Chapter 5

Guidelines for the Forensic Psychological Assessment of Posttraumatic Stress Disorder Claimants

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This chapter presents a multidimensional approach to the psychological assessment of posttraumatic stress disorder (PTSD), with a particular emphasis on reviewing the extant psychological tests, clinical interviews, and the data substantiating their use in the measurement of PTSD. Issues of etiology, causality, severity, and course generally are prominent in forensic examinations, but with respect to PTSD these factors assume increasing importance and salience. Procuring information and data that bear on each of these dimensions is a primary goal of the comprehensive assessment of PTSD recommended in this chapter. Accordingly, appropriate psychological assessment for PTSD involves a series of integrated steps for the clinician.

To obtain needed information on which the clinician can draw reliable and valid conclusions regarding the diagnosis of PTSD and its impact, the following steps are to be considered when possible:

1. The conduct of a standard comprehensive clinical examination that focuses on family and developmental history and preevent and postevent factors related to current day functioning; this examination would also include the procurement of information on the traumatic event itself in considerable detail

2. The use of a structured clinical interview that provides an opportunity to explore the range of possible Axis I and Axis II diagnoses that may be applicable to the individual (e.g., the Structured Clinical Interview for DSM-III-R [SCID; Spitzer et al. 1990])
3. The use of general personality questionnaires to provide information on functioning more broadly (e.g., the Minnesota Multiphasic Personality Inventory [MMPI; Hathaway and McKinley 1989])
4. The administering of specific tests that directly measure PTSD and its associated clinical features (e.g., the Mississippi PTSD Scale [Keane et al. 1988b])
5. The inclusion of measures of social role functioning to determine the extent of social and vocational impairment (e.g., Social Adjustment Scale [Weissman et al. 1990])

Clinical judgment is required when evaluating and integrating the data from all of these measures and in adjudicating information that is discrepant regarding the presence or absence of PTSD.

Since the inclusion of PTSD in the diagnostic nomenclature of the DSM-III (American Psychiatric Association 1980), research and development has centered on appropriate measurement strategies. In the intervening years there has been considerable progress in PTSD assessment, and these advances have been driven by conceptual models regarding the assessment of psychopathology generally and PTSD specifically (e.g., Keane et al. 1987; Sutker et al. 1991). These models have emphasized the importance of a comprehensive evaluation of 1) the nature of traumatic events (e.g., intensity, frequency, duration, detailed descriptors), 2) the characteristics of the person exposed (e.g., demographic data, personality factors, pretrauma vulnerabilities and strengths), and 3) the expression of symptoms by a person in certain ideographic patterns following exposure. The conceptual approaches advocated by clinicians to assessing PTSD are at once dynamic and interactive, placing a greater emphasis on longitudinal rather than cross-sectional views in understanding the many possible psychological outcomes associated with exposure to traumatic stressors. These conceptual models offer an excellent premise and foundation for the psychological assessment of PTSD in the forensic arena.

In addition to the conceptual models for assessing PTSD, Keane et al. (1987) also recommended that clinicians secure information from people other than the individual under examination and from as many sources as possible. The use of multiple methods of data collection within a measurement domain (e.g., psychological testing) was also recommended. Thus

information from the informant, collateral sources (e.g., family, friends, neighbors, employees), structured clinical interviews, psychometric measures, and even psychophysiological assessment creates vectors of convergence from which the clinician can draw conclusions regarding the presence or absence of PTSD and its impact on social, marital, and vocational functioning. Given the imperfect nature of any single measure of PTSD, or of any psychological disorder for that matter, it is important for the clinician to apply this multidimensional approach to the assessment of PTSD.

Issues in the Psychological Assessment of PTSD

As stated previously in Chapter 2 of this book, the proper evaluation of PTSD contains many dimensions for the clinician to consider. Possibly the most frequent problem made by clinicians in conducting psychological assessments for PTSD is the assumption by the clinician that when a person is exposed to a stressor of traumatic proportions the psychological consequences are necessarily PTSD. The research literature clearly suggests that PTSD is only one of many possible consequences associated with trauma exposure (e.g., Keane and Wolfe 1990; Shore et al. 1986). Other disorders such as depression, generalized anxiety, substance abuse, and panic can also occur after traumatic exposure. As a result it is critical to determine the extent to which PTSD is present or absent in the subject examined.

