

TRAUMA DAMAGES

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ABSTRACT

The concept of trauma has increasingly been used to describe the experiences of marginalized groups and has a special relevance to systemic injuries and abuses of power that can form the basis of personal injury claims. Although trauma would seem to have everything to do with tort law, not much attention has been paid to trauma and its connection to torts, either with respect to substantive claims or remedies. This article looks at three contemporary contexts of trauma—rape trauma, racial trauma, and birth trauma—and explores their implications for tort recovery. It compares trauma in each context to post-traumatic stress disorder (PTSD) and explains why many trauma victims are unable to qualify for a PTSD diagnosis, even though they experience many symptoms of PTSD. It explores the potential of victims of chronic racism to bring claims for intentional infliction of emotional distress and the possibility of classifying such persons as “eggshell plaintiffs” who are likely to suffer intensified injuries because they experienced trauma in the past. Connecting birth trauma to obstetric violence and mistreatment, it canvasses the sparse case law and the legal obstacles facing persons giving birth, particularly women of color, who are subjected to abuse, coercive tactics, and disrespect by medical personnel. The article calls for a dismantling of the artificial distinction between physical and emotional harm, which stymies recovery from traumatic injury, and for a recommitment to the eggshell plaintiff rule to respond to the realities of underserved communities marked by violence, injustice, poverty, and deprivation. If the widespread incidence of trauma were reflected in tort doctrine, it could change how we estimate losses and extend more generous tort recoveries beyond the usual class of affluent victims who suffer measurable economic loss.

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I. INTRODUCTION

“Trauma” is ubiquitous and has steadily gained prominence since its rediscovery following the Vietnam War. One writer even claims that “[t]rauma has become a defining characteristic of our times,”¹ complete with courses and graduate programs devoted to trauma studies in literature and culture. The ascendancy of trauma as a construct has become so pronounced that law schools have taken note, and students are now being taught about “trauma-informed” approaches to practicing law.²

In recent years, trauma has increasingly been used to describe injuries disproportionately experienced by marginalized groups, such as rape trauma, childhood sexual abuse trauma, racial trauma, and trauma to individuals giving birth (known as “birth trauma”). However, historically, trauma has had a broader application and has been used to describe the experiences of combat soldiers, accident victims, victims of natural disasters, and others subjected to horrific situations.

Trauma would seem to have everything to do with tort law. Many tort victims are traumatized by events caused by tortious behavior, and many others would seem to qualify as the classic “eggshell” or “thin-skull” plaintiffs who suffer intensified injuries because they have experienced trauma in the past.³ Trauma comes into play in at least two settings: (1) determining the type of injury suffered by the plaintiff (particularly whether we categorize an injury as physical or emotional) and (2) determining the severity and seriousness of the harm and the amount of damages. The existence of trauma is also potentially relevant to determine causation, *i.e.*, whether a plaintiff’s injuries resulted from a defendant’s tortious conduct rather than from some source unrelated to the defendant’s conduct.

As someone who approaches tort law from a social justice perspective,⁴ it seems clear to me that trauma has special relevance to systemic injustice and abuses of power that can form the basis of tort

1. Noa Ben-Asher, *Trauma Centered Social Justice*, 95 TUL. L. REV. 95, 96 (2020).

2. See generally Sarah Katz & Deeya Haldar, *The Pedagogy of Trauma-Informed Lawyering*, 22 CLINICAL L. REV. 359 (2016) (advocating for trauma-informed practice in law school clinics); Melanie Randall & Lori Haskell, *Trauma-Informed Approaches to Law: Why Restorative Justice Must Understand Trauma and Psychological Coping*, 36 DALHOUSIE L.J. 501, 505 (2013) (“[T]he law too should strive to become trauma informed.”); Angela Onwuachi-Willig & Anthony V. Alfieri, *Racial Trauma in Civil Rights Representation*, 120 MICH. L. REV. 1701, 1707 (2022) (citing Katz & Haldar, *supra* note 2, at 363) (“[A] trauma-informed perspective asks clients not ‘What’s wrong with you?’ but instead, ‘What happened to you?’”).

3. See generally JOHN C.P. GOLDBERG & BENJAMIN C. ZIPURSKY, TORTS: THE OXFORD INTRODUCTIONS TO U.S. LAW 347–50 (2010) (explaining eggshell skull rule).

4. See generally Martha Chamallas, *Social Justice Tort Theory*, 14 J. TORT L. 309 (2021) (analyzing a new genre of tort theory based on principles and perspectives of social justice).

claims. Noa Ben-Asher has recently examined what he calls the phenomenon of “trauma-centered social justice,” noting that many contemporary social justice movements rely on the rhetoric and logic of emotional trauma, including the #MeToo and #BlackLivesMatter movements.⁵ The social justice dimension of trauma was recently underscored by Judith L. Herman, the scholar who first popularized the concept for rape victims. She urges that trauma be recognized as “not only a matter of individual psychology but also, always, of social justice.”⁶ For Herman, the social justice frame is appropriate because “the violence at the source of trauma aims at domination and oppression, and even to recognize trauma, to name it, requires the historical context of broad social movements for human rights: for secular democracy, for the abolition of slavery, for women’s liberation, for an end to war.”⁷

In the realm of torts, the concept of trauma would seem important to push against the devaluation of injuries of marginalized groups—to help explain, for example, the seriousness of injuries that may otherwise be minimized, such as the trauma of a victim of non-consensual sexual assault who suffers no extrinsic physical injuries⁸ or the trauma of a woman giving birth whose doctor disregards her wishes about how to proceed. The concept of trauma can also potentially be used to provide much-needed compensation to vulnerable tort victims, such as children from impoverished neighborhoods, whose damage awards should reflect the intensified injuries they suffer due to a background of trauma. In this respect, giving fuller recognition to trauma might help offset the built-in bias of tort law that compensates more fully for measurable economic loss, advantaging individuals who already have resources and can access lawyers and insurance.

Interestingly, however, Tentative Draft No. 2 of the Torts Restatement of Remedies has little to say about trauma. The word comes up mainly in textual examples or in parentheticals in the Notes listing PTSD as one of the damages suffered by the plaintiff.⁹ This is not to say that the

5. Ben-Asher, *supra* note 1, at 97.

6. JUDITH L. HERMAN, TRUTH AND REPAIR: HOW TRAUMA SURVIVORS ENVISION JUSTICE 1 (2023).

7. *Id.*

8. W. Jonathan Cardi & Martha Chamallas, *A Negligence Claim for Rape*, 101 TEX. L. REV. 587, 645 (2023).

9. RESTATEMENT (THIRD) OF TORTS: REMEDIES § 8 & Reporters’ Notes (AM. L. INST., Tentative Draft No. 2, 2023) [hereinafter TD 2] (citing *Botek v. Mine Safety Appliance Corp.*, 611 A.2d 1174 (Pa. 1992)); *see also id.* § 8 (citing *Bendar v. Rosen*, 588 A.2d 1264 (N.J. Super. Ct. App. Div. 1991); *id.* § 20; *id.* § 21 cmt. e & illus. 5; *id.* § 21 cmt. g, illus. 8; *id.* § 21 note (b); *id.* § 21 note (g); *id.* § 23; *id.* § 27).

Restatement of Remedies refuses to recognize or is hostile to the idea of trauma as it relates to injury and remedies. Indeed, as far as I can tell, there is nothing in the current draft that would pose a barrier to recovery for trauma victims. Instead, by not saying much about trauma, the Restatement may have missed an opportunity to provide insight and guidance to courts and litigators about how trauma connects to tort law.

I recognize that the Restatement of Remedies attempts to separate liability issues from the question of available remedies. However, we know that, in practice, the two are often inseparable. For example, lawyers may not take even winning cases unless they yield sufficient damages, and the degree of harm or damages suffered by a plaintiff can impel courts to recognize a claim. There is often a blurry line between the recognition of harm (and non-recognition or devaluation of certain injuries) and the valuation of harm (the amount of damages awarded). My discussion about “trauma damages” implicates both liability and damages rules. I believe that as more is known about traumatic injury and the damages that flow from trauma, such knowledge will inform both liability rules and tort recoveries.

My article proceeds in three parts: (1) a discussion of the general concept and history of trauma; (2) an examination of three contexts in which trauma affects marginalized groups: rape trauma, racial trauma, and birth trauma; and (3) three lessons to be drawn for tort law from the study of traumatic injury. The discussion traces the origins of trauma through a variety of victims, from nervous shock claimants injured in railway accidents victims, combat soldiers suffering the effects of war, rape survivors, victims of racist public insults, members of vulnerable populations in underserved communities of color injured by intentional and negligent tortious behavior, to persons giving birth harmed by professional mistreatment and negligence. In these disparate settings, the concept of trauma allows us to see the link between injury and systems of subordination and oppression, even though trauma can happen to anyone exposed to a horrific event. While my analysis is influenced by the psychiatric definition of PTSD—particularly the symptoms associated with it—I argue for a more expansive view of trauma in tort law that would allow recovery for traumatized plaintiffs who suffer serious and long-lasting harm traceable to patterns of social injustice, even though their injuries may not meet all the technical requirements of a PTSD diagnosis. In each of the three contexts, I demonstrate how the arbitrary line between physical and emotional harm, still so prominent in tort law, prevents us from adequately addressing traumatic injury, which defies classification as either physical or emotional harm. My aspiration is that a social justice

approach to trauma and tort law might pave the way for addressing trauma as a central feature of substantive and remedial law, providing some measure of redress to marginalized persons whose injuries have been minimized or denied recognition.

II. THE CONCEPT AND HISTORY OF TRAUMA

When we think of trauma, the first association most of us make is to PTSD, the diagnosis of post-traumatic stress disorder, that first made it into the Diagnostic and Statistical Manual of Mental Disorders (DSM III) in 1980.¹⁰ The current DSM-5 definition of PTSD, adopted in 2013, is quite detailed and stringent.¹¹ To qualify for a PTSD diagnosis, eight criteria must be met, starting with Criteria A, a person's "[e]xposure to actual or threatened death, serious injury, or sexual violence."¹² The DSM recognizes that trauma can result not only from directly experiencing a traumatic event but also from witnessing the event firsthand or learning that a relative or close friend was exposed to trauma. The DSM goes on to require that the person experience a variety of symptoms, including "*intrusion symptoms*," such as recurrent flashbacks or nightmares or psychological distress in the face of reminders or triggers, and that they manifest "*avoidance*" of people, places, conversations, or activities associated with the trauma.¹³ Additionally, the DSM states that there must be documented "[n]egative alterations in cognition and mood," such as an inability to remember important details of the trauma or feelings of detachment or self-blaming, as well as deleterious "*alterations in arousal and reactivity*," such as irritability, angry outbursts, or hypervigilance.¹⁴ Finally, to qualify for a diagnosis, PTSD must last more than one month, cause "significant distress or impairment in social, occupational, or other important areas of functioning," and not be due to medication or substance abuse.¹⁵

10. AM. PSYCHIATRIC ASS'N, DIAGNOSTIC & STATISTICAL MANUAL OF MENTAL DISORDERS (3d ed. 1980).

11. AM. PSYCHIATRIC ASS'N, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS (5th ed. 2013) [hereinafter DSM-5]; *see also* BESSEL VAN DER KOLK, THE BODY KEEPS THE SCORE: BRAIN, MIND, AND BODY IN THE HEALING OF TRAUMA 29 (2014).

