

The Nature and Treatment of PTSD – Implications for Legal Client Care

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Opening of *Iliad* Book XXIV

[The siege of Troy has finally ended. Achilles, the greatest of the Greek heroes, has slain Hector in revenge for the death of his comrade and close friend Patroclus. The Games held to mark the end of the War have finished.]

“The games were over. The soldiers left the ring and scattered to their several ships: they were thinking of their supper and a good night’s rest. But Achilles went on grieving for his friend, whom he could not banish from his mind, and all-conquering sleep refused to visit him. He tossed to one side and the other, thinking always of his loss, of Patroclus’ manliness and spirit, of all they had been through together and the hardships they had shared, of fights with the enemy and adventures on unfriendly seas. As memories crowded in on him, the warm tears poured down his cheeks. Sometimes he lay on his side, sometimes on his back, and again on his face. At last he would get up and wander aimlessly along the salt sea beach. Dawn after dawn as it lit up the sea and coastline found Achilles stirring...”

Translated by E V Rieu

The definition and nature of PTSD

Definition

1. This paper will deal with the present definition of PTSD, the modern understanding of the condition and contemporary treatment approaches. The aim in the second half will be to alert lawyers to the ways in which this knowledge can be used to the advantage of their clients. Many will ask in conference questions such as “What is this cognitive behavioural therapy recommended by the psychiatrist? I am not going to a counsellor.” They often claim that they are unwilling to take the anti-depressant medication suggested.

While it is not the role of the lawyer to take on the mantle of doctor or therapist, the lawyer's role certainly includes supporting the client and dispelling their fears when they arise and not leaving them to fester.

2. It should be the common aim in litigation for the relationship between lawyer and client to be one of mutual trust and understanding. Without it in PTSD litigation nothing can be achieved: the client will be unable or unwilling even to recount the history of trauma fully or the current symptoms unless he has a rapport similar to that between patient and therapist. A repeated response of PTSD sufferers, when asked to give a detailed account, is to be dismissive, on the basis that no one who has not lived through the trauma and its effects can possibly understand. Unless this attitude, part and parcel of the condition, can be broken down the lawyer can do little to help his client, still less draft a proof of evidence which will withstand later scrutiny. The lawyer, even before the GP, is often the first person in whom the sufferer confides his suffering at all. There may be no outpouring, but a series of subtle signs from the history and presentation in interview to alert the specialist lawyer. As the first point of contact, the lawyer should do his best not only for the case, but to facilitate a proper diagnosis and therapy. In fact, there is little conflict between the legal and humanitarian roles. Even in eliciting and evaluating the evidence at a trial, allowances must be made for the witness' condition; and without an understanding of the effects of PTSD, often leading to the repression of the vital traumatic experiences, the wrong conclusions can easily be drawn.
3. It would require a paper of its own to describe the development and re-discovery of knowledge which led to the first formulation of PTSD as a discrete psychiatric disorder or illness in the 1980 edition of the American Psychiatric Association's (APA) Diagnostic and Statistical Manual - DSM-III. Homer's Iliad is probably the first of many historical descriptions of combat-related, post-traumatic symptoms, showing that such conditions are not a modern construct driven by an over-litigious or blame-seeking society.
4. DSM-III differed from its two predecessors in taking a primary phenomenological or symptom-based approach to classification. Conditions were defined by the symptoms a patient was required to demonstrate before a particular diagnosis could be properly made. PTSD was and is unique in this context in requiring, in addition to specific symptoms or

symptom complexes, an aetiological factor as part of the definition, in the form of a stressor event or events which precipitated the disorder.

5. Despite this extra diagnostic feature, PTSD was placed within the anxiety disorder section of DSM-III because of its symptomatology. Sufferers often have co-morbid depression; but PTSD is not a form of depression and many will not be depressed at all. However, when PTSD was included in the revision of the International Classification of Diseases (the European but less good classification for PTSD), ICD 10 in 1992, a separate category for disorders precipitated by stressful events was introduced, including PTSD.
6. DSM-IV was formulated in 1994 and the APA remained of the view that PTSD was correctly classified as an anxiety disorder. This remains the main stream view to this day. However, there were changes to the diagnostic formulation from DSM III and DSM III-R (Revised). DSM IV now reads as follows:

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

- (1) The person experienced, witnessed, or was confronted with an event or was involved in actual or threatened death or serious injury, or a threat to physical integrity of self or others.
- (2) The person's response involved intense fear, helplessness or horror.

B. The traumatic event is persistently re-experienced in one (or more) of the following ways:

- (1) Recurrent and intrusive distressing recollections of the event, including images, thoughts or perceptions.
- (2) Recurrent distressing dreams of the event.
- (3) Acting or feeling as if the traumatic event were recurring (includes a sense of reliving the experience, illusions, hallucinations and dissociative flashback episodes)
- (4) Intense psychological distress or physiological reactivity at exposure to internal or external clues that symbolise or resemble an aspect of the traumatic event.
- (5) Physiological reactivity on exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event

C. Avoidance of stimuli associated with the trauma and numbing of general responsiveness (not present before the trauma) as indicated by three (or more) of the following:

- (1) Efforts to avoid thoughts, feelings or conversations associated with the trauma.
- (2) Efforts to avoid activities, places or people that arouse recollections of the trauma.
- (3) Inability to recall an important aspect of the trauma.
- (4) Markedly diminished interest or participation in significant activities.
- (5) Feeling of detachment or estrangement from others.
- (6) Restricted range of affect (e.g. unable to have loving feelings)
- (7) Sense of a foreshortened future (e.g. does not expect to have a career, marriage, children or a normal lifespan)

D. Persistent symptoms of increased arousal (not present before the trauma) as indicated by two (or more) of the following:

- (1) Difficulty falling or staying asleep
- (2) Irritability or outbursts of anger
- (3) Difficulty concentrating
- (4) Hyper vigilance
- (5) Exaggerated startle response

E. Duration of the disturbance (symptoms in criteria B, C, and D) is more than one month.

F. The disturbance causes clinically significant distress or impairment in social, occupational or other important areas of functioning.

Specify:

Acute: if duration of symptoms is less than three months,

Chronic: if duration of symptoms is three months or more.

Specify:

With delayed onset: if onset of symptoms is at least six months after the stress.

7. The principal changes from DSM III were to category A, the so-called 'gate-keeper' criteria, related to the precipitating trauma. DSM-III had required this to be "outside the run of normal human experience" and such as "would evoke significant distress in almost everyone" and ICD-10 uses an essentially similar formulation. This was an objective criterion. DSM-IV does more to recognise the subjective nature of human experience. The emphasis now is on how the individual actually reacted to the stressor and this is an

area which must be covered properly in the witness evidence. The sufferer often cannot give a good history of what happened during and immediately after the stressor and the best way is to make the case through onlookers describing the behaviour. Further, category A(1) recognises the importance of a threat to others as well as the patient in provoking symptoms, whilst A(2) can be satisfied not only by the engendering of *fear* but also by feelings of *horror* or *helplessness*. This encompasses the reactions of soldiers to the brutalities as witnessed in Bosnia, when they came upon them after the event or were unable to intervene during the perpetration because of the restrictive conditions of engagement.

