Irwin N. Perr,[1] *M.D., J.D.*

Claims of Psychiatric Injury After Alleged False Arrest

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ABSTRACT: Litigation has increased rapidly in the United States; those who feel aggrieved sue readily for damages. Police officers and security people may be sued after arrests or detention followed by unsuccessful prosecution or dropping of criminal charges. Claims of psychiatric injury may be made where there are no discernible damages otherwise. Examiners must keep in mind that physical abuse or grossly inappropriate police behavior may be factors in the ultimate results. This paper reviews 13 cases of claimed psychiatric injury after arrest. Almost all were settled, some for significant amounts. Appropriateness of evaluation, the value of nuisance suits in this type of litigation, the role of attorneys' fees, and the effect of Federal suits as opposed to state suits are discussed.

KEYWORDS: psychiatry, jurisprudence, litigation, psychiatric injuries

Not infrequently, those who are allegedly injured by being erroneously arrested claim damages. This paper is based on a review for the defense of 13 cases involving 11 incidents of false arrest by police officers. Defendants included mayors, chiefs of police, store security people, and even a newspaper that reported the arrest.

Generally, the plaintiffs were found innocent on criminal charges or the charges were dropped. As a group, the plaintiffs were angry, resentful, or self-righteous. In some cases, a clear police error had occurred; in others, arrest was probably justified even though a conviction was not obtained.

Inasmuch as plaintiffs do not receive direct physical injury in such cases (other than those in which police brutality is claimed), the purported injury to plaintiffs becomes one of damage to reputation or violation of civil rights. In addition, the claim of mental injury may be made because this is often the only way that specific adverse consequence can be asserted.

Where police brutality or inappropriate behavior by the police is at issue, the examiner has the problem of not knowing whether such, indeed, did occur. Today even the most obvious criminals may claim that they were the victims of brutality or coercion.

The examiner is confronted with the need to ascertain whether or not the plaintiff has a definable mental condition and, if so, to ascertain if the condition was related in any way to the claimed alleged violation of rights. The examiner must also evaluate whether the condition is continuing and whether any treatment is required or permanent deficit is present.

The examiner is confronted with the possibility of suppressed or distorted information,

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[1]Professor of psychiatry, Robert Wood Johnson Medical School, University of Medicine and Dentistry of New Jersey, Piscataway, NJ.

denial by the plaintiff of prior difficulties, and fabricated claims supported by professionals and other people with an interest in the case. Occasionally, the relationship of claimed emotional trauma as an aggravating factor in a prior physical condition must be evaluated. Of the 13, 6 had not had therapy, 2 had prior treatment, and 5 some type of treatment consequently.

Case 1

Mrs. A, a 25-year-old married woman, was subjected to a house search in an inner city 2-apartment house. The narcotics squad had a warrant to search, and a "drug bust" did ultimately occur in the building on this occasion in the other apartment. Initially the police searched Mrs. A's apartment by mistake. Later the correct apartment was raided; a number of people were arrested and later convicted.

Mrs. A stated that the police came in at gunpoint; she was only partially dressed. Her husband was picked up on a "forged document" charge, dating back 12 years. Apparently her 49-year-old husband had a criminal record, but she denied knowing about this. Her husband was arrested and held for several hours. She worked part-time at a discount store and missed one night's work. One month later, at the request of her attorney, she saw a psychiatrist who claimed that she had a "post-traumatic anxiety psychoneurosis, with depression" attributable to this incident, that her condition was guarded, and that she had a permanent neuropsychiatric disability. She stated to the defense psychiatrist that because of this incident she was forced to move from her apartment and developed irritability, loss of patience, not talking readily to people, not sleeping at night unless her husband was home, and not liking to go out at night. She also stated that she did not like to be out by herself (she had told the first psychiatrist a year earlier that she felt safer away from home). She continued to work, changing occupation to working as a restaurant hostess. Her eating habits were unchanged; she described herself as a restless sleeper bothered by noises from a 24-h limousine service located across the street.

In the interview one year after the event, she was affable, pleasant, lively, cooperative, laughed readily. She could repeat seven numbers forward and six backward. She responded readily and showed no signs of anxiety or depression. Psychological testing (Rorschach and Thematic Apperception Test [TAT]) was unremarkable. No thought disorder was present. She described the incident with anger and resentment, but showed no abnormality otherwise.

In my report I pointed out that (1) she did not have symptoms of a post-traumatic stress disorder; (2) she had not required any treatment or seen anyone for treatment purposes; (3) the description of her as guarded was inappropriate on the basis of a brief interview (she stated that it was 1/2 h) and had no current justification; and (4) subsequent events did not bear out the appraisal.

Her claim was for deprivation of constitutional rights, invasion of privacy, illegal trespass, and extreme mental and emotional distress, embarrassment, and humiliation.

She received a $17 500 settlement.

Case 2

Mrs. B, a 38-year-old divorced woman, was arrested for driving while her license had been revoked. Her car was impounded and she was taken to jail for 2 1/2 h until her correct identity was ascertained.

She was erroneously arrested in a case of mistaken identity. When apprehended, she did not have her license, insurance card, or registration with her. She had a credit card with her name and other cards with two other last names (from prior marriages). Curiously, she lived at the same address, an apartment house, as the woman with whom she was confused and

who had the same first name, which was not a common name. In addition, she herself had been at the Municipal Court a month earlier on a motor vehicle violation.

