**ARIZONA SUPREME COURT**

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| TIMOTHY MATTHEWS,<br>Petitioner Employee,<br>vs.<br>INDUSTRIAL COMMISSION OF ARIZONA,<br>Respondent,<br>CITY OF TUCSON,<br>Respondent Employer,<br>TRISTAR,<br>Respondent Carrier. | No. CV-21-0192-PR<br><br>2 CA-IC 20-0001<br>Court of Appeals, Division Two<br><br>ICA Claim No. 20182-540202<br>Ins. Claim No. 18736339 |

# AMICI CURIAE BRIEF OF THE ARIZONA MUNICIPAL RISK RETENTION POOL AND ARIZONA COUNTIES INSURANCE POOL

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## INTEREST OF AMICI CURIAE

This amici curiae brief is submitted by the Arizona Municipal Risk Retention Pool ("AMRRP") and the Arizona Counties Insurance Pool ("ACIP") pursuant to Arizona Rule of Civil Appellate Procedure 16. AMRRP and ACIP have read the relevant petition for review and response, supplemental briefs, as well as the amicus curiae brief from the Arizona Association of Lawyers of Injured Workers.

AMRRP is a self-insurance and risk-management pool, owned and operated by the 77 cities and towns plus the League of Arizona Cities & Towns. ACIP is a self-insured public entity comprised of 13 of Arizona's 15 counties. Seventy-six AMRRP's members and all of ACIP's members participate in their workers' compensation coverage

AMRRP, ACIP and their members have a significant practical and financial interest in upholding the constitutionality of A.R.S. § 23-1043.01(B), which codifies the reasonable and objective standards this Court adopted to evaluate compensability of work-connected mental injury and illness claims under Arizona's workers' compensation law. In 1980, the Legislature specifically codified the words 'unusual, unexpected or extraordinary' as the standard by which to determine compensability. The underlying Opinion of the Court of Appeals correctly upheld A.R.S. § 23-1043.01(B) as constitutional. *Matthews v. Industrial Commission*, 251

Ariz. 561, ¶¶ 10-18, 495 P.3d 333, 339-41 (App. 2021). Reversing the Opinion will lead to the application of inconsistent standards for compensability of mental injury and illness, potentially expanding workers' compensation coverage to include mental injury and illness arising out of expected, typical, or gradual stress experienced by employees. This will also cause a significant financial impact to Arizona employers in higher workers' compensation costs, employee turnover and the cost of doing business. Since AMRRP and ACIP are self-insured, this will have a direct and long-lasting impact on their members, and as all are public entities, ultimately upon Arizona taxpayers.[1]

[1] Arizona is one of 16 states that have lifetime loss of earning and medical benefits with no offset for Social Security, retirement or disability benefits. U.S. CHAMBER OF COMMERCE, 2020 ANALYSIS OF WORKERS' COMPENSATION LAWS (2020) (Appendix at 25-33).

## I. A.R.S. § 23-1043.01(B) is not unconstitutional.

This Court places substantial weight in favor of upholding the constitutionality of a statute. *Gallardo v. State*, 236 Ariz. 84, 87, ¶ 9, 336 P.3d 717, 720 (2014) ("We do, however, presume that "the legislature acts constitutionally."). As a co-equal branch of government, this Court recognizes that the legislature "is far better equipped than the judiciary to amass and evaluate the vast amounts of data bearing upon' legislative questions.'" *Ariz. Minority Coal. for Fair Redistricting v. Ariz. Indep. Redistricting Comm'n*, 220 Ariz. 587, 595, 208 P.3d 676, 684 (2009) (quoting *Turner Broad. Sys., Inc. v. FCC*, 520 U.S. 180, 195–96 (1997)).

### A. Codifying this Court's reasonable, objective standard in *Sloss*

Arizona has long-recognized that mental injuries arising out of a work-connected accident are just as compensable as a physical injury arising out of a work-connected accident. *See Sloss v. Indus. Comm'n*, 121 Ariz. 10, 11, 588 P.2d 303, 304 (1978) (recognizing compensability of mental condition caused by unexpected, injury-causing event as long as it is work-related); *Brock v. Indus. Comm'n*, 15 Ariz. App. 95, 96, 486 P.2d 207, 208 (1971) (finding mental injury sustained from an unexpected, work-connected event just as compensable as physical injury arising out of same event). However, neither the workers' compensation act nor the Arizona constitution define "accident" for purposes of

determining the compensability of an injury. While an "accident" may be easier to deduce in the context of a physical injury claim, determining the "accident" for purposes of a mental injury presents a more complex question.

Prior to the enactment of A.R.S. § 23-1043.01(B), Arizona courts long declined to interpret Arizona's workers' compensation law as requiring compensation of work-connected mental injury arising out of expected and typical daily employment stress. *See Sloss*, 121 Ariz. at 11-12, 588 P.2d at 304-05 (no "injury by accident" where claimant was not exposed to anything other than ordinary stress of employment experienced by other similarly situated highway patrolmen); *Shope v. Indus. Comm'n*, 17 Ariz. App. 23, 25, 495 P.2d 148, 150 (1972) ("The evidence here reveals no unexpected injury-causing event but rather a buildup of emotional stress for a period of years preceding the day that petitioner walked off the job."). *See also Fireman's Fund Ins. Co. v. Indus. Comm'n*, 119 Ariz. 51, 54, 579 P.2d 555, 558 (1978) (finding mental injury caused by accident where events leading up to injury were more than routine, ordinary stresses).

To ensure that a mental injury was an "injury by accident" and compensable under workers' compensation, this Court required that the "condition must have been produced by the unexpected, the unusual, or the extraordinary stress." *Sloss*, 121 Ariz. at 11, 588 P.2d at 304. This Court rejected the view that "ordinary stresses of employment to which all workers are subjected to provide a basis for

workmen's compensation for a work-related nervous condition." *Id*. This Court's distinction between mental injury caused by general work-connected stress without any identifiable, work-connected unexpected, unusual or extraordinary event and a compensable mental injury understands the inherent differences between mental and physical injury workers' compensation claims.

**B. Balancing complexities of work-connected mental injury claims**

It is widely acknowledged that mental injury workers' compensation claims present complex evidentiary issues. *See, e.g*., *Archer v. Indus. Comm'n*, 127 Ariz. 199, 203, 619 P.2d 27, 31 (App. 1980), overruled on other grounds by *Bush v. Indus. Comm'n of Ariz.*, 136 Ariz. 522, 525, 667 P.2d 222, 224 (1983 ("Emotional stress cases in the workmen's compensation field—whether the emotional stress results in a heart attack or a disabling mental disorder—are extremely difficult."); David P. Torrey and Donald T. DeCarlo, *Mental Stress Causing Mental Disability Under Workers' Compensation Laws: A Short History, the Competing arguments, and a 2021 Inventory*, 56 TORT TRIAL AND PRAC. L.J. 91 (Winter 2021) (Appendix at 38-65).

While mental injuries and conditions may be better understood today than in past decades, "the science is still weak on diagnosis and causation of the same." Torrey and DeCarlo, *supra*, at 113-115 (Appendix at 51-52). For instance, diagnosis of PTSD relies heavily "on subjective reporting by the patient of both the

stressor event and the resulting reactions, as well as the subjective impressions of the diagnostician." Deirdre M. Smith, *Diagnosing Liability: The Legal History of Posttraumatic Stress Disorder*, 84 TEMP. L. REV. 1, 54-56 (2011) (Appendix at 120-121). While PTSD requires medical diagnosis, the diagnosis also requires a determination of legal causation. *See id*. at 54 ("The determination of causation as required by the A Criterion raises questions of bias and skewed subjective assessment on the part of both the clinician and the patient, decreasing the validity and reliability of PTSD diagnoses.") (Appendix at 120). Some researchers have theorized that it is "not entirely accurate to state that the A Criterion event caused the PTSD symptoms to develop because the primary determining factor in whether someone develops such symptoms is the way in which the person recalls the event." *Id*. at 56 (Appendix at 121).

In the context of recovery of workers' compensation for mental injuries, "[d]etermination of work causation is not merely a matter of gathering and interpreting empirical evidence but rather a complex social phenomenon." Torrey and DeCarlo, *supra*, at 105 (internal quotations and citations omitted) (Appendix at 47). Disputes over compensability of mental injury claims often end in competing medical testimony and as one commentator noted, "[u]nless the psychiatrist or psychologist has reason to believe that the claimant is not giving a full and accurate history, it is highly possible, if not probable, that he will accept the claimant's

emphasis on the work stress and conclude that the disorder was primarily the result of those stresses." Torrey and DeCarlo, *supra*, at 115 (internal citation and quotation omitted) (Appendix at 52).

The Court's unexpected, unusual or extraordinary standard adopted in *Sloss* and codified in A.R.S. § 23-1043.01(B) strikes an appropriate and sustainable balance. This objective standard gives effect to the statutory language requiring a work-connected accident for a compensable workers' compensation injury claim. As first recognized in *Brock*, "the concept of what is an 'accident' has been the subject of frequent consideration by our courts, and it is now commonly viewed to include any unexpected injury-causing event, so long as it is work-connected." 15 Ariz. App. at 96, 486 P.2d at 208. Allowing recovery of any work-connected mental injury, especially in cases of high-stress employment as petitioner suggests, would ignore the word "accident," and represents a drastic shift in the compensability of such claims in Arizona.

At the same time, legal analysts note this standard "work[s] to ferret out false or weak claims, those based primarily on pre-employment maladies, and ensure (by definition) that claims based merely on subjective reactions to normal work conditions will not end in a disability claim. Torrey and DeCarlo, *supra*, at 117. (Appendix at 53). As demonstrated by claims history in states in which courts did open the door for compensating any mental injury claims that were work-related,

removing the long-adhered to accident requirement would drastically increase the number of claims filed as well as insurance premiums. *See* Torrey and DeCarlo, *supra*, at 106-111 (analyzing drastic increase in claims in California, Arkansas, West Virginia, and Pennsylvania following key court rulings in each state expanding coverage for mental injury claims and state legislative reactions to the same) (Appendix at 47-50).

**C. No unconstitutionally higher burden in high-stress occupations**

The objective, unexpected and unusual burden adopted in *Sloss* and codified in A.R.S. § 23-1043.01(B) does not place an unconstitutionally higher burden on employees in high-stress occupations, such as police, fire, emergency room personnel, trauma surgeons, air traffic controllers, or electrical linemen. As noted in *Findley v. Industrial Comm'n*, all individuals with stress-related mental injuries are treated alike and all are compared to similarly situated employees. 135 Ariz. 273, 276, 660 P.2d 874, 877 (App. 1983). Petitioner's allegations that in highly stressful jobs like police officers it would qualify when compared to their daily stresses. In *France v. Industrial Commission*, this Court found that the event triggering claimant's mental injury *was* unexpected, unusual or extraordinary when compared to what is actually experienced by similarly situated officers in the same or similar duty and not just based on job duties or requirements. 250 Ariz. 487, 491-92, ¶¶ 20-23, 481 P.3d 1162, 1166-1167 (2021).

In contrast, the evidence in this case reveals claimant's mental injury is far more comparable to *Sloss*. In *Sloss*, this Court upheld the finding of the administrative law judge who determined, after weighing the evidence, that the claimant's "emotional condition" was due to chronic anxiety from daily or typical stress suffered by a highway patrolman. There was thus no work-related "accident" giving rise to the claim. As in *Sloss*, the claimant's own medical expert here testified that the "event and stressors were 'standard issue.'" *Matthews*, 251 Ariz. at ¶ 7, 495 P.3d at 337. The ALJ therefore appropriately weighed the available evidence and found that the event giving rise to the mental injury did not constitute a work-connected accident.

It should also be noted that while petitioner argues that A.R.S. § 23-1043.01(B) is unconstitutional under Arizona Constitution, article XVIII, § 8, petitioner fails to acknowledge that the constitutional mandate *by its terms*, applies to a "workers' compensation law applicable to workmen ***engaged in manual or mechanical labor*** in all public employment . . ." (Emphasis added.) As noted by this Court in *Atkinson, Kier Bros., Spicer Co. v. Industrial Comm'n*, 35 Ariz. 48, 52-53 274 P. 634, 635 (1929), article XVIII, § 8 of the Arizona Constitution was a mandate to enact a workers' compensation law for at least two types of employees and not a grant of power to the legislature to so enact such a law. It was the legislature, in the exercise of its inherent power, that enacted a workers'

compensation law applicable equally to all public employees, including those in high-stress occupations such as police officers. *Id*. *See also* A.R.S. § 23-1021 (providing right of workers' compensation to all employees covered by the act for injuries arising out of employment). It should therefore be a legislative issue and not a constitutional one as to how that additional scope of coverage is defined.

**D. No alteration of the legal burden of proof for mental injury claims**

Petitioner's argument that A.R.S. § 23-1043.01(B) unconstitutionally bars legally permissible claims misunderstands *Grammtico v. Industrial Commission*, 211 Ariz. 67, 117 P.3d 786 (2005). In *Grammatico*, this Court did not interpret the accident requirement, but a statutory change to the claimant's burden of proof to demonstrate that the accident was work-connected. *Id.* at 72, ¶ 23, 117 P.3d at 791. The Court identified this as a legal standard that could not be legislatively modified. *Id*. Notably, however, this Court concluded that "the legislature has some latitude to establish the requisite medical causation for workers' compensation recovery." *Id.* at 71-2, ¶¶ 20- 21, 117 P.3d at 790-91.

Section 23-1043.01(B) does not unconstitutionally alter the legal burden of proof defined by *Grammatico*. It does not require that a mental injury be *wholly* caused by a necessary risk of employment before it is compensable. The focus, instead, is on a mixed medical-legal causation standard that recognizes the intrinsic complexities of mental conditions and their numerous potential causes and balances

them with the injury by accident requirement. The provider's opinion and diagnosis of mental injury is based not only on the patient's self-report of symptoms, but by objective evidence that the stress was unusual as compared to what most similarly-situated employees experience. This establishes an objective standard to distinguish compensable mental injuries from those caused by every day or non-work-related stress rejected by this Court in *Sloss* and reaffirmed by this Court a year ago in *France*. *See France*, 481 P.3d at 1167, ¶ 23 ("We emphasize that our holding today is limited to mental injuries arising from a specific work-related incident and does not encompass gradual injuries resulting from ordinary stresses and strains of the work regimen.")

In this sense, § 23-1043.01(B) addresses both medical and legal causation and is more closely akin to the mixed medical and legal causation addressed by statue addressing recovery for occupational disease related to employment. This Court "found that special standards of causation for occupational disease cases is to insure that the disability causing the disease is one related to employment, and not one which is part of the ordinary hazards of life to which the general public is exposed." *Ford v. Indus. n of Arizona*, 145 Ariz. 509, 518, 703 P.2d 453, 462 (1985) (rejecting constitutional challenge to A.R.S. § 23-901.01).

Petitioner's argument that this Court should interpret the "accident" requirement as satisfied in mental injury or illness claims so long as the resultant

mental injury is unexpected based on *Paulley v. Industrial Commission*, 91 Ariz. 267, 371 P.2d 888 (1962), is misplaced. *Paulley* is inapplicable to compensability of work-connected mental injury claims as it involved compensability of a physical injury with no mental injury component. 91 Ariz. at 267-69, 371 P.2d at 889-90.

Additionally, *Paulley* pre-dates the Arizona cases interpreting what constitutes an injury by accident in the context of purely mental injury and illness claims. *See, e.g.*, *Sloss,* 121 Ariz. at 11, 588 P.2d at 304; *Brock*, 15 Ariz. App. 95, 96, 486 P.2d 207, 208; and *Shope,* 17 Ariz. App. 23, 25, 495 P.2d 148, 150. In those case, this Court refined its analysis of an accident in the specific context of mental injury claim. This Court refused to view the compensability of a mental injury causing accident solely in terms of whether the result (i.e. mental injury) was intended, but instead applied an objective test to determine if the stress placed upon claimant was unexpected as compared to the stress placed upon others similarly situated. Notably, no jurisdictions allow recovery in workers' compensation cases for "purely subjective feelings of stress." Torrey and DeCarlo, *supra*, at 123 (Appendix at 57.)

Addressing the daily stresses faced by first responders is a policy issue to be addressed by the Legislature and/or employers. As noted by AMRRP in the amicus and supplemental amicus briefs filed in *France*, there are layers of benefits to fairly compensate police officers for their service and actions on the job, of which

workers' compensation is only one. In addition to the traumatic event counseling services provided by A.R.S. § 38-673, police officers have disability benefits through the Public Safety Personnel Retirement System that are *independent* from workers' compensation, which includes wage replacement benefits for ordinary, accidental, temporary and catastrophic disabilities. A.R.S. § 38-844. (*See also* PSPRS Member Handbook at 12-15, *available at* https://www.psprs.com/uploads/forms/PSPRS%20Member%20Handbook%20Rev%208-2016.pdf.) Employers also offer benefit packages, which may include short-term disability, gap insurance, and mental health counseling services. Petitioner and others similarly situated who may experience a mental injury arising out of the daily stresses and events experienced in a high stress occupation are not without remedy if the mental injury or illness is not legally compensable under Arizona's workers' compensation system.[2]

## III. The Opinion should be upheld.

The ALJ's decision and Opinion should be affirmed. Both appropriately apply this Court's objective and reasonable standard to determine the compensability of work-connected mental injury claims under Arizona's workers'

[2] In some instances, a police officer or other first responder may be entitled to benefits under both workers' compensation and PSPRS. In such cases, the computation of benefits owed ***cannot*** be offset or account for benefits paid under the other.

compensation law. There is no basis to find A.R.S. § 23-1043.01(B) unconstitutional as applied to employees in high stress occupations. Any expansion of workers' compensation coverage or other coverage of mental injuries suffered by employees in high stress jobs while performing work-related duties is a policy decision more appropriately addressed by the legislature or employers of high stress occupations.

Respectfully submitted this 15th day of March 2022.

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# Excerpts from U.S. Chamber Of Commerce, *2020 Analysis of Workers' Compensation Laws* (2020)

# 2020 Analysis of Workers' Compensation Laws


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U.S. CHAMBER OF COMMERCE

# CONTENTS

# PART 2—BENEFITS PROVIDED

Because workers' compensation imposes an absolute (but limited) liability on the employer for employee disabilities caused by employment, the benefits payable to an injured employee attempt to cover most of the worker's economic loss. This loss includes both loss of earnings and extra expenses associated with the injury.

Specifically, the benefits provided are as follows:

- Cash benefits, which include impairment benefits and disability benefits. The former are paid for certain specific physical impairments while the latter are available whenever there is an impairment and a wage loss.

- Medical benefits, which are usually provided without dollar or time limits. In the case of most workplace injuries, only medical benefits are provided since substantial impairment or wage loss is not involved.

- Rehabilitation benefits, which include both medical rehabilitation and vocational rehabilitation for those cases involving severe disabilities.

Cash Benefits—In considering workers' compensation income or cash benefits—which replace employee loss of income or earning capacity resulting from occupational injury or disease—four classifications of disability are used:

- Temporary total (TT)

- Permanent total (PT)

- Temporary partial (TP)

- Permanent partial (PP)

Permanent partial is divided into nonscheduled and scheduled disabilities.

Most cases involve temporary total disability. That is, the employee—although totally disabled during the period when benefits are payable—is expected to recover and return to employment. Permanent total disability generally indicates that the employee is regarded as totally and permanently unable to perform gainful employment.

## Income Benefits for Total Disability (Chart VI)

Income or cash benefits payable under either temporary total or permanent total disability are shown in Chart VI. For computing weekly benefit payments, a formula—expressed as a percentage of wages—is used. In most states, limitations are placed on maximum and minimum benefits payable weekly; some states also limit the total number of weeks and the total dollar amount of benefit eligibility. Where there is permanent total disability, most states provide payments extending through the employee's lifetime.

For either temporary total or permanent total disability, the wage-replacement percentage in each jurisdiction is the same. However, in permanent total disability cases, the time limits tend to be longer and the total dollar amounts higher than in cases of temporary total disability. Some states provide additional amounts and other benefits for dependents.

Allowances for dependents are charted as a range in the "Maximum Weekly Payment" and "Notations" columns.

- **Partial Disability**—Most awards and the preponderance of dollars paid out as income benefits are for temporary total and permanent partial disability.

As partial disabilities involve current earnings or wage-earning ability, many state weekly benefit payments for temporary or permanent partial disabilities of the nonscheduled type are based on a wage-loss replacement percentage. The percentage applies to the difference between wages earned before and after the injury. In some states, nonscheduled permanent partial disabilities are compensated as a percentage of the total disability cases.

## Income Benefits for Scheduled Injuries (Chart VII)

Chart VII indicates maximum amounts payable in cases of scheduled injuries. Listed by law, these injuries involve loss, or loss of use, of specific body members, where wage loss based on the nature of impairment is presumed. In most jurisdictions, the actual amount payable is a specified number of weeks of benefits (based on the body member involved) multiplied by the weekly benefit amount (based on earnings at the time of injury).

The chart also indicates whether the scheduled award is in addition to any payment otherwise payable to the employee while he or she may be temporarily totally disabled (healing period). Some states limit the amount payable for such periods of temporary total disability.

The Canadian statutes do not typically provide specific injuries; cases are decided individually using medical impairment ratings as guidelines.

## Fatalities: Income Benefits for Spouses and Children (Chart VIII)

Benefits payable in the event of fatal injuries are shown in Chart VIII. The benefits provided include a burial allowance as well as a proportion of the worker's former weekly wages.

Although accidental death is always a tragedy, the economic loss associated with death cases is often less than that of a permanent total disability. Because of these considerations, death benefits are generally paid to the spouse until remarriage and to the children until a specified age. In addition, some laws provide a maximum benefit total expressed as maximum period for the payment of benefits. Figures for one child only reflect compensation if sole survivor.

## Waiting Period for Income/Medical Benefits (Chart IX)

- **Waiting Period**—Statutes provide that a waiting period must elapse during which income benefits are not payable. This waiting period affects only compensation; medical and hospital care are provided immediately. If disability continues for a certain number of days or weeks, most laws provide for payment of income benefits retroactive to the date of injury. Statutory provisions for waiting periods are summarized in Chart IX.

- **Choice of Physician**—Practices vary with respect to choice of attending physician. States are divided nearly evenly between those that give this decision to the employer and those that give the choice to the employee. In some states, selection must be made from an approved list. The employer normally has the right to select a physician to conduct an examination.

- **Medical Benefits**—Medical benefits, which make up a sizable portion of all workers' compensation benefits paid, are shown in Chart IX. In most instances, unlimited medical benefits are provided either specifically by statute or by administrative discretion.

## Rehabilitation of Disabled Workers (Chart X)

Mutual interests of disabled employees and employers generally favor starting rehabilitation as soon as possible. Although rehabilitation is considered an integral part of complete medical treatment, its uses may extend beyond this—for example, where it includes vocational rehabilitation and retraining.

Specific rehabilitation provisions now in workers' compensation laws are outlined in Chart X. However, rehabilitation is provided in all states even if unspecified in the law. Maintenance allowance amounts and special fund sources to finance rehabilitation also are indicated.

Insurance carriers and many employers having medical departments are leaders in carrying on rehabilitation for the industrially injured. Likewise, many major industries have comprehensive programs for employment of the physically handicapped. Smaller industries maintain modified programs for placement of disabled individuals in congenial tasks. All of these private programs help employees and employers alike.

The Federal Vocational Rehabilitation Act is now effective in all states; it includes federal funds to aid states in vocational rehabilitation of the industrially disabled.

## *Chart VI—Income Benefits for Total Disability*

| Jurisdiction | Percentage of Wages | Maximum Weekly Payment | | Minimum Weekly Payment | | Time Limit | Amount Limit ($) | Automatic Cost-of-Living Increase | Offsets | Notations |
|---|---|---|---|---|---|---|---|---|---|---|
| | | Amount ($)[1] | Rate (%)[2] | Amount ($)[1] | Rate (%)[2] | | | | | |
| **Alabama** | 66$^{2}/_{3}$ | 892 | 100 | 245 | 27.5[3] | TT—disability; PP/TP—300 weeks | | | | Annual increase in maximum effective 7/1.[3,4] |
| **Alaska**[5] | 80 (of spendable earnings) | 1,255 | 120 | 276 | 22 (of maximum) | TT and TP disability compensation cease if underlying medical condition becomes "medically stable." | | | Social Security, retirement, survivor, or disability; portion of qualified pension or profit-sharing plan payments received, and portion of employer-paid disability benefits exceeding 100% of employee's spendable weekly wage | TT and PT compensation not payable for periods during which employee receives unemployment benefits. |
| **Arizona** | 66$^{2}/_{3}$ | 1,222.14 | | | | Disability | | | | Benefits payable monthly. Additional $25 monthly if one or more dependents, not subject to maximum. If claim was handled in bad faith or was done unfairly, additional benefit of 25% of total or $500, whichever is greater. |
| **Arkansas** | 66$^{2}/_{3}$ | 711 | 85 | 20 | | TT—450 weeks PT—life | | | Unemployment benefits when claimant receives an award of TTD as a result of litigation of controversial benefits | Maximum effective 1/1. TT, TP, and PT not payable for periods during which claimant is receiving unemployment benefit. Penalty of 18% for failure to pay without an award; 20% for failure to pay with an award. Benefits are subject to child support. |
| **California**[6] | 66$^{2}/_{3}$ | 1,299.43 | | 194.91 | | TT—104 weeks for most injuries[7] PT—life | | TT—after two years | Social Security and unemployment compensation | Maximum effective 1/1/18. 50% increased compensation if injury was due to employer's serious, willful misconduct. Compensation increased by 10% if undue delay in payment. If injury was caused by employee's intoxication by alcohol or other controlled substance, no compensation is payable. |
| **Colorado** | 66$^{2}/_{3}$ | 1,022.56 | 91 | 320.90 | 31 (of maximum) | TT—disability[8] PT—life | 94,330.19/ 188,658.00 | | Social Security, unemployment compensation, and employer-paid pension plan | Annual maximum effective 7/1. Compensation decreased 50% if injury results from worker's failure to obey safety regulations or from intoxication or use of nonmedically prescribed controlled substances. |
| **Connecticut**[9] | 75 (of after-tax income)[9] | 1,328 | 100 | 265.60[9] | 20 (of maximum) | Disability | | | | Annual increase in maximum effective 10/1/2019. |

## *Chart VI—Income Benefits for Total Disability, cont.*

| Jurisdiction | Percentage of Wages | Maximum Weekly Payment | | Minimum Weekly Payment | | Time Limit | Amount Limit ($) | Automatic Cost-of-Living Increase | Offsets | Notations |
|---|---|---|---|---|---|---|---|---|---|---|
| | | Amount ($)[1] | Rate (%)[2] | Amount ($)[1] | Rate (%)[2] | | | | | |
| **Delaware** | 66⅔ | 725.89 | 66⅔ AWW | 241.96 | 33⅓ (of maximum) | Disability | | | None | Annual increase in maximum effective 7/1/19. |
| **District of Columbia** | 66⅔ | 1,535.44 | 100 | 383.86 | 25 | Disability | | | | Annual increase in supplemental allowance (cost of living) effective 1/1 if the state AWW for the year ending on the preceding 6/30 results in an increase of $2 or more in the state AWW. No increase shall exceed 5%. |
| **Florida** | 66⅔ or 66.67 | 971 | 100 | 20 | | Entitlement to Permanent Total Benefits ceases at age 75 or at five years following determination of PTD for accident date on or after an employee reaches age 70. | | PTD—3%[10] | Social Security and unemployment compensation | Annual-based state AWW and maximum effective 1/1. Additional payment of interest or greater of 12% per year or $5, if any installment of compensation is not paid when it becomes due, and an additional 20% penalty assessed if paid more than seven days late. Compensation reduced 25% if employee refuses to use safety device. If injury was caused by employee's intoxication by alcohol or other controlled substance, no compensation is payable.[10] |
| **Georgia** | 66⅔ | 675 | | 50 | | 400 weeks | | | Employer-funded portion of disability plan, wage continuation plan, or unemployment benefits | If convicted of misdemeanor offense of receiving and fraudulently retaining benefits, employee is subjected to penalty between $1,000 and $10,000, one year's imprisonment, or both.[11] |
| **Hawaii** | 66⅔ | 925 | 100 | 231 | 25 | Disability | | PT—injuries prior to 1/1/92 and 1/1 of every 10th year thereafter | | Annual increase in maximum effective 1/1. Compensation may be increased 20% for failure to pay within 31 days after decision or award or within 10 business days for uncontroverted TT disability case. |
| **Idaho** | 67 | 733.50 | 90 | 122.25 | 15 | Disability | | 1/1 of following year and after 52 weeks of total disability benefits | | Annual increase in maximum effective 1/1.[12] For first 52 weeks, benefit is 67% of worker's wages; after 52 weeks, benefit is 67% of the AWSW. Worker earning an AWW of less than 15% of AWSW receives no less than 15% of AWSW for the first 52 weeks, 45% of AWSW thereafter. If injury was caused by employee's intoxication by alcohol or other controlled substance, no indemnity is payable. |

## *Chart VI—Income Benefits for Total Disability, cont.*

| Jurisdiction | Percentage of Wages | Maximum Weekly Payment | | Minimum Weekly Payment | | Time Limit | Amount Limit ($) | Automatic Cost-of-Living Increase | Offsets | Notations |
|---|---|---|---|---|---|---|---|---|---|---|
| | | Amount ($)[1] | Rate (%)[2] | Amount ($)[1] | Rate (%)[2] | | | | | |
| **Illinois** | 66 2/3 | 1,549.07 for max TTD and PTD; 836.69 for max PPD | 133 1/3 | 580.90, min PTD and death[13] | PT—50 | TT—disability PT—life | | PT—7/15 of second year | | Semi-annual increases in maximum effective 1/15 and 7/15. |
| **Indiana** | 66 2/3 | 780[14] | | 50 | | 500 weeks | 390,000 | | | After 500 weeks, additional benefits are payable from second injury fund in 150-week increments. TT disability benefits subject to child support withholding. |
| **Iowa** | 80 (of spendable earnings)[15] | 1,819 TTD, PTD, and death; 1,673 PPD | 0.94 | 319[16] | | Disability | | | | Annual increase in maximum effective 7/1. Benefits up to 50% if late or stopped without good cause. |
| **Kansas** | 66 2/3 | 666 | 75 | 444 | | Disability | TT—130,000 PT—155,000 (includes TT) PP—functional impairment only—75,000 | | Retirement benefits provided by employer, including Social Security retirement; no offset for Social Security disability | Annual increase in maximum effective 7/1. |
| **Kentucky** | 66 2/3[17] | 979 | 100 | 178 | 20 | Disability; injuries and diseases after 7/14/18, award terminates upon age 70 | | | Injuries and dates of last exposure on or after 12/12/96—employer-funded disability or sickness and accident plan covering same disability, unless plan contains internal offset provision unemployment benefits | |
| **Louisiana** | 66 2/3 | 688 | 75 | 183 | 20[3] | TT[18] and PT—disability | | | Social Security, unemployment compensation, employer-funded disability, federal, and other state workers' compensation | Annual increase in maximum effective 9/1/19–8/31/20. 12% penalty if undue delay in payment. No compensation paid if intoxication was proximate cause of injury. |

## *Chart VI—Income Benefits for Total Disability, cont.*

| Jurisdiction | Percentage of Wages | Maximum Weekly Payment | | Minimum Weekly Payment | | Time Limit | Amount Limit ($) | Automatic Cost-of-Living Increase | Offsets | Notations |
|---|---|---|---|---|---|---|---|---|---|---|
| | | Amount ($)[1] | Rate (%)[2] | Amount ($)[1] | Rate (%)[2] | | | | | |
| **Maine** | 80 (of after-tax AWW) for injuries prior to 1/1/13, two-thirds the employee's gross AWW, but no more than the maximum benefit. | 771.11 for injuries from 1/1/93–12/31/12. 856.79 for injuries on or after 1/1/13. | 90 | | | PP/PT—disability TP/TT—520 weeks under §213. No durational limit under §212. | | Injuries on and after 1/1/93—no provision for automatic COLA | Employer-funded benefits, old-age Social Security, unemployment benefits | Annual increase in maximum effective 7/1. Employee who terminates active employment, is receiving nondisability pension and retirement benefits, and was paid weekly benefits is presumed not to have loss of earnings. May be rebutted because of work-related disability. Benefits under §213 may be based on the extent of permanent impairment resulting from the injury. |
| **Maryland** | 66⅔ | 1,080 | 100 state AWW yearly maximum figure | TT—50[3] PT—25 | | TT—disability | PT—45,000 | PT—1/1, percentage change in most recent annual CPI not to exceed 5% | | Annual increase in maximum effective 1/1; statutory formula utilized. |
| **Massachusetts** | 60 | 1,431.66 | 100 | 286.33 | 20 | TT—156 weeks PT—260 weeks | [19] | PT—percentage change in most recent annual CPI, not to exceed 5% | Unemployment compensation, pension, and old-age Social Security | Annual increase in maximum effective 1/1. Additional $6 weekly per dependent child if total benefit does not exceed $150 or 100% of wages. Double compensation if injury due to employer's serious and willful misconduct.[20] |
| **Michigan** | 80 (of spendable earnings) | 1,037.10 | 90 | 259.28 | PT—25 | Disability[21] | | | Disability, unemployment compensation, pension, and old-age Social Security[22] | Annual increase in maximum effective 1/1. Additional $50 per day for award unpaid after 30 days, maximum $1,500. |
| **Minnesota** | 66⅔ | 1,134.24 | 102 of state AWW for period ending 12/31 of the preceding year. | 130[23] | PT—65 | TT—90 days after MMI or end of retraining, up to max 130 days.[24] PTD ends at age 72, or after five years if injured after 67. | | Annual increase to most recent percentage increase in state AWW, up to 3%. With first adjustment on third anniversary of injury[25] | Government disability benefits or Social Security old-age survivor benefits after $25,000 paid for PT disability and same-injury | Increase in maximum effective 10/1/19. For late payment, interest increased 25% if inexcusably delayed. Late payment interest increased 30% if payment delayed with no legal basis. |
| **Mississippi** | 66⅔ | 505.43[26] | 66⅔ state AWW | 25[27] | | 450 weeks | 227,443.50 | | | Annual increase in maximum effective 1/1. Additional rehabilitation allowance up to $25 weekly for 52 weeks. If award is not paid within 14 days, 20% penalty added (10% if not award). |

## *Chart VI—Income Benefits for Total Disability, cont.*

| Jurisdiction | Percentage of Wages | Maximum Weekly Payment | | Minimum Weekly Payment | | Time Limit | Amount Limit ($) | Automatic Cost-of-Living Increase | Offsets | Notations |
|---|---|---|---|---|---|---|---|---|---|---|
| | | Amount ($)[1] | Rate (%)[2] | Amount ($)[1] | Rate (%)[2] | | | | | |
| **Missouri** | 66⅔ | 981.65 | 105 state AWW | 40 | | TT—400 weeks PT—life | TT—392,660 (400 weeks x $981.65) | | | Annual increase in maximum effective 7/1; benefit set on rate on date of injury; 10% interest for late payments. One-time lump-sum award may be reached through a compromise settlement.[28] |
| **Montana** | 66⅔ | 819 | 100 | | | TT—disability until MMI, restrictions are identified and job analyses are approved, or return to work. PT—disability until a person receives Social Security or is eligible for full retirement benefits from Social Security or alternative system. | | As of 7/1/03, annual COLA for PT; no more than percentage increase in state AWW | Social Security | Annual increase in maximum effective 7/1. PT lump-sum settlements may be discounted to present value based upon the average rate for U.S. 10-year Treasury bills in the previous calendar year. |
| **Nebraska** | 66⅔ | 882 | 100 | 49 | | TT—disability until MMI or return to work PT—life | | | | Annual increase in maximum effective 1/1. Additional 50% compensation is due for failure to pay within 30 days of notice of injury where no reasonable dispute exists or for failure to pay within 30 days from the entry of final order, award, or judgment.[29] |
| **Nevada**[30] | 66⅔ | 934.64 | 150 state AWW | | | TT—disability PT—life | | | PT—benefits subject to offset for previously received PP—lump-sum awards | Annual increase in maximum effective 7/1. Listed maximum is for injuries 7/1/19–6/30/20. TT benefits payable biweekly; PT payable monthly. PP cannot be received during same period of time.[31] |
| **New Hampshire** | 60[32] | 1,629.00 | 150 | 325.80[33] | 30[3] | Disability | | Third anniversary of injury, 7/1 thereafter | | Annual increase in maximum effective 7/1/19–6/30/20. Double compensation if employer violated prior recorded safety standard. Employer not liable for injury if worker was intoxicated by nonprescription controlled substance, unless employer was aware of intoxication. |

## *Chart VI—Income Benefits for Total Disability, cont.*

| Jurisdiction | Percentage of Wages | Maximum Weekly Payment | | Minimum Weekly Payment | | Time Limit | Amount Limit ($) | Automatic Cost-of-Living Increase | Offsets | Notations |
|---|---|---|---|---|---|---|---|---|---|---|
| | | Amount ($)[1] | Rate (%)[2] | Amount ($)[1] | Rate (%)[2] | | | | | |
| **New Jersey** | 70 | 945 | 70 | TT—252<br>PT—35 | TT—20<br>PT—n/a | TT—400 weeks<br>PT—600 weeks | | | Social Security Public Disability Pension | Annual increases to rate if date of injury occurred prior to 1/1/80. After 450 weeks at reduced rate if employed; at full if PP or PT. |
| **New Mexico** | 66$^{2}/_{3}$ | 845.10 | 100 | 36 | | PT—life<br>TT—80% or more, 700 weeks $591,570; less than 80%, 500 weeks $422,550 | | | Unemployment benefits, wages, and employer-financed disability benefits if offset contractually exists | Annual increase in maximum effective 1/1. 10% additional compensation payable by employer for failure to provide safety device; 10% decrease for failure to use safety device. Up to 25% increase if judge finds unfair claims processing. If award is untimely, judge may order entire balance of award due plus penalties. 10% to 90% reduction in proportion to degree intoxication or influence of drugs contributes to the accident. |
| **New York** | 66$^{2}/_{3}$ | 934.11[34] | | 100 | | Disability | | | Social Security Disability benefits reduced based on workers' compensation awarded | Persons receiving PT benefits may collect full compensation and wages, but not in excess of pre-injury wage base. Provision for collection of full wages and compensation applies only to statutory PT or TT for loss of both eyes, hands, arms, feet, or legs or any two thereof. No compensation paid if injury is caused solely by intoxication from alcohol or controlled substance or by willful intention to injure oneself or another. |
| **North Carolina** | 66$^{2}/_{3}$ | 1,066 | 110 | 30 | | TT—disability<br>PT—500 weeks and extended by commission if employee has sustained a total loss of wage-earning capacity | | | Extended compensation reduced by 100% of Social Security full retirement benefits | Annual increase in maximum effective 1/1. |
| **North Dakota** | 66$^{2}/_{3}$ | 1,248 | 125 | 599[3] | | TT—104 weeks or MMI 260 weeks[35]<br>PT—life or retirement | | Based on AWW on PT only after two years | Social Security disability and Social Security retirement[36] | Annual increase in maximum effective 7/1. Additional $15 weekly per dependent child younger than 18 or 22 if child attends a full-time educational institution; total benefits may not exceed claimant's net take-home pay. |

## *Chart VI—Income Benefits for Total Disability, cont.*

| Jurisdiction | Percentage of Wages | Maximum Weekly Payment | | Minimum Weekly Payment | | Time Limit | Amount Limit ($) | Automatic Cost-of-Living Increase | Offsets | Notations |
|---|---|---|---|---|---|---|---|---|---|---|
| | | Amount ($)[1] | Rate (%)[2] | Amount ($)[1] | Rate (%)[2] | | | | | |
| **Ohio** | First 12 weeks—72 After 12 weeks or if receiving Social Security benefits—66 2/3[37] | First 12 weeks—980 | 100 | TT—326.67 PT—490 | TT—33 1/3 PT—50 | TT—disability[38] PT—life | | | Employer-funded benefits | Annual increase in maximum effective 1/1. PT benefit plus Social Security is less than $394.79 weekly, Disabled Workers' Relief Fund rate and PT or Social Security; amount increased annually by increase in CPI. |
| **Oklahoma** | TT—70% of employee AWW PT—70% of employee AWW | TT—629.04 PT—898.63 | TT—70 PT—100 | | | TT—104 weeks, extendable for 52 additional weeks for consequential injury. PT—For continuance of the disability until employee reaches the age of maximum Social Security retirement benefit or 15 years, whichever is longer. | | | | Maximum amounts adjusted annually based on state AWW. Current rates pertain to injuries occurring on or after 1/1/20–12/31/20. TT equivalent benefits during PT evaluation up to 52 weeks during participation in retraining or job placement. No TT during period of unemployment benefits; provided, TT in excess of unemployment benefits received by the employee is payable if TT is disputed and later determined compensable. |
| **Oregon** | PT and TT—66 2/3 | TT—1,389.05 PT—1,389.05 | PT and TT—133 | TT—$50, or 90% of actual wages, whichever is less. PT—$344.65. | PT—33 | TT—until claim closure PT—life | | Annually on 7/1 | PT—Social Security PT and TT—overpayments, penalties for failure to attend IMEs, child support | PT—For dates of injury before 1/1/18, the maximum is 100% of state AWW, and the minimum is $50 or 90% of actual wages, whichever is less. If the worker returns to work, PTD is reduced if the wages plus the PTD benefit exceed the worker's wage at injury. |
| **Pennsylvania** | 66 2/3 | 1,081 | 100 | 600.55 | 90% of AWW if AWW is $600.55 or less | TT—disability PT—disability, up to 500 weeks | | | Unemployment compensation, old-age Social Security, and certain severance and pension payments | Claimants suffering injuries after 6/24/96 who receive TT for 104 weeks may be required to undergo an impairment rating evaluation, requested by insurer within 60 days following expiration of the 104 weeks of receipt of benefit by claimant to determine degree of impairment utilizing AMA *Guides*. A disability rating of less than 50% will result in compensation reduction from total to partial status. |

## *Chart VI—Income Benefits for Total Disability, cont.*

| Jurisdiction | Percentage of Wages | Maximum Weekly Payment | | Minimum Weekly Payment | | Time Limit | Amount Limit ($) | Automatic Cost-of-Living Increase | Offsets | Notations |
|---|---|---|---|---|---|---|---|---|---|---|
| | | Amount ($)[1] | Rate (%)[2] | Amount ($)[1] | Rate (%)[2] | | | | | |
| **Rhode Island** | 75 (of spendable income) | 1,275[39] | 125 state AWW | | | Disability | | Increases effective 5/10 and based on CPI for employees receiving TT/PT for one year or TP/PP extending beyond 312 weeks | | Annual increase in maximum effective 9/1. Additional $15 per dependent child younger than 18; younger than 23 if in an accredited institution. Total benefit may not exceed 80% of pre-injury wages.[40] |
| **South Carolina** | 66⅔ | 866.67 | 100 | 75[3] | | 500 weeks[41] | 433,335 | | | Annual increase in maximum effective 1/1. |
| **South Dakota** | 66⅔ | 829 | 100 | 415 | 50[3] | TT—disability PT—life | | All PT claims | | Annual increase in maximum effective 7/1. |
| **Tennessee** | 66⅔ | 960[42] | 100 | 144 | 15 | TT—450 weeks PT—eligibility for old-age Social Security. | None | | LTD fully funded by employer | Annual increase in maximum effective 7/1. Compensation may be increased 25% for failure to pay claim. |
| **Texas** | TT—70 PT—75 PP—70[43] | 971 | 100 | 146[44] | 15 | TT—104 weeks PT—for life PP—401 weeks | [45] | 3% for PT | | Maximum and minimum benefits in effect on date of injury applicable the entire time benefits are payable. Claimant is presumed intoxicated if tests positive for a controlled substance. |
| **Utah** | 66⅔ | $916 | TT—100 PT—85 | 45 | PT minimum is 36% of state AWW | TT/PP—312 weeks PT—life[46] | | | | Annual increase in maximum effective 7/1. Additional $20 for spouse, plus $20 per dependent child younger than 18 (up to four); total benefit may not exceed maximum.[47] |
| **Vermont** | 66⅔ | 1,353 | 150 | 451 | 50 | Disability[48] | | Annually on 7/1 | | Benefits may be disallowed if injury occurs during worker's intoxication or results from worker's intent to injure or failure to use provided safety device. |
| **Virginia** | 66⅔ | 1,102 | 100 | 27550 | 25 | TT—500 weeks PT—life | TT—551,000 | 10/1/19–9/30/20—1.85%[49] | | Annual increase in maximum effective 7/1. 20% penalty for failure to pay within two weeks after due. Benefits subject to child support withholding. |

## *Chart VI—Income Benefits for Total Disability, cont.*

| Jurisdiction | Percentage of Wages | Maximum Weekly Payment | | Minimum Weekly Payment | | Time Limit | Amount Limit ($) | Automatic Cost-of-Living Increase | Offsets | Notations |
|---|---|---|---|---|---|---|---|---|---|---|
| | | Amount ($)[1] | Rate (%)[2] | Amount ($)[1] | Rate (%)[2] | | | | | |
| **Washington** | 60 to 75 (depending on marital status and number of children) | 1,506.95 | 120 state average monthly wage (SAMW) | Amount is affected by marital status, number of dependents, and worker's gross wages.[50] | 15 SAMW for date of injury after 7/1/08[50] | | | Annually on 7/1 | Social Security | Annual increase in maximum effective 7/1. Benefits payable monthly and are 60% of wages, with an additional 5% for spouse and 2% per child up to five. |
| **West Virginia** | 66 2/3 | 865.11 | 100 | 193.33 | 33 1/3 (subject to federal minimum weekly wage) | TT—104 weeks PT—until age 70[51] | | | If a claimant is receiving benefits paid through a retirement plan, wage replacement plan, salary continuation plan or other benefit plan provided by the employer to which the employee has not contributed, and that plan does not provide an offset for PTD benefits, an offset is possible. | Annual adjustment in maximum and minimum effective 7/1. All but TP/TT payable monthly.[52] |
| **Wisconsin** | 66 2/3 | 1,051 | 110 | 20 | | TT—disability PT—life | | | Social Security | 10% penalty assessed on payments unreasonably delayed. Adjusted up or down by 15% (up to $15,000) for failure to use safety device or obey code or order. Employer, insurer, or both may be assessed penalty up to double amount of compensation (up to $30,000) for bad-faith failure to make payments. For injuries on or after 3/2/16, no recovery of indemnity or death benefits when an employee violates the employer's drug and/or alcohol policy and where there is direct causation between the violation and the workplace injury. |
| **Wyoming** | 66 2/3 or state average monthly wage | [53] | [53] | [53] | [53] | TT—24 months PT—life[54] | | PT not to exceed 3% | | Quarterly adjustments in maximum effective 1/1, 4/1, 7/1, and 10/1. Benefits paid monthly. |
| **American Samoa** | 66 2/3 AWW | | | | | TP—disability, up to five years | | | | |

## *Chart VI—Income Benefits for Total Disability, cont.*

| Jurisdiction | Percentage of Wages | Maximum Weekly Payment | | Minimum Weekly Payment | | Time Limit | Amount Limit ($) | Automatic Cost-of-Living Increase | Offsets | Notations |
|---|---|---|---|---|---|---|---|---|---|---|
| | | Amount ($)[1] | Rate (%)[2] | Amount ($)[1] | Rate (%)[2] | | | | | |
| **Virgin Islands** | 66⅔ | 617 | 66⅔[55] | 122.71[3, 55] | | Disability | | After two years on 1/1 | PT—Social Security | Annual increase in maximum effective 1/1. Total disability benefits begin after medical and vocational rehabilitation end. Compensation increased 15% for injury caused by employer's failure to obey safety order. |
| **FECA** | 66⅔ or 75 | 2,050.67 | 66⅔ or 75 of highest rate for GS-15 | 316.93 | 75% of the minimum rate of a GS-2 | TT—disability PT—life | | 3/1 | [56] | Benefits paid every four weeks. |
| **Longshore Act**[57] | 66⅔ | 1,560.08 | 200 national AWW | 390.02[58] | 50 national AWW[3] | Disability | | PT—10/1 | Other benefits | Annual increase in PT and related death cases up to the maximum effective 10/1. |
| **Alberta** | 90 (of net income) | [59] | | 428.53 | | | | | | PT payable monthly. Adjustments are made 1/1 annually. |
| **British Columbia** | PT—90 (of net earnings) | 1,507.50[60] | 90 (of average net income) | 423.54 | | TT—disability PT—age 65[61] | 87,100 | 1/1; based on CPI minus 1% | 50% of any CPP benefits | PT benefits are paid on a monthly basis.[62] |
| **Manitoba** | 90 (of net average earnings)[63] | [64] | | [65] | [65] | To age 65[66] | No limit on insurable earnings[63] | First day of month following second anniversary of accident and annually thereafter | CPP benefit, other disability benefits, any payment made by an employer, and employment insurance benefits | Benefits payable periodically. |
| **New Brunswick** | 85 (of net earnings) | 785.82[67] | | | | To age 65[68] | | Benefits indexed by CPI[69] on anniversary of accident | Remuneration or income replacement from an employment source and proportion of CPP disability benefits with respect to injury | Annual increase in maximum on 1/1. Maximum annual earnings are $66,200. Benefits payable biweekly. |
| **Newfound-land and Labrador**[70] | 85 (of weekly net earnings) | 1,288.08 | | No minimum | | To age 65 or maximum of two years wage loss benefits if injury occurs after age 63[70] | | Indexed annually by CPI for long-term benefits | 75% of employer-sponsored pension plan benefits and CPP benefits | PT payable monthly. Maximum annual assessable earnings per employee are $66,980. |
| **Northwest Territories and Nunavut** | 90 (of net income) remuneration | Maximum payment deter-mined by the Year's Maximum Insurable Earnings | | | | TT—disability PT—life | | | | If the worker's monthly payment is less than 2.75% of the Year's Maximum Insurable Remuneration for the year in which the personal injury or disease occurs, the payment must be increased to the lesser of 100% of the worker's net monthly remuneration and 2.75% of the Year's Maximum Insurable Remuneration. |

## *Chart VI—Income Benefits for Total Disability, cont.*

| Jurisdiction | Percentage of Wages | Maximum Weekly Payment | | Minimum Weekly Payment | | Time Limit | Amount Limit ($) | Automatic Cost-of-Living Increase | Offsets | Notations |
|---|---|---|---|---|---|---|---|---|---|---|
| | | Amount ($)[1] | Rate (%)[2] | Amount ($)[1] | Rate (%)[2] | | | | | |
| **Nova Scotia** | First 26 weeks—75 After 26 weeks—85 (of net loss of earnings) | 75%—840.08 85%—952.09[71] | | No minimum | | TT/TP—disability[72] PP/PT—life | | Based on half percentage change in CPI for preceding year, effective 1/1 | 50% of CPP | Maximum insurable earnings are 104.2% of AIW for province. Additional 5% of long-term disability set aside to provided annuity after age 65. |
| **Ontario** | 85 (of net average earnings)[73] | 1,736.50—probable deductions times 85% deductions include probable income taxes, CPP/QPP premiums, and unemployment insurance premiums. | 175 of AIW in Ontario | [74] | | To age 65 where worker was younger than 63 on the date of injury, or two years after the date of injury if worker was 63 or older on the date of injury. | | In accordance with increases in CPI[75] | CPP disability benefits | Maximum annual earnings are $88,500 to $90,300. |
| **Prince Edward Island** | 85 (of net average earnings) | 640.33 | | | | TT—disability PT—to age 65. To age 65 where worker was younger than 63 on the date of injury, or two years after the date of injury if worker was 63 or older on the date of injury. | | The lesser of 80% change in CPI or 4% | CPP disability benefits and employer-paid collateral benefits | Payable biweekly. Maximum annual earnings are $55,300 for 2020. |
| **Québec** | 90[76] | 1,358.65 | | 472.87 | | TT—disability[77] PT—to age 68 | | Annual re-valorization; 2.3% | | Minimum annual earnings are $27,321.36 effective on 5/1/20. PT payable biweekly. Maximum annual earnings are $78,500 effective 1/1/20. |
| **Saskatchewan** | 90 (of net income) | 1,538.76[78] | | 690.80[79] | | To age 65[80] | | Payments indexed by CPI on anniversary of earnings loss | After 12 months—50% of CPP benefits | Maximum annual earnings are $88,906 for injuries on or after 1/1/14. Maximum earnings for injuries before 1/1/14 are $62,454. After two years' disability, an additional amount equal to 10% of compensation is set aside to purchase annuity for benefits after age 65. |
| **Yukon Territory** | 75 (of gross earnings)[81] | 1,308.89 | | Minimum applies only if permanently totally disabled | | When worker reaches age that entitles him or her to apply for benefit under Part 1 of the Old Age Security Act, R.S.C. 1985, c. | | 12 months' payments indexed by Whitehorse CPI on anniversary of earnings loss. | 50% of CPP disability benefits | Maximum assessable earnings are $90,750 for 2020. |

# Notes

[1.] Amounts are in Canadian dollars for all Canadian provinces and territories.

[2.] State AWW, unless noted.

[3.] Actual wage less Social Security and income tax deduction.

[4.] Alabama—Compensation may be increased up to 15% for failure to pay within 30 days after due. Disqualification may occur if impairment by illegal drugs caused accident. A drug test may be performed after accident. No compensation awarded if employee refuses to submit to drug test.

[5.] Alaska—$110 without wage documents; $276 with documents or spendable weekly earnings if 80% of spendable weekly wages is less than $276.

[6.] California—U.S. Department of Labor first-quarter state AWW determines minimum and maximum TD rates effective 1/1 of the next year.

[7.] California—Time limit for TD is limited to 104 weeks within a period of five years from the date of injury for most injuries. Limited exceptions for specified injuries and conditions are extended to 240 weeks.

[8.] Colorado—TT payments cease when claimant reaches MMI, is released or returns to work, or as otherwise defined by statute and rule.

[9.] Connecticut—75% of AWW if less.

[10.] Florida—If employee refuses to take a drug test, it is presumed that drug use caused the accident. Except when statutorily PTD, employee may be entitled to increased TTD 80% of AWW, not to extend beyond six months from date of accident when employee has sustained the loss of an arm, leg, hand, or foot, has been rendered a paraplegic, paraparetic, quadriplegic, quadriparetic, or has lost the sight of both eyes. Combined weekly payable may not exceed maximum weekly compensation rate in effect at time of payment.

[11.] Georgia—If AWW is less than $50, the benefit will be equal to the AWW. Income payable without award increased 15% if not paid within 21 days of becoming due, unless claim is controverted or board excuses. Awarded benefits increased 20% if not paid within 20 days unless appealed. No compensation payable if employee was intoxicated or under influence of controlled substance. Blood alcohol reading of 0.08 within three hours of accident or confirmation of controlled substance use within eight hours of accident creates rebuttable presumption that it was the proximate cause of accident.

[12.] Idaho—Additional weekly benefits were paid for dependent children for accidents that occurred prior to 7/1/91.

[13.] Illinois—Minimum TTD rate and PPD rate if not amputation of a body member or enucleation of an eye is $220 if unmarried and no dependents, with a maximum of $330 if four or more dependents. In all cases, claimant receives rate based on actual wages if less than statutory maximum.

[14.] Indiana—Award increased 5% to 10% if employer loses on court appeal.

[15.] Iowa—Elected or appointed officials may choose to have their compensation based on their weekly earnings or receive compensation equal to 140% of state AWW.

[16.] Iowa—Minimum weekly benefit amount for PP, PT, or death is 35% of state AWW.

[17.] Kentucky—80% of AWW during rehabilitation.

[18.] Louisiana—TT payable until physical condition of the claimant has resolved itself to the point that a reasonable, reliable determination of extent of the disability of claimant may be made and claimant's physical condition has improved to the point that continued, regular treatment by a physician is not required.

[19.] Massachusetts—Maximum limited by weeks of eligibility rather than dollar amounts.

[20.] Massachusetts—If no benefits are paid prior to final decision of claim, award is based on benefits in effect at time of decision instead of date of injury. Eligibility for supplementary benefits after 24 months, calculated on 10/1, equal to base benefit times percent increase in state AWW over state AWW at time of injury.

[21.] Michigan—PT up to 800 weeks from injury, thereafter determined in accordance with facts.

[22.] Michigan—Benefits reduced if eligible for Social Security and benefits are not being coordinated.

[23.] Minnesota—Employee's AWW if less.

[24.] Minnesota—With exception for approved retraining.

[25.] Minnesota—Different provisions apply to injuries prior to 10/1/95. For injuries occurring on or after 10/1/13, no adjustment increase shall exceed 3% a year. If the adjustment under the formula of this section would exceed 3%, the increase shall be 3%. No adjustment under this section shall be less than 0%.

[26.] Mississippi—Lump sum awarded in special cases, equal to present value of future payments.

[27.] Mississippi—Except in cases of partial disability.

[28.] Missouri—Compensation increased 15% if the injury is caused by the employer's failure to comply with any Missouri statute or order of the Division of Workers' Compensation or the Labor and Industrial Relations Commission. Compensation decreased by 25% to 50% if the injury is caused by the failure of the employee to use safety devices provided by the employer, or from the employee's failure to obey any reasonable rule adopted by the employer for the safety of employees. Compensation decreased by 50% if the injury was sustained in conjunction with the use of alcohol or nonprescribed controlled drugs in violation of employer's rule or policy prohibiting their use in the workplace. Compensation is forfeited if the use of alcohol or nonprescribed controlled drugs in violation of the employer's rule or policy is the proximate cause of the injury. Compensation is forfeited if the employee refuses to take a test for alcohol or a nonprescribed controlled substance if the employer had sufficient cause to suspect use of alcohol or a nonprescribed controlled substance by the employee, or if the employer's policy clearly authorizes post-injury testing.

[29.] Nebraska—Injuries caused by employee's intoxication or willful negligence are not compensable, unless covered by willful and unprovoked physical aggression by a co-employee, officer, or director. Lump-sum settlements may be discounted to present value upon the basis of interest calculated at 5% per annum with annual rests.

