KAPLAN CONSULTING AND COUNSELING
(216) 766-5743

Winter 2006

Volume 1, Issue 3

Insights.... On Trauma and PTSD

Trauma and PTSD in Litigation

In civil and criminal courts of law, Post Traumatic Stress Disorder (PTSD) is often alleged whenever there has been an accident, criminal violence, and even sexual harassment.

Specifically, PTSD can be alleged in cases that include:

- Personal Injury
- Disability or pension claims
- Child custody, domestic violence, or marital disputes
- Criminal litigation where PTSD has been used as a complete defense for a crime (insanity defense)
- Partial defense to refute an element of a crime (diminished capacity)
- As a basis for mitigation of a criminal penalty

Since PTSD claims are becoming more and more common, it is imperative that legal professionals have a good understanding of this mental disorder. In many cases, PTSD is often either overlooked or misdiagnosed, as well as malingered. There is confusion over what types of events can cause PTSD. Symptoms of PTSD also overlap with symptoms of many other mental disorders. Furthermore, not everyone exposed to the same traumatic event will automatically develop PTSD. Studies show that some individuals are more vulnerable to the disorder. PTSD is often complicated by other mental disorders as when individuals use alcohol or drugs to medicate their PTSD symptoms. Furthermore, PTSD may not develop until years after a traumatic event. This issue will explore all of these aspects of PTSD.

Problems Diagnosing PTSD in Litigation

Errors leading to an underdiagnosis or an overdiagnosis of PTSD reduce the credibility of the diagnosis. Consequently, such errors warrant serious consideration.

Common errors leading to the overdiagnosis of PTSD include the following:

- Failure to distinguish expectable emotional distress from mental disorder
- Application of fewer criteria than are required for the proper diagnosis
- Failure to consider the contribution of earlier, unrelated traumatic events to the claimant's distress with resulting false attribution to the traumatic event
- Failure to diagnose preexisting psychopathology
- Failure to identify a family history of mental disorder that may point to biological or genetic causes
- Failure to consider an alternative diagnosis

Common errors leading to the underdiagnosis of PTSD include the following:

- Characterization of PTSD symptoms as a normal reaction to the traumatic event
- Basing opinion on general interviews, without an attempt to explore details of the traumatic event and subsequent symptoms
- Using idiosyncratic thresholds for diagnosis
- Failure to acknowledge the possibility of a PTSD diagnosis despite the presence of vulnerability factors
- Attributing PTSD symptoms to preexisting psychopathology
- False attribution of symptoms to other life events
- Adherence to narrow, outdated theories of etiology (e.g., all mental illness is inherited)
- Failure to consider relevant, supportive PTSD literature

Inside this issue:

Prepared by

Kaplan Consulting and Counseling, Inc.
Robert G. Kaplan, Ph.D.
3401 Enterprise Parkway
Suite 340
Beachwood, Ohio 44122
Call: (216) 766-5743
RKapan@KaplanCC.com

Expertise in

- Forensic Psychological Evaluation
- Posttraumatic Stress Disorder
- Workers' Compensation
- Disability Evaluation
- Workplace Violence
- Sexual Harassment

Insights is a newsletter published by Kaplan Consulting and Counseling, Incorporated as a free service to legal professionals. Comments regarding this issue, suggestions for future issues, and requests for additional copies can be directed to the attention of Thomas A. Moran, J.C.D., B.C.E.T.S., Senior Litigation Analyst. Call (440) 225-4614 or e-mail thmoran@comcast.net.

Diagnostic Symptoms of PTSD

Gateway Criteria (A Criteria) — both of the following are required for the diagnosis

- The individual experienced or witnessed an event that involved or threatened serious injury, death, or violation of one's person (A_1)
- The event caused great fear, helplessness, or horror (A_2)

Reexperiencing Symptoms (B Criteria) — one of the following

- Recurrent and intrusive recollections of the event (B_1)
- Nightmares of the traumatic event (B_2)
- Experiences that cause one to feel as if he/she were reliving the event (B_3)
- Increased fear, anxiety, or terror on exposure to reminders of the trauma (B_4)
- Increased symptoms of arousal on exposure to reminders of the trauma (B_5)

