

The Litigant-Patient: Mental Health Consequences of Civil Litigation

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Civil litigation often has profound psychological consequences for plaintiffs and defendants alike. For those individuals who are involved in ongoing psychotherapy, or those who enter psychotherapy during litigation, the stress of litigation often adds to whatever issues produced the lawsuit. This article reviews the effects of that stress, the mechanisms through which it arises, and its manifestations in psychotherapy and offers suggestions to increase psychotherapist awareness of the influence of litigation stress on treatment.

Recent attention has focused on the effects of role conflict for the therapist choosing to act as expert witness for a patient in treatment.^{1,2} This article will examine the more general issue of the effect of litigation itself on the process of psychotherapy. Characteristic issues encountered by the psychotherapist treating persons involved in civil litigation will be reviewed, noting some of the perils and pitfalls in such treatments.

It is a truism that we live in a litigious society, especially we Americans. So many individuals are involved in civil lawsuits that it may be a rare psychotherapist who has not had the experience of treating a current or former litigant. Despite our awareness that lawsuits are an

everyday phenomenon, few psychotherapists or litigants are truly prepared for the forces of aggression that are released and sanctioned by our judicial system. Although it may be that we have exchanged swords and cudgels for subpoenas and depositions, an aura of combat continues to hover about the judicial process, and combat produces casualties.

Lawsuits are frequently about loss and tragedy. Indeed, few areas of the law do not have emotional consequences for someone. The workers' compensation system is obviously about injury. Adoptions and even trusts and estates law are often at their psychological (compared with legal) cores contests of who loves whom, and how much. For a physician, a malpractice suit may place her whole sense of professional identity at stake. (The very thought of being sued brings a chill to the hardest of us.)

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This ubiquitous civil litigation is stressful for plaintiffs and for defendants. There is an inherent irony in the judicial system in that individuals who bring suit may endure injury from the very process through which they seek redress. The legal process itself is often a trauma. Although many hope—and some find—that it is ultimately restorative, no one brings a lawsuit for his or her health. Justice Learned Hand observed that, “as a litigant I should dread a lawsuit beyond almost anything short of sickness and death.”³

Contemplating, undergoing, or having undergone a lawsuit is disruptive. The experience saps energy and distracts the litigant from the normal daily preoccupations that we call “life.” Litigants, who commonly feel alone, isolated, and helpless, are challenged to confront and manage the emotional burden of the legal process.* The distress of litigation can be expressed in multiple symptoms: sleeplessness, anger, frustration, humiliation, headaches, difficulty concentrating, loss of self-confidence, indecision, anxiety, despondency; the picture has much in common with the symptoms of posttraumatic stress disorder (PTSD).

Litigants are often further distressed as various members of their support systems “burn out.” Their need for human connection and their need to talk about their experience often exceeds the tolerance of family members and friends. Embarrassment and humiliation shrink their social world. Doctors involved in malpractice

suits frequently do not talk to their colleagues about their experience.^{4,5} In the judicial system, where all damages are seen in terms of money, the system is ill equipped to produce the kind of sympathetic understanding that litigants often wish for.⁶

Attorneys are aware of the stress, but they vary widely in their capacity to be emotionally supportive to clients. Some, understanding that early treatment for emotional damages improves the psychological prognosis, actively encourage their clients to obtain counseling or psychotherapy during the litigation process. Some attorneys see such consultation as a way to benefit their case. Unfortunately, some withhold referral, believing that the more distressed the client appears in front of a jury, the more likely are the chances of winning the suit.

Attorneys often engage in a dialog similar in manner to a physician obtaining informed consent for a medical procedure. In a medical context this consultation strengthens the therapeutic alliance.⁷ In a legal setting it is to the advantage of both attorney and client to attend to the risks and inevitable psychological stress of the litigation process before the client commits to litigation. Unfortunately, in law as well as in medicine, this psychological preparation of the individual does not always occur. Market conditions in which many attorneys are scrambling for work worsen the situation. Indeed, It may be in a litigator’s financial self-interest to attract a new client rather than to have a potential client, appropriately informed about expected stress, decide to resolve

* T. G. Gutheil, H. Bursztajn, A. Brodsky, L. H. Strasburger: Preventing “critogenic” harms: minimizing emotional injury from civil litigation. Unpublished manuscript.

