

## Post Traumatic Stress Disorder and the Practice of Family Law

by

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The issue of post traumatic stress disorder (PTSD) began to surface in the American consciousness after Viet Nam when soldiers began exhibiting symptoms of nightmares and the recurrence of reliving traumatic events. PTSD is a psychiatric disorder that has been included in the DSM-IV-TR.<sup>1</sup> It is a disorder that may occur as the result of experiencing or witnessing life threatening events or personal assaults such as rape and violent abuse. Individuals who suffer PTSD symptoms often report reliving the traumatic experience through nightmares and flashbacks. These people report having difficulty sleeping and feeling detached or estranged from others. Often, these symptoms can become severe enough and may last long enough to significantly impair a person's daily life.

Increasingly, family law attorneys are faced with clients who describe traumatic experiences that occurred during their marriage. Sometimes the stories contain examples of physical violence characterized by hitting, slapping, shoving, punching, and additional forms of more severe physical aggression. They may describe examples of abuse in which one spouse exercises economic dominance through the control of marital finances and other material resources. Some clients even tell stories about emotional abuse characterized by name calling, badgering, controlling, humiliation, and other similar psychological threats and insults.

Clients who report these experiences of abuse and/or maltreatment may also manifest emotional reactions to these abusive

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<sup>1</sup> AMERICAN PSYCHIATRIC ASSOCIATION, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS 463-68 (4TH ED. REV. 2000)(HEREINAFTER DSM-IV).

experiences, including suffering from post-traumatic stress and other psychological sequelae of trauma reactions.<sup>2</sup> Post traumatic stress disorder is one type of psychological reaction to traumatic events.

In this article, we describe the prevalence of family violence, the need for family law attorneys to understand how to identify reactions to family violence and maltreatment and how to deal with issues of family violence and maltreatment in the courtroom. Both early domestic violence scholarship such as that of Lenore E. A. Walker, in her important work, *THE BATTERED WOMAN SYNDROME*<sup>3</sup>, and more recent scholarship<sup>4</sup> notes that it is not only women who have been abused by a violent spouse who may suffer PTSD, but that children who have been exposed to violence in the home may suffer it as well.

## **I. Myths About Family Violence and Child Custody**

The past two decades have witnessed increasing attention in the legal and psychological literature to women's exposure to domestic violence. Sometimes, an act of domestic violence is the reason for a marriage to end. Other times, acts of domestic violence during the marriage are revealed during the divorce process.<sup>5</sup>

Behavioral science research also has revealed that children who live in a home characterized by domestic violence are at risk

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<sup>2</sup> AMERICAN PSYCHOLOGICAL ASSOCIATION, REPORT OF THE APA PRESIDENTIAL TASK FORCE ON VIOLENCE AND THE FAMILY (1996); CHILDREN EXPOSED TO MARITAL VIOLENCE: THEORY, RESEARCH AND APPLIED ISSUES (George W. Holden et al. eds., 1998); DOMESTIC VIOLENCE IN THE LIVES OF CHILDREN: THE FUTURE OF RESEARCH, INTERVENTION, AND SOCIAL POLICY (Sandra A. Graham-Bermann & Jeffrey L. Edleson eds., 2001); PETER G. JAFFE ET AL., CHILD CUSTODY AND DOMESTIC VIOLENCE: A CALL FOR SAFETY AND ACCOUNTABILITY (2003); Peter G. Jaffe & Robert Geffner, *Child Custody Disputes and Domestic Violence: Critical Issues for Mental Health, Social Service, and Legal Professionals in CHILDREN EXPOSED TO MARITAL VIOLENCE: THEORY, RESEARCH AND APPLIED ISSUES*, *supra*, at 371 (1998).

<sup>3</sup> LENORE A. WALKER, *THE BATTERED WOMAN* (2000).