Avoidant/Numbing Symptoms (C Criteria) — at least three of the following

- Efforts to avoid thoughts, feelings, conversations, activities, places, or people associated with the traumatic event (C_1 and C_2)
- Amnesia or gaps in the recalled chronology of the traumatic event (C_3)
- Diminished interest in previously enjoyed activities (C_4)
- Feelings of detachment or estrangement from others (C_5)
- Emotional numbing with the appearance of being emotionally flat, unresponsive, cold, indifferent, or lacking in vitality (C_6)
- A sense that one's expected course of life will be short lived or altered (C_7)

Hyperarousal Symptoms (D Criteria) — at least three of the following

- Sleep disturbance (D1)
- Irritability and outbursts of anger (D_2)
- Difficulty concentrating (D_3)
- Being constantly on guard and vigilant for signs of danger (D_4)
- Exaggerated startle responses to unexpected noises, flashes of light, movements, etc. (D_5).

Duration

- Symptoms must last more than 1 month
- Symptoms can develop long after the traumatic event

PTSD Criteria:

Traumatic Event

Reexperiencing

Avoidance and Numbing

Hyperarousal

What is a *Traumatic* Event?

In order to determine if an event that precipitated litigation was of sufficient magnitude and threat to qualify as a traumatic stressor, the following questions should be asked:

- Did the claimant suffer a severe or life-threatening injury as a result of the traumatic event?
- Did the claimant suffer a physically disabling injury that could conceivably limit employment or the accomplishment of important life goals?
- Did the claimant witness a death or severe injury?
- Did the claimant have a realistic fear that his/her life was in danger despite the lack of a traumatic injury?
- Did the claimant suffer some threat to or violation of his/her person (e.g., rape)?

Should the claimant respond "yes" to one or more of these questions, one must then ask for a description of his/her emotional state at the time of the traumatic event. The diagnostic criteria require that an individual experienced great fear, helplessness, or horror as a result of this event.

One should also ask the claimant what he/she anticipated happening to him/her during the trauma (e.g., loss of life, life-threatening injury, threat to personal well being) and inquire about the diagnostic symptoms of PTSD listed above.

Ask About:

A Life-Threatening Injury

A Disabling Injury

Witnessing Death

Witnessing Severe Injury

Fearing for One's Life

Violation of One's Person

Risk Factors for PTSD

Early PTSD studies focused on establishing the primacy of the trauma as the causal agent, rather than individual vulnerability factors. Nonetheless, it was clear that not all trauma survivors developed PTSD. Data actually indicate that the rate of exposure to trauma exceeds the prevalence of PTSD. Having learned that most people do not develop PTSD following a traumatic event, researchers then investigated risk factors that increased vulnerability to chronic forms of the disorder. To date, several significant risk factors have been identified:

- **Environmental Risk Factors**. A history of prior exposure to trauma, especially if experienced at a younger age, is an extremely potent risk factor for PTSD. The type of prior trauma is equally important. For example, prior assault and history of family instability are associated with an increased prevalence of PTSD.
- **Demographic Risk Factors**. Studies indicate that the female gender, lower levels of education and income, and marital status as divorced or widowed, all increase one's vulnerability to PTSD.
- **Prior Mental Disorders**. A past history of behavioral or psychological problems has also been associated with the development of PTSD. Personality dimensions also warrant consideration. Avoidant, antisocial, or neurotic personalities prior to the traumatic event carry an increased risk for the development of PTSD.
- **Dissociation**. Those whose state of consciousness or level of alertness is easily altered by stress have increased vulnerability to PTSD.
- **Cognitive and Neurological Risk Factors**. According to studies, lower intellectual functioning and preexisting impairments in brain development act as risk factors for the development of PTSD.
- **Biological Risk Factors**. Studies also have shown that preexisting health problems increase one's vulnerability to the effects of trauma.

Risk Factors for PTSD:

Prior Trauma

Gender and Social Status

Prior Mental Disorders

Low Intelligence

Developmental Delays

Health Problems

Complications of PTSD

PTSD often occurs with at least one other disorder. The National Comorbidity Study of 1995 reported that approximately 80% of all men and women with PTSD exhibited at least one other diagnosis. The other mental disorders most likely to occur with PTSD are:

- Alcohol Dependence - 52%
- Major Depressive Disorder (severe depression) - 48%
- Simple Phobia (specific fears) - 30%
- Social Phobia (social anxiety) - 28%
- Dysthymia (mild depression) - 22%
- Generalized Anxiety Disorder - 16%

Notable gender differences also were found. In addition to PTSD, females were likely to have Major Depressive Disorder, followed by Simple or Social Phobia and Alcohol Abuse/Dependence. Males were more likely to have Alcohol Abuse/Dependence, followed by Major Depressive Disorder and Conduct Disorder.