12. DSM-5, *supra* note 11, at 271.

13. *Id.* at 271–73 (emphasis added).

14. *Id.*

15. *Id.* at 281, 289.

As a psychiatric concept, trauma straddles the line between the physical and the emotional.¹⁶ Although it is found in the Manual of Mental Disorders and is considered a psychiatric disorder, it is most often anchored in physically violent events and manifests itself in the victim's body. As the author of bestselling book *The Body Keeps the Score* puts it, "trauma produces actual physiological changes, including a recalibration of the brain's alarm system, an increase in stress hormone activity, and alterations in the system that filters relevant information from irrelevant."¹⁷ Scholars of trauma argue that trauma is best understood through a "bio-psycho-social lens," taking into account its "biological and physiological, psychological, and social impacts."¹⁸

One challenge facing courts in tort cases is determining the legal effect of trauma, including the role of a PTSD diagnosis. Should a PTSD diagnosis automatically mean that an injury suffered by the plaintiff is legally compensable if the defendant's conduct amounts to a tort and causation is proven? In other words, should the medical diagnosis play a central role in tort litigation? Conversely, what role should allegations of trauma play in tort cases where the victim has not been diagnosed with PTSD? Should a notion of "trauma" distinct from PTSD have relevance for tort claims, or is the traditional list of types of emotional distress, such as "fright, fear, sadness, sorrow, despondency, anxiety, humiliation, depression (and other mental illnesses)"¹⁹ still an adequate way to categorize traumatic injuries?

It is important to recognize that much like legal and cultural concepts, psychiatric concepts such as PTSD evolve and are highly contested. They are also affected by the political pressures of the day, including backlashes following recognition. In her legal history of PTSD, Deirdre Smith contends that "[m]edical diagnoses are largely the result of 'negotiations' among various institutions and stakeholders rather than being pure scientific 'discoveries.'"²⁰ To complicate matters, in some instances,

16. Until the late nineteenth century, trauma was a term associated exclusively with physical wounds. Deirdre M. Smith, *Diagnosing Liability: The Legal History of Posttraumatic Stress Disorder*, 84 TEMP. L. REV. 1, 5 (2011). Indeed, we still tend to view the prototypical traumatic accident as a "sudden unexpected event which results in immediate injury." ORIN KRAMER & RICHARD BRIFFAULT, WORKERS COMPENSATION: STRENGTHENING THE SOCIAL COMPACT 13-27 (1991).

17. VAN DER KOLK, *supra* note 11, at 2-3; *see also* Onwuachi-Willig & Alfieri, *supra* note 2, at 1728-29.

18. Randall & Haskell, *supra* note 2, at 510.

19. RESTATEMENT (THIRD) OF TORTS: LIABILITY FOR PHYSICAL AND EMOTIONAL HARM § 45 (AM. L. INST. 2012).

20. Smith, *supra* note 16, at 3.

medical diagnoses are affected by the prospect of litigation and the perceived need for compensation.

PTSD and trauma have a long history with gendered origins. Although the origin of PTSD is usually associated with combat trauma, the concept of psychiatric trauma was first used in connection with railway accidents in the mid-nineteenth century to explain “nervous shock” and what was then called “railway spine,” nervous disorders sustained by passengers whose immediate physical injuries appeared minimal.²¹ The diagnosis allowed some plaintiffs whose onset of symptoms developed after the accident to recover settlements and awards. But the railroads soon fought back and enlisted medical experts who expressed the view that such injuries were purely psychological and were traceable to the pre-existing nervous temperament of the victims—many of whom were women—rather than the fault of the railroad.²² This toggling between internal explanations (pre-existing conditions) and external explanations (traumatic events) would become a familiar refrain, mirroring the larger struggle between dispositional and situational explanations of causation and harm identified by cognitive psychologists.²³ Moreover, the move to conceptualize such plaintiffs’ injuries as purely emotional generally had the legal effect of rendering the claims not legally cognizable, given that negligence law generally did not extend its protection to pure emotional harm.

The modern precursor of PTSD arose in the World War I era under the name of shell shock. The name was “based upon an assumption that the symptoms’ primary origin was a neurological injury from a specific event, such as the discharge of an explosive in very close proximity.”²⁴ From the outset, military and political forces resisted recognition of the condition because of concerns about the effects of such a diagnosis on the “efficiency of the fighting forces.”²⁵ “The official view was that well-trained troops, properly led, would not suffer from shell shock and that servicemen who had succumbed to the disorder were undisciplined and unwilling soldiers.”²⁶ A similar pattern occurred when trauma (then traveling under the name of “traumatic neurosis”) resurfaced and subsequently disappeared

21. *Id.* at 5; see also Martha Chamallas & Linda K. Kerber, *Women, Mothers, and the Law of Fear: A History*, 88 MICH. L. REV. 814, 824–34 (1990); BARBARA YOUNG WELKE, RECASTING AMERICAN LIBERTY: GENDER, RACE, LAW, AND THE RAILROAD REVOLUTION, 1865–1920, at 154–56 (2001).

22. Smith, *supra* note 16, at 7.

23. See Martha Chamallas, *The Architecture of Bias: Deep Structures in Tort Law*, 146 U. PA. L. REV. 463, 484–85 (1998) (discussing dispositional/situational dichotomy).

24. Smith, *supra* note 16, at 10.

25. VAN DER KOLK, *supra* note 11, at 187.

26. *Id.*

in the World War II era, with the last scientific writing on combat trauma being published in 1947.²⁷

The aftermath of the Vietnam War, however, witnessed a re-emergence of trauma in a broader and more profound way that has had enduring effects on psychiatry and law. After intense lobbying efforts by Viet Nam veterans' groups and their families, the PTSD diagnosis was finally adopted in the DSM III in 1980. The new formulation was tailor-made for legal use, with its foundational connection to a discrete traumatic event ("Criteria A") and its list of required symptoms. In many respects, the PTSD diagnosis in the DSM reads like a Restatement provision.

The new PTSD diagnosis catalyzed interest in trauma beyond the combat context. The ascendant feminist movement, in particular, latched onto the concept to explain the experiences and suffering of survivors of rape, domestic violence, and childhood sexual abuse. Since the 1970s, the anti-rape and battered women's movements have focused attention on the pervasiveness and devastating effects of sexual violence in the U.S., maintaining that the high levels of rape and domestic violence were a product of systemic sexism, male dominance, and patriarchy.²⁸ In the 1990s, however, feminist activists and researchers mobilized the concept of trauma to address these problems and used the new vocabulary to push against the invisibility and minimization of such injuries. Judith Herman's popular book *Trauma and Recovery*²⁹ struck a responsive chord; trauma became linked to sexual assault, and the DSM was eventually revised to list "sexual violence" as one of the qualifying events that anchors the PTSD diagnosis.

As in the past, however, there was also resistance and backlash, particularly around the concept of repressed memory. Although memory loss had been part of the criteria for PTSD since the diagnosis was first introduced, the reliability of trauma plaintiffs' "recalled memory" was hotly contested in litigation against the Catholic Church and other institutions.³⁰

27. *Id.* at 190.

28. Leigh Goodmark, *The Anti-Rape and Battered Women's Movements of the 1970s and 1980s*, in OXFORD HANDBOOK OF FEMINISM AND LAW IN THE UNITED STATES 223 (Deborah L. Brake et al. eds., Oxford Handbook Series, 2023).

29. See generally JUDITH HERMAN, *TRAUMA AND RECOVERY: THE AFTERMATH OF VIOLENCE—FROM DOMESTIC ABUSE TO POLITICAL TERROR* (1997) (discussing the concept of psychological trauma through the prism of trauma survivors).

30. One issue is that memory loss and delayed recall of traumatic experiences has not been documented in the laboratory. "The terror and helplessness associated with PTSD simply can't be induced *de novo* in such a setting. We can study the effects of existing traumas in the lab, as in our script-driven imaging studies of flashbacks," but even laboratory experiments such as exposure to extremely violent films will not cause "normal" people "to develop symptoms of PTSD." VAN DER KOLK, *supra* note 11, at 194.

The debate over repressed memory recapitulated an older debate in Freudian psychology about the origins of “hysteria” affecting women patients, which Sigmund Freud initially attributed to traumatic childhood sexual events and then backtracked and hypothesized that repressed trauma was instead traceable to childhood *fantasies* of sexual seduction.³¹

While some critics of the PTSD diagnosis have worried that it is too broad and subjective, others have criticized the diagnosis as too narrow. Researchers and clinicians studying the effects of chronic or widespread racism in U.S. culture, for example, have advocated for reconceiving trauma to respond to injuries experienced by African Americans and other racial and ethnic minorities. They point out that many racist incidents are not acts of physical violence but microaggressions and other kinds of racist behaviors, such as verbal or emotional abuse and resource denial, which accumulate over time and produce effects very similar to those demonstrated by “prototypical” trauma victims.³² Proposals to amend the DSM to include a new diagnosis of Race-Based Trauma Stress Syndrome (RBTSS) have been made to address the problem but have not yet been adopted, leading one writer to lament that “modern racism remains largely outside the scope of PTSD.”³³

A related controversy surrounding trauma today involves what is known as “complex PTSD” (C-PTSD) or “developmental trauma” disorder. This type of trauma largely affects children who experience violence, abuse, and neglect, especially by caregivers, and has relevance for concretizing the concept of racial trauma.³⁴ In many cases, complex trauma involves “[r]epeated exposure to or victimization by violence, often coupled with severe environmental deprivation associated with endemic poverty.”³⁵ The basic idea is that adverse childhood experiences (ACEs) can have enduring negative effects on brain development produced by dysregulation of stress hormones, leading to problems with attention and concentration, getting along with others, obesity, mood swings, detachment, and self-harm. This collection of debilitating symptoms means that children are “forced to be on guard at all times, not to trust anyone or any systems to

31. Smith, *supra* note 16, at 9.

32. See generally Kimeu W. Boynton, *Repeated, Ongoing, and Systemic Incidents of Racism and their Harmful Mental Health Effects: Addressing Trauma in the Lives of African Americans*, 6(5) DELA J. PUB. HEALTH (2020) (discussing the correlation between racial incidents and psychological trauma).

33. Hafsa S. Mansoor, *Modern Racism but Old-Fashioned IIED: How Incongruous Injury Standards Deny “Thick Skin” Plaintiffs Redress for Racism and Ethnoviolence*, 50 SETON HALL L. REV. 881, 895 (2020).

34. Randall & Haskell, *supra* note 2, at 504, 511.

35. Onwuachi-Willig & Alfieri, *supra* note 2, at 1710.

ensure self-protection, and to repeatedly have to rebuild life and hope after constant abandonment or loss,” thus narrowing the “possibilities that children may see for themselves and often caus[ing] them to quite reasonably believe they may have no future at all.”³⁶ In our society, complex trauma is not randomly distributed. As Angela Onwuachi-Willig and Anthony Alfieri explain it, “complex trauma . . . is individualized, but can happen collectively to people ‘living in particular zip codes.’”³⁷

In 2011, the DSM rejected the “complex trauma” diagnosis, and it has not yet made it into the DSM as a distinct category.³⁸ A large percentage of children treated for trauma thus do not meet the diagnostic criteria for PTSD, particularly because they rarely talk about being hit, abandoned, or molested, even when asked.³⁹ The decision to exclude the “complex trauma” diagnosis from the DSM is controversial, and the DSM is currently being reviewed to address concerns of racial equity.

