POSTTRAUMATIC STRESS DISORDER

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INTRODUCTION

As plaintiffs' personal injury lawyers, most of us have a great deal of experience in recognizing, understanding, and proving physical injuries associated with run-of-the-mill car wrecks and the like. However, physical injury is not the only aspect of human injury with which we should concern ourselves if we are to be effective advocates for our clients. Instead, we need to have the skills necessary to recognize, understand, and prove the emotional injury that far too often accompanies severe physical injuries and sometimes exists even when only minor physical injuries are suffered. In particular, we need to understand the psychological injury known as Posttraumatic Stress Disorder ("PTSD"). This injury, coded as Diagnosis 309.81 in the Diagnostic and Statistical Manual of Mental Disorders, 4th Edition, commonly known as the DSM-IV, published by the American Psychiatric Association, has real consequences for our clients and presents genuine challenges to us as trial lawyers to ensure that this aspect of our clients' injuries are properly compensated.

POSTTRAUMATIC STRESS DISORDER

The human reaction to horrible events has been with us forever. However, it was not always called PTSD. It was diagnosed as railway spine in the nineteenth century as train wrecks were hugely outside the then human experience and were causing some severe emotional reactions. It was thought that concussion of the spine with concomitant injury to the sympathetic nervous system caused the observed traumatic neurosis (Trimble 1981). In World War I and II, there was shell shock, battle fatigue, traumatic neurosis, and the concentration camp syndrome. With the advent of the DSM (American Psychiatric Association

1962), the disorder was labeled gross stress reaction. In DSM-II (American Psychiatric Association 1968), it was named *adjustment reaction of adult life*. Finally, with the publication of DSM-III (American Psychiatric Association 1980), the diagnosis of PTSD was created. In DSM-IV (American Psychiatric Association 1994), PTSD underwent further modification in diagnostic criteria. Simon, *Post Traumatic Stress Disorder in Litigation*, at 32.

The DSM-IV is now the manual universally used to describe psychiatric injuries. It provides that:

> "[t]he essential feature of Posttraumatic Stress Disorder is the development of characteristic symptoms following exposure to an extreme traumatic stresser involving direct personal experience of an event that involves actual or threatened death or serious injury, or other threat to one's physical integrity; or witnessing an event that involves death, injury, or a threat to the physical integrity of another person; or learning about unexpected or violent death, serious harm, or threat of death or injury experienced by a family member or other close associate (criterion A-1). The person's response to the event must involve intense fear, helplessness, or horror (or in children, the response must involve disorganized or agitated behavior) (criterion A-2). The characteristic symptoms resulting from exposure to the extreme trauma include persistent re-experiencing of the traumatic event (criterion B), persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness (criterion C), and persistent symptoms of increased arousal (criterion D). The full symptom picture must be present for more than one month (criterion E), and the disturbance must cause clinically significant distress or impairment in social, occupational, or other important areas of functioning (criterion F)."

DSM-IV at 424.

More plainly speaking, Posttraumatic Stress Disorder is an injury suffered by a person who has been caused to experience a traumatic event. Usually the event, known as a "stressor," that might trigger PTSD must be outside the range of typical human experience. Typical problems such as grieving the loss of a loved one or marital conflict are not considered severe enough to lead to PTSD. Instead, plaintiffs suffering from PTSD:

> A. have experienced, witnessed, or were confronted with a traumatic event which involved the **threat of death or serious injury to themselves or others** and the person responded with intense fear, helplessness, or horror.

B. **persistently re-experience** the event through **intrusive thoughts**, dreams, acting or feeling as if the event were reoccurring, and/or intense distress and psychological reactivity when exposed to cues that symbolize or resemble the event.

C. **avoid stimuli associated with the event** and numbing of general responsiveness by:

i. avoiding thoughts, feelings, conversation, activities, places, or people associated with the trauma.

ii. an inability to recall important aspects of trauma.

iii. a lost interest in participating in activities.

iv. a feeling of detachment from others.

v. a restricted range of emotions, often unable to have loving relationships.

vi. little hope for their future.

D. Symptoms of increased arousal such as **difficulty sleeping**, irritability or angry outbursts, difficulty concentrating, and exaggerated startle response.

E. These disturbances continue **at least a month** and cause significant distress or impairment in social, occupational, or other important areas of functioning.

(emphasis added, *Clinical Tools, Inc*., 1998) Traumatic events are more likely to lead to PTSD if they are the result of human malice as opposed to an accident or a natural disaster. Thus, clients who perceive that the event occurred because of the intentional act of another are more likely to suffer PTSD.