[30.] Nevada—Injuries caused by the employee's willful intention to injure himself or herself or another or proximately caused by the employee's intoxication or use of a nonprescribed controlled substance are not compensable. The intoxication/controlled substance is presumed to be the proximate cause, but the injured worker has the burden of rebutting the presumption. NRS 616C.230.

[31.] Nevada—The date of a person's injury established all benefits, including his or her average monthly wage (the Nevada Legislature, on occasion, has provided an increase in benefits for permanent total disability; see NRS 616C.453 et seq.). So, the injured worker's date of injury determines the maximum temporary total disability award he or she would receive throughout the life of his or her claim.

[32.] New Hampshire—Any claimant who holds two jobs concurrently shall have his or her AWW computed from the two salaries, but not to exceed 100% of after-tax earnings.

[33.] New Hampshire—If AWW is 30% or less of state AWW, employee is compensated at a rate equal to his or her AWW, but not to exceed 90% of employee's after-tax earnings.

[34.] New York—$500 effective for accidents and disabilities occurring on and after 7/1/07; $550 effective for accidents and disabilities occurring on and after 7/1/08; $600 effective for accidents and disabilities occurring on and after 7/1/09; two-thirds of the New York state AWW effective for accidents and disabilities occurring on and after 7/1/10; adjusted each 7/1 thereafter to remain at two-thirds of the New York state AWW.

[35.] North Dakota—TP benefits in addition to TT benefits; total seven years.

[36.] North Dakota—Offset for retirement may not exceed 40% of weekly Social Security benefit. Offset for disability may not exceed 50% of weekly Social Security benefit. If eligible to receive supplemental benefits, claimant may receive minimum of $599 per week.

[37.] Ohio—Maximum PT rate is $66^2/_3$% of state AWW unless claimant receives Social Security, which, combined with PT, brings maximum up to 100% of the state AWW.

[38.] Ohio—After 200 weeks, claimant examined to determine if disability is permanent. Claimant who receives an initial award of 90 days' TT compensation will be required to be examined by bureau to determine continued eligibility for compensation, rehabilitation, and medical treatment.

[39.] Rhode Island—Total award (TT and payments to dependents) may not exceed 80% of AWW.

[40.] Rhode Island—No compensation for TP if worker is earning pre-injury wages. Lump-sum benefits available after benefits have been received for six months. Dependency allowance may be increased if number of dependents increases during time employee is receiving weekly benefits. Medical review is required 26 weeks from date of compensable injury.

[41.] South Carolina—Person who is paraplegic, quadriplegic, or has suffered brain damage shall receive PT benefits for life. Commission may not order lump-sum payment in such cases.

[42.] Tennessee—Weekly rate applies to PP/PT; paid from date injury is determined to be permanent. TT/TP benefits raise cap on weekly compensation rates to 110% of state AWW for TTD only.

[43.] Texas—For injuries that occurred before 9/1/15, TTD compensation ratio is 75% if earning less than $8.50 per hour for first 26 weeks; 70% thereafter. For injuries that occurred on or after 9/1/15, TTD compensation ratio is 75% if earning less than $10 per hour for first 26 weeks; 70% thereafter. PP compensation rate as follows: for Impairment Income Benefits—70% and for Supplemental Income Benefits—80% of the difference between 80% of a claimant's pre- and post-injury wages.

[44.] Texas—On and after 10/1/06, state AWW will be 88% of AWW in covered employment as determined by the Texas Workforce Commission. By rule, commissioner may increase this percentage up to 100%.

[45.] Texas—For life in cases of amputation or paralysis of two limbs, loss of vision in both eyes, third-degree burns over 40% of body and requiring skin grafts, or permanent insanity or imbecility at rate of 75% of AWW. PT benefits (lifetime income benefits) are increased 3% annually.

[46.] Utah—For injuries before 7/1/94, PT owed after 312 weeks is payable from Employers' Reinsurance Fund; minimum is 36% of state AWW adjusted annually. Employers/carriers have lifetime responsibility for PT occurring after 7/1/94.

[47.] Utah—Compensation provided by Workers' Compensation Act reduced 15% if injury caused by willful failure of employee to use safety devices when

## Notes, cont.

provided by employer or to obey any order or reasonable rule adopted by employer for the safety of the employee. Disability compensation may not be awarded under the Utah Workers' Compensation or Occupational Disease Acts when major contributing cause of employee's injury is use of illegal substances, intentional abuse of prescribed drugs, or intoxication from alcohol with a blood or breath alcohol concentration of 0.08 or greater. If the use of illegal substances is not found to be the major contributing cause of the injury, disability benefits may be reduced by 15% if the use of illegal substances is found to contribute to the cause of the injury. The presumption established by use of illegal substances may be rebutted by evidence.

[48.] Vermont—Prior to terminating TT payments, employer must notify employee who has not successfully returned to work (unless employee successfully returns to suitable employment) and the commissioner. Notice of payment discontinuation must include date, documented reason for discontinuation, and supporting evidence. PT benefits payable at least 330 weeks, after temporary disability benefits cease. After 330 weeks, PT benefits continue while there is lost earning capacity.

[49.] Virginia—Recipient of Social Security may be eligible for cost-of-living increases.

[50.] Washington—After 7/1/08, minimum benefits are 15% of state average monthly wage, plus $10 if married, plus $10 for each dependent up to five dependents. However, if this amount is more than 100% of worker's gross wages, the monthly minimum is 100% of the gross wages or the monthly minimum amount effective through 7/1/08, whichever is greater.

[51.] West Virginia—All awards with dates of injury before 5/12/95, and awarded before 7/1/03, until death. If date of injury is on or after 5/12/95, and award is before 7/1/03, until claimant attains the age necessary to receive federal old-age retirement benefits under the Social Security Act. All awards made on or after 7/1/03, until claimant attains age 70, regardless of date of injury. Rate adjustment not applicable for any PT award made on or after 7/1/03; PT awards made prior to 7/1/03 are frozen at the 6/30/03 benefit rate.

[52.] West Virginia—Employees of the state or any of its subdivisions may not simultaneously receive temporary workers' compensation benefits and sick/vacation pay.

[53.] Wyoming—Benefits paid monthly, maximum is state average monthly wage, which changes quarterly. Worker's benefits are capped by state average monthly wage at time of injury. PT benefits are based on a percentage of the worker's actual monthly earnings, not to exceed state monthly average wage. Minimum amount for TT disability benefits of 30% of the statewide average wage, but not to exceed 100% of actual monthly earnings at time of injury.

[54.] Wyoming—PT benefits are awarded for 80 months. Extensions must be filed yearly and are approved by the division.

[55.] Virgin Islands—During vocational rehabilitation, income benefits are 75% of AWW, maximum state AWW, minimum $75 or actual wage if less.

[56.] FECA—Election required if benefits from Civil Service Retirement and Disability Fund (CSRA) or Federal Employees' Retirement System (FERS) are payable. In addition, individuals who receive Social Security benefits due to federal service are subject to offset.

[57.] Longshore Act—Effective 9/29/84. Nonappropriated Fund Instrumentalities Act employees subject to same maximum and minimum weekly rates as employees covered under Longshore Act.

[58.] Longshore Act—Minimum weekly payment does not apply to Defense Base Act 42 USC 1652 (a).

[59.] Alberta—There is no cap on weekly compensation rates for workers with dates of accident on or after 9/1/18. While there is no limit on insurable earnings used for the calculation of a worker's benefits, there is a limit on assessable earnings per worker used in the calculation of an employer's assessment. The 2020 maximum assessable earnings level is set at $98,700. Business owners may purchase personal coverage up to the same maximum as assessable earnings ($98,700 for 2020).

[60.] British Columbia—Based on $87,100 as of 1/1/20, maximum wage (RS&CM 69.00).

[61.] British Columbia—TT and TP benefits are payable until the later of age 65 or date of retirement, as determined by the board, for workers younger than 63 on the date of injury. For workers 63 or older on the date of injury, benefits are paid until the later of two years after the date of injury or the date of retirement [§201(1), Act]. Benefits for PT disabilities are payable until the later of age 65 or the date of retirement per RSCM policy #37.00.

[62.] British Columbia—Weekly benefits are based on 90% of net earnings minus CPP, employment insurance, and income tax deductions [§§220 and 221, Act]. If net average earnings are less than the minimum weekly level of benefits, 100% of the net average earnings are less than the minimum weekly level of benefits, 100% of the net average earnings will be paid without deductions [§191, Act].

[63.] Manitoba—Net average earnings minus probable deductions for income tax, CPP contributions, and employment insurance premiums. The tax-free status of Workers Compensation Board benefits is also considered.

[64.] Manitoba—For workers with mandatory coverage, there is no ceiling or cap on insurable earnings for accidents occurring after 12/31/05. While there is no limit on insurable earnings used for the calculation of a worker's benefits, there is a limit on assessable earnings per worker used in the calculation of an employer's assessment. The 2020 maximum assessable earnings level is set at $127,000. Business owners may purchase personal coverage. In 2020, the policy limit is $513,990.

[65.] Manitoba—Injured workers earning less than minimum annual earnings will receive wage-loss benefits based on 100% of net average earnings. Since 10/1/19, the minimum annual earnings level is set at $24,232. Workers who earn slightly above $24,232 will have their wage-loss benefits based on the higher of 90% of worker's actual net average earnings or 100% of net average earnings based on a minimum wage income level ($24,232).

[66.] Manitoba—Injured workers who are 61 years of age or older at time of injury are eligible to receive wage-loss benefits until they are fit to return to work or 48 months, whichever comes first. This applies to accidents after 12/31/05.

[67.] New Brunswick—For single worker; $832.31 if married.

[68.] New Brunswick—If 63 or older at time of injury, two years of benefits.

[69.] New Brunswick—CPI calculated based on Statistics Canada information from July to June of each year.

[70.] Newfoundland and Labrador—If worker is 63 or older at the time of injury, maximum time for benefits is two years.

[71.] Nova Scotia—TD Code 1.

[72.] Nova Scotia—Until loss of earnings ends, no longer resulting from injury, or worker reaches age 65.

[73.] Ontario—Net average earnings are gross wages minus probable income taxes, CPP/QPP premiums, and unemployment insurance premiums. Lower figure if single, higher figure if married with one child.

[74.] Ontario—The amount of the payment for loss of earnings is 85% of the difference between the worker's net average earnings before the injury and the net average earnings that the worker earns or is able to earn in suitable and available employment or business after the injury. However, the minimum amount for full loss of earnings is the lesser of $17,559.88 or the worker's net average earnings before the injury.

[75.] Ontario—CPI paid on full loss of earnings benefits. CPI paid on partial loss of earnings are indexed according to 50% of CPI—1%, not less than 0%, not more than 4%.

[76.] Québec—Gross income less federal and provincial income tax net of credits established in relation to family situation of worker, unemployment insurance and Québec Pension Plan premiums, and contributions to Québec Parental Insurance Plan.

[77.] Québec—Income replacement indemnity is reduced by 25% at age 65, 50% at age 66, and by 75% at age 67.

[78.] Saskatchewan—The maximum wage rate is $1,709.73 (in 2020) for workers injured on or after 1/1/14. Workers are paid the 90% net amount, which is $1,538.76 minus probable income tax, employment insurance and CPP deduction amounts (in 2020).

[79.] Saskatchewan—Minimum compensation is either $690.80 per week (as of 1/1/20) or the deceased worker's average earnings, whichever is less.

[80.] Saskatchewan—Up to 63 or older at time of injury, two years of benefits.

[81.] Yukon Territory—Injured workers earning equal to or less than the minimum compensation amount will receive 100% of their weekly loss of earnings. If earnings are more than the minimum compensation amount, an injured worker will receive 75% of his or her weekly gross earnings or the minimum compensation amount, whichever is greater. The determination of PT disability will be made after a functional capacity assessment.

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# MENTAL STRESS CAUSING MENTAL DISABILITY UNDER WORKERS' COMPENSATION LAWS: A SHORT HISTORY, THE COMPETING ARGUMENTS, AND A 2021 INVENTORY

***92 I. INTRODUCTION**

The law of mental stress causing mental disability, and its compensability under workers' compensation (the law of the "mental-mentals"), has ***93** been the subject of considerable study.[1] The topic is treated in encyclopedias published for lawyers, most famously in the multi-volume treatise originally authored by Arthur Larson, and now carefully updated on the subject.[2] And, when mental-mentals constituted a crisis area of workers' compensation, the academic law journals were full of pro and con analyses of whether coverage of such claims was proper and, if so, under what conditions.[3] Such analyses can still be found in the present day.[4]

This article examines anew this still controversial aspect of workers' compensation. It does so in a period when, after several decades during which many states withdrew or limited coverage, legislatures are enacting or considering presumption and other laws to ease the ability of first responders (police, fire, and emergency medical professionals) to secure coverage for mental injury and disability, particularly Post-Traumatic Stress Disorder (PTSD). The present day is also marked by a seeming parallel trend: at least some state courts are reading their traditional laws in the mental-mental area liberally, so as to award compensation to such traumatized workers.[5] Finally, this examination of laws is undertaken in the aftermath of successive Middle East wars, which generated an epidemic of mental illness and suicide among soldiers, a phenomenon which raised awareness about PTSD and which only now is being fully analyzed.[6]

***94** This article features tables in which the laws of the state and federal programs are identified and specifically referenced by statute and/or important case law. The first table is an unabridged recounting of the mental-mental laws;[7] the second identifies the special first responder laws which have been enacted, or which are being considered;[8] and the third details the statutory features of the first responder laws that have been enacted as of December 28, 2020.[9]

An introduction to the law in this area requires a definition of the term *mental-mental*. In these claims, the injured worker has experienced purely mental stress and thereafter sustains a purely mental disability. An example is the bank teller faced with deadlines and mandatory overtime, without additional pay, who develops depression, agoraphobia, and panic attacks and, as a result, is unable to work.[10] Notably, while this mental-mental terminology may sound like an insensitive reductionism of a serious malady (this writer would not use the phrase in the presence of a distressed worker), the term is used by courts in published decisions[11] and by legislatures in statutes,[12] and has taken hold universally.

More importantly, the mental-mental phrase, likely coined by Arthur Larson, is intended to set off such claims from two less controversial categories of mental injury. These are the "physical-mentals" and the "mental-physicals." A physical-mental is typified by the worker who sustains a violent trauma to the body and is physically injured, but who is left, in the aftermath, with anxiety and depression.[13] A mental-physical, meanwhile, is typified by a worker who develops stress at work (for example, an encounter with a menacing supervisor) and who, in the aftermath, is left with a physical injury (for example, a heart attack).[14] These types of injuries are universally held compensable as long as medical causation is established.[15]

***95** These three categories are crucial to the understanding of how mental injuries are treated by workers' compensation laws. With few exceptions, state laws place a *heightened burden* of causation ("abnormal working conditions" or the like) on the mental-mental cases, or even *preclude* them. In contrast, state laws freely accommodate the compensability of the physical-mentals and mental-physicals.

The subject of this article is the mental-mental cases but, as will be seen, on occasion lawyers and/or courts blur the distinction.[16] Fortunately for the legal analyst, most courts have created impressive bright lines between the categories.

An introduction also requires appreciation of two phenomena that have attended the recognition of mental-mental injuries, a recognition that in itself has only widely existed since the 1970s. First is the majority rule that, if a workers' compensation statute will not allow, as a matter of law, a claim for mental stress causing mental disability, then presumably a negligence suit against the employer by the worker (typically based on a theory of failure to provide a safe workplace) will be cognizable.[17] Second is the majority, if not universal, rule that a worker who has completely imagined his or her workplace stress will possess no cognizable claim;[18] as the Larson treatise correctly declares, claims based on misperceived stress, though originally recognized by a few courts, "have not fared well."[19]

With these introductory items in mind, this article first provides an historical account of how mental injuries have been addressed in workers' compensation laws. This article then sets forth the arguments, pro and con, with regard to compensability. Thereafter, this article, addressing the first of the tables, discusses the laws among the states on the subject of mental-mental injuries. In that discussion, a discrete examination of each jurisdiction's laws is necessarily not undertaken (the current Larson treatise "digest," which admirably undertakes this feat, runs to 275 pages), but the discussion sets forth key statutory features and details how lawyers and judges have approached and interpreted them. That discussion is followed by an analysis of the first responder PTSD laws, which constitutes the emerging development in this area. That analysis addresses the tables of the second and third appendices. This article concludes with ***96** recommendations for how mental-mental cases are best treated under workers' compensation laws.

## II. A SHORT HISTORY OF THE MENTAL-MENTAL CLAIM

### A. *The Emergence of Mental-Mental Claims*

The mental-mental injury, and the popularization of the three-part categorization to which it gave rise, are phenomena that had their genesis in the 1980s. The workers' compensation literature is unanimous on this point. Donald DeCarlo and Martin Minkowitz, writing in 1989, stated that, between 1980 and 1988, such claims more than doubled. Claims for mental disability "were nearly unheard of ten years ago and nonexistent in most states five years ago."[20] The Larson treatise, meanwhile, features an entire subsection addressing the "upsurge of stress claims" during this period.[21] In California, a state which experienced a litigation explosion in this realm, the number of stress injury claims rose from 1,282 in 1980 to 6,812 in 1986.[22]

The idea that the rise of mental-mentals is a 1980s phenomenon is well apparent. One only need examine the 1972 National Commission Report to see that the issue of mental-mental claims was not only a non-issue a decade before but an item that is completely unremarked upon. The Report--relevantly--calls for "broad coverage ... of work-related injuries and diseases," but the mental-mental claims were not on the Commission's radar.[23]

In any event, the phenomenon, at the time, was treated as a crisis, because of vast potential workers' compensation liability on the part of employers and carriers.[24] Donald DeCarlo and Deborah Gruenfeld, writing in 1989, remarked that stress claims were typically twice as expensive as traditional claims, and "once the word gets out [about the compensability of mental-mentals] ..., the workers compensation and insurance industries could face claims of unprecedented magnitude ...."[25]

***97** As will be seen, a pattern of many courts liberally allowing such claims, even those based upon purely subjectively perceived stress, eventually gave rise, a decade or so later, to a striking "swinging of the pendulum." Legislatures (West Virginia, for example) and courts (Pennsylvania, for example) began to prohibit, or limit the compensability of, mental-mental claims. This rise and reaction are discussed below.

### B. *A Retrospective: The Prior Thinking and Cases Before the 1970s*

It is first important to consider, however, that the issue of the purely mental stress-induced impairment and disability had long been recognized. What is now called a "conversion reaction," unfolding in the wake of injury, and causing psychosomatic symptoms,[26] is addressed in both workers' compensation treatises and occupational injury texts from well before World War II. These were called "traumatic neuroses" (a now-discarded term) and typically followed a physical injury.

**C.** ***An Early View of the Law***

The treatise writer Arthur Honnold, writing in 1917, cites multiple cases from England and the U.S. states where a sudden *physical* injury was attended by a shock or fright, which in turn led to a conversion reaction (impairment or disability with no objective findings). The book endorses compensability of such cases--at least when authentic.

Under the Honnold rule, however, even a purely *mental* shock arising out of employment can be compensable. The lead example from the text is of a worker who develops "nervous shock, producing neurasthenia and incapacity, received by a workman while assisting [the rescue of] an injured fellow workman." He adds that the "possibility of witnessing some shocking injury to a fellow workman and receiving a nervous shock therefrom is a risk of any employment. Such nervous shock arises out of and is incidental to the employment, and is compensable if it definitely causes the injury ...."[27]

**D.** ***An Early View of the Diagnosis***

Meanwhile, the occupational medicine expert Henry H. Kessler, MD, writing in 1932, devoted an entire subchapter to such "traumatic neuroses."[28] Like Honnold, he was aware of mental stress developing exclusively from ***98** shock, and he, too, included them with other traumatic neuroses. Notably, he had sympathy for authentic cases (though he termed the subjects' mental and/or physical make-up "below par"[29]) and was not averse to compensation for the unfortunate victims of such a disabling phenomenon. He notes, in this regard, a credible account of a worker moving a co-worker's dead body; though the worker himself was unharmed, the next day his hand was paralyzed.[30]

Kessler also identified what Larson, in an entire subchapter, terms *compensation neurosis*[31]--that is, a worker who has a *bona fide* injury but who, because of the promise, or receipt of, weekly workers' compensation, authentically believes himself to be continually physically or mentally afflicted. "The constitutional make-up" of such patients, Kessler further explained, "may be such as to predispose the injured to such a psychopathic condition, and in the very nature of the case the desire for compensation is awakened following trauma."[32] Kessler added, sarcastically, that many such patients recover after a settlement is reached, referring to such resolutions as the "gold treatment."[33] While such callous assertions may seem unsurprising for the day, a further editorial remark is jarring: "During the World War, hospitals were filled with patients suffering from apparent traumatic neuroses in a different setting, but no hospitals were needed for the prisoners of war who knew they were out of danger."[34]

While a few mental-mental cases can thus be found in the older literature, most mental disability and conversion cases involved a *physical* stimulus. These older cases are of interest, however, because one can perceive in the attitudes of pivotal writers such as Kessler that mental illness and claims based on the same were looked upon with suspicion. That suspicion, and a more general frustration that the true causation of mental problems is impossible to determine, endure to the present day and have shaped the law.

***99** A key admonition of Kessler, an icon of the prior thinking, also defines much *current* thinking: "To define the exact causation of the neuroses in general would be equivalent to solving the riddle of human behavior."[35]

**E.** ***Traumatic Neuroses Cases Before the 1970s***

We know from the Honnold and Kessler treatises that at least some form of mental-mentals has long been appreciated in law and medicine. They were, however, invariably limited to a sudden fright or shock as the mental cause. Courts could award benefits in such situations because the sudden and unexpected nature of the event could be conceived of as the type of "accident" that workers' compensation was intended to compensate. (That term and concept endures in most states, though typically interpreted liberally.) Of course, the idea of awarding benefits for *gradual* stress would have been thought absurd.

Throughout the decades before the 1970s, courts in many cases continued to award benefits in fright or shock cases. These cases are significant as they typically justified their holdings by explaining, over employer resistance, that an injury or accidental injury cannot reasonably be limited to one's flesh and bones. Later courts were influenced by this logic. Four such cases, long characterized as landmarks, belong in this category.

In a 1944 Virginia case, a factory worker who suffered a mental shock from being surprised by an electric flash at a nearby machine developed an immediate traumatic neurosis. Her affliction, counterintuitively, was characterized by fainting at the sight of the worker who had originally *come to her aid*. True, claimant was not physically injured, but her disabling malady was held to be an injury under the Virginia Act. In this regard (as in many of these landmarks), all physicians confirmed causal connection. And, pivotally, "her incapacity was as effectual as if it had been caused by visible lesion."[36]

In a 1953 New Jersey case, meanwhile, a maintenance worker who suffered an emotional shock from a violently exploding boiler pipe, which incident resulted in the death of his supervisor, caused him to develop a "severe state of psychoneurosis." This disabling condition was held to be an injury under the New Jersey Act. The court declared, "There is nothing in the law to exclude from the import of this term such injuries as result from non-physical, that is, psychic, trauma."[37]

In 1954, the Florida Supreme Court considered such a case. There, a hospital typist, apparently shocked when lightning struck the hospital, developing ***100** chest pain and other maladies, not objectively verifiable, was held to have sustained an injury. While the compensation judge had required a "visible injury," thus dismissing her case, that requirement was error. In this regard, the pivotal Florida term "trauma" was to be defined by consulting *Webster's*: "injury, wound, shock, or the resulting condition of neuroses." Reversing the trial judge, and awarding benefits, the court declared, "We find no definition which limits the word to a *visible* injury."[38]

In a 1955 Texas case, finally, the claimant was a skilled ironworker who, in a calamitous accident, observed his co-worker fall to his death in a scaffold collapse, nearly perishing himself during the event. He thereafter developed anxiety and depression, which disabled him from his job. The Texas Supreme Court determined that claimant had sustained a compensable injury, and this was so even though the statute read, as to the definition of injury, "damage or harm to the physical structure of the body."[39] As to this tension, the court remarked:

> The substance of all of the testimony shows agreement that plaintiff's body no longer functions properly. Now, can we say that, as a matter of law, even though a "physical structure" no longer functions properly, it has suffered no "harm"? What meaning can the word "harm" to the body have if not that, as a result of the event or condition in question, the body has ceased to function properly?[40]

With this thought in mind, the court stated, "Even though an accident may not produce an anatomical pathology, nevertheless if the workman does in fact become disabled as a result of that accident, the injury is compensable, although such disability may be the result of hysteria--and may be traceable to a mental condition and not a physical disorder."[41]

**F.** ***Mental-Mentals: Rise and Reaction***

Mental-mental cases were known to the law for decades, but it was only in the 1980s that the great surge in filings occurred. At least three forces were seemingly at work. The first was liberalized court decisions in the 1970s and early 1980s that accommodated potential recovery. The second was the socio-cultural changes of the period that caused more and more individuals to perceive disabling stress at work. Third was the sociological phenomenon that, once a diagnosis is named, and identified as compensable, individuals, with the assistance of their physicians, are more likely to pursue claims based on the same.

***101 1. Liberalized Legal Doctrine**

At least three cases, all from influential courts, are well known for having hastened the rise of the mental-mental claim. It is with these three cases that the modern legal history of the mental-mental begins.

In the 1975 decision *Wolfe v. Sibley, Lindsay & Curr Co.*,[42] the New York Court of Appeals awarded benefits in a case with jarring facts. There, the claimant was a key assistant to the security chief of a large department store. The chief became highly stressed with work and developed a fear of failure. When he finally committed suicide by gunshot, in his office, claimant was the first to discover the body. She developed not some conversion reaction but, instead, an "acute depressive reaction." The appellate division turned down the claim, ruling that mental-mentals were not compensable as a matter of law. In its view, a physical stimulus was required.

The Court of Appeals, rejecting an explicit opening-of-the floodgates argument, and featuring a dissent, which warned of significant costs in allowing such claims, reversed. Recognizing the mental-mental cause of action, the court remarked, poetically, that there is "nothing talismanic about physical impact"[43] and held:

> We hold today that psychological or nervous injury precipitated by psychic trauma is compensable to the same extent as physical injury. This determination is based on two considerations. First, as noted in the psychiatric testimony there is nothing in the nature of a stress or shock situation which ordains physical as opposed to psychological injury. The determinative factor is the particular vulnerability of an individual by virtue of his physical makeup. In a given situation one person may be susceptible to a heart attack while another may suffer a depressive reaction. In either case the result is the same--the individual is incapable of functioning properly because of an accident and should be compensated under the Workmen's Compensation Law.[44]

In the 1978 Massachusetts case, *In re Fitzgibbons*,[45] meanwhile, the Supreme Judicial Court recognized mental-mentals. It did so in a case where a corrections supervisor, who had dispatched a subordinate to an emergency, sustained a "psychotic depression," culminating in suicide, after the subordinate perished in the course of his task. As far as the Massachusetts court was concerned, "There is no valid distinction which would preclude mental or emotional stimulus caused by mental or emotional trauma from compensation."[46]

***102** In the 1982 California case, *Albertson's Inc. v. WCAB (Bradley)*,[47] finally, a California court awarded benefits in a case where a supermarket cake decorator, who suffered from significant pre-employment emotional problems, suffered a nervous breakdown. The worker in that case accused her supervisor of a series of various harassments, and she eventually went off of work. During the proceedings, the credible lay and medical evidence was that claimant had in essence imagined the harassments. Yet, the same expert testimony certified that claimant was authentic in her *imaginings*. This fact was enough for the court to award benefits:

> The proper focus of inquiry, then, is not on how much stress should be felt by an employee in his work environment, based on a "normal" reaction to it, but how much stress is felt by an individual worker reacting uniquely to the

> work environment. His perception of the circumstances (e.g., crowded deadlines, mountains of paper, a too-fast assembly line) is what ultimately determines the amount of stress he feels.[48]

The court compared this approach to the Michigan "honest perception" rule, and it identified that state as one where the courts had created a similarly permissive standard.[49]

This case led Larson to remark, "It is difficult to overstate the breadth of coverage implied by the court's holding. Compensability was judged purely on claimant's subjective perception of work stress, not objective reality."[50] As discussed below, the legislature overthrew this rule (as did the Michigan legislature), but in the intervening decade California experienced an unequalled upsurge in claims, lawyer involvement, and fractious litigation.

**2. Social Developments**

A major theme of current literature is that life in the present day is afflicted with much more stress than prevailed in an earlier day, before the rise of the service-based economy, automation, globalization, and the astonishing advances in communications that largely fueled all three. Such stress can afflict an individual both at work and in one's personal life, a fact that complicates the mental-mental claims and guarantees that, in essence, each and every such claim is subject to denial and, typically, litigation.

One writer, asserting in 2000 that the Missouri workers' compensation law should more freely cover mental-mental claims, summarized common thinking about how social developments have caused more stress at work:

> America's shift from a manufacturing industry towards a more service-oriented industry has introduced workers to divergent task requirements, ***103** atypical work environments, new technology, and an unfamiliar social setting. ... Furthermore, the likelihood that an employee remains with the same company until retirement has decreased. Instead, employee stress levels have increased with the realization that one's job is in constant jeopardy because of "plant closings, technological obsolescence, mergers and acquisitions, the replacement of people with technology, and downsizing .... Moreover, the market's demand for increased productivity has resulted in additional work-related stress because of the need for new products and services to stay viable with competitors ...."[51]

Commentators who were experiencing the rise of mental-mental claims in real time also endeavored to identify the cause of the phenomenon. DeCarlo and Minkowitz (1989) identified economic conditions (which were poor in the United States during the 1980s), increased automation, employee surveillance via monitoring, and sexual harassment perceived by female workers.[52] Larson, meanwhile, observed, "In a world of computer cubicles and global competition, stress-related disability is ... no longer a rare occurrence."[53]

DeCarlo and Gruenfeld, in *Stress in the American Workplace: Alternatives for the Working Wounded* (1989) dug deeper with their inquiry into why more and more Americans felt such stress in that era (which they referred to as a period of "plague") that workers' compensation claims were often the result. They identified the introduction of computers, increased workloads, time pressures, poor relationships with supervisors and co-workers, troublesome relationships with the public and other customers, noise pollution, and "densely-populated offices."

Meanwhile, citing a study by the National Council on Compensation Insurance (NCCI), DeCarlo and Gruenfeld also identified many white-collar workers developing anxiety over the "merger mania" of the day--and the plant closings and lay-offs that often attended that phenomenon. And, like Larson, DeCarlo and Gruenfeld identified the very nature of a service-based economy:

> In times when work involved physical output, overworked employees felt the wear and tear on their bodies. In today's world, the mental capacity of humans to absorb and digest information is being put to the test. As workloads and stressful conditions exceed our power to think, the damage is bound to be mental.[54]

***104** The two authors, in their exhaustive inquiry, also identify a stressor that was certainly one of the times--many workers' often unfounded fear of contracting AIDS in the workplace.[55]

**3. Social Factors and the Filing of Claims**

If one accepts that the 1980s were a period when Americans felt an onslaught of stress in general, and at work, and were dealing with poor economic times, the question remains as to why the workers' compensation *claims* upsurge--and a resulting crisis in many jurisdictions--unfolded. Presumably, sufferers of such stress could have simply lived with the malady, had their providers submit treatment billings to group health insurance, filed for unemployment compensation, or simply absorbed the costs.

As submitted above, the advent of case law in many jurisdictions *allowing* mental-mental cases was critical. Lawyers will not file claims unless some reasonable prospect of recovery exists. This was the striking lesson of the Pennsylvania experience. When mental-mentals were first judicially recognized, a liberal rule encouraged a torrent of claims. After the pendulum swung back, with courts enforcing the restrictive "abnormal working conditions" rule with an iron fist, the upsurge ended: now, a very organized and skilled injured workers' bar will rarely file a mental-mental claim.

DeCarlo and Minkowitz added that, during the crisis period, tort law had also been liberalized to allow recovery for personal injury in negligence cases, even in lieu of physical injury. "It would not be surprising," they remarked, "if this increased recognition of mental injury in tort would also spill over into workers compensation, which, after all, replaces the employee's tort remedy against an employer for injuries arising out of employment."[56] DeCarlo and Minkowitz also identified the familiar phenomenon that, in general, lay-offs, common at the time, result in an upsurge in claim filing. Finally, they identified as a cause for the upsurge publicity surrounding the awarding of mental-mental claims:

> It has often been suggested that highly publicized workers compensation recoveries spur similar claims. This may be especially important in mental stress claims because of the universality of mental stress .... [M]ost workers can identify with an employee experiencing mental stress from such job pressures as a change in duties or a conflict with supervisors.[57]

DeCarlo and Gruenfeld, interestingly, suspected that many mental-mental claims of the period had their genesis in stressed-out workers ***105** simply wanting a good old-fashioned "pound of flesh." In a stressful, unfair society, "an overwhelming sense of powerlessness" exists. As a result:

> Society feels duped by the rule makers and is out for revenge. People are turning to lawsuits in an attempt to claim what they feel is rightfully theirs ....

> The victims of stress are finding their niche in this litigious society. Protesting excessive job pressures, harassment, and unpalatable supervisory conduct, the working wounded are queueing up to receive compensation for their troubles.[58]

In some jurisdictions, the lawyer community contributed significantly to the increase in mental-mental filings and consequent litigation. In California, the temptations of the *Albertson's* case (which held that even imagined stress was compensable) was apparently too much for certain attorneys to resist. Many lawyers advertised the recoverability of stress claims and/or unethically solicited workers to file for workers' compensation based on contrived allegations of stress.[59] When the final pro-business reform came, the governor remarked, alluding to lawyers and their associated doctors, "these reforms crack down on those who are defrauding the system. This legislation marks the beginning of the end for the stress-mill millionaires."[60]

**4. Experts, Social Factors, and Moral Hazard**

The rise in filings of mental-mental claims could never have unfolded without psychiatrists and psychologists validating work-stress induced diagnoses, and by thereafter providing expert reports and testimony. Workers' compensation systems, it has been correctly observed, ultimately look to physicians as the "gatekeeper[s], whose pronouncements about occupational causality affect subsequent actions by workers, employers, insurers, and public health officials." Disputes over causation "are generally resolved in the court of medical opinion, with physicians acting as experts on both sides of the issue." And social factors are involved in leading doctors to acknowledge particular ailments as work-related. Determination of work causation "is not merely a matter of gathering and interpreting empirical evidence but rather a complex social phenomenon."[61]

***106** Mental health professionals, during the rise of claim filings, supported workers' claims, certifying, no doubt in most cases correctly, that injured workers' mental-mental claims were valid. But plainly social factors were at play in validating such diagnoses and their assignment as work-related.

Allard Dembe, M.D., in *Occupation and Disease: How Social Factors Affect the Conception of Work-Related Disorders* (1996), asserts persuasively that social factors are relevant for understanding how occupational disorders are initially recognized and conceived. Virtually all of his principal points are pertinent in the expert-supported 1980s rise of the mental-mentals.

He notes, for example, that new technologies, and the reaction to the same by various societal groups, can lead to the increased reporting and diagnosis of occupational disorders. Meanwhile, legal decisions establishing financial compensation can bring increased attention to the question of whether or not a disorder is work-related. Further, occupational disorders are apt to be initially recognized during periods of economic instability and job loss, and attention by the national mass media to a particular workplace disorder can heighten medical awareness of the problem. Finally, medical attitudes arising in the course of military conflicts can influence the way that occupational disorders are subsequently studied and understood.[62]

Another social factor that was at work in the upsurge of claims filing was simple moral hazard, that is, the potential availability of workers' compensation. Once the courts accommodated such recoveries in terms of *legal* causation, and psychiatrists and psychologists were available to verify *medical* causation, the door was open to such claims' filing. It is likely that many mental disabilities depicted as having their genesis in work stress would never have manifested themselves in the first place if not for the presence of insurance. Mandatory insurance schemes like those of motor vehicle law and workers' compensation are known to create illnesses, drive treatment, and breed litigation.[63]

**5. Rise and Reaction in Four Select States**

As demonstrated by the table in Appendix 1, seventeen states now feature exclusions of mental-mental cases, most by statute. Several other states have provisos that specially *burden* recovery in such claims. These exclusionary and restrictive provisos were reactions to the pattern of liberalized case law, perceptions of increased worker stress, and the consequent increase in claims filings which have been discussed above. The "California ***107** story" was-- and remains--the most prominent of these episodes, but the rise and response has been well-documented in a number of jurisdictions.

*Arkansas*. The Arkansas legislature abolished mental-mental compensability as part the major 1993 amendments to the Act. Mental injuries had been "generous[ly]" compensated by the Arkansas Commission and courts.[64] The court in the case that recognized mental-mentals, notably, remarked, "We can conceive of no reason why harm to the body of a worker should be limited to visible physical injury to the bones and muscles and should exclude work-related trauma which results in an injury to the mind. We hold that that such psychological injuries may be compensable under our Act."[65]

The law did require, as part of the claim, a showing that "more than ordinary day-to-day stress to which all workers [were] subjected." Thus, in the decision quoted above, a delivery driver who had fallen behind in her deliveries and sustained a nervous breakdown was *denied* benefits.

Despite this elevated burden, compensability of such claims did not survive a reform effort that had its genesis in perceptions of system-wide fraud, premium rates which had increased 72.3% between 1987 and 1992, and the "expansion" of the law by administrative law judges (ALJs), the Commission, and the courts.[66] A critic at the time decried this complete abolition of the mental-mental claim, lamenting that Arkansas had "deserted" what Larson had described as the "impressive majority" approach.[67]

*West Virginia*. The West Virginia legislature, in a scenario similar to that of Arkansas, disallowed mental-mentals in a 1993 reform.[68] The Supreme Court had, in 1981, recognized mental-mental cases in a case where a grocery store worker had alleged a series of harassing comments and acts by a supervisor.[69] Later, after complaints of claim and litigation abuse, the legislature eliminated such claims, overturning the leading case and declaring, ***108** explicitly, "It is the purpose of this section to clarify that so-called mental-mental claims are not compensable under this chapter."[70]

*Pennsylvania.* The Pennsylvania legislature, in 1972, eliminated the restrictive "accident" requirement and replaced that concept with the term *injury*. In so doing, Pennsylvania was responding to the National Commission recommendation that the accident terminology be jettisoned and that, instead, "broad coverage of work-related injuries and diseases" be afforded. The courts have, since then, afforded a liberal interpretation to the term *injury*.[71]

One occasion for liberal interpretation was the Commonwealth Court's 1979 recognition of purely mental-mental cases. There, a University of Pittsburgh physician and the head of a major clinic developed a stress-induced psychosis and ultimately committed suicide.[72] The employer opposed the claim, asserting that, despite the elimination of the accident requirement, "the term 'injury' [should be] confined to the occurrence of physical harm to the body."[73] The court, rejecting this assertion and affirming an award to the widow, quoted at length the influential comment of the Larson treatise: "[T]here is no really valid distinction between physical and 'nervous' injury. Certainly[,] modern medical opinion would support this view, and insists that it is no longer realistic to draw a line between what is 'nervous' and what is 'physical.'"[74]

This ruling was perceived by some as heralding an era of wide-open compensability of mental-mental cases. And, indeed, many were filed. In a remarkable development, however, several judges of the Commonwealth Court (a middle-level appeals court) came to question whether such claims should be freely cognizable. This cynicism was exacerbated after one panel of the court, in 1984, granted benefits in what came to be known derisively as the "Peter Principle" case.[75] There, an employee suffered a disabling mental illness as a result of the stress involved in his promotion from manual ***109** tasks to a management job.

The court held, in that case, that he had sustained a compensable mental-mental injury. The mental stress cynics at the court, in the face of that case, thereafter started to resist the idea that routine promotions, demotions, and lay-offs should form the basis of workers' compensation claims.

This concern, and the worry that Pennsylvania would experience a California-style mental-mental litigation crisis, soon won the day.[76] In a series of rulings, the pendulum swung dramatically, and the court soon generated a series of rules that significantly burdened mental-mental claims.[77] Now, stress cannot be a subjective reaction to normal working conditions and, to the contrary, must be an objective reaction to abnormal working conditions--with the point of reference the stresses of similarly situated workers.

The Supreme Court was soon to ratify this doctrine,[78] and the Commonwealth Court in turn enforced the "abnormal working conditions" rule with the proverbial iron fist. If the stressor was foreseeable, given the type of occupation involved, it could not be deemed abnormal.[79] This rule was (and remains) particularly burdensome on police and corrections officers, who generally must be ready for virtually any stressful circumstance.[80]

Pennsylvania does not exclude mental-mental claims, but the effort of the Commonwealth Court to avoid a California-style crisis worked. One modern critic has correctly remarked that "Pennsylvania's approach ... effectively close[d] the floodgates before they [could] open ...."[81] While the Supreme Court, in a surprising 2013 case, lightened the worker's burden somewhat,[82] it is still correct that "the abnormal working conditions ***110** rule and the specificity of medical evidence linking the injury to work-related causes continues to be prohibitive of most claims of mental injury caused by mental stimuli."[83]

*California*. The experience of California with the rise of mental-mentals had such notoriety that Larson devotes an entire subsection to it, called the "California Story."[84] In the wake of the *Albertson's* case, noted above, mental-mentals became very popular. Claim filings increased dramatically. Stress claims in the state went from 1,282 in 1980 to 4,236 in 1984 to 6,812 in 1986.[85] By 1992, the volume was still increasing to the low double-digits.[86] A contemporary account, which characterizes *Albertson's* having "good intentions but unintended results," states that the "floodgates" really did open.[87] These claims were said to be especially onerous for business, as the cost of defending and resolving them was "typically much higher than for 'old-fashioned' physical claims."[88]

By several accounts, the upsurge in claims was caused, or at least attended by, overreaching and outright fraud:

> Advertising by physicians and attorneys [was undertaken] which invited dissatisfied workers to file stress claims. [Such activities were often] criticized as fostering fraud. [S]ome attorneys and physicians involved in high-volume workers' compensation practice assert[ed] a stress disability for virtually every applicant. Additionally, some practitioners employ[ed] recruiters to encourage workers to file claims in order to generate medical charges for insurance billings.[89]

In one case, by report, a large restaurant closed permanently, and 115 of its 119 employees purportedly filed stress claims. According to the report, "Attorneys had stationed themselves outside the door the day of the layoffs to intercept the newly unemployed, influencing them to file these claims ...."[90]

The 1993 amendments to the law (the third of a series) tightened coverage standards by requiring (1) that the complained of stress must be based on "actual" employment conditions; (2) that the claim be proven by the preponderance of the evidence; (3) that the diagnosis must be made under the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM*); (4) that the employee

be employed for at least six months; and (5) that the claim cannot ***111** be based on a "good faith personnel action." The revised law also sharply limited the post-employment filing of claims.[91]

## III. ARGUMENTS FOR AND AGAINST COMPENSABILITY

Legislative and judicial disputes addressing under what conditions mental-mentals should be covered, if at all, by workers' compensation are now largely quiescent. The period of state legislatures taking drastic action and *completely eliminating* coverage seems to have ended. Further, though claims in California and Illinois are said to be increasing,[92] no jurisdiction seems to be experiencing any remarkable crisis of claims filing that is kindling the fires of retractive reform.

On the other hand, in the present day a trend exists for legislatures to enact special laws that will provide coverage for mental-mentals, particularly PTSD, for first responders like police officers, firefighters, and EMTs.[93] To a limited extent, accordingly, the pendulum seems to be swinging back in favor of compensability.

Also, some advocates, not surprisingly, assert that complete elimination, found in seventeen states, as noted, is unfair and that the issue of coverage should be revisited. In South Carolina, for example, the Supreme Court has derided as anachronistic the restrictive abnormal working conditions rule of that state and has called for the legislature to abandon it.[94]

It is worthy, accordingly, to revisit the arguments for and against compensability.

### A. *Arguments for Compensability and Against Exclusion*

The most compelling argument favoring compensability is that mental injuries and their causes are no longer great mysteries as they were in the past.[95] Larson, in his treatise, has long admonished that drawing a distinction between mental injuries and physical injuries is simply "unsound." A ***112** well-known dissent in a West Virginia case exemplifies this advocacy. In disagreeing that a PTSD-like reaction by a coal miner who had been traumatized, and feared for his life, was different from that of a lung injury, the dissent asserted:

> [M]odern medical science shows that traumatic stress disorders are, in fact, a physical injury. The shock of a terrifying event--like a rape, a robbery at gunpoint, or fearing death by suffocation when lost in the smoky darkness of a mine for ninety minutes--triggers chemical reactions in the brain that measurably scar and injure nerve tissue. The brain is actually, physically "rewired" and injured. To somehow suggest that the injury to the plaintiff's brain is different from the lung injury that suffocated the decedent in *Jones* [the other case] reflects a primitive, outdated view of science.[96]

This argument is likely the best as against those who would argue that workers' compensation is simply not an appropriate remedy for mental injury. If such injuries arise out of and in the course of employment, and medical cause is persuasively established, no basis exists to assert that this time-honored test of compensability has not been met.

Related to this argument is the assertion that it is simply unfair, indeed intolerable, to deny insurance benefits to a worker when all experts agree that work stress has caused impairment and disability. Such are the circumstances of many reported cases in the modern day. To the reply that the afflicted worker simply did not have the necessary mettle and true grit to withstand the emotional challenges of work, another time-honored proposition applies: that the employer should take the employee as it finds him or her.[97]

One skilled commentator, like Larson, condemns hostility to mental-mental cases as retrograde and inconsistent with the whole purpose of workers' compensation. Viewing the issue in a historical light, he remarks:

> The reluctance of most courts to extend workers' compensation coverage to injuries not traceable to a single isolated event reflected a conservatism which contrasts markedly with their stated desire to liberally construe workers' compensation statutes .... This conservatism appears to stem from a fear that to adopt a broad definition of injury would lead to a large number of cases being found compensable, thus resulting in great economic liability for employers. This is a theme repeatedly found throughout the history of workers' compensation laws in this country, and explains much of the judicial and statutory approach to stress-related disability today.[98]

***113** Proponents of a wide availability of benefits for mental-mental injuries do not deny that causation may be at issue in many cases, despite the advances of medicine and psychiatry. Many argue, however, that if causation is in question, simply let the judge or hearing officer decide the issue. "Undoubtedly," one 1980s advocate asserted, "some claimants will attempt to recover for feigned mental injuries or mental injuries unrelated to work, but it is preferable to adopt a broad rule and administer it closely than to allow the fear of overcoverage to compromise the workers' compensation system as a whole."[99] Advocates, with the same reasoning, often dismiss claims that freely allowing mental-mentals will open the floodgates. In objecting to *institution* of a restrictive abnormal working conditions rule, the dissent in a Rhode Island case declared:

> [P]rotection against abuse in the award of workers' compensation lies in the competence and good judgment of the members of the commission, an organization that through the years has performed its duties in an exemplary fashion. "In the last analysis, the problem of malingering is one of fact, which must be left to the skill and experience of medical and psychiatric experts, and of compensation administrators, who usually manage in time to develop considerable facility in detecting malingerers at the factfinding level."[100]

Many proponents of compensating mental-mentals *do perceive*, as appropriate, unusual stress as part of the worker's burden.[101] The same advocate of open compensability (quoted above), however, complains:

> A serious shortcoming of the unusual-stress test is that it is predicated on the fallacious belief that the existence of extraordinary or unusual events assures that subsequent mental injuries are genuine and work-related and on the converse belief that the absence of such events indicates that the alleged injuries are not genuine or work-related .... [But] judicial reliance on tangibility as one of the indicia of an injury's genuineness is misguided.[102]

He would again leave the question of genuineness to doctors and judges: "[A]lthough the concern over fraudulent claims is valid, professionals may be able to detect certain feigned psychoneurotic reactions more easily than some more commonly feigned physical injuries."

An intuitive argument favoring coverage of mental-mentals is that, if employers are free of liability for even *bona fide* mental-mental claims, they will not be leveraged to safety in the area of employee mental health. "The ***114** present state of affairs," one observer comments, referring to abnormal working condition requirements, "provides the employer with no incentive to work on reducing stresses that are hard to detect, or to create a more bearable or pleasant working environment."[103]

**B.** ***Arguments Against Unrestricted Compensability of Mental-Mentals***

Arguments resisting compensation of mental-mentals, and even for completely outlawing them, have often succeeded. In excluding such claims from compensation, for example, the Montana legislature included a public policy statement which remarks, "The legislature recognizes that these claims are difficult to objectively verify and that the claims have the potential to place an economic burden on the workers' compensation and occupational disease systems."[104] These two concerns, voiced unapologetically, underlie most resistance to unrestricted compensability of mental-mental claims. In a 2007 case, meanwhile, a Nevada court claimed that "stress-related injury claims are the most nebulous type of workers' compensation claim, and the most susceptible to fraud."[105]

The precise anxieties are (1) fear of compensating mental ailments that are not, in any material contributing aspect, related to work exposures; (2) fear of compensating claims which are authentic when they first manifest, but then morph into assertions of indefinite disability; and (3) fear of outright fraud.

Most agree that medical science has progressed and that psychic injuries and disabilities are better understood in the present day. Certainly no one would characterize (as in the old days) those susceptible to stress as mentally "below par." Yet, many have argued that, while physicians say that mental injury is real, the science is still weak on diagnosis and causation of the same. To declare that mental-mental injuries are equal to physical injuries may sound compelling "idealistically," but, in the end, experience shows that psychiatrists and psychologists are indeed weak on causation.[106] Notably, many have assailed the integrity of the PTSD diagnosis itself.[107] ***115** DeCarlo and Minkowitz (1989) concluded that it is "not surprising that courts are cautious" in the realm of mental-mental claims.[108]

A lawyer from the insurance industry, writing in 1984, voiced the concern as follows:

> "No method exists either to quantify or qualify the extent to which one reality and not the other is a cause of the mental disorder." ... Thus, the door is left wide open for the claimant who has filed or plans to file a workmen's compensation claim to emphasize the stresses of his workplace over the numerous other personal, social and environmental stresses which have contributed to his mental disorder. Unless the psychiatrist or psychologist has reason to believe that the claimant is not giving a full and accurate history, it is highly possible, if not probable, that he will accept the claimant's emphasis on the work stress and conclude that the disorder was primarily the result of those stresses.[109]

To blithely say that questions as to cause can simply be fought out in dispute resolution before compensation judges is not a satisfying answer to these concerns. Litigation over mental-mentals encourages individuals to stay out of work, generates discovery of the most invasive kind, and engenders hostility between employers and employees.

And, at the end of the dispute, a layperson (in most jurisdictions) will be choosing one expert another in another iteration of the "dueling doctors" situation. Notably, scholars Little, Eaton, and Smith characterize as especially acute the cynicism of such dueling-expert regimes in the context of mental injuries.[110] In this spirit, they identify the 1954 Louisiana case *Ladner v. Higgins*. There, in response to the question, "Is [it] your opinion that this man is a malingerer?," the expert responded, "I wouldn't be testifying if I didn't think so, unless I was on the other side, then it would be a post traumatic condition."[111]

Wariness of compensating mental-mentals includes a concern that, once the claim is accepted, and the worker receives treatment and disability, he or she will develop, rightly or wrongly, a sense of enduring entitlement. The precise worry is that the claim, particularly in a wage loss state, will continue indefinitely. Workers who seem to develop this picture are not, typically, malingering. A psychiatrist who testified for many decades in Pittsburgh characterized as simply *stubborn* the workers who insisted that, ***116** because of continuing anxiety, they could not return to work. Utilizing old cigarette commercial lingo, he would posit, as to such an obdurate worker, "He'd rather fight than switch."

However, some portray this aspect of mental claims as in essence reflecting fraud. An insurance analyst, commenting on the 2019 rise in requests for psychiatric independent medical examinations (IMEs), remarked that PTSD is increasingly a common condition in claims, "but often it's added later, which employers say can be attempts to prolong the claim, an industry term known as 'malingering.'" "People [a defense lawyer stated] are getting a whole lot more treatment than they used to and in my practice in Illinois a lot of the cases I see start off as legitimate and then turn into malingering, which is why IMEs are being requested as frequently as they are ...."[112]

Opponents of unrestricted mental-mental compensability warn, of course, of opening the floodgates to uncontrolled litigation. This has been a caution raised both in the past and in the present.[113] When, for example, in 2013, injured-worker advocates in South Carolina advanced a bill that would eliminate the abnormal working conditions requirement, industry made precisely this argument.[114]

While some critics dismiss such cautions as phony catastrophism masking a judicial concern over narrow economic considerations,[115] the California experience, which everyone agrees was a misfortune, was attended by the opening of floodgates. In the realm of the mental-mental debates, the concern over a cascade of filings is the one concern that seems evidence-based.

***117** Another concern over mental-mentals (connected with the causation problem) is the sense that many claimants with a purported work-induced mental disorder (like PTSD) are simply riding the wave of the current (or, in this case, ongoing) diagnosis *de jeur*, with their providers as facilitators. As discussed above, researchers have long pointed to social factors like the popularity of certain diagnoses as influencing doctors to diagnose them--and workers to suffer from them.

Defenders of heightened-burden requirements, like abnormal working conditions, emphasize that such controls work to ferret out false or weak claims, those based primarily on pre-employment maladies,[116] and ensure (by definition) that claims based merely on subjective reactions to normal work conditions will not end in a disability claim. This position seems correct to this writer. A supporter of unrestricted mental-mentals, quoted above, asserts that "judicial reliance on tangibility as one of the indicia of an injury's genuineness is misguided," but this assertion is itself misguided-- and even strange. Corroboration and plausibility are factors that any judge utilizes to estimate whether a purported harm has occurred.[117] Identification of abnormal working conditions, or some "untoward" event, helps to satisfy these inquiries.

Many are wary of unrestricted compensability of mental-mentals, particularly where PTSD is implicated. System participants have argued that PTSD is over-diagnosed and that the diagnosis itself is a construct not based on scientific evidence.[118]

The impression of this writer has been that PTSD may, indeed, be over-diagnosed in compensation cases. Indeed, this assertion has been a common charge heard throughout the community for more than twenty years. This writer has seen many cases where a treating psychiatrist or psychologist perhaps sloppily makes the diagnosis, only to have it effectively picked apart by the IME psychiatrist. This phenomenon hardly means that the claimant was not credible or worthy of compensation, but it certainly raises an eyebrow as to the validity and basic integrity of the diagnosis.

## ***118 IV. LAWS AMONG THE STATES**

### **A. *General Findings; Categorization of State Laws***

Currently, among the fifty states, thirty-three permit recovery, under various tests, for mental-mental injuries. Seventeen, meanwhile, exclude such claims. The District of Columbia, the Longshore Act, and Federal Employees' Compensation Act (FECA) also allow recovery for mental-mentals.[119] Generally, bright lines are in place.

Still, it is difficult, in this realm, to speak in absolutes. Nuance attends some state laws. Thus, in Arkansas, mental-mentals are prohibited, except when the mental stress is attended by an act of violence.[120] Thus, presumably, an employee who is robbed, kidnapped, tied up, and otherwise terrorized, with no physical injury, can establish a claim.[121] Meanwhile, in California, mental-mentals are prohibited for gradual stress experienced in the first six months of employment, but such claims may be cognizable even during this initial period of employment if they have their genesis in a "sudden and extraordinary employment condition."[122] And, of course, some of the most restrictive states, like Florida, have established carve-outs accommodating mental-mentals, particularly for PTSD, in the case of first responders.[123]

The laws of the fifty states are depicted, with statutory and case law references, in the table of Appendix 1. The laws of states introducing and enacting special laws for first responders, some featuring causation presumptions, are depicted in the tables of Appendices 2 and 3. What follows is a brief account of statutory and case law features based on these three tables.

**1. States Disallowing Mental-Mentals**

DeCarlo and Minkowitz, surveying the laws in 1989, noted that the law of mental-mentals was almost entirely in the cases; in contrast, statutes on the subject were rare.[124] The landscape is different in the present day, with fourteen states featuring statutes that exclude mental-mental claims. These jurisdictions have, in effect, cut off at the pass the compensability of such claims. As discussed, Arkansas and West Virginia are states in this category.[125] Connecticut is the unusual northeastern state that is likewise ***119** in this category. (The law has since been amended to allow for PTSD in police officers.)[126]

Notably, not all states that exclude mental-mentals do so by statute. Some undertake the prohibition by common law: these states are Georgia, Kansas, and Nebraska.[127]

A complete denial in a common law state is exemplified by a 2007 Nebraska case. There, the court denied benefits to the dependents of a state police trooper who committed suicide in response to alleged stress. He had, in this regard, detained and then released a motorist who shortly thereafter committed a murder during a robbery. The trooper's distress at contemplating that scenario led him to take his own life. Yet, as far as the court was concerned, mental-mentals are not covered either as injuries or occupational diseases under the Nebraska Act.[128]

**2. States Not Requiring Exceptional Stress**

Four states do not seem to maintain a rule that extraordinary stress is required before a mental-mental is cognizable as a matter of law. In these states, presumably, certain episodes of gradual stress may be compensable. These jurisdictions are California (with the major caveat noted above), Delaware, Hawaii, and New Jersey. The laws of the District of Columbia, the Longshore Act, and FECA also do not seem to require abnormal working conditions.

A Hawaii case illustrates the compensation of a gradual stress injury. There, a municipal employee who developed an anxiety disorder from the back and forth of what sounds like a poorly administered system of promotions and demotions was held entitled to benefits.[129] This type of claim would likely not be cognizable in jurisdictions that require unusual stress.

**3. States Requiring Abnormal Working Conditions**

A plurality of states feature a regime that precludes gradual stress and will only recognize a mental-mental when abnormal working conditions (the phrase in Pennsylvania), unusual or untoward work conditions, or the like,[130] have been proven by the injured worker.