While a PTSD diagnosis is undoubtedly useful to document injury and damages in tort litigation, it would be unwise to regard the DSM’s description of PTSD as the “be-all-and-end-all” to define and understand trauma as it relates to law. Although it may reflect the best judgment of a sector of the psychiatric community, the DSM’s understanding of “trauma” has always been hotly contested. Moreover, it is not entirely objective in the sense that the definition of PTSD is immune from political and social currents. Rather, it makes sense to think of PTSD, like many other injuries, as “not objective and outside of culture” but as partly “determined by where one stands in relation to power in a given cultural moment.”⁴⁰

Equally as important, the DSM is designed to diagnose diseases and treat patients rather than to determine what injuries should be legally recognized or what damages should be recoverable. Rather than simply borrowing these contested concepts for use in tort law, we might be better off keeping our eyes on the prize—on providing compensation for serious, traumatic injuries, whether or not they meet the technical requirements of the DSM.

36. *Id.*; see also Randall & Haskell, *supra* note 2, at 512.

37. Onwuachi-Willig & Alfieri, *supra* note 2, at 1708.

38. However, C-PTSD is recognized in the World Health Organization’s International Classification of Diseases, ICD-11.

39. VAN DER KOLK, *supra* note 11, at 23.

40. Anne Bloom, *The Future of Injury (Tort Law in the Wake of the Pandemic)*, 71 DEPAUL L. REV. 209, 214 (2022).

III. THREE TRAUMA CONTEXTS

The idea of trauma has been mobilized by social groups to make their suffering visible and to push against misunderstandings and minimization of their injuries. In each of the three contexts I discuss below (rape trauma, racial trauma, and birth trauma), advocates have deployed the language of trauma—and sometimes assimilated their injuries to PTSD—to underscore the devastating and long-lasting effects of their experience of injury.

In these accounts, trauma is, by definition, serious injury, aptly characterized as “unbearable and intolerable.”⁴¹ Labeling each of these harms as “trauma” also has the effect of tying them together. Although a rape victim, a person giving birth, and a child living in an impoverished neighborhood who has been re-victimized by witnessing a brutal act of violence certainly have distinctive, individualized experiences, the use of the term trauma calls attention to the systemic and social dimensions of the injuries.⁴² In each instance, the claim is that the victims have been “set up” for traumatic injury by systems of subordination and injustice that tolerate high levels of rape, fail to protect women’s reproductive choices and health, and neglect the widespread suffering of communities of color beset by racial injustice, violence, and poverty every day. Although a person need not be a member of a marginalized group to experience trauma—think of automobile accident victims—the trauma label is particularly important when the systemic nature of the injury threatens to normalize suffering, locate the problem internally within the victim, and transform injury into “just the way things are.” Trauma can happen to anyone, but the risk that one’s trauma will be unacknowledged or underappreciated is related to social group identity and lack of power.

A. Rape Trauma

The trauma of rape victims is perhaps best known and has infiltrated many areas of the law, civil as well as criminal. The PTSD diagnosis has played an important role in rape cases, has made the trauma of rape more visible and concrete, and has served to distinguish the suffering of such victims from cases of emotional distress in other contexts. Many rape

41. VAN DER KOLK, *supra* note 11, at 1.

42. “Research suggests . . . that the more marginalized and most vulnerable members of society are at greater risk for trauma responses. It is common for youth, the impoverished, and minority groups to experience trauma, demonstrating the importance of social context in understanding trauma.” Randall & Haskell, *supra* note 2, at 508 (footnotes omitted). “Women are more likely to experience higher rates of trauma responses, indicating that gender is also important and relevant in understanding trauma, its causes, and its effects.” *Id.*

victims have taken advantage of the PTSD diagnosis to offer expert evidence to prove not only the severity of their injuries but to help establish their lack of consent or to explain their seemingly inconsistent behavior, like why they did not report the rape sooner. Although some courts caution juries not to use the PTSD evidence to prove the fact of the traumatic event or to judge the plaintiff's credibility, "the consensus of the courts at present is to admit PTSD (or related syndrome) evidence in sexual assault cases, generally with a limiting instruction."⁴³

A good example of how the PTSD diagnosis figures prominently in civil rape litigation is *Jordan v. McKenna*,⁴⁴ an assault and battery case against a defendant who had deceived the plaintiff into allowing him to use her phone when she was alone at home and then brutally raped her. To justify a \$430,000 award for compensatory and punitive damages, the court relied heavily on the testimony of the plaintiff's psychiatrist, who explained PTSD, reciting how trauma victims experience "intrusive" and avoidance symptoms, may "become more irritable and overreact to frightening or startling situations," "are always on the lookout for danger," and can suffer a loss of self-esteem, wondering what they "could have done to prevent it."⁴⁵ The court credited the expert's conclusion that the plaintiff "fit the profile" and painted a before-and-after picture of the plaintiff as a woman who was once "independent, tough, competent, and able to care for herself" and became "vulnerable, powerless, and without control over herself."⁴⁶

A more recent example is *Janice H. v. 696 North Robertson, LLC*,⁴⁷ a case involving the rape of a woman in the restroom of a bar and dance club. The plaintiff's expert psychologist testified that plaintiff had suffered from PTSD, causing her to have nightmares and forcing her to move to a more secure apartment because of her fear. Even after three years, the expert stated that the plaintiff "suffered significant distress, including feelings of disbelief, shock, horror, disgust and upset" and that the rape "still simply overwhelms her."⁴⁸ The court upheld a large award of \$5.35 million in noneconomic damages, concluding that the award was not "excessive" and did not "[s]hock the [c]onscience."⁴⁹

The value of a PTSD diagnosis in civil rape cases is readily apparent. It allows the plaintiff to show that her suffering is real, not exaggerated and

43. Smith, *supra* note 16, at 39.

44. 573 So. 2d 1371 (Miss. 1990).

45. *Id.* at 1377.

46. *Id.*

47. 205 Cal. Rptr. 3d 103 (Cal. Ct. App. 2016).

48. *Id.* at 119.

49. *Id.* at 118–19.

cements her claim that the abuse actually took place. However, when PTSD is used to establish and concretize an individual rape victim's injury, there is a tendency to sever the harm from the background of systemic or chronic sexism that enabled such sexual offenses to become widespread and, to some degree, tolerated in society. The PTSD diagnosis has the potential to neutralize the claim in the sense that it can draw attention away from the domination, oppression, and exploitation of defendant's behavior, shining the spotlight instead on the individual plaintiff's reactions.

The success of rape victims in using the PTSD diagnosis has encouraged advocates to use rape as a template for drawing parallels between rape and other types of traumas, for example, comparing racial trauma to rape trauma.⁵⁰ However, as will be discussed more below, the PTSD label maps more easily onto rape cases than it does in some other contexts. In the DSM-5, rape qualifies as a discrete event from which trauma typically flows, akin to death, threatened death, and other serious bodily injury. In this way, it resembles other singular traumatic events, such as exposure to combat, accidents, or natural disasters that trigger the onset of the condition. The PTSD diagnosis thus treats rape like other physical injuries and anchors the diagnosis to the physical realm, even though the symptoms of trauma are a mixture of the physical and psychological. Including sexual violence in the DSM's criteria for PTSD was a crucial step that set the stage for the widespread use of the diagnosis in rape cases.

In at least one respect, however, the significant influence of the PTSD diagnosis in civil rape cases has not altered tort law. Not all rape cases are approached by courts in identical ways, even if the trauma they cause is the same. The two cases cited above each involved violent rapes by strangers in which the plaintiff suffered physical injuries beyond the fact of penetration. In date and acquaintance rapes, and other instances where there is no other evidence of physical injuries, however, some courts continue to classify such cases as emotional harm, triggering the greater proof requirements for pure emotional loss in negligence law and relegating the plaintiff to arguing that her rape was an offensive (rather than physically harmful) battery when the claim is litigated as an intentional tort.⁵¹ The lesson from PTSD is that trauma due to rape is a distinctive kind of injury that cannot fully be understood as simply another kind of emotional distress, a lesson that has yet to be fully absorbed into tort law.

50. Thema Bryant-Davis & Carlota Ocampo, *Racist Incident-Based Trauma*, 33 COUNSELING PSYCH. 479, 487–91 (2005).

51. Cardi & Chamallas, *supra* note 8, at 621–31.

B. Racial Trauma

Since the 1980s, scholars in psychology and law have advocated for the recognition of trauma associated with chronic racism in society and for a definition of trauma broad enough to respond to the plight of people, particularly children, who live in underserved communities of color marked by violence, injustice, poverty, and deprivation. In the aftermath of the large-scale protests in the summer of 2020, following the police murder of George Floyd, the calls for recognition of racial trauma have multiplied and intensified. The #BlackLivesMatter platform integrates trauma into its master narrative, stating that “[i]n many ways, at its essence BLM is a response to the persistent and historical trauma Black people have endured at the hands of the State. This trauma and pain, unresolved and unhealed, lives on in our bodies, in our relationships, and in what we create together.”⁵² Citing a study on how trauma and #BlackLivesMatter feature on Twitter, Ben-Asher explains that the study found “many tweets regarding the trauma of racism, the trauma of kids from communities of color, intergenerational or historical trauma, and the traumatic effects of police violence against Black men.”⁵³

In comparison to rape trauma, there is less consensus about what racial trauma encompasses, and the boundaries of the concept are still being framed. Scholarly work identifying what concrete changes recognition of racial trauma would bring to law and legal doctrine is still in its exploratory phase. The most extensive law review article on this topic by Angela Onwuachi-Willig and Anthony V. Alfieri, *Racial Trauma in Civil Rights Representation*,⁵⁴ focuses on trauma-informed lawyering and legal ethics. It showcases an ADA case in which public interest lawyers used a novel “trauma litigation theory” aimed at requiring public school officials to address the wide-ranging needs of trauma-impacted students and teachers. The lawsuit sought to pressure schools to implement “reasonable accommodations in the form of trauma-sensitive policies and procedures that will allow student class members an opportunity to receive an adequate public education.”⁵⁵ Describing the litigation strategy and the settlement the parties ultimately entered into, the authors use the case to demonstrate some crucial elements of trauma-informed lawyering, including how to take a “trauma history” of clients. They underscore, however, the limitation of such public interest litigation is that, by its nature, it neither “directly

52. Ben-Asher, *supra* note 1, at 112.

53. *Id.* at 114 (footnotes omitted).

54. See generally Onwuachi-Willig & Alfieri, *supra* note 2.

55. *Id.* at 1721.

addresses or ameliorates the intractable sources—race discrimination and subordination and poverty—of community violence and racial trauma.”⁵⁶ The article looks to the long term, advocating the development of a theory of “community violence-centered racial trauma” that would inform lawyering and legal ethics, particularly in civil rights litigation.⁵⁷

1. Intentional Infliction of Emotional Distress

Perhaps the clearest way to envision the concept of racial trauma directly impacting tort law involves its potential role in delineating harm in intentional infliction of emotional distress (IIED) cases. IIED cases are notoriously difficult to prove, requiring plaintiffs to demonstrate that the defendant’s conduct was “extreme and outrageous” and that they suffered “serious” or “severe” emotional distress. The formidable barriers to recovery mean that relatively few cases alleging racist behavior are successful, leaving plaintiffs who are targets of racist incidents to look elsewhere for relief.⁵⁸ Although many scholars have critiqued and analyzed the high bar set for proof of outrageousness, including its effect of screening out cases of discriminatory harm,⁵⁹ less attention has been paid to the element of “serious emotional distress.”

