Posttraumatic Stress Disorder in Tort Actions: Forensic Minefield

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The authors discuss posttraumatic stress disorder (PTSD) as a basis for personal injury litigation. Three case examples raise issues related to: (1) the controversy surrounding expansion of tort liability, (2) the courtroom use of psychiatric nomenclature as represented in the DSM (e.g., PTSD), and (3) ethical concerns regarding psychiatric expert witnesses. Psychiatrists became easy targets when problems related to personal injury "stress" cases developed. A careful analysis, however, demonstrates that the issues are complex and multifaceted. For example, tort liability expansion was primarily instituted to compel a greater provision of liability insurance, not to reward stress claims. The increasing use of psychiatry's DSM in the courtroom has occurred despite explicit precautions against forensic application. Finally, the need for psychiatric expert witnesses has increased because courts have gradually usurped some psychiatric clinical prerogatives and because there has been a trend toward greater consideration of emotional pain and suffering. Although psychiatric expert witnesses have not been beyond reproach, critics have attempted to impeach the entire psychiatric profession for the questionable actions of the minority. The authors provide a detailed analysis of current problems, offer suggestions for improvement, and provide an educational counterpoint to the "hysterical invective" that often greets psychiatric testimony.

Posttraumatic stress disorder (PTSD) as the basis for a tort claim is a union of forensic problem children. Because of the increase in both the number of tort actions and awards of exemplary damages, tort law has been much discussed and much criticized in recent forensic literature.[1-5] The fervor of the discussion has been matched by controversy surrounding the psychiatric diagnosis of PTSD, particularly when PTSD crosses medical boundaries and emerges in the forensic arena.[6-13] Also, with PTSD as one example, some observers even have expressed reservations about the courtroom use of psychiatric nomenclature as represented in the *Diagnostic and Statistical Manual of Mental Disorders* (DSM).[14, 15] All this heat has been fueled by general debate about "stress" claims, particularly, as they relate to workers compensation.[16-19]

Finally, courtroom testimony by psychiatrists where "stress" is involved has interdigitated with an ongoing forensic controversy about ethical considerations involving psychiatric expert witnesses. Similar to calls for tort law reform, there have been proposals to modify the medical expert witness system.[20-23] Reformers have desired to make expert witness

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testimony less adversarial and, consequently, more impartial. Contradictory psychiatric testimony was a less serious problem when few legal situations raised psychiatric questions. Our society, however, has become more aware of psychiatric theories and the number of, and demand for, psychiatrists has increased together with the variety of uses of psychiatric testimony.[21]

Following three case examples, this article will address issues generated by psychiatric testimony regarding stress claims arising in the context of personal injury lawsuits. The three major areas to be discussed are: (1) torts and tort reform, (2) DSM-III-R (e.g., PTSD) in the courtroom, and (3) the psychiatric expert witness.

Case I

A 33-year-old female parking patrol officer was involved in an altercation with an irate man after she issued him a parking ticket. He grabbed her right arm and verbally abused her for writing the ticket. She sued him for $150,000 including punitive damages of $100,000, and asserted that he had been intentionally and willfully violent toward her. The plaintiff's statement claimed that "as a direct and proximate result of the defendant's assault and battery, plaintiff was caused to suffer permanent injuries including acute posttraumatic stress disorder with some associated regression, partial personality decompensation, depressive reaction, pain, suffering, stress, and anxiety."

It was alleged that the defendant's anger and physical force reminded the plaintiff of past traumas including childhood sexual abuse, her mother's death when she was a young girl, the death of her child from medical complications of premature birth, and right shoulder surgery for thoracic outlet syndrome due to an automobile accident.

The clinical evaluations by several mental health professionals described a variety of symptoms such as tearfulness, hand wringing, stuttering, and a pervasive feeling of helplessness. Although there was apparently no systematic inquiry for objective symptoms, all clinicians diagnosed the plaintiff as having PTSD without documentation of the requisite DSM-III criteria.

Case II

Numerous chronic symptoms led a young woman to file for damages for PTSD resulting from restaurant staphylococcus food poisoning. She alleged that she would probably continue to suffer physical and mental pain for much of her life. Although a thorough medical evaluation six months after her acute medical hospitalization included normal physical examinations, gastrointestinal radiologic procedures, and laboratory blood results, she continued to complain of headaches, abdominal pain, anxiety, agoraphobia, sadness, impaired concentration, social avoidance, fatigue, hopelessness, suicidal ideation, irritability, insomnia, nightmares (for less than six months), fear of eating, and dysphoric intrusive thoughts associated with food. Past history included suicidal thoughts beginning in the preadolescent years (with a suicide attempt as a young adult)

and drug abuse as an adolescent. In addition, the plaintiff was reportedly raped 10 years before the food poisoning incident.

Two clinicians diagnosed the plaintiff with PTSD secondary to food poisoning. One of them believed the significant stressor had been the entire experience of having been ill and obtaining acute treatment.

The case was ultimately settled out of court with the plaintiff receiving "less than six figures."

Case III

A middle-aged farm couple claimed PTSD resulting from the accidental release of anhydrous ammonia from an agricultural manufacturing plant and sued the parent corporation. Thirty people in the community, including the plaintiffs, were exposed to dangerous levels of ammonia over a period of 20 to 30 minutes. The plaintiffs were medically diagnosed with residual bronchospasm and restrictive airway disease secondary to pulmonary ammonia burns. Over the next several years the couple experienced some improvement in pulmonary function. The woman's improvement was more marked with lung volumes returning to normal after the use of bronchodilators.

