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Assessing for psychiatric injury and 'nervous shock'

Nigel Eastman

There is no direct coherence between medical and legal concepts or between medical and legal ways of thinking (Eastman, 1992). As a result, there are often substantial difficulties in translating the findings of one (medicine) into the decisions of the other (law). In order to minimise interdisciplinary confusion, it is necessary for each to have an understanding of the approach of the other. This paper attempts to elucidate the relationship between law and psychiatry as it is played out specifically in personal injury litigation and in relation to civil legal claims for (legal) 'nervous shock'. It is not confined solely to claims arising out of the development of post-traumatic stress disorder (PTSD) (Eastman, 1995; Napier, 1995), but is applicable to any psychiatric sequelae of events for which legal liability of a defendant can be established. It also offers general comments about the provision of civil psycho-legal assessments, advice and opinion writing (Carson *et al*, 1993) as a backcloth to its more specific purpose.

Negligence law

To establish negligence a plaintiff must show that:

(1) the defendant owed the plaintiff a duty of care (because the defendant should have had the plaintiff's possible injury in mind)
(2) there was a breach of the duty of care (according to the relevant legal standard)
(3) the damage suffered was caused by the breach (that is, the breach caused the psychiatric injury).

Except in cases of alleged psychiatric negligence, psychiatric expertise is relevant only to the *description* of any (psychiatric) damage, its *causation* and its *prognosis*, with or without treatment. The court will put a direct monetary value on any financial loss which flows from the psychiatric injury (for example, specific loss of employment), and will attempt to do so with regard to any non-financial loss (for example, loss of libido or suffering from psychiatric symptoms generally). Psychiatric evidence is therefore relevant in relation to causation of the first type of loss and in offering a description of the second type. The latter will directly affect the 'quantum' of damages, as will any estimate of appropriate treatment (and likely outcome), further damages being implied by virtue of treatment cost.

The law makes a distinction between psychiatric loss which flows, in an 'add-on' fashion, from physical loss (for example, a road traffic accident involving broken limbs *plus* symptoms of PTSD) and legally actionable events resulting solely in psychiatric loss. There is little logic to the distinction, but the courts have been concerned to avoid breaching a (perceived) 'floodgate' of claims for solely psychiatric loss, where the number of claims would be high and where there would be (again, perceived) substantial evidential difficulty in distinguishing valid from invalid ('normal mere emotions') cases (*Whitmore v. Euroways Express Coaches*, 1984). Hence, the recent Hillsborough case (*Alcock and others v. Chief Constable of the South Yorkshire Police*, 1991) reinforced this distinction for clear public policy reasons. This said, so-called (solely) 'nervous shock' is allowed in certain circumstances. Hence, direct experience of a sudden trauma oneself, or of such a trauma to someone 'in close ties of love and affection', can result in damages. However, aside from the need for development of a clearly established medical (psychiatric) condition, the damages must have been 'foreseeable' to the defendant and the plaintiff

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must have been of 'reasonable fortitude' (*Bournhill v. Young*, 1943). Hence by contrast with 'rescuers' (*Chadwick v. British Transport Commission*, 1967), 'mere by-standers' cannot claim; even close relatives cannot claim if their perception of the trauma to their relative was *indirect* (viewing on television will not do) (*Alcock and others v. Chief Constable of the South Yorkshire Police*, 1991), although they may be able to claim for directly viewing the 'aftermath' of a disaster affecting their relative (*McLoughlin v. O'Brian*, 1982). Hence, there can be psychiatric damage arising from a trauma which, in psychiatric terms, was caused by the event but the courts will, for public policy reasons, assume that there was no such causation.

