

POST-TRAUMATIC STRESS DISORDER

I. INTRODUCTION

While the term "Post-Traumatic Stress Disorder" (PTSD) is of only recent origin, having first appeared in 1980 in the third edition of the Diagnostic and Statistical Manual of Mental Disorder (DSM-III), the concept of the disorder has a long history. Indeed, the concept is as old as the history of warfare, where the psychic consequences of war were recognized but never really understood. By incorporating PTSD into DSM-III the diagnosis was officially acknowledged as the psychic reactions experienced by people attributed almost entirely to outside causes or to causes in society. It defined operational criteria focusing on the psychological symptoms pertaining to re-experiencing the initiating traumatic event ; avoidance and numbing ; and disturbances of attention and arousal (McFarlane, 1994). With the inclusion of PTSD in the DSM, it is now possible for victims to be recognized as psychiatric patients without the stigma of hysteria or psychosis.

The medical community has "embraced" PTSD because it is one of the few mental disorders where the **onset** is **clear-cut** . It is the development of characteristic symptoms following exposure to an extreme traumatic stressor involving a direct personal experience of an event. PTSD can result not only from excessive stress over an extended period (e.g. concentration camp, war) but also from catastrophes or other events of short duration (e.g. floods, rape, torture, auto accidents, industrial accidents, exposure to toxic substances and radiation) and after bodily disasters (e.g. heart attack), (Strian, 1992, Scrignar, 1996). Studies have shown there is a 1.0-12.3 percent prevalence of PTSD in the general adult population and the figure increases to well over 50 percent in rape victims and Vietnam combat veterans (Scrignar, 1996, DSM-IV, 1994).

With the induction of PTSD into DSM III much controversy has been put to rest. In the past this disorder has been overlooked, under diagnosed and sometimes ignored. In order to better understand its emergence and "rediscovery" by the medical world one must be aware of the historical development in order to understand the most recent formulations regarding the diagnosis of PTSD in the DSM-III- R 1987 and, most recently, DSM-IV, 1994 (309.81 Posttraumatic Stress Disorder).

In the litigation context, this history is crucial, because it helps the fact finder understand that this injury, which cannot be seen or measured, is in fact very real and can be very disabling. And, equally important, the fact finder can see and recognize that the long process which ultimately led to PTSD's inclusion in the DSM is medically sound, a critical point when one must persuade a fact finder.

II. HISTORY

There is no debate that the diagnosis of PTSD as we know it today has its roots as far back as the earliest war. War is the most "intense and destructive of human enterprises" which assaults all five senses. The sounds, sights and smells are no less frightening than the thoughts of imminent death or impending injury. Images become embedded in the mind like a VCR replaying itself over and over. (Scignar, 1996). The historical development of PTSD from soldiers exposed to war trauma, to neurobiological, cognitive-behavioral, and psychosocial features with the most recent formulations about PTSD in DSM-IV furnish a sound framework for the understanding of the disorder.

Early descriptions of PTSD focused only on the physical manifestations of the disorder. The first physician in the United States to study the relationship between war trauma and psychology was Jacob Mendez DaCosta. As early as 1871, he described what he termed "irritable heart" but was also known as "soldiers heart", or "DaCosta's syndrome" .

This disorder which he called "irritable heart" occurred in a soldier who fought in the Civil War. Because chest pain, palpitations and dizziness were the main symptoms, Da Costa thought the disorder was due to a functional cardiac disturbance characterized by hypersensitivity and sympathetic over activity. (Andreasen 1985)

He noticed symptoms similar to those described earlier among British troops in India and in the Crimea. Veterans of the Civil War (two-thirds of his 300 patients were 16-25 years old) complained of palpitations, increased pain in the cardiac region, tachycardia, cardiac uneasiness, headaches, dimness of vision and giddiness. With clinical astuteness, DaCosta theorized that since there was no evidence of myocardial disease, the condition was due to a disturbance of the sympathetic nervous system. (Scignar ,1996)

An early literary description of the syndrome associated with "irritable heart" can be found in Steven Crane's The Red Badge of Courage (Andreasen, 1985).

