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Fear of the "Floodgate of Liability" and Acknowledgment of the Recognisable Psychiatric Damage Into English Law of Tort

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Abstract

It is well-known that damages to a victim's psyche can occur due to witnessing or being victim of the traumatic event(s), and this was first recognised in ancient Greece[1]. However, it took centuries for this to be recognised by the common law. It originated within the concept of nervous shock which was first introduced by the *Coultas*[2] case through negligence in the duty of care. Before the Supreme Court of Victoria (Australia), the jury awarded damages for the shock which, however on a further appeal, the Privy Council held that the damage was too remote. This decision opened a door which was not shut until the present time: the strict relatedness between the physical and psychological injury and the recognition of psychiatric damages for recovery in the absence of physical injury.

There is no doubt that the *Alcock*[3] case has been considered as a "test case" for last two decades which shows all dilemmas and differences in endorsement of psychiatric damages within the English law of tort. This case certainly reflected the scepticism and uncertainty in acknowledging psychological injury and in some court cases, ignorance of medical opinion, or the courts' concerns about "opening the floodgates" to limitless or unrestricted liability and its ramifications for the insurance industry, or inherent problems of establishing a causative link, or imposing administrative and/or practical difficulties of psychiatric damages to produce a long-term protection to the mental tranquillity.

Key words: PTSD; Proximity; Remoteness; Primary/secondary victim; Impairment; Complex trauma; Dissociation

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1. INTRODUCTION

More than a century after first time being acknowledged in *Coultas,* psychiatric damage has caused many controversies in the English law of tort, but steadily increasing knowledge of the effect on the human psyche (in particular to the suffering of post-traumatic stress disorder) have gradually widened the ambit of recovery for psychiatric damage. There is no doubt that mental illness is still a cause of stigma for those who have suffered, as well as society at large. In law, some judges stigmatise the use of psychiatric damage as it is "misleading and inaccurate", on the proviso that it is understood to refer to the psychiatric illness which results from emotional stress, and not the emotional stress itself[4]. For example, in the *Relly*[5] case the Court of Appeal found that the fear, chest pain, panic and discomfort, vomiting, sleeplessness, nightmares, and claustrophobia, which

[1] Historian Herodotus wrote that during the battle of Marathon in 490 BC, an Athenian soldier who suffered no wounds became blind after witnessing the death of the soldier next to him. Achilles and Agamemnon, military heroes in the Homer's *Iliad,* also suffered trauma symptoms.
[2] *Victorian Railways Commissioners v Coultas* (1886) 12 VLR 895.
[3] *Alcock v Chief Constable of South Yorkshire* (1992) 1 AC 310.
[4] See: *Mount Isa Mines Ltd v Pusey* (1970) 125 CLR 383 per Widneyer J at 394; *Jaensch c Coffey* (1984) 155 CLR 549 per Brennan J at 560; *Attia v British Gas Plc* (1988) QB 304 per Dillon LJ at 311; *Alcock v Chief Constable of South Yorkshire Police* (1992) 1 AC 310 per Parker LJ at 351.
[5] *Relly & Relly v Merseyside Regional Health Authority* (1995) 6 Med LR, 249.

an elderly couple (plaintiffs) suffered over a two month period due to the negligently maintained hospital lift, was a "normal emotion in the face of a most unpleasant experience, for which it was the sound policy of the law not to provide compensation" (?). Whereas in principle even minor physical injury will be entitled to recovery, the negligent infliction of purely emotional harm, such as post-traumatic stress, anxiety, depression, or phobia, recognisable and diagnosable in medicine quite often is not considered under the law of tort.

The merits of psychiatric damages within the law of tort have been debated repeatedly and in particular about certain trauma circumstances which cause psychiatric illness. However, there is a discernible shift away from focussing on psychiatric damages in the law of tort since the *McLaughlin*[6] case. In recent years, interest in psychiatric damage in the English law of tort has been heightened by the widespread media coverage of high-profile cases, in particular after the disaster at the Hillsborough football stadium with 96 people being killed[7].

Historically, the English law of tort began to develop during the thirteenth century, covering a wide range of wrongdoings such as trespassing and various forms of liability for trespassing which required the wrongdoing to be direct but no actual damage or injury was required. The law of tort limited its engagement with emotional distress being preoccupied with physical injury and social disorder. The law needed to prove damage which must be visible or demonstrable with physical manifestation as a prerequisite of liability. The "injury to feelings" had been identified in terms of insult and affront rather than as emotional distress, and mental illness was not conceived in biological or psychological terms. In same court cases, emotional distress was seen as "parasitic" to the physical injury under the umbrella of "pain and suffering". Mental pain was seen as legally unquantifiable and unfocused in the law's conception of remediable emotional harm.

In an attempt to find an applicable approach in this area, it is necessary to be conscious that in common law relation to liability for psychiatric damage is still developing. In the past, the courts awarded recovery for the various medical conditions such as morbid depression, hysterical personality disorder, pathological grief disorder, and also a chronic fatigue syndrome. However, the medical evidence should establish that the plaintiff has suffered a recognisable psychiatric illness, as the ordinary emotions of anxiety, fear, apathy, sadness, restlessness, or transient shock are not conditions which the law recognises for recovery. When assessing the test of foreseeability in a psychiatric damage as a result of an injury or fear of injury to another person, it is first necessary to consider whether psychiatric damage is reasonably foreseeable, and whether the defendant assume that the plaintiff is a person of "customary phlegm" and has "a normal standard of susceptibility". Where danger lies in this particular infirmity is that it would include a dependence of all circumstances, and also the rule of remoteness, so that the susceptible plaintiff may recover to the full extent of the psychiatric damage. The second point about the psychiatric damage is the consideration of *ex past facto* in the light of what had happened—having immediate or delayed impact upon the victim's psyche.

2. FEAR, PAIN AND SUFFERING THAT "CONSTITUTE" PSYCHIATRIC ILLNESS

In *Dulieu v White & Sons*[8] it was stated (Kennedy J) that liability for the psychiatric damage is limited by a requirement that there "must be a shock which arises from a reasonable fear of personal injury to oneself". Accepting fear as a symptom (or syndrome) of psychiatric illness would deliver difficulties in both medicine and the law of tort. In the law of tort, it will preclude liability to someone who merely witnesses, even purposely, the traumatic event or the injury of another person. The *obitur dictum* from *Dulieu* case was rejected in *Hambrook v Stokes Bros*[9] where the defendants were held liable for a fatal nervous shock suffered by a person who watched as a driverless runaway lorry careered down a hill. The court dismissed the restrictions of liability proposed in the *Dulieu* case due to the following terms:

> It would result in a state of the law in which a mother, shocked by fright for herself, would recover, while a mother shocked by her child being killed before her eyes, could not, and in which a mother traversing the highway with a child in her arms could recover if shocked by fright for herself, while if she could be cross-examined into an admission that the fright was really for the child, she could not.

The *Dulieu* case brought about a number of questions in regard to witnessing the traumatic event. One of the most sensitive is the duty that arises when the witness has no relationship with the injured or person in danger, and what sort of relationship is required to endorse psychiatric damage. A further question posed is whether it should make any difference if psychiatric illness arose not from the perception or the eye witnessing of a traumatic event, but by being a subject of information about it after the event. Initially, all of these and similar questions should be considered under a big umbrella of foreseeability

[6] *McLaughlin v O'Brian* (1983) 1 AC 410.
[7] See: *The Times* 29 March 1995, *The Guardian* 29 March 1995, *The Independent* 29 March 1995 and the *Daily Mail* 30 March 1995. *The Times* 1 November and 12 December 1996, *The Guardian* 1 November and 12 December1996, *The Independent* 1 November 1996 and 19 February 1997, *The Sunday Times* 25 May 1997, and *The Evening Standard* 12 December 1996.
[8] *Dulieu v White & Sons* (1901) 2 KB 669.
[9] *Hambrook v Stokes Bros* (1925) 1 KB 141.

which test will vary according to, first of all, the precise description of what should have been foreseen and, secondly, the degree of probability which makes it foreseeable[10].

