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Special Edition on "Trauma and Its Medico-legal Implications"

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Special Issue: *"Trauma: an overview of its incidence and effects in the community".*

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WHAT IS 'TRAUMA' AND 'STRESS'

A significant proportion of cases litigated as 'personal injury' centre on what is called 'trauma' or 'stress'.

Exposure to an 'extreme traumatic stressor' involves the direct personal experience of an event involving threatened death or serious injury, or witnessing/learning about death or serious fear, helplessness and horror includes military combat, violent personal assault (sexual, physical, robbery, mugging), kidnap, terrorist attack, natural disaster (hurricane or earthquake), severe road traffic accident and life-threatening medical accident or illness. The more disturbing the experience, the more likely the development of post-traumatic stress disorder (PTSD).

The most traumatic events are

- Sudden and unexpected
- Continue for a long time
- Involve feeling trapped and unable to get away
- Cause one or more deaths
- Cause significant physical injury
- Involve children
- Perceived to be life threatening.

The description of traumatic stress first came to prominence during the First World War when soldiers experienced traumatic experiences in the trenches. The term 'post-traumatic stress disorder' was first used after the Vietnam War. In 1980, PTSD was officially recognised as a mental health condition when it was included in the Diagnostic and Statistical Manual of Mental Disorders (DSM), developed by the American Psychiatric Association (APA).

There have been debates about the definition and reliability of the PTSD diagnosis. The 'for' group used the label to validate treatment. The 'against' group felt there was no need to medicalise trauma and felt the label had a more litigious purpose than a clinical one. Criticism of PTSD has often come from concerns about the number of PTSD disability claims filed by individuals in the UK and North America, relating to both domestic traumas, rather than military ones. There are many varied ways in which such trauma can be experienced at the time, immediately after (peri-traumatic), and subsequently over weeks and months. The post-incident DSM-5 and ICD-10 classifications of mental disorders both clearly set out criteria for diagnosing this severe and intense form of traumatic stress [1,2].

PREVALENCE

Studies have found 51 – 61% of adults reported that they have had experience of at least one objectively traumatic event in their lives. Studies in the UK and USA have revealed a lifetime prevalence of PTSD ranging from 1 to 14% depending on the population sampled. At-risk individuals and communities (e.g. military combat, war zone communities, hurricane victims) yield higher rates (3 – 58%) and include those in risky professions (for example emergency service workers and police officers). Prevalence rates vary from one culture to another, and are not bound to western culture [3].

COURSE AND DURATION

Stress-related experiences and symptoms typically begin within the first three months of a traumatic event. A small number have persistent symptoms for longer than 12 months. The severity, duration and proximity of an individual's exposure to the traumatic event are the most important factors

affecting likelihood of disorder and prognosis. A very small minority develop PTSD several months later, either in terms of truly 'delayed onset' (no initial reaction) or, more commonly, 'slowly developing onset'. The more stressful and less supportive the individual's working or family environment, the greater the likelihood that a traumatic stressor will result in PTSD. The stressful sequelae of a trauma (such as a police interview, medical assessment, social questioning or family disruption) can be equally or even more disturbing than the actual traumatic event. The process of litigation, particularly when protracted, can serve to maintain the level of intrusive thoughts.

PTSD IN CHILDREN

Very young children tend not to develop PTSD due to their level of cognitive development. However, as soon as they are old enough to interpret events as stressors or traumatic, then their emotional responses can mirror those of adults. Important innovations have been developed for the psychological treatment of children and adolescents. They vary in terms of how much the actual trauma is focused on as opposed to their current coping mechanisms.

The following papers in this special edition cover a variety of issues relating to trauma assessment in the context of civil litigation.

1. Assessing trauma in children: a review of evidence [1]

2. Assessing neuropsychological implications of trauma [2]

3. Differential diagnosis and 'road maps' for trauma assessment [3]

4. Why do experts disagree on trauma: case study of the joint statement process [4]

Each of the papers illustrate key medico-legal aspects of how trauma is addressed in civil cases.

a) In the first paper [4] the importance of robust and reliable assessment of psychological symptoms in young people is highlighted in order that appropriate treatment or advice can be given. The civil courts in the UK are especially concerned to ensure any residual symptoms are clearly defined and appropriate treatment recommendations are made.

b) The implications for identifying mild, moderate or severe cognitive impairment are assessed [5], using a neuropsychological approach. It emphasises how stressful cognitive impairment can be and provides a case study, reinforcing the need for a full and thorough biopsychosocial neuropsychological assessment to determine cause, effect and prognosis.

c) The process of differential diagnosis [6] used to provide a robust opinion is described, involving the examination of several different sources of evidence. Reliable decision making is essential for arriving at an accurate prognosis for treatment. A case illustration exemplifies this process of differential diagnosis of traumatic psychological symptoms in a medico-legal context.

d) A unique aspect of civil litigation in the UK is the use of the Joint Statement process in which opposing experts discuss, face-to-face or remotely, their respective views about trauma and other symptoms. A case illustration involving post-traumatic stress symptoms is presented and discussed [7].

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