Supported by Evidence or Simply Opportunistic

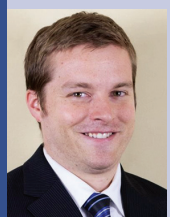
Defending Against the Growing Trend of PTSD Claims in Aviation Cases

By Kerry Mahedy, Brandon Woodard, and Greg Kendall

Defending against a PTSD claim requires taking a technical approach to discovery, engaging the right defense expert, and challenging or excluding altogether the plaintiff's expert's diagnosis and opinion.

In 1999, a domestic commercial flight went off the end of the runway into a flood plain. The accident killed 11 people. One of the surviving passengers recalled holding together a man's leg until rescue crews could arrive. Later, she was diagnosed with post-traumatic stress disorder (PTSD). She described her injuries as "afraid and depressed all the time." "I couldn't focus on anything, and I couldn't maintain relationships with my friends and family because I was always agitated and argumentative," she said. She alleged that the event caused her marriage to end and that she contemplated suicide as a result. Jennifer Wolff Perrine, *After Cheating Death, the Real Challenge of Living Begins* (January 4, 2011). http://www.nbcnews.com.

Decades of technological and policy advancements have greatly reduced the occurrence of physical injuries on commercial airlines. In the meantime, plaintiffs have increasingly asserted psychological injury claims with alleged significant value, especially PTSD. For several reasons, PTSD claims are difficult to value. Unlike physical injuries, which tend to be easier to prove through medical imaging or clinical examinations, PTSD consists largely of subjective symptoms that are difficult to verify objectively. Further, although physical injuries often come with medical bills and projected future treatment costs that help put a clear dollar amount on the value of a claim, the past and future monetary value of emotional harm is more difficult to assess. Lastly, jurors' reactions to arguments by attorneys and plaintiffs' experts regarding the debilitating nature of emotional trauma can be unpredictable. If an aviation-related PTSD claim is presented to a jury, testimony on the circumstances



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of the trauma and its effects on the individual can be compelling.

Recent aviation incidents reveal how plaintiffs' attorneys are attaching increasingly significant value to PTSD claims, even those unaccompanied by physical injury. Take, for example, the July 6, 2013, crash of Asiana Airlines Flight 214, which occurred when a Boeing 777 clipped the runway while attempting to land at San Francisco International Airport. Only three days after the incident, a personal injury attorney was quoted in the news as valuing each passenger's claim at $1 million or more. "Even the 123 passengers on the plane who escaped without any physical injuries are likely to see seven-figure settlements from the airline and its insurance carriers due to [PTSD]." Chris Isidore, *Asiana Passengers Likely to Get Millions*, CNN Money (July 9, 2013), http://money.cnn.com. The attorney continued, "PTSD is an insidious illness… many can't return to work. Even those who think they're fine and return to work, six months later they find out they're a blob on the floor, because it finally comes home to roost." *Id*.

Severe turbulence, emergency landings, aborted take-offs, in-flight altercations with passengers or crew members, and distressing messages from the cockpit are only a few examples of situations that create an opportunity for passengers aboard commercial and private aircraft to experience trauma.

In light of the increasing public awareness and medical recognition of PTSD, both of which affect the value of PTSD claims, this article offers a strategy for attorneys to evaluate plaintiffs' PTSD claims to determine whether they are supported by medical evidence or are simply opportunistic and lack the support of generally accepted medical and psychological diagnostic criteria. The key to defending PTSD claims is to understand what a PTSD diagnosis actually means.

PTSD Claims in Aviation Cases

Severe turbulence, emergency landings, aborted take-offs, in-flight altercations with passengers or crew members, and distressing messages from the cockpit are only a few examples of situations that create an opportunity for passengers aboard commercial and private aircraft to experience trauma. Even if these events are not associated with any physical injuries, a passenger may still allege emotional injuries as a result of the traumatic experience. Often, passengers do not undergo treatment for physical injuries; however, these same passengers may allege a claim with significant value centered on emotional distress.