8. Criteria A (1) and (2) are conjunctive requirements and the satisfaction of both criteria is a point to be proved in all cases.
9. Despite the expansion and re-definition of the aetiological or stressor criteria, PTSD retained the classification of an anxiety disorder within DSM-IV because of the significant overlap between many of the symptoms of PTSD and those of other forms of anxiety disorder. Symptoms of fear and avoidance such as those defined in C(1) and (2) are typical of anxiety disorders generally and phobic problems in particular. Generalised Anxiety Disorder (GAD) produces symptoms of increased arousal such as hyper vigilance, irritability, concentration difficulties and insomnia.
10. These anxiety-like symptoms are important to the present theoretical understanding of PTSD, as is Criteria A(2) above, the subjective response at the time of the material event(s). There are two principal approaches to understanding PTSD: psychological and psychobiological, giving rise to separate but synergistic treatment strategies. Whoever can knit the two approaches together will likely receive the Nobel Prize.

Psychological Theories

11. There are many different and overlapping theoretical ways of approaching PTSD as a mental phenomenon and while what follows is a reliable guide, it is also a considerable simplification.

12. It can be seen that many of the symptoms described in Criteria B and C of the DSM-IV definition relate to memories and to ways of avoiding painful recall of events, even to the point of significant limiting of activities. Sufferers often live in turmoil, or a cycle, in which sometimes memories intrude to overwhelm them, so that they live in the past, stuck at the time of the trauma; later, avoidance mechanisms succeed but at the expense of anxiety/somatic symptoms. The cycle can go round many times, sometimes with PTSD in partial remission only to come raging back. In PTSD it is clear that the traumatic event is not dealt with or 'processed' in the same way as other, less overwhelming, life events or experiences. Memory of the event is not laid to rest, to be recalled only voluntarily or perhaps not all, but continues to affect or even dominate the present and to blight the future.
13. In addition to the problems of memory *per se* there are then maladaptive responses to the unwanted recollection of events. It is these responses that give rise to some of the most damaging symptoms in terms of the ability to function effectively in society.
14. Taking these primary propositions as the starting point it is illustrative to consider two specific theoretical approaches, which derive from distinct therapeutic traditions; Psychodynamic Theory and Emotional Processing Theory.

Psychodynamic Theory

15. The psychodynamic approach to PTSD derives from Freudian psychoanalysis and the tension between the unconscious and conscious mind. In anyone faced with an overwhelming traumatic experience, the individual's mental defences against trauma are mobilised. There is an attempt to master the traumatic memories through repetition and, at the same time, a paradoxical attempt to avoid the same memories. The same psychic defences are employed in response to bereavement or other stressors that would not satisfy the 'gate-keeper' or category A criteria in PTSD.
16. In most cases, these defences are successful, and a new state of balance or equilibrium is achieved so that the individual is able to move on in life. In cases of PTSD this normal adaptive process is simply overwhelmed by the magnitude of trauma as it affects that particular individual with his or her personal characteristics and history. This causes

sufferers to become 'stuck' in the process with their defence mechanisms entangled with the very traumatic impressions against which they are meant to defend. The resulting Freudian 'complexes' manifest themselves in the observable symptoms of persistent reliving of the experiences and/or avoidant or numbed behaviour. Psychodynamic therapy is therefore aimed at helping the patient work through this stuck position to achieve equilibrium once again.

Emotional Processing Theory

17. This is based on the premise that anxiety disorders, including PTSD, result from the mental 'processing' of the traumatic event or the stimuli giving rise to the emotion of fear. In situations of real danger, the danger or 'fear stimulus' evokes a mental response or 'fear programme' leading to the feelings of fright we are all familiar with and which pass off again once the danger has been eliminated or escaped. But the successful laying down of memory is an important part of the human condition.
18. Primitive man needed to know for future encounters, having survived attack by a lion, of its dangers so as to have the body primed for fight or flight upon its first detection. This gives him a practical and evolutionary edge over the competition. If, however, the memory of the lion's attack is laid down wrongly, so that the same response of fast heart beat, collywobbles, anxiety etc is elicited by subsidiary features of the attack or memories, our ancestor's whole life can become a fight or flight situation. The same fear response might be generated, where there is necessarily contact with animals, by seeing or thinking about a smaller cat, or an animal with brown fur, or any animal with a tail, and so on. The whole world, erroneously, is perceived as a dangerous place.
19. In PTSD there is abnormal processing of information relating to the danger or threat. The 'fearful stimulus' results not in a passing, adaptive response to danger but to altered thought and behaviour patterns. In essence, the traumatic event gives rise to an abnormal mental programme or 'fear structure' which, once present, can then be provoked or caused to 'run' by a variety of stimuli associated with the original danger and not simply re-exposure to that danger or 'fearful stimulus'.

20. The variety of stimuli that can evoke the ‘fear structure’ and the unpleasant emotions and feelings unleashed give rise to the distorted belief that the world is full of danger. Simple every day sensory experiences may give rise to intense feelings of fear with or without active recall of the original trauma. With so many different triggers evoking a disabling fear response, the sufferer perceives the world differently and that danger is all around. This is the first of the two principal abnormal cognitions or beliefs in PTSD, encapsulated as ‘the world is extremely dangerous’.

21. In the modern world, the criminal offence of rape is a highly potent cause of PTSD. A woman is raped by a young, bearded, red-haired man in a lift generating intense fear but she is unable to resist. Thereafter, the fight or flight response might be triggered by travelling in a lift or seeing a lift on television – a reasonably contained response. It might, however, be triggered when she sees a bearded, red-haired man; or any man with red hair, or any man with a beard, or any young man, or indeed any man at all. By the final stage, the whole world has truly become an overwhelmingly dangerous place, likely to trigger a fight or flight response. It is no surprise that the woman will not sit with her back to the door in your office, but position herself so that she can see everything as she constantly monitors the world for danger.

22. In addition, the sufferers’ recollection of their own thoughts and actions during the traumatic event is *distorted* by their ‘fear structure’. This gives rise to the further damaging belief that they themselves are no longer competent to deal with life. The feeling may be manifested in many ways, including guilt at surviving when others have perished or shame for perceived inaction at the time. This altered perception of self is summarised in the second fundamental erroneous cognition in PTSD as ‘I am extremely incompetent’. It explains why rape, in which the woman feels incompetent to resist, and irrationally guilty thereafter for not resisting, is the potent cause of PTSD that it is.

23. If our primitive man was in a group at the time of the lion’s attack and over-reacted, or flunked what the group expected of him to beat off the attack, this too is a potent factor in the causation of PTSD. In terms of combat, the soldier reacting in this way feels a coward in a band of heroes, guilty and incompetent. He is almost certainly wrong in terms of the remainder of the band, who are likely to have been intensely fearful in combat too, but not showing it as blatantly; but that he may have been right about his

own poor performance by the standards expected of the regiment only makes it more difficult to treat his almost inevitable PTSD later.