In a recent article, Hafsa S. Mansoor examines the case of a 26-year-old Black woman subjected to “a tirade laden with racial invectives” by the owner of a donut shop when she complained that her donut was stale. The outburst occurred in front of other customers and greatly upset the plaintiff. She alleged that she felt “embarrassed, shocked, mortified, hurt, angry and humiliated” and that “her self esteem had deteriorated and . . . she viewed herself differently.”⁶⁰ For reasons not stated in the case file, however, she did not seek therapy or psychiatric treatment. The court dismissed her claim for IIED on summary judgment on the basis that she did not suffer “severe emotional distress.” The court reasoned that since the plaintiff offered no “medical or expert proof to corroborate her feelings of lost self-

56. *Id.* at 1725.

57. *Id.* at 1737.

58. Employees who are sexually assaulted on the job, for example, can sometimes recover under Title VII of the federal Civil Rights Act alleging a sexually hostile working environment. See MARTHA CHAMALLAS, *PRINCIPLES OF EMPLOYMENT DISCRIMINATION LAW* 122–25 (2019).

59. See Martha Chamallas, *Discrimination and Outrage: The Migration from Civil Rights Law to Tort Law*, 48 WM. & MARY L. REV. 2115, 2127–32 (2007); see also Martha Chamallas, *Feminist Legal Theory and Tort Law*, in RESEARCH HANDBOOK ON FEMINIST JURISPRUDENCE 391 (Robin West & Cynthia Grant Bowman eds., 2019); see generally Martha Chamallas, *Race and Tort Cases*, in OXFORD HANDBOOK ON RACE AND THE LAW (Khiara Bridges, et al. eds., 2022) (providing an overview of the contemporary “race and torts” legal landscape).

60. Mansoor, *supra* note 33, at 882.

esteem or anger” and since her “claimed distress never manifested itself physically or objectively by way of headaches, loss of sleep, inability to perform her daily functions, or any condition that was professionally diagnosed,” the racist incident was not actionable in tort.⁶¹

Mansoor argues that the “severe emotional distress” injury standard has a special propensity to bar recovery in racism and ethnoviolence cases. Her basic claim is that “[m]any people of color, in response to decades of chronic racism, develop ‘thick skins.’”⁶² Consequently, “they will not manifest the mental and emotional injuries of racist incidents in the ‘right way’ to enable them to sue because their experiences do not fit within the rigid confines of pathological disorders.”⁶³ This aspect of Mansoor’s argument is highly debatable, given that the “thick skin” label of people of color’s responses to chronic racism may well be more stereotype than reality. Rather than reflecting a capacity to shrug off or internalize the pain, victims’ reluctance to seek psychiatric or other medical assistance may be traceable to structural features, such as a lack of access to quality health care or racial bias by health care providers.⁶⁴ Nevertheless, Mansoor’s main point is that the injury produced by racist insults against the background of chronic racism should be regarded as likely to produce severe emotional distress. Her solution is to incorporate the theory of race-based traumatic stress (RBTS) into the IIED injury standard in cases involving racism and ethnoviolence.

The RBTS theory was developed by psychologists, most prominently Robert T. Carter, who set out to create a framework to understand “the unique aspects of the racial experience,” addressing what he saw as a gap in the prevailing stress models to “adequately consider an individual’s race or color.”⁶⁵ His and others’ research supports the theory that stress unconnected to a specific life-threatening event can produce reactions very similar to those experienced by individuals with a PTSD diagnosis, including avoidance or psychic numbing, intrusion or reexperiencing, and arousal or hyperactivity. The difference between PTSD and RBTS comes mainly in the nature of the event that produces the trauma, with racist

61. *Id.*

62. *Id.* at 883.

63. *Id.*

64. See generally Nathan N. Cheek & Eldar Shafir, *The Thick Skin Bias in Judgments About People in Poverty*, BEHAV. PUB. POL’Y (2020) (documenting perceptual bias by professionals and others leading to the belief that persons of low socio-economic status are less harmed by adverse life events).

65. Mansoor, *supra* note 33, at 896; see also Robert T. Carter, *Racism and Psychological and Emotional Injury: Recognizing and Assessing Race-Based Traumatic Stress*, 35 COUNSELING PSYCH. 13 (2007).

insults, microaggressions, and other discriminatory behaviors replacing combat, accidents, or other life-threatening events. Not every event precipitated by racism produces traumatic stress, however. “For race-based traumatic stress to be present,” the triggering event must be perceived as negative and experienced as “*sudden*, and *uncontrollable*,”⁶⁶ but it need not be physical or explicitly tied to a physical event, such as witnessing the sudden death of a relative. For example, RBTS may arise from “one powerful insult”⁶⁷ or some other race-based incident like the denial of access to certain services or denial of a promotion. More often, however, it is the cumulative effect of chronic racism and attendant chronic stress that takes its toll when an individual is subjected to a “last straw” encounter or experience.⁶⁸

Mansoor draws on this psychological research to critique the judicial application of the “severe emotional distress” requirement in IIED cases. She observes that many jurisdictions set the bar for proof of severe emotional distress so high that “even deeply emotionally-harmed plaintiffs,” who have been the deliberate targets of racist verbal attacks, may be unable to satisfy it.⁶⁹ Thus, courts have dismissed plaintiffs’ allegations of trauma-like symptoms such as being “so angry he felt physical pain” and being “haunted by fears that occupied his waking moments, interrupted his sleep, and prevented him from enjoying life” as insufficient to qualify as severe emotional distress.⁷⁰ Some courts even require that emotional distress be “debilitating” and render the plaintiff incapable of being able to function and engage in day-to-day activities. Absent a PTSD diagnosis,⁷¹ such courts are apt to screen out plaintiffs’ IIED cases, ruling as a matter of law that the plaintiff did not prove that her distress was “so severe that no reasonable person could be expected to endure it.”

Mansoor maintains that the law’s failure to appreciate the psychological effects of chronic racism particularly disadvantages plaintiffs who end up not seeking psychiatric care. She argues that insofar as “racism is a daily occurrence to which people of color become too accustomed to directly react,” they may manifest their distress differently than other

66. Carter, *supra* note 65, at 90.

67. *Id.* at 84.

68. *Id.*

69. Mansoor, *supra* note 33, at 899.

70. *Id.* at 900.

71. It should be noted that researchers have also found that African Americans have elevated rates of PTSD, not fully explained by the stressful event or other factors. Carter, *supra* note 65, at 15.

trauma victims, even though they have “equally deep psychological wounds (i.e., trauma reactions).”⁷² Drawing on the mental health literature, she claims that “[d]ata shows injuries from racism run as deep as DSM trauma, but because of their non-lethal triggers, cumulative nature, and origin in everyday stressors, that injury does not manifest in a currently legally-recognized way.”⁷³ Mansoor advocates incorporating RBTS theory to inform the standard of severe emotional distress in IIED cases. Her proposal presumably would permit plaintiffs to introduce evidence that their symptoms are consistent with RBTS, given their background and the circumstances of the case, allowing such evidence to satisfy the requirement of severe emotional distress without the need to prove either that their condition was disabling or that they suffered from PTSD.

Mansoor’s proposal is medicalized in that she advocates for incorporating RBTS into the injury standard for tort law. However, her proposal does not rest on adding RBTS to the DSM or tying legal recovery strictly to medical diagnoses. Instead, as I understand her argument, it is that chronic racism in our society has been clinically and empirically shown to produce stress in affected individuals and that racist incidents can trigger serious symptoms akin to those experienced by patients with PTSD. Mansoor’s proposal would have courts acknowledge the reality of race-based traumatic stress and treat it as a marker of serious harm, as the label “trauma” signifies. Much in the same way that we now regard rape as traumatic harm that is qualitatively different from other kinds of emotional distress, Mansoor hopes to forge a “new conceptualization of equally genuine severe emotional distress from racism and ethnoviolence.”⁷⁴ Importantly, she would provide relief even to resilient plaintiffs in line with the purpose of tort law to vindicate plaintiffs’ rights and deter anti-social conduct.

In some respects, Mansoor’s arguments recapitulate similar arguments that progressive scholars have made with respect to the “outrageousness” element of IIED. The parallel argument is that discriminatory behavior should often be regarded as “intolerable” and per se “outrageous” and need not be uncommon or bizarre to meet the threshold requirement for IIED.⁷⁵ Instead, it is the repetitive, cumulative, and identity-crushing aspect of

72. Mansoor, *supra* note 33, at 901–02.

73. *Id.* at 907.

74. *Id.*

75. *But see* RESTATEMENT (THIRD) OF TORTS: LIABILITY FOR PHYSICAL AND EMOTIONAL HARM § 46 cmt. d (AM. L. INST., 2012) (indicating that conduct must be “extreme and outrageous,” a “double limitation . . . that requires both that the character of the conduct be outrageous and that the conduct be sufficiently unusual to be extreme”).

discrimination that makes it worse than other kinds of aggressive or bullying conduct not tied to systemic bias. Labeling emotional distress “traumatic” signals its elevated seriousness and may encourage legal actors to regard it as “so severe that no reasonable person could be expected to endure it.”

Such a move to reframe some injuries as traumatic, rather than as simple emotional distress, also complements the renewed interest in affording greater recognition and weight in tort law to dignitary injuries.⁷⁶ Particularly in the context of gross racial insults made in public, it is clear that such behavior is a classic affront to one’s dignity, akin to an offensive battery where a defendant spits in the plaintiff’s face in front of a crowd of people.⁷⁷ Building on the work of Kenneth Abraham and G. Edward White,⁷⁸ the Restatement of Remedies proposes that a new head of damages for dignitary harm be recognized, authorizing factfinders to infer damages from the facts and circumstances of the case, without further evidence of harm.⁷⁹ Unfortunately, such a remedial reform would not solve the problem that, to establish liability, plaintiffs must still prove the “severe emotional distress” prong in IIED cases, and thus, reliance on trauma is still necessary. It does, however, reinforce the larger point that the physical/emotional dichotomy is inadequate to address the many kinds of recurring serious harms that tort law ought to address. With respect to injuries caused by systemic sexism, racism, and other inequalities, we may well need a “both/and” strategy that reframes some discriminatory harms as traumatic (assimilating them to physical injuries) and also upgrades the category of dignitary harm, separating it from diffuse emotional harm that can obscure and minimize a plaintiff’s injury.⁸⁰

2. Eggshell Plaintiffs

Beyond IIED predicated on racist incidents, if race-based traumatic stress was recognized and regarded as a widespread phenomenon, it would significantly increase the number of individuals classified as eggshell plaintiffs—people who are vulnerable to suffering intensified injuries if

76. See e.g., Hila Keren, *Beyond Discrimination: Market Humiliation and Private Law*, 95 COLO. L. REV. 87, 149 (2024) (proposing an anti-humiliation principle in tort and contract law).