A second feature of the PTSD examination is to ensure that PTSD, when it is observed, is secondary to the event in question. As our society enters an increasingly technological era, the possibilities for exposure to high-magnitude stressors over the course of the lifetime expand. Coupled with the dramatic rise in violence, and in particular sexual assault and domestic battering, there is a distinct possibility that a person can be exposed to multiple traumatic events. Some researchers have found that exposure to a traumatic event and the subsequent development of PTSD may indeed be related to previous trauma exposure (e.g., Helzer et al. 1987; Kilpatrick et al. 1992; Kulka et al. 1990). These research findings compel clinicians to examine patients for a range of traumatic events beyond the target event in litigation. Efforts to attribute psychological functioning to a single event will be significantly diminished if examinations by others indicate the presence of exposure to additional high-magnitude life events that could themselves yield PTSD. Assessment of social role functioning before and after the event in question is of paramount importance in understanding the

role of the targeted event in the life of the person.

A third issue of some importance in PTSD assessment is the presence of a previously existing psychological disorder. Research to date indicates that one of the major vulnerabilities in the development of PTSD once an individual is exposed to a traumatic stressor is the existence of preexisting psychopathology (Helzer et al. 1987; Keane et al. 1993; Kulka et al. 1990). If preexisting psychopathology is evident, then the clinician's attention should address issues of severity of disorder by virtue of the addition of the PTSD comorbidity. Moreover, deterioration in psychosocial functioning that may be apparent in the interpersonal, social, marital, parental, or, most important, the vocational domain would then assume increased importance. Identification of changes in functioning concurrent with the traumatic exposure is generally key in circumstances of litigation but is crucial when a psychiatric history is present. Moreover, the addition of a concurrent disorder (in this case, PTSD) to the preexisting condition unquestionably leads to a more severe psychological condition, and this would be reflected most aptly in clinician ratings on Axis IV (i.e., psychosocial stressors' severity) and Axis V (i.e., global assessment of functioning). Such information would be clearly relevant to the forensic case at hand.

A fourth issue associated with the assessment of PTSD is the frequent association of PTSD with other Axis I disorders. Even in cases in which there is no previous psychological disorder, the presence of PTSD is often complicated by the emergence of other disorders concurrently or over time. In particular, disorders such as major depression and substance abuse can obfuscate the clinical picture and confuse even the most discerning eye. With respect to major depression, the clinician is most often struck by the unremitting course of the disorder since the occurrence of the traumatic event. Unlike other forms of depression seen in the absence of PTSD, depression, when combined with PTSD, seems to remain relatively constant—and sometimes in the most nefarious cases it is even exacerbated over time. Phenomenologically, the depressive state appears more as a "double depression," bearing characteristics of both major depression and dysthymia.

If substance abuse is involved, it is important to clarify the onset of the alcohol or drug use. Most often in cases of trauma, the substance abuse is an effort to self-medicate the anxiety, depression, and emotional numbing of PTSD (Keane et al. 1988a). This pattern obviously contributes to the complexity of the case as the substance abuse, seen as secondary to the development of PTSD, contributes to the downward spiral in multidimensional life functioning.

Attention to each of these issues can prevent problems for the clinician as litigation proceeds. A comprehensive history, noting onset of problems and their phenomenological course, can promote optimal understanding of the person being evaluated and the legitimacy of his or her claim and case. Failure to appreciate the interrelationship of the disorders and issues highlighted above can mitigate the cogency of the arguments proffered by the clinician and lawyer.

Psychological Assessment of PTSD

The purpose of this section is to provide empirical information regarding psychometric characteristics of structured clinical interviews that have been developed for the measurement of PTSD and psychological tests that have been especially developed for assessing PTSD. Each of the assessment instruments included in this section has been selected on the basis of substantive research, and although the list included here is not exhaustive, it provides an excellent starting point for clinicians who are interested in evaluating clients for the presence of PTSD.

