result, they believed that the Tevis claim would be neither successful nor cost-effective for plaintiff.

In support of her malpractice claim, plaintiff relied on the expert opinion of attorney Ronald Edelman. In his brief report, Edelman opined that plaintiff had a "potential Tevis claim" and, further, that defendants "had the obligation to advise her of her Tevis rights" and "to protect her rights." The report did not expressly address whether defendants breached their duty of care by not filing such claims, nor did it discuss whether they would have succeeded.

The court granted in part and denied in part without prejudice defendant's first motion for summary judgment, which was filed before the end of discovery. In an oral decision in March 2015, Judge Katie A. Gummer dismissed plaintiff's claim for damages tied to alleged permanent physical or mental injury. Specifically, the court noted, "it is undisputed that plaintiff did not suffer any permanent physical injuries as a result of the purported physical and verbal abuse inflicted upon her by her former husband." The court concluded that plaintiff "neither factually nor legally" established that she had suffered any "disability or ongoing physical or mental injury" or that she was entitled to damages flowing therefrom. Nonetheless, Judge Gummer concluded plaintiff had a viable Tevis claim for damages arising out of the injury she

allegedly experienced after the three assaults. The court rejected defendants' argument, which relied on Merenoff v. Merenoff, 76 N.J. 535 (1978), that the husband's actions and plaintiff's injury were too trivial to be litigable.

The court also concluded that because plaintiff's malpractice action concerned "the soundness of decisions made by lawyers as to what they should relay to their clients and what actions to take in a matrimonial matter[,]" expert testimony would be required to establish proximate causation. The court noted that plaintiff had not alleged (at least at that point) that she would have filed a Tevis claim if her attorneys had informed her of the potential claim. The judge stated it was unclear whether Edelman's opinion that the attorneys had failed to protect plaintiff's interests was intended to convey a view on proximate causation. However, giving plaintiff the benefit of the doubt, the court assumed it did, subject to clarification in discovery.

In his subsequent deposition, Edelman denied opining "as to whether any actions of the lawyers proximately caused any damage to" plaintiff. He stated his report focused on "whether or not the attorney[s] fulfilled [their] obligation to [their] client," by failing "to advise the client of her Tevis rights." Edelman stated he did not form an opinion as to the value of the Tevis claim, whether it was negligent of the attorneys to conclude it

should not be filed, whether plaintiff would have pursued the claim if she had been advised about it, or the impact of filing the claim on other issues in the divorce.[2]

Defendants submitted an expert report by attorney David Wildstein, who stated he had extensive experience with Tevis claims. He explained that, in general, Tevis claims are "a rarity" in matrimonial matters. He noted that successful claims usually require "medical or expert testimony and serious or substantial injury." He asserted it was "doubtful" that plaintiff would have succeeded if she had brought a claim. Wildstein stated, "Plaintiff has failed to provide any evidence that she would have prevailed in recovering damages." He endorsed Bachman's strategic decision to utilize the FRO in connection with the custody dispute rather than bring a Tevis claim.

Wildstein also noted that the filing of a weak Tevis claim would disadvantage the client's case in the matrimonial matter. For example, "if a non-viable Tevis count was filed, it could be viewed by a Judge or arbitrator as a legal tactic to obtain leverage which could prejudice plaintiff's custody case." He also

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[2] Edelman admitted a plausible reason not to pursue the Tevis claim in this case was the fact that it would have opened the door for plaintiff's husband to introduce evidence of plaintiff's alleged extramarital affair, which had prompted his verbal and physical response.

stated that "the Court frowns upon weak or non-viable Tevis claims which may be used as leverage."

In the meantime, plaintiff filed a certification stating that she would have pursued a Tevis claim if she had been informed about the possibility. She filed no further expert certifications or other reports.

Based on this expanded record, Judge Gummer granted defendants' renewed motion for summary judgment. She concluded that Edelman's deposition clarified he was not, in fact, offering an opinion as to proximate cause. Reaffirming her prior holding regarding the necessity of expert testimony on this subject for plaintiff's prima facie case, the judge concluded that its omission was fatal to plaintiff's cause of action. The court entered final orders dismissing plaintiff's malpractice complaint with prejudice. This appeal followed.

