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In tort lawsuits, plaintiffs may seek damages for loss of enjoyment of life, so-called hedonic loss, which occurred as a result of an accident or injury. In 2 studies, we examined how people judge others’ adaptation and hedonic loss after an injury. Laypeople’s forecasts of hedonic loss are relevant to concerns about whether jurors appropriately compensate plaintiffs. Longitudinal data of subjective well-being (e.g., Binder & Coad, 2013) show that hedonic loss is domain-specific: Many physical impairments (e.g., strokes) inflict less hedonic loss than many persistent yet invisible ailments (e.g., mental illness and conditions that cause chronic pain). We used vignette methodology to determine whether laypeople (n = 68 community members and 65 students in Study 1; 87 community members and 93 students in Study 2) and rehabilitation professionals (n = 47 in Study 2) were aware of this fact. In Study 1, participants’ ratings of hedonic loss subsequent to a physical injury and a comparably severe psychological impairment did not differ. In Study 2, ratings of short- and long-term hedonic loss stemming from paraplegia and chronic back pain showed that neither laypeople nor professionals understood that hedonic loss is domain-specific. These findings imply that observers may forecast a future for people who suffered serious physical injuries as grimmer than it is likely to be, and a future for people who experience chronic pain and psychological disorders as rosier than is likely.

Keywords: affective forecasting, hedonic adaptation, hedonic damages, jury decision making

In tort lawsuits, people who sustain injuries can recover for losses that they are unable to quantify. These noneconomic damages compensate for pain and suffering, disability, disfigurement, and loss of enjoyment of life. This article focuses on judgments about lost enjoyment of life, often referred to as hedonic loss, by laypeople and by professionals who treat injury victims.

Hedonic damages are intended to compensate for hedonic loss, the reduced ability, as a result of an injury, to find pleasure in the normal activities of life, including practical activities like eating and shopping, cognitive and emotional activities, interpersonal and leisure pursuits, and occupational tasks (Berlá, Andrews, & Berlá, 1999). They are distinct from damages for pain and suffering that compensate for physical and emotional discomfort caused by the injury itself (Boan v. Blackwell, 2001). Damages for hedonic losses can be claimed by people who were injured and by those close to them who were deprived of a relationship or services provided by the injured or deceased person.

To our knowledge, only two empirical studies have examined how jurors determine damages for hedonic losses. Poser, Bornstein, and McGorty (2003) showed that when mock jurors were instructed to make separate awards for hedonic loss and pain and suffering, resulting noneconomic damage awards were larger than when participants awarded a single sum for both, a finding confirmed by Gregory and Winter (2011). These results suggest that hedonic loss represents a fuzzy concept to laypeople, which makes it difficult to assess and quantify.

Our research asks a different question about how people determine hedonic losses. We focus on the possibility that jurors’ judgment of hedonic loss and subsequent assignment of damages is fraught with error because laypeople lack awareness of how others adapt, emotionally, to injuries and illness. So our studies explore how laypeople and professionals who work with injured patients determine the extent of hedonic loss in various injury scenarios. There is reason to suspect that laypeople, at least, may do poorly. According to legal scholar Cass Sunstein (2008), hedonic losses are often exaggerated because many injuries inflict less hedonic damage than observers (i.e., jurors) anticipate. Sunstein dubbed these “illusory losses.” On the other hand, hedonic losses can also be undervalued because other sorts of injuries inflict more hedonic damage than observers expect. Sunstein termed these “enduring losses.” He contended that unless the legal
system distinguishes between “harms that impose enduring losses, such as chronic pain and mental illness, and harms that do not, such as losses of fingers and toes” (p. S158), tort cases will be rife with errors.

There is support for these concerns. Empirical studies have shown that people can adapt affectively to very severe injuries such as spinal cord damage (e.g., Krause, 1992). But laypeople lack the ability to predict future emotional states (Igou, 2008), which suggests they may be unaware of this fact and, as a result, overestimate hedonic losses associated with serious injuries. Yet other studies have shown that people cannot adapt well to conditions that cause chronic pain (e.g., Shields & Wheatley Price, 2005) and to certain degenerative illnesses (e.g., Smith & Wallston, 1992). Lacking the ability to forecast affective states, laypeople might underestimate the long-term effects of these conditions on subjective well-being. Bagenstos and Schlinger (2007) suspect that plaintiffs’ lawyers capitalize on this fact by highlighting the great distance between a “normal” life and their clients’ “disabled” lives.

The present research uses vignette methodology to examine estimations of hedonic loss. We ask whether laypeople misappraise hedonic loss in a manner consistent with Sunstein’s (2008) assertions. The answer to this question has relevance to the size and predictability of jury damage awards for hedonic loss. We also examine how rehabilitation professionals who treat injury sufferers and are arguably better positioned to understand variability in hedonic adaptation, assess hedonic loss.

Before we describe our studies, we tackle two important questions: To what extent can injury victims adapt hedonically to different types of injuries, and to what extent can laypeople and professionals predict others’ emotional reactions, initially and over time? To answer these questions, we review studies on affective adaptation postinjury and illness, including theoretical explanations of how and why some people adapt emotionally to their changed circumstances and others do not. We also describe the research on affective forecasting that examines laypeople’s and experts’ abilities to forecast emotional reactions and adaptation to life-changing events. This will set the stage for our studies on how laypeople (in Study 1) and both laypeople and rehabilitation professionals (in Study 2) forecast hedonic loss.

Can People Adapt Affectively to Illness and Injury?

Affective adaptation occurs when the emotional response to an injury or illness fades and a person gradually regains a preinjury or preillness level of contentment. An early example of hedonic adaptation came from research by Brickman, Coates, and Janoff-Bulman (1978); one year after sustaining a serious injury, paraplegics, though not as happy as a control group, still rated their happiness at above the midpoint of the scale and anticipated that they would attain a level of happiness comparable with that of the control group in the future. More recently, studies have shown that despite variability in the extent and time course of adjustment (Stanton, Revenson, & Tenn, 2007), people can adapt hedonically to a variety of physical conditions including paraplegia (Schulz & Decke, 1985), quadriplegia (Wortman & Silver, 1987), amputation (Horgan & MacLachlan, 2004), severe burns (Patterson et al., 1993), heart disease (Wu, 2001), locked-in syndrome (Bruno et al., 2011), and kidney disease (Riis et al., 2005).