During World War I a number of Veterans were noted to be suffering from "shell shock". G.Elliot Smith and T.H. Pear (1917) used the term to describe what they thought was a physical disorder. The disorder was thought to be organic brain damage caused by carbon monoxide gas, atmospheric pressure changes and/or micro bits imbedded in the brain released during bomb explosions. Smith and Pear paid significant attention to the impact of war trauma on the brain and in so doing introduced the beginnings of the psychodynamic theories.

In describing "shell shock" in World War I veterans they stated. "The term is vague; perhaps its use implies too much; but this is not altogether a disadvantage, for never in the history of mankind have the stresses laid upon body and mind been so great". (Scrignar, 1996)

Other terms for "shell shock" during World War I were "effort syndrome" (Sir Thomas Lewis) and "neurocirculatory asthenia" (Oppenheimer) encompassing both the psychoneurotic and cardiac manifestations of the disorder (Scrignar, 1996).

Summing up, Lewis said, "it is because these symptoms and signs are largely, in some cases wholly, the exaggerated physiological response to exercise...That I term the whole the "effort syndrome." Noting that nervous manifestations were "more or less prominent". Lewis wrote that 'a proportion of the patients whom I include in the group, "effort syndrome" sooner or later acquire a diagnosis of neurasthenia.'" Oppenheimer (1918), a contemporary of Lewis, noting psychoneurotic and cardiac manifestations of some combat soldiers, preferred the term "neurocirculatory asthenia" to characterize the disorder. (Scrignar, 1996)

The British Army reported 80,000 "shell-shocked" troops of which a quarter of those ended up in psychiatric institutions. There was much debate whether the soldiers experiencing this syndrome were exhibiting moral cowardice or were psychologically disabled. The English psychiatrists on the "home front" diagnosed temporary "hysteria" or "mental breakdowns" and suggested the best remedy was to ignore it.

As recently as 1939, the British government spent £2 million on benefit payments to shell-shocked World War I victims. Stone (1985) observed that shell-shock was labeled an 'illness' in order to justify the tremendous fall-out of conscripts in the battle zones, rather than admit that in human terms war, in itself, is horrific, and for some people literally unbearable. " (Gersons 1992)

On the advice of French psychologist C.S. Myers, special treatment units were set up by the front lines so soldiers could get immediate attention and return to battle. Myers used hypnosis to relieve "painful and suppressed experiences and emotions" . It was considered a catharsis that led to a return to emotional stability. It was this approach that gave rise to "sweeping changes" in mental health care (Gersons, 1992).

The response to the large number of traumatized soldiers was "out-patient" clinics. One clinic, the now famous Tavistock Clinic, introduced "the psychoanalytical therapy" for the inner conflict between fear and duty. War trauma was reformulated into an "inner neurotic conflict" As the "traumatic neurosis" theory developed, a new factor emerged as an explanation for the term posttraumatic stress syndrome (PTSS). Early childhood experiences based on fear, guilt, and loneliness were thought to "predispose" individuals to PTSS. Later, such stressors as war, accidents, and disasters would

"reawaken" these unresolved fears and conflicts and the person would succumb to PTSS or "traumatic neurosis".

" . . .In other words, the war trauma had served primarily to open a tin of libidinous worms and had been reformulated in terms of the patient's early childhood emotional war with members of his family." (Stone, 1985) The war trauma was thus exchanged for an inner neurotic conflict, and became the point at which treatment began. (Gersons, 1992)

It was during the 1940's the first extensive description of PTSS occurred following a civilian catastrophe. There were 500 fatalities when a fire swept through a Boston night club. Alexander Adler interviewed and examined victims and family. Adler documented both the physical and emotional aspects of PTSS including anxiety, depression, apathy, and an intense autonomic arousal. Other reports and documentation began to emerge describing similar symptoms associated with industrial accidents, natural catastrophes, and accidents. Research and treatment of PTSS began to take new but related directions into the areas of neurobiological and behavioral responses to stress.