II.

"The necessity for, or propriety of, the admission of expert testimony, and the competence of such testimony, are judgments within the discretion of the trial court." State v. Zola, 112 N.J. 384, 414 (1988), cert. denied, 489 U.S. 1022, 109 S. Ct. 1146, 103 L. Ed. 2d 205 (1989). Accordingly, we must "generously sustain" such determinations, so long as they are "supported by credible evidence in the record." Estate of Hanges v. Metro.

Prop. & Cas. Ins. Co., 202 N.J. 369, 384 (2010). Conversely, if the trial court applies the wrong legal test when analyzing admissibility, we apply de novo review. Konop v. Rosen, 425 N.J. Super. 391, 401 (App. Div. 2012).

The evidentiary question here is whether the trial court appropriately required expert testimony to establish proximate cause in plaintiff's legal malpractice claim. As a general matter, expert testimony is barred "unless it relates to a subject matter which is so distinctively related to some science, profession, business or occupation as to be beyond the ken of the average layman." Boland v. Dolan, 140 N.J. 174, 188 (1995) (internal quotation marks and citation omitted). Although N.J.R.E. 702 speaks permissively – stating that "[i]f . . . specialized knowledge will assist the trier of fact to understand the evidence or to determine a fact in issue . . . [an expert witness] may testify thereto" (emphasis added) – "New Jersey courts have required expert testimony to explain complex matters that would fall beyond the ken of the ordinary juror." State v. Fortin, 189 N.J. 579, 596 (2007).

Legal malpractice actions often present such complex matters. The elements of legal malpractice consist of: "(1) the existence of an attorney-client relationship creating a duty of care by the defendant attorney, (2) the breach of that duty by the defendant,

and (3) proximate causation of the damages claimed by the plaintiff." Jerista v. Murray, 185 N.J. 175, 190-91 (2005) (internal quotation marks and citation omitted). The client bears the burden of proof. Sommers v. McKinney, 287 N.J. Super. 1, 10 (App. Div. 1996).

The attorney's duty of care involves the "exercise [of] the knowledge, skill and ability ordinarily possessed and exercised by members of the legal profession similarly situated" and the "exercise [of] a reasonable degree of care and prudence having reference to the character of the service [an attorney] undertakes to perform." Passante v. Yormark, 138 N.J. Super. 233, 238 (App. Div. 1975), certif. denied, 70 N.J. 144 (1976). Whether an attorney has fulfilled that duty is not ordinarily a matter within the jury's common experience or knowledge. Brizak v. Needle, 239 N.J. Super. 415, 432 (App. Div.), certif. denied, 122 N.J. 164 (1990).

Accordingly, we generally require expert testimony to establish the first two elements of a malpractice claim. See Carbis Sales, Inc. v. Eisenberg, 397 N.J. Super. 64, 78 (App. Div. 2007) (internal quotation marks and citation omitted); Restatement (Third) of Law Governing Lawyers § 52, comment g (2000) ("[A] plaintiff alleging professional negligence . . . ordinarily must introduce expert testimony concerning the care reasonably required

in the circumstances of the case and the lawyer's failure to exercise such care."). Only in the exceptional case, where the breach of duty is basic or obvious, is an expert not required. See Brizak, supra, 239 N.J. Super. at 431-32 (App. Div.) (no expert needed when attorney "fail[ed] to conduct any investigation" into client's alleged malpractice claim); see also Sommers, supra, 287 N.J. Super. at 10 ("In rare cases, expert testimony is not required in a legal malpractice action where the duty of care to a client is so basic that it may be determined by the court as a matter of law.").