A prototypical study was conducted by Riis et al. (2005) questioning 50 dialysis patients and 50 healthy controls about the global moods and specific emotions they experienced in a typical week. Both groups reported that their moods were generally positive for the majority of waking hours. There were no differences in reports of the extent to which they experienced happiness, frustration, anger, depression, and joy. Life satisfaction levels were comparable and although dialysis patients reported their health as being much worse than did healthy controls, they did not consider themselves to be less happy.

A number of studies examined the reasons that people are able to return (approximately) to preinjury and preillness levels of happiness. Across the board, these studies show that the emotional impact of an event dampens with time as people habituate to their new circumstances (Brickman et al., 1978), alter their activities and adjust their aspirations (Easterlin, 2003; Menzel, Dolan, Richardson, & Olsen, 2002), or reduce their focus on the life-changing event itself (Frederick & Loewenstein, 1999). As Sunstein (2008) noted, what once may have seemed a serious hedonic loss “often becomes part of life’s furniture” (p. S169). Other research shows that after enduring inexplicably negative events, victims strive to reappraise the situation to find meaning in their experiences (Park, 2010) which leads them to realize some benefit from their distress (Tenn, & Affleck, 2002). An overarching model of affective adaptation suggests that people show intense affective reactions to unexplained events that they then attempt to explain or understand. If successful, they adapt to and attend less to these events (Wilson & Gilbert, 2008).

Importantly though, studies showing broad levels of affective adaptation used cross-sectional data, and without information on participants’ previous levels of well-being, their conclusions can be called into question. The more useful studies employ longitudinal data, tracking the reported life-satisfaction levels of individuals before and after they became disabled. These studies, described next, show that for many people, subjective well-being improves with time after the onset of a disability, but does not completely rebound.

Oswald and Powidhvee (2008) analyzed responses to the British Household Panel Survey in which, since 1966, individuals rated their psychological well-being and reported whether and to what extent they suffer from a disability. Among people who became disabled over the course of the study, ratings of happiness on a 7-point scale, where larger numbers indicate greater life satisfaction, were 4.8 for the two years preceding disability, 3.7 at the onset of the disability, and 4.1 for the two years following onset. The researchers distinguished between people with moderate and severe disabilities and showed approximately 50% adaptation in the former and 30% adaptation in the latter. Findings from a nationally representative sample of Australian adolescents and young adults who became disabled over the course of a 7-year study (Emerson, Kariuki, Honey, & Llewellyn, 2014) support the conclusion that many people adapt, hedonically, to disability, but some do not: Sixty-nine percent of participants reported high and stable levels of subjective well-being after the onset of disability, and 22% reported reduced levels of well-being. Finally, analyzing the British data set with a different measure of disability, Lucas (2007) found only partial adaptation in disabled individuals who were followed for five to seven years postinjury. His data showed, for example, that participants’ distress levels increased by 0.24
points on a 4-point scale following onset of a disability, but dropped to 0.15 points above baseline four years after onset.

The fact that the studies using longitudinal data showed incomplete adaptation is worthy of further consideration. Bronsteen, Buccafusco, and Masur (2008) speculate that one reason that studies did not indicate higher levels of adaptation was because they did not distinguish between disabilities to which people can readily adapt, at least in the long run, and those to which they cannot. This distinction points to an important caveat in the data on hedonic adaptation. Although people can adapt to certain life-changing physical impairments, their adaptation to other adverse events, particularly psychological conditions and chronic pain—both of which result in persistent reminders but are largely invisible to observers—is far less likely (Dolan, 2011; Swedloff & Huang, 2010).

Various studies document the negative effects of health conditions such as chronic pain and anxiety on subjective well-being. Shields and Wheatley Price (2005) discovered persistently low levels of psychological well-being in migraine sufferers, and Graham, Higuera, and Lora (2011) found that even after controlling for variations in optimism, individuals experiencing chronic pain and anxiety were significantly less happy than those suffering severe physical impairments. Degenerative conditions such as rheumatoid arthritis (e.g., Smith & Wallston, 1992) and multiple sclerosis (e.g., Antonak & Livneh, 1995), both of which result in depression and anxiety in many patients, are also resistant to hedonic adaptation.

A longitudinal study reached a similar conclusion. Binder and Coad (2013) examined subjective well-being across more than 100,000 observations of approximately 10,000 individuals in the British Household Panel Survey between 1996 and 2006, assessing, among other things, patterns of adaptation for different health conditions. The survey tapped individuals’ assessments of their health during the previous 12 months and the presence of specific health conditions and impairments. Analyses showed clear variation in adaptation by the type of impairment, with anxiety, depression, and other mental illnesses leading to greater reductions in subjective well-being than stroke, and stomach, chest, and heart problems.

Pondering the failure to adapt to persistent and enduring ailments, Binder and Coad (2013) suspect that the uncertainty associated with some impairments, including the inability to anticipate the next headache or anxiety attack, may hinder adaptation. Sunstein (2008) speculates that apprehension about whether a condition has stabilized and when further deterioration will occur—as is likely in degenerative illnesses—may explain failure to adapt to certain conditions.

Data showing that people can adapt hedonically to some conditions but not to others should temper the assertion that laypeople routinely overestimate hedonic loss. Rather, they suggest that because hedonic adaptation is domain-specific, laypeople may actually underestimate the hedonic effects of enduring ailments like pain and depression because they are common, easy to imagine, likely to be experienced by many people albeit in mild form, and often hidden from view (Sunstein, 2008). Presumably, professionals with experience assessing and treating individuals post-injury would be aware that adaptation varies by injury type, and neither overestimate the impact of serious physical injuries nor underestimate the effects of persistent, enduring conditions on future enjoyment of life.

Can People Predict Future Emotional States?

Affective forecasting is the ability to predict the emotional impact of future experiences. Data show that people are generally poor predictors of how they or others would feel after experiencing a life-changing circumstance and suggest that laypeople will overestimate how much and for how long one’s emotional well-being will be affected by an accident or illness. Will those with professional expertise do the same?

Although people can anticipate fairly well the valence of emotions they are likely to experience in the future, they are generally poor predictors of the intensity and duration of those feelings (Wilson & Gilbert, 2005). People are also poor predictors of the intensity and duration of others’ future emotional states and are likely to overestimate the duration of negative affect experienced by others as compared to themselves (Igou, 2008). Healthy people generally predict that disabled people will have diminished happiness for a longer period of time than they actually do (e.g., Ubel, Loewenstein, & Jepson, 2005).

