

# Asbestos Exposure and Post-Traumatic Stress Disorder

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In 48 cases of claims of psychic injury due to exposure to asbestos, post-traumatic stress disorder (PTSD) was alleged as a basis for damages in nine (19%). PTSD as currently defined refers to a specific syndrome following exposure to a life-threatening traumatic event, one outside the general range of people's experiences such as military combat, floods, earthquakes, bombing, torture, death camps—events either natural or man-made. The symptoms include reexperiencing of the event with intrusive thoughts or nightmares of the event, startle reactions, psychic numbing, and survival guilt. The application of this concept to chronic illness, often of minor degree, is quite inappropriate. The clinical data in the nine cases reveal no pertinent precipitating event and the lack of a clinical syndrome compatible with the disorder. The cases also generally reflect no psychiatric impairment, inadequate medical review, and lack of background history—common characteristics in asbestos litigation with no disabling pulmonary parenchymal impairment. If the results in this group are typical, then one must suspect the legitimacy of claims of psychic injury such as post-traumatic stress disorder from asbestos exposure and at the very least the reasonableness of the experts who provide input into the medicolegal process.

In a previous article in this journal,<sup>1</sup> 48 cases of litigation based on exposure to asbestosis and claims of psychic injury were reviewed. Of the total 48, the forensic expert on behalf of the claimant utilized the concept of post-traumatic stress disorder (PTSD) in nine (the words used varied from post-traumatic stress disorder, post-traumatic disorder, post-traumatic response, post-traumatic syndrome, and post-traumatic depression). These nine case studies by two plaintiff

examiners are reviewed in some depth to examine the appropriateness of a finding of PTSD. In my experience in personal injury litigation and criminal cases, PTSD is now a frequently misused and abused psychiatric concept. Some initial comments about the current diagnostic and classification system are relevant, for if PTSD claims do not conform to diagnostic or clinical standards, then such acts might well be a serious reflection on medicolegal practices and the ethics of forensic experts.

The history of the so-called post-traumatic neurosis or a verbal equivalent is presented in most every psychiatric text or encyclopedia. Suffice it to say that many texts deal with the important his-

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torical antecedent, neuroses of war, as described by authors like Freud, Kardiner, Grinker, and Spiegel. Keiser<sup>2</sup> presented a rather broad view of his 1968 text, *The Traumatic Neurosis*, which dealt with various psychiatric problems after trauma. More recently, Scignar<sup>3</sup> presented his perception of PTSD, which was rather broad in including matters that some might question; for example, he concluded that Winston Churchill had a PTSD after an automobile accident in New York in 1931. Scignar's concept of stress for purposes of PTSD is clearly more encompassing than that utilized in the current diagnostic standards.

In DSM-I, published in 1952,<sup>4</sup> the equivalent of post-traumatic stress disorder was categorized under transient situational personality disorders, the specific terminology being gross stress reaction, a condition occurring under conditions of great or unusual stress. Usually such a condition would be temporary but it could possibly progress to one of the neurotic reactions. "This diagnosis is justified only in situations in which the individual has been exposed to severe physical demands or extreme emotional stress, such as in combat or in civilian catastrophe (fire, earthquake, explosion, etc)." The particular stress would be specified as (1) combat or (2) civilian catastrophe. The symptoms were not clarified but it is clear that reaction to a significant, life-threatening event was involved.

In 1968 in DSM-II,<sup>5</sup> the term, gross stress reactions, was incorporated under transient situational disturbances, but

was recategorized as adjustment reaction to adult life. It was applied to more or less transient disorders of any severity (including those of psychotic proportions) that occur in individuals without any apparent underlying mental disorders as an acute reaction to overwhelming environmental stress.

In 1980 in DSM-III,<sup>6</sup> due in part to the experiences from the Vietnamese conflict, a highly defined entity was created with the now current terminology, post-traumatic stress disorder. ICD-9 (International Classification of Disease, Ninth Revision) and later ICD-9-CM (Clinical Modification) utilized the term, acute reaction to stress, referring to a transient reaction to exceptional physical or mental stress or battle, usually subsiding quickly. Other terms noted were catastrophic stress, exhaustion delirium, and combat fatigue as well as gross stress reaction.