World War II precipitated an increased interest in the PTSS that subsequently led to its inclusion into the official psychiatric nomenclature. Due to the number of psychiatric casualties during this war, a special task force of psychiatrists was set up to investigate the effects of combat. PTSS was known by several names " traumatic war neurosis", "combat neurosis" and "gross reaction".

The concept of anxiety neurosis gained acceptance and the 1940's psychiatrists applied this new knowledge to World War II veterans who mentally broke down following battle. Although these soldiers suffered from the same symptoms as those observed by DaCosta (1871), Oppenheimer (1918), and Lewis (1919), the diagnostic labels "irritable heart," "effort syndrome," and "neurocirculatory asthenia" were replaced by "traumatic war neurosis" and "combat neurosis". The symptoms were considered to be manifestations of anxiety and thought to be neurotic in origin. Some clinicians utilized the concept of stress and preferred the terms "combat or battle stress," "battle fatigue," "combat exhaustion," and "acute combat reaction". (Scrignar. 1996)

Hans Selye (1946, 1950, 1956) was the first to introduce the term "stress" or "alarm reaction" when describing the endocrine response to an emergency situation. The response or reaction accounted for changes in cardiovascular function, respirations and muscle tone. The "stress" research followed a scientific neurobiological approach to explain environmental influences on the nervous and endocrine systems.

Selye added the concept of heterostasis, thereby indicating the existence of an area between "maintaining a normal equilibrium" and "succumbing to a physical and mental break down." It is an area where the ""battle" against the threat factor

is fought. This creates stress and the person becomes "stressed."

These concepts, derived from physiology, are important in understanding PTSD, especially the symptoms of increased irritability. They indicate what are in themselves adequate physiological reactions to a threatening provocation (such as heightened perception, increased muscle tension, quickening heart beat), experienced by the individual as a feeling of overwhelming fear, heightened alertness, and tension...It is for this reason that PTSD has been called a "physio-neurosis." PTSD is more than an adequate or inadequate psychic reaction to frightening experiences; it also comprises a lasting physical and physiological reacting mechanism. (Gersons, 1992)

As a result of the "stress" research, the term "gross stress reaction" (GSR) was included in DSM-1 in 1952. The use of the term "reaction" throughout DSM-I reflected the influence of Adolf Meyer's psychobiological view that mental disorders represented reactions of the personality to psychological, social and biological factors. GSR was defined as a "reaction to a great or unusual stressor that invoked overwhelming fear in a normal personality." It was considered a transient and reversible reaction. If symptoms persisted another diagnosis was to be made (Andreasen, 1985).

Stress researchers concentrated their efforts on the study of environmental influences on the nervous and endocrine systems and their effect on the various organ systems of the body. This proved to be a more scientific approach to the study of stress as compared to most clinicians of the time who observed stress but called it anxiety and postulated intrapsychic theories of neurosis. Stress thus stood apart from anxiety in the minds of researchers and clinicians, although both terms referred to the same neurobiological system ... Even today, "stress" and "anxiety" should be interchangeable terms, but they are not because they connote different frames of references for clinicians, researchers and the public. (Scrignar, 1996)

GSR also appeared for the first time in the International Classification of Diseases (ICD-6) in 1952. Interesting, the category GSR was omitted from DSM-II that was published in 1968 and it is assumed the importance of the category was just overlooked during a rather peaceful time between World War II and the Vietnam War.

Following the Vietnam War, psychiatrists interested in psychosomatic medicine and forensic psychiatry provided convincing evidence of the disorder and demanded the category be reinstated. Work began on DSM-III in 1974 and was published in 1980. It was based on laboratory research, Pavlov's stimulus-response theory and observed adverse cognitive, physiological and emotional reactions in traumatized persons.

The development of cognitive-behavior therapy clarified the relationship between mental processes (intrusive images and thoughts) and posttraumatic symptoms.