One explanation of errors in prediction is the focusing illusion (Schrade & Kahneman, 1998). When asked to predict emotional reactions to a particular change in life circumstances, people focus excessively on the narrow aspects of life that are affected by the event and not on the many ways that one’s life will not change: “When people are asked to think about the effect paraplegia would have on their lives, they tend to focus on the limitations it would create rather than, say, their unaltered ability to enjoy a glass of wine” (Bronsteen et al., 2008, p. 1533). Further, when evaluating the happiness of a person who has become paralyzed, people have a tendency to focus on the experience of becoming paralyzed rather than on the state of being paralyzed. More generally, they tend to focus on the early stages of adapting to change—the time when hedonic reactions may be most intense—and tend not to realize that after a period of time, adaptation can occur.

Closely related to focalism is the phenomenon of “immune neglect,” the failure to anticipate the ability of one’s psychological immune system to counteract the negative effects of adverse experiences (Gilbert, Pinel, Wilson, Blumberg, & Wheatley, 1998). Through a series of cognitive processes, people can transform their reactions to adverse events, becoming less susceptible to negative emotions and allowing more positive emotions to prevail. Forecasters tend to be unaware of such tendencies.

Another reason that people mispredict future emotional states is that they lack familiarity with the emotional experience in question. As Blumenthal (2004) notes, lottery winners hit the jackpot only once, so they, like others who experience once-in-a-lifetime sorts of events, have no repository of past knowledge and reactions to fall back on. Forecasts of their future emotional states occur largely in a void, without useful information on which to rely.

There are reasons to suspect that people with relevant expertise (in our research, rehabilitation professionals) might be immune from these biases. First and most simply, they have undoubtedly seen patients rebound emotionally from serious injuries and illnesses to regain a sense of pleasure and happiness within their lives. This should help them avoid the focalism problem. In addition, when people in a laboratory setting think about how the
experience of paraplegia changes over time or how to enhance emotional reactions to a disability, their paraplegia-related quality of life ratings increase (Ubel et al., 2005). Finally, reminding people that negative injury experiences will fade from one’s thoughts makes affective forecasts more accurate (Wilson, Wheatley, Meyers, Gilbert, & Axsom, 2000). Clinicians often provide patients with these kinds of reframes, so they should be less susceptible to immune neglect.

So what can we expect about laypeople’s and professionals’ ability to forecast hedonic losses and adaptation? Both groups probably know that the impact of injuries and illnesses diminishes over time. But the concept of long-term hedonic adaptation, especially to serious conditions, may be counterintuitive to laypeople though understood by professionals. Affective forecasting errors may further diminish laypeople’s ability to gauge future emotional well-being in others, but may have less deleterious effects on professionals. Thus, we suspect that when estimating long-term hedonic loss, laypeople and professionals will respond differently to distinct kinds of injuries.

The Current Studies

In Study 1, we examined laypeople’s awareness of hedonic adaptation by assessing what they believe about the impact of physical and psychological injuries on a victim’s well-being. In Study 2, we assessed judgments of lost enjoyment of life as a result of paralysis (an illusory loss) and back pain (an enduring loss) by laypeople and rehabilitation professionals. Our primary focus is on how these groups judge others’ well-being and adaptation post-injury. Because we lack objective measures of adequate compensation, we only tangentially address the size and accuracy of hedonic damage awards.

Study 1

In this study, we ask how laypeople think about hedonic adaptation in response to physical and psychological impairments of approximately equivalent severity. We examine how they rate hedonic loss subsequent to a visible physical injury and a comparably severe but largely invisible psychological injury. Obviously, it is difficult to find physical and psychological injuries of comparable severity, given the subjective nature of this perception (Vallano, 2013) and the fact that physical injuries can have psychological sequelae and vice versa. Thus, we used scenarios developed by Andrews (1993) and employed by Andrews, Meyer, and Berlá (1996) to ascertain mental health professionals’ ratings of the lost enjoyment of life experienced by people suffering from various injuries. We selected scenarios that depicted two types of primarily physical injuries and two types of primarily psychological injuries, with one of each type involving an injury that mental health professionals rated as causing moderate long-term hedonic loss and the other as causing mild long-term hedonic loss.

If laypeople are aware that hedonic adaptation is domain-specific, they would forecast fewer losses and limitations in response to physical injuries to which people can more readily adapt than to psychological injuries to which people can less readily adapt. In other words, accurate understanding of hedonic adaptation should lead to assessments of greater loss of well-being, enjoyment, and opportunity subsequent to an enduring psychological injury than to a comparably severe but illusory physical injury. But various errors in affective forecasting impair laypeople’s ability to forecast hedonic losses, which leads to the following hypotheses:

1. Participants will rate loss of enjoyment of life as greater following a physical injury than a comparably severe psychological injury
2. Participants will rate loss of future opportunities as greater following a physical injury than a comparably severe psychological injury
3. Participants will estimate a longer timeframe to return to normal functioning following a physical injury than a comparably severe psychological injury

Although we expected higher ratings of hedonic loss in the moderate than the mild loss scenario, given the novelty of this subject area it was unclear whether that effect would hold for both physical and psychological injuries. Thus, we had no specific hypotheses regarding interactions.

Method

Participants. One hundred thirty-three individuals participated, including 68 community members and 65 students at a mid-sized university. Participants ranged in age from 18 to 81 and all were fluent in English, consistent with the requirements for jury service in many jurisdictions. Community members were contacted at a farmers’ market or while waiting near a bus stop and were asked to volunteer. They were not compensated monetarily. Students received extra course credit for participating.

Design and procedure. Participants were randomly assigned to one condition of a 2 (Primary Injury Type: physical, psychological) × 2 (Extent of Long-term Hedonic Loss as rated by mental health professionals: mild, moderate) between-subjects design. After providing informed consent, they read a vignette that described an individual who had been injured in the past and whose condition had now stabilized. Then they answered several questions about the impact of the injury on the victim and about recovery time, after which they were thanked and debriefed.

Materials.

Vignettes. Two vignettes (one involving primarily physical injuries and the other primarily psychological injuries) depicted injuries that mental health clinicians in Andrews et al.’s (1996) study rated as causing mild long-term loss. The physical injury scenario depicted a woman who was attacked by and fell off a horse, suffered a bulging disk and shoulder infection, and required several surgeries. The psychological injury scenario depicted a woman who became terrified of sudden loud noises and highly anxious about incurring an injury after being struck in the face by a projectile from a machine she operated in a factory.

Two vignettes depicted injuries that clinicians rated as causing moderate long-term loss. The physical injury scenario depicted a woman who was involved in a car accident in which she sustained a head injury as well as broken ribs, clavicle, and scapula, and was hospitalized for two months. The psychological injury scenario depicted a woman who became depressed and suicidal after sus-
taining injuries to her knee that aggravated a preexisting back problem and led to abuse of pain medications and alcohol.

