Common Faults in PTSD Assessments[1]

This fact sheet is embarrassing to write because it illustrates the marked divergence between psychological science and everyday clinical practice among mental health professionals who are providing "expert" opinion about PTSD.

Inadequate interviews – Psychiatric (mental health) diagnoses had unsatisfactory levels of reliability until the advent of structured diagnostic interviewing in the past two decades. Thus, in research or teaching hospital settings, structured diagnostic interviews are commonly used in order to increase the accuracy of diagnoses. Such interviews involve a standard set of questions to ascertain the presence and severity of symptoms thought to describe the disorder. Unfortunately, many forensic mental health experts do not regularly use even part of a structured diagnostic interview in their clinical practice. One should not be surprised, therefore, that two interviewers arrive at different diagnoses if they are unlikely to even be asking the same questions.

Confirmatory bias[2] – This is the diagnostician's version of "jumping to conclusions". The most common effect of confirmatory bias in PTSD assessments is for the clinician to focus his/her attention on PTSD symptoms as soon as he hears that a distressed client has been involved in a traumatic event (e.g., childhood sexual abuse, MVA). Confirmatory bias can act as a "filter" that implicitly screens out some questions as "unnecessary" and selects others as "necessary". Alternatively, it can act as a filter that changes the evaluation of the information obtained by the interviewer. Confirmatory bias usually shows up as selective questioning during interviews (e.g., presence of questions related to one diagnosis, absence of questions related to an alternative diagnosis), or as acceptance of evidence as indicative of one diagnosis without adequate consideration of how those symptoms might comprise part of another disorder.

Reliance on common "myths" about PTSD – Clinicians all to often fall prey to what I call the "benefits of experience myth" about themselves and their professional activities. That is, they come to believe that there is something about their own work experience that has given them a unique insight into how a particular mental health condition works. This is both understandable and good for their self-esteem. However, over-reliance on "experience" leads to unfortunate inferences such as "patients with traumatic brain injuries (TBIs) don't get PTSD", "only very severe car accidents cause PTSD", etc. Of course, experience is important in providing expert assessments and treatment, but only to the extent that it is coupled with up to date knowledge of the related psychological science and reliance on reliable and valid assessment methods. Clinicians should not allow their practice to drift too much as a result of impressions gained with their idiosyncratic sample of clients, unless there is confirmatory research evidence. One mental health professional of whom I am aware asserts frequently in forensic assessments of MVA victims that PTSD seldom results from rear end MVAs. To my knowledge,

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[2] For further information on diagnostic bias, see Garb, H.N. (1998). Studying the Clinician: Judgment Research and Psychological Assessment. American Psychological Association: Washington, D.C.

there is no published scientific study showing that any aspect of the collision increases or decreases the risk of PTSD following MVAs.

Single method assessments – Psychologists are taught early in their training that assessment of human behavior and emotion is best done within a "multi-trait, multi-method" model. The bases for this model are (a) the human condition, and (b) statistical limitations on measurement. First, humans vary on many different dimensions (traits); including such characteristics as basic personality traits, coping skills, intelligence, social support, financial resources, physical well-being, among others. Ergo, to adequately understand a person's behavior (e.g., their PTSD, fear/anxiety, or mood problems), one needs to measure his/her status on several of these dimensions. It is a bit of a truism, nonetheless useful, that the greater one's knowledge of a particular person, the more accurate (valid) the predictions of future behavior.

Second, there are many different ways to get information about one particular trait. Take fear, a common problem among PTSD clients, as an example. Human emotions such as fear are thought to be expressed along three dimensions. The physiological dimension includes processes like heart rate. The subjective dimension includes thought content such as predictions of dangerous events or frightening imagery. The behavioral dimension involves avoidance of activities or places, or "safety behaviors" that others think are unnecessary. Therefore, in a multi-method assessment of fear, a mental health professional should interview the client about his/her subjective experience of fear and predictions of risk in given situations. Further, the mental health professional can observe the client's behavior in a feared situation to assess reluctance or refusal to enter the situation and "safety behaviors" when in the situation. Finally, although not very practical for usual clinical practice, the mental health professional can assess the client's heart rate in response to exposure to the feared situation.

Of course, one can increase the reliability of measuring fear by gathering data other than directly from the client. For example, one can ask family members if they have observed fearful behavior in the client. One can review past medical records to see if the client has complained to his/her family physician about fear or anxiety. There are also multiple psychological tests that can contribute to understanding how fearful a client might be in comparison with members of the general public or known groups of patients with similar fear conditions. These tests include multi-scale inventories that measure several dimensions and usually consist of hundreds of questions, or shorter tests designed to measure single dimensions (e.g., fear of pain, general apprehension).

Use of more than one of these methods will increase the reliability of diagnosing a fear condition. Reliability refers to the consistency of a measurement procedure. A procedure should be reliable across time (test-retest reliability), and reliable between different examiners (inter-rater reliability). If an assessment method is not reliable, it can not be valid. In effect. gathering data from multiple sources (interviews, tests, records, family members) is meant to ascertain how many of these sources of information point to the same conclusion, increasing the reliability, and thus the accuracy, of the entire assessment.