Much has been written describing the various aspects of PTSD. The following, from Scribner, *Post Traumatic Stress Disorder*, 3rd ed., describing what the expert witness and fact witnesses must describe is particularly helpful in understanding the complex interplay of events and symptoms necessary to constitute a true PTSD diagnosis.

1. The Stressor. The expert witness and attorney must demonstrate that the plaintiff experienced, witnessed, or was confronted with a stressor which caused intense fear, helplessness, or horror. On the witness stand, the plaintiff will describe in detail the entire traumatic experience (thoughts, feelings, and actions) before, during, and after impact. When the plaintiff clearly relates a vivid word picture of the trauma, the judge and jury can more easily identify with the incident. Obviously, verbal skills vary with different plaintiffs; however, testimony involving the threat of injury or death immediately commands the attention of jurors. It is important that the plaintiff describes the emotional impact of the trauma without exaggeration or distortion, and simply "tell it like it was." Others who may have witnessed the trauma can also give evidence regarding the nature of the incident and the plaintiff's reactions. Coworkers, bystanders, police investigators, and safety experts can add depth to the account of the trauma the testimony of the mental health expert for the plaintiff can contribute a professional touch by evaluating all data and placing the trauma and its impact into a psychiatric context. When physical injury is also a consequence of the trauma, medical specialists can testify regarding the relationship between the physical injury and the traumatic incident.

2. Re-experiencing (Intrusive) Symptoms. Flashbacks, recurrent intrusive thoughts, and distressing dreams about the traumatic event comprise the mental phenomena which are self-reported by PTSD patients. Frightening dreams can be substantiated by a spouse who observes agitated sleep and later talks to the victim about the content of the nightmare. Others can attest to intense psychological distress and physiological reactivity when the plaintiff has been exposed to cues that symbolize or resemble an aspect of the traumatic event. For example. an accident victim coming upon the place where the trauma occurred may exhibit signs of anxiety and agitation (anxious look, change in speech, hyperactivity. a strong desire to leave the scene, or a verbal report of intense fear). During the mental status examination, the clinician inquires into the re-experiencing symptoms and this data becomes part of the expert opinion.

When testifying about re-experiencing symptoms, the expert may find it helpful to utilize the analogy of the video tapes of the mind to explain re-experiencing symptoms. Psychophysiologic testing, which measures physiological reactivity on exposure to cues that resemble an aspect of the traumatic event, can add a measure of objectivity to the diagnosis of PTSD (Chapter 10); however, because of logistical problems, PPT is not in widespread use at the present time.

3. Avoidance and Numbing Criterion. During direct examination, the plaintiff testifies about attempts to avoid thoughts, activities, places, or people that arouse recollections of the trauma. Besides the plaintiff, other witnesses (spouse, relatives, friends, coworkers) can corroborate the presence of avoidance behavior. For example, a wife may testify: "My husband never talks about the trauma; he refused to go to the place where the accident happened; when we had to go back to the scene of the accident, he looked like a ghost." During direct examination, the plaintiff's expert testifies about the avoidance criterion, explaining how phobic behavior was conditioned by the trauma.

The numbing or depressive features of PTSD can be confirmed by those persons who are emotionally close to the plaintiff. These witnesses can attest to diminished interest in significant activities, feelings of estrangement from others, inability to have loving feelings, and a pessimistic outlook. Following a trauma, the victim dwells on the adverse consequences of PTSD, and depression thrives on negative thinking. The clinician draws of biologic factors to amplify the reasons for the plaintiff's numbing of general responsiveness (depressed mood).

4. Arousal (Anxiety) Symptoms. On the witness stand, the plaintiff may look nervous and report anxiety symptoms; the spouse or significant others as fact witnesses can verify anxiety-related symptoms of insomnia, irritability, problems with concentration, hypervigilance, and an exaggerated startle response. In the consulting room, as a patient relates the details of the trauma, the clinician observes signs and symptoms of anxiety and can testify about hyperactivity, anxious faces, quaking voice, moist palms, increased pulse rate, together with a fearful self-report.

5. Significant Distress in Important Areas of Functioning. An examination of the plaintiff's milieu gives the clinician an opportunity to assess posttraumatic changes and the enjoyment of life. The psychiatric evaluation may reveal marital difficulties, disturbed sexual functioning,

at. 221-223.