***120** A 2018 New York case serves as an example of a worker who did *not* meet the test. There, the court held that substantial evidence supported the Board's determination that a registered nurse, who alleged harassment and bullying in connection with her work, did not "establish that the stress that caused the injury was greater than that which other similarly situated workers experienced in the normal work environment." Further, "Claimant's supervisors described normal oversight and monitoring practices undertaken to assist her in correcting deficiencies in and improving her performance, and claimant failed to identify any unusual stressors or conduct that would constitute harassment or bullying as alleged in her claim for benefits."[131]

A 2008 Pennsylvania case, on the other hand, exemplifies a case where the claimant prevailed. There, the workers' compensation judge, Board, and court all held that claimant had been exposed to abnormal work conditions after her employer had both sexually harassed her and pressured her to participate in Islamic religious rituals, including wearing special garb.[132]

States in this category establish points of reference for what is *considered* abnormal stress. These reference points are (1) others in the general workforce; (2) others in the same type of work with the same employer; and (3) others in the same type of work regardless of employer.[133] On occasions these reference points are established by case law, but certain jurisdictions establish the criterion of comparison by statute. Of course, it is presumably easier to show abnormal working conditions when the point of reference is the general workforce.[134]

A 2017 New York case shows a state in the third category, with the coverage reference point established via case law. There, an internal claims adjuster who, after a change in company policy, was harassed by fellow employees whose claims he was adjusting, developed PTSD. He was held to have established a cognizable mental-mental claim. The court characterized the law as follows: "For a mental injury premised on work-related ***121** stress to be compensable, 'a claimant must demonstrate that the stress that caused the claimed mental injury was greater than that which other similarly situated workers experienced in the normal work environment.'"[135]

Under Vermont law, meanwhile, the statute, via a 2017 amendment, provides that the criterion of comparison as to unusual stress is "pressures and tensions experienced by the average employee across all occupations ...."[136] That amendment, notably, overthrew a precedent that had identified the reference point as "all other employees performing similar work."[137]

**4. States Requiring Shock or Fright**

Jurisdictions in the most restrictive category, requiring shock or fright, maintain regimes with a heritage (if not via precedent, in spirit) in the "traumatic neuroses" claims discussed above. Many (though not all) courts, as we have seen, long accommodated recovery.[138]

Some shock or fright requirements are, as before, found in case law, while others are found in modern statutes. The preeminent case law example is the 1976 Illinois landmark, *Pathfinder Co. v. Industrial Commission.*[139] There, the court, against an argument that physical injury must always attend a cognizable mental disability, changed the law and held that a mental-mental, when supported by sudden and severe emotional shock, "traceable to a readily perceivable cause," is compensable. In *Pathfinder*, the claimant, a factory worker, had come to the aid of an injured co-worker laboring at a press, and had retrieved her severed hand from the machine. The worker's promptly ensuing anxiety reaction was held compensable.

A clear statutory example is found in the Louisiana Act. There, a mental-mental is only compensable if the "mental injury was the result of a sudden, unexpected, and extraordinary stress related to the employment and is demonstrated by clear and convincing evidence."[140] Such criteria doomed the claimant in a recent case. There, a convalescent home nurse's aide who

became stressed over extra work to be done on her night shift, because of ***122** the day shift's utter indolence, was held not to have experienced stress of an unexpected nature.[141]

**5. Jurisdictions With Complex Laws: California and Washington**

Some jurisdictions have, in their statutes, established complex schemes that stand out from most. They likely do so to try to avoid controversies as to coverage. (Pennsylvania, in contrast, is a *minimalist* state, where the entire law of mental-mentals is in the case law. Lawyers and judges are hence left to the vagaries and vicissitudes of the courts for guidance.)

California, in the wake if its claim and litigation crisis, has obviously tried to eliminate as much ambiguity in the law as possible with its Labor Code, section 3208.3. That proviso (a) allows a gradual stress mental-mental in employees with six months or more of employment; but (b) for newer workers, obliges the same to prove "a sudden and extraordinary employment condition"; and (c) in all cases, except those subject to violence, obliges claimant to prove that work stress is the predominant cause of the injury. As to (c), the statute is extraordinary in providing that, for a victim of violence, only "substantial cause" must be shown, with that phrase meaning "at least 35 to 40 percent of the causation ...."[142] The statute also restricts mental-mentals associated with a separation or termination of work; such claims are viable, but only under special showings--for example that the termination or layoff was attended by "sexual or racial harassment."[143]

Washington state, which may be categorized as a shock or fright state, likewise seeks to foreclose ambiguity in the law. It does so by providing administrative guidance with regard to what is and is not potentially covered. The key regulation (with statutory authority omitted here) provides, in part:

> (2)(a) Stress resulting from exposure to a single traumatic event will be adjudicated as an industrial injury ....
>
> (b) Examples of single traumatic events include: Actual or threatened death, actual or threatened physical assault, actual or threatened sexual assault, and life-threatening traumatic injury.
>
> (c) These exposures must occur in one of the following ways:
>
> (i) Directly experiencing the traumatic event;
>
> (ii) Witnessing, in person, the event as it occurred to others; or
>
> (iii) Extreme exposure to aversive details of the traumatic event.
>
> ***123** (d) Repeated exposure to traumatic events, none of which are a single traumatic event as defined in subsection (2)(b) and (c) of this section, is not an industrial injury ... or an occupational disease .... A single traumatic event as defined in subsection (2)(b) and (c) of this section that occurs within a series of exposures will be adjudicated as an industrial injury ....[144]

No other jurisdiction, notably, maintains such a regulatory feature.

**B.** ***Select Statutory Features***

**1. Purely Subjective Mental-Mentals Excluded**

As noted at the outset, all jurisdictions exclude mental-mental claims based upon a worker's purely subjective feelings of stress. Even proponents of unrestricted compensability are likely to acknowledge that allowing such claims would be unworkable and an employer's "worst nightmare."[145]

In any event, this exclusionary rule is found in both statutes and case law. The Michigan statute was enacted after a memorable early court decision *allowed* a claim based on subjectively perceived stress.[146] The Michigan statute now provides, in part, "Mental disabilities are compensable if arising out of actual events of employment, not unfounded perceptions thereof, and if the employee's perception of the actual events is reasonably grounded in fact or reality."[147] A Delaware court, meanwhile, denied benefits in one claim, agreeing that claimant had "merely imagine[d] or subjectively conclude[d]" that work events were the source of her problems.[148]

**2. Good Faith Personnel Action Exception**

A common statutory exclusion bars a mental-mental claim when the animus for the distress is a good-faith personnel action such as demotion, discipline, layoff, or termination. The California statute noted above features such an exception, as do the laws of at least nine other states. The otherwise permissive Hawaii statute, for example, provides that mental-mental claims "resulting from disciplinary action taken in good faith by the employer" are not compensable.[149]

Pennsylvania, meanwhile (via case law), generally considers such claims to be based on normal working conditions. During the heavy litigation period of mental-mentals in Pennsylvania, an entire body of law developed that this writer categorized as "promotions, demotions, and other common workplace stresses."[150] In a renowned case of this type, the Supreme ***124** Court denied benefits to an ALCOA executive's "Girl Friday" who, from a demotion and purported humiliation, sustained disabling emotional symptoms.[151] According to the court, abnormal working conditions had not been shown:

> An abnormal working condition is not established by evidence that a displaced employee was unable to obtain an identical job with his same employer. We reject the [idea that our abnormal working conditions precedent] suggested by [the claimant] that would allow any change in the status quo of an employment situation to be compensable simply because a claimant established that the change was actual, rather than imagined or perceived, and resulted in psychic injury.[152]

Under this Pennsylvania rule, notably, bad economic times that give rise to stress and psychic ailments, like anxiety over business failure or laying off workers, are also not reflective of abnormal work conditions.[153]

**3. Statutes Requiring Precise Diagnoses**

One feature observed in at least two statutes, meant to narrow coverage and screen out marginal claims, is a proviso that requires any mental-mental to be supported with a diagnosis, typically under the DSM-5, the manual published by the American

Psychiatric Association. This requirement is especially notable in the first responder laws popular in the current era,[154] but can be found in general statutes as well.[155]

The Minnesota law is most prominent in this regard. There, mental-mentals are precluded unless, as to *any* occupation, the diagnosis of PTSD under the DSM is proven. In 2019, that requirement was at center stage in a case decided by the Supreme Court. There, the claimant's expert diagnosed PTSD, but the insurance evaluator rejected the proposition that claimant suffered from the ailment. The WCJ credited the defense expert, but the Appeals Court reversed, "determin[ing] that the 2013 amendment requires that the compensation judge conduct an independent assessment to verify that the diagnosis of a psychologist or psychiatrist conforms to the PTSD criteria in the DSM-5 before accepting the expert's diagnosis." The ***125** Supreme Court reversed,[156] holding that the law said no such thing, and restoring the denial of benefits.

### C. *Heightened Burdens and the Issue of Unequal Treatment*

Workers who have sustained mental injuries and have been denied workers' compensation under restrictive laws have argued that such disparate treatment is a violation of constitutional guarantees of equal protection of the laws. These arguments, however, have been unsuccessful. Courts usually respond that rational-basis review applies and that legislatures may legitimately place extra burdens on such claims.

The leading case to this effect is *Sakotas v. WCAB (Motel 6)*,[157] in which a California court identified, as legitimating the law, the legislative concern over fraudulent claims that had arisen during the period of claims-filing upsurge. The court found a legitimate state interest and a rational basis for the heightened burdens featured in the 1992 California amendment.[158]

### D. *Exclusion of Mental-Mentals and the Exclusive Remedy*

Courts have held that when a workers' compensation statute is amended to exclude mental-mentals as a matter of law, the employer thereupon loses its immunity to the worker's tort suit. This was the holding in a 1996 Montana case.[159] That decision was based on the constitutional principle that a state cannot abolish the common-law cause of action to sue in personal injury (that is, by creating workers' compensation) and then abolish the same cause of action within the workers' compensation law. The principle itself derives from the state constitution's "Open Courts" provisions.

A Washington case from 2019 reveals a potentially cognizable action. There, the worker, a public defender, was stalked and otherwise harassed by a former criminal court client to whom she had been assigned. When she complained to her supervisor of repeated harassing episodes, he reportedly ***126** failed to take action. She ultimately filed for workers' compensation and instituted a negligence action against her employer. Of course, in Washington, only singular traumatic events will constitute a cognizable work injury. In civil court, the employer argued that the claimant's mental injury was from a singular event and hence that her negligence claim was barred by the exclusive remedy. The trial court agreed, dismissing the claim. On appeal, however, the court held that a genuine issue of material fact existed with regard to whether the injuries were gradual or singular. The court thus reversed and remanded. If the jury found that her injury from gradual traumatic events, she would be allowed her negligence suit.[160]

West Virginia is a jurisdiction where the argument for employer tort liability in the face of mental-mental abolition has been unsuccessful. Under the 1993 reform, mental-mentals were excepted from compensability as a matter of law. Thereafter, a coal miner emotionally traumatized by a mine explosion sued his employer in tort. The issue of availability of remedies was before the court, but such considerations were overwhelmed by the majority's conviction that the legislature desired that employers remain immune from such suits.[161]

**E.** ***Attempts to Avoid Special Mental-Mental Rules***

A phenomenon, perhaps inevitable, of regimes that exclude or limit mental-mentals, are legal "end-runs" around such roadblocks to recovery. Three such strategies exist.

**1. Casting the Mental-Mental as a Physical-Mental**

Under this approach, the injured worker encounters a situation, usually an accident, that features a superficial physical affect, but then develops a mental disability. The lawyer--or court--thereupon casts the case as a physical-mental to avoid a complete prohibition or abnormal working conditions requirement. This approach has not been successful in Pennsylvania. For example, in one case, the worker, an aide in a group home for the disabled, developed a mental disability after combative residents pulled at her hair and blouse. As Pennsylvania is an abnormal-working-conditions jurisdiction, claimant sought to portray the injury as a physical-mental. This attempt was unsuccessful, with the court holding that such level of stimulus was insufficiently physical.[162] A similar portrayal, however, was ***127** successful in Colorado.[163] There, to prevail in a mental-mental, the statute requires the testimony of a psychiatrist or psychologist. In the case at hand, claimant had no such expert evidence, but the court allowed the "grabbing, pinching, and kissing," to which she was subjected, to serve as a physical injury. In this manner, the requirement of the special expert was avoided.

**2. Casting the Mental-Mental as a Mental-Physical**

Under this approach, the injured worker encounters a situation, usually one of mental stress, which leads to a mental disability, but one accompanied by physical problems, such as high blood pressure or gastrointestinal upset. The lawyer--or court--thereupon casts the case as a mental-physical to avoid the complete prohibition or abnormal working conditions requirement. Larson has long identified this strategy, remarking, "There is the natural tendency for employees living in states that bar altogether claims for mental injury based on mental stimuli, but which allow claims for physical injury caused by mental stimuli, to attempt to expand the 'physical' component of their injuries in order to qualify for benefits under the statute's definitions."[164]

The exemplary case provided by Larson--*Luttrell v. Clearwater County Sheriff's Office*[165]--involved a police dispatcher. There, the claimant worked as a police dispatcher who sustained an emotional breakdown caused by a stressful emergency call. She sought to portray her disability as mental-physical, with the physical consequence reflected by an increased heart rate. The court denied the claim, holding that she had failed to present "clear and convincing evidence that the increased heart rate was anything other than part of the psychological response to her own reaction .... This was a 'mental-mental' case and therefore not compensable in Idaho."[166] Meanwhile, a Pennsylvania police officer who was subject to stress sought to avoid the abnormal working conditions rule by depicting his symptoms of sweating, crying, and uncontrollable bowel movements as physical injuries. The court rejected this strategy, dismissing such maladies as nothing more "than manifestations of the stress that he experienced ...."[167]

**3. Conceptualizing the Mental Disability as a Biological Disorder**

The two approaches identified above accept the proposition that mental-mental injuries are, rightly or wrongly, treated by the law in a restrictive manner. The third strategy, however, rejects the entire premise that any ***128** such disparate treatment should exist and relies, instead, on scientific arguments that mental illnesses constitute biological disorders and, hence, are really physical injuries.[168]

This strategy rejects prejudiced thinking with regard to mental illness and argues that a "duality between body and mind" exists. That is, that the "structure of the body includes the basic organ systems, as well as the brain and mind--itself anatomically

sited in the frontal cortex--functioning 'as an integrated whole, chemically, electrically, biochemically,' and that there can be an injury to the mind without a physical touching of some part of the body."[169]

Though compelling, the approach has been unsuccessful. The leading case on this strategy is the 2010 case *Wheeler v. State ex rel. Wyoming Workers' Safety and Compensation Division*.[170] There, a volunteer firefighter, fighting a fire and witnessing the deaths of two co-workers, developed PTSD. His later claim of permanent partial disability was denied on the grounds that his PTSD was reflective of an excluded mental disability. Claimant sought to avoid the exclusion via expert testimony that PTSD is reflective of an organic brain disorder, to wit, a physical injury:

> Q: And, Doctor, could you explain in layman's terms what your opinion is with respect to the physical organic basis of a posttraumatic stress disorder condition?
>
> A. Very succinctly. The brain is traumatized physically by the experience of a traumatic event where one's life is threatened or one is witnessing another life-threatening or potentially life-threatening type of event. And in the experience of that the brain goes into a very heightened state of arousal biologically ..., the chemistry that subserves that arousal sets into motion a cascade of biological events as if dominoes are falling, and they affect a number of physical aspects of brain functioning .... Structurally over time these events can even cause radiographically demonstrable changes .... And you can actually visualize radiographically changes that have occurred structurally in the brain as a result of posttraumatic stress disorder.[171]

The hearing officer and state supreme court nevertheless denied the claim. Though not discounting the expert testimony, the court held that the legislature's explicit decision to exclude mental injuries would be ***129** meaningless, and undermined, if diagnoses like PTSD were considered physical injuries and hence not excluded.[172]

The proposition that mental illness is really *biological* illness has also been floated in a Pennsylvania case. The fact-finding (though not the holding) of that decision was that mental stress causing *schizophrenia* was a biological disorder and hence could be considered a mental-physical.[173] Yet, while the court approved an award of benefits, the conceptualization of schizophrenia, or other serious mental disorders, as a physical injury, has not, since that time, captured the imagination of Pennsylvania courts.[174]

This writer, meanwhile, has argued that one DSM-recognized mental disorder, shiftwork maladaptation syndrome (SMS), caused by working unusual shifts, and never getting a good night's rest, should be conceptualized as a physical disorder. Appellate courts that have considered this diagnosis have uniformly rejected compensability. Perhaps at some point the mental injury as biological disorder will, however, be accepted in the realm of SMS. This is so as scientific evidence of verifiable pathology is strong in this realm.[175]

**F.** ***Mental-Mental Claims Based on Sexual Harassment***

Sexual harassment via psychological pressures is typically held compensable as a claim of the mental stress causing mental disability type. For example, in a Pennsylvania case, the Supreme Court held that a coal miner, victimized by a supervisor's coarse and joking harassments proposing brutalizing same-sex rape, showed abnormal working conditions and was entitled to benefits.[176] The Ohio statute, meanwhile, excludes mental-mentals but makes an exception if the mental injury has arisen from "sexual conduct in which the [employee] was forced by threat of physical harm to engage or participate."[177]

***130** Of course, claims based on Title VII alleging sexual harassment are not barred by the exclusive remedy.[178] Such claims are not usually based on personal injury. However, when such lawsuits including a count alleging mental and/or physical harm, and/or the need for medical and psychiatric treatment, a court may well strike the same.[179] This is so, anyway, in jurisdictions where sexual harassment is cognizable as a work injury; in short, the worker's tort claim sounding in negligence will likely be dismissed.

The potential bar of the New York law's exclusive remedy was recently implicated in the litigation that enveloped the controversial movie producer Harvey Weinstein and his various enterprises and associates. In a decision ruling on the defendants' summary dismissal motion, a federal court ruled that the plaintiff, a victim of sexual abuse by her sometime-employer Weinstein, potentially was asserting certain claims that were barred by the exclusive remedy.[180]

There, a movie producer, Canosa, filed a multiple-count lawsuit against Weinstein, his business partners, and his business (TWC). Among the several counts were allegations of rape, sexual abuse, intimidation, and harassment. The defendants, beyond Weinstein, were implicated on allegations (among others) that they had facilitated Weinstein's behavior. The defendants raised several defenses in their 12(b)(6) motion, asserting (among others), that certain claims were barred by the exclusive remedy.

As to that defense, Weinstein's business and its officers argued that the New York workers' compensation law was "the exclusive remedy for work-related injuries, including those involving sexual assault ...." They hence ***131** sought dismissal of the case. The court, however, ruled that, pending discovery, it was too early in the proceedings to ascertain whether the claims that the plaintiff was making even had their basis in the employer-employee relationship. The court, denying the motion to dismiss, stated, "The Court is persuaded that, prior to discovery, Canosa does not yet have the factual tools to make a confident showing that her work for Weinstein and TWC fell outside the WCL, so as to preserve her negligence claims ...."[181] The import of the ruling, however, was that, if discovery showed that she was in an employer-employee relationship with Weinstein, her sexual harassment claims would be barred.

## V. THE PLIGHT OF FIRST RESPONDERS: CASES, LAWS, AND PRESUMPTIONS

### A. *Work Stress and Challenges for First Responders*

Workers laboring as first responders, such as police, firefighters, and EMTs, have jobs that most agree are naturally stressful. Many such workers have encountered difficulty in succeeding with mental stress claims even when exposed to the extreme violence and appalling tragedies that are so regretfully common in the present day. As demonstrated in Appendix 1, seventeen states do not provide coverage at all. In the abnormal-working-conditions jurisdictions, meanwhile, an afflicted police officer (for example) must typically prove that his or her stress is greater than that of other police officers. When coupled with the related rule that police officers must, in effect, be ready for virtually any violent situation, they are often left without a compensation remedy.

Though some courts strain to award benefits in extreme cases,[182] in many instances brutalized police officers and others simply cannot meet the considerable burden of proof required in the mental-mental sphere.[183]

***132** Three responses, within workers' compensation laws, to the first responder situation are evident. The first is a law to allow the worst of the illnesses, PTSD, to be covered in the case of all occupations. The second is an enactment which covers PTSD and/or other psychological maladies, but leaving the burden of proof on the worker. The third is creation of a presumption of causation for PTSD in the case of first responders. Several states have enacted such presumption laws. Both proposals and enactments among the states are noted and referenced in the tables of Appendices 2 and 3.

This impetus toward loosening mental-mental restrictions, by whatever means, is borne of a societal view that first responders, in the modern day, deserve access to medical and disability coverage in the face of exposure to an increasingly violent society.

The everyday labor of such workers is stressful, but many newspaper stories recount, as well, the appalling stresses to which first responders are exposed when they arrive at the scenes of mass shootings such as that at the Sandy Hook, Connecticut, elementary school. A psychologist commenting on such events commented, "These mass shootings, especially when children are involved, that's when you see [first responders] break down."[184]

Meanwhile, an inordinate number of first responders are, in general, reportedly diagnosed with PTSD, and this fact has increasingly been understood by the public.[185] Advocates seeking easier access to mental-mental claims for first responders often assert that suicide rates among first responders are remarkably high.[186]

The impetus of loosening restrictions has also been tied to the "debt of 9/11 and its aftermath." A risk-management expert ventures that, as a result of that catastrophe, "[f]irst responders have earned unquestionable protection of [their] health under the law ... [and] a generation of veterans now fills the ranks of first responders."[187] The same expert suggests that workers' compensation, with its typical insistence on scrutiny as to work causation, has, in effect, been diverted. In this regard, concerns over causation fall by ***133** the wayside given that providing benefits under the program becomes a "very easy means of assuaging the community's need to help."[188]

**B.** ***The Minnesota and Colorado Enactments***

Minnesota, a state that otherwise excludes mental-mentals, enacted a unique law facilitating PTSD awards. It did so in response to a notoriously harsh denial to a police officer who had been mentally traumatized but was left without a remedy. The Minnesota law, however, is democratic and covers *all* workers. The Colorado legislature also enacted a law which covers PTSD. That state is a "shock or fright" jurisdiction where compensability of mental-mentals is hence highly restricted. After reports that first responders would routinely use group health insurance for such mental injuries, a lobby developed to amend the law. In the current version, all workers can potentially secure an award for PTSD.[189]

**C.** ***The Florida Enactment***

Florida, a state which has traditionally been hostile to mental-mentals, took another approach. It, too, enacted a law covering PTSD, but it applies only to first responders. This expansion of rights is likely the most publicized of the statutory enactments to address the plight of such workers.

The enactment unfolded in March 2018. The legislature in that month approved Senate Bill 376, which established PTSD as a compensable occupational disease for first responders. The law as codified, notably, is not part of the workers' compensation laws (title 440) but, instead, is codified at title 112, "Public Officers, Employees, and Records."

The genesis of the law is clear. Florida, in this regard, was a state where mental-stress injuries like PTSD were covered by workers' compensation only if the condition had its genesis in a physical injury. In the wake of the massacres at Pulse nightclub and the Marjory Stoneman Douglas High School, however, a lobby developed so that law enforcement officers, firefighters, and EMTs (career and volunteer) would be covered for the condition even in lieu of physical injury.[190]

Under the law, PTSD must have been diagnosed consistently with the DSM-5 and have been occasioned by exposures to or experiences with at least one of eleven situations (for example, "directly witnessing the death of a minor" or "directly witnessing death, including suicide, that involved ***134** grievous bodily harm of a nature that shocks the conscience."). With regard to this latter criterion, the Florida agency is directed to adopt definitional rules.[191]

The first responder must, in any event, prove the existence of the disorder "by clear and convincing medical evidence."[192] Thus, Florida has added PTSD as a compensable condition. Importantly, however, the first responder in Florida does not enjoy a presumption of causation, a popular statutory device that has been enacted in several jurisdictions.[193]

### D. *Presumption Laws for First Responders*

#### 1. The Trend

A vigorous trend is for states to make exceptions, within exclusionary laws, for first responders via the legislative "presumption of causation" device.[194] In February 2020, the National Council on Compensation Insurance (NCCI), which carefully monitors proposed bills and enactments on this topic, characterized the PTSD bills, including those featuring a presumption, to be the "top trending issue" for 2019.[195] These laws, as proposed and enacted, as they stood as of December 28, 2020, are listed in the tables of Appendices 2 and 3.

First-responder advocates have argued, often with obvious success, that current workers' compensation laws are inadequate to address the problem of first responder stress, injury, and suicide.[196] The idea behind such laws ***135** is that when a first responder (or similar worker) develops PTSD or other listed condition, he or she will no longer bear the burden of showing causation. Instead, the law presumes, or takes for granted, that work causation exists, and it is for the employing municipality to prove that the condition has its genesis in some non-work-related cause.

Maine and Vermont were states which, in 2018, enacted such laws. Meanwhile, NCCI identified Idaho, California, Louisiana, Nevada, New Hampshire, New Mexico, and Oregon as states which, during the first half of 2019, enacted laws establishing PTSD presumption laws for first responders.[197] Minnesota and Washington also have first-responder statutes that feature presumptions.

No two presumption laws are precisely alike. All feature PTSD, as defined by the DSM, as the malady covered, though New Hampshire and Oregon also include the diagnosis, "acute stress disorder." Meanwhile, the range of occupations is different for each jurisdiction. Oregon seems the most expansive, affording the PTSD presumption to full-time firefighters, EMS personnel, police officers, correctional officers (adult and youth), parole and probation officers, emergency dispatch personnel, and 911 operators.[198]

#### 2. Exemplary State: Vermont

An example of one of these provisos is that of Vermont. The workers' compensation law of that state now provides, "In the case of police officers, rescue or ambulance workers, or firefighters, post-traumatic stress disorder that is diagnosed by a mental health professional shall be presumed to have been incurred during service in the line of duty and shall be compensable, unless it is shown by a preponderance of the evidence [by the employer] that the post-traumatic stress disorder was caused by nonservice connected risk factors or nonservice-connected exposure."[199] Notably, other mental conditions suffered by these Vermont workers are now covered as well, but in such cases the worker will bear the initial burden of proof of causation.[200] And, notably, a statute of repose is a feature of the statute: "A police officer, rescue or ambulance worker, or firefighter who is diagnosed with post-traumatic stress disorder within three years of the last active date of employment [in such occupation] ... shall be eligible for benefits under this subdivision."

#### ***136** 3. Presumptions as Not Meaning Automatic Payment

A worker benefitted by a presumption of causation does not automatically receive an award of compensation, at least under presumption statutes as traditionally designed.[201] Presumptions are "rebuttable," which means, in the first responder context, that the defending municipality, as in Vermont, may develop its own proofs and defend itself in litigation. The presumption gives the claimant "a leg up" in court, but is not the equivalent of a pay order. This aspect of presumptions has on occasion been misunderstood.[202]

In some jurisdictions, the presumption of causation may be very weak. For example, under the Pennsylvania Act occupational disease provisos, as soon as the defense presents any evidence of lack of causation (identifying some other potential cause) the presumption--which is merely procedural-- "disappears." The claimant thereupon, once again, has the burden of proof.[203] This type of presumption, in academic literature, is called a "Wigmore-Thayer" presumption. Such presumptions are not substantive rules of law (the so-called "Morgan" approach to presumptions) as found in certain jurisdictions, which may strengthen claimant's case.[204]

Given this level of nuance, a mandate exists in this area: each state presumption law must be carefully read to determine its precise operation. Still, in *any* jurisdiction, once litigation commences, a first responder who hopes to rely solely on the presumption to win his or her case may be disappointed. Indeed, lawyers with experience in occupational-disease litigation rarely rely completely on presumptions. This was the case in southwest ***137** Pennsylvania in the extensive Black Lung litigation of the 1970s and 1980s. Counsel for coal miners never relied on the pneumoconiosis presumption enjoyed by deep miners. To the contrary, they always presented an expert pulmonologist or similar specialist.

**4. Opposition to and Critique of Presumption Laws**

Opposition exists to the trend of PTSD presumption laws. Some argue that evidence simply does not exist that PTSD is more prevalent among first responders than in other occupations, and hence that it is unsatisfactory that such workers receive the advantage that a presumption affords. One risk management expert writing on the topic is hardly hostile to first responders, but he quips that support of presumptions is on the rise despite "lack of persuasive scientific evidence ...." "[S]entiment over science," he complains, prevails among presumption advocates.[205] A California-based researcher, in a full-frontal attack on firefighter *cancer* presumptions, also rejects the proposition that the presumption should be expanded to PTSD. He admonishes that "the evidence for elevated risk among firefighters for any of these conditions is nonexistent, inconsistent or even contradictory."[206]

More common opposition is voiced by those who are concerned that PTSD-presumption laws will strain or overwhelm municipal workers' compensation budgets.[207] A particular challenge is estimating costs: "every source weighs the cost of PTSD differently."[208] An NCCI actuary in 2018 remarked that

> putting a dollar amount on the presumption bills is not feasible, given that "many of the occupational diseases typically included in proposals providing presumptive coverage to first responders have long latency periods. Therefore, it may take several years before claim activity associated with first responder occupational diseases emerge in the [available] data ...."[209]

A critique of a different kind is that it is unfair to allow the presumption to first responders, but *disallow* it to other workers who are exposed to extreme stress--*without* such exposures even being part of their jobs. Both Robinson, the editor of the Larson treatise, and Cleveland attorney Donald Lampert question the disparate treatment that is created by PTSD presumptions. Robinson ponders:

> ***138** [O]ne might imagine that in Florida, Connecticut, Kentucky, Washington, Idaho, and any other state that limits PTSD to so-called "first responders," it is the long-haul truck driver who is actually the first on the scene

> at many serious auto accidents. It [was] a teacher who was first on hand [at the Sandy Hook massacre] to hold the hand of a dying child shot by a crazed assailant. It was a bartender or other wait staff employee [who] was the first to comfort a wounded customer or co-employee at Pulse, the Orlando nightclub.[210]

Lampert, noting that, in Ohio, a PTSD bill was submitted but never enacted, posits, "Police and fire unions were obviously disappointed. Absent from the debate[, however], were the legal and constitutional issues that workers' compensation practitioners would recognize. What about non-public safety workers? An over-the-road truck driver and/or Good Samaritan can just as easily come upon a horrible scene causing PTSD."[211]

A final critique of the presumption laws is that, in typically limiting recovery to PTSD, less extreme yet disabling forms of psychic illness are excluded. That critique, in other words, asserts that the presumption laws in their current typical manifestation do not go far *enough*.

## VI. CONCLUSION

The last word has obviously not been spoken on the issue of mental-mentals. As demonstrated by the last section, evidence exists that the pendulum has begun to swing back towards a more available mental-mental remedy. This is so, at least, when a pinpointed diagnosis of PTSD is made and the victim is a first responder. It may be, however, that the increased sensitivity to mental suffering that is reflected by the trend of first-responder laws may transfer to the benefit of the general working public. That seems to have been the case in Minnesota and Colorado.

It is submitted that complete disallowance of mental-mental cases is unsatisfactory. While, on the one hand, such exclusionary rules by their very nature prevent fraudulent and exaggerated claims, many workers who sustain serious mental injuries arising in the course of their employment are denied the reasonable remedies of medical treatment and disability payments during their period of convalescence. On the other hand, unrestricted compensability seems unworkable and, to revisit some earlier rhetoric, may be the employers' "worst nightmare." We know from the California and Pennsylvania experiences that open-ended regimes invite all sorts of marginal claims, contentious litigation, and public disrespect for ***139** the system. A reasonably applied abnormal-working-conditions rule seems best suited as a compromise.

It is submitted, also, that allowing mental-mentals indiscriminately and simply letting the judge decide all disputed claims is no answer to the overall challenge of the mental-mentals. True, it is the office of courts to decide disputes. Yet, virtually *all* mental-mentals *are* disputed, and litigation of many such claims encourages individuals to stay out of work, generates invasive discovery, and promotes hostility between workers and their employers.

Perhaps another compromise measure (for the exclusionary jurisdictions) is to allow, for the mental-mental case, psychiatric and psychological treatment only, and/or a maximum number of weeks of disability.[212] True, such a proposal goes against the National Commission condemnation of arbitrary limits on duration of benefits,[213] but such a compromise may relieve the employer anxiety that mental-mental claims will be of indefinite duration and unpredictable cost while providing injured workers with some measure of reasonable care.[214]

## *141 APPENDIX 1

### COMPENSABILITY OF MENTAL STRESS/MENTAL DISABILITY CLAIMS UNDER STATE WORKERS' COMPENSATION LAWS (JANUARY 2021)

**C** = Potentially Compensable

**GS** = Gradual Stress Potentially Compensable

**AWC** = Abnormal Working Conditions/Unusual or Untoward Work Conditions Required

**S/F** = Sudden Stimulus: Shock, Fright, or the Like

| STATE | C | GS | AWC | S/F | STATUTE | LEADING OR EXEMPLARY CASE LAW |
|---|---|---|---|---|---|---|
| AL | No | | | | Ala. Code § 25-5-1(9) ("Injury does not include a mental disorder or mental injury that has neither been produced nor been proximately caused by some physical injury to the body."). | |
| AK | Yes | | x | | Alaska Stat. § 23.30.010(b) ("compensation and benefits under this chapter are not payable for mental injury caused by mental stress, unless it is established that (1) the work stress was extraordinary and unusual in comparison to pressures and tensions experienced by individuals in a comparable work environment; and (2) the work stress was the predominant cause of the mental injury ."). [215] | *Kelly v. State of Alaska (Dep't of Corrections)*, 218 P.3d (Alaska 2009) (correctional officer who was threatened with death by inmate, and who developed PTSD, encountered "extraordinary and unusual" work circumstances). |
| AZ | Yes | | x | | Ariz. Rev. Stat. § 23-1043.01(B) ("A mental injury, illness or condition shall not be considered a personal injury by accident arising out of and in the course of employment and is not compensable pursuant to this chapter unless some unexpected, unusual or extraordinary stress related to the employment or some physical injury related to the employment was a substantial contributing cause of the mental injury, illness or condition."). | *France v. Indus. Comm'n*, 2020 WL 772524 (Ariz. Ct. App. Feb. 18, 2020) (court, reversing ALJ, awards benefits to deputy who was traumatized by shotgun-wielding madman and who thereafter developed PTSD), *vacated*, 2021 WL 800755 (Ariz. Mar. 2, 2021); *Marks v. Indus. Comm'n (Crossroads Carriers, LLC & Sentry Ins. Co.)*, 2016 WL 3176467 (Az. Ct. App. 2016) ("A disabling mental condition is not compensable if it is brought about by the general building of emotional stress rather than an injury-causing event ."). |
| AR | No[216] | | | x | Ark. Code Ann. § 11-9-113 (disallowing all mental-mental claims, except when injury is sustained by "any victim of a crime of violence."). [217] | *Amlease, Inc. v. Kuligowski,* 957 S.W.2d 715 (Ark. 1997) (interpreting statute and denying claim to truck driver for his PTSD, incurred after motor vehicle accident involving fatality). |
| CA | Yes | x[218] | | | Cal. Labor Code § 3208.3 (extensive proviso on compensability of psychiatric injuries, (a) seemingly allowing gradual stress in | *Sakotas v. WCAB (Motel 6)*, 95 Cal.Rptr.2d 153 (Cal. Ct. App. 2000) (claimant, front desk clerk and occasional manager, who |

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| | | | | | employees with six months or more of employment, but (b) for newer workers obliging same to prove "a sudden and extraordinary employment condition"; and (c) in all cases, except those subject to violence, obliging claimant to prove that work stress is the predominant cause of the injury).[219] | became stressed by increase of work over time, failed to show that such stress was predominant cause of injury). |
| CO | Yes | | | x | Colo. Rev. Stat. § 8-41-301(2), (3) (stating, *inter alia*, that, to constitute an injury, a "psychologically traumatic event" must have been experienced, and "the claim of mental impairment cannot be based, in whole or in part, upon facts and circumstances that are common to all fields of employment.").[220] | *Kieckhafer v. Indus. Claim App. Off.*, 284 P.3d 2020 (Colo. Ct. App. 2012) (mental health nurse, in failing to submit expert report, necessarily failed to establish psychologically traumatic event, and ALJ and Appeals Office committed no error in dismissing claim). |
| CT | No | | | | Conn. Gen. Stat. § 31-275(16)(B)(ii) ("'Personal injury' or 'injury' shall not be construed to include: (ii) A mental or emotional impairment, unless such impairment ([1]) arises from a physical injury or occupational disease, [except] ([2]) in the case of a police officer [detailing certain circumstances]. ").[221] | |
| DE | Yes | x | | | Del. Code Ann. tit. 19, § 2301(12) (basic definition of injury; does not refer to mental stress). | *State v. Cephas*, 637 A.2d 20 (Del. 1994) (claimant must prove that the mental illness was the result of stressful working conditions by an objective causal nexus test; claimant must prove both the existence of the stressful working conditions and relate those conditions to the mental disorder; here, correctional officer established his case under this test by showing that his duties had increased significantly over time) (court reviewing Larson treatise and, as well, the then-extant laws of multiple jurisdictions). |
| FL | No | | | | Fl. Stat. § 440.093(1) ("A mental or nervous injury due to stress, fright, or excitement only is not an injury by accident arising out of the employment. Nothing in this section shall be construed to allow for the payment of benefits under this chapter for mental or nervous injuries without an accompanying physical injury requiring medical treatment. A physical injury resulting from mental or nervous injuries unaccompanied by physical trauma requiring medical treatment shall not be compensable under this chapter"). | *Kneer v. Lincare (Travelers),* 267 So. 3d 1077 (Fla. Dist. Ct. App. 2019) (limit on psychiatric care (post-physical injury) was not unconstitutional) (noting also, "benefits have never been available for stand-alone mental injuries without an accompanying physical injury."). |
| GA | No | | | | Ga. Code Ann. § 34-9-1(4) (basic definition of injury; does not refer to mental stress). | *Abernathy v. City of Albany*, 495 S.E.2d 13 (Ga. 1998) (mental-mentals are not compensable; hence, where municipal worker, after massive flooding, had to retrieve unearthed caskets and corpses, and suffered nervous breakdown, claim denied). |
| HI | Yes | x | | | Hawaii Rev. Stat. § 386-3 (basic definition of injury; refers to mental stress only to | *Davenport v. City & County of Honolulu*, 59 P.3d 932 (Haw. Ct. App. 2002) (explaining |

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| | | | | | exclude certain claims "resulting from disciplinary action taken in good faith by the employer ."). | 1998 amendment which recognizes good faith disciplinary action exclusion, and holding that claimant, who sustained anxiety disorder from the back-and-forth of promotions and demotions, was not subject to such exclusion). |
| ID | No | | | | Idaho Code Ann. § 72-451 (allowing mental stress claims only for mental-physicals, and expressly disallowing mental-mental claims). | *Luttrell v. Clearwater Cnty. Sheriff's Office*, 97 P.3d 448 (Idaho 2004) (clarifying that mental-mentals are not compensable). |
| IL | Yes | | | x | Ill. Comp. Stat. § 305/1(d) ("To obtain compensation , an employee bears the burden of showing, by a preponderance of the evidence, that he or she has sustained accidental injuries arising out of and in the course of the employment.").[222] | *Moran v. Ill. Workers' Comp'n Comm'n,* 59 N.E.3d 934 (Ill. App. Ct. 2016) (court, reversing Industrial Commission, awards benefits to fire company supervisor who directed firefighters at site of deadly house fire); *GM Parts Div. v. Indus. Comm'n*, 522 N.E.2d 1260 (Ill. App. Ct. 1988) (claimant did not show that altercation with supervisor met the test of *Pathfinder*, which requires "a sudden severe emotional shock which produces immediate disability and is caused by an uncommon nontraumatic work-related experience out of proportion to the incidents of normal employment activity."); *Pathfinder Co. v. Indus. Comm*'n, 343 N.E.2d 913 (Ill. 1976) (landmark case changing the law and confirming that a mental-mental claim, when supported by sudden and severe emotional shock, "traceable to a readily perceivable cause," is compensable; in case, prevailing claimant, a factory worker, had come to aid of injured co-worker laboring on press, and had retrieved severed hand of such co-worker from machine, thereafter suffering an anxiety reaction). |
| IN | Yes | | x | | Ind. Code § 22-3-6-1(e) (basic definition of injury - does not mention mental injuries). | *Hansen v. Von Duprin*, 507 N.E.2d 573 (Ind. 1987) (claimant, a victim of past violence, harassed by a teasing supervisor (who was unaware of such history, and who in the end set off a cap pistol near claimant), causing claimant's nervous breakdown, demonstrated cognizable injury). |
| IA | Yes | | x | | Iowa Code § 85.3(1) (referring to employer's obligation to pay for "any and all personal injuries sustained by an employee arising out of and in the course of the employment").[223] | *Dunlavey v. Econ. Fire & Cas. Co.,* 526 N.W.2d 845 (Iowa 1995) (landmark case allowing for mental-mental claims, in case involving an insurance executive who had developed psychological condition in face of increased duties; remand required for determination of whether claimant met test of compensability, which is as follows: "in order for an employee to establish legal causation for a nontraumatic mental injury caused only by mental stimuli, the employee must show that the mental injury 'was caused by workplace stress of greater magnitude than the day-to-day mental stresses experienced |

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| | | | | | | by other workers employed in the same or similar jobs,' regardless of their employer"). |
| KS | No | | | | Kan. Stat. Ann. § 44-508 (general definition of injury; does not mention psychological injuries, but has been interpreted to exclude them). | *Followill v. Emerson Elec. Co.*, 674 P.2d 1050 (Ks. 1984) (claimant who developed PTSD after seeing co-worker's dead body, in a "grisly" scene, did not have cognizable claim); *see also Howell v. State of Kansas*, 84 P.3d 636 (Kan. 2004) (claim denied: suicide case involving corrections psychologist who had developed depression from work stressors). |
| KY | No | | | | Ky. Rev. Stat. § 342.0011 (general definition of injury, stating that stress injuries can only be cognizable if prompted by physical animus). | |
| LA | Yes | | | x | La. Rev. Stat. § 23:1021(b) ("Mental injury or illness resulting from work-related stress shall not be considered a personal injury by accident and is not compensable unless the mental injury was the result of a sudden, unexpected, and extraordinary stress related to the employment and is demonstrated by clear and convincing evidence."). | *Emerson v. Willis Knighton Med. Ctr.*, 257 So. 3d 243 (La. Ct. App. 2018) (convalescent home nurse's aide who became stressed at extra work to be done on her night shift, because of day shift's indolence--experiencing the "same old thing"--did not experience stress of an unexpected nature as required by the statute). |
| ME | Yes | | x | | Me. Rev. Stat. Ann. tit. 39-A, § 201 (3-A) ("Mental injury resulting from work-related stress does not arise out of and in the course of employment unless: | *Caron v. Maine Sch. Admin. Dist. No. 27,* 594 A.2d 560 (Me. 1991) (school teacher who experienced increased pressures after her duties were drastically changed, did establish claim under this statute). |
| | | | | | A. It is demonstrated by clear and convincing evidence that: | |
| | | | | | (1) The work stress was extraordinary and unusual in comparison to pressures and tensions experienced by the average employee; and | |
| | | | | | (2) The work stress, and not some other source of stress, was the predominant cause of the mental injury ."). [224] | |
| MD | Yes | | x | | Md. Code Ann., Labor and Employment § 9-101(b) (providing that "Accidental personal injury" means: "(1) an accidental injury ," including "frostbite or sunstroke caused by a weather condition," but not referencing mental injuries). | *Belcher v. T. Rowe Price Found., Inc.,* 621 A.2d 872 (Md. Ct. App. 1993) (court recognizing mental-mental claims but requiring objective proof of harm and excluding gradual stress claim: "an injury under the Act may be psychological in nature if the mental state for which recovery is sought is capable of objective determination"); *Means v. Baltimore Cnty.*, 689 A.2d 1238 (Md. Ct. App. 1997) (paramedic who developed PTSD could potentially prevail on her claim as an occupational disease). |
| MA | Yes | | x | | Mass. Gen. Laws ch. 152, § 1(7A) ("Personal injuries shall include mental or emotional | *Bisazza's Case*, 897 N.E.2d 1 (Mass. 2008) (substantial evidence existed that claimant, |

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| | | | | | disabilities only where the predominant contributing cause of such disability is an event or series of events occurring within any employment."). | correctional officer harassed in the wake of prison murder of renowned pedophile, did incur his PTSD in wake of series of such harassments, court remarking, as to intent of statute, "amendments are consistent with the goal of denying compensation for nonspecific emotional and mental disabilities."). |
| MI | Yes | | x | | Mich. Comp. Laws § 418.301(2) ("Mental disabilities are compensable if contributed to or aggravated or accelerated by the employment in a significant manner. Mental disabilities are compensable if arising out of actual events of employment, not unfounded perceptions thereof, and if the employee's perception of the actual events is reasonably grounded in fact or reality."). | *Robertson v. DaimlerChrysler Corp.*, 641 N.W.2d 567 (Mich. 2002) (in case dealing with autoworker who felt he had been maltreated by supervisor, court insists that objective standard is to apply, and that claimant's perception of events must be "grounded in reality"). |
| MN | Yes | | | x | Minn. Stat. § 176.011(15), (16) (providing, in definitions of occupational disease and injury, that PTSD is included).[225] | *Smith v. Carver Co.,* 931 N.W.2d 390 (Minn. 2019) (WCCA committed error in reversing denial of PTSD claim by former police officer; ALJ had no obligation to ascertain whether defense psychologist closely held to the DSM-5 diagnosis of PTSD in his opinion); *Schuette v. City of Hutchinson*, 843 N.W.2d 233 (Minn. 2014) (pre-amendment case disallowing PTSD in a police officer who had responded to fatal motor vehicle accident scene in which family friends were involved). |
| MS | Yes | | | x | Miss. Code. Ann. § 71-3-3 ("'Injury' means accidental injury or accidental death arising out of and in the course of employment without regard to fault which results from an untoward event or events, if contributed to or aggravated or accelerated by the employment in a significant manner. Untoward event includes events causing unexpected results ."). | *Scarborough v. Miss. Dep't of Transp.*, 764 So. 2d 488 (Miss. 2000) (worker who felt unsupported by co-workers and supervisors, especially after he alleged various conspiracies, did not persuade ALJ and Commission that he had sustained a cognizable mental-mental injury; opinion setting forth required burden of proof, to wit, injuries caused "by some untoward or unusual event or events," and remarking that ordinary stress not sufficient enough to establish cognizable claim). |
| MO[226] | Yes | | x | | Mo. Rev. Stat. § 287.120.8, .9 (indicating, *inter alia*, that stress must be "extraordinary and unusual"). | *Mantia v. Mo. Dep't of Transp.*, 529 S.W.3d 804 (Mo. 2017) (highway department worker who was exposed to repeated stressful highway accident scenes did not show extraordinary and unusual work conditions); *Schaffer v. Litton Interconnect Tech.*, 274 S.W.3d 597 (Mo. Ct. App. 2009) (executive in charge of national workplace safety programs did not show that stress was extraordinary and unusual). |
| MT | No | | | | Mont. Code Ann. § 39-71-119(3) (injury does not mean a physical or mental condition arising from emotional or mental stress; or a nonphysical stimulus or activity); § 39-71-116(23) (occupational disease does | *Yarborough v. Mont. Mun. Ins. Auth.*, 938 P.2d 679 (Mont. 1997) (in light of statute, firefighter's PTSD was excluded from coverage, court finding unpersuasive the theory that violence of fireball at fire scene |

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| | | | | | include a physical or mental condition arising from emotional or mental stress or from a nonphysical stimulus or activity).[227] | constituted a physical animus); *Stratemeyer v. Lincoln Co.*, 915 P.2d 175 (Mont. 1996) (police officer with PTSD did not sustain injury which was compensable under WCA; thus, he was able to sue employer in tort--exclusive remedy is not applicable if the *quid pro quo* of the compromise fails). |
| NE | No | | | | Neb. Rev. Stat. § 48-141(4) (basic definition of injury; does not refer to mental stress). | *Zach v. Neb. State Patrol*, 727 N.W.2d 206 (Neb. 2007) (police trooper who committed suicide in response to alleged stress did not sustain compensable death; this was so even if evidence showed chemical imbalances within brain; also, mental-mentals are not covered either as injuries or as occupational diseases). |
| NV | Yes | | | x | Nev. Rev. Stat. § 616C.180 (statute providing for "[i]njury or disease caused by stress" stating, *inter alia*, that "extreme stress in time of danger" must attend any mental-mental injury, and not be caused by "any gradual mental stimulus"). | *McGrath v. Dept. of Pub. Safety*, 159 P.3d 239 (Nev. 2007) (state trooper who alleged mental injury from series of harassing and retaliatory acts by co-workers showed only gradual stress injury, and did not make out a claim under this statute). |
| NH | No | | | | N.H. Rev. Stat. § 281-A:2(XI) (injury does not include disease or death "resulting from stress without physical manifestation").[228] | *Appeal of Lettelier*, 35 A.3d 629 (N.H. 2011) (company president, seriously depressed after failure of his steel-making business, did not establish compensable mental injury). |
| NJ | Yes | x | | | N.J. Stat. Ann. § 34:15-31 (basic definition of injury; does not refer to mental stress). | *Rizzo v. Kean Univ.*, 2014 WL 2590281 (N.J. Super. 1981) (social work professor did not meet burden of proof to show mental breakdown from perceived stressors at work; said burden of proof requires "objectively stressful working conditions 'peculiar' to the particular workplace"). |
| NM | Yes | | x | | N.M. Stat. § 52-1-24 (defines "primary mental impairment" to rule out gradual stress and requires a "psychologically traumatic event that is generally outside of a worker's usual experience and would evoke significant symptoms of distress in a worker in similar circumstances").[229] | *Romero v. City of Santa Fe*, 134 P.3d 131 (N.M. Ct. App. 2006) (worker who was obliged to daily attend to pigeon excrement as part of his job as municipal pool manager did not suffer psychologically traumatic event); *Douglass v. State of New Mexico*, 812 P.2d 1331 (N.M. Ct. App. 1991) (white collar worker with responsible job, who developed increase in duties because of personnel cutbacks, did not suffer traumatic event but, instead, gradual stress) (court referring to leading case of *Jensen*, which explained the nature of the legislative enactment) (citing *Jensen v. N.M. State Police*, 788 P.2d 382 (N.M. Ct. App. 1990)). |
| NY | Yes | | x | | N.Y. Workers' Compensation Law § 2(7) ("'Injury' and 'personal injury' mean only accidental injuries arising out of and in the course of employment and such disease or infection as may naturally and unavoidably result therefrom. The terms 'injury' and 'personal injury' shall not include an injury | *Matter of Lanese v. Anthem Health Servs.*, 85 N.Y.S.3d 262 (App. Div. 2018) (substantial evidence supported Board's determination that RN, who alleged harassment and bullying in connection with her transfer within the employer to a different job, did not "establish that the stress that caused the injury |

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| | | | | | which is solely mental and is based on work-related stress if such mental injury is a direct consequence of a lawful personnel decision involving a disciplinary action, work evaluation, job transfer, demotion, or termination taken in good faith by the employer."). | was greater than that which other similarly situated workers experienced in the normal work environment"); |
| | | | | | | *Kraus v. Wegmans Food Markets, Inc.*, 67 N.Y.S.3d 702 (App. Div. 2017) (internal claims adjuster who, after change in policy, was harassed by fellow employees whose claims he was adjusting, developing PTSD, did establish cognizable mental-mental claim, court characterizing law as follows: "For a mental injury premised on work-related stress to be compensable, 'a claimant must demonstrate that the stress that caused the claimed mental injury was greater than that which other similarly situated workers experienced in the normal work environment."). |
| NC | Yes | | x | | N.C. Gen. Stat. § 97-2(6) (basic definition of injury; does not refer to mental stress). | *Bursell v. Gen. Elec. Co.*, 616 S.E.2d 342 (N.C. 2005) (worker accused of theft--as it turned out, wrongfully--potentially established claim of work injury for his subsequent psychic illness; psychic trigger must be an "unlooked for and untoward event"); *Pitillo v. N.C. Dep't of Env't Health & Nat. Res.*, 566 S.E.2d 807 (N.C. Ct. App. 2002) (worker who felt unfairly treated in employment performance review did not meet burden of showing mental stimulus).[230] |
| ND | No | | | | N.D. Cent. Code § 65-01-02(11)(b)(10) (the term *injury* does not include a "mental injury arising from mental stimulus."). | |
| OH | No[231] | | | | Ohio Rev. Code § 4123.01 (stating, among other things, "injury" does not include: "(1) [p]sychiatric conditions except where the claimant's psychiatric conditions have arisen from an injury or occupational disease sustained by that claimant or where the claimant's psychiatric conditions have arisen from sexual conduct in which the claimant was forced by threat of physical harm to engage or participate"). | *Armstrong v. John E. Jurgensen Co.*, 990 N.E.2d 568 (Ohio 2013) (truck driver who suffered physical injuries in accident, in the aftermath of which he also observed dead body, and who thereafter developed PTSD, did not establish a physical-mental claim, court rejecting theory that, because worker had sustained physical injury in collision, claim was cognizable; in this regard, credited medical evidence was that PTSD developed from observing the dead body, not the physical aspects of the accident). |
| OK | No[232] | | | | Okla. Stat. tit. 85A, § 13 ("A mental injury or illness is not a compensable injury unless caused by a physical injury to the employee, and shall not be considered an injury arising out of and in the course and scope of employment or compensable unless demonstrated by a preponderance of the evidence; provided, however, that this | |

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| | | | | | physical injury limitation shall not apply to any victim of a crime of violence."). | |
| OR | Yes | | x | | Or. Rev. Stat. § 656.802(3) | *Whitlock v. Klamath Co. Sch. Dist.*, 974 P.2d 705 (Or. Ct. App. 1999) (elementary school teacher whose duties were vastly expanded after ballot measure eliminated music classes, requiring him to undertake hours of off-duty preparation, experienced obligation not "generally inherent in every working condition"). |
| | | | | | ("[A] mental disorder is not compensable under this chapter unless the worker establishes all of the following: (a) The employment conditions producing the mental disorder exist in a real and objective sense; | |
| | | | | | (b) The employment conditions producing the mental disorder are conditions other than conditions generally inherent in every working situation or reasonable disciplinary, corrective or job performance evaluation actions by the employer, or cessation of employment or employment decisions attendant upon ordinary business or financial cycles; | |
| | | | | | (c) There is a diagnosis of a mental or emotional disorder which is generally recognized in the medical or psychological community; | |
| | | | | | (d) There is clear and convincing evidence that the mental disorder arose out of and in the course of employment.").[233] | |
| PA | Yes | | x | | Section 301(c)(1) of the Workers' Compensation Act, Pa. Stat. Ann. tit. 77, § 411(1) (defining *compensable event* as "injury" without reference to mental stress injuries).[234] | *City of Lower Burrell v. WCAB (Babinsack)*, 2020 WL 1190603 (Pa. Commw., filed Mar. 12, 2020) (police officer already stressed from working with angina found to have experienced abnormal working conditions when he observed dead body of his colleague, who had been murdered by escaped fugitive); *Payes v. WCAB (State Police),* 79 A.3d 543 (Pa. 2013) (while "abnormal working conditions" must be proven before a mental stress case is cognizable, here state trooper who struck and killed woman, who was apparently seeking to commit "suicide by cop," had established cognizable claim). |
| RI | Yes | | x | | R.I. Gen. Laws § 28-34-2(36) ("The disablement of an employee resulting from mental injury caused or accompanied by identifiable physical trauma or from a mental injury caused by emotional stress resulting from a situation of greater dimensions than the day-to-day emotional strain and tension which all employees encounter daily without | *Tessier v. R.I. Hosp.*, W.C.C. 02-01732 (R.I. Work. Comp. App. Ct. 2003) (phlebotomist who felt harassed and unfairly treated at work did not establish cognizable claim; employer's motion for summary judgment granted).[235] |

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| | | | | | serious mental injury shall be treated as an injury as defined in § 28-29-2(7).”). | |
| SC | Yes | | x | | S.C. Code Ann. § 42-1-160(B)(1) (providing, *inter alia*, that the “employee's employment conditions causing the stress, mental injury, or mental illness were extraordinary and unusual in comparison to the normal conditions of the particular employment”). | *Bentley v. Spartanburg Co*, 730 S.E.2d 296 (S.C. 2012) (deputy sheriff who developed PTSD after he shot and killed a suspect who attempted to assault him did not establish cognizable claim--“incident was not extraordinary and unusual, but was a standard and necessary condition of a deputy sheriff's job.”). |
| SD | No | | | | S.D. Codified Laws § 62-1-1 (“The term [injury] does not include a mental injury arising from emotional, mental, or nonphysical stress or stimuli. A mental injury is compensable only if a compensable physical injury is and remains a major contributing cause of the mental injury, as shown by clear and convincing evidence. A mental injury is any psychological, psychiatric, or emotional condition for which compensation is sought. ”). | |
| TN | Yes | | | x | Tenn. Code Ann. § 50-6-102. (17) (“‘Mental injury’ means a loss of mental faculties or a mental or behavioral disorder, arising primarily out of a compensable physical injury or an identifiable work-related event resulting in a sudden or unusual stimulus, and shall not include a psychological or psychiatric response due to the loss of employment or employment opportunities.”). | *Edwards v. Fred's Pharmacy*, 2018 WL 9365652017 (Tenn. Work. Comp. App. Bd. 2018) (retail manager who was assaulted by shoplifter established “sudden and unusual stimulus”). |
| TX | Yes | | | x | Tex. Lab. Code § 408.006 (announcing, as to the 1993 amendments to law, “(a) It is the express intent of the legislature that nothing in this subtitle shall be construed to limit or expand recovery in cases of mental trauma injuries .”).[236] | Appeal No. 030169, 2003 WL 1733971 (Tex. Work. Comp. Comm'n 2003) (claimant, director of victim advocacy center, who suffered mental breakdown after learning that district attorney was calling organizations to attempt to get her fired, did not establish cognizable claim, Commission noting that claimant suffered mental stress from multiple stressors which were not work-related and that hearing officer specifically found that “the claimant did not suffer a work related single event which resulted in a work related mental trauma injury.”; Commission also stating, “While a specific stressful incident of sufficient magnitude occurring on the job can result in a compensable mental trauma injury, repetitive mentally traumatic activity or stressful events do not constitute a compensable injury.”). |
| UT | Yes | | | x | Utah Code Ann. § 34A-2-402(2)(a) (“extraordinary mental stress from a sudden stimulus” required to establish a cognizable claim). | *Marks v. CLR Transp., Inc.*, 2019 WL 2100963 (Utah Labor Comm'n 2019) (although truck driver involved in catastrophic motor vehicle accident with multiple fatalities “resulted from a sudden stimulus,” remand required so that |

