Post-Traumatic Stress Disorder – Contemporary Analysis of medico-legal evidential issues

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In DSM-5, one of the two main classification schemes of mental disorders (APA, 2013), the diagnosis of Post-Traumatic Stress Disorder (PTSD) has undergone multiple, albeit minor, changes. It now comprises four, not three, symptom clusters with the addition of persistent negative beliefs and distorted negative beliefs about oneself, plus a dissociative specifier (depersonalisation and derealization). Overall prevalence of this diagnosis is unlikely to change, but the greater heterogeneity of individuals being diagnosed with PTSD is probable (Zoellner et al, 2013). This paper summarises and discusses the many important medico-legal issues surrounding the PTSD disorder and its diagnosis and implications for both experts and lawyers.

Experts, psychological and psychiatric, working in civil forensic context provide opinion on the presence or absence of psychological injury on the basis of diagnosis, causation and prognosis. The DSM diagnostic criteria for PTSD have been revised repeatedly since the mid-nineteenth century (Thomas, 2013) with PTSD being referred to as “Psychiatry’s problem child” (Gaughwin, 2008). Difficulties have included: ambiguity about traumatic nature of the event; absence of symptom development after traumatic nature of event; confounding prior history of traumatic events, and the coherence of traumatic experiences and their disruptive nature.

The application of the concept PTSD has been further complicated by apparent overlap with other conditions in which a wide array of cognitive, behavioural and emotional symptoms are also present; such as Borderline Personality Disorder. The concept of *Complex-PTSD* appeared in the clinical literature in the early 1990’s (Herman, 1992) and it helpfully made the link between multiple traumatic experiences in childhood and subsequent clinical presentations in adulthood. Importantly, the array of cognitive, behavioural and emotional symptoms often associated with Borderline Personality Disorder and Psychosis, can then, in some cases, be seen as a way of coping with, and as a reaction to, repeated and cumulative traumatic experiences in childhood.

Medico-legal implications of these changes and the overall diagnosis itself include the following key areas: Traumatic Stressor definition, differential diagnosis and comorbidity, causation, reliability and validity concerns, the use of legal tests and overall evidential robustness.

As with previous versions of DSM, the new DSM-5 has been criticized for both reliability and validity problems, and PTSD is no exception. For trauma survivors, clinical diagnosticians need to carefully assess pre-trauma functioning and consider that another diagnosis besides PTSD may be equally or even better warranted and have more accurate prognostic opinions.

The legal background to PTSD in the context of Tort Law

The discourse on post-traumatic stress disorder in medico-legal settings has been centred on the validity and aetiology of this disorder leading to the determination of diagnosis which is required as proof before any court of law. PTSD has been described as a disorder, “that makes a direct causal link between an event and disability,” (McFarlane, 1995).

The diagnosis of PTSD was only formally included into the diagnostic system in 1980 and accepted as a disorder in DSM-III, resulting from the development of social psychiatry’s investigation of the role of adversity, bereavement and trauma; an increase in crisis intervention literature and the social and political movements of the time such as anti-war movements and feminism.

Prior to this time, diagnosis was inadequate in describing the effects of post-traumatic stress. Questions around the accuracy of assessments, whether diagnosis was being applied without precaution, the availability of expert opinion to corroborate evidence and the accuracy of findings from investigation of the aetiology of this disorder, in essence what triggers the onset remained uncertain to this day.

Psychologists have expressed the need for quality assurance measures in the medico-legal process to ensure that rights of litigants are protected (McFarlane, 1995). This call for vigilance to avoid the possibility of malingering in the assessment of trauma victims is pertinent, especially where there are indications of missed diagnosis in petitions raised by claimants. These cases of missed diagnosis and unsuccessful claims could be due to the variability of diagnostic skills of expert witnesses, which makes it difficult for courts to accurately assess the emerging issues. With increased reliability and validity of aetiology, diagnosis and treatment of PTSD, the current legal process may not be as hostile and unreceptive to litigants. Although this may have been the case previously, this has led to questions on ethics by the courts. Medical experts and evidence available can contest any myths of malingering.