She had been seeing an internist (also described as being a diet doctor) for a period six months before her apprehension. She saw him five months after the incident. He described her as nervous and agitated when she described the incident, and she was given medication which she had taken since (seven months). She had been seen fifteen times since then by him and would see him every four to six weeks. Apparently she was hypertensive. She also had seen a chiropractor, but was not seen by a psychiatrist.

She was very upset and angry at the time and discussed how she finally got the police to check her identity. When her identity was clarified, she was released and her car returned. She stated that she was now afraid of the police (she was seen by me one year after the event). She felt that her health had gone downhill, that she had a problem sleeping. Ascertaining her "diet" medication was difficult; she did take chlorazepate (Tranxene®), 7.5 mg, one pill every day or two. Appetite was good, and no current sleep problems were noted. She continued to work at her job where she managed a small business. She had had a varied educational and occupational history as well as two prior marriages which ended in divorce. At one point, she moved to Europe but left because of language and school difficulties with her children.

Initially hesitant, she became quite talkative and cooperative, though vague on details, particularly about her past life. No current symptoms were noted. She seemed to be an impulsive, expressive, even dramatic individual. No pathology was noted on the mental status examination or testing. No work or functional impairment was manifest. She had had no psychiatric treatment, and none was indicated.

In her suit, Mrs. B claimed various violations of her constitutional rights and sought $100 000 in general damages, $1000 in special damages, and $500 000 in punitive damages. Her case was settled for $5000.

Case 3

Mrs. C, a 35-year-old black nurse, was riding with her sister, who was given a ticket for speeding. After the driver was ticketed, the ticket was seen to go out the car window. In the altercation that followed, both the driver and Mrs. C were arrested and brought to the police station. Mrs. C claimed that she was subjected to racist remarks, physically abused, and that an officer grabbed her hair and banged her head against the wall. After being put in a cell, she complained of chest pain and was taken to the hospital emergency room. The next day swelling of the cheek, limited shoulder movement, and tenderness in the neck were noted by her doctor, who had been treating her for costochondritis and mitral valve prolapse syndrome. She worked for two days two months later, finally returning to work in three months. She blamed this loss of time on her not getting a merit increase in salary the next year.

She also had a history of cluster headaches, but said that she had been doing well until the event with the police.

She saw a psychologist two and one-half months after the incident. Her presenting complaint was given as "mental confusion, forgetfulness, nightmares, sleeping disorders, poor appetite, fear of men, life with husband recycled, self-depreciation, self-accusations, pessimism, psychomotor retardation, severe depression, and anxiety." He described her as a "heart patient" who was beaten when she attempted to intervene to prevent her sister's going to jail because she did not have money to pay a fine. On testing, anxiety and hostility to men were noted. The psychologist made a diagnosis of DSM III Axis I Reactive Depression and Axis IV Psycho-Social Stress. His recommendation was unusual. "The writer would recommend that this client be seen for counseling on a twice-a-week basis. The writer would also recommend that this client take periodic vacations. It is suggested a five-day trip be taken

every three months. The writer would recommend theater, concerts, and other cultural activities be attempted regularly."

When seen, she indicated that she had seen the psychologist for four years—predating the event at issue. She had been seen for marital counseling. Apparently her son was the primary patient, although this was unclear. She was ultimately divorced one year before this event (after having been separated for three years).

She had obtained a bachelor's degree in nursing and had three children. Her oldest son had had a speech and hearing impairment. Five years earlier, she was in an automobile accident with severe "whiplash," broken ribs, and a resulting splenectomy. She did not work for one and one-half years and received a moderate settlement. She stated that, after the accident, she saw the psychologist first two to three times a week, then once a week. The patient's marriage, as noted, was quite stormy. Her husband was physically abusive and frequently disappeared over weekends, and would not let her have friends. She had a prior history of mitral valve prolapse and osteochondritis ("The ribs never healed right"). She would take Fiorinal® for headaches and stated that she had a small ulcer (her last X-ray was eight years earlier).

She was overweight, but her weight was constant. Her appetite was unchanged. She would sleep to 4 a.m. and then do household chores. She claimed that headaches lasted from 1/2 h to 1 1/2 weeks. She had major debts, some because of extensive house repairs (the roof of the house fell in).

She was well-dressed and well-groomed, pleasant, affable, cooperative, talkative. She had many intellectual interests. She was vivacious, related well, and showed no anxiety or depression. She was of at least average intelligence and probably of above-average capacity. Her only suicidal thoughts had occurred during the period of her separation and divorce. The Rorschach and TAT showed no particular psychopathology.

At the time of examination (three and one-quarter years after the incident), she did not demonstrate any psychiatric disorder. Notable were her above-average capacity, the numerous stresses that she had had throughout her life, and her good functioning in a single-parent household. She had no psychiatric condition requiring treatment and showed no disability referable to the events 3 1/4 years earlier. She continued to be quite angry at the way that she was handled by the police.

Her case was settled for $17 500.

Case 4

Mrs. D, a 23-year-old black, single woman with 3 children aged 10, 8, and 3, was arrested after an automobile accident on an outstanding warrant from a bad-check charge. She was jailed for 2 days. Subsequently it was shown that the check had been paid, and the charges were dropped.

