

## **Psychological perspective on Posttraumatic Stress Disorder and on the assessment of family/child protection issues**

By John M Pinschof

### Posttraumatic Stress Disorder

In a recent edition of this journal, Robert J Edelman presented an article entitled What is the psychologists role in the assessment of chronic pain and Posttraumatic Stress Disorder? Edelman points to some differences in outcome measures when comparing the results of the DSM IV (Diagnostic and Statistical Manual of the American Psychiatric Association) and that of the ICD (International Classification of Diseases and Related Problems). He makes the point that Posttraumatic Stress Disorder is diagnosed more than twice as often under ICD criteria than under DSM IV criteria. He also refers to the widely used and useful structured diagnostic interview schedules that have been developed according to DSM IV criteria. This article attempts to take forward some thoughts on Posttraumatic Stress Disorder and its methods of assessment.

The DSM IV diagnostic category of Posttraumatic Stress Disorder lists the various symptoms under three main groupings. Having ascertained that the victim feared the trauma/accident might threaten their life or cause serious injury or caused intense fear, (listed as category A) the various symptoms are then grouped under criterion (B) namely symptoms involving persistent re-experience of the traumatic event. There are 5 individual such symptoms. Criterion (C) then lists symptoms that relate to persistent avoidance of stimuli associated with the trauma, of which there are 7 such individual symptoms. Finally criterion (D) lists symptoms characterized by persistent increased arousal following the trauma. Two symptoms

under criterion (B), three symptoms under criterion (C) and two symptoms under criterion (D) must be present before a diagnosis of Posttraumatic Stress Disorder can be made. This strict rule is the cause of much disquiet and is likely to be the reason behind the comment made by Edelman that Posttraumatic Stress Disorder is diagnosed less often using DSM IV criteria than when using the ICD criteria.

It seems absurd to suggest that, for example, if a trauma victim showed the presence of two symptoms under criteria (B), and two symptoms under criteria (D) but only two symptoms instead of three under criteria (C) that that individual does not suffer Posttraumatic Stress Disorder. That person surely does, but then the psychological assessor can say that the number of symptoms of Posttraumatic Stress Disorder are less than others, but those problems that are suffered nevertheless constitute a serious problem to the sufferer and/or concentrate on pointing out the actual severity of each symptom.

The above view was re-iterated at a conference in Bristol in 1998 entitled 'Road Accidents and The Mind', organised by Lyons Davidson, Solicitors. There was widespread agreement amongst the many clinical psychologists and psychiatrists present that this rigid 'head counting' method of diagnosis needed amendment to a more flexible approach. If one adopts the practice of focusing upon the various symptoms, more sense can be made of the various psychological problems resulting from trauma. One can then talk of the various aspects of stress that arise and comment upon their severity, placing less emphasis on rigid diagnostic labels or criteria.

Another aspect of the problem, not so frequently commented upon is that the problem may partly arise as a result of the very nature of

the differential diagnostic system employed by DSM IV, which essentially follows the medical system of careful categorisation of illness. The DSM IV categorises mental health problems under various main headings including that of 'anxiety disorders'. This group includes acute stress, agoraphobia, general anxiety disorder, panic disorder, posttraumatic stress disorder, specific phobias, personality disorders, sleep disorders etc. Specific symptoms are grouped and combined to form one of the above diagnostic categories.

Many individual symptoms are listed in more than one category. Whilst victims of trauma /personal injury frequently show many of the symptoms of Posttraumatic Stress Disorder as listed in DSM IV, there are frequently other symptoms reported that are listed by the DSM IV in other categories, or some symptoms not listed at all. This DSM approach appears to place the main emphasis on the 'label' attached to the cluster of symptoms, as opposed to concentrating on the various individual symptoms themselves.

This is not to suggest that the DSM IV system is of little use. Indeed, agreeing with Edelman, an interview schedule is extremely helpful as an aid to examine all the various subtle details of the state of mind of the trauma victim. But there needs to be a flexible approach when assessing the affect upon the victim of their trauma which personal injury lawyers need to be aware of when judging the consequences of injury to their clients. If an individual does not fit neatly into one diagnostic category or another, it does not mean that that individual is not suffering as a result of the trauma experienced. Furthermore, insistence by some assessors for the defending insurance company to provide a differential diagnosis along DSM IV lines in cases where the problems do not fit exactly into one or other category makes little

sense.