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the problem in some way other than litigation.

Once the litigation is over, both plaintiff and defendant are left to deal with the residue of having undergone a stressful process. Some form of psychological amelioration of the stress will likely be needed. Money does not make people whole.⁸ A successful lawsuit does not provide the "greenback poultice," that mythical curative lampooned by skeptics, and even more so, an unsuccessful lawsuit is bound to produce its own form of psychological suffering.

At least two authors have commented on mechanisms through which litigation-induced harm can occur. Pittman⁶ notes that for PTSD patients involved in lawsuits, the psychological defense of avoidance is thwarted by the obligatory interviews with attorneys and consultants, depositions, and courtroom testimony. This failure of avoidance causes a resurgence of intrusive traumatic ideation and increased arousal.

Halleck⁹ has commented on the painful psychological consequences for participants in personal injury litigation. He has proposed a theory of negative reinforcement, defined as the avoidance of painful stimuli, such as the perceived attitudes of others who may doubt the genuineness of "sick" behavior: "The patient whose level of functioning is diminished after an injury or stress is under considerable pressure to convince him or herself and others that these new behavioral patterns are involuntary." Others may be critical, and the patient may be self-critical as well, doubting the authenticity and severity of symptoms as an inherent part of the ad-

versary process. "The easiest way for the plaintiff to refute any allegation that he or she could do better is simply to become more symptomatic." This process, which may operate within or outside of awareness by the plaintiff, appears to be a mechanism for preserving self-esteem for the injured individual at the expense of worsening symptoms.

Therapists who undertake the treatment of litigants, or those who have a patient in treatment who then enters litigation, need to have an awareness of some of the effects of litigation to anticipate both patient needs and potential pitfalls. They should also be alert to the altered contract with a patient who comes solely with a litigation agenda rather than a wellness agenda. Such "patients" are usually referred by attorneys for case enhancement, and little therapeutic progress is made with such nonclinical motivation.

Although there are fundamental differences in the response of any given individual involved in litigation, and circumstances vary too much to take a checklist approach to this area, some pertinent questions come to mind. What should the therapist anticipate when a patient comes to psychotherapy from an experience with litigation? What moments may be seized when the therapist has real power to effect therapeutic gain? What are some of the "dos and don'ts" for a therapist who has a patient in ongoing litigation?

What to Expect: The Plaintiff and Defendant as Patients

The therapist of a litigant will encounter not only the trauma that produced the lawsuit, but the distress and disruption of

litigation as well, including the delays, rehashing and reliving the original trauma, and challenges to honesty and integrity. The patient may come after years of feeling frustrated and thwarted by a system that moves at a snail's pace, preventing the litigant from putting the issue of the litigation behind him and "moving on" with life. Gutheil *et al.** have recently coined the term "critogenic harm" to describe these emotional harms resulting from the legal process itself.

The experience of giving testimony in a public forum can be exquisitely painful. Having a deposition taken is sometimes described as "like being stripped naked." Both direct and cross-examination may make plaintiffs feel that they themselves are on trial, exacerbating a sense of vulnerability and victimization. Self-blame and ambivalence may be aggravated through an attorney's legitimate attempts to challenge or discredit the litigant, producing a sense of humiliation and debasement. Litigation is not for the faint hearted.

In their excellent review, Lenhart and Shrier¹⁰ note that "those patients who fare best emotionally with litigation are those who (1) set realistic goals; (2) maintain a sense of control of the litigation process; (3) seek out adequate support from at least one significant source (family, therapist, peers, attorney); (4) appreciate and focus energy on restoring the original equilibrium of their lives independent of the litigation process; and (5) adequately acknowledge and grieve the losses inevitably involved even when the litigation has a favorable outcome."

It is important to recognize that even

though it is stressful and possibly traumatic, the legal process can also be genuinely empowering to a plaintiff. Lenhart and Shrier¹⁰ believe that in sexual harassment suits emotional trauma is reduced and a sense of empowerment is increased when litigation is part of a class action suit, when several targets of sexual harassment join forces, or when the litigant has strong and enduring support as well as appropriate psychiatric consultation throughout the course of the legal process.