The reader is referred to DSM-III and its later revision, DSM-III-R for a full clinical description, but some review is appropriate. First, the precipitating event would be a traumatic event outside the general range of human experience, such as military combat, floods, earthquakes, and other catastrophes (natural or man-made). Bombing, torture, and death camps were examples of deliberate man-made disasters. Specifically noted as *not* to be included as a precipitating event for PTSD were such matters as simple bereavement, chronic illness, business losses, or marital conflict.

Characteristic of the disorder was reexperiencing of the traumatic event

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with intrusive recollections and recurrent dreams and nightmares. "Psychic numbing" or "emotional anesthesia" was another element. Hyperalertness, exaggerated startle reflexes, and guilt feeling about survival were other somewhat specific findings. In 1980, acute and chronic forms were described, a distinction no longer in use. In 1987<sup>7</sup> standards for post-traumatic stress disorder were further defined. The manual did note that "the classification of post-traumatic stress disorder is controversial since the predominant symptom is the reexperiencing of a trauma, not anxiety or avoidance behavior."

The words, "post-traumatic," seem to have great popularity for legal purposes, and thus the concept has been used rather freely for those claiming damage. The reader should be reminded that other psychic conditions can be related to stress or injury, not the least of which are adjustment disorders (as currently defined), various affective disorders (particularly reactive depressions), anxiety syndromes, and so forth. This paper does not deal with those possibly legitimate issues; it is directed specifically at the reasonableness of the use of PTSD in a current significant medicolegally controversial area, asbestos litigation.

### The Group Reviewed

This paper reviews nine cases of alleged asbestosis, or asbestos exposure in which a claim of post-traumatic disorder was reported, either as post-traumatic stress disorder, post-traumatic disorder, post-traumatic response, or post-traumatic syndrome; these were to be a fac-

tor in the damages that were sought. As a group, little functional pulmonary disability was noted but some degree of pulmonary pathology on radiologic study, such as pleural thickening or plaques, was noted.

This group is part of a large group of 48 cases where psychic injury was claimed in association with asbestos exposure. The total group had a mean age of 62.6. The post-traumatic group was white, male, with a mean age of 64.0. Excluding the youngest, age 51, the mean age was 65.6. Aside from the youngest, none were working. Seven of the eight were retired, six by choice and one on the basis of a cardiac disability. One, now 66, was no longer working but his stopping work at 61 was a result of his being terminated for misbehavior. Thus, none had a pulmonary disability related to inability to work; nor did any have a psychiatric problem as the basis for inability to work.

### Case Summaries

*Case 1* A, in his evaluation at age 66 by a psychologist, was described as having worked at a refinery for 31 years, retiring five years earlier at 61. He reported breathing difficulties for 10 years with progressive dyspnea, being able to walk as long as things are level. He had been aware of asbestos problems for 13 years. A stated that he was upset when told asbestos was untreatable, that he was depressed, angry, and that "the diagnosis has taken away all his excitement of retirement." He was grumpy and irritable, hard to live with; this pro-

duced temporary separations from his wife. He also stated that he had considered suicide and that because of loss of appetite, he had lost 25 lbs. He had numerous complaints on a symptom check list—"he sees himself as lacking self-confidence and being physically unattractive." A stated that he was treated unfairly, that he gets into fights, that his mind wanders, that he has a bad temper, and that he has a poor social life. The Minnesota Multiphasic Personality Inventory (MMPI) was "clearly indicative of a post-traumatic syndrome." The psychologist stated that his exposure to asbestos resulted in asbestosis, which "clearly produced decrements in his capacity to function and in his adjustment. He is depressed, chronically anxious, has insomnia," and so forth.

