

Stressing the Point: Post Traumatic Stress Disorder Claims


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In prehistoric times, when humans lived in dread of their mortal enemy, the saber-toothed tiger, those cave men (and women) who were fortunate enough to be genetically endowed with the quickest “fight or flight” reactions survived, and became our ancestors. That’s where the story begins . . . a story which flourishes today in a medical-legal climate where Post Traumatic Stress Disorder (PTSD) claims comprise a substantial and costly portion of personal injury and employment litigation.

INTRODUCTION

Until recent years, personal injury claims generally alleged orthopedic injuries from automobile, industrial, or slip-and-fall accidents. A small portion alleged neurological injuries, but those involving the brain were limited to closed head injuries and brain trauma; mental trauma or psychological injury was rarely a basis for litigated claims.

However, the recent sea change in our cultural and social attitudes has resulted in an epidemic of psychological injury claims, not only in connection with physical injury suits but also as a by-product of “repressed memory/false memory” hysteria. In the field of employment law, sexual harassment and discrimination claims alleging PTSD are growing by leaps and bounds. The dramatic size of several recent psychological injury/sexual harassment awards has not escaped the attention of the plaintiffs’ bar. This change in the litigation climate makes it essential for both insurance and employer defense counsel, as well as claims adjusters, to become knowledgeable about the medical-legal concept of mental trauma.

Among the various diagnoses found in psychological injury claims, PTSD is one of the most highly compensated. Consequently, workplace allegations of discrimination, abuse, or sexual harassment, are often based on PTSD. In order to properly manage these claims, both defense counsel and insurance claims adjusters require a sophisticated and detailed understanding of the

psychiatric diagnosis of PTSD: what it is, and — possibly more importantly — what it is not. Since many members of the plaintiffs' bar still do not fully understand how to assess and litigate psychological injuries (as opposed to the more concrete closed head injuries), the defense team familiar with this type of injury will have a decided advantage.

PTSD derives its authority from the *Diagnostic and Statistical Manual of Mental Disorders*. The fourth edition of this compendium, known widely as DSM-IV, was published by the American Psychiatric Association in May 1994. See Lees-Haley, "DSM-IV Alert: Changes Important to Claims Evaluation," June 1995 *For The Defense* 29. The comprehensive manual covers the entire landscape of mental disorders and conditions, and describes all psychiatric diagnoses and assessments of functional impairment. Because DSM-IV is considered the diagnostic "Bible" in medical-legal psychiatric evaluation, a working understanding of it is essential to evaluating and defending any claim of alleged psychological injury.

THE HISTORY OF PTSD

Post Traumatic Stress Disorder has had a long and interesting history. It has been called many things in the 150 years since it was first scientifically recognized, but every definition has one fundamental characteristic in common: "hysterical" physical symptoms — i.e., "anxiety" expressed as bodily complaints, without suffering any physical injury.

The process of Darwinian "natural selection" supported the evolution of people with highly developed stress responses, those with the most effective "fight or flight" reflexes. These reflexes lead to a range of psycho-physiological responses to danger: increased pupil size so that more information can enter the eye, increased heart rate so that oxygen can be pumped to the muscles and brain, and rapidly contracting muscles and other organs with enhanced energy. These physiological changes encourage men and women to become aggressive or rapidly run away when confronted by danger.

Modern man is still "hard wired" with this physiological reflex — it is our legacy from ancient times. However, when an employed man or woman feels threatened in their workplace, they would be regarded as bizarre if they suddenly rose from their chair and ran from the room or engaged in physical combat with another employee. Under most circumstances, perceived threats may not be real threats, and the threatened person must sit and bear it. *This conflict between our minds and our physiological reflexes is responsible for what are known as stress response syndromes.* Stress also may contribute to secondary illnesses such as cardiovascular and immune system diseases.

PTSD is a condition that arises from exposure to *life-threatening circumstances*; it was first diagnosed among some of the survivors of wartime combat. In World War I, the syndrome was known as "shell shock" and was thought to be primarily motivated by the soldier's effort at self-preservation. In World War II, it was called "war neurosis" or "combat fatigue." The modern label, PTSD, is a by-product of the Vietnam War; it falls within the general DSM-IV category of "Anxiety Disorders," under the sub-category of "Stress Disorders." The discussion of PTSD diagnostic criteria below is based on the DSM-IV criteria.

DIAGNOSIS OF PTSD

Like pregnancy, Post Traumatic Stress Disorder is something one has or does not have. For medical-legal purposes, there are no "shades of PTSD gray," even though in actuality and in some current research, the condition is viewed more in terms of gradient of symptoms. One is either in or out of PTSD, according to whether or not the individual fulfills the six specific, detailed criteria discussed below.

