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The Psychological Impact of Litigation: Compensation Neurosis, Malingering, PTSD, Secondary Traumatization, and Other Lessons from MVAS

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THE PSYCHOLOGICAL IMPACT OF LITIGATION: COMPENSATION NEUROSIS, MALINGERING, PTSD, SECONDARY TRAUMATIZATION, AND OTHER LESSONS FROM MVAS

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INTRODUCTION

According to the U.S. Department of Transportation,[1] nearly two percent of the U.S. population will have a motor vehicle accident (MVA) each year, and the majority of American men and women will have had a car crash by the age of thirty. The National Highway Traffic Safety Administration reported that there were approximately 41,800 MVA-related fatalities and 3.2 million personal injuries in 2000.[2] The overall cost of MVAs, when one considers lost work, medical care, and the impact on an individual's life, is in the tens of billions of dollars each year.

A trauma can be any painful experience, either physical or emotional, that can pose a threat of injury or death to oneself or to others. The Albany Motor Vehicle Accident Project at the Center for Stress and Anxiety Disorders began studying the psychological impact of motor vehicle accidents in the late 1980s and early 1990s. We have continued those studies to the present day. One major focus of those studies was to learn about one particular traumatic reaction—post-traumatic stress disorder that (PTSD)—which, at the time of the initial study, was not thought to occur following MVAs. This reflected the thinking in the late 1980s that to meet diagnostic criterion for

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1. NAT'L HIGHWAY TRAFFIC SAFETY ADMIN., U.S. DEP'T OF TRANSP., TRAFFIC SAFETY FACTS 2000: A COMPILATION OF MOTOR VEHICLE CRASH DATA FROM THE FATALITY ANALYSIS REPORTING SYSTEM AND THE GENERAL ESTIMATES SYSTEM (2002).

2. *Id.* at 85.

posttraumatic stress disorder, one needed to experience a trauma that was outside of the range of usual experience.[3] By definition, since most people experience an MVA in their lifetime, MVAs were not considered sufficiently outside the range of usual experience to warrant this diagnosis. Yet the patients seen in clinical psychology practice presented with symptoms of anxiety and posttraumatic stress disorder that appeared very similar to the patients that shared similar diagnoses seen in a Veterans Administration (VA) Hospital.

Subsequently, we began to study car crash victims, believing that the trauma provided an unending supply of recently traumatized victims from whom we could learn how people deal with the trauma. Wars and natural disasters, in contrast, provide far fewer opportunities. Car crash victims also seemed easier to talk to than rape or assault victims, especially if we were not going to treat them, but just follow them to assess change over a prospective, longitudinal period of time. We were ultimately awarded our first National Institute of Mental Health (NIMH) grant to study and follow the psychological course of people who had been in car crashes.

II. OVERVIEW OF THE ALBANY MOTOR VEHICLE ACCIDENT PROJECT

This Part describes the PTSD study we undertook to explore MVAs. First, we explain the mechanics of our assessment studies and explain some of our subsequent findings. Next, we discuss the treatment studies we ran and explain some of those findings.

A. Assessment Studies

Over a five-year period we were able to study 158 car crash victims and assess what the impact of the accident was on the victims' psychological functioning for up to two years after each victim's accident.[4] We also assessed, as a comparison group, ninety-three individuals who had not been in an accident. The study examined participants in an MVA within the past one to four months who sought medical attention for an injury sustained in the MVA (in our effort to rule out small fender-bender accidents).[5] We performed extensive, state of the art assessments for PTSD and other psychological reactions and we fol-

3. *See* AM. PSYCHIATRIC ASS'N, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS (3d ed., rev. 1987).

4. *See* EDWARD B. BLANCHARD & EDWARD J. HICKLING, AFTER THE CRASH: ASSESSMENT AND TREATMENT OF MOTOR VEHICLE ACCIDENT SURVIVORS (2d ed. 2004).

5. The state of the art in psychiatric assessment is structured interviews of demonstrated reliability and validity, used by trained, doctoral-level mental health professionals. We used the Cli-

lowed these people at six-month intervals for up to two years from the time of their MVA. We found that of the MVA survivors in our study, a surprisingly large number—about forty percent—had developed PTSD. This population of MVA survivors was also investigated internationally. Perhaps the largest sample comes out of Oxford, England, where Ehlers' group found that around twenty-three percent of car crash victims in this sample developed PTSD.[6] Our best estimate, for all samples, is that one can anticipate that around twenty-five percent of the population of injured car crash victims will develop this disorder.

