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Civil Claimant Embitterment: Five Case Studies Exploring Clinical Presentation and Management

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Abstract

Trauma victims/litigants frequently feel irritable, angry and a sense of injustice alongside feelings of stress, low mood and anxiety. This can be equally distressing and destructive to being actively and positively involved in a civil compensation case. Five case study illustrations are given, culminating in essential skills for the lawyer and clinician to display irrespective of whether the angry, embittered reaction is mild or severe.

Keywords: Trauma; Irritability; Paranoid personality disorder; Blame; Stress

Introduction

It is well documented that being involved in any traumatic incident results in stress of varying intensity both at the time, immediately afterwards and over a period of weeks and months thereafter. Terms 'stress', 'trauma', 'depression' and 'anxiety' are typically used both clinically and legally to when discussing and describing these unpleasant and distressing experiences.

It has been suggested that traumatic stress becomes persistent when individuals develop a sense or belief of serious current and ongoing threat, as a result of excessively negative thoughts about the index trauma and it's after effects [1].

A less well documented set of feelings include anger, irritability, embitterment and blame, especially when the source of a trauma or personal injury is another person i.e., not one's fault. Blame towards the wrongdoer is often associated with psychological stress and needs to be recognized and at times treated as a legitimate part of the claims process [2]. It has been found that blame is associated with greater health-care utilization.

A key element of feelings of blame centers on the perception of injustice – the adverse impact on the claimant or aggrieved party that occurs as a consequence of being hurt or 'failed' by one or more other parties.

Opportunities to complain and assert individual's rights through the pursuit of claims and grievances although part and parcel of a customer responsive culture can also reinforce the 'querulous' behaviour of vexatious litigants and unusually persistent complaints [3].

A recent study by the Parliamentary and Health Service Ombudsman [4] in the UK developed a typology of injustice consisting of four main categories of injustice:

1) Emotional Injustice: The impact of maladministration or service failure on the aggrieved person's feelings. This is typified by, but not limited to, feelings of upset, anger, worry or uncertainty.

2) Material Injustice: This arises where there is a negative impact on the aggrieved's material existence. This may involve money or property, but also non-physical entities such as rights, relationships, opportunities, quality of life and loss of employment, job role or career.

3) Physiological Injustice: The impact on the aggrieved's physical or mental health or wellbeing. This include all aspects of pain, injury and illness, and any worsening (or worsened prognosis) of the aggrieved's physical or mental health.

4) Bereavement: This injustice may arise in any situation where service failure is a direct or contributory cause of death; or where failures in care, service or administration either before or after death exacerbate the grief suffered by the deceased person's spouse, partner or close family.

Whilst the injustice suffered may be similar to types within the Emotional Injustice category, the Bereavement category

recognizes that the impact of a death will be different to, and usually greater than, most forms of emotional injustice.

Each category is further subdivided into a number of types of injustice, which describe the specific impact of maladministration or service failure on the aggrieved.

Category 1: Emotional injustice

1. Anger, frustration and outrage.
2. Anguish; worry; anxiety; uncertainty.
3. Distress at witnessing or learning of pain to loved one.
4. Embarrassment; humiliation; loss of dignity.
5. Loss of enjoyment of significant event.
6. Significant traumatic experience.
7. Loss of opportunity to prepare for distressing news.
8. Loss of confidence in public service or health service provision.
9. Inability to move on or obtain closure.
10. Financial worry.
11. Disempowerment including loss of confidence working.
12. Perceived negative attitude of employer.

Category 2: Material injustice

1. Inconvenience or additional time and trouble.
2. Hardship/privation.
3. Loss of material opportunity.
4. Tangible loss of quality of life and independence.
5. Adverse impact on family relationships.
6. Loss of entitlement to material benefit.
7. Material uncertainty relating to immigration status, tax status or job security (current and future).
8. Loss of opportunity to make an informed choice.
9. Loss of opportunity to fully resolve complaint.
10. Complaint not addressed or investigated adequately.
11. Family/friends of patient left to provide care without support.
12. Damage to reputation.

Category 3: Physiological injustice

1. Minor pain/injury/harm/illness.
2. Serious pain/injury/harm/illness.
3. Psychological harm and mental illness.
4. Loss of opportunity for better health outcome/chance of recovery; worsened prognosis.
5. Damage to fertility or ability to start a family.
6. Permanent disability, disfigurement or loss of body part.
7. Unnecessary, avoidable or additional surgery or other treatment.