For some time after the accident, however, the couple remained preoccupied with their residual physical disabilities and were said to have a fear of dust-clouds or fog. Other symptoms included depression, disturbed sleep, bad dreams, and fatigue. One examiner noted that both plaintiffs possessed characterologic traits associated with personal rigidity and inflexibility.

A mental health consultant for the plaintiffs diagnosed PTSD, but a consultant for the defendant believed that the plaintiffs were experiencing an understandable emotional reaction to their medical problems. All examiners reported the plaintiffs to be friendly, pleasant, and able to establish good rapport with others. Although not pursuing activities of former interest, they had a great desire to do so but were limited by their physical incapacities. A pretrial settlement awarded the plaintiffs exemplary damages of $100,000 and $10,000 for each of their children. The children were not exposed to ammonia but were adversely affected by their parents' impairment.

Torts and Tort Reforms

In the past 20 years courts have been tracing a somewhat irregular line between compensable and noncompensable psychic impairment in personal injury cases.[24] Many years ago liability for psychic impairment was contingent on physical impact or physical injury. Other than that, there was no tort liability for a "broken mind." When the concept of psychological injury became more accepted, the courts became more willing to compensate for emotional distress in the absence of physical impact or injury.[25] Specific examples are: an individual who is within the radius of risk from negligent physical contact and, as a result, suffers an emotional disturbance; an individual who suffers emotional distress after witnessing the peril or harm

to a third person such as a spouse or child; an individual who does not actually see the physical injury of a third person but suffers a severe shock when hearing of it or seeing the results.

In consideration of the above situations, the trend of the law has been to give increasing protection to feelings and emotions of injured parties and to enlarge redress in reparation for psychic injury. One estimate is that approximately 2 to 3% of all torts are associated with psychiatric disability.[26] As in the case examples, psychiatrists are increasingly being asked to assist the courts in evaluating the cause, extent, and severity of emotional reactions that follow a wide variety of injuries.[27] Modlin and Felthous's[28] 12-year survey of their forensic psychiatry practices yielded 403 civil cases, with 55 percent involving personal injury lawsuits or workers compensation claims. The number of personal injury lawsuit filings between private parties in federal courts has risen more than 50% (to about 32,000) just since 1980.[29] Finally, although this is a relatively new area of litigation, the courts are beginning to recognize the reality of the indirect effect of psychic trauma on family members. These claims can be quite substantial—for instance, a spouse or parent becomes chronically depressed as a result of a motor vehicle accident and this adversely affects other family members by impairing the quality and nature of the relationship between the injured person and the affected family members (Case Example 3).[27]

The most common modern examples of torts are motor vehicle negligence, product liability, and professional malpractice. Less common examples include negligence, invasion of privacy, defamation, misrepresentation, nuisance, assault and battery, and false imprisonment.[27] Legal claims involving physical injury may or may not be accompanied by claims of psychic or emotional trauma.

Tort cases where negligence is not clear may involve complex causation issues. Causation is crucial in the resolution of a claim for compensation. The claimant is entitled to recover damages only for those problems that are caused by the defendant's wrongful act. Physicians sometimes have difficulty understanding legal approaches to causation that include not only the initiation of physical or psychological injury, but also the production of additional damage or dysfunction in individuals with preexisting problems (Case Examples 1 and 2).[30]

A causal role may be legally significant if it can be shown to have played some part, not necessarily the major one, in initiating, contributing to, accelerating, or aggravating a plaintiff's injury. Most jurists also have difficulty empathizing with this view. An astute defense attorney, therefore, endeavors to draw opinions from expert witnesses about the plaintiff's preexistent susceptibility to stress in an effort to influence the jury despite the letter of the law.[31] Defense attorneys will try to find and emphasize factors unrelated to the specific trauma that may have caused the emotional suffering. They will try to prove that the emotional symptoms or disability would

have occurred without the accident or that the symptoms are the result of the patient's conscious exaggeration or fabrication.[32]

In personal injury litigation, psychiatrists typically offer an opinion about whether or not a traumatic event—albeit physical injury, psychological stress, and/or exposure to a noxious substance—is the proximate cause (in the sense that the problem would not likely have occurred but for the trauma) of the plaintiff's ensuing psychic injury. The court follows the reasoning that the test for allowing a plaintiff to recover in a tort suit is not scientific certainty, but legal sufficiency. Thus, a cause in fact relationship need not be conclusively proven before a psychiatrist can testify that, in his or her opinion, a causal relationship exists.[30]

To compensate for pain and suffering outside of actual or compensatory damages, courts may award exemplary or punitive damages which have typically been applied in a context of intentional negligent conduct that usually involves behavior beyond ordinary negligence. Exemplary damages were designed to deter abhorrent or morally reprehensible conduct. Exemplary damages were also historically justified as a means for the injury to compensate victims for elements of damage otherwise not recoverable by common law.[2]

