

Certain Conceptual Difficulties in Making the Diagnosis of

POSTTRAUMATIC STRESS DISORDER

and the Potential Implications for the Legal System

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Abstract

The authors of this article consider some of the potential difficulties involved in making the diagnosis of Posttraumatic Stress Disorder (PTSD). The nature of these difficulties raises very significant questions about the underlying presumptions about the cause or causes of PTSD. Although the criteria set forth in the *Diagnostic and Statistical Manual: DSM-IV-TR* seem clear and complete, this article demonstrates that additional clarity is necessary. The authors explore some of the confusion in the conceptual premises that leads to the disorder being called "Posttraumatic." Further, this article explores the lack of clear legal responsibility for such psychiatric problems under current workers' compensation laws.

Introduction

This article explores the aspects of some of the fundamental premises about how the diagnosis of Posttraumatic Stress Disorder (PTSD) is made and issues about who develops PTSD. Questions are addressed and evaluated about whether or not the condition develops in the work environment, and who is responsible in terms of paying for treatment and for time lost from work due to the condition.

Memories and Known PTSD v. Physiological Reactions to Alleged Alien Abductions

Individuals who reported that they had been abducted by aliens and other individuals with known Posttraumatic Stress Disorder (PTSD) were compared in a study by Dr. McNally and his co-author to determine if memories of alleged abduction by space aliens would provoke the same or similar physiological reactions that occur when other individuals, such as combat veterans and those who have survived deadly car accidents, recall their own traumatic experiences (Cromie, 2003, February 20). The two psychologists who conducted the study interviewed and tape-recorded sessions with each of 10 people who had reported alien abduction. The same procedure was performed on 8 people haunted by traumatic experiences unrelated to abduction by aliens. Later, with suitable physiologic monitoring equipment in place, each of the 18 subjects listened to their own tape-recorded interview.

When the two sets of measurements were compared, the results were striking. Alleged abductees showed surprisingly strong physiological reactions to hearing the tapes of their interviews about alien encounters. Their reactions were as great or greater than those of individuals who could not shake memories of combat, sexual abuse, and other prior traumatic events. Dr. McNally announced these findings on February 16, 2003, at a meeting of the American Association for the Advancement of Science in Denver. The researchers concluded, "The results underscore the power of emotional belief.... Abductees react emotionally like people who have real mem-

ories of combat, abuse, and near-death encounters” (Cromie, 2003, February 20).

One of the conclusions of the researchers’ study was, “People who sincerely believe they have been abducted by aliens show patterns of emotional and physiological response to these ‘memories’ that are strikingly similar to those of people who have been genuinely traumatized by combat or similar events” (Cromie, 2003, February 20). The researchers related their findings to physiologic aspects of sleep.

Literature Reveals Diverse Causes and Conditions Associated with PTSD

Hidalgo and Davidson indicated, “Most people will experience a traumatic event at some point in their life, and up to 25% of them will develop the disorder (PTSD). Demographic and socioeconomic factors also play a role in the risk for exposure to traumatic experiences and subsequent PTSD” (2000, p. 5). These authors believe that it is extremely important to consider why the other 65% to 75% who have experienced a traumatic event do not develop PTSD.

According to Bowles, James, Solursh, Yancey, Epperly, Folen, and Masone, even a spontaneous abortion (a miscarriage) can lead to PTSD: “After spontaneous abortion, as many as 10% of women may have acute stress disorder and up to 1% may have Posttraumatic Stress Disorder” (2000).

Bowman states, “Greater distress arises from individual differences than from event characteristics. Important individual differences that interact with threat

exposures include trait-negative affectivity (neuroticism); beliefs about emotions, the self, the world, and the sources and consequences of danger.... Reasons for the discrepancies between the evidence and the current model of post-traumatic distress are proposed” (1999, p. 21).

Bowman’s conclusions were that: “In accounting for responses to threatening life events, the relatively minor contribution of event qualities compared with individual differences has significant treatment implications. Treatment approaches assuming that toxic event exposure creates a posttraumatic disorder fail to consider individual differences that could improve treatment efficacy” (1999, p. 21).

D’Souza and other authors have recognized that Posttraumatic Stress Disorder symptoms can affect the rest of one’s life (1995).