77. See generally *Alcorn v. Mitchell*, 63 Ill. 553 (1872) (analyzing tort suits as a substitute for revenge).

78. See generally Kenneth S. Abraham & Edward White, *The Puzzle of the Dignitary Torts*, 104 CORNELL L. REV. 317 (2019) (analyzing types of dignitary harm cases).

79. TD 2, *supra* note 9, at § 22.

80. Chamallas, *supra* note 4, at 332 (listing “enhance dignity and recognition” as a guiding principle of social justice tort theory).

subjected to tortious behavior. Research indicates that “past trauma, rather than buffering people, makes them more vulnerable, and often exacerbates the effects of future trauma.”⁸¹ An analogy would be raping a rape survivor or shooting at a person who had survived a prior mass shooting. In each instance, the commission of the tort compounds the pre-existing injury and logically should increase the award of damages.

Even if the tortious behavior alleged in the lawsuit is not explicitly racist, damage awards in cases involving plaintiffs with a background of trauma will reflect the pre-existing effects of chronic racism. This reconceptualization could change the way we estimate potential losses. For example, rather than viewing low-income, minority neighborhoods as places where economic losses from tortious conduct are likely to be lower than they would be in more affluent neighborhoods,⁸² the calculus would be altered to consider the increased cost of inflicting harm on persons already suffering from traumatic stress. Thus, if a toxic spill or train derailment occurred in a low-income neighborhood characterized by extreme poverty and violence,⁸³ the defendant would have to respond to cover the full cost of the injuries inflicted on victims suffering intensified emotional distress due in part to their pre-existing condition. In such cases, legal liability might even make the need for “trauma counseling” and other mental health services more visible and increase the funds available for such purposes.⁸⁴ As with injuries in general, however, tort law responds to just a small slice of the problem, compensating only those persons who are proven to be victims of tortious conduct, thus playing only a relatively minor role in addressing the larger systemic problems of chronic racism and racial trauma.

Admittedly, the move from using racial trauma to establish the injury or damage element in an individual IIED case to using it to transform the torts remedial landscape through broadened application of the eggshell plaintiff rule is a leap. The former fits into a conventional, even

81. Cheek & Shafir, *supra* note 64, at 2.

82. The lower economic loss results in part from lower estimates of loss of future earning capacity and lower awards for pain and suffering, damage calculations that are themselves tainted by racial and gender bias. See MARTHA CHAMALLAS & JENNIFER B. WRIGGINS, THE MEASURE OF INJURY: RACE, GENDER, AND TORT LAW 158–70 (2010) (discussing bias in damages for loss of future earning capacity); see generally Maytal Gilboa, *The Color of Pain: Racial Bias in Pain and Suffering Damages*, 56 GA. L. REV. 651 (discussing bias in pain and suffering damages).

83. Such environmental disasters disproportionately affect low-income minority neighborhoods. See generally Danielle W. Mason, *Environmental Justice for All*, 59 TRIAL 18 (2023) (discussing studies indicating that people of color are disproportionately impacted by environmental hazards).

84. See Randall & Haskell, *supra* note 2, at 507–09 (describing most effective and best trauma treatments).

conservative, account of tort suits as vehicles for rectifying an imbalance between the individual parties caused by the defendant's tortious conduct. However, the latter plugs into social systems of racism and social inequality and seems aimed at a broader social goal. Thus, a proponent of corrective justice or civil recourse theory might have little difficulty endorsing the use of an RBTS diagnosis to prove severe emotional distress but may balk at attempts to augment recoveries for larger populations of torts plaintiffs whose prior experiences of violence and poverty have made them vulnerable to traumatic injury. Herein likely lies the distinction between corrective justice and social justice theories of tort law. If one of the aims of tort law is to rectify or ameliorate unjustified social inequalities, as social justice theorists propose,⁸⁵ using trauma in both contexts makes sense. After all, baked into the concept of trauma, at least as I envision it, is an appreciation of the harms of domination and oppression, systemic social structures that affect large groups of subordinated persons. Although these systems of oppression lurk in the background when a rape victim sues for battery or a person of color claims injury from a racist insult, they are nonetheless present, making the victim an easy target and thus vulnerable to injury, not unlike the eggshell plaintiff who can expect to suffer exacerbated injury if exposed to future trauma.

However, when a rule such as the eggshell plaintiff rule is applied to address and remedy effects of systemic injustice, such as chronic racism, it would be naïve not to expect that the recurring internal/external struggle over the causes of trauma will emerge with a vengeance.⁸⁶ As was the case with combat veterans, defendants are sure to argue that something internal within the victims, rather than the external tortious conduct of the defendant, is the real culprit producing the lion's share of damage. A cautionary tale comes from litigation in Canada involving indigenous children who sued the government of Canada and the United Church of Canada for the massive harm they suffered—including loss of their language and culture—when they were forcibly separated from their families and sent to residential schools.⁸⁷

In *Blackwater v. Plint*,⁸⁸ the plaintiffs were required to base their entire case on the sexual abuse they suffered at the schools, principally because other claims of non-sexual abuse and deprivation that occurred at the

85. Chamallas, *supra* note 4, at 315.

86. See *supra* note 23 and accompanying text.

87. Carole Blackburn, *Culture Loss and Crumbling Skulls: The Problematic of Injury in Residential School Litigation*, 35 POL. & ANTHROPOLOGY REV. 289, 290–93 (2012) (providing historical background of the litigation).

88. 2005 SCC 58, S.C.R. 3 (2005).

schools were time-barred. Moreover, many of the children had family backgrounds characterized by extreme poverty mixed with violence and trauma before coming to the schools. In a progressive move, the Canadian Supreme Court recognized that the plaintiffs ought to be regarded as vulnerable persons entitled to have their damages measured by the “thin skull” rule, meaning that the “effect of the sexual assaults [committed by the school personnel] would have been greater because of [the plaintiffs’] pre-existing injury.”⁸⁹ The Court did not end its analysis of damages there, however, and went on to discuss another special rule of damages law—known in Canada as the “crumbling skull” rule—that undercut the force of the eggshell plaintiff rule. Under the crumbling skull rule, defendants are entitled to argue for a lower amount of compensation by showing that the plaintiff’s pre-existing condition would have inevitably produced the trauma even in the absence of the defendant’s conduct. Put in other words, in a crumbling skull scenario, a defendant may receive a discount to a damage award if plaintiff’s pre-existing condition is characterized as degenerative or deteriorating. The fine line sought between the two competing doctrines—between the thin skull and the crumbling skull—is that the crumbling skull doctrine presumably allows for a more precise determination of the original position of the already-damaged plaintiffs and ensures that defendants do not have to restore plaintiffs to a better position than they were in before the defendant’s tortious act.⁹⁰ Somewhat like an evaluation of life expectancy in U.S. law (where the “crumbling skull” rule is not well established⁹¹), even an eggshell plaintiff’s award may be affected by an evaluation that their pre-existing condition would have reduced their life expectancy and that defendants are not required to compensate them based on the average person’s life expectancy.

In practice, it is often difficult, sometimes impossible, to determine how damaged a plaintiff was before the tortious event at issue in the lawsuit occurred. The damages awarded to the aboriginal children in *Blackwater* were criticized as woefully inadequate, ranging from \$10,000 to \$145,000, much lower than the \$300,000 to \$1,000,000 sought by the plaintiffs.⁹² Although the litigation was inherently difficult because the plaintiffs were forced to isolate only that harm caused by their sexual abuse in the schools,

89. *Id.* at 79.

90. *Id.* at 78.

91. See *Steinhauser v. Hertz Corp.*, 421 F.2d 1169, 1173 (2d Cir. 1970) (indicating that defendant would be entitled to a reduction in damages if plaintiff would have developed schizophrenia even absent car accident); see generally *Dillon v. Twin State Gas & Elec. Co.*, 163 A. 111 (N.H. 1932) (jury could take into account that plaintiff would have died from non-tortious conduct moments after defendant’s life threatening tortious act).

92. Blackburn, *supra* note 87, at 300.

it is still telling that the crumbling skull doctrine was the peg the courts used to locate the injury internally (within the children and their families), rather than hold the defendants more fully accountable for the effects of the trauma they experienced. Perhaps it is most disappointing that none of the victims received awards for loss of future earning capacity and only two received awards for the costs of future treatment.⁹³ This less-than-transformative litigation⁹⁴ led one commentator to lament that “tort victims often have blame turned back upon them”⁹⁵ and that “injury can be a difficult site from which to assert agency and make claims; those who do so risk having it returned to them not only as their true identity but also as their individual failing.”⁹⁶

However, even in the face of a damages-diluting rule, such as the crumbling skull doctrine, it is still possible for plaintiffs to receive sizeable recoveries. First, it is far from clear that persons who have experienced trauma should have their condition characterized as a deteriorating or degenerative condition rather than merely a pre-existing vulnerability that may or may not ripen into a more serious condition. Additionally, as one commentator notes, even if the crumbling skull doctrine applies to pre-existing traumatic injuries, plaintiffs may resist any discount by arguing that a defendant’s tortious conduct interfered with their ability to fight the pre-existing condition or prevented them from prolonging the inevitable.⁹⁷ The tension between the two doctrines could also be alleviated by assigning respective burdens of proof to the parties, e.g., requiring a plaintiff to prove that they are indeed an eggshell plaintiff (consistent with the plaintiff’s burden to establish proximate cause) and requiring a defendant to prove that the damages ought to be reduced or discounted because the plaintiff’s pre-existing condition would have inevitably deteriorated and produced the same level of injury (consistent with a defendant’s duty to establish a special affirmative defense respecting damages).

Although *Blackwater* reveals how difficult measuring tort recoveries for subordinated persons who suffer multiple traumas throughout their lives may be, another possible take-home message of the litigation is that courts cannot and should not avoid dealing with the complex reality of trauma (and systemic injustice) if they wish to provide fair compensation for

93. *Id.*

94. However, the litigation did play a role in prompting the Canadian Prime Minister to apologize, enter a Settlement Agreement to provide compensation for residential school victims, and set up a Truth and Reconciliation Commission. *Id.* at 301.

95. *Id.* at 299.

96. *Id.* at 290.

97. Erik S. Knutsen, *Clarifying Causation in Tort*, 33 DALHOUSIE L.J. 153, 185 (2010).

severely injured plaintiffs and deter harm. Application of the eggshell plaintiff rule may be just a starting point inviting courts to devise fair and workable methods to acknowledge trauma and apportion costs among responsible parties, rather than simply assuming that subordinated people are already damaged beyond repair and that further injury, however tortious, is costless or costs very little.

