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The Future of Emotional Harm

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ARTICLES

THE FUTURE OF EMOTIONAL HARM

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Why should tort law treat claims for emotional harm as a second-class citizen? Judicial skepticism about these claims is long entrenched, justified by an amalgam of perceived problems ranging from proof difficulties for causation and the need to constrain fraudulent claims, to the ubiquity of the injury, and a concern about open-ended liability. To address this jumble of justifications, the law has developed a series of duty limitations to curb the claims and preclude them from reaching the jury for individualized analysis. The limited duty approach to emotional harm is maintained by the latest iteration of the Restatement (Third) of Torts.

This Article argues that many of the justifications for curtailing this tort have been discredited by scientific developments. In particular, the rapid advances in neuroscience give greater insight into the changes that occur in the brain from emotional harm. Limited duty tests should no longer be used as proxies for validity or justified by the presumed untrustworthiness of the claim. Instead, validity evidence for emotional harm claims—like evidence of physical harm—should be entrusted to juries. This approach will reassert the jury's role as the traditional factfinder, promote corrective justice and deterrence values, and lead to greater equity for negligent infliction of emotional distress (NIED) claimants. The traditional limitations on tort recovery, including the rules of evidence and causation, are more than adequate to avoid opening the floodgates to emotional distress claims.

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INTRODUCTION

In October 2002, four-year-old Daniel Ware, Jr., fell asleep on a school bus on his way to preschool.[1] The driver accidentally left Daniel on the bus in the school district bus lot.[2] When Daniel awoke, he got off the bus and began walking to the downtown pharmacy where his mother worked.[3] A relative spotted him in a McDonald's parking lot and returned him to his mother.[4] For the next several months, Daniel was scared about going to school and sometimes needed a relative to take the bus with him.[5] In March 2003, "Daniel became upset and vomited at school when he was told that he would be going on a bus field trip the next day."[6] At home, he cried and begged his mother not to make him go, and he vomited again.[7] Three months later, he was diagnosed with posttraumatic stress disorder (PTSD).[8]

Daniel's parents brought suit against the preschool alleging negligent infliction of emotional distress (NIED) stemming from the bus incident.[9] The preschool moved for summary judgment.[10] In its motion, the defendant did not dispute the diagnosis of PTSD or that the PTSD was the result of the bus incident.[11] During the argument for summary judgment, the defense counsel was willing to concede, for purposes of the motion, that "this kid did sustain a real mental injury."[12] Instead, the preschool argued

1. Ware v. ANW Special Educ. Coop., 180 P.3d 610, 612 (Kan. Ct. App. 2008).
2. *Id.*
3. *Id.*
4. *Id.*
5. *Id.*
6. *Id.*
7. *Id.*
8. *Id.*
9. *Id.*
10. *Id.*
11. *Id.* at 612–13.
12. *Id.* at 620 (Greene, J., dissenting) (emphasis removed) (citation omitted).

that Daniel did not suffer a compensable injury under Kansas law.[13] The trial court granted summary judgment, which was upheld on appeal.[14]

Why would a court leave a person like Daniel, whose emotional harm was undisputed, without a legal remedy? In upholding the grant of summary judgment, the appellate court found that Daniel's symptoms, including the vomiting, did not qualify as physical injuries or a physical impact, as required by Kansas law for NIED claims.[15] The court stated that these requirements are based on "sound legal principle," in order to "prevent plaintiffs from recovering for emotional distress that is feigned or counterfeit . . . . [E]motional distress is a common experience of life and is usually trivial. Therefore, the courts limit recovery to cases involving severe emotional distress which is evidenced and substantiated by actual physical injury."[16]

The result in Daniel's case typifies NIED claims in our civil justice system. Courts are skeptical of the claims, so they erect barriers to prevent juries from ever hearing them. This Article urges a different analysis. Given neuroscientific advances, courts should not fear a case-by-case examination of the NIED claim, with fact disputes over genuineness going to the jury. Even though the U.S. Supreme Court has generalized that "claims for emotional injury [are] far less susceptible to objective medical proof than are their physical counterparts,"[17] science is at a turning point in recognizing, ascertaining, and quantifying emotional pain. The rapid advances in neuroscience give greater insight into the changes that occur in the brain from emotional harm. These developments should matter to the judicial system and warrant individualized analysis of emotional harm claims. If courts continue barring NIED claims, validity is no longer a defensible rationale. Other values or moral judgments would need to justify the unique skepticism of these claims.[18]

The traditional—and current—view does not treat emotional harm and physical harm in parity.[19] The Restatement (Third) of Torts treats emotional harms separately from physical harms, demanding a showing of "serious" emotional harm before the claim can proceed.[20] It distinguishes bodily harm from emotional harm noting that "[u]sually the existence of bodily harm can be verified objectively while the existence and severity of

13. *Id.* at 612 (majority opinion).
14. *Id.*
15. *Id.* at 613–14.
16. *Id.* at 617 (quoting Reynolds v. Highland Manor, Inc., 954 P.2d 11, 13 (Kan. Ct. App. 1998) (internal quotation marks omitted)).
17. Metro-N. Commuter R.R. Co. v. Buckley, 521 U.S. 424, 434 (1997) (quoting Consol. Rail Corp. v. Gottshall, 512 U.S. 532, 552 (1994)).
18. *See* Betsy J. Grey, *Neuroscience and Emotional Harm in Tort Law: Rethinking the American Approach to Free-Standing Emotional Distress Claims*, *in* LAW AND NEUROSCIENCE: CURRENT LEGAL ISSUES 211 (Michael Freeman ed., 2011).
19. Dov Fox & Alex Stein, *Dualism and Doctrine*, 90 IND. L.J. (forthcoming 2015) (calling for treating physical and emotional harm in parity: "bodification of harm doctrine underlies the federal and most state systems of torts").
20. RESTATEMENT (THIRD) OF TORTS: PHYSICAL & EMOTIONAL HARM § 47 (2012).

emotional harm is ordinarily dependent on self-reporting."[21] While courts continue to observe this distinction, other areas have changed course. Neuroscience has made significant advances in quantifying mental injury.[22] In the medical arena, the Diagnostic and Statistical Manual 5 (DSM-5) has arrived with a broadened view of psychiatric illness,[23] and our normative views of emotional harm have changed as well.[24]

Judicial skepticism about the NIED claim is long entrenched. Part I briefly reviews the complicated and rather illogical history of the development of emotional harm tort claims in the United States. This skepticism has been explained by an amalgam of reasons, including the lack of medical expertise, inherent proof difficulties for causation, the need to curtail fraudulent claims, the ubiquity of the injury, and the overriding concern of open-ended liability.[25] Given this parade of concerns, courts do not apply ordinary negligence principles to NIED claims. Instead, the law has developed a series of limiting duty tests to curtail the claim and determine whether it "merit[s] inclusion among the exceptions to the general rule of no liability."[26] These tests aim to prevent individualized analysis and to limit aggregate liability.[27]

Can these tests be justified by the underlying theories of tort law? That is the subject of Part II, which examines NIED claims in light of rights-based and instrumentalist theories of tort law. From a rights-based point of view, tort law promotes the natural right to be free from injury as a result of the actions of others. Under this view, victims of emotional harm are as deserving as victims of physical harm. But rights do not necessarily have a counterpart in remedies, particularly in the NIED area. Instrumentalist concerns predominate. The fear of ripple effects of recognizing a remedy for emotional injury coincides with the value judgment that operates throughout tort jurisprudence: namely, that physical harms are more important and deserving of compensation than emotional harms.[28] Courts and legislatures always have been hesitant about compensating for losses that cannot readily be measured in dollars.[29] There is also the concern that increased liability will inhibit productive activities for an arguably nebulous benefit.[30] Thus, the balance of individual and social interests is struck

21. *Id.* § 45 cmt. a.
22. *See infra* Part III.A.
23. *See infra* Part III.B.
24. *See infra* Part III.C.
25. *See* RESTATEMENT (THIRD) OF TORTS: PHYSICAL & EMOTIONAL HARM § 47 cmt. a.
26. *Id.* § 47 cmt. i (discussing the relationship between one of the limiting tests and the general foreseeability test used in negligence).
27. *See* Robert J. Rhee, *A Principled Solution for Negligent Infliction of Emotional Distress Claims*, 36 ARIZ. ST. L.J. 805, 806 (2004).
28. *See* John C.P. Goldberg & Benjamin C. Zipursky, *Unrealized Torts*, 88 VA. L. REV. 1625, 1668 (2002) ("[C]ourts have long given 'second class' citizenship to emotional distress . . . as harms or protected interests.").
29. *See* John Diamond, *Rethinking Compensation for Mental Distress: A Critique of the Restatement (Third) §§ 45–47*, 16 VA. J. SOC. POL'Y & L. 141, 153 (2008).
30. *Id.* at 153–54.

differently for negligently inflicted physical harm and negligently inflicted emotional harm.[31]

In striking this balance, the definition of harm has become the central issue for NIED claims. Part III offers three different perspectives from which to examine emotional harm—scientific, medical, and normative—and demonstrates how developments in those areas have changed our understanding of emotional harm claims. The argument that emotional injury is untrustworthy or cannot be adequately proved is losing its force. Technological developments, especially advances in neuroscience, soon may be able to provide reliable quantification evidence for emotional injury.[32] If we choose not to treat emotional harm as equivalent to physical harms in tort law despite these advances, we will be forced to confront the reasons for the distinction more directly. If we could eliminate factual concerns regarding validity and reliability, on what basis can we distinguish NIED claims for unequal treatment?

Part IV argues that the time is ripe to remove limited duty barriers based on validity concerns in the NIED area. Validity evidence for NIED claims, like evidence of physical harm, should be entrusted to juries. This approach should alleviate the concern of using limited duty analysis to advance outdated or unjustified policy goals and lead to greater equity for NIED claimants. Other instrumentalist concerns over NIED claims, such as unlimited liability, can be addressed in other ways, such as traditional duty and proximate cause analyses.

Accordingly, in Part IV, this Article proposes that we should recast legal barriers that stem from questions of validity in emotional harm cases and test those questions through traditional evidentiary admissibility rules, allowing the fact-finder's individualized analysis of the harm. Under this approach, courts should not require special pleadings or reject a claim of emotional harm as a matter of law based on validity concerns but instead scrutinize the evidence through traditional evidentiary rules, including *Daubert*[33] testing. Assuming the evidence is admissible, the jury will fulfill its traditional role of individually assessing the validity of the injury on a case-by-case basis. This approach would reassert the jury's role as the traditional fact-finder and promote corrective justice and deterrence values, which have been overtaken by instrumentalist concerns. Individuals like Daniel will not be deprived of a hearing because of outdated assumptions about failure of proof.

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31. *See id.* at 177 ("The current approach to negligent infliction of mental distress appears to treat it as a wayward stepchild to be tolerated out of historical, if not family loyalty, but constrained, where not entrenched, to avoid further embarrassment."); *see also* Martha Chamallas, *Removing Emotional Harm from the Core of Tort Law*, 54 VAND. L. REV. 751, 752 (2001) ("In the hierarchy of torts, emotional and relational harms are not as fully protected as physical injury and property damage."); Goldberg & Zipursky, *supra* note 28, at 1672 ("The law in this area can do no better than announce restrictions on liability whose only justification is: 'We can't do any better than this.'").

32. Neuroscience has begun to show that emotional harm can be physically and objectively verified. *See infra* Part III.A.

33. Daubert v. Merrell Dow Pharm., Inc., 509 U.S. 579, 579 (1993).

I. A BRIEF BUT COMPLICATED HISTORY OF EMOTIONAL HARM CLAIMS

The story of the development of the common law claim for emotional distress resulting from negligent behavior has been told many times, with various explanations for why the tort has never achieved the same status as physical or property harms in American tort law. The claim started with a presumption of no duty and gradually evolved into a subset of negligence law that allows some sharply circumscribed recovery in certain limited situations, creating a patchwork of seemingly inconsistent liability rules.

This patchwork of rules developed in part because of the different avenues along which emotional harm traveled in American jurisprudence. Emotional harm has long-standing recognition as a compensable injury as a parasitic harm to personal injury or property damage claims, usually referred to as a claim for pain and suffering.[34] Common law also traditionally recognized emotional harm claims as a component of trespassory torts like assault, false imprisonment, and defamation, allowing a presumption of damages without a showing of related physical injury.[35] If emotional harm is proven in these cases, damages are recoverable as attached to some other tort, not as a stand-alone claim of emotional distress.

The stand-alone or "pure" claim of emotional distress developed separately, along two tracks—one for intentional infliction of emotional distress (IIED) and the other, a later outgrowth of IIED, of emotional distress resulting from negligent behavior (NIED). These stand-alone claims do not require that the plaintiff show that the defendant committed a separate tort or inflicted physical harm. Instead, the claim exists on its own.[36]

To satisfy the scienter requirement for IIED, the plaintiff must show that the conduct involved was extreme and outrageous, as well as demonstrate that the actor purposefully caused the severe emotional harm.[37] The Restatement (Third) defines the extreme and outrageous requirement as "conduct [that] goes beyond the bounds of human decency such that it

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34. *See* Stanley Ingber, *Rethinking Intangible Injuries: A Focus on Remedy*, 73 CAL. L. REV. 772, 814 (1985) ("Initially, most jurisdictions required a concurrent physical injury or condition.").

35. *See* Willard H. Pedrick, *Intentional Infliction: Should Section 46 Be Revised?*, 13 PEPP. L. REV. 1, 13 (1985); *see also* Vitale v. Henchey, 24 S.W.3d 651, 659 (Ky. 2000) (noting "showing of actual damages is not an element of battery" (citation omitted)).

36. *See* Dillon v. Legg, 441 P.2d 912, 914 (Cal. 1968). As the Restatement (Third) explains with regard to IIED, "the outrage tort [IIED] originated as a catchall to permit recovery in the narrow instance when an actor's conduct exceeded all permissible bounds of a civilized society but an existing tort claim was unavailable." RESTATEMENT (THIRD) OF TORTS: LIABILITY FOR PHYSICAL & EMOTIONAL HARM § 46 cmt. a (2012).

37. RESTATEMENT (THIRD) OF TORTS: LIABILITY FOR PHYSICAL & EMOTIONAL HARM § 46. The American Law Institute recognized an independent tort of intentional infliction of mental distress in the Restatement of Torts in 1948. *See generally* David Crump, *Evaluating Independent Torts Based upon "Intentional" or "Negligent" Infliction of Emotional Distress: How Can We Keep the Baby from Dissolving in the Bath Water?*, 34 ARIZ. L. REV. 439 (1992) (describing the history of IIED).

would be regarded as intolerable in a civilized community."[38] The focus is on the extreme conduct, and courts largely presume that emotional harm will follow.[39] As a result, the plaintiff is generally not required to use medical testimony to show either the severity of the distress or its cause.[40]

Although the claim of NIED, the second type of stand-alone emotional harm claim, developed as an outgrowth of IIED, it focuses squarely on the harm suffered rather than the extremity of the defendant's conduct.[41] Courts moved cautiously in the development of the stand-alone claim of NIED, creating exceptions to the general rule of no duty through a series of small steps, including: (1) dropping the requirement of a preceding physical injury in favor of a requirement of "physical impact;"[42] (2) expanding beyond the "impact" test to allow claims arising within a "zone of danger," where the defendant's negligence placed the plaintiff in danger of physical harm;[43] (3) requiring physical manifestations of objective symptoms;[44] (4) demanding a showing of a "serious" injury[45] or a medically diagnosable one;[46] and (5) imposing some combination of these requirements.[47] Although these requirements have been criticized as

38. RESTATEMENT (THIRD) OF TORTS: LIABILITY FOR PHYSICAL & EMOTIONAL HARM § 46 cmt. d.

39. *See* State Rubbish Collectors Ass'n v. Siliznoff, 240 P.2d 282, 286 (Cal. 1952) ("Greater proof that mental suffering occurred is found in the defendant's conduct designed to bring it about than in physical injury that may or may not have resulted therefrom."); Kenneth B. Baren, *Bystander Emotional Distress: Should Third Parties Recover Regardless of the Negligent Tort?*, 25 J. LEGAL MED. 351, 353 (2004) (noting that the focus in IIED claims traditionally is on the outrageousness of the defendant's conduct, not the physical impact or physical manifestation of the claim); Diamond, *supra* note 29, at 143; Rhee, *supra* note 27, at 864 (explaining that in IIED, "culpability is the prime focus"). *But see* Rogers v. Louisville Land Co., 367 S.W.3d 196, 209–10 (Tenn. 2012) (requiring severity showing for both IIED and NIED claims).

40. DAN B. DOBBS, THE LAW OF TORTS § 303 (2000).

41. *See* Rhee, *supra* note 27, at 864–65.

42. Some states retain the impact requirement. *See, e.g.*, Lee v. State Farm Mut. Ins. Co., 533 S.E.2d 82 (Ga. 2000); Atl. Coast Airlines v. Cook, 857 N.E.2d 989 (Ind. 2006); Steel Tech. v. Congleton, 234 S.W.3d 920 (Ky. 2007).

43. *See, e.g.*, AALAR, Ltd. v. Francis, 716 So. 2d 1141 (Ala. 1998). The "zone of danger" rule later gave rise to the "bystander" rule, under which a bystander can recover for emotional harm for contemporaneously witnessing bodily harm to a close relative. *See* RESTATEMENT (THIRD) TORTS: LIABILITY FOR PHYSICAL & EMOTIONAL HARM § 48 cmt. a.

44. Some states retain this requirement as well. *See* Brueckner v. Norwich Univ., 730 A.2d 1086 (Vt. 1999). However, other states have abolished this requirement. *See, e.g.*, Molien v. Kaiser Found. Hosps., 616 P.2d 813 (Cal. 1980). Still, others have diluted it. *See, e.g.*, Paz v. Brush Engineered Materials, Inc., 949 So. 2d 1 (Miss. 2007) (requiring medically diagnosable disorder).

45. RESTATEMENT (THIRD) OF TORTS: LIABILITY FOR PHYSICAL & EMOTIONAL HARM, § 47 cmt. d.

46. *See* Johnson v. Ruark Obstetrics & Gynecology Assocs., 395 S.E.2d 85, 97 (N.C. 1990).

47. *See, e.g.*, Willis v. Gami Golden Glades, LLC, 967 So. 2d 846 (Fla. 2007) (holding that the plaintiff may show either impact or physical manifestation of emotional harm); *see also* Fox & Stein, *supra* note 19 (describing the ways these "verification requirement[s]" vary from jurisdiction to jurisdiction); Goldberg & Zipursky, *supra* note 28, at 1633 ("courts employ, or have employed, a tangled array of concepts such as 'predicate injury,' 'parasitic damage,' 'impact,' 'zone of danger,' 'foreseeability,' 'direct/indirect,' and 'bystander.'").

arbitrary,[48] the broader foreseeability of harm test, the traditional basis for negligence, has not been accepted as basis for liability except by a few jurisdictions.[49] Instead, the no duty or limited duty rules are designed to preclude a case-by-case analysis.[50] If a claimant can get beyond the duty barriers, courts generally apply an objective test for proof of harm—that a reasonable person would suffer severe emotional harm under the circumstances, as well as a subjective test, that the plaintiff in fact suffered severe emotional harm.[51]

The development of the NIED claim is confusing and perhaps illogical,[52] but the claim continues to evolve and change, with limited modifications of the barriers.[53] The most recent section of the Restatement (Third) addressing NIED claims,[54] which states have begun to adopt,[55] currently

48. *See, e.g.*, Peter A. Bell, *The Bell Tolls: Toward Full Tort Recovery for Psychic Injury*, 36 U. FLA. L. REV. 333, 399 (1984) (arguing that mental injuries should be treated the same as physical injuries in tort); Elizabeth Handsley, *Mental Injury Occasioned by Harm to Another: A Feminist Critique*, 14 LAW & INEQ. 391, 486–87 (1996) (arguing that NIED discriminates against women and should be treated the same as general tort law); Richard S. Miller, *The Scope of Liability for Negligent Infliction of Emotional Distress: Making "The Punishment Fit the Crime,"* 1 U. HAW. L. REV. 1, 47 (1979) (suggesting duty should be owed to all foreseeable plaintiffs, but damages should be limited to economic loss); Rhee, *supra* note 27, at 883 (stating current NIED doctrine is inherently arbitrary and proposing a complete overhaul of the law).