Finally, in considering what factors are most important in the development of Posttraumatic Stress Disorder in the individual, Breslau & Davis conclude:

There is as yet little empirical research on the validity of the diagnosis. Literature on disasters, civilian and wartime, and on more ordinary stressful life events does not support the view that extreme stressors form a discrete class of stressors in terms of the probability of psychiatric sequelae or the distinctive nature of subsequent psychopathology. Extraordinary stressors are like more ordinary stressful events with respect to their complex differential effects upon individuals. Personal characteristics

and the nature of the social environment modify the likelihood and form of the response of individuals to all types of stressors. (1987, p. 255)

Questions to Be Addressed in this Article

- 1.) Is the issue in the development of PTSD the severity of a particular experience or group of experiences, or is it the re-experiencing of the event?
- 2.) Does everyone have to agree on what the external events were that caused PTSD? Or is the significance of these events evident only in the eyes of the beholder?
- 3.) In the development of PTSD, is the memory of the traumatic event an important factor?
- 4.) In the development of PTSD, does the memory of the traumatic event or events have to be based on actual external events?
- 5.) Is the memory of an experience alone (without a “real” experience actually occurring) enough to cause PTSD? What if there were no external events at all? (That does not necessarily mean that there was not an experience.)
- 6.) What if a minor external event occurred, but this event was greatly distorted by misinterpretation on the part of the person experiencing it?
- 7.) In what proximity to the person experiencing the event must the event take place?
- 8.) Why is it that regardless of the level of trauma (with the possible exceptions of rape and extended torture), only 25% to 35% of people exposed to trauma develop the full-blown PTSD syn-

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drome? Even when a group is exposed to major trauma, why is it that far less than 100% of the group develop the syndrome?

9.) What is the legal precedent recognizing PTSD as a defense or as a compensable injury under the legal system?

10.) Would the existing workers' compensation laws permit an award of benefits if the diagnostic criteria under DSM-IV-TR permitted finding the disorder in employees who were affected by some minor or non-existing external event?

11.) Is the issue in the development of PTSD significantly based on individual susceptibility to succumbing to the disorder?

These are only some of the questions that are emblematic of the difficulties of making a diagnosis of PTSD and awarding benefits for the presence of that condition within the judicial system.

Diagnostic Criteria for PTSD

The American Psychiatric Association first officially recognized PTSD in 1980. According to the DSM-IV-TR, the "A" diagnostic criterion required to make the diagnosis of PTSD is as follows:

A. The person has been exposed to a traumatic event in which both of the following were present:

1.) The person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others.

2.) The person's response involved intense fear, helplessness, or horror. Note: In children, this may be expressed instead by disorganized or agitated behavior (American Psychiatric Association).

One of the primary focal points of this article is to explore what the word "experienced" might actually mean (in terms of Criterion A1 for PTSD in the DSM-IV-TR). Once the term "experienced" is considered it becomes obvious that we are dealing with subjective issues, and that the nature of the trauma becomes an issue because it is the internal recog-

nition of the perceived event that seems to be the ultimate determining factor. That may help account for why there seems to be such wide variability about who is vulnerable to the development of the disorder (American Psychiatric Association).

As another concern, it seems necessary to explore how a more expanded view of PTSD might impact the workers' compensation systems and how it might affect other legal claims or defenses. Criterion A1 suggests by its wording that *any* of the following can result in PTSD: witnessing, experiencing, *or* being confronted with trauma. "Experiencing" is not necessarily the equivalent of witnessing (American Psychiatric Association).

The Challenge to American Jurisprudence and the Medical Community in Determining if PTSD Is a Compensable Injury

PTSD presents a challenge to the legal system because its diagnosis requires an event-specific trauma, thereby illuminating the potential defendants responsible for the injury. Therefore, PTSD by its very nature gives a plaintiff's lawyer the tool to develop the legal theory to justify the award of damages or benefits to the injured worker.

It should not be surprising that claims based on PTSD should be increasing due to its acceptance by psychiatrists and psychologists as a recognized disorder. For example, in California, the state that has the most open approach to compensation for mental injuries under workers' compensation laws, the number of mental stress cases increased from 1,282 in 1980 to 6,812 in 1986 (Larson, 1996).