<sup>4</sup> LUNDY BANCROFT & JAY G. SILVERMAN, *THE BATTERER AS PARENT: ADDRESSING THE IMPACT OF DOMESTIC VIOLENCE IN FAMILY DYNAMICS* (2002); RICHARD J. GELLES, *INTIMATE VIOLENCE IN FAMILIES* (3d ed. 1997).

<sup>5</sup> See JAFFE ET AL., *supra* note 2.

for emotional and psychological problems. Studies suggest that in approximately 70 percent of families in which women are physically abused, their children are also victims of abuse by the perpetrator.<sup>6</sup>

Jaffe and his colleagues<sup>7</sup> identify several myths of domestic violence and child custody and what they posit is the reality of these myths. Among these myths are:

1. Domestic violence is rarely a problem for divorcing couples involved in child custody disputes. The reality is that the majority of parents in “high-conflict divorces” involving child custody report a history of domestic violence;
2. Domestic violence ends with separation for abused women. The reality is that abused women often face continuing risks from their partner after the separation;
3. As long as children are not abused directly, they are not harmed by exposure to domestic violence. The reality is that children exposed to domestic violence may suffer from significant emotional and behavioral problems related to this traumatic experience;
4. Since domestic violence is behavior between adults, it is not relevant for the determination of child custody. The reality is that domestic violence is highly relevant to the determination of child custody by courts and court-related services.

## II. Prevalence of Intimate Violence in Family Law Cases

Researches have estimated that one-quarter of the women in this country are reported to be abused by their husbands or by men with whom they have an intimate relationship.<sup>8</sup>

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<sup>6</sup> Susan M. Ross, *Risk of Physical Abuse to Children of Spouse Abusing Parents*, 20 CHILD ABUSE & NEGLECT 589 (1996)

<sup>7</sup> Peter G. Jaffe et al., *Common Misconceptions in Addressing Domestic Violence in Custody Disputes*, 54 JUV. & FAM. CT. J. 57 (FALL 2003).

<sup>8</sup> See JAFFE, ET AL., *supra* note 2; See Jaffe, et al., *supra* note 7; PATRICIA TJADEN & NANCY THOENNES, U.S. DEPARTMENT OF JUSTICE, EXTENT, NATURE, AND CONSEQUENCES OF INTIMATE PARTNER VIOLENCE: FINDINGS FROM THE NATIONAL VIOLENCE AGAINST WOMEN SURVEY (JULY 2000) *avail-*

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In 1988, women in the United States accounted for about 75 percent of the victims of intimate murder and for about 85 percent of the victims of non-lethal violence.<sup>9</sup>

About 43 percent of female victims of intimate partner violence live in households with children under the age of 12.<sup>10</sup> Children of women who are abused by a male partner are at a higher risk for being abused themselves by these same men. Some estimates indicate that domestic violence and child abuse co-occur, with some researchers reporting that 40 to 70 percent of the children of battered mothers have been found to be directly abused by their mother's batterer.<sup>11</sup>

Researchers are identifying important links between intimate partner abuse, child abuse, and custody disputes. Child and visitation arrangements often provide a context for abusive men to continue their attempts to control and victimize their former intimate partners and children.<sup>12</sup>

Men are more likely to report only violent acts they commit when they have an intent to harm, suggesting that self-report data from men may underestimate the frequency of aggressive acts in a marriage.<sup>13</sup> Women tend to report a wider variety of

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able at <http://www.ncjrs.org/pdffiles1/nij/181867.pdf>; PATRICIA TJADEN & NANCY THOENNES, U. S. DEPT. OF JUSTICE, FULL REPORT OF THE PREVALENCE, INCIDENCE, AND CONSEQUENCES OF INTIMATE PARTNER VIOLENCE AGAINST WOMEN: FINDINGS FROM THE NATIONAL VIOLENCE AGAINST WOMEN SURVEY (Nov. 2000) available at <http://www.ncjrs.org/pdffiles1/nij/183781.pdf>.

<sup>9</sup> MAUREEN HENNEBERG, U. S. DEPT. OF JUSTICE, BUREAU OF STATISTICS, BUREAU OF JUSTICE STATISTICS 2000: AT A GLANCE (2000).