The legal process provides an opportunity for an individual to stand up for her or himself and to hold accountable those who have wronged and/or damaged him or her. The process creates an arena in which a victim can turn the tables and force a response from a victimizer. Although a sexual harassment victim may not be able to gain control by requiring the abuser to come to her therapy and acknowledge the harm caused, she can force him to respond to interrogatories, submit to depositions, and appear for trial.

Some litigants genuinely feel that accountability is what is primarily important to them, and any monetary consideration is secondary. As one plaintiff in a malpractice suit said to me, "They offered me a lot of money to shut up and go away, but I don't care about money. I want that guy out of business and I'm prepared to pay for it." A sense of restitution, vindication, social acceptability, and self-esteem may be derived from a favorable verdict. A plaintiff in an intentional injury case said, "What had meaning for me was that the jury, a group of twelve people,

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stood with me and said this was abuse and the defendant was responsible.”

On the other hand, psychiatrist Sara Charles¹¹ notes in her book *Defendant*, “I experienced. . . no sense of victory after the trial. . . . There is always too much sadness and disruption for everyone concerned on both sides of the case.” Defendants, as well as plaintiffs who have been successful in their litigation, will still undergo personal suffering despite having been vindicated. (The multiple meanings of the word “vindicate” capture many facets of litigation; 1) to avenge, revenge, or punish; 2) to set free, deliver, or rescue; 3) to clear from censure, criticism, or doubt; 4) to justify; 5) to assert, maintain, or make good; 6) to claim as properly belonging to one’s self or another as rightful property.)¹² Vindication, however, does not necessarily restore the self-confidence eroded by the demoralization and isolation that litigants often experience. Exoneration does not salve the bruised sense of personal integrity that so many defendants feel, even those who are innocent of the claims or charges against them.

Both plaintiffs and defendants are troubled by a sense that they have lost control over their lives. Issues of power and control inherent in the attorney-client relationship aggravate the sense of loss of control. With rare exceptions, no matter how sophisticated litigants may be, they are ultimately lay persons who have neither the education nor the experience to direct a lawsuit. Ultimately they are confronted by the need to defer to the judgment of their attorney.

The adversarial system is also a threat

to the maintenance of personal boundaries. Formal complaints, interrogatories, depositions, public testimony, and cross-examination are intrusive procedures that aggravate feelings previously caused by trauma. Such procedures amplify feelings that the world is an unsafe place, redoubling the litigant’s need to regain a sense of control—often in any way he or she can, including exhibiting characteristic symptoms or defenses. It is not unusual to find entries such as the following in the medical records of litigants: “Janet is hearing voices to cut herself again after talking to her lawyer today.” Similarly, a male plaintiff in a sexual harassment suit threatened violence when he was informed that he was to be deposed, and he required hospitalization.

One personal boundary commonly violated is normal privacy. The sense of public exposure and the shame engendered by having to endure trial testimony can be painful beyond endurance. (It came with sadness to me, but as no surprise, to learn of a defendant’s death soon after his trial was over. He had told me that after hearing me testify about his psychological functioning he had resolved to end the pain by jumping from a high story, open window in the courthouse. Within weeks of this traumatic exposure in court he had a fatal heart attack.)¹³

Transference-like feelings, for better or worse, may be displaced to the therapist from the litigant patient’s relationship with his or her attorney. If the attorney has been genuinely helpful, this may add to and further complicate an idealizing transference. The cynical or devaluing at-

torney, the seductive or sexually exploitative attorney, the too busy attorney, or the authoritarian attorney who demands unconditional trust and compliance may all generate feelings in their clients that are subsequently enacted with the therapist. Feelings of helplessness, rage, eroticization, shame, or despondency in the therapeutic relationship may result. If the client trusts the attorney and the suit is lost, a sense of betrayal may then be enacted with the therapist. Likewise, transference-like feelings can be displaced from the patient's psychiatric expert witness, expressed in questions such as, "Why aren't you going to bat for me as Dr. X did?"

Countertransference feelings in this setting also must be recognized. An alliance-building identification with the patient may be obscured and distracted from by the therapist's interest in the legal ramifications of the case. Advocacy may come too easily and, consciously or unconsciously, becoming the patient's advocate can occlude the focus of psychotherapy. On one hand lie the risks of being insufficiently attuned to the traumatic and situational issues. On the other lies an overidentification with the patient's cause, leading to an overlooking of unconscious meaning and fantasy and personal responsibility. The therapist also may have to cope with his/her envy of the litigant's financial award.