The question of foreseeability has also been explored in *Palsgraf*[11], a famous and well-know American case which considered the risk of suffering a psychiatric illness due to witnessing a traumatic event. The New York Court of Appeal rejected the claim on the grounds that the plaintiff was owed no duty because it was not foreseeable that the allegedly careless acts of the guards could create a risk of harm to the plaintiff:

> Negligence is not a tort unless it results in the commission of a wrong, and the commission of a wrong imports the violation of a right, in this case, we are told, the right to be protected against interference with one's bodily security. But bodily security is protected, not against all forms of interference or aggression, but only against some.

The above statement is controversial as everyone owes the duty of care to refrain from an act that may unreasonably threaten the safety of others, or risk another's safety. On the one hand, in everyday life, the risk of safety is evident and occurs, however those who have a duty of care must take reasonable actions to avoid wrongdoing or harm, and avert the threat to safety. On the other hand, those who are aware of risk or danger to life should take reasonable action to escape or find a way as to not put themselves into a dangerous zone. Harm to someone as a result of natural circumstances (i.e., flooding or earthquake) cannot be seen as someone's negligence in duty of care. If individuals take unreasonable risk despite warnings from the authorities of forthcoming natural disaster, the consequences upon them cannot be taken in tort for the sustained harm.

This makes consideration of the "proximity" between a victim and defendant (authority or individual) in regard to the plaintiff's injury. In the *Palsgraf* case, the concept of "proximity" was not seen as the concept of "duty". In another way, it appears that a man ought not to be responsible for unforeseeable consequences:

> (As) there was no duty to her, it seems she would have had no remedy even in this case, but of course if it had happened it would have been held that she was near enough to have an interest.

However, the "proximity" cause in the *Palsgraf* has been highly criticised for its controversial decision. The first thing to clarify whether fear is a symptom or syndrome of psychiatric illness is to examine the nature of the trauma in question. Obviously it would be enough if one had been shot or blown up - that is a traumatic event. Fear is coherent cognitive-affective structure located within the defensive motivational system and a sense of uncontrollability focused largely on possible future threat, danger, or other potentially negative events[12].

However, there is naturally much more to it. It is difficult to believe that a very frightening event(s) or situation(s) would not produce an immediate bodily response. The longer a trauma continues, the more an individual would break down. Thus, a negative-affective state is accompanied by a shift of attention which is primarily self-focused or a state of self-preoccupation where one's (inadequate) capabilities have to deal with the threat/danger/risk which cannot be taken as another's carelessness. Regardless of the individual's experiencing/suffering severe psychological or somatic components due to known or ordinary fear (i.e., fear of terrorism attack, nuclear war, etc.), from a medical point of view, the fear itself does not constitute a recognisable (even it is still diagnosable) psychiatric illness applicable for recovery in the law of tort. This means that the fear as an emotional condition could be taken into consideration as a "pre-conditioning" for a recognisable psychiatric illness. Unlike in medicine where fear is seen as one's emotional condition regardless of the cause (relatedness), in the law of tort there is a distinction between the same clinical conditions: fear for own safety and fear for the safety of another ("proximity").

As stated in *Hambrook v Stokes Bros,* it was held that a plaintiff outside the zone of danger could recover from shock caused by fear for the safety of others, which is highlighted by: (a) the *presence* at the scene of an accident, and (b) the *perception* of danger (as opposed to being informed by someone else). These elements of physical proximity to time and place are the emphasis of the relationship between the plaintiff and the primary victim; it also determines whether the psychiatric damage is foreseeable in the circumstances of an accident.

In *Chaster v Council of Municipality of Waverly*[13], a mother suffered from psychiatric damage through seeing the body of her son recovered from a water-filled trench. It was found that the council who left the trench unprotected owed her no duty of care in preventing the cause of her son's injury. Certainly, the outcome would have been different if she was present at the time when her son suffered injury. In *King v Phillips*[14], a mother who heard a scream looked out of the window and saw her son, as she thought, disappear under the wheels of a taxi. She was not awarded damages because it was not foreseeable

[10] See: Hoffman LJ in *Johnston v NEI International Combustion Ltd* (2007) UKHL 39.
[11] *Palsgraf v Long Island Railroad* (1928) 162 NE 99 (NY).
[12] V Zepinic, *Exposure therapy of panic disorder using support person* (AABCT, 1997); See also: DH Barlow, (ed.), *Anxiety and Its Disorders,* (The Guilford Press 2002); CA Courtois, (ed.), *Treating Complex Traumatic Stress Disorder* (The Guilford Press 2009); MJ Friedman, (ed.) *Handbook of PTSD* (The Guilford Press 2007); MJ Horowitz, *Stress Response Syndrome* (Jason Aronson Inc. 2001); H Teff, *Causing Psychiatric and Emotional Harm* (Hart Publishing 2009); O van der Hart, (ed.) *The Haunted Self* (WW Norton 2006).
[13] *Chaster v Council of Municipality of Waverly* (1939) 62 CLR 1.
[14] *King v Phillips* (1953) 1 KB 429.

that she might be watching from such a position and suffers psychiatric damage.

However, the courts have on many occasions held that it was foreseeable that a plaintiff not present at the scene of the accident but who arrived shortly afterwards ("aftermath doctrine") should be awarded recovery for damages. One of the first was the case of *Boardman v Sanderson*[15], where father and son accompanied a friend to the garage to collect a car. The father left his son outside and went into the garage office. The friend while taking the car outside the garage negligently ran over the son's foot. The father heard his son screaming and immediate ran to his son. The court found that the defendant knew the father was nearby and could foresee that in such circumstances he would immediately come to the scene of the accident.

In an Australian case of *Storm v Geeves*[16], the potential from the *Boardman* case was extended: A child was run over by a truck and killed while waiting for a bus close to her home, and her mother suffered shock and consequently psychiatric damage due to the sight of her daughter's crushed body. The court held that she should be rewarded recovery because it was foreseeable that the circumstances would bring her to the site of the accident. In the *Mount Isa Mines Ltd v Pusey*[17], the plaintiff was quite close to where the accident took place, heard the explosion and went to the scene to assist in the rescue but suffered psychiatric damage as a result of the shock.

The 'aftermath doctrine" received its full endorsement by the House of Lords in *McLaughlin v O'Brian,* in which the plaintiff did not go to the scene of the accident, but to the hospital, where she saw injured members of her family still covered in mud and oil, and crying and screaming. Lord Wilberforce reported:

> As regard proximity to the accident, it is obvious that this must be close in both, time and space… Experience has shown that to insist on direct and immediate sight or hearing would be impractical and unjust and that under what might be called the "aftermath doctrine", one who, from close proximity, comes very soon on the scene, should not be excluded.

The "aftermath doctrine" was accepted outside UK, and indeed extended, by the decision of the Australian High Court in the *Jaensch v Coffey*[18] case. In this case, the plaintiff went not to the scene of the accident but to the hospital where her seriously injured husband had undergone surgery and was in critical condition. She stayed at the hospital for a long period of the day, witnessing the condition her husband had suffered, and a few days later it was evident that she had sustained psychiatric illness. In delivering judgement, Deane J stated that the "aftermath doctrine' was accepted as it was not necessary to look at the immediate point of impact:

> … the aftermath of an accident encompasses at the scene after its occurrence, including the extraction and treatment of the injured. In a modern society, the aftermath extends to the ambulance taking an injured person to hospital for treatment and to the hospital itself during the period of immediate post-accident treatment.

However, the "aftermath doctrine" accepted in the *Jaensch v Coffey* case was challenged in another Australian case *Spence v Percy*[19]. Here it was stated that the Deane J's inclusion of the 'aftermath doctrine" was quite inappropriate, as it represented no further meaning than the conclusion of the existed 'immediate post-accident treatment". Similar to the *Spence v Percy,* the British Columbia Court of Appeal in the *Rhodes v Canadian National Railway*[20] case gave a narrow construction to the theory of causal proximity and doubted utility in determining either foreseeability or causation. In the Australian case *Annetts v Australia Stations Pty Ltd*[21], the 'aftermath doctrine" was tested in regard to perceived perception about the event. *Annetts* concerned psychiatric injury suffered by parents on hearing of the disappearance, and subsequently death, of their 16 years old son who was employed as a jackaroo in Western Australia. In spite of received reassurance that the company would take care of their young boy who would always work under constant supervision, after only seven weeks in the job, he was sent to work on his own in an isolated property and he had gone missing. Two months latter his parents were informed about son's disappearance and, when they heard the news, his father collapsed. After approximately five months of searching, in which the parents took part, their son's remains were found in the desert. The High Court of Western Australia held that a duty of care was owed to the parents in respect of their psychiatric injury in the aftermath of their son's disappearance.

3. PRIMARY V SECONDARY VICTIM

From a legal view of point, it is apparent that the law of tort should be able to develop incrementally, as relevant law experts learn more about psychiatric damages and society recognises its debilitating consequences on the victim's psyche. At the end of the spectrum is the view that psychiatric damages should not be treated any different from a physical injury to the person. Medical knowledge of psychiatric illnesses has advanced to a sufficient stage which will enable for a complete codification of liability for psychiatric damage either as a result of direct victimisation (primary victim), or the eye-witnessing, or hearing about the accident (secondary victim).

[15] *Boardman v Sanderson* (1964) 1 WLR 1317.
[16] *Storm v Geeves* (1965) Tas SR 252.
[17] *Mount Isa Mines Ltd v Pusey* (1970) 125 CLR p.383.
[18] *Jaensch v Coffey* (1984) 155 CLR p.549.
[19] *Spence v Percy* (1991) 21 QLSJ 427.
[20] *Rhodes v Canadian National Railway* (1990) 75 DLR 248.
[21] Annetts v Australian Stations Pty Ltd (2002) 211 CRL p.317.

In a legal practice, the vast majority of claims for psychiatric illnesses concern damage sustained as a result of the perception of death, injury or danger to a person other than the claimant. This is usually due to a fear or uncertainty about the person's injury or other outcomes of the accident involving the person who is a loved one to the claimant. The question arises as to whether recovery is, or should be, barred in other situations, for example when a psychiatric illness is brought about as a result of perception of physical danger to the plaintiff. While considered a liability in the *Jaensch* case for the shock-induced psychiatric damage, Dean J stated that it will not arise unless:

> The reasonably foreseeable psychiatric injury was sustained as a result of the death, injury or peril of someone other than the person whose carelessness is alleged to have caused an injury.

From a logical standpoint there is no sound reason why recovery is not applicable if it is medically proven that the plaintiff suffered psychiatric illness and that it was sustained as a result of the defendant's negligence. Certainly, it is inconceivable that a court would consider a claim brought by the plaintiff who suffered a shock-related psychiatric illness as a result of an accident due entirely to his or her own fault. If a driver, for example, due to a lack of care killed a pedestrian he cannot claim "psychiatric damage" and sue the deceased for shock caused by the body smashing through the windscreen as a result of an impact. The Dean's formula was that the victim's shock arose as a result of the defendant negligently killing, injuring or endangering a third party and shock results not due to a fear for safety of that third party but from a realisation of what the defendant had done, or due to the perception of what would happen to the victim (plaintiff) if he or she had been in the third party's position.

In *Harrison v State Government Insurance Office*[22], the plaintiff was a passenger driven by her husband who caused an accident due to his carelessness. The driver died as a result of the accident and his wife, albeit suffering a minor physical injury, sustained psychiatric illness caused by the trauma because of the accident and her husband's death. The wife brought action against her husband's insurer and the court held that it was impossible to separate the shock caused by death of her husband and trauma caused by the accident itself. This was notwithstanding that the nervous shock and the subsequently suffered psychiatric illness had been a reasonably foreseeable consequence following the death of her husband. Similar findings were held in the cases of *Dwyer v Dwyer*[23] and the *Kohn v State Government Insurance Commission*[24].

However, it was quite interesting finding in the *Rowe v McCartney*[25] case in which the passenger (plaintiff) suffered a minor physical injury due to the driver's negligence while driving the plaintiff's car but sustained depressive neurosis neither from the perception of her own injury nor for witnessing the driver's injury but from a sense of guilt because of the permission given to the driver, a quadriplegic, to drive her car. She failed in her claim for psychiatric damage on the grounds of the type of damage she sustained (guilt-induced neurosis). Similar findings were imposed in the *Klug v Motor Accidents Insurance Board*[26] ruling that the plaintiff's condition was the result of his irrational feeling of guilt.

From the abovementioned, it is obvious that limitations in claiming psychiatric damages for a secondary victim are quite obscure. It may be bound up in the concept of proximity or from the pure public policy consideration, or both. However, there is no logical or sound policy as to why recovery should be refused when the plaintiff suffers a psychiatric damage not from perception of the death or injury of a loved one, but from the realisation as to what would happen to the plaintiff if he or she was there, or in a 'near miss' situation. In these circumstances, the plaintiff's psychiatric illness is not from perception of a narrow avoidance of death or injury to another but from realisation of his or her own fortune or misfortune.

It was quite interesting observation by the House of Lords in the *Johnston v NEI International Combustion* where the claimant was rewarded recovery for psychiatric damage as he suffered clinical depression after he was informed that his pleural plaques indicated a significant exposure to asbestos and the risk of future disease. Lord Hoffman was of the opinion that, unlike anxiety considered in *Hicks v Chief Constable of the South Yorkshire Police*[27], the psychiatric illness does constitute damage for the purpose of founding an action in negligence. His Lordship based his opinion by referencing the principles of *Hatton v Sutherland*[28] and *Barber v Somerset County Council*[29]. The foreseeable event in the *Johnston* case was that the claimant would contract an asbestos-related disease. However, even if this did not occur, he had sustained a psychiatric illness caused by an apprehension – long-standing anticipatory fear of developing an asbestos related disease.

In *Wilks v Haines*[30] the plaintiff was a dormitory supervisor at a school who organised a switch of her working shift so that she was not on duty at night as she was usually would have been. During the early hours, an intruder broke in and killed two of the three supervisors

[22] *Harrison v State Government Insurance Office* (1985) QLD SC.
[23] *Dwyer v Dwyer* (1969) 90 WN.
[24] *Kohn v State Government Insurance Commission* (1976) 15 SASR 255.
[25] *Rowe v McCartney* (1976) 2 NSWLR 72.
[26] *Klug v Motor Accidents Insurance Board* (1991) Aust Torts Rep 81-134.
[27] *Hicks v Chief Constable of the South Yorkshire Police* (1992) 2 All ER 65.
[28] *Hatton v Sutherland* (2004) ICR 613.
[29] *Barber v Somerset County Council* (2004) 1 WLR 1089.
[30] *Wilks v Haines* (1991) Aust Torts Rep 81.

on duty and injured the third. When told about the incident, the plaintiff suffered shock and consequently psychiatric illness not because of the death and injury to her workmates, but as a result of her 'fortune' as she had altered her shift pattern. Although her claim was struck out, the question remains if the requisite criterion necessary for the duty of care was present, and whether the plaintiff did in fact genuinely believe she suffered a compensable injury due to the defendant's carelessness. On the other hand, in the *Klug* case, Oliver LJ was troubled with the restrictions and considered it fundamentally flawed from the standpoints of principle and logic:

> The limitations must be based upon policy rather than upon logic, for the suffering and shock... as it must be, on the combination of proximity and foreseeability, there is certainly no logical reason why a remedy should be denied in such a case.

