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Specific Phobia Following Road Traffic Collision: Medico-Legal Issues of Causation, Diagnosis, and Prognosis in Single Case Study

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ABSTRACT

The multi-faceted assessment process involved in providing evidence of psychological injuries to the courts is illustrated with particular reference to a case study of a road traffic collision claimant diagnosed with a specific travel phobia. The need for reliable medico-legal processes is emphasized.

KEYWORDS

Road Traffic Collision (RTC); Medico-legal postulates; Diagnosis.

INTRODUCTION

Assessing trauma in personal injury compensation cases in the civil courts is complex. It involves consideration of many overlapping clinical and medico-legal issues [1]. Experts providing evidence need experience in assessing reliability and truthfulness [2, 3]. This publication addresses these issues in the context of a road traffic collision (RTC) and a common cluster of psychological symptoms, diagnosed as a specific phobia (travel), classified as DSM-V 300.29 [4]. The case study individual presented here who was seen by the first author is anonymised, and an aggregation of salient features seen across several cases are discussed here.

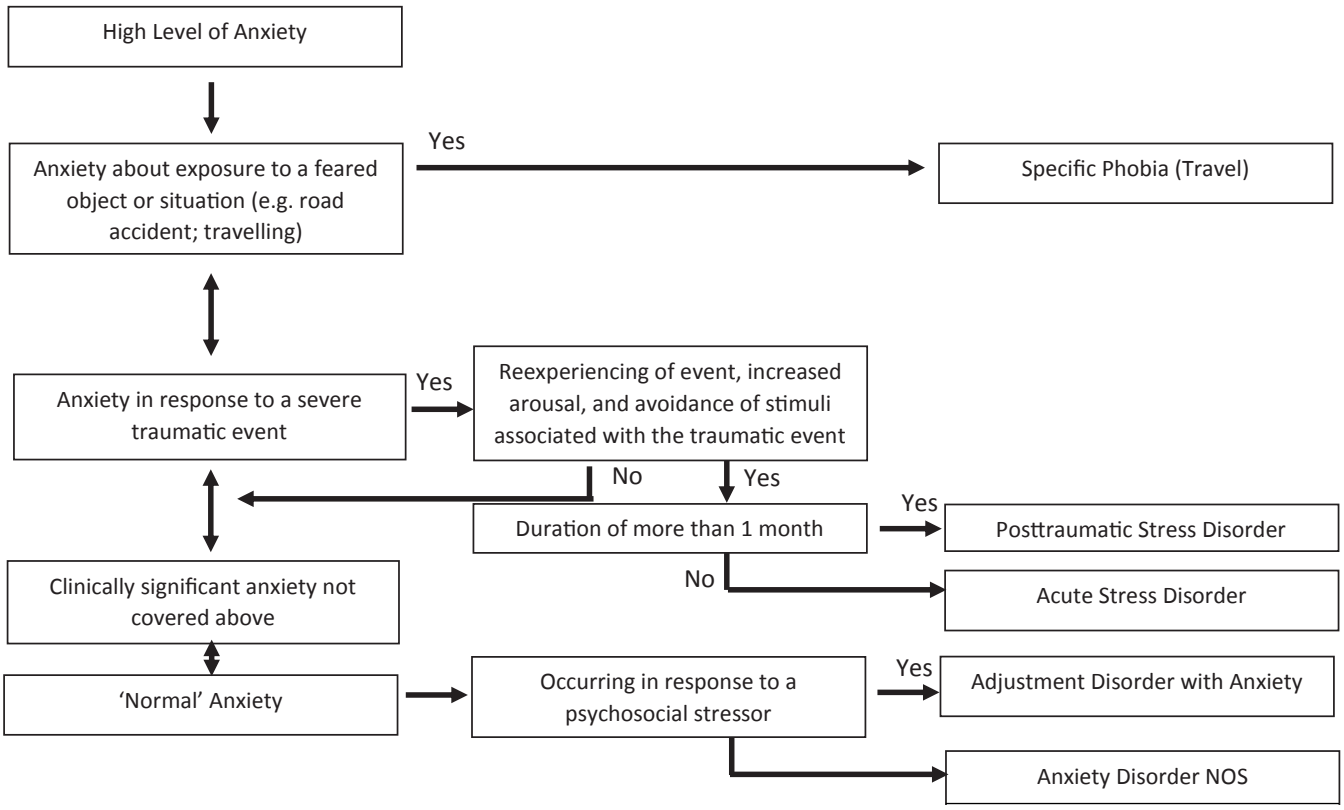
BACKGROUND OF RTC CASE

Mr. Smith (21 years of age) was a rear seat passenger in a 4x4 vehicle travelling on a dual carriageway outside London. The vehicle was hit by an oncoming vehicle - both vehicles were travelling at approximately 60 mph. The claimant's vehicle was knocked into a ditch and rolled over partially. The claimant attended a nearby hospital with physical injuries to his neck, shoulders and back, however he was not admitted to hospital. He sought help and advice from his general practitioner (GP). He had previously been learning to drive prior to the index accident.

FIRST ASSESSMENT

The claimant was interviewed approximately 9 months post-accident. He described a mixture of post-traumatic stress symptoms, mood disturbance, social withdrawal, and, predominantly, travel anxiety as both a passenger and a 'learner' driver. This was supported by history of GP attendance. Although the stress and mood disturbance had largely subsided, his main difficulty with travelling remained. The interviewer considered a range of diagnoses as illustrated in the amended road map/decision tree, for anxiety, [5] in (Figure. 1) below.