Some writers on PTSD claim that there are five standard questions concerning every PTSD claim:

1. Does the alleged PTSD claim actually meet specific clinical criteria for this disorder? The answer to this question is determined by going through the diagnostic criteria set forth above.

2. Is the traumatic stressor that is alleged to have caused the PTSD of sufficient severity to produce this disorder? Take a look at the Impact of Event Scale printed below to answer this question.

3. What is the pr-incident psychiatric history of the claimant? This is important but not a case breaker. Certain prior psychiatric history and family problems make the onset of PTSD more likely.

4. Is the diagnosis of PTSD based solely on the subjective reporting of symptoms by the claimant? This is important. There needs to be strong family and witness support for the facts supporting the claimed symptoms.

5. What is the claimant's *actual* level of functional psychiatric impairment? In other words, how badly is the plaintiff injured?

Simon, *Post Traumatic Stress Disorder in Litigation*, at 33.

One of the most significant problems in establishing PTSD as an element of damages is proving that the event, known as the stressor, is outside the normal human experience. Obviously, we need to show that the particular incident was more horrendous than the usual similar event. One tool in establishing this is the Impact of Event Scale. This scale allows us some degree of quantitative analysis of an event. The questionnaire is as follows:

IMPACT OF EVENT SCALE—REVISED

Instructions: The following is a list of difficulties people sometimes have after stressful life events. Please read each item, and then indicate how distressing each difficulty has been for you during the past 7 days with respect to _____. How much were you distressed or bothered by these difficulties?

	Not At all	A little bit	Mod-erately-	Quite	Extremely a bit
1. Any reminder brought back feelings about it.	0	1	2	3	4
2. I had trouble staying asleep.	0	1	2	3	4
3. Other things kept making me think about it.	0	1	2	3	4
4. I felt irritable and angry.	0	1	2	3	4
5. I avoided letting myself get upset when I thought about it or was reminded of it.	0	1	2	3	4
6. I thought about it when I didn't mean to.	0	1	2	3	4
7. I felt as if it hadn't happened or wasn't real.	0	1	2	3	4
8. I stayed away from reminders about it.	0	1	2	3	4
9. Pictures about it popped into my mind	0	1	2	3	4
10. I was jumpy and easily startled.	0	1	2	3	4
11. I tried not to think about it.	0	1	2	3	4
12. 1 was aware that I still had a lot of feelings about it, but I didn't deal with them.		0	1	2	3 4

13. My feelings about it were kind of numb.	0	I	2	3	4
14. I found myself acting or feeling like I was back at that time.	0	1	2	3	4
15. I had trouble falling asleep.	0	1	2	3	4
16. I had waves of strong feelings about it.	0	1	2	3	4
17. I tried to remove it from my memory.	0	1	2	3	4
18. I had trouble concentrating.	0	1	2	3	4
19. Reminders of it caused me to have physical reactions, such as swearing, trouble breathing, nausea or a pounding heart.	0	1	2	3	4
20. I had dreams about it.	0	1	2	3	4
21. I felt watchful and on guard.	0	1	2	3	4
22. I tried not to talk about it.	0	1	2	3	4

Wilson & Keane, *Assessing Psychological Trauma and PTSD*, at 408.

The professional literature clearly demonstrates that the stressor dose is a major risk factor in the development of PTSD, determined in part by life threat, physical injury, object loss, and, in part, by the grotesqueness of the traumatic event (March 1993). Thus the initial traumatic psychological response is predicated on the severity of the stressor. The subsequent adaptational response varies according to the psychological meaning of the experience rather than the precise nature of the traumatic event. The definition of the traumatic event is of critical importance to the diagnosis of PTSD. This criterion (criterion A) in DSM-III-R and DSM-IV serves as the gatekeeper to the diagnosis of PTSD.

According to DSM-III-R, the symptoms of PTSD develop after one experiences a psychologically stressful event that is outside the range of usual human experience (e.g., natural disasters, rape, torture). The traumatic stressor is expected to be markedly distressing to almost any person, though not necessarily everyone. It usually is experienced with intense fear, terror, and helplessness (subjective dimension of stressor definition). Chronic illness, ordinary bereavement, marital discord, and business reverses are not considered sufficiently stressful to cause PTSD. DSM-III-R distinguishes stressors based on duration: predominantly acute events (duration of less than 6 months) and predominantly enduring circumstances (duration of greater than 6 months).