In PTSD, cognition, commonly called 'videotapes of the mind,' could now be correlated with anxiety and analyzed in terms of trauma. The sequence-traumatic event, cognition, anxiety (stress)-explains what is observed clinically in traumatized patients. (Scrignar,1996)

The DSM-III incorporated specific criteria that was to be use in the diagnosis of PTSD. It was the first time, a mental disorder precipitated by a specific, identifiable, environmental event was officially endorsed by the American Psychiatric Association and other medical groups world wide (Scrignar, 1996) . DSM-III also introduced the multiaxial system which facilitates a comprehensive and systemic evaluation that addresses various mental disorders and general medical conditions, psychosocial and environmental problems and level of functioning that might be overlooked if the focus were on assessing a single problem.

Many researchers felt DSM-III was not explicitly clear on several of its PTSD criteria and was revised in 1987 as DSM-III-R. The revised edition expanded on the "reexperiencing" category, gave greater importance and recognition to the "avoidance of stimuli" and introduced "arousal" or "physiologic reactivity "as a specific criterion.

However a rapid and substantial increase in behavioral research, field data, and new knowledge in the area of PTSD led to another revision in 1994, DSM-IV. Documentation of years of research and treatment in the areas of psychodynamics, neurobiology and behavioral responses has been the essential foundation for the revisions found in DSM-IV. The DSM-IV was the result of a three-stage process that included a comprehensive and systematic review of the published literature, a reanalyses of the already collected data sets and extensive issue-focused field trials (DSM-IV, 1994) .

III. DSM-IV - PTSD DIAGNOSTIC CRITERIA

The essential feature of Post-Traumatic Stress Disorder is the development of characteristic symptoms following exposure to an extreme traumatic stressor involving direct personal experience. The diagnostic criteria for PTSD in DSM-IV defines the person's response and post-traumatic symptoms. PTSD is a complex, predictable and well-organized set of pathological behaviors intertwined with multiple issues that occur. Diagnosis of PTSD is not complicated if the guidelines that are set forth in DSM-IV are applied.

CRITERIA A: STRESSOR

The person has been exposed to a traumatic event in which both of the following were present:

1. The person experienced, witnessed or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat

to the physical integrity of self or others

2. The person's response involved intense fear, helplessness, or horror (or in children the response must involve disorganized or agitated behavior).

Criterion A-1 indicates an individual **must be present** at the traumatic scene and is personally endangered or is present and witnesses the sudden and violent death someone as a "shared danger". Witnessing death such as a loved one dying from cancer does not qualify as a stressor event for PTSD (Scrignar, 1996). In PTSD the stressor must be of an **extreme** nature.

A-2 involves the response of the individual following exposure to the traumatic event. It comprises perception, cognitive awareness, activation of the sympathetic nervous system, and conduct related to intense fear (horror) or fear behavior (helplessness) (Scrignar, 1996). This includes major disasters, and personal crises such as rape, torture and accidents.

CRITERIA B: RE-EXPERIENCING

The traumatic event is persistently reexperienced in one (or more) of the following ways:

1. Recurrent and intrusive recollections of event, including images, thoughts, or perceptions. (In young children, repetitive play may occur in which themes or aspects of the trauma are expressed).
2. Recurrent distressing dreams during which the event is replayed. (In children, there may be frightening dreams without recognizable content).
3. Acting or feeling as if the traumatic event were recurring (includes a sense of reliving the experience, illusions, hallucinations, and dissociative flashback episodes, including those that occur on awakening or when intoxicated). (In young children trauma-specific reenactment may occur).
4. Intense psychological distress at exposure to internal or external cues that symbolize or resemble as aspect of the traumatic event.
5. Physiological reactivity when exposed to internal or external cues that symbolize or resemble as aspect of the traumatic event (e.g., anniversaries of the traumatic event, cold, snowy weather or uniformed guards for survivors of death camps in cold climates; hot, humid weather for combat veterans of the South Pacific; entering an elevator for a woman who has been raped in an elevator).

An analogy that can be used is a "videotape in the mind" replaying upon cues, forcing the person to relive the event over and over again. Psychophysiological testing can measure physiological reactivity to exposure to cues that resemble an aspect of the

traumatic event Testing should be encouraged as test results can be used to reinforce objectivity in a court of law. (Scrignar, 1996).