Structured Interviews

The SCID (Spitzer et al. 1990) is the interview most frequently employed to date in the evaluation of PTSD. The SCID provides a comprehensive evaluation of all Axis I and Axis II psychiatric diagnoses. The PTSD module is concise, it is relatively easy to administer and score, and it addresses the major diagnostic features of the disorder. Kulka et al. (1990), in their study of Vietnam War veterans, found that the SCID had a kappa interrater reliability score of .93 when a second clinician listened to audiotapes of the target interview and then made independent diagnoses. McFall et al. (1990) reported 100% diagnostic reliability between two clinicians who completed independent SCIDs on 10 subjects. Keane et al. (1988c) observed a kappa of .68 for PTSD SCID diagnoses derived from two independent clinicians who individually interviewed the same patients ($N = 39$). Kulka et al. (1990) also found the SCID diagnosis to be strongly correlated with other psychometrically sound indices of PTSD (i.e., Mississippi Scale, Impact of Event Scale, and Keane PTSD Scale of the MMPI). These results suggest that the PTSD module of the SCID is a measure with respectable reliability and validity. The instrument does, however, have limitations. The SCID yields only dichotomous information about the presence or absence

of each of the symptom criteria for the disorder. Consequently, measures of disorder severity and changes in symptom level over time cannot be easily detected using the SCID. Yet this instrument is clearly the most widely used measure for evaluating PTSD and accompanying disorders and has significant value in terms of its structured nature in guiding a clinician's evaluation for PTSD.

The Diagnostic Interview Scale (DIS-NIMH; Robins et al. 1981) is a highly structured interview that can be administered by either technicians or clinicians. Providing a comprehensive examination of the diagnostic categories, this instrument has been used in many epidemiological studies across the world. In a review of the literature on PTSD assessment, Watson et al. (1991) noted that in clinical settings, the PTSD-DIS functioned well, correlating highly with other known measures of PTSD. However, Kulka et al. (1991) indicated that when used with a community sample in which the base rate of PTSD was low, the DIS performed poorly, with estimates of .23 for sensitivity (i.e., the proportion of true cases identified by the test) and .28 for kappa (i.e., the proportion of agreement above chance levels). The use of this highly structured instrument for making diagnoses in field studies has, therefore, been challenged, and additional work is needed to substantiate its utility in those settings. Data on its use in clinical settings seem to more strongly support its usefulness. As a structured interview, the DIS also suffers from the same limitation as the SCID in that the presence or absence of a particular symptom is rated dichotomously. This, then, reduces the capacity of the clinician to distinguish symptom and disorder severity.

The PTSD Interview (Watson et al. 1991) yields both dichotomous and continuous scores, thus addressing some of the limitations of the SCID and DIS-NIMH. Reports of high test/retest reliability (.95), internal stability ($\alpha = .92$; i.e., a test's internal reliability), sensitivity (.89; i.e., the proportion of true cases correctly identified by a test), specificity (.94; i.e., the proportion of noncases correctly identified by a test), and kappa (.82) recommend this instrument for use in diagnosing PTSD. This instrument differs, however, from other clinical instruments in that it asks the subjects to make their own rating of symptom severity rather than requiring this task of the clinician. This self-rating minimizes the role of the experienced clinician in the diagnostic process. It also minimizes the experience that the clinician has in comparing symptom severity from one case of PTSD to others that he or she may have seen in clinical practice.

Davidson et al. (1990) offer the Structured Interview for PTSD (SI-PTSD) as an alternative to the SCID and DIS. This instrument also contains continu-

ous and dichotomous symptom ratings, and the researchers have found that it is a psychometrically sound instrument. Measures of excellent test/retest reliability (.71), interrater reliability (.97–.99), and perfect diagnostic agreement ($N = 34$) were reported in the preliminary article by Davidson and colleagues. More comprehensive utility analyses revealed a sensitivity of .96, a specificity of .80, and a kappa of .79 when compared with diagnoses by clinicians using the SCID. Clearly, this instrument has major advantages for use in the clinic setting and is an excellent prototype for use when making PTSD diagnoses in the forensic setting.