4. EXISTING LAW OF TORT ON RECOVERY DUE TO A PSYCHIATRIC DAMAGE: THE *ALCOCK* CASE AND BEYOND

In numerous tort law cases, textbooks and law journals, the *Alcock v Chief Constable of South Yorkshire* has been considered as a "test case" which shows the differences in endorsement of psychiatric damage within the law of tort. Apart from the restricted policy approach due to the possibility of 'floodgate liability', this case created most public and professional interest than any other case in the English law of tort. The case examines the limits of the aftermath problem either upon the primary or secondary victim and proximity and it is related to the tragedy which occurred during a football match at Hillsborough[31]. Some of the plaintiffs were at the ground where the tragedy took place, others went to find their missing relatives, and in some cases they visited a temporary mortuary which had been set up. Some of the plaintiffs went to the local hospitals in search of their loved ones, and others simply waited at home watching TV, or listening the radio, in a hope of receiving some news. There were those who travelled to Sheffield (UK) to search for their loved ones, relatives or friends. With the strain of searching and with the agony of all the waiting, in all of these cases, it was simply the scale of the disaster which prevented immediate contact with the dead or the injured.

The case was brought by 16 claimants who were relatives or friends of Hillsborough victims and sought damages for psychiatric illness, mainly for posttraumatic stress disorder. Psychiatric harm and causation were assumed for the purpose of witnessing, which centred the scope for recovery when the claimants were neither a parent nor spouse of an immediate victim, and whether the communication other that direct involvement could ground a claim. Any further claim applications not only in regard to the Hillsborough disaster would depend on the *post factum* (success or failure) of the *Alcock* case.

At first instance, nervous shock was deemed reasonably foreseeable in principle for claimants who witnessed the tragedy via a live TV broadcast but not for those who had been told of the disaster or heard live radio broadcasting and only later saw the events on TV news items. Watching the disaster live on TV was deemed close enough to "being there" to count as a medium of communication for the purposes of liability:

> The visual image... is all important. It is what is fed to the eyes... the instant effect upon the emotions and the lasting effect upon the memory.

The court emphasised that the "instant visual effect" inevitable caused distress and shock resulting in the development of recognisable psychiatric illness (compensable injury), mainly post-traumatic stress disorder. According to Hidden LJ, recovery was entitled to siblings but no to the other categories beyond parent or spouse as:

> Once (the line) is extended to include brother or sister… it has reached the margin of what the process of logical progression would allow. The other relationships are not so immediate to make it reasonably foreseeable to a defendant that psychiatric illness, rather than grief and sorrow, would follow death or damage to the loved one.

However, the *Alcock* case questioned many things in relation to clarify the meaning of the "near", "loved one" or "close" relatives in the scope of "extension" while considering the inclusion of brother or sister. The House of Lords held that there is a rebuttable presumption of sufficiently close ties of love and affection between spouses, parents and children, but in all other cases the closeness of the tie had to be proved by the plaintiff. However, one plaintiff had been present at the ground and witnessed the disaster in which his two brothers were killed, but his claim failed as he was "unable to produce evidence of a close tie of love and affection to his brothers". In a subsequent case, psychiatric damages, however, were awarded to the half-brother of one of the Hillsborough victims because the judge found evidence that he was close to his half brother. Apart of inconsistence regarding the court requirement for "close tie of love and affection to the immediate victim", the most puzzles are

[31] During the football match at the Hillsborough stadium one part of the stadium collapsed and in a massive panic among the spectators 96 people died and hundreds have been injured. The legal action was taken by friends and relatives of those caught in the crush, killed or injured, and case brought together a number of claims identified as representative of the different legal issues raised by the group of claims as a whole. For the purpose of the test case, it was presumed that the plaintiffs had suffered post-traumatic stress disorder as a result of their experience (M Lunney, K Oliphant, *Tort Law, Text and Materials,* (4th edition, Oxford University Press 2010).

how the plaintiff could provide reliability of such *post mortem* evidence.

In *Turbyfield v Great Western Railway*[32] the twin sister was awarded for a shock, without any suggestion that she had a special status as a twin. More generally, there is no logic reason to exclude a fiancée, partner or grandparent considering proximity and/or close affection. This has in particular been considered in the *McLaughlin v O'Brian* case in which Lord Wilberforce stated that 'near relative' may recover and he did not accept a rigid application for proximity and rather emphasised a common sense to individual situations in their entirety. This is in particular in regard to the restrictive liability for 'secondary' claimants when the harm is reasonably foreseeable. The principle of proximity was the predominant issue in the *Alcock* case with a different approach and in the first instance it was the opinion that the 'floodgate liability' issue could compromise the claims. From the medical point of view, this approach was quite senseless and unacceptable – it is begs the question as to what could be a more horrific accident than the Hillsborough tragedy and why despite the horrible scenes with 96 killed people and hundreds injured, the 'scale of horror' had not been horrible enough for the court?!

In many cases before the *Alcock* it was clear that the claimant need not actually be at the scene of the accident ('proximity in time and place')[33], in particular in the Australian case *Jaensch v Coffey.* This causes some theoretical question should proximity and liability for psychiatric damage depends on a race between the claimants and the ambulance or of the A&E waiting list and busy ward. In *Galli-Atkinson v Seghal*[34]*,* the claimant's daughter was killed by a car which dangerously mounted the pavement. The claimant was looking for her, came to the police surrounding the accident, and was told that her daughter was dead. She then together with her husband went to the mortuary and saw her daughter's dead body, which had devastating and disfiguring injuries. The court ruled that this constituted continued sequence of the traumatic event and that the accident's immediate aftermath extended to the moment when the claimant left the mortuary.

Needless to say that this decision could not be delivered by the court if ruled by the *Alcock* principle in which the relatives who travelled to Sheffield to search for loved one and subsequently identified their dead bodies in the temporary mortuary were not entitled to recover based on the aftermath doctrine. For Parker LJ in the Hillsborough case, there would be liability only if the plaintiff had to identify a body as part of the immediate aftermath of the accident. This opinion contradicted the *Hevican v Ruane*[35] case which was delivered only a few months before. In that case, the plaintiff suffered psychiatric illness as a result, *inter alia,* seeing the body of his dead son in the mortuary approximately three hours after he was killed in a bus accident, along with other members of his school football team.

Unlike the *Hevican* case, Parker LJ held a position that identification took place at about midnight, nearly nine hours after the tragedy occurred and ten or more hours after the gates were opened. Even in the aftermath at the hospital it was interpreted narrowly by Parker LJ stressing that this was to be regarded as part of the catastrophe "because none of the victims had been cleaned up or attended". This opinion was quite controversial as suggests that if victims had received preliminary A&E treatment they could no longer be within the aftermath of the accident. However, it does not sound reasonable to exclude from a potential case of action from the victim's relatives or friends due to the shock suffered seeing and knowing what had happened. The efficiency of the A&E treatment depends on many circumstances and it would be interesting to know application of the "aftermath doctrine" if the accident happened on a busy Saturday night, where treatment may be delayed for several hours. Clearly, the 'aftermath' cause should be taken more flexibly and longer than one or two hours as was suggested by *McLaughlin.* The House of Lords in the *Alcock* case have almost certainly limited the aftermath doctrine to a narrower scope than was accepted in the *Jaensch* case.

In *Alcock,* the House of Lords recognised the proximity of relationship between parent, and spouses, but required 'sufficiently close' ties of love and affection to be proved in the case of other relatives or friends. This requirement did not provide directions how the claimant can produce the evidence of a "closeness" with the dead person, and what *onus probandi* for affection should be used considering that the affection is an implied feeling and emotion, and used to refer to love or positive feelings for another that are not sexual. Further difficulties in accepting principle from the *Alcock* in regard to proximity of perception is uncertainty about how much perception of the accident the claimant must experience to be compensatory. In *Hambrook v Stokes Bros* the claimant was awarded recovery because of having a reasonable fear for the life or safety of a loved one. It is quite difficult to find a reasonable explanation for dismissing the claim in *Alcock* for those claimants who "witnessed" the shocking scenes on live television or had been told that their loved one was killed or severely injured.

As all roads lead to Rome, the House of Lords alluded to the most likely reason for the controversial decision in *Alcock* – the anticipatory fear of the "floodgate liability"

[32] *Turbyfield v Great Western Railway* (1937) 54 TLR 221.
[33] See: *Benson v Lee* (1972) VR 879; *Fenn v City Peterborough* (1976) 73 DLR 177; *McLaughlin v O'Brian* (1983) 1 AC 410; *Jaensch v Coffey* (1984) 155 CLR p.549.
[34] *Galli-Atkinson v Seghal* (2003) EWCA Civ 697.
[35] *Hevican v Ruane* (1991) 3 All ER 65.

applications. In the *Page v Smith* case, Lloyd LJ giving leading speech stated that:

> … in cases involving nervous shock, it is essential to distinguish between the primary and secondary victims… in claims by secondary victims the law insists on certain control mechanisms, in order as a matter of policy to limit the number of potential claimants.

The House of Lords again considered "nervous shock" as the plaintiff was outside the range of foreseeable physical injury. The case was about a car crash in which the plaintiff was driving with due care when suddenly without warning the defendant who was coming from the opposite side caused the accident. The plaintiff did not suffer physical injuries but three hours later felt exhausted and such conditions continued such that he never fully recovered. At the time of appeal, almost eight years after the accident occurred, he still was not working and was diagnosed with a chronic myalgic encephalomyelitis. In the first instance, the plaintiff was awarded recovery but the defendant made an appeal on the grounds that it had not been reasonably foreseeable that the person of normal fortitude would suffer psychiatric damage without any physical injuries at the accident.

5. PSYCHIATRIC DAMAGE IN THE LAW OF TORT AFTER THE *ALCOCK* CASE

Because of many similarities, it appears that *White v Chief Constable of South Yorkshire*[36] was a "test case" in regard to the decisions delivered in *Alcock*. In this case, a number of police officers made applications for claim against their employer, the Chief Constable, in respect of post-traumatic stress disorder suffered in the aftermath of the Hillsborough disaster. All of the police officers had been on duty at the stadium when the tragedy happened and took different roles in an attempt to help injured spectators and all of them had witnessed chaotic and horrible scenes. The court found that claim is entitled to succeed either on the basis that the officers had encountered exceptionally horrific scenes in the course of their employment or that they were rescuers. The case came in front of the House of Lords after the Chief Constable appealed against the finding and claims were rejected. Part of the reason for this was undoubtedly public policy – since all the claims for compensation by relatives of the victims had already been rejected in *Alcock* where the psychiatric injuries were not reasonable foreseeable, it could and did cause a public furore if police officers were compensated in less deserving cases.

The House of Lords found that plaintiffs in this case were rescuers by virtue of their employment not 'personally threatened' or in relationship of love and affection with any of the deceased. Their Lordships observed that there is no authority which decides that a rescuer is in any special position in relation to liability for a psychiatric injury. The *White* case questioned *Chadwick v British Railways Board*[37], however, Lord Hoffman did not use principles from this case and Waller J's judgement but rather logic from the *Alcock* case:

> There does not seem to me to be any logical reason why the normal treatment of rescuers on the issues of foreseeability and causation should lead to the conclusion that, for the purpose of liability for psychiatric injury, they should be given special treatment as primary victims....

Unlike in the *Alcock* case where the plaintiffs were the secondary victims, in *Page v Smith* the plaintiff was the 'participant' of the defendant's negligence, not a spectator or bystander. He was the primary victim with the foreseeability of physical injury but instead suffered psychiatric illness. The factual distinction between the primary and the secondary victim was recognised in *Bourhill v Young*[38] where the plaintiff was not directly involved in the accident but after hearing the crash and seeing blood left on the roadway, she suffered the extreme shock of the occurrence, but also wrenched and injured her back. At the time of the accident she had been about eight months pregnant, and five weeks later she gave birth to a still-born child as a result of her injuries. The House of Lords found that she was observer who merely heard a noise of the actual accident and that defendant was under no duty to the plaintiff to foresee that his negligence in driving at an excessive speed and consequently causing an accident might result in injury to the plaintiff.

Observing the decision in *Bourhill v Young,* Lord Lloyd in *Page v Smith* stated that:

> The secondary victim is almost always outside the area of physical impact, and therefore outside the range of foreseeable physical injury. But where the plaintiff is the primary victim of the defendant's negligence, the nervous shock cases, by which I mean the cases following on from *Bourhill v Young,* are not in point.

His Lordship's opinion challenged not only the decision in *Bourhill v Young* but tested the judgement delivered in the *Alcock* case in regard to the range of foreseeable physical injury. Albeit the condition of myalgic

[36] *White v Chief Constable of South Yorkshire* (1999) 2 AC 455.

[37] In *Chadwick v British Railway Board* [(1967) 1 WLR 912, an action was brought by the plaintiff as a personal representative of her late husband in respect of the injury she sustained as the aftermath of the Lewisham train disaster in 1957. In bad weather condition two trains collided and 90 people were killed. The accident happened at 6pm, some 200 yards from the Chadwicks' house. Mr Chadwick immediately ran out to help and did rescue until 3am when he came home covered with mud and blood on his hands. He was shaking, upset and distressed, unable to sleep. The accident made him suffer psychiatric illness and he lost interest for previously enjoyable activities, and was unable to work. He required hospital treatment for approximately six months. Waller J held that the defendant owed the deceased a duty of care as a foreseeable victim of their negligence.

[38] *Bourhill v Young* (1943) AC 92.

encephalomyelitis is a neurological disease and not listed in the diagnostic manual (DSM-V or ICD-11) the symptoms can predominantly be seen as a psychiatric disorder. The House of Lords in the *Page v Smith* case adopted Lord Denning's *obiter dictum* that "the test of liability for shock is foreseeability of injury by shock"[39]. Their Lordships found that the injury had to have been reasonably foreseeable in person of a normal fortitude, a requirement related to a minor accident in which no one had been physically injured. As in fact the plaintiff did not suffer physical injury as a direct aftermath of the accident, the finding in *Page v Smith* has been controversial in several aspects.

It is important to note that the myalgic encephalomyelitis could indicate the "ill-defined" nature of this medical condition itself with uncertainty about the causes, but the most controversial point is that such condition is not recognised as a "pure" or recognised psychiatric illness. Lord Lloyd's finding received much criticism by Lord Goff in *White* case who described the decision in *Page v Smith* as "markedly departs from generally accepted principles". We can summarise criticism into three categories: (a) there was no similar approach in any other case and there are cases quite contrary; (b) the approach that Lord Lloyd reached appears inconsistent with findings in the *Wagon Mound*[40] where a particular type of damage to property by fire was differentiated from other types of damage to property for the purpose of deciding whether the defendant could reasonable have foreseen damage of that particular type. Strict differentiation between psychiatric illness and physical injury is quite debatable and inconsistent with the scientific advances that psychiatric illnesses may have a physical basis, or that psychiatric injury should be regarded as another form of injury; (c) the majority in *Page* case may have misunderstanding the *eggshell skull role* – the rule that a tortfeasor cannot complain if the injuries he has caused turn out to be more serious than expected because his victim suffered from a pre-existing weakness, such as an unusual thin skull, and tortfeasor must take his victim as he finds him.

The *Alcock* case is still the subject of a number of academic as well as practical debates, and will occupy the attention of books and scientific journals, for quite some time before it is clearly defined and clarified. Mullany & Handford[41] are of the opinion (contrary to the findings in *Alcock)* that the mental repercussions of traumatic event are more serious, are more deserving of the law's attention than physical injury. The psychiatric illness frequently persists long after organic injuries have disappeared and that the healing process is often more complicated due to severity and complexity of the symptoms of the mental disorder. This is particularly in delayed PTSD or in complex trauma followed by dissociation[42]. In clinical practice, it is common that the after-effects of trauma never fully dissipate and continue to haunt the traumatised individual for the remainder of his/her life, eroding continuity of the sense of self. However, the courts, such as in the *Alcock* case, create precedents irrespective of the medical findings as psychiatric illness is commonly unrelated to physical injury at the accident but can cause organic changes, even in blood cells, in case of severe trauma.