She was referred by her attorney to a local mental health center where she was seen a total of five times; she was classified as having "acute reaction to stress." She was never seen by a psychiatrist. The mental health center noted that she could not fix her car because she did not have insurance. Focus at the mental health center was on her social problems. She later was arrested for not having a car inspection sticker. Two years later she was upset because she was facing eviction as the house that she was living in was to be torn down.

In the original accident for which she was arrested, she had damaged another car while she was making a left turn. She agreed to pay $100 for damages. She was suing the supermarket chain (the store involved in the check) as well as the police. She claimed that her wrists were hurt when she was arrested and that she occasionally took aspirin for her wrist.

When I saw her two years after the event, she was vague on details. She was on welfare. She had no sleep problems, she maintained a constant weight, and she played tennis in the summer. She was pleasant, cooperative, relaxed, and appropriate. She used very poor gram-

mar and had limited communications skill. She could not multiply 8 by 9 or subtract 7 from 100. She had no anxiety or depressive symptoms. Her Rorschach responses were brief, mundane, somewhat repetitive, and simple. On a prorated Wechsler Adult Intelligence Scale (WAIS), she had a full scale IQ of 73, verbal IQ of 72, and performance IQ of 78. Her drawings were small and simple, in keeping with the other findings of borderline intelligence. She seemed to be a somewhat dependent person of limited social and educational skills.

She never had psychiatric treatment, nor did she have any psychiatric or other medical diagnosis. She did not have any meaningful psychotherapeutic treatment and was seen after the initial visits at the mental health center three times in two years for acute situational problems. I felt that there was no evidence of psychiatric disorder related to the arrest.

I might add that the mental health center workup was not very detailed. The diagnosis initially given was "Acute Reaction to Stress, 308." (The closest [*Diagnostic and Statistical Manual of Mental Disorders*] DSM classification is 308.30 Post-Traumatic Stress Disorder, Acute, a classification obviously not appropriate.)

She received $1000 in settlement.

Case 5

Mrs. E, a 72-year-old widow, was arrested under unusual circumstances. She lived on the second floor of a garden apartment above a tenant with whom she had had some conflict. When the first-floor tenant had problems with her heater, the apartment complex maintenance man was concerned over a possible gas leak. Access to the first-floor heater was through the entranceway to the second floor apartment of Mrs. E. Mrs. E would not allow access by the maintenance man (she was about to take a bath, was angry at the tenant on the first floor, and did not wish to be disturbed [about 9:45 p.m.]). After her refusal, the police were called and came with the maintenance man. When she threatened to call the police, she was told that it was the police. She apparently became extremely agitated and obstructive and hit the policeman, kicked, and screamed. She was arrested and jailed overnight, resulting in her lawsuit. Charges against her were ultimately dropped.

She was seen eleven days later at a hospital emergency room where she said that she had been robbed on the night in question. She had a slight discoloration over the left maxillary area and left lower eyelid and an old bruise on the inner side of the right arm. The emergency room (ER) physician noted possible old multiple bruises and possible anxiety state. She was seen two weeks later in followup with no physical findings and was to continue chlorazepate (Tranxene), 3.75 mg just before sleep (h.s.), as needed.

No concrete allegations referable to mental disorder were made in any psychiatric report. When seen six months later, Mrs. E was adamant about how she had been mistreated. She felt that the whole incident had been manipulated by the downstairs neighbor. Mrs. E had retired four years earlier as a legal secretary and was active in volunteer activities. She apparently functioned well; she was garrulous, likeable, articulate, personable. She spoke rapidly and was an impulsive individual of well above-average intelligence. Aside from her hypersensitivity and apparent misperception of some of the events, she was an assertive, independent person with a history of good functioning. No mental disorder was noted, and no treatment was indicated.

Her case was settled for $10 000.

Case 6

The case of Ms. F was immensely complicated, and mere summary cannot convey the numerous issues raised. Ms. F, a 35-year-old woman, claimed that the police had deprived her of the use of her property, damaged property, and had injured her mentally and physi-

cally after entering her apartment on a search warrant. She claimed to have been sexually propositioned, threatened, and harassed, and that the police were trying to get her on a prostitution charge related to an escort service. She stated that the police came to her apartment on two separate days, ransacked the place, and left numerous broken items, including glass upon which she cut her foot.

She had seen a number of psychologists, psychiatrists, and others over the years, having seen a psychiatrist as early as nine years previously. She was previously involved in litigation over her competence to perform a certain quasi-public job. Though contradictory information from that litigation was reviewed, one outside psychiatrist noted he could not make a diagnosis because of lack of cooperation, but considered a diagnosis of Atypical Psychosis. A treating psychiatrist stated that she had never been psychotic but offered no particular diagnosis. A number of reports prepared for the earlier litigation in which she was seeking to show competency in job functioning described her as without a psychiatric condition; several of these evaluations were prepared after the events involved in the current litigation.

One psychiatrist who had treated her two years before the incident in question, in a report after the event, described her as enraged, "paranoidly" sensitive, not psychotic, exquisitely vulnerable. He stated that she had a refractory depression. His diagnosis was severe adjustment disorder, a traumatic neurosis overlay to a preexisting depressive disorder causally related to the invasions of her home. He further stated: "The psychological trauma of the invasion of one's home and the taking of personal property and of being the subject of false accusations or allegations is too well known and obvious superfluously to elaborate upon here."