The pulmonologist that he saw when he was 63 noted shortness of breath walking up hills and a chronic cough when he smoked cigarettes. That report noted that he was exposed to asbestos, welding fumes, metal dusts, epoxy resins, paints and solvents, oils, fibrous glass, sand from sandblasting, mineral dusts, acids and alkalies, exhaust fumes, and other irritating gases, vapors, fumes, and dusts. He had a history of chronic bronchitis in the 1960s, arthritis, and hypertension, as well as orthopedic difficulties in his wrists, which had required surgery. He was on diazide. He was noted to have retired three years earlier. Spirometry showed reduction in flow at low lung volume (suggesting small airways disease) and normal ventilatory ability; pulmonary function tests done elsewhere were normal; x-rays showed

pleural thickening and calcifications and an increase in interstitial markings. Diagnosis was pleural asbestosis. Review by a pulmonologist for the defense one year later noted a history of coronary artery disease with angina pectoris of three years' duration and chronic bronchitis for 41 years. He was described as having daily anginal pain but an ability to climb two flights of stairs without stopping. Pulmonary function tests were normal. X-rays showed multiple small bilateral pleural plaques without calcification and normal parenchyma. Diagnosis was minor asbestos-related plaque formation. The examiners described different smoking histories.

In other records, a healed posterior wall myocardial infarction was noted when he was 62 as well as a diagnosis of chronic bronchitis.

The most striking piece of information was a letter from his company to him when he was 61 indicating that he was terminated from his job for serious misconduct including—(1) threatening a manager and another worker with bodily harm, (2) receiving personal services from company contractors for work charged to the company, (3) soliciting cash and other gifts from outside contractors and making solicitations in a threatening manner, and (4) receiving company property removed from the place of work.

A, when seen at age 66, stated that he had breathing problems whatever the tests showed. He denied any cardiac difficulties and blamed any limitations on his breathing. His only other complaint was not sleeping well. He noted that he

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had had a cardiac catheterization and several stress tests; he was told that he had a 90% blockage in one artery and 30% in another. He has been treated for "hypertension, stress, and arteriosclerosis," and was on a beta blocker, an arterial dilator, and aspirin. He followed a diet and walked a couple of miles a few times a week as recommended. He denied restrictions due to cardiac difficulties—"it isn't the heart . . . I can't jog." He had been encouraged to swim. He was told to bring his weight down and had done so—going from 160 to 170 lbs. five years earlier to 147–148, and eliminating red meat, dairy products and eggs from his diet. His only current medical care was that of a cardiologist. He went to sleep at 11 p.m. to 1 a.m. and at times had to get up to urinate. No marital difficulties were described.

In the psychiatric examination, he was a blunt, expressive, assertive man who seemed to have a powerful or dominant personality. A was verbal, intense, expressing anger readily but also laughing easily and appropriately. No psychomotor slowing or depressive mood was observed. He was frequently evasive and resistant. Most striking was the difference between his clinical presentation and the content of the words used. He was quite alert and bright; he enjoyed testing procedures such as general information and arithmetic, handling them with gusto and competitive spirit. "I enjoy this." His recall of eight numbers forward and six backward showed good memory and little anxiety. In contrast, he was guarded with only few, sparse responses on the Rorschach. He was not

considered to be a reliable informant but was keenly aware of the implications of his communications.

Of particular note here was the different histories given to different examiners and the indications of a significant behavior problem reflecting on the claimant's judgment and reliability.

*Case 2 B*, seen by a psychologist when he was 61, complained of worry about the future, fear of loss of his house, fear of incapacitation, tearfulness, withdrawal, and a tendency to be more quiet. He was described as having "progressive lung disease of the asbestosis type" with progressive loss of lung capacity, weight loss, lack of stamina, and shallow breathing—for two years. He would cry for no reason, walking was more halting, and he did not have much of an appetite. He was not able to think coherently and would stutter and cry. His sex life had diminished (although he tried for his wife's sake). He was diagnosed as having a post-traumatic depression, the stressor being in the psychologist's opinion, "the progressive lung disease as the patient is brought face-to-face with that reality every waking minute of his existence." The psychologist commented, "The patient has flashbacks of being incapacitated."

The medical history showed a different and more complicated story. B had a long history of ulcer, tachycardia, and respiratory infections. As early as 17 years before, he was on quinidine and digoxin. For three years, he had been diagnosed as being diabetic and was put on a 1500 calorie diet. He was put on antidiabetic medication because of poor

sugar control. He did have a significant weight loss two years earlier.

