POSTTRAUMATIC STRESS DISORDER THE COURTROOM DIAGNOSIS

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Posttraumatic Stress Disorder (PTSD) is the mental illness of the nineties. In fact, with the number of cases of PTSD being diagnosed today, it can almost be called a growth industry. This apparent epidemic has been fueled by litigation in which PTSD serves a role as evidence of emotional damages. Its popularity springs from many reasons, not the least of which is that the symptoms of the disorder are difficult to prove or disprove. However, the main reason for its popularity in civil litigation is that causation is built into its name. No other mental disorder both establishes damage as well as the source of that damage, i.e. an identified trauma. There is no question that the disorder exists, but its increasing use requires closer scrutiny into the natural course of this condition, the reliability of its features, and its actual cause. The trauma in its name may not deserve the blame.

PTSD historically arose from the understanding that individuals in wartime might suffer from extreme emotional experiences during the horrors of battle. This was at times called shell shock or battle fatigue. Psychiatrically, formal labels like gross stress reaction or traumatic neurosis were applied. By 1980, the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders III (DSM III) officially listed Posttraumatic Stress Disorder (PTSD) as a recognizable diagnosis. The essential feature of the disorder was the development of characteristic symptoms following a distressing event which was outside the range of usual human experience. Besides wartime experiences, this could include rape and assault, natural disasters such as floods and earthquakes, large fires, bombings, torture, or airplane crashes. They did not include such common experiences as simple bereavement, chronic illness, business losses, marital conflict, or minor accidents. The fundamental element of the trauma was that it created a situation of intense fear, helplessness, or horror. Typically, it was life threatening and the individual felt trapped. The impact was considered so severe that it caused an insult to the psychological integrity of the individual from which reverberated emotional after-shocks. As if it was a broken record, the mind would play back the event over and over, attempting to subdue its emotional impact. This unconscious and intrusive process of recollections would be out of the control of the individual. In addition, the individual would form a protective psychological shield against further trauma by becoming numb or removed from the environment, often in a dazed or dissociated way. Characteristically, contact with anything that reminded the individual of the traumatic experience would elicit an excessive emotional response.

Of course, being exposed to traumatic events is part of living and it is difficult to measure what is outside the range of usual human experience. Some studies report that 75% of the population is exposed to traumatic events that might meet the criteria for PTSD. In the last 60 years, countless numbers of Americans have participated in military combat in three major wars and numerous other campaigns. 75% of women report being the victim of a crime and 25-50% of sexual assault. Childhood sexual abuse is estimated to occur in more than 25% of young girls and close to 20% of young boys. Domestic violence is a growing problem in our society as is violence generally. Regularly, we read about natural disasters throughout our land and their devastation on individuals, families, and communities. Yet, not everyone who is exposed even to severe trauma develops the characteristic symptoms of PTSD, perhaps no more than 25%. Even if PTSD symptoms appear after a traumatic experience, this rarely results in a major disability.

Looking back historically most holocaust survivors, combat veterans, and prisoners of war did not become disabled even if they could not totally erase the trauma from their minds. Yet, in litigation today, even minor motor vehicle accidents, insults and harassment, and relatively

insignificant confrontations and conflicts are all claimed to be the precipitants of PTSD. The American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders IV (DSM IV) has tried to narrow and refine the definition, recognizing how its over broad use has led to abuse. Specifically, it now requires that the traumatic event is one in which: the person experienced, witnessed, or was confronted with an event or events that involved actual or threaten death or serious injury, or a threat to the physical integrity of self or others, and the person's response involved intense fear, helplessness or horror.

The traumatic event must be persistently re-experienced through recurrent or intrusive distressing recollections, dreams, actions or feelings as if the event were recurring; and should include intense psychological or physiological reactions when exposed to something that symbolizes or reminds the person of the trauma. In addition, individuals with PTSD demonstrate a persistent avoidance of stimuli that are associated with the trauma and a numbing of their general responsiveness to the environment. Finally, there must be evidence of increased arousal or hypervigilance as an aftermath of the traumatic experience. The course of PTSD is variable. At times the symptoms present themselves acutely in the immediate aftermath of the traumatic event. These are known as acute symptoms. If the duration is longer than three months, they become chronic. In some instances the onset is six months or more after the traumatic event and is known as delayed onset (see Diagnostic and Statistical Manual of Mental Disorders IV. Washington, D.C., American Psychiatric Association Press, 1994.)

Unfortunately, as sophisticated as these revised criterion seem, the diagnosis is still difficult to make and is based primarily on subjective descriptions by the individual who is suffering. Although there are numerous psychological tests and scales which attempt to objectify the diagnosis, they too are based on subjective accounts. Physiological measures have also been developed but positive results may represent a general stress response that is not limited to someone who has actually experienced a trauma. Some psychologists try to erroneously conclude that the presence of symptoms of PTSD must mean that a trauma actually occurred. To date there is no scientifically reliable research or other data to conclude that this can be done. Individuals may experience intense distress even at something that they imagined occurred or their perception of having been traumatized, regardless of what the actual event was. Similarly, it is almost impossible to discern whether someone is experiencing an intrusive recollection of a traumatic event or is just choosing to keep a bad memory. As unusual as it may seem, people do retain bad memories because of their anger, feeling of victimization, or pursuit of vindication in a law suit. In fact, litigation is sometimes the major stressor that keeps bad memories alive and the secondary gain expected from a damage award can maintain or even increase symptoms over time. Understanding that PTSD victims even after extremely traumatic experiences are usually not disabled, it is then surprising to see the degree of disability that is part of the litigation of PTSD today. Coupled with these disability claims are often colorful and dramatic descriptions of flashbacks and functional impairments, while possible, they are usually unverifiable.

The evaluation of PTSD requires a comprehensive analysis which starts with a thorough understanding of the alleged traumatic event. Accident reports, police and hospital records must be examined carefully because they often contain the first accounts of what occurred and what the individual really encountered. The claim must be assessed in relation to the specific criteria established by DSM IV. Are the symptoms claimed in proportion to the severity of the stressor? What corroborative data exists besides the individuals subjective account? Even if posttraumatic stress symptoms are possible, is an actual disorder likely, and would disability be expected? What alternative explanations are there for the individuals distress? What life factors and situational conflicts may be playing a greater role? Are there personality characteristics or pre-existing emotional disorders which may be more instrumental in the claimed distress? Does the context of the claimed traumatic event

demonstrate reasons for anger, vindication, avoidance, or other conflict resolution? Because 60-80% of individuals with PTSD have substance abuse disorders, is this a secondary complication or a pre-existing problem? Is the presence of an anxiety or depressive condition also a complication or a pre-existing problem? The evaluation of PTSD claims should not take away from the legitimate distress of traumatized victims, but the rampant use of this diagnosis in litigation trivializes their plight and, therefore, should be carefully and objectively scrutinized. (see Simon, R. I.: Posttraumatic Stress Disorder in Litigation: Guidelines for Forensic Assessment Washington, D.C., American Psychiatric Association Press, 1995)