At the same time, PTSD faces even more legal challenges than usually raised for any other mental injury, including doubts about its existence, its severity, and the possibility of secondary gain or malingering by the injured worker. "Exaggeration or fabrication of PTSD symptoms is possible and information about diagnostic features of PTSD is

common in the media" (Eldridge, 1991). "Experience with forensic and disability cases where there is a high possibility of secondary gain reveals that Posttraumatic Stress Disorder is a difficult diagnosis to establish" (Sparr & Atkinson, 1986, p. 613). It is in this context that the legal system faces the challenge presented by the injured worker with a diagnosis of PTSD. This challenge must be met not only by lawyers, but also by the mental health professionals who make the diagnosis of PTSD in their patients.

The medical community has an ethical obligation to work with other professionals, including lawyers, to provide assistance to patients. "If a patient who has a legal claim requests a physician's assistance, the physician should furnish medical evidence" (American Medical Association, 2001, para. 9.07). In fact, some courts have found that such assistance is not only ethical, but a legal duty! A doctor can be held jointly liable for the consequences of the denial of insurance coverage (*Murphy v. Godwin*, 1973; *Wilson v. Blue Cross*, 1990). "The question of a doctor's legal duty toward his patients with respect to completing insurance forms is apparently novel. The existence of such a duty may be found, however, by reference to established tort theory and recognized incidents of the doctor-patient relationship" (*The Inter-professional Code*, 1988).

Experience Without Memory

Case One: The following case illustrates an argument about whether or not a person could develop PTSD after experiencing a significant head injury that resulted in profound unconsciousness. An example of this debate occurred in providing an assessment of a young woman who had been involved in a head-on collision. The collision took place when a truck crossed the center line of a highway. The woman was the unrestrained driver of the other vehicle. She had serious facial and head trauma from her encounter with the windshield.

When she arrived at the emergency room (ER), her Glasgow coma score was 3, which is the lowest possible score, meaning she was profoundly unconscious. This would thus prevent the development of long-term memory that can develop in PTSD as a result of that injury.

The woman remained unconscious in the hospital in the intensive care unit (ICU) for 1 week. She had retrograde amnesia (of events that had occurred before the accident) for approximately a 12-hour period. Family members had told her extensively about the accident by the time that she came for evaluation. Litigation became an issue. She met many of the criteria for the diagnosis of PTSD. However, she did not remember the accident and she was not re-experiencing it, hence she could not be given the diagnosis of PTSD. She had developed a phobic response to driving. (Note: if the recalled experience of various treatments at the hospital had been sufficiently traumatic, she might have developed PTSD on that basis alone, but that was not the case, nor is it the issue being addressed.)

Although she could not recall the accident or how she felt at the time, she had clearly “experienced” the accident. She was there when the accident occurred and was alert (presumably) until she was knocked into unconsciousness when her head hit the windshield. Could she have met the criteria for PTSD even with no recollection of experiencing the event and no recollection of her feelings at the time of the event?

Experience Without True Memory, but with a False Memory

What if, in the situation described above, a false memory were constructed about the nature of the traumatic event based on information offered or suggested by people who witnessed or who read about how the event happened? (These people could include family members, health care providers, etc.)

Case Two: A second case involved a

person who was crushed by a heavy table he was constructing. This man also suffered severe head injuries. On arrival to the emergency room, his Glasgow coma score was 3, the lowest possible score, meaning he was in a profound coma. This man remained profoundly unconscious for several hours after his arrival at the ER. He required an emergency neurosurgical intervention and then remained in the ICU for 4 days. His first memory following the event began 7 to 14 days later. He required extensive rehabilitation services for his organic brain damage.

The evaluating physician in this case, concluded that this patient had developed a false memory about the events that took place at the time of his injury. The basis for this opinion was that a retrograde amnesia of at least of 30 to 60 minutes would typically be expected in a case such as this. (It was believed that, based on the severity of the brain injury, it was unlikely that the man would ever recall the incident.) During the first year after the injury, the man repeatedly reported that he did not recall the events of his injury. However, during the second year, he gradually developed increasing “memories” of the event.