The Clinician-Administered PTSD Scale (CAPS; Blake et al. 1991) was developed to address the limitations of previous clinical interviews for assessing PTSD. Available in both a lifetime and current version, the CAPS contains diagnostic symptoms of PTSD, the associated features of PTSD, symptom severity measures, indices of impairment in social and occupational functioning, and an assessment of validity and degree of confidence by the clinician in the patient's responses. The CAPS also provides continuous and dichotomous scores to suit the needs of the clinician or the research investigator. Preliminary results from a sophisticated psychometric assessment of its properties (Weathers 1992) indicate that the CAPS is promising with respect to issues of diagnostic reliability and validity as well as with regard to measures of sensitivity, specificity, and kappa. Perhaps the major advantage of the CAPS in a forensic setting is that it not only requires the clinician to evaluate the presence and severity of various symptoms associated with PTSD but also provides an opportunity for the clinician to evaluate the impact of the symptoms on an individual's social and vocational function. Impact on these domains is a key determinant of damages by plaintiffs in civil litigation suits.

Psychometric Measures

Numerous questionnaires and self-report measures of PTSD have been developed and enjoy widespread use in clinical, research, and forensic settings. Each measure has diagnostic utility as well as the capacity to assess the severity of the disorder. The major advantage of the use of psychometric measures is that the clinician can compare scores on these measures of PTSD for the person being evaluated against hundreds and sometimes even thousands of people on whom the norms for these questionnaires have been based. Each of the measures described below has diagnostic utility and, because these measures are relatively inexpensive to employ, several are frequently administered in conjunction with the clinical interview

to provide multiple indices of PTSD. As mentioned in the introductory section, no single measure of PTSD is perfectly reliable and valid; therefore, the use of multiple measures is important to the clinician to ensure that the conclusions made clinically are supported by data obtained from multiple methods of study.

The Keane PTSD Scale of the MMPI (Keane et al. 1984) consists of 49 items from the 399 Form-R version of the MMPI. These 49 items were found to differentiate a PTSD sample from non-PTSD patients in both a test sample and a cross-validation sample of veterans. Eight-two percent of 200 subjects were correctly classified using a cutoff score of 30. Subsequent studies have not found the same diagnostic hit rate, a problem that might be due to varying base rates of PTSD in the sample under study, different diagnostic methods for arriving at cases and noncases, or the overreliance on a single cutoff score to make the diagnosis. In a study of forensic cases, Koretsky and Peck (1990) found that a cutoff score of 20 or above was strongly correlated with a diagnosis of PTSD among people who were exposed to life-and-death situations, such as train crashes, car wrecks, and industrial accidents. Because few studies have been conducted on this measure with multiple trauma categories, it is impossible to arrive at one single cutoff score that may reflect PTSD. Rather, the clinician is encouraged to consider the PTSD scale of the MMPI as a continuous measure of "PTSD-ness," indicating the extent and severity of PTSD, rather than serving as a rigid, dichotomous measure of PTSD.

With the publication of the MMPI-2, Lyons and Keane (1992) described the use of the Keane PTSD Scale within the context of the improved overall instrument. For the most part, the scale remains unchanged in terms of the specific wording of items; however, three repeated items have been deleted, as were all repeated items on the test. The performance of the PTSD Scale in the National Vietnam Veterans Readjustment Study (NVVRS) (Kulka et al. 1990) indicates that the MMPI-2 modifications have not altered the general interrelationship of the Keane PTSD Scale with other measures of PTSD.