Numerous pharmacy records were submitted. Ms. F had been on tricyclic antidepressants, mild sedatives, and amphetamines at various times. She went to multiple pharmacies on days close in time. For example, she got a prescription for a mild tranquilizer on one day at one pharmacy and then filled a prescription for a similar drug the next day at another pharmacy. These were allegedly prescribed by a nonpsychiatrist (an inventory from her apartment indicated that she had a blank prescription pad in the name of this doctor!). She also filled amphetamine prescriptions in the name of the psychiatrist quoted above in the previous paragraph for 21-day supplies of dextroamphetamines (Dexedrine®) and amphetamine-dextroamphetamine (Biphetamine®) filled three days apart. The overall multidrug use, the numerous pharmacies, and overlapping use (refills from different pharmacies every few days) suggested inappropriate drug use.

She did not come for one appointment, walked out on a second, did not appear for a third, and arrived 2 1/3 h late for a fourth. In essence, she discussed only the incident. She was hostile and gave no further information, claiming the questions were irrelevant. She gave no information about schooling, jobs, marital history, medical history, and so forth. In my initial report I stated that no diagnosis could be made because of the unsatisfactory examination. I did note indications of a behavioral problem by history, a prior psychiatric history, and possible misuse of drugs.

Another examination was mandated by the court. At that time she brought in a tape machine whose use was denied. She claimed that she had taped the previous sessions. Once again, she would not respond to questions and did not cooperate in any psychological tests, and in a subsequent report, I related a review of the records and detailed what occurred, without offering a diagnosis.

Of particular interest were the reports prepared for the initial litigation in which she was trying to assert competence and which described her as functioning well. These were written after the police episode, but for another purpose. Some of the same evaluators then described her impaired functioning, contemporaneous in time, for the purpose of this litigation.

She received $7500 in settlement. Subsequently she has twice been arrested on charges of running a prostitution ring.

Cases 7 and 8

Mr. and Mrs. G were involved in a joint lawsuit stemming from the arrest of Mr. G at a department store where he was accused of shoplifting men's clothing. Mr. G stated that he had picked out a windbreaker and was taking it to another floor to show it to his wife (she had gone shopping elsewhere) for her approval. The police were called and he left a note on his car windshield stating that he was going to the police station. He was brought back to the mall 1 1/4 h after the stores closed. In the meantime, Mrs. G was quite upset when she could not find him, though she ultimately found the note. On his return, she saw him and collapsed; the emergency squad was called and she was taken to a nearby hospital where it was concluded that she had been hyperventilating.

Mr. G was found guilty of shoplifting by a municipal judge, but this was overturned on appeal to a regular court.

Mr. G claimed that since the event they both were afraid to go shopping, that he feared his picture was given out and that the people at the stores would be looking for him so that now, when they go shopping, they stay together. He now uses mail orders. He claimed to have terrible nightmares and would not perform or enjoy sex at first, though this returned.

He was referred by his attorney to a psychologist who saw the 2 a total of 20 or 30 visits, at first 2 to 3 times a month. He had also seen the psychologist individually. The details were unclear. When I saw him 2 years after the event, he was seeing the psychologist once a month. He reported that their sex life had been impaired for 6 to 8 months but was now normal. He was concerned about being followed and a similar event occurring again.

Mr. G was 37 at the time of the incident. He was a college graduate who attended law school for 1 1/2 years. He gave as a reason for leaving law school his need to return to his state of residence in order to be subject to induction in the military (he was never drafted nor did he return to law school). He became a claims adjuster and attended a 1-year course as a paralegal. His father was an attorney, and Mr. G had done work for him. He also owned a business that he ran. He married at 35; he had no children. Medical history was minimal.

Mr. G was a pleasant, talkative person who was expressive in discussing certain aspects of his life and vague in discussing others. He displayed no anxiety or depression. He tended to be impulsive. He had only nine responses on the Rorschach, four of which were anatomical or X-ray (he had been a biology major). His TAT showed no particlar problem areas.

He described his anger at what occurred and his hypersensitivity to possible similar situations in the future.

The psychologist described him as having a rigid, insensitive personality with qualities exacerbated by his illegal arrest and detainment. The psychologist stated that Mr. G "is incapable of sociopathological behavior and presents one of the least likely profiles for acting out in public." Mr. G was moody, prone to outbursts. He stated that the marriage was strained as a result of the incident and that he had some paranoid ideation. No specific diagnosis was made.

In my report, I noted that a "rigid, insensitive personality" structure would reflect a basic lifelong characteristic. I noted his lifelong pattern occupationally and socially was in keeping with low self-esteem and some constriction. My conclusion, assuming the accuracy of what was reported, was that Mr. G may have had an adjustment reaction, with mixed emotional features, mild in degree, with preexisting personality constriction. At the time seen, no significant psychopathology was noted, nor were there indications of occupational or other significant impairment. I also noted his familiarity with the law. I did not offer any opinion as to the psychologist's statement that Mr. G was incapable of such behavior, but generally felt that examiners should avoid such comments.

