PTSD and the Law of Psychiatric Injury in England and Wales: Finally Coming Closer?

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With the increase in terrorism in several parts of the world, more people are exposed to traumatic events that could cause psychiatric injury either to them or to members of their families. In Britain, terrorist attacks or other catastrophes are not unknown; indeed, the case law relating to psychiatric injury is vast. However, the intersection between medicine and the law is minimal. The result is a law that lags behind the scientific evidence and, on occasion, may seem unfair.

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With the events of September 11 still fresh in our minds, we cannot fail to wonder what the impact might be on the lives of people present at the World Trade Center and the Pentagon, or even on the viewers of television who witnessed this catastrophe. An early report[1] of a national survey assessing the immediate mental health effects of the terrorist attacks has already found 44 percent of adults reporting one or more substantial symptoms of stress.

Britain has had its share not only of terrorist attacks but of other catastrophes. On some of these occasions, claims were brought forward for compensation, resulting in the development of the case law for psychiatric injury, previously called "nervous shock." We will first discuss how well this case law stands up to criticism when the findings of medical research on post-traumatic stress disorder (PTSD) are applied. Second, we will attempt to bridge the two disciplines of medicine and law in discussing how the current medical research on PTSD can reform the current case law.

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Post-traumatic Stress Disorder

PTSD is a special case in psychiatric classification. It is the only syndrome, besides the adjustment disorders, with an existence that depends on an identifiable external event. Classified as an anxiety disorder, it is typically defined by the coexistence of three clusters of symptoms: re-experiencing, avoidance, and hyperarousal.

The core features of PTSD in DSM IV-TR[2] are: (1) a traumatic event that involved actual or threatened death or serious injury, or threat to the physical integrity of self and others, resulting in a person's responding with fear, feelings of helplessness, or horror; (2) the re-experiencing of the trauma in nightmares, intrusive thoughts (flashbacks); (3) the numbing of responsiveness, or avoidance of thoughts or acts related to the trauma; and (4) symptoms of dysphoria and hyperarousal.

The diagnosis of PTSD requires the persistence of symptoms for at least one month. It is specified as acute if the duration of symptoms is less than three months and chronic if it lasts longer. It is specified as having delayed onset if the onset of symptoms occurs at least six months after the stressor.

PTSD is still described in English law by the obsolete term "nervous shock." This term dates back to 1882 when a purely physical syndrome that developed after railway accidents was originally described by Erichsen, a professor of surgery in London.[3] In

1885, Page,[4] another London surgeon, attributed nervous shock to psychological origins. Soon after, in 1901, English law also recognized the existence of nervous shock as a psychological reaction and awarded damages to a pregnant barmaid who was frightened after seeing a pair-horse (a small carriage) driven into the bar where she was serving.[5] Currently, nervous shock is used by lawyers to signify a medically recognized psychiatric illness that can result in psychiatric damage.[6] Psychiatric damage, a broader and better term, encompasses "all relevant forms of mental illness, neurosis, and personality change."[7]

Basics of Negligence Liability

Legal responsibility for psychiatric damage is an aspect of negligence liability, which means that, for patients to be compensated in a case of psychiatric injury, they must prove that the development of a psychiatric syndrome was someone's fault. In negligence, three general elements must be satisfied as a condition of liability: there must be a duty of care owed by the defendant to the patient, a breach of that duty, and resulting damage. For patients to receive compensation after claims for damages for negligently inflicted psychiatric illness, they must overcome several additional hurdles to these conditions.

The single most important additional hurdle to the patients is to prove they are suffering from a recognizable psychiatric illness or as differently called in law, nervous shock. Any recognizable psychiatric illness will suffice[8]; there is no need to prove the existence of PTSD. Damages have been awarded in the past for morbid depression,[8] hysterical personality disorder,[9] PTSD,[10] pathological grief disorder,[11] and chronic fatigue syndrome.[12] The ordinary emotions of anxiety, fear, grief, or transient shock are not conditions for which the law gives compensation.[8,12–15]

The other hurdle that patients must overcome is reasonable foreseeability. In applying the test of reasonable foreseeability, the judge should treat him- or herself as a representative of the reasonable person. The best yardstick by which to determine whether the harm was foreseeable in law is the consensus of an informed judicial opinion by an expert witness who provides psychiatric evidence. The level of what is reasonably foreseeable has changed through the years. It spans from reasonable fear of injury to oneself,[5] to the requirement to establish that the psychiatric illness suffered was a reasonable consequence of the defendant's conduct.[16] Still, not every emotional disturbance or every shock should have been foreseen by a defendant.[17]