Most of the rules governing tort liability have traditionally been set by common law. State courts have been free to expand or restrict the concept of negligence according to their own wisdom and to define in their own way concepts such as proximate cause or pain and suffering, and to accept or reject new causes of action. With a few obvious exceptions, such as statutes of limitation, and laws that have replaced the common law system of contributory negligence with comparative negligence, the tort system operates independently of the legislature. The tort reform concept, therefore, is an anomaly in that it is essentially a call for the enhancement of new state legislation to alter the current common law system.[3]

The first round of tort reform took place throughout the nation in the 1970s when health care providers and insurers vigorously brought to the attention of state legislatures the existence of a medical malpractice insurance crisis. Concerned groups pressured state legislatures to pass radical revisions of the tort liability system as it related to medical malpractice. They were tremendously successful because 49 states, between 1975 and 1977, enacted legislation designed to reduce the number and size of medical malpractice settlements and judgments.[3]

The outcome of the changes, however, was only partially successful, and recently there has been a new insurance crisis not only in the malpractice arena but with liability insurance in general. According to a recent justice department statement, only wide ranging tort law reform will cure this new crisis.[33]

Much of the problem may be attributed to a conceptual foundation of modern law which says that the expansion of personal injury liability will lead to a greater provision of liability insurance.

Since the mid-1960s, the expansion of liability has been chiefly motivated by the concern of the courts to provide insurance to victims who have suffered personal injury. It is an indirect method of protecting individuals, especially the poor, who have not purchased or could not purchase insurance themselves. The courts rationalized that by increasing tort liability they were forcing employers and others to purchase insurance to avoid ruinous tort actions. The courts have invoked this insurance rationale to limit defenses of contributory negligence, assumption of risk (by the victim), and the effectiveness of statutes of limitation. At the same time, they have supported the affirmative extension of liability through the adoption of standards of strict liability, retrospective liability, relaxation of causation requirements, and, more generally, through the near universal acceptance of comparative negligence that permits the jury to render judgments against defendants even if they are responsible only in some small proportion for a plaintiff's injury. Thus, courts interpreted policy coverage provisions broadly and policy exclusions narrowly to achieve compensation goals. Courts also expanded the range of losses for which compensation might be sought, chiefly allowing increased recovery for emotional and other noneconomic losses. Thus, the overall effect of modern tort law is to expand corporate liability exposure and compel a very substantial level of provider insurance.[34]

Some say that an unintended side effect of these court interpretations is a modern insurance crisis, particularly surrounding personal injury claims. The justice department,[33] therefore, recommended tort law reforms that included reinstating a fault liability (contributory negligence) standard, adopting scientific rather than less stringent legal causation standards, instituting a cap on punitive damages, eliminating joint liability, and upgrading the qualifications of expert witnesses. Since 1985, on the basis of the justice department's recommendations, 42 states have enacted tort reform or insurance legislation.[34]

Some observers, however, have not agreed entirely with the justice department analysis or recommendations. For example, Priest[34] sees the problem related to another consequence of modern tort law, a broad shift from individual first party insurance to third party corporate insurance. This has been the result of shifting the liability obligation to providers, thereby requiring them to obtain third party market insurance. The insurance premium for a provider insurance pool must be set according to the average level of risk brought to the pool. The wider the range of risk between pool members, the greater the difference between the average risk and the low risk. If the disparity between the premium and the risk becomes too substantial, low-risk members may segregate into a risk pool of their own or drop out of the pool altogether because they find alternative means of protection that is less expensive than market insurance. As insurance pools consist of more high-risk members, premiums need to be raised placing greater pressure on the remaining low-risk members.

When high premiums drive low-risk firms from the commercial casualty market the original objective (providing broad insurance coverage) is lost. As premiums increase, large numbers of firms decide to self-insure by establishing their own reserves or use no insurance. Since the early 1980s, insurers have been progressively changing the terms of basic commercial insurance to make market insurance more attractive to low-risk providers and keep them in insurance pools. Insurers have changed coverage terms in three separate ways: increasing deductible and coinsurance levels, lowering aggregate policy limits, and expanding coverage exclusions. In effect, these changes reduce the level of commercial coverage offered to providers. Yet despite the reduction—in many instances sharp reduction—insurers have simultaneously been forced to raise premiums substantially and, in some markets, to refuse to offer coverage altogether.[34]

Losses representing pain or suffering or other emotional effects of an injury are never insured in first party markets because it is not worthwhile for consumers to pay the premiums necessary to support their coverage. First party insurance coverage, which corresponds to what consumers are willing to purchase, is much different in magnitude than third party insurance provided through expanded tort liability.[34] Currently, awards for pain and suffering and other nonpecuniary losses comprise a large portion of tort damages (the most commonly mentioned figure is 25 to 50%).[35] More detailed empirical studies of trial awards in Cook County, Illinois, showed that nonpecuniary losses comprised 47.2 percent of total damage awards.[36]

Specific reforms have tried to address these problems. Slovenko[5] notes that when limits to noneconomic damages have been enacted, the result has been that the cap is nearly always awarded, whether the case is minor or serious, with the net result of higher damage awards. Slovenko[5] also criticizes newly enacted fault legislation (comparative negligence) that strikes down joint liability. It stipulates that in any personal injury case in which the plaintiff is at fault to any degree, the court determines the percentage of fault of each party, and the financial liability of each party is also determined by that percentage. In the past, with joint liability, a plaintiff enforcing a judgment would proceed against the defendant up to his insurance limit and then proceed against other defendants for the balance. Rarely, if ever, did a plaintiff proceed against a defendant (e.g., doctor) beyond his insurance limit. Now, under recent reform legislation, the plaintiff must recover the judgment against the defendants according to their respective percentages of fault. Lawyers will probably no longer respect insurance limits that fall below a fault judgment because they cannot compensate by collecting more than stipulated fault percentages against other defendants. As a result, defendants will need more insurance or will have to go into bankruptcy to protect future earnings.[5]