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| | | | | | | determination could be made as to whether "such stress was greater than [his] non-industrial stress ."). |
| VT | Yes | | x | | Vt. Stat. Ann. tit. 21 § 601(11)(J) (providing, *inter alia*, that, for mental condition to be compensable, "the work-related event or work-related stress was extraordinary and unusual in comparison to pressures and tensions experienced by the average employee across all occupations").[237] | *Crosby v. City of Burlington*, 844 A.2d 722 (Vt. 2003) (mental-mental claims are legitimate under Vermont constitution, but directing that purported unusual level of stress is determined vis-à-vis "all other employees performing similar work," and not "as compared with the general population of employees"). |
| VA | Yes | | | x | Va. Code Ann. § 65.2-101 ("'Injury' means only injury by accident ") (no reference to mental injury). | *Owens v. Va. Dep't of Transp.,* 515 S.E.2d 348 (Va. Ct. App. 1999) ("To qualify as a compensable injury by accident, a purely psychological injury must be causally related to a physical injury or to a sudden shock or fright arising in the course of employment," and highway worker exposed to unexpected loud noise of dropped manhole cover did not reflect exposure to sudden shock or fright). |
| WA | Yes | | | x | Wash. Rev. Code § 51.08.100 ("'Injury' means a sudden and tangible happening, of a traumatic nature, producing an immediate or prompt result, and occurring from without, and such physical conditions as result therefrom."). Essential regulation pursuant to this section: Wash. Admin. Code § 296-14-300(2)(a) (stress from a "single traumatic event"--like "threatened death or assault"--can constitute a work-related injury). | *Larose v. Dep't of Lab. & Indus.,* 456 P.3d 879 (Wash. Ct. App. 2020) (public defender who suffered repeated episodes of harassment at the hands of a former criminal court client did not suffer mental injury cognizable under statute); *Kinzey v. Dep't of Lab. & Indus.*, 2015 WL 7723006 (Wash. Ct. App. 2015) (paramedic's mental stress and breakdown developed over time, so hence could not qualify as either an injury or an occupational disease); *Rothwell v. Nine Mile Falls Sch.*, 295 P.3d 328 (Wash. Ct. App. 2013) (high school custodian's mental breakdown came on in response to stress of a single event, and hence she was limited to workers' compensation and had no cognizable claim against employer in tort--exclusive remedy applied).[238] |
| WV | No | | | | W. Va. Code § 23-4-1f ("[N]o alleged injury or disease shall be recognized as a compensable injury or disease which was solely caused by nonphysical means and which did not result in any physical injury or disease to the person claiming benefits .").[239] | |
| WI | Yes | | x | | Wis. Stat. § 102.01(2)(C) ("'Injury' means mental or physical harm to an employee caused by accident or disease ."). | *Highman v. LIRC*, 621 N.W.2d 385 (Wis. Ct. App. 2000) ("Pursuant to the standard established in *School Dist. # 1*, Highman cannot recover duty disability benefits unless he experienced stress of a greater dimension than that ordinarily experienced by police officers.") (citing landmark case, *School Dist. #1 v. DILHR*, 215 N.W.2d 373 (Wis. 1974) (guidance counselor, exposed to harsh |

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| | | | | | | criticism and calls for resignation by students, did not prove extraordinary stress)). |
| WY | No | | | | Wyo. Stat. Ann. § 27-14-102(a)(xi) (injury does not include "[a]ny mental injury unless it is caused by a compensable physical injury"). | *Wheeler v. State*, 245 P.3d 811 (Wyo. 2010) (volunteer fire-fighter did not prove a physical injury in the form of PTSD--mental-mentals are barred under Wyoming statute, and while some experts believe that PTSD is conceptually a physical injury, because of changes caused by trauma to the brain, such was not the spirit of the exclusion as established by the legislature). |
| DC | Yes | x | | | D.C. Code § 32-1501(12) ("'Injury' means accidental injury or death and such occupational disease or infection as arises naturally out of such employment or as naturally or unavoidably results from such accidental injury .") (no reference to mental injury). | *Jones v. D.C. Off. of Unified Comm'ns*, CRB No. 09-049, 2009 WL 1651413 (2009) (911 operator, to establish a mental-mental claim, did not have to show that work incident that gave rise to stress was peculiar to her occupational duties). |
| Longshore Act | Yes | x | | | 33 U.S.C. § 902(2) ("The term 'injury' means accidental injury or death and such occupational disease or infection as arises naturally out of such employment or as naturally or unavoidably results from such accidental injury .") (no reference to mental injury). | *Ceres Marine Terminals, Inc.,* 848 F.3d 115 (4th Cir. 2017) (court rejecting employer's argument that, for mental-mental injury, with worker in case alleging PTSD, said worker had to prove that he was in "zone of danger," as under Federal Employers Liability (FELA)). |
| FECA | Yes | x | | | 5 U.S.C. § 8102(a) (establishing criterion of personal injury as one "sustained while [worker is] in performance of his duty ."). | *Lilian Cutler*, 28 ECAB 125 (1976) ("Where the disability results from his emotional reaction to his regular and specially assigned work duties or to a requirement imposed by the employment, the disability comes within the coverage of the Act."). *See Claim of G.J.* (Dep't of Def., Defense Logistics Agency), No. 19-0801 (Sept. 16, 2019) (Board, affirming denial of benefits, sets forth law of mental injuries as established in *Cutler*; claimant had alleged mental injury from being publicly berated by a supervisor).[240] |

***173 APPENDIX 2**

**JURISDICTIONS WITH SPECIAL FIRST RESPONDER PTSD/MENTAL STRESS LAWS AS PART OF, OR PROPOSED FOR, THEIR WORKERS' COMPENSATION STATUTES**

| STATE | STATUTE OR PROPOSED LEGISLATION |
|---|---|
| AL | Proposed Legislation: H.B. 44, https://legiscan.com/AL/bill/HB44/2020. |

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|---|---|
| AK | No special workers' compensation law with regard to first responders. |
| AZ | Proposed Legislation: HB 2501 passed the House in 2018. Note: A separate law imposes counseling responsibilities on municipalities. |
| AR | No special workers' compensation law with regard to first responders. |
| CA | Cal. Labor Code § 3212.15. |
| CO | Colo. Rev. Stat. § 8-41-301(2)(a), (b). Proposed Legislation: SB20-026 (expanding coverages). |
| CT | Conn. Gen. Stat. § 31-275(16). |
| DE | No special workers' compensation law with regard to first responders. |
| FL | Special legislation for first responders. (No presumption.) Fl. Stat. § 112.1815(5)(a)-(e). |
| | 2019: HB 983 ratifies adopted rule 69L-3.009, F.A.C. that specifies the types of third-party injuries qualifying as grievous bodily harm of a nature that shocks the conscience, for the purposes of allowing wage replacement benefits for first responder post-traumatic stress disorder. Proposed legislation has been proposed to add corrections officers. |
| GA | No special workers' compensation law with regard to first responders. |
| HI | Proposed Legislation: https://www.capitol.hawaii.gov/session2020/bills/HB263_.HTM. |
| ID | Idaho Code § 72-451(4). |
| IL | Proposed Legislation: SB 2530, http://www.ilga.gov/legislation/billstatus.asp?DocNum=2530&GAID=15&GA=101&DocTypeID=SB&LegID=123351&SessionID=108. |
| IN | No special workers' compensation law with regard to first responders. |
| IA | No special workers' compensation law with regard to first responders. |
| KS | No special workers' compensation law with regard to first responders. |
| KY | No special workers' compensation law with regard to first responders. |
| | Note: BR140 of 2019 did not advance in the legislature. |
| LA | SB 107 (2019), 23 La. Rev. Stat. § 1036.1, 33 La. Rev. Stat § 2581.2, and 40 La. Rev. Stat. § 1374. |
| ME | 39-A Me. Rev. Stat. § 201(3-a)(B). |
| MD | No special workers' compensation law with regard to first responders. |
| MA | Proposed Legislation: SB 1509, https://malegislature.gov/Bills/191/S1509. |
| | Note: Most police are not covered by workers' compensation; a separate statute, Chapter 111F, which provides injured on duty pay, is the statute to be amended. |
| MI | Proposed Legislation, House Bill No. 4473, http://www.legislature.mi.gov/documents/2019-2020/billintroduced/House/pdf/2019-HIB-4473.pdf. |
| MN | Minn. Stat. § 176.011(15)(e). |
| MS | No special workers' compensation law with regard to first responders. |
| MO | Proposed Legislation: SB 710, http://senate.mo.gov/20info/BTS_Web/Bill.aspx?SessionType=R&BillID=26838225. |
| MT | Legislature, in 2019, amended section 39-71-105 to suggest that firefighters with mental injuries may be covered, but statutory language is inconclusive. |
| NE | Neb. Rev. Stat. § 48-101.01(B-D). |
| NV | AB 492: Nev. Rev. Stat. § 616C.180, § 616C.400, § 616C.420, and § 617.420. |

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|---|---|
| NH | SB 59: N.H. Rev. Stat. § 281-A:2 and § 281-A:17; new sections § 281-A:17-b and c. |
| NJ | No special workers' compensation law with regard to first responders. |
| NM | N.M. Rev. Stat. § 52-3-32.1. |
| NY | Proposed Legislation: Senate Bill 5292A, https://legislation.nysenate.gov/pdf/bills/2019/S5292A. |
| NC | Proposed Legislation: H.B. 622, https://www.ncleg.gov/Sessions/2019/Bills/House/PDF/H622v2.pdf. |
| ND | No special workers' compensation law with regard to first responders. |
| OH | Proposed Legislation: House Bill 308, https://www.legislature.ohio.gov/legislation/legislation-summary?id=GA133-HB-308. |
| OK | Proposed Legislation: H.B. 3360. |
| | Note: Covers correctional officers; Term “PTSD” not featured, H.B. 2271 |
| | Note: Covers first responders. |
| OR | Ore. Rev. Stat. § 656.802. |
| PA | Proposed Legislation, H.B. 432, https://www.legis.state.pa.us/CFDOCS/Legis/PN/Public/btCheck.cfm?txtType=PDF&sessYr=2019&sessInd=0&billBody=H&billTyp=B&billNbr=0432&pn=2568. |
| RI | No special workers' compensation law with regard to first responders. |
| SC | Proposed Legislation: H. 3106, https://www.scstatehouse.gov/query.php?search=DOC&searchtext=H%203106&category=LEGISLATION&session=123&conid=29470597&result_pos=0&keyval=1233106&numrows=10. |
| SD | Proposed Legislation: H.B. 1142, https://sdlegislature.gov/Legislative_Session/Bills/Bill.aspx?Bill=HB1142&Session=2020. |
| TN | Proposed Legislation: HB2577/SB2691, http://wapp.capitol.tn.gov/apps/BillInfo/Default.aspx?BillNumber=HB2577. |
| TX | Tex. Lab. Code § 504.019. |
| UT | Utah said to have passed legislation establishing a working group to study the compensability of mental stress claims from first responders. (NCCI 2019). |
| VT | Vt. Stat. § 601(11)(I)(i). |
| VA | Va. Code § 65.2-107. |
| WV | Proposed Legislation: HB 440 http://www.wvlegislature.gov/Bill_Text_HTML/2020_SESSIONS/RS/bills/HB4400%20INTR.pdf. |
| WA | Wash. Rev. Code § 51.08, § 51.08.142, § 51.32.185. |
| WY | Wyo. Stat. § 27-14-102. |
| WI | Proposed Legislation: AB 569, also SB 511, https://docs.legis.wisconsin.gov/2019/proposals/reg/sen/bill/sb511. |
| DC | No special workers' compensation law with regard to first responders. |

***177 APPENDIX 3**

**STATUTORY FEATURES: SEVENTEEN STATES WITH FIRST RESPONDER PTSD/MENTAL STRESS LAWS**

| STAT | OCCUPATIONS | INJURY | DSM NOTED? | PRESUMPTION? | EFFECTIVE DATE | CITATION; SELECT REMARKS |
|---|---|---|---|---|---|---|
| CA | Firefighters (career and volunteer), peace officers, fire and rescue service coordinators. | PTSD | Yes | Yes | 1/2/20 | Cal. Lab. Code § 3212.15. |
| | | | | | | Sunset 1/1/2025. |
| CO | All employees.[241] | PTSD with three enumerated criteria. | No | No | 7/1/2018 | Colo. Rev. Stat. § 8-41-301(2)(a), (b). |
| | | | | | | Expands statute to detail that "psychologically traumatic event" includes PTSD. |
| CT | Police officers, parole officers, firefighters. | PTSD with six enumerated criteria. | Yes | No | 7/1/19 | Conn. Gen. Stat. § 31-275(16). |
| | | | | | | DSM "most recent edition" is to be used. |
| FL | Law enforcement officers, EMTs (career and volunteer). | PTSD with eleven enumerated criteria.[242] | Yes | No | 10/1/18 | Fl. Stat. § 112.1815(5)(a)-(e). |
| | | | | | | No six-month duration of TTD as otherwise applicable to physical-mentals. |
| ID | Peace officers, firefighters, career and volunteer EMTs, EMS providers, emergency telecommunications officers. | PTSD | Yes | No | 7/1/19 | Idaho Code § 72-451(4). |
| | | | | | | Claim must be proven by clear and convincing evidence. |
| LA | Firefighters, career and volunteer, EMS personnel, police, state police. | PTSD | Yes | Yes | 2019 | SB 107 (2019), 23 La. Rev. Stat. § 1036.1, 33 La. Rev. Stat. § 2581.2, and 40 La. Rev. Stat. § 1374. |
| | | | | | | Psychologist or psychiatrist must verify the diagnosis. |
| ME | Law enforcement officers, firefighters, EMS personnel. | PTSD | No | Yes | 11/1/17 | 39-A Me. Rev. Stat. § 201(3-a)(B). |
| | | | | | | Rebuttal must be by clear and convincing evidence. |
| MN | Police officers, firefighters, EMTs, police dispatchers, correctional officers, | PTSD | Yes | Yes | 6/1/18 | Minn. Stat. § 176.011(15)(e). |

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| | sheriffs, deputy sheriffs, state patrol officers. | | | | | |
| | | | | | | Presumption must be rebutted by "substantial factors." To gain presumption, worker must establish lack of pre-existing PTSD. |
| NE | Sheriffs, deputy sheriffs, police officers, state patrol officers, firefighters (career and volunteer), EMS personnel (career and volunteer), corrections officers, other state employees with contact with "high-risk individuals." | "Mental injuries and mental illness." | No | No | 8/24/17 | Neb. Rev. Stat. § 48-101.01(B-D). |
| NV | Firefighters (career and volunteer), police officers, emergency dispatch operators, EMTs. | Injury from "extreme stress," defined in detail, with two enumerated criteria. | No | No | 6/3/19 | AB 492: Nev. Rev. Stat. § 616C.180, §§ 616C.400, 616C.420, 617.420. |
| | | | | | | No waiting period. |
| NH | Firefighters (career and volunteer), law enforcement officers, corrections officers, emergency communications dispatchers, EMTs (career and volunteer). | PTSD and acute stress disorder. | No | Yes | 1/1/21 | SB 59: N.H. Rev. Stat. §§ 281-A:2, 281-A:17; new sections § 281-A:17-b, -c. |
| NM | Firefighters (career). | PTSD | No | Yes | 6/14/19 | N.M. Rev. Stat. § 52-3-32.1. |
| | | | | | | (1) If claimant does not qualify for the presumption, claim can be proven with claimant carrying the burden of proof. |
| | | | | | | (2) A claimant qualifying for the presumption is to be paid medical treatment benefits until an adjudication to the contrary. |
| OR | Full-time firefighters, EMS personnel, police officers, correctional officers (adult and youth), parole and probation personnel, emergency dispatch and 9-1-1- operators. | PTSD, acute stress disorder. | Yes | Yes | 9/29/19 | Or. Rev. Stat. § 656.802. |
| | | | | | | (1) Nature of rebuttal defined: "clear and convincing medical evidence that duties as a covered employee were not of real importance or great |

| | | | | | | |
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| | | | | | | consequence in causing the diagnosed condition." |
| | | | | | | (2) Seven-year statute of repose. |
| TX | Peace officers, EMTs, firefighters. | PTSD | Yes | No | 9/1/19 | Tex. Lab. Code § 504.019. |
| | | | | | | DSM-V "or a later edition adopted by the commissioner of Workers' Compensation" is to be used. |
| VA | Law-enforcement officers, firefighters, and emergency medical service workers (as to the last two, both career and volunteer). | PTSD | Yes | No | 7/1/20 | Va. Code § 65.2-107. |
| | | | | | | A cap of 52 weeks on duration of disability payments; statute of repose provides that no medical treatment or disability payments may be made beyond four years from the date of the qualifying event. |
| VT | Police officers, EMTs, firefighters. | PTSD | No | Yes | 6/8/17 | Vt. Stat. § 601(11)(I)(i). |
| | | | | | | Three-year statute of repose. |
| WA | Firefighters, law enforcement officers. | PTSD | Yes | Yes | 6/7/18 | Wash. Rev. Code §§ 51.08, 51.08.142, 51.32.185. |
| | | | | | | 60-month maximum statute of repose. |
| WY | Peace officers, career and volunteer firefighters, search and rescue personnel and ambulance personnel. | PTSD | Yes | No | 7/1/20 | Wyo. Stat. § 27-14-102. |
| | | | | | | Benefits for mental injuries shall not extend for more than 36 months beyond diagnosis.[243] |

Footnotes

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1 *See* Donald T. DeCarlo & Roger Thompson, Workers Compensation: The First Hundred Years 54-59 (2012); Donald T. DeCarlo & Martin Minkowitz, Workers Compensation Insurance Law & Practice: The Next Generation ch. 11 (1989); Donald T. DeCarlo & Deborah H. Gruenfeld, Stress in the American Workplace: Alternatives for the Working Wounded 1-37 (1989).

2 Arthur Larson, Workers' Compensation, ch. 56 & Digest to ch. 56 (updated through June 2019); *see also* 2 Modern Workers' Compensation, § 109:29 (2019); Eric M. Larson & Jean A. Talbot, *Recovery Under Workers' Compensation Statute for Emotional Injury or Disease Caused by Work-Connected Stress Without Physical Cause or Result*, 45 Causes of Action2d 341 (2010, with Oct. 2019 update).

3 *See, e.g.*, Thomas S. Cook, *Workers' Compensation and Stress Claims: Remedial Intent and Restrictive Application*, 62 Notre Dame L. Rev. 879 (1987) (decrying restrictions on coverage); Edward J. Mills, *Mental Stimulus Causing Mental Disability: Compensability Under the Pennsylvania Workers' Compensation Act*, 23 Duq. L. Rev. 375 (1985) (arguing for a restrictive law).

4 *See, e.g.*, Logan Burke, *Finding a Way out of No Man's Land: Compensating Mental-Mental Claims and Bringing West Virginia's Workers' Compensation System into the 21st Century*, 118 W. Va. L. Rev. 889 (2015).

5 *See*, *e.g.*, France v. Indus. Comm'n, 460 P.3d 1253 (Ariz. Ct. App. 2020) (court, reversing ALJ, awards benefits to deputy who was traumatized by shotgun-wielding madman and who thereafter developed PTSD), *vacated*, 2021 WL 800755 (Ariz. Mar. 2, 2021); Moran v. Illinois Workers' Comp'n Comm'n, 59 N.E.3d 934 (Ill. App. Ct. 2016) (court, reversing Industrial Commission, awards benefits to fire company supervisor who directed firefighters at site of deadly house fire); Payes v. WCAB (Pennsylvania State Police), 79 A.3d 543 (Pa. 2013) (court, reversing lower tribunal, awards benefits to state trooper who, on darkened interstate, struck and killed woman who was apparently trying to commit suicide-by-cop).

6 *See* David Kieran, Signature Wounds: The Untold Story of the Military's Mental Health Crisis (2019) (arguing that, even in wake of Vietnam War experiences, U.S. Army and military medicine were unreceptive to, and unprepared for, phenomenon of mental stress suffered by soldiers subjected to repeated, unexpected, and seemingly endless deployments overseas).

7 *See infra* App. 1.

8 *See infra* App. 2.

9 *See infra* App. 3.

10 These are the facts of the Pennsylvania case, *Williams v. WCAB (Phila. Nat'l Bank)*, 548 A.2d 1344 (Pa. Commw. Ct. 1988).

11 *See, e.g.*, City of Lower Burrell v. WCAB (Babinsack), 2020 WL 1190603 (Pa. Commw. Ct. 2020); Moran v. Ill. Workers' Comp. Comm'n, 59 N.E.3d 934 (Ill. App. Ct. 2016).

12 *See, e.g.*, W. Va. Code § 23-4-1f (precluding such claims from compensation, and providing, "It is the purpose of this section to clarify that so-called mental-mental claims are not compensable under this chapter.").

13 Donovan v. WCAB (Academy Medical Realty), 739 A.2d 1156 (Pa. Commw. Ct. 1995) (worker, a janitor who cleaned dentist's office, and who twice sustained needle sticks from moving rubbish, requiring medical treatment, and who thereafter developed "dysthymic disorder or depression," had sustained a physical-mental injury).

14 Panyko v. WCAB (U.S. Airways), 888 A.2d 724 (Pa. 2005).

15 Larson, *supra* note 2, § 56.02[1]; § 56.03[1]. An exception is found in Montana, where the workers' compensation statute provides that mental-physicals are not compensable. Mont. Code Ann. § 39-71-119(3).

16 *See infra* Part IV(E).

17 *See, e.g.*, LaRose v. King County, 437 P.3d 701 (Wash. Ct. App. 2019) (tort case) (genuine issue of material fact existed with regard to whether plaintiff's injuries were reflective of gradual stress or, instead, a singular incident; if the former, no claim existed as a matter of law under the Washington Act for benefits, and hence plaintiff would be allowed her negligence suit).

18 *See, e.g.*, Camp v. Dade-Behring, 2005 WL 2249761, at *8 (Del. Super. Ct. 2005) (no recovery for mental-mental claimant when she "merely imagine[d] or subjectively conclude[d]" that work events were the source of her problems).

19 Larson, *supra* note 2, § 56.04[4].

20 DeCarlo & Minkowitz, *supra* note 1, at 283; *see also* Donald T. DeCarlo, C*ompensating Stress in the '80's*, 52 Ins. Couns. J. 681 (1985).

21 Larson, *supra* note 2, § 56.06[1].

22 California Work Injuries and Illnesses--1986 (Cal. Div. of Lab. Stat. & Rsch. 1986), cited in Joseph W. Little, Thomas A. Eaton & Gary R. Smith, Cases and Materials on Workers' Comp'n 297 (3d ed. 1993).

23 *See* Report of the National Comm'n on State Workmen's Comp'n Laws 15 (1972), https://workerscompresources.com. Commission Recommendation 2.12 was to abolish the accident requirement and cover all injuries, but mental injuries are not otherwise referenced.

24 DeCarlo & Gruenfeld, *supra* note 1, at 10-11; *see also* Janet C. deCarteret, *Occupational Stress Claims*, 42 AAOHN Journal 494 (Oct. 1994), https://journals.sagepub.com/doi/pdf/10.1177/216507999404201007.

25 DeCarlo & Gruenfeld, *supra* note 1, at 10.

26 *See, e.g.*, Commonwealth, Dep't of Highways v. Lindon, 380 S.W.2d 247 (Ky. Ct. App. 1964) (claimant sustained injury but then developed a "psychoneurosis conversion hysteria" that was superimposed on a minor foot injury; worker became convinced that he had constant pain in his foot and leg and, as a result, was unable to work--ultimately, he was obliged to undergo a "sodium amytal" (truth serum) interview).

27 1 Arthur B. Honnold, Honnold on Workmen's Compensation § 95, at 294 (1917).

28 Henry H. Kessler, Accidental Injuries: The Medico-Legal Aspects of Workmen's Comp'n and Pub. Liab. ch. 18 (1932).

29 *Id.* at 530.

30 Still, foreshadowing the current, ubiquitous concern about purely mental phenomena, Kessler urged fellow occupational medicine practitioners to watch for the common malingerer among those suffering from *bona fide* conversion reactions. *Id.* at 542 ("It is with those persons who have more or less combined real and unreal physical injury that the greatest difficulty arises. Here is the largest field for malingering, and the abilities of the examiner are taxed in making the differentiation.").

31 Larson, *supra* note 2, § 56.05.

32 Kessler, *supra* note 28, at 531.

33 *Id.* ("What is true today in this regard was true as long ago as 1894, when Ricolins spoke of the gold treatment which can be made of bank notes, referring to the causal relation between liability legislation and traumatic hysteria."). In the present day, some cynics refer to this phenomenon as the "Greenback Poultice."

34 *Id.*

35 Kessler, *supra* note 28, at 530.

36 Burlington Mills Corp. v. Hagood, 13 S.E.2d 291, 294 (Va. 1944).

37 Simon v. R.H.H. Steel Laundry, 95 A.2d 446, 450 (N.J. Super. 1953), *aff'd without opinion*, 98 A.2d 604 (N.J. App. Div. 1954).

38 Lyng v. Rao, 72 So. 2d 53, 56 (Fl. 1954).

39 Bailey v. Am. Gen. Ins. Co., 279 S.W.2d 315, 318 (Tex. 1955).

40 *Id.* at 318-19.

41 *Id.* at 319 (quoting Peavy v. Mansfield Hardwood Lumber Co., 40 So. 2d 505, 508 (La. Ct. App. 1949)).

42 Wolfe v. Sibley, Lindsay & Curr Co., 36 N.Y.2d 505 (1975).

43 *Id.* at 506.

44 *Id.*

45 *In re* Fitzgibbons, 373 N.E.2d 1174 (Mass. 1978).

46 *Id.* at 1177.

47 Albertson's Inc. v. WCAB (Bradley), 182 Cal. Rptr. 304 (Ct. App. 1982).

48 *Id.* at 308.

49 *Id.* at 314-15 (citing Deziel v. Difco Lab'ys, Inc., 268 N.W.2d 1 (Mich. 1978)).

50 Larson, *supra* note 2, at § 56.06[1][a].

51 Natalie Riley, *Mental-Mental Claims--Placing Limitations on Recovery Under Workers' Compensation for Day-to-Day Frustrations*, 65 Mo. L. Rev. 1023, 1024 n.6 (2000) (citing Amy S. Berry, *The Reality of Work-Related Stress: An Analysis of How Mental Disability Claims Should Be Handled Under the North Carolina Workers' Compensation Act*, 20 Campbell L. Rev. 321 (1998)).

52 DeCarlo & Minkowitz, *supra* note 1, at 280-82.

53 Larson, *supra* note 2, § 56.06[1].

54 DeCarlo & Gruenfeld, *supra* note 1, at 47.

55 *Id.* at 69-75. Seven single-spaced pages of the book are devoted to workplace fear of AIDS.

56 DeCarlo & Minkowitz, *supra* note 1, at 281.

57 *Id.* at 280.

58 DeCarlo & Gruenfeld, *supra* note 1, at 6.

59 Aya V. Matsumoto, *Reforming the Reform: Mental Stress Claims Under California's Workers' Compensation System*, 27 Loy. L.A. L. Rev. 1327, 1337 (1994), https://digitalcommons.lmu.edu/cgi/viewcontent.cgi?article=1862&context=llr.

60 *See* Sakotas v. WCAB (Motel 6), 95 Cal. Rptr.2d 153, 160 (Ct. App. 2000).

61 Allard Dembe, M.D., Occupation and Disease: How Social Factors Affect the Conception of Work-Related Disorders xi, 5, 12 (1996). Other experts beyond psychiatrists and psychologists during the crisis period also identified for the working public the import of stress at work. DeCarlo and Gruenfeld verify in the 1980s that an entire industry developed: "In recent years," they noted, "the stress problem has been addressed by social scientists, organizational psychologists, family therapists, and management consultants .... The deluge of media coverage it has received has progressively broadened the term 'stress' into a generic, catch-all concept that generally refers to the feelings of frustration and anxiety that are exceedingly common in a complex society such as ours." DeCarlo & Gruenfeld, *supra* note 1, at 1-2.

62 Dembe, *supra* note 61, at 19-20.

63 *See* Andrew Malleson, M.D., Whiplash and Other Useful Illnesses 1-6 (2002).

64 John D. Copeland, *The New Arkansas Workers' Compensation Act: Did the Pendulum Swing too Far?*, 47 Ark. L. Rev. 1, 17 (1994).

65 Owens v. Nat'l Health Lab'ys, Inc., 648 S.W.2d 829 (Ark. 1983).

66 Copeland, *supra* note 64, at 3.

67 *Id.* at 18.

68 *See* Logan Burke, *Finding a Way out of No Man's Land: Compensating Mental-Mental Claims and Bringing West Virginia's Workers' Compensation System into the 21st Century*, 118 W. Va. L. Rev. 889 (2015).

69 Breeden v. Workmen's Comp. Comm'r, 285 S.E.2d 398 (W. Va. 1981) (relying on Montgomery v. State Comp. Comm'r, 178 S.E. 425 (W. Va. 1935) (addressing claim of miner suffering from exhaustion and disability after having been lost in his mine for a period of seven days, and stating "it is clear that the term 'personal injury' as used in the ... Act ... contemplates and includes the result of unusual exposure, shock, exhaustion, and other conditions not of traumatic origin, provided that they are attributable to a specific and definite event arising in the course of, and resulting from, the employment.")).

70 W. Va. Code § 23-4-1f. In referencing the 1993 reform, Burke notes that "West Virginia's workers' compensation system has been through several rounds of reform. One of the recurring concerns of [such] reform is preventing abuse of the system and fraudulent receipt of benefits, which, in turn, creates a drag on the entire system. In the 1990s, reform measure specifically targeted preventing abuse by claimants and health care providers. One of these reforms addressed mental-mental claims ...." Burke, *supra* note 68, at 905.

71 For a thorough retrospective of how the "injury" criterion was interpreted by Pennsylvania courts, see Justin D. Beck, *From the Glass Lined Tanks of Old Latrobe: 30 Years of Pawlosky*, in VII Pa. B. Ass'n Workers' Comp'n L. Sec. Nwsltr No. 129 (Appendix) (Mar. 2017) (noting that the term *injury* in Pennsylvania is defined as "any adverse or hurtful effect").

72 Univ. of Pittsburgh v. WCAB (Perlman), 405 A.2d 1048 (Pa. Commw. Ct. 1984).

73 *Id.* at 1050.

74 *Id.* at 1051 (quoting 1B A. Larson, Workmen's Compensation Law § 42.23(a), at 7-632 (1978)).

75 Bevilacqua v. WCAB (J. Bevilacqua Sons, Inc.), 475 A.2d 959 (Pa. Commw. Ct. 1984). The Peter Principle provides that "anything that works will be used in progressively more challenging applications until it causes a disaster."

76 David B. Torrey & Andrew E. Greenberg, Pennsylvania Workers' Compensation: Law & Practice, § 4:9 & n.8 (2008 & Supp. 2020-2021).

77 An account of the swinging of the pendulum is found in Bradley R. Smith, *Pennsylvania's Mental Lapse: A History of Pennsylvania's Treatment of Mental Disabilities Caused by Mental Stress in Workers' Compensation* ch. 17, *in* The Centennial of the Pa. Workers' Compensation Act: A Narrative and Pictorial Celebration (David B. Torrey ed., 2015).

78 Martin v. Ketchum, 568 A.2d 159 (Pa. 1990).

79 Torrey & Greenberg, *supra* note 76, § 4:24; *see* City of Pittsburgh v. WCAB (Plowden), 804 A.2d 82, 87 (Pa. Commw. Ct. 2002) (municipal worker who was employed in job seeking rehabilitation of urban gang members did not experience abnormal working conditions: "[C]ertainly, when Plowden accepted these job duties, working with the 'Mayor's Task Force on Youth Violence,' he should have realized that conflict, and perhaps even some slight element of danger or unrest, might be involved.").

80 Torrey & Greenberg, *supra* note 76, § 20:83 ("[L]aw enforcement professionals such as police officers and prison guards typically face a difficult burden when seeking to establish a compensable 'mental-mental' claim because of the unusual environment in which they work and the inherent dangers associated with criminal activity.").

81 Burke, *supra* note 68, at 910.

82 Payes v. WCAB (State Police), 79 A.3d 543, 555 (Pa. 2013) (one cannot simply conclude that because an occupation is inherently stressful that any eventuality, no matter how shocking, is normal; court, on appeal, must take into account and be bound by the "unique factual findings of the case"). *See* Smith, *supra* note 77, at 472-74.

83 *Id.* at 475.

84 Larson, *supra* note 2, § 56.01[1][a].

85 *Id.*

86 Janet C. deCarteret, *Occupational Stress Claims*, 42 AAOHN J. 494, 497 (Oct. 1994), https://journals.sagepub.com/doi/pdf/10.1177/216507999404201007.

87 Matsumoto, *supra* note 59, at 1336-37 (1994) ("As if the floodgates had opened, claims for mental stress injuries have inundated workers' compensation systems."), https://digitalcommons.lmu.edu/cgi/viewcontent.cgi?article=1862&context=llr.

88 Larson, *supra* note 2, § 56.01[1][a].

89 Matsumoto, *supra* note 59, at 1337.

90 deCarteret, *supra* note 86, at 497.

91 Larson, *supra* note 2, § 56.01[1][a]. The law is currently codified in substantially the 1993 form at Cal. Labor Code § 3208.3. The California provisions are plainly the most detailed of the state mental-mental laws. *See also infra* Part IV(A)(5).

92 Louise Esola, *Reviews of Psych Claims in Comp Increase*, Bus. Ins. (Oct. 2, 2019), https://www.businessinsurance.com/article/20191002/NEWS08/912330957/Reviews-of-psych-claims-in-comp-increase#.

93 *See infra* Part V(D).

94 Bentley v. Spartanburg County, 730 S.E.2d 296 (So. Carolina 2012) (deputy who shot umbrella-wielding suspect at short-range, and observed him die, did not experience unusual stress; though denial of benefits was affirmed, court recommends that legislature abandon the restrictive statutory test); *see also* Burke, *supra* note 68.

95 *See*, *e.g.*, *Bentley v. Spartanburg Co.,* at 299 ("those in favor of allowing broader recovery point out that advances in medical science have made it easier for medical professionals to diagnose and verify the validity of mental injuries, enabling courts to weed out fraudulent claims."); Larson, *supra* note 2, § 56.04[1].

96 Bias v. E. Associated Coal Corp., 640 S.E.2d 540, 553 (W. Va. 2006) (Starcher, J., dissenting); *see also* Burke, *supra* note 68, at 898-900 (setting forth the ways in which stress affects the body).

97 *See* Glenn M. Troost, *Workers' Compensation and Gradual Stress in the Workplace*, 133 U. Pa. L. Rev. 847, 860-61 (1985).

98 Thomas S. Cook, *Workers' Compensation and Stress Claims: Remedial Intent and Restrictive Application*, 62 Notre Dame L. Rev. 879, 886 (1987).

99 Troost, *supra* note 97, at 864.

100 Seitz v. L&R Indus., 437 A.2d 1345, 1354 (R.I. 1981) (Kelleher, J., dissenting) (quoting Arthur Larson, *Mental and Nervous Injury in Workmen's Compensation*, 23 Vand. L. Rev. 1243, 1259 (1970)).

101 *See, e.g.*, Natalie D. Riley, *Mental-Mental Claims--Placing Limitations on Recovery Under Workers' Compensation for Day-to-Day Frustrations*, 65 Mo. L. Rev. 1023 (2000).

102 Troost, *supra* note 97, at 863.

103 Letitia J. Mallin, *Disease, Not Accident: Recognition of Occupational Stress Under the Workmen's Compensation Laws,* 13 Colum. J. of Env't L. 357, 386 (1988).

104 Mont. Code § 39-71-105(5).

105 McGrath v. Dept. of Pub. Safety, 159 P.3d 239, 243 n.13 (Nev. 2007) (citing, in support, Gatlin v. City of Knoxville, 822 S.W.2d 587 (Tenn. 1991)).

106 Edward J. Mills, *Mental Stimulus Causing Mental Disability: Compensability Under the Pennsylvania Workmen's Compensation Act*, 23 Duq. L. Rev. 375, 382 (1984) ("[S]erious questions still exist with respect to whether the fields of psychology and psychiatry have advanced to the point where it is possible to consistently give a credible and unequivocal opinion regarding causation.").

107 *See infra* this section (discussing Deirdre Smith, *Diagnosing Liability: The Legal History of Posttraumatic Stress Disorder*, 84 Temp. L. Rev. 1 (2011)).

108 DeCarlo & Minkowitz, *supra* note 1, at 288 (discussing the "uncertainty of psychiatry").

109 Mills, *supra* note 106, at 382 (quoting Lawrence Joseph, *The Causation Issue in Workers' Compensation Mental Disability Cases: An Analysis, Solutions, and a Perspective*, 36 Vand. L. Rev. 263, 272 (1983)).

110 *See* Joseph W. Little, Thomas A. Eaton & Gary R. Smith, Cases and Materials on Workers' Compensation 300 (3d ed. 1993).

111 Ladner v. Higgins, 71 So. 2d 242, 244 (La. Ct. App. 1954).

112 Louise Esola, *Reviews of Psych Claims in Comp Increase,* Bus. Ins. (Oct. 2, 2019), https://www.businessinsurance.com/article/20191002/NEWS08/912330957/Reviews-of-psych-claims-in-comp-increase#.

113 The dissent in the leading New York case *Wolfe*, summarized above, was full of foreboding:
In an era marked by examples of overburdening of socially desirable programs with resultant curtailment or destruction of such programs, a realistic assessment of impact of doctrine is imperative. An overburdening of the compensation system by injudicious and open-ended expansion of compensation benefits, especially for costly, prolonged, and often only ameliorative psychiatric care, cannot but threaten its soundness or that of the enterprises upon which it depends.
Wolfe v. Sibley, Lindsay & Curr Co., 36 N.Y.2d 505, 513-14 (N.Y. 1975) (Breitel, C.J., dissenting).

114 Frank Knapp, *Lawmakers Grapple with Mental-Mental, Longshore Bills,* Blog Post, S.C. Small Bus. Chamber Com. (Feb. 15, 2013), https://scsbc.org/lawmakers-grappling-with-mental-mental-longshore-bills ("Mike Chase, legal advisor to SCSIA, said Thursday that Pope's bill will allow claimants' attorneys to argue that workers suffered compensable mental trauma from normal working conditions and may open the flood gates to mental-mental claims.").

115 *See* Cook, *supra* note 98, at 897-98 (charging that courts resist recognizing mental-mental cases on doctrinal grounds "as convenient ways in which to deny compensation for legal disability which courts and legislatures deem unwise due to economic considerations.").

116 *See* Riley, *supra* note 101, at 20 ("Requiring unusual stress for recovery also reduces the possibility of an employer becoming a general health insurer when an employee with preexisting metal health problems is hired.").

117 *See* David B. Torrey, *How Judges Judge and Why*, Seminar Paper, ABA Workers' Compensation Sections CLE, Coral Gables, Fla. (Mar. 16, 2013), https://paworkinjury.files.wordpress.com/2013/03/torreycredibility.pdf; *see also* John L. Kane, *Judging Credibility*, 33 Litig. (No. 3) (ABA Spring 2007).

118 Deirdre Smith, *Diagnosing Liability: The Legal History of Posttraumatic Stress Disorder*, 84 Temp. L. Rev. 1 (2011). Smith asserts that lawyers should gain sophistication about the legal history--and legalistic aspects--of PTSD: "Courts," she accurately posits, "are likely unaware of PTSD's legal origins, the persistent controversies within psychiatry and psychology about the theoretical underpinnings of the diagnosis, and the complicated notion of 'causation' within contemporary psychiatry." *Id.* at *4.

119 *See* App. 1.

120 Ark. Code Ann. § 11-9-113.

121 *See, e.g.*, Pa. Liq. Control Bd. v. WCAB (Kochanowicz), 108 A.3d 922 (Pa. Commw. Ct. 2014) (benefits granted under such a scenario under Pennsylvania's abnormal working conditions rule).

122 *See* Cal. Lab. Code § 3208.3.

123 *See infra* Section V(C).

124 DeCarlo & Minkowitz, *supra* note 1, at 284.

125 *See supra* Section II(F)(5).

126 Conn. Gen. Stat. § 31-275(16)(B)(ii) ("'Personal injury' or 'injury' shall not be construed to include: ... (ii) A mental or emotional impairment, unless such impairment ([1]) arises from a physical injury or occupational disease, [except] ([2]) in the case of a police officer [detailing certain circumstances] ....").

127 *See infra* App. 1.

128 Zach v. Neb. State Patrol, 727 N.W.2d 206 (Neb. 2007).

129 Davenport v. City & County of Honolulu, 59 P.3d 932 (Haw. Ct. App. 2002).

130 This writer has, in this article, used the phrase "abnormal working conditions" as a shorthand to capture all the characterizations of the unusual stress necessary to make out a cognizable claim in this category.

131 *In re* Lanese v. Anthem Health Servs., 85 N.Y.S.3d 262, 265 (App. Div. 2018).

132 Empowerment Ass'n v. WCAB (Porch), 962 A.2d 1 (Pa. Commw. Ct. 2008).

133 These categories are discussed at length in Natalie D. Riley, *Mental-Mental Claims--Placing Limitations on Recovery Under Workers' Compensation for Day-to-Day Frustrations*, 65 Mo. L. Rev. 1023, 1024 n.6 (2000).

134 *Id.* In critiquing the three standards, Riley remarks, correctly,
Comparing the claimant's work-related stress to the "working world at large" is impractical. This standard would allow the parties to always produce a witness whose work-related stress is either significantly less or significantly greater than the stress experienced by the claimant. Furthermore, courts find this approach to be "difficult to analyze in practice and biased towards employees who work in perceived stressful occupations."
*Id.* at 1043 (quoting Marvin E. Duckworth & Tina M. Eick, *Recent Developments in Mental/Mental Cases Under the Iowa Workers' Compensation Law*, 45 Drake L. Rev. 809, 837 (1997)).

135 Kraus v. Wegmans Food Mkts., Inc., 67 N.Y.S.3d 702, 706 (App. Div. 2017) (quoting *In re* Guess v. Finger Lakes Ambulance, 812 N.Y.S.2d 393 (N.Y. App. Div. 2006)).

136 Vt. Stat. Ann. tit. 21 § 601(11)(J).

137 Crosby v. City of Burlington, 844 A.2d 722, 730 (Vt. 2003) (mental-mental claims are legitimate under Vermont constitution, but directing that purported unusual level of stress is determined vis-à-vis "all other employees performing similar work," and not "as compared with the general population of employees").

138 *See supra* Part II(D).

139 Pathfinder Co. v. Indus. Comm'n, 343 N.E.2d 913 (Ill. 1976). For a recent case that seems to apply the rule liberally, see *Moran v. Illinois Workers' Comp'n Comm'n*, 59 N.E.3d 934 (Ill. App. Ct. 2016) (court, reversing Industrial Commission, awards benefits to fire company supervisor who directed firefighters at site of deadly house fire and who became distraught at death of fellow firefighter).

140 La. Rev. Stat. § 23:1021(b).

141 Emerson v. Willis Knighton Med. Ctr., 257 So. 3d 243 (La. Ct. App. 2018).

142 Cal. Lab. Code § 3208.3(b)(3).

143 *Id.* § 3208.3(e)(4).

144 Wash. Admin. Code § 296-14-300(2).

145 Glenn M. Troost, *supra* note 97, at 847, 849 n.5 (1985).

146 Deziel v. Difco Lab'ys., Inc., 268 N.W.2d 1 (Mich. 1978).

147 Mich. Comp. Laws § 418.301(2).

148 Camp v. Dade-Behring, 2005 WL 2249761, at *8 (Del. Super. 2005).

149 Hawaii Rev. Stat. § 386-3.

150 Torrey & Greenberg, *supra* note 76, § 4:25.

151 Wilson v. WCAB (Aluminum Corp. of Am.), 669 A.2d 338 (Pa. 1996).

152 *Id. at* 344.

153 *See, e.g.*, McCoy v. WCAB (McCoy Catering Servs., Inc.), 518 A.2d 883 (Pa. Commw. Ct. 1986), *appeal denied*, 535 A.2d 84 (Pa. 1987) (denial of fatal claim benefits to a widowed claimant whose husband's psychological stress and resulting suicide was derived from an inability to support his family as a result of his failing catering business).

154 *See infra* Section V(H). *See* App. 3.

155 For example, the Oregon statute, which also sets forth an abnormal working conditions rule, provides that a mental-mental is only compensable when "[t]here is a diagnosis of a mental or emotional disorder which is generally recognized in the medical or psychological community." Or. Rev. Stat. § 656.802(3).

156 Smith v. Carver County, 931 N.W.2d 390 (Minn. 2019) (WCCA committed error in reversing denial of PTSD claim by former police officer; ALJ had no obligation to ascertain whether defense psychologist closely held to the DSM-5 diagnosis of PTSD in his opinion), *reversing*, Smith v. Carver County, 2019 WL 235685, at *1 (Minn. W.C.C.A. 2019).

157 Sakotas v. WCAB (Motel 6), 95 Cal. Rptr.2d 153 (Ct. App. 2000).

158 *Id.* at 160 ("[T]he Legislature enacted section 3208.3, subdivision (b)(1) to combat the proliferation of fraudulent psychiatric claims and reduce the costs of workers' compensation coverage."); *see also* McCrone v. Bank One Corp., 839 N.E.2d 1 (Ohio 2006) (R.C. 4123.01(c)(1) did not violate equal protection by complete exclusion of psychological and psychiatric injuries from workers' compensation coverage); Frantz v. Campbell Cnty. Mem. Hosp., 932 P.2d 750 (Wyo.1997) (noting that state workers' compensation law did not violate equal protection by excluding mental injuries from workers' compensation coverage: "rationale behind the exclusion includes the steadily growing number of claims for psychological disorders, the difficulty with verifying such claims because the claimant's description of his condition is often the sole basis for diagnosis and the difficulty with determining whether a causal relationship exists between the claimant's employment and the mental injury").

159 Stratemeyer v. Lincoln Cnty., 915 P.2d 175 (Mont. 1996).

160 LaRose v. King County, 437 P.3d 701 (Wash. Ct. App. 2019). The LaRose workers' compensation claim, meanwhile, was dismissed, as the judge found that the mental injury was from gradual stress. The appellate court affirmed in a 2020 ruling. LaRose v. Department of Labor & Industries, 456 P.3d 879 (Wash. Ct. App. 2020).

161 Bias v. E. Associated Coal Corp., 640 S.E.2d 540 (W. Va. 2006). This holding provoked a blistering dissent.

162 Anderson v. WCAB (Wash. Greene Alt.), 862 A.2d 678 (Pa. Commw. Ct. 2004).

163 Oberle v. Indus. Claim App. Off., 919 P.2d 918 (Colo. Ct. App. 1996).

164 Larson, *supra* note 2, § 56.02[3].

165 Luttrell v. Clearwater Cnty. Sheriff's Off., 97 P.3d 448 (Idaho 2004).

166 Larson, *supra* note 2, § 56.02[3].

167 Young v. WCAB (New Sewickley Police Dept.), 737 A.2d 317, 322 (Pa. Commw. Ct. 1999).

168 This writer discussed the strategy at length in David B. Torrey, *Pennsylvania Experiences with the Mental Injury/Physical Injury Dichotomy: Cases Involving Schizophrenia and Shiftwork Maladaptation Syndrome*, 47 IAIABC J. 57 (2010), https://iecdp.files.wordpress.com/2011/08/iaiabc_journal_spring_2010_webversion1.pdf.

169 Todd v. Goostree, 493 S.W.2d 411, 421 (Mo. Ct. App. 1973).

170 Wheeler v. State *ex rel.* Wyo. Workers' Safety & Comp'n Div., 245 P.3d 811 (Wyo. 2010).

171 *Id.* at 815.

172 *Id.* at 817 ("Based upon the statutory language which clearly differentiates between mental and physical injuries, the fact that the legislature made a specific change in 1994 to exclude mental injuries that were not caused by compensable physical injuries and our case law interpreting the statute, we conclude that the requisite 'physical injury' must be something outside of the biological changes in the brain associated with mental disorders. While we respect that [the expert] disagrees with the legislature's policy choice to disallow mental injuries, we cannot overlook the clear language of the statute.").

173 Leo v. WCAB (Borough of Charleroi), 537 A.2d 399 (Pa. Commw. Ct. 1988). In that case, the claimant was a municipal worker for a small city. According to the opinion, "Upon transfer from the Street Department to the Police Department, Claimant experienced a mental breakdown, a biological illness diagnosed as paranoia schizophrenia. His physical illness was triggered by the stress he experienced in his efforts to fulfill the post of a police officer." *Id.* at 400.

174 Torrey & Greenberg, *supra* note 76, § 4:33.

175 Torrey, *supra* note 168.

176 RAG (Cyprus) Emerald Res., LP v. WCAB (Hopton), 850 A.2d 833 (Pa. Commw. Ct. 2004), *rev'd*, 912 A.2d 1278 (Pa. 2007).

177 Ohio Rev. Code § 4123.01 (stating in part that "[i]njury" does not include: "(1) Psychiatric conditions except where the claimant's psychiatric conditions have arisen from an injury or occupational disease sustained by that claimant or where the claimant's psychiatric conditions have arisen from sexual conduct in which the claimant was forced by threat of physical harm to engage or participate").

178 As the editor of the Larson treatise admonishes, "It is axiomatic that the exclusive remedy provisions of a state's workers' compensation act cannot trump federal anti-discrimination laws, such as Title VII of the Civil Rights Act of 1964, which generally prohibits discrimination and/or harassment of employees on the basis of, among other things, their sex [see The Supremacy Clause (USCS Const. Art. VI)]." Thomas A. Robinson, *Sexual Harassment Claims and Workers' Compensation Exclusivity*, Blog Post (Dec. 12, 2008), https://www.lexisnexis.com/legalnewsroom/workers-compensation/b/workers-compensation-law-blog/posts/larson_2700_s-spotlight_3a00_-sexual-harassment-claims-and-workers_1920_-compensation-exclusivity. He also posits, correctly, that "in most jurisdictions, ... some tort claims are successful as against the exclusivity defense, being treated as outside the ambit of the workers' compensation system. Decisions of this kind generally rely on one of three distinguishing features: [1] the intangible or emotional nature of the plaintiff's injury; [2] the intentional--rather than accidental--quality of sexual harassment; or [3] the personal--rather than work-related--origin of sexual harassment." *Id.*

179 Torrey & Greenberg, *supra* note 76, § 4:28 ("Federal courts are often presented with civil complaints that include sexual harassment counts pleading physical and mental injury. Most courts dismiss such counts, convinced that the Pennsylvania Supreme Court would hold that sexual harassment in the workplace is a condition of work, and that when an injury from the same occurs, it has arisen in the course of employment.").

180 Canosa v. Ziff, 2019 WL 498865 (S.D.N.Y. 2019).

181 *Id.* at *11.

182 *See, e.g.*, City of Lower Burrell v. WCAB (Babinsack), 2020 WL 1190603 (Pa. Commw. Ct. 2020) (police officer already stressed from working with angina found to have experienced abnormal working conditions when he observed dead body of his colleague, who had been murdered by escaped fugitive); Moran v. Ill. Workers' Comp'n Comm'n, 59 N.E.3d 934 (Ill. App. 2016) (court, reversing Industrial Commission, holds that claimant was exposed to sudden shock or fright, and Commission's finding to the contrary was against the manifest weight of the evidence: claimant was a supervisor at fire scene at which a subordinate was caught in a flashover and died; claimant developed guilt, mental collapse, and PTSD).

183 *See, e.g.*, Smith v. Carver County, 931 N.W.2d 390 (Minn. 2019) (court, affirming ALJ's denial of benefits, holds that court of appeals committed error in reversing denial by former police officer; ALJ had no obligation to ascertain whether defense psychologist closely held to the DSM-5 diagnosis of PTSD in his opinion); Bentley v. Spartanburg County, 730 S.E.2d 296 (S.C. 2012) (deputy who shot umbrella-wielding suspect at short-range, and observed him die, did not experience unusual stress; though denial of benefits was affirmed, court recommended that legislature abandon the restrictive statutory test).

184 Rene Ebersole, *First Responders Struggle with PTSD Caused by the Emergencies, Death, Tragedies They Face Every Day*, Wash. Post (Oct. 15, 2019) (including an account of a volunteer firefighter/EMT traumatized by providing aid at the Sandy Hook elementary school massacre).

185 John E. Hanson, *Addressing the Emergence of [the] PTSD Presumption: Issues and Solutions*, Power Point Slides (Willis Towers Watson 2018), https://www.nlc.org/sites/default/files/users/user118/PDF%20Hanson%C20PTSD%20d.3a.pdf.

186 *See* Hannah Wiley, *New California Law Lets First Responders Seek Workers' Comp for PTSD*, Sacramento Bee (Oct. 2, 2019) (reporting on the signing of S.B. 542 and stating that more firefighters and police officers died from suicide in 2017 than injuries sustained in the line of duty).

187 Hanson, *supra* note 185, at 4.

188 *Id.*

189 Colo. Rev. Stat. § 8-41-301(3).

190 *See, e.g.*, Louisiana Comp Blog, *New Louisiana PTSD Law for First Responders Stands out in Region* (July 25, 2019) (observing that the "new law is part of a larger national trend that seeks to address, in part, public outcry from what some considered to be negligent treatment of first responders struggling after mass shootings like that at the Pulse nightclub in Orlando").

191 These rules have now been published. They are available at *First Responder FAQs for PTSD*, https://www.myfloridacfo.com/Division/WC/InfoFaqs/PTSD-FAQs.pdf.

192 *See* Fla. Stat. Ann. § 112.1815(5)(a) *et seq.*

193 Texas is another state where eligibility standards have been eased, but where the worker still has the burden of proof. Tex. Lab. Code § 504.019.

194 Thomas A. Robinson, *Challenges for First Responders (and a Society That Respects Them)*, *in* Workers' Compensation: Emerging Issues Analysis, 2019 Ed., vii *et seq.* (2019). This writer and colleagues have also tracked the trend for the last few years. *See* David B. Torrey, Lawrence D. McIntyre & Justin D. Beck, *Recent Developments in Workers' Compensation and Employers' Liability Law (2019 Survey Issue)*, 55 Tort Trial & Ins. Prac. L.J. 467, 470 (2020); David B. Torrey, Lawrence D. McIntyre, Kyle D. Black & Justin D. Beck, *Recent Developments in Workers' Compensation and Employers' Liability Law (2018 Survey Issue)*, 54 Tort Trial & Ins. Prac. L.J. 761, 766-67 (2019). A journalist's early account of this legislative activity is Louise Esola, *First Responder Comp Bills Introduced to Limited Success*, Bus. Ins. (Sept. 19, 2018), https://www.businessinsurance.com/article/20180919/NEWS08/912324081/First-responder-comp-bills-introduced-to-limited-success.

195 Workcompwire, *NCCI Release INSIGHTS: 2020 Workers' Compensation Legislative Session Review* (Feb. 12, 2020), https://www.workcompwire.com/2020/02/ncci-releases-insights-2020-legislative-session-workers-comp-preview.

196 *See, e.g.*, *New Louisiana PTSD Law for First Responders Stands out in Region*, La. Comp. Blog (July 25, 2019), https://compblog.com/new-louisiana-ptsd-law-for-first-responders-stands-out-in-the-region (observing that the "new law is part of a larger national trend that seeks to address, in part, public outcry from what some considered to be negligent treatment of first responders struggling after mass shootings like that at the Pulse nightclub in Orlando"); *see also* Hanson, *supra* note 185, at 2.

197 *See* Nat'l Council on Comp'n Ins. Leg. Trends Report (July 2019), https://www.ncci.com/Articles/Documents/II_Regulatory-Legislative-Trends2019.pdf.

198 Or. Rev. Stat. § 656.802.

199 Vt. Stat. § 601(11)(I)(i).

200 *Id.* § 601(11)(J).

201 On the other hand, the New Mexico statute seems to suggest that a claimant qualifying for the presumption is to be paid medical treatment benefits until an adjudication to the contrary. The statute provides, "Medical treatment based on the presumptions created in this section shall be provided by an employer as for a job-related illness or injury unless and until a court of competent jurisdiction determines that the presumption does not apply. If the court determines that the presumption does not apply or that the illness or injury is not job related, the employer's workers compensation insurance provider shall be reimbursed for health care costs by the medical or health insurance plan or benefit provided for the firefighter by the employer." N.M. Rev. Stat. § 52-3-32.1(F).

202 Howard Fischer, *Arizona Officials Tackle Workers' Comp Law for Firefighters with Cancer*, YourValley.net (Jan. 16, 2020) (discussing a new bill that would eliminate "loophole" of rebuttal proviso and replacing same with presumably guaranteed recovery: "This new proposal would spell out that if a firefighter was diagnosed with one of the listed cancers in the law, that provides 'conclusive and irrebuttable' evidence that the disease is work related. And that, in turn, ensures that workers' compensation benefits are available."), https://www.yourvalley.net/stories/arizona-officials-tackle-workers-comp-law-firefighters-cancer,131201

203 Bristol Borough v. WCAB, 206 A.3d 585, 607 (Pa. Commw. Ct. 2019) ("As a general rule, a presumption is but an evidentiary advantage and its only effect is to shift the evidentiary burden of going forward to the opponent .... When evidence is introduced that rebuts the presumption, it disappears.").

204 David B. Torrey, *Firefighter Cancer Presumption Statutes in Workers' Compensation and Related Laws: An Introduction and a Statutory/Regulatory/Caselaw Table* (Nat'l Ass'n Workers' Comp'n Judges White Paper 2012), http://www.nawcj.org/wp-content/uploads/2019/06/NAWCJ-FIREFIGHTER-PRESUMPTIONS-Essay-Table-2013.pdf.

205 Hanson, *supra* note 185, at 4.

206 Frank Neuhauser, *Cancer Presumption for Firefighters: Good Policy or Give Away?,* IAIABC Persps. 7 (July 2019).

207 Esola, *supra* note 194 (noting that PTSD presumption bills "have been opposed by municipalities concerned about the potential for their costs to run in the 'hundreds of millions of dollars'").