Most of the case law regarding PTSD in the aviation context involves emotional damage claims on international flights, which are governed by the Convention for the Unification of Certain Rules for International Carriage by Air, otherwise known as the "Montreal Convention." May 28, 1999, S. Treaty Doc. No. 106-45 (200), 2242 U.N.T.S. 309. Aviation attorneys know well that the United States Supreme Court has held that plaintiffs may not recover under the Montreal Convention for *purely* mental injuries unaccompanied by physical injuries. *Eastern Airlines, Inc. v. Floyd,* 499 U.S. 530, 552 (1991).

As a result, the majority of courts have held that damages resulting solely from PTSD are not recoverable for international flights due to the Montreal Convention. For example, in *Bobian v. Csa Czech Airlines,* passengers brought claims for alleged PTSD when the airline flew through severe turbulence caused by a hurricane. 232 F. Supp. 2d 319, 324 (N.J. Dist. 2002). To satisfy the "bodily injury" requirement of Article 17 of the Montreal Convention, the passengers attempted to recharacterize PTSD as a physical injury, based on its effects on certain structures in the brain. Rejecting that argument, the U.S. District Court for the District of New Jersey stated, "PTSD is not a compensable injury under the [Montreal] Convention, and no expert recharacterization of emotional injury—or correlation of it with physical manifestations—will permit recovery for such injury under the Convention." *Id.* at 324.

Despite the Montreal Convention's clear prohibition against recovery for pure emotional distress damages, recent federal court opinions have suggested that future PTSD plaintiffs may be able to avoid that bar by making arguments based on evolving medical theories regarding the physical effects of PTSD on the brain. For example, in 2010, a passenger alleged PTSD after a confrontation that she had with a flight attendant while disembarking, which ultimately led to her arrest and detention. The U.S. District Court for the Eastern District of New York suggested that it would be willing to consider the argument that PTSD causes physical changes in the brain's structure, thereby permitting plaintiffs to avoid the Montreal Convention's bar against recovery for purely emotional injuries. However, the court held that the evidence in the case was insufficient to demonstrate a physical injury and withstand summary judgment. *Kruger v. Virgin Atl. Airways, Ltd.,* 976 F. Supp. 2d 290, 304 (E.D.N.Y. 2013).

The debate regarding the characterization of PTSD as a "physical injury" in the brain is likely to continue, and this may create a path for recovery for PTSD claims in future Montreal Convention cases. Additionally, plaintiffs may recover for PTSD arising out of domestic flights, which are beyond the reach of the Montreal Convention. Thus, aviation attorneys should familiarize themselves with PTSD and understand how to approach these claims in personal injury litigation.

In addition to the Montreal Convention, plaintiffs often must overcome common law limitations on the ability to recover emotional distress damages. Some jurisdictions require physical manifestations

of emotional injuries, documented treatment, being within the "zone of danger," or a physical impact experience of some kind. Analysis of state-by-state legal requirements for purely emotional injuries is beyond the scope of this article. Instead, this article assumes that these legal obstacles have been met. The article will instead focus on approaches to analyzing and challenging the validity of the underlying diagnosis of PTSD.

What Actually Is PTSD?

PTSD is a psychological condition that can occur when a person is exposed to a traumatic event, either as a direct witness or as a victim of physical or emotional trauma.

The term "PTSD" is frequently used, by plaintiffs and doctors alike, in an unscientific sense. Often, doctors label any subjective complaints of anxiety after an incident as PTSD. For instance, doctors frequently "diagnose" PTSD in the days after a motor vehicle accident, based on only a few subjective complaints, such as nightmares and anxiety. Depending on the precipitating trauma, many individuals are likely to experience some emotional effects for a few days or weeks afterward, which eventually resolve with time. However, such a diagnosis would not meet the criteria espoused by the DSM-5, the diagnostic manual of psychiatric illnesses written by the American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, (DSM-5)* 726 (Am. Psych. Press 2013).

The DSM-5 requires "exposure to actual or threatened death, serious injury, or sexual violence," which can include directly experiencing the trauma, witnessing the trauma occurring to others, learning that the trauma has occurred to a close family member or friend, or "experiencing repeated or extreme exposure to aversive details of the traumatic event." *Id*. The individual must exhibit one or more specific symptoms from four broader categories of symptoms:

- Intrusive thoughts or memories relating to the trauma ("re-experiencing"),
- Persistent avoidance of stimuli associated with the trauma,
- Negative alterations in cognition or mood associated with the trauma, and
- Alterations in arousal and reactivity associated with the trauma.