Overall, tort reform has only had modest success, most likely because the

philosophy of expanded tort liability is essentially unchanged and because the increase in third party market insurance has underwritten the expansion. It now appears that broad third party coverage has been maximized and will, at the very least, give way to more narrowly defined risk pools and fewer coverage provisions. Theoretically, insurance carriers will thus become less appealing targets for massive tort actions. Another area of controversy, psychiatric expert witnesses, will be discussed in the last section. In brief, efforts to upgrade the qualifications of expert witnesses have been about as ineffective as other tort reform measures.

The Diagnostic and Statistical Manual in the Courtroom

The case examples do not represent a problem with DSM-III or DSM-III-R as much as they represent lack of adherence to the DSM criteria. Nevertheless, in a broader forensic context, there has been trepidation about cookbook psychiatric diagnostic criteria that may be used by individual lawyers and clinicians who represent a wide range of sophistication and clinical acumen. Some fear that the DSM allows for diagnostic shortcuts via checklist and that descriptive psychiatry may become a lost art. On the other hand, when descriptive information is given, as in two of the case examples, the stated symptoms may have little relevance to the DSM guidelines. Sometimes it appears that clinicians are providing their own criteria for DSM diagnoses.

In fact, there is an increasing belief that the DSM is misused in the courtroom.[14,15] This occurs despite cautionary statements in the manual about the use of DSM-III and DSM-III-R for nonclinical purposes (e.g., determination of legal responsibility, competency, insanity, or justification for third party payment). DSM-III-R states specifically that the manual is for clinical and research purposes and that a specific diagnostic category does not necessarily meet legal or other nonmedical criteria for mental disease, mental disorder, or mental disability. Precautionary notes were included in the manual because the drafters recognized that many of the DSM disorders have judicial consequence.[14]

Some believe the DSM should address legal aspects of those diagnostic categories that regularly arise in the courts. Shuman[14] notes that the use of DSM in the courts is growing, and the magnitude and mode of its use appears unaffected by the precautionary statements. He says that if legally relevant behavior was included in the DSM describing in detail what psychiatry knows about certain disorders, the problem of psychiatrists' acting beyond their expertise may be avoided. He says that because of the DSM's failure to address legally relevant behavior, testimony by "expert" witnesses sometimes exceeds the limits of professional knowledge based on competent research. This problem says Shuman, is more extensive both in number and in effect than the problem of lawyers or judges interpreting psychiatry through the DSM.[14]

Ciccone[15] believes that DSM-III is a helpful guide to the experienced psychi-

atric clinician and valuable as a teaching tool. In the hands of an inexperienced individual, however, the apparent ease at arriving at a diagnosis gives a false sense of security. He says that psychiatrists must recognize that a DSM-III diagnosis does not automatically answer forensic questions such as competency, nonresponsibility, or compensation. Consequently, he suggests that the precautionary statements in the beginning of the DSM be expanded and be included before each diagnosis that frequently appears in forensic contexts. Ciccone[15] further suggests that emphasis is needed to underscore the fact that DSM-III represents guidelines that should be subject to clinical judgment and that adherence to the diagnostic criteria is not mandatory, but advisory. For example, a diagnosis may be made when all the DSM-III criteria are not fully met, or there may be circumstances where the DSM-III criteria are apparently met, yet clinical judgment indicates the diagnosis is not appropriate.

Stone[15] is quite critical of DSM-III, and presumably DSM-III-R, because the manuals lack diagnostic validity ratings. Furthermore, there is no acknowledgment that some diagnoses are more controversial than others. Therefore, every diagnosis is equally "official" and has equal weight. Stone[15] believes, however, that this problem is not confined to the courtroom, but is also a problem in clinical practice and psychiatric professional literature. He says that in both instances DSM-III diagnoses are given improper weight by many psychiatrists. "There is a whole generation of psychiatrists for whom official DSM-III is science. They quote chapter and verse, not as provisional ordering of complex sets of phenomenon, of varying significance, but as state of the art scientific technology."[15] In short, Stone[15] believes DSM-III is generally overvalued. If some DSM diagnoses have unacceptable consequences in the courtroom, the best remedy may be to identify them. When the American Psychiatric Association[37,38] separately considered the insanity defense and civil commitment, they singled out certain diagnoses as being appropriate or inappropriate for use in such contexts.