49. *See, e.g.*, Montinieri v. S. New Eng. Tel. Co., 398 A.2d 1180, 1184 (Conn. 1978) (upholding jury charge based on foreseeability of the emotional distress resulting in bodily harm); Leong v. Takasaki, 520 P.2d 758, 762–64 (Haw. 1974) (striking down requirements of physical impact and physical manifestation as "artificial bars" to recovery; shifting to general foreseeability test for bystander NIED); Rodrigues v. State, 472 P.2d 509, 520 (Haw. 1970) (striking down physical manifestation requirement for NIED); Gammon v. Osteopathic Hosp. of Me., Inc., 534 A.2d 1282, 1285 (Me. 1987) (allowing jury to determine validity of the claim despite the plaintiff showing no physical manifestations of emotional injury, suffering no physical impact, and in the absence of any underlying or accompanying tort).

50. *See* Rhee, *supra* note 27, at 809.

51. *See* RESTATEMENT (THIRD) OF TORTS: LIABILITY FOR PHYSICAL & EMOTIONAL HARM § 47 cmt. l (2012).

52. *See* Rhee, *supra* note 27, at 846 (stating that the common law barriers to the NIED claim can be "understood as crude attempts to force mental injury claims into the analytical framework of physical injury claims."); *id.* at 883 ("Courts and scholars know that the current rules of law are arbitrary, and that is the problem.").

53. Commentators and courts have suggested various ways to modify the common law tests to make them less arbitrary or more effectively serve the policy concern of limiting liability. *See* Miller, *supra* note 48, at 38–39 (arguing for capping actual damages or limiting recovery to economic losses); Rhee, *supra* note 27, at 846 (suggesting that courts could have imposed a higher evidentiary burden like the clear and convincing standard); Herbert Winston Smith, *Relation of Emotions to Injury and Disease: Legal Liability for Psychic Stimuli*, 30 VA. L. REV. 193, 285 (1944) (advocating for the categorical rejection of all emotional injury claims).

54. RESTATEMENT (THIRD) OF TORTS: LIABILITY FOR PHYSICAL & EMOTIONAL HARM § 47.

55. *See, e.g.*, Vumbaca v. Terminal One Grp. Ass'n L.P., 859 F. Supp. 2d 343, 373 (E.D.N.Y. 2012) (barring recovery where emotional injury is not "serious" or suffered under "severe" circumstances, in a suit against an airliner for being locked in a grounded plane for seven hours); Cohen v. NuVasive, Inc., 164 Cal. App. 4th 868 n.15 (2008) (permitting recovery where the defendant mishandled human remains); Hedgepeth v. Whitman Walker Clinic, 22 A.3d 789, 800 (D.C. 2011) (permitting recovery where serious emotional harm is

has broken down the NIED claim into two main types. It provides that "[a]n actor whose negligent conduct causes serious emotional harm to another" is liable if: (a) the negligence places the plaintiff "in danger of immediate bodily harm and the emotional harm results from the danger;" or (b) the negligent conduct "occurs in the course of specified categories of activities, undertakings, or relationships in which negligent conduct is especially likely to cause serious emotional harm."[56]

The first type of NIED claim traces back to the traditional requirements of "impact" and "zone of danger," in which the conduct of the negligent actor places the plaintiff in danger of bodily harm and the plaintiff suffers emotional harm as a result.[57]

The second type of claim, which some courts classify as an independent duty, involves emotional harm arising in the context of certain limited relationships, undertakings, or activities, drawing on the traditional line of cases involving hospitals and funeral homes mishandling corpses or negligently misinforming someone about the death of a loved one.[58] More recently, courts have begun to use this category to award damages in cases involving consumption of a food that contains a repulsive foreign object,[59] cases in which a physician negligently diagnoses a patient with a serious disease, or cases in which a hospital misplaces a newborn.[60] This category is narrowly cabined, in order to address the concern of indeterminate and

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"especially likely" in HIV-misdiagnosis suit against medical clinic, given nature of the defendant's relationship with the plaintiff); Miranda v. Said, 836 N.W.2d 8, 28 (Iowa 2013) (permitting recovery where negligent conduct in attorney-client relationship in the immigration context was "especially likely to cause serious emotional harm"); Osborne v. Keeney, 399 S.W.3d 1, 17 (Ky. 2012) (rejecting impact test and adopting "serious" or "severe" emotional injury test for emotional harm when a plane crashed into the plaintiff's home); Boorman v. Nev. Mem'l Cremation Soc'y, 236 P.3d 4, 8 (Nev. 2010) (holding claimant does "not need to observe or perceive the negligent conduct, or demonstrate any physical manifestation of emotional distress" in deciding certified question on negligent mishandling of deceased family member's remains); Strickland v. Medlen, 397 S.W.3d 184, 192 (Tex. 2013) (finding no recovery for negligent euthanasia of plaintiffs' dog); Vincent v. DeVries, 72 A.3d 886, 897 (Vt. 2013) (holding that emotional distress damages are not available to client in legal malpractice suit where nature of emotional harm not sufficiently "serious").

56. RESTATEMENT (THIRD) OF TORTS: LIABILITY FOR PHYSICAL & EMOTIONAL HARM § 47. Some examples of the kinds of activities, undertakings, or relationships that might give rise to liability include the mishandling of dead bodies or the erroneous delivery of the news that someone has died. *Id.* § 47 cmt. f; *cf.* Rhee, *supra* note 27, at 854 (arguing for two classes of victims for NIED claims, the direct victim class and the collateral victim class, with the direct victim class including situations where the defendant and the plaintiff have a preexisting relationship).

57. RESTATEMENT (THIRD) OF TORTS: LIABILITY FOR PHYSICAL & EMOTIONAL HARM § 47 cmt. b.

58. *Id.* § 47 cmt. f.

59. *Id.*

60. *Id.*; *see* Oswald v. LeGrand, 453 N.W.2d 634, 639 (Iowa 1990) (independent duty for emotional distress in context of a medical malpractice action); Johnson v. Ruark Obstetrics & Gynecology Assoc., 395 S.E.2d 85, 93 (N.C. 1990) (same); Fox & Stein, *supra* note 19 (manuscript at 13) ("In exceptional cases, actors assume a duty to avoid emotional harm when they have a special relationship with the victim," citing medical care from psychiatrists and fertility clinics as examples).

excessive liability.[61] "Typically, the undertaking or relationship is one in which serious emotional harm is likely or where one person is in a position of power or authority over the other and therefore has greater potential to inflict emotional harm."[62] These undertakings are likely to cause serious emotional distress if negligently performed.[63] Courts have not provided clear guidelines on how to identify which activities, undertakings, or relationships give rise to this duty,[64] although several commentators have offered ways to define such a duty.[65]

Outside of these two areas, the Restatement (Third) does not encourage actions for NIED. In particular, the Restatement (Third) discourages actions for fear of future injury arising from toxic exposure.[66] The cancerphobia cases present a concern of multiple lawsuits—one brought at exposure and the other brought when bodily injury occurs.[67] It distinguishes cancerphobia cases from the HIV exposure cases, however, because the HIV exposure cases have a relatively confined period during which the exposed individual would suffer from emotional harm and is more akin to automobile accidents.[68] Several commentators find this distinction ironic because the cancerphobia claim is arguably the more significant one.[69]

While the NIED claim for direct victims developed, courts also gradually began to allow a bystander who witnessed an accident and suffered

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61. *See* RESTATEMENT (THIRD) OF TORTS: LIABILITY FOR PHYSICAL & EMOTIONAL HARM § 47 cmt. d.

62. *Id.* § 47 cmt. f.

63. *See generally* Hedgepeth v. Whitman Walker Clinic, 22 A.3d 789 (D.C. 2011) (citing cases from various jurisdictions). Some courts have rejected this idea, however. *See, e.g.*, Spangler v. Bechtel, 958 N.E.2d 458, 464 (Ind. 2011) (stating that to recover under a NIED claim, the plaintiff must either suffer an impact or satisfy the bystander rules).

64. RESTATEMENT (THIRD) OF TORTS: LIABILITY FOR PHYSICAL & EMOTIONAL HARM § 47 cmt. f.

65. *See generally* Dan B. Dobbs, *Undertakings and Special Relationships in Claims for Negligent Infliction of Emotional Distress*, 50 ARIZ. L. REV. 49 (2008) (arguing that the independent duty should be commensurate to the extent of the undertaking); Jeffrey A. Ehrich, *Negligent Infliction of Emotional Distress: A Case for an Independent Duty Rule in Minnesota*, 37 WM. MITCHELL L. REV. 1402 (2011) (proposing an independent duty rule examining factors such as historical industry acceptance of a duty, the subject matter of the harm involved, and countervailing policy considerations).

66. *See* RESTATEMENT (THIRD) OF TORTS: LIABILITY FOR PHYSICAL & EMOTIONAL HARM § 47 cmt. k.

67. *Id.*

68. *Id.* (explaining that in HIV exposure cases, a "person can determine within a known and relatively short interval whether or not the exposure actually did cause the physical injury," like an automobile accident).

69. *See, e.g.*, Diamond, *supra* note 29, at 164 (explaining that the anomaly of compensating for lesser but not greater injuries can be explained by the concern that "compensating for short-term distress is not economically burdensome while compensating for long-term distress would be"); Robert L. Rabin, *Harms from Exposure to Toxic Substances: The Limits of Liability Law*, 38 PEPP. L. REV. 419, 425 (2011) ("[R]espectable argument can be made that it is perverse to recognize the tort claim of an individual traumatized by almost being hit by a negligent driver (a fleeting moment of terror?), but to deny recovery to an individual living with a long-term prospect of contracting cancer due to a defendant's wrongful conduct.").

emotional harm as a result to recover in certain limited settings. "Bystander" NIED cases also developed a series of limited duty barriers. *Dillon v. Legg*[70] became the leading case recognizing bystander liability, articulating certain factors required before recovery could go forward.[71] The Restatement (Third) has adopted a version of the *Dillon* rule, requiring the bystander to contemporaneously observe sudden serious bodily harm to a close family member before being allowed to recover for emotional harm.[72]

This brief chronicle omits a great deal of historical description. However, the main point is that the courts began with the general rule that an actor is not liable for negligent conduct that causes only emotional harm. Then, as they began to recognize exceptions to the general rule in certain limited settings, courts set up a series of barriers to the stand-alone claim of emotional injury on an ad hoc basis. Courts generally recited a number of concerns—based on proof problems and the widespread nature of the injury—to justify the barriers.

This type of claim screening through limited duty rules may not sufficiently take into account modern developments in the understanding, diagnosis, and verification of mental illness. In particular, as we gain greater ability to empirically measure emotional harm claims, we should shift to using traditional evidentiary screening for fact-based validity evidence rather than relying on special pleading rules and limited duty barriers, allowing the fact-finder to decide the question. Separating out our validity concerns will force us to judge whether limiting tests are justified for other reasons, theoretical or policy-based, which require us to go back to first principles.

II. THE UNDERLYING THEORIES OF TORT LAW IN NIED

This part examines the theories behind negligence-based torts, and NIED claims in particular, to explore whether we can carve out verification questions in NIED claims from other substantive concerns. Separating these concerns would allow the traditional fact-finder to determine factual validity questions—subject to traditional evidentiary limitations—instead of having the judge make factual findings on validity in the context of applying limited duty rules.

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70. 441 P.2d 912 (Cal. 1968).

71. The court named three factors to be used in determining the degree of foreseeability: (1) the plaintiff's proximity to the accident; (2) whether the plaintiff directly observed the accident; and (3) whether the plaintiff had a close relationship with the victim. *Id.* at 920. Before *Dillon*, courts allowed recovery for witnessing bodily harm to another only if the person was subjected to physical impact from the defendant's negligent conduct or was personally in the "zone of danger" from the defendant's negligent conduct. RESTATEMENT (THIRD) OF TORTS: LIABILITY FOR PHYSICAL & EMOTIONAL HARM § 48 cmt. a.

72. RESTATEMENT (THIRD) OF TORTS: LIABILITY FOR PHYSICAL & EMOTIONAL HARM § 48. This claim is considered derivative of the physically injured person's tort claim against the tortfeasor, so that the plaintiff must prove that the physically injured person could recover from the tortfeasor. *Id.* § 48 cmt. d.

Identifying the rationale behind tort law is a complex enterprise. Two main theories have dominated the jurisprudence over the last several decades: a rights-based theory and an instrumentalist theory.[73] Some scholars argue that tort law is rights-based—that is, that torts should redress, or provide recourse for, wrongs. This approach looks backward to the relationship between the victim and the injurer. Other scholars see torts as more instrumental—that is, torts should be used to prevent wrongs or shift injury costs away from those who have suffered loss. This approach looks beyond the relationship between the injurer and the victim to examine the effect that imposing liability will have on others.[74] These two views have offered a unified, or monist, theory of how tort cases have been decided historically.[75] Yet, many scholars of tort law find monist theories to be overly restrictive and incomplete, embracing instead a more pluralistic conception of tort law.[76]

In examining these main theories, we must begin with the two major functions of tort law that are generally accepted: corrective justice and deterrence.[77] A rights-based theory of tort law draws from the first major function, corrective justice. It calls on tort law to distribute responsibility according to the injustice that results from the tortfeasor's conduct and serves to correct the moral imbalance that results when one party wrongs

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73. *See* John C.P. Goldberg, *Two Conceptions of Tort Damages: Fair v. Full Compensation*, 55 DEPAUL L. REV. 435, 468 (2006) ("[S]ince the 1970s it has been standard in academic discussions of tort . . . to divide the world of tort theory into justice-based theories on the one hand and welfarist or utilitarian theories on the other.").

74. *See* W. Jonathan Cardi, *A Pluralistic Analysis of the Therapist/Physician Duty to Warn Third Parties*, 44 WAKE FOREST L. REV. 877, 887 (2009) ("[I]nstrumentalist theories view tort law as the state's means of achieving certain goals external to the dispute between the parties—the dominant theory being economic instrumentalism with the goal of reducing injuries to their most efficient level.").

75. *See id*.

76. *See* Larry Alexander & Kimberly Kessler Ferzan, *Confused Culpability, Contrived Causation and the Collapse of Tort Theory*, *in* PHILOSOPHICAL FOUNDATIONS OF THE LAW OF TORTS 406 (John Oberdiek ed., 2014) (noting that tort law consists of a "motley collection of doctrines" that are difficult to justify under normative principles); Jason M. Solomon, *Equal Accountability Through Tort Law*, 103 NW. U. L. REV. 1765, 1772 (2009) (describing how many scholars fall back to pluralistic account of tort law).

77. Numerous other functions of tort law are also used to justify tort liability, in particular the functions of loss distribution and compensation. *See* Guido Calabresi, *Some Thoughts on Risk Distribution and the Law of Torts*, 70 YALE L.J. 499, 505 (1961). The loss distribution view recognizes that defendants frequently do not shoulder the burden of compensation themselves, but rather pass it on to a larger number of individuals. *Id.* Loss distribution is used to justify rules of liability that impose liability on businesses and institutions that can redistribute their losses to insurance or customers. *Id.* Although some authors suggest that compensation is a goal of tort law, others characterize it more as an effect of imposing tort liability. Under this view, awarding compensation is a way to serve other goals of tort law, like deterrence and corrective justice. In other words, compensation is not awarded simply because an individual suffered injuries resulting from a defendant's activity; other factors explain the imposition of liability and consequent requirement of payment of monetary damages. *See* OLIVER WENDELL HOLMES, JR., THE COMMON LAW 91 (1963) ("The undertaking to redistribute losses simply on the ground that they resulted from the defendant's act would not only be open to [other] objections but . . . to the still graver one of offending the sense of justice.").

another.[78] "[C]orrective justice narrowly focuses on the question of what is just between the parties, rather than on the implications that a decision in one case might have for society as a whole . . . ."[79]

Some scholars from the rights-based school focus less on ensuring that an injustice is corrected and more on providing victims with recourse for civil wrongs.[80] This civil recourse approach views as paramount the victims' need for recognition that they have been wronged.[81] Under this view, payment of damages should be proportional to the seriousness of the injury and the seriousness of the wrong. The civil recourse view does not deny that emotional distress is a harm or view it as a less serious form of harm than physical injury; instead it "assert[s] that actors are not ordinarily under a legal duty to be vigilant of others' emotional well-being."[82]

The second generally accepted major function of tort law, deterrence, draws from instrumentalist concerns and tries to prevent future injurious behavior by threatening liability for tortious actions.[83] This view looks beyond the relationship between the injurer and the victim to reducing the overall social consequences of risky activity.[84] Some risks (and the consequent losses that may ensue) are not worth avoiding from a societal perspective. For example, there are social benefits to having people drive, even though driving is a risky activity; we seek to promote optimal deterrence by deterring unnecessarily risky driving.

In seeking optimal deterrence, some supporters of the theory use an economic lens to determine quantitatively which risks are worth deterring and which are not. They compare the monetary costs of risking certain losses with the monetary costs of preventing those losses. "[T]his idea emphasizes the impact of legal rules on incentives, and in injury law it often utilizes a comparison of costs and benefits."[85] This strict economic

78. *See generally* ERNEST J. WEINRIB, THE IDEA OF PRIVATE LAW (1995) (elucidating account of corrective justice as unifying structure in tort law); Cardi, *supra* note 74, at 887 ("Corrective justice generally posits that the tort system is exclusively about establishing justice through examining the relationship between the parties to the action, balancing their respective rights and obligations under the circumstances, and resolving their individualized dispute justly."); Jules L. Coleman, *Tort Law and the Demands of Corrective Justice*, 67 IND. L.J. 349, 353 (1992) (explaining that losses can be wrongful if they invade a legally protected right); John C.P. Goldberg, *Twentieth-Century Tort Theory*, 91 GEO. L.J. 513, 570 (2003) ("Tort law, on this view, aims both to specify the primary duties actors owe to one another and to provide a vehicle by which the secondary duty to repair is enforced.").

79. MARSHALL S. SHAPO, AN INJURY LAW CONSTITUTION 217 (2012) (tracing the corrective justice approach from the writings of Aristotle).

80. *See, e.g.*, Benjamin C. Zipursky, *Civil Recourse, Not Corrective Justice*, 91 GEO. L.J. 695 (2003).

81. *See* Goldberg & Zipursky, *supra* note 28, at 1672–73 ("[T]he right question to ask is: 'Has the plaintiff been wronged such that she is now entitled to seek recourse?'").