X-ray five years earlier suggested granulomatous disease; two years later x-rays showed an infiltrate in the left upper lobe with less on the right side, compatible with reactivation of tuberculosis. Hypertension was noted. A urological review two years earlier revealed curvature of the penis on erection; diagnosis was Peyronie's disease, mild (fibrosis of the penis). Pulmonary function tests showed severe restrictive lung disease. His pulmonologist reported bilateral interstitial changes and pleural plaquing with a diagnosis of parenchymal asbestosis. The pulmonologist felt his cardiac status could be attributed to asbestos exposure. B was then evaluated at a university medical center where the similar findings were made plus possible chronic left pneumothorax, but the most likely diagnosis on this occasion was inflammatory disease, possibly related to tuberculosis.

B reported a good appetite limited by dietary restrictions for diabetes. His only sleep problem was urinary frequency; he had about six hours of actual sleep a night. After his weight loss three years earlier, his weight was now stable for the last year. His only complaint about sexual activity was a decrease from every two or three days a decade earlier to one to two times in a two-week period. "You get older. You slow down." He had retired two years earlier because of an incentive program at his company. No anxiety or depression was noted. B did have decreased pulmonary function, and he was concerned about his health.

Five different radiologists noted apical disease most likely due to an infective process. No evidence of a post-traumatic stress disorder was present.

Ordinarily, the word flashback is used to apply to a sensory perception of a prior event. In this case, the expression was used in an inappropriate fashion to describe a potential future condition, and not to a prior event in a traditional sense, and certainly not to a past traumatic occurrence, which is the essence of the use of the word when applied to PTSD.

*Case 3* C, 66, retired at 65 after 43 years with the same company. Two years earlier he was seen by the psychologist, who stated that C was hospitalized for a collapsed lower lobe of the left lung two years earlier. A diagnosis of asbestosis was made. C reported to the psychologist that since he learned the diagnosis, he had a sleep disturbance and had an unexplained loss of 15 lbs. in two years despite a good appetite. He was irritable and completely impotent (though he had some trouble before the diagnosis). His wife reported that he was constantly eating and that relations between them were worse. He had no nightmares. His main complaint was the "time bomb" of getting cancer. He is able to climb stairs and run when necessary. C was described as calm, dependable, honest, simple, and conventional. C "clearly has what amounts to a post-traumatic stress disorder." . . . "Given the chronicity and the exacerbatory nature of his disease, it is felt that his concerns will need management and if management is not obtained, will probably worsen if the

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course of his disease continues to deteriorate." Psychotherapy was recommended.

The medical history revealed much of interest. Twenty years earlier he had paroxysmal tachycardia, elevated blood sugar, had his weight reduced to 142 lbs. by diet. Another complaint was impotency, and x-rays showed "old pleural thickening" (this was in 1964). In 1977 he was diagnosed as having emphysema. He was treated with cardiac medication such as digoxin for many years. In 1987 and 1988 he had no complaints when seeing his personal physician. The only complaint in two years was mouth lesions. In 1986 he had atelectasis of the left lower lobe, paralysis of the left diaphragm and suspected infection. X-ray showed bilateral pleural fibrosis and plaques. Other findings were arteriosclerotic disease and calcified pleural plaques. A pulmonary specialist that he consulted diagnosed benign asbestos disease and left lung atelectasis. Subsequently, weight was constant and pulmonary function good. He also had a history of severe herniated disc disease and radiculopathy as well as hypertension. In 1986 he was rehospitalized with diagnoses of possible pneumonia (lower left lobe) due to *Hemophilus influenzae*, chronic lung disease, cholelithiasis, peptic ulcer disease, osteoporosis, paralysis of the left diaphragm, atelectasis, and degenerative disease of the cervical spine. The hospital records indicated that he could walk a mile without getting short of breath. A university medical school work-up after the psychologist's examination for the defense indicated

extensive bilateral pleural thickening with calcification of the diaphragmatic pleura. Pulmonary function tests were normal. He was felt to have pleural disease but no diagnosis as to etiology was made.