PTSD is an example of a psychiatric disorder that appears frequently in forensic settings (e.g., "stress" cases). Perhaps, as Stone and others[14,15] suggest, the manual should contain more cautionary statements regarding diagnoses such as PTSD or, as Shuman[14] advocates, the addition of a section on legally relevant considerations. At any rate, PTSD cases are often involved in legal proceedings where there are efforts to see the problem as a psychiatric condition that is purely the consequence of some severe trauma.[10]

A thorough understanding of PTSD is important, not only for clinical purposes, but also because of these forensic implications.[39] The diagnosis has evolved since the 1952 DSM-I (gross stress reaction) from an acute reaction in an individual with good premorbid adjustment to a specific syndrome occurring as an acute or chronic response with or without preexisting or concurrent pathology. The DSM-III-R PTSD

definition includes emphasis on the rare occurrence of the stressor and its nearly universal ability to evoke symptoms. However, it adds a list of generic characteristics of traumatic stressors. Some stressors "frequently produce the disorder" (e.g., combat, torture), and others produce it only "occasionally" (e.g., natural disasters, car accidents). The most common traumas involve "either a serious threat to one's life or physical integrity; a serious threat or harm to one's children, spouse or other close relatives and friends; sudden destruction of one's home or community; or seeing another person who has recently been, or is being, seriously injured or killed as the result of an accident or physical violence." DSM-III-R states that the disorder is apparently more severe and longer lasting when the stressor is of "human design."

Much of the early diagnostic formulations regarding PTSD were influenced by work with combat veterans and emphasized the process of reexperiencing severe trauma. Symptomatology was observed as long as 20 years after combat participation.[40] As Marin[41] has stated, genuine victims of PTSD are often struggling with profound moral issues including realization of the consequences of human aggression and of evil in themselves and others. These moral issues also have applicability to victims of rape.[42] The chronicity of the symptoms appear to be primarily related to the profundity of the moral pain.

The tenor of DSM-III-R discussion on the severity of a stressor required to produce PTSD suggests that events must be serious or severe in order to warrant the diagnosis. It is noted that the precipitating event is "outside the range of usual human experience." It is further stated that the stressor producing this syndrome would be "markedly distressing to almost anyone, and is usually experienced with intense fear, terror, and helplessness." Forensic factfinders should compare the DSM-III-R descriptions with the actual events purported to cause PTSD in psychic injury claimants. For example, when a claim is made following a minor or moderate car accident, one might look at the DSM-III-R statement suggesting that even car accidents with serious physical injury only "occasionally" produce PTSD.

As in the case examples, it appears that many claims of PTSD that follow stressors which are not particularly unusual or severe would be more properly classified as adjustment disorder or some other psychiatric disorder. By definition, an adjustment disorder disturbance begins within three months of the onset of a stressor and lasts no longer than six months. If the stressor persists, however, as in chronic physical illness, it may take much longer to achieve a new level of adaptation (Case Example 3). In some forensic venues, however, an adjustment disorder may not be compensable, which may be the crux of the problem. A claimant has to suffer "stress."

Platt and Husband[7] believe that there exists a "mutually exclusive gap" between the PTSD and adjustment disorder diagnoses. This gap includes individuals who reexperience a traumatic event

although the trauma is a relatively common occurrence such as a motor vehicle accident. In such cases, adjustment disorder does not appear to be the appropriate diagnosis because of the presence of intrusive recollections or recurrent nightmares of the accident, yet the stressor is not severe enough to justify a PTSD diagnosis. Slovenko[43] aptly states that the meaning of the trauma to the individual and the trauma resolution are so varied that it cannot be said that the effect of a stressor are the same for all. The best conclusion seems to be a statistical probability that people exposed to trauma develop stress symptoms to a greater extent than those not exposed to trauma. To add to the diagnostic difficulty, DSM-III-R states that in "adjustment disorder, the stressor is usually less severe and within the range of common experience; and characteristic symptoms of PTSD, such as reexperiencing the trauma, are absent." Therefore, symptomatology that ordinarily would seem to constitute an adjustment disorder cannot be so designated.

Hoffman[32] reviewed nearly 100 litigation cases following car accidents; fewer than 10 patients seemed to meet the criteria for PTSD. McFarlane[44] reported on the consequences of a disastrous fire in Australia in which 2,697 adults and children were registered as victims, 28 individuals were killed, and 385 houses were destroyed or extensively damaged. He notes that although special clinical services were set up for possible victims and widely publicized, not a single victim initiated psychiatric contact on his or her own. A survey of 36 of the victims showed that as many suffered from chronic pain syndromes, depression, and specific phobias as symptoms of PTSD. Platt and Husband[7] examined approximately 150 personal injury cases arising from automobile accidents and discovered only two instances where the "hitter" in the accident sought psychiatric treatment for accident-attributable symptomatology.

Hoffman[32] says that the most common applicable DSM-III diagnosis after motor vehicle accidents is psychological factors affecting physical condition. Other Axis I diagnoses that occur after trauma may include the somatoform disorders (conversion disorder and psychogenic pain disorder), phobic disorder, generalized anxiety disorder, major depression, dysthymic disorder, and occasionally factitious disorder. Rutter[45] believes that psychiatric symptoms precipitated by severe physical illness such as may be seen after natural disasters can be viewed as normal stress responses rather than psychiatric disorders (Case Example 3).