208 Hanson, *supra* note 185.

209 Esola, *supra* note 194.

210 Thomas A. Robinson, *Challenges for First Responders (and a Society that Respects Them)*, *in* Workers' Compensation: Emerging Issues Analysis, 2019 Ed. ix-x (2019).

211 Donald E. Lampert, *Recent Developments in Ohio, in* Workers' Compensation: Emerging Issues Analysis, 2019 Ed. 165 (2019).

212 Some states limit the maximum number of weeks of disability available in *physical-mental* claims to six months after maximum medical improvement. *See, e.g.*, Fla. Stat. Ann. § 440.093(3). Wyoming maintains essentially the same law. Wyo. Stat. § 27-14-102(xi)(J)(I). The new Virginia first-responder PTSD statute imposes a cap of fifty-two weeks on duration of disability payments; meanwhile, a statute of repose provides that no medical treatment or disability payments may be made beyond four years from the date of the qualifying event. *See* Va. Code § 65.2-107.

213 *See* Recommendation 3.17, Report of the Nat'l Comm'n on State Workmen's Comp'n Laws 65 (1972), https://workerscompresources.com.

214 By way of analogy, it is notable that, in the wake of the chronic pain/opioid abuse crisis, employers and carriers have been encouraged, as a substitute for narcotic use, to point workers to psychotherapy for pain management. This is so in the name of cost savings, but also for the improved health of the patient.

215 **Alaska:** Alaska Stat. § 23.30.010(b) also provides, "The amount of work stress shall be measured by actual events. A mental injury is not considered to arise out of and in the course of employment if it results from a disciplinary action, work evaluation, job transfer,

layoff, demotion, termination, or similar action taken in good faith by the employer." This latter requirement is hereinafter referred to as the "Good-Faith Personnel Action" exception.

216 **Arkansa**s: An exception exists when the claimant is a victim of a "crime of violence."

217 **Arkansas**: The restrictive 1993 reform in Arkansas was noted and criticized in John D. Copeland, *The New Arkansas Workers' Compensation Act: Did the Pendulum Swi*ng too Far?, 47 Ark. L. Rev. 1 (1994).

218 **California**: Gradual stress claims not cognizable for workers who have been employed fewer than six months. The California law, and how it was changed in 1993, is discussed at Aya V. Matsumoto, *Reforming the Reform: Mental Stress Claims under California's Workers' Compensation System*, 27 Loy. L.A. L. Rev. 1327 (1994), https://digitalcommons.lmu.edu/cgi/viewcontent.cgi?article=1862&context=llr.

219 **California**: Statute features a Good-Faith Personnel Action exception. Lighter burden of proof on claimant when injury alleged to have been caused by violent act or exposure to same.

220 **Colorado**: July 2018 amendment clarifies that PTSD is covered. Also, statute features a Good-Faith Personnel Action exception.

221 **Connecticut**: *See generally* Lee R. Hansen, "*Mental-Mental" Workers' Compensation in Nearby States*, Office of Legislative Research Report (March 3, 2014) (examining the law of mental-mental injuries in Massachusetts, New Jersey, New York, and Rhode Island), https://www.cga.ct.gov/2014/rpt/pdf/2014-R-0080.pdf.

222 **Illinois**: "Accidental" is not defined in the Act.

223 **Iowa**: Statute does not otherwise refer to mental injuries.

224 **Maine**: Statute features a Good-Faith Personnel Action exception.

225 **Minnesota**: Statute features a Good-Faith Personnel Action exception.

226 **Missouri**: Statute discussed at Natalie Riley, *Mental-Mental Claims--Placing Limitations on Recovery Under Workers' Compensation for Day-to-Day Frustrations*, 65 Mo. L. Rev. 1023 (2000).

227 **Montana**: Law precludes not only "mental-mentals" but "mental-physicals" as well.

228 **New Hampshire**: Statute features a Good-Faith Personnel Action exception.

229 **New Mexico**: Gradual stress was held to be compensable in one case, but legislature thereafter changed the law to require a psychologically traumatic event. See Candelaria v. Gen. Elec. Co., 730 P.2d 470 (N.M. Ct. App. 1986).

230 **North Carolina**: For an academic treatment, see James R. Martin, Comment, *A Proposal to Reform the North Carolina Workers' Compensation Act to Address Mental-Mental Claims*, 32 Wake Forest L. Rev. 193 (1997).

231 **Ohio**: Exception for injury via "sexual conduct in which the claimant was forced by threat of physical harm to engage or participate ...."

232 **Oklahoma**: An exception is made with regard to a victim of violent crime.

233 **Oregon**: Requirements codified in the occupational disease sections.

234 **Pennsylvania**: Case law has interpreted "injury" to include mental-mentals, but the injured worker must show abnormal working conditions--a heavy burden. Gradual stress claims, meanwhile, are not cognizable.

235 **Rhode Island**: A leading case from 1981, *Seitz v. L&R Indus.*, 437 A.2d 1345 (R.I. 1981), addressed mental-mental cases, and a rule allowing the same under certain conditions was eventually codified. The *Seitz* case is still cited as precedent even though a statute is now in place. In *Seitz*, the court held that an office manager who suffered from the ordinary stress and rigors of moving her office from one city to another was not entitled to obtain benefits under the Workers' Compensation Act for her alleged psychological injuries.

236 **Texas**: Statute features a Good-Faith Personnel Action exception.

237 **Vermont**: Statute features a Good-Faith Personnel Action exception. **Note also**: The *Crosby* standard of assessing extraordinary stress via-a-vis similarly-placed workers was changed, in a 2017 amendment, to average employees across all occupations. Bergeron v. City of Burlington, 2018 WL 5823071 (Vt. Dep't of Lab. & Indus., 10.25.2018).

238 **Washington**: A program remarkable in that discrete mental injuries are recognized via administrative *r*egulation. Meanwhile, statute provides that mental-mentals cannot be recovered as an occupational disease.

239 **West Virginia**: Statute provides, remarkably, "It is the purpose of this section to clarify that so-called mental-mental claims are not compensable under this chapter." This statute is thoroughly discussed at Logan Burke, *Finding a Way out of No Man's Land: Compensating Mental-Mental Claims and Bringing West Virginia's Workers' Compensation System into the 21st Century*, 118 W. Va. L. Rev. 889 (2015).

240 The law under FECA surrounding stress claims is discussed at American Postal Workers Union, *Stress Claims*, https://apwu.org/news/stress-claims.

241 **Colorado**: The law as ultimately enacted does not limit expanded PTSD coverage to first responders, but had its genesis in a concern that such employees typically did not recover workers' compensation for the condition. A unique 2020 amendment clarified that "audible trauma" is covered. By this amendment, the legislature intended to include mental trauma sustained by 911 operators.

242 **Florida**: These items are further refined by regulation.

243 During consideration of the Wyoming law, Professor Michael C. Duff expressed concern that the proposed PTSD presumption might be constitutionally questionable as an impermissible "special law." Michael C. Duff, *Is Wyoming's Proposed Workers' Compensation PTSD Bill a "Special Law"?*, Workers' Comp'n L. Prof Blog (Mar. 7, 2020), https://lawprofessors.typepad.com/workerscomplaw/2020/03/is-wyomings-proposed-workers-compensation-ptsd-bill-a-special-law.html.

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**Deirdre M. Smith, *Diagnosing Liability: The Legal History of Posttraumatic Stress Disorder*, 84 Temp. L. Rev. 1 (2011)**

**84 Temp. L. Rev. 1**

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**Articles**

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**DIAGNOSING LIABILITY: THE LEGAL HISTORY OF POSTTRAUMATIC STRESS DISORDER**

*This Article examines the origins of the unique relationship between the psychiatric diagnosis Posttraumatic Stress Disorder (PTSD) and the law and considers the implications of that relationship for contemporary uses of the diagnosis in legal settings. PTSD stands apart from all other diagnoses in psychiatry's standard classification system, the Diagnostic and Statistical Manual of Mental Disorders (DSM), and is the focus of significant controversy within psychiatry, because its diagnostic criteria require a determination of causation. By diagnosing a person with PTSD, a clinician necessarily assigns responsibility to a specific event or agent for causing the person's symptoms, a practice more commonly associated with law. In short, the diagnosis uniquely medicalizes liability. The law has turned to PTSD, on the erroneous assumption that its location in the DSM signifies that it is well-settled science, to serve as a mechanism to resolve difficult problems in assessing legal responsibility. These uses include determining whether a criminal complainant is credible and when emotional distress from another's negligence is sufficient in itself to serve as a basis for liability. However, by adopting PTSD's conceptualization of causation of psychological injury, courts unknowingly delegate normative determinations of liability to psychiatry broadly and to the individual psychiatrists who* ***2** *present PTSD evidence at trial. This Article argues that the legal system should consider PTSD's origins and its persistent controversies as part of a broader reexamination of the role of the diagnosis in the law.*

> *"[A]s soon as you accepted that the man's break down was a consequence of his war experience rather than of his own innate weakness, then inevitably the war became the issue."*[1]

## I. Introduction

The psychiatric diagnosis Posttraumatic Stress Disorder (PTSD) is powerful on many levels. The term permeates our culture, and the very mention of it can evoke imagery of the horrors of war, genocide, child abuse, and epic disasters. Affixing the label of PTSD to an individual suggests that the person was once mentally healthy and, as a result of a distinct and horrific experience, is now psychologically damaged and scarred. The person "reexperiences" the event through frightening symptoms such as flashbacks, fear, anxiety, avoidance, and nightmares. It is the diagnosis that attaches to psychological injuries--that is, a mental disorder attributable to an external cause. And, for all of these reasons, it is a diagnosis that appears uniquely suited for aiding the determination of liability in court.

PTSD has generated much attention and controversy within both law and psychiatry in large part because it contains elements of two fields that do not always fit together easily. PTSD stands apart from all other diagnoses in the American Psychiatric Association's (APA) standardized classification, the Diagnostic and Statistical Manual of Mental Disorders (DSM), because it has a determination of causation built into the definition,[2] whereas other listings are agnostic as to the etiology of disorders. That is, although PTSD's listing has the typical descriptive cluster of symptoms found in all psychiatric diagnoses, its criteria also require a diagnostician to assign the cause of such symptoms to a specific external event or other source, known as the "A Criterion,"[3] a practice more commonly associated with the law.[4] In short, the diagnosis medicalizes liability.

This Article traces the historical origins of the unique relationship between PTSD and the law and explores the implications of such relationship for contemporary uses of the diagnosis in legal settings. Part II examines the early conceptualizations of psychological injury within medicine and the relationship of those theories to questions of legal responsibility from the late nineteenth to mid-twentieth centuries. It reviews ***3** the history of PTSD's forerunners--railway spine, shell shock, and traumatic neurosis--and demonstrates that a link to external causes, often with an association with liability questions, has been a key attribute of these diagnoses, even though the specific symptomatology and theories of the precise causal mechanisms at work have differed significantly over time. Part II then considers the parallel developments in the law regarding liability for psychological injuries during this same period.

Part III recounts the campaign for the inclusion of PTSD in the DSM and the unusual place of the diagnosis, and specifically the A Criterion, within the APA's classification system. The diagnosis first appeared in the third edition of the DSM in 1980 as a result of heavy lobbying by Vietnam veterans' groups who saw it as a mechanism to legitimate the extreme symptoms of veterans, enabling them to receive care and benefits for combat-related mental illnesses.[5] However, the APA subsequently loosened the diagnostic criteria to reflect use of the diagnosis for people experiencing a wide range of life experiences, and the diagnosis became ubiquitous in personal injury litigation and widely used in criminal law as well. Although psychiatry broke away from the psychoanalytic and other psychodynamic theories of the origins of mental disorders in the rest of the DSM-III, PTSD represented a rooting in the past, both for the patients and for the field.

This historical discussion serves as the backdrop for Part IV of this Article, which explores the uses of PTSD in the legal context and considers how PTSD, as one group of commentators put it, "acquired [its] own legal currency."[6] This Part focuses on two particular uses of the diagnosis to address problems of establishing liability: (1) proving that a criminal complainant or civil plaintiff was subjected to an alleged trauma to prove criminal or civil liability for such trauma; and (2) enabling personal injury plaintiffs to pursue "stand-alone" claims for psychological injuries. Part IV also examines the minimal evidentiary limitations that courts impose on such uses.

Part V returns to psychiatry and reviews two key controversies concerning PTSD that challenge many of the core assumptions upon which the APA based its recognition of the disorder: (1) the validity of the A Criterion and the causal relationship between events and symptoms; and (2) the extent to which PTSD is a "construct" rather than a "scientific discovery." This discussion concludes that the inherent complexities of both the formation of emotional responses to life events and the development of psychiatric diagnoses preclude any simple "resolution" of these debates.

Part VI concludes the Article by reviewing the lessons for law from PTSD's history and by considering the implications for the role of PTSD evidence in litigation specifically and for the relationship between the law and psychiatry on a broader level. Medical diagnoses are largely the result of "negotiations" among various institutions and stakeholders rather than being pure scientific "discoveries." The history of PTSD's negotiations reveals a particularly prominent role for legal interests. From the late ***4** nineteenth century to the publication of DSM-III, medicine produced various diagnostic labels for psychological injuries, particularly those for which individuals sought compensation or other legal benefit. Psychiatry thus addressed socio-legal needs as well as medical needs when it established PTSD. The law has turned to PTSD and its unique linking of an identifiable event and psychiatric symptoms to serve as a mechanism to resolve difficult problems in assessing legal responsibility, such as determining whether a criminal complainant is credible and when emotional distress from negligence is sufficient in itself to serve as a basis for liability.

However, most courts that admit evidence of PTSD for such purposes impose minimal scrutiny to the diagnosis. Rather, the fact of PTSD's location within the DSM (coupled with courts' misplaced assumptions about the DSM itself) has led most courts to grant PTSD the status of well-settled science. Courts are likely unaware of PTSD's legal origins, the persistent controversies within psychiatry and psychology about the theoretical underpinnings of the diagnosis, and the complicated notion of "causation" within contemporary psychiatry. All of this suggests that courts should exercise caution before permitting the diagnosis to serve as evidence in a determination of liability.

Accordingly, the legal system should consider PTSD's historical development and contemporary controversies as part of a broader reexamination of the role of the diagnosis in the law. By adopting PTSD's particular (and unsettled) conceptualization of the causation of psychological injury, courts may unknowingly delegate the normative determinations of legal responsibility to psychiatry broadly and to the individual psychiatrists who present PTSD evidence at trial. Such uses recast PTSD as essentially a legal tool, potentially undermining its clinical function in aiding those who have experienced the horrors of war, assault, and disaster.

## II. The Psychiatric Forerunners of PTSD and Parallel Developments in Law

Although the term "posttraumatic stress disorder" was first coined in the 1970s during the development of the diagnosis that eventually appeared in the third edition of the DSM, the direct lineage of the term extends to at least the late nineteenth century.[7] As PTSD's history reveals, the link between medical concepts of psychological injury and legal notions of responsibility is not of recent origin but was present from the earliest conceptualizations of such injuries. Thus, it is impossible to talk of PTSD and its forerunners apart from broader socio-political attempts to attach legal responsibility for psychological injuries to identifiable sources.

### A. Early Medical Conceptualizations of Psychological Injury

The history of psychiatry reflects a wide range of theories on the origins of mental illness. Some have thought that the symptoms of mental instability originate from spirits, humors, vapors, or demons.[8] The notion that an exogenous event could alter one's behavior, thinking, and beliefs--that one could sustain a psychological injury--is ***5** of more recent origin, and has always been controversial. Freud and other followers of his theories were significant proponents of the notion that one's prior life experiences, particularly negative ones, can have lasting influence on one's psyche.[9] Although Freud himself later altered these theories to give fantasy a more prominent role, the essential notion of a lasting emotional reaction to a specific event has persisted to this day.

PTSD is often associated with exposure to combat, and indeed military psychiatry is where many of the concepts of PTSD found their origins during the First World War.[10] However, the story of PTSD in fact begins with the railways.[11] Prior to the spread of the railways, and the accompanying spate of railway accidents, traumatic injuries were not commonly the subject of either everyday conversation or litigation.[12] The word "trauma" was, until the late nineteenth century, a term associated exclusively with physical wounds.[13] John Erichsen, a British surgeon and academic, is often credited with being the first to apply the term to psychiatric injuries[14] in his book, On Railway and Other Injuries of the Nervous System, first published in 1866.[15] Erichsen theorized that railway injuries from "Jars, Shakes, Shocks, or Concussions" to the spinal cord could cause injuries (specifically, lesions) that could have several manifestations, including "cerebral" changes affecting memories, thoughts, temper, and sleep.[16] Erichsen did not and could not explain the specific causal mechanism in place leading to so-called "railway spine,"[17] but his work led to that of others who more thoroughly developed the association between railway injuries and nervous system disorders.[18]

***6** Erichsen developed his theory and diagnostic term with litigation specifically in mind.[19] At the time, British and American societies were confronting the impact of industrialization, and particularly railways, on society. Railway accidents were "frequent, terrifying and highly publicized instances of the capacity of industrial technology to maim and kill."[20] A significant number of railway accidents led to claims for compensation.[21] However, in a number of these cases, railways were able to escape with little or no financial liability where, notwithstanding the presence of negligence, the physical injuries were minimal.[22] Accordingly, Erichsen, who testified frequently on behalf of patients in these cases, developed his theory of railway spine to decrease the "discrepancy of surgical opinion" regarding those who exhibited symptoms that arose after the accident, and when

it had been assumed that there had been no injury.[23] These symptoms included "headache, confusion of thought, loss of memory, disturbance of the organs of sense, [and] irritability of the eyes and ears."[24] His work initially had an enormous impact on litigation against the railways, resulting in large damages awards and settlements.[25]

Medicine did not uniformly embrace Erichsen's theories and, given the financial impact on the railways and the lack of empirical basis for railway spine, they provoked swift criticism.[26] One of his most prominent critics was Herbert Page, a physician who, not surprisingly, did consulting work for a railway.[27] Page immediately challenged the causal assumptions underlying Erichsen's theory of traumatic railway injuries. He rejected Erichsen's purely somatic hypothesis in favor of one that included a potential causal role for fear in the mix, thus recharacterizing the symptoms as psychosomatic.[28] He referred to the condition as "nervous shock," and concluded that it arose only in those with a preexisting "nervous temperament."[29]

***7** In his criticism, Page specifically raises the specter of malingering-- the exaggeration or falsification of symptoms[30]--in light of the potential for compensation for railway injuries made possible by the passage in England in 1864 of an amendment to the Campbell Act, allowing recovery for railway injuries.[31] Page, among others, suspected that desire for compensation played some role in the development and persistence of symptoms, even in unconscious ways.[32] The resistance by doctors associated with the railways to permitting recovery of compensation for injuries that were not obviously physical was unrelenting, and some turned their criticism specifically to the doctors who diagnosed such conditions, who, they claimed, were responsible for the role of "suggestion" in the persistence of symptoms.[33] Those arguing a purely psychological (or "hysterical") origin for lasting symptoms also challenged Erichsen and other proponents of such conditions in the courtroom,[34] and had some success in limiting the railways' exposure for such claims.[35]

The debate regarding diagnoses such as "railway spine" soon spread beyond Britain. In Germany in the 1880s, neurologist Hermann Oppenheim developed the term "traumatic neurosis," and saw a key role for direct neuropathological injury in its onset.[36] His theory, like Erichsen's, developed as a result of work treating individuals who developed a range of symptoms after railway and other industrial accidents.[37] Unlike Erichsen, however, he also saw a significant etiological role for "the psyche: terror, emotional shock."[38]

Across the Channel in France, neurologist Jean-Martin Charcot was also interested in the development of traumatic syndromes. Charcot focused entirely on the causal impact of fear in creating symptoms even in the absence of any spinal injury or ***8** lesions.[39] This interest grew out of his close study of "hysteria," and he opined that Oppenheim's descriptions of "traumatic neuroses" were essentially indistinguishable from hysteria, as he had classified it.[40] He suspected that traumatic experiences often accounted for hysteria in men.[41] In an argument that would foreshadow controversies arising a century later about PTSD, Charcot challenged the creation of traumatic neurosis as an "entity" aside from hysteria, distinguished only by having a specific origin, such as fear or fright.[42] The term "traumatic hysteria" soon found use not only to explain the unusual symptoms experienced by those who had been exposed to an event but also to bring more credibility to the concept of "hysteria" generally, which had become a disparaging term by this time, used primarily to describe a "condition" (or perhaps simply malingering) displayed by overdramatic women.[43]

Oppenheim resisted Charcot's linking of post-traumatic responses with hysteria.[44] He was concerned that Charcot's use of the term "traumatic hysteria" suggested too strong a role for the individual's thoughts and ideas and raised the specter of malingering.[45] Oppenheim's theories were eventually rejected by the German psychiatric establishment, in part because they had been successfully used to support compensation claims brought by railway and factory workers and because (unlike Page, for example) he did not suggest a significant role for individual predisposition in the onset of these neuroses.[46] Although

Oppenheim is regarded as only a minor player in the development of modern notions of posttraumatic psychological injury (in fact, his name is nearly forgotten), his conceptualization of "traumatic neurosis" had a more lasting impact than the theories of any of his contemporaries, and, as we shall see, that term played an increasingly important role in personal injury litigation in the twentieth century.[47]

***9** Work on the psychological impact of accidents continued with a number of researchers in Europe and the United States at the turn of the twentieth century.[48] American neurologist George Miller Beard first suggested the diagnosis of "traumatic neurasthenia," the symptoms of which resemble those of railway spine.[49] The term "neurasthenia" had been around for a few decades, and it was regarded as being more legitimate than hysteria, although its symptoms were vague and not well defined.[50] It was seen as a condition caused by "the stresses of advanced civilization," and, for that reason, many readily accepted a causal link with industrial accidents.[51] Beard asserted that neurasthenia had a physical cause (as Erichsen had claimed was true for railway spine) and "defined as 'disease' what before had been seen as self-willed, and in the process shifted causation away from the individual to modern civilization."[52]

Many of those examining these questions of psychological injury turned their focus to the role of memory in the emergence of psychological symptoms--the "pathogenic memory" or "traumatic memory"[53]--and such "traumatic remembering" is a core concept of PTSD.[54] Sigmund Freud's original theories about traumatic memory (developed in conjunction with Josef Breuer) tied pathology to a patient's memory of a traumatic event.[55] The pathological mechanism was thought to stem from a patient's inability to "discharge" his emotional reactions to the event, forcing the nervous system to "manage a sudden surge of excitation."[56] Memories of these events then became isolated from a person's consciousness and could no longer be reached.[57] The key to treatment, therefore, was to bring such traumatic memories to the surface and verbalize them through "abreaction"[58] to achieve "catharsis,"[59] so that the memories would lose their "pathogenic power."[60] Freud's "seduction theory" suggested that psychoneurosis stemmed from early childhood trauma, generally sexual abuse, whereas "actual neurosis" emerged from trauma later in life.[61] He later abandoned the theory to place more emphasis on the role of early fantasy in the development of neuroses.[62]

***10** The theories of pathogenic memory advanced by Freud, Breuer, and French psychologist Pierre Janet[63] in the years leading up to the First World War began to displace the approaches to psychological injury described by Erichsen, Page, Beard, and Charcot.[64] Interest in pathogenic memory in particular became strong during the war, when there was horror on a scale (both in terms of frequency and degree) that was previously unfathomable, at a time when clinicians in many countries were exploring these new notions of memory and consciousness.[65] Suddenly, the countries involved in the fighting had thousands of emotionally-wounded soldiers and little plan to address the widespread epidemic.[66]

The British military establishment set a number of distinct labels to diagnosis the psychiatric conditions seen in officers and enlisted men during this time.[67] The most prominent and lasting was "shell shock,"[68] which, like Erichsen's original conceptualization of railway spine, was based upon an assumption that the symptoms' primary origin was a neurological injury from a specific event, such as the discharge of an explosive in very close proximity.[69] Shell shock soon became a blanket synonym for all war neuroses, particularly in light of the challenge of differentiating among the various conditions as they appeared in different individuals and a lack of a uniform classification system (or "nosology") in psychiatry or neurology at that time.[70] There is no indication that military psychiatrists followed anything resembling diagnostic criteria or shared a common understanding of how to differentiate among these various diagnoses.[71]

The controversy continued regarding whether individual disposition played a role in the development of these conditions.[72] Some physicians concluded that "inborn ***11** timidity or neuropathic disposition" explained why some soldiers and not others

developed these conditions.[73] Many army psychiatrists assumed that a combination of "flawed heredity and constitution" accounted for the cause of most war neuroses.[74] The issues raised in those debates are echoed in the contemporary controversies about the interaction of the psychological and physiological (such as the endocrine system) in the symptoms of PTSD and the role of preexisting psychopathology in those who develop PTSD.[75] Most physicians at the time were not particularly concerned with identifying the specific causal mechanisms of these conditions since the treatments employed did not depend upon such understanding.[76]

However, the adoption of shell shock was a considerable change for the military, which had previously attached a label of "cowardice" to such symptoms.[77] And the fact that one in six who received the diagnosis was an officer made it a nearly "respectable" condition.[78] The British military did attempt initially to distinguish between a reaction properly classified as a "wound" incurred in battle and a mere "breakdown," which carried far more of a stigma.[79] If the shell shock was not linked to a specific shell explosion, the soldier was labeled as "sick," not "wounded," and such designation precluded a pension award.[80]

By 1916, several military doctors concluded that the symptoms classified as shell shock did not necessarily depend upon a person's proximity to an explosion for the cause, but, in fact, may have a gradual onset or cause due largely to "emotions of extreme and sudden horror and fright"[81] or "sudden psychic shock."[82] Furthermore, a great number of soldiers were claiming to have the condition by name.[83] Thus, the psychiatrists rejected the label "shell shock" and officially replaced it with "war neuroses," or "functional nervous disorders."[84] But the term was not easily discarded, as it made a lasting impression upon soldiers and the general public as a "neutral, physical label for a psychological condition."[85]

W.H.R. Rivers, who was a Royal Army Medical Corps officer and psychiatrist in Great Britain who served for a time as a psychiatrist in Craiglockhart Military Hospital ***12** in Scotland, was one of the early developers of what came to be known as PTSD.[86] He was notable for his "humane treatments" and for his use of abreaction-based treatments resembling what we would now call psychotherapy.[87] He theorized, drawing largely on the work of Freud, that the symptoms of war neuroses, particularly in officers, came from the repression of fear.[88] Thus, the key to treatment was to reverse the repression of traumatic memories by confronting them directly.[89]

Freud revisited the question of traumatic memory himself shortly after the war ended, and it is clear from these writings that he had not entirely abandoned the notion that external events can produce neuroses.[90] He noted similarities between war trauma and others and concluded that all traumatic neuroses were based upon fear (in psychoneurosis, however, the origin of the fear was sexual conflict).[91] In both contexts, repression operated as a psychological defense.[92] He regarded an injury to the "organ of the mind" from trauma that was unexpected[93] as one that was functional, not psychological.[94] His most significant contribution, and one we can see in the development of PTSD specifically, is the notion of an initial "traumatic blow" to the "protective shell of the ego," which was then followed by psychological consequences.[95] Although Freud's writings do not, as a whole, provide an entirely coherent theory of traumatic psychological injury, it is his ideas that have made the most significant indelible impact on contemporary psychological conceptualizations of PTSD.[96]

As the war progressed with an unexpectedly high number of apparent psychological casualties, it became particularly important for the military to be able to ***13** distinguish those with true war neuroses from those who were malingering.[97] Taking a cue from the literature developed to weed out individuals with mere "compensation neurosis" among those filing claims against railways for injuries,[98] military doctors consulted books that described mechanisms to identify those who might be feigning a neurosis to avoid further combat duty and to distinguish between true hysteria and mere malingering.[99]

Once the war was over, concern shifted to reabsorbing these emotionally damaged soldiers into civilian society. More than 160,000 former British service members had received an award or were drawing a pension for a psychiatric injury.[100] In the United States, more than one-third of military hospitalizations at the end of the war were for psychiatric conditions.[101] Psychiatrists noted that some men recovered quickly upon return to civilian life, whereas others continued to struggle with symptoms.[102] Psychiatrists began to draw a distinction between "true" and "false" war neuroses, with the former appearing only in those who had "a minimal predisposition" and the latter appearing in those with a predisposition that indicated that the war was not the true cause of the neurosis.[103] Those with the "false" label were simply neurotics whose breakdown was inevitable.[104] The British government attempted unsuccessfully to convince psychiatrists to assign specific veterans to each class for purposes of limiting the pension awards.[105]

In 1941, Abram Kardiner, an American psychoanalyst, published The Traumatic Neuroses of War, a detailed study of the long-term psychological impact of combat on World War I veterans.[106] He noted that there were also soldiers whose breakdowns did not occur until after they returned home and then persisted for many years.[107] His book remained a "bible" for those studying war neuroses through the 1970s, when the ***14** diagnosis of PTSD was first discussed and formulated.[108] He urged quick intervention after men first exhibited symptoms to prevent the adaptive responses manifested as aversion and avoidance.[109] He theorized that a complex "physio-neurosis," a series of adaptive responses, accounted for the symptoms occurring in war neurotics.[110]

In the late 1930s, with the Second World War looming, the British Ministry of Pensions was the driving force behind the renewed debate on war neuroses. There were still a great number of World War I veterans receiving (or claiming) benefits due to a psychiatric disorder based upon the prior war.[111] The Ministry's resident psychiatrist, Dr. Francis Prideaux, argued that many soldiers had incorrectly received diagnoses linked to exposure to battle, and that the men's predispositions, not traumatic experiences, were the key causal agents for most war neuroses.[112] He was successful in convincing other psychiatrists and bureaucrats of his view, but the debate left unresolved the question of how to differentiate between those very few soldiers who did deserve pensions and the vast majority who would only be encouraged to break down by the availability of a pension.[113] Eventually, the British government decided not to award any pensions for war-related psychoneurosis until after the war had concluded.[114]

Given the assumption that predisposition was the single most significant factor in who ended up with a war neurosis, the British and American armies attempted to screen recruits for psychiatric disorders during World War II.[115] However, by the end of the war, perhaps due to the utter failure of this approach, American military thinking had shifted from an assumption that preselection screening could keep out those men vulnerable to psychoneurosis to the view that "every man has his breaking point" and factors other than predisposition (including leadership) played a role in the cause of some men's breakdowns.[116] However, the military did not remove soldiers with apparent psychological injuries from service. Rather, in 1943, American military leadership determined that all psychiatric casualties should be given an initial diagnosis ***15** of only "exhaustion,"[117] or "combat fatigue," which would be treated with brief rest not far from the front.[118]

Research interest in trauma-induced psychopathology waned significantly until the final years of the Vietnam War.[119] However, well before that time, there was an emerging consensus that there could be a causal role for the "fright" and "shock" during severe accidents or other intense events that lead to injuries to the nervous system.[120] These discussions were framed around notions of responsibility; that is, whether an external event or agent could cause such symptoms and the role of the individual's predisposition in whether the person developed the condition.[121]

**B. Legal Mechanisms for Psychological Injury Claims**

Given that during the first decades of the twentieth century there were at least some segments of medicine that accepted that external events could lead to psychological injuries, it followed that attorneys and plaintiffs would seek to assign legal responsibility for such injuries to the persons who were responsible for the precursor events as a means to recover compensation. Despite Herbert Page's attempt to stem the tide of these claims for posttraumatic psychological injuries, his work and that of his contemporaries served as the foundation for refining the theories that served as a basis for the recovery of emotional damages, at least in cases where physical damages had also been sought.[122]

The history of the recovery for mental injuries, however, is one of a tension between those who asserted that such injuries were real and could be traced to specific stressors, and those who were more skeptical of such claims and argued that such recoveries should be permitted only where the possibility of recovery for meritless claims could be minimized. Reflecting the concern in the British military with ***16** separating the truly neurotic from the merely malingering so as to not deplete the ranks, legal systems have similarly sought rules and standards that offered a way to distinguish the claims of those seeking compensation through a specious claim.

As the American tort system came under increasing demand to address traumatic injuries from the industrial age, especially railways, courts immediately reacted with skepticism to notions of a "pure" emotional injury.[123] By the turn of the twentieth century, courts permitted recovery for emotional distress injuries as part of "pain and suffering" or "loss of enjoyment of life" damages in tort claims, but only where such distress was incidental to the primary physical injury,[124] as so-called "parasitic damages."[125] Some courts and commentators simply expanded notions of what constituted "bodily harm" and did not make a specific distinction for injuries that were psychological in nature.[126]

However, courts were far more reluctant to permit claims to proceed that were based upon assertions of emotional injury alone, particularly for mere negligence.[127] Courts largely followed the lead of Lord Wensleydale's 1861 ruling in the House of Lords: "Mental pain or anxiety the law cannot value, and does not pretend to redress, when the unlawful act complained of causes that alone."[128] American courts expressed their resistance by raising concerns about malingering, a potential explosion of litigation,[129] or an assumption that people with normal constitutions (and particularly, men) could not be "shocked" into a mental disorder (and tortfeasors should not have to bear responsibility for compensating women's overemotional reactions).[130]

***17** Courts developed a range of "bright-line" rules to control the circumstances under which one could recover for psychic harm as the sole or primary injury.[131] Some of these rules limited the underlying theory of liability of the particular tort. Assault has traditionally permitted recovery for psychological harm even in the absence of physical contact, but only where the tortfeasor is found to have intentionally put the plaintiff in fear or apprehension of injury.[132] Intentional infliction of emotional distress was first recognized as a tort in the United Kingdom at the end of the nineteenth century in a case in which the defendant told the plaintiff, as a joke, that her husband had been seriously injured in an accident.[133] The ensuing shock produced "serious and permanent physical consequences," and the court permitted recovery on the assumption that this was a claim for physical injury even if the origin was a psychological shock.[134]

In the United States, the tort of intentional infliction of emotional distress was slow to develop outside of the very specific and narrow context of claims against common carriers, innkeepers, and telegraph companies, or for the mistreatment of dead bodies.[135] It was not until the middle of the twentieth century that the American Law Institute's Restatement of Torts made reference to the tort,[136] and some courts interpreted it to limit recovery to instances where the tortfeasor "subjects another to the mental suffering incident to serious threats to his physical well-being."[137] In 1965, the Restatement (Second) of Torts permitted recovery for intentional conduct that resulted in "bodily harm"; however, such recovery was premised on the plaintiff's ability

to prove that her emotional distress was "severe" and the defendant's conduct was "extreme and outrageous."[138] If the conduct was sufficiently atrocious, a court could assume that there would be some psychological injury, diminishing concerns about malingering or unexpectedly strong reactions.[139]

***18** Recovery for emotional distress where a negligent, as opposed to intentional, act caused no other injury--the "stand-alone" tort of "Negligent Infliction of Emotional Distress"--has been recognized by courts only within the last fifty years or so.[140] Courts' reluctance to permit stand-alone claims for emotional distress can be generally traced, not only to concerns about malingering or exaggeration and the great difficulty in quantifying emotional distress,[141] but also to an assumption that if the only resulting harm is emotional the defendant's negligence did not rise to a level that should trigger liability of any kind.[142] The Restatement also reasoned that any emotional injury that would occur in the absence of physical injury would be "'so temporary, so evanescent and so relatively harmless' that the task of compensating for it would unduly burden defendants and the courts."[143] Some courts thought that an emotional injury itself was "too remote" from the original accident to be compensable.[144] As a result of these views, a strange body of case law developed, with a significant number of different approaches. One high court referred to this as "one of the most disparate and confusing areas of tort law," characterized by "inconsistency and incoherence."[145]

Although American law generally did not recognize claims based solely on emotional distress damages due to negligence until recently,[146] courts developed a variety of exceptions and requirements to permit some recovery, while retaining broader limitations on the claims.[147] The "impact rule" required a plaintiff to show some kind of initial physical contact or injury in order to recover for emotional distress, and denied recovery for the physical consequences of an initial emotional shock.[148] ***19** Later, several courts required evidence that the alleged emotional distress had some kind of physical manifestation--such as insomnia, nightmares, weight loss, irritability, fatigue, and extreme nervousness[149]--even where the emotional distress itself was severe.[150] This requirement imposed a kind of objective proof on mental distress claims so that they more closely resembled claims for physical injury. The "physical manifestation" rule was an alternate means to recover for emotional distress when there was no accompanying physical injury at the time of the accident.[151] Usually neither of these standards required showing an extensive physical injury or manifestation but both ensured that plaintiffs could not recover for purely psychic injuries (assuming that such a dichotomy could be drawn and understood).[152]

Some states limited negligence-based emotional distress recovery to people who were within the "zone of danger" of the event; that is, someone who was sufficiently close to the accident to be at risk of physical injury, even if none resulted.[153] This requirement limited recovery by "bystanders," generally family members who learn of the death or serious injury of a loved one, and was sometimes linked with the "impact rule."[154] And some courts permitted recovery by a bystander who was not in the zone of danger (i.e., fearing for own safety) so long as the person had a "close relationship" with the person actually injured.[155] A few courts eliminated all limitations on negligent infliction of emotional distress claims on the assumption that concerns about severity ***20** and malingering were best left to be addressed by defendants through the adversarial process.[156]

Faced with this well-entrenched judicial hostility toward recovery for emotional distress and psychological injuries, many lawyers evoked quasi-medical concepts, such as "traumatic neurosis," in an attempt to bring legitimacy to their clients' claims for such injuries.[157] In practice, traumatic neurosis was not a clinical diagnosis per se, but rather a term generally reserved to describe psychological injuries in the context of personal injury litigation or claims for industrial and other occupational accidents.[158] One psychiatrist described the condition in 1959 as being "the total neurotic reaction to a physical injury or, occasionally, near-injury," which "may take many forms, e.g., conversion hysteria, anxiety reaction, obsessive-compulsive reaction, reactive depression, and other less well-defined symptom complexes."[159] By the time of the development of the DSM-III in the 1970s, it does not appear that the term was in wide use in litigation. One psychiatrist wrote an article in 1971 calling on attorneys to pursue more claims based upon traumatic neurosis, characterizing such conditions as being "[r]elatively

[u]ntried in the [c]ourts."[160] He attributed the reluctance of attorneys to bring such claims, in part, to their "orientation . . . toward factual proof,"[161] lack of objective tests to confirm such condition, and fear "of treading in the uncharted waters of traumatic neurosis."[162]

By the middle of the twentieth century, some cases referred to "compensation neurosis."[163] Like "traumatic neurosis," it was not a recognized clinical term, but rather was a shorthand label for a subtype of traumatic neurosis that arose when there was the possibility of recovering compensation through a claim or litigation.[164] Although it was ***21** generally a pejorative term, some psychiatrists used it to draw a distinction from true malingering and regarded it as the mechanism through which the possibility of secondary gain could unconsciously aggravate the primary traumatic neurosis, similar to Herbert Page's theories published in the 1880s.[165] In fact, in the workers' compensation realm--which generally permitted a more liberal approach to causation and traumatic neurosis than did tort law[166]--some awards were expressly based upon "compensation neurosis."[167]

Therefore, in the century prior to PTSD's recognition by the APA, courts permitted individuals to recover for psychological injuries only to a very limited degree. The limitations imposed by courts on such recovery reflected the contemporaneous theories of psychological injuries during this period and raised many of the same debates, such as the distinction between the emotional and the physical, the role of individual predisposition, the impact of litigation on the development and persistence of symptoms, and concerns of malingering. These same themes later emerged during the debate leading to (and resulting after) the recognition of PTSD by the psychiatric establishment.

### III. The Development of the PTSD Diagnosis in the DSM

Although some psychologists and psychiatrists advanced theories of psychological injury in the nineteenth century, the notion of psychopathology attributable to a specific external cause did not take root in mainstream psychiatry until it was embodied in the American Psychiatric Association's psychiatric classification system in the Diagnostic and Statistical Manual of Mental Disorders. Early editions of the DSM included some references to psychological reactions to stress. However, it was through the addition of PTSD in the DSM's third edition--with criteria that required a clinician to identify a specific event as a cause of symptoms--that psychiatry unambiguously recognized a particular mental disorder as an injury attributable to exogenous forces, initially the horrors of war and later a wide range of distressing events.

#### A. The Campaign for PTSD in DSM-III

There is a striking irony in the history of psychiatry and the Vietnam War. In 1967, some in the United States military claimed that the "incidence of neuropsychiatric illness"[168] in Vietnam was markedly lower as compared to prior wars, ***22** and were confident that the problem of combat-induced psychoneurosis had been resolved.[169] However, the war later served as the catalyst for bringing the notion of psychopathology induced by an identifiable external cause into the mainstream of both psychiatry and law. Once the lens of PTSD was in place, those initially optimistic assessments seemed sharply out of focus. The 1990 Vietnam Veterans Study concluded that between twenty-five and thirty-three percent of those who served in Vietnam met the criteria for PTSD at some point, and that, as of the date of the study, fifteen percent still met the criteria.[170]

The formal recognition of PTSD occurred at a time when American psychiatry was particularly concerned with diagnostic labels as it sought to overhaul its classification system. The APA published the first DSM in 1952 to create a standardized classification of diagnoses for use by clinicians.[171] Prior to the release of the DSM, there were only a limited number of clinical psychiatric labels, which were generally limited to major mental illnesses seen in large public asylums.[172]

After World War II, the spread of psychoanalytically-inclined psychiatry resulted in a great many more people being treated in the community who did not have the severe mental illnesses of those in the hospitals, creating a need for a broader range of

diagnostic labels. Although the first edition of the DSM made significant strides towards addressing that need, it did not reflect a large consensus of psychiatrists.[173] The notion of "diagnostic criteria" was not in keeping with the psychodynamic approach that dominated American psychiatry at this time.[174]

The DSM-I did not include a term such as "traumatic neurosis" to reflect specific trauma-induced disorders.[175] Although it did include the diagnosis of "gross stress reaction," described as a "transient," situational personality disorder, this was essentially a short-term reactive disorder and not indicative of any underlying neurosis or psychosis.[176]

***23** The second edition of the DSM was published in 1968, during the height of the Vietnam War,[177] and its editors aimed to be consistent with the International Classification of Diseases.[178] The edition dropped "gross stress reaction" as a distinct diagnosis, and the editors suggested that the associated symptoms could be subsumed into the category "transient situational disturbances,"[179] which consisted of "acute reaction[s] to overwhelming environmental stress" in adults "without any apparent underlying mental disorders."[180] The symptoms would "usually recede as the stress diminishes" provided that the patient had "good adaptive capacity."[181] The subcategory of "[a]djustment reaction of adult life" encompassed "[f]ear associated with military combat and manifested by trembling, running and hiding."[182] However, reflecting the hold that psychoanalytic schools maintained on American psychiatry, the broad notion of "neurosis," with its primary symptom being anxiety, remained in the manual,[183] in a category separate from the "transient situational disturbances."[184]

Thus, during the Vietnam War there was no diagnosis specifically tied to either combat or trauma, perhaps because that generation of DSM editors had not treated those with war neurosis.[185] The term "combat fatigue," a holdover from World War II, was sometimes used to describe the psychological effects of combat on soldiers, but it was not regarded as a true diagnostic label.[186] This lack of a specific term equivalent to "shell shock" or "war neurosis" meant that, as veterans began to seek treatment and compensation for their persistent psychiatric difficulties, there was no diagnosis that ***24** clearly captured their symptomatology. This created a substantial barrier to receiving medical care or benefits from the Veterans Administration (VA), since such care and benefits were available only for "service-connected" injuries.[187] If the symptoms did not appear until at least a year after the veteran's discharge, the VA would not consider them to indicate a service-connected condition.[188] In the absence of a recognized diagnosis to capture the cluster of symptoms (and delayed onset) exhibited by many soldiers and veterans, military and VA psychiatrists diagnosed them with "character disorders" or schizophrenia, ruling out any "service-connected" disability compensation.[189] Therefore, the veterans and their advocates made it a goal to see that the next edition of the DSM included a diagnosis that would remedy this problem.[190]

The push to introduce a diagnosis that captured combat-related psychopathology began with a small organization called Vietnam Veterans Against the War, which held "rap groups" of veterans in New York City.[191] The organization began working with two prominent psychoanalysts, Chaim Shatan and Robert Jay Lifton.[192] These discussions led to the founding of the National Veterans Resource Project.[193] The successful efforts to alter the listing of homosexuality in the then-draft edition of DSM signaled to the veterans and their supporters that any DSM listing could be the focus of debate and advocacy.[194] One major target of the advocacy for specialized treatment of Vietnam veterans was the VA, which was still oriented towards serving the veterans of World War II, as were other major institutions serving veterans (congressional committees and organizations like the Veterans of Foreign Wars).[195] The advocates' ***25** primary objective was to ensure that Vietnam veterans with continuing psychological difficulties could obtain health care and benefits from the agency.[196]

Shatan initially coined the missing diagnosis as "post-Vietnam syndrome,"[197] which he described as cluster of delayed-onset symptoms such as alienation, guilt, rage, the feeling of being scapegoated, and psychic numbing.[198] Shatan made no secret of

his political goals with the diagnosis: "This is an opportunity to apply our professional expertise and anti-war sentiments to help some of those Americans who suffered most from the war."[199]

In making the case for Post-Vietnam Syndrome, Shatan and Lifton drew from post-war psychiatric literature about the Holocaust and Hiroshima.[200] In these contexts as well, the issues of psychological impact and compensation were closely tied. The West German government had a program to compensate concentration camp survivors, but only if a causal nexus could be established between the person's experience and the psychiatric symptoms that persisted.[201] Around this time, Jewish psychoanalysts felt pressure to present research that, contrary to the claims of German psychiatrists, the psychological effects of trauma could last well beyond the traumatic event.[202] Such persistent symptoms were classified as "survivor syndrome," which was characterized by feelings of guilt as well as "depression, anxiety and nightmares."[203] As with the psychiatrists working with the veterans, those psychiatrists had taken on the dual roles of medical professionals and advocates.[204]

The timing of the campaign for the new diagnosis was significant. The DSM-III, which was finally published in 1980, embodies and reflects a revolution in psychiatry.[205] Specifically, it represents a power shift within psychiatry from those ***26** following psychoanalytic theory, which had dominated psychiatry (particularly in the United States for the previous half-century), to those associated with so-called biological psychiatry, which regards all psychiatric illness as having origins in brain chemistry and development.[206] The editors of DSM-III aimed to create a common language for not only clinicians but also for researchers to describe mental disorders in a way that did not require one to subscribe to any particular theoretical orientation.[207] One of the editors' key objectives was to address the twin problems of the reliability (the extent to which examiners apply the same diagnosis to a set of symptoms) and validity (the extent to which a diagnosis reflects a "real" condition) in psychiatric diagnosis.[208]

In a new approach, the editors adopted the basic framework of early twentieth century German psychiatrist Emil Kraepelin, considered to be the father of psychiatric nosology,[209] in rejecting any diagnosis that did not have a basis in empirical findings. Each disorder was assigned a set of specific criteria to be used to assess patients and to assign diagnoses. Previously, the DSM had included only vague, brief descriptions of each disorder.[210] The classifications and criteria ultimately adopted in the DSM-III would be the result of field trials.[211] To underscore the scrubbing of all whiffs of Freudianism, notions of the "unconscious" (and other invisible mechanisms) would be absent from the manual,[212] and the editors were careful to note that the term "neurotic disorder" did not implicate any "special etiological process."[213]

At first, the lead editor of the DSM-III, Robert Spitzer, rejected the call for the new "post-combat disorder" diagnosis as unnecessary based upon the recommendations of other researchers studying the psychological problems of Vietnam veterans; a campaign to reverse this position was underway soon thereafter.[214] The advocates' key ally within the psychiatric establishment was psychoanalyst Mardi Horowitz, who had by this time developed an extensive theory, based largely upon the work of Freud, ***27** Kardiner, and others, about "stress response syndromes."[215] Horowitz described a number of different reactions to traumatic stress, including avoidance of things associated with the events (including memories) and "intrusive" effects when the memories nonetheless caused a reexperiencing of the events, both of which Kardiner had described in his studies of World War I veterans.[216] Although the number of acute psychiatric casualties initially appeared to be lower in Vietnam,[217] some officials noted the impact of "stress" on soldiers during their one-year stints.[218] Towards the end of the war, Horowitz predicted a high incidence of delayed-onset psychiatric reactions or "stress response syndromes" by soldiers.[219]

The advocates of the new diagnosis were careful not to limit it to combat reactions, but rather applied it to a broad category of individuals exposed to "trauma."[220] In their work with the APA, they revised the name of the proposed diagnosis to "catastrophic stress disorder," with a sub-type of "post-combat stress reactions."[221] The symptom list for the initial formulation of PTSD developed by Shatan, Lifton, and Horowitz[222] was largely taken from Abram Kardiner's The Traumatic Neuroses of War.[223]

Together, these psychiatrists refined a "unitary kind of 'trauma"' that was ultimately embodied in the diagnostic criteria of PTSD.[224] It drew heavily on Freudian theory about the emotional impact of repressed memories of earlier traumatic events:[225] the pathogenic memory.[226] They expressly stated that there were ***28** no predisposing factors, other than the exposure to the traumatic event.[227] However, this description contained more etiology than the editors could tolerate. They responded that but for the link with a specified event the symptoms could be found in other conditions, and therefore the diagnosis was unnecessary.[228]

The sole empirical support for the proposed diagnosis that Shatan and Lifton could offer was anecdotal evidence that some VA doctors had been noting "traumatic war neurosis" on patient charts for years in the absence of a recognized diagnosis.[229] Although this was not the type of empirical data that Spitzer aspired to have as the sole basis for the DSM-III diagnoses,[230] these case histories had a significant impact on Nancy Andreasen, the chair of the DSM-III Committee on Reactive Disorders and a psychiatrist within the APA mainstream who had worked on the psychological impact of trauma, specifically with burn victims.[231] However, what was perhaps more convincing for those within the APA was the "moral" case for including the diagnosis.[232] By adopting the diagnosis, the psychiatric establishment would help eliminate one of the key barriers to veterans' access to compensation and health care for their mental troubles. To do otherwise would leave the responsibility on the shoulders of the veterans themselves.[233]

The final name and criteria for PTSD emerged from the Committee on Reactive Disorders, and it largely followed the recommendation of Lifton, Shatan, and others on the working group that had developed the "catastrophic stress disorder" diagnosis, changing little other than the name of the diagnosis and eliminating the "post-combat" subtype.[234] It was placed within the "Anxiety Disorders,"[235] and its "essential feature" was described as "the development of characteristic symptoms following a psychologically traumatic event that is generally outside the range of usual human experience."[236] The "characteristic symptoms" were "reexperiencing the traumatic event; numbing of responsiveness to, or reduced involvement with, the external world; ***29** and a variety of autonomic, dysphoric, or cognitive symptoms."[237] The criteria differentiated between "acute" PTSD, with an onset within six months of the trauma and a duration of less than six months, and "chronic or delayed" PTSD, which had either or both an onset of more than six months or duration longer than six months.[238] In short, the diagnosis appeared to provide the veterans precisely what they needed to pursue claims for compensation and care.

### B. The A Criterion

The publication of the diagnostic criteria for PTSD in the DSM-III marked a significant moment in the history of both psychiatric diagnosis and legal claims for psychological injuries. PTSD provided psychiatry with a means to classify a psychological injury that developed "in normal people . . . following an extremely traumatic event."[239] Accordingly, unlike the remainder of DSM-III diagnoses, the criteria for PTSD were not "atheoretical," as that term is employed in psychiatric nosology.[240] Specifically, the list of diagnostic criteria for the disorder includes the "A Criterion" (also commonly referred to as the "stressor criterion"), which, in DSM-III, is described as "a recognizable stressor that would evoke significant symptoms of distress in almost everyone."[241] As described in the explanatory text, the diagnosis required the prior occurrence of a specific etiological event "outside the range of usual human experience" that would create "significant symptoms of distress in most people."[242] In other words, the diagnosis itself contains a theory of the etiology of the symptoms. Robert Spitzer has acknowledged this to be the case: "[A] key distinguishing feature of PTSD is that it is not agnostic to etiology. Unlike virtually all diagnoses in the [DSM], PTSD rests on the assumption of a specific etiology, whereby a distinct set of events (criterion A) is assumed to be the uniformly most potent contributor to outcome."[243] ***30** Similarly, the Institute of Medicine's recent analysis of PTSD observed that "the necessary cause of PTSD is by definition a traumatic event."[244]

The A Criterion has been described as the "gatekeeper"[245] and the "defining feature"[246] of the diagnosis because the "DSM theory of PTSD" is that "time and causality move from the traumatic event to the other criterial features."[247] Absent "the event," the symptomatology would be assigned a different diagnosis. Once the event is identified and deemed to fit within the A Criterion definition of "traumatic," the symptoms are transformed into markers of PTSD.[248] DSM-III also set forth a specific list of symptoms or reactions to the A Criterion event, and it distinguished between reactions that had an onset soon after the event and those that were latent, occurring more than six months after the event.[249] A key feature in the symptom cluster described in DSM-III is the role of memory and dissociative experiences such as "flashbacks."[250] In other words, the past remains very much in the person's present and is the subject of "persistent reexperienc [ing]."[251]

The new diagnosis therefore "violated basic guidelines about theory and research that had been established for the DSM-III," and, most notably, the editors' attempts "to eliminate etiology from their description of disorders."[252] At the time of the first iteration of PTSD, there was a controversy over whether the event, as opposed to a person's predisposition, should be regarded as the primary cause of the symptoms.[253] PTSD, as it finally appeared, reflected a break from the way traumatic neurosis and ***31** similar conditions were viewed in that the persistence of the symptoms was not regarded as being due to an individual's inability to adapt.[254] The drafters of PTSD considered what they assumed to be the legal implications of this debate; as Horowitz later recalled: "If trauma were the main cause of symptoms, the institutions or people responsible for causing or not preventing the traumatic events could be held legally responsible for damage to victims."[255]

The explanatory text accompanying the original PTSD criteria provided several examples of the kinds of traumatic events that meet the A Criterion (rape, military combat, floods, earthquakes, plane crashes, torture), and notes: "The disorder is apparently more severe and longer lasting when the stressor is of human design."[256] One psychiatrist explained the rationale for this observation as follows: "Stressors caused by man appear to have a greater traumatic impact than natural events. The injured person usually feels that a manmade stressor is preventable, whereas natural disasters are unavoidable acts of God. Feelings of rage, retribution, and vengeance are commonly experienced."[257] In other words, categories of trauma for whom another person (whether natural or corporate) could be held responsible were assumed to be most likely to result in reactions like PTSD.

Notions about legal obligation thus drove the specific criteria of PTSD. In order for the veterans to be able to claim entitlement to "service-connected" benefits the proponents of the diagnosis concluded that such "connection" to military service needed to be built into the diagnosis. By framing the condition as it did, the DSM-III made it unquestionably clear that those who were previously psychiatrically healthy could suffer severe functional limitations as a result of being exposed to traumatic stress that was not of their own making. Thus, we see a diagnosis that embodies a shift of responsibility from one to another, or at least away from the patient. Without such a feature embodied in A Criterion, PTSD would have emerged in 1980 looking like all of the other DSM-III diagnoses, or more likely, it would not have emerged at all since its symptoms overlap with other disorders in the manual.

With a diagnosis built around their experiences, veterans were indeed more successful in obtaining not only health coverage and disability benefits but also validation from the United States Government itself that they had endured an experience that transformed a "normal" person into one who was ill and in need of care and compassion. With PTSD cast as it was, there was little room for debate that its occurrence in Vietnam veterans was "service-connected," and therefore the veterans with such diagnosis would be among those receiving "top priority" care and compensation.[258] Once PTSD was accepted for inclusion in the DSM, the veterans advocacy groups took the next step and successfully lobbied the Senate Veterans Affairs Committee to issue a report authorizing the VA to recognize and compensate PTSD in Vietnam veterans.[259]

***32** There have been two revisions to the A Criterion since its initial inclusion in the DSM-III in 1980. In 1987, with the publication of the revised edition of the Third Edition, DSM-III-R, the APA revised the criterion as follows:

> The essential feature of this disorder is the development of characteristic symptoms following a psychologically distressing event that is outside the range of usual human experience . . . . [and] would be markedly distressing to almost anyone . . . .
>
> The most common traumata involve either a serious threat to one's life or physical integrity; a serious threat or harm to one's children, spouse, or other close relatives and friends; sudden destruction of one's home or community; or seeing another person who has recently been, or is being, seriously injured or killed as the result of an accident or physical violence. In some cases the trauma may be learning about a serious threat or harm to a close friend or relative, e.g., that one's child has been kidnapped, tortured, or killed.[260]

This revision moved some of the explanatory description into the criterion itself (with minor rewording), and provided a list of examples of the kinds of events that would be considered "outside the range of human experience" and "markedly distressing to almost anyone."[261] The aim of this revision was to address the problem of different individuals having different "stress thresholds."[262] The editors had hoped that providing the list of examples would clarify that the A Criterion stressors were "at the extreme end of the stress continuum," since it was assumed that the more "severe and life-threatening" events would be more likely to produce psychopathology such as PTSD.[263]

The APA revised the diagnostic criteria for PTSD for a second time in 1994.[264] For the DSM-IV, the APA divided the A Criterion into two parts:

> 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.[265]

These changes broadened the criterion to allow a wider range of events and experiences to qualify for the criterion and also introduced a subjective component.[266] ***33** DSM-IV eliminated the "normative criterion of the 'average' person," by removing the reference to "almost anyone."[267] The revisions also removed the reference to the event being "markedly distressing" to the average person without specifying when such distress occurs--whether at the time of the event or in the recollection of it.[268]

There was also no longer a reference to events being "outside the range of usual human experience."[269] This revision ostensibly conformed the language of the criteria to its use in practice.[270] Clinicians frequently disregarded the original phrasing in that they did not attempt to determine the actual frequency of such events or the appropriate context for such analysis.[271] For example, among Vietnam veterans, exposure to death and dismemberment was not unusual. Sexual assault is not infrequent, particularly in certain cultures or locations.[272] And clinicians did not hesitate to diagnose PTSD in war veterans or rape survivors. However,

some commentators have claimed that the DSM-IV revision to the A Criterion resulted in a substantial increase in people diagnosed with PTSD.[273]

The revisions to PTSD and the A Criterion did not silence the critics within psychiatry who questioned the validity and utility of having a disorder in the DSM linked categorically to a specific and identifiable cause rather than being no more than a set of frequently coexisting symptoms. In fact, the expanded range of potential stressor events, coupled with the contemporaneous increase in the forensic use of PTSD as discussed in the next Part, only served to fuel the debate.