Present Law

In tort law, until recently, it was generally assumed that without physical injury, there was no financial recovery for negligently inflicted psychiatric illness. The law of tort is primarily concerned with providing a remedy to persons who have been harmed by the contact of others. In the case of psychiatric injury, the tort law reflected accurately the well-reported societal views of ignorance, suspicion, and fear about mental illness.[18] Suffering from psychiatric illness alone was differentiated from suffering from physical illness and was considered noncompensable. In contrast, a patient with a psychiatric illness as a direct consequence of a physical injury could gain compensation.[19,20]

The present English law on liability for psychiatric illness that is not the result of physical injury to the plaintiff is effectively summarized in two decisions of the House of Lords: *McLoughlin v. O'Brian*[21] and *Alcock v. Chief Constable of South Yorkshire Police*.[7]

In the case of McLoughlin, the plaintiff was a woman who claimed damages for psychiatric injury following an accident involving her husband and children. The woman did not witness the accident itself, but, on arriving at the hospital, she was confronted with a distressing scene of physical suffering. It was what she saw while there that caused psychiatric injury. The two main issues considered were, first, the proximity in time and space to the accident itself and, second, whether policy issues were such that the claim would be defeated. Although the House of Lords was finally unanimous that the claim should succeed, there was a difference of opinion as to the appropriate test for liability.

Alcock was an action by the relatives of some of the people killed in the Hillsborough football stadium disaster, claiming psychiatric injury as a result of the negligence of police officers in mismanaging the crowds, allowing some to be confined in the "pens" of the terraces. The claimants with psychiatric injury were people both with and without physical injuries who had been present at the match and also people who had witnessed the televised scenes, both live and on news bulletins subsequently transmitted. *Alcock* was effectively a test case, because the police admitted

their negligence and the case was taken on matters of law alone.

McLoughlin v. O'Brian[21] set the limits of emotional ties, physical proximity to the accident, and the means by which the psychiatric illness had been caused. In *Alcock v. Chief Constable of South Yorkshire Police*[7] the physical proximity to the accident was discussed further. In that case, a distinction was made: the patient who had been an active participant in the traumatic event was considered a primary victim, and the passing, unwilling witness of injury caused to others, without being injured himself, a secondary victim.

In *Hunter v. British Coal Corp.*,[22] the claimant who was near a water hydrant that exploded resulting in the death of a workmate, was not himself at risk of physical injury nor did he see his workmate dying. In this case, three categories of primary victims were identified: (1) those who were caused to fear physical injury to themselves; (2) those who came to the rescue of the injured; and (3) those who believed that they were about to be, or had been, the involuntary cause of another's death or injury.

A secondary victim must satisfy further requirements to succeed in a claim, such as: (1) the nature of the relationship between the plaintiff and the primary victim; (2) the proximity of the plaintiff to the accident or its immediate aftermath; (3) the means by which the plaintiff perceived the events or received the information; and (4) the manner in which the psychiatric illness was caused. An additional rule is that the event must be one that is shocking to a person of normal fortitude.[17]

The primary and secondary victims are treated differently in law. For example, the primary victim only has to demonstrate that he or she has suffered a genuine psychiatric illness in circumstances in which a person of reasonable fortitude would have suffered foreseeable psychiatric illness.

Policy reasons are mostly responsible for the distinction between primary and secondary victims. Doubt about the ability of the medical profession to distinguish the genuine from false claims[23] raised the fear that there might be a flood of fraudulent claims. However, with the introduction of classification systems such as the DSM (DSM-IV-TR)[2] or the Classification of Mental and Behavioral Disorders (ICD-10)[24] and structured diagnostic interviews such as the Structured Clinical Interview for DSM (SCID-I)[25] and the Present State Examination (PSE-10),[26] accurate diagnoses can be made. Although the possibility of fraudulent claims still remains, it should not be a factor that puts in doubt the question of compensation.

The Tests for Secondary Victims: Medically Valid?

In the case of the primary victim, the matters are clear. If the physical injury to the patient-claimant was foreseeable, he or she can succeed in claiming unforeseeable psychiatric harm. If the physical injury was unforeseeable, then the patient must prove that the psychiatric injury suffered was foreseeable.[12] The secondary victim has to satisfy the additional criteria discussed in the following section.