The third element, proximate cause, requires a showing that the malpractice was a "substantial factor in bringing about" an injury. Conklin v. Hannoch Weisman, 145 N.J. 395, 419 (1996) (internal quotation marks and citation omitted). Proof must be based on "competent credible evidence," Sommers, supra, 287 N.J. Super. at 10, and not "mere conjecture, surmise or suspicion," 2175 Lemoine Ave. Corp. v. Finco, Inc., 272 N.J. Super. 478, 488 (App. Div. 1994) (internal quotation marks and citation omitted). Here as well, our courts have required the use of expert testimony except when "the causal relationship between the attorney's legal malpractice and the client's loss is so obvious that the trier of fact can resolve the issue as a matter of common knowledge." Id. at 490; see also Sommers, supra, 287 N.J. Super. at 11 (accord);

4 Ronald E. Mallen & Jeffrey M. Smith, Legal Malpractice, § 37:23, at 1653 (2013 ed.) ("[U]nless the causal link is obvious or can be established by other evidence, expert testimony may be essential to prove [causation.]"); Allen v. Martin, 203 P.3d 546, 569 (Colo. App. 2008) (noting "most jurisdictions have concluded that causation in a legal malpractice action must be proved by expert testimony, unless causation is within the jury's common understanding" and collecting cases); Bozelko v. Papastavros, 147 A.3d 1023, 1030 (Conn. 2016) ("Because a determination of what result should have occurred if the attorney had not been negligent usually is beyond the field of ordinary knowledge and experience possessed by a juror, expert testimony generally will be necessary to provide the essential nexus between the attorney's error and the plaintiff's damages.").

Whether a particular causal chain is so obvious that expert testimony is unnecessary is a fact-sensitive inquiry. We required expert testimony when the alleged malpractice concerned the manner in which a complex transaction had been structured. 2175 Lemoine Ave. Corp., supra, 272 N.J. Super. at 487-90. Conversely, we concluded that no expert testimony was required to demonstrate that an attorney's misrepresentation about the strength of an adversary's position had a substantial, negative impact on the terms of his client's settlement. Sommers, supra, 287 N.J. Super.

at 8-9. Although we held that the plaintiff needed an expert to challenge the quality of work done on her behalf, an expert was not required "to announce that an attorney may not charge for work that has not been performed . . . . [or] to establish the causal connection between a charge for services not performed and lesser proceeds to the plaintiff." Id. at 14.

Here, the trial court found expert testimony was required to establish proximate cause. We will not disturb that discretionary conclusion. It bears repeating that the alleged malpractice here pertains to a failure to notify plaintiff of a potential claim under Tevis during the course of a matrimonial dispute.

Accordingly, in order to meet the proximate cause prong of her negligence claim, plaintiff had to demonstrate: (1) that she would have brought the Tevis claim; (2) that the Tevis claim would have produced an award greater than the cost of bringing it; and (3) that such a net award would not have been offset by negative repercussions in the broader matrimonial litigation. This is a far more attenuated and intricate chain of causation than was presented in Sommers. Even assuming plaintiff would have filed a Tevis claim, the second and third elements implicate complex questions of the law beyond the ken of average jurors.

Plaintiff had to demonstrate she would have brought the Tevis claim because she provided no evidence that defendants would have

acceded to a request, if she made one, to file such a claim on her behalf. As noted above, the attorneys believed the claim would have been ill-advised and counter-productive, assertions corroborated by Bachman's expert. Edelman admittedly offered no opinion on whether defendants' actions caused plaintiff compensable harm.

Plaintiff also had to demonstrate not only that the Tevis claim would succeed, but it would produce a net positive award. There is no evidence that an attorney would have pursued the claim on a contingency basis (even assuming doing so would not run afoul of Rule of Professional Conduct 1.5(d)(1)). Plaintiff thus may have been required to incur fees and costs to pursue the claim. To prove damage, plaintiff would need to establish that those fees and costs did not exceed the value of a recovery for the tort.

Furthermore, filing the claim could have complicated and prolonged the underlying matrimonial litigation and increased costs. Perhaps more significantly, it could have resulted in a less favorable outcome on other issues of value and importance to plaintiff in the divorce case. For example, as noted above, the Tevis claim may have opened the door to evidence about plaintiff's alleged extra-marital affair, which may have had an impact on custody and financial issues pertinent to both alimony and equitable distribution.

Additionally, if plaintiff secured any recovery in a Tevis action, the court would subsequently need to guard against a double-recovery based on application of the same facts to the calculation of equitable distribution. As we have warned:

> [P]laintiff's age, physical and emotional health and occupational limitations, if any, attributable to defendant's tortious conduct, may not again be considered in evaluating the equitable division of property issues. Likewise, defendant's actual liability in tort resulting in judgment must be considered in the court's decision respecting the division of property. The judgment debt owed plaintiff must also be considered in evaluating plaintiff's demand for alimony and particularly defendant's ability to pay alimony. There may not be a double recovery from defendant.
>
> [Giovine v. Giovine, 284 N.J. Super. 3, 29 (App. Div. 1995) (authorizing marital tort claim for battered woman's syndrome).]