1. *What About Other Disorders?*

We and others have found a high incidence of comorbid diagnoses in this group, with over fifty-six percent developing a mood disorder (depression), while over ninety percent will develop anxiety that impacts their driving.[7]

2. *What Happens Over Time to These People?*

In our research, we found that about forty-eight percent will show an improvement in symptoms by six months so they no longer meet diagnosis for PTSD, and by one year about sixty-five percent will show improvement.[8] After that, our data shows that without intervention, there are very few people who will improve any further.[9] Other studies have shown that for as long as six years, even with treatment, over forty percent of the victims will remain symptomatic.[10] Clinically, we have seen patients decades later who still show ongoing problems. These findings raised two questions, discussed below.

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nician Administered PTSD Scale (CAPS) and Structured Clinical Interview for DSM-III-R (SCID).

6. *See* Anke Ehlers et al., *Psychological Predictors of Chronic Posttraumatic Stress Disorder After Motor Vehicle Accidents*, 107 J. ABNORMAL PSYCHOL. 508 (1998). Twenty-three percent represents the percentage of study participants who had developed PTSD after three months. *Id.* The number drops to 16.5% after one year. *Id. See also* R.A. Mayou et al., *Posttraumatic Stress Disorder After Car Accidents: 3 Year Follow Up of a Prospective Longitudinal Study*, 40 BEHAV. RES. & THERAPY 665 (2002). After three years, the incidence of PTSD was eleven percent. *Id.*

7. Edward B. Blanchard et al., *One-Year Prospective Follow-Up of Motor Vehicle Accident Victims*, 34 BEHAV. RES. & THERAPY 775 (1996).

8. *See* BLANCHARD & HICKLING, *supra* note 4.

9. *Id.*

10. *See id.*

3. *Who Develops PTSD?*

We found that there are several factors that lead to a good prediction of who seems most at risk for PTSD. These factors are: previous major depression, fear of dying in the accident, and extent of the injury. Another powerful variable, discussed further below, is the presence of ongoing litigation. Other predictive variables, in our studies and others, have included the occurrence of dissociative symptoms, reoccurring symptoms, strong avoidance, prior diagnosis of PTSD, gender (females more likely), responsibility,[11] and the occurrence of fatalities.[12]

4. *Who Gets Better Over Time?*

We could predict improvement in a fair number of MVA victims if we had certain information. Such information included: the degree of physical improvement, whether the individual was depressed at the time of the original assessment, whether there was pre-MVA history of psychiatric treatments, the degree of vulnerability felt at the time of the MVA, and the amount of family support.[13]

B. Treatment Studies

As clinical psychologists, once we learned about the possible consequences of car crashes, we wanted to treat and help these people. We were able to win additional NIMH support for a series of treatment studies that ran from 1995 to 2000. The details for this are recorded elsewhere[14] and summarized in our book,[15] but the broad strokes are set forth below.

We entered ninety-eight people into treatment, seventy-eight of whom completed the program of care. The treatment program involved either a ten-week cognitive behavioral intervention (CBT), a ten-week supportive psychotherapy treatment, or a control (no treatment) comparison group.[16] Ultimately, CBT proved to be the most effective treatment, with over seventy-six percent of those treated

11. *See* Edward J. Hickling et al., *Effects of Attribution of Responsibility for Motor Vehicle Accidents on Severity of PTSD Symptoms, Ways of Coping, and Recovery Over Six Months*, 12 J. TRAUMATIC STRESS 345 (1999).

12. *See* Edward B. Blanchard et al., *Who Develops PTSD From Motor Vehicle Accidents?*, 34 BEHAV. RES. & THERAPY 1, 8 (1996).

13. *See* BLANCHARD & HICKLING, *supra* note 4.

14. *See* Edward B. Blanchard et al., *A Controlled Evaluation of Cognitive Behavioral Therapy for Posttraumatic Stress in Motor Vehicle Accident Survivors*, 41 BEHAV. RES. & THERAPY 79 (2003).

15. *See* BLANCHARD & HICKLING, *supra* note 4.

16. For elaboration on the various treatment programs, see Blanchard et al., *supra* note 14.

with CBT showing an improvement in diagnostic status. Those placed in supportive treatments showed a forty-seven percent improvement. About twenty-four percent of those who were only assessed and put on a waiting list showed improvement. Both of the treatment groups fared better than the no treatment group. Improvement held up over time, with little decrease in the CBT group and gradual improvement in the supportive psychotherapy condition. Thus, while we concluded we had one of the most successful treatments to date, a fair number of individuals still had lingering symptoms that required additional care. Overall though, we were pleased with the outcome of our intervention.