Category 4: Bereavement

1. Bereavement arising from avoidable death.
2. Bereavement where survival chances were compromised or where there was a loss of opportunity to provide treatment that may have prevented or delayed death
3. Bereavement where the impact of death was exacerbated by poor standards of care or treatment, where there is no evidence that service failure was a contributory cause of the death.
4. Bereavement where, due to poor communications, opportunity was lost to properly prepare for death or to be with the deceased at the time of death; or where the deceased person's family was excluded from decisions about care and treatment.
5. Bereavement exacerbated by poor complaint handling or by failure to provide explanations about the circumstances of a death.

Moving on from legitimate causes of injustice, the actions of vexatious litigants resulting in unusually persistent complaints and practitioners consume an inordinate amount of time and organizational resources in the pursuit of grievances that, in and of themselves, seem, if not trivial, at least lacking in appropriate complexity or importance [5]. The anomalies found frequently in written communications from the 'queruious' are shown in below **Table 1**.

Table 1 Anomalies in written communications [3].

Form
· Curious formatting
· Many, many pages
· Odd or irrelevant attachments – e.g. copies of letters from others and legal decisions, UN Charter on Human Rights etc., usually, extensively annotated
· Multiple methods of emphasis including

Highlighting
Underlining
Capitalisation
· Repeated use of “”, ???, !!!
· Numerous foot and marginal notes
Content
· Rambling discourse characterized by repetition and a pedantic failure to clarify
· Rhetorical questions
· Repeated misuse of legal, medical and other technical terms
· Referring to self in the third person
· Inappropriately ingratiating statements
· Ultimatums
· Threats of violence to self or others
· Threats of violence directed at individuals or organizations

Five case studies are presented which reflect, on the one hand, three clinical presentations of anger and blame of increasing severity and two studies of intervention.

Case Study A: Well-Adjusted Claimant Experiencing Litigation Stress

Typically, the most common psychological injuries occurring involve symptoms of depression, anxiety (e.g. trauma-related, generalised, phobic and/or social anxiety) and neuropsychological impairment (i.e., when a brain injury has occurred).

These traditional psychological symptoms can be confounded by feelings of irritability, blame and injustice previously described.

Case Study A illustrates these various experiences of Mrs. E (36 yrs) who had been in a traumatic road accident sustaining multiple physical injuries plus post-traumatic stress. Prior to the index accident, she had been a well-adjusted individual, employed and happily married. Her feelings of irritability, blame and injustice centred on:

1. The other driver whose careless actions had caused the accident.

2. The delayed and poor care she received on attending her local accident and emergency hospital department.

3. Her employers' unsympathetic attitude and impractical approach to her return to work on a phased return possibility.

These three sources of irritability were very stressful, distressing and frustrating for Mrs. E at an already difficult time. This injustice had perceived potentially to result in further adverse consequences for example about her care and treatment and possible future material loss, and some could have been resolved at an earlier date.

The mild/moderate feelings of injustice exemplified in Case Study A are typically short lived and get resolved within a reasonably finite length of time.

Case Study B: Claimant Preoccupied with Sense of Injustice

This next case study illustrates how feelings of injustice can generalise to a number of different situations or contexts and although they do not necessarily result in a recognised psychological disorder, can, if not managed sensitively and appropriately, result in significant emotional distress and consequences.

Mrs. A (79 yrs) was admitted to hospital for a routine hip operation but unfortunately slipped, when unattended, on a wet floor and then had post-surgical infection complications due to negligent post-operative care (admitted by team). She had multiple feelings of anger and injustice as follows:

1. Pain and distress on admission and post-operatively.

2. Anxiety and pre-occupation with her impaired mobility.

3. Failings in care and treatment on the surgical ward including lack of care planning, incidents of constipation and incontinence.

4. Malnutrition and Lack of proper assessment to use a hoist.

Subsequently, on being discharged, she was advised to bring a medical negligence claim. She then experienced two further sources of irritability.

5. Poor communication with legal firm undertaking her case and

6. Poor interviewing behaviours from orthopaedic expert who prepared her medico-legal evidence.

As a result, she developed a chronic defensive reaction centered predominantly of her feelings of helplessness which emanated from these five sources of injustice.

Case Study C: Abnormal Psychological Presentation of Embitterment, Oversensitivity and Paranoia

In most individuals, even those who have some vulnerability or pre-disposition to psychological over-reactivity, feelings of blame, irritability and injustice will typically be short lived and respond to lawyer management or brief CBT intervention (see case study D). However, in a small number of cases, an individual may have significant pre-existing personality disturbance which then becomes exacerbated by a traumatic incident and he/she then displays significant cognitive, emotional and behavioural difficulties to the lawyer, experts and the court. This often makes sensible and logical resolution of any claim very difficult. However, it is also difficult to make a clear thorough assessment of in the one-off style of medico-legal interview.