In the courtroom setting, the term PTSD has DSM-III-R "legitimacy" and the concept of stress following trauma is easily understandable to the layperson (e.g., juror, compensation board member). The PTSD diagnosis may elicit more sympathy for, and identification with, the patient because of perceived external causation as opposed to internal causation (e.g., personal weakness) in the case of depression, anxiety, or adjustment disorder.[7] Also, the previously discussed gap between the PTSD and adjustment disorder diagnoses might

tempt some clinicians to overdiagnose by erring on the side of giving a patient the PTSD diagnosis whenever intrusive reexperiencing is present. (The gap may, of course, tempt defense oriented witnesses to err on the side of diagnosing adjustment disorder.) This temptation may be particularly strong in the case of automobile accident victims. In contrast to individuals with more resilient personality structures, it has been shown that predisposed individuals may react to a minor or moderate traumatic event, such as an automobile accident, with a cluster of symptomatology that is a mixture of PTSD and depressive symptoms.[7]

There is absolutely no doubt that traumatic accident victims experience stress. Insurance carriers frequently shortchange patients who undergo psychiatric care following an accident.[46] Suspicions of malingering may help to explain why damages awarded for posttraumatic psychological symptoms are often substantially less than those for physical injury, in spite of the fact that limitations on the patient's life may actually be greater.[47]

Continued incapacity, despite apparent medical recovery after an injury, may be due to factors other than malingering. Resnick[46] contends that physical injury and pain often produce a regression characterized by breakdown of more mature coping mechanisms. Injury that causes incapacity is a stress upon one's psychological integrity, a challenge to one's mature self concept, and a fundamental threat to one's sense of personal worth. The resultant depression and dependency may be seen as a psychological reaction to physical illness.[46] Intrusive reexperiencing is also common and usually occurs when an individual psychologically fixates on an accident (Case Examples 2 and 3).

Perhaps forensic psychiatrists and other clinicians should follow the advice of Tanay[48] in rendering forensic diagnostic opinions. Tanay[48] says that it is important to differentiate between diagnostic accuracy and diagnostic precision. In the context of a forensic evaluation for stress compensation, it is only necessary to address the issue of whether or not the claimant experiences stress. Accuracy is more important than precision. When the examiner is able to accurately state that psychic injury has occurred, an adequate level of precision has been gained. A specific diagnosis may be important for therapeutic purposes, but in a legal setting this is a distinction without difference.

Psychic injury, particularly in the forensic context, casts a broad net. The definition of mental stress for legal purposes does not require a level of precision of a Swiss watch. Yet, it is important that PTSD be diagnosed only if the facts fit. To do otherwise dilutes and trivializes the diagnosis. When mental stress due to food poisoning or being grabbed on the arm is called PTSD, one wonders whether or not we are questioning if human beings can adapt to anything. Although sloppy diagnosis of PTSD is to be deplored, too much preoccupation with precise diagnostic categories does not serve legal needs. It is important for the diagnostician to com-

municate to insurance carriers, attorneys, or other fact finders that the claimant is experiencing stress-related symptoms. The precise diagnosis is less important than a thorough description of these symptoms. PTSD should not be the only admission ticket to the ballpark.

The Expert Witness

Unpopular judicial decisions sometimes are blamed unfairly on psychiatry and "the battle of the experts."[49] This is most apparent in criminal cases that are sensationalized by the media. Slovenko[23] has noted that a trial without a psychiatrist is usually bland, and that without psychiatric testimony, jurors tend to go to sleep. Psychiatric testimony makes headlines. By the same token it also can lead to considerable criticism when the courtroom decision goes against public sentiment. Most controversies resolved in the civil courts have at stake a monetary damages award; an unjust decision deprives one party of an economic advantage to which he or she is entitled. Cases requiring psychiatric expertise, however, may have a far more important issue at stake; a person's liberty.[2]

Comments frequently are made about the supposed willingness of some mental health professionals to compromise themselves for fees as expert witnesses; about lawyers who search assiduously for experts who will agree with a predetermined position; and about lawyers who have a stable of experts who are available whenever needed to take a particular position in court. These comments are frequently supported by examples of psychiatric disagreement in the courtroom.[50] In *Ex Parte Morris*,[51] a 1988 Alabama case, the dissenting opinion noted the proliferation of expert "locator" services that can help litigants find an expert who will advocate a desired position.[52]

Nevertheless, psychiatry has established itself as an inextricable cog in the machinery of the law and the demand for qualified psychiatric expert witnesses has multiplied exponentially at every conceivable stage of both criminal and civil cases.[53] In part this has come about because over the past two decades the legal system has taken discretionary authority away from psychiatrists and handed it to the courts. But the courts, in order to take on this burden responsibly, require more (not less) psychiatric testimony.[54] As Stone[54] says, "the more they hate us the more they need us."

Another reason for the criticism and confusion regarding psychiatric testimony is because people do not fit neatly into diagnostic categories. Therefore, the battle of the experts is actually a "battle of the categories."[23] The battle of the categories is the direct result of the complexities of psychiatric diagnosis. Clinical training teaches distrust of any unilateral and hence, unbalanced view of motivations and feelings. In psychiatry, certainty is an elusive commodity.[55]

Some psychiatrists, however, have been critical of their brethren.[56, 57] Stone and Perr[54, 58] lament the lack of sophisticated psychiatric testimony. In the case examples the psychiatric determinations of PTSD were either totally inaccurate or poorly substantiated. In two recent

not guilty by reason of insanity cases, a clinician known for his advocacy for PTSD victims was duped by plaintiffs who were claiming PTSD by fabricating their symptoms.[59, 60]

Weinstock[49] found that the "hired gun" problem in forensic psychiatry was of most concern to the largest number of respondents in his forensic ethics survey. The survey revealed other matters related to the expert witness, including becoming an advocate, not giving an honest evaluation, and testifying in court without adequate knowledge. The hired gun problem, however, may not be as prominent as commonly thought. Goldstein[61] interviewed six lawyers of his acquaintance under guarantee of anonymity to determine whether or not there was utilization of a subgroup of psychiatrists who embodied the advocate's approach. There was a consensus among the participants that the majority of practicing attorneys used experts properly, but there was also consensus that a small minority misused psychiatric experts. These lawyers would "tirelessly search" through their stable of "user friendly" experts to find support for a client's position.[61] Watson[62] asserts that most civil cases are settled by negotiation and that experts by and large are used properly. He makes the point that the vast majority of cases involving psychiatric expert testimony are resolved without trial.

