Emotional distress claims: Get it right from the start

It can be tricky to differentiate between "mere emotional distress" and PTSD

By Allison J. Fairchild

I have a love-hate relationship with client intakes. Some client intakes are funny enough to make writers at *Saturday Night Live* drool. For instance, a woman comes into the office with her cat, proposing to sue her landlord on behalf of the cat for slipping down the stairs and spraining a paw. Or, a man comes into the office reeking of cigarette smoke, demanding to sue "big tobackee" for his emphysema because he is too uneducated to understand the warnings on the cigarette cartons and packs. This obviously satisfies both slapstick and witty sensibilities.

Client intakes can also be exciting, waking us up from a tedious or stressful day. A stranger comes in, sits in your conference room or your office and describes actionable facts; ears perk, eyes shine, and notes begin to fill up an intake form and/or pages of a yellow legal pad. Here's the one that might be the stuff that profits are made of – or at least the stuff that brings in a settlement sufficient enough to cover some of that overhead expense.

Put in the wrong hands, though, an intake can result in dropping a hot potato and letting it slip through the gate and into a file. Granted, there are times when a bad case gets through because the potential client lies, or the pleasant, potential client morphs into a "nightmare" client who probably *was* fired from her job because of insubordination and anger issues.

However, there are also some invisible factors that can be dangerous if left undiscovered – but which are controllable if incorporated into your intake questionnaire. One such invisible factor is the presence of clinically diagnosed psychiatric disorders; both those caused by the facts of the case at hand and those that are pre-existing conditions.

While such clients are not necessarily dishonest nor nightmare clients, their invisible disorders may involve you in a maze of medical, legal and even ethical issues throughout the course of the litigation.

You can avoid stepping on any such landmines if you discover their presence in a case at the intake level. I don't presume to be an expert, but there are some basic issues that present in such cases.

First, you will need to counsel such a potential client about the reality of litigation and the potential negative effects on his or her mental health and/or regarding the possible discovery of his or her mental-health medical records and testimony.

The presence of a psychiatric disorder in the case, or as a pre-existing condition, will also directly inform the pleading of and pursuit of general damages in the case, as well as affect your discovery plan.

You will also need to determine if you want to spend the additional resources that such a case may require in terms of experts, discovery and law and motion.

Finally, the failure to discover these disorders at the intake level may result in unintentional lapses in ethical duties related to your client's rights to fiduciary, confidentiality and loyalty.

The role of intake in psychiatric disorders

The facts of a case that involve psychological consequences severe enough to involve a clinical diagnosis are often heart-wrenching: a baby dies; a woman is raped by her boss; or a man suffers near-fatal injuries while watching his wife bleed out in the passenger car seat only a foot away.

The clinical diagnosis in these situations may be Post Traumatic Stress Disorder (PTSD). It is better for you and your resources as well as your potential client if this information is discovered at the intake level – or, at least, the issue of its presence in the case is discovered at the intake level.

A client or a client's representative might come into an intake and tell you that the client suffers from PTSD. The follow-up question should always be, "Who diagnosed the PTSD?" If the client is not clear who diagnosed, be suspicious. Consider different methods to follow up.

If the case is otherwise actionable, you might obtain a list of treating psychiatrists and psychologists at the intake for your subsequent follow up. It might be quicker, however, for the client, or the client's representative to identify the diagnosing physician and follow up with you.

The issue may not always be clear-cut. A client may not admit to being diagnosed, or may not be able to communicate anything specific enough to key you into the possibility that there is a PTSD diagnosis. His or her representative may not know of the diagnosis.

Either way, if there is no inquiry into the presence of PTSD in a particular case, the failure to know may very well disrupt your representation of the client and the litigation of the case.

Every person is unique, and there is the potential for PTSD to develop in

cases in which you would not expect it to be diagnosed. The most conservative course would therefore be to include the question on *all* intake forms for causes of action involving accidents or other traumatic events.

There is also the issue of potential clients who suffer from pre-existing psychiatric disorders. These clients may be quite resistant to discussing or even admitting to such disorders. The stigma and bias against such persons, and the resulting personal and professional ramifications often force them into a mental illness "closet."

However, if you fail to uncover this information, then there is no opportunity to properly advise the client. For instance, you may want to advise this potential client that if the facts of the case at hand caused an exacerbation of their pre-existing condition, then such damages could be claimed.

The client also needs to be counseled that the case may involve the release of private mental health records. Both the fact of the pre-existing psychiatric disorder and the mental health records may become part of the public records.

If the client chooses not to claim exacerbation of a pre-existing condition, then it would be your duty to protect the client's state and federal constitutional rights to privacy during the course of litigation.