24. Relatives in a clinical negligence case, who have witnessed appalling suffering or the death of a loved one, are quite likely to have PTSD when you meet them in conference. They are particularly prone to the corrosive belief that they were incompetent to intervene and save their loved one, helpless while the doctors they trusted made mistakes. That the law does not give them a remedy in damages, unless the PTSD can be shown to flow from what it narrowly defines in terms of *proximity* and as being induced by *shock*, does not make PTSD arising out of a series of cumulative insults any less real or severe – but see the recent cases of *North Glamorgan NHS Trust v Ceri Ann Walters* [2002] EWCA Civ 1792, [2003] Lloyd's Rep Med 49 and *Giulietta Galli-Atkinson v Sudbaker Seghal* [2003] EWCA Civ 697, [2003] Lloyd's Rep Med 285. Those who have witnessed a relative in ICU, or nursed a husband with mesothelioma have a right to our compassion and help even if, perhaps especially if they have no case or come to us in respect of a Fatal Accidents' Act claim. The problem for such people is that, just as the first erroneous cognition of *danger* expands to fill the whole world, so too the second erroneous cognition of *incompetence* spills over from the direct context of nursing, medical intervention, or wherever the stressor originated, into the wider aspects of life.
25. Modern psychotherapeutic approaches are aimed at correcting these two abnormal cognitions and will be expanded on below.

The Psychobiology of PTSD

26. The psychobiological approach to PTSD is based on observable physiological and neurological responses to stressful stimuli whether external as in, say, images or reminders of the original trauma or internal as in memories of the event(s).
27. We are all familiar with some of the basic physiological responses to danger, such as the rise in heart rate, which prepare us to respond by 'fight or flight'. The overall bodily responses to danger are complex and are mediated by a combination of hormonal and nervous system activity giving rise to changes in activity in a number of organs or functional systems. It is accordingly necessary to deal with some basic principles of

anatomy and physiology in order to understand the place of contemporary pharmacotherapy in the treatment of PTSD.

28. In any part of the nervous system, nerve impulses or signals are transmitted between nerve cells, or neurones, at junctions known as synapses. There is no physical connection between neurones meeting at a synapse. Transmission of the signal across the synapse is achieved by the release of a chemical, or neurotransmitter, by the 'upstream' or pre-synaptic neurone. The neurotransmitter molecules then bind temporarily to specific receptor sites in the cell wall of the 'downstream' or post-synaptic neurone. This process is likened to a lock and key arrangement. If sufficient numbers of receptors are bound in this way they trigger the onward transmission of the signal in the post-synaptic neurone. Neurotransmitter molecules that are not bound, or are released by the receptors after activation of the post-synaptic neurone, are subject to re-uptake by the pre-synaptic neurone. They may be stored for re-use or rendered inactive and broken down by specific enzymes.
29. Ultimately, the nerve impulse is conveyed to the 'target' organ or tissue that the individual nerve acts upon by a similar process of neurotransmitter release and uptake by the individual target cells. This may typically be the triggering of a muscle to contract or to relax. Within the brain, transmission of complex patterns of such neurotransmitter conveyed signals results in the generation of thoughts, emotions or behaviours.
30. It follows that nervous system activity, both centrally and peripherally, can be altered by, variously, altering [1] the release, [2] the uptake or [3] the breakdown of neurotransmitters. This is what the various drugs are aimed at doing in different ways.
31. Regulation by the nervous system of bodily functions that are not under conscious control is the function of the autonomic nervous system (ANS). The ANS has two anatomical and functional sub-components, the sympathetic nervous system (SNS) and the parasympathetic nervous system (PNS). The SNS and PNS are essentially antagonistic and, in very general terms, the SNS is excitatory and the PNS inhibitory. The SNS is accordingly the system principally involved in mediating the 'fight or flight' response and the neurotransmitters used in this are primarily noradrenaline and adrenaline. As a result this process is often referred to as the adrenergic response. It should be noted here that

noradrenaline and adrenaline are referred to as norepinephrine and epinephrine respectively in some texts.

32. Central control of the ANS is complex but only matters relating to the response to stressors are considered here. There are two principal central mechanisms that are involved in this, both involving the use of hormones. Hormones are chemical agents that are released into, and delivered by, the bloodstream. Accordingly they generally tend to have a less focussed effect than that resulting from the activation of any part of the nervous system, targeting a number of organs or systems at the same time.
33. When faced with a dangerous or stressful situation, the brain releases a hormone called Corticotropin Releasing Factor (CRF). CRF in turn activates the neurones in a specific area of the brain, the locus ceruleus. The locus ceruleus in turn activates the adrenergic response in the SNS but also stimulates other centres in the brain that mediate arousal, emotional reactivity and memory. These centres include the hypothalamus, the amygdala and the hippocampus.
34. CRF also activates another central response to stress, known as the General Adaptation Syndrome. CRF released by the hypothalamus is carried rapidly to the nearby pituitary gland where it provokes the release of Adrenocorticotrophic Hormone (ACTH). ACTH is carried by the bloodstream to the adrenal glands at the upper poles of the kidneys, which respond by releasing Cortisol. Cortisol has a widespread effect on the body by raising blood glucose levels to ensure an optimal supply of energy for muscle activity, such as wrestling the lion or storming the opposing trenches.
35. Cortisol has been called the stress hormone because blood levels are elevated during the normal human response to stress. When we feel butterflies in our tummies, it is the blood draining out of our guts in readiness for use elsewhere in response to a threat. Soldiers frequently lose control of their bowels in combat. In PTSD patients a paradoxical response has been observed with lower cortisol levels than in normal subjects exposed to the same stressor. This finding focussed attention on the hypothalamic-pituitary-adrenocortical (HPA) axis.

36. Serotonin is neurotransmitter that is involved in the function of both the adrenergic response of the SNS and the HPA axis. It has been shown to have a modulating effect on both systems. Serotonin is also thought to be involved in the mediation of a number of other emotional responses such as anger, depressed mood and panic, together with more complex problems such as impulsivity and obsessional thought. The modulation of serotonin is the main focus of modern drug therapies.
37. There is now research evidence that PTSD sufferers show abnormalities in their adrenergic, HPA, serotonergic and CRF mechanisms. The adrenergic system is more active and CRF levels are generally elevated. Advanced neuro-imaging techniques have demonstrated reduction of the volume of the hippocampus in PTSD sufferers. The responses to specific chemical challenges known to affect the serotonergic and adrenergic systems differ from those observed in normal subjects and may precipitate specific symptoms such as flashbacks. The research paves the way for litigation to distinguish the House of Lords' decision in *Morris v KLM Royal Dutch Airlines; King v Bristow Helicopters Ltd* [2002] 2 All ER 565 on the basis that *chronic* PTSD at least is a *bodily injury* within the meaning of Article 17 of the Warsaw Convention, as amended and set out in Schedule 1 to the Carriage by Air Act 1961. It is a shame that the evidence, which has been around for some time, was not presented to the court in those cases.
38. The abnormalities described here are characteristic of PTSD but much of the analysis may be relevant to other forms of disorder following trauma, in particular sub-clinical forms of PTSD where function is preserved despite serious symptoms.