Mrs. G was 36 at the time of her husband's arrest. She stated that she worked regularly for 17 years with a year off for ulcerative colitis. She had a long history of ulcerative colitis (since age 29) and hypertension but had never been hospitalized and had been on numerous medi-

cations. She married for the first time when she was 34 or 35. She stopped working when she moved to New Jersey to marry. She described how she could not find her husband and became anxious and then, when the stores closed, went to wait by the car (she did not have a key). At 5:45 p.m., she found the note. She finally contacted the police station, and he said that he would be back shortly. She described the events as a "nightmare" and collapsed when he arrived.

Mrs. G was seen on several occasions by the psychologist when she accompanied her husband to the couples' therapy. The psychologist noted that he did not evaluate her in regard to her psychological status. The psychologist stated specifically that he had never evaluated her psychological status. He then proceeded "to clearly state that the shoplifting incident . . . [had] severely exacerbated her chronic ileitis/colitis condition." I noted in my report: "Simple general or conclusory statements by a non-physician (about her physical condition) have been made without any documentation, medical or otherwise—despite the use of such words as 'severely exacerbated,' 'difficult medical crisis,' 'severe anticipatory anxiety attack,' 'profound impact,' and so forth."

Mrs. G described herself as angry, frustrated, and depressed about what happened and the anxiety until Mr. G was cleared. She did not know how many times they had seen the psychologist. She felt that she was sicker, bled more, was anemic, depressed, insecure. She stated that she saw the doctor once a month rather than every three to six months as previously. She claimed initial sexual problems which had improved. She claimed sleep problems because of the colitis and loss of 20 lbs (9 kg).

When seen, she was noted to be overweight, talkative, but hesitant in communicating at times. No anxiety, depressive, or other symptoms were noted. She was probably of well above-average intelligence. I did not find evidence of any significant emotional disorder and noted a chronic medical history. I noted my assumption that she had a chronic, relatively mild case of ulcerative colitis that had not required hospitalization or surgery. I also noted that her fainting at the time was a result of probable hyperventilation.

After preparation of that initial report, I received the data from her medical doctors, hospital records, and so forth, as well as interrogatories from a prior lawsuit which stemmed from an automobile accident two years before the events at issue.

Even though Mrs. G had denied any prior hospitalizations, she had been hospitalized for a week two years before for various orthopedic complaints purportedly related to her prior job and was described as permanently disabled as a result of the car accident (this was the cause of her not working, not her reported ulcerative colitis). Several months after the police episode, she was noted to have orthopedic problems, ulcerative colitis, hypertension, and mitral prolapse. This was in a report for social security disability which described her as totally disabled from the automobile accident.

Other medical records indicated that her weight when I saw her was in the same range that it had been for five years. The records indicated that she had been seen more frequently before the shoplifting episode than she had admitted to; for example, she was seen four times by her doctor in the previous three months, not every three to six months.

The local hospital emergency room record indicated a diagnosis of hyperventilation syndrome on the day in question.

I noted that the supplemental information provided considerable information not previously known and that much pertinent information had been withheld or distorted and that the contradictions indicated that Mrs. G had been an unreliable informant.

The two received a settlement for $65 000.

Cases 9 and 10

Mr. and Mrs. H were involved in complex litigation with both civil and criminal aspects in a situation which achieved much public notoriety. Both were harassed and threatened in addition to a civil suit.

In the criminal case, the Hs were found guilty of aggravated assault. Mr. H receiving a jail sentence and probation and Mrs. H being placed on probation. Because of a lack of money, Mr. H handled his own appeal, and ultimately, on appellate review, the appeals court overturned the conviction. The Hs also had a civil suit brought against them, and this was settled for a very large sum of money. Mr. H claimed that he had not assented to the settlement. Mr. H, in turn, sued police public officials, city officials, and attorneys, prosecutors, and so forth.

Mr. H was 39 at the time of the incident involved. He was examined for purposes of his lawsuit five years later by a psychiatrist. He was described as having pressured speech which was probably his usual way of speaking. He expressed a general feeling of distrust, feeling "jumpy," being easily startled. At one point, he stayed at home, drank heavily, would not go out, and was withdrawn. On the Minnesota Multiphasic Personality Inventory Test (MMPI), the F scale was noted to be borderline high, indicating a strong need to deny to self the inner turmoil (my interpretation would be exactly the opposite). The D and Pd scales were reported as high, as was the Sc scale (the actual profile was not submitted). The psychiatrist stated that Mr. H had a chronic post-traumatic stress disorder that was essentially permanent, that such a condition would lead to an erosion of his ability to deal with others.

The exact details of the events involved will not be elaborated upon here. Mr. and Mrs. H were involved in a prolonged period of litigation, charges, and conflict with authority and people in their area. They were so involved over a prolonged period of time and were under considerable financial stress. By the time they were seen, the criminal charges had been disposed of and the civil charges settled. In the meantime, their financial situation had considerably improved, leaving them with assets of considerable value which would allow them to move to a more rustic environment, which was their desire.