CRITERIA C: AVOIDANCE

Persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness (not present before the trauma), as indicated by two (or more) of the following:

1. Person commonly makes deliberate efforts to avoid thoughts, feelings or conversations about traumatic event.
2. Avoidance of activities, situations, or people who arouse recollections of the event.
3. Avoidance of reminders may include amnesia for an important aspect of the traumatic event.
4. Diminished responsiveness to the external world, referred to as "psychic numbing" or "emotional anesthesia," usually begins soon after the traumatic event. The individual may complain of having markedly diminished interest or participation in previously enjoyed activities.
5. Feeling detached or estranged from other people.
6. Having markedly reduced ability to feel emotions (especially those associated with intimacy, tenderness, and sexuality).
7. Individual may have sense of a foreshortened future (e.g., not expecting to have a career, marriage, children or a normal life span).

Avoidance is a phobic mechanism to reduce anxiety. The victims try to avoid thoughts, activities, places and people that are associated with the trauma. Anxiety is decreased and unfortunately further phobic behavior is reinforced. Such avoidance behavior can significantly compromise important areas of functioning and cause significant disability. The numbing responsiveness is frequently seen as depression and it accompanies chronic PTSD. Victims show a lack of interest in life, family, and work further deterioration takes place.

CRITERIA D: AROUSAL

Persistent symptoms of increased arousal (not present before the trauma) as indicated by two (or more) of the following:

1. Difficulty falling or staying asleep.
2. Irritability or outbursts of anger.
3. Difficulty concentrating or completing tasks.
4. Hypervigilance.
5. Exaggerated startle response.

Further traumatic experiences are anticipated. Severe free-floating anxiety develops with physiological manifestations, such as sweating, palpitations and panic. Phobic anxiety such as fear of travel or social situations, is common. There is a preoccupation with the traumatic event. The person is in a constant state of irritability. Lack of sleep leads to fatigue. **The presence of increased arousal symptoms only after a specific traumatic event differentiates PTSD from other anxiety disorders** (Scrignar).

CRITERIA E: DURATION

Duration of the disturbance (symptoms in Criteria B, C and D) is **more than 1 month**.

Symptoms must be present for **more than one month** to qualify for the diagnosis of PTSD.

CRITERIA F: IMPAIRMENT

The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

PTSD frequently accompanies impairment from work, family, social and recreational activities. Criteria F is a new dimension of DSM-IV to the diagnosis of PTSD. It recognizes the importance of psychosocial functioning. If these areas are impaired then so is the enjoyment of life which are listed on the Axis IV of the Multiaxial Assessment and Classification. (Multiaxial Assessment has been included for reference). PTSD rarely exists as an isolated disorder once it has become chronic.

SPECIFIERS

The following specifiers are used to specify onset and duration of the symptoms of PTSD;

Acute: Duration of symptoms is less than 3 months.

Chronic: Symptoms last 3 months or longer.

Delayed Onset: At least 6 months have passed between the traumatic event and the onset of the symptoms.

ASSOCIATED FEATURES AND DISORDERS

1. Painful guilt feelings about surviving when others did not survive or about things they had to do to survive.
2. Phobic avoidance of situations or activities that resemble or symbolize the original trauma may interfere with interpersonal relationships and lead to marital conflict, divorce or loss of job.

Symptoms more commonly seen in association with an interpersonal stressor such as:

- a. childhood sexual or physical abuse
 - b. domestic battering
 - d. being taken hostage
 - e. incarceration (prisoner of war, concentration camp, torture).
3. Impaired affect modulation.
 4. Self destructive and impulsive behavior.
 5. Dissociative symptoms.
 6. Somatic complaints.
 7. Feelings of ineffectiveness, shame, despair or hopelessness.
 8. Feeling permanently damaged.
 9. Loss of previously sustained beliefs.
 10. Hostility.
 11. Social withdrawal.
 12. Feeling constantly threatened.
 13. Impaired relationships with others.
 14. A change from person's personality characteristics.