6. PROBLEMS IN ACKNOWLEDGING THE PSYCHIATRIC DAMAGE BETWEEN THE LAW AND THE MEDICINE

While considering recovery for "nervous shock" it is necessary to clarify the meanings of "recognisable psychiatric illness/injury" and endeavour to apply the contrasting approaches between the law and medicine. In medicine, the meaning of 'emotional distress or suffering' has not always been clearly and precisely defined[43]. While responding to the UK Law Commission in regard to the liability for diagnosable psychiatric illness[44], the UK

[39] See Lord Denning in *King v Phillips* (1953) 1 QB 429.
[40] *Overseas Tankship* (UK) Ltd v Miller Steamship Co Ltd (The Wagon Mound No.2) (1967) 1 AC 617.
[41] NJ Mullany, PR Handford, *Tort Liability for Psychiatric Damage,* (The Law Book Company 1993).

[42] V Zepinic, *Hidden Scars: Understanding and Treating Complex Trauma,* Xlibris, 2011 (See also: V Zepinic: *The Self and Complex Trauma,* 2012*;* S Boon, *The treatment of traumatic memories in DID,* 1997; D Brown, et al., *Memory, trauma treatment, and the law,* 1998; JD Ford, et al., *Treatment of complex posttraumatic self-dysregulation,* 2005; JL Herman, *Trauma and Recovery,* 1992; K Steel K, et al., *Dependency in the treatment of complex posttraumatic stress disorder and dissociative disorder,* 2001.
[43] Posttraumatic stress disorder (PTSD), one of the most common human reactions to traumatic event, has been differently defined with a variety of formulations by well-respected professionals in the field of psychotraumatology. Because of the presence of autonomic cardiac symptoms, this mental health condition was named *soldier's heart d*uring the US civil war; in early 1900s because of influence of psychoanalysis the clinicians applied diagnosis of *traumatic neurosis*; in World War I the syndrome was called *shell shock* and was hypothesised to result from brain trauma by exploding shells; during World War II, as well as symptoms described by survivors of Nazi concentration camps and the survivors of the atomic bombings in Japan, the syndrome was called *combat neurosis* or *operational fatigue*; the psychiatric morbidity associated with Vietnam War veterans finally brought the concept of *posttraumatic stress disorder* being defined for the first time as an independent disorder in the Diagnostic and Statistical Manual (DSM) published in 1980. In all these traumatic situations, the appearance of the disorder was roughly correlated with the severity and complexity of the stressor, and the most severe stresses resulted in the occurrence of the syndrome in more than 75 percent of the victims (See more details in: BJ Sadock, VA Sadock, *Kaplan & Sadock's Synopsis of Psychiatry*, 9th ed, 2003; RE Hales, SC Yudofsky, JA Talbot, *Textbook of Psychiatry*, 3rd ed, 1999; M Gelder, R Mayou, P Cowen, *Oxford Textbook of Psychiatry*, 2001); M Jones, *Liability for Psychiatric Illness – More Principle, Less Subtlety,* 1995.
[44] UK Law Commission, No 249, *Liability for Psychiatric Illness* (HMSO 1998).

Royal College of Psychiatrists' Mental Health Law Group stated:

> For psychiatrists the 'shock-induced' requirement causes serious problems. The term is vague, has no psychiatric meaning and is emotively misleading. The requirement should be abandoned... The requirement to fit the evidence around the concept of whether or not the disorder is "shock-induced" has no scientific or clinical merit[45].

In recent years a significant proportion of claims for damages for psychiatric illness have specifically alleged that they have been suffering from post-traumatic stress disorder. It seems likely that the emphasis given to post-traumatic stress disorder stems from the courts requirement that the plaintiff prove that he or she is suffering from a shock-induced recognisable psychiatric illness as a result of the defendant's negligence. It is conflicting to make distinction between "illness" and 'disease' not only in the law of tort but even in general medicine as well. In general, "disease" refers to a defined morbid process having characteristic symptoms of the pathology. On the other hand, "illness" is defined as the appreciated dimensions of a medical condition, the subjective awareness of distress or limitation in functioning. Although these two often coexist or interplay, they are mutually exclusive concepts of impact upon the person. For example, a person may be diseased without being ill such as well-controlled diabetes; or being ill without having disease such as loss of limb as a result of an accident.

The World Health Organisation defines "health" as "a state of complete physical, mental, and social well-being, and not merely the absence of disease or infirmity". However, a majority of psychiatric conditions which are potentially the subject of tort claims are best regarded as "mental illness' based on the presence of suffering. In practice, rather than struggle to find a global definition for the "mental illness", psychiatrists allocate various psychiatric disorders to diagnostic categories designed to represent distinct entities, grouping collectively under the umbrella of the "mental illness". However, in the case of "recognisable psychiatric illness" the law of tort does not accept terms such as "mental distress", "emotional suffering", "mental anguish', or "emotional distress", but assessed psychiatric illness in accordance with the diagnostic criteria, either prescribed by the DSM or ICD. It should also be stated that in medicine, the term "emotional" indicates a person's mood or spirit (often a state of agitation or excitement), and the term "mental" indicates a psychological or psychiatric condition but not an exact psychiatric illness. In the US the courts adopted a practice of using the term "emotional distress" (and occasionally "mental distress") to cover both initial emotional response to stimuli and the mental consequences of response. In the Commonwealth countries, however, the distinction between the two remains and, from the medico-legal point of view, it remains so in order to avoid the use of the terms "emotional distress" or "mental illness" while referring in the medico-legal report to recognisable psychiatric illness.

It is thus the best option covering a variety of unpleasant or detrimental emotional reactions universally accepted in recognisable psychiatric illness. This approach defines "emotion" as a multidimensional referent: (a) individual, consciously felt effect; (b) the complex set of biochemical processes which constitute the internal milieu in which multiple reactions take place at various physiological integration, as well as functioning of various neurological mechanisms (central or autonomic nervous system) related with the somatic expression of emotions; and (c) more or less typical apparent patterns of behaviour which express the felt effect to be manifested.

In general, there four basic human emotions: sadness[46], joy[47], anger[48], and fear[49]. For a proper understanding of the emotions it is necessary to understand the nervous system and its anatomical and physiological distinctiveness. In *Kline v Kline*[50], Gillett J described mental or emotional distress as "a touching of the mind, if not of the body". This description is incorrect as not every type of emotional response is purely mental suffering. The general conclusion is that emotion as a purely mental thing does not exist. The bodily reactions are usually short-term,

[45] See also: WG Earengey, *The Legal Consequences of Shock*, 1992; RE Kendell, *The distinction between mental and physical illness,* 2001; D Mendelson, *The Interfaces of Medicine and Law,* 1998; NJ Mullany, P Handford, *Tort Liability for Psychiatric Damage,* 1993; C Tennant, *Liability for Psychiatric Injury: an Evidence-based Approach,* 2002; S Wessely, *Liability for Psychiatric Illness,* 1995.

[46] The emotions associated with sadness: defeated, dejected, depressed, despairing, desperate, devastated, disappointed, discouraged, embarrassed, guilty, helpless, hopeless, hurt, ignored, inadequate, incompetent, inferior, inhibited, insecure, isolated, lonely, melancholy, miserable, misunderstood, needy, pessimistic, preoccupied, pressured, regretful, rejected, remorseful, self-conscious, shy, sorry, stupid, tired, trapped, troubled, unappreciated, unattractive, uncertain, uncomfortable, unfulfilled, useless, victimised, violated, vulnerable, weary, worried.