We have continued to look at treatments—how much and what type of treatments will be effective—and now have several ongoing self-help studies. Self-help studies made sense to us given the limited number of psychologists that are trained and using empirically supported treatments and given the sheer number of MVA victims. In addition to a self-help book,[17] we have an online treatment program in place.[18] Both are subject to ongoing empirical treatment studies. Those results regarding effectiveness of these interventions are still not known.

This is the background that led to the following area of interest—the psychological effect of litigation. We found that a fair number of our subjects were involved in litigation, and this variable turned out to be one of our better predictors of continuing problems following MVAs.

III. LITIGATION AND PTSD IN CAR CRASH VICTIMS

A. *The Myth of Accident-Compensation Neurosis and Miller*

This section begins with a brief overview of some of the more important literature. It has been widely believed that litigation and settlement play a large role in the natural history of psychological symptoms and disability among accident victims. Conventional wisdom suggests that individuals continue to have symptomatic complaints until a suit settles, ostensibly to enhance the chances of collecting a large settlement. Further, conventional wisdom also suggests that once the suit settles, one should expect to see a dramatic improvement, especially in psychological symptoms.

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17. *See* EDWARD J. HICKLING & EDWARD B. BLANCHARD, OVERCOMING THE TRAUMA OF YOUR MOTOR VEHICLE ACCIDENT: A COGNITIVE BEHAVIORAL TREATMENT PROGRAM (forthcoming 2006).

18. *See* After the Crash, www.afterthecrash.com (last visited Oct. 18, 2005).

Research traces this notion to 1961, and a paper presented by the eminent British neurologist Henry Miller.[19] The paper, "Accident Neurosis," presented data on fifty accident victims—thirty-one industrial accidents and nineteen traffic accidents—and followed victims for two to four years after settlement of each victim's compensation suit.[20] Miller found evidence of "gross psychoneurosis" when the participants were examined before settlement, including an "unshakable conviction [on the part of the patient] of unfitness for work" and "an absolute refusal to admit any degree of symptomatic improvement."[21] Predisposition to neurosis was supposedly evident in only fifteen of the fifty cases. When these patients were examined after settlement, forty-one of the forty-five working participants had returned to work; only two had received psychiatric treatment for their symptoms.

These findings led Miller to conclude that the cause of accident neurosis was not the result of physical injury. Rather, the neurosis arises when (a) someone else is at fault for the accident, and (b) the accident "has occurred in circumstances where the payment of financial compensation is potentially involved."[22] Miller stated unequivocally that accident neurosis was "not a result of the accident but a concomitant of the compensation situation and a manifestation of the hope of financial gain."[23] This condition is not encountered when this hope does not exist or where it has been finally satisfied or dissipated.[24]

B. Almost All Subsequent Studies Have Failed to Support Miller's View[25]

First, Mendelson's 1981 study[26] evaluated 101 accident victims, finding that after their compensation claims had been settled, thirty-five resumed work prior to settlement,[27] while forty-four of the remaining sixty-six had not returned to work even after the settlement.[28]

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19. The paper was presented at an invited address and was subsequently published in the *British Medical Journal*. Henry Miller, *Accident Neurosis*, 1 BRIT. MED. J. 919, 919–25, 992–98 (1961).

20. *Id.*

21. *Id.* at 922.

22. *Id.* at 992.

23. *Id.* at 994.

24. *Id.*

25. While not an exhaustive review for today's purposes, interested readers are referred to our 2004 book. BLANCHARD & HICKLING, *supra* note 4.

26. *See* George Mendelson, *Persistent Work Disability Following Settlement of Compensation Claims*, 55 LAW INST. J. 342, 344 (1981).

27. *Id.*

28. *See id.*

Second, this study followed an earlier finding[29] of a similar pattern in a study of 500 accident victims with "accident neurosis." That study found that the effects of the financial settlement on the course of the illness had a negligible benefit.[30]

Third, Tarsh and Royston studied thirty-five of fifty patients who had been assessed on medico-legal referral because of gross somatic symptoms for which no adequate physical basis could be established.[31] The average time from injury to settlement was five years.[32] Two patients never left work, two others returned to work before the settlement. After the settlement, four more returned to work and four others returned to light duty.[33] The majority, over two-thirds, never returned to work.[34]

