The Demographic and Psychiatric Characteristics of 110 Personal Injury Litigants

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One hundred ten litigants who were suing for emotional damages were assessed by the author for medical-legal reasons. Most of the plaintiffs were involved in motor vehicle accidents and suffered from "whiplash" injuries. Semi-structured interviews were used to reach criteria based on DSM-III-R diagnoses. Requests for consultation, on average, came 25 months after the patient's accident. Approximately 70 percent of patients had evidence for continuing physical injuries to account for the physical and emotional symptoms. The most common DSM-III-R diagnoses were psychiatric condition affecting physical illness (N = 56), major depression (N = 27), and somatoform disorder (N = 12). Alternative diagnoses relating the effect of the accident on the patient's life included: emotional reaction to physical condition (N = 29), difficulty coping with developmental tasks (N = 20), severe depression (N = 20), aggravation of normal premorbid personality (N = 18), aggravation of abnormal premorbid personality (N = 14), phobia (N = 7), no permanent effect (N = 12), and independent illness (N = 2). Severe emotional problems and disability are common among litigants. The causes of their suffering are more complex and less poorly understood than is assumed from the pejorative labels that are sometimes applied. Lawyers and the courts need the help of psychiatrists to understand this suffering. Empirical data such as these may lead to better classification systems and improve our understanding and treatment of these patients.

Lawyers frequently ask psychiatrists to assess clients to report on the emotional and psychiatrist consequences of a traumatic injury that is leading to a litigation claim. This can occur when the client believes that (s)he has suffered a physical or emotional injury due to someone else's unintentional negligence or fault,[1-3] or suffers emotional trauma because of some outrageous act intentionally caused by another person.[4] Psychiatrists are asked to complete a psychiatrist assessment and address a variety of legal issues such as the direct and proximate causes of the plaintiff's emotional symptoms, the credibility of the plaintiff, establishing the presence of psychic pain and suffering, and commenting on prognosis or the patient's ability to mitigate the suffering or disability.[1,5]

If the insurance and legal systems are to become informed about this important area of human pain and suffering,

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it is essential for psychiatrists to develop a base of knowledge by systematically collecting data about these patients, as well as accident and outcome variables that affect posttraumatic phenomena and patterns. A literature search found few recent studies on this topic and none that used criteria-based diagnoses as developed in DSM III. This prompted the author to compile data on 110 medicolegal assessments over four years to examine the relationship between patient characteristics, accident variables, and outcome measures in litigation cases. Hopefully, these data will provide a fresh picture of the psychiatric issues and generate new explanations and testable hypotheses.

Methodology

The author collected demographic and clinical information during 110 medical-legal consultations on clients referred by lawyers who were asking for a psychiatric assessment of the emotional consequences of a personal injury for which the patient was seeking financial compensation. All were referred by the plaintiff's (victim's) lawyer. The consultation consisted of a complete psychiatric history and mental status examination of the patient, and an interview with a relative, with particular emphasis on that person's view of the effect of the accident on the patient's emotions and ability to function. The lawyer was asked to forward all of the available medical records, consultant reports, and work records, and these were reviewed before each consultation. In a few cases other tests or consultations (medical and nonmedical) had to be requested to assist in the assessment, for example, psychological testing or repeat orthopedic consultations. The consultant attempted to formulate a comprehensive and unbiased view of the patient's emotional state and family, social, and work functioning both before and after the accident.

One method of organizing the medical-legal report has been described previously.[6] For this study, the data were organized under the following headings:

1. Demographic data: age, gender, marital status, children, education, employment, history of parental loss.

2. Accident variables: type of accident, severity of physical injury, severity of emotional threat to the patient, injury to others, time since accident, and evidence for continuing physical problems.