The Mississippi PTSD Scale (Keane et al. 1988b) is available in both civilian and combat versions. It is a 35-item instrument that has high internal consistency ($\alpha = .94$), test/retest reliability (.97), sensitivity (.93), and specificity (.89). This instrument performed effectively in both clinical settings (e.g., McFall et al. 1990) and in field settings (e.g., Kulka et al. 1990), an unusual finding for any psychological test. These results indicate general utility for measuring PTSD across settings and for different purposes. The Mississippi PTSD Scale measures the diagnostic criteria from the DSM

as well as the associated features of PTSD. It is self-administered by the patient, and its scoring and interpretation are relatively straightforward. Numerous research studies from different laboratories have concluded that the Mississippi PTSD Scale is an excellent instrument for assessing PTSD across clinical and research settings (Keane et al. 1988b; McFall et al. 1990; Watson 1990).

The Impact of Event Scale (IES; Horowitz et al. 1979) focuses on the assessment of the intrusions and avoidance or numbing symptoms of PTSD. Designed prior to the inclusion of PTSD in the DSM-III, the IES does not contain a comprehensive evaluation of PTSD and its associative features. Despite this limitation, the IES is perhaps the single most widely used instrument for assessing the psychological consequences of traumatic events. Not surprisingly, studies have found that the IES is correlated with other diagnostic measures of PTSD even though the IES does not contain all of the symptoms associated with PTSD. These findings are indicative of the central importance of the intrusive or reliving symptoms and the avoidance/numbing symptoms in the PTSD diagnosis. The IES has been found to have strong internal consistency (.78 for intrusion; .82 for avoidance) and test/retest reliability (.89 for intrusion; .79 for avoidance). Used in conjunction with other, more comprehensive measures of PTSD, the IES is an excellent choice for evaluating the subjective distress related to a specific stressful event in a person's life.

Saunders et al. (1990) derived a 28-item PTSD scale for the Symptom Checklist—90 (SCL-90; Derogatis 1983) using items that best discriminated women with crime-related PTSD from those who did not have PTSD. With good sensitivity (.75) and high specificity (.90) using the DIS-NIMH as the criterion, this instrument can be a particularly valuable addition to the psychological battery of the clinician. The SCL-90 is a widely used psychological test that evaluates the presence, absence, and severity of a wide range of psychological symptoms that can be associated with traumatic stressors. Although this PTSD scale needs cross-validation and replication, the possibility of employing a subsection of the SCL-90 to measure PTSD would be a welcome addition to the psychological test armamentarium of the clinician.

The Penn Inventory for PTSD (Hammerberg 1992) is an important new diagnostic tool for the measurement of PTSD because it was developed and validated with both combat veterans and trauma-exposed, nonveteran samples. This particular instrument has internal consistency ($\alpha = .94$) and high test/retest reliability (.96). Sensitivity was .90 and specificity was 100% among a sample of 83 veterans; in a sample of disaster survivors, sensitivity

was 94%, with specificity observed to be 100% for the PTSD diagnosis. Although these findings are with relatively small numbers of subjects, it is clear that the Penn Inventory for PTSD has excellent potential as a questionnaire measure of PTSD symptomatology. Further research studies documenting its overall utility in a variety of settings would be welcome. Its major advantages are that it is easy to use, straightforward to administer, and it already contains norms on both combat and civilian populations.

Psychophysiological Studies of PTSD

The search for biological measures of a psychological disorder transcends the study of PTSD and has been the focus of considerable interest of psychobiologists and biological psychiatrists. Early work in the area of PTSD indicated that a psychological challenge (i.e., exposure to cues of a traumatic event) can provoke systematic physiological responses across several measurement domains (e.g., heart rate, skin conductance, EMG, blood pressure). Blanchard et al. (1982) and Malloy et al. (1983) found that this reactivity predicted the PTSD diagnosis when using auditory and audiovisual cues to stimulate reactivity. Some years later, Pitman et al. (1987) observed the same reactivity using personal scripts of traumatic events that were then read to subjects. These studies all observed robust physiological reactivity when combining the presentation of a psychologically meaningful cue and concurrently measuring psychophysiological responses. This challenge model for assessing PTSD may help us identify other psychophysiological parameters associated with this disorder. With respect to forensic cases, the use of ideographic cues stemming from the traumatic incidents while concomitantly measuring psychophysiological reactivity may provide measures of PTSD other than self-report. In addition, the psychophysiological reactivity can provide important biological information regarding the actual physiological effects of an assault, an accident, or another form of disaster.