Rather than the hired gun, a common problem may be the psychiatrist who knows very little about the law but goes to court or gives deposition out of sympathy for a client or for a cause. For some forensic psychiatrists these are the real villains, the amateurs who do not recognize forensic psychiatry as a subspecialty.[54] Another situation that may introduce inappropriate testimony occurs when psychiatrists, who have been caring for a patient, find themselves drawn into court on the patient's behalf. There is the risk that the psychiatrist "will go too far and twist the rules of justice and fairness to help the patient."[54]

Needell[21] says that inaccuracy and bias may assume three major forms: (1) experts who offer biased opinions, based on either calculated or unconscious prejudices; (2) physicians lacking in psychiatric sophistication who offer expert psychiatric testimony; or (3) fully qualified experts who, through inadvertence or laziness, perform examinations that do not serve as a professionally adequate basis for their conclusions. Needell[21] also maintains that use of unqualified experts may be more problematic in psychiatry because: any physician can testify as a psychiatric expert; collateral impeachment of psychiatric witnesses is extremely difficult; indices of objective professional review are often inadequate; and psychiatry has no uniform standards that clearly demarcate a thorough clinical examination (a controversial assertion).

In a sensational case, *Barefoot v. Estelle*,[63] two psychiatrists agreed, without interviewing the subject, that Barefoot had a sociopathic personality disorder and based their diagnosis on hypothetical questions posed by the prosecuting attorney. Even the hypothetical ques-

tions, however, failed to provide the necessary information to make a DSM-III diagnosis of sociopathy. As a result, the diagnosis was made without sufficient data either to meet the criteria or to rule out the possibility that other psychiatric conditions might have accounted for Barefoot's behavior.[64]

In summary, psychiatric expert testimony has been the subject of considerable controversy. Resnick[22] lists five major criticisms ("hysterical invective"): psychiatrists excuse sin; always disagree; give confusing, subjective, uninformed, jargon-ridden testimony; dictate the law, and give conclusory opinion. What are the solutions? How does the psychiatric profession provide the courts with accurate, relatively unbiased testimony? The answers lie in partially overcoming two weaknesses that are absolutely inherent to the system. The first is that lawyers do not necessarily choose experts on the basis of their scientific expertise, but rather on the basis of whether they are the "best witness" for their case. The second is that the adversarial process is not well suited to the dispassionate presentation of data.[21]

Proposals for changing the present system basically fall into two categories: one type would increase the sophistication of those who resolve the issues requiring expertise; the second would enhance the quality of the testifying experts. Some plans such as those requiring a decision-making body composed solely of experts are fiscally prohibitive. A plan proposed by Needell[21] is presently used in some states to screen malpractice and personal injury cases. A panel composed of a doctor, lawyer, and judge determine whether there is sufficient evidence to bring a malpractice or personal injury case to trial. The rules of evidence are relaxed somewhat, and panel members can question witnesses directly. Needell[21] says that this plan would considerably strengthen the courts ability to identify bias and inaccuracy, and would discourage baseless claims. He says that it is not necessary to limit the panel to the pretrial phase but to use the panel instead of a jury to decide all psychiatric issues in cases requiring psychiatric testimony. Presumably this would result in a bifurcated trial because it would be necessary to impound a lay jury as well as the expert panel. The excessive expense and procedural complications could result in detrimental delays. Needell's plan is probably most desirable as a pretrial screening procedure to discourage frivolous claims. Psychiatrists who testify may be less likely to introduce biased or inaccurate conclusions if they know they are going to be questioned by a peer.

A second alternative that has been proposed for decades, if not centuries, is the court-appointed expert.[22,65,66] Under such plans the court appoints an independent expert who testifies in addition to, rather than instead of, witnesses provided by the litigants. His or her function is to testify as any other witness, and to provide an independent opinion, subject to courtroom examination and cross examination.[21] The court chooses the independent expert from a pool of physicians, previously qualified by predetermined criteria. The

advantages are obvious in that, presumably, the court's expert can reach conclusions and render opinions more independently than the opposing attorney's experts.

Critics say that bias free testimony is an illusion, that the expert may appear to have the stamp of approval of the court and bias the outcome, and that it may be difficult to get a suitable expert pool.[27,67-69] Slovenko[26,70] believes that partisanship is necessary for the adversary system and that neutrality may be a disservice to litigants. Resnick[22] notes that real experts, citing professional obligations, may shy away from the proceedings and those with lesser qualifications will seek the positions. In a recent decision, *Ake v. Oklahoma*,[71] the judge pointed out that the frequent difference of opinion among psychiatric experts was indicative of the uncertainties in the mental health field and, therefore, there was a need to subject expert opinions to confrontation with different points of view. Appelbaum[72] states that after *Ake*, although the impartial expert may survive in situations requiring evaluation of competency to stand trial and may even flourish in civil cases such as those involving child disputes, the death knell has been sounded for this approach at a criminal trial.