3. Outcome variables: measures of pain, depression and anxiety at consultation; assessment of disability in house work, social life, family life, and work; enjoyment of recreation and sexual life; standardized clinical diagnoses and a global assessment of effect of the accident on the patient's life.[6]

Demographics of the Population

One hundred ten patients were assessed, including 47 men and 63 women. One hundred one victims were involved in motor vehicle accidents and nine were involved in other types of accidents such as a fall in a store. There were 46 men and 55 women assessed following motor vehicle accidents and one man and eight women in nonmotor vehicle accidents. Of the motor vehicle accidents, 50 were

drivers, 34 were passengers, 14 were pedestrians, and 2 were bicycle riders.

The average age of a plaintiff was 40.2 years. On average they were seen 25 months after the accident. The majority were married, had children, and most were working at home or at school prior to the accident. One hundred and six of the patients were essentially employed, including 85 with paid jobs, 16 housewives, and five students. Sixty-two percent of patients had not completed high school. Thirty-eight percent had completed high school, and approximately half of these had attended a community college or university.

Of the 110 cases, only three proceeded to trial and required psychiatric testimony in court; the others settled out of court. Although this may be related to legal traditions in Ontario, the author would like to believe that a fair, unbiased psychiatric assessment and report encourages out-of-court settlements.[1,5]

Results

Physical Injuries. At the time of the psychiatric consultation, 33 (30 percent) of the litigants had no ongoing medically proven organic cause to account for their continuing symptoms. In these cases, the nonpsychiatric physicians, after extensive examinations and investigations, could find no physical cause for the patient's current symptoms, and the psychiatric consultant agreed that there was evidence that current symptoms were likely perpetuated or aggravated by psychological factors. If there was any doubt, a physical cause was rated positive. Of 77 patients with evidence for a continuing physical injury, 42 (38 percent) patients had evidence for a mild physical problem, 25 (23 percent) patients had a moderately severe physical problem and 10 (9 percent) patients had a severe physical condition causing disability.

Symptoms and Disability

Ninety-eight (89 percent) patients suffered from some emotional symptoms at the time of the consultation that they attributed to their accident (see Table 1). As a group, they experienced a full spectrum of emotional symptoms from mild depression or anger at some visible physical injury, to a formal thought disorder and auditory hallucinations that appeared to be independent of the accident or injury. One hundred one (91 percent) patients had some pain at the time of consult. Seventy-eight (69 percent) patients had some depressive symptoms (greater than 10 on the Hamilton Depression Scale), and 42 patients (34 percent) had significant depressive symptoms (greater than 17 on the Hamilton Depression Scale). Seventy-six (69 percent) patients had continuing anxiety or fears attributed to the accident that they reported interfered with their life. At the time of consult, over 95 percent of patients reported having some difficulty in one or more areas of life that they attributed to the accident such as housework, socialization, family relationships, work, recreational, or sexual activities. In each category of life functioning, approximately 80 percent of patients reported some disability or inability to carry out their usual duties or

Table 1
Patient, Accident, and Outcome Variables of 110 Personal Injury Litigants

Patient variables	(N = 110)	Objective threat to life/limb	
Male	47	Severe	30
Female	63	Moderate	27
Age (years)		Minor	53
10–19	2	Ongoing physical cause for symptoms	
20–29	21	Definite severe	10
30–39	33	Definite moderate	25
40–49	30	Likely	42
50–59	15	Unlikely	33
60–69	8	Outcome variables	(N = 110)
70–79	1	Symptoms	
Marital status		Pain	
Married	72	Nil	10
Single	17	Mild	30
Separated	9	Moderate	45
Divorced	6	Severe	25
Widowed	6	Depression	
Children		Mild	34
Yes	75	Moderate	34
No	35	Severe	42
Education		Anxiety	
Less than grade 8	15	Nil	34
Completed grade 8	53	Mild	35
Completed high school	20	Moderate	23
Attended college/university	12	Severe	18
Graduated college/university	9	Disability (moderate–severe)	
Accident variables	(N = 110)	Housework	64
Motor vehicle accident		Social life	68
Driver	50	Family life	83
Passenger	34	Recreational	74
Pedestrian	14	Work	74
Bicycle	2	Sexual	63
Indirect injury (spouse killed)	2		
Nonmotor vehicle accident	9		

activities. More patients (N = 97, 88 percent) reported disruptions in their family relationships than with other areas of their life. Ninety-one (82 percent) patients had difficulty completing their duties at work; 21 (19 percent) patients were unemployed and unable to do any work at all after the accident. At the time of the consult, 88 (80 percent) patients suffered from some loss of sexual enjoyment and performance and nine (8 percent) reported they were unable to participate in any sexual activity.