Mr J (47 yrs), a previously unemployed accountant due to many years of psychiatric disturbance, was involved in an unusual accident whilst shopping. A piece of ceiling fell in a supermarket knocking him unconscious momentarily. He was admitted to hospital for seven days with a head injury and cognitive impairment. He also developed low mood due to his inability to concentrate and remember things like he used to.

He displayed significant and pervasive irritability and anger. He distrusted those around him at home, medical personnel in the hospital and his legal and medico-legal team. He believed, inaccurately, that people's motives were to harm him. He had intermittent explosive episodes acting out verbally and physically aggressive.

His presentation was consistent with him having a Paranoid Personality Disorder (DSM-V 301.0) [6,7] characterized by:

1. Suspects, without sufficient basis, that others are exploiting, harming or deceiving him or her.

2. Is preoccupied with unjustified doubts about the loyalty or trustworthiness of friends or associates.

3. Is reluctant to confide in others because of unwarranted fear that the information will be used maliciously against him or her.

4. Reads hidden demeaning or threatening meanings into benign remarks or events.

5. Persistently bears grudges (i.e., is unforgiving of insults, injuries, or slights).

6. Perceives attacks on his or her character or reputation that are not apparent to others and is quick to react angrily or to counterattack.

7. Has recurrent suspicions, without justification, regarding fidelity of spouse or sexual partner.

Mr J had a core belief that the world-is-a-dangerous-place; this resulted in his misinterpreting other people's behaviour as hostile, with intentions to harm him. He frequently felt threatened. He had great difficulty being rational and logical.

As a result of his vexatiousness, his relationships deteriorated. He had a series of lawyers but failed to sustain relations with any of these. He accrued significant debts in relation to the litigation and general finances. He felt disconnected, became increasingly fixated on his grievances.

Case Study D: Cognitive-Behavioural Therapy Approach for Embitterment and Paranoid Symptoms

As we have previously discussed, in addition to experiencing anxiety and depression after a traumatic event, one very common undiagnosed or unrecognized symptom is anger, because the individual rightly or wrongly perceive that they have or had been treated badly (e.g. by the other driver or their employer), are not getting better, are being poorly assessed by doctors or lawyers or misunderstood by family members. This tends to be trivialized, or ignored partly perhaps due to it not being explicitly recognized as a DSM-V or ICD 10 disorder. The closest diagnoses available in DSM-V include – Intermittent Explosive Disorder (312.34) or Adjustment Disorder Unspecified (309.9) or Paranoid Personality Disorder (301.0).

Perceptions of injustice may not simply be 'understandable' non-significant reactions to experiencing a non-fault debilitating injury. Research and clinical experience indicate that perceived injustice, after an injury, can impede successful recovery from that injury and associated psychological and physiological changes which compromise recovery [6-8].

A new term – Post-Traumatic Embitterment (PTED) – has been recently proposed and discussed by Yamada in 2015. PTED is a collection of symptoms originally proposed by Linden in 2003, a German psychiatrist. He found that many individuals may become so entrenched in their anger and feel so embittered by a negative life event, not of their making, that normal everyday functioning occupationally and/or socially may be impaired. He defined the elements of PTED as:

- A single exceptional negative life event precipitates the onset of the illness.
- The present negative state developed in the direct context of this event.
- The emotional response is embitterment and feelings of injustice.
- Repeated intrusive memories of the event.
- Emotional modulation is unimpaired, patients can even smile when engaged in thoughts of revenge and,
- No obvious other mental disorder that can explain the reaction.

PTED is not actually a recognised condition in DSM-V, currently the most authoritative source of clarifying mental disorders. Although the term 'embittered' can carry negative connotation and both experts and the court can discount disruption and distress by a simplistic view of someone's anger, a more considered approach acknowledges that, for some individuals, deeply felt anger is an understandable and disruptive response to unjust actions and behaviours that threaten or adversely affect someone's occupational, social and psychological wellbeing.

The cognitive style of the querulous is that of seeking confirmation of their viewpoint [3], rejecting or minimizing all counter-examples. Cognitive distortions include the following:

- Those that do not fully support their cause are disliked, rejected as 'enemies'.
- Any lack of progress or obstacles is the product of malevolent interferences from someone.
- Any compromise is unwelcome, unwise or humiliating.
- The grievance is a significant and defining moment of their life.

Providing effective therapy for severe post-trauma anger requires a careful assessment of which aspects of thinking and behaviour are causing difficulties and preventing a natural resolution of trauma-related stress.