Because of a number of highly publicised 'disaster' cases, the concept of 'nervous shock' has become inextricably linked with PTSD. However, it is important to emphasise that any valid nosological entity can amount to 'nervous shock'. Indeed, neurotic conditions clearly tend to cross-relate diagnostically, and this is reflected in the legal rules. All that is necessary is a valid diagnosis and causation. It is also important to emphasise that there are examples of essentially solely psychiatric injury which have been allowed in circumstances not amounting to legal 'nervous shock'. Hence, for example, PTSD following an episode of anaesthetic wakefulness has been allowed within 'personal injury' on the basis that physical pain was experienced (*Phelan v. East Cumbrian Health Authority*, 1991).

Since this brief account must cover a variety of psychiatric diagnoses, there will be no explicit detailed reference to the assessment of a particular symptomatology. Rather, the description will concentrate on:

(1) general psycho-legal issues relating to civil legal assessment and opinion writing; and
(2) specific problems of the interface of law and psychiatry relating to psychiatric injury, both within personal injury cases and in relation to 'nervous shock' cases.

Civil psycho-legal assessment and opinion writing

Psychiatric and legal purposes are entirely different; psychiatry is concerned with diagnosis and treatment, and law with liability and recompense. It is unsurprising, then, that their concepts vary greatly (Eastman, 1992). The psychiatrist must recognise at the outset of any psycho-legal assessment that she (or he) is providing psychiatric information for an entirely non-psychiatric (legal) purpose. She must also recognise that the adversarial legal system drives a different evidential approach, and even standard, from that which applies within medicine. Writing opinions or giving evidence is therefore somewhat analogous with batting in cricket against the delivery of a fast or spinning rugby ball, a game I have called elsewhere 'rugby-cricket'. There is little purpose in complaining about or resisting the shape of the ball. The medical expert must adapt his game to the unusual context, conditions and rules.

Playing 'rugby–cricket' requires an approach which emphasises the following.

Assessment

(See Box 1)

(1) There should be clear definition (by the lawyers) of the legal questions to which medical evidence is thought to be relevant. Instructions equivalent to the general practitioner (GP) letter to the house surgeon reading "Dear Doctor, query abdomen" will not suffice, and should be rejected.

(2) The relationship with the 'assessee' is not similar to that with a patient. Indeed, she is not a 'patient' but, at best, a 'client once removed' (coming, as he or she does, from a lawyer whose clients he may directly be, or even from a lawyer who 'opposes' the client). This properly gives rise to a wholly different set of ethical, legal and clinical expectations (Carson *et al*, 1993).

Box 1. Good practice for assessment

Insistence on clear posing of legal questions
Recognition that the assessee is a 'client once removed' and not a patient
Explanation of unusual doctor–client circumstances, including lack of confidentiality
Consideration of all past medical records
Use of other informants
Use of all relevant legal documents
History-taking with an awareness of legal questions
History structured with event and psychiatric sequelae towards the end
Specific reference to need for data validation

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(3)Related to point (2), there is no presumption of confidentiality or of legal 'privilege' of information given from the client to the doctor.

(4) Because of the detailed evidential approach of the law, the doctor should be even more obsessional than is clinically usual (or necessary) in gathering all past medical records (it is embarrassing to write an opinion about negligence causing an anxiety state only to find that there was a life-long pre-existing condition evident in the medical notes).

(5) There should be substantial usage of other informants, albeit some of the best of whom will have vested interests (for example, spouses).

(6) All relevant legal documents must be studied (it may be that the plaintiff's history is contradicted by statements to his solicitors, as further reflected in the legal 'pleadings').

(7) Albeit that history-taking should be standard, it should reflect specific legal questions to which the information will be applied (the idea is to adopt the 'one eye on legal questions' approach).

(8) Related to (7), the interview must take account of the very unusual (non-therapeutic) circumstances of the assessment. It should not, for example, begin with discussion of the history of the presenting complaint, which will relate directly to the person's emotive concern with his case, but should, by contrast, leave such matters until relatively late in the interview, when the psychiatrist has already formed a general opinion about the 'client'.

(9) There must be specific reference, both within the interview and more generally, to the need for data validation. Albeit that all psychiatric history-taking and mental state examination should be carried out in a way which is mindful of the possibility of either subconscious or deliberate distortion or faking, in a psycho-legal context the motivation for such distortion/faking is obvious and needs to be addressed specifically. Box 2 lists a number of aids to validation.