One measure of disability was to note posttraumatic changes in employment. Only four patients were unemployed prior to their accident, and all four remained unemployed after their accident. At consultation, a further 24 (22 percent) patients reported that they were totally disabled and unemployed because of their injuries. Four others said that they had given up paid employment because of the accident to become homemakers. Six patients improved their preaccident employment status to

Table 2
Diagnoses and Effects, N (patients) = 110

Most important diagnosis (DSM-III-R)*	
Psychiatric condition affecting physical illness	56
Major depression	27
Somatoform disorders	12
Posttraumatic stress disorder	9
Phobia	7
Malingering	7
Other—grief (6); Ulcer, Alcoholism	9
Total	N = 127
Effects of the accident on the person†	
Emotional reaction to physical condition	29
Difficulty coping with developmental tasks	20
Severe depression	20
Aggravation of normal premorbid personality	18
Aggravation of abnormal premorbid personality	14
Phobia	7
No permanent effect	12
Independent illness	2
Total	N = 122

* Multiple diagnoses allowed.
† Multiple effects allowed.

higher levels after the accident (for example, a student upgraded to professional). Seventy-six patients held the same kind of job before and after their accident, although many worked part-time, had decreased responsibilities, or reported that they were less effective at work.

Married patients compared with single patients tended to have a drop in the status of employment they had after an accident. However, having children was significantly correlated with an improved employment situation by the time of assessment ($p < .001$). Improvements in employment also correlated in a positive direction with higher education levels ($p < .001$).

Changes in employment did not correlate with the type of accident or the apparent severity of the physical injury.

The amount of pain suffered by a patient at consult correlated inversely with the education of the patient ($p = .030$) but not with other variables including the severity of the injury. Levels of posttraumatic anxiety correlated significantly with motor vehicle accidents (driver: $p = .027$; and passenger: $p = .041$) and not with other types of accidents ($p = 3.56$). Anxiety also correlated with the severity of the accident ($p = .047$), with being female ($p = .016$), and with being married ($p = .016$).

Depression correlated with being a driver in a motor vehicle accident ($p = .003$), with severity of accident ($p = .018$), and with loss of mother before the patient was 19 years old ($p = .033$).

Diagnoses and Clinical Descriptions

Two-thirds of the patients had an identifiable physical cause for their

symptoms at the time of consult. DSM-III-R psychiatric diagnoses were reached by using a checklist format in a semi-structured interview. For this study only the most prominent or severe psychiatric disorder contributing to each patient's current suffering or disability was listed. Posttraumatic stress disorder was rarely diagnosed in these patients because of the absence of intrusive thoughts, memories, or nightmares; thus, most of the litigants received other psychiatric diagnoses (see Table 2).

The commonest clinical diagnosis was "psychiatric condition affecting a physical condition" affecting 56 patients (50 percent). These patients had anxiety, depression, or frustration superimposed on an identifiable physical injury. Major depression affected 27 (21 percent) patients. Somatoform disorders occurred in 12 patients, nine had posttraumatic stress disorders, and seven had specific phobias. Seven of the patients were thought to be malingering. Nine received other diagnoses including grief reaction related to the death of a loved one in the same accident, peptic ulcer, alcoholism, and adjustment disorders.

In the author's experience, DSM-III-R diagnoses do not adequately describe the effect of the accident or injury in a patient's life. That is, a DSM-III-R diagnosis does not identify whether the psychiatric disorder is caused by or is unrelated to the accident or injury. Therefore, the author developed another classification system, previously described,[6] that took the patient's premorbid personality into account. It is obviously difficult to reliably assess premorbid personality and functioning retrospectively, but this is an important part of the clinical exercise to assist the court to compare preaccident and post-accident states.[1,7]

Emotional Reaction to Physical Injury: N = 29 (24 percent) Emotional distress is considered a normal reaction to a traumatic physical injury. For instance, a 67-year-old store owner suffered from moderate depressive symptoms two years after having his hand crushed by a runaway car. His multiple compound fractures of the hand caused posttraumatic arthritis with considerable pain and an inability to pick up small objects in the store, carry his grandson, or enjoy sex.

Difficulty Coping with Developmental Tasks: N = 20 (18 percent) With this condition, the severity of the emotional reaction is related to a developmental task that the patient had to face at the time of the accident. For example, a whiplash injury is likely to have a protracted course in an insecure young person who had been recently married or promoted prior to the accident.

Aggravation of Normal Premorbid Personality Traits: N = 18 (16 percent) In these cases, the patient appeared to be functioning within normal limits prior to the accident but decompensated after the accident with an exaggeration of specific personality traits that had not been disabling prior to the accident (e.g., schizoid, obsessional, or depressive traits).

Aggravation of Preexisting Personality Disorder: N = 14 (13 percent) Here the patient's history revealed significant

personality difficulties and dysfunction prior to the accident, and this pattern became worse after the accident. Examples include alcoholics and patients with paranoid or histrionic personality disorders.

Specific Phobias Occurring After an Accident: N = 7 (6 percent) The patient may have no premorbid psychiatric symptoms or dysfunction but develop a specific phobia after an accident such as a fear of driving, traffic, or agoraphobia. Many more patients had specific posttraumatic phobias, but the clinical picture was dominated by other syndromes such as severe depression.

Severe Depression: N = 20 (18 percent) This category was slightly more restrictive than DSM-III-R major depression (N = 27) in that the examiner felt that the depression was not only clinically significant, but it seemed to be out of keeping with the physical injury and events in the patient's life. Most clinicians would consider biological treatments or hospitalization for these patients.

Independent Illness: N = 2 (2 percent) In two cases the patient was referred for symptoms that appeared to be independent of the accident. One man was referred to assess the causal factors of a stroke that occurred 7 months after a minor motor vehicle accident. In a second case, a woman developed a schizophreniform psychosis 3 months after a minor accident.

No Permanent Effect: N = 12 (11 percent) These patients had no significant emotional symptoms or any disability related to the accident at the time of consultation.

Discussion

Although psychiatrists are more frequently involved in civil litigation cases, there is virtually no psychiatric literature on the characteristics of victims or litigants. This study is an effort to deal with this deficiency. It must be recognized, however, that it is difficult to generalize from this or any study, to the larger group of civil litigation cases. Each group is unique and influenced by a variety of factors such as the referral sources and the types of injury.[8]

The population included all age groups. More women were referred than men. Since there is no reason to suspect that women are injured or involved in litigation more frequently than men, it is probable that a lawyer will more often refer a woman who is more likely to ask for or accept a psychiatric referral than a man.

The majority of the litigants were married, had children, and were working in business or in the home prior to the accident. This contrasts markedly with the referrals in most mental health clinics. This study found a significant correlation between being married and higher levels of posttraumatic anxiety and disability that was independent of the severity of the accident or injuries. Factors that appear to be protective against more forms of mental illness, such as being married and being employed, seem to be a liability in the area of posttraumatic reactions to an injury caused by another person. Married liti-

gants were more likely to report a drop in their level of employment and a higher level of dysfunction in family relationships and sexual life.

The vast majority of the plaintiffs appeared to be hard working, feel their work obligations strongly, and have harsh superegos even prior to their accident. Nevertheless, in interview they also appeared to be somewhat unimaginative, alexithymic, and lack creativity. Excluding seven patients with a diagnosis of malingering, the remainder appeared to be law-abiding, with no history of unemployment, breaking societal rules, or of alcohol or drug abuse prior to the accident.