## *34 IV. PTSD and Questions of Liability

Once the psychiatric establishment fully embraced the concept of a psychological injury by adopting PTSD in DSM-III, attorneys began to explore potential uses of this diagnosis in a wide range of settings in which the key question was how to assign responsibility, whether civil or criminal. In some respects, this was the continuation of the strategy used with the nonclinical term "traumatic neurosis," but it came at a time when there was also a turning point in law regarding the role of psychiatric diagnosis in legal proceedings. This change was due in large part to the fact that DSM-III was the first edition of the manual to have widespread use beyond the psychiatric profession. Psychiatric diagnosis itself had a new and central role in litigation that touched on mental issues, and the DSM-III's code-like structure and ostensible "scientific" basis eased the way for the diagnoses themselves to be evidence in litigation.

As noted in Part III, the DSM-III marked a revolutionary moment in the history of psychiatry.[274] Beginning with that edition, the DSM had remarkable impact. It is referred to by some as a "bible,"[275] by others as a "consensus document."[276] It is used universally throughout the psychiatric profession in the United States and in a great deal of the rest of the world.[277] However, its true power comes from its wide adoption outside of the mental health profession, in a range of institutional, educational, and administrative settings. The legal system is one such institution that has widely incorporated use of the DSM.[278] Philosopher Ian Hacking, who writes about the interactions between science (including psychiatry) and the wider culture, observes that, although we assume that the classifications we create merely reflect what is there, such classifications in fact shape the systems that use them and the people within that system, creating a "looping effect."[279] PTSD's influence on the legal system serves as an example of this effect.

Although the APA certainly was aware that recognition of PTSD would yield immediate benefits for countless Vietnam veterans, the editors of DSM-III apparently anticipated the appeal the manual as a whole would hold for the legal system. Near the ***35** end of his introduction to DSM-III, lead editor Robert Spitzer included a brief paragraph titled "Cautions," which stated:

> The purpose of DSM-III is to provide clear descriptions of diagnostic categories in order to enable clinicians and investigators to diagnose, communicate about, study, and treat various mental disorders. The use of this manual for non-clinical purposes, such as determination of legal responsibility, competency or insanity, or justification for third-party payment, must be critically examined in each instance within the appropriate institutional context.[280]

However, the nonclinical and nonresearch uses of DSM-III, and specifically PTSD, were soon widespread in the legal system with scant little of the critical examination urged by Spitzer. Indeed, perhaps in response to this trend, the editors' caution has grown more emphatic with each new edition of the DSM, to little avail.[281]

PTSD has had many applications in the law in a wide range of contexts, including criminal law (with respect to defenses and sentencing)[282] and workers' compensation.[283] However, the discussion here will focus on two contexts in which courts have permitted PTSD, and particularly the A Criterion, to take a critical role in establishing liability: (1) to prove that a criminal

complainant or civil plaintiff was subjected to a traumatic event, such as child sexual abuse; and (2) in tort cases, to establish liability for stand-alone claims for emotional distress. As one psychiatrist noted, PTSD is particularly powerful in legal settings because it "carries a legal and moral implication that someone else is responsible for an event so overwhelming that anyone could develop a potentially severe psychiatric disorder as a result."[284] Such ***36** power is particularly apparent in these two contexts because the fact of the medical diagnosis is assigned a role in the determination of legal liability.

### A. The Fact of the Traumatic Event

With the recognition of PTSD by the APA, Vietnam veterans began using the diagnosis in the criminal law as part of defenses or in seeking lighter sentences. However, PTSD's impact in criminal settings attracted more notice when prosecutors began using the diagnosis in criminal trials for sexual assault and child sexual abuse. Prosecutors have long faced "distinctive evidentiary problems" when prosecuting child sexual abuse cases because generally the only witness is the child complainant.[285] The child may be particularly young or inarticulate, either of which could implicate problems of competency or credibility. Similarly, in rape prosecutions, the key factual disputes often turn on the credibility of the complainant.[286] In both cases, there is often little other evidence to corroborate the complainant's allegations. The recognition of PTSD by the APA suggested new potential strategies to address these challenges.

Soon after the release of DSM-III, prosecutors sought to offer testimony through psychological experts centered on the theory and criteria of PTSD to opine that the complainant's behavior was consistent with having been sexually abused or assaulted, and, from that assessment, to opine that the complainant in fact had been sexually abused[287] or assaulted.[288] PTSD and the "traumatic stress model" of child sexual abuse were useful due to "the unequaled etiological significance [PTSD] placed on 'outside' (external to psyche) trauma."[289] Such experts generally employed the criteria or general concept of PTSD, but some also used terms such as "child sexual abuse accommodation syndrome" (CSAAS)[290] or "rape trauma syndrome" (RTS).[291] Such uses of the DSM and PTSD were met with fierce resistance from defense attorneys, and courts struggled with the question of whether to admit such evidence and for what ***37** purposes. A significant body of case law, with a wide variety of approaches, developed in the first twenty years after PTSD was recognized.

The least controversial use of such PTSD evidence is on rebuttal to rehabilitate the complainant after impeachment by offering possible alternative reasons (based upon the diagnoses) for the person to have acted in a manner that, on the surface, would appear to be inconsistent with being a victim of rape or sexual abuse.[292] Courts have been significantly more conflicted, however, on the issue of whether to admit during a prosecutor's case in chief expert testimony that the complainant had PTSD symptoms for the purposes of establishing that the person had been a victim of rape or abuse.[293] The prosecution would offer an expert to testify that the alleged victim displayed "typical" or hallmark symptoms of these syndromes indicating that the victims had experienced trauma consistent with that alleged by the prosecution.[294]

Courts have been sharply divided on the admissibility of such evidence.[295] One court that upheld the admission of such evidence concluded that, since the incidence of PTSD in an individual "indicates that she might have been sexually abused," such evidence is probative of one of the central questions in these cases, even if the evidence is not being offered in response to an issue raised by the defense.[296] Other courts that have admitted such evidence reasoned that it was not being admitted to prove that a crime had been committed but rather only to help the jury understand the behavior of sexually abused children[297] or to negate suggestions or defenses of consent.[298] The excluding courts' concern with admitting PTSD testimony for such purposes, even if not articulated precisely this way, essentially stems from the role of the A Criterion--that the application of the diagnosis to an individual appeared to represent a clinical opinion that the person had in fact been exposed to a traumatic event.[299]

***38** The various judicial opinions in the litigation of a Maryland rape case, Allewalt v. State,[300] exemplify the key arguments in this debate. In the 1983 trial, during which the defendant asserted a consent defense, the trial court permitted the state to offer rebuttal testimony of a forensic psychiatrist.[301] The psychiatrist had examined the complainant and concluded that she had the symptoms of PTSD.[302] The trial court admitted the testimony after conducting a voir dire examination of the expert, concluding that PTSD "has been around for a long time," is "nothing new," and was "recognized" within psychiatry.[303] The trial court reasoned that the witness would "assist [the] jury in making a determination as to [the complainant's] state of mind at the time of the event on the basis of post event findings."[304] However, on cross-examination, the psychiatrist conceded that in developing his opinion about whether the complainant had PTSD, he assumed that she had in fact been raped by the defendant: "I think it is more important that the individual reporting, that is the patient or person you are evaluating, believes that it took place. But . . . the whole diagnosis is predicated on the assumption that some traumatic incident occurred."[305] The psychiatrist also opined that none of the complainant's other circumstances (i.e., a history of depression and "marital and domestic problems") would account for her symptoms.[306]

An intermediate appeals court reversed the conviction on the basis that the expert testimony was improperly admitted because its prejudicial effect outweighed the probative value, which was quite small in light of the fact that the assumption the rape had taken place rendered the expert's conclusions unreliable in establishing that she had not consented to the sexual encounter.[307] The appellate court was also concerned that the testimony appeared to be bolstering the credibility of the complainant: "By stating that a rape could cause the disorder, an expert implicitly verifies the victim's claim that rape did cause it."[308]

***39** The Court of Appeals of Maryland, in a sharply divided opinion, reversed and reinstated the conviction.[309] The majority specifically noted the diagnostic criteria for PTSD and concluded that the psychiatrist was "acting well within the field of his special training and experience" when he opined, as part of the diagnostic process, that the alleged victim had experienced a sexual assault.[310] In other words, arriving at an opinion about the occurrence of a trauma was simply part of what the PTSD criteria required. The majority concluded that the appellate court had imposed too high a standard on the admission of such testimony. Rather, it reasoned, this was simply another form of expert testimony as to causation of symptoms, which is generally admissible.[311] The majority reviewed the competing line of cases on the issue of admitting PTSD (or RTS) testimony in the prosecution of rape cases and concluded that the testimony of the expert was sufficiently limited to warrant its admission at trial:

> Just as a jury can understand that evidence of the complainant's hysteria shortly following an alleged sexual assault tends to negate consent, so a jury, with the assistance of a competent expert, can understand that a diagnosis of PTSD tends to negate consent where the history, as reviewed by the expert, reflects no other trauma which in the expert's opinion could produce that medically recognized disorder.[312]

The concurring justice opined that there was some role for a forensic psychiatrist to offer testimony about PTSD generally (since it would not be within the general knowledge of the fact-finder), but thought that courts should draw the line at permitting a psychiatrist to opine that the witness had PTSD resulting from the alleged crime.[313] The author of the dissenting opinion, however, reasoned that "[b]ecause post-traumatic stress disorder is not a fact-finding tool, but a therapeutic tool useful in counseling, and the relevant scientific literature does not even purport to claim that the disorder is a scientifically reliable means of providing that a rape occurred," the testimony should not have been admitted.[314] He also thought that there was no way to guard against the jury concluding that the expert had reached a conclusion about the alleged victim's credibility and using the testimony to reach their conclusions about that issue.[315]

Courts across the country debated the admissibility of such evidence for several years after the first reported cases, and apparently the consensus of the courts at present is to admit PTSD (or related syndrome) evidence in sexual assault cases,

generally with a limiting instruction to jurors regarding the appropriate use of the evidence.[316] The ***40** admissibility of PTSD or CSAAS evidence in child sexual abuse prosecutions, however, remains varied from state to state.[317] Some courts that have rejected RTS or CSAAS have done so largely because, unlike PTSD itself, they are not found in the DSM,[318] or because such terms have assumptions about the specific cause of the symptoms built into the names of the terms.[319]

The use of PTSD evidence to prove the fact of the traumatic event is not limited to the criminal context. In civil cases, although a plaintiff may offer evidence of PTSD for the purportedly limited purpose of proving the extent of her damages, the nature of PTSD and its A Criterion suggests a finding of liability as well. Some plaintiffs suggest that their PTSD symptoms are probative of whether they had in fact been subjected to trauma.[320] For example, if someone displays symptoms of PTSD, such evidence could be persuasive on the question of whether she did in fact experience sexual harassment. Courts have been less wary of its use in civil cases as compared with criminal prosecutions, but some have expressed concern about the potential inferential leap invited by such evidence and put strict limitations on the extent of an expert's testimony.[321]

The A Criterion in the civil context raises the same problem of circularity as seen in the sexual abuse and rape cases. Clinicians cannot apply the PTSD diagnostic criteria without opining about the nature, extent, or even the existence of a reported or purported stressor event. Although a doctor setting a broken leg may refer to the fact of a motor vehicle collision in her report, whether or not a collision occurred has no bearing on whether the doctor concludes that the leg is broken. By contrast, the A Criterion requires an assessment of the stressor event on the part of the clinician to determine whether it met whatever the A Criterion required at that time. The existence of such a clinical determination cannot be deemed insignificant since the APA has amended the diagnostic criteria specifically (and more than once) to define who can be diagnosed with the disorder.

If a psychiatrist cannot in fact diagnose a person as having PTSD without making a determination as to whether a stressor event satisfying the A Criterion occurred, then ***41** there is considerable question as to whether psychiatrists can testify in the more theoretically limited role that some courts assign in terms of rehabilitating victims who have been impeached or in cases in which the occurrence of the stressor event is a central controversy. This problem is not unique to the A Criterion since several other PTSD criteria also tie back to the supposedly traumatic "event." For example, if a person is "re-experiencing" an event, there is an explicit assumption that the person previously "experienced" the event that now arises in intrusive thoughts and nightmares. Similarly, if someone is avoiding something, such avoidance is a "symptom" only if it is associated with an identified traumatic event.[322] These symptoms each link to the diagnostician's initial assessment of the fact of "the event."

Use in criminal and civil cases as proof of the occurrence of the traumatic event is based upon an assumption that a psychologist or psychiatrist, employing specialized skills, can attribute an individual's symptoms to a specific event, isolated from the "myriad other sources encountered in life."[323] Thus, although the courts that found PTSD evidence to be potentially useful to fact finders claimed that they were not admitting expert testimony to bolster the credibility of the plaintiff or complainant, there can be little doubt that the evidence potentially has such effect.[324] Given the central role of credibility in these cases and the challenge of reconciling competing stories, it is not difficult to imagine that a fact finder receiving the testimony of a mental health professional would, notwithstanding any limiting instruction, give it great weight as a measure of the truthfulness of the plaintiff-complainant's allegations.[325]

**B. Tort Liability for Psychological Injury**

As noted above, courts have been far less reluctant to admit PTSD in civil claims than in criminal cases. The diagnosis offers plaintiffs "a significant benefit" when ***42** proving causation and the extent of emotional injuries in tort cases,[326] and its potential use in personal injury litigation is apparent.[327] Articles appeared in legal publications assessing the potential impact on personal injury claims by the diagnosis,[328] particularly after the 1994 revisions of the A Criterion.[329] A psychiatrist observed that, by virtue of the A Criterion, "an external injury is by definition the explicit cause of this disorder," which then operates to

support "legal arguments regarding single and proximate causation of harm."[330] A forensic psychologist observed that PTSD is the "most common courtroom diagnosis" in claims of psychological injury.[331] One defense attorney cautioned others that any PTSD claims they encounter must be "fleshed out as soon as possible and attacked immediately."[332]

The APA's recognition of PTSD had a significant impact on the determination of liability for psychological injuries and, in the words of one group of commentators, "transformed and expanded the horizons of tort litigation, resulting in the recognition of a host of new claims tied to the diagnosis."[333] It has had this effect in several ways that will be briefly reviewed here.

The DSM-III appeared at a time when courts were grappling with the issue of whether and under what circumstances to permit recovery for emotional injuries, as described earlier in Part II. Although some courts permitted recovery for "traumatic neurosis," the notion of compensating for emotional injuries remained controversial. Many courts continued to apply the "impact rule" or the "physical manifestation" rule to limit damages for psychological injuries.[334] With PTSD now listed in the definitive authority on mental disorders, however, several courts began to build their legal standard for negligent infliction of emotional distress around whether the emotional ***43** injury was "medically diagnosable," often using PTSD expressly or impliedly as the basis for evaluating whether specific claims met that standard.[335]

Some courts concluded that psychiatry had sufficiently progressed to the point where there was less reason to be concerned regarding the validity of such claims.[336] For example, in 1983, the Supreme Court of Missouri in Bass v. Nooney Co.[337] was influenced by the "prevailing" belief among courts that "the development of psychiatric tests and refinement of diagnostic techniques have enabled science to establish with reasonable medical certainty the existence and severity of psychic harm" and "mental trauma."[338] Accordingly, the court's new legal standard included the requirement that "the emotional distress or mental injury must be medically diagnosable and must be of sufficient severity so as to be medically significant."[339] The dissent was less certain that the new standard was workable: "What does 'medically significant' mean in a courtroom?"[340]

Similarly, the Supreme Court of Tennessee dispensed with that state's "physical manifestation" rule in Camper v. Minor,[341] a personal injury case in which PTSD was the primary basis of the claim for damages, and instead imposed the requirement that claims of negligent infliction of emotional distress "be supported by expert medical or scientific proof."[342] A Louisiana appeals court reached a similar conclusion and allowed an award for emotional injury damages to stand because the plaintiff suffered from "more than fright[,]. . . . there was sufficient proof of emotional injury, post-traumatic stress disorder, to support the Trial Judge's award of damages."[343]

***44** Some of the changes to PTSD's A Criterion actually paralleled or even influenced the evolution in the legal standards for recovering for emotional distress. For example, many courts expanded the rules for liability to "bystanders" to include recovery for merely observing or encountering a trauma occurring to a family member.[344] Similarly, the revisions to the A Criterion in DSM-IV included extending "eligibility" for the diagnosis to one who "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."[345] Indeed, at least one court cited specifically to that amended diagnostic language in deciding where to draw the line in allowing recovery for negligent infliction of emotional distress claims.[346] Another court held, for purposes of summary judgment, that an expert witness's opinion that the plaintiff had PTSD "as a direct and proximate result of being personally involved in a collision that resulted in the death of a child" was sufficient to generate a factual issue as to causation.[347]

Not all courts embraced PTSD as a measure of the advancement of psychiatry's role in law, and some explicitly rejected legal standards for recovery based upon the presence of a psychiatric diagnosis such as PTSD.[348] The Supreme Court of Alaska, for example, reasoned that including a requirement of standard such as that in Bass--that the distress be "medically diagnosable or objectifiable"--would usurp the jury's function in determining the severity of the emotional distress as a question of fact.[349]

The recognition of PTSD also did not silence the concerns about malingering in claims for psychological injuries; indeed, malingering has been a central issue with PTSD, perhaps more than any other diagnosis, due to the strong association with litigation.[350] Although studies have documented the incidence of malingering, no ***45** empirical research has established a specific link between PTSD-related malingering and the prospect of compensation.[351] However, the diagnostic criteria are readily available, and some court opinions have noted incidents of coaching by attorneys.[352] The DSM-IV's addition of a subjective element in the A Criterion made the issue all the more acute.[353] Indeed, the DSM-IV includes a comment directed specifically at PTSD: "Malingering should be ruled out in those situations in which financial remuneration, benefit eligibility, and forensic determinations play a role."[354] This caveat is not directed at other diagnoses and did not appear in other editions.[355] This reflects psychiatry's own acknowledgment of the unique link between that diagnosis and determinations of compensation.

### C. Evidentiary Limitations on PTSD Evidence

The key mechanism in law to determine what a fact finder may consider in making determinations of liability (or resolving other legal controversies) is the body of relevant evidence law. Thus, questions of whether and where a fact finder may consider PTSD in assigning criminal or civil liability necessarily implicates the rules of evidence, particularly those pertaining to relevance and expert testimony. However, perhaps because courts have regarded PTSD as being a medical (and therefore "scientific") diagnosis uniquely suited for aiding in determinations of liability, courts have generally leaned in favor of putting such evidence in the hands of fact finders.

Evidence of PTSD is generally offered through expert witnesses, whether they are treating clinicians who describe their diagnostic impressions of their patients or forensic examiners retained by one of the parties to evaluate an individual and render an opinion on a specific issue tied to the civil or criminal litigation. Accordingly, the admissibility of PTSD evidence directly implicates the rules regarding the admissibility of expert opinion evidence. A comprehensive examination of the various rules governing the admissibility of evidence of PTSD and other mental disorders is beyond the scope of this Article,[356] but a few of the particular admissibility issues that PTSD evidence implicates will be addressed.

***46** The DSM-III was published only five years after Congress enacted the Federal Rules of Evidence, which evidenced a shift towards a bias of admissibility of a wide range of relevant evidence, including opinion testimony.[357] In 1993, the year before the DSM-IV was released with its broader A Criterion, the United States Supreme Court issued its opinion in Daubert v. Merrill Dow Pharmaceuticals, Inc.,[358] which, along with the follow-up cases in the following few years, significantly revised the approach federal and many state courts took to the admissibility of most kinds of scientific and other expert testimony.[359] The Court ruled that the federal common law Frye test for determining the admissibility of expert testimony--whether the basis for the opinion enjoyed "general acceptance" in the relevant scientific community[360]--did not survive the enactment of the Federal Rules of Evidence with their "'liberal thrust' . . . and their 'general approach of relaxing the traditional barriers to opinion testimony.'"[361] Rather, the Court held, courts should serve as "gatekeepers" of the admissibility of such evidence and consider a range of factors (rather than prerequisites) in assessing the reliability and relevance of the proffered expert testimony.[362]

Most psychiatric evidence generally fared well under Frye as being "generally accepted."[363] The courts that reached such conclusions with respect to PTSD often based them primarily on the fact that PTSD had been included in the DSM.[364] In theory, "abandonment of the Frye 'general acceptance' test" by the federal courts and the states that followed Daubert's lead should have precluded granting any kind of "immunity from judicial scrutiny" to the DSM generally or PTSD specifically.[365] However, few courts have used Daubert or other evidence rules to limit the admissibility of PTSD testimony, or indeed most other forms of clinical psychiatric evidence,[366] and it appears that the controversies in the psychiatric and related medical ***47** or academic literature over the validity and reliability of this diagnosis have not had any significant impact on its use in courts.

Courts also seem to be unconcerned with the fact that the PTSD criteria, including the A Criterion, were revised three times in fourteen years.

Courts have been somewhat more willing to play the role of "gatekeeper" for the use of PTSD and related diagnoses by prosecutors in sexual abuse and rape cases since such use directly implicates questions of the reliability of the testimony. Nonetheless, many courts provide fairly cursory analyses before admitting PTSD-based evidence. In 2001, the Supreme Court of Wyoming, applying Daubert, appeared to conclude that the broader question of admissibility of PTSD testimony in sex abuse cases was by then resolved.[367] In an appeal of a sexual abuse conviction, the defendant argued that the trial court erred in allowing the state to offer a psychiatrist's testimony that the complainant had PTSD on the basis that "the theory of PTSD related to child sexual abuse is not sufficiently developed to permit an expert to formulate a reasonable opinion on the subject."[368] The court rejected those arguments, noting first that PTSD's inclusion in the DSM was in itself evidence that it had "achieved acceptance in the fields of psychiatry and psychology."[369] Further, the court reasoned, "the PTSD diagnosis appears to be grounded in basic behavioral psychology."[370] More significantly, by that time, the diagnosis had been "widely, although not universally, accepted by other jurisdictions as a reliable form of expert testimony in this context," although the specific purpose for which it could be offered was still subject to some controversy.[371]

Another example of a court applying little scrutiny to the reliability of PTSD evidence as proof of sexual abuse is a 1993 opinion of the Supreme Court of New Mexico, State v. Alberico.[372] The court concluded: "We hold that PTSD testimony is grounded in valid scientific principle."[373] The inclusion of PTSD in DSM-III was a large part of that determination because the court reasoned that "[t]he existence of DSM III-R and its general acceptance in psychology indicate that PTSD has been exposed to objective scientific scrutiny and empirical verification."[374] The court also accepted the State's argument that trained psychologists could "isolate the cause of the symptoms because different stressors manifest themselves in different symptoms."[375] The court thought that the "current state of the technique" of the diagnosis of PTSD had advanced sufficiently since the time of earlier decisions to permit experts to testify ***48** that the complainant's PTSD symptoms were consistent with having been sexually abused.[376]

By contrast, some courts have declined to admit PTSD evidence specifically due to concerns about its reliability for purposes of proving that a trauma had occurred and have held that the fact PTSD is included in the DSM does not end the analysis required under Daubert's "gatekeeping" standard.[377] The Supreme Court of Washington held that it was improper to admit expert testimony on rape trauma syndrome, regardless of whether it was described as PTSD, on the basis that it was not a scientifically reliable method of determining whether a rape had occurred and it amounted to an expert opinion on the guilt of the defendant and the credibility of the plaintiff.[378] Similarly, the Louisiana Supreme Court concluded: "[I]t is widely accepted that PTSD has not been proven to be a reliable indicator that sexual abuse is the trauma underlying the disorder or that sexual abuse has even occurred."[379]

The concept of the "traumatic memory" underlying PTSD also led to the theory of the "repressed memory" of a traumatic event that could be subsequently "recovered" through psychotherapy.[380] This theory became a central issue in several lawsuits in which adults claimed to have recovered memories of childhood abuse and then sought compensation.[381] A federal district court considered the reliability of evidence of PTSD and repressed memory in Isely v. Capuchin Province.[382] Relying largely on the reasoning in Alberico and the extensive work of the plaintiff's expert witness--who ***49** had, among other things, served on the committees that revised Criterion A in DSM-III-R and DSM-IV--the court concluded that the expert "has met the foundational requirements to testify regarding PTSD and repressed memory."[383] The court further ruled that it would permit the expert to "not only testify as to her theories and opinions concerning PTSD and repressed memory, but also . . . to testify as to whether [the plaintiff's] behavior is consistent with someone who is suffering repressed memory or post-traumatic stress disorder."[384]

Although the court ruled that she could not go further and testify expressly that she believed the allegations, the court drew a very fine distinction there.[385]

In civil cases in particular, courts have grappled with the respective roles of the court, the fact finder, and the expert witness in applying the A Criterion to the issues presented at trial, particularly since the determination of the A Criterion so closely resembles the fact finding of causation typical in many trials.[386] These questions are particularly apparent in cases where the court or a party raises questions about whether the forensic examiners or clinicians strictly adhered to the DSM criteria, including the A Criterion, when assigning PTSD diagnoses.[387] Generally, courts do not exclude testimony on such basis, concluding that the issue goes to the weight rather than the admissibility of the testimony.[388]

For example, in Bachir v. Transoceanic Cable Ship Co.,[389] the defendant filed a post-verdict motion to set aside an award to a former cook employed on a ship for damages resulting from an accident in which he tripped and fell over some pipes.[390] A neuropsychiatrist had testified at trial that the plaintiff had PTSD as a result of the accident, which satisfied the "traumatic event" (i.e., A Criterion) requirement of the DSM-IV's criteria for PTSD.[391] Although the defense offered contradictory expert testimony on the issue of whether such incident could trigger PTSD, the trial court ***50** dismissed the post-trial challenge to the admissibility of the evidence as going only to "weight and credibility" and therefore an issue for the jury to decide.[392]

Some courts, however, have applied more scrutiny to plaintiffs' experts' opinions where they appear to stray from the DSM criteria, and at least one even substituted its own assessment. In the bench trial opinion in Nelsen v. Research Corp. of the University of Hawaii,[393] another injury-at-sea case, the district court made a specific factual finding that, despite the plaintiff's treating psychiatrist's testimony to the contrary, the underlying incident at issue in that case--an on-board flood on a research vessel due to a faulty bilge pump--did not meet the A Criterion as it appeared in the DSM-III-R.[394] Accordingly, for this reason, it was not "reasonably foreseeable" that the plaintiff would develop PTSD and he was not entitled to compensation for his psychological injury.[395]

Alvarado v. Shipley Donut Flour & Supply Co., Inc.[396] is one of the few federal court opinions in civil cases demonstrating close scrutiny of PTSD testimony under a Daubert analysis, but the result may have been due to the apparent overreaching by the plaintiffs and their expert.[397] The federal district court excluded plaintiffs' expert testimony in an employment discrimination claim brought by twelve employees.[398] The psychologist retained by the plaintiffs examined all twelve and diagnosed each of them with PTSD.[399] The district court conducted a close review of the psychologist's techniques under Daubert and concluded that they fell far short of being sufficiently reliable for admission.[400] Among the deficiencies noted were a failure to use any of the standardized diagnostic instruments available for PTSD evaluations and the absence of Criterion A1, the traumatic event.[401] The judge further noted that the expert's conclusion that all fifteen of the original plaintiffs had PTSD was highly suspect, given studies suggesting that the post-trauma incidence is closer to ten to fifteen percent.[402]

***51** In short, with few exceptions, courts generally do not use rules of evidence as a basis to restrict PTSD-based expert testimony. Rather, reasoning that due to its inclusion in DSM PTSD is a "medically recognized disorder,"[403] courts regard it as relevant, useful, and appropriate for fact finders to employ, even when making essential determinations of liability, and rely upon the adversarial process to flesh out the limitations of such evidence.[404]

There are several other possible reasons for courts' inclination (implicitly or explicitly) to use PTSD in liability determinations. Courts and attorneys are drawn to the DSM perhaps because the diagnostic criteria bear some resemblance to legal criteria, with "prongs" and categorical criteria. Courts may place significant weight on the identification of psychiatric disease by doctors because they are doctors, ascribing to them a special power to detect disease and malingering.[405] Courts may simply use PTSD

as a stand-in for a broader legal rule regarding recovery for psychological injuries.[406] Regardless of the specific reasoning, however, there is little indication that courts consider or acknowledge PTSD's development and long-standing association with assigning legal responsibility when deciding to admit such evidence.

## V. PTSD's Persistent Controversies

As demonstrated in Part IV, many courts assume that PTSD represents a well-settled scientific fact and, therefore, a reliable tool for fact finders to use when making liability determinations. However, during the three decades since the DSM-III's publication, the controversy over the diagnosis has not diminished and has perhaps intensified as a result of the extensive study of PTSD that took place only after the diagnosis was officially established.[407] Robert Spitzer, DSM-III's lead editor, noted ***52** recently that, since PTSD's introduction "no other . . . diagnosis, with the exception of Dissociative Identity Disorder (a related disorder), has generated so much controversy in the field as to the boundaries of the disorder, diagnostic criteria, central assumptions, clinical utility, and prevalence in various populations."[408] The large-scale epidemiological studies of PTSD have revealed strikingly diverse conclusions, putting some trauma researchers on the defensive regarding the validity of the diagnosis itself.[409] The original questions raised about PTSD have not been answered in the eyes of many in psychiatry, including, perhaps most centrally, whether it is a normal reaction to an extraordinary event.[410]

PTSD has been subjected to particular scrutiny within behavioral science in part because of the use of the diagnosis, or at least the term, in the courts and the broader culture.[411] Many psychiatrists and psychologists have been struck by the widespread adoption of PTSD as "a household word and courtroom plea."[412] Forensic psychiatrist Roger Pitman observed: "Perhaps more than any other psychological or medical disorder, [PTSD] has influenced, and been influenced by, the law. . . . [It] has become the most important diagnosis in the forensic psychology of personal injury."[413] Former APA President Alan Stone has been highly critical of PTSD's widespread adoption, particularly in personal injury law:

> ***53** No diagnosis in the history of American psychiatry has had a more dramatic and pervasive impact on law and social justice . . . .
>
> . . . .
>
> By giving diagnostic credence and specificity to the concept of psychic harm, PTSD has become the lightening rod for a wide variety of claims of stress-related psychopathology in the civil arena.
>
> . . . The recognition of this disorder by the medical community changed the nature of personal injury litigation.[414]

Several psychiatrists and psychologists, even those with forensic training and experience, raised questions early on regarding the ways that PTSD found its way into the courtroom. In 1983, Lawrence Raifman, with training in both law and psychology, questioned the use of PTSD in legal settings and argued that PTSD's underlying conceptual problems made it a particularly poor fit for answering legal questions, whether they arise in criminal or in civil matters.[415] He was particularly concerned that the misuse he observed in just the first few years of the diagnosis's official existence would eventually lead to "skepticism and possible stigmatization of PTSD complainants," which would "threaten the credibility and validity of the diagnostic entity."[416]

There is no dispute within psychiatry that many people who experience serious and distressing events may have resulting long-term psychological symptoms, some quite severe.[417] However, the specific conceptualization of PTSD as a stand-alone diagnosis with a defined set of symptoms has brought widespread attention and scrutiny within psychiatry.[418] Two key questions linger that have direct implications for the legal uses described in the prior Part: the validity of the A Criterion and the extent to which PTSD is a construct rather than a "scientific discovery."

**A. Revisiting the A Criterion**

The most significant area of dispute within psychiatry regarding PTSD is, as has been the case since the publication of DSM-III, the precise role of the A Criterion, or underlying stressor event, in the development of a person's PTSD symptoms.[419] ***54** Controversies regarding the A Criterion are often directly related to the increasing use of the diagnosis in civil litigation as a theory of recovery and the role of the diagnosis in the determination of legal causation.[420] In a recent editorial co-authored by Robert Spitzer, three psychiatrists observed that the diagnosis's narrow focus on a single specific event may lead clinicians to "ignore crucial pathogenic features," remarking that, "[u]nfortunately, what may be best for a lawsuit is not necessarily best for the patient."[421]

The determination of causation as required by the A Criterion raises questions of bias and skewed subjective assessment on the part of both the clinician and the patient, decreasing the validity and reliability of PTSD diagnoses.[422] Several studies have suggested a significant potential role for bias on the part of clinicians when diagnosing PTSD.[423] Research has indicated that PTSD is a diagnosis that may be particularly susceptible to "confirmatory" bias, in that a clinician who is aware of a person's experience (or allegation) of a potentially qualifying stressor may be more likely to assume that the person does have lasting symptoms from such an event (particularly if the distress from the trauma has led to the initiation of litigation).[424] In one study of forty-seven sexual harassment cases in which a plaintiff was subjected to forensic psychiatric evaluations by examiners retained by either the plaintiff or defense attorneys, seventeen plaintiffs received PTSD diagnoses from plaintiffs' examiners but only three plaintiffs received PTSD or chronic PTSD diagnoses from defense examiners.[425] Some courts have suggested in specific cases that the forensic examiners ***55** may have (perhaps even intentionally) attempted to support the plaintiffs' claims when diagnosing plaintiffs with PTSD.[426]

There are also concerns about the heavy reliance during the diagnostic process on subjective reporting by the patient of both the stressor event and the resulting reactions, as well as the subjective impressions of the diagnostician.[427] One study documented low inter-rater reliability in determining whether specific events met the A Criterion and noted that "interpreting Criterion-A1 is a highly subjective process influenced not only by the personal experience of the victim but also the experiences and mindset of those who rate them."[428] The researchers raised the question that courts struggled with in the personal injury cases in which the evaluator determined that the event at issue met the requirements of being a "stressor."[429] They questioned how a clinician conducting a diagnostic evaluation could "define a stressor as 'traumatic' without relying on [her] own subjective interpretation of the definition of Criterion-A1."[430] The widespread use has resulted in "conceptual bracket creep," meaning that clinicians are continuously broadening the categories of events that qualify for the criterion, thereby diminishing the significance of the criterion in the process.[431]

Even aside from these concerns about bias and subjective assessment, a number of studies have raised questions about the core assumption of PTSD (and its particular use in the legal context): that the symptoms of PTSD (that is, anxiety, poor sleep, irritability, flashbacks, and so forth) were in fact caused by a traumatic event. In a 2007 study, a group of researchers concluded that symptoms of PTSD were of equal prevalence among subjects divided into groups of those who identified as being "traumatized, non-traumatized, [or] equivocal."[432] The researchers noted that "the diagnosis of posttraumatic stress

disorder may harbor an uncertain theory of etiology within its name," which suggests caution due to the "practical importance, as psychotherapy may be structured, research studies designed, and legal compensation awarded on the basis of an unexamined assumption that symptoms of PTSD are caused by specific traumatic events."[433] This study also refers to research noting the presence ***56** of PTSD symptoms after "sub-threshold traumatic events," including divorce, money problems, and the death of livestock.[434] These findings suggest that the mere presence of PTSD symptoms may serve as an imprecise or perhaps even improper proxy for legal standards that are based upon the severity of an underlying event.

Some psychological researchers theorize that is it not entirely accurate to state that the A Criterion event caused the PTSD symptoms to develop because the primary determining factor in whether someone develops such symptoms is the way in which the person recalls the event. One group has suggested that a person's "memory of a stressful event, rather than the event itself, is the key to PTSD."[435] Thus, it is the way a person organizes and accesses the memory of an event that is most determinative of whether PTSD symptoms will develop.[436] It is widely understood by psychologists that certain individuals are predisposed to develop PTSD in response to particular events[437] and that individuals have widely varying responses to threatening events.[438] This suggests that any individual who develops PTSD had a preexisting, yet latent, condition, and that PTSD reflects merely a triggering of such condition.[439] Thus, the causal relationship between the stressor event and PTSD symptoms is not one of "mechanistic linear causality but of dynamic interaction," and therefore is far more complex than was originally assumed.[440]

The implications of these findings could be significant for the legal context, and at least one court has raised such questions. After a bench trial, the court in Burns v. Republic Savings Bank[441] concluded that one cannot readily determine where causation from the event ends and where perception and memory of the event begins.[442] The court rejected the plaintiff's forensic expert who had opined that the plaintiff had ***57** depression resulting from PTSD, and concluded instead that she had a "depressive episode . . . caused, at least in part, by [the plaintiff's incorrect] perception that she had been treated unfairly and discriminated against."[443]

PTSD was originally conceptualized as a "natural process of adaptation to extraordinarily adverse situations" that arose in "normal people."[444] The dispute over the validity of this assumption has social and political dimensions as well as legal ones.[445] The veterans' campaign for PTSD's recognition emphasized that the disorder was one caused entirely by their combat experiences.[446] However, subsequent research pointed to several "risk factors," and such findings "are inconsistent with the notion that traumatic events are the primary cause of symptoms and challenge the idea of PTSD as a typical stress response."[447] Some psychologists, particularly within the field of traumatology, resist such arguments, as they seem to redirect "blame" to the "victim"[448] and challenge the "every person has a breaking point" notion that led to the development of PTSD for veterans as a service-connected event.[449]

Commentators have also suggested that events are "traumatic" in part due to a person's experience with society's response to the event, and that certain events will have less effect as traumatic stressors "as society begins to supply victims with social ***58** support services."[450] For example, some attribute the widespread PTSD and other readjustment problems in Vietnam veterans to the hostile and unsupportive society they encountered upon their return. In fact, some studies have found that those with milder physical injuries are at a greater risk of developing PTSD because of the limited psychological support they received after a traumatic event.[451]

In addition to these studies evaluating the validity of the A Criterion generally, several studies have specifically concluded that the diagnosis cannot be reliably used to determine whether the person has been subjected to trauma, particularly in cases of child abuse.[452] A group of legal and psychological commentators concluded, based upon their review of the current literature,

that psychologists and psychiatrists have no skills grounded in "specialized knowledge" to identify whether a child has been a victim of sexual abuse, and there is no scientific basis for child abuse syndrome evidence.[453]

Given the controversies over the A Criterion--that it is unique, often disregarded, and seems to encourage use (and misuse) in legal settings--some psychiatrists have raised the question of whether, after thirty years, psychiatry should simply jettison the A Criterion or even the entire diagnostic category of PTSD.[454] However, the APA is unlikely to take steps that could be interpreted as a denial of the "close relationship of trauma and disorder."[455]

***59** Indeed, in 2010, the APA working group released its proposal for yet another revision to PTSD in the DSM-V, which would retain the A Criterion but would modify it once more:

> A. The person was exposed to one or more of the following event(s): death or threatened death, actual or threatened serious injury, or actual or threatened sexual violation, in one or more of the following ways:
>
> 1. Experiencing the event(s) him/herself
>
> 2. Witnessing, in person, the event(s) as they occurred to others
>
> 3. Learning that the event(s) occurred to a close relative or close friend; in such cases, the actual or threatened death must have been violent or accidental
>
> 4. Experiencing repeated or extreme exposure to aversive details of the event(s) (e.g., first responders collecting body parts; police officers repeatedly exposed to details of child abuse); this does not apply to exposure through electronic media, television, movies, or pictures, unless this exposure is work related.[456]

Additionally, Criterion A2, which was added in 1994 to describe the subjective reaction of the patient to the traumatic event, would be eliminated from the criteria.[457]

This proposal aims to "tighten[] up the A1 criterion to make a better distinction between 'traumatic' and events that are distressing but which do not exceed the 'traumatic' threshold" by restricting the types of events that can serve as a basis for a PTSD diagnosis to three: actual or threatened death, serious injury, or sexual violation.[458] The "threat to physical integrity" category would be removed, eliminating the application of the A Criterion to many events currently considered to be potential stressors, including sexual harassment.[459] The ambiguous term "confronted with" included in the DSM-IV revision would be replaced by a list of specific ways that the person was "exposed" to such events.[460] Finally, with the elimination of Criterion A2--now deemed to be of "no utility"--the subjective reaction of the individual would be irrelevant to the diagnostic process.[461] None of these changes, however, addresses the ***60** fundamental criticisms of the A Criterion and the role of causation in diagnosing PTSD.[462]

The research findings with respect to the uncertain reliability of the diagnosis of PTSD and the uncertain validity of the disorder itself underscore the dangers of admitting PTSD evidence in legal proceedings, particularly for the purpose of proving that

a traumatic event occurred. Not only is the A Criterion itself the subject of a great deal of scientific debate as to its utility and validity, there is little to no research to support many of the PTSD-related theories that have found their way into trials, such as the existence of "typical" or "hallmark" symptoms that are reliable indicators that a person has been subjected to a particular kind of trauma, such as child sexual abuse or rape, or has repressed memories of a trauma. To be sure, PTSD does have many defenders within psychiatry and psychology who offer responses to many of the key challenges to PTSD's validity.[463] However, even they are likely to concede that there is nothing resembling a scientific consensus within psychiatry about the core assumptions of PTSD as a stand-alone diagnostic category.[464]

Perhaps of most significance to the applicability of PTSD in legal contexts, these debates regarding PTSD and particularly the A Criterion exemplify the broader debate within psychiatry regarding the uncertain role of the concept of "causation" in that field. "Causation" has an unquestionably central operation in law, which uses the terms "legal cause" and "proximate cause" to construct normative rules to assign legal responsibilities between and among parties to a controversy. Such assignment is one of the core functions of law, particularly of litigation. However, causation has a far more uncertain--and some would argue nonexistent--role in contemporary psychiatry, which classifies and treats mental disorders based largely upon symptomatology without regard to etiology. Indeed, the role of "causes" of mental illness was the essential dispute between those within psychiatry who based their understanding of mental disorder upon psychoanalytic and other psychodynamic theories, and those who assumed that there were biological bases (even if they had not yet been precisely isolated) for most psychopathology.[465] PTSD's A Criterion, with its roots in the former, is an outlier (and some would say a relic) within contemporary psychiatry's DSM.

**B. PTSD as a Construct**

Courts' use of a PTSD diagnosis as discussed in Part IV implicates the scientific basis of that diagnosis. However, science has an uncertain role in PTSD. The scores of empirical findings that emerged after the diagnosis had been in place for many years led the American Journal of Psychiatry, the official publication of the American Psychiatric Association, to title a 1997 editorial "What is PTSD?" in light of research ***61** that challenged some of the basic assumptions upon which the diagnosis had been based, and to conclude that the question "has no one answer."[466]

This observation reflects the broader dispute within psychiatry regarding whether PTSD was a "discovery" or a "product" of psychiatric discourse.[467] One of the core assumptions of PTSD is that the symptoms included in the DSM diagnosis represent "the way" that trauma (or at least certain types of trauma) can lead to psychopathology.[468] Thus, the argument goes, PTSD is a disorder that was finally "recognized" by the APA in 1980, but it had in fact been in existence for decades, centuries, or longer.[469] However, many who have noted PTSD's conspicuously "political" origins question how organizing and lobbying could have resulted in the "discovery" of a new disease in an ostensibly science-driven document such as the DSM-III.[470] They challenge the notion that PTSD can be understood to exist apart from the APA determination through a show of hands in the late 1970s and that the cluster of symptoms constitutes a singular disorder. The implications of this debate go to the essential validity of using a unique diagnostic label to classify all psychological symptoms that are determined to be in reaction to identifiable events.[471]

A group of psychologists offering a critical historical analysis of PTSD explained why the origins of the diagnosis have become the focus of such a contentious debate:

> [I]f one can demonstrate that a disorder shows up repeatedly across time and across cultures, one has evidence that the disorder is a state of nature rather than a social and cultural artifact due to social mores and conventions. Conversely, when disorders come and go we typically suspect that their instability is indicative of a social rather than natural basis.[472]

Along these lines, many in the field of traumatology or who otherwise work regularly with PTSD attempt to point to the timelessness of the condition, stating that it ***62** is essentially the same disorder once diagnosed as shell shock.[473] However, a number of scholars, both within and outside of the field, conclude otherwise. For example, one study of World War I military pension records found that there were virtually no complaints of what would now be referred to as "flashbacks," the classic dissociation symptom of the PTSD experienced by Vietnam veterans; in fact, a significant number of soldiers receiving compensation for war neurosis or shell shock would not have met the current PTSD criteria if it were in place at the time.[474] Moreover, cross-cultural studies of PTSD have revealed "remarkable deviations from the PTSD symptom list."[475] Medical anthropologist Allan Young concluded from his study of the development of PTSD that the diagnosis "is not timeless, nor does it possess an intrinsic unity."[476] Rather, he observed, "it is glued together by the practices, technologies, and narratives with which it is diagnosed, studied, treated, and represented and by the various interests, institutions, and moral arguments that mobilized these efforts and resources."[477]

As an alternative to proving the "timelessness" of PTSD, several researchers have attempted to locate a precise biological cause or indicator of PTSD to establish the elusive independent validity of the diagnostic category.[478] Since 1980, numerous papers have attempted to align the diagnosis with the "new" biological psychiatry.[479] Many researchers hope to identify specific psychobiologic responses or "biomarkers" to PTSD to improve the reliability of diagnoses. Finding these biological markers, the hallmarks of a "naturally occurring and inevitable phenomenon," has become a key object of traumatologists.[480] The expectation is that finding physiological indicators of the disorder will put an end to the controversies within psychiatry and allow the diagnosis (and presumably the entire field of traumatology) to receive broader ***63** acceptance,[481] including within the legal realm specifically.[482] Most recently, a study claims to have identified a neurological abnormality in veterans with PTSD through magnetoencephalography (MEG) scans.[483] However, no consensus has emerged on any biomarkers for PTSD,[484] and thus far not one has been identified for diagnostic purposes.[485]

The debate regarding PTSD's origins, however, fails to note that PTSD is not unique in its "constructed" evolution; rather, such evolution is perhaps simply more conspicuous than in other diagnoses. PTSD provides an example of medical historian Edward Shorter's theory of the "symptom pool," the mechanism through which the mind experiences and explains a reaction within the person's cultural context at a particular time and place.[486] A patient's unconscious "striving for recognition and legitimization of internal distress" may lead the unconscious to manifest such distress through means that will lead to such result.[487] The patient is not alone in this process. Through "illness negotiation" with a physician, the two "shape each other's perceptions of the behavior" with the backdrop of what has been recognized as a "legitimate disease category," thereby leading to "scientific validation" of the patient's experience.[488]

This dynamic is particularly powerful with psychiatric diagnoses.[489] "Hysteria," a psychosomatic illness in which individuals experience paralysis or the sudden loss of the ability to speak, hear, or see, was the "archetypal disorder of the Victorian era"; however, such symptoms are rarely encountered today.[490] Similarly, the symptoms of World War I veterans' "shell shock" are quite different from those reflected in the current diagnostic criteria of PTSD (which themselves have undergone substantial ***64** revision since DSM-III).[491] What PTSD and its forerunners have in common then is not their symptomatology, their theoretical underpinning, or their treatment, but rather their utility outside of the clinical setting. This commonality suggests a particularly strong role for the symptom pool, but PTSD is by no means the only diagnosis that developed in this fashion.

Indeed, it would be accurate to say that all of the DSM is infused with the policy choices made by those in positions of authority to decide the parameters of what is a mental "disorder."[492] The diagnostic categories in the DSM do not, for the most part, "reflect

a coherent progression of empirical research," but rather, are, "at best, a categorization of the pain, suffering, or distress."[493] The development of medical diagnoses generally reflects "negotiation," rather than discovery, and the resulting classifications "serve to rationalize, mediate, and legitimate relationships between individuals and institutions in a bureaucratic society."[494] And the legal system is one of the players in such negotiations, particularly with respect to psychiatric diagnoses, given the extensive association of psychiatry with the legal system throughout the twentieth century.[495] The demands the legal system brings to these negotiations often include consistency, certainty, and reliability and, more generally, the ability to aid in the resolution of legal questions and problems.[496] DSM-III, at least on its face, appeared to satisfy all of these demands,[497] and thus it should not be surprising that PTSD--which purported to provide consistent, certain, and reliable answers on the causation of injury--found a central place in litigation so quickly. Therefore, that PTSD is a "construct" is simply a given. It is remarkable, rather, because of the manifestly socio-political and legal origins of this particular psychiatric construct and, accordingly, the implications of such origins for its use in determining liability in legal settings.

The construct-versus-discovery argument itself has implications for the role of PTSD in law. As discussed above, many courts and legislatures have framed legal standards or requirements directly or indirectly around PTSD on the assumption that it ***65** represents an advancement in scientific understanding of the psychological impact of traumatic events.[498] A few courts, by contrast, have dismissed the diagnosis as a mere "human construct," using the term to signify that "PTSD" is nothing more than a label.[499] However, in making either assumption, these courts fail to recognize the complexity not only of psychopathology itself, but of our very understanding and explication of mental disorders and, indeed, all medical diagnoses.

## VI. Conclusion - The Lessons of PTSD's Legal History

At the time of PTSD's recognition by the APA, few within the psychiatric establishment raised concerns about recognizing, treating, and compensating the psychological injuries of the people who fought a violent and controversial war. However, since that time, PTSD's association with law, and particularly with compensation, has led to a backlash against the diagnosis. Many psychiatric and legal commentators regard it as a medical term co-opted by the legal profession and its clients to be a mechanism either to acquire undeserved compensation or to evade personal responsibility.[500] As a result, the very real psychological impact of horrific events is often minimized and claims of psychological injuries continue to be regarded with suspicion.

Some commentators from within psychiatry who have expressed particular skepticism about the role of PTSD in legal settings urge a decoupling of legal and medical notions of causation embodied in PTSD. The assignment of responsibility to a source is the purview of law, not psychiatry. Regardless of the particular school or theory, psychiatry has always seen the workings of the psyche as being far more complex than the liability questions raised in most civil and criminal cases resolved by non-expert fact finders. Those within psychiatry who criticize the legal system for taking PTSD and running with it,[501] however, fail to acknowledge that PTSD and the legal conceptualizations of emotional injuries share a common past and have evolved ***66** together.[502] Where physicians have built a theory of causation into the "signs and symptoms" themselves, it is not so simple to suggest that "the physician delineates signs and symptoms; the legal system decides on compensation."[503] Jerome Wakefield and Allan Horwitz, two noted scholars of the development and implications of psychiatric diagnoses, recently observed of PTSD: "No other psychiatric diagnosis involves issues where drawing boundaries is not just a matter of diagnostic convenience but also of justice and injustice."[504] The line between law and medicine is not merely blurred in PTSD; it is absent.

PTSD's inextricable relationship to notions of causation and responsibility does not, however, mean that the legal system should utilize it freely. In fact, PTSD's distinctly legal history suggests that the law should in fact apply far greater scrutiny to the role of PTSD in litigation than it does for other psychiatric diagnoses. The studies that have called into question the original theoretical assumptions of PTSD and the problems inherent in the A Criterion demonstrate that courts should be reluctant to allow a PTSD diagnosis to be assigned legal significance in itself. Permitting PTSD to play a central role in legal settings risks conflating the unsettled psychiatric conceptualization of "causation" with the questions of legal or proximate cause reserved for fact finders.[505]

Although unquestionably infused with policy choices, psychiatric diagnoses were developed to serve that profession's clinical and research needs. Law, by contrast, serves distinctly normative goals through the development of legal rules or standards, which determine the framework to allocate responsibility based upon policy determinations reached by "lawmakers" (generally legislators and judges) applying their notions of "justice."[506] When courts employ legal standards that incorporate conceptualizations of "diagnosable" conditions, they are thereby assuming something legally significant about the thresholds the psychiatric profession chooses to set.[507] However, courts do not acknowledge or understand the construction of psychiatric ***67** disease and the limitations of using psychiatric labels outside of clinical and research settings.[508] Linking PTSD--with its built-in clinical determination of causation--to legal standards effectively delegates to the psychiatric profession determinations of legal responsibility.[509]

Accordingly, although PTSD is now commonplace in the legal system, this Article suggests that courts and other legal policymakers consider PTSD's legal history as part of a reexamination of the roles that law has assigned to the diagnosis. PTSD evidence arises in a wide range of legal contexts, including workers' compensation claims, criminal defenses and sentencing, and explaining the extent of a personal injury plaintiff's emotional distress damages, and there are varying degrees of danger of misuse in each of these settings. However, the uses described in Part II--where a fact finder is permitted to use PTSD's construction of causation to make a finding of civil or criminal liability--likely pose a greater danger of courts unknowingly permitting a policy-driven diagnosis to influence a legal outcome.

Courts should also be cognizant of the fact that laypersons lack the tools to understand the limitations of this diagnosis and may misapprehend the significance of the diagnostic label. PTSD evidence, like any other expert opinion testimony, should not be exempt from the application of the rules of evidence, particularly Daubert scrutiny. It represents precisely the kind of expert opinion that is often presented as the ipse dixit conclusion of a treatment provider or forensic examiner that Daubert and its progeny warn are of little use to lay fact finders who cannot evaluate the reliability of the testimony for themselves.[510] It is unlikely that the typical cross-examination of a forensic examiner can bring out the full extent of the construction of trauma and psychological injury embodied in the diagnosis, the role of the diagnostician's own value judgments about causation in applying the diagnosis, and the overall complexity of the psychological mechanisms involved in mental disorders, including PTSD.

Using PTSD as the stand-in for severe emotional distress or proof of a traumatic event asks fact finders to distill an elaborate and poorly understood psychological process into simple determinations of liability. A PTSD diagnosis provides fact finders "a semantic handle for the complexity inherent in diagnostic issues,"[511] particularly since jurors (like all of us) are drawn to "simple causal explanations."[512] Nonetheless, the widespread use of the term, particularly in the wider culture, has rendered it loaded, ***68** diluted, and confused, and it risks being a misleading and unreliable tool in the hands of lay fact finders for purposes of assigning legal responsibility or assessing harm.[513] Indeed, encouraging challenges to PTSD to be played out in front of the fact finder may even undermine a plaintiff's claim for emotional distress damages or a complainant's allegation of sexual assault where the fact finder then links the problems of the diagnosis with the legitimacy of such claims and allegations; such a result would hardly be just.

It is important to emphasize here that scrutinizing the use of a PTSD diagnosis as evidence of liability does not require us to discount or diminish the recognition of and compensation for the events that can give rise to such liability, ranging from the horrors of combat, to the exploitation of children, to discrimination in workplaces, to the negligent operation of automobiles. Rather, this argument urges that determinations of liability for such actions must remain within the legal system without overreliance on psychiatry, and that legal barriers to recovery should be removed through legal mechanisms such as legislation, judicial opinions, and rules, rather than through the adoption of psychiatric standards of causation. PTSD may serve several important roles within psychiatry, including those which do not require any particular level of scientific reliability, such as to validate a person's reactions to an event or to encourage a person to pursue treatment. But psychiatric diagnoses are not fact-finding tools and have no place in litigation for such purpose.

One could certainly say that PTSD has provided important roles in legal contexts by, for example, enabling Vietnam veterans to receive critical benefits and health care for psychological injuries after exposure to a horrific and arguably unjust war. But such arguments are based upon a misplaced assumption that psychiatry was the proper route to fix the problem of compensation standards for veterans. The fault was with the VA and Congress for failing to provide compensation in the absence of a targeted diagnosis and for relying upon psychiatry to dictate compensation determinations in the first place. Courts repeat such mistakes by looking to psychiatry to fix problems with legal standards when they create legal rules such as "medically diagnosable" requirements to recover emotional distress damages.[514] Although psychiatry may have created a diagnosis that is intertwined with legal concepts, the law should not implement legal standards that are intertwined with psychiatric concepts without first considering the full implications of doing so.[515]

PTSD has served as a critical mechanism in law for other important purposes, such as the recognition that misconceptions about sexual assault victims can skew the results in prosecutions. It has also played a role in the erosion of the rigid mind-body dichotomy in personal injury law to permit expanded recovery for psychological injuries in tort actions. The problems in the legal systems that PTSD has been used to ***69** remedy should not go unaddressed. Rather, courts should use legal tools to dispel such misperceptions about sexual assault so that they do not interfere with fact-finding in such cases.[516] For example, "rape shield" laws such as Federal Rule of Evidence 412 limit a defendant's ability to exploit common (yet wrong) assumptions about the role of a woman's sexual "predisposition" in sexual assault cases.[517] Also, courts should allow compensation of psychological injuries through testimony of plaintiffs and their mental health providers who can describe symptoms and treatment for such injuries without being obliged to convey the impression that the cluster of symptoms signals something transformative in the person. Indeed, the American Law Institute's forthcoming Restatement (Third) of Torts permits recovery for emotional injury without any requirement for a medical diagnosis.[518]

Although PTSD, given its well-documented legal and political origins, may offer perhaps the most stark example of how psychiatric diagnoses can reflect legally-significant assumptions, we must also recognize that all psychiatric diagnoses reflect assumptions and conclusions about human behavior and emotion that reflect the time when they were developed. Indeed, unlike many legal rules, such framing can shift quite rapidly, with diagnoses being added, removed, or revised, within just a few years of the prior conceptualizations.[519] If the law decides to address problems of justice by looking to psychiatry or other branches of medicine and science for solutions, it must only do so with a full appreciation and understanding of the origins and limitations of the concepts it seeks to adopt. Absent such acknowledgement, together with a determination that such concepts are in fact appropriate to import into law, the legal system simply delegates juridical authority to those fields.

Footnotes

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1 Pat Barker, Regeneration 115 (1991) (Barker's fictionalized account of World War I British military psychiatrist W. H. R. Rivers).

2 See Am. Psychiatric Ass'n, Diagnostic and Statistical Manual of Mental Disorders 467-68 (4th ed., text rev. 2000) [hereinafter DSM-IV-TR] (listing "expos[ure] to traumatic event" among diagnostic criteria for Posttraumatic Stress Disorder).

3 The name "A Criterion" results from the fact that the requirement of an external traumatic cause appears in subsection A of the DSM's PTSD criteria. DSM-IV-TR, supra note 2, at 467.