Box 2. Aids to validation of interview data

- Awareness of potential simulation or dissimulation
- Open questions (initially)
- Care with direct questions
- Use of false positive questions (those which do not fit the diagnosis but to which the client may falsely answer positively)
- Negative answers where simulation would suggest a positive answer
- Mental state changes associated with relevant topics (e.g. anxiety when discussing traumatic event)
- Consistency (with written legal documents)
- Jigsaw of symptoms fits the diagnosis
- Temporal development and waning of symptoms fits the diagnosis
- Specific content of symptoms reflects the traumatic events
- Psychometric tests (for cross-validation)
- Other informants (but care needed)
- Medical records for relevant time period

Opinion writing and oral evidence

Aside from principles of assessment, there is also 'good practice' for the presentation of psychiatric findings in a legal context via written opinion or oral evidence. Report writing involves education of lay readers, and a sequential approach whereby the psychiatric information is described first, using psychiatric concepts, language and notions (for example, of causation), and then translated into legal concepts and implications (for example, the translation of PTSD into 'nervous shock'). Reflection on the legal purpose will highlight unusual uses to which some medical information can be put. Hence, a background history may function coincidentally as an estimate of base-line functioning relevant to the life impact of an event and consequent damages. Again, the previous psychiatric and medical histories will be of great importance in determining the presence of any pre-existing condition or 'eggshell personality' (*Malcolm v. Broadhurst*, 1970) in relation to causation. Yet again, it is essential to distinguish clearly 'source data' from 'opinion'; it is legally confusing not to do so. It is also essential to offer a reasoned opinion, not an opinion purportedly validated on the basis of length of experience or standing; as in a mathematics examination, the advice is 'show your workings'.

It is good practice to offer an opinion in terms of one (or both) of the accepted international classificatory systems of mental disorders (DSM or ICD). Such a discipline is important for the individual clinician (in terms of achieving inter-case consistency) and to the psychiatric profession in general (in terms of interrater reliability). It also offers a clear definitional standard against which lawyers can match the clinical assessment of the expert whose evidence is being considered. Such an approach

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will not rule out individual clinical judgement, particularly where there are issues of degree rather than presence/absence of symptoms (of particular relevance in neurotic conditions), but it will minimise individual clinical idiosyncrasy.

It is a good idea (sensible lawyers require it) to offer standard text references (page referenced and quoted) in support of any opinions that the writer offers in relation to psychiatric causation, prognosis or treatment. Again, this helps validation and avoids idiosyncrasy.

Assessment of psychiatric injury

The assessment of psychiatric injury does not differ between circumstances where such injury is associated with primary physical injury and where there is solely psychological injury, including potentially giving rise to legal 'nervous shock', even though the implications may vary between the different legal situations.

Legal instructions

Instructing solicitors (whether for the plaintiff or the defendants) are likely to pose questions such as "Has this plaintiff developed a mental disorder?" and, "If so, was it caused by event X?". These are the primary questions to which will then be added further questions such as "What is the level of disability which results from the injury?", "What is the prognosis of the condition if untreated?" and "What treatment is appropriate and what is the likely outcome of such treatment (in modifying the prognosis)?". Clearly, only some of these questions relate to assessment of the disorder *per se*, and indeed, questions of causation should necessarily be answered in a much more speculative fashion.

If the instructions from the solicitors are not clear, then it is important that the psychiatrist asks for clarification before undertaking any work at all. Again, if there are papers clearly missing from the bundle which has been provided (for example, past medical records), then it is important to request those at the outset (albeit that the existence of some records may not become known until after the client has been seen). Again, if there is a suspicion that there may be rather specific legal definitions or questions to which the psychiatrist has to work, then she should ask for clarification of these before seeing the client.