If you fail to catch the presence of a pre-existing psychiatric disorder at the intake level, you will not have the opportunity to decide for yourself if you *want* to proceed given the additional resources that will be needed – whether the client goes forward with an exacerbation of a pre-existing claim *or* chooses to go forward with "mere" emotional-pain-and-suffering general damages.

Again, the conservative approach is to ask any potential client at intake about their psychiatric history. It may be uncomfortable, and you may have to do some explaining – but the benefits to you and to any potential case outweigh the deficits.

Discover at intake?

Once you take on the client, you are bound to your oath as an attorney and to your ethical responsibilities toward your client. We take an oath to uphold both constitutions:

> I solemnly swear (or affirm) that I will support the Constitution of the United States and the Constitution of the State of California, and that I will faithfully discharge the duties of an attorney and counselor at law to the best of my knowledge and ability.

Any violation of this oath constitutes a cause for disbarment or suspension. (Bus.&Prof. Code, § 6103.)

In addition, if you do not know about the pre-existing condition, you will be hard-pressed to meet your ethical duty of confidentiality. The duty of confidentiality is located in Rule 3-100 of the Rules of Professional Conduct.

> (A) A member shall not reveal information protected from disclosure by Business and Professions Code section 6068, subdivision (e)(1) without the informed consent of the client, or as provided in paragraph (B) of this rule.

This duty of confidentiality is one of the most sacred trusts between an attorney and his or her client.

> To maintain inviolate the confidence, and at every peril to himself or herself to preserve the secrets, of his or her client.' A member's duty to preserve the confidentiality of client information involves public policies of paramount importance. (*In Re Jordan* (1974) 12 Cal.3d 575, 580.) Preserving the confidentiality of client information contributes to the trust that is the hallmark of the client-lawyer relationship. The client is thereby encouraged to seek legal assistance and to communicate fully and frankly with the lawyer even as to embarrassing or legally damaging subject matter. The lawyer needs this information to represent the client effectively and, if necessary, to advise the client to refrain from wrongful conduct. Almost without exception, clients come to lawyers in order to determine their rights and what is, in the complex of laws and regulations, deemed to be legal and correct. Based upon experience, lawyers know that almost all clients follow the advice given, and the law is upheld. Paragraph (A) thus recognizes a fundamental principle in the client-lawyer relationship, that, in the absence of the client's informed consent, a member must not reveal information relating to the representation.

(See, e.g., *Commercial Standard Title Co. v. Superior Court* (1979) 92 Cal.App.3d 934, 945) (Rule 3-100, Discussion [1] *Duty of Confidentiality.*)

Every intake in every case involving general damages should include questions regarding the potential client's psychiatric history – whether such disorders are material to the claims in the case at hand or not.

Any potential resistance may be overcome through a discussion of this duty of confidentiality, i.e. that the intake is totally confidential; that the potential client is not obligated to move forward with the litigation *or* to disclose his or her psychiatric history during the course of the litigation (or if so, cannot move forward with the litigation).

In addition, a gentle bedside manner when discussing such issues may go a long way in obtaining this necessary information. If this is difficult because you have some negative opinions about people living with psychiatric disorders, then a little self-reflection can go a long way.

If you still believe it might be difficult to represent someone that you have a hard time understanding, even if that person's pre-existing disorder is stable and not symptomatic, then it might be a good idea to refer the client elsewhere. Otherwise, you may be bumping into your duties of loyalty, fiduciary and competence.

This may be a hard pill to swallow, but ultimately, will be in the best interest of the client.

> Attorneys have a duty to maintain undivided loyalty to their clients to avoid undermining public confidence

in the legal profession and the judicial process. (See *Santa Clara County Counsel Attys. Assn. v. Woodside* (1994) 7 Cal.4th 525, 547-548, fn. 6 and accompanying text.) The effective functioning of the fiduciary relationship between attorney and client depends on the client's trust and confidence in counsel. (*Flatt v. Superior Court* (1994) 9 Cal.4th 275 at pp. 282, 285.) The courts will protect clients' legitimate expectations of loyalty to preserve this essential basis for trust and security in the attorney-client relationship.

(*People ex rel. Dept. of Corporations v. SpeeDee Oil Change Systems, Inc.* (1999) 20 Cal.4th 1135, 1146-1147.)

This might also be the case if you are having a hard time with a client's decision not to claim exacerbation of his or her pre-existing psychiatric illness. There is an important issue to consider in this situation. Do you have a dog in this fight or not?

We are counselors of law as well as money-making machines. If a client is averse to publicly disclosing information that could detrimentally affect his or her reputation, employment, etc., the client certainly has a right to refuse that public disclosure.

If it is possible to protect the client from public disclosure and you find yourself pushing for such disclosure to increase the damages in a case, you may be pushing up against a conflict of interest between you and your client.