82. *Id.* at 1673.

83. *See* Andrew F. Popper, *In Defense of Deterrence*, 75 ALB. L. REV. 181, 181 (2012) ("The civil justice system deters misconduct.").

84. *Id.* ("Civil judgments, settlements, the potential for litigation—the tort system itself—has a beneficial effect on the behavior of those who are the subject of legal action as well as others in the same or similar lines of commerce.").

85. SHAPO, *supra* note 79, at 229 (noting that this analysis often focuses on the "least cost avoider," or the party that can most cheaply avoid an injury).

approach is sometimes criticized for ignoring other social costs, including important human values that may not have a monetary value attached to them.[86]

The jurisprudence of the NIED tort represents a mixture of corrective justice and instrumentalist reasoning, with a heavier emphasis on the latter. Although courts frequently focus on the relationship between the parties and draw upon community notions of harm, both critical to the theory of corrective justice, many theorists and courts emphasize the instrumentalist concerns, looking to factors such as overdeterrence in justifying limits on the NIED tort. Moreover, despite the courts' recitation of these factors, they sometimes muddy the concerns and seem to be relying on mere intuition.[87] A more thorough examination reveals the need for a clearer, if theoretically pluralistic, understanding of duty in this context.

A. Corrective Justice Concerns

Rights-based theories of tort law recognize that victims have certain rights that, when violated, demand compensation from the injurer. The nature and extent of a victim's harm is determined by looking to the victim's rights and evaluating the relationship between the victim and the injurer to determine if the victim's rights were violated under the circumstances.

There are numerous ways to conceptualize a victim's rights under corrective justice theory.[88] Under basic principles of corrective justice, as outlined by Aristotle, the right to equality is the governing factor.[89] The right to self-preservation is another right that is recognized, and can be conceptualized as deriving from a fundamental right to exist free of harm from wrongful conduct.[90] It also has been explained in terms of Locke's

86. *See* Michael D. Green, *Negligence=Economic Efficiency: Doubts*, 75 TEX. L. REV. 1605, 1640 (1997) ("How much is a broken arm, a shattered brain, or a life worth? . . . [M]ost people react to comparisons of lives and limbs with the dollars it would cost to save them as jarring, inappropriate, or even absurd.").

87. *See* Erica Goldberg, *Emotional Duties*, 47 CONN. L. REV. 809, 817 (2015) (finding emotional harm cases in tort law "have generated doctrine that perhaps embodies our intuitions").

88. *See* Zipursky, *supra* note 80, at 700 n.18 (listing various schools of corrective justice).

89. Alan Calnan, *The Instrumental Justice of Private Law*, 78 UMKC L. REV. 559, 579 (2010) ("Justice's private dimension, which addresses the unique dynamics of interpersonal transactions, is embodied in the Aristotelian notion of corrective justice. Corrective justice seeks to restore moral equilibrium to human relations that become imbalanced by wrongful conduct . . . by forcing the wrongdoer to disgorge her gain and extinguish the victim's loss."). In order to determine the proper remedy, a neutral party (the judge) first determines the position of equality of the parties before the injury occurred. Next, the judge determines if the injury caused any unjust gain or loss. Finally, to restore the parties to a position of equality, any unjust gain is returned to the victim, and any unjust loss is compensated. *Id.*; *see* Mark C. Modak-Truran, *Corrective Justice and the Revival of Judicial Virtue*, 12 YALE J.L. & HUMAN. 249, 257–59 (2000).

90. *See* Rhee, *supra* note 27, at 855–57 (2004).

social contract theory.[91] Still another rights-based theory sees a victim's right as a right to a remedy.[92]

John Rawls's theory of social justice offers another way to conceptualize victim's rights.[93] Under this theory, every person is entitled to justice as fairness, or, put differently, every individual should be given an equal ability to pursue his or her conception of what is good.[94] Since physical and mental well-being are necessary to participate completely in and enjoy the human experience, any trespass that causes physical or mental harm interferes with the victim's right to equal opportunities in life.[95]

Under all of these interpretations of rights-based theory, a victim should be able to recover for injuries of any sort, both physical and emotional, if the victim's right has been violated.[96] But, this is not the case. Tort law has traditionally deemphasized rights-based concerns in the NIED context. One reason is because courts believe they are limited in being able to recognize or quantify effectively emotional harm, and therefore they are less willing to emphasize corrective justice concerns. They are less certain that the claims have merit.[97]

Consequently, courts measure the values of corrective justice differently in the NIED context than in other tort contexts. Although all line drawing

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91. *See* John C.P. Goldberg, *The Constitutional Status of Tort Law: Due Process and the Right to a Law for the Redress of Wrongs*, 115 YALE L.J. 524, 542–44 (2005). In Locke's state of nature, each individual possessed the right to self-preservation, along with the right to redress injuries caused by the trespass of others. The right to redress injuries encompassed both an individual right to reparation and a more general right to punish trespass on behalf of all society. Once the social contract was formed, government was granted the right to punish trespass or refuse remedy for trespass against the whole society. However, each member of society retained the individual right to reparation for trespasses against them. Thus, under this theory, a victim is entitled to seek compensation for any trespass that threatens his or her right to self-preservation. *See* JOHN LOCKE, THE SECOND TREATISE OF GOVERNMENT § 11 (1690).

92. *See generally* Eric Encarnacion, *Corrective Justice As Making Amends*, 62 BUFF. L. REV. 451 (2014). Under this view, the wrongdoer has a duty to make amends to the victim, but it does not equate to the traditional duty to make restitution or make the victim whole. *See* W. Jonathan Cardi, *Damages As Reconciliation*, 42 LOY. L.A. L. REV. 5, 18 (2008) ("[C]ourts can and should embrace reconciliation as one of the law's central goals in litigation, particularly in tort cases."). Instead, the wrongdoer is only required to make reasonable, adequate conciliatory gestures. *Id.* at 15 ("[O]ffering of reparations by the wrongdoer is a strong sign that apology, remorse, and the desire to reconcile are real and not manufactured. Without assurances that the offender is genuine, few victims are willing to walk the path of reconciliation.").

93. *See generally* JOHN RAWLS, A THEORY OF JUSTICE (rev. ed. 1999).

94. *Id.* at 10–11.

95. *See* Bell, *supra* note 48, at 342 (stating that under this view, "[p]sychic well-being is the core of what is important to human existence and is too important to the individual to surrender").

96. *See* Gregory C. Keating, *When Is Emotional Distress Harm?*, *in* TORT LAW: CHALLENGING ORTHODOXY 273, 305 (Stephen G.K. Pitel et al. eds., 2013) ("[P]sychological integrity is as essential to effective agency as physical integrity is."); Rhee, *supra* note 27, at 852 ("Ideally, every person should have a right to be free from the imposition of wrongful conduct that would cause injuries.").

97. *See* Adam J. Kolber, *The Experiential Future of the Law*, 60 EMORY L.J. 585, 622 (2011) (noting that limited duty tests stood as "inaccurate proxies for the measurement of the intensity of a plaintiff's emotional distress").

used in common law torts reflects the inherent tension between exercising the freedom to act and the need to conform to societal constraints, in the emotional harm area, courts rely more heavily on the degree of culpability involved; the more egregious the behavior, the more likely the harm will be recognized. For example, as described above, the initial recognition of a claim for recovery of emotional injury grew out of the intentional tort context. This tort does not require a specific showing of harm; injury is presumed. It appears that the paramount value promoted by IIED is the interest in regulating conduct, with a lesser concern about the actual injury suffered or the need to provide compensation.[98] In other words, the social interest in ensuring conformity is stronger than the individual interest in receiving recognition for a wrong suffered.[99]

The balance struck between these values shifted as recognition of the tort expanded from the intentional to the negligence area. As the degree of culpability shifted down, moving from intentional, to gross, and finally to negligent behavior, so did the social interest in regulating behavior. But the interest in recognizing a harm suffered did not grow commensurately; the value of freedom of action takes on greater significance under this view.[100] This approach helps keep NIED claims to a minimum and allows courts to reserve valuable and limited resources for less speculative (and more important) physical harm claims.

Only the historical exceptions, in which courts did not require a showing of injury in certain specific contexts (the negligent handling of a corpse and the negligently delivered death announcement), shifted the emphasis to more corrective justice concerns. This may reflect a consensus about the likely validity of the harm and strong public interest in protecting the sanctity of death, including burial and misinformation regarding death, or it may reflect a consensus about the nature of certain relationships in which one party requires extra protection.[101]

B. Instrumentalist Concerns

Instrumentalist concerns dominate the NIED field. As described above, courts historically expressed general disapproval of emotional harm as a compensable injury, originally finding no duty and then gradually setting up

98. *See* Brian L. Church, *Balancing Corrective Justice and Deterrence: Injury Requirements and the Negligent Infliction of Emotional Distress*, 60 ALA. L. REV. 697, 704 (2009).

99. *See* Crump, *supra* note 37, at 448–49. That is not to say, however, that all intentional conduct that causes emotional harm has little social value. *Id.* (citing examples like a "fire-and-brimstone preacher" and a lawyer cross-examining a witness to suggest instances of socially desirable activities that inflict emotional distress).

100. This general view also creates more subtle value-laden judgments that have a disparate impact on certain classes of claimants. *See* Martha Chamallas & Linda K. Kerber, *Women, Mothers, and the Law of Fright: A History*, 88 MICH. L. REV. 814, 816 (1990) (claims by women); Goldberg & Zipursky, *supra* note 28, at 1669; Rhee, *supra* note 27, at 844 (same-sex marriage).

101. At least one author has categorized these actions as intentional torts. John J. Kircher, *The Four Faces of Tort Law: Liability for Emotional Harm*, 90 MARQ. L. REV. 789, 796 (2007).

a series of unique limiting tests in the form of special pleading requirements.[102] Various explanations that reflect instrumentalist concerns are offered for this disparate treatment. However, at bottom, the instrumental concern of optimal deterrence is calculated differently than for other negligence claims. The underlying message behind the limitations is that these claims are of lesser importance in the tort system than personal injury or property harms.[103] Undervaluing loss from emotional harm lowers the value of deterrence in this area.

This concern is often expressed as a fear of opening up the proverbial floodgates of litigation. Initially, this concern served as an absolute barrier to the claim.[104] Small inroads were made in certain limited situations—the mishandling of a corpse and the erroneous announcement of a death of a family member[105]—special recognition that exists to this day.[106] From an instrumentalist standpoint, these exceptions may reflect the assurance of both the genuineness as well as the infrequency of the claim.[107]

Other inroads occurred that were fashioned to meet instrumentalist concerns of uncontrolled liability exposure. Imposing the spatial restriction to victims of emotional distress within the "zone of danger" of serious physical injury reflects the same commitment to avoid opening of the floodgates of litigation. This means that victims of "near-misses" of airline or car crashes are eligible to recover for emotional distress[108] but that "cancerphobia" cases may not afford the opportunity for recovery for emotional distress. In the latter cases, in which an individual has been exposed to some toxins that may have long-term health consequences, the zone of danger requirement has been retained as a barrier to NIED claims.[109]

Cancerphobia cases also demonstrate a related instrumentalist concern involving the need to prioritize claims to avoid depletion of a defendant's resources that other ("more deserving") claimants may later pursue. This view has been highlighted in the asbestos litigation. As the Supreme Court

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102. *See supra* notes 40–48 and accompanying text.

103. *See* Mark Geistfeld, *The Analytics of Duty: Medical Monitoring and Related Forms of Economic Loss*, 88 VA. L. REV. 1921, 1935 (2002) (explaining the need for prioritization; if a more expansive duty for emotional harm would significantly decrease the possibility for full compensation for physically injured claimants, then emotional harm duty must be limited); Goldberg, *supra* note 87, at 825 n.78 (listing scholars who question tort law's lesser protection afforded emotional harm over physical injury).

104. *See* Mitchell v. Rochester Ry. Co., 45 N.E. 354 (N.Y. 1896), *overruled by* Battalla v. State, 176 N.E.2d 729 (N.Y. 1961).

105. *See* Robert L. Rabin, *Emotional Distress in Tort Law: Themes of Constraint*, 44 WAKE FOREST L. REV. 1197, 1199 (2009).

106. *See* RESTATEMENT (THIRD) OF TORTS: PHYSICAL & EMOTIONAL HARM § 47 (2012); DOBBS, *supra* note 40, § 308, at 836–37.

107. *See* Rabin, *supra* note 105, at 1199.

108. *See, e.g.*, Quill v. Trans World Airlines, Inc., 361 N.W.2d 438 (Minn. Ct. App. 1985) (discussing how the airplane plunged 34,000 feet before gaining control); Falzone v. Busch, 214 A.2d 12 (N.J. 1965) (discussing evolution of near miss doctrine); Rabin, *supra* note 105, at 1199, 1208.

109. *See* Rabin, *supra* note 105, at 1200.

wrote in *Metro-North Commuter Railroad Co. v. Buckley*,[110] "[i]n a world of limited resources, would a rule permitting immediate large-scale recoveries for widespread emotional distress caused by fear of future disease diminish the likelihood of recovery by those who later suffer from the disease?"[111] When the claims of those who suffer anxiety about what ultimately may happen to them are pitted against those whose fears actually come to fruition, the courts signaled that the "more deserving" victims were those who suffered the most serious physical consequences.[112]

Related to the need to prioritize claims is the concern of the award's disproportionality to the tort involved. Here, court decisions seek to ensure fairness to the injurer by invoking the principle that "the punishment should fit the crime."[113] Although the move from no duty to the limited duty of NIED suggests that courts now recognize greater social interest in regulating conduct that affects emotional well-being, the rules are designed to ensure that certain conduct affecting emotional well-being is not (over) deterred. Optimal deterrence has a different equation in this context. From this point of view, the concern is not the legitimacy of the claim; it's that there will be too many claims. The limiting tests are designed to ensure that defendants and the other entities to which they passed on costs are not overly burdened with NIED claims.[114] Thus, the Supreme Court justified the line that it drew between physical and mental harms in *Buckley* by explaining that it allows a "tort system that can distinguish between reliable and serious claims on the one hand, and unreliable and relatively trivial claims on the other."[115]

As our understanding of and ability to measure empirically emotional harm changes, so should our emphasis on the values we promote. The instrumentalist perspective is motivated partly by a set of concerns that advances in neuroscience can allay. We may not need to prioritize physical damage claims over emotional harm claims, as we learn that emotional harm has a physical correlate. As the sharp distinction between the two can

110. 521 U.S. 424 (1997) (examining NIED claims under the Federal Employers' Liability Act for exposure to asbestos without symptoms).

111. *Id.* at 435–36.

112. Rabin, *supra* note 105, at 1200; *see also* Peter H. Schuck, *The Worst Should Go First: Deferral Registries in Asbestos Litigation*, 15 HARV. J.L. & PUB. POL'Y 541, 560–62 (1992). The asbestos litigation has also developed an intermediate situation in which the claimant suffers some intermediate injury, like asbestosis, which may develop into a life-threatening disease. The Supreme Court recognized that this situation may warrant recovery since the claim is now more "genuine and serious" emotional distress. *See* Norfolk & W. Ry. Co. v. Ayers, 538 U.S. 135, 156–57 (2003); Rabin, *supra* note 105, at 1201. The lower courts remain divided on the duty to compensate for emotional distress in the "precursor-disease" context. *See* Rabin, *supra* note 105, at 1201–02.

113. *See* Rabin, *supra* note 69, at 425–26 ("The diversity of treatment of NIED claims has floodgates written all over it.").

114. *See id.* at 430. As Professor Rabin states: "Boundless litigation is, from the judicial perspective, an attack on the very foundations of tort law: from a judicial administration vantage point, the capacity to process cases efficiently, and from the parties' vantage point, a recognition of claims to 'just deserts' in the face of prospectively insolvent responsible parties." *Id.*

115. *Metro-N. Commuter R.R. Co.*, 521 U.S. at 444.

no longer be maintained, the case for differential promotion in values falls away as well. Instead, the presumption should be that we strike the same balance between individual and social interests for NIED claims as for other negligence claims and, as we restore this balance, the burden should shift to those who would argue otherwise. In other words, as we learn more about the validity of emotional harm, we should promote more prominently the value of corrective justice and recognition of victims' rights. The next part explores developments in science and medicine and how they have begun to change our normative view of emotional harm as well.

III. DEFINING THE HARM: SCIENCE, MEDICINE, AND COMMON SENSE

Common law courts have struggled with the legal definition of emotional harm in their quest to distinguish worthy from unworthy NIED claims. Defining what it means to be harmed emotionally depends critically on the framework used to examine the question—whether from a scientific, medical, or normative perspective. These three viewpoints influence each other and offer different, but overlapping, ways to define emotional harm. Legal definitions frequently reflect an attempt to create an amalgam of all of these perspectives, while trying to address different theoretical and policy concerns.

When courts began to recognize the tort of NIED, a major definitional concern was addressing the subjectivity associated with the harm and the potential for fraud. Courts distinguished emotional from physical harm because it is a mental state not directly observable by others that is highly subjective, based mostly on self-reporting. This could lead, in turn, to the ability by plaintiffs to feign emotional injuries to get compensation, leading to excessive and fictitious lawsuits.[116]

Although courts continue to maintain the distinction between recognition of physical harm and emotional harm, there has been a movement in science and medicine away from a strong distinction between those harms. Both scientists and scholars have moved away from explanations that treat "mental" and "physical" as separate categories. Neuroscientists have begun to develop new models of looking at the interaction between mind and

116. Many of the same problems, such as subjectivity, measurement uncertainty, and potential for fraud, exist with pain and suffering associated with physical injuries. These parasitic damages have not concerned courts in the same way, perhaps because courts are willing to say it is easier to believe that pain and mental suffering occurs following a physical injury. *See* Goldberg, *supra* note 87, at 823 n.68 ("[P]arasitic damages 'avoid[] the trivial or fraudulent claims that have been thought to be inevitable due to the subjective nature of [emotional] injuries.'" (quoting Flax v. DaimlerChrysler Corp., 272 S.W.3d 521, 527 (Tenn. 2008))). This only gets the plaintiff over the threshold, however. The level of pain and suffering that a plaintiff experiences presents the same difficulties as in the NIED context, and yet courts allow the pain and suffering elements in the conventional tort injury cases full consideration by jurors. Perhaps the difference is that the tort system is not really addressing compensation for the mental element, but allowing an offset for the legal fees that cut into the special damages and restoring full compensation for the physical injuries. *But see* Goldberg & Zipursky, *supra* note 28, at 1673–74 (theorizing that emotional tranquility on its own, except rarely, is insufficient to impose duty on defendants to protect others' emotional well-being).

body.[117] Scholars have begun to integrate this in their view of looking at legal questions.[118] And even courts have begun to recognize that the distinction between mind and body has become blurred.[119] As these changes occur, we will need to recognize them in the jurisprudence of NIED as well. At the outset, those changes may force courts to unpack validity from other concerns and allow us to address the differing concerns through different judicial mechanisms.

A. Scientific Advances in Assessing the "Neural Basis of Emotion"

Although the field is in the early stages, neuroscience advances may someday allow us to measure physiological changes in the brain regions that occur after a traumatic event.[120] These advances are significant because they may offer a way to document physical changes that result from emotional harm, allowing us to verify and objectively measure a claim of emotional harm. In other words, these advances suggest a potential, objective biomarker of emotional harm. Through the use of neuroscience and neuroimaging, scientists have begun to link cognitive disorders from exposure to trauma to neurological conditions.[121] While individual differences such as age, gender, and genetics may influence whether an individual will develop a cognitive disorder following a traumatic event, neuroscientists have come to understand that dysfunction occurs in the neural systems that regulate emotion when an individual experiences acute stress.[122]

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117. *See, e.g.*, Kolber, *supra* note 97.

118. *See, e.g.*, ANTONIO R. DAMASIO, DESCARTES' ERROR: EMOTION, REASON, AND THE HUMAN BRAIN (1994); PETER ALCES, THE MORAL INTERSECTION OF LAW AND NEUROSCIENCE 41 (Univ. Chicago forthcoming 2017) ("Once we have a way to 'see' emotional injury as clearly as we can 'see' a broken bone . . . there would be no reason to maintain the tort law's distinction between physical and emotional injury."); Shaun Cassin, *Eggshell Minds and Invisible Injuries: Can Neuroscience Challenge Longstanding Treatment of Tort Injuries?*, 50 HOUS. L. REV. 929, 954 (2013) ("Neuroscience is making it harder to support a legal distinction between physical and emotional injuries."); Dan M. Kahan & Martha C. Nussbaum, *Two Conceptions of Emotion in Criminal Law*, 96 COLUM. L. REV. 269 (1996); Kolber, *supra* note 97.

119. *See* Allen v. Bloomfield Hills Sch. Dist., 760 N.W.2d 811, 815 (Mich. Ct. App. 2008) (ruling that PTSD suffered by the plaintiff was a bodily injury to the brain). In the context of insurance policies, many courts have found emotional harm constitutes "bodily injury." *See* Pekin Ins. Co. v. Hugh, 501 N.W.2d 508, 512 (Iowa 1993) (finding that whether a claimant suffered "bodily injury" involved "a medical or psychological problem of proof rather than purely a question of law . . . . [Compensation] should not therefore turn on any artificial and arbitrary classification such as 'physical' or 'psychological'"); Trinh v. Allstate Ins. Co., 37 P.3d 1259, 1264 (Wash. Ct. App. 2002) (concluding that defendant experienced physiologic/neurobiologic injuries as a direct result of her PTSD).

120. This section draws on my earlier work, *see supra* note 18, as well as others. *See* Adam J. Kolber, *Will There Be a Neurolaw Revolution?*, 89 IND. L.J. 807 (2014); Jean Macchiaroli Eggen & Eric J. Laury, *Toward a Neuroscience Model of Tort Law: How Functional Neuroimaging Will Transform Tort Doctrine*, 13 COLUM. SCI. & TECH. L. REV. 235 (2012).

121. *See, e.g.*, Amir Garakani et al., *Neurobiology of Anxiety Disorders and Implications for Treatment*, 73 MOUNT SINAI J. MED. 941 (2006).

122. Kevin N. Ochsner et al., *Neural Correlates of Individual Differences in Pain-Related Fear and Anxiety*, 120 PAIN 69, 69–70 (2006); Jason J. Radley et al., *Stress Risk Factors and*

Neuroscientist and Professor Joseph E. LeDoux is an early advocate of the view that emotions, like other physical sensations, result from physiological processes and therefore can be studied objectively.[123] He explains:

> If we want to understand feelings, it is likely going to be necessary to figure out how the more basic systems work. Failure to come to terms theoretically with the importance of processing systems that operate essentially unconsciously has been a major impediment to progress in understanding the neural basis of emotion. To overcome this, brain researchers need to be more savvy about the nature of emotions, rather than simply relying on common sense beliefs about emotions as subjective feeling states.[124]

Researchers are heeding LeDoux's call to investigate the "neural basis of emotion."[125] In particular, an increased awareness of PTSD and trauma-related disorders, as well as troops returning from wars in Iraq and Afghanistan with trauma-related disorders, has led to an increase in research funding for PTSD since 2007.[126] Resulting research has begun to shed light on the specific neural circuitry dedicated to emotional function. Evidence indicates that individuals with psychiatric disorders have abnormalities in these neural circuitry systems and exposure to traumatic events can change this circuitry in previously healthy individuals.[127]

Witnessing or experiencing a traumatic event results in a state described as acute stress, characterized by activation of a number of hormonal and neurotransmitter systems.[128] These systems trigger a chain of chemical processes that result in alterations in the neural networks that regulate

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Stress-Related Pathology: Neuroplasticity, Epigenetics and Endophenotypes, 14 STRESS 481, 481–82 (2011).

123. *See* Joseph E. LeDoux, *Emotional Circuits in the Brain*, 23 ANN. REV. NEUROSCIENCE 155, 156 (2000).

124. *Id.* at 157.

125. *See, e.g.*, Lisa Feldman Barrett et al., *The Experience of Emotion*, 58 ANN. REV. PSYCHOL. 373 (2007); Naomi I. Eisenberger, *Identifying the Neural Correlates Underlying Social Pain: Implications for Developmental Processes*, 49 HUM. DEV. 273 (2006); Ethan Kross et al., *Coping with Emotions Past: The Neural Bases of Regulating Affect Associated with Negative Autobiographical Memories*, 65 BIOLOGICAL PSYCHIATRY 361 (2009); Ochsner et al., *supra* note 122.

126. Editorial, *Neuropharmacology Special Issue on Posttraumatic Stress Disorder (PTSD): Current State of the Art in Clinical and Preclinical PTSD Research*, 62 NEUROPHARMACOLOGY 539, 539 (2012).

127. Adriana Feder et al., *Psychobiology and Molecular Genetics of Resilience*, 10 NATURE REVS. NEUROSCIENCE 446, 451–52 (2009); Roger K. Pitman et al., *Investigating the Pathogenesis of Posttraumatic Stress Disorder with Neuroimaging*, 62 J. CLIN. PSYCHIATRY 47, supp. 17 (2001).

128. Roger K. Pitman et al., *Pilot Study of Secondary Prevention of Posttraumatic Stress Disorder with Propranolol*, 51 BIOLOGICAL PSYCHIATRY 189, 190–92 (2002); Benno Roozendaal et al., *Stress, Memory and the Amygdala*, 10 NATURE REVS. NEUROSCIENCE 423, 427 (2009); Yvonne M. Ulrich-Lai & James P. Herman, *Neural Regulation of Endocrine and Autonomic Stress Responses*, 10 NATURE REVS. NEUROSCIENCE 397, 404 (2009).

memory and fear.[129] These physiological changes can materialize in the form of emotional distress symptoms, particularly anxiety symptoms.[130]

Extensive and replicated research has revealed several brain regions that are associated with emotional trauma.[131] Research suggests emotional disorders from trauma occur when this circuitry malfunctions.[132]

This section proceeds in two parts: (1) it describes briefly the processes, structures, and neural networks underlying memory and fear that are believed to be foundational to emotional harm; and (2) it highlights studies indicating the dysfunction that occurs when an individual experiences trauma and stress-related disorders, focusing in particular on the disorder of PTSD.[133] The focus on PTSD is appropriate for several reasons. As noted above, PTSD is probably the most heavily researched trauma-related disorder in neuroscience at this stage. Further, PTSD is comparable to what we recognize as emotional harm in law, since the disorder is trauma-induced and has a delayed manifestation of outward symptoms. Moreover, development of PTSD is relatively frequent in individuals exposed to trauma: researchers estimate 10 to 15 percent of individuals exposed to trauma will develop the disorder, and 6.8 percent of Americans will experience PTSD at some point in their lifetime.[134]

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129. Pitman et al., *supra* note 128, at 189; Roozendaal et al., *supra* note 128, at 424; Ulrich-Lai & Herman, *supra* note 128, at 398.

130. Roozendaal et al., *supra* note 128, at 427.

131. In particular, structural and functional neuroimaging results implicate the hypothalamic-pituitary-adrenal (HPA) axis, the locus coeruleus (LC)-noradrenergic systems, the amygdala, hippocampus, specific subregions of the medial prefrontal cortex (mPFC), orbitofrontal cortex (OFC), anterior cingulated (ACC) and insular cortices, in the processing and storage of stressful events and emotional information. Cora Hubner et al., Ex Vivo *Dissection of Optogenetically Activated mPFC and Hippocampal Inputs to Neurons in the Basolateral Amygdala: Implications for Fear and Emotional Memory*, 8 FRONTIERS BEHAV. NEUROSCIENCE 1, 1–5 (2014); Martin P. Paulus, *The Role of Neuroimaging for the Diagnosis and Treatment of Anxiety Disorders*, 25 DEPRESSION & ANXIETY 348, 349 (2008); Pitman et al., *supra* note 128, at 189; Kelly Skelton et al., *PTSD and Gene Variants: New Pathways and New Thinking*, 62 NEUROPHARMACOLOGY 628, 631 (2012); Hidenori Yamasue et al., *Gender-Common and -Specific Neuroanatomical Basis of Human Anxiety-Related Personality Traits*, 18 CEREBRAL CORTEX 46, 46 (2007).

132. Paulus, *supra* note 131, at 351–52.

133. Posttraumatic stress disorder (PTSD) is classified as a traumatic and stress-related disorder in the DSM-5. The essential element of PTSD is the development of certain symptoms after exposure to an extremely traumatic event or experience that involves actual or threatened death or serious injury to oneself or others. The categories of symptoms resulting from exposure to the triggering event include persistent reexperiencing of the trauma, persistent negative cognitions and mood, avoidance of stimuli associated with the trauma and a numbing of general responsiveness, as well as a number of symptoms associated with increased arousal. To receive a diagnosis of PTSD, these symptoms must be present for more than one month, must interfere with regular functioning, and must not be attributable to a medication, substance use, or other illness. AM. PSYCHIATRIC ASS'N, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS § 309.81 (5th ed. 2013) [hereinafter DSM-5]. Otherwise, the individual is eligible for a diagnosis of acute stress disorder, which will change to PTSD if the symptoms are still present one month after the trauma occurred. *Id.* § 308.3.

134. Thomas Steckler & Victoria Risbrough, *Pharmacological Treatment of PTSD—Established and New Approaches*, 62 NEUROPHARMACOLOGY 617, 617 (2012).

1. The Neural Foundations of Memory and Fear

Learning, memory, and perception are all involved in experiencing acute stress.[135] Learning and memory are complex processes in which neurons modulate the strength and structure of their interconnections.[136] These processes are a type of brain plasticity, which is the relatively rapid and reversible change in brain structure and function.[137] Studies in neuroscience indicate that even a single exposure to a traumatic event can cause long-lasting cellular changes (or stress-induced plasticity) in the amygdala, the structure believed to be central to both anxiety and memory.[138]

When an individual experiences stress, the experience is encoded into the working memory, the short-term memory,[139] and finally consolidated into the long-term memory.[140] Memories are stored in the form of an increase in synaptic strength or in the pattern of the synapses themselves.[141] The consolidation process involves the transfer of information from labile, short-term memory into long-term memory.[142] The consolidation process enables the interpretation of emotional information as well as controls the mechanisms that influence what individuals perceive in their environment and how they interpret that information (the attentional and interpretive processes).[143]

The brain is very efficient in creating long-term memories of emotionally significant events, both positive and traumatic.[144] Two key structures are

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135. James L. McGaugh & Benno Roozendaal, *Memory Modulation*, *in* LEARNING AND MEMORY: A COMPREHENSIVE REFERENCE 521–53 (John H. Byrne ed. 2009).

136. *Id.*

137. Rudi De Raedt, *Does Neuroscience Hold Promise for the Further Development of Behavior Therapy? The Case of Emotional Change After Exposure in Anxiety and Depression*, 47 SCANDINAVIAN J. PSYCHOL. 225, 226 (2006); *see also* Feder et al., *supra* note 127, at 453.

138. Roozendaal et al., *supra* note 128, at 429.

139. Short-term memory is the modification of already synthesized molecules, which strengthens existing connections. Kelsey C. Martin et al., *Molecular Mechanisms Underlying Learning-Related Long-Lasting Synaptic Plasticity*, *in* THE NEW COGNITIVE NEUROSCIENCES 121 (Michael S. Gazzaniga ed., 2000).

140. Long-term memory involves the synthesis of new messenger RNA and new proteins, a process that can result in the induction and stabilization of long-lasting forms of entirely new synthesized neural connections. Gary Lynch, *Memory Consolidation and Long-Term Potentiation*, *in* THE NEW COGNITIVE NEUROSCIENCES, *supra* note 139, at 139. *See generally* Amy F. T. Arnsten, *Stress Signaling Pathways That Impair Prefrontal Cortex Structure and Function*, 10 NATURE REVS. NEUROSCIENCE 410 (2009); Robert S. Blumenfeld & Charan Ranganath, *Dorsolateral Prefrontal Cortex Promotes Long-Term Memory Formation Through its Role in Working Memory Organization*, 26 J. NEUROSCIENCE 916 (2006).

141. Lynch, *supra* note 140, at 139.

142. Garakani et al., *supra* note 121, at 944–45; Oliver T. Wolf, *Stress and Memory in Humans: Twelve Years of Progress?*, 1293 BRAIN RES. 142, 144 (2009).

143. LeDoux, *supra* note 123, at 174; Wolf, *supra* note 142, at 147.

144. James L. McGaugh, *Memory Consolidation and the Amygdala: A Systems Perspective*, 25 TRENDS NEUROSCIENCE 456, 456 (2002); McGaugh & Roozendaal, *supra* note 135, at 521. Emotionally significant experiences tend to be well remembered. McGaugh, *supra* note 144, at 456; Roozendaal et al., *supra* note 128, at 423; Wolf, *supra* note 142, at 148–49.

associated with this process. The amygdala, or the "emotion center," stimulates the "arousal system" when trauma and stress are experienced,[145] and the prefrontal cortex is considered the controlling mechanism to keep our emotions in check. The prefrontal cortex regulates our experience of emotion and naturally compensates for aversive events. When functioning properly the prefrontal cortex facilitates the formation of new connections that override the traumatic memory, a process called extinction.[146]

The consolidation of a traumatic memory forms the basis for trauma and stress-related disorders, including PTSD.[147] The amygdala and the prefrontal cortex circuitry is central to this process.[148] Research suggests that when this circuitry is disrupted, anxiety results.[149] This is because the amygdala is hyperactive and the controlling mechanisms in the prefrontal cortex are inadequately recruited. In other words, acute stress impairs the prefrontal cortical function.[150] This malfunction or dysregulation leads to alterations in interpretive processes, or more precisely, a threat-oriented bias in anxious individuals. As a result of this bias, individuals with anxiety disorders react to stimuli that objectively would be interpreted as neutral or only mildly aversive with distress, hyperarousal, and attempts to avoid the anxiety-provoking object or situation.[151]

During and following a stressful event, the brain is flooded with stress hormones, which results in a number of physiological changes to the neural networks that regulate memory and fear.[152] The flooding of stress hormones solidifies the memory of the trauma by enhancing the consolidation process of the mental and emotional experience of the event.[153] In addition, the neurotransmitter norepinephrine has a central role in regulating stress effects on memory consolidation.[154]

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145. McGaugh, *supra* note 144, at 456–57 (discussing how the basolateral complex of the amygdala (BLA) is activated by emotional arousal and helps make significant experiences memorable by enhancing the consolidation of long-lasting memory in other brain regions); Roozendaal et al., *supra* note 128, at 423.

146. Roozendaal et al., *supra* note 128, at 427, 430–31.

147. Pitman et al., *supra* note 128, at 189.

148. Amit Etkin & Tor D. Wager, *Functional Neuroimaging of Anxiety: A Meta-Analysis of Emotional Processing in PTSD, Social Anxiety Disorder, and Specific Phobia*, 164 AM. J. PSYCHIATRY 1476, 1484 (2007); Kevin S. LaBar et al., *Human Amygdala Activation During Conditioned Fear Acquisition and Extinction: A Mixed-Trial fMRI Study*, 20 NEURON 937, 939 (1998); Ulrich-Lai & Herman, *supra* note 128, at 401.

149. Sonja J. Bishop, *Neurocognitive Mechanisms of Anxiety: An Integrative Account*, 11 TRENDS COGNITIVE SCI. 307, 308 (2007); *see* Richard A. Friedman, *Why Teenagers Act Crazy*, N.Y. TIMES, June 29, 2014, at SR1 (describing amygdala and prefrontal cortex circuit dysfunction in anxiety disorders).

150. Arnsten, *supra* note 140, at 410–11.

151. Bishop, *supra* note 149, at 307.

152. Roozendaal et al., *supra* note 128, at 424–25.

153. McGaugh & Roozendaal, *supra* note 135, at 205.

154. Roozendaal et al., *supra* note 128, at 423–25. Noradrenergic activity in the BLA is critical to modulating other hormones and transmitters involved in memory consolidation. A neurotransmitter system comprised of noradrenergic neurons is how norepinephrine is transmitted through the brain. Noradrenergic neurons act on adrenergic receptors located in the amygdala, hippocampus, hypothalamus, thalamus, as well as numerous other brain structures and the spinal cord. Because of the large number of areas that contain adrenergic

During acute stress, the hypothalamic-pituitary-adrenal (HPA) axis becomes hyperactive. This hyperactivity affects the delicate balance of neurochemicals in an individual and has been shown to cause illness.[155] Chronic activation of the HPA axis can cause elevated levels of cortisol in the body, which can cause atrophy of the hippocampus.[156] Studies show that this series of events—adrenal stress hormones which trigger the regulation and consolidation of memory—holds true for emotionally arousing information, such as trauma and stress, but does not affect the consolidation of memory of emotionally neutral information.[157] When memory is "retrieved," the fear response can be retriggered, which forms the basis for PTSD.[158]

2. Neuroscience Studies of PTSD

Scientists study disproportionate fear responses by using fear conditioning,[159] and focusing on different parts of the brain, to gain valuable insight into the origins and neural bases of those responses.[160] The lateral amygdala has been a primary structure of interest in the study of memory and fear,[161] and research studying fear conditioning in both animals and humans supports the hypothesis that a common element of PTSD specifically, and emotional distress in general, may be amygdalar dysfunction.[162] Recent research reveals that dysfunction in PTSD goes beyond the amygdala itself and encompasses the corticolimbic circuit,

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receptors, when the norepinephrine system is activated, a significant area of the brain is affected. The BLA influences the consolidation of memory through its many connections to other brain structures. The BLA projects directly to the caudate nucleus and both directly and indirectly to the hippocampus. The BLA also has connections to the insular cortex, which other studies have revealed is a common denominator in the manifestation and maintenance of anxiety disorders. *Id.*; McGaugh & Roozendaal, *supra* note 135, at 205.

155. Mario Francisco Juruena, *An Integrative Science Approach: Neuroscience in the DSM-V and ICD-11*, 23 ACTA NEUROPSYCHIATRICA 143, 143 (2011).

156. Michael Randall, *The Physiology of Stress: Cortisol and the Hypothalamic-Pituitary-Adrenal Axis*, DARTMOUTH UNDERGRADUATE J. SCI. (2010), *available at* http://dujs.dartmouth.edu/fall-2010/the-physiology-of-stress-cortisol-and-the-hypothalamic-pituitary-adrenal-axis#.U5ltEfmwLec.