In Andrews et al.’s (1996) study, the vignettes described women aged 34 (physical injury-mild loss) and 33 (psychological injury-mild loss), and men aged 38 (psychological injury-moderate loss) and 71 (physical injury-moderate loss), but to control for the effects of age and gender, we depicted each injury-sufferer as a 44-year-old woman who had reached maximum medical recovery. We consider the implications of this choice in the Discussion. The vignettes were between 110 and 133 words.

**Questionnaire.** We asked four questions about the impact of the injury: to what extent it impaired the victim’s physical well-being, to what extent it impaired her emotional well-being, to what extent it limited her future enjoyment of life, and to what extent it limited her future opportunities. Responses were recorded on a 7-point Likert scale from 1 (not at all) to 7 (extremely). We also asked “in how many months or years will she return to her original level of happiness?” Using a fill-in-the-blank format, respondents could answer with a number of months, years, a combination thereof, or could answer “never.”

**Results**

After determining that responses to questions about limitations in future enjoyment of life and future opportunities—the variables of prime interest—did not differ significantly between the community and student samples (ps > .53, two-tailed), we combined the samples in all subsequent analyses. We used a series of 2 (Primary Injury Type: physical, psychological) × 2 (Extent of Long-Term Hedonic Loss: mild, moderate) factorial ANOVAs to analyze the data. Missing data were deleted pairwise. Effect sizes are Cohen’s D (d) and eta squared (η²); all eta squares are partial.

The questions concerning impairment to physical and emotional well-being served as manipulation checks. The manipulations were successful; ratings of physical impairment were significantly higher in the physical injury scenarios (M = 5.75, SD = 1.12) than in the psychological injury scenarios (M = 5.08, SD = 1.19), F(1, 129) = 10.42, p = .002, d = .59, 95% CI [0.24, 0.94], and in response to injuries that clinicians rated as leading to moderate hedonic loss (M = 5.73, SD = 1.02) than to injuries rated as involving mild loss (M = 5.12, SD = 1.29), F(1, 129) = 8.61, p = .004, d = 0.53, 95% CI [0.18, 0.87]. Conversely, ratings of emotional impairment were higher in the psychological injury scenarios (M = 5.78, SD = 0.92) than in the physical injury scenarios (M = 5.45, SD = 1.17), F(1, 129) = 4.35, p = .04, d = 0.31, 95% CI [-0.03, 0.66], and in response to moderate loss injuries (M = 5.82, SD = 0.94) than to mild loss injuries (M = 5.39, SD = 1.15), F(1, 129) = 6.51, p = .01, d = 0.41, 95% CI [0.06, 0.75].

Hypothesis 1 predicted that because participants lack accurate understanding of hedonic adaptation, they would rate the loss of enjoyment of life following a physical injury as greater than the loss of enjoyment of life following a comparably severe psychological injury. Although lost enjoyment of life ratings were significantly higher for moderate loss injuries (M = 5.37, SD = 1.29) than for mild loss injuries (M = 3.86, SD = 1.41), F(1, 128) = 40.21, p < .001, d = 1.12, 95% CI [0.75, 1.49], they did not differ as a function of injury type (physical injury M = 4.87, SD = 1.45; psychological injury M = 4.37, SD = 1.61), contrary to our hypothesis, F(1, 128) = 2.52, p = .12, d = 0.33, 95% CI [−0.02, 0.68]. The interaction was not statistically significant, F(1, 128) = 1.24, p = .27, η² = .01.

Hypothesis 2 predicted that lacking an understanding of hedonic adaptation, participants would give higher ratings of loss of future opportunities following physical injuries than psychological injuries of comparable severity. This hypothesis was supported. Participants gave significantly higher scores for lost opportunities following physical injuries (M = 5.51, SD = 1.31) than psychological injuries (M = 4.03, SD = 1.58), F(1, 129) = 35.28, p < .001, d = 1.02, 95% CI [0.65, 1.38]. They rated loss of future opportunities as greater after moderate loss injuries (M = 5.45, SD = 1.22) than mild loss injuries (M = 4.14, SD = 1.72), F(1, 129) = 27.21, p < .001, d = 0.88, 95% CI [0.52, 1.24]. The interaction was not statistically significant, F(1, 129) = 3.86, p = .05, η² = .03.

Responses to the question about the time necessary to return to original levels of well-being showed only an effect of Primary Injury Type. We recoded the data to form a 4-point scale (1 = 0–12 months; 2 = 13–24 months; 3 = more than 24 months; 4 = never). Consistent with Hypothesis 3, mean estimates were significantly greater for the physical injury (M = 2.70, SD = 1.29) than for the psychological injury (M = 2.14, SD = 1.08), F(1, 128) = 6.59, p = .01, d = 0.46, 95% CI [0.12, 0.81]. There was no statistically significant main effect of Extent of Long-Term Hedonic Loss, F(1, 128) = 0.42, p = .52, d = −0.16, 95% CI [−0.51, 0.18], or an interaction, F(1, 128) = 0.12, p = .73, η² < .01.

**Discussion**

Results of this study seem to support the contention that laypeople lack an awareness of hedonic adaptation to physical and psychological injuries. Respondents’ ratings of limitations to future enjoyment of life subsequent to a physical injury and to a comparably severe psychological injury did not differ, and their ratings of limitations to future opportunity were actually greater in response to a physical injury than to a psychological injury. This was true despite data (e.g., Binder & Coad, 2013) showing better hedonic adaptation to physical injuries (because losses are often illusory) than to psychological injuries (because losses are often enduring). Participants were also more likely to assume that a person with a physical injury would be unable to return to a preinjury level of happiness than one with a comparably severe psychological injury.

An alternative explanation tempers this conclusion, however. Regardless of their beliefs about hedonic adaptation, people may simply devalue psychological injuries and underestimate their impact on subjective well-being and functioning over time. Indeed, judges and jurors alike question the legitimacy of psychological injuries because of erroneous beliefs about their causes and consequences (Vallano, 2013).