Modern Treatment

Atmosphere of trust and safety – the first stage

39. The first stage in treating PTSD (or other forms of disorder following trauma) is to obtain an atmosphere of trust and safety between patient and therapist, to obtain a detailed history both to reach a reliable diagnosis and then to form the basis for treatment itself. It is emotionally threatening for PTSD sufferers to relinquish their cognitive, emotional and behavioural avoidance strategies, which they have used to cope with

intolerable intrusive recollections and arousal symptoms. This point is also vital when Claimants are interviewed by lawyers and doctors in a medico-legal context. It explains why the condition is often missed by lawyers when interviewing; and why doctors, often instructed by the Defendants and perceived as threatening, fail to obtain a decent history of the stressors and the subjective response, and deny the diagnosis of PTSD.

What to treat first?

40. Returning to the chronic case, having obtained the diagnosis or series of diagnoses in respect of PTSD and other post-traumatic disorders, the clinician must decide upon which elements of the diagnosis or constellation of symptoms to focus first. Where the patient is a psychiatric emergency because suicidal, homicidal or otherwise so out of control that he needs the safety, structure and control of an inpatient hospital setting, he must be hospitalised without delay. A discharge plan can be developed to implement PTSD treatment, along with other necessary measures, when the patient is ready to leave the hospital.
41. It may be unproductive to initiate PTSD treatment with someone who is too caught up in the addiction/intoxication/withdrawal cycle of alcohol and drugs to participate meaningfully in any psychotherapeutic initiative. In this sort of patient, treatment for alcohol/drug abuse may have to come first and may include inpatient detoxification and post-detoxification rehabilitation. During the acute withdrawal period within the first few days of detoxification, previous alcohol/drug-suppressed PTSD symptoms come raging to the forefront of conscious awareness and a co-ordinated approach is required.
42. Research reveals that about 80% of people with PTSD will have at least one other psychiatric disorder during their lives and sometimes the severity of the co-morbid disorder demands initial attention. The lawyer and medico-legal expert should always be on the look out for other disorders and previous PTSD may be in comparative remission so as not to warrant a current diagnosis of PTSD as such. As to treatment, severely depressed individuals (with co-morbid PTSD), who may not need to be hospitalised, may still need aggressive treatment for depression before PTSD treatment can be considered. The same is true for people with an immobilising panic disorder or other psychiatric problems that are currently more incapacitating or potentially dangerous than the PTSD.

There may often be a disabling phobic anxiety associated with driving following a road traffic accident, with or without a PTSD, which requires to be addressed in its own right.

43. Whether or not there is any additional psychopathology, in some instances family, vocational or environmental complications will require addressing. The family dynamic, with the spouse at their wits' end, is often to be detected in conference. It should not be ignored so that the couple have split by the time of the next conference: the lawyer must gently guide the couple to the appropriate therapists. If they will not go, at least the lawyer has tried. Family therapy may be necessary in some cases before the PTSD is tackled. In others, family/marital therapy may be concurrent with, or subsequent to, specific PTSD treatment. We have all seen the complications of PTSD leading to the break down of family relationships: the maintenance of the family unit may be the first priority if it is on the rocks.

44. The central point here is that treatment of PTSD or other post-traumatic disorders must be aimed at the individual as whole, as a matter of clinical judgement and bearing in mind any relevant factors that will affect the treatment programme. Client handling in the legal context will require a widespread knowledge of the consequences of trauma. All lawyers specialising in PI litigation should be alive to the possibilities of claims for disorders other than PTSD. We also owe our clients a duty to act not only to maximise damages but to point them in the direction where they can obtain proper diagnoses and treatment. Early diagnoses lead to straightforward claims for interim payments and proper treatment through specialists, usually lacking in the NHS and always with waiting lists preventing effective early intervention. Those still suffering from significant distress after 3 months, or by the time they get to a lawyer, always require early skilled intervention.

Psycho-education

45. The establishment of trust and safety required by the clinician in order to elicit the history and reach the diagnosis at all, in a condition such as PTSD, where denial and avoidance is part of the condition, must be extended further to the patient as a sound basis for treatment itself. At this point psycho-education is useful, both to establish the safety and trust but also as an introduction to more intensive treatment. The first step in any

therapeutic undertaking is to make sure that patients understand the nature of PTSD and its effects on them. They need to understand how their various symptoms fit into a coherent picture; that they are not losing their minds; and that many other people have suffered or are suffering in a similar way after exposure to catastrophic stressors. This psycho-educational intervention is an extremely powerful and productive way to initiate therapeutic activity. Most feel substantially better just for having been told this simple message and it should not be beyond the wit of the lawyer suspecting PTSD to give such simple reassurance. It helps them to recognise that they are not mad. It relieves the feelings of stigma and shame, which are such powerful erroneous cognitions within the psychological mechanisms underlying PTSD. Lawyers, if they understand the basics, can provide some psychological first aid for their clients in the form of support during interview and conference. The necessary legal investigations involve risk to their client's mental health, in relinquishing their avoidance strategies simply to tell their story, and this must be fully understood. Where a client becomes acutely distressed, the lawyer should try to institute some professional first aid immediately. Where a badly damaged client faces the trauma of giving evidence, or even a hostile medico-legal examination, the lawyer should ensure that the client is not to be left alone unsupported immediately afterwards; and in an extreme case might even approach an expert witness at court to see what can be arranged there and then.

46. There must be an attempt to alleviate self blame and self doubt. This is a powerful message that most patients/clients can hear readily. It is an important message to deliver quickly, because most patients/clients have not faced the overwhelming events as they would have wished, and have unrealistic feelings of self blame and doubt as to how they performed and how they coped. Many soldiers castigate themselves for not having been more heroic and for not having saved the life of a comrade or sacrificing their own. Psycho-education as to the normal human responses to overwhelming stress, including guilt, can be given by the lay lawyer. It may be the only way to end satisfactorily an intensely emotional and upsetting conference.
47. The final advantage of psycho-education, both in the acute and chronic context is to allow patients /clients to know that the clinician/ lawyer understand their problem at its most fundamental level. This rapid communication serves to convey that the giver deserves trust and is qualified to treat/help and allows patients/clients to make sense of

their disturbing and disruptive symptoms. It therefore will form the basis for the relationship required to bring the case to a successful conclusion and may be the only way to get a meaningful conference started. Subtle psycho-education, dropped casually into wider conversation at the beginning and end of a conference should be the order of the day.

48. No element of this psycho-education can conceivably be categorised as dangerous for the patient/client. In avoiding misunderstandings, removing self blame and self doubt and normalising the reactions of the sufferer during and after the event, one of the two main erroneous cognitions underlying PTSD - I am extremely incompetent - is assuaged.

