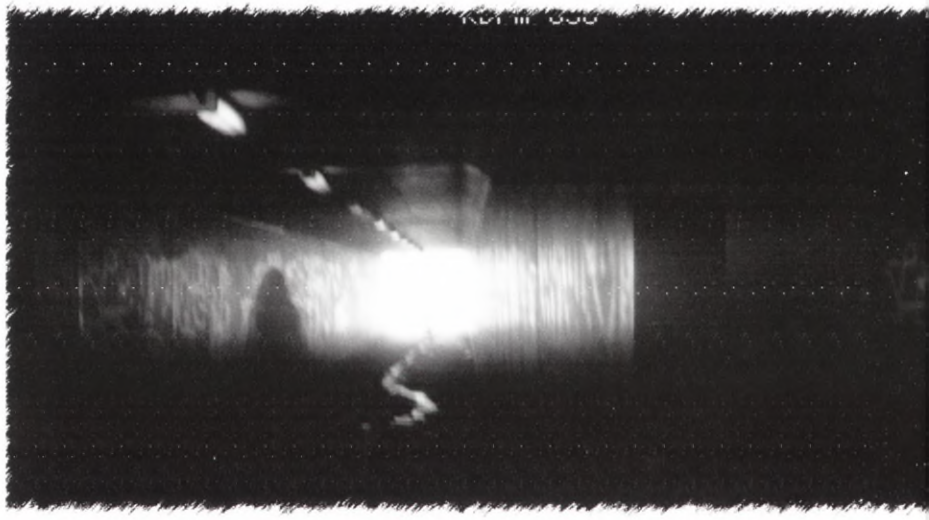
# Mental health

## perspectives for the

Psychological injuries after traumatic events represent a comparatively small number of personal injury claims, but they are often the most complex and difficult claims to litigate.

Rather than provide a dense, ivory-tower academic mantra of the 'evidence base', this article gives an overview of the current issues in mental health following trauma, and attempts to highlight the complexities of traumatic stress syndromes from a clinical and medico-legal perspective.



In 1994, 19.5% of claims to the NRMA compulsory third party scheme included a claim for psychiatric injury.[1] Moreover, New South Wales Motor Accidents Authority data indicate that the percentage of claims with a psychiatric component rose from 2.2% to 8% between 1990 and 1998.[2]

The growth of psychological injury in the workplace has recently been highlighted in the media. In January 2004 it was reported that, in the past two years, 60% of medical discharges in the New South Wales Police Service were due to post-traumatic stress disorder (PTSD), or because a psychiatric condition contributed to related medical problems.[3]

Recent rhetoric on terrorism and national security reflects the increasingly traumatic nature of modern society. The workplace, public gatherings and the roads have generated considerable traumatic stress-related litigation over the last decade. This has resulted in draconian tort reform in a number of jurisdictions, with a somewhat misanthropic attempt on the part of state governments to conduct a headline-driven crusade against personal injury litigation.