In a fourth study, more recently, Mayou and colleagues collected follow-up data on 171 of 200 MVA victims.[35] The team addressed the role of litigation and compensation among MVA victims. At a three-year follow up, they compared ninety-six individuals who had filed claims to seventy-five who had not.[36] They found no differences between the groups in psychological distress and concluded that overall, there was no evidence that there were significant differences in any aspect of outcome between those who sought compensation and those who did not.[37] They further stated that there were no evident differences between those who settled early and those who settled late. But the team also noted that information (on individuals who settled after one year but before the third year) suggested that the subjects did report some improvement at this follow-up point compared to those who had not settled.[38]

Fifth, in a six-year follow up of Mayou's Oxford sample, Bryant, Mayou, and Lloyd-Bostock obtained data on eighty-one of ninety-six

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29. *See* George N. Thompson, *Post-traumatic Psychoneurosis—A Statistical Survey*, 121 AM. J. PSYCHIATRY 1043 (1965).

30. *See id.*

31. Michael J. Tarsh & Claire Royston, *A Follow-up Study of Accident Neurosis*, 146 BRIT. J. PSYCHIATRY 18 (1985).

32. *Id.*

33. *Id.*

34. *Id.*

35. *See* Richard Mayou et al., *Psychiatric Consequences of Road Traffic Accidents*, 307 BRIT. MED. J. 647, 648 (1993); Richard Mayou, *Medico-Legal Aspects of Road Traffic Accidents*, 39 J. PSYCHOSOMATIC RES. 789 (1995); Richard A. Mayou, *Psychiatric Consequences of Motor Vehicle Accidents*, 25 PSYCHIATRIC CLINICS OF N. AM. 27 (2002).

36. *See* Mayou et al., *supra* note 6.

37. *Id.*

38. *Id.*

individuals who filed cases one year post-MVA.[39] Five of the cases had not settled and seven had been dropped, leaving sixty-nine cases that had settled. The researchers found whiplash cases settled earlier (eighty-two percent by three years) than the other, more severe injury cases (forty-three percent by three years).[40] The median award for the severe injury cases was about £10,000 (about $16,000 at the time) and about half that for whiplash.[41] Many of those involved were frustrated and angry over the slowness of the process and the modest size of the awards.[42] Many endured considerable financial hardship during the litigation.

Again, contrary to Miller's assertion, the study showed no dramatic improvements in physical symptoms, mental state, or social functioning once the case settled.[43] Instead, the authors noted the continued anger and frustration of participants, which often increased because of disappointing settlements.[44]

Lastly, Bryant and Harvey[45] investigated the role of litigation and compensation in an Australian sample of MVA survivors who had been hospitalized because of their injuries. Of the 171 patients initially assessed, they were able to reassess 106 at two years.[46] Of these, ninety-three initiated litigation within the first six months, whereas thirteen did not.[47] Of the ninety-three, twenty settled within two years.[48]

Comparisons across the three groups—nonlitigants, settled litigants, and nonsettled litigants at two years—showed no significant differences on any demographic, injury variables, or psychological distress at any time across assessments. Those who sought compensation did not differ statistically from those who did not seek compensation, and those who settled were no different than those whose cases were still pending. Litigants (nonsettled plus those who settled) versus nonlitigants had higher percentages of acute stress disorder initially,[49] and

39. Bridget Bryant et al., *Compensation Claims Following Road Accidents: A Six Year Follow-up Study*, 37 MED. SCI. & L. 326, 328 (1997).

40. *Id.*

41. *Id.*

42. *Id.*

43. *Id.*

44. *Id.*

45. Richard A. Bryant & Allison G. Harvey, *The Influence of Litigation on Maintenance of Posttraumatic Stress Disorder*, 3 J. NERVOUS & MENTAL DISEASE 191 (2003).

46. *Id.* at 191.

47. *Id.* at 191–92.

48. *Id.*

49. Eighteen percent versus eight percent. *Id.* at 192.

higher percentages of PTSD[50] at two years.[51] Our recalculations showed a trend at six months and a significant difference at two years for litigants to show a more diagnosable psychopathology than the nonlitigants.

Again, despite Miller's claim, settling the case had no beneficial psychological effect on these MVA survivors.

C. *Our Studies*

As explained more fully in this section, our study examined the differences between MVA survivors based on the variable of litigation. As we found, litigants and nonlitigants differ on many features, such as their level of PTSD, their overall improvement, and their ability to return to work.