We must also acknowledge concerns about our methodology. Andrews et al.’s (1996) case descriptions did not include situations that fit with our manipulations and that held all other variables constant. Thus, to control for age and gender effects, we altered the age and (in two scenarios) the gender of injury sufferers in our vignettes. This meant that we were not completely faithful to Andrews et al.’s case descriptions and their clinicians’ analyses but we opted for this tradeoff to maintain internal validity. Another
limitation of our methodology is the stark distinction we made between physical and psychological injuries. This dichotomy ignores the obvious and multiple ways in which one affects the other, for example, that a physical injury could result in chronic pain that leads to impairment of emotional well-being. Possibilities of this sort blur the distinction we made between primarily physical, and primarily psychological injuries. Accordingly, in Study 2 we eliminated the physical-psychological distinction and focused instead on how laypeople and professionals assess hedonic loss as a result of paraplegia which, according to Sunstein (2008), is an injury with illusory loss, and back pain, which Sunstein claims results in enduring loss.

Study 2

In this study, laypeople and rehabilitation professionals read two vignettes that provided considerably more detail about accident victims’ functioning over time; one described an individual who was paralyzed in a car accident and the other described an individual who experienced persistent back pain subsequent to a fall. We selected the former to represent an injury causing illusory loss and the latter, to represent an injury causing enduring loss. After reading each vignette, participants estimated the lost enjoyment of life experienced by each victim in the short- and in the long-term and determined hedonic damage awards. One goal of the study was to determine whether laypeople and rehabilitation professionals have a nuanced understanding of hedonic adaptation, namely, that it varies over time and as a function of the type of injury. Supporting research leads to the following predictions:

1. Laypeople will have a general sense that hedonic loss decreases over time. Thus, their long-term hedonic loss ratings will be lower than their short-term loss ratings, regardless of injury type (Hypothesis 1a). But they will lack awareness that the type of injury affects the extent of adaptation. Hence, the difference between short-term and long-term loss ratings will not depend on the type of injury (Hypothesis 1b).

2. Rehabilitation professionals will also understand that hedonic loss decreases over time, so their long-term hedonic loss ratings will also be lower than their short-term loss ratings, regardless of injury type (Hypothesis 2a). However, they will also understand that the extent of long-term adaptation varies with injury type. Thus, there will be no difference between short-term and long-term loss ratings for back pain but there will be a decrease from short-term to long-term loss ratings for paraplegia (Hypothesis 2b). That is, professionals will be aware that hedonic loss in paraplegia is illusory, but that hedonic loss as a consequence of back pain is enduring.

3. Laypeople’s hedonic damage awards will be greater in the case of paraplegia than back pain because jurors put significant weight on apparent injury severity when determining damages for pain and suffering (Wissler, Evans, Hart, Morry, & Saks, 1997), and we expect the same pattern for hedonic damages.

Method

Participants. One hundred eighty laypeople participated in this study. As in Study 1, all were age 18 or older and able to speak, read, and write fluently in English. They ranged in age from 18 to 87 (M = 57.32); 59% were female. Ninety-three participants were recruited from a mid-sized university and received extra credit for participating. Eighty-seven participants were recruited from the community and were given monetary incentives in the form of scratch-off lottery tickets and gift cards in exchange for participating. Approximately half of the laypeople had at least some college or vocational training; one-quarter had only a high school degree.

Data from 47 rehabilitation professionals were collected via an electronic survey distributed to the listservs of the American Psychological Association’s Divisions 22 (Rehabilitation Psychology) and 38 (Health Psychology), requesting responses from members with professional expertise in injury rehabilitation. Respondents included 43 doctoral level psychologists and four individuals who held a professional degree (e.g., MD, DO). The professionals’ experience in rehabilitation work ranged from 1 to 38 years (M = 15.0 years, SD = 10.1 years) with approximately 19% having less than four years of experience, 17% having four to nine years of experience, and 64% having more than 9 years of experience in injury rehabilitation. Most (59.6%) had completed fewer than 24 formal disability assessments whereas the rest had completed more than 24 assessments. Notably, 17% had completed more than 100 disability assessments. No incentive was provided to this group for participating.

Design and procedure. Both laypeople and professionals participated in this 2 (Injury Type: paraplegia, back pain) × 2 (Time Frame: short-term, long-term) within-subjects design. After providing informed consent, participants read vignettes that described individuals who sustained injuries resulting either in paraplegia or chronic back pain. To control for order effects, we presented the vignettes in counterbalanced order: 51% of laypeople read the paraplegia scenario first, as did 45% of professionals. After reading a vignette, they answered several questions about the perceived impact of that condition. The main dependent variables were ratings of hedonic loss experienced by the victims in the short-term and the long-term. In addition, participants answered questions regarding their decisions about hedonic loss and laypeople assessed hedonic damage awards. At the conclusion of the study, all participants were thanked and laypeople were debriefed.

Materials.

Vignettes. We used two vignettes created by Andrews et al. (1996) to develop the Lost Pleasure of Life scale. The vignettes included descriptions of victims’ functional capacities in the four domains related to hedonic loss and adaption: (a) practical, that is, activities of daily living; (b) emotional/psychological; (c) social, that is, interpersonal and leisure pursuits; and (d) occupational, that is, vocational activities and identity. Experts consider these areas as crucial to an individual’s overall enjoyment of life, and impairments in any of these areas can influence a person’s sense of well-being (Andrews, 1993; Berlát et al., 1999).

One vignette described a 23-year-old male who became paraplegic as a result of an automobile accident. It included many details regarding the impact of the accident on his practical functioning (e.g., no bowel or bladder control, confined to a wheel-
chair), psychological functioning (e.g., diminished self-image as an active male, sleep problems), social functioning (e.g., limited social contact because of transportation and wheelchair access difficulties), and occupational functioning (e.g., suspended his career goal to become a research chemist). It included the fact that he has reached maximum medical recovery, and it was 301 words long. The other vignette described a 24-year-old female who was injured when she fell from a carnival ride, underwent back surgery, and continues to experience back pain. Details included practical functioning (e.g., difficulty walking and standing or sitting for more than 30 min), psychological functioning (e.g., nightmares, self-conscious about physical appearance), social functioning (e.g., pain with intercourse), and occupational functioning (e.g., ineligible for anticipated military career). It also included the fact that she has reached maximum medical recovery, and it was 274 words in length.