<sup>10</sup> CALLIE MARIE RENNISON & SARAH WELCHANS, U. S. DEPT. OF JUSTICE, BUREAU OF JUSTICE STATISTICS SPECIAL REPORT, INTIMATE PARTNER VIOLENCE (MAY 2000), available at <http://www.ojp.usdoj.gov/bjs/pub/pdf/ipv.pdf>.

<sup>11</sup> See Ross, *supra* note 6.

<sup>12</sup> See BANCROFT & JAY G. SILVERMAN, *supra* note 4; See JAFFE, ET AL., *supra* note 2.

<sup>13</sup> Gayla Margolin et al., *Affective Responses to Conflictual Discussions in Violent and Nonviolent Couples*, 56 J. CONSULTING & CLINICAL PSYCHOL. 24 (1988).

aggressive acts and, as a result, may be viewed as more reliable reporters of the frequency of such actions.<sup>14</sup>

Though it has been acknowledged that most battered women use violence in reaction to the abuse they experience, some data suggest that a small group of women initiate violence or are equal contributors to the physical violence in the family.<sup>15</sup> Therefore, attorneys may need to conduct family violence screening assessments on both men and women.

Women are far more often than men the victims of violent actions that injure. Battered women seek medical attention for injuries sustained as a consequence of domestic violence significantly more often than men and they sustain injuries as a consequence of domestic violence more often after separation than during cohabitation. As many as 75 percent of visits to the emergency room by battered women occur after separation.<sup>16</sup> The risk for continued intimate partner violence increases during the separation period.<sup>17</sup> The risk for children to domestic violence also increases during the separation period.<sup>18</sup>

Therefore, it is critical that attorneys routinely screen for domestic violence in child custody disputes. Attorneys should maintain an acute awareness of current trends, methodological changes, and developments in the field of domestic violence. Domestic violence is an important risk factor in many child cus-

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<sup>14</sup> Lela Walker, *Current Perspectives on Men Who Batter Women—Implications for Intervention and Treatment to Stop Violence Against Women: Comment on Gottman et al.*, 9 J. FAM. PSYCHOL. 264, 265 (Sept. 1995).

<sup>15</sup> James N. Bow & Paul Boxer, *Assessing Allegations of Domestic Violence in Child Custody Evaluations*, 18 J. INTERPERSONAL VIOLENCE 1394 (Dec. 2003); Denise A. Hines & Kathleen Malley-Morrison, *Psychological Effects of Partner Abuse Against Men: A Neglected Research Area*, 2 PSYCHOL. MEN & MASCULINITY 75 (2001); Janet R. Johnston & Linda E. G. Campbell, *A Clinical Typology of Interparental Violence in Disputed Custody Divorces*, 63 AM. J. ORTHOPSYCHIATRY 190 (1993).

<sup>16</sup> CARRIE CUTHBERT ET AL., *BATTERED MOTHERS SPEAK OUT: A HUMAN RIGHTS REPORT ON DOMESTIC VIOLENCE AND CHILD CUSTODY IN THE MASSACHUSETTS FAMILY COURTS* (2002); MARTHA R. MAHONEY, *LEGAL IMAGES OF BATTERED WOMEN: REDEFINING THE ISSUE OF SEPARATION*, 90 MICH. L. REV. 1, 656 (1991).

<sup>17</sup> T. K. Logan et al., *Child Custody Evaluations and Domestic Violence: Case Comparisons*, 17 VIOLENCE & VICTIMS 719 (2002).

<sup>18</sup> See CUTHBERT ET AL., *supra* note 16; See Logan et al., *supra* note 17.

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tody cases<sup>19</sup> and, at the very least, attorneys should conduct an initial screening for domestic violence in all family law cases, whether or not allegations of domestic violence are voiced in the initial consultation.