A traumatic event: the "A" criterion. The first criterion requires an individual to have been exposed to a life-threatening circumstance. According to DSM-IV, this criterion requires that "the person experienced, witnesses or was confronted with an event or events that involved actual or threatened death." This definition conforms closely to the kind of actual life-threatening circumstances, such as combat, where PTSD was first observed. In essence, the trauma must be

sufficiently severe that it ruptures a person's "bubble of invulnerability."

Persistent recurrence: the "B" criterion. PTSD victims re-experience the trauma over and over again, in a variety of ways. The event is revisited repeatedly in an effort by the psyche to manage and eventually integrate the traumatic stimuli that originally overwhelmed the victim's psychological equilibrium. The "B" criterion includes five different re-experiencing phenomena, any one of which is deemed sufficient to satisfy this diagnostic requirement.

- Recurrent or intrusive distressing recollections of the event, including images, thoughts, or perceptions.
- Recurrent or distressing dreams of the event.
- Acting or feeling as if the traumatic event were recurring (include illusions, hallucinations, and flashback episodes).
- Intense psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event.
- Physiological reactivity to cues that symbolize or resemble an aspect of the traumatic event.

Avoidance: the "C" criterion. As a psychological defense against being overwhelmed and feeling helpless, traumatized individuals are constantly oscillating between re-experiencing the trauma and trying to avoid it. Their efforts to avoid may take many forms, of which any three of those listed below will satisfy this criterion.

- Efforts to avoid activities, places or people that arouse recollections of the trauma.
- Inability to recall an important aspect of the trauma.
- Markedly diminished interest or participation in significant activities.
- Feeling of detachment or estrangement from others
- Inability to have loving and other strong feelings.
- No expectation of a career, marriage, children, or a normal life span.

Increased arousal: the "D" criterion: PTSD is always associated with signs of increased arousal (not present before the trauma) as indicated by any of the following:

- Difficulty falling or staying asleep.
- Irritability or outbursts of anger.
- Difficulty in concentrating.
- Hypervigilance, or being in extreme alert.
- Exaggerated startle response.

Duration of the disturbance: the "E" criterion. To satisfy the diagnostic requirement for PTSD, the disturbance must last longer than three months. It is distinguished from the brief, transient stress response reaction, called an acute stress disorder. If the duration of symptoms is three months or more, the diagnosis is *chronic* PTSD. If the onset of symptoms is at least six months after the stressor, it is labeled *delayed onset* PTSD.

Impairment of function: the "F" criterion. In addition to the first five criteria, the condition must cause *clinically significant* distress or impairment in social, occupational, or other important areas of functioning.

Differential diagnosis. As with many psychological conditions, individuals experiencing PTSD may be diagnosed with other problems, such as adjustment disorder, acute stress disorder,

obsessive-compulsive disorder, generalized anxiety disorder, mood disorder, substance abuse, organic brain syndrome, and malingering.

ROLE OF THE MEDICAL EXPERT

Psychoanalysts are psychiatrists (M.D.s) or psychologists (Ph.D.s) who have completed extensive advanced training beyond that required for their psychiatric or psychological certifications. They are specifically trained as careful observers who can understand a person's present behavior in terms of their past experiences. This perspective enables psychoanalysts to supplement the static DSM-IV diagnosis with a dynamic psycho-historical understanding of why an individual behaves in a particular way. Because this is an explanation drawn ultimately from the individual's unique life story, it is frequently heard by a jury as more plausible and comprehensible than an assemblage of dry criteria and technical jargon. Simply stated, psychoanalysts are able to "tell a story" that is cohesive, interesting, and that makes sense to a careful listener. It is not surprising, therefore, that many of the most effective psychiatric medical-legal experts are also trained psychoanalysts.

TREATMENT OF PTSD

Most individuals suffering from PTSD are treated through psychotherapy and pharmacotherapy.

Psychotherapy. This treatment has as its purpose to help the individual master and integrate the overwhelming stimuli generated by the traumatic event. One very effective method is abreaction, which is helping the patient discuss and reexperience the ideas, actions, and emotions associated with trauma in the safety of a therapeutic setting.

Psychotherapeutic treatment may be required for a period lasting from six months to several years. Since estimated length of required treatment is a crucial element in any settlement negotiation, the defense's psychiatric expert must carefully review these estimates in terms of the plaintiff's general level of functioning. For example, a plaintiff who is able to adjust to a new job, successfully manage intimate relationships, or embark upon arduous vacation travel is unlikely to be seriously impaired psychologically, and will probably not require extensive treatment.