**Questionnaire.** Ratings of the short- and long-term hedonic losses were on a 6-point Likert scale, ranging from 1 (minimal) to 6 (catastrophic). We defined short-term and long-term in the same way as Andrews et al. (1996). The former referred to the period between the injury and the time of maximum medical improvement, and the latter to the period between maximum medical improvement and death. Participants then rated the importance of four factors to their decisions, using a 6-point Likert scale from 1 (not at all) to 6 (extremely): the extent to which the victim’s life was changed by the injury, the extent of harm suffered by the victim, the status of the victim’s health prior to injury, and the general human capacity to adapt to injuries. Finally, laypeople read jury instructions on hedonic loss assessment that are typically provided in personal injury cases and were asked to select a damage award from an 11-point scale on which dollar amounts were approximately intervallic when converted to logarithmic values (1 = nothing; 2 = $1–$12,000; 3 = $12,001–$25,000; 4 = $25,001–$50,000; 5 = $50,001–$100,000; 6 = $100,001–$250,000; 7 = $250,001–$500,000; 8 = $500,001–$1 million; 9 = $1 million–$2 million; 10 = $2 million–$4 million; 11 = more than $4 million; Stevens, 1958).

**Results**

We combined the community and student layperson samples after determining that ratings of hedonic loss—the primary dependent variable—did not differ significantly across groups, all ps > .16, two-tailed. The analyses are split into three sections. First, we tested Hypotheses 1 and 2 using two separate ANOVAs: one for laypeople and another for professionals. This was necessary because the nature of participant recruitment resulted in radically different population sizes in the lay and professional groups. Each ANOVA tested a 2 (Injury Type: paraplegia, back pain) x 2 (Time Frame: short-term, long-term) within-subjects factorial model.

Next, we followed up on these ANOVAs with a series of four regressions (one for laypeople and another for professionals for each injury type) to examine which participant-endorsed factors predicted ratings of long-term hedonic loss. Finally, we tested damage awards related to Hypothesis 3 with a repeated measures t test. Throughout, missing data were deleted pairwise, all eta squared effect sizes ($\eta^2$) are partial, and all coefficients of determination ($R^2$) are adjusted.

**Hedonic loss assessments as a function of injury type.** All univariate results are shown in Table 1. One objective of this study was to assess whether laypeople are aware that injury sufferers can adapt hedonically but that the extent of adaptation over time is influenced by the type of injury. There was a main effect of Injury Type: Laypeople rated paraplegia as resulting in greater hedonic loss (M = 4.85, SD = 0.99) than back pain (M = 4.29, SD = 0.95). Hypothesis 1a led us to expect a main effect for the Time Frame (short- vs. long-term). This hypothesis was supported. Mean hedonic loss ratings were significantly lower in the long-term (M = 4.45, SD = 1.01) than the short-term (M = 4.69, SD = 0.93), indicating that regardless of injury type, laypeople had a rudimentary awareness that injury sufferers can adapt hedonically with time. Apparently they understood that any initial decline in enjoyment of life eventually abates and that emotional well-being generally improves.

Importantly though, and consistent with Hypothesis 1b, their understanding did not extend to the differential impact of injury type, as the interaction between Time Frame and Injury Type was not significant. The time frame effect was similar in the back pain condition and the paraplegia condition. These data are shown in Figure 1a. This finding suggests that laypeople lack nuanced understanding of the fact that people adapt differentially as a function of injury type, and in particular, that they have difficulty adjusting to a state of chronic pain.

### Table 1

**Overview, Univariate Results, Study 2**

<table>
<thead>
<tr>
<th>Main effect/interaction tested</th>
<th>df</th>
<th>F</th>
<th>Effect size</th>
<th>CI</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Within-group (Laypeople)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Injury type</td>
<td>1, 173</td>
<td>17.04</td>
<td>1.19*</td>
<td>.91, 1.31</td>
<td>&lt;.001**</td>
</tr>
<tr>
<td>Time frame</td>
<td>1, 173</td>
<td>61.48</td>
<td>.63*</td>
<td>.52, .74</td>
<td>&lt;.001**</td>
</tr>
<tr>
<td>Time Frame × Injury Type</td>
<td>1, 173</td>
<td>.14</td>
<td>&lt;.01*</td>
<td>&lt;.01, .03</td>
<td>.910</td>
</tr>
<tr>
<td>Time frame (back pain)</td>
<td>1, 174</td>
<td>61.48</td>
<td>.46*</td>
<td>.35, .57</td>
<td>.003*</td>
</tr>
<tr>
<td>Time frame (paraplegia)</td>
<td>1, 174</td>
<td>12.02</td>
<td>.51*</td>
<td>.40, .62</td>
<td>&lt;.001**</td>
</tr>
<tr>
<td>Within-group (Professional)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Injury type</td>
<td>1, 45</td>
<td>11.99</td>
<td>1.03*</td>
<td>.81, 1.25</td>
<td>&lt;.001**</td>
</tr>
<tr>
<td>Time frame</td>
<td>1, 45</td>
<td>115.99</td>
<td>3.21*</td>
<td>2.90, 3.52</td>
<td>&lt;.001**</td>
</tr>
<tr>
<td>Time Frame × Injury Type</td>
<td>1, 45</td>
<td>.16</td>
<td>&lt;.01*</td>
<td>&lt;.01, .10</td>
<td>.690</td>
</tr>
<tr>
<td>Time frame (back pain)</td>
<td>1, 45</td>
<td>64.69</td>
<td>2.40*</td>
<td>2.13, 2.67</td>
<td>&lt;.001**</td>
</tr>
<tr>
<td>Time frame (paraplegia)</td>
<td>1, 46</td>
<td>61.01</td>
<td>2.30*</td>
<td>2.03, 2.57</td>
<td>&lt;.001**</td>
</tr>
</tbody>
</table>

* Cohen’s $d$ effect size estimate.  
* Partial Eta Squared effect size estimate.  
* $p < .05$.  
* *p < .001.
This last point—that laypeople lack understanding of the differential impact of injury type on long-term hedonic loss—begs the question of whether professionals possess such understanding. Our data suggest that they do not. Surprisingly, a pattern similar to laypeople’s emerged for professionals. Like laypeople, professionals rated paraplegia as leading to greater hedonic loss (M = 4.41, SD = 0.81) than back pain (M = 3.95, SD = 0.96). Also, and in support of Hypothesis 2a, mean hedonic loss ratings were significantly lower in the long-term (M = 3.70, SD = 0.90) than the short-term (M = 4.66, SD = 0.87). Like laypeople but in contrast to Hypothesis 2b, the interaction between Time Frame and Injury Type was not significant. Again, the time frame effect was similar in the back pain condition and the paraplegia condition. These data are shown in Figure 1b. This finding suggests that people with experience in injury rehabilitation also lacked a nuanced understanding that injury sufferers adapt differentially based on injury condition. Apparently neither laypeople nor rehabilitation professionals were aware that emotional well-being is more likely to improve over time for a paraplegic than for a chronic pain sufferer.

