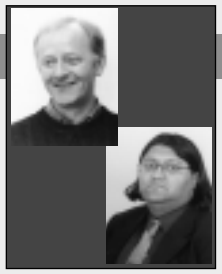

MICHAEL J. SCOTT AND SUNDEEP SEMBI

Unreliable assessment in civil litigation

PSYCHOLOGISTS are often called on to provide medico-legal assessments of psychological damage following traumas such as road accidents and assaults. Structured interviews rarely form part of such assessments, yet they have long been established as an essential standard in research. Prior to the development of structured interviews the level of agreement between different assessors was so poor (32–54 per cent according to Beck *et al*., 1962) as to gravely impair research. But 20 years later, Williams and Spitzer (1982) could declare: 'It is widely accepted now that there is a need for research investigators to employ a standardised and reliable diagnostic system to select and describe samples of subjects for research.' In this article we argue that current medico-legal practice lags behind developments in research methodology.

Researchers have been concerned to enhance the reliability of diagnosis by using structured interviews to minimise two sources of variance. *Criterion variance* refers to differences in the inclusion and exclusion criteria that clinicians use to summarise data into psychiatric diagnoses. *Information variance* occurs when clinicians have different amounts and kinds of information about patients. An assessment that does not include a structured interview is not standardised, the steps taken to minimise criterion and information variance are not explicit, and no statement can be made on the inter-rater reliability of the interview. This all applies whether the interview takes place in either a research or a legal context, but it may be particularly important in the latter – if compensation is to be awarded according to a diagnosis, this diagnosis must be reliable.

Inadequacies of routine clinical assessment

The practice in routine clinical settings is to use an unstructured interview for assessment – in Britain this is also the cornerstone of medico-legal examinations in civil litigation. Comparisons between unstructured and structured interviews in routine clinical practice show poor levels of agreement (e.g. Shear *et al*., 2000) and inaccurate diagnosis has proved common. Zimmerman and Mattia (1999) had a cohort of 500 patients attending psychiatric outpatients assessed using routine unstructured clinical interview, and the next cohort of 500 patients were interviewed with the Structured Clinical Interview for DSM–IV Axis 1 Disorders (SCID) (First *et al*., 1995). Fifteen disorders were more frequently diagnosed in the SCID sample, and these differences occurred across mood, anxiety, eating, somatoform and impulse-control disorder categories. From the point of view of civil litigation claims it is particularly salient that the rate of detection of post-traumatic stress disorder using an unstructured interview was 50 per cent of that using a structured interview.

In the Zimmerman and Mattia (1999) study, more than one third of the patients interviewed with the SCID were diagnosed with three or more disorders, in contrast to fewer than 10 per cent of the patients assessed with an unstructured interview. Detection of comorbidity is clinically important because it carries prognostic implications: patients with multiple disorders have poorer outcomes (see for example Keller *et al*., 1984, and Noyes *et al*., 1990). The failure to detect comorbidity in the unstructured interview is particularly important in litigation because post-traumatic stress disorder has tended to become the gateway to comprehensive compensation and it has high rates of comorbidity. (Breslau, 1998, concluded that for patients with PTSD the lifetime prevalence of major depression was 36.6 per cent, other anxiety disorders 58.1 per cent, alcohol abuse/dependence 31.2 per cent and drug abuse/dependence 21.5 per cent.) So we would argue that claimants are disadvantaged both in terms of diagnosis and prognosis if a structured interview is not included in medico-legal assessments.

'current medico-legal practice lags behind developments in research methodology'

The need for a three-stage assessment

Stage 1: Unstructured interview The first stage of the assessment process should allow the client to tell their tale of the trauma in an unfettered way. Using a series of prolonged open-ended questions the assessor distils the nature of the trauma and its effects. It is also at this stage that the assessor can make initial judgements about malingering.

Stage 2: Structured interview The second stage of the assessment should involve a structured interview in which direct questions are asked about each of the symptoms or criteria that are defined as constituting the disorder. DSM–IV–TR (2000, p.*xxxii*) states that 'valid application of the diagnostic criteria…necessitates an evaluation that directly accesses the information contained in the criteria sets'. The structured interview ensures that there is coverage of all the symptoms that constitute the disorder.