Another aspect of psychotherapy is didactic, i.e. educational. The patient is told what he or she is likely to expect in the days, weeks, and months ahead, so that those reactions can be anticipated and not experienced as a loss of control or feeling "crazy." Such feelings may further traumatize the victim, and delay recovery.

Psychopharmacotherapy. Excessive anxiety or sleep disturbance can frequently be managed with temporary prescription of minor anti-anxiety medications, while transient sleep disturbances can be managed with the short term use of mild hypnotics (sleeping pills). Be aware, however, that all of these medications contain the potential for abuse and addiction.

Depression and guilt. Not infrequently, significant depression develops during the days and weeks following a traumatic event, especially if the traumatized individual feels rational or irrational responsibility for the trauma. Under these circumstances, more intensive treatment is required. Psychotherapy must investigate and explore both the early life experiences and losses that have been re-activated by the recent traumatic event. As an adjunct to psychotherapy, antidepressant medication may be very helpful in rapidly relieving depressive symptoms, reducing anxiety, and restoring normal sleep. Antidepressant medications are all non-addictive.

PTSD IN THE WORKPLACE

People can suffer Post Traumatic Stress Disorder in a wide variety of situations. Stressful events at the place of employment are a common cause of PTSD. What follows are hypothetical workplace situations in which an employee alleges PTSD.

CASE #1

A catastrophe adjuster employed by a major property insurer was transferred from another part of the country to work with insureds whose homes had been destroyed in a massive fire. The adjuster had worked with fire victims in other locations for many years without incident. However, this particular assignment elicited tears, difficulty in sleeping, and impaired mental concentration.

A psychotherapist took a detailed history from the adjuster. He learned that a decade earlier, the adjuster was engaged to be married to his childhood sweetheart. They had purchased a house in which they were going to live together. Suddenly, she was killed in a freak automobile accident. After her death, he sold the house and moved to a different city. He never adequately mourned her death, never married, nor even seriously dated during the decade since she had died. He simply “started over” and dedicated himself to his new job, putting his personal needs “on hold.”

After arriving at his latest assignment, the adjuster discovered that the house that he had purchased to share with his bride was exactly the same design and appearance as one that had been devastated by the fire. The recognition brought back his terrible and unmourned loss of ten years earlier, which overwhelmed him with its intensity.

This case of delayed onset PTSD was fairly easily resolved. A consultation and brief psychotherapy enabled the adjuster to complete his mourning, make a few life changes, and return to his formerly productive level of functioning.

CASE #2

Mrs. A is an attractive, petite, twice married thirty-six year old Asian-American woman. She worked for a major oil company, delivering the company mail to various department heads and supervisors. She was friendly, engaging, and enjoyed the positive attention she received from some of the older men in managerial positions.

Mrs. A had always maintained a close relationship with her father. He taught her automobile mechanics when she was an adolescent. By going to work for the oil company, she wanted to demonstrate that she could “become somebody.” She approached her job with determined enthusiasm and dedication.

After two years as a mail clerk, one of the supervisors, Mr. H, “recruited” her to join a half-time machinist training program for minority employees sponsored by the company. Mr. H is a fifty-seven year old mechanical engineer, married and divorced four times and a veteran employee of the company. Mr. H told Mrs. A that if she was accepted into the training program and completed it, she would be his prodigy. She was flattered.

During the last three years, two different women have asked for and received transfer away from Mr. H’s supervision because of what they vaguely described as his “pressure tactics” and “sexually inappropriate” comments. There is also a rumor that Mr. H has a drinking problem, although he has never been accused of drinking on the job.

Mrs. A worked extra hours in order to maintain her income while pursuing the half-time training, under Mr. H’s supervision. After six months of training, he required her to accompany him on a business trip to a refinery in a distant city to repair equipment. He told her that she would assist him and that this assignment would constitute an important part of her training. She made arrangements with her family to be away from home overnight.

After completing the first day’s work at the refinery, Mr. H knocked on her hotel room door and said he needed to show her diagrams of the work for the next day. When she let him in, she noticed the odor of alcohol on his breath. With no warning, he began to caress her hair and cheek and told her that she “owed” him sexual favors because of all the effort he had invested to further her career. Against her vehement protests, he then forcibly raped her. However, she reported the incident to no one.

She explained that she told no one at the company about the rape because she doubted that any male supervisor would believe her word against that of a colleague with managerial

authority. She also decided against telling her husband because she feared that he might take matters into his own hands and act violently against Mr. H. She also acknowledged that she was afraid he would insist that she leave her job and the training program which she so desperately wanted to complete.