His primary complaint was the "idea of knowing what I have, the chances." He also said that he did not fall asleep as readily as he used to, taking 15 to 20 minutes. He was rather evasive as to everyday functioning. He denied ever taking cardiac medicine or that he ever had weight difficulties. The record indicated that in 1964 his weight went from 164 to 136 1/2. He would go to sleep at 11 to 11:30 p.m. and awakened at 7 or 8 a.m. He slept well and had a good appetite. He denied having a heart rate irregularity (responding, "supposedly"). He denied any impotency difficulties before the last five or six years (the records noted problems 20 years previously). He traveled a great deal, was pleasant, affable, smiled readily, was intelligent, with broad interests. His evasiveness and lack of clarity in discussing his medical history contrasted with his communication on other subjects. No signs of any psychiatric disorder were noted. Striking was the lack of complaints in the reports of his own treating doctor as compared with the varying reports to the doctors who saw him for legal purposes.

**Case 4** D, when seen at age 50 by a psychologist, reported that his internist had noted that D had pleural thickening with calcification of the parenchyma with a diagnosis of asbestosis. A forensic pulmonologist reported similar findings. The psychologist report stated that the

claimant could no longer play golf, could walk only a few stairs and then would fall to his knees gasping, and that he could walk only a few feet without respiratory distress. He was able to work until his hospitalization two years earlier, returning three or four months later. He was fearful of palpitations and hyperventilation, but slept satisfactorily. Though on the MMPI he portrayed himself in a "positive state," his record was suggestive of a "post traumatic response"—with physical complaints involving pain, weakness, tiredness, dizziness, and numbness. His avoidance of exertion and fear of restricted breathing has "resulted in palpitations and what can be characterized as a like panic response." Relaxation training and a bio-feedback program "to give him greater control over his breathing difficulties" were recommended. "As the nature of his physical disease is chronic and progressive, it is felt that his adjustment to it will continue to represent difficulties for him and be psychiatrically significant."

From other records it was noted that 11 years earlier interstitial fibrosis and emphysema were noted on x-ray. Two years earlier, he was seen in an ER for difficulty in breathing. Pleural thickening and plaque were noted on x-ray. He also had 56 smoking years. D was hospitalized for dyspnea on exertion with a diagnosis of mitral valve prolapse with arrhythmia and a history of stroke 20 years earlier (with no apparent residuals). He was transferred to a second hospital where mitral valve prolapse was not substantiated, and diagnoses of atyp-

ical chest pain, exhaustion, and anxiety were made. Nine years earlier he had an orthopedic injury and a Workers Compensation claim (he was out of work for two years). The internist first noted above felt that he had obstructive airway disease and that he was totally and permanently disabled; however, a corrected report a month later noted no respiratory impairment related to asbestos. X-rays continued to show parenchymal and pleural changes of the same degree, and his palpitations were attributed to anxiety. However, to his forensic pulmonologist, in addition to reporting tightness in his chest and shortness of breath when he "plays ball in excess." D added that he could jog one-half mile, climb three to four flights of stairs, play 18 holes of golf, and carry his own golf bag. Pulmonary function tests at a university hospital were normal. A forensic pulmonologist for the defense reported bilateral pleural thickening, interstitial lung markings at the bases, mild obstructive findings on spirometry, and normal pulmonary function tests.

When I saw him, he said that he could no longer do what he used to do and that he would get winded after 8 or 10 steps. His actual activities were difficult to pin down. He had been working regularly in construction for one and one-half years during which time he missed about two weeks of work but had required no medical treatment (other than for back) and was on no medication. He had a history of a herniated disc and was hospitalized for traction two years earlier. He admitted going to a rehab center "to strengthen (his) lungs," but appar-

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ently this was a physiotherapy regime for his back. He was rather guarded in giving information. He had no sleeping difficulties.

*Case 5* A 62-year-old man, E, had similar findings to those described for D. The psychologist reported increasing problems for five years when "he first had conscious awareness of his decreased strength and vital capacity." He would get winded at work. After hearing from fellow workers about the asbestos situation two years earlier, he saw a doctor who told him that he had asbestosis. His wife had died of lung cancer, and he felt alone and alienated and worried who would take care of him; he was depressed about breathing and back problems. Because he did not complain much on a symptom check list, the psychologist stated, "much of his difficulty is underreported"; he also related a fear of unemployment to his asbestosis. The MMPI was described as showing a post-traumatic response. "Due to the chronic and irreversible nature of his disorder, it is expected that the identified psychological distress is permanent."

