The Role of PTSD in Litigation

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The use of the diagnosis of posttraumatic stress disorder in litigation has been called "a forensic minefield" (Sparr and Boehnlein, 1990). Since its inclusion in the *DSM-III*, PTSD has been increasingly utilized over the past decades in both civil and criminal litigation (Slovenko, 1994; Sparr and Boehnlein 1990)--so much so that the provision of PTSD testimony into the legal system has been characterized as "a cottage industry" (Stone, 1993).

Attorneys introduce PTSD arguments into legal cases through the use of expert testimony. A diagnosis of PTSD can provide advantages in litigation. In civil litigation, it creates an assumption of obvious causation. It also carries a legal and moral implication that someone else is responsible for an event so overwhelming that anyone could have developed PTSD as a result. Finally, it provides strong support for arguments regarding damages (Gold, 2003; Gold and Simon, 2001). The stressors alleged to cause PTSD and the class of victims who could suffer PTSD from those stressors have expanded the horizons of tort litigation (Shuman, 2003). Posttraumatic stress disorder is also increasingly used in criminal cases, typically in arguments of justification or mitigation in sentencing. In these circumstances, attorneys argue that anyone exposed to the trauma the defendant suffered might find themselves committing similar crimes under similar circumstances.

Common misconceptions about the nature of trauma and PTSDs are partially responsible for the increased frequency of a PTSD diagnosis in litigation. The terms *trauma* and *stress* are routinely used synonymously. All traumatic experiences are stressful. However, not all stress is traumatic. Lawyers, laypeople and clinicians all frequently confuse the popular concept of stress as a synonym for trauma with the medical concept of a specific psychiatric disorder that may occur following exposure to a true traumatic event.

Credible Expert Testimony

At times, clinical and forensic psychiatrists ignore the requisite diagnostic criteria and regard as PTSD any emotional disturbance that follows an adverse stressful event. To maintain credibility when providing diagnostic assessments of PTSD in litigation, psychiatrists should be familiar with the definition of this disorder and the types of traumatic stressors that can precipitate it. The *DSM-IV* defines PTSD as a disorder for which six criteria must be met. These include specific symptoms and a degree of functional impairment.
The most important of these in the context of litigation is Criterion A: a person must have been exposed to a traumatic event or stressor. Criterion A defines a traumatic stressor as consisting of an objective and subjective element. Both elements must be met for an event to constitute an emotional stressor that can cause PTSD. In the objective element, the person must have experienced, witnessed or have been confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others. These include such experiences as combat, violent personal assault, terrorist attack, being kidnapped, being diagnosed with a threatening illness and automobile accidents, among others. The subjective element of Criterion A requires that the person's response must have involved intense fear, helplessness or horror.

However, even if both elements of the traumatic exposure are present, not every traumatic event causes PTSD in every individual exposed to that event. Epidemiological studies suggest that only 15% to 24% of adults exposed to Criterion A trauma develop PTSD (Breslau, 2001). The risk of developing PTSD also varies by type of trauma and stressor intensity or magnitude. Specific risk factors associated with victim characteristics, such as gender, age, race, socioeconomic class, family dysfunction, comorbid psychopathology or a history of psychopathology, and a previous history of trauma, are also associated with the likelihood of developing PTSD following trauma exposure (Breslau, 2001, 1998; Breslau et al., 1999, 1991; Briere, 1997; Green and Kaltman, 2003).

Epidemiological statistics and identification of risk factors for the development of PTSD should not be used to discount the inherently traumatic nature of many events. Regardless of pre-existing vulnerabilities, PTSD can occur in those without significant risk factors in the face of a high magnitude or intensity traumatic exposure. A previously well-functioning adult can experience a sharp deterioration in functioning after exposure to severe trauma (van der Kolk et al., 1996). However, an examiner should not assume that any traumatic stressor, much less a stressful situation that does not meet Criterion A, will necessarily produce PTSD.

It is possible for individuals to develop PTSD without meeting the stressor criterion. For example, exposure to multiple events appears to increase the risk for the development of PTSD, even if the last stressor does not meet all the elements of Criterion A. Similarly, individuals may be diagnosed with subthreshold PTSD after exposure to a traumatic event if they do not meet the DSM-IV requisite number of symptoms for a formal diagnosis of PTSD (Blank, 1993; Schutzwohl and Maercker, 1999; Stein et al., 1997; Weiss et al., 1992). Nevertheless, unless the stressor criterion of serious threat to life or bodily integrity and a corresponding reaction of fear, terror or helplessness occur, the diagnosis of PTSD should not be made without substantial justification and support from the literature. Otherwise, opposing counsel will, without doubt, question the reliability and credibility of the expert offering the testimony.

In the event of a recognizable traumatic exposure and the presence of psychological symptoms that do not meet the criteria for PTSD, the forensic evaluator should carefully assess whether the individual meets the criteria for other DSM diagnoses. Forensic clinicians should consider whether other mood or anxiety diagnoses are more appropriate (Simon, 2003). These disorders can also be influenced by external events, and many have a higher incidence following a traumatic exposure than does PTSD, and a number of the symptoms of PTSD overlap considerably with the symptoms of such disorders.