### THE CHEQUERED HISTORY OF POST-TRAUMATIC STRESS DISORDER

In PTSD, the medico-legal world has its apotheosis of a substantive

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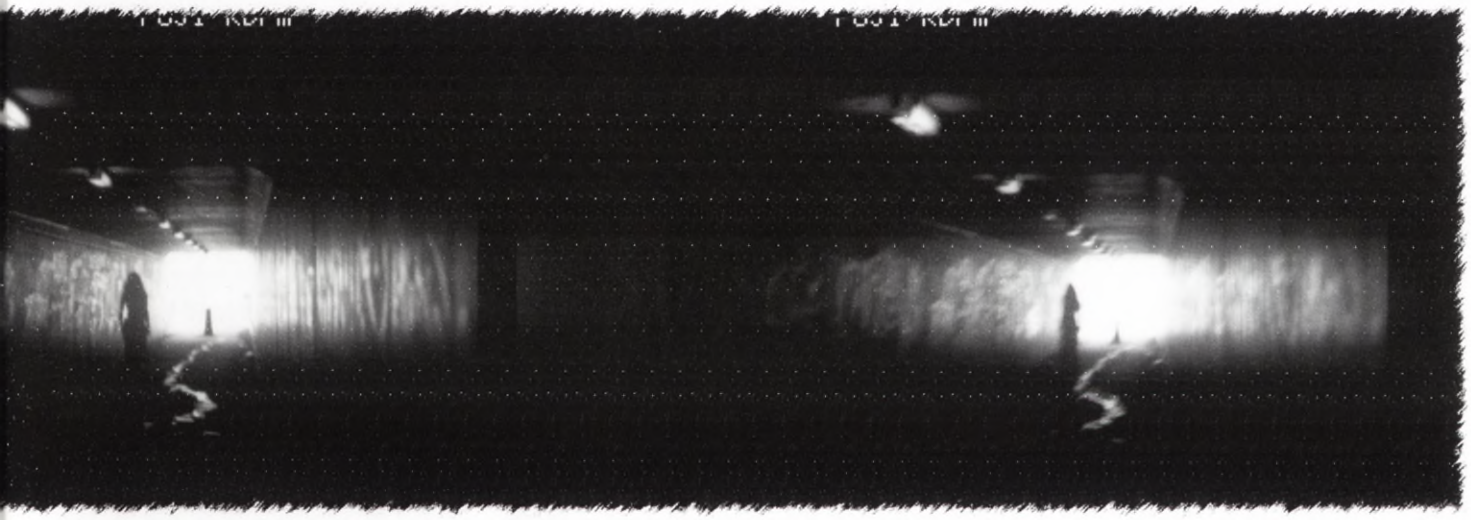
# in the aftermath of trauma: personal injury lawyer



"Why do two-thirds of people walk away from a traumatic event without problem..."

psychological injury in the aftermath of traumatic stress. PTSD and adjustment disorders are two diagnostic labels for psychological injuries that are ineluctable to respondents or defendants. These conditions, by their very nature, require a stressful event to cause them. Vicarious liability for such events can be laid squarely at the feet of employers and insurers and, as such, there is a subliminal pressure on the part of the expert witness for the plaintiff to establish the presence of these conditions. The converse is usually the case for defendant or respondent experts.

The nature of the DSM-IV diagnostic criteria for PTSD is a consistent source of polemic debate in mental health circles. PTSD had its lineage in the Great War era diagnosis of 'shell shock'. It was reified in the 1980 DSM-III after strong lobbying on the part of two New York psychoanalysts, Chaim Shatan and Robert J Lifton, who were deeply moved by the plight of much-maligned Vietnam War veterans. Shatan and Lifton's midwifery of PTSD was essentially to note the psychological complaints of Vietnam veterans, compose a list of diagnostic 'criteria' for PTSD, and intensely lobby the DSM committee for 'reactive disorders' to be included in the DSM-III.

PTSD was the bastard child of the Vietnam era, and has been lamented as 'a tragedy, a disastrous incursion of politics into medicine, the hijacking of traditional values by a small minority of activists'.[4]

The subsequent DSM-IV criteria for PTSD are often unrepresentative of the true nature of the psychological responses after trauma. They are derived largely from observations of military or mass trauma, and fail to capture the subtleties of psychopathology in children, older adults, or where there is long-term, low-grade cumulative trauma. A person can be severely debilitated by a few features of PTSD and yet not be considered to have the condition if they fail to meet the requisite number of DSM-IV diagnostic criteria. Being ▶

a totally symptom-based diagnosis, it is relatively easy to over-report symptoms, particularly in medico-legal settings, leading to vexed situations where the medico-legal psychiatrist asserts malingering, when the psychopathology is perhaps more subtle.

## THE SPECTRUM OF POST-TRAUMATIC MENTAL HEALTH

The available evidence suggests that PTSD is by no means an inevitable consequence of traumatic stress. An Israeli study that followed up emergency room presentations following traumatic events found that four months later, 66% had no psychiatric disorder, 17% had PTSD, 15% other anxiety disorder and 14% major depression. While this may be indicative of the resilient Israeli temperament, another study[5] examining survivors of motor vehicle accidents replicated the observations. The study found that of the 30% or so with psychiatric disorders, the most common was major depression followed by phobic anxiety (travel phobia), generalised anxiety disorder and then PTSD. This pattern is replicated in a number of other studies in different settings.