The psychologist did not report that E had injured his back two and one-half years earlier and had a herniated disc resulting in his being on disability pay from Workers Compensation of 80 percent since that time. He was hospitalized one and one-half years earlier and had a disc removed (L4-L5). He had applied for Social Security and Medicare because of his back. He had tingling, stiffness, and a right leg limp. Though he denied having asthma, he had shown the psychologist a letter from an asthma

center and was currently on two bronchodilators. He had a 50-year cigarette history and was apparently a heavy drinker; at one point there was a question of alcohol neuropathy when he had "burning in both feet." He described no sleep problem, ate well, was gaining weight, and liked to travel. Mental status review revealed no significant findings.

*Case 6* F, 72, was exposed to various industrial chemicals 25 years earlier and had a chemical tracheobronchitis (diagnosed on various occasions as exposure to phthallic anhydride). Other diagnoses 22 years earlier were chronic bronchitis and cor pulmonale. Though he was considered to have a poor prognosis, F proceeded to work for 10 more years before having a heart attack at 61; that same year he was given a pacemaker. Some of his other past diagnoses reported by his forensic pulmonologist were encephalitis, emphysema, arteriosclerotic heart disease, and borderline diabetes. X-rays showed pleural thickening and calcification (left) with blunting of the left costophrenic angle and impaired pulmonary function tests. Diagnosis was pulmonary and pleural asbestosis.

His own doctor reported that he was depressed 12 years earlier; seven years earlier he had status asthmaticus. A hospitalization report 12 years before noted acute coronary insufficiency, chronic obstructive lung disease, and cor pulmonale. Other diagnoses were angina pectoris and degenerative spinal canal stenosis. For two years he had constant pain from the waist down, sharp pains, and burning in the lower extremities. The neurologist felt that the problems

were related either to vascular insufficiency or narrow spinal canal syndrome (as did one other doctor previously).

The psychologist noted only that F was retired omitting any mention of a cardiac disability; F had learned of his "asbestosis" three years earlier when seen by his forensic pulmonologist. F stated that he lost his appetite for two years and had lost 22 lbs., and that he was no longer ambitious, and that he was irritable, arrogant, and nasty. The only medical report seen by the psychologist was that of the forensic pulmonologist to whom F had been referred. The psychologist concluded, "This illness and the information regarding the disease has caused a clear psychiatric syndrome characterized by a post-traumatic response, the stressor being the asbestosis."

Psychiatric interview revealed that F after his myocardial infarction was on sick leave for four years prior to retiring at 65. He indicated several other hospitalizations not included in the records sent for review. Six months before being seen, his pacemaker malfunctioned and had to be replaced. His weight had been relatively constant over the years (average weight through adult life—175 lbs.; current weight 165 to 168, on a limited diet). Sleep pattern was unremarkable. He was keenly aware of his legal situation and quite evasive in discussing his medical background with a sparring quality to his communication. On the other hand, he was quite bright with an obvious sense of humor. He focused on his "asbestosis" and more or less ignored the other aspects of his medical history until questioned directly.

*Case 7* G, 69, retired at 62, went for an asbestosis check-up after his friends saw an advertisement in the newspaper. He was referred to a forensic pulmonologist who made a diagnosis of pleural asbestosis and chronic bronchitis. The x-rays indicated increased bronchovascular markings, pleural thickening, and increased interstitial markings. Also noted was a tumor of the left carotid for which biopsy was recommended. History indicated exposure to asbestos, hydrogen sulfide, and "other irritating fumes." Spirometry was normal.