There may be an increased risk of the following Disorders:

1. Panic disorder
2. Agoraphobia
3. Obsessive-Compulsive Disorder
4. Social Phobia
5. Major Depressive Disorder
6. Somatization Disorder
7. Substance-Related Disorders.

ASSOCIATED LABORATORY FINDINGS

Increased arousal may be measured through studies of the autonomic functioning (e.g., heart rate, electromyography, sweat gland activity).

ASSOCIATED PHYSICAL EXAMINATION FINDING/GENERAL MEDICAL CONDITION

General medical conditions may occur as a consequence of the trauma (e.g., head injury).

SPECIFIC CULTURE AND AGE FEATURES

1. Persons emigrated from areas of social unrest and civil conflict have elevated rates of PTSD. Assessment of traumatic experiences is needed.

2. Young children display PTSD in distressing dreams, nightmares of monsters, repetitive play of event, diminished interest in significant activities, changes or constriction of affect, sense of foreshortened future, omen formation and various physical symptoms such as stomach aches and headaches.

PREVALENCE

Community-based studies according to the DSM-IV reveal a lifetime prevalence for PTSD ranging from 1% to 14%. Studies of at risk individuals (e.g., combat veterans, victims of volcanic eruptions or criminal violence) have prevalence rates ranging from 3% to 58%.

COURSE OF PTSD

1. Can occur at any age.
2. Symptoms usually begin within the first 3 months after the trauma but could be delayed months or years before symptoms appear.
3. Disturbance frequently meets criteria for Acute Stress Disorder in immediate aftermath of trauma.
4. Symptoms the reexperiencing, avoidance and hyper arousal symptoms may vary over time.
5. Duration of symptoms varies, with complete recovery occurring within 3 months in approximately half of cases, with many others having persisting symptoms for longer than 12 months after the trauma.

Severity, duration and proximity of person's exposure to traumatic event are the most important factors affecting the likelihood of developing PTSD. Some evidence that social supports, family history, childhood experiences, personality variables, and preexisting mental disorders may influence development of PTSD. PTSD may develop in persons without any predisposing conditions, particularly if stressor is especially extreme.

IV. THE PLAINTIFF'S UTILIZATION OF PTSD DIAGNOSTIC CRITERIA

The fundamental assertion involving PTSD is that the trauma caused the mental disorder. The presentation to persuade the jury of its existence and severity should center around the utilization of the diagnostic criteria for PTSD: (1) The stressor, (2) The reexperiencing of the stressor (3) Avoidance and numbing criteria, (4) arousal symptoms and (5) the clinically significant distress or impairment in important areas of functioning (Scrignar, 1996).

STRESSOR

1. Demonstrate the plaintiff experienced, witnessed or was confronted with a

- stressor which caused intense fear, helplessness, or horror.
2. Plaintiff, would describe in detail entire experience (thoughts, feelings, actions) before, during and after impact. Use of vivid word pictures so judge and jury can identify with incident.
 3. Plaintiff describes emotional impact without exaggeration/distortion.
 4. Others who witnessed event could testify regarding nature of trauma and plaintiff's reactions. Coworkers, bystanders, police, investigators, and safety experts can add depth to account of traumatic event.
 5. Mental health experts for plaintiff can add evaluation of all data and placing the trauma and its impact into a psychiatric context.
 6. If physical injury also occurred, medical specialists can testify regarding relationship between physical injury and traumatic event.

REEXPERIENCING

1. Flashbacks, dreams, etc. can be substantiated by spouses.
2. Witnesses can attest to plaintiff's reactions when exposed to cues that resemble an aspect of traumatic event (e.g., anxious look, change in speech, hyperactivity, desire to leave scene, intense fear).
3. Experts can testify to the reexperiencing evidence as plaintiff has related and by psychophysiology testing results which measures physiological reactivity on exposure cues that resemble traumatic event. Test results are presented as objective findings of PTSD.

AVOIDANCE AND NUMBING

1. Plaintiff testifies to his/her attempts to avoid thoughts, activities, places or people that arouse recollections of the trauma.
2. Witnesses (e.g., spouses, relatives, friends, coworkers) can corroborate avoidance behavior.
3. Expert testifies to the use of avoidance criteria in PTSD and explains plaintiff's phobic behavior was conditioned by the traumatic event.

