Posttraumatic Stress Disorder: Clinical and Forensic Issues

Presented by
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ASSESSING ALLEGATIONS OF TRAUMA IN FORENSIC CONTEXTS

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AGENDA

- Define and discuss “Mental Disorder” and importance of Diagnosis
- Describe the development and history of the posttraumatic stress disorder (PTSD) diagnosis.
- Compare and contrast the DSM-IV and DSM 5 criteria for PTSD
- Describe the diagnosis and symptom picture of PTSD and related disorders
- Identify special challenges of assessing persons alleging emotional harm or trauma in personal injury, disability, and criminal contexts
- Describe strengths and weaknesses of tests frequently used to assess trauma in forensic contexts
- Identify best practice when assessing litigants reporting emotional harm or trauma
- Identify special challenges of assessing complaints of emotional harm and trauma with persons from diverse backgrounds

THE SAN DIEGO MARATHON
Cautionary Statement for Forensic Use of DSM-5

• "...it is important to note that the definition of mental disorder included in the DSM-5 was developed to meet the needs of clinicians, public health professionals, and research investigation rather than all of the technical needs of the courts and legal professionals."

• "When DSM-5 categories, criteria, and textual descriptions are employed for forensic purposes, there is a risk that diagnostic information will be misused or misunderstood. The dangers arise because of the imperfect fit between the questions of ultimate concern to the law and the information contained in a clinical diagnosis."

• "In most situations, the clinical diagnosis of a DSM-5 mental disorder does not imply that an individual with such a condition meets legal criteria for the presence of a mental disorder or a specified legal standard."

• "It is precisely because impairments, abilities, and disabilities vary widely within each diagnostic category that assignment of a particular diagnosis does not imply a specific level of impairment or disability."

(DSM-5, pg. 25)

Reputation of psychiatric diagnosis as imprecise...

Diagnostic criteria in psychiatry are as reliable and valid as medical diagnoses made in other medical disciplines using objective tests such as X-rays and EKGs

(North & Yutzy 2010; Cloninger 1989)

“MENTAL DISEASE” OR “MENTAL DEFECT” OR “MENTAL ABNORMALITY”

“DMS-5 is a Guide not a Bible-Ignore Its Ten Worst Changes...be skeptical and don’t follow DSM-5 blindly down a road likely to lead to massive over-diagnosis and harmful over-medication. Just ignore the ten changes that make no sense.”

Allen Frances
The Definition

“DSM” is explicitly referenced in the federal statute and some state statutes and rules.
The problem: Some jurisdictions define mental disease, mental defect, and mental abnormality independent of an explicit reference to DSM while many do not.

Federal statute-

State statute-

Definition of a Mental Disorder

“A clinically significant behavioral or psychological syndrome or pattern that occurs in an individual and that is associated with present distress (e.g., a painful symptom) or disability (i.e., impairment in one or more important areas of functioning) or with a significantly increased risk of suffering death, pain, disability, or an important loss of freedom. In addition, this syndrome or pattern must not be merely an expectable and culturally sanctioned response to a particular event, for example, the death of a loved one.” DSM IV-TR

Importance Of Diagnosis

- Differentiating disorders is the keystone of medical practice – everything else that doctors do depends on it
- Disorders with similar clinical features require differentiation (e.g., pneumonia, pulmonary embolus, congestive heart failure, lung CA)
- These different conditions require different treatment
- Differentiating psychiatric disorders is equally important
  - E.g., schizophrenia, mood disorders, substance abuse are different illnesses
  - These conditions require different treatment and have different prognosis

Why Should We Care About Diagnosis?

Diagnosis is essential for:

- Communication among providers/experts
- Selecting effective treatment
- Accurate prognosis
- Research
- Educating clinicians and researchers
- Educating the court
To diagnosis or not?

**PRO**
- American Psychiatric Association Practice Guideline
  - 87% of psychologists and 93% of psychiatrists indicated a formal diagnosis was “essential” or “recommended”

**CON**
- Formal diagnosis does not answer the legal question
- DSM-IV-TR caution: “In determining whether an individual meets a specified legal standard...additional information is usually required beyond that contained in a DSM-IV diagnosis.”


The Question of Diagnosis

**ADVANTAGES**
- Some jurisdictions have specific diagnoses that are excluded from consideration
- A useful construct to gather and evaluate data
- Diagnostic criteria can be useful in evaluating the validity of claimed impairments

**DISADVANTAGES**
- Diagnosis itself is useless to the Court
- The presence of a diagnostic entity does not necessarily mean that the criminal behavior was caused by that entity
- Can lead to confusing and largely irrelevant battle about whether diagnostic criteria are met

(Melton et al. 2007)

Unmasking Forensic Diagnosis

**ADVANTAGES**
- A diagnosis can confuse rather than enlighten
  - The Court may misunderstand the validity of the diagnostic categories themselves, which have largely remained a collection of consensus-based disorders

**DISADVANTAGES**
- Within the diagnostic categories of antisocial and obsessive-compulsive personality disorders, it is possible for two cases to share no features at all
  - A diagnosis implies a false sense of certainty, accuracy, and precision
  - Forensic use of diagnostic categories medicalizes behavior and endows it with an aura of objectivity

(Greenberg et al., 2004)

Unmasking Forensic Diagnosis

Experts should offer diagnoses judiciously and realize that a functional analysis provides the Court with more helpful information without the confusion that diagnoses create

“Experts should always address legally relevant behaviors, capacities, and functioning. If the expert can show that offering a diagnosis adds information that is reliable, predictive of legally relevant functioning, and not unfairly prejudicial, then it should also be offered. If these criteria cannot be met, then diagnoses should not be included in the expert’s testimony.”

(Greenberg et al., 2004)
Diagnosis: Final Considerations

• Who asked you?
• Is the Court expecting it?
• Are you prepared to answer questions about reliability and validity?
• Will it help the finder of fact to understand the nature of defendant’s present mental condition?
• Will it help the finder of fact to understand the severity of the defendant’s present mental condition?
• Will it lead to a distracting and possibly irrelevant battle over whether diagnostic criteria are met?

#10: “DSM-5 has opened the gate even further to the already existing problem of misdiagnosis of PTSD in forensic settings.”