4 See Gillian Mezey & Ian Robbins, Usefulness and Validity of Post-Traumatic Stress Disorder as a Psychiatric Category, 323 Brit. Med. J. 561, 562 (2001) (attributing criticism of PTSD diagnosis to its unique status as the only compensable psychiatric disorder).

5 See Am. Psychiatric Ass'n, Diagnostic and Statistical Manual of Mental Disorders 236, 237 (3d ed. 1980) [hereinafter DSM-III] (showing inclusion of Posttraumatic Stress Disorder in a chapter on anxiety disorders generally); Wilbur J. Scott, PTSD in DSM-III: A Case in the Politics of Diagnosis and Disease, 37 Soc. Problems 294, 309 (1990) (attributing the inclusion of PTSD in DSM-III to the collaboration between key psychiatrists and the Vietnam veteran community).

6 Stuart A. Greenberg et al., Unmasking Forensic Diagnosis, 27 Int'l J.L. & Psychiatry 1, 10 (2004).

7 Allan Young, The Harmony of Illusions: Inventing Post-Traumatic Stress Disorder 5 (1995).

8 See generally Roy Porter, Madness: A Brief History 1-61 (2002).

9 See Young, supra note 7, at 36-38 (describing Freud's belief that hysterical attacks are caused by the failure to discharge emotion attached to prior traumatic experiences).

10 Two scholars, a historian and an anthropologist, have produced excellent and highly regarded historical analyses of the early development of PTSD. See generally Ben Shephard, A War of Nerves: Soldiers and Psychiatrists in the Twentieth Century (2000); Young, supra note 7.

11 In this important respect, the origins of PTSD share a critical link with the development of American tort law and its conceptualizations of liability. Jennifer B. Wriggins, Torts, Race, and the Value of Injury, 1900-1949, 49 How. L.J. 99, 108 (2005) ("Railroad injuries in the mid and late nineteenth century spurred the development of tort doctrine and tort practice.").

12 Shephard, supra note 10, at 16.

13 Young, supra note 7, at 13; see also Ruth Leys, Trauma: A Genealogy 19 (2000) (linking psychical "trauma" to the term's original use to describe a surgical wound); Scott Baldwin et al., The Creation, Expansion, and Embodiment of Posttraumatic Stress Disorder: A Case Study In Historical Critical Psychopathology, 3 Sci. Rev. Mental Health Prac. 33, 43 (2004) (explaining psychological trauma as a metaphor for literal physical trauma).

14 Young, supra note 7, at 13; see also Edward M. Brown, Regulating Damage Claims for Emotional Injuries Before the First World War, 8 Behav. Sci. & L. 421, 421-22 (1990) (discussing Erichsen's description of a disorder afflicting railway accident victims who show no obvious physical injury); Flora V. Woodward Tibbits, Neurasthenia, the Result of Nervous Shock, as a Ground for Damages, 59 Cent. L.J. 83, 85 (1904) (discussing Erichsen's etiology of "traumatic neurasthenia").

15 John Eric Erichsen, On Railway and Other Injuries of the Nervous System (1866).

16 Id. at 94, 96-99. Another nineteenth century proponent of the theory of actual physical damage to the nervous system (in his case, lesions) as the cause of traumatic neurosis was Berlin neurologist Hermann Oppenheim. See infra notes 36-38 and accompanying text for a discussion of Oppenheim's study.

17 Erichsen, supra note 15, at 94 (conceding that, how the injuries to the spine "directly influence its action I cannot say").

18 Barbara Young Welke, Recasting American Liberty: Gender, Race, Law and Railroad Revolution, 1865-1920, at 154-56 (2001); Young, supra note 7, at 14-15.

19 Erichsen, supra note 15, at 2-3; Welke, supra note 18, at 150-51; Brown, supra note 14, at 423.

20 Brown, supra note 14, at 423; see also Welke, supra note 18, at 139-46 (describing American society's fear in reaction to frequent railway accidents and their media coverage in the late nineteenth century).

21 Brown, supra note 14, at 423.

22 See id. (explaining a legal defense that sometimes prevented railway employees from collecting damages against their employers before the advent of workers' compensation laws).

23 Erichsen, supra note 15, at 3-4.

24 Id. at 119.

25 Brown, supra note 14, at 424; see Welke, supra note 18, at 162-63 (discussing corporate doctors and lawyers who blamed Erichsen for his pro-plaintiff bias and for huge damage awards in American courts).

26 See Welke, supra note 18, at 153 (discussing the mobilization of railway doctors against Erichsen and his conclusions about railway spine); Brown, supra note 14, at 424 (explaining that railway spine theory was vulnerable to criticism because of vague diagnoses and victims who recovered after settled cases).

27 Young, supra note 7, at 16-17; Brown, supra note 14, at 425-26.

28 Brown, supra note 14, at 425-26; see also Welke, supra note 18, at 154-55 (explaining Page's argument against Erichsen's theory of injury to the spinal cord); Young, supra note 7, at 16-17 (describing Page's emphasis on mental factors, including fear, in the onset of symptoms); J. David Kinzie & Rupert R. Goetz, A Century of Controversy Surrounding Posttraumatic Stress-Spectrum Syndromes: The Impact on DSM-III and DSM-IV, 9 J. Traumatic Stress 159, 160 (1996) (describing Page's rejection of Erichsen's theory of injury to the spinal cord and his belief that mental factors contribute to the disorder).

29 Brown, supra note 14, at 425-26.

30 The current edition of the DSM defines malingering as the "intentional production of false or grossly exaggerated physical or psychological symptoms, motivated by external incentives" including "obtaining financial compensation." DSM-IV-TR, supra note 2, at 739.

31 See Young, supra note 7, at 17 (attributing to Page the contention that railway accident victims could not think of injuries in isolation from their monetary significance).

32 Shephard, supra note 10, at 16; Welke, supra note 18, at 167-68; Young, supra note 7, at 17; see also Brown, supra note 14, at 426-27 (describing the attempts of Erichsen's critics to define objective symptoms that could distinguish malingering).

33 Welke, supra note 18, at 166, 168.

34 See id. at 163-64 (describing the cottage industry that arose among anti-Erichsen expert medical witnesses).

35 Shephard, supra note 10, at 16.

36 See id. at 98 (discussing the development of Oppenheim's theory that "actual physical damage to the brain and nervous system" caused victims' symptoms); Welke, supra note 18, at 156 (attributing to Oppenheim the term "traumatic neurosis," a phrase indicating chronic nervous system disorders could be "produced by the stresses of modern industrial life itself"); Paul Lerner, From Traumatic Neurosis to Male Hysteria: The Decline and Fall of Hermann Oppenheim, 1889-1919, in Traumatic Pasts: History, Psychiatry, and Trauma in the Modern Age, 1870-1930 140, 144 (Mark S. Micale & Paul Lerner eds., 2001) [hereinafter Traumatic Pasts] (indicating Oppenheim's theory that "traumatic neurosis" was caused, in part, by minute lesions in the brain or nervous system, which lead a victim's nervous system to deteriorate).

37 Lerner, supra note 36, at 144.

38 Id. at 145 (translating Hermann Oppenheim, Die traumatischen Neurosen nach den in der Nervenklinik der Charité in den letzen 5 Jahren gesammelten Beobachtungen (1889)).

39 See Young, supra note 6, at 19 (detailing Charcot's theory that fear produced traumatic symptoms during a self-induced hypnotic state).

40 Id. at 20; see also Welke, supra note 18, at 156 (discussing the emergence of labels, including Oppenheimer's "traumatic neurosis" and Charcot's "traumatic hysteria," used to describe the same psychological ailment).

41 See Shephard, supra note 10, at 9 (noting Charcot's belief that male hysteria was "usually traumatic in origin"); Kinzie & Goetz, supra note 28, at 161 (noting Charcot's belief that "much of male hysteria was traumatic hysteria").

42 Young, supra note 7, at 20 (quoting Jean-Marin Charcot, Clinical Lectures on Diseases of the Nervous System Delivered at the Infirmary of la Salpêtrière 224-25 (New Sydenham Soc'y 1899)).

43 Brown, supra note 14, at 426. See generally Ian Hacking, Rewriting the Soul: Multiple Personality and the Sciences of Memory 185-88 (1995); Edward Shorter, From Paralysis to Fatigue: A History of Psychosomatic Illness in the Modern Era 112-17 (1992).

44 Lerner, supra note 36, at 145. Erichsen similarly disagreed with Charcot on this point, in part because he could not fathom the notion that men could be "hysterical." Welke, supra note 18, at 173-74.

45 Lerner, supra note 36, at 145.

46 Id. at 151-52. Many were also concerned that the application of his theory to war neuroses would have an impact on Germany's army during World War I. See, e.g., id. at 157 (noting Oppenheim's theory became regarded as "a threat to national health and strength" because its application would create significant pension obligations to soldiers diagnosed with traumatic neurosis).

47 Paul Lerner & Mark S. Micale, Trauma, Psychiatry, and History: A Conceptual and Historiographical Introduction, in Traumatic Pasts, supra note 36, at 1, 13-15.

48 Brown, supra note 14, at 427.

49 Welke, supra note 18, at 157-58.

50 Brown, supra note 14, at 427; see also Kinzie & Goetz, supra note 28, at 162 (describing neurasthenia as a common diagnosis in the 1900s for "nonspecific emotional" injuries caused by traumatic events).

51 Brown, supra note 14, at 427; see also Welke, supra note 18, at 157-58 (discussing Beard's theory that nervousness was caused by "noises that were necessary accompaniments of civilization").

52 Welke, supra note 18, at 159.

53 Young, supra note 7, at 25, 39.

54 Id. at 34.

55 Leys, supra note 13, at 19-20; Young, supra note 7, at 36.

56 Young, supra note 7, at 36.

57 Id. at 37.

58 Id. at 38.

59 Shephard, supra note 10, at 13.

60 Young, supra note 6, at 37; see also Shephard, supra note 10, at 13 (describing Freud's treatments resulting in the restoration of a patient's mental state).

61 Young, supra note 6, at 37-38.

62 Id. at 38. With that shift came the accompanying shift from abreaction to psychoanalysis. Id.; see also John P. Wilson, The Historic Evolution of PTSD Diagnostic Criteria: From Freud to DSMV-IV, 7 J. Traumatic Stress 681, 683-84 (1994) (explaining the external pressures influencing the underpinnings of Freud's seduction theory to include "the role of fantasy"). Although Freud's impact on the development of PTSD cannot be underestimated, his rejection of the seduction theory has led present-day proponents of the trauma theory (and repressed memory theory) of child sexual abuse to revile him. Leys, supra note 13, at 18-19.

63 Janet's writings on dissociation have played a key role in contemporary conceptualizations of PTSD and particularly the theory of "traumatic" and "narrative memory." Leys, supra note 13, at 105 (internal quotation marks omitted).

64 Shephard, supra note 10, at 13.

65 Young, supra note 7, at 41-42.

66 Id.

67 The diagnostic labels included “hysteria,” “neurasthenia,” and “disordered action of the heart.” Young, supra note 7, at 50-52; see also Shephard, supra note 10, at 58, 65-66 (discussing “soldier's heart,” a diagnosis similar to disordered action of the heart). Some historians have traced the use of the term “soldier's heart” to the American Civil War. E.g., Wilbur J. Scott, Vietnam Veterans Since the War: The Politics of PTSD, Agent Orange, and the National Memorial 29 (Univ. of Okla. Press 2004). The final classification was “not yet diagnosed (nervous)” (often known by its acronym “NYD [N]”), which was intended to serve as an interim label, but in practice was often the only “diagnosis” applied. Young, supra note 7, at 52-53 (emphasis omitted).

68 Cambridge psychologist C. S. Myers is credited with coining this term in a 1915 article, although it is possible that the term was already in use in the military by that time. Shephard, supra note 10, at 1.

69 Young, supra note 7, at 50-51. See supra notes 16-24 and accompanying text for a discussion for Erichsen's original conceptualization.

70 Id. at 60.

71 Id. at 61.

72 Shephard, supra note 10, at 110-112; Young, supra note 7, at 54-55.

73 Young, note 7, at 54 (quoting Frederick Mott, The Lettsomian Lectures on the Effects of High Explosives upon the Central Nervous System, 187 The Lancet 331, 331 (1916)); see also Shephard, supra note 10, at 30 (discussing Mott's views that predisposition affected post-war psychological impact).

74 Young, supra note 7, at 55.

75 Shephard, supra note 10, at 111-12, 125.

76 Young, supra note 7, at 55. These conditions were generally treated with rest, hypnosis, diet, and electricity. Id. at 55-56.

77 Shephard, supra note 10, at 28.

78 Id. at 73-75.

79 Id. at 28-29.

80 Id. at 29.

81 Id. at 31 (quoting Charles A. Myers, Shell Shock in France, 1914-1918, at 36 (1940)).

82 Id.; see also Young, supra note 7, at 60 (explaining how one-third of soldiers described symptoms that appeared gradually and without memorably significant events).

83 Shephard, supra note 10, at 29.

84 Id. at 31.

85 Id.

86 Young, supra note 7, at 42-44.

87 Id. at 42, 56; see also id. at 69-70 (distinguishing Rivers's “painless talking cure” from “physical suffering” inflicted by Lewis Yealland's and others' electrotherapy treatments).

88 Id. at 65-66; Shephard, supra note 10, at 87-88. Rivers was not strictly a “Freudian,” but he did adopt many of Freud's ideas and approaches. Shephard, supra note 10, at 87; Young, supra note 7, at 65-66.

89 See Shephard, supra note 10, at 87-88 (noting River's method of treatment of war neuroses involved allowing the patient to "confront the memories" so that he could "reduce the horror"); Young, supra note 7, at 67 (noting that Freud and Rivers agreed that treating anxiety neurosis required addressing the traumatic memory); see also Scott, supra note 67, at 30 (noting Freud's suggested method for treating war neurosis was psychoanalysis).

90 Leys, supra note 13, at 21-23; Wilson, supra note 62, at 685.

91 Sigmund Freud, Beyond the Pleasure Principle 6-7 (James Strachey trans., rev. ed. 1961) (1950); Young, supra note 7, at 78-79.

92 Wilson, supra note 62, at 685.

93 Shephard, supra note 10, at 108.

94 Wilson, supra note 62, at 686.

95 Kinzie & Goetz, supra note 28, at 162; see also Leys, supra note 13, at 23 (describing the term "traumatic" as "an experience which within a short period of time presents the mind with an increase of stimulus too powerful to be dealt with or worked off in the normal way"); Shephard, supra note 10, at 107-08 (describing trauma as an outside excitation powerful enough to break through the shield which protects the brain from stimuli that will surely result in exhaustive defensive measures); Wilson, supra note 62, at 686-87 (explaining that "both the traumatic stressors and secondary ones can overwhelm the now depleted ego-defenses, thereby setting-up the possibility of long-term post-traumatic stress disorder and other co-morbid conditions").

96 See Leys, supra note 13, at 18, 25-27 (noting that Freud is "a founding figure in the history of the conceptualization of trauma").

97 Shephard, supra note 10, at 113-14.

98 See infra notes 163-67 and accompanying text for a discussion of examples of how feigning a neurosis had been used to exacerbate legal claims or increase recovery.

99 Young, supra note 7, at 57-59.

100 Shephard, supra note 10, at 144.

101 Id. at 153.

102 Id. at 150-51.

103 Id. at 151.

104 See id. (indicating that those with "false" neuroses had predispositions).

105 Id. at 158. Some raised the concern that the pension awards actually inhibited recovery or encouraged the reporting of symptoms. Id. at 151. Based upon these assumptions, France did not award any pensions to those with war neuroses. Id. at 152. Similarly, as the number of psychiatric casualties increased, German psychiatrists began to attribute the symptoms to malingering to avoid combat or to obtain pensions and employed "treatments" that were particularly brutal. Herb Kutchins & Stuart A. Kirk, Making Us Crazy: DSM: The Psychiatric Bible and the Creation of Mental Disorders 103-104 (1997).

106 Abram Kardiner, The Traumatic Neuroses of War (1941); Shephard, supra note 10, at 154-55; Kinzie & Goetz, supra note 28, at 165. The other influential works from this period include Roy Grinker and John Spiegel's War Neuroses and Men Under Stress, both published in 1945 and also heavily influenced by Freudian theory. Shephard, supra note 10, at 331. See generally Roy R. Grinker & John P. Spiegel, Men Under Stress (1945); Roy R. Grinker & John P. Spiegel, War Neuroses (1945).

107 Shephard, supra note 10, at 152.

108 Young, supra note 7, at 89 (explaining that Kardiner's book is "routinely cited as a landmark in the history of the posttraumatic disorders" and was used in creating "the symptom list for post-traumatic stress disorder").

109 Shephard, supra note 10, at 156.

110 Id.

111 Id. at 165.

112 Id. at 165-66. He also specifically rejected the possibility of a delayed onset of neuroses after seven years had elapsed from the date of exposure. Id. at 166.

113 Id. at 166-67.

114 Id. at 167 (noting that one of the "main legac[ies] of the First World War [was] an official determination that quasi-medical words like 'shell-shock' should never be used, that the whole question of psychoneurosis should be both recognized and played down and that few pensions should be paid").

115 Id. at 187-90, 197-201.

116 Id. at 326; see also Kinzie & Goetz, supra note 28, at 168-69 (indicating that although some individuals had predispositions to mental illness, "even persons with sound personalities would break if the stress was high enough").

117 Shephard, supra note 10, at 216-17.

118 Scott, supra note 67, at 30-31; Young, supra note 7, at 92. Military psychiatrists started treating soldiers with "narco-analysis," administering high dosages of barbiturates, especially sodium amytal and pentothal, to not only calm the patient but to encourage the soldier to access and recount repressed memories of painful events as a form of drug-aided abreaction. Shephard, supra note 10, at 208-210, 214-15; Young, supra note 6, at 92.

119 Young, supra note 7, at 85; see also Leys, supra note 13, at 15 (characterizing the history of trauma as one "marked by an alternation between episodes of forgetting and remembering," in which "it took the experience of Vietnam to 'remember' the lessons of World War II").

120 Welke, supra note 18, at 154-56. The various terms referring to disorders resulting from "fright" or "shock" were often used interchangeably and their exact boundaries were not always well defined. See Welke, supra note 18, at 156. For example, in a 1904 article, one legal commentator referred to railway spine as the "traumatic" form of neurasthenia, and indicated that it was the form of "most importance from a legal aspect, as railway accidents often cause it, and suits for damages often result.... Many cases are said to be much improved or cured by the award of substantial damages." Tibbits, supra note 14, at 85.

121 Historian Barbara Young Welke has analyzed in detail the role of gender, both implicit and explicit, in the development of modern conceptualizations of psychological injuries during this period. In particular, she has noted that the role of predisposition was minimized by Erichsen, Beard, and others specifically because it was assumed that "normal" men, who comprised a significant number of those with symptoms of traumatic neurosis, were not generally at risk of developing nervous conditions, and therefore the cause of such conditions must be some external force. Welke, supra note 18, at 171-202.

122 Brown, supra note 14, at 428, 433.

123 Welke, supra note 18, at 205-207; Richard Abel, General Damages Are Incoherent, Incalculable, Incommensurable, and Inegalitarian (But Otherwise a Great Idea), 55 DePaul L. Rev. 253, 303 (2006); William L. Prosser, Intentional Infliction of Mental Suffering: A New Tort, 37 Mich. L. Rev. 874, 875, 877 (1939).

124 Restatement (Second) of Torts § 905 (1965); see, e.g., Sarauw v. Oceanic Navigation Corp., 622 F.2d 1168, 1175 (3d Cir. 1980), vacated and remanded 451 U.S. 966 (1981) (holding that no plain error occurred when the court allowed the jury to assess as separate components pain and suffering, loss of enjoyment of life, and permanent disability).

125 Martha Chamallas & Jennifer B. Wriggins, The Measure of Injury: Race, Gender, and Tort Law 38 (2010); Prosser, supra note 123, at 875, 880.

126 John J. Kircher, The Four Faces of Tort Law: Liability for Emotional Harm, 90 Marq. L. Rev. 789, 832-33 (2007) (quoting Restatement (Third) of Torts: Liability for Physical Harm § 4 cmt. d (Proposed Final Draft No. 1, 2005)).

127 Brown, supra note 14, at 428-30; Prosser, supra note 123, at 874 ("'Mental anguish' has been an orphan child.").

128 Lynch v. Knight, (1861) 11 Eng. Rep. 577 (H.L.) 598; see also Victorian Rys. Comm'rs v. Coultas, (1888) 13 A.C. 222 (P.C.) 226 (Eng.) (holding that Plaintiff's shock-induced mental and physical injuries caused by a near-collision with a train were too remote to be compensable).

129 See Mitchell v. Rochester Ry. Co., 45 N.E. 354, 354-55 (N.Y. 1896), overruled by Battalla v. State, 176 N.E.2d 729 (N.Y. 1961); Welke, supra note 18, at 207-08, 210.

130 See Ward v. W. Jersey & Seashore R.R. Co., 47 A. 561, 562 (N.J. 1900), overruled in part by Falzone v. Busch, 214 A.2d 12 (N.J. 1965); Chamallas & Wriggins, supra note 125, at 90; Welke, supra note 18, at 210; Abel, supra note 123, at 303-04; Martha Chamallas & Linda K. Kerber, Women, Mothers, and the Law of Fright: A History, 88 Mich. L. Rev. 814, 829 (1990). Implicit in this skepticism as well is an assumption that emotional harm, as opposed to bodily injury or property damage, was not of sufficient value to warrant legal protection. Chamallas & Wriggins, supra note 125, at 37-38. Tort law generally recognizes a rule that permits a plaintiff to recover for all damages flowing from a tortfeasor's wrongdoing, even if the plaintiff's injury (physical or mental) is far greater than that of the average person with a latent or underlying vulnerability; the so-called "eggshell plaintiff" rule requires a defendant to "take" his plaintiff as he "finds him." Joseph H. King, Jr., Causation, Valuation, and Chance in Personal Injury Torts Involving Preexisting Conditions and Future Consequences, 90 Yale L.J. 1353, 1360-61 (1981). Courts may deny liability for emotional distress entirely as one way to limit the application of this rule to claims for psychological injury for "eggshell plaintiffs." Cf. Chamallas & Wriggins, supra note 125, at 112 (noting that in highly unusual cases involving public policy concerns such as racial prejudice, it may be justifiable to use the doctrine of proximate cause to cut off liability for emotional harm).

131 Abel, supra note 123, at 303-04.

132 Kircher, supra note 126, at 790.

133 Wilkinson v. Downton, (1897) 2 Q.B. 57 (Eng.); see also Kircher, supra note 126, at 795 (noting that the theory of intentional infliction of emotional distress can be traced to Wilkinson v. Downton, which did not explicitly name the tort but allowed recovery for the emotionally distressed plaintiff).

134 Wilkinson, 2 Q.B. at 58-59; Kircher, supra note 126, at 796.

135 Kircher, supra note 126, at 796-98.

136 Id. at 797; see also Prosser, supra note 123, at 874 (acknowledging the creation of a new tort yet to be named).

137 Kircher, supra note 126, at 798 (citing Restatement of Torts § 46 (Supp. 1948)).

138 Restatement (Second) of Torts § 46 cmt. k (1965); Kircher, supra note 126, at 800-01; Prosser, supra note 123, at 879 (noting that the character of the conduct ensures that genuine harm occurred and warrants redress).

139 Restatement (Second) of Torts § 46 cmt. k (explaining a court may assign liability without evidence of bodily harm if conduct is extreme and outrageous); Kircher, supra note 126, at 800 (noting "the defendant's extreme and outrageous conduct alone tends to prove the severity of the distress," eliminating a need for proof of any physical symptoms).

140 Kircher, supra note 126, at 807-08.

141 Payton v. Abbott Labs, 437 N.E.2d 171, 178 (Mass. 1982); see also Herbert F. Goodrich, Emotional Disturbance as Legal Damage, 20 Mich. L. Rev. 497, 504 (1922) (identifying courts' prior reluctance to assign liability because of "danger of fraud through simulated injuries"); Kircher, supra note 126, at 808 (quoting W. Page Keeton et al., Prosser and Keeton on the Law of Torts § 10, at 360-61 (5th ed., 1984)) (identifying the danger of falsified claims as a point of concern for courts in assigning liability for emotional distress).

142 Payton, 437 N.E.2d at 178-79; see Goodrich, supra note 141, at 504-05 (indicating that when conduct is intentional no impact is necessary for defendant's liability for emotional distress); Kircher, supra note 126, at 808 (quoting Keeton et al., supra note 141) (indentifying potential triviality of emotional harm and the potential for an undue burden on defendant points to caution for courts); Prosser, supra note 123, at 878 ("There has been much more readiness to grant a remedy where mental suffering is inflicted intentionally than where it is the result of mere negligence.").

143 Payton, 437 N.E.2d at 178 (quoting Restatement (Second) of Torts § 436A cmt. b).

144 Tibbits, supra note 14, at 87 (citing Ewing v. Pittsburgh, C., C. & St. L. Ry. Co., 23 A. 340, 341 (Pa. 1892), overruled by Niederman v. Brodsky, 261 A.2d 84 (Pa. 1970)).

145 Camper v. Minor, 915 S.W.2d 437, 440 (Tenn. 1996).

146 See, e.g., Restatement (Second) of Torts § 313(1) (stating that if an actor's negligent conduct creates an unreasonable risk of bodily harm or emotional disturbance, but results in only emotional disturbance, the actor is not liable).

147 Kircher, supra note 126, at 810 (stating that these limitation were due to "judicial concern over the genuineness of claims for negligently caused emotional distress").

148 Chamallas & Wriggins, supra note 125, at 40-45; Kircher, supra note 126, at 810-11; Tibbits, supra note 14, at 86. A handful of states still follow the rule. Kircher, supra note 126, at 810 n.113. In the nineteenth century, some courts recognized limited claims for "fright" or "shock" as a basis to recover for the psychological injuries on a theory of negligence, but only where there was an accompanying physical injury. Chamallas & Kerber, supra note 130, at 819-23. Several scholars have noted that the shaping (and limits) of such legal claims were often gender-based. See, e.g., Chamallas & Wriggins, supra note 125, at 37-47 (noting that the defendants in the first emotional distress cases were women, forging an early connection between women and fright-based injury); Welke, supra note 18, at 211-34 (describing the role of miscarriage in the legal recognition of the right to recover for harm resulting from nervous shock).

149 Kircher, supra note 126, at 812-13.

150 Chamallas & Wriggins, supra note 125, at 94; see also Camper, 915 S.W.2d at 442 (compiling cases evidencing such a rule); Fortes v. Ramos, No. CIV. A. 96-5663, 2001 WL 1685601, at *4 (R.I. Ct. App. 2001) (detailing Rhode Island's treatment of the physical manifestation requirement). It is not surprising that nightmares were among the physical manifestations that could serve as a basis for recovery of psychological injuries as they had long been associated with traumatic neurosis. The "Battle Dream" generated medical interest during World War I, and it was considered the "most characteristic symptom of war neurosis." Shephard, supra note 10, at 92; see also Barker, supra note 1, at 26. Freud in particular noted the role of traumatic experience with dreams. Rather than representing the fulfillment of fantasy, which was the case with most dreams, he claimed that the recurring dream of trauma was the result of a fixation with the event leading to a compulsion to repeat the experience. Jonathan Lear, Freud 154-56 (2005); Shephard, supra note 10, at 107 (citing Freud, supra note 91, at 7, 13).

151 Camper, 915 S.W.2d at 442. In Kaufman v. Western Union Telegraph Co., 224 F.2d 723 (5th Cir. 1955), the Fifth Circuit's approach was to be flexible regarding whether the "physical injury" that was required in any event preceded or came after the emotional injury. Id. at 731. In that case, the shock from a false death notice came first and led to an increase in the plaintiff's blood pressure. Id. at 725-26. There were a few cases, however, to the contrary. See Tibbits, supra note 14, at 88-89 (discussing three cases in which plaintiffs were permitted recovery for "nervous shock" in the absence of physical injury causing such shock).

152 See Camper, 915 S.W.2d at 442 (stating that the physical manifestation test was formulated in part due to the belief that physical impact requirements block many worthy claims for relief based solely on emotional damages).

153 Chamallas & Wriggins, supra note 125, at 113; Kircher, supra note 126, at 815.

154 Kircher, supra note 126, at 815-16, 823.

155 Nielson v. AT&T Corp., 597 N.W.2d 434, 442 (S.D. 1999); Dillon v. Legg, 441 P.2d 912, 920-21 (Cal. 1968).

156 See Kircher, supra note 126, at 816-18 (discussing cases that held no physical injury was required for plaintiffs to recover for emotional distress).

157 The "traumatic" conditions such as "traumatic hysteria," "traumatic neurasthenia," and particularly "traumatic neurosis" eclipsed "railway spine" in litigation claims. See supra notes 26-52 and accompanying text for a discussion of the evolution of these terms.

158 Kenneth M. Cole, Jr., Workmen's Compensation--Damages--Compensation Neurosis Held Compensable.--Miller v. United States Fid. & Guar. Co., 99 So. 2d 511 (La. App. 1957), 37 Tex. L. Rev. 361, 361 (1959); Kinzie & Goetz, supra note 28, at 165-66; see also Hubert Winston Smith, Relation of Emotions to Injury and Disease: Legal Liability for Psychic Stimuli, 30 Va. L. Rev. 193, 304

(1944) (explaining that this term has little relevance given the current state of science); Hubert Winston Smith & Harry C. Solomon, Traumatic Neuroses in Court, 30 Va. L. Rev. 87 (1943) (asserting that the common prerequisites for an official diagnosis are lacking for neuroses); Jay Ziskin, New Terminology for the "Traumatic Neurosis" Case: Challenging the Plaintiff's Psychiatrist, 32 Def. L.J. 72, 73 (1983) (stating that the American Psychiatric Association never recognized traumatic neurosis).

159 Cole, supra note 158, at 361 (citing Smith & Solomon, supra note 158, at 92-95).

160 Lester Keiser, Traumatic Neurosis; A Common Problem Relatively Untried in the Courts, 17 Med. Trial Tech. Q. 1, 1 (1971).

161 Id. at 4 (emphasis omitted).

162 Id. at 6.

163 Kinzie & Goetz, supra note 28, at 171-72; see also Smith & Solomon, supra note 158, at 148 (rejecting the notion of "compensation neurosis" as being medically distinct from traumatic neurosis; it is only one part of the total reaction to the event).

164 Cole, supra note 158, at 361-62. A highly publicized 1961 study suggested some legitimacy to the claim that a plaintiff's symptoms improved after the resolution of a legal claim for recovery from psychological injuries. Henry Miller, Accident Neurosis (pts. 1 & 2), 1961 Brit. Med. J. 919-25, 992-98.

165 Cole, supra note 158, at 361. See supra notes 27-35 and accompanying text for a discussion of Page's theories.

166 Brown, supra note 14, at 431-32.

167 See Thompson v. Ry. Exp. Agency, 236 S.W.2d 36, 39 (Mo. Ct. App. 1951) (noting that a psychoneurosis can be the basis of a workers' compensation award so long as a causal link to a workplace accident has been made); Bailey v. Am. Gen. Ins. Co., 279 S.W.2d 315, 316 (Tex. 1955) (sustaining cause of action for "anxiety reaction" in a workers' compensation case); Cole, supra note 158, at 361 (asserting that compensation neurosis was "tolerate[d]" in courts); Ramon A. Von Drehle, Workmen's Compensation-Neuroses Unaccompanied by Physical Trauma Held Compensable, 34 Tex. L. Rev. 496, 497 (1956) (describing awards of workers' compensation for psychoneurosis when there is a direct link with an accident).

168 Shephard, supra note 10, at 340.

169 See id. (noting that an Army researcher stated "psychiatric casualties need never again become a major cause of attrition in the United States military in a combat zone").

170 Id.

171 Am. Psychiatric Ass'n, Diagnostic and Statistical Manual: Mental Disorders (1st ed. 1952) [hereinafter DSM-I]; Shephard, supra note 10, at 363.

172 DSM-I, supra note 171, at v-vi; Edward Shorter, A History of Psychiatry: From the Era of the Asylum to the Age of Prozac 298 (1997); see also Shephard, supra note 10, at 363 (describing the prior status of diagnostic terminology).

173 Young, supra note 7, at 98; see also DSM-III, supra note 5, at 1 (reporting a new method of peer revision). Many of the labels were either a reflection of Adolf Meyer's biopsychosocial theory of mental disorder or based upon Freudian psychoanalytic practice. Shorter, supra note 172, at 299.

174 Young, supra note 7, at 93.

175 The initial diagnostic system established by the military had a category for "psychoneurotic disorders," but not a disorder specifically linked with exposure to trauma. Young, supra note 7, at 93.

176 Young, supra note 7, at 107; see Scott, supra note 67, at 32 (noting that the editors of DSM-I thought the disorder was "temporary" and normally disappeared in the absence of combat); Shephard, supra note 10, at 364.
DSM-I defined the disorder as follows:
000-x81 Gross stress reaction

> Under conditions of great or unusual stress, a normal personality may utilize established patterns of reaction to deal with overwhelming fear. The patterns of such reactions differ from those of neurosis or psychosis chiefly with respect to clinical history, reversibility of reaction, and its transient character. When promptly and adequately treated, the condition may clear rapidly. It is also possible that the condition may progress to one of the neurotic reactions. If the reaction persists, this term is to be regarded as a temporary diagnosis to be used only until a more definitive diagnosis is established.
> This diagnosis is justified only in situations in which the individual has been exposed to severe physical demands or extreme emotional stress, such as in combat or in civilian catastrophe (fire, earthquake, explosion, etc.). In many instances this diagnosis applies to previously more or less "normal" persons who have experienced intolerable stress.
> The particular stress involved will be specified as (1) combat or (2) civilian catastrophe.
> DSM-I, supra note 171, at 40.

177 Am. Psychiatric Ass'n, Diagnostic and Statistical Manual of Mental Disorders (2d ed. 1968) [hereinafter DSM-II].

178 Id. at vii; see International Classification of Diseases, World Health Org., http://www.who.int/classifications/icd/en (last visited Nov. 14, 2011).

179 Scott, supra note 67, at 33; see DSM-II, supra note 177, at 48-49 (identifying "[a]djustment reaction of adult life" as a category of "[t]ransient situational disturbances").

180 DSM-II, supra note 177, at 48.

181 Id. at 48; Young, supra note 7, at 107.

182 DSM-II, supra note 177, at 49; see Wilson, supra note 62, at 690-91 (noting the "simplicity and inadequacy of these examples," particularly in light of the significant number of high-profile traumatic events that had occurred since the publication of DSM-I and the extensive research on psychological responses by that time).

183 Shorter, supra note 172, at 299.

184 DSM-II, supra note 177, at 39-41.

185 Scott, supra note 67, at 33; Shephard, supra note 10, at 364.

186 See Shephard, supra note 10, at 349 (stating that combat fatigue, or combat exhaustion, was seen as a character or behavioral disorder, not actually a disease).

187 See id. at 365 (explaining that the VA used the DSM-II nomenclature which contained no diagnoses for "war-related trauma"). In an interview by Wilbur Scott, Chaim Shatan stated that he suspected that gross stress reaction was dropped specifically to reduce the potential financial liability of the VA. Scott, supra note 67, at 32 n.15. However, Scott's research did not uncover any specific reason for the omission of the diagnosis. Id.

188 Scott, supra note 67, at 52.

189 Shephard, supra note 10, at 350 (discussing abnormal official statistics reflecting increases in diagnoses of character disorders, and noting that the Army did not consider those disorders psychiatric diseases); Scott, supra note 5, at 298 (noting that many VA physicians concluded that veterans who appeared to be "agitated by their war experiences, or who talked repeatedly about them, suffered from a neurosis or psychosis whose origin and dynamics lay outside the realm of combat").

190 Id. at 365.

191 Shephard, supra note 10, at 355-56; see Scott, supra note 67, at 14-15 (referring to the groups also as "rap sessions"). Sociologist Wilbur Scott's thoroughly researched history of the efforts of veterans' rights advocates to gain recognition of PTSD, Vietnam Veterans Since the War (originally published as The Politics of Readjustment), is regarded by many as the leading authority on this episode. See Baldwin et al., supra note 13, at 40 (noting that Scott's body of work, including Vietnam Veterans Since the War, provides "one of the most detailed examinations" of the subject matter).

192 Scott, supra note 67, at 6; Shephard, supra note 10, at 355-56.

193 Scott, supra note 67, at 46; Shephard, supra note 10, at 357.

194 See Scott, supra note 67, at 58 (indicating the homosexuality entry challenge created a large number of inquiries regarding revisions in DSM-II diagnoses list).

195 See id. at 52-54 (describing initial statutory efforts to introduce treatments specific to Vietnam veterans); Shephard, supra note 10, at 361-62 (detailing how the VA overcame political pressure to help Vietnam veterans and the efforts of advocates to effect change).

196 Kutchins & Kirk, supra note 105, at 100, 108-09.

197 Scott, supra note 67, at 43.

198 Id. at 43 (referencing Chaim Shatan, Post-Vietnam Syndrome, N.Y. Times, May 6, 1972, at 35).

199 Ethan Watters, Crazy Like Us: The Globalization of the American Psyche 114 (2010).

200 Shephard, supra note 10, at 361.

201 Id. at 359-60.

202 Id. at 360.

203 Id.

204 Id. at 360-61 The potential legal implications of the recognition of the unique psychiatric impact on veterans was apparent from early on in the advocacy. A public defender in New York representing a Vietnam veteran in a destruction of property case tried unsuccessfully to assert a defense based upon "traumatic war neurosis." Scott, supra note 67, at 58. The judge denied the defense on the basis that the diagnosis did not appear in the DSM-II. Id. The attorney appealed to Spitzer directly to find out if the DSM-III would reintroduce a diagnosis such as traumatic war neurosis and Spitzer informed him that "no change was planned." Id. Noted attorney William Kunstler contacted Shatan in 1973 because he hoped to present a "post-Vietnam syndrome" defense for eight clients (known as the "Gainesville 8") who were facing charges for planning to blow up the 1968 Democratic and Republican conventions. Id. at 47. The defendants were acquitted but apparently used no such defense. John Kifner, Defense is Short in Veterans Trial, N.Y. Times, Aug. 29, 1973, at 18; John Kifner, 8 Acquitted in Gainesville of G.O.P. Convention Plot, N.Y. Times, Sept. 1, 1973, at 1.

205 See generally Kutchins & Kirk, supra note 105, at 1-16. See Shorter, supra note 172, at 300-302 (explaining how DSM-III marked the shift from using clinical criteria to using fixed scientific criteria to diagnose psychiatric conditions); Isaac R. Galatzer-Levy & Robert M. Galatzer-Levy, The Revolution in Psychiatric Diagnosis: Problems at the Foundations, 50 Persp. Bio. & Med. 161, 161 (2007) (stating that DSM-III "not only revolutionized psychiatric diagnosis" but also "transformed and dominated American psychiatry").

206 Shephard, supra note 10, at 363-64 (providing historical examples of biological manifestations of psychological illness); Shorter, supra note 172, at 239, 300-02 (summarizing trend in 1970s toward biological psychiatry).

207 Young, supra note 7, at 94, 99.

208 Stuart A. Kirk & Herb Kutchins, The Selling of DSM: The Rhetoric of Science in Psychiatry 28-32 (1992); Alix Spiegel, The Dictionary of Disorder: How One Man Revolutionized Psychiatry, The New Yorker, Jan. 3, 2005, at 56, 57-58.

209 See Young, supra note 7, at 95-96, 99 (describing Kraepelin's pioneering work with psychiatric nosology).

210 See Shorter, supra note 172, at 301-02 (noting the increased length and detail of DSM-III as compared to previous DSM editions).

211 DSM-III, supra note 5, at 4-5; Shorter, supra note 172, at 302; Young, supra note 7, at 95.

212 Young, supra note 7, at 100.

213 DSM-III, supra note 5, at 9-10 (emphasis omitted); see also Shorter, supra note 172, at 304 (explaining that the editors of DSM-III differentiated between "neurosis" and a "neurotic process" in order to appease major interest group of psychoanalysts). Apparently,

DSM-III retained the term "neurosis" (which Spitzer had attempted to strike out) only as a compromise to the psychoanalytic camp, who otherwise would have refused to approve the new manual. Spiegel, supra note 208, at 60-61.

214 Scott, supra note 67, at 60-61; Young, supra note 7, at 109-10.

215 Shephard, supra note 10, at 367; see also Scott, supra note 67, at 62 (describing Horowitz's role with Vietnam Veterans Working Group).

216 Kinzie & Goetz, supra note 28, at 172. See supra notes 106-10 and accompanying text for a discussion of Kardiner's work regarding the long-term psychological impact of war.

217 Scott, supra note 67, at 33.

218 See Shephard, supra note 10, at 349 (describing how Army physicians in Vietnam measured the effects of stressful military activities).

219 See generally Mardi J. Horowitz & George F. Solomon, A Prediction of Delayed Stress Response Syndromes in Vietnam Veterans, 31 J. Soc. Issues 67 (1975). The delay was attributed to the widespread use of both illicit drugs, such as heroin, as well as tranquillizers, such as chlorpromazine, both widely available. Shephard, supra note 10, at 351-53.

220 See Shephard, supra note 10, at 366 (noting that "Shafton, Lifton and their allies" began to look at post-combat disorder as a sub-class of a more general phenomenon, and thus began reviewing "literature of catastrophes in general").

221 Scott, supra note 67, at 64.

222 Shephard, supra note 10, at 367.

223 Young, supra note 7, at 89, 91.

224 Shephard, supra note 10, at 367.

225 Kutchins & Kirk, supra note 105, at 114; see also Marilyn L. Bowman, Problems Inherent to the Diagnosis of Posttraumatic Stress Disorder, in Psychological Injuries at Trial 820, 821 (Izabela Z. Schultz & Douglas O. Brady eds., 2003) (Am. Bar Ass'n CD-ROM) (describing the relationship between Freud's theory regarding "conflict-laden early experiences" and modern views of adult emotional disorders); Mardi J. Horowitz, Introduction to Essential Papers on Posttraumatic Stress Disorder 1, 3 (Mardi J. Horowitz ed., 1999) (explaining that posttraumatic symptoms derive from the Freudian theory of shock mastery); Wilson, supra note 62, at 691 (noting that the PTSD diagnostic criteria in DSM-III reflect Freud's observations about the impact of trauma on human emotion, cognitive processes, ambition, relationships, and "physiological functioning").

226 See supra notes 53-66 and accompanying text for a discussion of theories that indicate the pathogenic memory plays a role in psychoneurosis.

227 Shephard, supra note 10, at 367; Scott, supra note 67, at 64.

228 Young, supra note 7, at 110.

229 Scott, supra note 67, at 34, 62-63; see also Young, supra note 7, at 111 (noting the significance of the Vietnam War in defining PTSD in the DSM-III).

230 Kutchins & Kirk, supra note 105, at 114; see also Thomas Maier, Post-Traumatic Stress Disorder Revisited: Deconstructing the A-Criterion, 66 Med. Hypotheses 103, 103-104 (2006) (noting that although PTSD did not emerge from a traditional "Popperian view of scientific progress," it is a good example of a "paradigm shift" as that term was used by Thomas Kuhn to describe "how scientific progress is never exclusively guided by empiric observations, but by theoretical concepts derived from highly selective observations").

231 See Scott, supra note 67, at 61-63 (indicating that a working group advocating for a category of "combat-induced disorder" felt "that they had won Andreasen over" with regard to their views).

232 Young, supra note 7, at 114; see also Kutchins & Kirk, supra note 105, at 116 (explaining that approval of PTSD was based largely on "demonstrating that victims suffer from impairments even if they do not show signs of debilitating physical trauma").

233 Young, supra note 7, at 114 (stating that failing to put PTSD in the DSM-III would mean "denying medical care and compensation" to veterans and that "[a]cknowledging PTSD would be a small step toward repaying a debt" to young soldiers who sacrificed their youth in Vietnam).

234 Scott, supra note 67, at 66.

235 DSM-III, supra note 5, at 225.

236 DSM-III, supra note 5, at 236.

237 Id. The text also states that "[p]reexisting psychopathology apparently predisposes to the development of the disorder." Id. at 237. This language regarding predisposition seems at variance with Scott's description of the committee report that was the basis for the final diagnosis, but he provides no explanation for its inclusion in the DSM-III.

238 DSM-III, supra note 5, at 238. There is no reference in the main text to the concept of "traumatic neurosis" or any other similar diagnostic labels that had been used (and were still in use) to describe psychological injuries. Baldwin et al., supra note 13, at 41. This is likely because the term was never accepted as part of any official psychiatric nosology.

239 Rachel Yehuda & Alexander C. McFarlane, Conflict Between Current Knowledge About Posttraumatic Stress Disorder and Its Original Conceptual Basis, 152 Am. J. Psychiatry 1705, 1706 (1995).

240 "Atheoretical" refers to an absence of an assigned specific theory for the cause of a mental disorder. See Dorthe Berntsen et al., Contrasting Models of Posttraumatic Stress Disorder: Reply to Monroe and Mineka, 115 Psychol. Rev. 1099, 1099-1100 (2008) (discussing how the PTSD diagnosis formed an exception to the absence of etiology throughout DSM-III); Young, supra note 7, at 115 (providing a further explanation of the term "atheoretical" in this context and his application of the term to PTSD and the DSM).

241 DSM-III, supra note 5, at 238.

242 Id. at 236.

243 Robert L. Spitzer et al., Editorial, Revisiting the Institute of Medicine Report on the Validity of Posttraumatic Stress Disorder, 49 Comprehensive Psychiatry 319, 319 (2008); see also DSM-III, supra note 5, at 7 ("DSM-III is atheoretical with regard to etiology ...."); Gerald M. Rosen & Scott O. Lilienfeld, Posttraumatic Stress Disorder: An Empirical Evaluation of Core Assumptions, 28 Clinical Psychol. Rev. 837, 839 (2008) (reiterating that the "core assumption" of PTSD is the causal connection between a traumatic event and the ensuing series of reactions).

244 Spitzer et al., supra note 243, at 319 (quoting Inst. of Med., Posttraumatic Stress Disorder: Diagnosis and Assessment 23 (2006)).

245 Robert I. Simon, Forensic Psychiatric Assessment of PTSD Claimants, in Posttraumatic Stress Disorder in Litigation: Guidelines for Forensic Assessment 41, 57 (Robert I. Simon ed., 2d ed. 2003) [hereinafter PTSD in Litigation].

246 Young, supra note 7, at 120.

247 Id. at 115.

248 Young, supra note 7, at 120; Baldwin et al., supra note 13, at 44.

249 DSM-III, supra note 5, at 238-39.

250 Edgar Jones et al., Flashbacks and Post-Traumatic Stress Disorder: The Genesis of a 20th-Century Diagnosis, 182 Brit. J. Psychiatry 158, 160 (2003). The term "flashback" was not directly mentioned in the DSM-III, but was included as a synonym for some PTSD symptoms in the DSM-III-R. Id.

251 Am. Psychiatric Ass'n, Diagnostic and Statistical Manual of Mental Disorders 250 (3d ed. rev. 1987) [hereinafter DSM-III-R]; see Jones et al., supra note 250, at 160 (stating that soldiers were "reliving episodes from ... active service"). This is at variance from the notion of the transformation of repressed memories into internal conflicts as a result of subsequent events in the person's life. See Jones et al., supra note 250, at 160 (discussing the idea that "certain experiences, which are neither salient nor meaningful when they

occur, acquire an emotional potency or importance by an additional piece of information" and, in a sense, "a normal recollection of an event becomes transformed into a disturbing and highly significant memory").

252 Kutchins & Kirk, supra note 105, at 114. Strictly speaking, the category of "Substance Use Disorders" could arguably include a link to causation since the category "deals with behavioral changes associated with more or less regular use of substances that affect the central nervous system." DSM-III, supra note 5, at 163; Correspondence from David Rubin to Deirdre M. Smith, Prof. of Law and Glassman Scholar, University of Maine School of Law (July 29, 2010) (on file with author). However, psychiatry does not appear to regard such association as having a basis in a "theory," in the same respect as PTSD's link with traumatic events.

253 Berntsen et al., supra note 240, at 1100.

254 Id.

255 Horowitz, supra note 225, at 1.

256 DSM-III, supra note 5, at 236.

257 Simon, supra note 245, at 57.

258 Young, supra note 7, at 113.

259 Young, supra note 7, at 114.

260 DSM-III-R, supra note 251, at 247-48.

261 Id. at 247.

262 Wilson, supra note 62, at 694.

263 Id. Wilson was on the committee that recommended the revisions.

264 Am. Psychiatric Ass'n, Diagnostic and Statistical Manual of Mental Disorders 427-29 (4th ed. 1994) [hereinafter DSM-IV].

265 Id. at 427-48. The DSM-IV also added a new disorder, "Acute Stress Disorder," which was also premised on the occurrence of a traumatic event, but, unlike PTSD, could be diagnosed within four weeks after the traumatic event to classify an individual's immediate emotional reaction. Id. at 429-32; see also Kutchins & Kirk, supra note 105, at 117-18 (providing an overview of the new Acute Distress Disorder diagnosis).

266 See Naomi Breslau & Ronald C. Kessler, The Stressor Criterion in DSM-IV Posttraumatic Stress Disorder: An Empirical Investigation, 50 Biological Psychiatry 699, 700, 703-704 (2001) (concluding that there was "no doubt that the intent [of the revision of Criteria A in the DSM-IV] was to enlarge the variety of experiences that can be used to diagnose PTSD" and that "the population's total life experiences that can be used to diagnose PTSD has increased materially by 59.2%"); Maier, supra note 230, at 105 (discussing changes in PTSD diagnosis from DSM-III to DSM-VI); Simon, supra note 245, at 57 (discussing new language in DSM-IV diagnosis).

267 Simon, supra note 245, at 59. Compare DSM-IV, supra note 264, at 427 (requiring "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"), with DSM-III, supra note 5, at 238 (requiring "[e]xistence of recognizable stressor that would evoke significant symptoms of distress in almost everyone"). Some studies suggest that clinicians generally waived that requirement even prior to the amendment. Young, supra note 7, at 124.

268 Young, supra note 7, at 124-25. Freud and others made a link between the experience of fear at the time of the event and the causation of traumatic neurosis. Id. at 125.

269 Kutchins & Kirk, supra note 105, at 118 (quoting DSM-III-R, supra note 251, at 247).

270 See Young, supra note 7, at 127 (comparing DSM-III-R's literal meaning of traumatic event and actual diagnostic practice of PTSD). This revision is somewhat similar to the distinction between intentional infliction of emotional distress and negligent infliction of emotional distress, where the former was more readily accepted by courts because it required a showing of conduct so "extreme and

outrageous" that the plaintiff's resulting emotional distress was not suspect. See supra notes 127-56 and accompanying text for a discussion of emotional injury and liability.

271 See Young, supra note 7, at 127.

272 Kutchins & Kirk, supra note 105, at 118.

273 Id. at 121. One study suggested a fifty percent expansion in those diagnosed after this revision. Lisa Appignanesi, Mad, Bad and Sad: A History of Women and the Mind Doctors 427 (2007); Judith Herman, Trauma and Recovery: The Aftermath of Violence--From Domestic Abuse to Political Terror 427 (rev. ed. 1997) (1992). Harvard psychiatrist Judith Herman, one of the leading figures in the effort to apply the PTSD diagnosis to women who had experienced sexual assault, sexual abuse, domestic violence, and other forms of violence, served on the APA committee that advanced the amendments. Herman, supra, at 426-27.

274 Kutchins & Kirk, supra note 105, at 5.

275 Id.

276 Renee L. Binder & Dale E. McNiel, Some Issues in Psychiatry, Psychology, and the Law, 59 Hastings L.J. 1191, 1197-98 (2008); see also Abilash Gopal & Harold Bursztajn, On Skepticism and Tolerance in Psychiatry and Forensic Psychiatry, Psychiatric Times, Apr. 15, 2007, at 2 (noting that some "ill-trained attorneys" erroneously believe that the DSM is the "bible of psychiatry" or that psychiatry "can be practiced from a cookbook").

277 See Kutchins & Kirk, supra note 105, at 10-12 (remarking that every mental health professional owns a copy of the DSM, and the DSM has had a broad impact on other sectors of life); Shorter, supra note 172, at 302 (noting that, by the early 1990s, the DSM had been translated into more than twenty languages and it was being used widely in France and Germany; "[t]he appearance of DSM-III was thus an event of capital importance not just for American but for world psychiatry").

278 Kutchins & Kirk, supra note 105, at 11-12; see also Greenberg et al., supra note 6, at 7 (noting that the DSM "has become a forensic mantra").

279 Ian Hacking, Kinds of People: Moving Targets, 151 Proc. Brit. Acad. 285, 285-86 (2006); see also Young, supra note 7, at 107 (explaining that diagnostic technologies like the DSM-III "are an integral part of the historical formation of some of the disorders (including PTSD) that they now identify and represent").

280 DSM-III, supra note 5, at 12.

281 Greenberg et al., supra note 6, at 6.

282 See, e.g., Coggin v. State, 745 P.2d 1182, 1184-85 (Okl. Crim. App. 1987) (describing expert testimony offered by defendant, which indicated that the night of the murder certain events had "triggered a 'flashback' to Vietnam which put the appellant in a disassociative state" and the defendant "did not remember stabbing the victim"); State v. Miller, No. 48316, 1984 WL 6384, at * 2 (Ohio Ct. App. Dec. 20, 1984) (describing expert testimony offered by defendant that the victim's attack "caused [defendant] to flash back to Vietnam" and he had no memory of the murder); see also Daniel W. Shuman, Persistent Reexperiences in Psychiatry and Law, in PTSD in Litigation, supra note 245, at 1, 9 (noting various uses of PTSD as a criminal defense strategy); Michael J. Davidson, Post-Traumatic Stress Disorder: A Controversial Defense for Veterans of a Controversial War, 29 Wm. & Mary L. Rev. 415, 422-40 (1988) (discussing use of PTSD as defense in criminal prosecutions involving Vietnam veteran defendants); John O. Lipkin et al., Post-Traumatic Stress Disorder in Vietnam Veterans: Assessment in a Forensic Setting, 1 Behav. Sci. & L. 51, 63-64 (1983) (discussing connection between criminal behavior and PTSD symptoms).

283 PTSD resulted in an expansion of recovery of workers' compensation benefits for employees who demonstrated psychological injuries from their workplaces. Much like the veterans who asserted "service-connected" injuries arising from their combat, employees attempted to analogize their workplace to traumatic stressors and to seek compensation for work-related mental injuries. See generally, Izabela Z. Schultz, Psychological Causality Determination in Personal Injury and Workers' Compensation Contexts, in Psychological Injuries at Trial, supra note 229, at 102. In one remarkable case, the Supreme Court of Arizona permitted a police officer to pursue a workers' compensation claim for PTSD, resulting from an incident in which he was shot nearly twenty-four years prior to the 1984 filing date. Henry v. Indus. Comm'n of Ariz., 754 P.2d 1342, 1344-45 (Ariz. 1988). The court permitted such a claim on the basis that PTSD was "not diagnosable" in 1960 when the incident occurred. Id.

284 Liza H. Gold, PTSD in Employment Litigation, in PTSD in Litigation, supra note 245, at 163, 164.

285 Lisa R. Askowitz & Michael H. Graham, The Reliability of Expert Psychological Testimony in Child Sexual Abuse Prosecutions, 15 Cardozo L. Rev. 2027, 2033 (1994).

286 See Richard Klein, An Analysis of Thirty-Five Years of Rape Reform: A Frustrating Search for Fundamental Fairness, 41 Akron L. Rev. 981, 1016-17 (2008) (explaining that a major reform in rape prosecutions deals with "weaknesses in the prosecutor's case arising from victim conduct which appears to be inconsistent with that of an individual who had just been sexually assaulted").

287 Askowitz & Graham, supra note 285, at 2046; see also Susan A. Clancy, The Trauma Myth: The Truth About the Sexual Abuse of Children--and Its Aftermath 100-101 (2009) (discussing the introduction of sexual abuse as a traumatic event in order to conceptualize the harm endured by a victim as a form of PTSD).

288 Klein, supra note 286, at 1016-17.

289 Clancy, supra note 287, at 101.

290 See, e.g., Allison v. State, 353 S.E.2d 805, 807-08 (Ga. 1987) (admitting testimony from an expert on child sexual abuse syndrome who discussed the behavioral characteristics and the stages an alleged victim goes through), superseded by statute, Ga. Code Ann. § 17-7-110 (West 2011), as recognized in Park v. State, 495 S.E.2d 886 (Ga. Ct. App. 1987).

291 People v. Taylor, 552 N.E.2d 131, 132 (N.Y. 1990); Ann Wolbert Burgess, Rape Trauma Syndrome, 1 Behav. Sci. & L. 97, 98 (1983); see also State v. Allewalt (Allewalt II), 517 A.2d 741, 754 (Md. 1986) (Eldridge, J., dissenting) (reviewing the origin of the term "rape trauma syndrome" and noting that it is recognized as "a sub-category of post-traumatic stress disorder in which the triggering trauma is rape").

292 See State v. Alberico, 861 P.2d 192, 207 (N.M. 1993) (explaining that nearly all jurisdictions have concluded that PTSD evidence is appropriate to explain a victim's behavior that is inconsistent with having been raped); Taylor, 552 N.E.2d at 138 (concluding that jurors can be assisted by evidence of RTS to dispel common misconceptions about rape).

293 Askowitz & Graham, supra note 285, at 2048-51.

294 See Burgess, supra note 291, at 110 (recounting a Montana Supreme Court case where evidence of the complainant's symptoms of rape trauma syndrome was found to be probative and helpful to the jury to resolve); Alberico, 861 P.2d at 207-08 (holding that the prosecution's introduction of expert testimony to show that a crime had been committed was proper).

