STRESS TESTING

Paul Rogers, Nathan J Hennah, Andrew Collingbourne and Kevin Gournay on developments in diagnosing post-traumatic stress disorder.

This article provides an overview of recent changes to the diagnosis of Post Traumatic Stress Disorder according to the North American classification system for mental disorder, which is the most widely used in the UK (DSM). We aim to give some useful advice to lawyers on what we believe are some of the main medico-legal practice issues associated with PTSD.

PTSD has existed as a diagnosis for around 35 years. At the time when it came into force - and still today – it has been controversial. For the first time, a mental health disorder was seen as being consequential to an event that happened to a person, and not because of some 'flaw' or deficit within that person's biological or psychological make-up. That said, the symptoms of PTSD have been historically well documented before the diagnosis existed, in examples such as 'shell shock', 'traumatic neurosis', 'rape trauma syndrome' and 'car-crash syndrome'. Samuel Pepys makes many references to nightmares, anxiety and avoidances in his diary regarding the 1666 Great Fire of London.

The diagnosis used in the North American DSM classification system for mental disorder has been revised four times since 1980, with the last changes in 2013. Since 1980 the two main issues in the evolution of the PTSD diagnosis have been: (1) Moving away from understanding PTSD as part of a disorder of anxiety, towards a new type of disorder known as 'trauma and stress related disorders'; (2) The move to view PTSD now as part of more 'normal', everyday life experiences. Previously it was seen as consequential to extreme or rare events such as war, torture, rape, and natural disasters (such as earthquakes, hurricanes, and volcano eruptions). One of the difficulties with the diagnostic criteria is the very broad spectrum of psychiatric injury suffered

by someone with low level symptoms following what some may consider a relatively minor accident – particularly when compared to someone involved in truly horrific events, who suffers the most severe and incapacitating psychiatric injuries. While one may define severity as mild, moderate or severe, most clinicians are troubled by the considerable heterogeneity of the condition. For example, it can currently be used in relation to a person who may have had a car accident at 20mph, while at the same time used to describe someone returning from a war, having witnessed comrades being killed and suffering serious injury.

Current PTSD diagnosis using DSM-5

The current DSM-5 criterion for PTSD includes four sets of symptom clusters, and two subtypes. There are requirements relating to duration of symptoms and how it impacts on a person's day-to-day functioning. There is now also a new, pre-school diagnosis for PTSD, which will not be covered in this article. So when diagnosing, these criteria must be met.

Criterion A determines the **severity** of the traumatic event. For PTSD to be diagnosed, the person must have been exposed to actual or threatened serious injury or sexual violence. The exposure can be direct; witnessed; or indirect, by hearing of a relative or close friend who has experienced the event. Criterion B determines the sub-cluster of symptoms known as **'Intrusion or Re-experiencing'**. These symptoms include: intrusive thoughts or memories; nightmares related to the traumatic event; flashbacks - which is a feeling that the event is happening again; and psychological and physical reactivity to reminders of the traumatic event, such as an anniversary reactions. Criterion C determines the sub-cluster of symptoms known as **'Avoidant symptoms'**. This relates to ways that someone may try to avoid anything related to the event or a cue for the memory of the event. For example, the place where the incident occurred, television, radio or news reports of similar type incidents, or talking or remembering the event. Criterion D determines the new sub-cluster of symptoms known as **'Negative alterations in mood or cognitions'**. This new criterion reflects many symptoms that have been reported and observed frequently by PTSD sufferers and those treating them. In short, the person becomes more negative in mood or thoughts, and symptoms can include: memory problems that are consequential to the trauma event (including psychogenic amnesia); negative thoughts or beliefs about one's self or the world that occur after the trauma event; distorted sense of blame for one's self or others, related to the event; being unable to escape quite severe emotions related to the trauma (for example, shame and horror). Criterion E determines the sub-cluster of symptoms known as **'Increased arousal symptoms'**. These include: hypervigilance and 'looking for threat'; difficulty concentrating; irritability; worsening temper or anger; difficulty falling or staying asleep; and being prone to being more easily startled. Criteria F, G and H describe the **severity** of the symptoms listed above. The symptoms must have been present for at least a month, have a serious effect on a person's day-to-day functioning, and cannot be caused by other mental health problems such as substance use, medical illness and so forth. If the person has full PTSD symptoms but it is less than 28 days after the traumatic event, then the correct diagnosis is usually Acute Stress Disorder (ASD). This diagnosis covers the range of anxiety, avoidant and intrusive symptoms seen in PTSD but present before the 28-day cut off period for PTSD.