### **III. The Role of Psychiatric Diagnosis in the Courts**

#### *A. Purposes of Diagnostic Categories*

Development of a diagnostic classification scheme such as the DSM IV is an inherently challenging task. While the essential objective is to group like persons, nature abhors clear boundaries.<sup>20</sup> Valid and reliable diagnostic categories requires both specificity and sensitivity. To avoid falsely including persons within a diagnostic category, the criterion must include symptoms deemed most useful in discriminating one disorder from similar disorders (high specificity) while the criterion must also include the symptoms that are most characteristic of the disorder (high sensitivity). Emphasis on high sensitivity results in groups composed of members with salient characteristics in common and fails to reliably exclude persons who appear similar but, in fact, do not share characteristics of the particular diagnostic category. Emphases on high specificity results in groups that include few persons falsely, but the remaining members may have little else in common. For example, diagnostic rules emphasizing sensitivity may successfully identify most persons who are depressed, but who may inadvertently group the persons with major depressive disorder, along with those who have dysthymia, bipolar disorder and borderline personality disorder. Diagnostic criteria emphasizing specificity may reliably distinguish among various diagnostic categories of similar persons, while those persons remaining in each group may share little else in common other than they have been manic or anxious or antisocial or delusional.<sup>21</sup> The original purpose for a diagnostic classification system for mental disor-

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<sup>19</sup> See JAFFE ET AL., *supra* note 2.

<sup>20</sup> Thomas A. Widiger, et al., *Toward an Empirical Classification for the DSM-IV*, 100 J. ABNORMAL PSYCHOL. 280 (1991).

<sup>21</sup> Stuart A. Greenberg et al., *Unmasking Forensic Diagnosis*, 27 INT'L. J. L. & PSYCHIATRY 1 (2004).

ders was the need to collect statistical information.<sup>22</sup> While reliability of diagnostic classification systems have improved over the past century, caution is advised when considering the probative value of mental health diagnoses. The historical section of the current DSM-IV states, "The need for classification of mental disorders has been clear throughout the history of medicine, but there has been little agreement on which disorders should be included and the optimal method for their organization."<sup>23</sup> Attorneys should note that while there is increased agreement on the reliability of some diagnostic categories, many psychiatric diagnosis in general provide less reliable information than well-established diagnoses in other fields of medicine.

The categories in the DSM do not reflect a coherent progression of empirical research. Many categories were based more on expert consensus than on any true empirical data.<sup>24</sup>

Although empirical research on psychopathology has proliferated in recent years, it is generally based on existing DSM diagnostic categories. Very little research has been reported investigating the validity of the DSM categories themselves, which have remained a collection of consensus-based disorders.<sup>25</sup>

Research that has investigated the categorical model of disorders has had mixed results. An on-going debate existed about the empirical support for the diagnosis of post-traumatic stress disorder and acute stress disorder.<sup>26</sup>

#### B. *Probative v. Prejudicial Value of Psychiatric Diagnosis.*

Concern for the misunderstanding of reliability of diagnostic labels in court led the authors of the DSM-IV to explicitly caution mental health professionals about the potentially prejudicial effects of a diagnostic label. DSM-IV-TR now notes explicitly that when used

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<sup>22</sup> See *Id.*

<sup>23</sup> DSM-IV, *supra* note 1, at xvi.

<sup>24</sup> Robert L. Spitzer, *In Outsider-Insider's View About Revising the DSMs*, 100 J. ABNORMAL PSYCHOL. 294 (1991)

<sup>25</sup> Lee Anna Coark et al., *Diagnosis and Classification of Psychopathology: Challenges to the Current System and Future Directions*, 46 ANN. REV. PSYCHOL. 121 (1995).

<sup>26</sup> Frank W. Weathers et al., *Clinician-Administered PTSD Scale: A Review of the First Ten Years of Research*, 13 DEPRESSION & ANXIETY 132 (2001).