Generally, the perception was that in personal injury litigation, recovery for damages arising from mental harm or emotional distress was difficult to accomplish due to the rigour of relevant legal definitions and the difficulty in translating diagnoses into legal standards. This is no longer the case. Psychology and psychiatry are no longer viewed as ‘soft sciences’, which implies scientific investigation for which it may be difficult to establish strictly measurable data (Hagen, 1997). It is no longer difficult to corroborate testimonies of alleged sufferers though the expertise of mental health professionals and the evidence of the sufferer. Judges may not need to be trained in science to appreciate the extent of the claimants suffering, but can apply legal principles to determine whether liability should be imposed. It is important to consider legal standards of proof and the underlying legal decisions in PTSD claims, the rules of evidence that apply to psychological injury litigation.

Tort, Case Law and PSTD

A satisfactory definition of tort law remains elusive. Tort is derived from the Latin ‘tortum’ which means twisted or wrong. Tort law is an area of civil law that provides remedy for a victim who has suffered breach of a protected interest. It is the law of non-criminal wrongs, a name given to a diverse collection of legal wrongs. Before liability can be imposed on a defendant by the courts, there must be an act or omission by the defendant, which causes damage including, for example, PTSD, to the claimant. The damage must be caused by the fault of the defendant and must be a kind of harm recognised as attracting legal liability. In summary, there must be an act of omission (intentional on unintentional) by the defendant, which results in the damage of injury to the victim.

Negligence is currently the most litigated tort, an area of tort law primarily developed by common law – judge-made law. For a successful claim in negligence, the burden of proof is on the claimant to show that the defendant owes a duty of care, which has been breached and as such has fallen below the standard of care required of them. *(Caparo v Dickman, 1990)* The claimant must also prove that the defendants’ act is the factual cause (the ‘but for’) test developed in *Barnett v Chelsea & Kensington Hospital* [1969] and the legal cause (also known as remoteness of damage) of the claimant’s loss or injury as established in *Wagon Mound (No 1).*

Shock: ‘Shell, ‘Nervous’ or Understandable Trauma

The law did not initially recognise psychiatric injury as basis for a claim in tort until the start of the twentieth century when the works of Sigmund Freud become known in England (Bermingham & Brennan, 2018). There was a general perception that people had more control over their mental state than we now understand. The term PTSD came into use during the first World War (1914) and then the Vietnam War (1960’s), commonly known as ‘shell shock’, subsequently such psychological conditions were referred to as ‘nervous shock’, an indication of a traumatic response to a particular event (Peel & Goudkammp, 2014). The expression nervous shock has fallen into disuse and the term psychiatric injury is now an accepted terminology, with PTSD being one of the severest of the injuries defined.

Despite advances in scientific knowledge of the workings of the human mind, it was also believed that psychological injury was more likely to be fraudulently claimed than physical injury, which is more visible. There was also the concern that such claims present a greater risk of inaccurate diagnosis. The fact is claims of psychological injury can be more readily substantiated and verified by medical evidence than some physical injuries such as whiplash, which can only be substantiated by the word of the sufferer. In Frost v CC South Yorkshire [1997] 3 W.L.R. 1194 at 1217, in addressing fraudulent shock claims, Henry LJ noted that the risks were no higher than ‘cases involving back injuries where there is often a wide gap between observable symptoms and complaints.’ Another reason why courts were hesitant to permit recovery for psychiatric claims are policy considerations – fear of the ‘floodgates’ being opened to indefinite number of legal actions which will be unmanageable by the legal system and burdensome on the state. Considering that the core function of tort law is to compensate the victim by putting them in the position they were in before commission of the tort, the courts are ever mindful of the economic implications of finding fault in cases of claims of psychiatric injury including PTSD. As well as an unwelcome increase in litigation from the point of view of wider social considerations.

PTSD and Psychological Injury: Absence of Physical Injury Requirement

Previously, mental injury, such as PTSD, unaccompanied by physical injury was not compensable and this non-recovery of compensation for mental injury without the occurrence of actual physical injury was confirmed in Victorian Railway Commissioners v Coultas (1888). The tide shifted with the decision in Dulieu v White (1901), where a pregnant barmaid suffered nervous shock from witnessing an incident, which caused her to have reasonable fear of her physical safety and immediate physical injury even though there was no actual physical impact. The shock she sustained caused her to suffer a miscarriage for which she recovered compensation. Through the development of case law, the law has distinguished between primary victims and secondary victims in psychiatric injury claims. The case of Page v Smith (1996) was novel in bringing questions on psychiatric injury by primary victims to the core. The court identified that applying the test of reasonable foreseeability by the tortfeasor to cases of physical injury was well grounded in law. Considering the definition of personal injuries by with Section 38 of the Limitation Act 1980 (any disease and any impairment of a person’s physical or mental condition), there should be no reluctance to accept a claim for psychiatric injury which is not the simultaneous result of physical injury; the same principles should be applicable in cases of psychiatric injury. Therefore, for a primary victim (a person who has suffered psychiatric injury without physical injury) reasonable foreseeability of physical injury is sufficient to bring with it a duty regarding psychiatric injury. It is not necessary to introduce any control mechanisms to minimise the number of claimants where a primary victim is involved such has been put in place for claims brought forward by secondary victims (Alcock v Chief Constable of South Yorkshire).

In Page v Smith, the recurrence of myalgic encephalomyelitis after a road accident where the defendant suffered no physical injury raised the question of whether a duty of care could be owed under such circumstances. The House of Lords opined that the circumstances of the accident were not such as to cause foreseeable psychiatric injury to a person of normal fortitude, the claimant in this case was entitled to recover on the basis of the “thin-skull rule”. In essence, liability is not limited to the injuries that were ‘reasonably foreseeable’ at the time but also extends to circumstances where the plaintiff has an abnormal susceptibility to injury due to a pre-existing weakness or ailment. The thin skull rule (egg-shell rule) embedded within the principles of legal causation, applies to psychiatric injury in the same way as physical injury.

Application of Legal Principles

In Attia v British Gas [1988] 1 QB 304, Bingham LJ recommended the application of the general legal principles of negligence in psychiatric injury claims involving primary victims. Firstly, it should be established that the claimant is owed a duty of care developed in Donoghue v Stevenson, if the claimant is ‘so closely and directly affected by the defendants act that he ought to reasonably have him or her in contemplation as being so affected when he directs his mind to the acts of omissions which are called in question.’ Where such a duty exists, the next stage would be to apply principles of causation and consider whether the claimant’s psychiatric damage is too remote to be recoverable because it is not reasonably foreseeable as a consequence of the defendant’s careless conduct. That is to say, the damage or injury is not of a type and class which is foreseeable by the defendant.

In Jaensch v Coffey [1984] 155 CLR 549, an Australian case, Brennan J stated that liability in negligence for psychiatric illness including PTSD is dependent upon the reasonable foreseeability of the precise events leading to the administration of the shock itself and a recognised psychiatric illness induced by it, as well as the causal relationship between the two. (at 566-7)

In Brice v Brown (1984), it was confirmed that if psychiatric injury would have been foreseeable in a person of ordinary fortitude, the fact that the plaintiff suffers excessive harm because she was prone to depression is irrelevant to her recovery of damages. The defendants argued against the foreseeability of the extent and precise nature of the mental shock sustained by the plaintiff who had an underlying ailment that was triggered after she sustained minor injury following a collision with an oncoming vehicle in the defendant’s taxi. The plaintiff had a hysterical personality disorder from childhood which manifested occasionally, after the accident her behaviour became erratic and she was hospitalised. The High Court held that the type and kind of injury she sustained (legal causation) is the same as that which could reasonably have been foreseen. The fact that they could not have foreseen the precise name of the mental condition or psychological process as known to psychiatrists, was immaterial.

In Hoffmueller v Commonwealth [1994] All ER 522, at 533, the plaintiff submitted that as long as the accident was caused by the defendants careless driving, it could foreseeably result in some form of personal injury and it would be necessary to prove that the particular form of injury was foreseeable. The Court did not accept the defendant’s submission, applying the eggshell rule. Once it was established that there was an underlying mental condition and a relapse can be triggered by the trauma of the accident, that the claimant suffered nervous shock as a result, it becomes a foreseeable consequence.

Changes in DSM-5 PTSD Diagnosis

In order to understand and be clear about the type and extent of PTSD arising from a personal injury, it is crucial to understand how successive versions of diagnosis have occurred.

Three main changes are summarised here –

1. PTSD requires exposure to a traumatic stressor, objectively and subjectively. DSM-5 includes indirect exposure e.g. learning that the traumatic event occurred to a close family member or close friend. It also includes experiencing repeat or extreme exposure to aversive details or the traumatic event e.g. first responders; police dealing with child abuse details. DSM-5, however, still does not address the need for corroboration of the traumatic event. There is also a need for pre-trauma functioning assessment in order to get a more complete picture of the presentation and history of the symptoms. There is still the possibility of a variety of interpretations of what constitutes a traumatic stressor, especially around indirect exposure.
2. The PTSD symptom clusters have been reorganised in DSM-5, with the introduction of a fourth cluster of negative beliefs and distorted thinking. The avoidance cluster is susceptible to manipulation by the claimants wishing to feign PTSD, with a high social desirability effect. The negative belief inclusion has the potential to increase the overlay between PTSD and depressive disorders, adding to an already high degree of co-occurrence with other disorders.
3. DSM-5 now includes a subtype specifying dissociative reactions to either depersonalisation (“out of body” experiences) or derealization. This subtype implies that these individuals are unique from individuals with PTSD who do not present with these persisted dissociative reactions. They typically show poorer response to treatment. Again because of the risk of fabrication of dissociation, it increases the importance of external corroboration of traumatic event details.

It is unlikely that DSM-5’s role in legal content will substantially change – it will still retain its place as the main source or method for mental ill health diagnosis. The prudent expert will focus on the functional/behavioural implication of the claimant’s circumstance, not just a diagnosis. This especially applies to PTSD.

Co-Morbidity and Differential Diagnosis

Several disorders can and do co-exist with the symptoms of PTSD. These include major depressive disorders, substance misuse disorder (especially alcohol use disorder) and chronic pain, anxiety disorders and neurocognitive disorders. DSM-5 gives extensive guidance on comorbidity and differential diagnosis between PTSD and other diagnosis.

Ranges of co-morbidity vary but have been estimated in the range of 10-60% (Young et al, 2015). Various theories exist as to why such co-morbidity occurs e.g., mutual maintenance in which developing PTSD induces drinking/drug use that maintains/exacerbates PTSD symptoms.

A key area for differential diagnosis which frequently occurs in medico-legal practice in the area of anxiety disorders, in which PTSD is included.

Figure 1 below illustrates a common decision-making tree for differentially diagnosing one or more anxiety-related disorders. In Personal Injury and Medical Negligence cases, PTSD is a rare diagnosis although stress symptoms per se frequently occur without the full PTSD diagnosis being valid (Furst, Frances and Pincus, 1995).

Figure 1

If yes

If yes

If yes

If yes

If yes

If yes

If no

If yes

If no

If no

If no

If no

If no

If no

If no

If no

ADJUSTMENT DISORDER WITH ANXIETY

Anxiety in response to a severe traumatic event.