[47] The emotions associated with joy: affectionate, alive, amused, beautiful, brave, calm, capable, caring, cheerful, cherished, comfortable, competent, concerned, confident, content, courageous, curious, delighted, desirable, eager, excited, forgiving, friendly, fulfilled, generous, giving, good, grateful, happy, hopeful, humorous, joyful, lovable, loved, loving, loyal, passionate, peaceful, playful, pleased, proud, quiet, relaxed, relieved, respected, safe, supportive, sympathetic, tender, thankful, thrilled, trusted, understanding, understood, unique, valuable, warm, wonderful, worthwhile, youthful.

[48] The emotions associated with anger: annoyed, bitter, contemptuous, distrustful, enraged, furious, hateful, hostile, humiliated, hurt, impatient, irritated, outraged, overwhelmed, provoked, resentful, stubborn, touchy, unappreciated, uneasy.

[49] The emotions associated with fear: afraid, apprehensive, ashamed, desperate, devastated, fearful, frantic, indecisive, helpless, hopeless, horrified, insecure, panicked, pressured, scared, self-destructive, self-hating, terrified, threatened, timid, trapped, uncertain, uncomfortable, victimised, violated, vulnerable.

[50] *Kline v Kline* (1902) 64 NE 9.

however, in the long-term these bodily changes may cause serious and permanent damage. It may be followed by a secondary, longer-term reaction, which occurs when the body cannot overcome the problem of emotional stress, or adequately cope with the traumatic event. Despite significant progress which has been made in psychiatric medicine, the line between "normal" emotional response to trauma and 'abnormal' is still unclear[51].

Complications to determine differences between normal and abnormal conditioning puzzle the courts in particular while distinguishing secondary damage from transitory or momentary human response (any injury, psychological or physical, taken by surprise or frightened). This was considered in *Brook v Cook*[52] case when an African monkey suddenly appeared on top of the plaintiff's garden wall, frightening her and she fell breaking her wrist. Similarly in *Slatter v British Railways Board*[53] the plaintiff was startled by a loud bang caused by a loaded wagon crashing into a stationary wagon. In both of the abovementioned cases, the recovery from physical injury cannot be regarded as one involving recognisable psychiatric harm, albeit it was caused by immediate impact upon the plaintiff's emotions resulting in uncontrollable reaction (behaviour) and physical injury. In essence, it was the initial response of exposure to trauma (as well as consequent and immediate physical injury) which may be classified as "emotional distress".

Trauma-induced disorder is the aftermath where a sufferer has been exposed to traumatic event(s) by the dread that all is not well, and that terrible is about to happen to him or those he loves. Because the person is afflicted, he does not know where the danger is going or coming from, his consistency is constantly under threat by the perceived need to worry even with no apparent reason. Such emotional tension produces severe stress resulting in severe symptoms such as nervousness and timidness, nausea, chest pressure, cardiac palpitations, shortness of breath, loss of weight, muscle spasm or pain, persistent headaches and backaches, stomach pains, weakness, and so on. It is also a common development of the conversion reactions into various physiological symptoms such as pain, muscular spasm, paralysis, mutism, and loss of hearing, or psychological blindness.

The effects of trauma do not manifest themselves only into recognisable psychiatric illness, but in terms of physical harm and chronic dysfunctions in some organs or parts of the body due to the overwhelming emotional reactions are purely psychological disturbances[54]. Somatoform complaints caused by the psychological factors are poorly understood by the law, but nevertheless by medicine as well. Traumatised individual may experience somatic sensations – feelings of coldness or hotness in the limbs, tingling, slight pains of a dull or sharp quality, feeling of fullness in the stomach, of distension in bladder or rectum, headaches or sensations of tightness or pressure on the head, etc. In severe traumatic cases, these symptoms may develop into somatoform dissociation – a condition which is characterised by (a) psychogenic symptoms, (b) causation is thought to be unconscious, and (c) occurs as a process of conversion or dissociation.

Alongside the somatoform problems, the effects of trauma manifest themselves in secondary reactions to the trauma: Hypochondria characterised by fear of illness and excessive concerns with the health; phobias which lead the traumatised individual to avoid contact with people or visit places or situations; obsessive-compulsive disorder leading people with continued appearance of unwelcomed ideas in the mind or a repeated urge to carry out certain acts or rituals; depressive reactions which cause sleeplessness, loss of appetite, impaired initiative and fatigue; hysterical reactions which affects sensory and motor system leading to possible loss of sensory capacities or partial paralysis (particularly in the extremities) and may also result in epileptic-like convulsions[55]. There have long been, and continue to be, widely diverging concepts of the psychiatric condition, making it the most difficult "recognisable psychiatric illness" to define and describe in the law of tort.

Among all of the recognisable psychiatric illnesses, the particular significance belongs to post-traumatic

[51] Freud argued that *traumatic neurosis* result when the *ego* is overwhelmed as a consequence of an extensive breach is made within defensive mechanisms ("protective shield") against traumatic stimuli. The *ego,* seen as executive of the personality, mediates between the needs of the self and reality. In case of unbalanced *ego* function normal adaptive capabilities are disturbed and person reverts to the primitive form of defence known as repetition compulsion which involves repeating the distressing happening over and over. The active re-creation of the event in this manner rather than the passive experience of it as in the original situation allows trauma victim to overcome it. (See: S Freud, *Beyond the Pleasure Principle* (Standard Edition 20, 1920).

[52] *Brook v Cook* (1961) 105 SJ.

[53] *Slatter v British Railway Board* (1966) 2 Lloyd's Rep 395.

[54] V Zepinic, *The Self and Complex Trauma* (Xlibris Publishing 2012). See also: MJ Friedman, (ed.) *Handbook of PTSD,* 2007; RR Grinker, LP Spiegel, *Men Under Stress,* 1945; MJ Horowitz, *Stress Response Syndrome*, 2001; A Kardiner, *Traumatic Neurosis of War,* 1941; RS Lazarus RS, *Psychological Stress and the Coping Process,* 1966; LJ Levenson LJ, (ed.) *Textbook of Psychosomatic Medicine,* 2005; CS Myers, *Shell Shock in France,* 1916; ZV Segal, et al., *The Self in Emotional Distress,* 1993; O van der Hart, (ed.) *The Haunted Self,* 2009; BA van der Kolk, (ed.) *Traumatic Stress,* 1996.

[55] See: SE Abbey, *Somatisation and Somatoform Disorders,* 2005; American Psychiatric Association: *Diagnostic and Statistical Manual of Mental Disorders (DSM-V),* 2012; M Aragona, et al., *The relationship between somatisation and posttraumatic symptoms amongst immigrants receiving primary care services,* 2010; C Archibald, et al., *Persistent stress reactions after combat,* 1965; JD Bremmer, et al., *Functional neuroanatomical correlates of the effect of stress on memory*, 1995; CV Ford, *Somatic symptoms, somatisation, and traumatic stress: An overview,* 1997; LJ Herman, *Trauma and Recovery,* 1992; W Katon, et al., *Somatisation: A spectrum of severity,* 1991.

stress disorder (PTSD), as the most present in the courtrooms. Although clinical features of the PTSD have been observed for hundreds of years, the psychiatric nomenclature of the disorder was for the first time defined in the early 1980s. It was in 1980 when the American psychiatrists introduced PTSD as a new diagnostic category in the DSM-III – standardised diagnostic psychiatric text. One catalyst for its inclusion was the growing research findings carried out on combat veterans, in particular the catastrophic condition of the Vietnam War veterans.

Soon after PTSD had been recognised as a psychiatric illness in diagnostic manuals (DSM and ICD), the suffering of plaintiffs had been identified as recognisable psychiatric illness adopting diagnostic criteria[56]. The courts accepted that the PTSD is an aftermath of the exposure to a distressing external event which is outside the range of usual human experience. Importantly, the courts also recognised that trauma may be experienced through direct physical perception or on learning of it through third parties, alone or in the company of others.