Specific Therapy

49. Once an atmosphere of trust and safety has been reinforced through psycho-education, the clinician must decide in the chronic case how to address more specific therapy.
50. In terms of chronic PTSD and other post-traumatic disorders, the clinician has two main branches of therapy available as the second stage following psycho-education. In the first the clinician focuses upon the trauma itself and in the second provides supportive therapy. Trauma focus therapy encourages patients to explore traumatic material in depth, gaining authority over traumatic memories and taking control of their lives. It can be conducted in individual or group contexts with techniques that vary from psychodynamic approaches to cognitive behavioural approaches.
51. There is little doubt that cognitive behavioural approaches are the most effective in the face of modern research. Cognitive therapy began to be described by Beck in 1976 while behavioural therapy (of which the most important mode is exposure therapy) was substantially already developed by the 1970s.
52. While scientific evidence shows that trauma focus treatments are proven to be the most effective treatments to date, some patients with chronic PTSD have absolutely no wish to re-visit traumatic material, because they want to put the past behind them or they fear that they cannot tolerate the intrusive and arousal symptoms exacerbated by such memories. Hence, some patients, particularly those affected later by a profound sense of

guilt, may benefit more from supportive PTSD treatments that deliberately avoid traumatic material. They promote coping strategies and practical solutions for the anxiety suffered in the here and now. That some people cannot tolerate treatment in which they have to relive their stressors points to the delicate touch required when attempting to take a witness statement. All the lawyer's support and bedside manner must be employed. Ample time, indeed excessive time should be set aside for this purpose. Arrangements should be made for the spouse or a friend to be with, and stay with the claimant immediately after this big event. Whether the spouse or friend should be present in the interview is much more problematic – soldiers often say that the last person they can confide in is their wife, whom they protect from their own horrors and in front of whom they do not want to show weakness. If the client has already opened up to his wife or the proposed friend there may be no detriment in having them present: where there has been no previous outpouring, their presence may in fact inhibit the relating of the trauma.

Cognitive Behavioural Therapy

53. Cognitive Behavioural Therapy (CBT) is based on principles of learning and conditioning. Given the fact that PTSD develops when exposure to an overwhelming stimulus (the Criterion A1 event) elicits a profound emotional reaction (the Criterion A2 response) it is understandable why learning and conditioning models have provided such a powerful conceptual approach to PTSD. The sudden, intense anxiety experienced by a soldier in response to the sight and sound of an enemy attack in which his comrade has died is an excellent example of fear conditioning. Here the traumatic stimulus (the battle/death) automatically evokes the post-traumatic emotional response (fear, helplessness and horror). The intensity of this emotional reaction provokes avoidance behaviours that will reduce the emotional impact of such a stimulus. Some form of avoidance behaviour will be required to allow him to carry on with the fight and not to break down there and then. However, there is a price: successful reduction of fear/helplessness/horror, in turn, reinforces such avoidant behaviour, so that it will be repeated in the future in response to traumatic stimuli. The group of patients/clients who only coped through the trauma and afterwards through dissociation, often describing out of body experiences, are the most prone to PTSD later. The very strength of their ability to avoid the trauma at the time predisposes them to continued avoidance and a maladaptive response. These sorts of

case, frequent where people are trapped helplessly in motor cars, provide clinicians and lawyers with a psychological legacy demanding their fullest and earliest attention.

54. Many PTSD symptoms can be formulated in terms of standard psychological conditioning, which occurs in a two-stage process. [1] The fear conditioning, in which a trauma-related stimulus automatically evokes intrusion and hyperarousal symptoms. [2] The avoidant behaviour, activated by the powerful and intolerable psychological response in the first stage. Successful reduction of intrusion/hyperarousal symptoms will increase the likelihood that avoidant behaviours will be repeated in the future because of their protective value.
55. Various CBT approaches are designed to counteract these conditioned responses by attacking this two-stage process with different techniques. The ultimate goal is to normalise the abnormal feelings, thoughts and behaviours exhibited by those with PTSD. CBT has proven to be the best psychosocial treatment for PTSD in the current published literature.
56. Cognitive behavioural techniques used in PTSD treatment are most often used in combination with each other and include:
- Exposure Therapy – techniques aimed at disconnecting the overwhelming sense of fear from trauma memories.
 - Cognitive Therapy – techniques focussed on relearning thoughts and beliefs, generated from the traumatic event, and which are impeding current coping skills.
 - Cognitive Processing Therapy (CPT) – techniques that focus on the emotional and cognitive consequences of trauma exposure.
 - Stress Inoculation Training (SIT) – a variety of anxiety management techniques designed to increase coping skills for current situations.
 - Systematic Desensitisation – a technique designed to help patients substitute a relaxation response for the anxiety response typically elicited by a reminder of the trauma.
 - Assertiveness training – a technique focussing on the replacement with an *assertive* response of the *anxiety* response typically elicited by a trauma reminder.
 - Biofeedback and relaxation training – anxiety management techniques used to help patients master overwhelming feelings of anxiety elicited by a trauma reminder.

57. For the moment, the discussion will centre on exposure therapy and cognitive therapy.

Exposure Therapy

58. Exposure therapy was developed to separate the traumatic memory from the conditioned emotional response so that it no longer has the power to dominate thoughts, feelings and behaviour. The technique uses Imaginal Exposure: re-exposure of the patients to traumatic stimuli through mental imagery. Sometimes *In Vivo* exposure, in which patients confront the actual scene of the traumatic event (e.g. for a veteran returning to the Falklands), is also used in exposure therapy. In general the process of exposure is graduated, to allow the patient to build confidence, until the feared memory can be coped with. For a phobic disorder associated with driving, exposure therapy will involve firstly sitting in a car, then driving it a short distance not on a public road etc so that the conditioned response of fear is gradually overcome when the patient realises that he can actually cope. Our rape victim may be taken to a lift and introduced gradually in the same way.

Imaginal Exposure

59. In Imaginal Exposure, the therapist asks the patient to narrate the traumatic event. If there have been a number of episodes, the clinician asks the patient to construct narratives about the worst events they clearly remember. The clinician prompts the patient to close his eyes and visualise (imagine) what happened, while repeating the narrative several times during a single session. Initially, the patient will experience great anxiety as he begins to imagine himself back in the traumatic situation. He is asked to rate the level of subjective distress every ten minutes on a 10-100 Subjective Units of Distress Scale (SUDS), where 10 is no distress and 100 is the most fear/helplessness/horror he has ever experienced. Distress levels are usually in the 70-90 range during initial Imaginal Exposure sessions. However, through repeated exposure to the traumatic memory, the patient experiences a progressive reduction in distress levels so that they may fall to the 10-20 range by the end of a single session and remain at negligible levels by the end of an 8-10 session Exposure Therapy treatment.

60. Exposure Therapy abolishes the first-stage, conditioned emotional response evoked by traumatic stimuli. Patients recognise that the traumatic memories are just memories and cannot harm them in any way. Following successful exposure treatment, patients can confront these memories without having the recollections trigger intrusive/hyperarousal PTSD symptoms. If the conditioned emotional response can be abolished, avoidance symptoms are no longer relevant. If fear is not provoked, neither will maladaptive coping strategies. This is undoubtedly why this approach has proven to be the most effective treatment for PTSD so far.