In summary, by the time the psychiatrist sees the client, she should have a clear understanding of the legal structure of the case so that any important issues to be dealt with in the interview will either have become directly apparent from the papers or will have arisen in the clinician's mind by implication.

The litigated event

Since the clinician will have to give an opinion as to any possible causal link between the litigated event and possible subsequent psychiatric sequelae, it is very important to take a clear history in detail of what happened to the client. Hence, details of the content of the event may be of substantial importance in relation to, for example, the content of subsequent traumatic symptoms (a client may have intrusive recollections or dreams of events which reflect the litigated event). This can potentially give rise to a firmer conclusion about causation. Also, details of the event will naturally flow into the development of physical and mental sequelae and the timing of the onset of the latter is potentially of substantial importance.

Quantum of damages

The quantum of damages which will be awarded on a finding of liability against the defendant will depend upon matters which may well go beyond psychological sequelae of the event, for example, physical injury resulting in loss of employment opportunities. Also, the law recompenses successful plaintiffs for 'ordinary (mental) pain and suffering' as part of the ordinary damages structure and this does not depend in any way upon expert psychiatric evidence. By contrast, 'special damages' can lie as a result of the development of a specific mental disorder which is consequent upon the event.

The hierarchy of diagnostic categories within psychiatry emphasises that the distinction between 'ordinary pain and suffering' and 'mental disorder' can be more easily defined in relation to some conditions than others. Hence, brain damage consequent upon a head injury with psychiatric sequelae, or functional psychosis, clearly go beyond 'ordinary pain and suffering'. However, the vast majority of cases involve neurotic disorders as sequelae of litigated events. Here, there is nearly always the potential for arguing that what the plaintiff suffers from amounts to no more than an ordinary response to the litigated event.

The fine line between mental disorder and

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'normal response' emphasises the importance of taking a very detailed history of the development and timing of symptoms, including clearly distinguishing between spontaneously described symptoms and symptoms which have been elicited by direct questions (this being of relevance to validity and faking). Detailing of symptoms will also assist the court in attempting to attach a monetary value to subjectively experienced symptoms.

Since disabilities are as legally relevant as symptoms *per se*, it is also important to detail the life impact of such consequences. This will be used by the court both to attach a direct monetary value to the damage (for example, where symptoms have resulted in loss of employment) and to determine some monetary value in relation to other types of life impact (for example, loss of sexual enjoyment).

The Mental State Examination is important not only in confirming the diagnosis (for example, where a client experiences anxiety while discussing a traumatic event which, it is suggested, has lead to PTSD), but in helping to establish the current level of disability.

The use of self-report questionnaires and other types of validated tests is ultimately up to the individual clinician. However, any information which cross-validates a diagnostic conclusion will be of substantial advantage in the context of the somewhat psychiatrically cynical legal arena.

The quantum of damages will also, of course, be determined substantially by the prognosis of the condition, and a view should be offered. Clearly, estimating the future is an inherently less valid activity than describing the past, and if the view is not thought by the clinician to be particularly reliable or valid, this should be made clear. If there are scientific publications which assist, then these should be appropriately quoted.

Prognosis is closely interlinked with treatment, and an opinion should be given as to the appropriate treatment for any disorder which persists. This will assist in determining further damages arising out of the cost of treatment. The likely impact of treatment on prognosis will also be important in determining the damages which lie in relation to prognosis itself.

Causation

In order for damages to lie at all, it is necessary for a plaintiff to demonstrate that the damage experienced (in this case mental disorder) was caused by the litigated event. The standard which the law uses is that of 'material contribution', that is, the litigated event must have 'materially contributed' to the damage suffered. The psychiatrist should be aware of this definition when writing sections of reports concerned with causation.