Comorbid substance abuse is a relatively common clinical occurrence that complicates psychological treatment considerably. Many use alcohol or drugs as a temporary relief from somatic complaints. General population estimates for comorbid Alcohol Abuse/Dependence are 52% for men and 28% for women. In the majority of these cases, PTSD is the primary disorder.

Fatigue, headaches, gastrointestinal complaints, immune system problems, chest pain, and various forms of physical discomfort are common in people with PTSD. Additionally, there is growing evidence to indicate that exposure to catastrophic events can cause medical disorders affecting cardiovascular, endocrinological, musculoskeletal, and other physical systems.

Comorbid Disorders:

Major Depression

Simple (specific) Phobia

Social Phobia (anxiety)

Dysthymia (mild depression)

Generalized Anxiety

Substance Abuse

Facts About PTSD

Estimated chances for developing PTSD following specific traumas:

- Rape (49%)
- Other sexual assaults (23.7%)
- Physical assault (31.9%)
- Serious accident or injury (16.8%)
- Shooting or stabbing (15.4%)
- Sudden unexpected death of relative or friend (14.3%)
- Child's life threatening illness (10.4%)
- Witness to killing or serious injury (7.3%)
- Natural disaster (3.8%)

Those most likely to develop PTSD include:

- Victims of violence
- Those who have witnessed acts of violence
- Those repeatedly exposed to life threatening situations
- Survivors of domestic abuse, rape, sexual assault, sexual abuse, and physical assault
- Survivors of hazards including automobile accidents, fires, and natural disasters
- Survivors of major catastrophic events (e.g., airplane crashes, acts of terrorism)
- Victims of industrial accidents
- Physically, sexually, or verbally threatened children
- Children who are victims of severe neglect
- Combat veterans
- Civilian victims of war
- Those diagnosed with a life-threatening illness
- Those who have undergone invasive medical procedures
- Professionals who respond to victims in traumatic situations (e.g., police, firefighters, search and rescue workers)
- Those who learn of the sudden, unexpected death of a relative or close friend

Recovery From PTSD

Like other psychiatric disorders, the severity of PTSD can vary from mild to severe. Most people recover fully from PTSD. Some people with PTSD are able to lead full and rewarding lives despite the disorder. For others, however, PTSD can be a persistent, incapacitating condition characterized by severe and intolerable symptoms. The long term course for most people with chronic PTSD is marked by remissions and relapses. Some make a full recovery, others experience partial improvement, and still others never improve. Generally, there are three categories of PTSD:

- **Lifetime PTSD**. Although 50% of initial PTSD cases remit without treatment within one year, a substantial number of cases do not remit for many years. Therefore, PTSD claims that are over a year old generally have a low probability of remitting without treatment. Moreover, 40% of patients who receive even the best treatments for PTSD have a significant chance of not being helped.
- **PTSD in Remission**. Those in remission may experience sudden relapses and begin to exhibit the full pattern of PTSD symptoms. These patients probably have been exposed recently to a situation that resembled the original traumatic event in a significant way.
- **Delayed Onset**. Some of those exposed to a traumatic event seemingly do not exhibit PTSD symptoms for months or even years later. As with relapse, the immediate precipitant is usually a situation that resembles the original trauma in a significant way.

Malingered PTSD

According to a clinical decision model of malingered PTSD, the presence of two or more of the following indicate malingered PTSD:

- Poor work record or job dissatisfaction
- Prior history of "incapacitating" injuries
- Discrepant capacity for work and recreation
- Non-cooperation with evaluation
- Antisocial personality traits
- Over-inflated report of functioning before the trauma
- Evasiveness or contradictions
- No nightmares or, if nightmares, exact repetitions of trauma
- Admission, test results, or other corroboration of malingering

For a fuller treatment on the general topic of malingering see ***Insights***, Issue 1.

We're on the web: http://www.KaplanCC.com