One treatise has observed that, although practitioners would be well-advised to "re-examine the financial viability" of marital tort claims after cases like Giovine, "most matrimonial practitioners recognized that these types of claims were illusive, spurious, inciteful [sic], rarely financially fruitful, and might, in some cases . . . invite an undesired and financially dysfunctional judicial response . . . ." 1 Gary N. Skoloff & Laurence J. Cutler, New Jersey Family Law Practice § 1:67 (15th ed. 2013) (emphasis added).

Accordingly, we discern no abuse of discretion by the trial court in its decision to require expert testimony on proximate cause.

Further, we reject plaintiff's argument that she could have proceeded without expert testimony because she could have established causation at trial in the "suit within a suit." Put simply, this argument confuses a procedural trial framework with plaintiff's prima facie burden.

The "suit within a suit" approach allows a plaintiff to prove proximate cause by "present[ing] the evidence that would have been submitted at a trial had no malpractice occurred." Garcia v. Kozlov, 179 N.J. 325, 358 (2004). Notably, the Court has emphasized that this is only one of a number of procedures available to the parties in a malpractice suit. Lieberman v. Employers Ins. of Wausau, 84 N.J. 325, 343-44 (1980). Another option is the "use of expert testimony as to what as a matter of reasonable probability would have transpired at the original trial." Ibid.

But this procedural choice does not relieve plaintiff of her substantive, prima facie burden as plaintiff seems to suggest. Just because the parties choose to proceed by a "suit within a suit" instead of by expert certifications does not mean that a trial court cannot still require expert testimony as part of

plaintiff's proofs. See 4 Mallen, supra, § 37:23, at 1650 ("In the trial-within-a-trial context, expert testimony that would have been mandatory remains such."); cf. Cellucci v. Bronstein, 277 N.J. Super. 506, 520-24 (App. Div. 1994) (reviewing expert testimony regarding negligence offered at a "suit within a suit" proceeding), certif. denied, 139 N.J. 441 (1995).

Plaintiff may not have needed an expert to establish the merits of her Tevis claim – that is, that her husband assaulted her, that she suffered pain, and that a monetary award is appropriate to compensate her for that pain. But, as we noted, it was beyond the ken of the average juror to determine whether such a compensatory award would have been offset by the direct costs of bringing it and the indirect costs upon her other claims in the divorce case. Only expert testimony could remedy that gap in understanding. The "suit within a suit" procedure would not suffice.

To the extent not already discussed, plaintiff's remaining claims lack sufficient merit to warrant discussion in a written opinion. R. 2:11-3(e)(1)(E).

In sum, we discern no abuse of discretion in the court's determination that plaintiff required expert testimony to meet her prima facie showing of proximate cause. As plaintiff failed to

do so, we affirm the court's grant of summary judgment for defendants.

Affirmed.

I hereby certify that the foregoing is a true copy of the original on file in my office.

CLERK OF THE APPELLATE DIVISION

About the Panelists…

Honorable Lisa F. Chrystal, PJFP (Ret.) is counsel to Brach Eichler, LLC in Roseland, New Jersey, where she concentrates her practice in alternative dispute resolution, mediation and arbitration, and discovery management. She is a former Presiding Judge, Family Division, Union County, and sat in Elizabeth, New Jersey. Appointed to the bench in 2000 by Governor Christine Todd Whitman, she also sat in the Civil Division.

Prior to her appointment to the bench, Judge Chrystal maintained a solo litigation practice in Scotch Plains, New Jersey. She also served as Assistant Union County Counsel and was a civil litigator for two law firms before opening her own office. Judge Chrystal served on the Supreme Court Model Jury Charge Committee and is a former Co-Chair of the Union County Minority Concerns Committee. A former Trustee of the Union County Bar Association, she has been a member of the Supreme Court Committee on Diversity, Inclusion and Community Engagement, and the Supreme Court Family Practice Committee, where she has served on the FM/FD Subcommittee. Judge Chrystal is a member of the New Jersey State and Union County Bar Associations, and serves on the Executive Committee of the NJSBA Family Law Section. She has also served on the Family Subcommittee on Mentoring of New Judges.