Cognitive Therapy

61. Cognitive Therapy addresses the thoughts and beliefs generated by the traumatic event rather than the conditioned emotional response addressed by Exposure Therapy. Cognitive Therapy focuses on how individuals with PTSD have interpreted the traumatic event with respect to their appraisals about the world and themselves. For example, those who have been overwhelmed by a catastrophic stressor typically perceive the world as dangerous and themselves as incompetent. As a result, PTSD patients see themselves as perennial victims powerless to cope with life and take charge of their personal destiny. Such a belief system becomes a 'hard-wired', self-fulfilling prophecy.
62. In Cognitive Therapy, the first step is to identify automatic thoughts (such as the soldier thinking himself supremely incompetent) and to understand that although originally developed from the trauma, these thoughts currently hinder adaptive functioning. Secondly, the therapy focuses on correcting erroneous thoughts with more accurate information, replacing automatic, dysfunctional thoughts with more realistic and adaptive ones. Successful cognitive therapy creates an accurate appraisal of [1] situations as safe or dangerous, rather than believing automatically that all external events are dangerous; and [2] one's own strengths and weaknesses in different situations, rather than an automatic belief that one is personally incompetent and unable to cope with life's challenges.
63. Clinicians often combine Cognitive Therapy with Exposure Therapy (the main active ingredient in Behavioural therapy) to work on both the conditioned emotional response and inaccurate appraisals about the world and oneself. Hence the term Cognitive Behavioural Therapy or CBT.

64. Some clinicians combine what are essentially exposure and cognitive techniques in different ways, asking patients to write a thorough account of their traumatic experiences, taking their own time, as against relating it in more abrupt Exposure Therapy. On the other hand there are Cognitive Techniques which are supportive and help the patient to cope in the here and now. These techniques are important for those who cannot tolerate the distress engendered in Exposure Therapy. Lawyers will meet clients who are unable to give a decent history at all, even with support, and the instigation of therapy and the obtaining of corroborative evidence of the trauma and the response will be the only way forward.
65. The efficacy of Exposure Therapy and Cognitive Therapy is covered in the recent scientific literature. Rothbaum, Meadows, Resick and Foy produced a comprehensive review in *Effective Treatments for PTSD: Practice Guidelines from the International Society for Traumatic Stress Studies* edited by Foa, Keane and Friedman which leads to the following summary, by way of introduction only.

Exposure Therapy – Efficacy

66. PTSD symptoms were reduced by 26-80% across thirteen different studies with the preponderance of results indicating improvement greater than 60% in all three PTSD symptom clusters. Improvements were maintained at 6 months (2 studies) and 12 months (1 study).

Cognitive Therapy – Efficacy

67. Two studies comparing Cognitive Therapy with Exposure Therapy found both equally effective, producing 60-70% improvement in PTSD symptoms.

Exposure plus Cognitive Therapy – Efficacy

68. Given the efficacy of each treatment separately, one might expect that combining these two CBT treatments would produce better results. This has not been found to be the case. Combined Exposure/Cognitive treatment results in the same success rate as either

treatment alone, producing the same 60-70% symptom reduction obtained with the one treatment alone. Nevertheless, it is often difficult in practice to differentiate entirely between exposure and cognitive elements within a treatment regime.

Psychodynamic Psychotherapy - Efficacy

69. Psychodynamic Psychotherapy has been used to treat post traumatic disorders for over a hundred years. Psychodynamic theory focuses on psychic balance, which sometimes can only be achieved when the patient forces intolerable thoughts and feelings out of conscious awareness through the process called repression. However, these now unconscious traumatic memories are still powerful enough to become expressed as symptoms, such as PTSD's intrusion, avoidance/numbing, and hyper arousal symptoms.
70. Psychodynamic treatment seeks to understand the context to the traumatic memories, and the defensive processes through which the unconscious transforms repressed memories into the maladapted symptoms that initially drive treatment. Psychodynamic therapists presume that those exhibiting PTSD symptoms have an abnormal psychological balance, due to repressed memories and symptom formation. According to psychoanalytic theory, simply focusing on symptom reduction can achieve little as long as repressed memories remain.
71. Using a process called working through, the clinician helps the patient understand the meaning of each unconscious process, to achieve a balance between traumatic memories, external demands, and subjective needs. Working through requires the clinician to maintain a stance of neutrality within the intense, therapeutic relationship. This allows patients to project feelings about "significant others" on to the clinician, bringing feelings and behaviours related to major relationships in the patient's life into the dynamic relationship between the patient and clinician for thorough exploration. By exploring these feelings and behaviours, patients gain insight into how their repressed memories (along with associated thoughts and feelings) have been transformed into their current symptoms. Ideally, this awareness helps the patient better to control the repression defence, ultimately leading to fewer symptoms.

72. Psychodynamic treatments can vary from 12 sessions to numerous sessions over years. Longer Psychodynamic treatments seek to create a fundamental change in psychic balance, while briefer forms (12-15 sessions) seek to foster improved self-understanding and ego-strength.
73. Brief Psychodynamic Psychotherapy (BPDP), conducted within 12-15 sessions, focuses on the traumatic event itself. Through the recounting of the story of trauma to a calm, impassive, compassionate and non-judgmental clinician, the patient achieves a greater sense of self-cohesion, develops more adaptive defences and coping strategies, and successfully modulates intense emotions that emerge during therapy. While working through the traumatic memories, the clinician also addresses the link between post traumatic distress and current life stress. Patients learn to identify current life situations and environmental triggers that set off traumatic memories and exacerbate PTSD symptoms.
74. Brief Psychodynamic Psychotherapy therefore has goals similar to those of Exposure/Cognitive Therapy but it uses different conceptual underpinnings and therapeutic techniques. Given those techniques, focusing primarily on psychic processes rather than psychiatric symptoms, it is difficult to attain efficacy studies. However, there is a voluminous and rich literature on psychoanalytical psychotherapy going back for decades. During the course of therapy the patient often undergoes an abreaction, or sudden outpouring of emotion, (which incorporates elements of Exposure Therapy into the treatment) and it may be that this element is important to its overall efficacy.
75. Given the intensity of time required between therapist and patient, and the prevalence of Behaviour/Exposure Therapy and Cognitive Therapy in the UK compared with the USA (where apparently endless Freudian counselling is still in vogue as an industry), it is to CBT that clinicians and lawyers here should direct their main attention. No one will pay for psychotherapy spanning years. This is not to say that in skilled hands Brief Psychodynamic Psychotherapy is ineffective. The one randomised clinical trial on its efficacy involved its use for 18 sessions and compared it with hypnotherapy and systematic desensitisation. Brief Psychodynamic Psychotherapy effectively reduced PTSD intrusion and avoidance symptoms by about 40%, which was sustained at three

months, and the measure was the result of comparison with the two other treatments (and significantly greater than the waiting group list which received no treatment).

Eye Movement Desensitisation and Reprocessing (EMDR)

76. EMDR is a relatively recent technique which has influential and vociferous supporters in the UK. Research reveals that it is essentially the other elements of Exposure and Cognitive Therapy inherent in the technique which account for its success. Again, in skilled hands it has its place; and it may certainly be tried where other methods of treatment have failed.