Unfortunately, most clinical assessments of PTSD involve only an interview. Even forensic assessments meant for the court often involve no more than an interview. While psychologists frequently administer psychological tests, and many experienced forensic experts review health, school, and employment records, few interview family members or conduct behavioral observations in feared situations. Of course, such omissions limit the reliability of these professionals' diagnoses. And, as said above, when an assessment is less reliable, it is at risk of being less accurate. Suffice it to say that single method (interview alone) assessments are less than ideal, but unfortunately characterize many clinical and forensic assessments of PTSD.

Failures to assess extent of impaired functioning – According to North American diagnostic standards, a diagnosis of PTSD requires "clinically significant distress or impairment in social, occupational, or other important areas of functioning."[3] This is important for the following reason. As one would expect, there are cases in which clients meet symptomatic criteria for PTSD but show only mild distress and no functional impairment. It appears that failure to address the extent of functional impairment leads to increased diagnoses of PTSD.[4] Thus, clinicians who do not review functional deficits associated with PTSD symptoms (e.g., problems at work, getting to work, problems with family, problems with friends/recreation) are more likely to over-diagnose PTSD in their clients.

Inadequate consideration of alternative diagnoses – This is part of the larger issue of confirmatory bias mentioned above. I have seen examples of confirmatory bias with respect to PTSD assessments cut both ways.

A well-known published example is the case of the Aleutian Enterprise disaster in which an unprecedented percentage of the fishing boat survivors were later diagnosed with PTSD by their therapists, but a much smaller percentage were diagnosed with PTSD by an independent assessor.[5] In such cases, it is likely that the over-diagnosis of PTSD occurs in the following manner.

1. The mental health professional holds an assumption that the terrible nature of some stressors lead to a very high rate of PTSD (i.e., he/she overestimates the prevalence of PTSD).
2. When assessing the client, such a professional may, because of this "high prevalence filter" conduct an inadequate interview for PTSD (e.g., rely on a few "cardinal signs" rather than a detailed inquiry about diagnostic criteria).
3. The mental health professional may collect no psychological test or collateral interview data to confirm or refute the results of his/her interview.
4. The mental health professional may neglect careful investigation of functional disability.

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[3] American Psychiatric Association. (1994). *Diagnostic and Statistical Manual of Mental Disorders: Fourth Edition.* American Psychiatric Association: Washington: D.C. P. 429.

[4] Peters, L., Slade, T., & Andrews, G. (1999). A comparison of ICD10 and DSM-IV criteria for posttraumatic stress disorder. *Journal of Traumatic Stress, 12,* 335-343.

[5] Rosen, G.M. (1995). The Aleutian Enterprise sinking and posttraumatic stress disorder: Misdiagnosis in clinical and forensic settings. *Professional Psychology: Research and Practice, 2*6, 82-87.

5. The mental health professional may not consider the natural course of remission for PTSD.[6]
6. The mental health professional may not investigate alternative diagnoses such as malingering.[7]
7. At its best under this scenario, deserving claimants with legitimate cases of PTSD are diagnosed as such despite inadequate assessment. At its worst, individuals with non-clinical levels of psychological distress and no functional impairment are mis-diagnosed with PTSD.

On the other hand, one frequently sees confirmatory bias that results in diagnoses of malingering or the absence of diagnoses of PTSD. This type of confirmatory bias operates more or less as follows.

1. A forensic expert receives a referral for a PTSD or other mental health disability case that arouses his/her suspicions before meeting the client. Various factors may lead to this increased suspiciousness[8] (referral from defense lawyer, some suspicion voiced by the defense lawyer or adjuster, past history of claims by the client).
2. The expert focuses attention more on the assessment of malingering (e.g., symptom overendorsement, exaggeration of disability) than on the assessment of the mental health disorder that has been claimed. In such events, the expert may not even conduct a detailed diagnostic interview for PTSD.
3. The expert is then left with data on malingering but very little data with respect to PTSD.
4. The expert "normalizes" some complaints or other client characteristics of distress. He/she may resort to this because he/she did not use appropriate psychological tests or structured diagnostic interviews for the conditions of which the client complains. Thus, the expert has no concrete means of comparing the severity of the client's complaints to appropriate normative standards.

[6] Approximately 50 percent of PTSD cases following MVAs improve so that they no longer meet criteria for PTSD within 6 months of the MVA. Approximately two-thirds of MVA-PTSD cases improve to this degree within the first year.

[7] Investigation of malingering requires very specific assessment tools such as multi-scale psychological tests with measures of symptom overendorsement, assessment of unusual symptoms, and marked discrepancies between the client's presentation during assessment and in other contexts.

[8] Suspiciousness, of course, is a good trait in forensic experts and increases the hit rate for detecting malingering. However, it must be tempered by the use of reliable and valid assessment methods.