The initial assessment study indicated that of 132 MVA survivors, eighteen settled litigation in the first year of follow up, forty-nine initiated litigation but had not settled, and sixty-five had never initiated litigation.[52] The study revealed no significant differences among these three groups on age, gender, or the distribution of initial diagnoses.[53] There was a significant difference in the extent of the initial injury as measured by the abbreviated injury scale; follow-up tests showed that the group who had settled within the first year was more severely injured than the other two groups.[54] There was also a significant difference between the nonlitigants who had less PTSD symptoms, and the two litigant groups who did not differ. It is of note that the presence of PTSD in a quarter of the nonlitigants showed it was not the primary determinant if someone became a litigant.

Over a one-year period, all groups showed a drop in PTSD symptoms, showing that even those with pending suits became less symptomatic over time. The groups with pending suits had the highest CAPS score,[55] the settled group had a lower score, and the nonlitigant group had the lowest scores at initial, six-month, and twelve-month assessments. Research suggested the groups with pending suits were significantly more depressed than the nonlitigant group, with the settled litigant group intermediate and not significantly different than the other two groups. Those with suits still pending were less likely to

50. Twenty-seven percent versus eight percent. *Id.* at 192 tbl.1.

51. Thirty percent versus zero percent. Bryant & Harvey, supra note 45, at 192 tbl.1.

52. Edward B. Blanchard et al., *Effects of Litigation Settlements on Posttraumatic Stress Symptoms in Motor Vehicle Accident Victims*, 11 J. TRAUMATIC STRESS 337 (1998).

53. *Id.*

54. *Id.*

55. CAPS score is the sum of the symptom frequency (0–4) and symptom severity (0–4) for the seventeen symptoms of PTSD. The total score is a very sensitive indicator of clinical status.

return to work.[56] The study showed, however, that those with suits still pending experienced more distress than those who settled; the differences were not significant and were consistent in general with findings since Miller's 1961 assertion.[57] Further, of the people who had been employed fulltime at the time of their accident, we found eighty-three percent with suits still pending were back at work full time (sixty-seven percent) or part time (sixteen percent)—clearly contradicting Miller's notion that people did not return to work until after the suit settled.[58] We further found that 100 percent of those who had settled were back to work.[59]

Our earlier study showed that ongoing litigation was a strong predictor of PTSD at one year.[60] We saw this as important, but cautioned viewing it as a causal variable since a correlation shows a relationship whose direction is not known. It could be that people who are involved in lawsuits are inclined to make themselves look more symptomatic, or it is quite possible that people who are seriously injured and distressed are more likely to seek the services of lawyers. Our data is supportive of this latter view, but as we discuss below, we rarely stop with just preliminary data when faced with such an interesting question.

IV. MALINGERING AND SYMPTOM EXAGGERATION

One concern that arises in research, forensic evaluations, and clinical practice is the veracity of symptoms presented. Because of the nature of personal injury law, sometimes the question becomes whether a person is exaggerating his or her symptoms or even faking those symptoms in an effort to realize financial gain. Excellent reviews on the detection of malingering can be found in the work of Resnick[61] or Rogers.[62]

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56. *See* Blanchard et al., *supra* note 52.

57. *Id.*

58. *Id.* at 351–52.

59. *Id.* at 351.

60. Other factors included fear of dying, prior history of depression, and extent of injury. *See* Blanchard et al., *supra* note 12.

61. Phillip J. Resnick, *Malingering of Posttraumatic Stress Disorders*, *in* CLINICAL ASSESSMENT OF MALINGERING AND DECEPTION 130 (Richard Rogers ed., 2d ed. 1997).

62. *See* CLINICAL ASSESSMENT OF MALINGERING AND DECEPTION, *supra* note 61; Richard Rogers & Robert Wettstein, *Drug-Assisted Interviews to Detect Malingering and Deception*, *in* CLINICAL ASSESSMENT OF MALINGERING AND DECEPTION, *supra* note 61, at 239; Richard Rogers, *Current Status of Clinical Methods*, *in* CLINICAL ASSESSMENT OF MALINGERING AND DECEPTION, *supra* note 61, at 373; Richard Rogers, *Researching Dissimulation*, *in* CLINICAL ASSESSMENT OF MALINGERING AND DECEPTION, *supra* note 61, at 398 [hereinafter Rogers, *Researching Dissimulation*].

As seen in the available data, however, and unlike Miller's assertion that potential and realized compensation is a large contributant to one's presentation of symptoms, the data shows compensation makes little difference in continuation or cessation of symptoms or a person's return to work.[63] Due to its link to a causal factor and subsequent psychological distress, PTSD has increasingly become a diagnosis with the potential for legal recourse and financial compensation. This has led to a growing concern about whether an individual may be exaggerating or even faking his or her disorder. With psychological disorders, we are often required to base our diagnoses on the history and description of symptoms given to us by a patient. There are not x-rays, CAT scans, or other medical tests that can definitively diagnose these conditions. Even our uses of psychological testing and psychophysiological assessment have been found problematic. All carry risks and problems about their sensitivity and their ability to discriminate true cases from simulated efforts.