Occurring in response to a psychological stressor.

‘Normal’ anxiety.

Clinically significant anxiety not covered above.

ANXIETY DISORDER NOS

ACUTE STRESS DISORDER

POST TRAUMATIC STRESS DISORDER

Duration of more than 1 month.

Reexperiencing of event, increased arousal, and avoidance of stimuli associated with the traumatic event.

HYPOCHONDRIASIS

Belief about serious physical illness is of delusional intensity.

Anxiety or worry about having a serious general medical condition despite reassurance to the contrary.

SPECIFIC PHOBIA

Anxiety about exposure to a feared object (e.g. spiders) or situation (e.g. heights, seeing blood).

SOCIAL PHOBIA

Anxiety or worry about being humiliated or embarrassed in social or performance situations.

PTSD and Causation

When a claimant alleges psychological injury in general, and PTSD in particular, the defence commonly challenges these allegations by introducing pre-existing psychological injury (PEI) evidence (Vallano, 2013). It is likely that many claimants who claim PTSD have PEI. 50% of the population meet diagnostic criteria for a psychological disorder during their lifetime (Moffit et al, 2010).

PEI, per se, does not, however, preclude claimants from recovering from their index-related psychological injuries (i.e., eggshell skull rule) but it does behove the expert to carefully unpick pre-event history and immediate post-event history to reliably assess what injury is clearly attributable to the index event, whether this be a de-novo disorder/symptoms or an exacerbation of pre-existing symptoms. This exists in the ever-present context of the claimant’s truthfulness or otherwise.

Assessing causality of PTSD-related symptoms is highly specialised and fascinating endeavour (Gholizadeh and Malcarne, 2015). There are different conceptualisations of causality in the fields of psychology and law and especially associated with determining the apportionment of causality across various life factors. Although some level of subjectivity is unavoidable, it is crucial to bring an evidence-based approach and scientific rigour to the causal evaluations required for determining compensation for trauma.

In law, causality is not a scientific phenomenon but rather a practical endeavour involving principles like the ‘but for’ test and the material cause(s) relating to an index event. In contrast, in psychology, causation involves a scientific analysis of the multiple underlying mechanisms to describe a phenomenon. Whereas the mental health professional will adopt a biosocial psychological perspective in which “complexity rules”, the lawyer will adopt a more reductional approach, encouraging logical and concise causation analysis.

Legal decision making and legal tests

The court requires experts and counsel to have credibility and understanding of the applicability of legal tests when discussing psychological disorders such as PTSD.

Key phrases which are pertinent include: on the balance of probabilities; ‘But for’; reasonable expectations/Bolam test of negligence. The U.S-based tests worthy of note include the Frye test and the Daubert ruling (Woody, 2016). But what do these tests mean and how do they apply to PTSD?

1. **On the balance of probabilities** – asking yourself is it more likely than not that situation X or symptom cluster Y would have arisen.
2. **‘But for’** – asking yourself what the likely to probable symptomatic picture would have been if the index event had not occurred.
3. **Frye test** – applied to most experts in the U.S, the question asked is does the evidence presented have ‘general acceptance’ in the particular area of professional expertise.
4. **Daubert ruling** – this added more scientific criteria to Frye and asks whether there is an adequate scientific basis for testimony.

Three case studies illustrating pertinent diagnostic issues in PTSD

The case studies summarised here relate to potential PTSD diagnosis in three very different contexts: a high-speed motorway road traffic accident; a case of sexual harassment; and a military post-war zone case. It is impossible for a single case study to illustrate all potential issues but these three vignettes clarify some of the issues presented in this paper.