Lack of familiarity with DSM diagnostic criteria or excessively flexible and idiosyncratic application of diagnostic criteria or conventions substantially reduces the utility of psychiatric diagnoses. Any assessment of PTSD, even one that concludes in a diagnosis of subthreshold PTSD, must adhere to DSM criteria in order to be credible.

**Misdiagnosis of PTSD**
Diagnoses of PTSD are commonly made inaccurately in litigation contexts. Clinicians treating trauma survivors or retained as experts by such individuals when they become plaintiffs tend to overdiagnose PTSD (Rosen, 1995). Defense experts in civil litigation and experts retained by the prosecution may tend to underdiagnose the disorder.

Misdiagnosis may occur for reasons other than misunderstanding the nature of the disorder or misapplication of diagnostic criteria. Adversarial bias, that is, conscious or unconscious pressure to formulate an opinion favorable to the retaining party, may exert a profound influence in some cases. At times, a misapplied diagnosis of PTSD can represent a vehicle for promoting the forensic psychiatrist's values of support for victims' rights (Stone, 1993). Conversely, antipathy toward the diagnosis and its implications may result in the misinterpretation or overlooking of genuine posttraumatic symptomatology (Briere, 1997; Pitman et al., 1996).

Indirect Assessments

Attorneys frequently attempt to use psychiatric testimony to make indirect statements regarding a plaintiff's credibility. As a rule, expert evidence on the credibility of a witness is not permitted. Nevertheless, attorneys may try to use psychiatric terminology and diagnoses to introduce indirect credibility assessments through expert testimony.

Certain diagnoses lend themselves to this type of misuse. A diagnosis of PTSD in a plaintiff carries implications that the plaintiff's allegations are true. Certain personality disorder diagnoses, such as borderline or histrionic personality disorder, carry the implication that the plaintiff's allegations are not credible. The use of psychiatric diagnoses to indirectly establish the credibility of a legal claim should be viewed as a misuse of psychiatric expertise (Halleck et al., 1992).

Use of Syndrome Evidence

In recent years, attorneys have also increasingly sought expert testimony about various trauma-related syndromes, such as battered woman syndrome, rape trauma syndrome or battered child syndrome. Syndrome diagnoses are based on the presence of constellations of certain symptoms and have been offered in both civil and criminal cases. In civil cases, the presence of a syndrome may be used in attempts to establish that a particular stressor actually occurred, thus establishing witness credibility (Simon and Gutheil, 1997). In criminal cases, arguments for the presence of a syndrome in the defendant may serve as justifications for criminal acts or mitigation of sentence.

Although they may have some relation to the diagnosis of PTSD, syndromes are not formal DSM diagnoses. The description of certain syndromes may serve a variety of clinical and sociopolitical purposes, but their utilization in litigation requires careful consideration. The use of a claimant's psychological symptoms in the form of syndrome evidence (or even an established DSM diagnosis) to establish the occurrence of a traumatic event generally has not found favor with the courts (Boeschen et al., 1998; Slovenko, 1995). However, by offering such testimony that a complainant is or is not suffering rape trauma syndrome, battered woman syndrome or some other type of psychological syndrome, the expert's testimony may arguably be characterized or construed as testifying to the truthfulness of the complainant or the presence of mitigating circumstances for a crime. Almost all states refuse to admit this level of testimony (Boeschen et al., 1998).

These and other concerns have resulted in courts taking a purpose-specific, qualified approach to syndrome testimony. Courts most often accept syndrome evidence by experts where the defense argues that the woman did not act the way a "real" survivor of rape would, or where the defense argues that if her domestic situation had really been that bad, she would have left. Courts are more divided on whether
to allow syndrome evidence where there is no overt need to rebut the defense's reliance on myths about women (Orenstein, 1999).

Courts have been most sympathetic to syndrome testimony when the expert spoke generally about typical responses to sexual assault rather than offering an opinion regarding whether the particular woman suffered from a specific posttraumatic syndrome. Most are also receptive to syndrome evidence when it is offered to dispel myths about behaviors associated with sexual assault, domestic violence or child abuse (Massaro, 1999; Melton et al., 1997).

Conclusion

Although imperfect and subject to continuous updating and refinement, the DSM is regarded by mental health professionals and the courts alike as a generally valid and reliable diagnostic system (Shuman, 1989). The diagnostic criteria and research supporting a diagnosis of PTSD is extensive. However, the tactical legal exploitation of the diagnosis of PTSD most often arises from the use of DSM diagnoses for nonclinical purposes. Psychiatrists who enter the legal arena are well advised to provide reliable, credible testimony if the diagnosis of PTSD is raised as a legal defense or claim.

References

11. Halleck SL, Hoge SK, Miller RD et al. (1992), The use of psychiatric diagnoses in the legal process:


