

MARSHALL, DENNEHEY, WARNER, COLEMAN & GOGGINA PROFESSIONAL CORPORATION www.marshalldennehey.com

200 Lake Drive East, Suite 300. Cherry Hill, NJ 08002
 (856) 414-600 · Fax (856) 414-6007

Direct Dial: (856) 414-6001
 Email: lizucker@mdwgc.com

PENNSYLVANIA
 Bethlehem
 Doylestown
 Erie
 Harrisburg
 King of Prussia
 Philadelphia
 Pittsburgh
 Scranton
 Williamsport

NEW JERSEY
 Cherry Hill
 Roseland

DELAWARE
 Wilmington

OHIO
 Akron

FLORIDA
 Ft. Lauderdale
 Jacksonville
 Orlando
 Tampa

**HOW TO DEFEND
POSTTRAUMATIC STRESS DISORDER (PTSD) CLAIMS**

LARY I. ZUCKER, ESQUIRE



Posttraumatic stress disorder (PTSD) has become a common element of damages in personal injury litigation. PTSD has an unsavory reputation among claims adjusters and defense counsel because it is often seen as nothing more than an attempt to build medical specials in an otherwise minor claim. Although PTSD is over diagnosed and misdiagnosed, it is a true mental disorder with well defined diagnostic criteria. The question is, what is PTSD and how does one tell a real case from a manufactured model?

Technically, a person diagnosed with PTSD must meet the diagnostic criteria for PTSD contained in the *Diagnostic and Statistical Manual of Mental Disorders Fourth Edition* (DSM-IV). The purpose of DMS-IV is to provide clear descriptions of diagnostic categories in order to enable mental health professionals to diagnose, study and treat people with various mental disorders. A diagnostic code is assigned to each disorder for the purpose of medical recordkeeping and compilation of statistical information. For example, the diagnostic code for PTSD is 309.81. A copy of the diagnostic criteria is PTSD contained in DSM-IV (309.81) is attached to this summary.

DSM-IV is published by the American Psychiatric Association (APA). In 1952, the APA published the first diagnostic and statistical manual (DSM-I). Although DSM is not a textbook, the inclusion of a mental disorder in this manual is widely accepted as a sign that the mental health community recognizes the disorder and is seeking a uniform system of diagnosis and treatment. Each edition of the book reflects new knowledge and evolving new information. For example, PTSD was not included as a specific diagnostic category in DSM-I (1952) or DSM-II (1968). PTSD was finally incorporated into DSM-III in 1980. The diagnosis of PTSD did not arise in litigation prior to 1980. Since 1980, PTSD has become an important compensable element of damages which is often used to enhance an underlying claim for physical injury.

WHAT IS PTSD?

PTSD is often misused as a "catch-all" diagnosis to describe the development of any emotional response to an accident or trauma. If you believe that PTSD is being

improperly diagnosed, a good place to start your analysis is with Section 309.81, the diagnostic criteria for PTSD contained in DSM-IV. The essential features of PTSD are:

1. The development of symptoms following exposure to an extreme traumatic stressor involving a direct personal experience or the witnessing of an event that involves actual or threatened death or serious injury. The plaintiff's response to the event must involve intense fear, helplessness or horror.
2. Persistent re-experiencing of the traumatic event through recurrent and intrusive memories and dreams.
3. Persistent avoidance of stimuli associated with the trauma such as inability to recall an important aspect of the trauma or a feeling of detachment or estrangement from others.
4. Persistent symptoms of increased arousal such as difficulty falling asleep or staying asleep, irritability, anger, and difficulty concentrating.
5. The full symptom picture must be present for more than one month and the disturbance must cause clinically significant distress or impairment of social occupational or other important areas of functioning.
6. The following specifiers may be used to describe onset and duration of symptoms of PTSD:
 - (a) Acute – When the duration of symptoms is less than three months.
 - (b) Chronic – When the symptoms last three months or longer.
 - (c) Delayed onset – At least six months have passed between the traumatic event and the onset of symptoms.
7. PTSD can occur at any age including childhood. Symptoms usually begin within the first few months after the trauma although there may be a delay of months or even years before symptoms appear.

The severity, duration and proximity of an individual's exposure to the traumatic event are the most important factors effecting the likelihood of developing PTSD. Such factors as social support, family history, childhood experiences, personality variables, and preexisting mental disorders may influence the development of PTSD.