Factors that influenced hedonic loss ratings. We asked both laypeople and professionals about the importance of four factors in the assessment of long-term loss of enjoyment of life: (a) the extent to which the victim’s life was changed by the injury, (b) the extent of harm experienced by the victim, (c) the status of the victim’s health prior to the injury, and (d) the general human capacity to adapt to injuries. We conducted multiple regression analyses (one for each injury type for each participant group) in an attempt to predict long-term loss assessment from these variables. After excluding four multivariate outliers for the case of paraplegia and two for the case of back pain (outliers were present only in the laypeople data), we entered all predictors simultaneously. Results for laypeople respondents are shown in Table 2 and for professionals in Table 3.

The overall model for losses associated with paraplegia in the laypeople group was statistically significant, adjusted $R^2 = .27$, $F(4, 163) = 16.58, p < .001$, 95% CI [.16, .38]. Approximately 27% of the variance in ratings of long-term hedonic loss was accounted for by the regression. Three of the four individual
predictors were statistically significant: extent of life change, t(163) = 5.32, p < .001; extent of harm suffered, t(163) = 2.74, p = .007; and general human capacity to adapt, t(163) = 2.05, p = .042. Higher ratings of the influence of these items were separately related to long-term hedonic loss ratings as a result of paraplegia. Of the significant predictors, extent of life change explained the greatest amount of variance and capacity to adapt explained the least.

The overall regression for the losses associated with chronic pain in the laypeople group included the same four predictors and was found to be statistically significant, adjusted R² = .28, F(4, 167) = 17.86, p < .001, 95% CI [-.02,.10]. The set of variables in the model accounted for 28% of the variance in long-term hedonic loss assessments and only two of the four predictors were statistically significant: the extent of harm suffered, t(167) = 2.91, p = .004, and the extent of life change, t(167) = 5.38, p < .001. They uniquely explained 1% and 12% of the variance in long-term loss assessments, respectively.

The overall model for losses associated with paraplegia in the professionals group was statistically significant, adjusted R² = .27, F(4, 39) = 4.87, p = .003, 95% CI [0.07, 0.46]. Approximately 27% of the variance in ratings of long-term loss assessment was accounted for by the regression. One of the four individual predictors was statistically significant: the extent of life change, t(39) = 2.63, p = .012. Higher ratings of the influence of this predictor were uniquely related to ratings of long-term hedonic loss for the paraplegic and this predictor explained approximately 12% of the variance.

The overall regression in the professionals group for the losses associated with chronic pain included the same four predictors and was also found to be statistically significant, adjusted R² = .13, F(4, 41) = 2.68, p = .045, 95% CI [-.03,.29]. The set of variables in the model accounted for 13% of the variance in long-term hedonic loss assessments but none of the four predictors was statistically significant on its own.

**Laypeople’s damage awards as a function of injury type.**

Hypothesis 3 predicted that laypeople would assign higher hedonic damage awards to the paraplegic than the chronic back pain sufferer. A repeated measures t test supported this prediction. The mean hedonic damage awards were $750,000 to the paraplegic (on an 11-point scale, M = 7.50, SD = 2.24) and $372,500 to the back pain sufferer (M = 6.49, SD = 2.14), t(172) = 8.21, p < .001, d = 0.47, 95% CI [0.25, 0.68]. Correlations between hedonic damage awards and long-term hedonic loss assessments were significant for both types of injuries: r(174) = .28, p < .001, 95% CI [.14, .42] (paraplegic); r(175) = .23, p = .003, 95% CI [.08, .37] (back pain sufferer).

**Discussion**

Both laypeople and professionals rated long-term hedonic loss as less than short-term loss, indicating an awareness that with time,
emotional reactions to adverse health conditions subside. But in evaluating the extent of long-term hedonic losses, neither laypeople nor, surprisingly, professionals, seemed aware that people are more likely to adapt hedonically to paraplegia than to chronic pain. This suggests that both groups may forecast a future for people who have suffered serious physical injuries as considerably grimmer than it is likely to be. People adapt—at least partially—to these injuries, allowing them to experience levels of contentment and satisfaction of which laypeople and rehabilitation professionals are apparently unaware. The data also suggest that both groups underappreciate the long-term emotional consequences of less visible injuries (e.g., chronic back pain) to which people cannot easily adapt and that both groups forecast a rosier future than is likely.

These findings are consistent with Sunstein’s (2008) contention that jurors are likely to overestimate how much hedonic harm is imposed by a serious physical injury in which losses “turn out to be low or even illusory, at least in the long run” (p. S168). They also support his suspicion that jurors are likely to underestimate how much hedonic harm results from conditions like depression and chronic pain that impose enduring losses.

It surprised us that rehabilitation professionals were insensitive to the fact that long-term adaptation varies by type of injury. Perhaps the extent of their experiences played a role. Despite an average of 15 years in the field, the majority had conducted fewer than 24 disability assessments, so may have been unfamiliar with the time course of adaptation to different conditions. Paraplegia, in particular, is a relatively rare event for which clinicians may have scant knowledge on which to rely. (Obviously, laypeople would also lack relevant insight.) Further, the majority of their patients may be in the early stages of rehabilitation so clinicians would not be privy to information about long-term adaptation. Finally, like most people, professionals may fail to learn from past forecasting errors (assuming they are aware of them) and to make adjustments in the future (Novemsky & Ratner, 2003).

Another finding from our data suggests that adaptation may simply not factor prominently in hedonic loss judgments. Recall that we asked participants to rate the importance of four items to their judgments of long-term hedonic loss and conducted regression analyses to examine the predictors of this decision. The capacity to adapt was related to long-term loss assessments only for laypeople and only when judging the case of paraplegia.

Although examination of hedonic damage awards was not the main focus of this study, it is worth noting that the awards produced here support an oft-made observation about damage awards, namely vertical equity, which occurs when awards correlate with apparent injury severity (Wissler et al., 1997). Long-term hedonic losses were rated as higher for the paraplegic than the chronic pain sufferer (though, as we noted, those forecasts may be erroneous), and damages were larger for the former than the latter.

We acknowledge some concerns about our vignettes. Conceivably, the fact that we did not control for gender or injury severity could confound our results. In this study, we made the choice to opt for realism over tight experimental control, so used Andrews’ (1993) descriptions of actual accident victims that included details about their functional limitations; some of those details were gender-specific. And we intentionally chose cases that varied in apparent severity at the time of the injury to assess how respondents would forecast hedonic adaptation. We also acknowledge that despite successful counterbalancing, there were order effects on ratings of long-term hedonic loss: Both laypeople and professionals gave higher ratings to the paraplegic when that case was presented second, and laypeople gave lower ratings to the back pain sufferer when that case was presented second. It is possible that our results were influenced by these potential confounds.

