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# TRAUMATIC NEUROSIS AND MALINGERING: ILLUMINATING ALADDIN'S LAMP

How has he the leisure to be sick  
In such a justling time?<sup>1</sup>

Hal and Falstaff would find our time "justling" indeed, even in comparison to wartime in 16th Century England. But as demanding as modern life is—perhaps because of its demands—many people do become seriously debilitated by imagined illness, by some process of unconscious choice. These psychosomatic illnesses, called functional disorders, become a lawyer's concern when they are involved in some compensatory litigation, such as a tort claim or a workman's compensation case. If they result from some specific injury—physical or psychological—they are given the label traumatic neurosis.

The difficulty in assessing damages for injuries that may inherently contain an element of volitional devising is obvious. One trial attorney has termed traumatic neurosis "an Aladdin's Lamp for transforming a simple, low verdict negligence case into one of astronomical figures."<sup>2</sup> Traumatic neuroses stem from a spectrum of precipitating occurrences that range from the truly overwhelming to the mildly upsetting, with the most dependable factor being a predisposition on the part of the patient to psychological dysfunction rather than the severity of the stimulus. In addition, the development of some traumatic neuroses is so closely related to the prospect of financial restitution (so-called compensatory or litigation neurosis) that it would seem that the prospect of the "cure" causes the disease. An attorney's confusion is understandable when confronted with a case where the illness depends on the compensation, rather than the reverse.

The concept of malingering is often the darker side of a traumatic neurosis case, and most authorities recognize the indistinctness of the line between simulating symptoms consciously, and unconsciously fabricating them. This comment will attempt to review and synthesize contemporary thought on the dilemmas involved in the confluence of traumatic (especially compensatory) neurosis and malingering, with special attention to the attorney's role in recognizing—and resolving—the unique problems of the traumatic neurosis victim.

## THE BASIS OF TRAUMATIC NEUROSIS

Traumatic neurosis is sometimes termed a "gross stress reaction." In simple terms, it is a psychological upset caused by a physical injury

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1. W. Shakespeare, *King Henry IV*, Part I, Act III, Scene I, Line 17.

2. Rosen, *Musings on Traumatic Neurosis*, 3 *Trial Lawyers Q.* 82 (1965).

to the patient or a severe fright or shock. Psychodynamically, the shock or injury so disorganizes the structure and functioning of the victim's personality that it precipitates personality breakdown, regression, and hysterical symptomatology. Given a trauma severe enough, virtually anyone could suffer a traumatic neurosis,<sup>3</sup> although the degree of dysfunction is far more dependent on predisposing factors within the individual than on the severity of the trauma. Some psychological disruption is normal and to be expected following a physical trauma, but when the disruption "takes root" inside the victim causing a widespread and lingering dysfunction, the crippling effect of a full-blown traumatic neurosis can easily eclipse whatever physical injuries may have been suffered in the original trauma-producing incident.

Although "to list all possible symptoms would be to copy a medical dictionary,"<sup>4</sup> the traumatic neurosis most frequently manifests itself in symptoms of chronic anxiety, mental unrest, and various pains and physical dysfunctions of the voluntarily controlled muscles of the body.<sup>5</sup> A partial list of disorders related to traumatic neurosis includes asthma, rheumatoid arthritis, diabetes mellitus, peptic ulcers, impotence, psoriasis, hypertension, and all the known psychiatric disorders.<sup>6</sup> Recently, a 29-year-old woman in San Francisco received a large settlement for traumatically precipitated nymphomania.<sup>7</sup>

Although the occurrence of traumatic neurosis is not uncommon,<sup>8</sup> only in a comparatively few cases is the psyche so overwhelmed by the trauma that substantial or long-term psychological harm results. The causal factors responsible for severe cases of traumatic neurosis have been extensively treated in the medico-legal literature on the subject.

Common in all traumatic neurosis cases is the ego defense

3. Davidson, *Psychiatric Aspects of Head Injury*, 5 Med. Trial Tech. Q. 1, 12 (1959) [hereinafter cited as Davidson].

4. Miller & Fellner, *Compensable Injury and Accompanying Neurosis, The Problem of Continuing Incapacity Despite Medical Recovery*, 1968 Wis. L. Rev. 184, 187.

5. The medical term is "gross conversion and somatization," which means a "neurotic dysfunction affecting muscles and sensory apparatus innervated by the voluntary muscle systems, as distinguished from psychosomatic dysfunctions, which affect organs innervated by the autonomous nervous system." Davidson, *supra* note 3, at 12.