Putting trauma into the past requires clearer trauma memory, re-appraising the trauma and its consequences (e.g. sense of threat currently), and altering dysfunctional behavioural and cognitive strategies that prevent or impair accurate, realistic memory. A wide range of CBT-based interventions help to achieve this with support from family, friends or therapists.

Given the research indicating that perceived injustice and anger are predictors of ongoing disability, interventions that can modify extreme perceptions of injustice are likely to be associated with reduction in chronic pain, as well as depression and anxiety.

Clearer understanding of cognitive, emotional and behavioural aspects of anger-generating trauma experience help the lawyer and the expert arrive at a more robust opinion of diagnosis, causation and prognosis and also aid the therapist in focusing on interventions which are beneficial and accelerate recovery.

Experts should consider whether the level of anger and frustration experienced by a claimant meets the criterion for a recognized psychological disorder or is a normal, time-limited reaction, aided by conclusion of litigation (Koch Postulate XVII) [9].

Treatment by others which is construed as 'unfair' is a 'healthy' understandable response but it is the severe and entrenched nature of the anger and PTED symptoms which prolong or entrench psychological and physiological symptoms. Unless this is correctly diagnosed by the expert or therapist and if left unaddressed this can sabotage recovery in therapy.

Psychotherapy and CBT therapy (and other types of therapy) concentrated on developing a typically long-term relationship with the claimant characterized by:

- Positive praise in a supportive approach.
- Rapport building.
- Developing their trust in the therapist.
- Encouraging self-disclosure.
- De-emphasis on confrontation, disagreement and challenge.
- Sensitivity to issues of control.
- Being straight forward and clear.

Long term prognosis for this type of presentation is poor. Claimants who suffer from this disorder often remain affected with prominent symptoms throughout their lifetime.

Case Study E: Practical Strategies for Lawyer Management of Claimant Feelings of Injustice

Lawyers are likely to meet clients who fall into one of the three case study scenarios given above. These clients, especially case study C, will take up disproportionate levels of time and energy handling their cases. The level of positive lawyer-client interaction will be a predictor of how well their case runs and its resolution [10].

Six desirable characteristics for lawyers have been identified:

- **Communication –** Involvement of claimant in the compensation process in the sense that their lawyer listened to their story and their opinions and responded to issues they had risen, either by taking action or explaining why no action was taken. In addition, being available to the claimant is essential and expected. Proper information on the compensation procedure i.e. to be informed about what was going to happen and what they should expect during claims settlement. Some were displeased by being left in the dark and not being given a step-by-step overview.
- **Mode of communication –** More face-to-face contact, at least at the start and subsequently at least once a year, rather than having only written correspondence or a conversation by telephone. Personal contact gave clients a feeling of being taken seriously and was seen as an efficient way of communicating.
- **Empathy –** Clients appreciate their lawyer being compassionate, understanding, interested, involved, human, accessible, personal and friendly. They appreciated the lawyer asking how they felt, showing genuine interest, always being there for them, being able to put their mind at rest, and realising how the injury hampered them in doing the things

they value in life. It also involved being acknowledged by the lawyer and being understood and taken seriously. They indicated that they needed their lawyer to be empathic at the beginning of the claims settlement, whereas later on in the process they were ready for more business-like communications.

- **Decisiveness –** They appreciate having an active, decisive lawyer, as they could then step away from their claim, confident that their interests were being represented. Many were burdened by feeling that they had to keep their lawyer on his/her toes and that they had to call their lawyer to get things done. Some were bothered by their lawyer being passive and even putting a lot of work into the clients' hands, like asking clients to put things on paper.

- **Independence –** Some were enraged by their belief that their lawyer did not want to 'rub the insurance company up the wrong way'. Some gained confidence in their lawyers' independence because their lawyer was seen to be open and honest about his/her attitude to the insurance company, explaining positions in the light of reoccurring professional contacts with the insurer.

- **Expertise –** Participants regarded lawyers as having good expertise if lawyers informed them about the types of damages eligible for compensation and how such compensation was assessed.

Discussion and Conclusion

This paper has illustrated the range of behaviour displayed by civil claims litigants who feel frustrated and a serve of injustice. This range goes from normal everyday irritation to querulous, paranoid and often intractable behaviour.

Whereas mild everyday frustration can be managed successfully by skilled and empathic communication by lawyers and experts and the court, querulous behaviour impose significant burdens of the courts. The querulous complainant suffers significant damage to their personal, social and psychological functioning and frequently requires or would benefit from psychological treatment to ameliorate their distress and reduce the disruption they create for themselves and others.

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