In essence, the vast majority of people who survive traumatic stress do not develop a psychiatric syndrome that meets DSM-IV criteria for PTSD. In fact, most do not develop any significant disorder – those who do are as likely to suffer depression, anxiety disorders, alcohol abuse, or PTSD. Those who do develop psychiatric disorder tend to accumulate a number of diagnoses – all of the listed conditions in variable combinations.[6]

## THE DIAGNOSIS OF PTSD AND THE GAMES PSYCHIATRIC EXPERTS PLAY

One of the intrinsic problems with psychiatric assessment and the process of diagnosis is its reliance on clinical assessment. A psychiatric assessment is a highly subjective interpersonal process. As such, it is vulnerable to biases deriving from various sources, ranging from the nature of the assessment to the quality of rapport in the interview. Many psychologists attempt to ameliorate this by relying on psychometric measures such as the Minnesota Multiphasic Personality Inventory (MMPI), the Clinician Administered PTSD scale (CAPS) and the Impact of Events Scale (IES). While these instruments are useful in research settings, they are subject to biased findings as they are either self-report questionnaires or structured interviews that ask leading questions such as, 'Did you act and feel as if you were living through the event again?'

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As discussed earlier, PTSD is a tendentious diagnosis – without a traumatic stressor, there can be no PTSD. The import of this is that a diagnosis of PTSD is a meaningful finding in a medico-legal setting, as it is usually wholly attributable to a particular event. In some settings, such as the *Veteran's Entitlement Act* 1986 (Cth), PTSD is associated with a greater level of compensation.[7] Other psychiatric conditions that commonly occur after trauma, such as depression, panic disorder or substance abuse, are equally explicable in terms of heredity, other life events or stressors outside of the event in question, thus limiting defendant liability.

The propensity for psychiatrists who conduct examinations on behalf of defendants to diagnose conditions other than PTSD, is well recognised within the world of personal injury litigation. Post-traumatic depression or alcohol abuse may well complicate underlying PTSD. In the setting of a 'one-off' cross sectional diagnosis, it is possible to see only depressive symptoms and not those of PTSD. This is explicable in terms of depression or the ongoing abuse of alcohol 'trumping' PTSD clinically. In other words, it is difficult to diagnose PTSD when there are other conditions masking it. A series of assessments over time is frequently a more reliable indicator of post-traumatic psychopathology.

A related controversy is that surrounding memory and PTSD. It is now believed that traumatic events are encoded in memory differently from more mundane events. Current thinking suggests that traumatic memories are encoded in ways that make them accessible only when similar levels of arousal to the traumatic event are present.[8] Moreover, these memories may be more sensory than linguistic and subject to a degree of malleability. It is apt for a highly distressed person to report memories or symptoms more adequately with their treating clinician than when faced with a hostile or indifferent medico-legal assessor. The malleability of traumatic memories has been advanced as a potential explanation of the so-called 'recovered memory' controversy.[9]

### Case example

V, aged 67, was involved in a side-on motor vehicle collision as a front passenger. There were no deaths, although the driver of her car sustained scalp lacerations which bled profusely. V sustained fairly minor physical injuries. Within six weeks of the accident she began to suffer nightmares and intrusive recollections of the accident. She felt nauseated in her car, and had to be driven everywhere. Her sleep was severely disturbed and she required regular sleeping medication. She was referred to a psychologist for treatment, but had difficulty attending the appointments because of her anxiety and fear of

driving. The psychologist provided a number of home visits.

The third party insurer had V examined by a psychiatrist with whom V spent 25 minutes. The psychiatrist omitted to ask about nightmares or phobic anxiety. He diagnosed V as suffering from a personality disorder, mild depression and alcohol abuse. He was highly critical of her treating clinician. Based upon this psychiatrist's report, V's treatment costs were declined by the insurer. Being a pensioner, she was unable to afford private fees for her treatment. There were no suitable public sector facilities available in her local area. She ceased treatment and became grossly psychiatrically incapacitated.

Unfortunately, this situation is all too common. A technique to reduce the likelihood of an opinion being formed on the basis of an incomplete history is to have a strategy in relation to the medical evidence. This will ensure that all available information and reports are available to the plaintiff's medico-legal experts, and that in turn this information is provided to the defendant.