1. High speed motorway road traffic claimant

One of the most common ‘domestic’ type of accident occurring and claimed for. As in case studies a. and b., the PTSD diagnosis rests significantly on the meeting criterion A of life-threatening experience. Most RTAs occur very suddenly and within a second or two have stopped. The claimant rapidly realises he/she is alive, with or without physical injuries. Subsequent thoughts (“what might have happened”) and comments from first responders (“you were very lucky, another second and…”) both contribute to subsequent high levels of anxiety but are not necessarily confirmation of criterion A. Other common psychological symptoms, for example, ‘flashbacks’ and ‘intrusive thoughts’ are widely known as labels by claimants but when disclosed do not meet the criteria of semi-dissociative experiences. Dissociative avoidance is common. Common range of diagnostic opinion include Acute Stress Disorder, Specific Phobia (travel) and Somatic Symptom disorder.

1. Sexual harassment claimant

Allegations of sexual harassment combined with PTSD create a high level of controversy when brought before the courts, with over-simplification of the complexity of the symptom patterns under scrutiny. Harassment is rife with the potential for clinical misunderstanding and litigation-related misuse because it manifests in many forms (Fitzgerald et al, 2013). One key difficulty is the absence of classical criterion A despite a high level of stress and anxiety being associated with the index event. This can result in the use of other non-PTSD diagnoses such as Adjustment Disorders or Anxiety Disorders. An alternative is to utilise the ICD-10 diagnosis of PTSD which is less reliant on the criterion A in DSM-5. However, in the Fitzgerald et al judgement, rather than engaging in an academic, and somewhat arid, debate about the phenomenological reality of the incident and its aftermath, it is better to give a full description of the symptom cluster(s), with causation and prognosis, much of which will be consistent with what we know to be PTSD.

1. Military post-war zone claimant

PTSD is a diagnostic category developed in war zone-type contexts such a post-Vietnam conflict, mid-20th Century, and complex psychological and social ramifications were aptly described in films such as ‘The Deer Hunter’. Despite debates about the motivation and personality-type of soldiers and military action, the horrendous types of experience that military personnel experience, makes PTSD criterion A much more likely to be met. Co-morbidity with substance abuse disorders and major depressive disorders in common, and treatment and prognosis is lengthier and more problematic.

Validity and the narrative fallacy

DSM-5 alongside clinical and medico-legal practice over the past 6+ years, raises a range of new conceptual, methodological and clinical practice issues when considering the presence or absence of PTSD. Discussions extend to the issue of disorder threshold and the risks of over- or under-diagnosis with associated vulnerability of experts during courtroom testimony as a result (Schultz, 2013).

Low diagnostic thresholds for PTSD means that more people with normal variations of stress will receive a diagnosis of PTSD, with resulting increase rates of false-positives. These may consequently be questioned in terms of legitimacy and reliability.

The inclusion of functional/behavioural activities for daily living (ADL) implications of PTSD is an important advantage/issue in DSM-5, alongside social, occupational and recreational function. As in all other areas, this needs reliable assessment, perhaps hampered by lack of psychologist and psychiatrist preparation for Activities For Daily Living (ADL) assessment.

A serious question for experts is to what extent they are influenced by, what is called, the “narrative fallacy” (NF) when assessing the psychological issues of trauma victims. The NF is associated with our tendency to establish logical links between different facts, resulting in over-diagnosis, heightened severity, and negative implications for legal decision makers i.e., at risk of awarding disproportionately high compensation for injury or rehabilitation. Research indicates that claimants are more often assigned a diagnosis such as PTSD if the psychological symptoms had been caused by a traumatic event than if that hadn’t been the case. It was speculated that experts “filled in missing information” and were over-suggestible to justify the assignment of a diagnosis of, for example, PTSD by imagining PTSD-specific symptoms of intrusion and avoidance (Kunst et al, 2016).

Despite being trained and experienced in conducting assessments, not all psychologists and psychiatrists are familiar with the specific demand and nuances of medico-legal evaluations (Piechowski, 2015). Misconception about the nature and purposes of these assessment, errors in data collections and use of flawed reasoning in interpretation can reduce the validity of the evaluation.