A former Master of the Richard J. Hughes American Inn of Court, Judge Chrystal has been a member of the Barry I. Croland American Inn of Court and The Justice Virginia Long Hudson County American Inn of Court. She has trained newly-appointed judges and those transferring to the Family Division in the Comprehensive Judicial Orientation Program (C.J.O.P.) and co-authored the judges' "Dissolution Manual." Judge Chrystal has taught CLE classes for the Union County Bar Association and Ethics for Trial Attorneys for ICLE, and was an Adjunct Legal Writing Instructor at Seton Hall Law School. In 2022 she was the recipient of the prestigious William J. McCloud Award bestowed by the Union County Bar Association, which recognizes significant contributions to the administration of justice in the Family Part.

Judge Chrystal is a graduate of Syracuse University and a *cum laude* graduate of Seton Hall University School of Law.

Raj Gadhok is a Partner in Mandelbaum Barrett P.C. in Roseland, New Jersey, where he focuses his practice in civil litigation, complex business disputes, employment discrimination, whistleblower and wrongful termination cases, catastrophic personal injury, wrongful death and medical malpractice cases, contested estate matters and other substantial litigation. He utilizes his background in both legal and financial disputes to represent leaders from the business, professional, and sports and entertainment worlds in many high-profile and complex litigation matters; and has both represented and sued publicly and privately-held corporations, partnerships and individuals in connection with a wide range of litigation issues.

Admitted to practice in the state and federal courts of New Jersey and New York, and before the United States Supreme Court, Mr. Gadhok is an active member of his community and has taken leadership roles on the Executive Boards of both the Essex County Bar Association (ECBA) and the New Jersey State Bar Association (NJSBA). Past President of the Essex County Bar Association, where he has served as a member of the Board since 2006, he served as Chair of the ECBA Young Lawyers Section from 2006 through 2007 and served on the Executive Committee of the NJSBA Young Lawyers Division from 2008 through 2010. As President of the

ECBA he spearheaded an initiative, together with the Essex County Prosecutor's Office, to buy back illegal guns off of the streets and to raise public awareness of the gun violence epidemic in our Country today.

The recipient of the ECBA Young Lawyers Achievement Award, Mr. Gadhok has also regularly appeared as a panelist and guest speaker for educational and legal training programs approved for continuing legal education credit, including a recent program at MetLife Stadium on the issue of the National Anthem protests during the 2017-18 NFL season. His cases have been widely featured in the national media, including *The New York Times*, the *Wall Street Journal*, *Forbes*, *USA Today*, the Star Ledger, the *New York Daily News*, the *New York Post*, Bloomberg, Reuters, ABC News, CBS News, NBC News, Fox News, ESPN, CNN and 20/20. He is the recipient of several other honors.

Mr. Gadhok received his B.S. from Rutgers University and his J.D. from Seton Hall University School of Law. While at Rutgers, he served as Vice President of the Rutgers School of Business Governing Association (1995-1996). He continued with his extracurricular community efforts at Seton Hall Law School, where he served for two years as a volunteer for the New Jersey Mentor Program and tutored inner city youths for moot court competition.

Eileen A. Kohutis, Ph.D. is a licensed psychologist in private practice in Livingston, New Jersey. She conducts evaluations for child custody, Tevis claims (marital tort) and personal injury cases, and her areas of expertise are psychological testing, Munchausen by proxy (now called factitious disorder imposed on another) and reunification. She is also a rebuttal expert.

A member of the International and state chapter of the Association of Family and Conciliation Courts, Dr. Kohutis is a Trustee of the New Jersey Psychological Association Foundation and a member of the American and New Jersey Psychological Associations. She is a member of the American Psychological Association Divisions 41 (America Psychology-Law Society) and 42 (Psychologists in Independent Practice), and is the Editor of the *Independent Practitioner* of the latter. She is a former Program Chair of the New Jersey Chapter of the Association of Family and Conciliation Courts (NJ-AFCC) and is on the Medical Staff at St. Barnabas Medical Center in Livingston, New Jersey.