295 See Allewalt II, 571 A.2d at 751 (finding PTSD expert testimony is admissible by distinguishing it from RTS testimony, which most courts find inadmissible); Chapman v. State, 18 P.3d 1164, 1172 (Wyo. 2001) (stating that although most courts find testimony about PTSD to be sufficiently reliable to warrant admission, the purposes for which this testimony may be admitted remains a subject for debate). See generally Missy Thornton, State v. Chauvin: Determining the Admissibility of a Post-Traumatic Stress Syndrome Diagnosis as Substantive Evidence of Sexual Abuse, 78 Tul. L. Rev. 1743 (2004) (discussing split among both federal and state courts on whether expert witness testimony about PTSD to establish the trauma in fact occurred is admissible).

296 Alberico, 861 P.2d at 207-09.

297 E.g., Chapman v. State, 18 P.3d 1164, 1172 (Wyo. 2001).

298 State v. Huey, 699 P.2d 1290, 1294 (Ariz. 1985).

299 See State v. Chauvin, 846 So. 2d 697, 707-08 (La. 2003) (stating that the method of diagnosing a person with PTSD is designed for therapeutic purposes and is not reliable as a fact-finding tool); People v. Taylor, 552 N.E.2d 131, 138-139 (N.Y. 1990) (finding the therapeutic nature of RTS makes it unreliable when introduced to prove a crime took place); State v. Black, 745 P.2d 12, 18 (Wash. 1987) (holding that RTS expert testimony is not a scientifically reliable means of proving rape occurred because the diagnosing individual is not concerned with the accuracy of the victim's description of the event); People v. Bledsoe, 681 P.2d 291, 301 (Cal. 1984) (noting that RTS testimony is not scientifically reliable because it is not based on a narrow set of criteria and its purpose is to help a victim of trauma, not to prove the trauma occurred). The opinion is "clinical" in the sense that it is based upon an examination of the person for purposes of making a medical assessment.

300 (Allewalt I) 487 A.2d 664 (Md. Ct. Spec. App. 1985), vacated, 517 A.2d 741 (Md. 1986).

301 Allewalt I, 487 A.2d at 665-66.

302 Id. at 666.

303 State v. Allewalt (Allewalt II), 517 A.2d 741, 743 (Md. 1986).

304 Id.

305 Allewalt I, 487 A.2d at 666 (omission in original) (quoting cross-examination testimony).

306 Id.

307 Id. at 669-70. Other courts have also excluded similar evidence on the basis that jurors would be confused by the evidence or the defendant would be unfairly prejudiced, and based their rulings on rules similar to Federal Rule of Evidence 403. See, e.g., People v. Taylor, 552 N.E.2d 131, 138-39 (N.Y. 1990) (excluding RTS expert testimony because it might create an inference in the minds of jurors that rape occurred, which presents undue prejudice against the defendant). Federal Rule of Evidence 403 provides: "Although relevant, evidence may be excluded if its probative value is substantially outweighed by the danger of unfair prejudice, confusion of the issues, or misleading the jury, or by considerations of undue delay, waste of time, or needless presentation of cumulative evidence." Fed. R. Evid. 403.

308 Allewalt I, 487 A.2d at 670.

309 Allewalt II, 517 A.2d at 752.

310 Id. at 746-47.

311 Id. at 746-48.

312 Id. at 751 (emphasis added). The court noted that there was a "nice question" that was "[l]urking" in the case, which was whether a defendant could offer testimony of the absence of PTSD as evidence of consent. Id.

313 Id. at 759-61 (McAuliffe, J., concurring).

314 Id. at 755 (Eldridge, J., dissenting) (citations omitted) (internal quotation marks omitted); see also People v. Bledsoe, 681 P.2d 291, 300-01 (Cal. 1984) (concluding that evidence that a witness suffers from rape trauma syndrome is inadmissible to show that the witness was raped).

315 Allewalt II, 517 A.2d at 755-58 (Eldridge, J., dissenting).

316 Klein, supra note 286, at 1019 (discussing the trend of courts finding expert RTS testimony as relevant and appropriate); see, e.g., People v. Baenziger, 97 P.3d 271, 275 (Colo. App. 2004) ("It has been repeatedly held that rape trauma syndrome evidence is reasonably reliable."); People v. Nelson, 804 N.Y.S.2d 373, 373-74 (N.Y. App. Div. 2005) (ruling that RTS evidence was properly admitted in part because the court provided a limiting instruction).

317 Dyane L. Noonan, Note, Where Do We Go From Here? A Modern Jurisdictional Analysis of Behavioral Expert Testimony in Child Sexual Abuse Prosecutions, 38 Suffolk U. L. Rev. 493, 494-95 (2005).

318 E.g., State v. Alberico, 861 P.2d 192, 212 (N.M. 1993).

319 See State v. Roles, 832 P.2d 311, 318 n.4 (Idaho Ct. App. 1992) (noting that the term RTS is much more inflammatory than the term PTSD); State v. Gettier, 438 N.W.2d 1, 5-6 (Iowa 1989) (finding no error in admitting evidence where an expert testified to PTSD instead of the more prejudicial term, RTS).

320 See, e.g., Martin v. Cavalier Hotel Corp., 48 F.3d 1343, 1358 (4th Cir. 1995) (upholding admission of expert psychological testimony opining that the plaintiff's symptoms "were consistent with those of someone who had been sexually assaulted"), overruled, Pa. State Police v. Suders, 542 U.S. 129 (1994).

321 See, e.g., Isely v. Capuchin Prov., 877 F. Supp. 1055, 1067 (E.D. Mich. 1995) (holding that an expert on PTSD may only testify to her theories and opinions of the syndrome and whether the plaintiff's behavior is consistent with someone who is suffering from PTSD); Garcia v. Los Banos Unified Sch. Dist., No. 1:04-CV-6059-SMS, 2007 WL 715526, at *3-5 (E.D. Cal. Mar. 8, 2007) (denying defendant's motion to exclude PTSD testimony from plaintiff's expert but cautioning plaintiff's counsel to ask only about the diagnosis, causation, and extent of harm, rather than the underlying events in that sexual harassment case).

322 PTSD's connection to memory raises the prospect of treating or perhaps even preventing PTSD using memory dampening techniques. If this is the case, this raises the possibility that plaintiffs are expected to mitigate their damages, shifting responsibility for PTSD back to the plaintiffs. See Adam J. Kolber, Therapeutic Forgetting: The Legal and Ethical Implications of Memory Dampening, 59 Vand. L. Rev. 1561, 1592-95 (2006). For a broader discussion of the question of mitigation of psychological injuries, see generally Lars Noah, Comfortably Numb: Medicalizing (and Mitigating) Pain-and-Suffering Damages, 42 U. Mich. J.L. Reform 431, 448-79 (2009).

323 Ralph Slovenko, Introduction to PTSD in Litigation, supra note 245, at xix, xxiv.

324 One court excluded PTSD evidence in a sexual harassment case in part out of concern that the expert witness had drawn his own conclusions about whether the rape had occurred and therefore his testimony would constitute improper bolstering of the plaintiff's credibility, or, at the very least, would appear to do that. Spencer v. General Electric Co., 688 F. Supp. 1072, 1077 (E.D. Va. 1988), overruled in part by Pesso v. Montgomery Gen Hosp., No. 98-1978, 1999 U.S. App. LEXIS (4th Cir. May 24, 1999), and Ellis v. Director, CIA, No. 98-2481, 1999 U.S. App. LEXIS 21638 (4th Cir. Sept. 10, 1999).

325 See Christopher Slobogin, Psychological Syndromes and Criminal Responsibility, 6 Ann. Rev. L. & Soc. Sci. 109, 118-19 (2010) (reviewing studies regarding the impact of RTS testimony on juror decision-making). Indeed, one court that concluded that PTSD should be admissible in sexual abuse prosecutions declined to draw distinctions among the various purported uses of the evidence. State v. Alberico, 861 P.2d 192, 210-12 (N.M. 1993). The court reasoned that there was no “logical difference” between using such evidence to explain a complainant's behavior, to opine as to the complainant's credibility, or to provide a specific opinion as to the “causality” of the complainant's symptoms in relation to sexual abuse. Id.

326 Richard L. Newman & Rachel Yehuda, PTSD in Civil Litigation: Recent Scientific and Legal Developments, 37 Jurimetrics J. 257, 258 (1997); see, e.g., Allewalt v. State (Allewalt I), 487 A.2d 664, 667-70 (Md. Ct. Spec. App. 1985) (explaining how PTSD testimony is useful in civil cases arising out of rape for establishing damages and evaluating compensable injuries), vacated, 517 A.2d 741 (Md. 1986).

327 See, e.g., Alphonso v. Charity Hosp. of La. at New Orleans, 413 So. 2d 982, 987 (La. Ct. App. 1982) (affirming $50,000 emotional distress award that was based upon PTSD diagnosis resulting from sexual assault in hospital).

328 See, e.g., Ziskin, supra note 158, at 73 (noting that all claims for “traumatic neurosis” would be cast using PTSD, “which appears to cover most of the cases formerly called traumatic neurosis”).

329 See, e.g., Kutchins & Kirk, supra note 105, at 122 (explaining how changes in PTSD diagnoses were recognized by an audience that included non-psychotherapists); Paul R. Lees-Haley, DSM-IV Alert: Changes Important to Claims Evaluation, For the Def., June 1995, at 29, 30 (noting that problem of PTSD for defense attorneys may become worse under the DSM-IV revisions); Mark I. Levy, Stressing the Point: Post Traumatic Stress Disorder Claims, For the Def., Nov. 1995, at 27, 27 (observing that PTSD claims were “growing by leaps and bounds” and resulting in particularly large awards, especially in employment cases).

330 Gold, supra note 284, at 164.

331 Albert M. Drukteinis, Understanding and Evaluating Mental Damages, Psychiatric Times, Apr. 15, 2007, available at http://www.psychiatrictimes.com/display/article/10168/55241.

332 James T. Brown, Compensation Neurosis Rides Again: A Practitioner's Guide to Defending PTSD Claims, 63 Def. Couns. J. 467, 482 (1996).

333 Greenberg et al., supra note 6, at 7 (internal quotation marks omitted).

334 E.g., Chappetta v. Bowman Transp., Inc., 415 So. 2d 1019, 1022-23 (La. Ct. App. 1982).

335 See Jarrett v. Jones, 258 S.W.3d 442, 449 (Mo. 2008) (holding that plaintiff's PTSD was sufficient to establish that his emotional injury was "medically diagnosable and of sufficient severity to be medically significant"); Hamilton v. Nestor, 659 N.W.2d 321, 329-30 (Neb. 2003) (holding that although plaintiff did suffer diagnosable and medically significant emotional distress, it was not of sufficient severity to be actionable); Johnson v. Ruark Ob/Gyn, 395 S.E.2d 85, 97 (N.C. 1990) (finding that severe emotional distress must be generally recognized and diagnosed by medical professionals); Hegel v. McMahon, 960 P.2d 424, 431 (Wash. 1998) (holding that "nightmares, sleep disorders, intrusive memories, fear, and anger" would be sufficient to satisfy the "objective symptomatology" requirement for negligent infliction of emotional distress, but only if they "constitute a diagnosable emotional disorder" such as PTSD).

336 Molien v. Kaiser Found. Hosps., 616 P.2d 813, 821 (Cal. 1980), abrogated by Burgess v. Superior Court, 831 P.2d 1197 (Cal. 1992); Noah, supra note 322, at 437-39. The dissent in that case specifically disputed that psychiatry had "become better equipped to evaluate the traumatic effects of psychic stimuli." Molien, 616 P.2d at 825 (Clark, J., dissenting).

337 646 S.W.2d 765 (Mo. 1983)

338 Bass, 646 S.W.2d at 769; see also Paugh v. Hanks, 451 N.E.2d 759, 765 (Ohio 1983) (criticizing the persistence of the physical manifestation rule because it "completely ignores the advances made in modern medical and psychiatric science").

339 Bass, 646 S.W.2d at 772-73. A 1971 Georgetown Law School student piece was one of the authorities upon which the court derived its "medically diagnosable" standard. Comment, Negligently Inflicted Mental Distress: The Case for an Independent Tort, 59 Geo. L.J. 1237 (1971).

340 Bass, 646 S.W.2d at 781 (Donnelly, J., dissenting).

341 915 S.W.2d 437, 446 (Tenn. 1996).

342 Camper, 915 S.W.2d at 439, 446.

343 Id. at 1023 (emphasis added). One notable implication of the increased use of PTSD in making emotional distress, such as to "medically diagnosable" standards, was the prospect of extensive discovery of a plaintiff's mental health history or a requirement to submit to an independent psychiatric examination on the theory that such plaintiff has waived the psychotherapist-patient privilege. See generally Deirdre M. Smith, An Uncertain Privilege: Implied Waiver and the Evisceration of the Psychotherapist-Patient Privilege in the Federal Courts, 58 DePaul L. Rev. 79 (2008).

344 E.g., Clohessy v. Bachelor, 675 A.2d 852, 865 (Conn. 1996); Cameron v. Pepin, 610 A.2d 279, 284 (Me. 1992); Gates v. Richardson, 719 P.2d 193, 199 (Wyo. 1986).

345 DSM-IV, supra note 264, at 427; see also Baldwin et al., supra note 13, at 42 (noting that DSM-IV expanded the qualifications for PTSD to include one who "'witness[ed]'" or "'learned about'" a threat to a loved one's life).

346 Marzolf v. Stone, 960 P.2d 424, 429, 429 & n.2 (Wash. 1998) (citing DSM-IV, supra note 264, at 429, and permitting recovery for family member who observed an injured family member at the scene of an accident). In an article titled Compensation Neurosis Rides Again defense attorney James T. Brown wrote: "PTSD[] is demonstrating an ability to influence the current tort system, both economically and doctrinally. The diagnosis is being used to erode traditional legal restrictions and barriers to recovery." Brown, supra note 332, at 467.

347 Jarrett v. Jones, 258 S.W.3d 442, 449 (Mo. 2008).

348 See, e.g., Chizmar v. Mackie, 896 P.2d 196 (Alaska 1995) (rejecting requirement of medical diagnosis in claims of emotional distress); Fortes v. Ramos, No. CIV. A. 96-5663, 2001 WL 1685601, at *4-9 (R.I. Super. Ct. Dec. 19, 2001) (reviewing Rhode Island's physical manifestation requirement and its underlying principles).

349 Chizmar, 896 P.2d at 205. However, among the reasons that the jury would have had sufficient basis to award the plaintiff damages was that she "presented medical testimony that she suffered from post-traumatic stress disorder." Id.

350 Phillip J. Resnick, Guidelines for Evaluation of Malingering in PTSD, in PTSD in Litigation, supra note 245, at 187, 188. Defense-oriented commentators have attempted to resurrect notions of "compensation neurosis" to suggest that the secondary gain from

alleging a potential traumatic stressor are the real causes of the plaintiff's symptoms, even in the absence of intentional mendacity. E.g., Brown, supra note 332, at 468-69.

351 See Resnick, supra note 350, at 187 (asserting that financial gain is primary motivation to malinger); Simon, supra note 245, at 81-82 (noting that secondary gain may be one of several factors in maintaining PTSD symptoms); Richard A. Bryant & Allison G. Harvey, The Influence of Litigation on Maintenance of Posttraumatic Stress Disorder, 191 J. Nervous & Mental Disease 191 (2003) (noting the "widely held view" that PTSD is "often mediated by compensation factors").

352 Some national service organizations reportedly distributed the PTSD criteria to Vietnam veterans, which could have made malingering easier. Resnick, supra note 351, at 195. See also Nelsen v. Research Corp. of Univ. of Haw., 805 F. Supp. 837, 844-445 (D. Haw. 1992) (finding lack of candor on part of plaintiff alleging PTSD for, among other things, reviewing diagnostic criteria for disorder before reporting the full range of symptoms).

353 See Resnick, supra note 351, at 187 (noting that PTSD diagnoses are made "almost entirely" on subjective symptoms, and that the accessibility of DSM-IV's criteria makes malingering easier).

354 DSM-IV, supra note 264, at 427 (emphasis omitted).

355 Gerald M. Rosen & Steven Taylor, Pseudo-PTSD, 21 J. Anxiety Disorders 201, 201-02 (2007).

356 For an overview of the applicable rules and case law, see generally Daniel W. Shuman, Psychiatric and Psychological Evidence (3d ed. 2005); David Faust et al., The Admissibility of Behavioral Science Evidence in the Courtroom: The Translation of Legal to Scientific Concepts and Back, 6 Ann. Rev. Clin. Psychol. 49 (2010).

357 Shuman, supra note 282, at 5-6.

358 509 U.S. 579 (1993).

359 See generally Daubert, 509 U.S. at 579 (abandoning "general acceptance" test, and prescribing trial court judges to assess admissibility of expert testimony on the scientific techniques and methodologies used); Gen. Elec. Co. v. Joiner, 522 U.S. 136 (1997) (reinforcing Daubert's principle of an independent judicial reasonableness evaluation of the conclusion, methodologies, and facts in expert admissibility determinations by prescribing an abuse-of-discretion standard of review on appeal); Kumho Tire Co. v. Carmichael, 526 U.S. 137 (1999) (extending the Daubert analysis to nonscientific areas of expertise).

360 Frye v. United States, 293 F. 1013, 1014 (D.C. Cir. 1923).

361 Daubert, 509 U.S. at 588-89 (quoting Beech Aircraft Corp. v. Rainey, 488 U.S. 153, 169 (1988)) (internal quotation marks omitted).

362 Id. at 592-97.

363 Christopher Slobogin, Psychiatric Evidence in Criminal Trials: To Junk or Not to Junk?, 40 Wm. & Mary L. Rev. 1, 34 (1998).

364 See, e.g., People v. Taylor, 552 N.E.2d 131, 134-35 (N.Y. 1990) ("[T]he diagnostic criteria for posttraumatic stress disorder that are contained in DSM III-R have convinced us that the scientific community has accepted that rape as a stressor can have marked, identifiable effects on a victim's behavior ....").

365 Shuman, supra note 282, at 6.

366 See Slobogin, supra note 325, at 118-24 (discussing psychological syndrome evidence specifically and concluding that courts "seldom examine closely all four of the evidentiary components described here (materiality, probative value, helpfulness, and prejudice)"); Slobogin, supra note 363, at 27 (noting a "mammoth study," which demonstrated that "courts ignore [Frye and Daubert] when psychiatric testimony is at issue").

367 See Chapman v. State, 18 P.3d 1164, 1173 (Wyo. 2001) (applying Daubert and stating that "[t]he pivotal question in determining the admissibility of PTSD testimony in sexual assault cases is the testimony's relevance to the issues in the case").

368 Id. at 1169.

369 Id. at 1171.

370 Id. at 1172.

371 Id.

372 861 P.2d 192, 206-08 (N.M. 1993).

373 Alberico, 861 P.2d at 208.

374 Id.

375 Id. at 209.

376 See id. at 209 (finding testimony, which indicated that psychologists have ability to isolate the cause of different symptoms, more persuasive than "judicial determinations of validity based on evidence that [was] many years old"); id. at 213 (holding that it was not an abuse of discretion for the trial court to admit expert testimony on PTSD because the expert testimony was convincing based on the validity of the science and contradictory case law was based on out-dated scientific evidence).

377 See, e.g., State v. Chauvin, 846 So. 2d 697, 705, 709 (La. 2003) (holding expert testimony inadmissible due to a lack of showing reliability and accuracy of PTSD evidence, and noting that despite PTSD being catalogued in the DSM, evidence that trial court performed its "gatekeeping" function was still necessary).

378 State v. Black, 745 P.2d 12, 19 (Wash. 1987).

379 Chauvin, 846 So. 2d at 707-08 (concluding that the diagnostic criteria for PTSD was intended to be used for dealing with the aftermath of severe traumatic events, not for providing clinical and forensic tools). In civil cases as well, courts restricted the admissibility of PTSD evidence to prove that a plaintiff had experienced a traumatic event. In Spencer v. General Electric Co., 688 F. Supp. 1072 (E.D. Va. 1988), a federal district court (applying Frye in a pre-Daubert case) excluded the plaintiff's proffered psychological expert who would have testified that the alleged victim in the underlying sexual harassment case suffered from PTSD and therefore some kind of trauma must have occurred for such symptoms to be present, and that the only stressors in her life that could have caused such symptoms were the alleged rape and harassment. Id. at 1074. The court reasoned that "[e]vidence of PTSD occasioned by rape ... is not a scientifically reliable means of proving that a rape occurred." Id. at 1075-76.

380 See Richard J. McNally, Remembering Trauma 8-11 (2003) (discussing the evolution of repressed memory theory throughout the development of the current PTSD diagnosis); Richard J. McNally, Progress and Controversy in the Study of Posttraumatic Stress Disorder, 54 Ann. Rev. Psychol. 229, 241-44 (2003) (discussing the debate surrounding the validity of repressed memory theory); Steven Taylor & Gordon J.G. Asmundson, Posttraumatic Stress Disorder: Current Concepts and Controversies, 1 Psychol. Inj. & L. 59, 67-69 (2008) (discussing the controversy surrounding whether repressed memories exist in PTSD patients).

381 Shephard, supra note 10, at 390.

382 877 F. Supp. 1055 (E.D. Mich. 1995).

383 Isley, 877 F. Supp. at 1066.

384 Id. at 1067.

385 Id.

386 Compare Marzolf v. Stone, 960 P.2d 424, 429 (Wash. 1998) (determining that the court has the authority to determine the sufficiency of emotional trauma to impose liability on a defendant), and Nelsen v. Research Corp. of Univ. of Hawaii, 805 F. Supp. 837, 844 (D. Haw. 1992) (determining that the court has the ultimate authority to determine if an individual meets the criteria for PTSD), with Bachir v. Transoceanic Cable Ship Co., No. 98 Civ. 4625(JFK), 2002 WL 413918, at *8 (S.D.N.Y. Mar. 15, 2002) (determining that it is the jury's task to weigh and assess the credibility of expert witnesses regarding psychiatric testimony).

387 Apparently, it is not uncommon for treating or evaluating clinicians to vary from following the DSM criteria for PTSD and other disorders. See Robert I. Simon, Preface to PTSD in Litigation, supra note 245, at xv ("In litigation, it is quite common to find the

diagnosis of PTSD made without any attempt to follow the diagnostic criteria for this disorder."). Cf. Owen Whooley, Diagnostic Ambivalence: Psychiatric Workarounds and the Diagnostic and Statistical Manual of Mental Disorders, 32 Soc. Health & Illness 452, 458 (2010) (finding that "[t]o carve a space of autonomous practice psychiatrists develop a series of workarounds to insulate their practice from [a] literal, reductionist application of the DSM").

388 See Lingo v. Burle, No. 4:06-CV-1392 CAS, 2008 WL 1914148, at *3 (E.D. Mo. Apr. 25, 2008) (denying a defendant's motion to exclude expert testimony based on the fact that courts "rarely exclude an expert from testifying under Daubert for failure to adhere to the DSM").

389 No. 98 Civ. 4625(JFK), 2002 WL 413918 (S.D.N.Y. Mar. 15, 2002).

390 Bachir, 2002 WL 413918, at *1.

391 Id. at *8.

392 Id. at *8-9 (holding that the question of whether the incident at issue in the litigation was severe enough to satisfy the PTSD A Criterion was a matter for the jury, and that the plaintiff's expert testimony was properly admitted despite indications that he did not follow the DSM criteria when diagnosing plaintiff with PTSD); see also S.M. v. J.K., 262 F.3d 914, 921-22 (9th Cir. 2001) (concluding that the fact that the plaintiff's psychiatrist did not follow the PTSD criteria in effect at the time of the examination only indicated the "range where experts might reasonably differ, and where the jury must decide among the conflicting views" (quoting Kumho Tire Co. v. Carmichael, 526 U.S. 137, 153 (1999))).

393 805 F. Supp. 837 (D. Haw. 1992).

394 Nelsen, 805 F. Supp. at 843-44; see also Perkins v. Gen. Motors Corp., 709 F. Supp. 1487, 1495-96 (W.D. Mo. 1989) (rejecting plaintiff's psychological expert's testimony that plaintiff had PTSD as a result of the alleged sexual harassment because "the stressor essential for the diagnosis does not exist").

395 Nelsen, 805 F. Supp. at 844-46. Although the court concluded that the plaintiff was entitled to some compensation for his depression following his discharge from employment by the defendant, he was not otherwise entitled to compensation for a psychological injury. Id. at 845-46. The court also appeared to discount the experts' assessment of PTSD since one of them had furnished the plaintiff with the DSM-III-R criteria before he was evaluated. Id. at 844-45.

396 Civil Action No. H-06-2113, 2007 WL 4480134 (S.D. Tex. Dec. 18, 2007).

397 Alvarado, 2007 WL 4480134, at *3-7.

398 Id. at *7.

399 Id. at *1.

400 Id. at *3-7.

401 Id. at *4-6.

402 Id. at *6.

403 Attewalt v. State (Allewalt II), 517 A.2d 741, 751 (Md. 1986).

404 See, e.g., Jarrett v. Jones, 258 S.W.3d 442, 449 (Mo. 2008) (allowing expert testimony of PTSD to show causation).

405 See Lars Noah, Pigeonholing Illness: Medical Diagnosis as a Legal Construct, 50 Hastings L.J. 241, 270 (1999) (stating that some courts have allowed tort plaintiffs to be awarded damages on the basis of a PTSD diagnosis and that psychiatric testimony that the plaintiff suffers from a diagnosable mental illness may provide some reassurance of legitimacy); Deirdre M. Smith, Who Says You're Disabled? The Role of Medical Evidence in the ADA Definition of Disability, 82 Tulane L. Rev. 1, 43-47 (2007) (explaining that courts' reliance on expert medical testimony in disability cases results from the "central role" society accords physicians in deciding who is truly disabled).

406 Noah, supra note 405, at 270-71 ("It may be ... that courts have accepted general evidence concerning PTSD as a nosological entity to support a doctrinal expansion of emotional distress claims, recognizing that stressful events can cause serious psychological injuries even without physical manifestations, in which case the accuracy of individual diagnoses arguably becomes less important."). British commentators have suggested the development of legal standards that follow more closely the current understanding of PTSD, while noting that "policy reasons and not medical evidence ... inform the law of psychiatric injury." Marios C. Adamou & Anthony S. Hale, PTSD and the Law of Psychiatric Injury in England and Wales: Finally Coming Closer?, 31 J. Am. Acad. Psychiatry & L. 327, 331-32 (2003).

407 See Gerald M. Rosen et al., Editorial, Problems with the Post-Traumatic Stress Disorder Diagnosis and its Future in DSM-V, 194 Brit J. Psychiatry 3, 3-4 (2008) (noting that "since its inception in 1980 little about PTSD has gone unchallenged"); Rosen & Lilienfeld, supra note 243, at 853 (stressing "that most every core assumption underlying the diagnostic construct [of PTSD] has met with questionable support, if not falsification"); Yehuda & McFarlane, supra note 239, at 1705 (noting the "competing agendas" and "theoretical inconsistencies" that emerged in the years after the inclusion of PTSD in the DSM-III); Taylor & Asmundson, supra note 380, at 65-66 (finding criterion for traumatic stressor to be too liberal in some instances, such as viewing of film The Exorcist being classified as a traumatic stressor for individual who developed PTSD-like symptoms afterwards). Cf. Chris R. Brewin, Posttraumatic Stress Disorder: Malady or Myth? 25-28 (2003) (examining historical divergence in diagnosis of diseases similar to PTSD).

408 Robert L. Spitzer et al., Saving PTSD from Itself in DSM-V, 21 J. Anxiety Disorders 233, 233 (2007).

409 Young, supra note 7, at 130-33; see also Leys, supra note 13, at 6-7 ("[T]he very terms in which PTSD is described tend to produce controversy.").

410 Yehuda & McFarlane, supra note 239, at 1705-07.

411 See Appignanesi, supra note 273, at 427-28 (explaining that when the criteria delineating what qualified as PTSD were broadened, the diagnosis rate rose by half); Shephard, supra note 10, at 355, 385-87 (stating that the mental health field's adoption of PTSD as "scientific truth" and the ensuing media attention led to an "infinite" amount of literature on the subject); Shorter, supra note 172, at 290 (noting that after entry into popular culture, PTSD was "trivialized ... as a way of psychologizing life experiences"); Baldwin et al., supra note 13, at 45-48 (questioning legitimacy of popular concern about American citizens developing psychological injuries from learning about the September 11, 2001 terrorist attacks with an absence of such concern in following the Japanese attack on Pearl Harbor); Rachel Yehuda & Alexander C. McFarlane, PTSD is a Valid Diagnosis: Who Benefits from Challenging Its Existence?, 26 Psychiatric Times, no. 7, July 9, 2009, at 31, available at http://www.psychiatrictimes.com/display/article/10168/1426957 (suggesting that some psychiatrists are bothered by PTSD due to their "resentment that some persons fake [PTSD] symptoms for secondary gain" or that some patients cease treatment as soon as they are awarded compensation).

412 Paul R. McHugh & Glenn Treisman, PTSD: A Problematic Diagnostic Category, 21 J. Anxiety Disorders 211, 212 (2007). One psychiatrist commented that the concepts "traumatic" and "stress" for PTSD have become so non-specific as to be almost meaningless, and suggested that a more accurate term is "Post Something Really Horrible Disorder." Chris Cantor, Post-Traumatic Stress Disorder's Future, 192 Brit. J. Psychiatry 394, 394 (2008).

413 Roger K. Pitman et al., Legal Issues in Posttraumatic Stress Disorder, in Psychological Injuries At Trial, supra note 229, at 861, 861-63; see also Landy F. Sparr & James K. Boehnlein, Posttraumatic Stress Disorder in Tort Actions: Forensic Minefield, 18 Bull. Am. Acad. Psychiatry & L. 283, 283 (1990) ("[PTSD] as the basis for a tort claim is a union of forensic problem children.").

414 Alan A. Stone, Post-Traumatic Stress Disorder and the Law: Critical Review of the New Frontier, 21 Bull. Am. Acad. Psychiatry & L. 23, 23, 29, 34 (1993).

415 Lawrence J. Raifman, Problems of Diagnosis and Legal Causation in Courtroom Use of Post-Traumatic Stress Disorder, 1 Behav. Sci. & L. 115, 119-29 (1983).

416 Id. at 126.

417 See Rosen & Lilienfeld, supra note 243, at 838 (stating that even though PTSD may not be entirely valid as a diagnosis, the "serious and often disabling" symptoms associated with it are not imaginary).

418 Shephard, supra note 10, at 390-91 (PTSD's "theoretical underpinning ... [is] unravelling").

419 Miranda Van Hooff et al., The Stressor Criterion-A1 and PTSD: A Matter of Opinion?, 23 J. Anxiety Disorders 77, 77 (2009); Frank W. Weathers & Terence M. Keane, The Criterion A Problem Revisited: Controversies and Challenges in Defining and Measuring Psychological Trauma, 20 J. Traumatic Stress 107, 107-12 (2007). For examples of literature applying the varying views on this dispute, see Naomi Breslau & Glenn C. Davis, Posttraumatic Stress Disorder: The Stressor Criteron, 175 J. Nervous & Mental Disease 255, 259-62 (1987) (classifying stressors as extraordinary and ordinary); Meaghan L. O'Donnell et al., Criterion A: Controversies and Clinical Implications, in Clinician's Guide to Posttraumatic Stress Disorder 51, 60-67 (Gerald M. Rosen & B. Christopher Frueh eds., 2010) [hereinafter Clinician's Guide to PTSD] (separating A Criterion into narrow and broad definitions to analyze how diagnosis changes with definitional change). The other PTSD criteria are the subject of dispute as well, but I will focus here only on the A Criterion since that is the one that most clearly implicates legal questions. See Preface to Posttraumatic Stress Disorder: Issues and Controversies, at xi-xii (Gerald M. Rosen ed., 2004) [hereinafter PTSD: Issues and Controversies] (listing current disputes involving PTSD's criteria).

420 See Landy F. Sparr & Roger K. Pitman, PTSD and the Law, in Handbook of PTSD: Science and Practice 449, 454 (Matthew J. Freidman et al. eds., 2007) (attributing the "geometric increase" in PTSD-based civil claims to the expansion of the DSM-IV's criteria for PTSD); Pitman et al., supra note 413, at 861 ("Non-psychiatric incentives (e.g., the prospect of financial gain or avoidance of criminal punishment), which are present in all civil and criminal legal systems, have cast a shadow over the validity of the PTSD diagnosis and delayed its acceptance into diagnostic systems in psychiatry.").

421 Rosen et al., supra note 407, at 4.

422 William J. Koch et al., Empirical Limits for the Forensic Assessment of PTSD Litigants, 29 L. & Hum. Behav. 121, 128-29 (2005).

423 E.g., Bowman, supra note 225, at 826-39; see also Olav Nielssen, et al., The Reliability of Evidence About Psychiatric Diagnosis After Serious Crime: Part I. Agreement Between Experts, 38 J. Am. Acad. Psychiatry & L. 516, 523 (2010) (finding lower reliability for PTSD in criminal forensic settings than for any other tested diagnosis, and attributing the findings, in part, to the fact that "it is difficult, with the current diagnostic criteria, to make the diagnosis in a reliable way in legal settings").

424 Bowman, supra note 225, at 826-39; see also William J. Koch, Posttraumatic Stress Disorder Following Motor Vehicle Accidents: Clinical Forensic Guidelines, in Psychological Injuries At Trial, supra note 229, at 794, 803-04 (noting confirmatory bias following motor vehicle accidents generally); Gerald M. Rosen, The Aleutian Enterprise Sinking and Posttraumatic Stress Disorder: Misdiagnosis in Clinical and Forensic Settings, 26 Prof. Psychol. Res. & Prac. 82, 84-85 (1995) (using marine disaster as case study and finding confirmatory bias among survivors).

425 B.L. Long, Psychiatric Diagnoses in Sexual Harassment Cases, 22 Bull. Am. Acad. Psychiatry & L. 195, 196-97 (1994).

426 See, e.g., Alvarado v. Shipley Donut Flour & Supply Co., Inc., Civil Action No. H-06-2113, 2007 WL 4480134, at *6 (S.D. Tex. Dec. 18, 2007) (excluding evidence of forensic psychologist who diagnosed all twelve plaintiffs with PTSD); Nelsen v. Res. Corp. of Univ. of Haw., 805 F. Supp. 837, 844-45 (D. Haw. 1992) (discounting plaintiff's experts' PTSD diagnosis because one of them had provided him with the DSM criteria before evaluations by the others); Perkins v. Gen. Motors Corp., 709 F. Supp. 1487, 1495 (W.D. Mo. 1989) (excluding PTSD evidence in a sexual harassment case on the basis that it appeared to be the "current diagnosis of choice with [the plaintiff's] psychologists and they fit their patient to that diagnosis"); see also Pitman et al., supra note 413, at 875 (stating that bias can arise when diagnosing PTSD because of "sympathy" or "antipathy" the diagnostician may hold toward a patient's status as a victim).

427 Roger K. Pitman & Scott P. Orr, Forensic Laboratory Testing for PTSD, in PTSD in Litigation, supra note 245, at 207, 207.

428 Van Hooff et al., supra note 419, at 85.

429 See supra notes 367-79 and accompanying text for a discussion regarding the judicial scrutiny of stressors and their use in diagnosing PTSD.

430 Van Hooff et al., supra note 419, at 78.

431 McNally, supra note 380, at 231; Van Hooff et al., supra note 419, at 77.

432 J. Alexander Bodkin et al., Is PTSD Caused by Traumatic Stress?, 21 J. Anxiety Disorders 176, 176 (2007).

433 Id. at 181.

434 Id.; see also Harold Merskey & August Piper, Posttraumatic Stress Disorder Is Overloaded, 52 Can. J. Psychiatry 499, 499-500 (2007) (arguing that PTSD is diagnosed in a great number of cases where there has been no actual traumatic experience).

435 Berntsen et al., supra note 240, at 1104. Indeed, such a view is more consistent with Freud's initial conceptualization of traumatic neurosis. Leys, supra note 13, at 20.

436 David C. Rubin et al., Memory In Posttraumatic Stress Disorder: Properties of Voluntary and Involuntary, Traumatic and Nontraumatic Autobiographical Memories in People with and Without Posttraumatic Stress Disorder, 137 J. Experimental Psychol.: Gen. 591, 594 (2008) ("[P]roperties of the memory of the event rather the A1 and A2 criteria of the event itself will predict PTSD symptoms. Thus, individual differences factors influencing the availability of the memory (such as personality and temperament) will have a well-specified role to play." (citation omitted)); see also Bowman, supra note 225, at 824-25 (noting that pre-event "traits" appear to contribute more significantly to the development of PTSD than the severity of the traumatic event itself); Young, supra note 7, at 136, 141 (noting that some non-combat war veterans, after hearing of others' traumatic experiences, will "remember" false events).

437 Bowman, supra note 225, at 825-26; Horowitz, supra note 225, at 9.

438 Bowman, supra note 225, at 821-23.

439 See Bowman, supra note 225, at 833 ("The clinical model for PTSD is biased by simple dose-response thinking, as if humans and flatworms had their well-being and behavior equally totally determined by external events."); John A. Call, Liability for Psychological Injury: Yesterday and Today, in Psychological Injuries at Trial, supra note 229, at 40, 52-53 (citing studies associating PTSD with "childhood behavior problems, dysfunctional families, physical abuse, current unemployment, genetic predisposition, and experience with previous traumas").

440 Berntsen et al., supra note 240, at 1105.

441 25 F. Supp. 2d 809 (N.D. Ohio 1998).

442 Burns, 25 F. Supp. 2d at 822 n.7.

443 Id. at 821-22 (emphasis added). Although the "eggshell plaintiff" rule would nonetheless allow recovery of any damages that could be found to flow from the tortfeasor's actions (assuming such calculation can be made), it would not implicate essential questions of liability.

444 Yehuda & McFarlane, supra note 239, at 1706; see also McNally, supra note 380, at 87 (characterizing original view of PTSD as a "normal response to an abnormal stressor").

445 Yehuda & McFarlane, supra note 239, at 1706.

446 See supra Part III.A for a discussion of how veterans of the Vietnam War were largely responsible for the official recognition of PTSD.

447 Yehuda & McFarlane, supra note 239, at 1707-08; see also McNally, supra note 380, at 237-39 (noting that the risk of developing PTSD symptoms is influenced by genetic and other vulnerability factors); Simon, supra note 245, at 59 (citing studies that have identified risk factors for exposure to traumatic events); Taylor & Asmundson, supra note 380, at 60 (emphasizing the important role played by risk factors in the development of PTSD).

448 See McNally, supra note 380, at 89 (noting that some "people" are offended by risk factor research because "it entails blaming victims for their plight"). Some researchers have alleged that the link between PTSD and its political and legal uses has inhibited scientific debate on the validity of the diagnosis. Editorial, Challenges to the PTSD Construct and its Database: The Importance of Scientific Debate, 21 J. Anxiety Disorders 161, 161-62 (2007); see also Maier, supra note 230, at 105 ("[I]t is still difficult and sometimes even impossible to mention other influencing factors, especially in psychotherapies or in litigation contexts. This is not helpful for the further development of therapeutic and preventive interventions in PTSD."); Van Hooff et al., supra note 419, at 85 ("[D]iscussions about PTSD are often polarized because of the role this diagnosis plays in determining causation, and hence negligence, in many litigation settings.").

449 One reviewer theorizes several reasons why the clinical model and DSM criteria continue to be based upon a dose-response, event-causative model, including the fact that the model was based upon those who sought treatment; that individuals "make errors in

reasoning about the causes and meanings of emotional arousal"; and clinicians "may fear being accused of 'blaming the victim' in looking at factors beyond the event.... This fear represents a shift away from a scientific approach to PTSD to a moralistic model." Marilyn Laura Bowman, Individual Differences in Posttraumatic Distress: Problems with the DSM-IV Model, 44 Can. J. Psych. 21, 27 (1999). She also suggests that "the DSM model for PTSD developed partly in response to advocacy groups attempting to normalize the condition of people with certain experiences." Id. at 29.

450 Raifman, supra note 415, at 129. It has even been suggested that "[a]s with other medical diagnoses oriented to legal consequences, PTSD will-- in the future--no longer be a medical syndrome." Id.

451 Simon, supra note 245, at 60.

452 Askowitz & Graham, supra note 285, at 2047-48. Some have specifically criticized its use on the basis that child sexual abuse did not meet the A Criterion because it often occurs over time. E.g., David Finkelhor, Early and Long-Term Effects of Child Sexual Abuse: An Update, 21 Prof. Psychol. Res. & Prac. 325, 328-29 (1990); see also William J. Koch et al., Empirical Limits for the Forensic Assessment of PTSD Litigants, 29 L. & Human Behav. 121, 136-40 (2005) (discussing how documentation of the trauma experienced from sexual abuse, which rarely occurs, is critical to a careful forensic assessment of the Criterion A status); Steve Herman, Improving Decision Making in Forensic Child Sexual Abuse Evaluations, 29 L. & Human Behav. 87, 107 (2005) ("The current finding of low overall accuracy in clinician judgments about unconfirmed allegations of child sexual abuse is consistent with the almost universal consensus among top scientific experts that these evaluations currently have no firm scientific basis."). See generally Clancy, supra note 287.

453 Gary B. Melton et al., Psychological Evaluations for the Courts: A Handbook for Mental Health Professionals and Lawyers 516 (3rd ed. 2007); see also Daniel W. Shuman, The Diagnostic and Statistical Manual of Mental Disorders in the Courts, 17 Bull. Am. Acad. Psych. L. 25, 28 (1989) (noting that child abuse accommodation syndrome, although often the subject of expert psychological testimony, is not consistent with the diagnostic criteria for PTSD and not supported by scientific literature).

454 E.g., Gerald M. Rosen et al., Afterword: PTSD's Future in the DSM: Implications for Clinical Practice, in Clinician's Guide to PTSD, supra note 419, at 263, 264-65; Olav Nielssen & Matthew Large, Post-Traumatic Stress Disorder's Future, 192 Brit. J. Psych. 394, 394 (2008); see also Maier, supra note 230, at 105 (arguing that since the criterion has little use in the clinical setting, it should be eliminated from the diagnosis); Rosen & Taylor, supra note 355, at 206 (discussing how PTSD would be diagnosed if the field of traumatology were to do away with the A Criterion); Yehuda & McFarlane, supra note 416 (noting that "the existence of PTSD is being called into question").

455 Maier, supra note 230, at 106; Yehuda & McFarlane, supra note 411 (arguing that, although original assumptions PTSD was based on have been proven incorrect, the diagnosis should be retained since it has been "on-target in so many ways for so many trauma survivors"). Such a step would likely render the diagnosis superfluous: How can something be post-traumatic if the precursor was irrelevant?

456 Am. Psychiatric Ass'n, G 05 Posttraumatic Stress Disorder, DSM-5 Development, http://www.dsm5.org/ProposedRevisions/Pages/proposedrevision.aspx? rid=165 (last visited Nov. 14, 2011) (citation omitted). One reason for this new language is in response to the findings of Van Hooff et al., supra note 419, at 82, about the low inter-rater reliability in terms of meeting the A Criterion when the event was witnessed by the patient, rather than directly experienced.

457 See supra notes 264-73 and accompanying text for a discussion of the 1994 DSM-IV revisions to the diagnostic criteria for PTSD.

458 Am. Psychiatric Ass'n, supra note 456 (follow "Rationale" tab). The use of the term "event(s)" in the proposed A Criterion revision suggests that, for the first time, diagnosticians could assign the cause of a person's PTSD to more than one distinct event.

459 In an influential article, psychologists Claudia Avina and William O'Donohue suggest that "threat to physical integrity" in the DSM-IV's Criterion A1 potentially extends to sexual harassment in three ways: "(1) by threatening the victim's financial well-being, (2) by threatening the victim's physical boundaries, and (3) by threatening the victim's control over situations that she should legitimately be able to have some control." Claudia Avina & William O'Donohue, Sexual Harassment and PTSD: Is Sexual Harassment Diagnosable Trauma?, 15 J. Traumatic Stress 69, 73 (2002).

460 Compare DSM-IV, supra note 264, at 427, with Am. Psychiatric Ass'n, supra note 461.

461 Am. Psychiatric Ass'n, supra note 456 (follow "Rationale" tab).

462 Rosen et al., supra note 454, at 268 ("[T]he new working proposal for Criterion A does not resolve any of the core issues that constitute the 'Criterion A problem ....'").

463 See generally Brewin, supra note 407.

464 Id. at 1-3.

465 For a more detailed discussion of the use and conceptualization of "causation" within law and psychiatry respectively, see Deirdre M. Smith, The Disordered and Discredited Plaintiff: Psychiatric Evidence in Civil Litigation, 31 Cardozo L. Rev. 749, 755-71 (2010).

466 Editorial, What is PTSD?, 154 Am. J. Psych. 143, 144 (1997).

467 Young, supra note 7, at 121; Patrick J. Bracken, Post-Modernity and Post-traumatic Stress Disorder, 53 Soc. Sci. & Med. 733, 735-36 (2001).

468 See Watters, supra note 119, at 4 (listing some of the cultural assumptions that lie behind Western ideas of mental health); Gerald M. Rosen et al., Searching for PTSD's Biological Signature, in Clinician's Guide to PTSD, supra note 419, at 97, 97 (noting that the goal of medical nosology, including psychiatric classification, is to "reflect[] the true state of affairs in nature"); Bracken, supra note 467, at 733 ("Most of those who research and write about PTSD appear confident that the syndrome captures something fundamental about the way in which human beings deal with trauma.").

469 Leys, supra note 13, at 3; Jones et al., supra note 250, at 158 (noting that some scholars claim to identify PTSD symptoms in the Iliad and seventeenth century writings); Donna Trembinski, Comparing Premodern Melancholy/Mania and Modern Trauma: An Argument in Favor of Historical Experiences of Trauma, 14 Hist. of Psychol. 80, 80 (2011).

470 Shorter, supra note 172, at 304-05; Jerry Lembcke, The "Right Stuff" Gone Wrong: Vietnam Veterans and the Social Construction of Post-Traumatic Stress Disorder, 24 Critical Soc. 37, 38 (1998).

471 In 2000, a resolution proposed in the Royal College of Psychiatry in the United Kingdom that would have stated that the body "believes that PTSD is largely a fictional condition" was defeated only narrowly. Bowman, supra note 225, at 821; see also Celia Hall, Stop Cashing In On Stress, Says Psychiatrist, The Daily Telegraph (July 4, 2000), http:// www.telegraph.co.uk/news/newstopics/politics/health/1346618/Stop-cashing-in-on-stress-says-psychiatrist.html (criticizing the "compensation culture" created by psychoanalysis and lawyers through the application of PTSD to everyday experience).

472 Baldwin et al., supra note 13, at 37.

473 See, e.g., Brewin, supra note 407, at 25-28 (detailing similarities between symptoms of PTSD and symptoms of shell shock).

474 Jones et al., supra note 250, at 160-61. One theory to account for the incidence of "flashbacks" in the later twentieth century is that the symptom is derived from the cinematic technique. Id. at 162. See also Baldwin et al., supra note 13, at 40 (noting the "discontinuity" of the conceptualization of PTSD over time).

475 Watters, supra note 199, at 102; see also Derek Summerfield, Cross-Cultural Perspectives on the Medicalization of Human Suffering, in PTSD: Issues and Controversies, supra note 419, at 233, 233-44 (noting that Western medicalization of distress has resulted in a wide range of symptoms being attributed to PTSD).

476 Young, supra note 7, at 5.

477 Id.

478 Young, supra note 7, at 105-06; Rosen et al., supra note 468, at 98; see also Baldwin et al., supra note 13, at 38 ("[P]hysiological differences between persons with a diagnosis of PTSD compared with those without the diagnosis ha[ve] been used rhetorically to champion the 'reality' of PTSD and to discredit critics."); Leys, supra note 13, at 254 (noting that the "plausibility" of trauma theories would be "enormously enhanced" if they were "supported by neurobiological evidence").

479 Shephard, supra note 10, at 388-90; see also Taylor & Asmundson, supra note 380, at 63-64 (reviewing various studies examining potential neurobiological and behavioral-genetic causes of PTSD). Much research has focused on the potential role of hormones such as cortisol or norepinephrine. Appignanesi, supra note 273, at 436-37.

480 Baldwin et al., supra note 13, at 48-49; see also Yehuda & McFarlane, supra note 411 (noting the progress made in identifying biomarkers for PTSD and that "[s]oon it will be more difficult ... to dismiss the 'validity' of the PTSD diagnosis").

481 Baldwin et al., supra note 13, at 49.

482 Two excellent, recent works, Adam J. Kolber, The Experiential Future of the Law, 60 Emory L.J. 585, 609-22 (2011), and Betsy J. Grey, Neuroscience and Emotional Harm in Tort Law: Rethinking the American Approach to Free-Standing Emotional Distress Claims, in 13 Law and Neuroscience: Current Legal Issues 2010, at 203, 204-06 (Michael Freeman ed., 2011), explore the potential impact of emerging technological advances for identifying biological markers for PTSD and other psychological injuries on legal decision-making in the future.

483 See Katie Drummond, Neuroscientists Say Brain Scans Can Spot PTSD, Wired.com (Jan. 22, 2010, 8:00 A.M.), http://www.wired.com/dangerroom/2010/01/brain-biomarker-could-be-the-key-to-ptsd-diagnosis (study indicating that new brain imaging technology permitted researchers to spot specific brain biomarkers, allowing them to diagnose PTSD with ninety percent accuracy).

484 Baldwin et al., supra note 13, at 49-52 (critiquing various psychophysiological studies).

485 See Pitman & Orr, supra note 427, at 207 (noting that diagnosis of PTSD continues to rely on "the veracity of the complainant").

486 Shorter, supra note 43, at 2-4; Watters, supra note 199, at 32.

487 Watters, supra note 199, at 32 (noting that "[t]his sort of cultural molding ... happens imperceptibly and follows a large number of cultural cues that patients simply are not aware of").

488 Id. at 33.

489 Id. at 60 (noting that there is "[a] pervasive mistaken assumption in the mental health profession: that mental illnesses exist apart from and unaffected by professional and public beliefs and the cultural currents of the time").

490 Id. at 72; see also Welke, supra note 18, at 158 (noting that "neurasthenia" was regarded as "America's primary mental disorder" at the turn of the twentieth century and had become "a household word").

491 Bracken, supra note 467, at 735. One analysis of the shifting criteria of PTSD noted eleven distinct changes to the diagnosis in the DSM-III-R and fifteen changes to the DSM-IV criteria, all in the space of fourteen years. These changes were so significant that a great number of patients who met the criteria under one would not meet the criteria under another, and that, under the current version, two patients without any overlapping symptoms could have the same PTSD diagnosis. Kutchins & Kirk, supra note 105, at 124.

492 Daniel W. Shuman, Softened Science in the Courtroom: Forensic Implications of a Value-Laden Classification, in Descriptions and Prescriptions: Values, Mental Disorders, and the DSMs 217, 224-25 (John Z. Sadler ed., 2002); Elizabeth C. Cooksey & Phil Brown, Spinning on Its Axes: DSM and the Social Construction of Psychiatric Diagnosis, 28 Int'l J. Health Sci. 525, 548-49 (1998).

493 Greenberg et al., supra note 6, at 5, 12.

494 Charles E. Rosenberg, Framing Disease: Illness, Society, and History, in Framing Disease: Studies in Cultural History, at xii, xxi (Charles E. Rosenberg & Janet Golden eds., 1992) [hereinafter Framing Disease]; see also Geoffrey C. Bowker & Susan Leigh Star, Sorting Things Out: Classification and Its Consequences 47 (2000) (noting the "multitude of local political and social struggles and compromises that go into the constitution of a 'universal' classification" such as the DSM or the International Classification of Diseases).

495 Janet A. Tighe, The Legal Art of Psychiatric Diagnosis: Searching for Reliability, in Framing Disease, supra note 494, at 206, 207-08.

496 Id. at 215-16, 219.

497 See id. at 217 (noting that DSM-III was the most technologically sophisticated edition of the DSM).

498 See, e.g., Edgar Garcia-Rill & Erica Beecher-Monas, Gatekeepting Stress: The Science and Admissibility of Post-Traumatic Stress Disorder, 24 U. Ark. Little Rock L. Rev. 9, 37-39 (2001) (noting that "PTSD ... is based on solid science and should be admissible under Daubert").

499 E.g., Spencer v. Gen. Elec. Co., 688 F. Supp. 1072, 1075-76 (E.D. Va. 1988) (noting that "PTSD is simply a diagnostic category created by psychiatrists; it is a human construct, an artificial classification of certain behavioral patterns"), overruled in part by Pesso v. Montgomery Gen Hosp., No. 98-1978, 1999 U.S. App. LEXIS (4th Cir. May 24, 1999), and Ellis v. Director, CIA, No. 98-2481, 1999 U.S. App. LEXIS 21638 (4th Cir. Sept. 10, 1999).

500 See, e.g., Brown, supra note 332, at 468 (stating that "symptoms of PTSD can be easily coached and simulated," and that some "individuals and their counsel take advantage of these ploys"); Derek Summerfield, The Invention of Post-Traumatic Stress Disorder and the Social Usefulness of a Psychiatric Category, 322 Brit. Med. J. 95, 96 (2001) ("Once it becomes advantageous to frame distress as a psychiatric condition people will choose to present themselves as medicalised victims rather than as feisty survivors.... There is a veritable trauma industry comprising experts, lawyers, claimants, and other interested parties ...."). For an example of such backlash in the popular culture, see generally Alan M. Dershowitz, The Abuse Excuse: and Other Cop-outs, Sob Stories, and Evasions of Responsibility (1994).

501 See, e.g., Maier, supra note 230, at 105 ("The legal system ..., which is based on strictly causal thinking, gratefully picked up the diagnosis and has built in the meantime a whole industry of victimology on PTSD." (emphasis omitted)).

502 In this regard, PTSD can be seen as a "co-production" of psychiatry and law, to borrow a concept from noted science and technology studies scholar Sheila Jasanoff. Sheila Jasanoff, The Idiom of Co-Production, in States of Knowledge: The Co-Production of Science and Social Order 1, 2 (Sheila Jasanoff ed., 2004) ("Briefly stated, co-production is shorthand for the proposition that the ways in which we know and represent the world (both nature and society) are inseparable from the ways in which we choose to live in it."). I am appreciative of Allan Young for bringing this term to my attention in our correspondence.

503 Kinzie & Goetz, supra note 28, at 166.

504 Jerome C. Wakefield & Allan V. Horwitz, Normal Reactions to Adversity or Symptoms of Disorder?, in Clinician's Guide to PTSD, supra note 419, at 33, 42.

505 See Shuman, supra note 282, at 7 ("Both Daubert and the DSM make clear that it is not appropriate to assume that a psychiatric diagnosis is relevant to, let alone dispositive of, an issue in a case.").

506 To be sure, PTSD is not unique in this respect since law has certainly relied upon the presence of a "diagnosable" mental disorder in other contexts, particularly with respect to preventative detention laws. For example, people are subject to involuntary commitment, only where an examiner has found the presence of a mental illness. Similarly, sexually violent predator laws universally require a finding of a mental disorder as well as a history of sexual violence in order to detain a person. Several conceptualizations of the insanity defense require the presence of a mental disease or defect in addition to specific cognitive or volitional impairments. Melton et al., supra note 453, at 210-12.

507 Shuman, supra note 282, at 10 ("[T]he role of PTSD in litigation turns, in part, on diagnostic nomenclature that psychiatry largely controls ....").

508 See Sparr & Pitman, supra note 420, at 454 ("Beyond its significance as an apparent solution to the legal problem of causation, PTSD's greatest importance is that it seems to make scientific and objective matters that the court once considered too subjective for legal resolution." (citation omitted)). See generally Greenberg et al., supra note 6 (critiquing the forensic use of DSM diagnoses).

509 See Smith v. Schlesinger, 513 F.2d 462, 477 (D.C. Cir. 1975) ("[P]sychiatric judgments may disguise, wittingly or unwittingly, political or social biases of the psychiatrist; and excessive reliance on diagnoses will pre-empt the primary role of legal decision-makers.").

510 See, e.g., Gen. Elec. Co. v. Joiner, 522 U.S. 136, 146 (1997) ( "[N]othing in either Daubert or the Federal Rules of Evidence requires a district court to admit opinion evidence that is connected to existing data only by the ipse dixit of the expert."); see also Smith, supra note 465, at 810-15 (discussing some of the unique dangers of admitting psychiatric evidence, particularly DSM diagnoses).

511 Greenberg et al., supra note 6, at 10.

512 Chamallas & Wriggins, supra note 130, at 125 n.25 (citing Neal Feigenson, Legal Blame: How Jurors Think and Talk About Accidents 51-52 (2000)); see also Sparr & Pitman, supra note 420, at 454 (commenting that "PTSD posits a straightforward causal relationship that plaintiffs' lawyers welcome").

513 Noah, supra note 405, at 243 (noting that when legal institutions "rely heavily on clinical judgments" it can in turn "distort the diagnostic process").

514 See Robin Feldman, The Role of Science in the Law, at xi (2009) ( "We continually look to science to rescue us from the discomfort of difficult legal decisions ....").

515 Maintaining a clearer demarcation between the legal and medical judgments not only protects the legal system from unintentionally delegating policy-making to medicine, it also protects medicine from the influence of the law. See Noah, supra note 410, at 244 (arguing that "legal institutions should better insulate the diagnostic enterprise by delinking their decisions from clinical judgments").

516 Melton et al., supra note 453, at 226.

517 Fed. R. Evid. 412.

518 The Restatement (Third) of Torts includes Section 46, which provides as follows:
An actor whose negligent conduct causes serious emotional disturbance to another is subject to liability to the other if the conduct: (a) places the other in immediate danger of bodily harm and the emotional disturbance results from the danger; or (b) occurs in the course of specified categories of activities, undertakings, or relationships in which negligent conduct is especially likely to cause serious emotional disturbance.
Restatement (Third) of Torts: Liab. For Physical & Emotional Harm § 46 (Tentative Draft No. 5, 2007); see also Chamallas & Wriggins, supra note 125, at 95 (noting "[t]he Restatement's emphasis [is] on the relational context in which the tort is committed," not "on the categorization of the injury marks").

519 See, e.g., Jonathan M. Metzl, The Protest Psychosis: How Schizophrenia Became A Black Disease (2009) (discussing the radical re-conceptualization of the diagnosis of schizophrenia in the United States in 1950s and 1960s).

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