By the time of the psychiatric assessment, at least 30 percent of patients had no identifiable physical injury to account for the continuing disability. Nevertheless, 70 percent of the plaintiffs had real and identifiable physical injuries that could both cause and be aggravated by subsequent depression, frustration, and anger. In such cases, the psychiatrist has an important role to play in the litigation proceedings in describing the effect of physical injuries on the mind and how this can influence thinking, feeling, and behavior.

The examiner was left with the impression that most of the victims were not faking, looking for a get-rich scheme, but rather they were obsessive, brittle personalities with harsh superegos who took great pride in their work and in their family relationships until they were injured. They then became dysfunctional because of real but temporary physical injuries that shattered their high expectations of themselves, increased guilt, and started them on a downhill course. In the clinical interview, the patients' illness behavior appeared to be related to excessive dependency needs, a wish for justice and revenge, and excessive guilt about temporary disability rather than greed, although greed was an apparent motivator in a small number of cases.[9] The high percentage of married litigants suggests the possibility that family dynamics may be an important factor in understanding the motivational factors. It is possible that the quest for financial compensation is partly a homeostatic mechanism triggered by family stresses created by the accident.[10]

Approximately 30 percent of litigants appeared to have exaggerated personality traits or personality disorders that were aggravated by the accident and prolonged the recovery period. This finding is consistent with other reports.[7,11] Nevertheless, the fact of predisposition, according to the "thin-skulled principle," does not decrease a plaintiff's right to compensation but in fact helps the court to understand why some patients appear to be more affected than others with similar injuries.[1]

Twenty-six percent of the sample appeared to have a major depression, which compares to the one-third of patients at pain clinics who appear to have treatable depression.[12] Not all patients with chronic pain suffered from an identifiable depressive syndrome and this contrasts with Blumer and Heilbronn[13] who believe that chronic pain is a variant of depressive disease. It is clear to this author that a major depressive episode,

including those with melancholia, can be precipitated by the emotional and physical trauma of accidents such as reported here.

Numerous studies have concluded that the vast majority of litigants do not improve after settlement including excellent follow-up studies by Tarsh and Royston,[14] Balla and Moraitis,[15] Mendelsohn,[16] Woodyard,[17,18] Kelly and Smith,[19] and Thompson.[20] There is evidence that posttraumatic symptoms may develop equally in compensation seekers and nonseekers.[21]

It is also true that the courts and clinicians must be sceptical of some claims for compensation following relatively minor motor vehicle accidents.[8,9,21] In this study, seven patients were diagnosed as malingering on the basis of gross exaggerations, inconsistencies, and lies associated with many of the subtle signs of malingering described by Resnick[22] and others.[23,24] Fortunately the legal system has other methods for detecting malingering such as surveillance, that may be more useful than the clinical interview. Because a psychiatrist is not particularly adept at picking out malingerers, the commonest role of the psychiatrist in litigation cases is to assess the emotional symptoms and disability and make a judgment as to whether it is compatible with the clinical picture and course of known psychiatric disorders.

Although there is sometimes debate whether plaintiffs who are involved in litigation suffer from predominately physical or emotional disorders, the role of the psychiatric consultant is to assess each patient as an individual and not prejudge the issue. A bio-psycho-social understanding of the patient is usually required. Eventually psychiatry may develop and modify new empirically based diagnostic and classification systems, such as the one advocated above, that more accurately chart the relationship between the accident in question and subsequent clinical course. There is also a clear need to systematically study all of the factors that play a significant role in precipitating and perpetuating posttraumatic psychiatric disability including personal and family attitudes,[8–10,13] work conditions and satisfaction,[11] and the role of physicians, lawyers, insurance companies, and courts.[3,21,26]

What is clear is that many of these patients do suffer physically and emotionally and that their symptoms and disability continue long after their case is settled. Like other victims in our society, they often suffer silently and alone and feel that they are not understood by others because their injuries and their rage are frequently invisible. Like others with dual diagnoses, they often fall between the gaps, in this case with the law saying that they have to wait for settlement and doctors sometimes saying that they cannot be treated until the settlement is complete. Because these patients do not regularly improve with settlement, psychiatry should try to devise early intervention strategies to prevent long-term disability despite the complications of the litigation proceedings.

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