Provided that it can be shown that the various symptoms/problems complained of occurred after and as a result of the incident/trauma in question, then one can present an argument that there are, or have been, significant psychological problems caused by the incident whatever the official diagnostic category as recognised by the DSM IV may be, or even if the psychological symptoms do not fit into any recognised DSM IV category.

A further issue when addressing whether or not a person is suffering various psychological problems following a trauma, is that one should always compare that person to how that same person was before the trauma. This requires detailed clinical assessment. This obvious point is made because there is still a tendency for some psychologists to rely on psychometric assessment tools such as personality tests or IQ tests, which are essentially instruments that compare that individual with the general population. In some circumstances, such as when assessing for brain injury following trauma, psychometric tests as used by neuropsychologists may be essential, but for the purposes of assessing psychological trauma and stress, such devices can only be of use if data from the same test instruments are available from a time prior to the trauma. In such cases, one is then assessing the individual against that same individual prior to the trauma. Otherwise, such psychometric devices are pointless. What is required is skilled clinical assessment.

### Family/child protection issues

With regard to family/child protection issues and Expert psychological assessments, there has been criticism recently from Judges concerning the use by some psychologists of psychometric assessments.

In Re (a child) (adoption: psychological evidence) (2004) EWCA Civ 1029 (unreported) 30 July 2004. The Court of Appeal (Ward, Arden and Scott Baker) ruled that undue prominence had been given to personality testing at the hearing presided over by His Honour N Fricker QC. One appeal Court Judge, Arden, commented that personality testing cannot be used to resolve issues such as parenting skills unless validated by other evidence. Part of the case involved the use of a personality test that included a so called lie scale. This led Scott Baker to state that psychometric testing did not ordinarily have any place in cases concerning parenting. He stated that it is for the Judge to evaluate the facts and assess questions of credibility.

In another case, a psychologists report and details of the assessments measures have been asked for by the Appeal Court. The details are confidential, but one presumes the assessments have been challenged.

This criticism by the Judges of psychometric testing has been rejected by some psychologists, but the author of this article agrees with the Judges views.

In cases where the psychologist has been instructed to assess the competence of a parent, or whether or not it is safe to allow a parent

to have access to a child, or the many variations on this theme, it has been the view and practice of some psychologists over many years to administer various psychometric instruments such as intelligence tests and personality tests to the parent. The assumption is that such instruments provide useful evidence as to the competence and/or safety of a parent in relation to a child.

For the above to be the case and for such psychometric instruments to be of any use, there needs to be evidence that the psychometric measures used provides direct evidence as to the competence/safety of the parent. But is this the case?

In the authors view, a test of competence/ safety issues requires an assessment of the parent as to his/her actual abilities and competence in relation to the child and that is only obtained by assessing competence by interview and observation if practical and appropriate reference to any available background material as to actual parenting. If it is felt that there are indeed problems with the parenting abilities of the individual(s) or other safety issues, what is then needed is an appraisal of why the parent is unable to provide good enough or safe enough parenting. If one can understand the why one is in a position to be able to comment on the likelihood of that parent being able to change, given appropriate help.

In a long career providing therapy for children and their parents/ carers and providing therapy for adults in their own right, common background issues emerge. Seeing adults for their own problems almost invariably brings up emotional issues that arose first in their childhood as a result of their own experiences with their parent(s) carer(s). The same problems can be seen when assessing children

and observing how they react to their experience with their parent(s) carer(s). In almost all case where there is a satisfactory outcome for the child, progress has been obtained as a result of getting the parent/carer to confront their own emotional problems from their past, learning from it and then , if able and possible, changing how they care for their child.

These childhood experiences of the parent (s) are likely to determine whether or not the parent can react appropriately towards the child, or to any or all of the child's behaviour. If the parent was physically abused, hit or told they were stupid etc as a child, or never allowed a voice or opinion or self-expression, to take just some examples, the chances are that they will grow up with very little or no self confidence. They will then be unlikely to have the knowledge or to develop the confidence to care for their own child in any other way to that they themselves experienced.