Do you agree or disagree?

Allen Frances

Brief History of PTSD Diagnosis

• Is PTSD something new?
• Historical prospective…..
PTSD is as old as human culture

<table>
<thead>
<tr>
<th>Year</th>
<th>Event</th>
</tr>
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<tbody>
<tr>
<td>1900 B.C.</td>
<td>Egyptian physicians first report hysterical reactions</td>
</tr>
<tr>
<td>700 B.C.</td>
<td>Homer's The Odyssey describes the &quot;travails of Odysseus,&quot; veteran of Trojan Wars, including flashbacks and survivor's guilt</td>
</tr>
<tr>
<td>490 B.C.</td>
<td>Herodotus writes of a soldier going blind after witnessing the death of a comrade next to him</td>
</tr>
<tr>
<td>1597</td>
<td>Shakespeare vividly describes war sequela (Lady Percy in King Henry IV)</td>
</tr>
<tr>
<td>1600</td>
<td>Samuel Pepys describes symptoms in survivors of the great fire of London</td>
</tr>
<tr>
<td>1840's</td>
<td>Prussian military physicians</td>
</tr>
<tr>
<td>1879</td>
<td>Rigler coins term <em>compensation neurosis</em></td>
</tr>
</tbody>
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1880s | Pierre Janet studies and treats traumatic stress; "hysterical and dissociative symptoms, inability to integrate memories, biphasic nature" of suppression and intrusion, and other symptoms often resulting from abuse |
1880s | "Spinal shock syndrome" civilian PTSD |
1899 | Helmut Oppenheim coins term traumatic neurosis |
1872 | Dacosta (1872) "cardiorespiratory" syndrome after the American Civil War |
WWI | "Shell shock" WWI neuropsychiatric "molecular" theory |
WWII | "Combat neurosis" WWII psychiatric theories |
1957 | Rape Trauma Syndrome |
1980 | Vietnam → “Post-Traumatic Stress Disorder” DSM-III |

Trauma Syndromes: DSM-I (1952)

- **Gross Stress Reaction**: Transient response to "severe physical demands or extreme emotional stress such as in combat or in civilian catastrophe (fire, earthquake, explosion, etc.)"
  - symptoms not described
  - could evolve into a chronic neurotic reaction in accordance with predisposing character traits
  - Publication coincided with Korean war

Trauma Syndromes: DSM-II (1968)

- **Transient Situational Disturbance**: "An acute reaction to overwhelming environmental stress"
  - stressors include unwanted pregnancy, combat, receiving death sentence
  - symptoms not described
  - (Eliminated Gross Stress Reaction)
  - Period of relative global peace
PTSD: DSM-III (1980)

• First time in DSM – politics surrounding Vietnam War

• Criterion A trauma: “recognizable stressor that would evoke significant symptoms of distress in almost everyone”
  
  (Text: development of characteristic symptoms following a psychologically traumatic event that is generally outside the range of usual human experience. Simple bereavement, chronic illness, business losses, and marital conflict do not count)

• 12 symptoms in 3 groups:
  • B: re-experience
  • C: numbing
  • D: arousal and avoidance

• Specifiers: acute/chronic ~ duration of symptoms /+ 6 mos
  
  delayed onset = onset of symptoms > 6 mos post trauma

  Breslau N, Kessler RC (2001)


• Criterion A trauma: “event that is outside the range of usual human experience and that would be markedly distressing to almost anyone”

• Criterion A trauma exposure:
  • serious threat to one's life or physical integrity
  • serious threat or harm to close relatives and friends - NEW
  • sudden destruction of one's home or community - NEW
  • seeing another person who has recently been, or is being, seriously injured or killed by accident or physical violence

• 17 symptoms in 3 groups:
  • B: re-experience (intense psychological distress to reminders added)
  • C: avoidance/numbing (avoidance of activities that remind moved D
  • D: hyperarousal (survival guilt removed; irritability/anger added)

Breslau N, Kessler RC (2001)

PTSD: DSM-IV (1994)

• Criterion A1 trauma: “actual or threatened death or serious injury, or a threat to physical integrity of self or others”

• Criterion A1 trauma exposure: experienced, witnessed, or was confronted:
  
  (Text): 1. directly experienced
  2. witnessed
  3. learning of events experienced by close a

• Criterion intense

• Same B, C, D specifiers moved D

• Chronic type: duration of symptoms reduced to >3 mos

  Breslau N, Kessler RC (2001)


• Same
Evolution of PTSD criteria in *DSMs* have altered apparent prevalence of traumatic events and associated PTSD (Breslau & Kessler 2001).

- **DSM-III-R → DSM-IV:**
  - ↑ A1-qualifying traumatic events by 59%  
  - Some of an event was from new event types (e.g., trauma of loved one)
  - Addition of A2 criterion (intense fear, helplessness, horror) limited ↑ of criterion A (A1+A2)-qualifying events to 22%  
  - A2 added little to PTSD Dx: very few people not endorsing intense fear, helplessness, or horror met PTSD Sx threshold – suggests best utility for A2 is screening (to rule out cases unlikely to meet full criteria)

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**Trauma Criteria Evaluated**

Breslau N, Kessler RC (2001)

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**New section** for trauma and stress exposure-related disorders  
- Disorders with exposure to trauma or stress listed explicitly as diagnostic criterion  
- Placement of this chapter in DSM-5 reflects close relationship between these diagnoses and disorders in surrounding chapters (anxiety disorders, obsessive-compulsive and related disorders, dissociative disorders)

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**Trauma & Stressor-Related Disorders Section Diagnoses**

- Reactive Attachment Disorder  
- Disinhibited Social Engagement Disorder  
- Posttraumatic Stress Disorder (PTSD)  
- Acute Stress Disorder (ASD)  
- Adjustment Disorders-unchanged
Trauma & Stressor-Related Disorders Section

- PTSD and Acute Stress Disorder are from DSM-IV Anxiety Disorders section
- Reactive Attachment Disorder and Disinhibited Social Engagement Disorder are from DSM-IV Disorders Usually First Diagnosed in Infancy, Childhood, or Adolescence section – internalizing and externalizing disorders respectively
- Adjustment disorders are from DSM-IV Adjustment Disorders section