The Nature of the Relationship between the Secondary Victim and the Primary Victim

In *Alcock*,[7] it was said that the class of persons to whom a duty could be owed was not limited by reference to a particular relationship, such as husband and wife, or parent and child. The crucial factor was the existence of a relationship between the primary victim and the claimant-patient that involved close ties of love and affection. A tie would have to be proved by the claimant. It is apprehended by a lay person that the closer one feels to someone injured the more intensively one may experience emotions of sadness or distress. However, in the medical literature, there is no study to suggest that proximity in a relationship with a victim can determine the likelihood of development or the severity of PTSD. The current medical research does not support this criterion, although lack of evidence does not prove this hypothesis to be untrue.

The Proximity of the Plaintiff to the Accident or Its Immediate Aftermath

Historically, the courts required the plaintiff to witness events personally, which meant the plaintiff had to be physically present at the scene of the accident. However, in *McLoughlin v. O'Brian*[21] the requirement was extended to the "immediate aftermath" which was held to include seeing the victims at the hospital two hours later before they had been properly attended to by medical staff.

What medical evidence is there to support the proximity and immediate aftermath criterion? In DSM IV-TR,[2] one of the core features of PTSD is "a traumatic event which involved actual or threatened

death or serious injury or threat to the physical integrity of self and others resulting in a person's response of fear, helplessness or horror." (Ref. 2, p 463) The traumatic event is the single most important part in establishing a diagnosis of PTSD. No trauma, no PTSD, and, consequently, no loss. However, although the criteria imply some form of physical proximity, they do not impose any immediate-aftermath criterion. The medical evidence for the development of PTSD does not suggest there is a causal relationship between the time frame of witnessing a traumatic event and the development of the syndrome. Whenever the trauma occurs, PTSD can develop. Unless there is medical evidence in the future to suggest the contrary, DSM will not include an immediate-aftermath criterion. At the moment, the imposition of the immediate-aftermath criterion by the courts is neither based on medical evidence, nor supported by classificatory criteria such as the DSM IV-TR's, rendering the existence of this criterion arbitrary.

The Means by Which the Plaintiff Perceived the Events or Received the Information

The case of *Alcock v. Chief Constable of South Yorkshire Police*,[7] confirmed that a claimant must either see or hear the event or its immediate aftermath to succeed in a claim. Psychiatric illness induced by communication of events by a third party was insufficient. The scenes broadcast on television were seen as the equivalent of communication by a third party, because they did not depict the suffering of recognizable individuals, and therefore the viewing of the scenes could not be equated with the claimant's being within sight or hearing of the event or its immediate aftermath. As a result of this decision, relatives of people working at the World Trade Center in New York on September 11, who observed the course of the horrific events through their television screens in the United Kingdom cannot be compensated for a likely psychiatric injury.

In the medical literature, the means by which the claimant received the information is irrelevant. What is important is how stressful the event is to the person. There is a belief that the level of the stressor is the most important; as the degree of stress becomes more severe, more people break down.[27] The intensity of the trauma may have a bearing on the severity and chronicity of PTSD.[28–30] The level of combat was considered a critical variable in the development of PTSD among Vietnam veterans.[31–35] The more intense the combat experience was, the higher the risk for the disorder.[36–39] A few investigators have focused on identifying specific aspects of the military experience that increase the risk for chronic PTSD. These include killing civilians[29] and witnessing or participating in abusive violence.[40,41] These articles have indicated that such stressor experiences are associated with the symptoms of PTSD but have not questioned whether they predict other diagnoses as well, in part because the previous studies did not tend to have specific diagnostic information.[42]

It will be very difficult to differentiate whether an event is more stressful to a person if it is perceived with one sense—for example, eyesight rather than another sense, such as hearing. This is exactly what the criterion, the means by which the plaintiff perceived the events or received the information, proposes. This proposal is medically unsubstantiated and could be replaced by a severity-of-stressor criterion.

The Manner in Which the Psychiatric Illness Was Caused

Originally, common law appeared to require that to recover financially because of psychiatric illness, that illness must be induced by a shock caused by directly experiencing a threatening or horrifying event. For examples, Lord Keith in *Alcock*[7] alluded to "a sudden assault on the nervous system" and Lord Ackner "the sudden appreciation by sight or sound of a horrifying event, which agitates the mind" (Ref. 7, p 401).This requirement of a sudden assault or affront on the plaintiff's nervous system was initially imposed in an attempt to distinguish between non-shock-induced sorrow and grief occurring after a traumatic event that is seen as an unfortunate part of the ordinary vicissitudes of life. In contrary, nervous shock is obtained at the scene of the accident, which is considered to be something exceptional and unbargained for in everyday living and therefore compensable.