Marital/Family Therapies

77. These therapies are largely self-explanatory and best used in combination with other therapies. They focus on symptom relief through increasing help and understanding in the family unit – psycho-education again. Clinicians often use marital and family therapy to treat those with PTSD because the patient's symptoms can produce a major disruption to the entire family. The marriage or family suffers from secondary traumatisation as a result of living with the PTSD sufferer exhibiting his symptoms. Further, the avoidance/numbing symptoms in PTSD prevents normal emotional expression and closeness, which is often misunderstood by family members who blame themselves, sometimes becoming depressed and often withdrawing to protect themselves from additional disappointment. In short, marital or family therapy helps to alleviate these problems and to promote a more salutary healing environment for the patient.

78. Apart from its role in the treatment of chronic PTSD, a generally supportive environment is now known to be important in the aftermath of the initial trauma. Indeed lack of support following trauma is the single largest vulnerability factor leading to chronic PTSD. Support, both from family and from unit/regiment in the forces, upon return from combat reduces the risk factor for PTSD. How often do we hear PTSD sufferers complain after an accident at work that their manager did not even come to visit them in hospital, or that the Occupational Health Department has treated them shabbily? We should not make the same mistake and matters worse: support from the legal team later

on is a logical extension of the support to be given immediately following trauma.

Group Therapy

79. How often do we hear clients say, “I am not sitting around discussing my private fears and upset with strangers?” A brief word of encouragement and explanation from the lawyer may just make the difference to persuade our client to attend the first meeting.
80. Group Therapies can utilise any of the main techniques of cognitive, behavioural, psychodynamic or supportive focus. Group Therapy is effective and popular for those who have all survived the same type of trauma, such as that engendered in combat. However, an homogenous group is not essential for its success, as the groups at Ticehurst have shown. As members of the group share experiences, they become connected to one another through recognising their common human fears, frailties, guilt, shame and demoralisation. Through the guidance of the clinician these thoughts, feelings and behaviours are validated and normalised. More adaptive coping strategies are acquired and symptoms reduced. Meaning can be derived from the traumatic experience.
81. In a cognitive behavioural focus therapy group, the same concepts are applied as in individual therapy. By way of example, one specific group approach uses Exposure and Cognitive Therapy where the clinician guides one group member at a time through a typical exposure session followed by cognitive restructuring. During the session, the other members are vicariously exposed to their own traumatic memories through the observation of another’s treatment.
82. Group members do more for each other than provide social support. They validate one another’s post traumatic reactions, share their struggles to cope with PTSD-related problems and provide honest criticism of maladaptive coping behaviour, but from a sympathetic and accurate empathy arising out of their own experience. Group members carry out homework assignments in which they focus or expose themselves to traumatic material, through writing exercises or repeatedly listening to an audiotape previously recorded during a group session in which they underwent exposure to their own traumatic material.

Integration following Treatment

83. Whether the treatment is done individually or in a group, having obtained authority and control over their symptoms, patients are then in a position to disconnect from their previous preoccupation with traumatic memories and to reconnect with their future lives, families, friends and work. Hence, the final sessions of treatment usually focus upon these positive aspects, with marital and sexual therapy and the drawing up of future job and life plans. This, after all, is what we as lawyers have to do in presenting the claim for future losses. How much better if this has been addressed in treatment and the notes support the way the case is put? The uncertainties in the litigation are considerably reduced and medical support will be there for the future loss claim. Better still if the client has acted on the therapy and established himself in a new way of life.
84. Here it is important for lawyers to understand that in facilitating early treatment they do not necessarily reduce the damages substantially. Where treatment has not been tried there will be inevitable discounts in the assessment of damages for the chance of later recovery, even if explicit arguments are not raised over failure to mitigate the loss through treatment. However, it is common as part of successful therapy for the patient to reorient life ambitions. It extremely common for patients, even if notionally “cured” (there is always a risk of relapse), not to return to previous employment, and quite reasonably so. A supportable claim for retraining and a continuing partial loss of earnings and pension usually results, leaving the case with a substantial value and, more importantly, a much happier client and his family. Nevertheless, always remember to cover the possibility of relapse, even if in the form of a modest sum for Loss of Earning Capacity and further treatment based on the chance of relapse.

Social Rehabilitative Therapies

85. For those so severely afflicted by chronic PTSD that they are unable to sustain a marriage, support a family, maintain gainful employment or even care for themselves, more radical social rehabilitative therapies can provide some quality of life. Patients may be homeless, living on the fringes of society, primarily supported through State benefits. At this point, when candidates are not suitable for the psychotherapies already described, the recommended approach is through psycho-social rehabilitation. A wide spectrum of

interventions designed to improve the functional capacity, social interaction and quality of life are provided for those with PTSD who are the most severely avoidant and incapacitated. Although psycho-social rehabilitation techniques have yet to be formally tested with PTSD patients, they have proven effective in cases of chronic schizophrenia and other persistent mental impairments. Such interventions appear to generalise well from patients with one mental disorder to another and it is reasonable to infer efficacy in relation to PTSD.

Pharmacological Treatment of PTSD

86. After CBT, drug therapy is the second major modality for current treatment of PTSD.

The Big 3

87. The three families of drugs that are presently known to be the most efficacious for use in PTSD were all first developed as treatments for depression. They are, in ascending order of age Selective Serotonin Re-uptake Inhibitors (SSRIs), Tri-Cyclic Anti-depressants (TCAs) and Monoamine Oxidase Inhibitors (MAOIs).

Selective Serotonin Re-uptake Inhibitors

88. SSRIs, as the name implies, act by blocking the pre-synaptic re-uptake site on serotonergic neurones. The result is that more Serotonin remains available within the synapse and thus to bind the post-synaptic receptors. SSRIs were first licensed for use in depressive illness in the late 1980s. Sertraline (trade name Zoloft) is the only licensed drug in the USA for the specific treatment of PTSD. However, fluoxetine (Prozac) is also often used successfully and is so close in its composition and effect to sertraline that its efficacy can safely be inferred. Other SSRIs (e.g. paroxetine (Praxil) and fluvoxamine) can be used to good effect where sertraline and fluoxetine are not readily tolerated by the patient. Where the knowledgeable lawyer has a client with PTSD who is not receiving drug therapy, it should be part of the support provided to facilitate a consultation with the GP or psychiatrist to consider its use. Psychotherapists, unless also medically qualified, cannot prescribe drugs in their own name but usually have close links with

someone who can. Where there is a co-morbid depression, as so often, the results of drug therapy can be outstanding.

Tri-Cyclic Anti-depressants

89. TCAs (e.g. amitriptyline (Elavil), desipramine (Norpramin) and imipramine (Tofranil)) act by blocking the pre-synaptic re-uptake of both Serotonin and Norepinephrine, thereby making more of both of these neurotransmitters available to bind to their respective post-synaptic receptors. They are thus capable of enhancing both serotonergic and adrenergic transmission – see the earlier section on the physiological underpinning of PTSD for the logical reasons behind their application. TCAs are a much older family of drugs than SSRIs and have been in widespread use for the treatment of depression for many decades.