6. Strothman, *Traumatic Neurosis: A Medical-Legal Approach*, 6 Washburn L. J. 350, 354 (1967); L. Keiser, *The Traumatic Neurosis* 41 (1968) [hereinafter cited as Keiser]. Traumatic psychosis is rare. In one study, there were only 13 psychoses from 9000 head injuries, an incidence of only 1/7 of one per cent. Davidson, *supra* note 3, at 17.

7. *Medical Testimony in a Case of Trauma and Nymphomania*, 19 Medical Trial Technique Q. 83 (1972).

8. In one study of 112 litigated accident cases, 80% involved a clear traumatic neurosis. Keiser, *supra* note 6, at 109.

mechanism known as regression. As the humbling experience of injury or fright attacks the ego, the person in a sense "withdraws," becomes more dependent and infantile. This characteristic dependency, vital to the maintenance of chronic neurotic symptoms, can be aggravated by various factors pre-existent in the accident victim or peculiar to the specific trauma:

1. The severity of the trauma itself;
2. The trauma possessing a symbolic meaning especially disturbing to the victim, as an electric shock to a person whose parent was killed by electricity;
3. The victim possessing a psychological constitution simply unable to adequately handle the stress of the injury;
4. The trauma occurring on top of other unusual recent stresses: "the straw that broke the camel's back";
5. Severe neurotic conflicts pre-existing the trauma;
6. Poor handling by physicians or lawyers; the power of suggestion, or reaction to rejection and hostility;
7. Revenge; hostility toward the party the victim feels is responsible;
8. Low intelligence (generally cited to be a pre-disposing factor, as most chronic traumatic neurotics display medically unsophisticated symptomatology and poor insight into their problem); and
9. Desire for secondary gains (so-called compensatory neurosis).

As can be seen, a traumatic neurosis can possibly be only indirectly caused by the actual accident; a coincidentally precipitant occurrence could simply serve as an excuse for the "potential" neurotic to be sick, yet render someone legally liable to foot the bill. A widely quoted 1943 article stated that traumatic neurosis victims, suffering an injury "inadequate to injure a normal person, are not caused to develop a neurosis as a new and unusual condition. It is legally erroneous and socially unjust to compensate them on any such theory. Such cases are properly to be regarded as instances of aggravation of pre-existing injuries or impairments and are to be compensated modestly." The article then concluded that "traumatic neurosis after minimal stimulus is an idiosyncratic response, making cause and effect relationships hopelessly obscured."<sup>9</sup>

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9. Smith & Soloman, *Traumatic Neurosis in Court*, 30 Va. L. Rev. 87, 105-107 (1943).

What is a "minimal stimulus" is open to question, although actual physical impact is necessary in some jurisdictions. 64 A.L.R. 2nd 134 (1959). In one large-sample study, 5/8ths of traumatic neurosis cases involved almost negligible physical injury. Smith & Soloman, *id.* at 104.

One neuro-psychiatrist, quoted in the same article, announced a theory that still has adherents today. "It would be a signal service to deny compensation in *all* cases of traumatic neurosis, as it would do more than any medical means to banish the disorder." The courts and lawmakers, however, have not been willing to discriminate against the "bona-fide" traumatic neurosis victim by categorizing such injury as non-compensable. Thus the syndrome plays an important role in compensatory litigation, leaving to the trier of fact in each case the question of the legitimacy of the ailment complained of.

### MALINGERING

And if a man is not lame, blind, or halting and  
He feigns one of these, he will become one of these<sup>10</sup>

Until the 1930's the judicial wariness of spurious claims of damages arising from traumatic neurosis was so great that it largely prevented any recovery for that type of injury. Historically, dysfunction from hysterical conversion and "neurothenia" was largely a woman's complaint and looked upon scornfully. It has only been in recent times that traumatic neurosis has become commonly compensable, and it seems that the pendulum has come full swing. Modern medical thinking, in fact, appears to be that actual "pure-form" cases of malingering in this area are rare,<sup>11</sup> and has even proposed that perhaps the diagnosis of malingering by a physician is improper in any situation.<sup>12</sup>

By definition, malingering is "the feigning of injury or defect,"<sup>13</sup> but the difficulty arises in the degree of volitional devising necessary to "feign." Unconscious or *partly* conscious imitation of symptoms is ordinarily not considered malingering.