General Discussion

The picture that emerges from these studies is that people apparently lack nuanced understanding of hedonic adaptation. In Study 1, laypeople’s ratings of limitations to future enjoyment of life subsequent to a physical injury and a psychological injury of equivalent severity were not different despite the fact that people show better hedonic adaptation to the former than the latter (Binder & Coad, 2013). In addition, participants assumed that people who sustain a physical injury are less likely to return to their original level of well-being than people who sustain a comparably severe psychological injury. In Study 2, both laypeople and rehabilitation professionals were aware that enjoyment of life increases with time postinjury. But neither group seemed knowledgeable of the domain-specificity of hedonic adaptation in the long run, as both groups indicated that a severe physical injury would detract more from enjoying life than a persistent but largely invisible injury, despite evidence to the contrary (Binder & Coad, 2013). Had participants understood that humans adapt differentially to injuries and illness as a function of the type of ailment, that awareness would have affected their ratings of hedonic loss in both studies. It did not.

A premise of our research is that people adapt less well, in terms of enjoying life, if they experience psychological and other impairments involving persistent reminders of infirmity than if they sustain severe physical injuries. Can we be assured of that fact? Undoubtedly, serious physical injuries reduce people’s sense of well-being, and longitudinal studies show lingering effects of injuries and illness on happiness (e.g., Oswald & Powdthavee, 2008). But we would argue, like Sunstein (2008), that persistent and nagging injuries that cannot be ignored lead to even greater erosion of subjective well-being, and new longitudinal data (Binder & Coad, 2013) support that conclusion. Whereas many paraplegics, for example, eventually reduce their focus on the life-changing event and adjust to their altered circumstances, chronic pain sufferers and those experiencing mental illness apparently have difficulty doing so. When pain, anxiety, depression, and other persistent conditions such as tinnitus and dizziness color a person’s waking hours, that individual may be able to think of little else. Obviously, well-being suffers.

Why do laypeople and professionals alike lack understanding of this phenomenon? One reason may be the counterintuitive nature of hedonic adaptation, namely that people can regain a sense of happiness and satisfaction with life even after experiencing catastrophic injuries that result in amputations, paralysis, and the like. Relatedly, in forecasting the future happiness of a person who has sustained these conditions, observers probably attend to outward, visible signs of impairment and have little access to that person’s thoughts or feelings, including...
any adjusted aspirations and new pleasures. Finally, observers may simply fail to consider the human capacity to adapt to injuries. Indeed, our regression analyses showed that consideration of one’s capacity to adapt was, at best, only a very weak predictor of hedonic loss assessments.

**Limitations**

In addition to the caveats mentioned previously, we must acknowledge other limitations of our studies. We asked participants to determine the future happiness of particular individuals whose adjustment will surely depend on a large number of factors, including the type and timing of injury or illness, preinjury levels of subjective physical and emotional well-being, and other situational and dispositional factors. Obviously, vignettes cannot provide the richness of detail that is conveyed through interactions and observations, so participants’ access to information that may be vital to their judgments was limited.

In addition, it is worth asking whether participants were focusing exclusively on hedonic losses when answering our questions, rather than considering other components of noneconomic damages such as disability, disfigurement, pain, and suffering. We have no direct means of addressing this issue, though previous studies suggest that without explicit instruction, respondents might merge the components in their minds (Gregory & Winter, 2011; Poser et al., 2003). Whether and how the apparent lack of attentiveness to hedonic adaptation might affect awards for pain, suffering, and disability is unknown, though clearly stated jury instructions could inform jurors that lost enjoyment of life is wholly distinguishable from those other noneconomic losses.

**Implications and Future Directions**

Understanding what people presume about a victim’s ability to return to preinjury levels of happiness and satisfaction has significant practical importance for trial-related judgments. Not infrequently, jurors forecast how plaintiffs will fare in the future and then determine what amount of money will compensate them for any diminishment in their level of enjoyment of life, among other things. These judgments are rife with uncertainty, and an understanding of how such decisions are typically made is only a first step in making awards more equitable and predictable. Other steps can and perhaps should be taken.

If research continues to support the apparent misestimating of hedonic loss, then jurors could benefit from instructions that pointedly inform them of this tendency and explain how they can avoid making this common judgment error. Courts are increasingly willing to incorporate findings from psychological research studies into standardized jury instructions (see, e.g., Weiser, 2012), with the goal to assist jurors in determining verdicts and damage awards that are informed by scientific data rather than misconceptions. Instructions summarizing what is known about hedonic adaptation and affective forecasting errors could be helpful.

Another remedy involves the admission of expert testimony in cases involving assessments of hedonic losses. This testimony could take the form of social framework testimony (Mohanan & Walker, 1988) in which an expert with knowledge of relevant research would help jurors understand how most people adapt to injuries of a particular sort and that observers tend to assume, incorrectly, that the emotional effects of those injuries will linger. Alternatively, a mental health professional could conduct a forensic evaluation of a particular plaintiff, providing a more specific assessment of his or her subjective well-being that will help jurors to forecast that person’s future happiness. The landmark case of *Sherrod v. Berry* (1985) paved the way in allowing expert testimony in cases involving hedonic damage awards.

Two directions for future research arise from our studies. One involves longitudinal analysis of how victims of particular accidents and injuries fare hedonically as time passes, including how well they can forecast their own happiness. Measuring various components of subjective well-being across time and in individuals with different types of injuries would provide a more accurate understanding of the ways that people adapt affectively to injuries and to the changed circumstances these injuries impose. Doing a study of this nature would require following victims from their initial hospitalization, through rehabilitation, and at various points after they have stabilized. At each of these points they would report their level of subjective well-being and estimate how they expect to feel in the future, and these forecasts would be compared with actual data collected at later points in the study.

A second line of research could focus on mock jurors’ and jurors’ decisions regarding lost enjoyment of life in simulated trials using details from the cases of these real accident victims. In essence, jurors could hear evidence about an accident and the plaintiff’s recovery and make decisions regarding the plaintiff’s hedonic loss since the accident and into the future. Their judgments could then be compared with the actual losses reported by the real victims. This sort of research is undoubtedly complex and time-consuming, but it could provide more definitive conclusions about the ability of laypeople to accurately forecast others’ hedonic losses and, if that ability is shown to be wanting, test various legal remedies to correct errors in forecasting.

**References**


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