Id.

The disturbances exhibited in each of these categories must persist for longer than one month, must cause "clinically significant distress or impairment in social, occupational, or other important areas of functioning," and must not be attributable to a substance or another medical condition. *Id*.

The above definition provided by the DSM-5 is a substantial revision of the previous version, the DSM-IV-TR, with which many attorneys may be familiar. The DSM-IV-TR classified PTSD as an anxiety disorder and required that an individual be exposed to a traumatic event that resulted in feelings of "intense horror or helplessness." The DSM-5 reclassifies PTSD as a "trauma and stressor-related disorder" and emphasizes the temporal relationship between the trauma and co-occurring symptoms. This change helps mitigate claims involving secondhand exposure, such as hearing about a traumatic event. Brian P. Marx & Cassidy A. Gutner, *Posttraumatic Stress Disorder: Patient Interview, Clinical Assessment, and Diagnosis*, ch. 3, *in* A Practical Guide to PTSD Treatment 36-7 (Nancy C. Bernady & Matthew J. Friedman, eds., 2015).

When analyzing these PTSD claims, defense attorneys and insurance professionals can benefit from two general principles in the scientific literature. The DSM-5 criteria for PTSD demonstrate that a PTSD diagnosis requires more than mere exposure to trauma and more than just one or two particular symptoms. This means that PTSD is not a guaranteed outcome from every traumatic event. In fact, many people show surprising emotional resilience to even severe trauma, and only a small percentage of trauma victims actually go on to develop PTSD. Further, there is no singular pattern to PTSD; the nature of the trauma, and whether the trauma is a singular event or repeated occurrences, can affect the particular presentation of PTSD symptoms.

Within the civilian population, roughly 8 percent of people will face a traumatic event that results in PTSD. Gerald Rosen, *Risk-Factors and the Adversity Stress Model*, 2 Posttraumatic Stress Disorder: Issues and Controversies 15, 16 (2004). A variety of factors affect an individual's predisposition to developing PTSD, including demographic background, personality, and the factual circumstances of the trauma. For example, bereavement, depressive symptoms, and physical injuries were found to contribute to PTSD vulnerability in a study of survivors of the Tuninter Flight 1153 in 2005. Catenesi *et al*., *Posttraumatic Stress Disorder: Protective and Risk Factors in 18 Survivors of a Plane Crash*, in 58 J. Forensic. Sci. 5 (Sept. 2013). Individuals who are of lower socioeconomic or educational status, or who are divorced, widowed, unemployed, elderly, adolescent, or children, are also thought to be more vulnerable to developing PTSD. *See* Ayesha S. Ahmed, *Post-Traumatic Stress Disorder, Resilience and Vulnerability*, *in* 13 Advances in Psychiatric Treatment 369–375 (2007).

In addition to the Montreal Convention, plaintiffs often must overcome common law limitations on the ability to recover emotional distress damages. Some jurisdictions require physical manifestations of emotional injuries, documented treatment, being within the "zone of danger," or a physical impact experience of some kind.

Symptoms differ by case, but civilians who experience multiple traumas typically exhibit different symptoms than those who had a single traumatic experience. Hagenaars *et al*., *The Effect of Trauma Onset and*

Frequency on PTSD-Associated Symptoms, 132 J. of Affective Disorders 192, 192 (2011). Multiple traumas are also associated with higher levels of dissociation, anger, guilt, and shame. Symptoms also depend on the type of trauma. For example, assault victims are more likely to have suicidal ideations or to attempt suicide than victims of some other types of events. Holly C. Wilcox *et al.*, *Posttraumatic Stress Disorder and Suicide Attempts in a Community Sample of Urban American Young Adults*, 66 Archives of General Psychiatry 305, 305 (2009).

Most doctors believe that they understand and can accurately diagnose PTSD, but studies have shown that even experienced practitioners can issue false positive diagnoses.

Using the diagnostic criteria as a foundation, insurance professionals, defense attorneys, and their experts can approach PTSD claims with a critical eye and evaluate the strengths and weaknesses of these claims on a case-by-case basis.