Monoamine Oxidase Inhibitors

90. MAOIs (e.g. phenelzine (Nardil)) are the oldest of the 3 relevant drugs, their use as anti-depressants being established for many years. They act by blocking the action of the enzyme Monoamine Oxidase, which breaks down both Serotonin and Norepinephrine – again see above for why they might work with PTSD. By preventing this destruction, more Serotonin and Norepinephrine are available for pre-synaptic release and therefore for binding to post-synaptic serotonergic and adrenergic receptors.
91. All three classes of drug are proven to be effective in the treatment of PTSD but SSRIs are now the most commonly used. Noteworthy results indicate that SSRIs have a broad spectrum of action, with all three clusters of PTSD symptoms (re-experiencing, avoidance/numbing and hyper arousal) significantly reduced in patients traumatised by rape, criminal assault and motor vehicle accidents. They are also an attractive choice because they deal effectively with frequent co-morbidity of PTSD including depression, panic disorder, obsessive-compulsive disorder and alcohol dependence.
92. MAOIs have also been proven to produce moderate to good global improvement in 82% of PTSD patients, primarily due to a reduction in re-experiencing symptoms (e.g. intrusive recollections, traumatic nightmares and PTSD flashbacks). There is

improvement in insomnia but less in the PTSD avoidance/numbing or hyperarousal symptoms.

93. TCAs have shown to be less effective overall than either MAOIs or SSRIs but have some effect, particularly in reducing the re-experiencing symptoms of PTSD. They are not generally the drug of first choice in PTSD therapy today but they remain part of the treatment arsenal and may be deployed where SSRIs or MAOIs are not tolerated.
94. All three of these drug groups, as with any other drug, are known to have side effects and potential interactions with other drugs. MAOIs in particular require the use of dietary restrictions, including abstinence from alcohol, which if not observed will have serious consequences. SSRIs and TCAs are both generally, but not universally, tolerated.
95. This discussion is confined to the efficacy of these three drug families in 'pure' PTSD. Depression is a very frequent co-morbid feature in PTSD and all of these drugs are anti-depressants. It follows that they stand to be used to treat depression whether or not this is identified as co-morbid with PTSD. In those circumstances there is an unintentional but serendipitous effect on PTSD symptoms as well as the intended alleviation of depressive symptoms.

Other Drugs

96. Various other drugs [anti-adrenergic agents, anti-anxiety agents, anti-convulsants and anti-psychotics] may have a place in particular cases found to be resistant to other forms of treatment, or requiring specific symptomatic relief of rare psychotic symptoms and so on. Further discussion of these agents is beyond the scope of this introductory paper.

Conclusions

97. Only with an understanding of the nature of PTSD and the available treatments can the lawyer truly be of full assistance to his client. It is a real and disabling disorder as the detailed judgment in the largely unsuccessful PTSD Group actions has emphasised, to the wider common good in this sort of case. Even the JSB Guidelines are beginning to take the condition seriously, as reflected in the increasing amounts to be awarded. There

should no longer be any room for dismissive attitudes to PTSD. There is no such thing as a “touch of PTSD” and the widespread, bogus claims for PTSD as an appendage to simple RTA claims bring the diagnosis into disrepute. The prognosis is always guarded following chronic PTSD. Often the client will not be totally cured even as to current symptoms, but treatment usually helps substantially and allows the client to live a reasonable quality of life alongside the symptoms. In litigation, treatment success is often measured in terms of practical function rather than alleviation of symptoms. Even with a “cure”, there is a life-long risk of relapse. PTSD is a pernicious and debilitating disorder deserving of our detailed attention. It is common following serious RTAs and serious industrial accidents, as well as in disaster litigation, and may be present following a perceived mistake in medical treatment. It touches most aspects of serious Personal Injury litigation.

98. A particular area in which the Claimants were successful in the PTSD Group Actions was on the issue of Causation if CBT and SSRI treatments had been used. While the judgment is so lengthy that it will never be fully reported, it is now a powerful argument for Defendants (to the greater good of Claimants who are suffering and were previously ignored) to say that it is an unreasonable failure to mitigate if treatment has not been attempted or is not envisaged. The other side of the coin makes an application for an interim payment on account of funding for treatment (and a claim for the cost of future treatment if it has not yet been tried) overwhelming.
99. It is part and parcel of the condition for the client to deny it to himself and to delay seeking treatment until it is too late for the marriage, the job and all aspects of normal living. (On this foundation lay one of the main reasons why the PTSD Group Actions were lost – contrary to the Claimant’s arguments and evidence, the MoD could not reasonably have detected the condition in most service personnel, who hid their suffering.) Even then it is not too late for effective treatments, which can be carried out decades later; but too much damage may already have been done to the client’s life to make effective treatment more than a pyrrhic victory. It is one of the lawyer’s wider tasks to facilitate treatment and break the vicious circle of despair at the first opportunity.

Reflection

100. Dr Dan Enoch, a decorated war hero in the Israeli Defence Force, gave evidence in the course of the PTSD Group Actions. He served as a Sergeant in the infantry before becoming the equivalent of a Regimental Medical Officer. He saw the carnage of the battlefield when, on a mission with 20 men, they entered an unmarked minefield and the officers were immediately incapacitated. He, as a young general medical officer, had to take charge and evacuate, over 7 hours, 10 soldiers with traumatic amputations of the lower limbs. Since then he has devoted his life to the study and treatment of Combat Stress Reactions and PTSD, rising to the position of Head of the Clinical Psychiatric Branch of the IDF. In one of the most cogent passages of evidence in the PTSD Group Action trial, delivered in movingly hushed tones and broken English (corrected here), he gave the following description (in his fourth language) of the way that chronic PTSD sufferers become locked in time into the trauma, reliving the experience to the detriment of all else.

I will begin at the end: when we are talking, speaking with ... a severe PTSD casualty, we are always amazed by the vitality, the vivacity, the amount of energy involved in the detailed history they give us of the event.

It is as if the past becomes the present, and when the present is the past there is no future.

When we try to obtain some insight and to understand the phenomenon, it is as if all libidinal energy, or all psychic energy, is focussed into the traumatic event, is absorbed by the traumatic event.

Time stops at the moment of the traumatic event and all the energy, the libidinal energy, the energy of life, is trapped in time. So the energy necessary for interpersonal relationships, for having interest in the world, is not available

The theoretical underpinnings of PTSD as a concept and the science discussed in the early parts of this paper are real. PTSD and its consequences are to be observed by us in our clients, as Dr Enoch has done in his soldiers, if only we equip ourselves with the knowledge to unlock them.

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The writer is indebted to too many people in the course of the PTSD Group Actions to acknowledge all the help he has received in writing this paper. The medical and scientific aspects of it appeared as a Chapter in the Claimant's Opening Submissions, written jointly by the present author and Dr Jonathan Richards of Godolphin Chambers, Truro / Lamb Chambers, London, and reviewed by Leading Counsel Mr Stephen Irwin QC of Doughty Street Chambers, London. It draws heavily on the writings of Prof Matthew Friedman, National Center for PTSD, Veteran Affairs Medical Center, Vermont; and the original chapter was reviewed by Dr Jonathan Davidson, Director, Anxiety and Traumatic Stress Program, Duke University, North Carolina. Mistakes which remain and have been incorporated by the later additions of the author are his own.