Acute Stress Disorder

- The qualifying traumatic events are identical to those for PTSD except that the phrase “sexual violation” is used instead of “sexual violence.”
- This disorder is rarely the basis of an emotional damage claim. By definition it’s limited to a duration of only one month.
- Approximately 50% go on to develop PTSD

Posttraumatic Stress Disorder

- In new section: Trauma- and Stressor-Related Disorders
- Criterion A (trauma exposure) more specific with how the individual experiences the event; A2 (subjective reaction) removed
- DSM IV required three symptom clusters (re-experiencing, avoidance/numbing, and arousal). DSM 5 expanded symptom to 4 (avoidance/numbing cluster divided into avoidance cluster and persistent negative emotional states)
- Alterations in arousal and reactivity specifically includes irritable or aggressive behavior, reckless or self-destructive behavior, and a wider range of negative emotions
- More developmentally sensitive for children/adolescents; thresholds have been lowered for children. Separate criteria for children 6 years or younger

DSM-5 PTSD 309.81 (F43.10)

A. Exposure to TRAUMA (actual/threatened death, serious injury, sexual violence):
   1. Directly experienced
   2. Witnessed (in person) trauma
   3. Learned of direct exposure (vicarious) of close family
   4. Repeated or extreme exposure to aversive details of trauma
   - eg, first responders collecting human remains; police officers repeatedly exposed to (A2 subjective response of fear, helplessness, horror eliminated)
   - Exposure through electronic mass media, or pictures does not apply (unless work-related)

(Not all life-threatening illness or debilitating medical conditions necessarily qualify – must be sudden, catastrophic. (Only unnatural deaths count; also, medical catastrophe in one’s child, eg, life-threatening hemorrhage) death due to natural causes does not qualify)

(A2 subjective response of fear, helplessness, horror eliminated)
**Hair salon visit led to post-traumatic stress disorder, expert says**

*By William C. Lhotka*

Geremie Hoff suffered post-traumatic stress disorder after her hair went brittle and fell out in clumps, her psychiatrist testified Tuesday in a lawsuit against a hair salon at Plaza Frontenac.

Dr. Dawn M. Holmen joined a counselor, Linda Pernick, in supporting Hoff’s claim to unspecified damages for emotional and economic distress.

(http://overlawyered.com/early-years/april-2003-archives-parts-2-3/)

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**Examples of Criterion A Qualifying Exposures**

Which one(s) of these is not a qualifying exposure?

- Rape
- Combat
- Divorce
- Sexual Harassment
- Terrorist attack
- Unexpected death of loved one
- Incarceration as prisoner of war
- Losing your job

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**DSM-5 PTSD 309.81 (F43.10)**

B. >1 trauma-related **intrusion** symptom(s) beginning after trauma occurred:

1. Recurrent, involuntary, and intrusive distressing memories of the trauma
2. Recurrent distressing dreams with dream content and/or affect related to the trauma
3. Dissociative reactions (eg, flashbacks): the person feels or acts as if the trauma is recurring
4. Psychological distress with reminders of the trauma
5. Physiological reactions to reminders of the trauma

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**9/11 WORLD TRADE CENTER**

**Intrusion**

"Not a cloud in the sky and I look up: ‘Oh, my God, it’s that kind of a day.’ Those bring it back...gorgeous days bother me."

"I tense when I hear a plane. Is it going to...crash into the building?"

"Nightmares...that I was in the building, burning...screaming at them trying to get them on the elevators to try and get them out..."

"I keep re-seeing what I saw. It doesn't stop. It's like a videotape that you play over and over again...it just won't go away."

North et al 2015
C. >1 symptom(s) of persistent avoidance of trauma reminders, beginning after trauma occurred:
1. Avoidance of or efforts to avoid internal reminders (distressing trauma-related memories/thoughts/feelings)
2. Avoidance of or efforts to avoid external reminders (people, places, conversations, activities, objects, situations) that arouse distressing trauma-related memories/thoughts/feelings

D. >2 trauma-related negative cognitions/mood symptoms beginning/worsening after trauma occurred:
1. Inability to remember important parts of the trauma (typically, dissociative amnesia) - not from head injury, alcohol, or drugs
2. Negative beliefs or expectations about oneself/others/the world - eg, "I am bad," "No one can be trusted," "The world is completely dangerous"
3. Distorted cognitions about cause or consequences of trauma, leading to blaming self/others
4. Negative emotional state (eg, fear, horror, anger, guilt, shame) (new)
5. Markedly diminished interest or participation in significant activities (C4 in DSM-IV)
6. Feeling detached/estranged from others (C5 in DSM-IV)
7. Inability to experience positive emotions (happiness, satisfaction, love) (C6 in DSM-IV)
E. >2 trauma-related marked arousal and reactivity symptoms beginning/worsening after trauma occurred:
1. Irritable behavior and angry outbursts (with little or no provocation) expressed as verbal or physical aggression (revised D2 from DSM-IV)
2. Reckless or self-destructive behavior (new)
3. Hypervigilance (D4 in DSM-IV)
4. Exaggerated startle response (D5 in DSM-IV)
5. Problems with concentration (D3 in DSM-IV)
6. Sleep disturbance (eg, difficulty falling/staying asleep; restless sleep) (D1 in DSM-IV)

DSM-5 PTSD  309.81 (F43.10)

F. Duration of disturbance (Criteria B, C, D, and E) is >1 mo
G. Clinically significant distress or impairment in social, occupational, or other important areas of functioning
H. Not attributable to physiological effects of a substance (eg, Rx, EtOH) or another medical condition
Specify: (new)
• With dissociative symptoms (depersonalization or derealization)
• With delayed expression: the full diagnostic criteria are not met until >6 months post trauma (although onset and expression of some symptoms may be immediate)
Note separate criteria for kids <6 y/o and different Sx expression in kids >6 y/o

9/11 WORLD TRADE CENTER

Arousal and reactivity

"The next morning, I heard the military planes, and I literally went under the table."
"...sleeping in 20 minute increments...wake up in that heightened panic, my heart racing..."
"I have become very claustrophobic, so I don't ever do tunnels or subways, ever. I take the ferry."
"You know in your heart that something else will happen again, that it's inevitable...you're just waiting for it..."