Treatment Issues

The following ideas are not technical aspects of treatment, but rather, they are intended to illuminate the psychotherapist's attitudes, awareness, and knowl-

edge. Born of the author's personal experience and consultation with colleagues, these are suggestions that may prove helpful.

Psychotherapy for a patient involved in ongoing litigation can take on the aspects of managing a continuing crisis. The therapist, facing this need for crisis management, may be providing support more than insight. However, therapeutic opportunities abound in exploring the expectations, decisions, and meanings associated with the litigation. These explorations can be supportive and lead to insight, even for a patient caught up in the "storm" of litigation.

It can be helpful for the therapist to become even somewhat familiar with the legal process. To understand the meaning of the complaint, answer to complaint, interrogatories, production of documents, depositions, trial, and the time frame necessitated by each of these procedures can help the therapist to provide clarification for the patient. Reality testing can be useful for those patients who may have distorted ideas about the legal process. The therapist's self-education may even entail consultation with an attorney. Therapeutic neutrality is not compromised by proceeding from an informed position.

The therapist should note that the statute of limitations may have rushed the patient into litigation before he or she was psychologically ready to face an adversarial proceeding. A therapist must be alert to this threat to the patient's attempt to gain control of his or her life subsequent to trauma. What can be done about this? A therapist can at least recognize with the patient that an external process is

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forcing the patient's internal process faster than it would otherwise go. In fact, litigation may be seen as a developmental process out of phase with other development, even holding change hostage.

One should recognize that litigation is realistically and, at times, necessarily a lengthy process and thereby anticipate the patient's frustration with the amount and length of time required. In some ways litigation can be likened to an ongoing trauma in which the therapist's perspective is like watching an automobile accident in slow motion.

There will be pressures put on the therapist to support the case as well as the patient, and these should be resisted. The patient may be frustrated that the caregiver will not jump in and join the action to advance or defeat a legal claim or defense. In this climate of frustration with both the legal and therapeutic processes, do not expect too much of the patient. The psychotherapy may be very slow-going.

The legal battle enables people to put their lives on "hold," thereby avoiding other aspects of their lives. (*e.g.* "How can I be intimate with you when I'm involved in this lawsuit?") The patient may be so attuned to psycholegal issues and hypotheses that she focuses thereupon in resistance to dealing with significant personal conflict. As a result, she is continually "pleading her case" in the therapy hour. Or, the patient may use the "austere answers" of court in therapy ("a simple yes or no"), diminishing free association and spontaneity, missing the opportunity for a therapeutic focus upon acquisition of explicit coping skills for

affect regulation, stress management, and decision-making. Patients may have to be educated—either explicitly or by experiencing and marking the difference between the courtroom and the consulting room—about how role expectations must shift when the goal undertaken is a therapeutic rather than a legal one. The patient as well as the therapist must understand which hat to wear.

The issue of secrets will arise, particularly as the patient is required to disclose information through interrogatories or to undergo a deposition. The patient may be terrified by the discovery process, but the therapist can be helpful. Reality testing can be useful. Are these fears legitimate? Are they groundless? Some explicit recommendations may be helpful to treaters. For a defendant, it is helpful to understand that an out-of-court settlement is not an admission of guilt, and neither is it anything to be ashamed of, as so many medical malpractice defendants feel it to be. Reality testing of this issue helps to ameliorate the sense of helplessness and self-doubt, and it is especially important in helping a defendant repair the fabric of friends, associates, and family so often rent by litigation. Isolation can be countered by encouraging and facilitating supportive contact. Recognize that physicians often have an aversion to treating patients involved in litigation, thus increasing patients' isolation and stress by subtly rejecting them.

When a settlement agreement includes a "gag order," the patient may feel guilty or prohibited from talking about the litigation with a spouse or in subsequent therapy. Withheld information, obvi-

ously, can derail the formation of a therapeutic alliance. This problem may be avoided if the gag order is proactively written to allow telling a subsequent therapist and a spouse about the experience.