Finally, an additional legal obstacle facing the application of the eggshell plaintiff rule in the complex and racial trauma context is the same one present in IIED cases, *i.e.*, the penchant of courts to categorize trauma as pure emotional distress and to apply more stringent rules to that type of harm. Although many courts and the Restatement⁹⁸ apply the eggshell plaintiff doctrine to pre-existing mental as well as physical conditions, if the harm suffered by the plaintiff is categorized as pure emotional harm, recovery will be permitted for severe emotional harm only “when a person of ordinary sensibilities in the same circumstances would suffer severe harm.”⁹⁹ Thus, the eggshell plaintiff rule is blunted in emotional harm cases, and enhanced recovery is allowed only if persons without the pre-existing condition (*i.e.*, people who had never suffered trauma) would also suffer severe emotional distress under the circumstances. The all-important physical/emotional harm distinction surfaces again here, making the categorization of traumatic injury relevant to liability and damages.¹⁰⁰

98. RESTATEMENT (THIRD) OF TORTS: LIABILITY FOR PHYSICAL AND EMOTIONAL HARM § 31 (AM. L. INST. 2010).

99. RESTATEMENT (THIRD) OF TORTS: LIABILITY FOR PHYSICAL AND EMOTIONAL HARM § 46 cmt. j (AM. L. INST. 2012). *See generally* Mustapha v. Culligan of Canada, Ltd., 2008 SCC 27 (2008) (denying recovery to supersensitive plaintiff where defendant’s conduct would not cause an ordinary person to suffer serious emotional distress). However, if a person of ordinary sensibilities would suffer severe emotional harm under the circumstances, the eggshell plaintiff will be able to recover for the entire amount of their injury, preserving the eggshell doctrine in this limited respect.

100. A similar struggle over rules designed to compensate for mental stress injuries has occurred in workers’ compensation law. Early workers’ compensation schemes allowed recovery only in the so-called “physical-mental” cases (physical accident resulting in psychiatric harm) or in “mental-physical” cases (acute mental stress leading to physical harm, such as a heart attack) but denied recovery for “mental-mental” injuries (emotional injury arising from emotional causes in the absence of physical accident or impairment). *See* KRAMER & BRIFFAULT, *supra* note 16, at 13–27. Today, most states do not distinguish between physical and mental injuries “if the consequence is to disable the worker.” DANIEL L. SHUMAN, PSYCHIATRIC AND PSYCHOLOGICAL EVIDENCE § 14:10 (2020). However, such claimants typically must prove that their condition was caused by something other than “everyday work stress,” sometimes being required to prove that their mental injury was caused by “sudden, unexpected and extraordinary stress related to employment.” *See, e.g.*, Whetstone v. Jefferson Parish Sch. Bd., 117 So. 3d 566, 568 (La. Ct. App. 2013).

C. Birth Trauma

The third context in which trauma plays a significant role in illuminating the suffering of tort victims involves injuries experienced by persons giving birth. Following the terminology of medical health professionals, I call this type of injury “birth trauma.” As used in this article, “birth trauma” focuses not on injuries to the fetus or newborn child but on the harm caused to the individual giving birth, sometimes also referred to as “maternal birth trauma.”¹⁰¹ Compared to rape or racial trauma, there is less awareness of this kind of trauma, particularly in legal circles, although that has started to change in the last five to ten years. On the heels of a resurgence of the reproductive justice movement,¹⁰² we are witnessing the beginnings of a vigorous debate about the nature and extent of the problem, as well as discussions about potential tort liability and damages. This debate that will only intensify following the U.S. Supreme Court’s decision in *Dobbs v. Jackson Women’s Health Organization*,¹⁰³ overruling *Roe v. Wade*.¹⁰⁴

Although birth trauma can occur in situations where all medical professionals act reasonably and respectfully, the focus here is on birth trauma arising from what is known as “obstetric violence” or “obstetric mistreatment.”¹⁰⁵ A term first used by activists in Latin America, “obstetric violence” refers to the abuse and mistreatment of patients during labor and childbirth at the hands of physicians, nurses, and other medical personnel.¹⁰⁶ As one legal scholar observes, “it is clear the concept holds rhetorical power to help identify, condemn, and organize around the

101. In most instances, I use gender inclusive terminology to signal that birth trauma can affect transmen or non-binary persons who give birth. I refrain from referring exclusively to “women” or “mothers” giving birth, except when citing sources using gendered terms. Of course, despite the changing vocabulary, birth trauma remains a highly gendered phenomenon because most persons who give birth are women.

102. Mary Ziegler, *From Reproductive Rights to Reproductive Justice: Abortion in Constitutional Law and Politics* 287-90 in OXFORD HANDBOOK OF FEMINISM & LAW (Deborah L. Brake et al., eds., 2023).

103. 597 U.S. 215 (2022).

104. 410 U.S. 113 (1973).

105. There is a debate over whether to use the term “obstetric violence” or “obstetric mistreatment.” See Jonathan Herring, *Identifying the Wrong in Obstetric Violence: Lessons from Domestic Abuse*, in *CHILDBIRTH, VULNERABILITY AND LAW: EXPLORING ISSUES OF VIOLENCE AND CONTROL* 67, 68-69 (Camilla Pickles & Jonathan Herring eds., 2019) (shift in terminology from violence to mistreatment reflects a concern that “engaging with professionals may be problematic” if term “violence” is used).

106. Puerto Rico, Venezuela, Argentina, Brazil, and some Mexican states have passed criminal laws against obstetric violence. Alexa Richardson, *The Case for Affirmative Consent in Childbirth*, 37 BERKELEY J. GENDER, L. & JUST. 1, 5 (2022); Herring, *supra* note 105, at 70.

mistreatment of women in childbirth. It effectively conveys the seriousness of the harms experienced by women and connects such violations to other forms of violence.”¹⁰⁷

In 2015, the World Health Organization issued a statement recognizing the problem as an “important public health and human rights issue” and calling for the elimination of “disrespectful and abusive practices” in childbirth.¹⁰⁸ As more research has been conducted, it is now apparent that the problem is not limited to less-developed countries but exists in the U.S. as well. Indeed, one writer has recently described the U.S. as “the most dangerous place in the developed world to give birth.”¹⁰⁹

It is difficult to capture all the behaviors that fall under the heading of “obstetric violence,” and there is no agreed-upon definition of the problem. However, the taxonomy created by Elizabeth Kukura provides a starting point to describe the myriad forms that obstetric violence may take, leading to birth trauma. Kukura arrays the various practices along a “continuum of severity, ranging from less dramatic forms of subtle humiliation to coercion, unconsented clinical care, and more extreme instances of verbal and physical abuse.”¹¹⁰ Her three major, often overlapping, categories are (1) abuse in childbirth, (2) coercive treatment, and (3) disrespect.¹¹¹

The category of *abuse in childbirth* consists of the most serious violations, including forced surgeries (most often, forced cesarean sections and episiotomies), unconsented-to medical procedures (including labor induction, forceps-assisted delivery, and rupture of the membrane), as well as sexual violations and use of physical restraints to limit a birthing person’s ability to change positions or move during labor. In this category, Kukura also places non-physical conduct, such as the denial of pain relief and punishment, and hostile behavior that manifests itself in verbal attacks and “degrading put-downs” about patients’ “qualities as mothers” or their abilities to withstand pain. In the *coercive treatment* category, Kukura places the various tactics that have been used when a patient declines to follow medical advice, including threats to seek court orders, call in child welfare authorities, or withhold treatment. Finally, *disrespect* usually consists of patronizing and disrespectful comments, including being yelled at, ignored, or accused of being selfish. Although she regards this category

107. Elizabeth Kukura, *Obstetric Violence*, 106 GEO. L.J. 721, 764 (2018).

108. WORLD HEALTH ORG., THE PREVENTION AND ELIMINATION OF DISRESPECT AND ABUSE DURING FACILITY-BASED CHILDBIRTH, WHO/RHP 1, 3 (2015).

109. Jennifer Hickey, *Nature Is Smarter Than We Are: Midwifery and the Responsive State*, 40 COLUM. J. GENDER & L. 245, 245 (2020).

110. Kukura, *supra* note 107, at 728.

111. *Id.* at 721–22; *see also* Hickey, *supra* note 109, at 260–63 (summarizing Kukura’s taxonomy); *see generally* Herring, *supra* note 105 (discussing other taxonomies).

as less severe, Kukura observes that women who have experienced this type of mistreatment “talk about the violation of their dignity that comes from being treated as an object rather than a person” and recognizes that “[d]ehumanizing behavior on the part of maternity care providers is inappropriate, unprofessional, and can cause lasting harm to women.”¹¹² Added to the list in the post-*Dobbs* era, with its increased barriers to abortions and greater reticence by physicians to treat and offer advice to pregnant persons is the special trauma of “giving birth to a dead baby or being enlisted to cause [pregnancy] loss through bad advice about associated risks.”¹¹³

It is important to note that Kukura’s categories do not correspond to the familiar doctrinal categories found in tort law. She does not, for example, divide the behaviors into batteries, assaults, and negligence. Nor does she put physical and emotional harm into separate categories. Instead, Kukura’s categories are derived from the accounts and lived experiences of patients and are designed to paint an overall portrait of the mistreatment that occurs in perinatal care¹¹⁴ in the U.S. Like the descriptions of “hostile working environments” that feminists developed in the 1970s and 1980s to explain the scope and impact of sexual harassment in the workplace, Kukura’s taxonomy of obstetric violence makes visible the hostile medical environment that many patients encounter when they give birth in hospital settings.

To understand the magnitude of the problem, scholars have analyzed data from studies conducted in the past decade. Although the data on the prevalence of obstetric violence in the U.S. is more limited than it is internationally, one large study involving two thousand participants indicated that “28.1 percent of women birthing in the United States hospitals experienced mistreatment by providers during labor; rates were even higher for women of color.”¹¹⁵ Another study found that more than half of birth workers in the U.S. and Canada, including midwives, doctors, nurses, and doulas, had witnessed “the forcible performance of a procedure against a woman’s will, and two-thirds had witnessed providers *routinely*

112. Kukura, *supra* note 107, at 754.

113. Dov Fox & Jill Wieber Lens, *Valuing Reproductive Loss*, 112 GEO. L.J. 61, 83 (2023).

114. “Perinatal” care covers prenatal care and the period during and immediately following childbirth.

115. Richardson, *supra* note 106, at 15; see Saraswathi Vedam et al., *The Giving Voice to Mothers Study: Inequity and Mistreatment During Pregnancy and Childbirth in the United States*, 16:77 REPROD. HEALTH 1, 8 (June 11, 2019) (outlining the breakdown of rates of mistreatment as follows: Indigenous women (32.8%), Hispanic women (25.0%), Black women (22.5%), White women (14.1%)).

performing procedures without informed consent.”¹¹⁶ A third study covering the U.S., Canada, and Europe reported that one-third of birthing people reported being traumatized by their birthing experience, with most attributing their trauma to “care provider actions and interactions” rather than to the labor itself.¹¹⁷

The case law on obstetric violence is sparse. The few cases that have surfaced in the reporters and the media are extreme, most often involving physical harm.¹¹⁸ One case notable for its success and large recovery, *Malatesta v. Brookfield Baptist Medical Center*, involved the mistreatment of a woman who had chosen to give birth at the defendant’s center because of its professed commitment to “natural childbirth” and its willingness to allow mothers to move freely during labor and allow wireless fetal monitoring.¹¹⁹ When Malatesta arrived at the hospital, however, the nurses forced her onto her back, even though she argued with them and physically struggled to escape. They informed her that her doctor was not on call and then proceeded to hold the baby’s head for about six minutes after crowning to prevent delivery before the doctor arrived. As a result, Malatesta suffered permanent nerve damage and severe pain and discomfort in the pelvic region. A jury awarded her \$16 million.¹²⁰

Another successful claim was brought by a California woman who claimed that the physician delivering her baby ignored her refusal to consent to an episiotomy, a procedure that involves a surgical incision of the perineum, the area between the anus and the vulva. Suing for battery, the plaintiff alleged that her labor was progressing normally, and that no emergency required an episiotomy. While she was immobilized, however, the physician declared that he was going to do an episiotomy, ignored the plaintiff’s pleas to stop, and cut her perineum twelve times. Plaintiff’s mother videotaped the entire episode. After talking to over eighty lawyers reluctant to take the case, the plaintiff finally secured representation and convinced a court to allow her battery claim to proceed. The case eventually settled out of court. Four years after giving birth, the plaintiff

116. Kylea L. Liese et al., *Obstetric Iatrogenesis in the United States: The Spectrum of Unintentional Harm, Disrespect, Violence, and Abuse*, 28 ANTHROPOLOGY & MED. 1, 2 (2021).