North et al 2015

PTSD Criteria for DSM-5

Without a qualifying exposure you do not ask about B-E:
B. Intrusion symptoms
C. Persistent avoidance of stimuli associated with the trauma
D. Negative alterations in cognitions and mood that are associated with the traumatic event
E. Alterations in arousal and reactivity that are associated with the traumatic event
Adhering to Symptoms Criteria is Important

- Careful application of *DSM-5* criteria excludes unrelated Sxs not tied to qualifying event
- Sxs must be related to event either:
  - temporally (beginning or worsening after trauma)
    
    (e.g., distressing memories (b), problems concentrating (b or w), or loss of interest after the event (b or w), not just presence of Sx after event)
  - or contextually

    (eg, requiring nightmares of the event rather than just any nightmares; loss of memory specific to event details, not just general memory decline)

North (2011)

Diligence in Assessment is Critical

- Sx checklists & screeners using thresholds of summed Sxs scores to define caseness are:
  - Not equivalent to assessing full criteria with diagnostic algorithm
  - Notorious for confusing psychopathology with normal reactions or other problems*
- Despite appearances, taking care to evaluate postraumatic Sxs according to *DSM-IV-TR* criteria is not a subtle issue
- This distinction is vital to diagnostic validation and securing homogeneous research samples
- Measuring Sxs may have useful applications, but Sx scales cannot substitute for full diagnostic assessment

North (2011)

9/11 PTSD ESTIMATES: 500,000+ NYC CASES

<table>
<thead>
<tr>
<th>Estimated # exposed</th>
<th>Estimator</th>
<th># PTSD cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>Proximally exposed</td>
<td>163,000 (~56,000 at disaster site + ~105,000 immediate family)</td>
<td>34% (from North et al. OKC bombing study)</td>
</tr>
<tr>
<td>Manhattan</td>
<td>920,000 (from Galea study)</td>
<td>10%</td>
</tr>
<tr>
<td>NYC outside Manhattan</td>
<td>7,000,000</td>
<td>5%</td>
</tr>
<tr>
<td>Adjacent counties</td>
<td>4,800,000</td>
<td>1%</td>
</tr>
<tr>
<td>TOTAL</td>
<td>~530,000</td>
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Galea et al. NEJM 2002
Herman et al. J Urban Health 2002
Schlenger et al. JAMA 2002

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North (2011)
FACTS: WTC 9/11 ATTACKS

WTC 1
- Plane hit Floors 86-94
- Collapse: 3:46pm
- 965 died
- 595 died
- 1360 died
- 102 min

WTC 2
- Plane hit Floors 28-42
- Collapse: 9:59am
- 64 died
- 46 died
- 72 died
- 56 min

595 died
44 died
1360 died
72 died

SPECIFIC EXPOSURES BY 9/11 LOCATION

- Saw injured people/dead bodies
- Saw people falling from towers
- Endangered by planes hitting towers
- Endangered by towers collapsing
- Fled collapse of towers
- Injured in the attacks

*Compared with those in towers, p<.05
**Compared with all those within 0.1 mi, p<.001

North et al. 2011

PTSD SYMPTOM CRITERIA BY 9/11 GEOGRAPHIC DISTANCE FROM WTC

- % with PTSD symptom criteria
- All exposed
- Excluding those exposed but not within 0.5 mile of towers

In WTC towers
Within 0.1 mile
Within 0.5 mile

% with PTSD symptom criteria

Miles from WTC during attacks

25 unexposed met symptom criteria; 20 had pre-disaster disorder

Of the remaining 50 exposed symptom met, 1 was 1.9 miles away
and 1 was 3.4 miles away but worked with families of 9/11 victims

Maps courtesy of the New York City Department of Health and Mental Hygiene

14
G. Clinically significant distress or impairment in social, occupational, or other important areas of functioning

### Functioning and PTSD: OKC Bombing

![Graph showing functioning problems at 6 months and 7 years post-OKC Bombing.]

#### AT 6 MONTHS
- **No PTSD** (n=51)
- **PTSD** (n=31)
- **PTSD non-recovered** (n=21)
- **PTSD recovered** (n=10)

#### AT 7 YEARS

- ***p<.001***

North et al 2001

### Employment: OKC Bombing Survivors

Of 86 employed (83% full time) at time of bombing:

**Employment status at 7 years**
- Working full time: 71%
- Working part time: 8%
- Looking for work: 3%
- Housewife: 3%
- Retired: 8%
- Disabled: 6%

All 5 seriously injured: loss of eyes (n=3), head injuries (n=2), 20+ surgeries (n=2)

North et al 2001

### 10-Disaster Study Employment (3 Years)

(N=303)

- **At time of disaster**
  - Working: 261
  - Not working: 42

- **In the interim**
  - Continuous employment: 220
  - Discontinuous employment: 29

- **At 3-year follow-up**
  - Working: 254
  - Not working: 49

Rasco & North 2010
Working Day of Disaster, Not at Follow-up

- **F/U STATUS**
  - 3 retired
  - 5 housewife
  - 4 unemployed
  - 0 disabled

- 3 converted to housewife status shortly after disaster
- 2 stopped work 2-4 mos before 3-yr F/U
- 3 employees of destroyed Indianapolis hotel worked in interim; not working at 3 yrs
- 1 quickly obtained other work that ended 1 mo before 3-yr F/U

1 had PTSD

Summary of Major Changes from DSM-IV to DSM-5

- DSM-IV required six symptoms from three clusters—reexperiencing, arousal, and avoidance/numbing
- DSM-5 requires six symptoms from four clusters: intrusion symptoms, avoidance, negative alterations in cognitions and mood, and marked alterations in arousal and reactivity.
- Of the 20 possible symptoms in these four clusters, the 14 symptoms in the first three clusters are subjective and cannot be independently corroborated by objective evidence,
- Four of the six symptoms in the fourth cluster—angry outbursts, self-destructive behavior, exaggerated startle response, and sleep disturbance—may be witnessed by others and do not rely entirely on self-report.