157. McGaugh & Roozendaal, *supra* note 135, at 208; Roozendaal et al., *supra* note 128, at 423.

158. Roozendaal et al., *supra* note 128, at 423.

159. The Pavlovian fear-conditioning paradigm is the classic way to study fear conditioning in healthy control subjects. Garakani et al., *supra* note 121, at 941; Diane B. Paul & Arthur L. Blumenthal, *On the Trail of Little Albert*, 39 PSYCHOL. REC. 547, 547–49 (1989); John B. Watson & Rosalie Rayner, *Conditioned Emotional Reactions*, 3 J. EXPERIMENTAL PSYCHOL. 1, 2–3 (1920).

160. Garakani et al., *supra* note 121, at 941; LaBar et al., *supra* note 148, at 937.

161. LeDoux, *supra* note 123, at 161, 167; Roozendaal et al., *supra* note 128, at 424.

162. Bishop, *supra* note 149, at 307; M. Davis & P.J. Whalen, *The Amygdala: Vigilance and Emotion*, 6 MOLECULAR PSYCHIATRY 13, 13 (2001); Garakani et al., *supra* note 121, at 942; LeDoux, *supra* note 123, at 171; Elisabeth A. Murray, *The Amygdala, Reward and Emotion*, 11 TRENDS COGNITIVE SCI. 489, 491–92 (2007); Gleb P. Shumyatsky et al., *Identification of a Signaling Network in Lateral Nucleus of Amygdala Important for Inhibiting Memory Specifically Related to Learned Fear*, 111 CELL 905, 905 (2002); Wolf, *supra* note 142, at 147.

which includes the prefrontal cortex, hippocampus, and amygdala.[163] In addition, studies suggest that PTSD sufferers may have a preexisting genetic vulnerability of the HPA axis, which increases the likelihood of HPA dysregulation after acute trauma exposure and a higher likelihood of developing PTSD or other stress-related disorders.[164]

Neuroimaging results in human subjects using functional magnetic resonance imaging (fMRI) show that fear conditioning leads to increases in amygdalar activity.[165] Once the amygdala detects danger, it can activate various "arousal" networks, which then can influence sensory processing.[166] Following fear conditioning, the information transmitted from the amygdala results in the individual experiencing and exhibiting a fear response.[167] Functional MRI studies have also revealed the relationship between the amygdala and medial prefrontal regions in PTSD.[168]

For example, a 2004 study compared PET scans of thirty-six Vietnam veterans with diagnosed PTSD to PET scans of Vietnam veterans without PTSD.[169] Results of the study indicated hyperresponsivity of the amygdala and hyporesponsivity of medial prefrontal regions and that these responses are reciprocally related.[170] The more hyper- and hypoactive these regions were, the more severe the symptoms. These results support the hypothesis that PTSD symptoms reflect extreme dysregulation in these regions and neural mechanisms. While such a relationship between the amygdala and medial prefrontal regions in clinically diagnosed PTSD patients had been suspected, no previous studies in the literature had documented data in support of such a relationship.

Studies have also begun to document and distinguish at the chemical and structural level between PTSD and other anxiety disorders. In 2007, Etkin and Wager conducted a meta-analysis of studies that had used brain scans to investigate emotional processing in patients with anxiety disorders.[171] The meta-analysis compared fMRI and PET scans of individuals with one of

163. *See* Steckler & Risbrough, *supra* note 134, at 617.

164. Rachel Yehuda, *Status of Glucocorticoid Alterations in Post-traumatic Stress Disorder*, 1179 ANNALS N.Y. ACAD. SCI. 56, 58 (2009).

165. Christian Büchel et al., *Brain Systems Mediating Aversive Conditioning: An Event-Related fMRI Study*, 20 NEURON 947, 954 (1998); LaBar et al., *supra* note 148, at 937.

166. *See* LeDoux, *supra* note 123, at 177; Etkin & Wager, *supra* note 148, at 1482 (stating that information is transmitted from the amygdala to the behavioral, autonomic, and endocrine response control systems located in the brainstems).

167. Shumyatsky et al., *supra* note 162, at 905.

168. *See generally* Lisa M. Shin et al., *Regional Cerebral Blood Flow in the Amygdala and Medial Prefrontal Cortex During Traumatic Imagery in Male and Female Vietnam Veterans with PTSD*, 61 ARCH. GEN. PSYCHIATRY 168 (2004).

169. *Id.* at 169. The researchers used script-driven imagery to conduct the study. *Id.* All of the male participants had served in combat and all of the female participants had served as nurses in Vietnam. *Id.* None of the veterans had a history of head injury, neurological disorders, or other major conditions. *Id.*

170. *Id.* The reciprocal or inverse relationship between the two regions means that as the amygdala becomes more active or hyperresponsive, the prefrontal cortex becomes more inhibited or hyporesponsive.

171. Etkin & Wager, *supra* note 148, at 1476.

three anxiety disorders—PTSD, social anxiety disorder, and specific phobia—with the scans of healthy individuals who had undergone fear conditioning. The results indicated that patients with the anxiety disorders showed consistently greater activity in the amygdala and insula.[172] Even more significant, the dysregulation in the neural circuitry of PTSD patients was more exaggerated than that of patients suffering from the other anxiety disorders.[173] The results of this study have revealed both that the amygdala and insula are critical structures in the common neurobiological pathway in anxiety disorders and support the view that a core fear system exists and when it is activated, anxiogenic[174] symptoms result.[175]

Recent studies reveal further importance of the anterior cingulated corteces in PTSD. In 2008, Kasai compared twins with combat-related PTSD to their co-twins who had no history of trauma. The PTSD group had lower gray matter volumes in the subgenual anterior cingulated cortex (sACC) compared to their non-PTSD co-twins.[176] This finding is significant because it suggests that abnormalities in the sACC are a marker for PTSD instead of a risk factor for the disorder. A similar study examined the dorsal anterior cingulated cortex (dACC) and found both PTSD twins and their non-PTSD co-twins had increased metabolic rates in their dACC.[177] Since the abnormalities were the same in both twins, the effect is considered a risk factor for developing PTSD.[178]

Studies suggest that the dACC plays a crucial part in both physical and emotional pain.[179] Chronic pain patients who have their dACC removed say that they can still feel the pain but it no longer bothers them, linking unpleasantness with the physical sensation.[180] A recent neuroimaging study tested "social pain" reactions among subjects and found that the dACC

172. *See id.* at 1480–81.

173. *Id.* Only patients with PTSD showed hypoactivation in the dorsal and rostral anterior cingulated cortices and ventromedial prefrontal cortex—additional structures linked to the experience and regulation of emotion. *Id.* The effects unique to PTSD suggest that emotional dysregulation in that situation extends beyond an exaggerated fear response or beyond the fear response demonstrated in other diagnosable (medically significant) anxiety and trauma-related disorders. *Id.*

174. Anxiogenic is synonymous with reflecting, causing, or producing anxiety; not every anxiety disorder reaches the level of PTSD. Some individuals may simply experience generalized disturbances in anxiety or mood. But neuroscience advances now indicate that that these neural changes occur for anxiety disorder in general, with individuals diagnosed with PTSD displaying the most dramatic alterations in neural circuitry and consequently the most severe symptoms. *Id.*

175. *Id.* at 1485.

176. Kiyoto Kasai et al., *Evidence for Acquired Pregenual Anterior Cingulate Gray Matter Loss from a Twin Study of Combat-Related Post-Traumatic Stress Disorder*, 63 BIOLOGICAL PSYCHIATRY 550, 550 (2008).

177. Lisa M. Shin et al., *Exaggerated Activation of Dorsal Anterior Cingulate Cortex During Cognitive Interference: A Monozygotic Twin Study of Posttraumatic Stress Disorder*, 198 AM. J. PSYCHIATRY 979, 983 (2011).

178. *Id.*

179. *See, e.g.*, Naomi I. Eisenberger, *Broken Hearts and Broken Bones: A Neural Perspective on the Similarities Between Social and Physical Pain*, 21 CURRENT DIRECTIONS PSYCHOL. SCI. 42 (2012).

180. *Id.* at 43.

response in individuals who were socially excluded experienced heightened dACC activity compared to those who were not.[181] This suggests that physical pain and emotional pain are not that different as registered in the brain scan.

PTSD can also quantifiably affect the hippocampus. A meta-analysis of structural MRI results in 2005 revealed that trauma-exposed individuals with PTSD had significantly decreased bilateral hippocampal gray matter than healthy controls and trauma-exposed controls without PTSD.[182] Several meta-analyses using other imaging mechanisms have revealed similar results.[183] Another study suggests that hippocampal abnormalities may be the key to explaining symptomology of PTSD.[184]

As discussed above, acute stress results in neuronal remodeling through the creation of new synaptic connections in the basolateral amygdala (BLA) and medial amygdala. Some research reveals that a brief exposure to stress triggers a series of cellular changes that take time to come to an end, meaning there is a delay in the time it takes for the cellular changes in the BLA to be completed.[185] The result of this time delay is that once triggered, the plasticity mechanisms continue after the event, despite restoration of normal levels of neurotransmitters and hormones.[186] This means that a single brief exposure to stress results in some modest structural changes at the synaptic level that take time to build up and to slow down—that is, they have delayed anxiogenic effects at the behavioral level.[187]

This finding—that even a single exposure to a traumatic event can cause long-lasting cellular changes, or stress-induced plasticity, in the brain—is highly significant. It may be an important mechanism in the development of trauma-related disorders such as PTSD. Retrieving the memory of "emotionally arousing information induces greater activity in and connectivity between the amygdala and the hippocampus" than retrieving the memory of emotionally neutral information.[188] This evidence suggests that emotionally relevant and emotionally neutral information are treated differently and stored through different mechanisms and processes in the brain.

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181. *Id.* at 45.

182. Noriyuki Kitayama et al., *Magnetic Resonance Imaging (MRI) Measurement of Hippocampal Volume in Posttraumatic Stress Disorder: A Meta-Analysis*, 88 J. AFFECTIVE DISORDERS 79, 79–86 (2005).

183. Dean T. Acheson et al., *Hippocampal Dysfunction Effects on Context Memory: Possible Etiology for Post-Traumatic Stress Disorder*, 62 NEUROPHARMACOLOGY 674, 676–77 (2012).

184. *See generally* Chris R. Brewin et al., *Intrusive Images in Psychological Disorders: Characteristics, Neural Mechanisms, and Treatment Implications*, 117 PSYCHOL. REV. 210 (2010). It is unclear, however, whether the hippocampal abnormalities existed prior to acute trauma and therefore serve as a risk factor for developing the disorder or if they are symptomatic of the disorder itself. Acheson et al., *supra* note 183, at 681.

185. Roozendaal et al., *supra* note 128, at 429 fig.5.

186. *Id.*

187. *Id.*

188. *Id.* at 426.

Animal research further illustrates the importance of the hippocampal-amygdalar circuit in PTSD.[189] In one study, the authors focused on the inability of PTSD sufferers to restrict fear responses to appropriate predictors—i.e., panicking inappropriately when a car backfires. Noting that glucocorticoids increase stress and have been shown to be involved in the pathophysiology of PTSD, the team injected corticosterone into the dorsal hippocampi of one group of rats and tested their fear response against a control group.[190] As predicted, the corticosterone group displayed inappropriate fear responses similar to PTSD symptoms.[191] This study provides solid evidence for one potential mechanism of PTSD.

New research is also beginning to connect mild traumatic brain injury (mTBI) to PTSD. Veterans with mTBI develop PTSD at a higher rate than others.[192] A recent meta-analysis found overlap in abnormality in the middle frontal gyrus in both PTSD and mTBI.[193] Other researchers suggest that there may be dorsolateral prefrontal cortex, orbital frontal cortex, autonomic nervous system, and hippocampus involvement, but fMRI research on mTBI is too limited to gain an accurate picture of the relationship right now.[194] With increased attention focused on the detrimental effects of sports concussions and combat mTBI, there will likely be more studies examining the relationship between the two disorders in the near future.

In sum, the physiological changes that occur in the brain after an individual experiences or witnesses a traumatic event can result in a dysfunction of the neural networks that regulate memory and fear.[195] Even though the only clinical symptoms the individual may demonstrate are emotional in nature, scientists may now begin to document and observe multiple physiological changes that occur in the brain after experiencing trauma as a result of advanced neuroimaging techniques.[196] The fact that

189. *See generally* Nadia Kaouane et al., *Glucocorticoids Can Induce PTSD-Like Memory Impairments in Mice*, 335 SCI. 1510 (2012).

190. *Id.*

191. *Id.*

192. *See* Jon B. Williamson et al., *A Possible Mechanism for PTSD Symptoms in Patients with Traumatic Brain Injury: Central Autonomic Network Disruption*, 6 FRONTIERS NEUROENGINEERING 1 (2013).

193. Alan N. Simmons & Scott C. Matthews, *Neural Circuitry of PTSD With or Without Mild Traumatic Brain Injury: A Meta-Analysis*, 62 NEUROPHARMACOLOGY 598, 602 (2012).

194. *See id.*; Williamson et al., *supra* note 192, at 3.

195. *See, e.g.*, Arnsten, *supra* note 140, at 410; Bishop, *supra* note 149, at 307; Etkin & Wager, *supra* note 148, at 1476; Roozendaal et al., *supra* note 128, at 430; Shumyatsky et al., *supra* note 162, at 905–06.

196. Limitations to applying neuroscience studies to legal questions are not insignificant. *See, e.g.*, Teneille Brown & Emily Murphy, *Through a Scanner Darkly: Functional Neuroimaging As Evidence of a Criminal Defendant's Past Mental States*, 62 STAN. L. REV. 1119, 1167 (2010); Owen D. Jones et al., *Brain Imaging for Legal Thinkers: A Guide for the Perplexed*, 2009 STAN. TECH. L. REV. 5, ¶¶ 29–30, 36–38. These problems include establishing the plaintiff's baseline; extrapolating information from generalized studies to an individual, or "individuation"; and dealing with the different paces at which science will document different disorders. *See* Grey, *supra* note 18, at 226. Further, in neuroscience studies involving emotional harm, the neuroscience measures are tested by reference to conventional measures, such as behavior, questionnaires, self-reporting, and clinical

we have begun to detect these changes through neuroscience gives us the opportunity to quantify the effects of a stressful event without relying on self-reporting. This evidence is beginning to enter the legal landscape in various ways,[197] although it has not yet gained widespread use in the NIED area.

B. Medical Definition of Emotional Harm

Medicine, and more specifically psychiatry, offer a related definitional approach to emotional harm, and it has received more widespread use in court. Some courts have medicalized the legal definition completely, creating one of the highest thresholds for proof of emotional harm. In particular, the British courts have long insisted upon a "recognized psychiatric illness" (RPI) as a threshold requirement for recovery for NIED. This rule was designed as a "powerful control mechanism" to meet the instrumentalist and normative concerns of curtailing the claim.[198] This test has been adopted by other common law countries as well.[199]

The RPI threshold requirement has been justified on three familiar grounds: (1) as a mechanism to promote the policy of controlling the number and types of mental harm claims, thereby reducing the risk of indeterminate liability;[200] (2) as a way to preclude mere anxiety, grief, or other "normal" suffering, which are considered "too remote to be compensable," even if those harms are "reasonably foreseeable";[201] and

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diagnoses. In other words, we validate our new tools with our old tools. We have not yet reached the point at which these variables are an independent (and presumably more dependable) measure. A brain scan alone does not answer the question whether an individual has suffered emotional harm; the researcher must look to other indicia. Moreover, there may be imperfect correspondence between brain changes and behavioral dysfunction. We could measure changes in the brain that have no (or not yet any) manifestation in emotion, cognition, or behavior. Or the experienced changes in emotion, cognition, and behavior may be present, but not (or not yet) observable in brain changes. And there is always a danger that juries will prefer the evidence of neuroimaging over other forms of evidence, given our cultural addiction to faith in what is "physical," although some studies suggest otherwise. *See* Nicholas J. Schweitzer et al., *Neuroimages As Evidence in a* Mens Rea *Defense: No Impact*, 17 PSYCHOL. PUB. POL'Y & L. 357, 366 (2011) (finding no evidence that neuroimaging unduly influences juries over verbal neuroscience-based evidence; neuroscience evidence was more effective than clinical psychological evidence but the effect did not translate into differences in juries). But while these limitations may be fodder for evidentiary challenges or cross-examination, it does not justify an absolute legal barrier to use of brain scan technology in this area.

197. *See* Jean Macchiaroli Eggen & Eric J. Laury, *Toward a Neuroscience Model of Tort Law: How Functional Neuroimaging Will Transform Tort Doctrine*, 13 COLUM. SCI. & TECH. L. REV. 235, 249–52 (2012).

198. Rachael Mulheron, *Rewriting the Requirements for a "Recognized Psychiatric Injury" in Negligence Claims*, 32 OXFORD J. LEGAL STUD. 77, 78 (2012).

199. *See, e.g.*, ALLEN M. LINDEN & BRUCE FELDTHUSEN, CANADIAN TORT LAW 389–90 (9th ed. 2011); SCOTTISH LAW COMM'N, DISCUSSION PAPER ON DAMAGES FOR PSYCHIATRIC INJURY app. A, at 2.7 (2002), *available at* http://www.bailii.org/scot/other/SLC/DP/2002/120.html; Danuta Mendelson, *The Modern Australian Law of Mental Harm: Parochialism Triumphant*, 13 J.L. & MED. 164, 173 (2005).

200. Mulheron, *supra* note 198, at 82.

201. *Id.* at 83.

(3) as a way to create a de minimis rule of damages, regardless of how harmful the anxiety or distress may be to the individual claimant.[202]

The RPI test has been subject to numerous criticisms.[203] Most significantly, critics note that the medical and legal approaches have different goals: while the medical community is concerned with diagnosis and treatment, the law of emotional harm is concerned with whether the claimant has suffered and is entitled to compensation for some emotional harm.[204] The main approach of the psychiatric diagnosis is to use diagnostic checklists based on clinical features, which were designed to give more reliability to clinical diagnoses when planning treatment.[205] This means that a clinical diagnosis and the facts and judgment on which it is based may not align closely to the questions of concern in the law.[206] Further, some argue that reliance upon the classifications is problematic regardless of those differences, given that the diagnostic criteria change over time and may not be incorporated into the classifications.[207]

Furthermore, although an RPI may reflect a longer-lasting psychiatric illness rather than a temporary problem of emotional distress,[208] using an RPI to define emotional harm in law has been criticized as giving rise to inconsistencies and distortions in the law and as no longer being supported in the modern era.[209] Some argue that a lower threshold—casting a wider net—should be sufficient to trigger a compensable emotional harm in negligence.[210] Lowering the threshold would eliminate the problem of denying compensation to emotional suffering that is something less than a positive psychiatric illness.[211] At the same time, the Restatement (Third)

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202. *Id.* at 84.
203. *See id.* at 85.
204. *See id.* at 87.
205. *Id.*
206. *Id.* at 88.
207. *Id.* at 85. At some point, the advances in neuroscience in detecting mental illness presumably will merge with psychiatry and become part of the diagnostic analysis. *See infra* note 250.
208. *See* HARVEY TEFF, CAUSING PSYCHIATRIC AND EMOTIONAL HARM 144 (2009) (explaining that adoption of RPI test was intended "to exclude liability for transient distress of minimal impact"); *see also* PETER R. HANDFORD & NICHOLAS J. MULLANY, TORT LIABILITY FOR PSYCHIATRIC DAMAGE 81 (2006).
209. HANDFORD & MULLANY, *supra* note 208, at 81. *See generally* Mulheron, *supra* note 198. Deidre Smith argues, in the context of describing the political history of the recognition of PTSD by the American Psychiatric Association (APA) in the DSM-III:

> The line between law and medicine is not merely blurred in PTSD; it is absent . . . . If the law decides to address problems of justice by looking to psychiatry or other branches of medicine and science for solutions, it must only do so with a full appreciation and understanding of the origins and limitations of the concepts it seeks to adopt. Absent such acknowledgement, together with a determination that such concepts are in fact appropriate to import into law, the legal system simply delegates juridical authority to those fields.