Clearly, establishing psychiatric causation is potentially a far less valid exercise than describing past symptoms (or even predicting future symptoms) and the difficulties must be clearly acknowledged. However, an attempt must usually be made, and any such opinion should be based upon a number of factors. Firstly, if there is a clear temporal relationship between the event and subsequent symptoms (and no previous symptoms were ever experienced by the patient) then this will, on the face of it, suggest causation. Secondly, if the content of the symptoms (as already described in relation to PTSD) is closely associated with the content of the litigated event, then causation will be strongly suggested. However, the situation is rarely as straightforward as this. Some people who develop post-event symptoms have a demonstrated neurotic diathesis (including frank symptomatology), albeit they may experience substantially worse or different symptoms after the litigated event. In those circumstances a clear distinction has to be made between some pre-existing condition and the (subsequent) development of illness after the litigated event. If someone has not had any neurotic symptoms for ten years and then develops symptoms immediately after the event, there will be little difficulty in presuming causation. However, where there has been a much shorter period since the last experience of symptoms, the problem of estimating causation will be substantially greater.

Thirdly, the person may have experienced a 'priming event' some time before the litigated event, where the former had some major psychological significance for the plaintiff in relation to content of the latter. The litigated event will therefore have operated to 'kindle' symptoms from some previous priming experience. It is sometimes difficult to assess not only whether there were no symptoms after the priming event (and before the litigated event), but also whether the priming event or the kindling event was the more important in causal terms.

Fourthly, if the condition from which the plaintiff suffered after the litigated event is one that is inherently relapsing (for example, an affective illness), it may be argued that the person was 'ready' to have a relapse of his/her illness regardless of the event.

Fifthly, a problem arises if the symptoms occurred after not only the litigated event but also after some other significant life event which might, in itself, have given rise to the mental disorder.

Finally, there may be comorbidity between the mental symptoms of a disorder which appears to be the sequela of the event, and a disorder unrelated to the event.

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Apart from strict problems of causation, there are further problems relating to the notion of 'eggshell personality'. It is generally established in personal injury law that a defendant must take a plaintiff as she finds him. Hence, the defendant will be held liable even if the plaintiff was psychologically vulnerable. However, sometimes there are difficulties in distinguishing between an 'eggshell personality' and frank mental symptoms.

Finally, in 'nervous shock' cases there is a potential distinction between psychiatric causation and legal causation. Hence, as already indicated, in psychological reality there may be causation, and yet in legal fiction there may be assumed to be none (for example, in relation to PTSD arising in a sufferer who was a 'mere by-stander' of some disaster). This is ultimately a question for the lawyers and not for the psychiatrist, but she should be aware of the distinction.

Relationships with the lawyers

Because legal process has strict rules about exchange of reports and of other information, frequently the lawyers will wish to alter or amend an expert's report. This should be resisted if it relates to the opinion which is expressed, but it may be appropriate to agree not to include, in the list of sources of information, reports which have been provided to the psychiatrist but which have not been disclosed to the other side. This may set up a somewhat artificial situation in that the psychiatrist will have used information contained in such reports and yet have to pretend (on paper) that her opinion was not in any way determined by those reports. Ultimately this may be a question for individual ethical consideration, but the author's view is that it is impossible to work outside of the accepted rules of legal procedure, and so one has to accommodate one's medical approach and ethics to such procedure. The more uncomfortable a psychiatrist feels with the constraints imposed by legal process, the less she will be inclined to engage in psycho-legal activities.

Lawyers also occasionally ask for correction of details gained from the client in the history which is then relayed in the psychiatrist's report. Clients often say "I didn't say X, I said Y". In those circumstances the author's view is that no amendment should be made to the report other than possibly agreeing to include an addendum indicating those elements in the history with which the client does not agree. In this way, the court can determine which information source it intends to rely upon.

It is also common for lawyers to send psychiatric reports from the 'other side' for comment. It is, of course, entirely appropriate to offer a view on such reports and to attempt to distinguish clearly what the areas of difference are between one view and the other. Hence, it is important to try to minimise the differences in order to facilitate the legal process. However, there is no purpose in carrying out esoteric debates by letter. Only substantial differences of psychiatric view which have specific and different legal implications should be addressed.