> Claimants in the vast majority of cases seen in civil litigation experience the stressor for only a few seconds.
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> The stressor criteria for PTSD in DSM-IV are slightly but significantly different. The normative aspects of the DSM-III-R definition, such as "a psychologically distressing event that is outside the range of usual human experience" (American Psychiatric Association 1987, p. 247) and "the stressor producing this syndrome would be markedly distressing to almost anyone" (p. 247), have been deleted from DSM-IV. Thus the stressor criteria definition has been broadened. DSM-IV also dropped the distinction between stressors of acute and enduring duration. As a consequence individuals with extreme reactions to minor trauma pass through the wider gate of the DSM-IV traumatic stressor criteria (Pilowsky 1999).
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> The traumatic stressors as defined by DSM-III-R and DSM-IV that are most commonly associated with PTSD include serious threats to the life or bodily integrity of the person, his or her spouse, children. close relatives, or friends (American Psychiatric Association l987, pp. 247-248; 1994 p. 424).

Simon, *Post Traumatic Stress Disorder in Litigation*, at 48.

There is a tremendous amount of literature concerning this injury. The books quoted in this paper are probably the most useful for the trial lawyer new to this area of medicine. But it is certainly possible to obtain a very solid feel for PTSD without ever buying a single book or even opening one. The PILOTS database of PTSD materials located at http://www.ncptsd.org/PILOTS.html is a fantastic resource.

> The PILOTS database is an electronic index to the worldwide literature on PTSD and other mental-health sequelae of exposure to traumatic events. It is available to Internet users through the courtesy of Dartmouth College, whose computer facilities serve as host to the database. No account or password is required, and there is no charge for using the PILOTS database.
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> There are two ways to search the PILOTS database via the Internet:
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> 1. A new Web interface provides both a menu-like way to do simple searches and a command-driven "expert search" capability.
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> 2. The harder-to-use but more robust command-driven search engine we have offered in the past continues to be available for those whose Web browsers support the telnet protocol. (At prompt, type SELECT FILE PILOTS)

GOAL OF THE TRIAL LAWYER

"The fundamental assertion of the plaintiff's attorney in a personal injury lawsuit involving PTSD is that a trauma caused the mental disorder and the defendant, by negligence or intentional action, is at fault and liable for damages. Through the testimony of fact and expert witnesses, the attorney for the plaintiff will try to demonstrate the presence of PTSD, establish liability, prove causation, and determine a realistic prognosis." Scribner, *Post Traumatic Stress Disorder*, 3rd ed., at 221.

PTSD can only be proven with the assistance of expert testimony. Without expert testimony, the plaintiff will only be perceived as sad and frightened and probably malingering. "The presentation of expert testimony will center around the diagnostic criteria for PTSD: (1) the precipitant or stressor, (2) re-experiencing or intrusive symptoms, (3) avoidance and numbing criterion, (4) arousal symptoms, and (5) clinically significant distress or impairment in important areas of functioning." Id. Simply relying on a run of the mill psychologist or psychiatrist is not enough. Instead, careful counsel will assist the plaintiff in finding a practitioner who is experienced in this particular illness. Often, those with experience in the VA hospital system will have this kind of background because of the large number of veterans who suffer from this malady. Other sources include The American Academy of Experts in Traumatic Stress. The membership of that organization includes a multidisciplinary network of professionals who are committed to the advancement of intervention for survivors of trauma. The Academy aims to identify expertise among professionals, across disciplines, and to provide meaningful standards for those who work regularly with survivors. Its web address is http://www.aaets.org/.

Many writers believe that in a litigation setting the only credible testimony capable of establishing a PTSD diagnosis is from a non-treating expert. Certainly, in this writer's experience the retention of a non-treating expert to opine about the causes of PTSD is advantageous. This allows the treating care provider to be a fact witness about the effect of the PTSD on his patient without putting him in the tough spot of not only being required to describe the injury but also its history and cause.

CONCLUSION

In conclusion, the identification and understanding of PTSD is an essential tool for the trial lawyer who wants to represent the entire client, not just the broken bones and surgical sites. The practitioner who is aware of Posttraumatic Stress Disorder will not only be able to assist his client in obtaining full, fair, and just compensation, but will also have the ability to recognize the existence of this disorder, perhaps at a time when even the client does not do so. This allows us to not only prove and collect compensation for all damages suffered by our client, but also to assist our clients in obtaining the type of treatment necessary to allow them to move on with their lives in the healthiest state, both emotionally and fiscally, as is possible.