Dierdre M. Smith, *Diagnosing Liability: The Legal History of Posttraumatic Stress Disorder*, 84 TEMP. L. REV. 1, 66–69 (2011).
210. *See* Mulheron, *supra* note 198, at 107.
211. *See id.* at 109.

views its test of "serious emotional harm" as having more commonality than difference with the British test of RPI:

> While there may be a modest difference between "serious emotional harm," the term employed in [the] Restatement, and "psychiatric injury," the British term, both terms have in common the effect of screening out minor or modest emotional harm that most people confront in the course of an interactive life in modern society.[212]

Regardless of whether it is used as the determinative test, or one of several, the fundamental question is what constitutes a psychiatric injury from a medical perspective. Two main diagnostic classification systems are typically used by the psychiatric community to diagnose a recognized psychiatric illness: (1) the Diagnostic and Statistical Manual (DSM)[213] of the American Psychiatric Association (APA), the latest iteration of which is the DSM-5; and (2) the International Classification of Diseases (ICD),[214] sponsored by the World Health Organization (WHO), which creates a statistical classification of diseases, with a section on mental disorders. In general, these systems demonstrate that the nature of psychiatric diagnosis is constantly changing, and is not immune to political pressure.

1. DSM-5

The first Diagnostic and Statistical Manual was published in 1952, with 106 disorders.[215] That number has since grown to over 300 since the DSM-IV,[216] and the DSM-5 has approximately the same number of disorders listed.[217] As the quantity of disorders has increased, so has the DSM's recognition as the "Bible" for mental health issues. This widespread influence is not limited to the practice of psychiatry or medical academia. Insurance companies, litigators, and a number of patients' rights and mental health advocacy groups use the DSM for guidance.[218] However, the latest iteration of the manual, DSM-5, released in May 2013, has been broadly criticized by practitioners and outsiders alike, sparking an unusually high level of controversy compared to previous revisions.[219] The DSM-5 has been criticized as highly politicized, driven by special interests groups,

212. *See* RESTATEMENT (THIRD) OF TORTS: LIABILITY FOR PHYSICAL & EMOTIONAL HARM, ch. 8 (2012) (Scope Note).

213. DSM-5, *supra* note 133.

214. WHO, INTERNATIONAL CLASSIFICATION OF DISEASES (2010), *available at* http://apps.who.int/classifications/icd10/browse/2010/en.

215. Margarita Tartakovsky, *How the DSM Developed: What You Might Not Know*, PSYCHCENTRAL, http://psychcentral.com/blog/archives/2011/07/02/how-the-dsm-developed-what-you-might-not-know/ (last visited Mar. 25, 2015).

216. *Id.*

217. John M. Grohol, *DSM-5 Released: The Big Changes*, http://psychcentral.com/blog/archives/2013/05/18/dsm-5-released-the-big-changes (last visited Mar. 25, 2015).

218. *See id.*

219. *Id.*; Pam Belluck & Benedict Carey, *Psychiatry's New Guide Falls Short, Experts Say*, N.Y. TIMES, May 7, 2013, at A13; Sally L. Satel, *Why the Fuss Over the D.S.M.-5?*, N.Y. TIMES, May 12, 2013, at SR5 (discussing how the DSM-5 lacks validity, according to experts).

especially the pharmaceutical industry,[220] and overinclusive.[221] It also has been criticized as failing in both reliability (the ability to render consistent diagnoses) and validity (the ability to diagnose legitimate mental illnesses).[222] In general, the classifications are criticized because it is often difficult to fit a disorder into a distinct category as opposed to placing the disorder somewhere on a spectrum, and "modern psychiatry tends to aspire to the former, as does the law, [but] a lot of the tests used in the diagnosis of psychiatric disorder are of the latter sort."[223]

The DSM-5 has been highly controversial. Allen Frances, the head of the APA task force responsible for revising the DSM-IV, called the APA's

220. Generally, critics have noted that the subjective nature of the diagnosis and treatment of mental illness has made it a prime target for overprescription. Some mental health professionals act as consultants to the drug industry. Michael Gross, *Has the Manual Gone Mental?*, 23 CURRENT BIOLOGY R295, R297–98 (2013). Through them, the pharmaceutical companies "may try to influence the revision of diagnostic criteria in [their] favor." *Id.* at R298. Additionally, the strain on the healthcare system for mental health providers and dwindling primary doctor-patient interaction has made medication less expensive than long-term psychiatric therapy. Changes to the DSM-5 could lead to many diagnoses and drug regimens. Paula Span, *Grief Over New Depression Diagnosis*, N.Y. TIMES (Jan. 24, 2013, 6:40 AM), http://newoldage.blogs.nytimes.com/2013/01/24/grief-over-new-depression-diagnosis. Questions of the manual's legitimacy also may come from within the APA itself. Publishing profits from the DSM-5 may be considered an impure motive, an observation that is exacerbated by the fact that the APA cancelled field-testing on the DSM-5 in order to reign in an already $25 million outlay on its preparation. Allen J. Frances, *DSM 5 Is Guide Not Bible—Ignore Its Ten Worst Changes*, PSYCHOL. TODAY (Dec. 2, 2012), http://www.psychologytoday.com/blog/dsm5-in-distress/201212/dsm-5-is-guide-not-bible-ignore-its-ten-worst-changes. Allen Frances, chair of the DSM-IV task force and one of the APA's most outspoken critics, believes the conflict of interest lies elsewhere. He contends that the current task force's motives are not financial, but intellectual, resulting from "highly specialized experts [valuing] their [own] pet ideas [and] areas of research interest." *Id.*

221. One of the most hotly contested changes to the DSM-5 is the exclusion of the long-standing "bereavement exception" to the diagnosis of depression. Span, *supra* note 220. This is an attempt to compensate for the chronic underdiagnosis of depression in elderly patients, but practitioners fear that this will lead to a radical increase in the number of diagnoses with simple symptoms commonly associated with the aging process. *See* Bruce E. Levine, *DSM-5: Science or Dogma? Even Some Establishment Psychiatrists Embarrassed by Newest Diagnostic Bible*, HUFFINGTON POST (Feb. 11, 2013), http://www.huffingtonpost.com/bruce-e-levine/dsm-5_b_2657667.html. Other changes may also increase diagnostic rates, such as the condensing of four previously distinct categories of somatic disorders into one single category, *see* Gross, *supra* note 220, at R295, and the introduction of the Minor Neurocognitive Disorder, which creates a "huge false positive" in the elderly who are not at a particular risk of dementia. Frances, *supra* note 220.

222. Levine, *supra* note 221. The director of NIMH contends that the current DSM's greatest weakness is the lack of validity, because it is based on a subjective consensus of symptom cluster. Thomas Insel, *Director's Blog: Transforming Diagnosis*, NAT'L INST. MENTAL HEALTH (Apr. 29, 2013), http://www.nimh.nih.gov/about/director/2013/transforming-diagnosis.shtml. Practitioners have questioned the research schemes for a number of new DSM-5 diagnoses, specifically the latest personality disorders. Robert Freedman et al., *The Initial Field Trials of DSM-5: New Blooms and Old Thorns*, 170 AM. J. PSYCHIATRY 1, 2–3 (2013). Other critics suggested that the research supporting the DSM-5 is either no longer scientific or distorted. Paula J. Caplan, *Psychiatry's Bible, the DSM Is Doing More Harm Than Good*, WASH. POST (Apr. 27, 2012), http://www.washingtonpost.com/opinions/psychiatrys-bible-the-dsm-is-doing-more-harm-than-good/2012/04/27/gIQAqy0WlT_story.html.

223. John E. Stannard, *Sticks, Stones and Words: Emotional Harm and the English Criminal Law*, 74 J. CRIM. L. 533, 540 (2010).

final approval of the DSM-5 "the saddest moment in [his] 45 year career."[224] Other leading psychiatrists have branded it as a "broad overreach" by the APA, suggesting that the DSM no longer be considered the Bible but rather a dictionary for mental health diagnosis, at best.[225] This controversy is especially troublesome for legal practitioners, as courts may defer to the DSM's definitions of mental illness in various ways.[226] Perhaps most tellingly, the DSM is falling from its perch as the standard by which mental health resources are allocated. Beginning in the fall of 2015,[227] all HIPAA health care providers are required to switch to the World Health Organization's (ICD-10-CM) code sets.[228] Additionally, the National Institute of Mental Health (NIMH) is reorienting its research away from the DSM categories and instead has begun to support research based on empirical studies, focusing on genetic, imaging, psychological, and cognitive data.[229]

2. ICD

The ICD is issued by the World Health Assembly, which comprises health ministers from 193 countries.[230] The latest iteration of the ICD, the ICD-10, was issued in 1992, and the ICD-11 is scheduled for release in 2017.[231]

Unlike the DSM, the ICD attempts to catalogue all human disease, not just mental disorders.[232] Substantial differences exist between the DSM and the ICD's classifications of mental disorders. Some disorders find stricter diagnostic criteria under the ICD and others are more liberal.[233] Guidelines under the ICD do not include the social consequences of the disorder whereas diagnosis under the DSM often requires significant social impairment.[234] The different definitions under the two classification

224. Frances, *supra* note 220.

225. Insel, *supra* note 222; Span, *supra* note 220.

226. *See* Caplan, *supra* note 222 (noting the use of employment disputes, custody battles, and competency matters).

227. *See* Protecting Access to Medicare Act of 2014, Pub. L. No. 113-93, § 212, 128 Stat. 1040, 1047.

228. *See, e.g.*, N.C. Dep't of Health & Human Serv., *FAQs re: ICD-10*, NCTRACKS, https://www.nctracks.nc.gov/content/public/providers/ICD10/faqs-for-ICD-10.html (last visited Mar. 25, 2015) (stating that if providers do not use proper ICD-10 coding, they may experience delays in payment or even nonpayment).

229. Insel, *supra* note 222.

230. Am. Psychiatry Ass'n, *ICD vs. DSM*, 40 MONITOR ON PSYCHOL. 63 (2009), *available at* http://www.apa.org/monitor/2009/10/icd-dsm.aspx.

231. *International Classification of Diseases (ICD) Information Sheet*, WHO, http://www.who.int/classifications/icd/factsheet/en/ (last visited Mar. 25, 2015).

232. David Goldberg, Comparison Between ICD and DSM Diagnostic Systems for Mental Disorders, *in* 21ST CENTURY GLOBAL MENTAL HEALTH 38 (2013), *available at* http://samples.jbpub.com/9781449627874/Chapter2.pdf. The ICD-10 classifies nearly 2000 disorders in total. *Id.* at 39.

233. *See generally* Michael B. First, *Harmonisation of ICD-11 and DSM-V: Opportunities and Challenges*, 195 BRIT. J. PSYCHIATRY 382 (2009).

234. P.K. Dalal & T. Sivakumar, *Moving Towards ICD-11 and DSM-V: Concept and Evolution of Psychiatric Classification*, 51 INDIAN J. PSYCHIATRY 310, 314 (2009), *available*

systems can and often do result in differing diagnostic results for any given patient.[235] Both the WHO and the APA have worked on the DSM-5 and the forthcoming ICD-11 with an eye toward greater harmonization, but given the ubiquitous incongruence,[236] the slightly dissimilar goals of the respective projects,[237] and pragmatic concerns,[238] comprehensive harmonization is likely impossible.[239]

The difference in the approach under the two systems is highlighted by the diagnostic criteria for PTSD under both systems. DSM-5 is explicit as to what constitutes a qualifying traumatic event for PTSD, limiting these to exposure to threatened or actual death, serious injury, or sexual violence.[240] Following the event, the patient must experience "intrusion symptoms,"[241]

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at http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2802383. Assen Jablensky notes the conceptual differences "highlight the provisional nature of many nosological concepts and their arbitrary definitions." Assen Jablensky, *Towards ICD-11 and DSM-V: Issues Beyond 'Harmonization,'* 195 BRIT. J. PSYCHIATRY 379, 380 (2009), *available at* http://bjp.rcpsych.org/content/195/5/379.long.

235. "These definitional differences go beyond mere appearance; most studies which have investigated diagnostic concordance by applying both DSM-IV and ICD-10 criteria to the same individuals have found differences in case identification ranging from minor to significant." First, *supra* note 233, at 382.

236. As Michael First states:

> Harmonisation of [conceptual] differences is likely to be especially challenging as it will require that either the DSM-V or ICD-11 work group relinquish its diagnostic approach in favour of the other group's approach. On the other hand, many differences in DSM-IV and ICD-10 definitions are not conceptually based but instead represent different ways of operationalising the same underlying diagnostic constructs. Efforts to harmonise these non-conceptually based differences are comparatively more straightforward.

Id. at 382–83.

237. As Mario Maj states:

> In the case of the ICD, the main objective is to improve the public health utility of the system, and in particular its usability by a range of health professionals. In the case of the DSM, the main objective, or one of the main objectives, is to make the clinical characterization of each patient more comprehensive, by adding several dimensions to the categorical diagnosis.

Mario Maj, *Psychiatric Diagnosis: Pros and Cons of Prototypes vs. Operational Criteria*, 10 J. WORLD PSYCHIATRIC ASS'N 81, 81 (2011).

238. *See* First, *supra* note 233, at 382.

239. As Maj continues:

> It is almost inevitable that the DSM classification of mental disorders differs from that of the WHO. The ICD is a comprehensive classification of all . . . diseases and related health problems for use by a wide range of health professionals in countries of very varied sizes, cultures, and resources. The APA's classification is designed to meet the needs of one, or perhaps two, professions—psychiatrists and clinical psychologists—in a single country.

Id. at 38 (quoting Robert Kendell, *The Relationship Between DSM-IV and ICD-10*, 100 J. ABNORMAL PSYCHOL. 297, 299–300 (1991)).

240. DSM-5, *supra* note 213, at 271–80. "Exposure" may be either: direct; witnessing; indirect (learning that a close family member or close friend was exposed to violent or accidental trauma); or repeated or extreme indirect exposure to aversive details of the traumatic event(s), usually in the course of professional duties (for example, first responders collecting body parts and professionals repeatedly exposed to details of child abuse). *See id.*

241. The patient must experience one of the following: (1) recurrent, involuntary, and intrusive memories; (2) traumatic nightmares; (3) dissociative reactions (e.g., flashbacks) which may occur on a continuum from brief episodes to complete loss of consciousness;

persistent effortful avoidance of distressing, trauma-related stimuli,[242] "negative alterations in cognitions [or] mood,"[243] and "alterations in arousal and reactivity."[244] These symptoms must persist for at least a month.[245] Additionally, the patient must also suffer significant symptom-related social or occupational impairment.[246]

Though similar, the diagnostic criteria for PTSD under ICD-10 differ in several significant ways. The ICD-10 does not specify what constitutes a qualifying traumatic event, only requiring that the event be "of exceptionally threatening or catastrophic nature, which is likely to cause pervasive distress in almost anyone"; it has no criteria as to how long symptoms must persist; has no functional impairment requirement; and has no subtypes.[247] It is not hard to imagine differing diagnoses with regard to PTSD depending on which system the psychiatrist applies.

Regardless of the approach, there are considerable problems with the overarching categorical approach that is common to both the ICD and the DSM. This approach tends to falsely dichotomize what are likely non-discrete disease entities, while it underappreciates the individuality of the patient within each artificially drawn category.[248] Moreover, diagnoses are given purely symptomatically, according to the number of relevant symptoms that are present or absent as self-reported by the patient and subjectively interpreted by the physician.[249] This method of diagnosis is unique to psychiatric disorders and brings with it inherent problems.[250]

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(4) intense or prolonged distress after exposure to traumatic reminders; or (5) marked physiologic reactivity after exposure to trauma-related stimuli. *See id.*

242. That is, avoidance of either thoughts or feelings of the event, or external reminders of the event. *Id.*

243. The patient must experience two of the following (having either begun or worsened after the event): (1) inability to recall key features of the traumatic event (usually dissociative amnesia; not due to head injury, alcohol, or drugs); (2) persistent (and often distorted) negative beliefs and expectations about oneself or the world (e.g., "I am bad," "The world is completely dangerous"); (3) persistent distorted blame of self or others for causing the traumatic event or for resulting consequences; (4) persistent negative trauma-related emotions (e.g., fear, horror, anger, guilt, or shame); (5) markedly diminished interest in (pretraumatic) significant activities; (6) feeling alienated from others (e.g., detachment or estrangement); or (7) constricted affect: persistent inability to experience positive emotions. *See id.*

244. The patient must experience two of the following (having either begun or worsened after the event): (1) irritable or aggressive behavior; (2) self-destructive or reckless behavior; (3) hypervigilance; (4) exaggerated startle response; (5) concentration problems; or (6) sleep disturbance. *See id.*

245. *Id.*

246. *Id.* The DSM-5 maintains a PTSD subtype with differing criteria for children. *Id.*

247. WHO, THE ICD-10 CLASSIFICATION OF MENTAL AND BEHAVIOURAL DISORDERS: DIAGNOSTIC CRITERIA FOR RESEARCH (1992), *available at* http://www.who.int/classifications/icd/en/GRNBOOK.pdf.

248. *See* Goldberg et al., *supra* note 232, at 41–42.

249. *See* Tadafumi Kato, *A Renovation of Psychiatry Is Needed*, 10 J. WORLD PSYCHIATRY 198, 198 (2011).

250. As Kato states:

> To further refine psychiatric diagnosis, the only way is to establish a new disease classification based on the neurobiological features of each mental disorder . . . . We psychiatrists should be aware that we cannot identify "diseases"

Furthermore, not everyone views the use of the diagnostic classifications as dispositive in determining whether an individual suffers from a psychiatric illness. Instead, some legal experts believe that a clinical judgment can and should deviate from the classifications in certain circumstances.[251] Under this view, even for those courts that require an RPI for NIED claims, the classifications are not definitive in the courtroom.[252] At the other extreme, some courts in the United Kingdom applied the DSM criteria themselves, finding they are competent to do so as a "common sense application" of the criteria.[253] Still another approach is to create a statutory definition of RPI, drawing from a state-appointed panel of experts, although this approach was rejected by the English Law Commission, as "not practicable" and "fraught with difficulty."[254] In the United States, only a minority of jurisdictions use an RPI as a threshold requirement.[255]

Regardless of how evidence of an RPI is used, expert testimony from mental health professionals engenders the same problem as all claims that intersect law and science: expert witnesses might present conflicting diagnoses. As discussed below, this problem is more appropriately dealt with as a question of admissibility of evidence, including subjecting the testimony to *Daubert* tests.

C. Creating Norms

In addition to scientific and medical viewpoints, normative values inform the definition of emotional harm as well. From this perspective, emotional harm is a social construct that is intimately tied to setting norms about the

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> only by interviews. What we are doing now is just like trying to diagnose diabetes mellitus without measuring blood sugar. Medicine is fundamentally based on pathology. Psychiatry should also be based on pathology rather than psychology . . . . All the technologies we need to refine psychiatry have already been established. What we should do is to study the neurobiological basis of mental disorders using updated technologies and give rise to the renovation in psychiatry.