With ongoing large-scale physiological studies soon to be completed (Keane et al. 1988c), the potential value of these physiological markers for PTSD will be available in the very near future. To date, the data from several other research laboratories do, indeed, indicate that there is a strong physiological component associated with the diagnosis of PTSD. These findings, if replicated in larger scale studies, would provide important new information for use in forensic cases. Pitman et al. (1994) have recommended the use of psychophysiological measures to verify the presence of one dimension of the disorder, reactivity to cues reminiscent of the trauma, and as a

measure of the presence of PTSD. Using psychophysiological procedures for the former has been universally acceptable to courts. The latter use remains an open empirical question. However, it is important to consider that physiological reactivity to cues reminiscent of the traumatic event remains only one data point in the complex algorithm of psychological tests, structured interviews, and clinical interviews conducted by the clinician. All tests bear some imperfection, and differences in the vectors for PTSD must always be reconciled through clinical judgment. This judgment is best informed through the comprehensive history, a complete review of the medical records, and a thorough understanding of the circumstances surrounding the traumatic event and the person's role in that event.

As is readily observed by the results of this review on the psychological assessment of PTSD, progress in this arena has been rapid since the inclusion of this diagnosis in the DSM-III in 1980. Clinicians and researchers are now in an excellent position to conduct meaningful evaluations of their patients. Evaluations that include information from structured interviews and psychological tests can be informed by any of a number of outstanding instruments developed specifically to measure PTSD, its associated features, and the impact of these symptoms on multidimensional life functioning. Although PTSD is a disorder with a short history in the diagnostic manual, the measures of PTSD rival those now available for assessing major depression, schizophrenia, the anxiety disorders, and the personality disorders. Indeed, the appropriate assessment of PTSD now should include one or more of these standardized and validated instruments for use in forensic settings. These instruments can readily inform the clinician about the status of PTSD in an individual client compared with others with similar exposure and symptom complaints.

The Forensic Psychological Report

Perhaps the most critical piece of the forensic psychological examination is the report. Therein, the clinician records the nature and purpose of the examination and integrates the data obtained from all sources. Most important is the conceptual formulation of the case and its bearing on the legal points in question. Whether the report is written 1) for the defendant in an insanity plea in a criminal case, 2) for a plaintiff to describe the consequences of criminal victimization, or 3) for the plaintiff in a civil suit documenting damages, the report should contain coverage of specific topics. Table 5–1 contains an example of the format to be used in completing a

forensic psychological report. Each section of the report is explained in the following discussion.

Referral Source and Referral Questions

Contained in this section is the purpose for which the clinician conducted the examination and assessment. In addition, the source of the referral should be specified in the report, whether it be another health care professional, a lawyer, or a self-referral.

Limits of Confidentiality

Reports written for forensic purposes are usually disseminated to the lawyers involved in the case, the court, jury members, and other health care professionals involved in the case. These limits on confidentiality should be explained to the client in clear language. An estimate of his or her comprehension of these limits should be included in the body of the report.

Table 5–1. Template for use in preparing a report for forensic psychological examination

Forensic Psychological Report

1. Referral source and referral questions
2. Limits of confidentiality
3. Review of records (list and document):
   - ❑ Medical
   - ❑ Legal/police
   - ❑ Psychological
   - ❑ Social/vocational
4. Methods of assessment (list, date, duration):
   - ❑ Relevant history
   - ❑ Mental status examination
   - ❑ Structured interview
   - ❑ Psychological tests
   - ❑ Neuropsychological tests
   - ❑ Physiological tests (e.g., CAT, MRI, psychophysiological exams)
5. Results of examination and special test
6. Collateral reports (relationship, dates of inquiry)
7. Forensic case formulation
8. Diagnostic formulation/multiaxial classification

Review of Records

All records reviewed by the clinician that influenced the opinion on the case should be listed in the text of the report. Such records could include but are not necessarily limited to the following: 1) medical records, 2) legal records, 3) police documents, 4) psychological records and reports, and 5) social and vocational records that can assist the clinician in documenting pre- and postevent functioning. The records should be listed by date and name so that they can be readily identified by the reader. These records can detail the event, and in the case of a public disaster, media reports can be included from printed or televised sources.