PRACTICE TIPS ON CHALLENGING A CLAIM INVOLVING PTSD

1. Consider other diagnoses. In PTSD the stressor must be extreme in nature (life threatening). In contrast, in adjustment disorder the stressor can be of any severity. The diagnosis of adjustment disorder is appropriate for situations in which the response to an extreme stressor does not meet the criteria for PTSD and in situations for which the symptom patterns of PTSD occurs in response to a stressor that is not extreme

(e.g., a minor traffic accident). Once the stressor has terminated, the symptoms do not persist for more than an additional six months.

Acute distress disorder (308.3) is distinguished from PTSD because the symptom pattern of acute distress disorder is experienced during or immediately after the trauma and lasts for two days and resolve within four weeks after the conclusion of the traumatic event.

By definition, a diagnosis of acute stress disorder is temporary and is appropriate only for symptoms that occur within one month of the stressor. PTSD requires more than one month of symptoms.

If a diagnosis of PTSD is made within one month of the onset of symptoms or the experiencing of the trauma, consider the alternative diagnosis of acute stress disorder. If the symptoms persist beyond one month, the diagnosis can be changed to PTSD or the plaintiff may be suffering from a preexisting mental disorder.

2. What is the preincident psychiatric history of the plaintiff with PTSD? In some cases, the plaintiff's symptoms and behavior attributed to PTSD are lifelong character defects that belong to a clinical group of disorders known as personality and developmental disorders. Claims may be defended in cases where the plaintiff has an antisocial or borderline personality disorder, dependent, or compulsive disorders. An independent psychiatric examination would be necessary to distinguish among these various conditions.

3. How severe was the traumatic stressor alleged to have resulted in PTSD? PTSD is reserved for extreme stressors and not the every day stressor that we all experience. For example, minor automobile accidents without significant physical injuries are not likely to produce PTSD symptomology, especially if the accident did not cause a sense of horror or extreme hopelessness. If a relatively minor accident produced the PTSD, it is likely that the plaintiff suffers from an exacerbation of a preexisting disorder or an adjustment disorder. By definition, an adjustment disorder does not last beyond six months and usually is much less severe than PTSD.

4. Consider witness bias and treatment interference if the mental health professional diagnosing the plaintiff's PTSD is also the treating psychiatrist. In orthopedics, it is not necessary to form a bond with the patient to treat a broken limb. Psychiatry and psychology are different. Many long-term treating professionals in their mental health field become so involved with their patients that they are biased witnesses. They "like" their patients and those feelings often contaminate their professional judgment. A good defense analyst must recognize this potential lack of objectivity by plaintiff's treating expert.

5. Is the plaintiff's expert witness relying solely on the diagnostic criteria in DSM? If so, it could lead to many impeaching questions. For example:

(a) The diagnosis of PTSD has evolved and changed over time and you should be aware of the diagnosis of PTSD in DSM-III and DSM-III-R as well as DSM-IV.

(b) A diagnosis of PTSD does not carry and necessary implication regarding the cause of the individual's mental disorder or its impairment. Inclusion of PTSD in DSM-IV does not require that there be knowledge about its etiology.

- Under DSM-III-R criteria, the stressor giving rise to symptoms of PTSD must be "outside the range of normal human experience." That was a requirement until 1994 when it was deleted because it was "unreliable and inaccurate." DSM-IV criteria instead requires that the person's response to the stressor must involve intense fear, helplessness or horror, whatever the source.

- A criterion requiring that the symptoms cause clinically significant distress or impairment has been included in DSM-IV. This can be a very powerful argument for the defense professional. If a plaintiff does not experience clinically significant distress or impairment, the diagnosis of PTSD is not appropriate.

- The acute distress disorder (308.3) described above is new in DSM-IV and was added to describe acute reactions to extreme stress lasting from two days to four weeks.

SUMMARY

PTSD is often overdiagnosed and misdiagnosed. PTSD symptoms are subjective and self-reported. The plaintiff's treating psychologist is not motivated to independently verify the patient's allegations of psychological distress. Moreover, the stress of litigation in causing the patient to reexperience the traumatic event is often overlooked as a major contributor to the litigants current clinical picture.

Many patients with PTSD will never fully forget their accident or may continue to reexperience the traumatic event for a period of time. However, these patients may be able to function with little or no limitations thus mitigating damages and undermining the diagnosis of PTSD under DSM-IV.*

**Personal Injury Law Defense Bulletin*, published by Med-Psych Corporation.

\\06_ALIAB\LXZ\UFRM\711294\LXD\15000\60000