During the next two years, Mrs. A completed the training program and became a well-paid machinist. She was also required to make overnight business trips with Mr. H. On at least two of these trips, he again raped her while intoxicated.

Mrs. A eventually confided the problem to a female friend who urged her to leave the company. She then became seriously depressed and refused to work any longer with Mr. H. Consequently, she was reassigned away from her machinist job and back to the mail room. Enraged and tearful, she was referred by Human Resources to a psychiatrist who diagnosed depression with suicidal tendencies. At the end of a two-week hospital stay, she told her psychiatrist for the first time about the rapes. The psychiatrist changed his diagnosis to Post Traumatic Stress Disorder.

Mrs. A's husband, believing that she had been treated badly by her employer, retained an attorney for her. She confided in the attorney about the assaults. He filed a civil damages lawsuit on her behalf against the company and Mr. H, alleging PTSD resulting from sexual harassment and assaults.

The defendant claimed that he and the employee had an affair, that during the affair they had consensual sex, but that the affair ended more than a year before. He flatly denied any allegations of sexual coercion, rape, or wrongdoing.

The primary medical-legal question is not whether Mrs. A has a cause for action but whether she indeed is suffering from PTSD. Does she meet the diagnostic criteria described above, in particular the critical threshold "traumatic event" criterion? If she does not meet the full criteria for PTSD, is she suffering from any other mental disorder? To what extent did she have pre-existing psychiatric illness, and what role, if any, might it play in her current symptoms? Is she malingering? Is she delusional? If so, from what cause?

CASE #3

Mrs. B, a married, 35-year-old secretary working for a large corporation, ate a pastry left for word processors following a board meeting. After biting into a croissant, she had the sensation in her mouth of a chewy, malodorous substance. She was disgusted and spit out the material. She brought the remainder of the croissant to a laboratory and was told that it was contaminated by rat feces. She complained to her doctor of anxiety, insomnia, and recurrent thoughts of the rat feces. He treated her with a mild sedative and referred her to a psychotherapist, who made the diagnosis of PTSD.

Mrs. B claimed that she could never work in an office again and filed a workers compensation claim based on PTSD. She was awarded \$75,000 plus 18 months of private vocational rehabilitation. She then filed a personal injury suit against her employer, the caterer, and the bakery that made the croissant, alleging permanent psychological injury.

The central medical-legal question is again whether or not she is suffering from PTSD. If she is not, does she have any other mental illness or injury? If so, what is it? Is it pre-existing or as a consequence of the alleged traumatic incident? If she has no evidence of other mental illness or injury, is she malingering? If she had no industrially-related psychological injury, why was she given a substantial workers compensation award?

CASE #4

An attractive young woman, Ms. C, who was abused as a child and is the daughter of an alcoholic, suffered psychological problems. One day on her job as a secretary, she was sexually harassed by a man who is the age of her father. She rejected his attention and initially did not report the problem to her employer because, she said, she feared that by doing so she might lose

her job. Her job performance began to deteriorate, and eventually she was terminated. Ms. C brought a wrongful termination suit alleging sexual harassment and discrimination. After filing suit, she was treated by a psychologist who diagnosed PTSD resulting from the sexual harassment.

Is Ms. C indeed suffering from PTSD as alleged? What was the nature of her psychological problems *prior to* the sexual harassment? Why did she not report the harassment to her employer? If she does have PTSD, could it have been caused by childhood trauma? If she does not have PTSD, is she suffering from any other mental disorder? What role, if any, did the childhood abuse by her alcoholic father play in the formation of her character, her psychological defenses, and her ultimate difficulties at work?

Of course, in a case of alleged harassment, the independent psychiatric expert should, in addition to reviewing documents, interview the plaintiff and investigate all of these questions delicately and with sensitivity, without contributing additional trauma to the plaintiff's life and without giving even the appearance of blaming the alleged victim. At the same time, the examiner must respect the presumption of innocence of the accused. In this last regard, it can be helpful and is often essential to a successful defense for the psychiatric expert to not only examine the victim but also the accused harasser.

SUMMARY

Post Traumatic Stress Disorder is a psychiatric diagnosis with a long and established medical history as well as a vibrant medical-legal present and future. With increasing frequency, it is being claimed in a widening scope of personal injury, malpractice, and employment litigation. It is a complex diagnosis requiring the careful and detailed examination of a plaintiff by an experienced medical-legal psychiatric expert. Psychoanalysts are well trained for the combined tasks of diagnosing, understanding, and communicating to others the presence or absence of psychological injuries. Δ

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