AROUSAL

1. Plaintiff may look nervous and relate anxiety symptoms.
2. Spouse, friends, relatives and coworkers can verify anxiety-related symptoms of insomnia, irritability, problems with concentration, hypervigilance and exaggerated startle response.
3. Expert testifies to observed behaviors during examinations. Behaviors may include hyperactivity, anxiousness, quaking voice, moist palms, increased pulse rate, and patient's fearful self report.

SIGNIFICANT DISTRESS IN IMPORTANT AREAS OF FUNCTIONING

1. Assessment is made of the plaintiff's life and how PTSD changed his/her enjoyment of life. Use of testimony should include clinician , family, friends and coworkers to confirm changes in plaintiff life changes. Problem areas may include:
 - A. Marital difficulties.
 - B. Deterioration in social relationships.
 - C. Recreational activities and enjoyment of life decreases as PTSD becomes chronic.
2. Clinician can testify how post-traumatic symptoms and depression interfere with enjoyment of life by summarizing psychological environmental problems related to PTSD

EXPERT TESTIMONY

Experts will testify regarding diagnosis, treatment and prognosis and offer opinion concerning causation and plaintiff's credibility.

DIRECT EXAMINATION SHOULD INCLUDE:

1. **QUALIFICATION OF EXPERT WITNESS.**
2. **BASIS OF OPINION.** Should include all dates of examinations, all sources of information including tests, checklists, interviews of all persons, and all records and reports reviewed.
3. **FINDINGS.** State results of examination. Traumatic event is described in a chronological sequence, with emphasis on plaintiff's psychophysiological reactions moments before, during and immediately after the event. Symptom list is used as reference. Comparisons are made regarding plaintiff before and after the trauma. Conclusion "the trauma caused or precipitated PTSD".
4. **EXPLANATION.** Expert explains what is PTSD. Plaintiff's history is utilized to compare the DSM-IV criteria for PTSD.
5. **CAUSATION.** Expert testifies to the relationship between the trauma and the plaintiff's current mental state. Conclusion: the trauma caused the plaintiff's PTSD. Framework for presenting and explaining the diagnosis of PTSD requires close attention to three specific time periods: 1) Time just preceding the stressor event, 2) the trauma itself, 3)The time following the traumatic event. Comparisons are made to pre and post-traumatic symptoms. The presence of PTSD symptoms only after a well-documented trauma seals the diagnosis and settles the issue of causality.

Supplemental information from interviews with acquaintances of the plaintiff before and after the trauma can substantiate post-traumatic symptoms.

6. **TREATMENT.** Expert testifies to treatment principles and methods and those relevant to plaintiff's case.
7. **LENGTH OF TREATMENT.** Always difficult to determine. Studies have shown PTSD can persist for indefinite periods of time. Although symptoms of PTSD may diminish in intensity with time there may be an increase morbidity of developing other psychiatric disorders, susceptibility to stress, depression, or alcohol and drug abuse. PTSD victims are particularly sensitive to future stressors and may require intermittent treatment over a lifetime.
8. **WORK IMPAIRMENT.** Plaintiff's type of occupation, together with symptoms determine the impairment. If trauma is work related it is not unusual to develop a phobia regarding returning to work.. General anxiety may impair work performance. In industrial work, there may be an inherent danger with a worker with PTSD endangering themselves and coworkers. Lack of concentration, and diminish productivity are characteristic of PTSD . Physical injury and PTSD coexist, chronic pain and physical incapacity may prevent a return to work. Issues of work is of paramount importance in worker's compensation cases but also has prognostic significance in PI cases.
9. **ENJOYMENT OF LIFE.** PTSD interfere's with family life, marital satisfaction (including sexual pleasure), interpersonal relationships, social and recreational activities, work and other important areas of functioning. List all negative changes and impairments of pleasures in plaintiff's life which followed the trauma and can be attributed to it. Changes in enjoyment of life are of consequence in awarding damages and are listed on Axis IV of the Multiaxial Assessment in DSM-IV.
10. **MALINGERING.** Defendant will use antisocial behavior, character defects, substance-related disorders and other evidence to prove plaintiff's lack of credibility. To counter such claims the plaintiff's expert must refute the charge by listing all diagnostic criteria for those disorders to prove the plaintiff does not meet the criteria of the antisocial personality disorder.
11. **SUMMING UP.** Expert should make a brief summary of positive findings and reiterate that the trauma caused PTSD.