Exposure to the phenomena of traumatic events lead to a characteristic collection of the symptoms including re-experience of the traumatic event, avoidance of stimuli associated with the trauma, numbing of responsiveness to the external world and increased arousal. All four criteria must be present to diagnose PTSD which focuses on specific psychological response to an extreme environmental condition which would evoke distress symptoms. In severe cases, the PTSD victims may even experience memory fragmentation, developing psychogenic amnesia for important aspects of the trauma. Trauma sufferers also experience problems in concentrating or completing tasks and display irregular aggressive or violent behaviour ranging from irritability, with fears of losing control, to unpredictable explosion of anger, to inability to express anger at all.

The original definition of PTSD includes a distinction between three subtypes: An acute disorder which began within six months of the trauma and lasted less than six months; a chronic disorder lasting six months or longer; and delayed PTSD which had its onset at least six months after the event occurred. Clinical experience reveals that PTSD is a syndromal progression of features from acute to the chronic stage, although it is certainly true that this progression may be affected by "secondary symptoms", such as fatigue or tiredness due to involvement in continuing or progressive litigation.

Alongside the PTSD symptoms described in previous editions of the DSM, the fifth edition introduced new elements of the diagnostic criteria: dissociative symptoms[57]. In general, dissociation is a severe condition of distorted self, sudden disruption or alteration of some aspect of consciousness, identity, or motor behaviour. It can be sudden or gradual in onset, and transient or chronic in duration. Dissociation evolves over time into a maladaptive or pathological process and dissociative phenomena which exist in a continuum[58]. How, as a matter of relativities and practicality, it should be accommodated in the law of tort general structure for redressing personal suffering due to dissociation is difficult to say as the law is far from uniform in classifying and providing remedies for mental and emotional harm. The law is, in many aspects, imprecise and slow in adopting novel approaches in the medicine, in particular as medical opinions differ on how to define and label particular mental conditions. It is also apparent that with the differences within the same category of law, comparable legal system has adopted divergent rules and terminology for mental harm, such as 'emotional distress' in the US jurisdiction.

CONCLUSION

The analysis in this article has served to illustrate the complexity for both the law of tort and medicine to foster the imposition of inappropriate doctrinal restrictions on recovery for psychiatric damages and the influence of underlying concerns that continue to create uncertainty in this grey area. Damage to the psyche has throughout the history provoked apprehension, a sense uncertainty, and ignorance, as these injuries cannot be seen by the naked

[56] See: *Chapman v Lear* [1984] QSC 3732; *Clark v Criminal Code of QLS* (1992) QSC 363; *Pithworth v Bevan M Roberts Ltd* (1992) SASC 770; *Mullay v Bus Eireann* (1991) Irish HC .

[57] DSM-V diagnostic criteria for PTSD require specifying whether the disorder is with dissociative symptoms. The individual's symptoms meet the criteria for posttraumatic stress disorder, and in addition, in response to the stressor, the individual experiences persistent or recurrent symptoms of either of the following:

1. **Depersonalisation:** Persistent or recurrent experiences of feeling detached from, and as if one were an outside observer of, one's mental processes or body (e.g., feeling as though one were in a dream: feeling a sense of unreality of self or body or of time moving slowly).
2. **Derealisation:** Persistent or recurrent experiences of unreality of surroundings (e.g., the world around the individual is experienced as unreal, dreamlike, distant, or distorted).

[58] For more details about pathology, symptoms complexity and severity of dissociation see: Bernstein EM: *Development, reliability, and validity of a dissociation scale*, 1986; Branscomb LP: *Dissociation in combat-related posttraumatic stress disorder,* 1992; JD Bremner, *Trauma, Memory, and Dissociation,* 1997; J Briere, *Peritraumatic and persistent dissociation in the presumed aetiology of PTSD,* 2005; PF Deli, (ed.) *Dissociation and the Dissociative Disorder,* 2009; NC Feeny, *Anger, dissociation, and posttraumatic stress disorder among female assault victims,* 2000; AM Ludwig, *The psychobiological functions of dissociation,* 1983; ERS Nijenhuis, *Somatoform Dissociation: Phenomena, Measurement, and Theoretical Issues,* 2004; FW Putnam, *Development of Dissociative Disorder,* 1995; O van der Hart, (ed.) *Trauma-related dissociation: Conceptual clarity lost and found,* 2004; V Zepinic, *Healing traumatic memories: A case study,* 2008; v Zepinic: *The Self and Complex Trauma,* 2012; C Zlotnik, et al., *Chronicity in posttraumatic stress disorder and predictors of course of comorbid PTSD in patients with anxiety disorder,* 1999.

eye. However, it does not mean that psychiatric injury is any "less real" than physical injury which involve broken bones, the spilling of blood, the scarring of tissues or "physical" pain. In fact, the repercussions of trauma are more serious, more deserving of the law's attention than those of a physical nature. In many clinical cases is evident that the trauma is analogues to a high-velocity bullet piercing through the body, tearing apart internal organs which are critical for survival. As aftermath of the traumatic event(s) the suffering frequently persists long after the physical injuries have disappeared. Despite its history and movements forward, psychiatric damage in the law of tort is still a subject of development and in its embryonic stage and not clearly defined academically nor practically. It was not surprise that the *Coultas* decision was challenged by the courts in Ireland, UK, USA, South Africa, New Zealand, Canada and Australia. This was particularly evident since 1980 when PTSD was recognised as an independent disorder by the DSM-III and steadily increasing knowledge of the effect on the human psyche by traumatic event(s). The law started to march with the medicine the same beat but in the reality it is little limping.

The *Alcock* case illustrates the court reluctance to acknowledge the individual's suffering due to the influence of underlying concerns that recovery will open the window for "floodgate of liability". The decision has widened a gap between the law and the medicine and, in terms of doctrinal maturation, acknowledgment of psychiatric damage into the law of tort, after over a century, it is still in its embryonic stages. Given the legal requirements of a recognisable psychiatric illness, the law of tort is faced with this dilemma and uncertainty about the issue: To adopt unreservedly medical progress in assessing and diagnosing psychiatric illnesses or to follow the policy of limitations due to a fear of 'floodgate claims'. Considering this, it is worthwhile to mention the opinion expressed by the UK Association of Personal Injury Lawyers that:

> It would be inequitable for people who have suffered a recognised psychiatric illness to be denied the damages to which they are entitled due to an erroneous public policy aiming to prevent a mythical eventuality[59].

Some of the most outspoken critics, which include a call for the law reform for recovery of psychiatric damage, was given by Southin J in *McDermott v Ramadanovic Estate*[60]*:*

> What is logical difference between a scar on the flesh and a scar on the mind? If a scar on the flesh is compensable although it causes no pecuniary loss, why should a scar on the mind be any less compensable?

It seems that kinds of personal harms should not be treated differently in regard to the rules governing responsibility at law: The right to recover for psychiatric damage should not be subject to the relationship of the mentally disturbed person to the primary victim or whether he or she was present at the accident or its aftermath, news of distressing event was communicated by a third party or via modern media, the particular form of psychiatric complaint was shock-induced or developed rapidly or gradually, was lengthy in duration or short-lived or attributable to factors other than an accident to another or sensitivity to damage to the mind61. The law cannot persist in ignoring the valuable findings and contributions made by other disciplines in the formulation and development of the common law.

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[59] Association of Personal Injury Lawyers: *The Law on Damages: A Response by the Association of the Personal Injury Lawyers,* 2007.
[60] *McDermott v Ramadanovic Estate* (1988)] 27 BCLR (2nd) 45.

[61] NJ Mullany, PR Handford, *Tort Liability for Psychiatric Damage* (The Law Book Company 1993) See also: D Butler, *Identifying the Compensable Damage in "Nervous Shock" cases,* 1997; RW Evans, *The Effects of Litigation on Treatment Outcomes with Personal Injury Patients,* 1994; C Hilson, *Liability for Psychiatric Injury: primary and secondary victims revisited,* 2002; H Teff, *Causing Psychiatric and Emotional Harm,* 2009; C Tennant, *Liability for Psychiatric Injury: an Evidence-based Approach,* 2002.

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