The patient subsequently reported that he recalled being under the heavy table that crushed him. Still later, he reported that he recalled being unable to move any part of his body while being trapped beneath the table. He then began to report that he recalled gradually “fading out” over a short period of time while trapped beneath the table. Finally, he began to report that he recalled being intensely frightened at the time. (Realize that it is impossible to know whether his memories were false memories or not, but for the purposes of the hypothetical framework/thought experiment, we ask that the reader accept that these memories of the injury are/were false memories.)

In the re-education/restructuring process of rehabilitating the patient’s substantial organic brain deficits, the

events leading to his brain damage were repeatedly discussed with him. Eventually he was given materials to read about PTSD. It is quite possible that he learned about the manifestations of PTSD through this source rather than by his own experiences. He seemed to gradually develop more and more of the symptoms of PTSD over a 1- to 2-year period, beginning approximately 1 year after his injury.

When this man’s workers’ compensation income based on his physical injuries stopped, he applied for an additional allowance based on PTSD. On the forced-choice testing (symptom-validity testing) and other tests designed to measure test-taking attitude, motivation, and effort (that were carried out as a routine part of his evaluation), the man showed clear evidence of falsification, exaggeration, and lack of full, complete effort. One explanation for these results might be that the patient reported having (false) memories and also seemed to have substantial symptom exaggeration based on issues of financial and other gain(s). Unfortunately, this patient’s Minnesota Multiphasic Personality Inventory-2 (MMPI-2) F scale is no longer available.

False Memories

It is necessary to have some awareness of the vagaries of memory. One of the implications of the word “experienced” in the description of PTSD is that the experience must be remembered. But what if the remembered memory is unrelated to the events that took place, as in the aforementioned case?

Loftus and Pickrell described the formation of false memories in a groundbreaking experiment carried out on willing adults. The issue was whether or not a false memory of having been lost at a mall as a 5-year-old child could be created. Each subject was told three stories about his or her childhood that were known to be true and one story that was known to be a false event. After being interviewed on several different occa-

sions, each time being required to recall the four different events of his or her childhood, between 25% and 29% of the subjects "recalled" the false event as having occurred. Those who recalled false events generally reported that their memories were less clear for the false event than they were for the events that actually happened.

After being debriefed, when these subjects were asked which event was the false event, 5 of 24 subjects selected and identified a true event as the false one. One subject, after being told that her memory was false, "continued to struggle mildly with her persisting memory" (Loftus & Pickrell, 1995, December, p. 275). The authors of the study concluded, "These findings reveal that people can be led to believe that entire events happened to them after suggestions to that effect" (Loftus & Pickrell, 1995, December, p. 275).

Experience Without External Event

Can a person "experience" a traumatic event without the event really occurring? Reconsider the initial study described about alien abduction.

Sleep Disorders and PTSD

Narcolepsy is a disorder of rapid eye movement (REM) sleep. During REM sleep the large muscles of the body are paralyzed, the preponderance of dreaming sleep takes place, and the eyes move rapidly, apparently scanning the environment (but the eyelids are closed). In narcolepsy, these elements are no longer limited to the period of REM sleep. Paralysis can occur while awake (cata-

plexy) and when awakening from sleep (sleep paralysis). At times, dreaming no longer is limited to sleep times. Sometimes dreams occur immediately as one goes to sleep or while one is still awake (hypnagogic hallucinations). Dreams can also occur immediately on awakening (hypnopompic hallucinations). Considering the scope of paralysis and dreaming, reconsider the study of PTSD and alleged alien abductions.

Case Three: Let us explore a case of a woman who reported that she had fallen asleep upstairs, on the second floor of her home. Her husband was away on a business trip, and nobody else was present inside the home. It was winter. All the doors to the outside were locked with deadbolts, and the windows were closed and locked. She reported that at precisely 3 a.m., she was awakened by a disturbance in her bedroom and was assaulted by an intruder. She was severely beaten, raped, and choked into unconsciousness. During the struggle, many items in the room were broken, and the room was in complete disarray.

At 7 a.m., the woman awakened in her bed. Nothing in the room was disturbed. Nothing was broken or in disarray, and everything was in order. She had no bruises. All the deadbolts were still bolted, and the windows had not been opened. As she glanced around the perimeter of the house, it was clear that there were no footsteps in the newly fallen snow. She realized that the 3 a.m. event could not have taken place as she recalled; however, her memories of the events were quite real. She had "experienced" a series of events that did not take place. She had a clear-cut memory

of the events. This particular person did not go on to develop PTSD, but it is not difficult to imagine that some other person could very well develop PTSD following a similar set of circumstances or experiences, just as described in the article on alien abduction.

Now, suppose that instead of being at her home, the woman had been in a locked hotel room on the 15th floor. Imagine further that she was in the hotel room on a business trip for her employer. There was no way into the room except through the dead-bolted and locked door to the room. Let us also assume that this hypothetical person went on to develop PTSD.

Would such an experience and any subsequent psychiatric disorder be compensable under existing workers' compensation law and rules? The answer would probably be no, but not because the PTSD would not be recognized by the law. The claim would fail for not meeting one or more of the other statutory requirements. In some states, "mental-mental" conditions cannot be allowed under the law (*Baker v. City of Sanford*, 1996; *City of Aurora v. Industrial Comm'n*, 1985; *Davis v. Dynacorp*, 1994; Larson, A. 1996; *Martinez v. University of California*, 1979). Under most workers' compensation laws, not only would the employee need to prove that the PTSD had been contracted as the result of and in the course of employment, but he or she would also have to prove that it was due to the nature of an employment in which the hazards of the occupational disease exist. This condition would not be met in this hypothetical case because the woman depicted



Can a person 'experience' a traumatic event without the event really occurring?



was simply sleeping.

This hypothetical case would *not* prevent the injured worker from requesting a reasonable accommodation from the employer to continue working under the Americans with Disabilities Act (ADA) of 1990 or the Rehabilitation Act of 1973. One such accommodation might be part-time work or a longer than usual medical leave of absence. Many courts have recognized that PTSD is a disability under the ADA or Rehabilitation Act if it substantially limits a major life activity (*Coaker v. Home Nursing Servs., Inc.*, 1996; *Felix v. New York City Transit Authority*, 2001; *Hamilton v. Southwestern Bell Tel. Co.*, 1998; *Hetreed v. Allstate Ins. Co.*, 2001; *Johnston v. Henderson*, 2001; *Sherback v. Wright Auto Group*, 1997; *Zale v. Sikorsky Aircraft Corp.*, 2000).

False Experience

The ambiguities of making a diagnosis such as PTSD involve other situations in which misinterpretation or misperception of external events may be the cause of the “experienced” event. For example, consider a hypothetical situation in which a hostage is told that he is going to be executed. He is blindfolded. An unloaded gun is put to his temple. The hammer of the gun is cocked and the trigger is pulled. The hostage understood his circumstances. He heard the trigger being pulled and he heard the hammer of the gun fall. This was not an intrinsically dangerous situation from the viewpoint of an outsider who knew that the gun was not loaded. For the blindfolded person experiencing the event, however, the situation would certainly seem dangerous and would lead to great fear, helplessness, and horror. Most of us would agree that such an event could reasonably result in PTSD. Would such a circumstance, if this individual had been on a business trip, lead to a compensable claim for PTSD, if PTSD had developed?

Using the same scenario described above, suppose that the object that was put against the man’s temple was merely

a hollow pipe that felt like the barrel of a gun and a child’s cricket toy made the noise of the trigger/hammer. Would such a circumstance, if the man had been on a business trip, lead to a compensable claim for PTSD, if PTSD developed?

This hypothetical scenario presents an additional and more problematic legal issue on compensability. If this man’s work required him to go to a country that had a history of such kidnappings, such as Colombia or Saudi Arabia, the employee could argue that the PTSD he was suffering from was due to the hazards of the occupation and therefore should be covered by workers’ compensation laws (*Bedini v. Frost*, 1996; *Borden, Inc. v. Eskridge*, 1991; *Consolidated Freightways v. Drake*, 1984; *Dunlavey v. Economy Fire & Casualty Co.*, 1995; *Owens v. National Health Labs*, 1983; *Wilson v. WCAB*, 1996).

What if there were an instance with no external threat, but the man was merely blindfolded and his vivid imagination allowed him to picture such a scenario? Would that be compensable if he developed PTSD as a result? Could PTSD occur under such circumstances?

Suppose the described event experienced by our hypothetical man took place when he was simply dozing off in a chair while at work and, as he was falling asleep, he had a hypnogogic hallucination encompassing the exact experiences described above? If this man developed PTSD, would such a case be compensable? Could PTSD occur under such circumstances? The alien abduction information presented at the beginning of this article suggests that the answer is “yes.”

This previous hypothetical scenario falls again closer to the situation described earlier, of the woman in the hotel room. Again, this claim would probably be denied on the lack of causal connection between the type of job and the resulting PTSD.

Experience Without Memory

Does “experiencing” an event also require that the event be remembered? What if a given person experienced the event, but for one reason or another could recall nothing about that event? The first two cases described in this article are such cases. Some of the more common agents used for anesthesia (conscious sedation) do not lead to unconsciousness at the time of the procedure. The agents simply lead to the absence of any memory about the procedure. We are not aware of any cases of PTSD attributed to this kind of surgical anesthesia and have not seen any reports of cases of PTSD that have followed such events.

Failure to recall any of the details of an event is not a meaningless issue, because, for example, before there were general anesthetics, surgery took place without anesthesia. Of course, PTSD had not yet been defined at that time. Surgical procedures performed today can be assumed to be the same or similar, at least in terms of the potential to produce pain, fear, and feelings of helplessness. We assume that a patient is unconscious while undergoing surgery, and there is no real issue of experiencing pain or of being confronted with, experiencing, or witnessing the event. The body “experiences” these surgical events, but the mind does not. Surgery is not one of the recognized causes of PTSD. Could it ever be?

Workers’ Compensation and PTSD

The compensability of work-related mental disabilities unaccompanied by physical illness has been a controversial topic in the workers’ compensation area. Workers’ compensation claims based on mental injuries caused by mental stimuli have only been coined “mental-mental” claims (Larson, 1996).

A majority of the U.S. states have found mental-mental claims to be compensable under some circumstances based either on judicial opinions or explicitly by statute, but in other cases