Id. at 198–99.

251. Mulheron, *supra* note 198, at 89.

252. *See id.* at 90.

253. *Id.* at 92 (citing Calvert v. William Hill Credit Ltd., [2008] EWHC (Ch) 454, [134]). This is despite the APA's own admonition that "[i]t is important that [the DSM] not be applied mechanically by untrained individuals." AM. PSYCHIATRIC ASS'N, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS IV xxxii (4th ed. 1994).

254. ENGLISH LAW COMM'N, LIABILITY FOR PSYCHIATRIC ILLNESS LC249 ¶¶ 5.2, 5.4 (1998), *available at* http://lawcommission.justice.gov.uk/docs/lc249_liability_for_psychiatric_illness.pdf.

255. *See, e.g.*, Pierce v. Atl. Grp., Inc., 724 S.E.2d 568, 577 (N.C. App. 2012) (quoting Johnson v. Ruark Obstetrics & Gynecology Assoc., P.A., 395 S.E. 85, 97 (N.C. 1990) (defining severe emotional distress as "any emotional or mental disorder . . . which may be generally recognized and diagnosed by professionals trained to do so"); Agnesini v. Doctor's Assoc., Inc., 10 CV 9190 (BSJ) (FM), 2012 WL 5873605, at *3 (S.D.N.Y. Nov. 13, 2012) (same); Hegel v. McMahon, 960 P.2d 424, 431 (Wash. 1998) (bystander case); Asuncion v. Columbia Hosp. for Women, 514 A.2d 1187, 1189 (D.C. 1986) (same); Paz v. Brush Engineered Materials, Inc., 949 So. 2d 1, 4 (Miss. 2007) (medical monitoring case).

appropriate way to respond to an adverse event.[256] This is reflected in a deeper question of subjectivity and agency—the notion that emotional harm is sometimes in the victim's control.[257] When we tell children not to "make a mountain out of a molehill," we are suggesting to them that their response is at least partially within their control.[258] Professors Goldberg and Zipursky argue that "the much-vaunted fraud objection [in NIED] is in fact a loose way of expressing the concerns that particular plaintiffs in emotional distress cases are making mountains out of molehills, and that permitting a cause of action for pure emotional harm will invite or encourage citizens to make mountains out of molehills."[259] This reflects the norm that one should "just get over it," as well as expresses the ideal that individuals are responsible for their emotional response.[260] Under this view, a person's agency is integral to the response of emotional distress.[261]

Moreover, requiring a showing that the emotional harm is "severe" or "serious"[262] also can imply a normative value that an individual is partially responsible for her reaction to a situation. Cases awarding damages for "severe" or "serious" emotional harm could suggest that a plaintiff's emotional harm is severe as compared to others;[263] or it could demonstrate

256. Goldberg & Zipursky, *supra* note 28, at 1680 (claiming that "[d]on't make a mountain out of a molehill" reinforces social norms on appropriate response).

257. *Id.* at 1676–77 (labeling this as the "agency concern"); *see also* Goldberg, *supra* note 87, at 816–17 (arguing for a duty to reasonably regulate one's own emotional health based on normative ideals of mental well-being).

258. *See* Goldberg & Zipursky, *supra* note 28, at 1680.

259. *Id.* at 1680–81. Studies involving the nocebo effect, in which harmless substances cause harmful effects in patients who receive them, provide an interesting comparison. *See generally* Winfried Hauser et al., *Nocebo Phenomena in Medicine: Their Relevance in Everyday Clinical Practice*, 109 DEUTSCHES ARZTEBLATT 459 (2012) (including a meta-analysis of all studies mentioning "nocebo effect" in PubMed up to December 2011). These studies support the view that a patient's response to a given treatment is affected by the patient's expectations. *See id.* at 461. The response effects can be either psychological or physiological. *See id.* at 465.

260. *See* Goldberg & Zipursky, *supra* note 28, at 1681.

261. *See id.* Reliance on this idea of "agency," in which the plaintiff's emotional response is her responsibility, undercuts the notion that the defendant inflicted harm upon the plaintiff. *Id.* at 1685; *see* Fox & Stein, *supra* note 19 (describing the assumption in tort law that a victim of negligence can control his mental anguish, a power he lacks over his bodily injuries and how this assumption "makes standalone emotional harm unworthy of compensation"); Keating, *supra* note 96, at 300 ("Our emotional reactions are mediated by our minds. Emotional injury may thus be the product—not the negation—of our agency . . . . We can teach ourselves to toughen up and not be so sensitive, and we can steel ourselves against even exceedingly unpleasant experiences."); Goldberg, *supra* note 87, at 860 ("People have profound abilities to find ways to mitigate their emotional and psychological despair . . . ."). The normative concept of emotional harm, and the corresponding duty to regulate one's own emotional health, raises the issue of comparative fault: How will we evaluate whether individuals sufficiently avoided—or contributed to—their emotional harm?

262. RESTATEMENT (THIRD) OF TORTS: LIABILITY FOR PHYSICAL & EMOTIONAL HARM §§ 46–47 (2012).

263. *Id.* § 47 cmt. j (requiring that the "harm be serious, [and] that the circumstances . . . be such that a reasonable person would suffer serious harm"); *see* Rodrigues v. State, 472 P.2d 509, 520 (Haw. 1970) (defining a serious injury as one "where a reasonable man, normally constituted, would be unable to adequately cope with the mental stress engendered by the circumstances of the case"). Whether an injury is serious would

that the circumstances surrounding the event are particularly extreme.[264] Under either view, normative judgments are being made about the extent of agency and control. A reasonable person could not be expected to control her response in a situation that is particularly egregious or severe; in that case, she is a viewed as a victim rather than an agent.[265] It is not fair to expect the individual to exercise agency over her response in those extreme situations.[266]

Traditionally, normative values in tort law are reflected in jury decision making, but in NIED claims, these views of agency and emotional harm ultimately spill over into limited duty rules. No duty and limited duty rules in tort law reflect certain assumptions and biases; their main advantage is the certainty they create in curtailing the claim. The goal in the NIED area of precluding individual analysis reflects the "universal" nature of mental harm, naturally occurring while experiencing different life events.[267] An early bias developed that these inevitable stresses of life would create "a certain toughening of the mental hide [which] is a better protection than the law could ever be."[268] In addition, instrumentalist concerns come into play: "Mental injuries . . . are different [from physical ones] because they are not constrained by time and space proximity and physical laws."[269] This leads to concerns about imposing liability out of proportion to the negligent act: "[W]e do not expect society to walk on eggshells fearing that any conduct that fails to meet an objective standard of proper behavior may result in significant liability."[270]

Categorical thinking, which persists in NIED claims, perpetuates these normative views. But the compelling nature of those concerns is eroding. Views of agency, control, and malingering will continue to evolve in the face of scientific evidence of the physicality of those harms, as well as evidence of the impact of genetic and environmental factors on reactions to stressful situations. For example, the diagnosis of PTSD as a genuine claim has become increasingly accepted in our society.[271] Mental illness is

presumably fall more appropriately within the damages consideration. *See* Goldberg, *supra* note 87, at 816 n.25.

264. Goldberg & Zipursky, *supra* note 28, at 1688 (using as an example Portee v. Jaffee, 417 A.2d 521, 521 (N.J. 1980), in which a mother witnessed her five-year-old son die in an elevator shaft).

265. Goldberg & Zipursky, *supra* note 28, at 1688.

266. *Id.*

267. *Id.*

268. Calvert Magruder, *Mental and Emotional Disturbance in the Law of Torts*, 49 HARV. L. REV. 1033, 1035 (1936).

269. Rhee, *supra* note 27, at 841; *see* Fox & Stein, *supra* note 19 ("[S]ingling out physical harms for standalone recovery might shore up the belief that while our bodies are open to poking and prodding, our minds remain hidden from external observation . . . . Dualism helps to explain why the tort system scorns victims who suffer even serious and demonstrable emotional distress. . .").

270. Rhee, *supra* note 27, at 852.

271. *See* Betsy J. Grey, *Neuroscience, PTSD, and Sentencing Mitigation*, 34 CARDOZO L. REV. 53, 58–59 (2012).

becoming destigmatized in various ways.[272] As our societal view of emotional harm changes, this may eventually lead to allowing NIED claims to proceed like other negligence claims, allowing juries to determine the reasonable foreseeability that the defendant's negligent behavior would cause emotional harm to a direct victim of normal psychological fortitude. But even before we reach this point—recognizing that the foreseeability test may not "adequately" address instrumental concerns of curtailing the scope of liability—courts can still trade some limited duty barriers for increased jury determination that would reflect changing normative views on emotional harm. This shift will allow courts to adapt to the rapidly changing science and medical landscape as well, achieving more validity and flexibility in evaluating emotional harm.[273]

IV. REMOVING LIMITED DUTY BARRIERS BASED ON VALIDITY CONCERNS

Categorical duty rules usurp the role of the jury. Traditionally, the role of the jury is central to American tort law, in particular because we rely on the jury as members of the public to make factual and normative decisions on injury, causation, and fault. The most recent Restatement of Torts on negligence[274] contains a renewed emphasis on the centrality of the jury to negligence determinations for physical injury.[275] The Restatement (Third) rejects the element of foreseeability as part of the court's evaluation of legal duty, shifting the question for jury consideration.[276] Section 7 of the

272. *See* Francis X. Shen, *Mind, Body, and the Criminal Law*, 97 MINN. L. REV. 2036, 2038 (2013) (describing increasing acceptance among policymakers and the public that "illness of the brain must be treated just like illness anywhere else in the body").

273. *Cf.* Rhee, *supra* note 27, at 865–68 (proposing a foreseeability test for direct victims of mental injury and a graduated test based on culpability for collateral victims and arguing that the determination of classes of victims will capture the necessary controls for limiting liability). Rhee argues that the interest of direct victims derives from the right of self-preservation, while the interest of the collateral victim is the safety or well-being of others, derivative of the relationship with the primary victim, either through a preexisting relationship or by a temporal and spatial connection to the accident. *Id.* at 856.

274. *See* RESTATEMENT (THIRD) OF TORTS: LIABILITY FOR PHYSICAL & EMOTIONAL HARM (2012).

275. *See* Elizabeth G. Porter, *Tort Liability in the Age of the Helicopter Parent*, 64 ALA. L. REV. 533, 565 (2013).

276. *See* RESTATEMENT (THIRD) OF TORTS: LIABILITY FOR PHYSICAL & EMOTIONAL HARM § 7 (2010); *id.* § 7 cmt. a ("When liability depends on factors specific to an individual case, the appropriate rubric is scope of liability. On the other hand, when liability depends on factors applicable to categories of actors or patterns of conduct, the appropriate rubric is duty. No-duty rules are appropriate only when a court can promulgate relatively clear, categorical, bright-line rules of law applicable to a general class of cases."); *id.* § 7 cmt. j ("In order to determine whether appropriate care was exercised, the factfinder must assess the foreseeable risk . . . . The extent of foreseeable risk depends on the specific facts of the case and cannot be usefully assessed for a category of cases; small changes in the facts may make a dramatic change in how much risk is foreseeable. Thus . . . courts should leave such determinations to juries unless no reasonable person could differ on the matter."). This was a very controversial aspect of the Restatement (Third)'s attempt to constrain judicial power in negligence. *See* Benjamin C. Zipursky, *Foreseeability in Breach, Duty, and Proximate Cause*, 44 WAKE FOREST L. REV. 1247, 1258 (2009) (challenging this approach because "almost every jurisdiction does treat foreseeability as a significant factor (and frequently the most significant factor) in analyzing whether the duty element is met in a negligence

Restatement (Third) states that when an actor's conduct could create a risk of physical harm, the actor "ordinarily has a duty to exercise reasonable care,"[277] and that courts should depart from this general duty only in "exceptional" cases, when "countervailing principle or policy warrants denying or limiting liability in a particular class of cases."[278] The use of the word "exceptional" represents "a renewed commitment to the strong norm of reasonable care."[279] Further, section 8 emphasizes that the questions of breach and proximate cause are within the province of the jury rather than the court.[280] The combined effect of these provisions is to restrict the role of the court in making fact-based duty determinations, squarely assigning that role to the jury.[281] The price of this commitment to increased jury participation is an expansion of the circumstances under which negligence suits may get to a jury—it likely will increase the number of suits surviving dispositive motions and either proceeding to trial or settling in terms more favorable to the plaintiffs.[282]

At the same time, the Restatement (Third) does not follow the traditional balance of power between judge and jury for NIED claims, but instead assigns the fact-based duty determinations as a matter of law for the court.[283] As discussed above, various policy considerations are cited in support of this view, but the dominating ones are the need to ensure the genuineness of the claim,[284] to limit liability,[285] as well as to eliminate claims for ordinary stress that is part of modern life.[286]

We can begin to unpack the concerns captured by NIED limited duty rules and address them through different judicial mechanisms. Evidence on genuine validity issues should be addressed by traditional judicial evidentiary admissibility standards and then sent to the jury for factual findings. This would serve to reassert the jury's traditional role with regard to this claim. Instrumentalist concerns seeking to limit the claim for other reasons could still be addressed through certain special pleading requirements or more broadly be shifted to traditional duty and proximate cause analyses.

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claim."). Some states have begun to adopt this view. *See, e.g.*, Gipson v. Kasey, 150 P.3d 228, 231 (Ariz. 2007); Thompson v. Kaczinski, 774 N.W.2d 829, 835 (Iowa 2009); A.W. v. Lancaster Cnty. Sch. Dist. 0001, 784 N.W.2d 907, 917 (Neb. 2010); Behrendt v. Gulf Underwriters Ins. Co., 768 N.W.2d 568, 576 (Wis. 2009).

277. *See* RESTATEMENT (THIRD) OF TORTS: LIABILITY FOR PHYSICAL & EMOTIONAL HARM § 7(a).

278. *Id.* § 7(b); *see also id.* § 7 cmt. a.

279. Porter, *supra* note 275, at 565–66.

280. RESTATEMENT (THIRD) OF TORTS: LIABILITY FOR PHYSICAL & EMOTIONAL HARM § 8(b).

281. Porter, *supra* note 275, at 566.

282. *Id.* at 568.

283. *See* RESTATEMENT (THIRD) OF TORTS: LIABILITY FOR PHYSICAL & EMOTIONAL HARM § 47 cmt. g (2012).

284. *See id.* § 47 cmt. l.

285. *See id.* § 47 cmt. i.

286. *Id.* § 47 cmt. l.

Removing special pleadings requirements on validity issues follows naturally in the evolution of NIED claims. For example, after courts started allowing the NIED claim, they adopted the physical manifestation test to address the concern of fraud.[287] Courts gradually began to weaken the physical manifestation rule or reject it altogether, however, as science, medicine, and social norms changed and the test became inadequate or unnecessary. A California case, *Molien v. Kaiser Foundation Hospitals*,[288] proved to be the watershed. In *Molien*, the California Supreme Court rejected the physical manifestation test as both overinclusive (permitting claims with little emotional harm because they manifested physical consequences) as well as underinclusive (barring claims of serious emotional harm but no physical manifestation).[289] It rejected the claim-screening function of the test and found that the jury, rather than the judge, should determine the validity of the claim.[290] Consequently, plaintiffs did not need to present evidence of physical manifestation to meet either their burdens of production or persuasion—the jurors could simply rely on "their own experience" as well as the defendant's behavior in evaluating the claim.[291] This represented a major institutional shift to allowing more claims to be processed by the jury.

Molien prompted other courts to reevaluate the NIED claim and the physical manifestation requirement.[292] As courts began to move away from the physical manifestation rule, they cited a number of factors in this shift, including theoretical, scientific, and practical reasons, such as advances in science, a shift to a general foreseeability analysis, notions of fairness, and reliance on stronger evidentiary requirements. Some courts were driven by their interpretation of scientific understanding of emotional harm.[293] Other courts relied more heavily on common sense and equitable concerns.[294]

287. Physical manifestation could include a heart attack or an ulcer. *See* JOHN L. DIAMOND ET AL., UNDERSTANDING TORTS § 10.01[B][2] (4th ed. 2010). The physical manifestation of emotional harm is a prerequisite and does not measure the extent of the mental injury. *See* Diamond, *supra* note 29, at 146–47.

288. 616 P.2d 813 (Cal. 1980).

289. *Id.* at 820.

290. *Id.* at 821.

291. *Id.*

292. *See* Chizmar v. Mackie, 896 P.2d 196, 202–03 (Alaska 1995) (discussing how physical manifestation might not be sufficient for jury to decide whether emotional injury is foreseeable and sufficiently "severe" or "serious," even in the absence of accompanying physical injury or diagnosable illness, at least in cases where a preexisting duty is present); Corgan v. Muehling, 574 N.E.2d 602, 608–09 (Ill. 1991) (concluding that the "zone of danger" test does not apply to direct victims and allowing NIED claim regarding alleged malpractice of psychologist, despite lack of physical manifestation of emotional injury); Folz v. State, 797 P.2d 246, 259 (N.M. 1990) (allowing a cause of action in absence of physical injury and noting the "illogic of requiring as a threshold element the presence of physical injury to manifest the emotional trauma").

293. *See Corgan*, 574 N.E.2d at 608–09 (describing scientific view of emotional responses to stress to determine emotional harm); Leong v. Takasaki, 520 P.2d 758 (Haw. 1974) (using reasonable foreseeability test but relying on medical proof to determine harm).

294. *See* Montinieri v. S. New Eng. Tel. Co., 398 A.2d 1180, 1184 (Conn. 1978) (appealing to logic; rejecting physical manifestation and impact tests).

Gradually, use of the physical manifestation test was cut back, but it was replaced with other limited duty barriers.

One reason that these barriers persist is that, although the notion that fraud could lead to excessive and fictitious NIED lawsuits is consistently challenged,[295] it has never been abandoned; most courts have maintained limited duty barriers to address these fraud concerns. In particular, the Restatement (Third) does not require "physical manifestation," but it still requires a showing of "serious" emotional harm. The "seriousness" requirement acts as a screen to demonstrate the genuineness of the claim: "[t]he requirements that the harm be serious, that the circumstances of the case be such that a reasonable person would suffer serious harm, and that there be credible evidence that the plaintiff has suffered such harm better serve the purpose of screening claims than a requirement of physical consequences."[296] The seriousness requirement is designed to eliminate claims for everyday stress that is common in modern society as well as ensure that the claims are genuine.[297]

Molien teaches us, however, that it is appropriate to reexamine limited or no-duty tests for the NIED claim when those tests are not serving their intended purpose. Although the ability of neuroscience to predict psychological states remains controversial,[298] advances in neuroscience will continue to challenge the traditional emotional harm doctrines designed to validate and measure emotional harm.[299] Even if we are not at the point at which we can use neuroscience to establish definitively individual emotional harm, we are getting substantially closer to that point. These advances will influence, in turn, medical and normative definitions of emotional harm. As this occurs, limited duty rules, which serve as rough proxies for the genuineness and severity of harm suffered, need to be reexamined. In particular, the traditional but historically weak limited duty rules of physical manifestation of emotional injury and the zone of impact tests (the latest iteration found in the Restatement (Third)) are further weakened as indicators of the validity and severity of distress.[300] These barriers to emotional harm claims are now ripe for modification and dissolution.