It is not uncommon for there to be a 'conference in chambers' which includes consideration of the report that the psychiatrist has prepared. It is important to review the report and also carry out some 'refreshment' reading of the papers prior to going to such a conference. It will be tightly scheduled and there will be little time for fumbling through papers trying to remember what one had read one or two years before (not an uncommon time delay). Indeed, the time delays that commonly occur in civil litigation emphasise the advantage of writing comprehensive reports which clearly document, not only the history from the patient, but also relevant extracts from medical records and legal papers (as well as from other informants) which were important in determining one's opinion. Hence, on re-reading a report much later it is usually possible to 'reconstruct' in one's mind the thought processes and argument which lead to the opinion which was expressed. Essentially, the report reflects the 'architecture' of reasoning within the case and should be easily accessible at a second reading much later on.

Professional ethics

Aside from the importance of guarding objectivity through accepting instructions from lawyers for both plaintiffs and defendants, it is also important that the psychiatrist explains at the beginning of any consultation that she is unbiased, albeit that the relevance of which 'side' has asked for the report is reflected in 'ownership' of the report and (perhaps) whether the report is put into the proceedings. Furthermore, the lack of confidentiality should be emphasised and, although the client may wish to attempt to give information which she wishes to be kept secret, the doctor can only agree to do this if it is medically irrelevant, or irrelevant to the particular medical circumstances surrounding the litigation.

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Conclusions

Playing 'rugby–cricket' is a peculiar but stimulating exercise. Whether it is played in civil litigation (in that context rarely in the courts, since 95% of cases are settled out of court), or within criminal contexts, successful practice rests upon a clear understanding of the detail of the interface between law and psychiatry. Although theoretical papers and descriptions such as this one can be useful to the relatively inexperienced, becoming an aficionado rests largely upon practical psycho-legal experience. After enough years, it is unusual to find a new case type, and even minor and subtle psycho-legal issues within cases become diminishingly novel with greater experience. 'Rugby–cricket' may be somewhat daunting to the new batsman but, with experience and confidence, it can be an exhilarating game, with the requirement of greater exactitude and tightness of logical argument than is usually experienced in even the best of ward rounds.

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Multiple choice questions

1 Regarding cases which can be litigated:
- a psychiatric injury can only be recompensed if it is associated with physical injury
- b the legal questions relevant to the psychiatrist are determined by which side asks for the opinion
- c the psychiatrist is in a contractual relationship with the litigant for the report
- d lawyers can properly alter an expert report to allow for non-disclosure of reports and/or documents
- e nervous shock is the legal equivalent of PTSD

2 Negligence law:
- a is based on statute
- b holds a defendent potentially liable even if the plaintiff has an 'eggshell personality'
- c requires the breach of duty of care to be foreseeable
- d clearly differentiates between medical and other negligence
- e requires a DSM–IV or ICD–10 definition of mental disorder

3 Damages for nervous shock can be recovered:
- a by a bystander who is a fairly good friend of the victim
- b by a close relative seeing the direct aftermath of the event
- c by a close relative who watched the event on television
- d by a fireman assisting at the scene of the accident
- e by a mother who directly observed her son crushed by a car

4 Causation:
- a is determined by a psychiatric expert
- b is required for liability *per se*
- c affects the quantum of damages
- d is a medical concept in negligence law
- e can be established without medical evidence

5 Regarding the quantum of damages:
- a it will necessarily be higher for psychotic than for neurotic conditions
- b there will be special damages for ordinary (mental) pain and suffering
- c the psychiatrist will imply a monetary value in her report for a given psychiatric injury
- d it will be affected by prognosis and treatability
- e it will be reduced by the presence of pre-event symptoms

MCQ answers

1		2		3		4		5	
a	F	a	F	a	F	a	F	a	F
b	F	b	T	b	T	b	T	b	F
c	F	c	T	c	F	c	F	c	F
d	T	d	F	d	T	d	F	d	T
e	T	e	F	e	T	e	T	e	T

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