"In the absence of fraud, the imitation, distortion, and exaggeration of symptoms, the undue prolongation of an illness and unwillingness

10. Talmud, Mishvah Peah 8:9.

11. One practising psychiatrist states his feeling this way; "I have yet to see a case of malingering that was pure faking . . ." Keschner, *Simulation of Nervous and Mental Disease*, 44 Mich L. Rev. 715, 720 (1946). The modern view is that *something* must be psychologically wrong with the patient, or he wouldn't be *acting* sick.

12. Dr. Thomas Szasz, the vociferous exponent of reform in psychiatric diagnostic practices, has written, "Malingering is not a diagnosis. . . . It expresses the physician's or psychiatrist's moral condemnation of the patient." Szasz, *What is Malingering?*, 6 Medical Trial Technique Q. 29, 39 (1958). Other authors have provided terminology at least disguising their value judgments, for example; an ergophobe is a person afraid of working, sinestrosis is a label for wanting maximum retribution for injury or wrong, and a malingerer is sometimes classified as sociopath. Keschner, *supra* note 11, at 716-17.

13. The Macmillan Medical Dictionary (C. Wakely ed. 1954).

to return to work cannot be regarded as evidence of true malingering."<sup>14</sup>

Doctors expect some malingering in injury cases: "There is, undoubtedly, a small amount of malingering in most accidents . . . all patients with traumatic neurosis malingering to some degree."<sup>15</sup>

This liberal attitude is understandable when considering the typical case of traumatic neurosis, the below-average intelligence, the predisposing neurotic factors, the dependent regressed state of the patient, and the anger at having been wronged in an accident. There is little wonder that a doctor, examining such a patient, would realize the indistinctness of the line between consciously faked and partly—or un-consciously faked symptoms. This is especially a problem when the "faked" symptoms persist after damages are awarded; the patient is so convinced of his "faked" illness that it persists past any usefulness! The ramifications of our present liability litigation system upon the traumatic neurosis will be treated below, after a discussion on the techniques of detecting malingering.

There is a medical truism to the effect that, "It is extremely difficult to feign mental illness for more than a few days unless one is equipped with grim determination and an excellent knowledge of psychiatry."<sup>16</sup> Basically, the hysteric with a functional disorder will be forthright, talkative, eager to discuss his ailment, and display a characteristic *la belle indifférence* about his disorder. The conscious malingerer, however, is quite the opposite, and avoids examinations, is noncooperative, hostile, and evasive, depicts himself exclusively in good terms, and gives an overall impression of lack of frankness.<sup>17</sup>

There are many techniques used by doctors to spot malingerers, depending on the symptoms claimed. Malingerers are said to occasionally glance stealthily at their examiner to see what impression they are making, and the symptoms sometimes lessen dramatically when they feel themselves to be unobserved. The doctor will sometimes carefully record all symptoms claimed at the first interview, and compare them with symptoms claimed at later examinations. Discrepancies are indications of malingering. Interestingly, during narcosynthesis, (treatment by "truth-drugs"), the malingerer will exaggerate symptoms, while the hysteric's symptoms lessen.<sup>17</sup> Despite all the techniques available, of which these are just a sample, it is clear that diagnosis of malingering is still difficult to make.

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14. Keschner, *supra* note 11, at 718.

15. Keiser, *supra* note 6, at 128.

16. Halleck, *Psychiatry and the Dilemmas of Crime*, 304 (1967).

17. Strothman, *supra* note 6, at 368; Keiser, *supra* note 6, at 130; Keschner, *supra* note 11, at 720.

With so great an element of uncertainty in diagnosing malingering, it is not surprising that the substance of courtroom medical testimony may often depend more on the doctor involved than the patient. The ultimate subjectivity of a given doctor's assessment of malingering, as Thomas Szasz indicated, makes for considerable difficulty in the fair judicial administration of traumatic neurosis cases.

Assuming that any ultimate value judgment on malingering would be based on shifting sand, it is useful for an attorney to look at the question of traumatic neurosis and possible malingering from as objective a viewpoint as possible. As traumatic neurosis has become largely a legal phrase, many traumatic neuroses (compensation neuroses) are "legal" ailments: they are caused by the expectation of their "cure," and award of compensation. Assuming that they cannot be dismissed immediately as malingering, the lawyer must determine how to deal with a client with a possible traumatic neurosis complaint. First, though he may not be stroking "Aladdin's Lamp," a lawyer is still a "... salesman of pain, sorrow, agony and suffering."<sup>18</sup> The client has retained him to obtain restitution for a harm done, and it is the lawyer's obligation to render the best possible service to the client, within ethical bounds.<sup>19</sup> The lawyer must be prepared to identify a traumatic neurosis case if presented with one in the office.

There are a variety of clues an attorney might look for in a possible traumatic neurosis victim:<sup>20</sup>

1. Changes in personality since the accident;
2. Dramatic "cures" during the course of the injury or illness;
3. Radical variation between the diagnoses of different doctors;
4. Any reference to "functional" or "overlay" symptoms in the medical reports;
5. Diagnosis of stocking or glove anesthesia (a lack of feeling in the extremities, not following neurological patterns);
6. Emphasis in medical reports on subjective rather than objective ailments;
7. Excessive crying during the interview, or, conversely, an indifferent or *blasé* attitude toward the illness;
8. Loss of sex drive or function;

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18. Averbach, *The Medical Arsenal of a Personal Injury Lawyer*, 12 Clev.-Mar. L. Rev. 195, 196 (1963).

19. The question of malingering aside, the lawyer's efforts can cure the patient. One study showed that of 50 cases with monetary awards for traumatic neurosis, 44 were "cured" by the award, 2 remained disabled, and all but 4 went back to work. Keiser, *supra* note 6, at 59.

20. R. Cohen, *Traumatic Neurosis in Personal Injury Cases 89-90* (1970).

9. Dysfunction disproportionate to the actual trauma; and
10. Evidence of accident-related neurosis, phobias, etc.

If a traumatic neurosis appears to be present, the lawyer's next step should be a referral to a psychiatrist appreciative of the possible seriousness of traumatic neurosis.<sup>21</sup> If the psychiatrist finds a traumatic neurosis, it is imperative that the lawyer obtain a speedy and adequate judgment. The compensation should be a final, lump-sum payment, leaving no benefit contingent on further illness. In this way the lawyer trims to the minimum the duration of and impetus for the neurosis.

In the interest of his client's health, the attorney should scrupulously avoid encouraging feelings of hostility or dependency in the patient. The type of neurosis is very sensitive to suggestion.<sup>22</sup> Similarly, it is a grave mistake to encourage maintaining symptoms for purposes of the litigation. As the Talmud quotation implies, the longer the symptoms persist, the greater the chances of permanent dysfunction. There have been cases of attorneys denying a patient treatment by a psychiatrist, fearing a cure of the hysteric conversion symptoms before the case could be litigated. When the case is tried, it is unfortunate that the patient in the courtroom often has to sit and listen to himself being described as, ". . . a desperately and mortally injured person, a shambling wreck of his former self."<sup>23</sup> The description can easily become prescriptive.

The attorney in a traumatic neurosis case is put in a difficult role of a circumscribed advocacy, and must conscientiously balance effective trial tactics against a non-detrimental handling of his client.

Most of the cases involving traumatic neurosis complaints stem from automobile collisions and industrial accidents. Many instances of compensation neurosis could perhaps be avoided by the adoption of a strict "no-fault" insurance statute. While some extremely predisposed neurotics will maintain symptoms simply for medical treatment and a subsistence allowance, the elimination of "windfall" awards might operate to discourage many cases of compensation neurosis. In both no-fault and workman's compensation cases, a system of medical evaluation similar to New York's workman's compensation procedure might be of great value in avoiding the potentially debilitating effects of liability litigation. In New York, an impartial medical board arrives at a finding, which is reviewed by a panel of consultants if either side

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21. One psychiatrist reports that of 40 traumatic neurotics displaying symptoms from 3 months to 1 years, only 10 were referred by physicians, the remainder by attorneys. Modlin, *The Post-Accident Anxiety Syndrome, Psychological Aspects*, 123 Am. J. of Psychiatry 997, 1010 (1967).

22. Miller & Fellner, *supra* note 4, at 191.

23. Keiser, *supra* note 6, at 81.

disagrees with the original finding. If there is still controversy, the patient is sent to an "impartial specialist" whose word is final.<sup>24</sup>

It seems clear that if there are abuses and serious flaws in the area of traumatic neurosis litigation, they certainly cannot be cured either by simply making the syndrome incompensable, or by relying on discovering "malingerers." It is a confusing area of the conditionally-ill and the conveniently-wronged, as well as the legitimately incapacitated, and can only be adequately dealt with by the combined efforts of knowledgeable law-makers and conscientious lawyers and physicians.

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24. *Id.* at 108.