Some recent articles have even warned about the coaching of psychological symptoms that can take place prior to an evaluation.[64] Some have argued that with the availability of information today, it is nearly impossible to have a truly naïve individual show up for an evaluation without any ideas of what possible symptoms are probed, and even ways that are used to detect malingering. A recent article even reported on lawyers coaching clients to fake symptoms prior to a psychological evaluation.[65]

A. Our Studies

The Albany MVA Project saw our setting as a unique opportunity to explore some of the concerns of MVA victims involved in personal injury lawsuits. Because we had a steady stream of potential research participants evaluated for entry into a number of studies, we had a great opportunity to examine comparison groups with "true" or real victims.

In the first study,[66] we obtained a sample of people who had been in MVAs but did not develop PTSD or any other symptom and coached those people in PTSD. We then gained a sample of real world people

63. *See supra* notes 26, 29, 31, and 35.

64. *See* Rogers, *Researching Dissimulation*, *supra* note 62.

65. James R. Youngjohn, *Confirmed Attorney Coaching Prior to Neuropsychological Evaluation*, 2 PSYCHOL. ASSESSMENT 279 (1995).

66. *See* Edward J. Hickling et al., *Simulation of Motor Vehicle Accident-Related PTSD: Effects of Coaching with DSM-IV Criteria*, *in* INTERNATIONAL HANDBOOK OF ROAD TRAFFIC ACCIDENTS & PSYCHOLOGICAL TRAUMA: CURRENT UNDERSTANDING, TREATMENT AND LAW 305, 309 (Edward J. Hickling & Edward B. Blanchard eds., 1999).

who had not been in a recent MVA and coached those people. We controlled the amount of information each of these groups received (coached or uncoached-naïve), and then looked at how they did on a number of standard psychological measures as compared with victims of "true" PTSD (individuals we had no reason to suspect had malingered or facetious symptoms). We had 130 subjects overall. Simulators were able, at first glance, to look fairly similar to true cases of PTSD on measures of PTSD symptoms. To summarize a complicated analysis, we did a discriminative analysis where we looked at patterns of scores between the groups to see if we could combine the scores of the tests in a meaningful way to see if we could determine who was who. We found that trained simulators tended to have higher scores on depression and one of the PTSD scores than true PTSD patients, and had lower scores on the measure of anxiety than true PTSD patients. The results allowed us to correctly classify seventy-six percent of individuals in our study. Thus, it looks like you can train people to simulate symptoms of PTSD. If you look at the test scores, however, there is often a discernable pattern of scores that would help you find the simulators.

Given our preliminary success in detecting group differences between trained and untrained simulators of PTSD, and those with true cases of PTSD, we again looked at the unique setting under which we worked. Experts in the area of forensic evaluations have historically suggested that experiments should use highly trained individuals as simulators who could present to different clinicians a standardized presentation of a feigned disorder. We adopted and applied that model ourselves.

When thinking about the best "fakers" available, one does not generally consider introductory psychology undergraduates who are used in many of the simulator studies (mainly because they are available). And the people who are trying to catch simulators are often poorly trained graduate students, not representative of the real world with its experienced clinicians.

Our clinic has very well-trained, advanced students who are closely supervised, and questions of veracity, though rare, are entertained regularly as each case is presented and assigned to a study group. These were the people we wanted to see if we could fool. To fool them we wanted to get the best fakers possible. Obviously, one major flaw is that the real malingerers in life, especially the ones who are good at it, are rarely caught, and are not interested in being part of a psychological study. So, the next best group we could think of was another type of professional—professional actors.

For this study[67] we trained six professional actors and actresses in the DSM-IV criteria for PTSD and major depression. They were not provided any specific information about tests, but scenarios that would be used as part of their intake to the clinic were developed, and the actors were instructed with a method acting coach present for assistance.