1. Validity is the overall judgement of the degree to which available evidence (empirical and clinical) and theoretical rationale support the interpretations of the expert (Messick, 1995). Many aspects of validity are outside the control of the expert or the court e.g. intentional misrepresentation; less than full effort under examination. Several expert-related validity threats were identified by Piechowski (2015) covering
2. Conceptual errors: seeing evaluation as more clinical than forensic (Koch, 2018); less objectivity and impartiality; failing to understand disability as a legal construct; under-emphasis on functional capacity.
3. Data collection errors: failure to incorporate multiple data sources and over-reliance on self-report.
4. Inferential errors: unsupported assumptions about response style and effort; failure to consider alternative hypothesis; confirmation bias; financial/payment bias; under-utilisation of base rates of PTSD diagnosis.
5. Malingered PTSD and Detection systems

As with any psychological disorder, PTSD is subject to feigning by claimants and a robust legal system has checks and balances to increase the frequency of fake positives. This requirement is reinforced by the high rate of PTSD found in individuals involved in military combat and captivity, the level of monetary benefits and the fact that research suggests that PTSD is relatively easy to feign, malinger or magnify. Rates of feigning found in research studies can reach as high as 60% (Tolin et al, 2010).

Detection system layers depend on the semi-structured interview and consistency evaluation across multi-source information (e.g. medical records; occupational records).

Given the pressure to process PTSD claims in a certain amount of time and expense, many experts have to limit the amount of time provided to determine if an individual has PTSD and if this condition is related to a traumatic event or events. Despite these time limits, experts are ethically obliged to perform thorough, accurate and robust evaluation. Because PTSD is particularly easy to fake, expert examiners need to be extra careful when examining claimant claiming to have PTSD.

Whilst it is certainly quite possible to simply ‘describe’ a list of symptoms in an assessment situation it is, however, much more difficult to convincingly ‘fake’ the strong emotions that accompany the symptoms themselves. This is especially the case when discussing one’s traumatic experiences with a therapist (and assessor) who will have had a great deal of experience of working with strong, and very real, emotion in the therapy room. The test being that the assessor is considering the degree to which the narrative or the ‘telling’ of the events reflects, and is therefore congruent with, the emotion experienced in the room. By extension this also includes a shared awareness of the ‘shame’ that many feel when they are suddenly emotional in an assessment despite their best efforts to ‘keep a lid on things’.

Recognising Incoherence in Evidence

A common medico-legal experience, both with lawyers and experts, is being confronted by a number of apparent or paradoxical clusters of information about trauma with are logically incoherent (Merten, 2017).

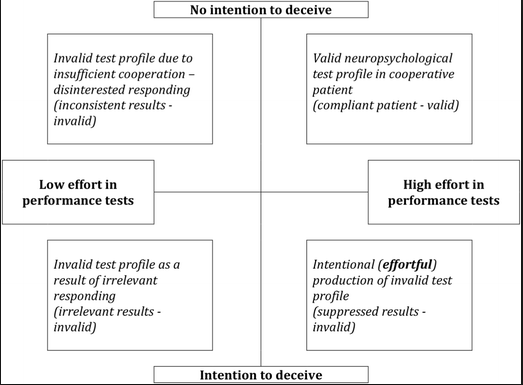
Typical examples of this involve concurrent chronic pain (with psychological features), dissociative experiences, and exaggeration/magnification of symptoms. Involuntary, unconscious motivation overlap or get confused with conscious manipulation and compensation seeking.

These logical dilemmas and paradoxes potentially undermine the quality of medico-legal determinations, resulting in incorrect diagnostic determinations and the formulation of logically flawed expert opinion about trauma symptoms or lack of trauma symptoms.

The ‘conscious/unconscious’ dimension is one which confronts experts and lawyers when dealing with trauma assessments and is often linked to the effort paradox linking potential intentions to deceive and effort level during evaluations.

The figure II below illustrates this (Merten, 2017).