The most obvious and important step is to specify any psychiatric and/or psychological injuries/impairment in the initial notice of claim. This makes it less likely that the insurer's psychiatrist can omit to ask about particular symptoms. Likewise, it can be useful to have the client assessed early by a psychiatrist and, where appropriate, annex that report together with a report of the treating psychologist to the claim form.

In the event that the insurer's expert opinion is based on an incomplete history, submissions to this effect accompanied by reports or clinical notes evidencing the relevant history, should be provided to the insurer. Obviously this is in addition to taking whatever steps are required in the relevant jurisdiction to challenge the determination to cease paying for treatment. Frequently the process by which the determination to refuse treatment costs is challenged requires the solicitor to outline what attempts have been made to resolve the dispute, so any correspondence with the insurer on the issue can be of use to show that appropriate efforts to resolve the matter have been made.

When challenging the determination, clearly state that the opinion upon which the third party insurer based its decision to decline payment of treatment costs was not based on a full history, and annex all documents that evidence the full history.

## PTSD AND THE ISSUE OF 'FORESEEABILITY'

Why do two-thirds of people walk away from a traumatic event without problems and yet a small minority develop catastrophic psychiatric decompensation? The answer is complex, yet can be summarised by the aphorism offered to medical students that 'things happen to people'. Certain traumatic events, such as sexual or serious physical assault with injury are apt to precipitate psychopathology in their aftermath. The rates of PTSD after sexual assault approximate 90%. As a rather simplistic rule of thumb, people with vulnerability to psychiatric disorder tend to develop psychiatric disorder after stressful events. Such vulnerability is indicated by previous experience of mental illness, prior traumatisation, particularly as a child, having a close relative with a psychiatric disorder, or having a personality that is prone to maladaptation to challenges or changes.

## THE TRUTH ABOUT DEBRIEFING

Psychological debriefing, or acute psychological interventions after trauma, have now come into focus in litigation circles. There now exists a large trauma industry, which routinely provides psychological debriefing in the aftermath of traumatic events. Failure to provide debriefing after trauma is a potential source of litigation, particularly with essential service personnel.

While not precedent in case law in Australia, the judicial determination in the recent Ministry of Defence (MoD) case in the United Kingdom may be prophetic for a potential raft of litigation ▶

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locally. In the MoD case, 2,000 claimants who fought in the Falkland Islands, Northern Ireland, the Persian Gulf, and Bosnia accused the MoD of failures in identifying vulnerable personnel, preparing them for the 'horrors of war', debriefing and treating them, and easing their path back into civilian life.

After a six-month trial, Justice Owen ruled in a 700-page judgment that the claimants were prohibited from suing the MoD by crown immunity, stating that under 'combat immunity' soldiers owe one another no duty of care when engaged with the enemy in the course of combat, and that the MoD was not under the usual employer's duty to provide a safe system of work. A significant factor in this case was the plaintiffs' abandonment of the claim that a failure to provide adequate 'debriefing' was a breach of duty of care by the MoD. This decision was taken when the MoD produced evidence indicating that there was no evidence that debriefing favourably altered the course of post-traumatic mental health.

The latter point is relevant for potential litigation locally, as the available evidence fails to demonstrate any benefit to debriefing or trauma counselling. A recent analysis of the Cochrane Database[10] found that single session individual debriefing did not reduce psychological distress, nor did it prevent the onset of PTSD; those who received the intervention showed no significant short term benefit in the risk of PTSD.

Moreover, one year after the trauma there was a significantly increased risk of PTSD in those who had received debriefing. There was also no evidence that debriefing reduced general psychological morbidity, depression or anxiety. The paper concluded that 'compulsory debriefing of victims of trauma should cease'.

## THE SOURCES OF PSYCHOSOCIAL IMPAIRMENT AFTER TRAUMA

Severe forms of traumatic stress and their psychopathological sequelae produce disability that is often long term. In the case of depression and chronic forms of anxiety, certain patterns of thinking and behaving evolve from 'state' into 'trait' – in other words, the depressive or anxious world view becomes 'hard-wired' into the lives of the victim and those around.

Employability is directly reduced by phobic anxiety and associated avoidant behaviour, irritability and interpersonal sensitivity, grossly impaired concentration and memory capacities and a propensity to psychologically decompensation in the face of minor environmental difficulties.