Actors covertly enrolled in our study over a four-month period of time, with only one of the researchers (EJH), along with the clinic secretary, knowing their identities. Following the assessment, if the evaluators found the actors met criteria for entry into a treatment study, the evaluators randomly assigned the actors to a true, ongoing treatment condition, and gave them the name of a treating psychologist (someone in the community who was part of another study). Once the actors had completed their role in the study, the six evaluators were told of an ongoing deception. Rather than just reveal the names of the actors, however, the evaluators were then requested to guess who they thought might have been a simulator among the cases they had seen over the past six months. They were not told how many simulators they might have seen, but each was told they had seen at least one. They were requested to collect all of the charts of the people they had seen, to review them, and to guess who they thought were the simulators. This was done to see how well they could guess if given all the available information (i.e., psychological tests, psychophysiological assessment data, structured interview records, and their notes). These six evaluators did twenty-three evaluations over the six-months test period.

The premise was very simple: could a group of ostensibly well-trained evaluators catch a group of the ostensibly best-trained simulators? None of the simulators were detected in the routine initial evaluation. When given access to all of the information, the overall hit rate correctly identifying those who had PTSD, and those who faked, was ninety-one percent. When other trained evaluators had access to the information, but lacked the actual participation in the interview, the correct rate of identification dropped to seventy percent. The conclusion was that well-trained interviewers could do a very nice job picking out the best fakers we could find. But, as a caveat, before the suspicion was raised, all of the subjects were successfully entered into our treatment studies having been diagnosed as having PTSD. None of the subjects during our weekly clinical meetings where we discuss

67. Edward J. Hickling et al., *Detection of Malingered MVA Related Posttraumatic Stress Disorder: An Investigation of the Ability to Detect Professional Actors by Experienced Clinicians, Psychological Tests and Psychological Assessment*, 2 J. FORENSIC PSYCHOL. PRAC. 33 (2002).

new participants were identified by the assessors to have raised any concern or suspicion about their veracity. The findings of the study support that the interview, with good reason it appears, remains the gold standard for diagnostic evaluations when done by skilled clinicians.

V. SECONDARY TRAUMATIZATION

Before addressing the issue of clinical impressions, this section briefly touches on the role of retraumatization. In this area we have no systematic data, but a great deal of experience.

Several prominent researchers have noted that the very process of litigation can result in retrumatization.[68] We believed that such a process accounted for some of the trends we found in data that suggested that people engaged in ongoing litigation were doing less well psychologically. This phenomenon is certainly found in clinical practice, as elaborated below.

Several scholars have pointed out how litigation may have an impact that perpetuates or exacerbates psychological distress.[69] Pitman and his colleagues, in fact, have suggested that the very act of litigation may affect PTSD symptoms by a process they termed "retraumatization."[70] They stated that the need to confront the traumatic history through interviews with attorneys, depositions, and courtroom testimony thwarts the victim's characteristic efforts at avoidance. This predictably results in the resurgence of intrusive ideation and increased arousal.[71] Further, this is done in an adversarial system that pits the plaintiff against the defendant, who through the occurrence of the traumatic event may already be seen as the enemy. Patients as participants in this process may come to see that even though they see

68. *See, e.g.*, Michael Napier, *The Medical and Legal Trauma of Disasters*, 59 MEDICO-LEGAL J. 157 (1991); Roger K. Pitman et al., *Legal Issues in Posttraumatic Stress Disorder*, *in* TRAUMATIC STRESS: THE EFFECTS OF OVERWHELMING EXPERIENCE ON MIND, BODY AND SOCIETY 378, 378–97 (Bessel A. van der Kolk et al. eds., 1996).

69. Napier, *supra* note 68; Pitman et al., *supra* note 68.

70. *See* Pitman et al., *supra* note 68.

71. Symptoms of PTSD by definition can be worsened (or exhibited) if the patient is exposed to stimuli that provide memories of his or her trauma. In treatment when this is done, it is important to spend sufficient time with the patient to make sure the level of provoked memory does not cause an overall increase in his or her anxiety. This presentation of provocative memories is most often accomplished by exposure treatments that require time to discuss the reaction, cognitive techniques to address the cognitive precipitants and distortions, relaxation techniques to quiet the physical arousal, and desensitization (over time) so that the response can lessen. In a courtroom or deposition situation where the questions can provoke the anxious or adverse response, but where there is no time or intent to lessen the reaction, the process can potentially increase the strength of the reaction (e.g., intrusive ideation and increased arousal) in the patient to the stimuli. *Id.* at 382.

themselves as the victims, they are now the ones placed on trial, exacerbating their sense of vulnerability and victimization.