An attorney's representation of his or client must be undivided, free of conflict from personal or financial interest. (See Rule3-10; and by analogy Rule 3-310 and related case law including *Jeffry v. L.J. Pounds, et al.* (1977) 67 Cal.App.3d 6; *Erskine & Tulley* (1988) 203 Cal.App.3d 884; *Anderson v. Eaton* (1930) 211 Cal. 113; *Stanley v. Richmond* (1995) 35 Cal.App.4th 1070; *Flatt v. Superior Court* (1994) 9 Cal.4th 275.) The common law duties against conflict include even the *temptation* to put his or her interests before those of the client. (*Ibid.*))

However, it is also true that keeping such information out of the litigation (if possible) may increase the costs of the case. Therefore, we also have to counsel the client regarding the costs to the client of keeping the information and the documents out of the litigation.

Ultimately, though, I have always kept my dog out of this one. The stigma associated with psychiatric conditions is alive and kicking in our culture, and therefore, seems like a no-brainer from the get-go. It takes some additional work, but it is certainly possible.

If it is possible to keep this information protected, your general-damages claim can be pled with an intentionally limited emotional-distress claim to avoid disclosing the client's entire psychiatric history. Of course, you need the information *before* you file a complaint in order to ensure you have protected this particular client's rights to privacy and confidentiality.

In addition, this information must be obtained *before* discovery or you may run amok of constitutional rights and ethical violations. If so, then first-look can be requested for medical records; medical records can be redacted; and rights to privacy can be asserted. This may involve meet and confer as well as law and motion work – and this is why you want to hold open your right to choose to move forward with a case at the intake level.

I have always considered these precautions to be my fiduciary responsibility to my client given the rights to privacy granted to all of us under the California and Federal Constitutions, along with my ethical duties, and have proceeded accordingly.

"Mere" emotional distress or PTSD

A claim for PTSD can result in a more significant general-damages award than "mere" pain and suffering. Therefore, such a claim will involve conflict with defense counsel and their carriers regarding the existence of PTSD and its cause.

A case with more conflict results in the expenditure of more resources during the course of a case. It is therefore important to have a basic understanding of the difference between "mere" emotional pain and suffering and PTSD.

If you do not know the specific difference between "mere" emotional damages and PTSD, you can find the diagnostic criteria for a PTSD diagnosis in the Diagnostic and Statistical Manual for Mental Illness, Volume IV TR, or DSM-IV. (Volume V of the DSM will be published in May 2013. For changes to the diagnostic criteria for PTSD, please see e.g. http://www.ptsd.va.gov/professional/pages/diagnostic_criteria_dsm-5.asp.)

Diagnostic criteria for PTSD include a history of exposure to a traumatic event meeting two criteria and symptoms from each of three symptom clusters: intrusive recollections, avoidant/numbing symptoms, and hyper-arousal symptoms. A fifth criterion concerns duration of symptoms and a sixth assesses functioning.

Criterion A: stressor

The person has been exposed to a traumatic event in which both of the following have been present:

1. The person has experienced, witnessed, or been confronted with an event or events that involve actual or threatened death or serious injury, or a threat to the physical integrity of oneself or others.

2. The person's response involved intense fear, helplessness or horror. [Note: in children, it may be expressed instead by disorganized or agitated behavior.]

Criterion B: intrusive recollection

The traumatic event is persistently re-experienced in at least one of the following ways:

1. Recurrent and intrusive distressing recollections of the event, including images, thoughts, or perceptions. [Note: in young children, repetitive play may occur in which themes or aspects of the trauma are expressed.]

2. Recurrent distressing dreams of the event. [Note: in children, there may be frightening dreams without recognizable content.]

3. Acting or feeling as if the traumatic event were recurring (includes a

sense of reliving the experience, illusions, hallucinations, and dissociative flashback episodes, including those that occur upon awakening or when intoxicated). [Note: in children, trauma-specific reenactment may occur.]

4. Intense psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event.

5. Physiologic reactivity upon exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event

Criterion C: avoidant/numbing

Persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness (not present before the trauma), as indicated by at least three 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 foreshortened future (e.g., does not expect to have a career, marriage, children or a normal life span)

Criterion D: hyper-arousal

Persistent symptoms of increasing arousal (not present before the trauma), indicated by at least two 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

Criterion E: duration

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

Criterion F: functional significance

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

Specify if:

Acute: if duration of symptoms is less than three months

Chronic: if duration of symptoms is three months or more

Specify if:

With or Without delay onset: Onset of symptoms at least six months after the stressor

References

1. American Psychiatric Association. (2000). Diagnostic and statistical manual of mental disorders (Revised 4th ed.). Washington, DC: Author.

(http://www.ptsd.va.gov/professional/pages/dsm-iv-tr-ptsd.asp. Emphasis added.)

After reviewing the technical criteria, and perhaps a little medical publication review, you can then have an informed discussion with your client's treating psychiatrist and/or psychologist *before* pleading damages in your complaint.

A duty not to file frivolous claims

When I start writing an article for a magazine, I usually do a broad search on the Internet about my subject – to rein in my attention and get my interest sparked.

This time was no different, and I got a juicy start. There in the search results was an article by a medical expert on PTSD damages in lawsuits. I double-clicked and started to read.

The first paragraph seemed tame enough, even leaning toward the objective. The second paragraph slapped my moment of naiveté in the face.

> Litigious plaintiffs, or their attorneys, often 'diagnose' PTSD even prior to a psychological evaluation. They assume that PTSD occurred in reaction to the stress-inducing events that are the subject of litigation.

(www.williamspsychologicalservices.com/SAdocs/PTSDvsAnger.html.)

No self-respecting plaintiffs' attorney is going to claim that a client has a broken ankle when she only has a sprain. Why would the same attorney claim PTSD when the client suffers from "mere" pain and suffering?

Apparently, the author of the article became caught up in the popular prejudice against attorneys in general. (See Allison J. Fairchild, *How many lawyers does it take to change the bias against lawyers?*, Plaintiff, April 2012.)

A California attorney's duty to be honest and forthright in their practice of law is explicit. This duty includes not filing frivolous lawsuits or claims.

> There are other duties contained in Business and Professions Code section 6068 that inherently, rather than explicitly, require attorneys practicing in California to be honest and forthright in their practice of law. For instance, we have an explicit duty not to bring actions, or present defenses or positions that are frivolous in nature. The law insists that attorneys in California must only present actions, proceedings and defenses that are "legal and just." (Bus. & Prof. Code, § 6068(c).) Further, the Code prohibits attorneys in California from bringing or continuing an action or proceeding based on "…any corrupt motive of passion or interest."

(Bus. & Prof. Code, § 6068(f).)

These duties are reflected in the California Rules of Professional Conduct section 3-200 which prohibits attorneys in California from accepting or continuing to maintain employment if he or she "knows or should know" that the representation is meant to present an action, position, defense or appeal without "…probable cause and for the purpose of harassing or maliciously injuring any person…" (Cal. Rules Prof. Conduct, rule 3-200(A).)

If you sign, file, submit or advocate any "…pleading, petition, written notice of motion, or other similar paper…" you certify that to the best of your "…knowledge, information and belief, formed after an inquiry reasonable under the circumstances…," that such matters are not presented for frivolous purposes, and are, or will be supported by the evidence.

(Code Civ. Proc., §128.7(b).) Sanctions may be imposed if any attorney in California certifies a document or advocates a position in violation of section 128.7(b). (*Id.* at (c).)

Working with the PTSD client

In addition to understanding the difference between "mere" emotional distress and PTSD, there is also a difference in working with a client with "mere" emotional distress and a client suffering from PTSD.

Once again, it is important to obtain this information at the intake level to avoid harming the PTSD client. The stress and anxiety that is a natural consequence of being a plaintiff in a lawsuit can have serious medical repercussions for a client suffering from PTSD.

PTSD can be exacerbated by something referred to as "triggers." Triggers are universal to those suffering from PTSD, but are also subjective to each patient.

There are both internal and external triggers that set off PTSD symptoms. Internal triggers include anxiety, racing heartbeat, feeling out of control or vulnerable – all aspects of litigation for a client. Therefore, the litigation itself may exacerbate the client's disorder.

External triggers may include argument, anything that reminds the client of the traumatic event, the anniversary of the event, seeing anyone related to the traumatic event. Again, the litigation itself may exacerbate the client's disorder.

Therefore, it is necessary to work with the client's treating psychiatrist and/or psychologist in order to prevent further damage to the PTSD client about the best way to communicate with the client about the traumatic event. This includes the appropriate manner to counsel such a client regarding the potential of the litigation itself to trigger the symptoms of the client's PTSD.

If the presence of PTSD comes up at intake, can you responsibly and reasonably act in the best interests of this potential client, or do you want to step over this bit of legal counseling and move forward, guns a' blazin'? Once again, do you have a dog in this fight?

My only hope with this article is that I've made my point – that if you catch this information at the intake level, the better it is for you and your resources; the client's informed decision to continue; and the progress and value of the case.


Fairchild

Allison J. Fairchild has represented plaintiffs in personal injury, products liability and employment cases in Sacramento, the Bay Area and Los Angeles for 17 years. Currently, Ms. Fairchild is taking a break from the practice of law to finish her novel, walk her flat-Coated retriever in Wildcat Canyon, practice yoga, and care for her family.