Dr. Kohutis is the co-author of "The Eggshell and Crumbling Skull Plaintiff: Psychological and Legal Considerations for Assessment" which was published in *Psychological Injury and Law* as well as another article, with Thomas DeCataldo, "The Legal and Scientific Perils of Modifying New Jersey's Custody Statute to Include a Presumption of Equal Custody" which appeared in *New Jersey Family Lawyer*. The author of articles on joint *v.* physical custody, she has presented locally, nationally and internationally on malingering, psychological testing somatic disorders and factitious disorders imposed on another (formerly called Munchausen syndrome by proxy).

Dr. Kohutis received her B.A. from Trenton State College and her M.A. and Ph.D. in Psychology from Yeshiva University. She also holds Certificates in Psychoanalysis and Psychoanalytic Psychotherapy from the Institute for Psychoanalysis and Psychotherapy of New Jersey.

Ronald G. Lieberman, Certified as a Matrimonial Law Attorney by the Supreme Court of New Jersey and as a Board-Certified Family Trial Lawyer by the National Board of Trial Advocacy, is a Shareholder in Rigden Lieberman, LLC in Moorestown, New Jersey. His practice is limited to

family law issues including matrimonial law, divorce, child custody, child support, parenting time, domestic violence and appellate work.

Admitted to practice in New Jersey, New York and Pennsylvania, and before the United States District Court for the District of New Jersey, the Third Circuit Court of Appeals and the United States Tax Court, Mr. Lieberman is Past President of the Camden County Bar Association, has served as Co-Chair of the Association's Family Law Committee and is Past Chair of the New Jersey State Bar Association Family Law Section. A Fellow of the American Academy of Matrimonial Lawyers (AAML), he is President of the AAML New Jersey Chapter and has also been a long-standing member of the Supreme Court's Family Law Practice Committee. He has been Chair of the NJSBA Legal Education Committee and has served on the Scholarships Committee and *Respect* Newsletter Editorial Board of the New Jersey State Bar Foundation.

A former Master of the Thomas S. Forkin Family Law American Inns of Court, Mr. Lieberman has lectured on family law topics for ICLE, the New Jersey Association for Justice, Sterling Educational Services, the National Business Institute and the New Jersey State, Burlington County and Camden County Bar Associations. He has been Executive Editor of the *New Jersey Family Lawyer*, has authored articles which have appeared in the publication and has been quoted in the *Courier Post*, *U.S. News and World Report*, *The New York Times* and on CBS 3 Philadelphia. He is the recipient of the 2014 Camden County Martin Luther King, Jr., Freedom Medal and several other honors.

Mr. Lieberman received his B.A. from the University of Delaware and his J.D. from New York Law School. He was Law Clerk to the Honorable F. Lee Forrester, P.J.F.P. (Ret.).

Cynthia W. Lischick, Ph.D., LPC, DVS is Clinical Director for Main Street Counseling in Allentown, New Jersey. She is a Licensed Professional Counselor specializing in trauma assessment and counseling trauma victims of military combat, sexual assault/incest/rape and relationship violence, forensic assessments, acquaintance/dating/interpersonal violence-coercive control research, victim advocacy and Large Systems Change Agent.

President of the New Jersey Chapter of the Association of Family & Conciliation Courts (AFCC-NJ), Dr. Lischick taught for Rutgers University in the Psychology and Criminal Justice Departments and has presented numerous professional and academic workshops and training over the past three decades for psychologists, judges, court personnel, social workers, attorneys and mediators. In 2022 the AFCC-NJ bestowed her the Phil Sobel Award and she is also the recipient of the New Jersey National Guard's Civilian Meritorious Service Medal, one of the highest honors a civilian can earn.

Dr. Lischick received her B.A., with Honors, from Rutgers University, her Master's degree in Psychology from Rutgers University, her Master's degree in Psychological Counseling from Monmouth University and her Ph.D. in Cognitive Psychology from Rutgers University. She holds the Domestic Violence Specialist (DVS) certification from the New Jersey Association of Domestic Violence Professionals.

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