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for forensic purposes, there are significant risks that diagnostic information will be misused or misunderstood. These 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 determining whether an individual meets a specified legal standard. . . additional information is usually required beyond that contained in the DSM-IV diagnosis. This might include information about the individual's functional impairments and how these impairments affect the particular abilities in question. 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.<sup>27</sup>

Expert testimony about psychiatric diagnostic categories may harm rather than help because of its impact on both the person whose mental status is at issue and the decision-maker.<sup>28</sup> The first concern is that placing a psychiatric diagnostic label on a person's mental status may provide incentives for the litigant to meet specific symptom criteria. The second concern is the impact that the use of psychiatric diagnostic label has on the decision-maker.

### **C. Parent Self-Reporting May Confound Diagnosis**

Information about most criteria needed to meet most DSM categories comes from an examinee's self-report. An examinee describes internal events and the examiner relies on the examinee's self-report of those internal events. Even with comprehensive examination of collateral sources of information, the evaluator often is limited to information obtained from the diagnostic interview. While patients who voluntarily attend therapy ordinarily have an interest in getting better and are motivated to report symptoms accurately, litigants often have other incentives. These may include appearing symptom free in a parenting contest, or appearing symptomatic in an insanity defense or a personal injury case.<sup>29</sup>

When presented in a clinical setting, a diagnosis based primarily on the patient's symptom picture and self-report of an al-

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<sup>27</sup> DSM-IV, *supra* note 1, at xxxii-xxxiii.

<sup>28</sup> See Greenberg et al., *supra* note 21.

<sup>29</sup> See *Id.*



leged event does not validate the presence of the traumatic event or explain what the traumatic event was. Yet when a diagnosis given to a person involved in litigation, based in part on self-reported information, the diagnostic label often is misused in a legal setting.

In court, diagnosis may be used both to prove disordered behavior and to prove the occurrence of an event that allegedly caused that disordered behavior. In the case of a parent claiming PTSD, the parent reports having experienced a horrifying event, describes symptoms associated with distress and trauma, and the evaluator diagnoses PTSD. This diagnosis is then used in a circular argument by counsel to prove that the distressing event actually occurred as reported and that it is responsible for the parent's impairments. In practice, a parent reports the symptoms of PTSD, reports responding with intense emotion, and completes self-report measures that assess trauma. The evaluator diagnoses the parent as having PTSD and counsel uses the diagnosis to prove the alleged events occurred. The diagnosis may stand without reference to *Fyre v. United States*,<sup>30</sup> *Daubert v. Merrell Dow Pharmaceuticals*,<sup>31</sup> or even in the face of independently collected behavioral, historical, or psychological test data. Hence, the judge may conclude that information obtained from the mental health profession about the accuracy of fit between the parent's reported symptoms and the diagnostic category is an objective diagnosis made by the expert witness on the basis of scientifically collected data.

In fact, the diagnosis may be the result of unverifiable self-report data in which the examinee and not the expert has provided a diagnosis. Once labeled a diagnosis, a veneer of objectivity surrounds the conclusion despite the fact that the diagnosis may be based on nothing more than the litigant repeating her story to an evaluator.<sup>32</sup>

While legal incentives to appear impaired or intact exist, the forensic use of diagnostic categories medicalizes behavior and provides it with an aura of objectivity. When mental health experts testify about behavior in terms of diagnostic categories, their testimony moves away from the judge's referent and leads

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<sup>30</sup> 293 F 1013 (D.C. Cir. 1923).

<sup>31</sup> 509 U. S. 579 (1993).

<sup>32</sup> See Greenberg at al., *supra* note 21.

to the belief that what matters are the diagnostic categories themselves, rather than the thoughts, feelings, or actions the diagnoses are intended to explicate. Judges are not selected because they possess any special scientific background or training in the assessment of diagnostic categories and, therefore, those categories do not provide them an appropriate metric for evaluating harm.<sup>33</sup>

#### **IV. What to Look for in Cases of Familial Maltreatment**

Clients who have experienced family violence often present with a stress reaction.<sup>34</sup> Two of the most common types of stress reactions seen by family law attorneys during an initial consultation are post traumatic stress disorder (PTSD) and acute stress disorder (ASD).<sup>35</sup>

##### *A. Post Traumatic Stress Disorder*

The essence of traumatic stress is the “exquisite intertwining of psychological and biological substrates.” According to the DSM-IV, PTSD is defined as follows:

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

(1) experience, witness, or confrontation with an event or events involving actual or threatened death or serious injury, or a threat to the physical integrity of self or others and (2) reactions of intense fear, helplessness, or horror.