Methods of Assessment

To provide the reader with an understanding of the nature and extent of the psychological examination conducted by the clinician, this section should include a listing of the many methods employed by the clinician to arrive at the opinion in the case. Interviews, their dates of occurrence, and their duration provide an in-depth understanding of the opportunities for sampling the examinee's behavior across settings and time. The greater the diversity and number of interviews, the larger the sample of behavior and, thereby, the more reliable the findings. If specialized tests are employed, these should be incorporated into this section of the report, and if the examiner ordered but did not conduct these tests him- or herself, the responsible or administering clinician as well as the location of the testing laboratory should be identified.

Results of Examination and Special Test

This section of the report should incorporate the precise results obtained from the clinical interview, the structured interview, the psychological tests, and the physiological tests if any were employed. The groundwork for the expert opinion is laid in this section of the report, and, correspondingly, considerable attention to detail and accuracy is required. The interrelationship of the various measures of PTSD and social functioning should be highlighted and the conceptual integration of results provided. Also in this section, the clinician provides relevant demographic, family, marital, and developmental information as it pertains to the issue in question. Previously existing psychological conditions or vulnerabilities should be identified here so that a more complete understanding of the examinee is

possible in view of the legal question under scrutiny. A special section of the results should be dedicated to explicating the findings from the mental status examination.

Collateral Reports

When it is possible and valuable to obtain information from collateral sources (e.g., family members, friends, neighbors, employees) for purposes of documenting a decline in social or vocational functioning or for verifying symptom complaints, then a listing of these interviews with results should be included in the report. These data are particularly useful in documenting changes in social or vocational functioning concomitant with the traumatic event per se.

Forensic Case Formulation

In this section, data from all sources are integrated into a conceptual framework from which statements can be made regarding the specific legal standards that are relevant to the case. Avoiding psychological jargon whenever possible, the examiner provides the most sophisticated conceptual analysis possible given the extant data. The basis for the expert opinion should be clearly presented and all relevant information organized in such a way that it is understandable to other health professionals, lawyers, the court, and, if relevant, the jury. Questions of damages, causation, and sanity when involved should be clearly stated in this section, and the opinion should be stated unmistakably, using language that meets the pertinent legal standard involved.

Diagnostic Formulation/ Multiaxial Classification

The DSM-III, DSM-III-R (American Psychiatric Association 1987), and DSM-IV (American Psychiatric Association 1994) all employ a multiaxial classification scheme. The final section of the report should include diagnostic formulations for Axes I–V. A report including only Axis I and II is necessarily incomplete, and all reports should contain information for all five axes, even if the opinion on a particular axis is deferred for insufficient information. Some individuals will meet criteria for multiple psychiatric diagnoses, and they can be listed on Axis I or II. The primary diagnosis of relevance to the case can, accordingly, be listed first within an axis if there

are multiple comorbid diagnoses on the same axis (e.g., PTSD and substance abuse).

Summary

Forensic psychological examinations can be of unique value to the court in deciding the outcome of a variety of complex cases involving PTSD. The current availability of excellent structured interviews for PTSD and a number of psychological tests expressly developed for assessing the presence and the severity of PTSD lends increased credibility in the courtroom to the clinician who chooses to use these contemporary methods.

Data on the presence or absence of any psychiatric disorder are usually based on self-report and thus warrant some skepticism in courtroom situations. The opinion of the informed clinician who relies on the use of multiple sources of information over time, who uses collateral informants, who assiduously peruses all pertinent records, and who employs psychological, neuropsychological, and physiological tests with sound psychometric properties merits the attention of all those involved in the case and minimizes the skepticism often associated with less thorough and competent psychological assessment. The use of these more contemporary methods in conjunction with a skillful and intuitive clinical examination is the hallmark of an outstanding psychological examination.

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