Non-economic loss manifests as loss of pleasure in daily activities, estrangement and loss of trust in friends and colleagues, marital harm and the transmission of traumatic stress to relatives or carers – what has been dubbed 'secondary PTSD'.[11] Rates of depression and anxiety are high in those around a traumatised person, frequently compounding the problems of the psychologically injured individual. Even with intensive treatment, the degree of improvement with PTSD, post-traumatic depression or anxiety is seldom adequate to facilitate a return to pre-trauma psychosocial functioning.

## A WORD ON TREATMENT

There is an expectation that depression and PTSD are in some way curable. Depression occurring in a non-trauma context responds to treatment in 55-60% of cases.[12] Even then, these figures are not truly reflective of 'real' patients, as the studies upon which these figures are based tend to exclude subjects with problems other than depression. PTSD is even less responsive to treatment, and usually requires different modes of intervention, requiring a variety of different therapeutic skills. Few psychologically injured people are able to access such specialised treatment, tending to be managed by their GPs with antidepressant medications. Access to psychologists is often limited outside of large urban areas. Even where access is available, the skill level of various clinicians in managing PTSD is highly variable.

Most treatment approaches to post-traumatic mental health aim at symptom reduction, although this is usually limited in scope, tending to provide better psychological homeostasis for the patient. Persisting psychosocial morbidity in the aftermath of severe trauma appears to be the rule. PL

**Endnotes:** **1** M Large, 'Relationship Between Compensation Claims for Psychiatric Injury and Severity of Physical Injuries from Motor Vehicle Accidents', *MJA* (2001) 177, pp129-32. **2** S Suhood, 'Claims Involving Psychiatric Disturbance', Motor Accidents Authority and Road Traffic Authority Publication, Sydney, September 2000. **3** L Kennedy, 'Job Stress Catches Up With Police Service', *Sydney Morning Herald*, 5 January 2004. **4** B Shepherd, *A War of Nerves: Soldiers and Psychiatrists 1914-1994*, p335. **5** R Mayou, B Bryant and A Ehlers, 'A Prediction of Psychological Outcomes One Year After a Motor Vehicle Accident', *American Journal of Psychiatry* (2001), 158(8), pp1231-38. **6** Centers for Disease Control, 'Vietnam Experience Study: The Status of Vietnam Veterans', Vol. III: Medical Examinations, Atlanta, GA, 1989; T Brett, T Keane, L Fisher et al, 'Physical Health Complaints in Combat-Related Post-Traumatic Stress Disorder: A Preliminary Report', *Journal of Traumatic Stress* (1992) 5, pp131-41; N Long, K Chamberlain and C Vincent, 'The Health and Mental Health of New Zealand Vietnam War Veterans with Post-Traumatic Stress Disorder' *New Zealand Medical Journal* (1992) 105, pp417-19. **7** The data from the Department of Veterans' Affairs indicates that PTSD is by far the most common diagnosis among veterans as it has no time limitation for its onset after war service. A PTSD diagnosis is more likely to attract a total and permanent impaired benefit. Treatment programs for PTSD are also much better remunerated than for depression or anxiety disorders. **8** B van der Kolk, 'The Body Keeps Score: The Evolving Psychobiology of Post-Traumatic Stress' *Harvard Review of Psychiatry* (1994), pp253-65; M Yapko, *Suggestions of Abuse*, New York: Simon and Schuster, 1994. **9** J Herman and E Schatzow, 'Recovery and Verification of Memories of Childhood Sexual Trauma', *Psychoanalytic Psychology* (1987), 4, pp991-14. **10** S Ro, J Bisson and S Wessely (2002), *Psychological Debriefing for Preventing Post-Traumatic Stress Disorder* (Cochrane Review). The Cochrane Library, Oxford University Press. **11** L Pearlman and P Maclan, 'Vicarious Traumatisation: An Empirical Study of Trauma Work on Trauma Therapists', *Professional Psychology: Research and Practice* (1995) 26, pp558-65. **12** C Zlotnick, I Elkin and M Shea, 'Does the Gender of A Patient or the Gender of A Therapist Affect the Treatment of Patients with a Major Depression?', *Journal of Consulting and Clinical Psychiatry* (1998) 66(4), pp655-9.