It is important to distinguish two types of structured interviews; those used in epidemiological studies, and those used for research purposes, such as the SCID (First *et al*., 1995) and CAPS (Blake *et al*., 1995), which we recommend for medico-legal purposes. The former are used by lay interviewers, and respondents' answers are taken at face value and decision trees used for allocating a diagnosis. The guidelines for the SCID and CAPS make it clear that the assessor is not rating the patient's response *per se.* Instead there are published agreed criteria as to what would constitute endorsement of a symptom (see Scott & Palmer, 2000) leading to levels of inter-rater agreement above 90 per cent. As Pitman *et al.* (1996) have pointed out, 'instruments such as the CAPS and SCID…do not require the interviewer to score an item positive just because the interviewee answers affirmatively, or vice versa. It is the interviewer's responsibility

through probing to determine whether the detailed historical data satisfy the symptomatic criterion in question' (p.390). In endorsing a symptom as present, the assessor is looking for specific graphic examples of the symptom in question. If a client's response to an enquiry is vague or over-general, a symptom is of doubtful validity and is not endorsed. A symptom would also be of doubtful validity if the response to a question in the structured interview is not consistent with what was said in the first stage of the assessment; malingering may then be suspected.

The style of questions in an instrument such as the SCID is also important. They are not leading questions (e.g. 'How bothered are you by dreams?') but direct questions needed to access information in the criterion set (e.g. 'What about dreams?'). Many of the symptoms that are part of the criteria set of a disorder will not be naturally volunteered for a variety of reasons. Feelings of emotional numbness or being distant and cut-off in post-traumatic stress disorder are unlikely to be volunteered by a client because they have not yet either labelled the emotion or seen the connection between such a symptom and the trauma. The trauma itself may not be described in its entirety because one of the symptoms of PTSD is avoiding talking about the trauma. Direct questioning is therefore necessary to guarantee coverage of all relevant symptoms and criteria.

Stage 3: Psychometric tests Despite these advantages of structured over unstructured interviews, both are reliant on just one source of data: the verbal or nonverbal behaviour of the client. An assessment is likely to be more reliable the greater the number of independent sources, for example records (GP, hospital notes, occupational health) and psychometric tests. Two self-report instruments – the Minnesota Multi-Phasic Personality Inventory (Butcher *et al*., 1989) and the Trauma Symptom Inventory (Briere, 1995) – contain validity scales (e.g. inconsistency of reported symptoms). When such scale scores suggest malingering they should be checked further against the Structured Interview of Reported Symptoms (SIRS: Rogers *et al*., 1992). Psychometric tests that contain validity scales or the SIRS should be the third stage of the assessment, as tests without validity scales can only be confirmatory.

'the best way to minimise bias is to move scientific validity to centre stage'

Minimising bias

We argue that a three-stage assessment process offers better protection against the operation of bias than the single first-stage approach that is commonplace in British civil litigation. The dangers of not including a structured interview are in the assessor operating idiosyncratic views of:

- what constitutes the disorder, exalting some symptoms of a disorder (e.g. nightmares in PTSD) and taking little or no account of other symptoms (e.g. startle response);
- what severity of a symptom is necessary for it to be considered present; and
- the prevalence of the disorder following a particular trauma.

One way of making bias explicit is to ask assessors for the prevalence of, say, PTSD, that they have detected in particular trauma populations and compare that with the level found in research studies. For example, Blanchard and Hickling (1997) found in their research study of road accident victims assessed initially within 12 months of their trauma, that for the subpopulation involved in litigation almost half the sample (44 per cent for those completing litigation within 12 months and 47 per cent for those completing litigation after 12 months) had PTSD. Of non-litigants, 28 per cent had PTSD. An assessor reporting that they identify, say, 20 per cent or 70 per cent as having PTSD would very likely find it difficult to rebut a charge of bias.

Building on Lord Woolf's report on access to justice in 1996, new rules of civil procedure (for England and Wales) introduced in 1999 have sought to minimise bias by making experts responsible to the court, not to the instructing solicitor. But it is still a particular solicitor who puts an expert 'in the frame', as it were, for consideration as a joint expert. Historically the courts have relied largely on the professional standing of the expert, but we would argue that the best way to minimise bias is to move scientific validity to the centre stage in medico-legal assessments.

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