The psychologist saw him one and one-half years later. By that time, G had been operated on for cancer in the neck and extensive lymph tissue removed from the neck, shoulder, chest, and arm (eight months earlier). G was told that the cancer was metastatic, and his surgery was followed by radiation; he said that he had an emotional impact from learning of his asbestosis and his dealing with the "subsequent cancer." He was quite concerned about his health and spoke of insufficient sleep, shortness of breath, cough, headaches, muscular aches, poor appetite, and so forth. He also lacked ambition, and was moody and irritable. The MMPI was "similar to individuals with post-traumatic responses." G was described as apt to overreact to minor problems. Psychotherapy was recommended. Or as the psychologist put it, "Mr. (G) is an individual who has suffered occupational exposure to asbestos. This had led to asbestosis. He also has had cancer. The effects of Mr. (G's) health problems and asbestos exposure have clearly resulted in a post-traumatic psychiatric disorder which is

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characterized by depression, anxiety, apathy, insomnia, and irritability. He clearly would benefit from some psychological intervention."

Medical reports reviewed prior to psychiatric interview indicated that G had a subtotal parotidectomy and radical neck dissection for metastatic squamous cell carcinoma of the left cervical and parotid lymph nodes with extensive spread. He also had a history of basal cell carcinoma and radiation treatment to the left cheek many years ago. He had a 30-year history of chewing tobacco. Curiously, his treating doctor reported clear x-rays (these were taken one and one-half years after the ones described in the forensic pulmonologist's report).

When seen psychiatrically, G did express concern about recurrence of his neck cancer (this was almost two years after his surgery). He expressed little otherwise. He had regained weight and was eating well though he had some loss of taste. His weight went from 200 to 145 after treatment to a current 183. He does some gardening, walks two miles a day, travels extensively, and likes to read about scientific matters. He was personable, energetic, and laughed readily. He was obviously a well-adjusted man realistically concerned about his neck cancer.

**Case 8** H, 67, was described by the forensic psychologist, as having reduced ability to breathe for many years, sensitivity to smoke, dust, and hair sprays, not playing golf as well, and trouble going up steps at home even though his split-level had only six steps per flight. He had a major weight loss two years earlier when various friends and his fa-

ther-in-law died and a son left for a distant location; he had six months of psychotherapy at that time. His forensic pulmonologist reported the year before that Mr. H had shortness of breath on walking up a steep hill; diagnosis was pleural asbestosis. H also had a history of a heart attack and took medication for that and his hypertension. The psychologist indicated that the MMPI showed an individual in psychiatric distress and was characteristic of "a post-traumatic response." The psychologist also stated, "While the record clearly shows the depression that Mr. (H) was previously under treatment for, its current general format is post-traumatic in nature and seems to be exacerbated by his fear of death and his concern over his illness."

The forensic pulmonologist did note in the report reviewed by the psychologist a history that included herniorrhaphy, lumbar sympathectomy for peripheral vascular disease, and transurethral prostatectomy. Chest x-ray showed pleural thickening and increased bronchovascular markings; spirometry showed obstructive pulmonary impairment; and pulmonary function tests were normal. Diagnoses were pleural asbestosis, chronic bronchitis, and partially reversible chronic obstructive pulmonary disease.

Other medical records indicated that subsequent to the forensic pulmonologist's evaluation but prior to being seen by the psychologist, H was hospitalized for anterior wall myocardial infarction, arteriosclerotic heart disease, and ventricular and atrial fibrillation. The hospital x-ray was reported as normal. A

year later (also before the psychologist's examination) he was again hospitalized for coronary artery disease and single vessel occlusion; a diagnosis of angina pectoris was made. Chest x-ray was again normal. Mitral valve prolapse was noted as well as evidence of extensive anteroapical myocardial infarction. One physician's note indicated that at the time of his depression two years earlier, H had to care for two children because of death in the family (a brother and sister-in-law died during this time period).

In a psychiatric interview, H complained of needing to get up at night to urinate, sleeping more than previously (six hours a night), pain in his left shoulder, shortness of breath walking up hill, and arthritis in his hips and shoulder. He stated that he could not play golf because of his shoulder but walked four to five miles four times a week. He described the depression that he had three years earlier at the time of the family stresses. He was somewhat pessimistic but did not have a clinical depression; his greatest (and realistic) concerns were about his cardiac and arthritis problems.