An Approach to Litigating PTSD Claims

PTSD is a complicated diagnosis that relies heavily on a plaintiff's subjective experiences rather than easily observed signs. When evaluating a case, an attorney can keep in mind two basic premises. First, specific diagnostic tools and methods exist in the medical and psychological community to confirm and validate the existence and severity of the condition. Therefore, defense attorneys should collect as much information as possible for a defense expert to review so that the expert can review a plaintiff's alleged symptoms critically. Second, the defense expert retained to analyze a PTSD claim must know how to analyze a plaintiff's symptoms with established diagnostic criteria and evaluation tools. A solid defense against PTSD claims requires understanding the diagnostic criteria and understanding the specific types of professionals that are qualified to make such a diagnosis. Focusing on these two premises, the defense plan begins with a technical approach to discovery by the attorney, followed by detail-oriented methodology from PTSD experts.

Discovery for Emotional Distress Claims Requires Careful Evaluation of Each Claimant's Complaints, Treatments, and Diagnoses

A technical approach to discovery for the attorney consists of (1) crafting discovery to obtain details on the nature and extent of a plaintiff's alleged PTSD symptoms; (2) collecting all of the data regarding the alleged PTSD symptoms (including statements, medical records, and social media); and (3) comparing the plaintiff's alleged PTSD symptoms with the current literature on PTSD.

Identifying a plaintiff's *specific* PTSD symptoms is essential to the discovery process in PTSD cases. In addition to medical records, important sources of information are witness statements, educational and employment records, and social media activity. Other individuals close to the plaintiff—significant others, family members, co-workers, and friends—may be valuable sources of information regarding objective symptomology and impairments in relationships and social, vocational, and educational functioning, as well. If these sources of information do not provide sufficient detail regarding the plaintiff's subjective experience, the symptomology should be explored in detail in the plaintiff's deposition.

Next, the plaintiff's symptoms must be compared against the current literature on PTSD. How well do the symptoms match the currently accepted diagnostic criteria for PTSD? At this stage, it is helpful to consider whether the complaints match the patterns associated with civilian PTSD versus military PTSD. Plaintiffs often report combat PTSD symptoms similar to those seen in movies, but the scientific literature has shown significant distinctions between the civilian PTSD due to an accident and the combat PTSD suffered by military veterans and portrayed by Hollywood.

Then, consider whether the plaintiff's medical providers have used the generally accepted diagnostic criteria and literature on PTSD to analyze the plaintiff's symptoms to arrive at their diagnoses. Understanding the depth and adequacy of the analyses done by the plaintiff's experts and treatment providers is important to evaluate the strength of the PTSD claims early.

Use Defense Experts Who Truly Understand PTSD, Will Evaluate the Claims Using Recognized Diagnostic Tools, and Not Rely Entirely on Subjective Symptom Reporting

Once an attorney has collected as much information as possible, it is time to select a detail-oriented PTSD expert. The right PTSD expert must know how to analyze the facts and determine the validity and severity of the PTSD diagnosis. Most doctors believe that they understand and can accurately diagnose PTSD, but studies have shown that even experienced practitioners can issue false positive diagnoses. Many doctors diagnose PTSD merely based on a person having psychological symptoms after a traumatic event. They often do not have a PTSD definition that they can point to, and they do not follow the DSM-5 requirements. Therefore, it is essential that defense attorneys retain experts who take an objective approach to diagnosing PTSD and use identifiable diagnostic criteria.

First, as with all experts, consider the depth of the expert's experience with PTSD. Retain a defense expert who knows the appropriate diagnostic criteria for PTSD and has clinical experience diagnosing and treating it in patients. In the same way that spine surgeons and ankle specialists are not the same even though both may be orthopedic surgeons, not all psychologists or psychiatrists have the same levels of experience diagnosing and treating PTSD sufferers. Ideally, the expert should have a demonstrated track record in the forensic evaluation of PTSD.

Second, ensure that the defense expert is thoroughly equipped to address the ever-present issue of malingering. The ease with which an individual can feign PTSD highlights the need for objectivity. However,

accusing a plaintiff of malingering should be done with caution because this can backfire without solid evidence to support it.