To aid in this endeavor, this Article proposes that any limited duty test should address only nonvalidity concerns. Duty barriers based on assumptions about failure of proof should be removed, and the question of

295. *See* Goldberg & Zipursky, *supra* note 28, at 1678–79. Professors Goldberg and Zipursky argue that the fraud objection to general recovery for NIED is "unpersuasive for several reasons": (1) most of the reported cases involve situations in which there is little doubt that some emotional harm exists; (2) the concern whether the events unfolded in the way alleged by plaintiff is not unique to NIED; and (3) that the claim is based on a subjective mental state is not an obstacle in other areas. *Id.*

296. RESTATEMENT (THIRD) OF TORTS: LIABILITY FOR PHYSICAL & EMOTIONAL HARM § 47 cmt. j (2012).

297. *Id.* § 47 cmt. l.

298. Cassin, *supra* note 118, at 960; Helen S. Mayberg, *Neuroimaging and Psychiatry: The Long Road from Bench to Bedside*, 44 HASTINGS CTR. REP. S31, S34 (2014).

299. Cassin, *supra* note 118, at 960.

300. *Id.* at 960–61.

validity should be determined on a case-by-case basis. Questions about the state of scientific and medical knowledge should be worked out through a *Daubert* hearing. This would allow individualized analysis of the harm itself. If courts choose to maintain limited duty rules aimed at curtailing the claim for instrumentalist reasons, the limited duty rules should be reconstituted to address categories of claims, not the nature of an individual claim. Alternatively, courts could go further and remove limited duty barriers in the NIED claim completely and rely upon traditional negligence duty and proximate cause tests as a way to curtail the number of claims.[301]

Under this proposal, the Restatement (Third) requirement of a "serious" emotional harm would no longer be part of the duty analysis. Instead, the seriousness of the harm would be a question for the fact-finder to determine. Similarly, other special pleading tests courts use in the duty analysis as a substitute for validity screening would no longer be used, such as a physical contact or impact test, requiring a diagnosable psychiatric illness or physical symptomology. Instead, duty barriers only would be used to address instrumental concerns of curtailing indeterminate liability. A type of limiting test to serve this purpose could be a zone of danger test, but one that includes either physical or emotional harm, or a relationship test based on reasonable expectations of the parties. Limited duty tests such as these may be used to prevent disproportional liability.[302]

Although relying on the artificial and arbitrary barriers developed by the courts no longer makes sense to address questions about the genuineness of the claim,[303] strictly applying the DSM-5 or ICD-10 may not be supportable as well, since some but not all cases will be susceptible to medical diagnosis. Even if they are susceptible, conflicting diagnoses may occur.[304]

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301. *Cf.* Keating, *supra* note 96, at 291 (emotional harm in preexisting relationship cases should be viewed as proximate cause, not duty, cases).

302. The idea of focusing solely on instrumentalist concerns borrows from the limited duty tests developed in the area of economic loss for financial advice. Most states follow the Restatement (Second) approach, which allows claims to proceed depending on the closeness of the relationship between the claimant and the defendant, an indication of "justifiable reliance." *See* Nycal Corp. v. KPMG Peat Marwick LLP, 688 N.E.2d 1368 (Mass. 1998) (applying the Restatement (Second) of Torts test to a claim for negligent misrepresentation). The purpose of the test is to limit the number of claims to which the defendant (frequently an auditor or accountant) is exposed; the amount or validity of the claim is tested through traditional means of duty and causation analysis. *See* Jay M. Feinman, *Liability of Accountants for Negligent Auditing: Doctrine, Policy, and Ideology*, 31 FLA. ST. U. L. REV. 17, 29–30, 41–48 (2003).

303. *See* Fox & Stein, *supra* note 19 ("As an experience of the body rather than mind, emotional harm is qualitatively the same as physical illness or injury. . . . It differs from [physical injury and illness] only in terms of evidence."); *see also* Kolber, *supra* note 120, at 834 (predicting that brain imaging technology may relieve legal limitations in tort law on recovery for stand-alone emotional harm claim); Emily F. Suski, *Dark Sarcasm in the Classroom: The Failure of the Courts to Recognize Students' Severe Emotional Harm As Unconstitutional*, 62 CLEV. ST. L. REV 125, 144–45 (2014) (arguing that courts should evaluate emotional harm in the same way as physical harm in cases of constitutional challenges under the Fourteenth Amendment for severe harm imposed by school officials).

304. *See supra* notes 240–47 and accompanying text. Although I suggested in earlier writings that courts should dispense with heightened pleading requirements in determining the validity of NIED claims, except perhaps requiring medical diagnosis of a psychiatric

Instead, all evidence on validity—including and perhaps especially neuroscience evidence—should be screened through traditional evidentiary tests, including *Daubert* screening if necessary.[305] Expert opinion could be used to demonstrate that the claimant's injury is real, even if the injury does not rise to the level of a recognized psychiatric illness. Allowing evidence on validity to proceed in this fashion should allow more flexibility to consider state-of-the-art scientific advances that occur in neuroscience. Although the plaintiff must still prove that he or she suffered actual damages, if successful, the plaintiff would recover for the full extent of the psychological harm, regardless of whether the full extent was foreseeable. In other words, the traditional "eggshell" plaintiff rule (we take our victims as we find them) would continue to apply.

Under this formulation, a claimant can rely on expert testimony to show a diagnosed psychiatric injury, and also rely on other traditional evidentiary methods to prove the mental harm, including physical symptoms, neuroscientific tests, treatment, hospitalization, fact witnesses, or a combination of these factors.[306] The jury will weigh this evidence for fact-

injury, *see* Grey, *supra* note 18, at 224, recent developments in this dynamic area have caused me to shift my views. First, because neuroscience is a rapidly developing field, particularly in this area, it has become clear that evidence on validity should be addressed through evidentiary means rather than categorical thinking. In addition, the controversies surrounding the DSM-5, as well as the increasing reliance on the ICD-10, also suggest that a medical diagnosis of psychiatric injury should be subject to traditional evidentiary standards, rather than used as a heightened pleading requirement.

305. With advances in technology proceeding rapidly, the technology's admission as evidence has become increasingly common. *See* Jones et al., *supra* note 196, at 5. Neuroimaging has been admitted in criminal cases to support a range of issues. *See, e.g.*, McNamara v. Borg, 923 F.2d 862, 862 (9th Cir. 1991) (mitigating factor from schizophrenia); United States v. Kasim, No. 2:07 CR 56, 2010 WL 339084, at *6 (N.D. Ind. Jan. 21, 2010) (incompetency to stand trial due to dementia); People v. Kraft, 5 P.3d 68, 98 (Cal. 2000) (mitigating factor due to obsessive-compulsive disorder); People v. Holt, 937 P.2d 213, 229–33 (Cal. 1997) (mitigation factor from brain abnormality); People v. Weinstein, 591 N.Y.S.2d 715, 722–23 (Sup. Ct. 1992) (non-responsibility because of a brain defect); Coe v. State, 17 S.W.3d 193, 232 (Tenn. 2000) (lack of competency to be executed). Similarly, in civil cases, neuroimaging has been admitted in a variety of contexts. *See* Boyd v. Bert Bell/Pete Rozelle NFL Players Ret. Plan, 410 F.3d 1173, 1179 (9th Cir. 2005) (head injuries); Entm't Software Ass'n v. Blagojevich, 404 F. Supp. 2d 1051, 1064–65 (N.D. Ill. 2005) (video game–caused aggression); Allen v. Bloomfield Hills Sch. Dist., 760 N.W.2d 811, 814–17 (Mich. Ct. App. 2008) (physical manifestation of PTSD); Fini v. Gen. Motors Corp., No. 227592, 2003 WL 1861025, at *2–6 (Mich. Ct. App. Apr. 8, 2003) (head injuries); Van Middlesworth v. Century Bank & Trust Co., No. 215512, 2000 WL 33421451, at *3 (Mich. Ct. App. May 5, 2000) (incompetency to contract).

306. Similarly, defendants will be able to dispute the claim using a range of evidence. For example, numerous psychological tests have been developed to detect an individual's malingering psychiatric injury or illness, with varying levels of success. *See, e.g.*, Jascha Rüsseler et al., *The Effect of Coaching on the Simulated Malingering of Memory Impairment*, 8 BMC NEUROLOGY 37, 37 (2008) (successfully using response times in short-term memory test to predict malingering, but method susceptible to coached patients); Fredric E. Rose et al., *A Comparison of Four Tests of Malingering and the Effects of Coaching*, 13 ARCHIVES CLINICAL NEUROPSYCHOLOGY 349, 358 (1998) (Portland Digit Recognition Test-Computerized correctly identified 70 percent of coached patients). It is particularly easy to malinger PTSD because diagnosis relies largely on the patient's subjective self-reporting of their symptoms, although tests have been developed to determine malingering in those patients. *See* Khodabakhsh Ahmadi et al., *Malingering and PTSD:*

finding. We are at the point at which the jury can adequately distinguish fraudulent and frivolous claims from legitimate ones—at least as much as for other tort claims—without having to set up artificial and arbitrary barriers to do the job for them.[307] This approach will allow judges and juries to take "invisible" harm as seriously as more visible physical harm. Courts can control jury decision making through traditional means: using jury instructions to correct cultural prejudices; using dispositive motions and directed verdicts if no reasonable jury could find injury; and using remittitur or ordering a new trial if the jury's damages awards seem excessive. Furthermore, trivial claims would receive trivial damages, the same recognition that trivial physical claims receive.[308]

In that way, it reasserts corrective justice concerns that have been downplayed or absent from the NIED claim. From a corrective justice (and civil recourse) point of view, individuals should have access to the courts for harm resulting from another's civil wrong. For over a century, we have limited that access. As the dissent stated in Daniel Ware's case, in arguing to reverse the district court's grant of summary judgment and remand for a trial:

> For Daniel to be left without a remedy under all the undisputed facts in this case is antithetical to the general policy of tort liability in Anglo-American jurisprudence: those who are legitimately injured due to the act or omissions of others should have a remedy in our courts.[309]

As the recognition of emotional harm evolves, so too should the tort.

Yet, we cannot ignore the instrumentalist concerns that surround this claim. While fraud and frivolous lawsuits can be addressed through evidence and procedure, those same mechanisms may not work to control potentially unlimited liability, and as noted above, may need to be addressed through limited duty rules.[310]

Exposure to liability depends both on the severity of harm suffered by an individual victim and the number of injured victims.[311] Tort law traditionally addresses the severity of harm through the eggshell plaintiff

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Detecting Malingering and War Related PTSD by M-FAST, 13 BMC PSYCHIATRY 154, 154 (2013) (Miller Forensic Assessment of Symptoms Test).

307. *See* Rhee, *supra* note 27, at 832–35 (noting that the vast amount of insurance fraud involves claims for property damage, physical injury, and economic loss; that pain and suffering for whiplash or other soft tissue injuries, which are no more difficult to fake than mental harm, have been widely accepted historically; that courthouses are replete with marginal cases, filed for various purposes including settlement and harassment, but that courts have learned how to separate out fraudulent from legitimate claims; also enumerating other disincentives to bring fraudulent claims).

308. Mulheron, *supra* note 198, at 99 n.165. Handford and Mullany argue that if minor physical injury is recognizable, a comparatively minor emotional harm should be recognized as well, distinguishing the ranking of the claim through a smaller award. *See* HANDFORD & MULLANY, *supra* note 208, at 82–85.

309. Ware v. ANW Special Educ. Coop., 180 P.3d 610, 622 (Kan. Ct. App. 2008).

310. Although this concern traces directly back to the distributive justice idea that physical harm is more important than mere emotional harm, and could be challenged on that basis, I do not address that question here.

311. *See* Rhee, *supra* note 27, at 837.

rule, even for claims it tries to limit through duty rules, like NIED. Limitations of recoverable damages typically occur through other governmental mechanisms, such as a limit on statutory damages, which imposes such value judgment through the legislative process.[312]

The core problem that should be addressed by limited duty rules involves the aggregate number of claims that could potentially be brought. Although tort law traditionally addresses this concern through the three major elements of a tort suit—duty, causation, and proximate cause—the common law of NIED has addressed the problem largely by limiting duty through a series of artificial and arbitrary barriers. This is effective in limiting exposure to a more specific number of plaintiffs, but it has proven to be too much protection; the barriers are no longer—if they ever were—theoretically supportable. The practical effect of the proposal advanced in this Article may well be that the number of plaintiffs who could potentially recover will be enlarged, as a trade-off for the institutional advantage of allowing jurors, rather than judges, to decide the validity of claims in this area as well the theoretical advantage of opening the door further to corrective justice.

Traditionally, physical harm is distinguished from mental harm in one significant aspect from a legal standpoint—physical injuries are circumscribed by time and space and the laws of physics. In other words, when a negligent driver strikes a victim, the physical injuries that result can be more readily anticipated. But the view that "invisible" emotional injuries that may result may not be as limited by the laws of physics and therefore less predictable[313] is beginning to change in the face of scientific

312. *See, e.g.*, 13 GEORGIA JURISPURDENCE PERSONAL INJURY & TORTS § 11:66 (1995) (placing a $250,000 statutory cap on punitive damages in the absence of an allegation and finding of specific intent to cause harm); Carol A. Crocca, *Validity, Construction, and Application of State Statutory Provisions Limiting Amount of Recovery in Medical Malpractice Claims*, 26 A.L.R.5th 245 (1995) (numerous states impose limits on non-economic damages in medical malpractice suits); *see also, e.g.*, 1 CIVIL ACTIONS AGAINST STATE & LOCAL GOVERNMENT § 6:13 (2014) (showing numerous states have statutory damage caps on suits brought against governmental agencies); Tim Snider, *COPYRIGHT: Statutory Damages—Limit on Punitive Damages Award*, LAWLETTER, http://www.nlrg.com/public-law-legal-research/bid/86884/COPYRIGHT-Statutory-Damages-Limit-on-Punitive-Damages-Award (last visited Mar. 25, 2015) (explaining that a single instance of copyright infringement can be awarded no less than $750 and no more than $30,000, unless the infringement was willful in which case up to $150,000 can be awarded). Courts also have imposed limits on damages, particularly in the punitive damages area. *See, e.g.*, BMW of N. Am., Inc. v. Gore, 517 U.S. 559, 579–83 (1996) (suggesting a 10:1 ratio of punitive to compensatory damages to meet constitutional concerns). Neuroscience advances will challenge the misconception that individuals experience pain similarly. Adam J. Kolber, *Pain Detection and the Privacy of Subjective Experience*, 33 AM. J.L. & MED. 433, 437–38 (2007). Acknowledging these differences may lead courts examining NIED torts to focus more on the defendant's negligent conduct and less on how a "normal" or "reasonable" person would react to the experience. This would more closely align to recognition of physical and property damage. *Id.* Or, even if courts resist this route to allow more subjectivity into the NIED analysis, then neuroscience may eventually help us to define the normative question of acceptable social behavior by empirically demonstrating average reactions to stress. Grey, *supra* note 18, at 228.

313. *See* Rhee, *supra* note 27, at 841.

advances suggesting the physicality of those harms. A related issue is that reactions may be delayed.[314] As such, this proposal may open the door to more cancerphobia claims. In particular, if the claim is based on the "special relationship" between a company and its workers who have been exposed to a toxin, it is likely that more claims will reach the jury. But this is not a new problem. For example, toxic exposure cases, such as asbestos and diethylstilbestrol (DES), have presented a similar knot, and courts have developed ways to handle large numbers of claims that may take a long time to manifest (such as through a proximate cause analysis).[315]

Another way to address the instrumentalist concerns of limiting frivolous and trivial lawsuits could be through pleadings requirements on damages. Although traditionally plaintiffs do not need to plead a specific amount of damages in their complaint, a state could statutorily require allegation of a certain level of damages. This would allow courts to strike the pleadings under a motion to dismiss analysis[316] for complaints that only include nominal damages, which would serve to inhibit trivial claims.[317]

This proposal may be criticized on the basis that it simply shifts the limited duty barriers to address other areas and does not eliminate them altogether. On one level, this criticism is apt—the test only removes the barriers for validity questions. On another level, however, it focuses more sharply the purpose of the barriers, and more properly resurrects the role of the jury in this area.

The proposal also could be criticized for allowing too many claims to go to the jury and not effectively curtailing the defendant's exposure to liability. True, it may very well allow more plaintiffs to be eligible for recovery. But, more importantly, it allows compensation for deserving victims and thus more fully satisfies the corrective justice theory of tort law. At the same time, it more effectively deters undesirable behavior by allowing more social behavior to be reached by the common law claim.[318]

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314. *See, e.g.*, NAT'L COLLABORATING CTR. MENTAL HEALTH, POST-TRAUMATIC STRESS DISORDER: THE MANAGEMENT OF PTSD IN ADULTS AND CHILDREN IN PRIMARY AND SECONDARY CARE § 2.1.3 (2005), *available at* http://www.ncbi.nlm.nih.gov/pubmedhealth/PMH0015848/pdf/TOC.pdf (noting that in some cases PTSD symptoms may not set in for years after the traumatic event).

315. *See, e.g.*, Menne v. Celotex Corp., 861 F.2d 1453, 1462–64 (10th Cir. 1988) (applying proximate cause analysis to manage asbestos cases); Tracey I. Batt, *DES Third-Generation Liability: A Proximate Cause*, 18 CARDOZO L. REV. 1217, 1250–51 (1996) (claiming that traditional notions of proximate cause are sufficient to fairly handle DES cases).

316. *See generally* FED. R. CIV. P. 12(b)(6); Ashcroft v. Iqbal, 556 U.S. 662 (2009).

317. JOHN C.P. GOLDBERG & BENJAMIN C. ZIPURSKY, TORTS 345–46 (2010) (describing use of nominal damages). Or if trivial claims go forward, the degree of injury could be recognized by giving a lower level of damages to acknowledge the weaker claim. *See supra* note 309 and accompanying text.

318. It also could be argued that allowing a broader-based negligence action would eviscerate the claim of IIED, since there would be no incentive to plead the intentional tort. *See* Crump, *supra* note 37, at 454–55. But that dichotomy is true of other broad-based negligence as opposed to intentional torts. As with other intentional torts, plaintiffs would have the availability of punitive damages, which can create a strong incentive for plaintiffs to seek recourse under the intentional tort. Further, if the tort occurs in the workplace,

CONCLUSION

For over a century, courts have struggled to accommodate conflicting views of emotional harm stemming from negligence. These struggles have not been distinguished by their logical consistency or their persuasive analysis. But one thing has remained constant: courts have exercised their power to shape the contours of recovery for emotional harm and have consistently shielded defendants from liability based on an array of justifications that stem from distrust of the claim to faulty science to fear of open-ended liability. As we attempt to move beyond this rigid conception of emotional harm, the law's respect for a defendant's rights should be matched by an enforceable respect for a plaintiff's rights.

The evolving notions of our views on emotional harm—from scientific, medical, and normative perspectives—make this an appropriate time for courts to reconsider these longstanding practices. Difficulties of proof of harm should not deprive the plaintiff of the opportunity to try to convince the trier of fact of the truth of his or her claim. We can test the validity of the claim of emotional harm the way we address it for other negligence-based torts; the fears about the genuineness of the claim may be dispelled with fundamental common law principles in negligence, procedure, and evidence. Common law courts should trust these principles.

pursuing the negligence tort may be precluded by workers' compensation schemes, whereas the intentional tort may not be precluded.