4.07 Use of Confidential Information for Didactic or Other Purposes

Psychologists do not disclose in their writings, lectures or other public media, confidential, personally identifiable information concerning their clients/patients, students, research participants, organizational clients or other recipients of their services that they obtained during the course of their work, unless (1) they take reasonable steps to disguise the person or organization, (2) the person or organization has consented in writing, or (3) there is legal authorization for doing so.
CASE #1
THE ALLEGATION

Criterion A

- Forced victim to hold his hand while they walked in public
- Propositioned her on two occasions to touch herself
- Rubbed his erect penis on her
- Masturbated in front of her
Conditions commonly mistaken for PTSD include major depression, persistent depressive disorder (previously known as dysthymic disorder), bipolar disorder, generalized anxiety disorder, acute stress disorder (similar, but duration is two days to four weeks), adjustment disorder with anxious mood, adjustment disorder with depressed mood, adjustment disorder with mixed depressive and anxious mood, and borderline personality disorder.

Malingering
“Moreover, if the symptom response pattern to the extreme stressor for another mental disorder (e.g., brief psychotic disorder, conversion disorder), these diagnoses should be given instead of or in addition to PTSD.”

**ASSESSMENT MEASURES**

- Clinician Administered PTSD Scare (CAPS-5)
- PTSD Checklist (PCL-5)
- Trauma Symptom Inventory (TSI-2)
- Detailed Assessment of Posttraumatic Stress (DAPS)
- MMPI-2
- PAI-2
- Moral Emotional Numbing Test

**Ethical Issues**

**9.01 Bases for Assessments**

- Base opinions on information and techniques sufficient to establish the findings.
- Provide opinions only after conducting an examination of the individual adequate to support findings.
- Explain the sources of information on which conclusions are based.
- Use instruments that whose reliability and validity have been established for the population tested.
- Use methods that are appropriate to the individual’s language preference.

**9.02. Use of Multiple sources of information**

- Forensic clinicians avoid relying on one source of data and corroborate important data whenever feasible.

**10.02 Selection & Use of Assessment Procedures**

- Forensic practitioners make known that examination results can be affected by factors unique to the forensic context (e.g., response style, situational stress).
CAPS-5

A gold standard for diagnosing PTSD
Matches 20 DSM-5 PTSD Symptoms
Semi-structured interview
Provides diagnosis as well as severity (frequency & intensity) scores for symptoms
Allows you to estimate severity of PTSD symptoms
Approximately 45 to 60 minutes
3 Versions: past week, past month, worst month

CAPS-5

Additional 10 items:
- Onset and duration of symptoms
- Subjective distress
- Impact of symptoms on social and occupational functioning
- Improvement since a previous CAPS
- Overall response validity,
- Overall PTSD severity
- Specifications for the dissociative subtype (depersonalization and derealization).

Conducting a CAPS-5 Interview

Assess exposure to traumatic events using Life Events Checklist (17 items)
Depending on purpose of interview, focus on worst to assess for presence of PTSD or trauma of interest for forensic assessment
“Of these events you have checked, which is the one that bothers you the most today?”
Life Events Checklist (LEC)

**DIRECTIONS:** Listed below are a number of difficult or stressful things that sometimes happen to people. For each event mark one or more of the boxes to the right to indicate that: (A) it happened to you personally, (B) you witnessed it happen to someone else, (C) you learned about it happening to someone close to you, or (D) it doesn’t apply to you. Then, for each event that happened to you or you witnessed or learned about, please indicate (E) the number of times it happened, (F) your age at the time the event happened, and (G) your marital status and (H) level of education when the event happened. Be sure to consider your entire life (growing up as well as adulthood) as you go through the list of events.

<table>
<thead>
<tr>
<th>Event</th>
<th>Happened to me</th>
<th>Witnessed it</th>
<th>Learned about it</th>
<th>Part of my job</th>
<th>Not sure</th>
<th>Doesn’t apply</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Natural disaster (for example, flood, hurricane, tornado, earthquake)</td>
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<td>2. Fire or explosion</td>
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<tr>
<td>3. Transportation accident (for example, car accident, boat accident, train wreck, plane crash)</td>
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<tr>
<td>4. Serious accident at work, home, or during recreational activity</td>
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</tbody>
</table>

Orienting Client to CAPS-5

- Explain that the CAPS interview is intended to:
  1. *briefly* inventory stressful life experiences that may or may not have occurred during the client’s lifetime
  2. assess how exposure to stressful events may have affected him/her.
- State that there are no right or wrong answers to the questions being asked. We want to know the client’s account of their experiences and any resulting difficulties.

Orienting Client to CAPS-5

- Describe the CAPS interview structure
- briefly assesses trauma history
- Ask a series of questions assessing how they were affected by exposure to specific stressors.
  - Frequency (have you had the symptoms?)
  - Intensity (how much distress or discomfort did it cause?)

Administration

- First, ask if client has EVER experienced the problem; if yes, then ask about how many times in the past month they had the problem/symptom
- If symptoms change over the month—example flashback before hospitalization—determine **typical symptoms**
General Administration Guidelines

- Read prompts verbatim, one at a time, in the order presented EXCEPT:
  a. Use the respondent’s own words for labeling the index event or describing specific symptoms.
  b. Rephrase standard prompts to acknowledge previously reported information, but return to verbatim phrasing as soon as possible. For example, inquiry for item 20 might begin: “You already mentioned having problems sleeping. What kinds of problems?”
  c. If you don’t have sufficient information after exhausting all standard prompts, follow up ad lib. In this situation, repeating the initial prompt often helps refocus the respondent.
  d. As needed, ask for specific examples or direct the respondent to elaborate even when such prompts are not provided explicitly.

Scoring

- Symptom severity ratings are based on symptom frequency and intensity, except for items 8 (amnesia) and 12 (diminished interest), which are based on amount and intensity.
- Single severity score combines information about frequency and intensity to make a single severity rating.
- Frequency is rated as either the number of occurrences (how often in the past month) or percent of time (how much of the time in the past month).
- Intensity is rated on a four-point ordinal scale: Minimal, Clearly Present, Pronounced, and Extreme.