Figure II.



It is crucial to understand that the judgement about malingering is not made on the basis of any one simple piece of data (Etherton, 2014). Instead an opinion on PTSD is a decision based on consideration of the full range of data including interview data, data from testing, information from medical records and collateral records, as well as clinical experience. The expert(s) must evaluate any apparent inconsistencies among these sources of information.

Impact of PTSD on Legal Decision Making

Vallano (2013) reviewed how psychological injury evidence impacts on legal decision making and identified the following themes:

1. Courts generally devalue psychological injury making it difficult for claimants to pursue and succeed in these claims.
2. These difficulties are likely a bi-product of legal decision makers’ misinterpretations of mental disorders. This particularly applies to PTSD.
3. Understanding the presence of admissibility of pre-existing psychological injury.

It is important to understand legal decision makers’ perceptions of PTSD and psychological injury, in general, because these perceptions will affect legal judgements in terms of liability determination (presence/absence of physical injury; severity of psychological injury), and compensatory damage determinations. The frequent underappreciation and difficulty to obtain fair recovery for valid PTSD claims is most likely due to erroneous perceptions about the causes, consequences and legitimacy of PTSD claims (Vallano, 2013). Although legal decision makers may perceive PTSD claims as lacking objectivity, severity, and at times, credibility, these beliefs have little empirical support.

Understanding Trauma-related dissociation

Chronic dissociative reactions and disorders can occur following traumatic events and can be disruptive and frightening.

They include depersonalisation, derealisation, flashbacks, dissociative amnesia and identity confusion. For example, depersonalisation includes experiences such as feeling unreal or emotionally numb, or seeing oneself at a distance, as if in a movie. Dissociation can occur in non-trauma contexts but is most prevalent in disorders linked to traumatic stress. Individuals who have experienced complex trauma i.e. traumatic events that occur throughout an individuals’ lifetime are especially likely to experience dissociation (Brand et al, 2017).

To avoid inadvertently providing ‘training’ to claimants who are inclined to exaggerate or malinger symptoms, expert assessors should not use professorial language such as ‘dissociation’ or ‘flashbacks’. Many people do not understand the meaning.

Malingering occurs in 2-14% of individuals with dissociation. Distinguishing between exaggerated, malingered and genuine dissociative disorders is complicated and feigning maybe partial.

Expert resilience in interviewing and evidential robustness

Using clinical and collateral interviews and thorough review of records, both lawyers and experts work to provide useful, objective information to the court. They must gather information that contradicts, as well as supports one’s opinion. In addition, collateral sources must be weighed up against self-report data, with evaluators striving for neutrality, logicality and fairness (Wygant and Lareau, 2015).

Very often the key psycho-legal question or questions will be clear. Occasionally the instructing lawyer will not have a thorough grasp of the specific issue needing to be evaluated.

Given the inherent and significant secondary gain of a PTSD diagnosis in a civil case, the evaluator must be ever-aware of potential distortion in symptom reporting – research estimates that symptom exaggeration occurs between 18-33% of the time in criminal and civil cases (Mittenberg et al, 2002).

Any distortion needs to be picked up in order to achieve clarity, objectivity and transparency. The cautious assessor must be aware of the various controversies, diagnostic and other, to be certain not to over- or under-diagnose PTSD.

Conclusion

The diagnosis of PTSD and identifying valid and reliable opinions on causation and prognosis require that both lawyers and experts have a comprehensive and robust awareness of the range of possible opinions, the significance of both reliable and unreliable evidence and the complexity of pre-index event and post-index event causation. Perhaps due to greater quantum implications of a PTSD diagnosis and narrative, greater care needs to be taken in assessing honesty, ­­­­overstatement of difficulties and differentiating between when a claimant’s motive is to convince rather than deceive (Koch, 2018) and also where one aspect of a claim appears invalid or, in extremis, dishonest whereas other aspects are valid.

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