Figure 1: Amended Decision Tree for Anxiety



To obtain a differential diagnosis for a specific phobia, this cluster of symptoms must be differentiated from other anxiety-based disorders as illustrated in (Figure 2) below [5].

Figure 2: Differential Diagnosis for Specific Phobia.

Specific Phobia must be differentiated from...	**In contrast to Specific Phobia, the other condition…**
Panic Disorder with Agoraphobia	Is characterized by recurrent unexpected Panic Attacks and avoidance of typically many different situations
Social Phobia	Is characterized by fear and avoidance of social situations
Avoidance in Posttraumatic Stress Disorder	Is related to stimuli that remind the individual of a previously experienced life-threatening event
Avoidance in Obsessive-Compulsive Disorder	Is associated with the content of the obsessions (e.g. dirt, contamination)
Avoidance in Separation Anxiety Disorder	Is associated with fear of separation from parents or caretakers
Avoidance in Psychotic Disorders	Is in response to a delusion (without the recognition that the fear is excessive or unreasonable)
Non-pathological avoidance of circumscribed objects or situations	Lacks clinically significant impairment or distress (e.g. person who fears snakes but lives in Manhattan)

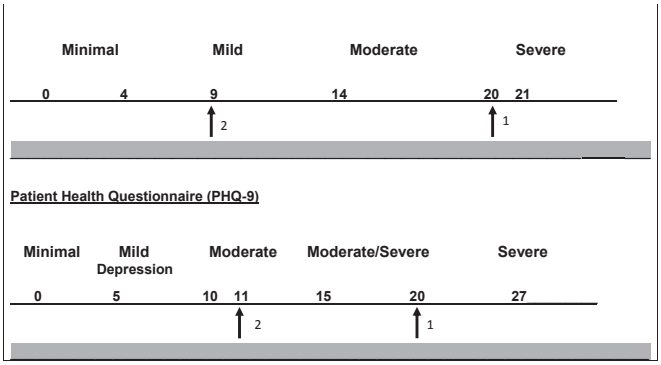
Having decided the 'best fit' diagnosis for Mr. Smith was a Specific Phobia (Travel), the expert assessed that the claimant's ongoing phobia of travelling was unlikely to resolve spontaneously and he therefore recommended 8 – 10 sessions of cognitive-behavioural therapy (CBT), focusing on a gradual re-exposure model in line with prevailing research [6]. Psychometric test data using the GAD-7 & PHQ-9 indicated a high level of low mood and anxiety which acted as a base line measure of his general psychological state/difficulties. [7, 8].

SECOND ASSESSMENT

12 months later, the expert was re-instructed to review Mr. Smith's psychological status, following receipt of 10 sessions of CBT which had focused on gradual re-exposure to travel situations of increasing complexity. He reported significant improvement in his travel anxiety and avoidance with no current disruption.

Repeated psychometric testing was consistent with a lowered level of mood disturbance and generalised anxiety, as shown in (Figure 3).

Figure 3: Psychometric Scores On Two Occasions.



Raw scores and ranges are shown above.

MEDICO-LEGAL ISSUES IN MR. SMITH'S CASE

The two assessments of Mr. Smith's psychological status and the opinions given to the Court were consistent with commonly held medico-legal postulates (9) shown in (Figure 4) below.

Figure 4: Koch's Medico-legal Postulates.

1. A robust opinion should address diagnosis, causation, and attribution, duration and prognosis.
2. A robust opinion will include more than one type of evidence. An opinion based on claimant self-report only may still be valid but is a 'weak' opinion in medico-legal terms.
3. The classification/diagnostic categories given in DSM V and ICD 10 are a part of an expert's opinion/formulation – this systematic check of relevant criteria must be balanced by wider clinical judgement.

(Figure 4 continued)

4. The expert's Mental State Examination should be consistent with the claimant's description of currently active symptoms – a clear discrepancy reduces the robustness/strength of an opinion.
5. A robust opinion should include a history of factors which could, on the balance of probabilities, affect a specific index event reaction.
6. A robust opinion should give particular emphasis to the 12 month period prior to and post the index event, but not to the exclusion of earlier or later history.
7. An expert opinion should incrementally increase in robustness over time with access to more data and discussion with other relevant professionals both legal and clinical.
8. An expert's opinion should be the 'best fit' professional view of all available data at that time, and should be modified, if appropriate, as and when new data becomes available.
9. It is incumbent on the expert to be impartial, independent of instructing party, and maintain as a high level of logicality as possible when appraising evidence.

In particular, Mr. Smith's history included the following

Causation

One previous road accident

Pre-existing vulnerability to anxiety

High frequency of driving prior to accident

Attribution

Post accident bereavement

Feelings of injustice

Use of 'but for' theorem to assess attribution (10)

Prognosis

Evidence-based 'default' model for post trauma recovery.

Credibility of Claimant

Given the complex area of claimant reliability in personal injuries previously described (3), a list of credibility variables were addressed by the interviewer which included verbal and non-verbal behavioral cues and content analysis of self-report, witness statement and pre-interview questionnaire. An overall aggregated score was consistent with Mr. Smith being a highly credible/reliable historian.

CONCLUSION

This case study and description of clinical and medico-legal aspects of assessing and treating a trauma reaction diagnosed as a specific phobia illustrates the many facets of this type of evidence collection in civil cases including the essential proof of causation [10]. It has shown the need for concise and reliable assessment followed by rapid formulation of treatment requirements in line with recommended guidelines [11]. It is essential that experts and lawyers are fully aware of diagnostic factors such as range of opinion and decision-making analysis as well as the medico-legal postulates underpinning the whole assessment process.

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