An extreme view of the role of the psychiatric expert is presented by Faust and Ziskin[20] who claim that all psychiatrists and psychologists fail to meet the legal standard for expertise because they cannot give opinions with reasonable medical certainty and, therefore, do not aid the courts any more than an average layperson might. They cite three studies that "demonstrate" that rates of disagreement for specific psychiatric diagnostic categories equal or exceed rates of agreement.[73-75] Two studies involve DSM-III, Axis II diagnoses and the third considers diagnoses made in an emergency room. To preclude bias, Faust and Ziskin[20] maintain that the role of the psychiatric or psychological expert should be limited to the explanation of actuarial testing procedures. Their recommendations, of course, would effectively remove psychiatrists from the courtroom because psychiatrists, by and large, do not administer psychological tests.

Quite obviously, these views are not shared by forensic psychiatrists. Slovenko[23] asks, "Is it not entirely reasonable to assume that one who has had special training in understanding people, one who spends his life studying and thinking about people, is in a position to bring relevant and probative testimony about behavior? Are their training and experience irrelevant in issues at trial?" Frazier and Borgida[76] have empirically demonstrated that psychiatric expert testimony is not irrelevant in rape trauma cases. Their study showed that laypersons were considerably less knowledgeable than mental health experts and that there was considerable consensus among the experts about the scientific data base regarding rape trauma. They concluded that psychiatric expert testimony could be helpful to jurors who often hold inaccurate beliefs about emotional issues. Shuman[14] suggests that legally relevant behavior be addressed in

the DSM in order to upgrade psychiatric testimony and make it more uniform. These provisions would set clear guidelines for other professionals who rely upon this information and permit psychiatry to describe the limits of its knowledge and expertise.[14]

Gutheil and Appelbaum[77] believe that the honest expert is selling a set of skills, a way of analyzing a problem, and the means of presenting this analysis in court, not an opinion. The expert should reach his conclusion by exercising his relevant skills impartially. It may be impossible to be totally unbiased, but it should be attempted during an evaluation. A retainer in advance may help. If the psychiatrist reaches the witness stand it implies that his conclusion fits the expectation of those who are paying his fee. Nevertheless, hypothetical questions should be answered honestly even if doing so would seem to weaken the case the psychiatrist is supporting. Sometimes such honesty can actually help his side by making the expert seem more credible.[49] Stone[54] believes that the hubris in psychiatry comes from passing psychiatric testimony off as certainty or claiming that psychiatrists know things beyond a reasonable doubt.

Goldstein[53] says that the forensic psychiatrist should be involved in patient care. This would refute inferences that the expert is a hired gun who makes his entire living by testifying at trials. In some states, as part of tort reform legislation, there is a limit to the percentage of total income that a physician may derive from expert witness activities. Other jurisdictions may require the expert to have regular clinical duties rather than serving as an exclusive expert witness.[52] Some suggest that expert credentials be given scrutiny by a court appointed review body. Sadoff[52] sees the day when records of past expert witness testimony will be used to aid the courts in determining individual patterns of bias. Addressing the implications of the case examples, regulatory agencies are placing expert testimony under increasing inspection. The duties and responsibilities of the expert witness require a high degree of integrity and professionalism. Hopefully, those who deviate from such standards will eventually be identified and appropriate remedial action will be taken.

Conclusion

Psychiatrists often occupy the forensic hot seat. Using case examples, this article has looked at three controversial medicolegal areas. Psychiatrists have appeared to be major players in the expansion of personal injury liability because the courts have increasingly been willing to compensate victims for emotional distress. In fact, psychiatry has played a minor role in the development of a general judicial philosophy to increase redress and reparation for victims. Efforts at tort reform have attempted to address the conceptual foundation of expanded personal injury liability but have been largely unsuccessful because tort reform statutes have been inadequate and because the philosophical tenet that drives expanded liability has not been reversed.

At times psychiatric expert witnesses in personal injury cases have given

grossly inaccurate or biased courtroom testimony which may be related to: (1) the widespread use of checklist diagnoses that have largely replaced descriptive psychiatry, (2) lack of adherence to the DSM criteria when making diagnoses, (3) lack of legally relevant information in the DSM, (4) lack of valid criteria in the DSM (e.g., adjustment disorder), or (5) incompetent or lackadaisical expert witness.

The public has routinely condemned psychiatric expert witnesses in controversial cases, but many psychiatrists also believe there is a problem. Critics who want to throw out the baby (psychiatry) with the bathwater (inaccurate psychiatric testimony) condemn the entire profession for the actions of the minority. Refinements in psychiatry's diagnostic manual or tort reform can do nothing to prevent inaccurate or lax testimony by individual psychiatrists.

There have been a number of proposals for reform including court appointed psychiatric experts, special panels for psychiatric cases, restricting psychiatric testimony to a description of actuarial procedures, limiting the percentage of total income that may derive from expert witness activity, and restricting testimony to those whose credentials have been reviewed and approved by a certification body. We have discussed some of these proposals in detail. The invective surrounding psychiatric testimony may never be stilled, but psychiatrists always will have a responsibility to closely examine their performance and advocate for corrective action when appropriate.

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