117. Richardson, *supra* note 106, at 15.

118. Developments in the Law, *Intersections in Healthcare and Legal Rights*, Chapter 3: *The Legal Infrastructure of Childbirth*, 134 HARV. L. REV. 2209, 2218 (2021).

119. Ivey E. Best, *This Is My [D]oulas—[S]he’s [A]lso a [L]awyer*, 50 CUMB. L. REV. 175, 184–86 (2019).

120. *Id.* at 184–86, 210.

still suffered from its physical and emotional effects, including PTSD, depression, and anxiety.¹²¹

These two successes are rare. Advocacy groups, journalists, and researchers maintain that most cases never get filed, and that those that do face long odds.¹²² An example of an extreme case that met with only limited success involved a Staten Island woman who wished to have a vaginal birth after two prior cesarean births (VBAC), a recurring context in which patients risk mistreatment after declining medical recommendations.¹²³ A Hasidic Jew who wanted to have a large family, the plaintiff was aware of the increased risks of complications following each cesarean and sought out a hospital with a reputation for supporting VBAC. Once at the hospital, however, both the on-call obstetrician and the attending physician pressured the plaintiff to have a C-section despite her adamant refusal, threatening her with a court order and claiming that the state was going to take her baby away. Eventually, the doctors decided to override her lack of consent and perform the forced surgery. She alleged that the doctor performing the surgery was “rough . . . almost as if to punish” her and lacerated her bladder in the process.¹²⁴ The court, however, denied most of the relief plaintiff sought on varying grounds, allowing only the claim that defendant’s doctors breached their professional duty of due care in determining that a C-section was necessary and lacerating her bladder.¹²⁵

Despite such notable cases and the data suggesting that obstetric violence is not uncommon, it is difficult for many to believe that physicians and nurses, ostensibly dedicated to the well-being of patients, would act in a way to undermine their patients’ interests and cause harm, including birth trauma.¹²⁶ Lack of awareness and disbelief has been compounded by the fact that “[p]rior to the twenty-first century, obstetric violence was a largely closeted subject, and many women felt too ashamed to tell anyone about

121. Rebecca Grant, *Ethics of the Delivery Room: Who’s in Control When You’re Giving Birth?*, INDEPENDENT (Dec. 18, 2017), https://www.independent.co.uk/news/long_reads/childbirth-delivery-room-ethics-doctor-patient-healthcare-a8085346.html [<https://perma.cc/U6MJ-S276>] (discussing case brought by Kimberly Turbin); see also Kukura, *supra* note 107, at 734; Richardson, *supra* note 106, at 13.

122. Hickey, *supra* note 109, at 288 (discussing rights without a remedy); Maria T.R. Borges, *A Violent Birth: Reframing Coerced Procedures During Childbirth as Obstetric Violence*, 67 DUKE L.J. 827, 836–42 (2018) (discussing reluctance of courts to allow recovery).

123. *Dray v. Staten Island Univ. Hosp.*, 160 A.D.3d 614 (N.Y. App. Div. 2018).

124. See generally Developments in the Law, *supra* note 118.

125. *Dray*, 160 A.D.3d at 619.

126. Liese et al., *supra* note 116, at 9 (discussing the “obstetric paradox” of “causing harm by intervening in birth, supposedly to keep it safe”).

their childbirth experience.”¹²⁷ Although the silence has been broken with the emergence of advocacy groups and litigation,¹²⁸ an appreciation for the underlying systems of subordination at work and the systemic nature of the problem is often lacking.

Obstetric violence and attendant birth trauma dramatically illustrate the intersectional nature of systemic harm that implicates both gender and race. Feminist scholars have strenuously objected to the paternalism that still characterizes the doctor-patient relationship in the context of childbirth. What many regard as the overmedicalization of childbirth has reinforced a paternalism “model,”¹²⁹ with claims that “women often encounter authoritarian physicians unwilling to consider their expertise on their own bodies.”¹³⁰ Although there is no express exception to the doctrine of informed consent for persons giving birth, a recurring complaint is that the law has “fail[ed] to uphold informed consent”¹³¹ and that the “vast power differentiation between providers and patients often renders informed consent a legal fiction.”¹³²

Critics charge that the distortion of the doctrine of informed consent comes from the dynamics of what is known as the “two patients” issue in childbirth, requiring the physician simultaneously to treat the person giving birth and the fetus. As tort law has developed, however, physicians have a greater incentive to protect the fetus when they perceive a conflict or trade-off, encouraging physicians to practice defensive medicine. Research by Jaime Abrams has documented that courts tend to privilege the claims of fetuses over that of birthing persons, resulting in huge damage awards for harm to the fetus during the birthing process but few damage awards for harm to pregnant persons.¹³³ Not surprisingly, plaintiffs’ lawyers “aggressively advertise for fetal harm cases . . . [but] rarely take maternal harm cases.”¹³⁴ This has led scholars to characterize childbirth as a situation where the fetus has become the “dominant” patient, driving some doctors to label a woman as selfish or irresponsible for challenging their

127. Best, *supra* note 119, at 206–07.

128. Borges, *supra* note 122, at 828 (discussing the #BreaktheSilence campaign).

129. Kukura, *supra* note 107, at 775 (“[T]he medical profession has not shed the influence of the paternalistic model.”).

130. Colleen Campbell, *Medical Violence, Obstetric Racism, and the Limits of Informed Consent for Black Women*, 27 MICH. J. GENDER & L. 47, 49 (2021).

131. Developments in the Law, *supra* note 118, at 2214–15.

132. Campbell, *supra* note 130, at 49.

133. See Jamie R. Abrams, *Distorted and Diminished Tort Claims for Women*, 34 CARDOZO L. REV. 1955, 1992 (2013); see also Development in the Law, *supra* note 118, at 2215.

134. Best, *supra* note 119, at 209.

advice with respect to medical interventions designed to protect the fetus.¹³⁵ When combined with longstanding gendered expectations of maternal self-sacrifice, the conditions for creating a “persistent culture of violation of consent on the ground” are presented.¹³⁶ Additionally, tort law does little to shore up informed consent when it makes it exceedingly difficult for patients to sue for unnecessary surgeries or procedures, like cesareans or episiotomies, if the birthing parent leaves the hospital with a healthy baby. In many instances, “[t]he existence of a healthy baby is often used to deflect women’s claims of emotional harms suffered as a result of obstetric violence and birth trauma.”¹³⁷

There is a little dispute that low-income women and women of color are “disproportionately subject to coercive tactics” in childbirth¹³⁸ and that Black women are exposed to a very high rate of unnecessary C-sections with their associated health risks.¹³⁹ Moreover, recent research has documented persistent racial disparities in rates of C-sections, even accounting for numerous health and economic factors, such as insurance status, pre-pregnancy weight, maternal age, and education, indicating that it may be “racism, not race” that is the most salient risk factor.¹⁴⁰

These concerns of medical racism, including implicit bias, were crystallized in Serena Williams’s account of her childbirth trauma.¹⁴¹ Unlike many other Black women, Williams did not undergo an unnecessary C-section; instead, her complaints about her treatment centered on the care she received after the C-section was performed. While recovering in the hospital, Williams felt short of breath and urged her doctors to perform a CT scan and administer IV heparin (a blood thinner), given her history of blood clots. The nurse initially refused, believing that Williams was “confused” because of the pain medicine she was taking. The doctors first ordered an ultrasound, but when they finally acceded to Williams’s request for a CT scan, they discovered several small blood clots in her lungs. Additional serious complications developed over a six-day period, requiring more surgery and an extended stay in the hospital. Going public with her

135. Liese et al., *supra* note 116, at 6 (discussing verbal threats and narratives of mother blaming by physicians).

136. Richardson, *supra* note 106, at 6; Borges, *supra* note 122, at 853–54.

137. Kukura, *supra* note 107, at 785.

138. Hickey, *supra* note 109, at 262.

139. Campbell, *supra* note 130, at 62.

140. *Id.* at 60–65. There is also a racial disparity in maternal morbidity rates, not explained by education.

141. This account is taken from Rob Haskell, *Serena Williams on Motherhood, Marriage, and Making Her Comeback*, VOGUE (Jan. 10, 2018), <https://www.vogue.com/article/serena-williams-vogue-cover-interview-february-2018> [<https://perma.cc/3QBK-AA6U>].

story, Williams described how she felt depressed for months after the birth, with feelings of anger, guilt, and sadness.

Serena Williams's story has resonated with women of color, offering the "lesson" that if such a celebrated, affluent Black woman could experience a near lethal and traumatic birth, Black women would be wise to "navigate pregnancy as potentially deadly terrain."¹⁴² Perhaps most telling was the reluctance of the medical personnel to credit Williams's account of what she was experiencing in her own body, particularly given her status as a preeminent athlete. Her account has led writers to theorize that the obstetric violence facing women of color is distinctive, implicating racialized stereotypes of Black persons as impervious to pain and causing some physicians and nurses to de-humanize their patients and "display[] apathy to Black women's physical pain and trauma."¹⁴³

That obstetric violence is embedded in systems of gender and racial subordination has led scholars to theorize that to fully capture the wrong that occurs, it is best to view obstetric violence "not as a one off incident or set of incidents, but rather as an on-going relationship of control."¹⁴⁴ Similar to the dynamic of domestic violence, "coercive control pervades the doctor-patient relationship," where "coercion and violence are used to enforce compliance with the provider's or the institution's wishes."¹⁴⁵ Parallels to rape are also often drawn by patients who experience non-consensual procedures during childbirth, with its invasion of intimate parts of the body and feelings of powerlessness.¹⁴⁶ For critical race theorists, obstetric violence is viewed as a contemporary form of racial exploitation of Black women's bodies, rooted in a long history of rape of enslaved women, sterilization abuse, and coercive experimental birth control therapies.¹⁴⁷ This theorization of obstetric violence as intersectional harm ties it to the systems of sexual and racial subordination discussed above relating to rape trauma and racial trauma, but like other intersectional harms, birth trauma affects childbearing persons in distinctive ways that are not just a sum of mistreatment based on sex and race.

The connection between obstetric violence and birth trauma is a close one. Although some experiences of childbirth can be traumatic in the absence of obstetric violence, qualitative studies of women's experiences of traumatic birth identify "interactions with care providers as a more

142. Campbell, *supra* note 130, at 49.

143. *Id.* at 73.