In addition, the traumatic event persistently re-experienced in one (or more) of the following ways: (1) Recurrent and intrusive distressing recollections; (2) recurrent distressing dreams; (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); (3) intense psychological distress at

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<sup>33</sup> See *Id.*

<sup>34</sup> See CHILDREN EXPOSED TO MARITAL VIOLENCE, *supra* note 2; See GELLES, *supra* note 4; See JAFFE ET AL., *supra* note 2.

<sup>35</sup> JOHN N. BRIERE, DETAILED ASSESSMENT OF POSTTRAUMATIC STRESS (2001); JOHN N. BRIERE, TRAUMA SYMPTOM INVENTORY (1995).

exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event; and (4) physiological reactivity on exposure to internal or external cues that symbolize or resemble as aspects of the traumatic event.

Another diagnostic prong is the persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness (not present before the trauma), as indicated by three (or more) of the following: (1) Efforts to avoiding thoughts, feelings, or conversations; (2) Efforts to avoiding activities, places, or people that recall the trauma; (3) inability to recall an important aspect of the trauma; (4) markedly diminished interest or participation in significant activities; (5) feeling of detachment or estrangement; (6) restricted range of affect (e.g., unable to have loving feelings); (7) sense of foreshortened future (e.g., does not expect to have a career, marriage, children, or a normal live span.).

A fourth diagnostic prong focuses on persistent symptoms of increased arousal not present before the trauma. At least two of the following must be present: (1) difficulty falling or staying asleep; (2) irritability or outbursts of anger; (3) difficulty concentrating; (4) hyper-vigilance; and (5) exaggerated startle response.

In addition, the duration of the symptoms described above is more than one month. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

#### B. *An Acute Stress Disorder*

Acute stress disorder is an anxiety disorder that develops within one month after a severe traumatic event or experience. Distressing dissociative symptoms are common in the person with ASD, including depersonalization, derealization, or dissociative amnesia. These symptoms can affect any sex or age group. Anxiety, irritability, and depression are also common in people who have ASD. People with ASD have a diminished ability to experience pleasure. There may be problems falling or staying asleep. A person with ASD will avoid any reminders of the trauma, but re-experience the event in dreams, nightmares, or painful memories.<sup>36</sup>

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<sup>36</sup> DSM-IV, *supra* note 1, at 429.

ASD may occur at any age and its symptoms start during or immediately after trauma exposure. The symptoms must last two days to four weeks. Symptoms that last longer than four weeks are diagnosed under the PTSD category.<sup>37</sup>

The individual diagnosed with ASD must have been exposed to a traumatic event or experience involving intense fear, horror, or helplessness. The event or experience must involve a threat of death, serious injury, or physical integrity. The event or experience may be to the patient or to others around the patient.<sup>38</sup>

Three or more of the following dissociative symptoms may develop during or after the event or experience: (1) Loss of emotion, numbing, or detachment; (2) Diminished awareness of surroundings; (3) Depersonalization; (4) Derealization and dissociative amnesia; (5) Avoidance of thoughts or feelings about the trauma; and (6) Avoidance of activities, places, persons, or things that set off feelings about the trauma.

The individual displays persistent indicators of increased arousal such as problems with falling or staying asleep, having problems concentrating, and showing signs of behaving in a hyper-vigilant manner. Finally, for the diagnosis to be confirmed, there must be impairment in important areas of functioning such as work impairment, difficulties with relationships, or social life.