Lifetime prevalence rates

UK data is scarce, but US research suggests that between 75% - 90% of the US general population has been exposed to a traumatic event which is significant enough to cause PTSD, in so far as it meets 'Criterion A'. It is also known that approximately 8% of the US population will have PTSD at some point in their lifetime. If this 8% figure is accurate, this means one in 12 people will develop PTSD in their lifetime. This can be a surprise to some clinicians and lawyers, and as noted above, PTSD can no longer be seen as a condition that is only related to extreme, rare events. US data suggests that the most prevalent forms of trauma were physical or sexual assault (52%), accident or fire (50%), death of a close family member or friend due to violence (49%), natural disaster (48%), threat or injury to a close family member or friend (32%), and witnessing physical or sexual assault (31%). One very notable finding across studies is the effect of gender. Female victims of traumatic events are at higher risk for PTSD than male victims. The reason is unknown. Another very interesting finding relates to the cause of the PTSD event, and the impact of whether it was seen as intentional or non-intentional.

PTSD trajectory

The most recent and comprehensive systematic review of all of the research evidence regarding the course of PTSD was published by Santiago *et al* in April 2013 entitled *A Systematic Review of PTSD Prevalence and Trajectories in DSM-5 Defined Trauma Exposed Populations.* The authors reviewed the published literature for longitudinal studies of directly exposed trauma populations, in order to review rates of PTSD in the first year after a traumatic event. The results were that the median prevalence of PTSD across all studies decreases from 29% at one month post trauma, to 17% at 12 months post trauma. But there was a very important finding that while untreated PTSD due to a non-intentional cause improved with time (30% at one month post trauma to 14% one year later), untreated PTSD due to an intentional cause worsened with time (12% at one month post trauma, to 23% one year later). This is a quandary for treating clinicians and those in the legal profession, as it calls into question the whole issue of treatability, psychiatric prognoses and the need to more carefully consider the sub-populations when considering PTSD outcomes.

Co-occuring or co-morbid conditions

Research, clinical experience and common sense suggest that a person with PTSD is more likely than not to experience another mental health condition at the time of their PTSD diagnosis. The most common are major affective disorders, dysthymia, anxiety disorders, and alcohol or substance misuse disorders.

Evidence-based care, treatment and management

It is wise to consider the NICE clinical guideline on PTSD (NCCMH, 2005; NICE, 2005), as it covers many issues based on best practice models, and not just the most effective treatments. The NICE guideline covers: the care people with PTSD can expect to receive from their GP or other healthcare professional; the information they can

expect to receive about their condition and its treatment; what treatment they can expect - this should include psychological therapies and drug treatment; the services that may help them with PTSD, including specialist mental health services.

PTSD and personal injury

The inception of a PTSD diagnosis heralded a breakthrough in the areas of personal injury and clinical negligence law. For the first time, the medical effects of an event on a person's mental state, usually suffered through the actions of another, was diagnosable and universally agreed. Loose diagnoses like 'anxiety with depression' no longer applied. One either had PTSD, or one didn't.

The following are practice considerations for the solicitor:

• **Consideration of overly optimistic prognoses.** A rule of thumb is that around 70% of people recover with the appropriate treatments; some naturally recover with no treatment (referred to as spontaneous recovery).