CAPS-5 Item 1: Intrusive Memories

1. (S1) Recurrent, involuntary, and intrusive distressing memories of the traumatic event(s). Note: In children older than 6 years, repetitive play may occur in which themes or aspects of the traumatic event(s) are expressed.

   - In the past month, have you had any unwanted memories of [EVENT] while you were awake, so not counting dreams? (Rate 0-7: absent or only during dreams)
   - How does it happen that you start remembering [EVENT]?
     - (If not clear) [Are these unwanted memories, or are you thinking about [EVENT] on purpose?] [Rate 1-7: absent unless preoccupied with intrusive thoughts]
   - How much do these memories bother you?
   - Are you able to put them out of your mind and think about something else?

   Code: Absent, Minimal, Clearly Present, Pronounced, Extreme

   How often have you had these memories in the past month? # of days

Key rating dimensions = frequency / intensity of distress
Minimal = at least 2 X month; distress strongly present, some difficulty dismissing memories
Moderate = at least 1 X week / pronounced distress, considerable difficulty dismissing memories
Severe = at least 7 X week / pronounced distress, considerable difficulty dismissing memories
Final Diagnosis

PTSD Diagnosis:
1. Symptoms “present” or “absent”
2. Symptom counts only if severity score is rated 2=Moderate/threshold or higher.
3. Items 9 and 11-20 also require a trauma-relatedness (TR) rating of Definite or Probable.
4. B=1; C=1; D=2; E=2; F and G met:
   - F=disturbance last at least 1 month
   - G = clinical sig. distress or functional impairment (2, moderate or higher on 23-25)

Issues with CAPS-5

• CAPS-5 requires a certain level of severity before the symptom counts
• Requires more than minimal distress before symptoms counts
• Either you have the symptom or you don’t

Example of Administration of the CAPS 5

https://www.youtube.com/watch?v=H1SglqqTclM&feature=youtu.be

PTSD Checklist (PCL-5)

• 20 item self-report questionnaire
• Corresponds to the DSM-5 symptom criteria for PTSD
• PCL for DSM IV has three versions-PCL-M (military), PCL-C (civilian), and PCL-S (specific)
• No PCL-M or PCL-C versions of PCL-5
PCL-5

- 3 formats:
  - Without Criterion A component
  - Criterion A component
  - LEC-5 and extended Criterion A component
- Good for tracking symptom changes during and after treatment
- Careful of checklists in forensic evaluations and diagnosis
- Careful of using cut-off scores for diagnosis
- https://www.ptsd.va.gov

Morel Emotional Numbing Test for PTSD (MENT)

- Symptom validity test designed to detect simulated symptoms of PTSD
- Forced choice recognition test
- 3 sets of 20 items each
- Takes 5 to 15 minutes
- Score = total number of errors
- Norms for different populations available
- 18-59 1 to 7 errors; 60-75 1 to 8 errors

MENT

Some individuals with PTSD may have difficulty recognizing facial expressions. This test is designed to assess how well you are able to identify different facial expressions. This booklet contains photographs of different facial expressions as well as words for different feelings........
“The patients performance on symptom validity testing indicates insufficient effort to produce valid results and strongly suggests that the examinee simulated symptoms. Consequently, the validity of the patient’s self-report and performances on other testing are of questionable validity.” pg. 31

MENT

- Cautions regarding disclosure of test material:
  - Should not be released to individuals not professionally qualified to obtain them
  - Request a protective order if non-psychologists are granted access during litigation
  - Should not be made publically available in records of court case
  - Testimony that could threaten test security should be sealed
  - Exclude references to test content and responses in all documents including judge’s opinions
MMPI-2

- Validity indicators
- There is no typical MMPI-2 profile for PTSD
- Typical elevations on Scales 2, 7, and 8
- PK scale—a raw score above 30 is considered elevated

PAI

- Validity indicators
- Traumatic Stress Scale—elevations above 80
- The diagnosis should not be made solely on this scale

Depression Scales

- DEP-C—taps into painful guilt associated with the incident.
- DEP-P—taps into recurrent distressing dreams leading to sleep disturbance
- DEP-A—taps into diminished interest in pleasurable activities

Anxiety Scales

ANX-P—physiological anxiety reactivity
**T-score Interpretative significance**

- **< 60T**
  Few complaints of tension or anxiety. Person describes self as calm, optimistic, and stress tolerant.
- **60T-69T**
  Moderate degree of anxiety and stress. Person is worried, sensitive, and emotional.
- **70T-90T**
  Significant anxiety and tension. Increased worry. Person may be seen as high strung, nervous, timid, and dependent.
- **>90T**
  Generalized impairment related to anxiety. Significant time spent worrying, unable to control worry, poor distress tolerance. Likely to have a clinically significant Anxiety Disorder.

**Schizophrenia**

- SCZ-S and WRM-measure feelings of detachment or estrangement from others.
- SCZ-P-taps into concentration problems

**Aggression Scales**

- AGG designed to assess cognitive and behavioral manifestations of aggression, anger, and hostility.
- Taps fundamental aggressive features that are not necessarily specific to any disorder.
- Measures outbursts of anger

**T-score Interpretative significance**

- **< 60T**
  Person has a reasonable control over the expression of anger and hostility. Score <40T may suggest an overly meek person.
- **60T – 69T**
  Person reports being impatient, irritable, and likely to have a short-temper. May experience excessive anger and is easily provoked.
- **70T-81T**
  Chronically angry person. Likely to express anger without reservation. Subscale elevations point to how anger is expressed (e.g., verbal, physical).
- **>82T**
  Clinically significant anger and high potential for aggressive behavior. Individual is overtly hostile and easily provoked, and may have history of violent actions. Functional impairment related to aggressive acting out is likely.
Mania

- Hypervigilance is measured by MAN-I.