When I saw Mr. H five and one-half years after the events at issue, he was an impressive figure. He was a big, rugged, articulate, challenging man, angry about what had occurred. He spoke extremely well with a good vocabulary and an almost pedantic, lecturing manner. He laughed a lot and was quite impressive as a communicator. No anxiety or depression was noted. There was some suggestion that underneath his aggressive, outgoing exterior there was a sense of underlying insecurity and a hesitancy to get involved with others. Appetite was good; sleep was described only as restless, because he would awaken with heartburn. Mr. H was an unusual, individualistic, assertive man, extremely energetic, strong in emotion, cautious in his involvements. He was felt to be an effective, hardworking, tenacious and productive individual. He did not show any psychiatric disorder, much less that of a post-traumatic stress disorder. Ordinarily one would expect an anxious, depressed, poorly functioning, withdrawn person with that diagnosis. Here it was clear that Mr. H was an unusual person who, with considerable environmental stress, aggressively pursued what he felt to be his rights and who was successful in formulating his own legal case at an appellate level.

Mrs. H, a 28-year-old woman, was described as having had insomnia, anger, resentment at being considered an outcast in their community. The same psychiatrist who saw the husband stated that the experience had taken a toll on her, with a fear of something happening, a feeling of distrust. She "has experienced the debasement, the humiliation that her husband has." She was also diagnosed as having a post-traumatic stress disorder, milder than that of her husband, chronic, and unlikely to change.

Mrs. H was pleasant, affable, cooperative, probably of above-average intelligence. She displayed no symptoms. No symptoms referable to appetite, weight, sleep, or sexual function were noted. She recognized that she and her husband had different value systems from most people (her husband delivered their baby at home). She seemed to be quite a capable person.

The data did not support a diagnosis of post-traumatic stress disorder. Neither Mr. H nor Mrs. H had ever had psychiatric treatment, nor was there any indication of a need for such. In view of the five years since the initial incidents and the continued legal conflict without impairment of function, a conclusion of any psychiatric impairment seemed inappropriate.

The court dismissed their suit; this decision may yet be appealed.

Case 11

Mr. I, a 22-year-old man, was arrested for a gas station burglary and associated arson (for which he was ultimately exonerated).

A day after this incident, he was arrested and jailed. Because of his behavior at the detention center (muteness, suspicion, not eating, lack of cooperation, assaultiveness, and so forth), he was seen after two more days at a local Community Mental Health Clinic (CMHC) and committed to a state hospital with a diagnosis of unspecified psychosis. He was totally unresponsive other than to state, "I want Angel Dust." A history of alcohol and drug abuse was noted.

At the state hospital (for eight days), he was noted to be disoriented, unable to concentrate, and convinced that people were against him. The hospital records indicated a poor work record (fired twice, the last for smoking marijuana on the job). He admitted to using almost all street drugs except heroin. He reportedly used Angel Dust every weekend.

Mr. I was seen ten days later at another CMHC for follow-up and was noted to be not psychotic. The diagnoses considered were Borderline Personality, Conduct Disorder, Alcohol Abuse (?), and "rule out Sleep Deprivation Psychosis." Medication was recommended, but he refused to continue taking it. He was seen six times over the next three months and then discontinued his attendance at the CMHC.

Two and a half years after the arrest, he was seen by a psychiatrist for purposes of his litigation. He told the psychiatrist that before his arrest he was well and generally happy and that he had worked steadily since his graduation with few disciplinary actions. The psychiatrist noted no prior work difficulties. The plaintiff described himself as happy, outgoing, with many friends. He was noted to be a polydrug abuser with a penchant for using the hallucinogen PCP. The plaintiff did admit to losing one job because of marijuana. He stated that he had a changed personality, poor work history following release, and sexual problems as a result of medication. Subsequently he had no therapy or medication. He showed no continuing paranoid ideas but expressed anger over his arrest. The psychiatrist made a diagnosis of post-traumatic stress disorder and indicated that without the arrest he would not have been hospitalized and that he did not function as well socially or occupationally since that time.

When I saw him three and one-half years after the arrest, he discussed his job history prior to his arrests—six jobs with some periods of not working. He claimed that he did not feel like working until his last job, at which he has worked for two years with much overtime. His mother was on probation for embezzling a large amount of money at her job. One sister had been hospitalized at the same state hospital. He had a juvenile history (five breaking and enterings) for which he was put on probation. Social life was poor; he was 5 ft 11 in. (180 cm) tall, weighed 295 lbs (132 kg), and had been grossly obese since age ten, being the butt of jokes since that time. He was a heavy drinker of beer (two to three 24-can cases a week). On work days, he would drink two to three six-packs and on days off, three to six six-packs. He started with marijuana and acid at 15; at 18 he was on speed and cocaine. He had used THC, Angel Dust, Quaalude, Tuinal, and so forth. He snorted THC and PCP. Two years after the arrest he was arrested for disorderly conduct when drunk. His weight had varied from 265 to 295 lbs (109 to 132 kg). Sleep was irregular (as was his work shift). Three years after the arrest he was held in a hospital briefly because of a reaction to Angel Dust which he did not remember very well. He had had no psychiatric treatment.

Mental status showed little. He tended to be impulsive and show poor social judgment. Projective testing showed some sexual preoccupation.

The etiology of his short-lived psychotic episode is unclear—particularly in view of his alcohol and drug history. He had been noted by various examiners to have had an episode of psychotic disorder, personality disorder, and substance abuse, mixed.

Clearly, the psychiatrist for the plaintiff was not given a balanced history. Various aspects of his past life had not been explored, and a diagnosis of post-traumatic stress disorder was

felt to be untenable. When seen, he was functioning well occupationally, but had substantial handicaps related to his obesity, personality disorder, and continued periodic substance abuse which had been present for many years.