In some cases, the condition may be chronic. Given the pressure on solicitors to settle cases quickly, it is difficult at the time of the expert's assessment to predict which people will suffer from chronic PTSD, unless the event occurred more than six months ago, and the person has had a trial of medication and CBT treatment. Occasionally, the illness does not show up until years after the traumatic event. This causes obvious difficulties with prognosis, as a person's PTSD can be triggered by a similar event or a 'near miss' event similar to the original trauma, but years later. Unfortunately, it is impossible to predict who will experience this. From a legal perspective, this can sometimes cause issues on limitation, and should be considered.

• **Careful consideration that medical opinions are 'NICE' compliant and recommend psychological therapies as well as medications.** NICE guidance constitutes evidence guidelines, and all clinicians are required to adhere to these, unless there is a very clear rationale regarding why a deviation from such guidance is appropriate. The NICE guidance on PTSD is clear that trauma-focussed psychological treatments and certain medications are the treatment of choice. To this effect, it is helpful for all solicitors to be aware of the main messages in the latest NICE guidance on PTSD. It is appropriate to ask experts to refer to the NICE guidance when instructing them. Further, following the implementation of the guidance for the instruction of experts in civil cases (2014) issued by the Civil Justice Council, it is important that the experts are also well versed with the new CJC criteria.

• **Pre-existing vulnerability (or is the PTSD simply a continuation of a pre-existing illness?).** If, before the index event, there was no evidence of symptoms that meet the criteria for an identifiable psychiatric illness, then simply put, even if there is a history of a previous serious psychiatric illness, as far as causation is concerned, we have to take the patient 'as we find them' - and the previous injury is therefore legally irrelevant. But if, at the time of the index event, the person is suffering from, say, a depressive illness, then matters become complicated, as depressive symptoms are a feature of PTSD. In this case, the expert needs to assist the court by first separating the causation of post event depressive symptoms, but also answering the question of how much the PTSD will exacerbate the pre-existing illness in the future. All of this amounts to a veritable conundrum for both legal team and expert. One should also have regard to the case of *Bailey v Ministry of Defence* [2008] EWCA Civ 883 and recent cases with further guidance in this regard, where one can show material contribution in any event.

• **Possible misleading use of statistics.** One difficulty facing the expert and the respective solicitors is the task of attempting to predict the future, or to 'quantify' the future risk of an event happening. For example, an expert may be asked to provide an opinion on the likelihood that a person may develop PTSD - or if co-morbid, depression - in the future, in a case where someone has had a previous depression. The expert will correctly note that around 60% of people with a first episode of depression will go on to develop a second episode. This means that of 100 people with a first onset depression, we would expect 60 to develop a second episode. What this *does not* mean is that that individual is at 60% risk of developing a second episode. One cannot take a population-based statistic and infer an individual risk. Each of those 100 people do not have an inherent 60% risk of future depression. The problem is that they may develop a second depression - but then again, they may not. So each person has either a 100% risk (yet to be determined) or a 0% risk (yet to be determined). In mental health, we cannot predict which group that person will be in, as our predictive measures and skills are not that advanced. The correct way of understanding or stating this would be something like: 'We know through research that for every 100 people with a first episode of depression, 60 (60%) will go on and develop a second episode. However, we cannot confidently predict which group this client falls within as the research is not that sophisticated. The client could be in either group. On the balance of probabilities, it is probable that the client will fall within the group that has a second episode as this is the most statistically likely. This does not mean that within him, there are inherent factors that increase his individual risk. That we do not know, and therefore we cannot quantify his individual risk of a second episode'.

In cases of this nature, solicitors should always be cautious about anticipated potential forthcoming events, and obviously have regard to provisional damages as opposed to outright conclusion of a case.