In the case of *Walker v. Northumberland County Council*,[43] a social worker successfully sued his employer for foreseeable mental injury caused through excessive, continuous, demanding, and distressing work. This case confirmed that damages can be recovered for psychiatric injury when there is no causative shocking event, where the injury was a foreseeable result of an excessive, stressful workload.

However, the claim in the case of *Duncan v. British Coal Corp.*[44] in which the claimant rushed to help a colleague trapped in a conveyor machine 257 meters away, did not succeed because of failure to meet the "impact" rule.

In the medical literature, there is no requirement that the assault on the patient's nervous system be sudden, for PTSD to develop. The traumatic event can also be chronic. Such chronicity is seen especially in patients with complex PTSD after prolonged abuse as a child.[45] Thus, the manner in which the injury is caused as seen in law is also medically unsubstantiated.

Normal Fortitude

In the case of *Page v. Smith*,[12] to limit the number of potential plaintiffs as a matter of policy, Lord Lloyd emphasized that in secondary victims the defendant would not be liable unless psychiatric injury was foreseeable in a person of "normal fortitude." In this case, the plaintiff had suffered from myalgic encephalomyelitis (ME) for about 20 years, but was in remission at the time of a car accident with the defendant. The crash, caused by the defendant's negligence, induced a fresh onset of ME, which was likely to prevent the plaintiff's working again. He was not physically injured.

Lord Lloyd's assertion appears to be based on an attempt to avoid a direct confrontation with the public policy issues in allowing professional rescuers to recover damages for psychiatric injury. It was alleged that professional rescuers are more hardened than nonprofessional ones, and therefore it may be more difficult to foresee psychiatric injury to them. How true is this? In one study Breslau *et al.*[46] found that previous exposure to trauma involving violent assault was associated with a higher risk of PTSD from subsequent trauma. This finding should lead the court toward an opposite decision, because the more violence one observes, (and one assumes the policemen are in the forefront of fighting violence) the more vulnerable an individual will be to the development of PTSD. This is consistent with the sensitization to stress observed with multiple life events in depression life events research.[47]

Conclusions

Despite the attempts of the courts to set new criteria by which compensation can be awarded in a tort-based system in patients suffering psychiatric injury, PTSD and nervous shock do not appear to be coming any closer.

A major criticism of the present state of the law is that, in an attempt to place limits on recovery for negligently inflicted psychiatric illness, the courts have established criteria that are arbitrary in their application. In many respects, the criteria do not correspond with the medical understanding of diagnosis, course, and symptomatology resulting from psychiatric injury. This in particular refers to the criteria placed for secondary victims on grounds of policy. When these criteria are scrutinized for support with medical evidence, they are found to be arbitrary and indefensible, risking bringing the law into disrepute with the general public.

We propose the introduction of a structured interview, such as the Clinician-Administered PTSD Scale (CAPS-1)[48] or the PTSD Symptom Scale—Interview Version (PSS-I),[49] and the introduction of a series of specifically articulated guidelines for the forensic assessment of PTSD, including the psychiatric examination of adults, adolescents, and children,[50] to establish reliably the diagnosis of PTSD, particularly in legal cases.

The use of structured instruments and guidelines would allow a more reliable diagnosis of PTSD. Although, as with the use of any screening instrument, not all PTSD cases will be identified, the use of such instruments will add credibility to the diagnosis of PTSD. This credibility should pass into the courtrooms and enable abolishment of the distinction between primary and secondary victims, making the issue more the diagnosis of PTSD than whether the victim was an active or nonparticipant in the traumatizing event.

In addition, the "shock" criterion should be abolished and replaced with a "stressor" criterion measured with validated instruments, such as the Post Traumatic Cognitions Inventory,[51] that would reflect better the current research in the development of PTSD. The stressor criterion, consistent with the research evidence that the intensity of the trauma may have a bearing on the severity and chronicity of the syndrome, would allow a more valid calculation of the awarded damages.

A revision of the law referring to psychiatric injury is well overdue. With medical research progressing so rapidly, an update of the Report From the Law Commission[52] may be necessary. Until then, policy rea-

sons and not medical evidence will continue to inform the law of psychiatric injury.

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