He received a settlement for $18 000.

Case 12

Mr. J, a 20-year-old man, was arrested for speeding in an apartment complex, during which time he attempted to drive away, dragging the policeman who had apprehended him. When caught by other police a short distance away, he was charged with reckless driving, failure to exhibit a driver's license, having bald tires, intent to commit bodily injury, and attempt by physical menace to put in fear. He ultimately pleaded guilty to speeding, driving an unsafe car, and reckless driving.

Mr. J claimed that a person had jumped in front of his car, cursed him, attempted to get his money, and he thought that he was being robbed. He had one prior arrest, apparently for driving under the influence, and was charged with careless driving. Mr. J described the police reports as lies and denied knowing the police officer was a policeman. He said that afterwards he had a nervous stomach and a year later saw a psychologist for 14½ "desensitization" sessions. The psychologist made no diagnosis and stated that he could make no judgment as to permanency (his letter was prepared 6 months after termination of contacts).

The plaintiff was noted to be overweight (approximately 5 ft-7 in. to 5 ft-8 in. [170 to 172 cm] tall, weighing 190 lbs [85 kg]). He had been heavy since age 13 or 14. He had no current sleep difficulties. He was not very verbal, but was pleasant. He did not spontaneously offer information. He did poorly on general information and arithmetic and seemed to be of average to low-average intelligence. On the fire-in-the-theater question, he showed questionable social judgment. He showed limited abstract thinking abilities in interpreting proverbs and gave up easily. On the Rorschach, he had only eight responses and was guarded and evasive, though the responses given showed no gross psychopathology. His TAT responses were simple and bland. No anxiety was noted.

No psychiatric diagnosis was made. The considerable differences between his account and those in the record were noted. He had been working steadily and had had no condition requiring medical treatment.

Settlement was $1000.

Case 13

Mr. K, a 34-year-old divorced professional, was charged with disorderly conduct and harassment when a policeman observed him watching a young woman through the window of her second-floor apartment in a garden apartment complex where he lived. The legal charge was questionable in view of the fact that Peeping-Tom behavior (if, indeed, it was) is not a crime under the current law. He also was charged with making obscene phone calls, a charge that was dropped following, I gather, mandated suppression of evidence. His arrest was attended with much publicity because of his profession and previous government position. Mr. K stated that he had merely been walking on the grounds.

He was found not guilty on the harassment charge. The obscene phone call charges were dismissed when the tapes used as a basis for the case were declared to be illegally obtained.

Mr. K claimed to be humiliated, depressed. He went into isolation, then moved, and has since worked in a store run by another family member and has begun work in another occupation, not that of his field of training.

An internist saw him 13 months later. Complaints were abdominal pain, excessive gas, constipation, and diarrhea. Workup was negative. Diagnosis was "functional bowel syndrome related to stress, anxiety, and tension from his false arrest." He was seen over a

5-month period and discontinued visits. He saw a psychologist starting 18 months afterwards, was seen once a week for a few months, and then at decreasing intervals (about once a month before finally discontinuing). When I saw him 2 1/2 years after the incident, he was not under treatment. At about the same time that he started seeing the psychologist, he also saw a forensic psychiatrist who described him as having a serious depressive reaction with anxiety. Six months later he continued to show anxiety, depression, fear, and humiliation because of his legal situation. A third report two months later agreed with the psychologist's appraisal of Adjustment Disorder. Another diagnosis in the psychologist's records was Generalized Anxiety Disorder.

I will not review the psychological testing other than to note that Mr. K was asked by the psychologist to answer the MMPI as he now felt and then do it again based on how he thought he felt before his arrest two years earlier. The details of the differences will not be discussed (the question of validity under the circumstances was acknowledged by the psychologist). None of the records provided details as to prior functioning.

Mr. K had quit his government job one month before the incident without having another job available at the time. Appetite and weight were normal; sleep pattern was not abnormal. When seen two and one-half years after the incident, he had no depressive symptoms. He had not seen his internist for a year. He described being burned out at one government job and was critical of his last job because there was too much politics and incompetence. He was divorced the year before the events after a separation of two years. Another subsequent relationship had broken up, but the details were unclear. When seen, he showed no symptoms, but expressed anger and resentment at what had happened to him. Psychological tests suggested conflict in interpersonal relations, ambivalence, lack of self-confidence, dependency, a sense of rebellion, and hypersensitivity. Optimism and depressive tones seemed in balance. No psychiatric diagnosis was made as to his status when seen at this time.

I pointed out that he had had some school, occupational, and social difficulties before the events at issue. Of note was the fact that he sought treatment one and one-half years after the incident (the diagnosis of Adjustment Disorder requires onset of condition within three months).

In any event, when seen two and one-half years after the event, psychiatric symptoms were not prominent. This case is still pending.

Discussion

Psychiatrists may become more frequently involved in alleged false-arrest cases. As demonstrated here, such cases may involve such a wide variety of circumstances that generalizations are difficult.