Additionally, if a parent felt that how their own parents brought them up was right and appropriate, however much they hated it at the time, they will again be quite unable to deal with their own child in any other way to that of their own parent because to do so would involve them in confronting their memories of their parent(s) behaviour towards them. Clinical experience has shown that children who hate what is done to them invariably hate the parent who does it, at least for the short time. Since it is a common and widespread perception among children that hating ones parent(s) is wrong, leading to enormous amounts of guilt, such feelings of hate are repressed or denied. The problem is that to bring up their own child in different way to that of their own parent involves confronting such memories and emotions towards their parent(s) and acknowledging

that their parent(s) way of upbringing was inadequate. Almost all the cases I have been involved with demonstrate many or all of the above problems in various ways.

Furthermore, any assessment of parenting/ safety issues needs to ascertain the likelihood of the parent being able to change and how long such change is likely to take. Assessment of such issues involves the assessment of whether or not the parent is capable of behaving differently to their own parents, either with the assistance of psychological therapy or on their own, with all the difficult issues of loyalty and perceived betrayal involved in such a change. These are all essentially emotional issues and not intellectual or personality issues.

In the clinical experience of the author over many years, parents who had problems with their child fell into all the possible permutations of intelligence, as judged by observation. No IQ assessment would have added any information of value as to the reasons why the parent was having problems, nor would such an assessment have led to any useful prediction as to whether or not the parent was able to change. Change came about by tackling the emotional issues that derived from their own childhood.

With regard to intelligence levels as a measure of competence, there is no evidence known to the author that relates any level of IQ to parenting competence. It has not been shown that if a parent has an IQ below a certain point they are likely to be inadequate or dangerous. Even if there was such a suggestion in the evidence, there is no evidence of the corollary, namely that an IQ above that point indicates that the parent is likely to be competent or not

dangerous. Even if there was some evidence that a certain level of IQ indicated the likelihood of competence or incompetence, such measures would only make sense if the parent was actually found to be competent or otherwise.

Is one to say that if, after clinical assessment the parent is felt to be competent enough to care for the child but an IQ test shows them to be of low intelligence, then this test result should override any observation and clinical assessment? Surely not. Alternatively, if a clinical assessment shows the parent to be likely to be not good enough to have continued care of the child, does an IQ test that indicated the parent to be bright override such a conclusion based upon a clinical assessment? Again, surely not. Thus IQ tests are irrelevant as they can have nothing useful to add.

Personality tests are similarly unhelpful as no measure of personality adequately assesses questions of parenting competence or safety. There is no usable evidence in the literature that shows that certain personality types make for safe/unsafe, or good or not good enough parenting. Again, even if there were suggestions that certain personality types were more likely to make good or not good enough parents, such evidence should never be used unless there was actual evidence as to ability of the parent, in which case the personality test result would be redundant.

A debate as to the usefulness of the Eysenck Personality Questionnaire to the courts arose in a case quoted above. Carstairs, in *Family Law* January 2005, challenged the Appeal Court judgments. She felt that the Lie Scale that is incorporated in this Eysenck Personality questionnaire could be useful, having pointed out that this

scale is more appropriately referred to as testing reliability or consistency in answering the other two measures on the test. In this respect I agree with her. She felt this measure could be useful as it may give an indication of the reliability of the parents answers to the main two scales on this questionnaire, which are measures of 'neuroticism and introversion/extroversion. Two points arise from this. First, the lie scale measures the reliability of the two other scales on that test. If the two other scales are irrelevant to the issue of parenting, which I contend to be the case, it is thus also irrelevant if the person being tested gave reliable or unreliable answers. There is no evidence I know of that giving reliable or unreliable answers to a personality test generalises to giving reliable or unreliable answers to other real life situations. Secondly, as mentioned above, it is the job of the judge to assess reliability.

While other experienced psychologists may view parenting and its problems in language different from that described briefly above, perhaps describing problems in behavioural terminology rather than emotional terminology, this brief article may be of assistance to instructing lawyers when deciding upon whom to instruct.

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