• **Identifying previous trauma claims.** When taking instructions in potential actions, solicitors need to be mindful of the appropriate questions to ask claimants in relation to events giving rise to a claim. As an example, often victims of road traffic collisions are simply seen and referred for a medical report dealing with whiplash, or indeed an orthopaedic report for bone injury - and instructions are not given to ascertain whether or not a claimant has sustained something other than an obvious physical injury. Victims of road traffic collisions can suffer from PTSD, and by its very nature, will obviously avoid talking about it. So it is important that a full history is taken, sometimes speaking to family members, so that this head of loss can be considered.

• **The potential negligence of solicitors.** For the reasons mentioned above, often non-visible injuries are missed when considering the claimant's cause of action. This can

lead to the claim settling at undervalue, with the claimant significantly traumatised from a psychological/psychiatric point of view. These injuries then go on to manifest themselves and can sometimes become worse without treatment. This is not just detrimental to the claimant, but can also lead to professional negligence claims against solicitors for settling claims too early without taking a full medical history.

• **Mitigating your loss.** In mitigating losses, solicitors acting for both the claimant and defendant should consider the need to determine whether recommended treatments are available through the GP/NHS. This will usually be in relation to physiotherapy, cognitive behavioural therapy, or psychiatric prescribing and monitoring of medication(s). Including this issue in a solicitor's instruction to medical experts can help by asking for any probable GP/NHS timescales associated with any recommended treatment interventions. But our experience is that GPs are unlikely to be able to access such interventions quickly, as waiting lists of up to two years are the norm for CBT across the UK. As a rule of thumb, one should always invite a GP or Local Health Board to fund such treatments, even if it is believed that the waiting list makes it non-viable. At least from that point of view, the claimant has sought to mitigate their loss and obtain treatment sooner rather than later.

• **Medication can 'mask' symptoms.** A particular problem for the expert and solicitor is the effect of medication. Antidepressant medications are often used in combination with CBT therapy, and can alleviate the symptoms of PTSD (and/or anxiety/depression) by managing the biochemical and physiological abnormalities that produce anxiety and depression. Medication(s) can reduce symptoms, but these can return when the medication is ceased. This is further compounded by current best practice that certain NICE recommended PTSD medications should be taken for at least nine months to a year.

So while someone may be symptom free two months after such medication is introduced, caution should be exercised in making statements that the PTSD is fully treated. Unless we discontinue the medication, we cannot be sure that the symptoms will not return, possibly with more severity. We also cannot discontinue the medication (usually done slowly over a month or two), until nine months to one year has passed. For this reason, it is best to consider the person to be 'improved with medication' rather than saying 'the PTSD has been successfully treated'.

• **Issues surrounding surveillance.** Surveillance may occur in cases of high value or where there are doubts regarding a client's claim. Claimants may be aware of this potential, through the internet or other media, through discussions with their solicitor, or because they have noticed that someone may be observing them. The thought of being under surveillance often causes significant anxiety. Clients will naturally worry; sometimes obsessively ruminating about what they have or have not been doing, and whether this is in line with their claim. They also may disclose thoughts that 'they are not believed', which can further their anxiety but also fuel thoughts and feelings of anger. One seemingly simple response to such stress is for the person to curtail their day-to-day activities, including working on the garden, playing with children or grandchildren, shopping, social activities, exercising, driving, and so forth. In effect, the client withdraws from their normal activity as a form of coping with the fear of surveillance. While this can reduce fear of being not believed, and the stress and worries associated with being under surveillance, there is a significant downside; such behavioural withdrawal is a significant risk factor for the onset of depression. By reducing activity, we also remove positive reinforcers or pleasure from our daily lives. This can actually cause a depressive illness, as well as potentially maintaining or exacerbating one that is already there.

While solicitors have a duty to their client, they have an overriding duty to the court. It is important that clients are advised of the potential for covert surveillance in appropriate cases, but a genuine victim will have nothing to hide. Finally, it is imperative that those who are medically treating claimants keep very accurate records of any instructions that they give to clients asking them to engage in activities they previously avoided, and if necessary prepare reports based on any surveillance that any party intends to rely on.

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