## **V. Legal Practice and Intimate Violence**

### *A. In-Office Assessment*

The diagnosis of PTSD is beyond the expertise of most attorneys who do not have training in diagnosis of mental disorders. While it is important for family law attorneys to be familiar with interview-based assessment procedures designed to screen for family violence, a diagnosis such as PTSD must be made by a competent mental health professional.

There are several interview formats that may be useful when interviewing a client suspected of having been involved in an abusive marriage. One is to gather information about family vio-

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<sup>37</sup> *Id.*

<sup>38</sup> *Id.* at 429-30.

lence related behaviors.<sup>39</sup> Another format is to interview the client about symptoms common to traumatic reactions. Published interview formats are available and some are appropriate to be administered by non-mental health professionals.<sup>40</sup> There are other published interview formats that are appropriate to be administered only by trained mental health professionals that assess trauma exposure,<sup>41</sup> acute stress reactions,<sup>42</sup> and PTSD.<sup>43</sup>

Where counsel believes that children have observed family violence, and a parent reports unusual symptoms in the child, such as recurring nightmares, difficulty in falling asleep, irritability, or difficulty in concentration, perhaps, or even explicitly claims that the child has observed violence in the family, an evaluation of the child by a mental health professional is probably warranted.<sup>44</sup>

#### B. *Litigation Skills for PTSD*

Once counsel believes that a client or a child of a client displays symptoms of PTSD, several steps should be considered. In a custody situation where the parents are disputing who should have primary residential parenting or primary custody, the attorney must be prepared to establish the mental health diagnosis or

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<sup>39</sup> The Academy of Emergency Room Physicians has published a list of key elements to investigate when assessing for family violence. Their *List of Key Elements of Family Violence Protocols* (2004) is found at [www.acep.org/1,4726,0.html](http://www.acep.org/1,4726,0.html).

<sup>40</sup> A useful interview protocol is the Santa Clara County Social Services Agency, Department of Family and Children's Services, *Family Violence Prevention Best Practice Guide*, [http://www.growing.com/nonviolent/worker/fvp\\_best.htm#SA\\_1](http://www.growing.com/nonviolent/worker/fvp_best.htm#SA_1).

<sup>41</sup> Brier's *Trauma Symptom Inventory* is a reliable measure of trauma exposure.

<sup>42</sup> The Stanford Acute Stress Reaction Questionnaire is one source of reliable data about ASD. See Etzel Cardeña et al., *Psychometric Review of the Stanford Acute Stress Reaction Questionnaire (SASRQ)*, in *MEASUREMENT OF STRESS, TRAUMA AND ADAPTATION* 293 (B. H. Stamm, ed. 1996).

<sup>43</sup> Briere's *Detailed Assessment of Posttraumatic Stress* is a reliable measure of PTSD symptoms.

<sup>44</sup> A measure of acute reaction in children was developed by SEAGRAVES, ET AL., *STANFORD ACUTE STRESS REACTION QUESTIONNAIRE—CHILDREN'S VERSION* (1994). A measure of trauma reaction in children was developed by BRIERE, JOHN N. BRIERE, *TRAUMA SYMPTOM CHECKLIST FOR CHILDREN* (1996).

must be prepared to challenge the finding of a mental health diagnosis. If the mental health professional has properly evaluated a family system and concluded that (1) abuse characterized the family system, (2) the perpetrator of the abuse was a parent, (3) the victim parent and the children have developed traumatic reactions to the abusive behavior, and (4) the victim parent and the children have been diagnosed as suffering from PTSD, attorneys must consider the next step. As mandated reporters, any mental health professional who concludes that a child suffers from PTSD as a result of abuse must report suspicion of abuse to the authorities. If the purported abuse is a result of a child observing abuse of the mother, the attorney must consider whether this is a sufficient factor to have the court award custody of the child to the victim. If on the opposite side of an allegation of abuse, the attorney must consider whether it is important to disprove the alleged abuse or to challenge the diagnosis in order to win the case.