State Law/Court Cases on the Compensibility of Mental-Mental Claims

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| Alaska | Alaska Stat. § 23.30.395(17) (1996). |
| Ariz. | Fireman's Fund Ins. Co. v. Industrial Comm'n, 119 Ariz. 51, 579 P.2d 555 (Ariz. 1978). |
| Ark. | Owens v. National Health Labs., 8 Ark. App. 92, 648 S.W.2d 829 (Ark. Ct. App. 1983). |
| Calif. | Cal. Lab. Code § 3208.3 (Deering 1996). |
| Colo. | Colo. Rev. Stat. § 8_41_302(1) (1996). |
| Del. | State v. Cephas, 637 A.2d 20, 27 (Del. 1994). |
| D.C. | Sturgis v. District of Columbia Dept. of Employment Servs., 629 A.2d 547, 551 (D.C. 1993). |
| Hawaii | Royal State Nat'l Ins. Co. v. Labor & Indus. Relations Appeals Bd., 53 Haw. 32, 487 P.2d 278 (Haw. 1971). |
| Idaho | O'Loughlin v. Circle A Constr., 112 Idaho 1048, 739 P.2d 347 (Idaho 1987). |
| Ill. | Pathfinder Co. v. Industrial Comm'n, 62 Ill. 2d 556, 343 N.E.2d 913 (Ill. 1976). |
| Ind. | Hansen v. Von Duprin, Inc., 496 N.E.2d 1348 (Ind. Ct. App. 1986), rev'd on other grounds, 507 N.E.2d 573 (Ind. 1987). |
| Iowa | Dunlavey v. Economy Fire & Casualty Co., 526 N.W.2d 845 (Iowa 1995). |
| Ky. | Yocom v. Pierce, 534 S.W.2d 796 (Ky. 1976). |
| La. | La. Rev. Stat. § 23:1021 (1996), Moore v. Pitt Grill, 871 So.2d 1128 (La.App. 3 Cir., 2004). |
| Maine | Me. Rev. Stat. tit. 39A, § 201 (1995). |
| Md. | Belcher v. T. Rowe Price, 329 Md. 709, 621 A.2d 872 (1993). |
| Mass. | Albanese's Case, 378 Mass. 14, 389 N.E.2d 83 (Mass. 1979). |
| Mich. | Dunlavey v. Economy Fire & Casualty Co., 526 N.W.2d 845 (Iowa 1995). |
| Miss. | Borden, Inc. v. Eskridge, 604 So. 2d 1071 (Miss. 1991). |
| Mo. | Fogelson v. Banquet Foods Corp., 526 S.W.2d 886 (Mo. Ct. App. 1975). |
| N.J. | Goyden v. State Judiciary, 256 N.J. Super. 438, 607 A.2d 651, 655 (N.J. Super. Ct. App. Div. 1991), aff'd per curiam, 128 N.J. 54, 607 A.2d 622 (N.J. 1992). |
| N.M. | N.M. STAT. ANN. § 52_1_24 (1996). |
| N.Y. | Wolfe v. Sibley, Lindsay & Curr Co., 36 N.Y.2d 505, 330 N.E.2d 603, 369 N.Y.S.2d 637 (N.Y. 1975). |
| N.C. | Jordan v. Central Piedmont Community College, 124 N.C. App. 112, 476 S.E.2d 410 (N.C. Ct. App. 1996). |
| N.D. | N.D. Cent Code § 65_01_02(9)(a)(3) (1995). |
| Ore. | Or. Rev. Stat. § 656.802 (1995). |
| Pa. | Wilson v. Workmen's Compensation Appeal Bd., 542 Pa. 614, 669 A.2d 338, 344 (Pa. 1996). |
| R.I. | R.I. Gen. Laws § 28_34_2(36) (1996). |
| S.C. | South Carolina, Stokes v. First Nat'l Bank, 298 S.C. 13, 377S.E.2d 922 (S.C. Ct. App. 1988). |
| Tenn. | Jose v. Equifax, Inc., 556 S.W.2d 82 (Tenn. 1977). |
| Texas | Bailey v. American Gen. Ins. Co., 154 Tex. 430, 279 S.W.2d 315 (Tex. 1955). |
| Utah | Utah Code Ann. § 35_1_45.1 (1996). |
| Vt. | Bedini v. Frost, 678 A.2d 893, 894 (Vt. 1996). |
| Va. | Burlington Mills Corp. v. Hagood, 177 Va. 204, 13 S.E.2d 291 (Va. 1941). |
| Wash. | Department of Labor & Indus. v. Kinville, 35 Wash. App. 80, 664 P.2d 1311 (Wash. Ct. App. 1983). |
| Wis. | JWis. Stat. § 102.01© (1995-96). |
| Wyo. | Consolidated Freightways v. Drake, 678 P.2d 874 (Wyo. 1984). |

these claims were categorically denied.

PTSD claims have increased dramatically over the past decade. Courts have recognized that PTSD may be compensable as an occupational disease under workers' compensation laws if the claimant can present sufficient evidence to meet the other statutory requirements (*Banks v. LTV Steel Co.*, 1995; *Daniel Constr. Co. v. Tolley*, 1997; *In re Sutton*, 1996; *Pulley v. City of Durham*, 1996; *Schottenfeld & Cullen*, 1986; *Southwire Co. v. George*, 1996; *Wood v. Laidlaw Transit, Inc.*, 1990).

Likelihood of Expanding Compensation for Employees Suffering from PTSD

There are competing philosophies regarding compensation for mental-mental claims. The broad intent of workers' compensation laws is to provide compensation for employees who sustain an injury arising out of, and in the course of, their employment. As such, the laws are to be liberally construed, and no technical or strained construction should be given to defeat this purpose (*Abels v. Renfro Corp.*, 1993).

Also, courts have expanded coverage based on the recognition of particular mental disorders by the medical community. "There is almost no limit to the variety of disabling 'psychic' conditions that have already been recognized as legitimately compensable conditions which, not many years ago, would have received little understanding or recognition on the part of courts" (Larson, 1996, § 42.22(a); see also Cook, 1987; Lawrence, 1993).

As one Judge observed:

"We have come to appreciate that a mind may be injured as well as a body maimed. A person's psychic trauma does not vary depending upon the type of legal action in which the harm is scrutinized. . . . The inability to work and the loss of earning power are the same" (Belcher v. T. Rowe Price, 1993).