Trauma Symptoms Inventory-2 (TSI-2)

- Evaluates posttraumatic stress and other psychological sequelae of traumatic events: effects of sexual and physical assault, intimate partner violence, combat, torture, motor vehicle accidents, mass casualty events, medical trauma, traumatic losses, and childhood abuse or neglect.
- Self administered, 136 items
- 2 Validity Scales
  - Response Level-RL
  - Atypical Response

TSI-2

- Four Factors
  - Self-Disturbance (SELF)
  - Posttraumatic Stress (TRAUMA)
  - Externalization (EXT)
  - Somatization (SOMA)

TSI-2 Criticisms

- The TSI-2 is theoretically based and diagnosis should be atheoretical like the DSM
- 3 of 4 Factors assessed: Self-Disturbance (insecure attachment and impaired self-reference), Somatization, Externalization are not part of DSM PTSD dx. There is a PTSD factor.
- PTSD subscales: defensive avoidance, anxious arousal, dissociation, & intrusive experiences
- Based on DSM-IV-TR
- Norms group included people with borderline dx (others: incarcerated women, veterans, sexual abuse victims, domestic violence victims). Heavily female norm sample
Detailed Assessment of Posttraumatic Stress

- Self administered
- Two validity indicators
- Several trauma relevant parameters including lifetime exposure to traumatic events, immediate cognitive, emotional, and dissociative responses to a specified trauma, and symptoms of posttraumatic stress disorder, and acute stress disorder.

Detailed Assessment of Posttraumatic Stress (DAPS) Criticisms

- The DAPS generates a tentative diagnosis. The diagnosis should then be confirmed by a clinical interview, i.e., the Clinician-Administered PTSD Scale for DSM-5.
- Associated features subtests on Suicidality and Substance abuse also require further clinical assessment
- Issue with providing comparisons to the “average” trauma. Traumas are differentially experienced by individuals (past trauma, personality, coping mechanisms, etc.)
- Current version is for DSM-IV-TR

PTSD Shares Some Symptoms in Common with Other Mental Disorders

- Depressive Mood Disorders
- Generalized Anxiety Disorder
- Obsessive-Compulsive Disorder
- Substance-Related Disorders
- Phobias
- Antisocial Personality Disorder
- Borderline Personality Disorder
- Adjustment Disorders
- Panic Disorder

Differentiating PTSD from other Mental Illness Diagnoses

- PTSD symptoms have their onset after exposure to a traumatic event.
- Compared to most other disorders, symptoms of PTSD are directly linked to traumatic event or memories of these events (i.e., 8 of 17 PTSD symptoms are directly referenced to reliving or deliberate avoidance of a traumatic stimulus).
- Stimuli reminiscent of traumatic events that activate PTSD symptoms are often pervasive and wide ranging, as opposed to singular or highly specific as in the case of phobias.
- Persons with PTSD are unique in that they often re-experience memories and feelings of the traumatic event(s) while awake and while sleeping (i.e., nightmares).
- Persons with PTSD are different from those with depression and anxiety disorders in their anger over terrifying and damaging effects of trauma exposure.
- Unique pattern of associated features often accompanies PTSD: survivor guilt, feeling permanently damaged, loss of previously sustained beliefs and values, and pervasive distrust and disillusionment following trauma exposure.
Differentiating PTSD from other Mental Illness Diagnoses

- Symptoms shared by PTSD and other disorders (e.g., cued distress, diminished interest in activities, sleep disturbance) that are present before exposure to the stressor should not be attributed to PTSD.

- Clinical judgment is required to make these determinations, as there are few clear rules or standards to resolve this dilemma.

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Unique to PTSD | Unique to Depression | Overlapping Symptoms |
--- | --- | --- |
Intrusive recollection of a trauma | Depressed mood | |
Dreams of trauma event | Loss or gain of appetite or weight | Diminished interest/participation in activities |
Dissociative or flashback episodes | Psychomotor agitation or retardation | Foreshortened future |
Distress upon exposure to trauma cues | Fatigue or loss of energy | Feelings of worthlessness or guilt |
Physiological reactivity to trauma cues | Suicidal ideation | |
Avoidance of trauma specific thoughts or feelings | | Restricted range of affect |
Avoidance of trauma specific stimuli | | Diminished concentration |
Psychogenic amnesia for trauma events | | Irritability or anger |
Hypervigilance | | Sleep disturbance (insomnia) |
Exaggerated startle response | | Distress or impairment in social, occupational, or other areas of functioning |

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CASE #2
Deployed Veteran

- Deployed four times-first deployment was in 2003
- While working in Afghanistan, “We got hit, what was my eighth IED.”
- When he returned to camp, he was evaluated by a mental health professional and assigned a diagnosis of PTSD
CASE #3
Wrongful Conviction

MMPI-2 Scores

<table>
<thead>
<tr>
<th>Scales</th>
<th>T Scores</th>
</tr>
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<tbody>
<tr>
<td>L</td>
<td>52</td>
</tr>
<tr>
<td>F</td>
<td>76</td>
</tr>
<tr>
<td>K</td>
<td>49</td>
</tr>
<tr>
<td>1(Hs)</td>
<td>77</td>
</tr>
<tr>
<td>2(D)</td>
<td>93</td>
</tr>
<tr>
<td>3(Hy)</td>
<td>89</td>
</tr>
<tr>
<td>4(Hp)</td>
<td>79</td>
</tr>
<tr>
<td>5(Mf)</td>
<td>54</td>
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<tr>
<td>6(Pa)</td>
<td>94</td>
</tr>
<tr>
<td>7(Pt)</td>
<td>102</td>
</tr>
<tr>
<td>8(Sc)</td>
<td>98</td>
</tr>
<tr>
<td>9(Ma)</td>
<td>85</td>
</tr>
<tr>
<td>0(Si)</td>
<td>74</td>
</tr>
</tbody>
</table>
• False conviction is not an experience

• What did the person experience during their incarceration, i.e., threatened assault, threatened rape, denial of human dignity

Facts Of The Case

• Caucasian male convicted of First Degree Murder. DNA evidence proved he was not the perpetrator, and he was consequently, released from prison.

• At age 10, he was adopted. Prior to age 10, he lived in “every trailer park south of here” with his biological parents. “We bounced around. We usually stayed wherever my grandmother was.” At age 8, he was placed in the custody of the Division of Family Services, and eventually foster care. He was placed in two different foster homes; he remained in both foster homes for one year. His adoptive parents were friends of his eventual adoptive parents.