The DSM-5 defines malingering as the "intentional production of false or grossly exaggerated physical or psychological symptoms, motivated by external incentives such as avoiding military duty, avoiding work, obtaining financial compensation, evading criminal prosecution, or obtaining drugs." Am. Psychiatric Ass'n, *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, (DSM-5)* 726 (Am. Psych. Press 2013). This behavior is influenced by external factors that motivate individuals to exhibit symptoms falsely for their personal benefit—whether they seek financial gains, outside attention, or relief from their work responsibilities. Practitioners should consider malingering when one or more of the following factors are present at the time of the psychological evaluation:

- Medicolegal presentation;
- Marked discrepancy between the claimed distress and the objective findings;
- Lack of cooperation during evaluation and in complying with prescribed treatment; or
- Presence of an antisocial personality disorder.

Id.

Some practitioners (especially treating doctors) are hesitant to address malingering. Conversely, some defense experts tend to find malingering in every case without taking the steps necessary to validate such an opinion fully. There are many reasons why a person may report PTSD-like symptoms and not have PTSD. In some cases, it may be the result of undiagnosed or preexisting mental health issues that simply do not meet the diagnostic threshold for PTSD. Nonetheless, research has identified a variety of patterns in the symptoms of PTSD sufferers, and symptoms that do not follow those patterns may demonstrate malingering. For example, a malingerer's symptoms may resemble the symptoms shown in television or movie depictions of PTSD, while not demonstrating some of the lesser-known symptoms associated with civilian PTSD.

Also, ensure that the expert will use all the available tools to analyze the PTSD claim. An accurate diagnosis requires more than just a clinical interview identifying a symptom or two. Clinicians are encouraged to use test instruments containing embedded validity measures to verify that a patient is reporting genuine symptoms. Jennifer Guriel, &William Fremouw, *Assessing Malingered Posttraumatic Stress Disorder: A Critical Review*, 23 Clin. Psych. Rev. 881, 901 (2003). Tests such as the Personality Assessment Inventory and the Minnesota Multiphasic Personality Inventory are designed to measure both the presence and severity of a person's subjective psychological symptoms and response biases that could indicate distortion or exaggeration of symptoms for secondary gain (such as financial compensation).

Leverage the Information Obtained Through Discovery to Exclude Diagnoses and Related Opinions that Are Not Based on Accepted Diagnostic Criteria

Although the DSM-5 diagnostic criteria are well-known in the relevant medical and scientific communities, the degree to which treatment providers or expert witnesses actually adhere to those criteria in litigation varies widely. We often encounter PTSD diagnoses issued by counselors or social workers who are only somewhat familiar with the DSM-5 criteria. Some diagnose PTSD based on a "look and feel" approach. On the other hand, we also encounter qualified medical experts who, despite being familiar with the diagnostic criteria for PTSD, apply them haphazardly and in a manner that benefits a plaintiff. Even experts that recognize the diagnostic criteria may fail to undertake the appropriate differential diagnosis required to diagnose PTSD and rule out other explanations for symptoms that they attribute to PTSD. Diagnoses and related opinions arrived at this way are ripe for exclusion through motion practice. Such exclusion requires obtaining the right information through discovery from a plaintiff and the plaintiff's experts.

Another area ripe for motion practice is an emerging but scientifically unproven theory explaining PTSD—that PTSD physically changes certain structures in the brain—thus turning a psychological condition into a physical brain injury. This approach, popular with the plaintiffs' bar, often relies on advanced neuroimaging techniques such as diffusion tensor imaging (DTI), positron emission tomography (PET), and other modalities in an attempt to demonstrate physical and functional changes in the brain. However, these neuroimaging techniques are not accepted by the medical community to diagnose PTSD. Nor is the theory that PTSD causes brain damage generally accepted by the scientific community. Both of these approaches should be challenged vigorously through cross-examination and motion practice.

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Conclusion

The proper defense against PTSD claims requires taking a technical approach to discovery, through which an attorney identifies the universe of a plaintiff's alleged symptoms. A defense expert can then determine whether the alleged PTSD claims are consistent with the current understanding of PTSD in the medical literature. If the plaintiff's claims are questionable, a technical cross-examination of the plaintiff's medical and PTSD experts can reveal a basis for an evidentiary challenge. This technical approach can assist with an accurate, early case evaluation or settlement and create a framework for excluding unsupported expert opinions before trial.