On the other hand, there has been a

severe reaction in the courts to alleged “junk science.”

“The advent of a large volume and variety of occupational—and particularly respiratory—diseases whose etiology ranges from the imperfectly understood to the downright mysterious has begun to precipitate questions on the extent to which awards can be based on incomplete medical evidence as to the nature and causation of the disease” (Larson, 1996; see also Hansen, 1986; Schwartz, 1993).

As a result of these concerns, the courts have adopted a stricter and more narrow view of the expert evidence that can be admitted as in a trilogy of cases: *Kumho Tire Co. v. Carmichael*, 1999; *General Elec. Co. v. Joiner*, 1997; *Daubert v. Merrell Dow Pharms., Inc.*, 1993). These decisions mandate that the court evaluate the scientific validity and relevance of any expert testimony before admitting it. These three cases transformed the way courts must approach scientific evidence (Slobogin, 2000).

Now, judges act as gatekeepers and must strictly evaluate the reliability of the proffered expert testimony before admitting it into trial. These decisions require the judge to look at a number of factors: error rate and the existence of protocols, peer review and publication, and general acceptance of theories being espoused by the expert. This could potentially seriously limit any attempts to expand the definition of PTSD in the legal system. “Mental disorders that are not specifically described in the DSM-IV generally will not meet the Daubert scientific validity test....” (*United States v. Scholl*, 1997). “ConEd has cited no cases in which a qualified psychiatrist was excluded from testifying because s/he did not follow the DSM-IV” (*Man-cuso v. Consolidated Edison Co. of N.Y., Inc.*, 1997; see also Edgar Garcia-Rill & Beecher-Monas, 2001, Fall).

Current Climate of PTSD and Workers’ Compensation

According to the present status of the law, employees trying to obtain compensation under a broader definition of PTSD will not be treated very sympathetically. For change to take place the medical community must conduct more research on PTSD. Also, amendments to workers’ compensation laws may be needed to bring injured workers under its coverage. The limitations on “occupational disease” under the current laws in most jurisdictions are too narrow, and can result in injured workers being denied benefits that they need and should be awarded. Better delineation of the criteria for PTSD and of the law regarding “mental-mental” cases is overdue.

Conclusion

A variety of new ways to review and view the conceptual basis of Posttraumatic Stress Disorder have been evaluated. The traditional belief has been that PTSD developed when a person witnessed/experienced a devastating, threatening event that led to a sense of horror, helplessness, or fear. This definition implied that the person needed to be present when the event occurred or very nearby. The response throughout the United States to the attack on the World Trade Center and other international terrorist events has led to concerns and consideration of other ways of experiencing traumatic events that might conceivably be thought of as possibly leading to the development of PTSD.

As stated above, the classical conceptual framework within which PTSD develops involves (implied) presence, real external world events, experience (which could be thought of as internal recognition of the external world events), and memory of the experienced event. This article has raised questions about the validity of applying this classical requirement to make a diagnosis of PTSD by posing the following questions:

1.) Is actual presence at a real-world event necessary for the development of PTSD?

2.) Must the internal experience of the external event and the event itself correspond to any significant degree?

3.) What could the hypothetical circumstances be if there were internal events but no corresponding external events?

4.) What if there were only false memories of an external event that actually took place?

5.) What if there were only false memories and no external event had actually taken place?

6.) How does individual susceptibility factor into the development of PTSD? Far less than 100% of people exposed to the same traumatic event (even an extreme trauma) develop the syndrome. Estimates range, indicating that only 25% to 35% of the population are susceptible to developing the syndrome, regardless of the level of trauma.

We urge our colleagues, both in the psychiatric and legal fields, to collect and disseminate evidence of persons exhibiting PTSD who have “experienced” events outside of the traditional sense of the word. For example, there must be forthcoming a number of cases of PTSD from people who merely witnessed on television the bombing of the World Trade Center. Such cases would need to be evaluated within the framework of the ideas presented in this paper, particularly regarding the concept of “witnessing” an event to help elucidate and further delineate these issues. There needs to be a re-examination and clarification of this aspect of the diagnostic criteria for PTSD.

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