The psychiatric examiner in such cases is confronted with a number of dilemmas, some of which differ from ordinary forensic science issues. In essence, the plaintiff is complaining about the behavior of special persons of sanctioned authority, resulting in injury based on abuse of that authority. The motivation for false arrest suits may be multifold. Certainly one reasonable basis can be an expression of normal psychologic functioning and appropriate emotionality. Some of the plaintiffs seen expressed great anger and resentment, some of which extended to feelings of retribution and revenge. Feelings, however, are not synonymous with diagnoses or disabilities. The issue of hypersensitivity and fear of authority figures such as police or other public officials fits into a similar framework. The use of the word *paranoid* may be quite problematic.

Second, the arrest is only the beginning of a process, and participating in the legal process in the United States certainly is often a stressful, onerous, unpleasant, costly, and humiliating experience.

On the other hand, police authorities may be readily accused of misbehavior. Many people

project their own doubts onto what they perceive as aggressors. The police role is doubly complicated by the fact that for a variety of reasons, many of those charged with crime are found innocent. Sometimes this is a result of legal technicality or arbitrary exclusion of evidence; sometimes it reflects that the charges simply cannot be proved beyond a reasonable doubt; sometimes the people are indeed innocent or wrongly apprehended. Social attitudes toward police may be involved. Minority people may perceive the arrest in terms of arbitrariness based on race or similar factors. In only one case of the thirteen reviewed here was this an issue.

The examiner is not in a position to judge the merits of the conflicting claims in this regard. That may be the crucial issue to be decided by the court. Similarly, a claim of physical brutality in association with arrest may be of great significance, but whether it occurred may not be clear to the examiner.

On the other hand, police personnel are increasingly fearful of exercising their authority for fear of lawsuit. For example, in many areas, the police will not intervene to help in the triaging of mentally ill people for fear of a suit.

Of note is the fact that eight of the thirteen plaintiffs were female. In view of the fact that the vast majority of people arrested are male, this may reflect that women may make, as plaintiffs, a figure with whom others may sympathize, or that cases involving women may be more carefully scrutinized.

The mere fact of an arbitrary and inappropriate detention may be the basis for a suit. That is not really a psychiatric matter; juries can make a judgment as to the meaning of an ill-advised arrest and detention. However, ordinarily the actual damage from such a detention would seem to be quite limited. As with other forms of litigation, attorneys seek to prove adverse sequelae, particularly where they may be long-term so as to provide a basis of a claim for significant damages. Thus, as noted, a number of these plaintiffs were referred by attorneys for workups to support such a contention, though few required treatment (and, in some cases, the "treatment" itself is quite suspect).

As usual, obtaining a history is difficult. Getting a record of prior functioning is often obstructed. Some physicians or other care providers who have seen the person previously provide no information or avoid data dealing with the baseline functioning. Some of the evaluations provided may reflect partiality, incompetence, and even fraud. Others are superficial or based on simplistic generalizations that are not necessarily so (for example, "everybody knows that those exposed to . . . get such and such").

Diagnoses are often diffuse and not in keeping with the nomenclature, or if they are, do not conform with the requirements for such nosology.

In particular, the misuse of the concept of post-traumatic stress disorder is striking. Often this category is used—though the precipitating event and the subsequent symptoms bear no relationship to the requirements of the current diagnostic system. Some recommendations are highly idiosyncratic, such as that of the psychologist who stated that a vacation every three months was required as therapy.

An examiner should carefully note the fact that the person in fact did not require treatment for a period of years subsequent to the event and shows no need for treatment when seen. The examiner must also attempt to analyze carefully those who do have emotional disorders to attempt to ascertain whether functioning after the event was any different from that before. Evaluating treatment that was provided is difficult; clearly here, as in other litigation, the treatment may be part of a plan to build up the damage part of a case.

The psychiatrist must be careful to limit his or her role to definable psychiatric pathology and its relation to the event. A person may be subject to police abuse but show no psychiatric sequelae. Those who have problems may have been subject to no abuse, or the abuse might be irrelevant. Some of those involved here have had psychiatric difficulties, but only careful study and availability of sufficient data may show whether there is causality to the claimed event.

Of the ten cases that have been finalized, all were settled. Three are still pending (two may yet appeal a dismissal).

Two settlements were for $1000. These clearly represented nuisance settlements and represented the cheapest course of action for the defendants. The settlements for $5000 and $10 000 represented situations of mistaken identity or poor police public relations (arresting a 72-year-old woman). In the latter case, the plaintiff did not even need a psychiatric or psychologic evaluation as a basis for suit but, as in some of the other cases, had physical bruises.

Why some were settled is unclear unless it represented the fact that both sides were hesitant to go to trial and that the settlements were for modest amounts by current legal standards. The problem of nuisance suits, high costs, and unpredictability of jury verdicts apparently plays a role here as it does elsewhere.

Apparently a major factor in the settlement of a number of cases is the fact that insurers are not responsible for punitive damages under New Jersey law. Thus the defense had to consider the exposure of individual police defendants in deciding whether to go to trial. Second, most of the claims involved purported violations of constitutionally protected rights pursuant to a Federal statute which allows an award of counsel fees to the litigant who is successful in any aspect of a claim. All the settled cases stipulated that the attorneys' fees were included within the settlement amount. Thus what happens in a lawsuit may be determined by realities other than those reflected in the narrow issues expressed in the initial claim. All settlements, as usual, stipulated that there was no admission of wrongdoing.

Address requests for reprints or additional information to
Irwin N. Perr, M.D.
Robert Wood Johnson Medical School
675 Hoes Lane
Piscataway, NJ 08854-5635