• Physical abuse by both his biological mother and father. This was the impetus for his eventual removal from their home. He added, “They had a drug problem as well, and they kinda fed off of each other. Drugs and violence.”

Facts Of The Case

• At age 16, he chose to leave his adopted parents’ home, and he subsequently began living in his truck. “That was a bad choice. Life is not so warm and mushy without mom and dad helping. Moral support goes a long way.”

• When asked about his home life with his adoptive parents he responded, “It was good. They taught me how to do the right things in life. We lived in the same home.”

• Expelled from school for “Spit chew in my principal’s pop.” Transferred to alternative school. He excelled in the alternative school. Moved to live with his biological grandmother and completed his high school education.

Facts Of The Case

• Before false conviction, he worked in construction and excelled.

• After false conviction, sporadic employment history.

• Since his release from the wrongful conviction, he has applied at several jobs, but has been turned down. He attributed this to his employers conducting a background check and learning about his wrongful conviction for murder.

• Before wrongful conviction, some substance abuse history. After, release from prison, he returned to using methamphetamine and started using heroin. He said that he became addicted to both.
Facts Of The Case

• Diagnosed as suffering from depression prior to his adoption. At age 16, he began getting into trouble, and he was referred for counseling. His counselor noted that he could not find “anything diagnosable.” Counselor recommended he undergo a medication assessment. He did, and he was prescribed Zoloft, an antidepressant.

Criminal History

• Involved in an automobile accident, and was convicted of driving under the influence. Sentenced to 15 days shock time to be served in the county jail. He was allowed to serve the shock time at his discretion. He chose to serve it in two increments. While serving the first phase of this 15 day sentence, he was charged with first degree murder and eventually wrongfully convicted of this crime.

• After release from prison, he was arrested for second degree burglary. He indicated that, because of his heroin addiction, he and a friend broke into the home to steal items and buy more heroin. He stole a bow and arrow. Several weeks after the crime, he confessed, and he eventually pled guilty to the charge.

Trauma

• While incarcerated, he was involved in several physical altercations that led to injuries including black eyes, bloody noses, and head traumas. He also described an attempted sexual assault that led to injuries. Following each altercation, he was placed in solitary confinement as punishment for the fight regardless if he was the victim or perpetrator.

• He sustained a concussion and was knocked unconscious for an unknown period of time. He was always placed on locked status, solitary confinement, following these incidents. He was incarcerated for eighteen months; out of those eighteen months, he was placed in solitary confinement for one third of his incarceration, six months.

• Since his exoneration of the murder charge, he continues to experience psychological difficulties including anxiety, hypervigilance, depression, nightmares, sleep problems, and difficulty trusting.

• “I use to think people were good. You can take people at their word. You can trust people. I’ve learned that’s not true. You see the bad in somebody before you see the good. Prison does that to you. That’s what I learned in prison. I try to block it out, but it happens anyway.”

• “I feel like I got a target on my head. Anything bad happens the cops always run my name.” “It really hard to get a job when you put that on the application. If you google my name all you see is murder.”
CASE #4
The Female Veteran

“…has been found to have a condition that may disqualify him/her for continued military service.”
“….recommended further evaluation, treatment, and care for identified conditions.”

Facts Of The Case
- African American enlisted in the National Guard
- No significant issues from childhood; frequently moved because father was in the military
- Following graduation from high school, she enlisted in the United States Army
- No significant issues from education or employment history
- Divorced, engaged to the father of her two youngest children twice
- One older son, likely the product of a rape by her superior officer

Psychiatric & Treatment History
- During deployment, learned that her long term boyfriend committed infidelity. Subsequently, she became very depressed and anxious. She was forbidden from carrying her weapon for one week, and she was required to attend four therapy sessions with the chaplain.
- Following her return from deployment, she voluntarily entered therapy because “I was having a hard time adjusting especially around my kids.” She was prescribed antidepressant and antianxiety medications. Started having migraines, was prescribed medication. Assigned diagnosis of PTSD, depression, and anxiety.
- In 2007, hospitalization was recommended-“I was just trying to readjust, and the stress of my relationship, it just really took a toll on me.” Because she was concerned she might lose her children if hospitalized, she convinced staff not to hospitalize her. In lieu of hospitalization, she was required to attend individual therapy and consistently take her medication.
Psychiatric & Treatment History

• From 2008 to 2015, she did not attend therapy, but she regularly took medication.
• In September 2015, she was required to appear before the Fitness for Duty Board. It was determined that she needed to return to therapy.
• She began attending therapy at the local Veteran’s Clinic but they refused to provide documentation to the Fitness for Duty Board. “state headquarters said we need more documentation and staff at the clinic would not provide what we were saying in therapy, so they wanted me to come here and see someone in this clinic to get the appropriate documentation and see if I really have PTSD.”
• At time of this evaluation, she was prescribed Ambien, Prozac, Minipress, Mirprex, Phentermine, and Ativan.

Medical History

• Fairly healthy
• In 2007, she was diagnosed with migraines and prescribed medication.
• In 2008, back problems
• Acid reflux

Military Career

• Following graduation from high school, she enlisted in the United States Army
• 1993-honorable discharge from the military, entered National Guard
• Deployments-to Iraq; twice to Kuwait;
• Stationed in Korea, active status,
• At age 17, she was groped by her drill instructor

“I was on fire watch, and I was standing by the gate. My drill instructor told me to come over to this office, so I did. He said, read this to me. I started reading it, and he said no, come over her and read it. He made me go behind his desk, and then he proceeded to grope me. After he finished, he told me I was relieved of my duties and to go back to my barracks.”

Military Career

• She suspects he is the father of her oldest son. She never reported it because “Back then, it was never talked about in the military.”
Military Career

- During first deployment, her post was mortared “every day, several times a day. It was like clockwork. So many, so many.” She was never physically injured but she lost four friends to the bombings.
- During her second deployment, her major stressor was her significant other’s infidelity and threats she was receiving from him. “The entire time I was there, he just kept threatening to take my kids while I was deployed. My kids were staying with my mom.”
- After deployment, she experienced night sweats and nightmares.
Special thanks to Carol North, MD for her data on 9/11, Capital Hill Anthrax, and the Oklahoma City Bombing