V. CONCLUSION

PTSD has been the subject of debate and study since the beginnings of war. It is one of the few mental disorders where the initiating factor, a traumatic event, can be identified. DSM-IV has evolutionized and provided the framework for the diagnosis of PTSD. The diagnostic criteria as presented in the DSM-IV can serve as an outline for the presentation of psychiatric evidence in the court of law. The DSM-IV criteria provides the framework for the plaintiff's expert to explain in logical scientific methods; causation, credibility, prognosis and cost of treatment.

MULTIAXIAL ASSESSMENT

- AXIS I** Clinical Disorders
Other Conditions that may be a focus of Clinical Attention
- A. Disorders usually first diagnosed in infancy, childhood or adolescence (excluding Mental Retardation - diagnosed in Axis II)
 - B. Delirium, dementia and amnesic and other cognitive disorders
 - C. Mental Disorders due to general medical conditions.
 - D. Substance-Related Disorders
 - E. Schizophrenia and other Psychotic Disorders
 - F. Mood Disorders
 - G. Anxiety Disorders
 - H. Somatoform Disorders
 - I. Factitious Disorders
 - J. Dissociative Disorders
 - K. Sexual and Gender Identity Disorders.
 - L. Eating Disorders
 - M. Impulse-Control Disorders not elsewhere classified.
 - N. Other conditions that may be a focus of clinical attention.
- AXIS II** Personality Disorders
Mental Retardation
- A. Paranoid Personality Disorder
 - B. Schizoid Personality Disorder
 - C. Schizotypal Personality Disorder
 - D. Antisocial Personality Disorder
 - E. Borderline Personality Disorder
 - F. Histrionic Personality Disorder
 - G. Narcissistic Personality Disorder
 - H. Avoidant Personality Disorder
 - I. Dependant Personality Disorder
 - J. Obsessive-Compulsive Personality Disorder
 - I. Personality Disorder not otherwise specified
 - J. Mental Retardation
- AXIS III** General Medical Conditions (with ICD-9CM codes)
- A. Infectious and Parasitic Diseases
 - B. Neoplasms
 - C. Endocrine, Nutritional, and Metabolic Diseases and Immunity Disorders
 - D. Diseases of the Blood, and Blood-Forming Organs
 - E. Diseases of the Nervous System and Sense Organs
 - F. Diseases of the Circulatory System
 - G. Diseases of the Respiratory System

- H. Diseases of the Digestive System
- I. Diseases of the Genitourinary System
- J. Complications of Pregnancy, Childbirth and the Puerperium
- K. Diseases of the Skin and Subcutaneous Tissue
- L. Diseases of the Musculoskeletal System and Connective Tissue
- M. Congenital Anomalies
- O. Certain Conditions Originating in the Perinatal Period
- P. Symptoms, Signs and Ill-Defined Conditions
- Q. Injury and Poisoning

AXIS IV Psychosocial and Environmental Problems

- A. Problems with primary support groups.
- B. Problems related to the social environment
- C. Educational problems
- D. Occupational problems.
- E. Housing problems
- F. Economic problems
- G. Problems with access to health care services
- H. Problems related to interaction with the legal system/crime
- I. Other psychosocial and environmental problems

AXIS V Global Assessment of Functioning.

Axis V is for reporting the clinician's judgement of the individual's overall level of functioning using the Global Assessment of Functioning (GAF) Scale. The GAF Scale is to be rated with respect only to psychological, social and occupational functioning and **does not include impairment** in functioning due to physical or environmental limitations.

RESOURCES

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