**Case 9** K, 67, stated to the forensic pulmonologist that he lost his job because of coughing. Examination showed wheezing; spirometry, small airways disease with normal ventilatory ability; chest x-ray, pleural thickening and non-calcified plaque; and pulmonary function tests, normal gasses and hyperinflation.

Mr. K had taken an early retirement. The psychologist reported that K said that his disease was incurable, that at

times he has shaky hands, that his relationship with his wife is altered (he tends to ignore her), and that he does not move around like he used to. The MMPI was reported as showing that he minimized and denied his difficulties. This remarkable statement follows, "Because of Mr. K's bias toward nonreporting, it is necessary to factor in some correction for his response bias. When that is done, then a clear post-traumatic response pattern emerges." K was described as increasingly depressed and anxious, requiring treatment.

No other reports dealing with a current pulmonary review were available.

K stated that his biggest problem was getting up and coughing phlegm; he did this a couple of times a month and after three or four coughs, was "OK." He described himself as restless, forgetful, getting tired, and not being able to walk uphill. He retired from his regular job at age 55 and then took another job. At 62 he went on regular Social Security, though he did some part-time work in a machine shop. He showed no significant sleep problem, but when asked about urinary status, indicated that he had started to dribble a little. He went with his wife to Atlantic City a few times a month. He was hesitant in speech, self-deprecating, apologized readily for his memory problems, and became perplexed in trying to provide a history or significant dates. He did not know the number of his siblings, the ages of his wife or children (he has two children who are twins), or the college his daughter went to. He became confused in trying to recall his work and military

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history. He did not drive because he had lost confidence and was forgetful. He was slow-speaking, vague, at times tremulous, and had an intention tremor. He could not recall the name of his family doctor and had difficulty naming the current president, which he finally did. He stated, "I know I'm slipping. It's wonderful I have my wife. She helps me." He was passive, pleasant, and personable. His high score on the Graham-Kendall Test was compatible with organic brain deficit. His wife, when interviewed, indicated that he had been getting worse for a few years, had a poor memory, was repetitious, would ask questions that he would repeat an hour later, having no recollection of earlier conversations.

Thus, K did show multifold evidence of organic brain deficit. With no history of cerebrovascular disease, the findings were compatible with early primary degenerative dementia (Alzheimer's disease). No psychiatric problems otherwise were apparent.

### Discussion

Nine cases have been presented in which various degrees of pulmonary pathology have resulted from exposure to asbestos; in some cases, the various physicians evaluating physical state have disagreed as to the presence of any pathology or as to the cause if pathology was present. Actual limitations in function were minimal. In each case post-traumatic psychiatric disorder was claimed as an element of damages.

The clinical description by the forensic expert for the claimant has been re-

viewed in each case as well as the fact base available to the examiner. Characteristically, the expert has offered an opinion with a limited medical fact base; often the expert offered conclusions that omitted significant events and relevant medical data. Frequently, the history obtained was quite inadequate; medical history from other sources cast great doubt on the contentions propounded on behalf of the litigants. This group was an elderly one with a wide variety of medical and other problems but generally well functioning.

The issue of the applicability of the MMPI remains problematic. The MMPI may be of use in making a positive diagnosis of PTSD,<sup>8-10</sup> but the use of negative findings in making a positive conclusion is questionable.

If these opinions are characteristic of current litigation, then indeed serious defects in professional forensic evaluations as they relate to a significant national health problem are present. Taking into account the possibility of legitimate professional disagreement, the reader can compare the totality of the data and opinions presented with the standards for diagnosis for PTSD and decide personally the appropriateness of the proffered conclusions.

The misuse of psychiatric concepts such as PTSD results in a trivialization of a significant disorder and casts a cloud on those, particularly, veterans, who have had such a condition. The analysis of these actual cases reflects an unpleasant reality in which psychic injury claims are clearly made in an unjustified fashion; this review further calls into

question the merits of an adversarial system using so-called expert opinions as a truth-seeking device. If the data reviewed in the nine post-traumatic stress disorder claims are reflective of asbestos litigation or of injury claims in general, then the issues are not really those of forensic medicine or forensic science but rather those of a morality play in which other values are the determinants of the behavior of the participants.

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