In addition, the MVA survivor may already have suffered a major loss financially as a result of the traumatic event; the pursuit of litigation necessitates additional financial risk and anxiety, as the outcome is not assured. The Pitman team found that accident victims are often seeking understanding and justice more than financial gain.[72]

VI. The Myth of Justice Versus The Legal System

We agree with most of Pitman's group's opinion. In our experience at the Center for Stress and Anxiety Disorders, with the Albany MVA Project, and in clinical practice, the majority of individuals speak of being wronged, and wanting to get some type of justice for the wrong that they had to suffer (through no fault of their own). They often wish they could speak to the other person to hear an apology or some acknowledgment of responsibility and understanding of the accident's impact on the victim's life. Often, at the advice of the attorney, there is no face-to-face confrontation after the MVA until the deposition.

How we think of any event—the trauma, the process of litigation, or the suffering taking place—is central to the psychological reaction in people. For many people, the MVA leads to their first real experience with the legal system. In a psychologist's office they often speak of how they think things will occur, and what they believe should happen. One caution they are given is that while it is great if justice truly occurs, more often they will experience the process of law—people conducting themselves according to a set of pre-established rules that are not always understandable to the nonlegal observer.

The awarding of compensation, if smaller than felt fair, is understandably likely to create a feeling of injustice. We have seen the same reaction where a patient was urged by her attorney to accept a multimillion-dollar settlement in order to adequately provide for a future that would likely require continued medical and psychological services. She complained of not being able to have her day in court. While she understood the wisdom of the advice, she felt so unresolved in her anger and her sense of injustice toward the people who were just buying her off, that a year later she wished she had turned down that advice and gone to trial. The risk of losing her financial security, she felt, was not offset by the chance to see the person who crashed into her punished and forced to admit the "crime" against her.

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72. *See id.*

VII. ADVERSARIAL AND INDEPENDENT MEDICAL EVALUATIONS

Another issue that we see in New York State, where we have no-fault automobile insurance laws, is the adversarial role of medical reviews and independent medical examinations. Here there is a sense that if the victim does not "prove over and over again" that he or she is injured and requires these services, the insurance company and its hired doctors can take away the care that the victim requires. Again, the person often feels that he or she was not at fault, but is often viewed as malingering or exaggerating his or her symptoms for the potential of future compensation. These examinations, besides raising anger by this perception, increase the anxiety of the patient, and create days and weeks of upset that again are viewed as part of the process.

Lawyers too can add to their own clients' distress. In a psychological practice, one may hear how a client depends heavily on the lawyer representing the patient—being the sole advocate interceding for medical benefits, lost compensation, and disability benefits. People are often at a time of great vulnerability, on medications, hurt, and feeling victimized by a system they do not agree with and do not understand. When calls are not returned, or they cannot access a lawyer, this erodes the trust of this vital relationship, which often goes on for years. Fortunately, the lawyer-client relationship can also be seen as a positive one, and we have seen lawyers continue professional relationships with clients even after compensation has been awarded. These relationships can help with financial decisions, medical decisions, and serve as a support for the client, whose life has been radically changed by his or her accident. MVA victims are often placed in very unfamiliar roles—independent people who now rely on others. They cannot support themselves. Not getting a disability check can be a life threatening event. They are embarrassed. Their pride and dignity are often affected by the reaction of others to them, including their lawyer. Perhaps no better rule than the golden rule is needed, but this rule is one that our system today often forgets or neglects.

VIII. BETTER, BUT HOW MUCH BETTER?

As one of the treatment and research centers that had perhaps one of the better treatment outcomes, it is still critical to understand what mental health people mean by improvement. PTSD has seventeen potential symptoms contributing to a diagnosis.[73] To become "PTSD-

73. *See* AM. PSYCHIATRIC ASS'N, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS 425 (4th ed. 1994).

free" does not mean you are necessarily symptom free; it means you do not meet PTSD criteria. Several clusters of symptoms need to be satisfied. Studies, including our own, can show impressive results where people are much better, but their lives can still be affected. If you still have regular nightmares or flashbacks, you could still be technically free from PTSD, yet have a greatly compromised life. This is an important qualification because, in this day of managed health care, we have been very concerned that insurance companies might believe that our "successful ten-session treatment" means a person is symptom free. Our fear is that such a misunderstanding could lead insurance companies to deny requests for additional treatment for people who still require ongoing mental health care. We offer the same caution to legal professionals—the quality of a person's life is not solely understood by the presence, absence, or agreement of a mental health diagnosis. Accidents can still cause adverse effects yet not sufficiently merit a DSM-IV diagnosis. And even when there has not been a diagnosis of PTSD or any mental disorder, traumatic events often leave some residual impact. Because attorneys are often close to individuals who are having very powerful memories stirred up in provocative emotional settings, attorneys can certainly benefit from sensitivity to the very human reactions that are often found in people at those times.