The DSM-IV is a good starting point for the litigator in establishing or disproving the diagnosis. Since the diagnostic criteria are laid out in this treatise, the mental health expert must provide information that supports the existence of the symptoms from diagnostic interviews, psychological tests data, the third party information sources. It is also important to establish that the alleged abuse is the proximate cause of the traumatic reactions. For example, the DSM IV cautions, “[n]ot all psychopathology that occurs in individuals exposed to an extreme stressor should necessarily be attributed to post traumatic stress disorder.”<sup>45</sup> The challenge to establishing the link between the alleged abuse and the PTSD diagnosis, might be to question the witness about other antecedent events that might have resulted in traumatic reactions. This is particularly important when dealing with children who have experienced their parents’ divorce as a significant life trauma, independent of familial abuse.

Additionally, as the witness describes the observed behaviors and compares them to the diagnostic criteria listed in the DMS-IV-TR, it is important to query the mental health professional about the source of the information and the degree to which the information about alleged PTSD behaviors is reported

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<sup>45</sup> DSM-IV, *supra* note 1, at 427.

across different situations, e.g., work, home, social events. It is also important to examine who first raised the question of a diagnosable disorder. The attorney may need to argue that a child's exposure to abuse is a dispositive factor for the tribunal in determining the child's placement.

If the parent is diagnosed with PTSD, the attorney needs to examine whether the symptoms are sufficiently severe to warrant a loss of custody. For example, it is important to examine the degree to which a parent's nightmares or flashbacks affect parenting and, if so, whether the degree of impairment warrants a change of placement of a child. As troops return from such hotspots as Iraq and Afghanistan, the issue of PTSD will become more important to the family law attorney. The exposure to the kind of violence in war time will revive the debate over PTSD. More and more divorces can be expected, as can the additional trauma of child custody litigation. Knowledge of this important syndrome is now critical to the practice of family law.

### *C. Cross-examination of the Expert When You Represent the Alleged Abusive Spouse*

The place to start is always the DSM-IV, the source of the characteristics and the required differential diagnosis. As with all psychiatric diagnoses, the expert must follow the steps necessary to come to the conclusion that the parent displays the diagnostic signs of PTSD. The first series of questions from the attorney to the expert should compare his or her findings to the specific diagnostic prongs set forth in this article. Among the questions to ask are:

1. From what source did the expert obtain the information?
2. How did the expert establish the reliability of the information?
3. Did the expert seek third party confirmation of the parent's (child's) self-reported information?
4. What sources confirm that the traumatic event or events occurred?
5. What sources confirm that the parent (child) displays behaviors consistent with a diagnostic category?"?
6. When did the parent (child) first seek mental health services?

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7. If no mental health services were sought, why not?
8. What did the expert examine to determine that symptoms of anxiety were not present prior to these alleged traumatic events?

A second attack on the expert is examination of the differential diagnosis. Among the question to ask are:

1. What other mental disorders incorporate the same or similar symptom?
2. How did the expert systematically examine other diagnoses as alternative explanations to the parent's (child's) reported symptoms? How did the expert rule out obsessive compulsive disorder?<sup>46</sup>
3. What is the empirical support for the reliability of the diagnosis?
4. How has the expert examined the role of malingering and deception in forming his or her opinion about the usefulness of the diagnosis?

Once the expert clears these hurdles, then counsel can approach the diagnostic criteria themselves. Since the patient must have experienced one or more re-experiences of the traumatic event, a series of questions designed to explore the hows and whens of these re-experiences should be explored. Challenging the experts to lay the foundation for their conclusions is the only way to set aside a misdiagnosis of PTSD symptoms.

## **Conclusions**

PTSD is an important issue for family law practitioners. From analyzing whether clients can withstand a contested dissolution proceeding to whether they can testify in court, to a factor in custody and placement proceedings, the more that is known about this syndrome, how to recognize and how it impacts clients, the better attorneys can serve those they represent.

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<sup>46</sup> DSM-IV suggests that 25 percent of those with PTSD also merit diagnosis of OCD based on the same symptoms.