Caution concerning note-taking is recommended. One should conform to the requirements of good practice, while simultaneously recognizing that notes may be subject to subpoena and that the therapist may be called to testify about the patient who has made an issue of his or her mental state. Discretion is advisable, especially regarding conclusory statements about causation. One can record the patient's symptoms, diagnosis, and treatment without making specific attribution to a legal causation. The therapist's notes should avoid making the attorney's strategy an open book. One should not include notations that reflect communications from the patient's attorney, such as "We're asking for \$600,000 but we'll settle for \$325,000."

When the therapist is required to give a deposition, it is important for both therapist and patient to remember that it is not the therapist who is on trial. If a therapist has to give a deposition as a "fact witness," being honest, professional, and appropriately limited in role will help the therapist endure the experience.¹⁴ The question will arise about what to tell the patient about the experience of having been deposed, an inevitable boundary issue. A matter-of-fact approach to this issue is best. One might say "Well, I think I'd rather not be deposed if I had the choice, but the experience is clearly one that can be survived, and I'm still here to help you get better."

A final parting caveat: the issue of *prognosis* offered in testimony by the therapist may be problematic. The patient may seek to live up to the estimated prognosis if it was an optimistic one, feeling constrained to downplay or conceal the seriousness of symptoms and trying to live up to the therapist's good opinion, thus validating the testimony. On the other hand, the patient may feel that her clinical case is hopeless or that she has free rein to regress in the face of pessimistic assertions about her future, with the onset of secondary gain and adoption of "the sick role." If a patient has heard or read this testimony about prognosis, a debriefing is definitely in order.

Frustration with the financial costs and length of time required to resolve cases by trial has led judges, clients, and some lawyers to seek other forums, such as mediation, arbitration, or settlement negotiations. Still, the ever increasing frequency of civil lawsuits has no end in sight. The result will be a continuous increase in the number of plaintiffs and defendants who are substantially distressed about their experience in the legal system as well as about what brought them into it. Many of these individuals will be seeking treatment for their distress. In this setting, it may be helpful simply to aid the litigant-patient become a more patient litigant. In this scenario there are pitfalls, challenges, and dilemmas for the therapist as well as the patient. An awareness of some of the issues involved for these litigant-patients will, one hopes, facilitate their treatment and alleviate their suffering.

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References

1. Strasburger LH, Gutheil TG, Brodsky A: On wearing two hats: role conflict in serving as both psychotherapist and expert witness. *Am J Psychiatry* 154:448-56, 1997
2. Greenberg SA, Shuman DW: Irreconcilable conflict between therapeutic and forensic roles. *Prof Psychol* 28:50-7, 1997
3. Hand L: Deficiencies of trial to reach the heart of the matter: three lectures on legal topics. Association of the Bar of the City of New York 89:105, 1926
4. Charles SC, Wilbert JR, Franke KJ: Sued and non-sued physicians self-reported reactions to malpractice litigation. *Am J Psychiatry* 142: 437-40, 1985
5. Charles SC, Wilbert JR, Kennedy EC: Sued and non-sued physicians self-reported reactions to malpractice litigation. *Am J Psychiatry* 141:563-5, 1984
6. Pitman RK, Sparr LF, Saunders LS, McFarlane AC: Legal Issues in PTSD, in *Traumatic Stress*. Edited by van der Kolk BA, McFarlane AC, Weisaeth L. New York: Guilford Press, 1996, p 382
7. Gutheil TG, Bursztajn H, Brodsky A: Malpractice prevention through the sharing of uncertainty: informed consent and the therapeutic alliance. *N Engl J Med* 311:49-51, 1984
8. Binder RL, Trimble MR, McNeil DE: Is money a cure?: follow-up of litigants in England. *Bull Am Acad Psychiatry Law* 19:151-60, 1991
9. Halleck SL: Perils of being a plaintiff. *Clin Orthop Relat Res* 336:72-8, 1997
10. Lenhart SA, Shrier DK: Potential costs and benefits of sexual harassment litigation. *Psychiatr Ann* 26:132-8, 1996
11. Charles SC, Kennedy E: *Defendant*. New York: The Free Press, 1985, p 176
12. *Compact Edition of the Oxford English Dictionary*. Oxford: Oxford University Press, 1971, p 210
13. Strasburger LH: Crudely, without finesse: the defendant hears his psychiatric evaluation. *Bull Am Acad Psychiatry Law* 15:229-33, 1987
14. Gutheil TG: *The Psychiatrist in Court: A Survival Guide*. Washington, DC: American Psychiatric Press, 1998