144. Herring, *supra* note 105, at 71–74.

145. Richardson, *supra* note 106, at 11.

146. Best, *supra* note 119, at 188; Herring, *supra* note 105, at 81–82.

147. Campbell, *supra* note 130, at 50.

important factor than medical intervention or type of birth.”¹⁴⁸ What women often describe as “traumatic” during childbirth is a lack of control fueled by disregard for their wishes and dismissal of their “embodied knowledge” about what is happening to them.¹⁴⁹ Some experience it as “violating,” with a lack of control associated with “a sense of violation.”¹⁵⁰ In this respect, what lawyers might call a lack of informed consent forms an important part of what laboring people experience as traumatic. Because giving birth is a moment of “intense vulnerability” in which patients have “limited mobility by virtue of pregnancy or labor contractions or [may] be fully immobilized by anesthesia, though still perfectly conscious,”¹⁵¹ it is not difficult to see how abuse, coercion, or other mistreatment by care providers in this special context would produce trauma. The erosion of trust in the patient/provider relationship can damage birthing persons’ perceptions of their experience and cause “a particular harm to the self,”¹⁵² not unlike the identity-altering experience described by rape victims.¹⁵³

The birth trauma experienced by laboring persons overlaps with PTSD, but the two are not identical. Some traumatic birth experiences fit within the DSM definition of trauma, but many others do not. According to two researchers, labor and delivery qualify as “stressors” under Criteria A of the DSM criteria because they arguably expose the person to “threatened death” or “serious injury,” and birthing persons may also be firsthand “witnesses” to the death or threatened death of their child.¹⁵⁴ Thus, unlike racial trauma, childbirth and delivery is a sufficiently “physical” event to ground a diagnosis of DSM. However, the same researchers indicate that only three to four percent of women develop the “full constellation of symptoms” of PTSD to qualify for a clinical diagnosis. The disparity between the 3-4% figure and nearly one-third of birthing women reporting being traumatized by childbirth is explained by the finding that a substantial number of women suffer from “clinically significant PTSD symptoms, even though their symptoms remain below the diagnostic threshold.”¹⁵⁵

148. Rachel Reed et al., *Women’s Descriptions of Childbirth Trauma Relating to Care Provider Actions and Interactions*, 17 BMC PREGNANCY & CHILDBIRTH 1, 2 (Jan. 10, 2017).

149. *Id.* at 4 (discussing disregard of “embodied knowledge”).

150. *Id.* at 5.

151. Richardson, *supra* note 106, at 10.

152. Herring, *supra* note 105, at 75.

153. Martha Chamallas, Lucky, *The Sequel*, 80 IND. L.J. 441, 467–71 (2005) (discussing rape victims’ trauma as “life altering” and effecting a change in identity).

154. Antje Horsch & Susan Garthus-Niegel, *Posttraumatic Stress Disorder Following Childbirth*, in *CHILDBIRTH, VULNERABILITY AND LAW: EXPLORING ISSUES OF VIOLENCE AND CONTROL* 51 (Camilla Pickles & Jonathan Herring eds., 2019).

155. *Id.* at 52.

It may be that as more is written and understood about birth trauma, clinicians will begin to diagnose more cases of PTSD. There is ample research documenting that birthing persons experience intrusive symptoms, including perceiving the role of caregiver for their newborns as “a strong reminder of the traumatic event.”¹⁵⁶ Particularly, birthing persons with a history of sexual assault are likely to experience obstetric violence as violating and as a trigger for re-experiencing the prior assault.¹⁵⁷ Additionally, patients traumatized during childbirth often exhibit avoidance symptoms, become fearful of having another baby, and avoid “all associations with the birth.”¹⁵⁸ Finally, the accounts of the postpartum difficulties mothers face caring for their newborns, including depression, feelings of inadequacy, panic, anxiety, and guilt, are familiar, although they may not often be characterized as the negative alterations to cognition or alterations of arousal and reactivity necessary to sustain a PTSD diagnosis.¹⁵⁹

Even if birth trauma does not qualify as PTSD under current standards, the medical evidence indicates that it constitutes a real, widespread, and serious injury and counsels that trauma traceable to obstetric violence and mistreatment should find a remedy in tort law. Indeed, plaintiffs’ attorneys may be inclined to take on such cases because plaintiffs in birth trauma cases can to frame their cases as medical malpractice or medical negligence cases, with the consequence that they are covered by defendants’ liability insurance, unlike the intentional torts claims for rape or racial insults that often fall within the “intentional-acts exclusion” in insurance policies.¹⁶⁰ Not unlike the reforms in the law governing consent in sexual assault cases, however, plaintiffs in obstetric violence cases may first need to convince courts and medical professionals that the doctrine of informed consent should be more vigorously enforced and, in some cases re-imagined, to provide fuller protection in the context of childbirth. One writer, for example, has advocated for adopting an affirmative consent standard in the childbirth context.¹⁶¹ Moreover, recognizing obstetric violence and birth trauma presents yet another challenge to the physical/emotional dichotomy that often stymies tort plaintiffs from recovering from verbal abuse and mistreatment. When abuse occurs in the undeniably “physical” experience

156. *Id.* at 51.

157. Reed et al., *supra* note 148, at 6.

158. Kukura, *supra* note 107, at 756; Horsch & Garthus-Niegel, *supra* note 154, at 55.

159. Horsch & Garthus-Niegel, *supra* note 154, at 55.

160. Cardi & Chamallas, *supra* note 8, at 641–45.

161. Richardson, *supra* note 106.

of childbirth and causes traumatic injury, it is inappropriate to categorize it as mere emotional distress, distinct and inferior to physical harm.

What is notable about each of the three contexts examined in this article is that the recognition of trauma functions not only to describe the harmful consequences of certain wrongs but also helps illuminate the systemic nature of those wrongs. The connection between rape, chronic racism, and obstetric violence, on the one hand, and trauma, on the other, is co-constitutive, revealing that the divide between a wrong and injury/damages is not nearly as clear-cut as tort doctrine would have us believe.

IV. TRAUMA LESSONS

Coming to terms with trauma requires adjustments to tort doctrine and re-evaluating the theoretical lenses we use to understand and criticize substantive and remedial law. Of the many potential insights one could draw from studying traumatic injury,¹⁶² my analysis of the three contexts examined in this article drives home three important lessons. First, trauma defies classification as either a physical or emotional injury yet is grievous enough to justify full recovery for damages sustained as a result of it. Second, the pervasiveness of trauma, particularly among vulnerable groups, requires a recommitment to the eggshell plaintiff doctrine and the idea behind it. Third, to appreciate trauma and its potentially important role in tort law requires a social justice lens that considers systemic forms of injustice in the larger society.

Appreciating the nature of trauma makes it evident that it is futile to insist on a rigid classification of traumatic injury as physical or emotional. Perhaps more so than other injuries, trauma lies at the intersection of the physical and emotional, stemming from a critical event or events that may either be physical, like death or sexual assault, or emotional, like long-term neglect or deprivation. The symptoms and consequences of trauma are likewise a mixture of the physical and emotional, from changes to the brain, blood pressure, and hormonal activity to hyperactivity, depression, and feelings of detachment or self-blaming. Although the DSM definition of PTSD, as we have seen, does not cover all forms of trauma relevant to tort law, it does provide a kind of template for understanding the complexity and seriousness of traumatic injury. Alleging that a plaintiff's symptoms track at least some of the classic PTSD symptoms can go a long way toward

162. For example, that psychiatric categories or diagnoses are not simply a product of objective science but are also bound up in culture or that both intentional and negligent actors can inflict traumatic injury.

proving the severity of the injury and calling attention to the quality of the defendant's actions that might have caused such a reaction. Although one can imagine providing generous recoveries to tort victims while still classifying trauma as pure emotional harm, treating trauma as a distinctive injury works against the minimization of the harm and echoes the language of victims who have experienced the harm. Overall, a nuanced understanding of trauma has the potential to upend the outmoded physical/emotional distinction in tort law and create a more secure basis for compensation for seriously injured tort victims.

Additionally, studying trauma exposes the truth that many (if not most) individuals are vulnerable, and that tort law should not ignore those vulnerabilities. As feminist theorist Martha Fineman has famously maintained, all individuals are vulnerable in the sense that they are in a constant state of possible harm (from injury, catastrophe, or misfortune) and are always at risk of becoming dependent (from disease, natural disasters, or economic or institutional crises).¹⁶³ In my view, the venerable eggshell plaintiff rule is not just a simple rule about proximate cause or damages. Instead, the eggshell plaintiff doctrine represents an ideal of individualized justice, requiring a response that fits the needs of the particular victim—vulnerabilities and all. Once the widespread incidence of trauma is revealed, the invocation to “take the plaintiff as you find him” takes on a new meaning. It can be seen as a fundamental principle that sets the basic terms of human interaction, requiring that actors take account of others’ “relevant personal qualities, including their distinctive characteristics and circumstances.”¹⁶⁴

Moreover, reinvigorating the eggshell plaintiff rule would require defendants to internalize more of the costs of injuring vulnerable persons, no longer allowing them to assume that injuring low-income, minority, or marginalized victims will translate into lower recoveries.¹⁶⁵ Of course, it is also possible that recognizing trauma will just tempt courts to dilute the eggshell plaintiff rule by carving out more exceptions, as we have seen in emotional harm cases where recovery is limited to instances where an

163. See generally Martha Albertson Fineman, *The Vulnerable Subject: Anchoring Equality in the Human Condition*, 20 YALE J. OF L. & FEMINISM 1 (2008) (developing the concept of vulnerability).

164. Hanoch Dagan & Avihay Dorfman, *Just Relationships*, 116 COLUM. L. REV. 1395, 1417 (2016).

165. See Martha Chamallas, *Civil Rights in Ordinary Tort Cases: Race, Gender, and the Calculation of Economic Loss*, 38 LOY. L.A. L. REV. 1435, 1458 (2005); Tsachi Keren-Paz, *An Inquiry into the Merits of Redistribution Through Tort Law*, 16 CAN. J.L. & JURIS. 91, 94–95 (2003) (explaining why it is cheaper to harm poor victims rather than rich victims).

“ordinary” or “normal” person would also suffer serious harm.¹⁶⁶ In my view, however, fully recognizing trauma requires a recommitment to the eggshell plaintiff rule and a willingness to extend more generous tort recoveries beyond the usual class of affluent victims who suffer measurable economic loss.

Finally, trauma and the damage it inflicts are more readily apparent through a social justice lens. It is no coincidence that trauma plays a central role in contemporary social justice movements and that the three contexts of trauma examined in this article only became visible in part because of such social movements. A social justice approach encourages us to untangle the systemic bias woven into the rules and remedies of tort law and can point us toward ameliorating doctrines that connect to people’s lives in concrete ways that take into account, rather than bracket out, the social context surrounding their injuries. One social justice theory tenet is that the compensatory ideal of tort law—the notion of making persons whole—cannot be extricated from the social inequalities and systemic forms of injustice in the larger society.¹⁶⁷ Although trauma affects individuals, often in individualized ways, we can only grasp its full force if we can see the larger picture, whether we are a Vietnam vet, a rape survivor, a target of racial attacks, or a person giving birth in a maternity ward.

166. Or worse yet, it is possible that increased reliance on the eggshell plaintiff rule could backfire and serve mainly to normalize the white male affluent standard, labeling all others as vulnerable and (arguably) inferior. Such a risk, however, is always present with progressive interventions into the law that recognize difference and attempt to provide accommodations.

167. Chamallas, *supra* note 4, at 315.