Addressing Bias in the Forensic Assessment of Sexual Harassment Claims

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This article addresses unique biases that arise in the assessment of sexual harassment claims by forensic psychiatrists. These include gender biases, diagnostic biases, sociopolitical biases, and bias that arises from lack of knowledge regarding sexual harassment or lack of formal psychiatric training. Forensic psychiatrists are ethically obligated to strive for objectivity and honesty in their assessments. By becoming aware of these biases and attempting to minimize them, we can meet our ethical obligations as forensic psychiatrists. In addition, we can provide more credible and valuable assessments to the courts in this increasingly litigated and partisan issue.

Psychiatrists, retained both by defense and plaintiffs attorneys, are frequently called upon to make evaluations of claimants and offer expert witness testimony in sexual harassment cases. The legal system has had to contend with an increasing number of aggressively litigated cases of alleged sexual harassment. The number of such complaints brought before the Equal Employment Opportunity Commission increased by 131 percent between 1991 and 1997.[1] The forensic psychiatrist's skills in providing accurate evaluations that encompass issues of proximate cause, psychological damage, functional impairment, credibility, treatment recommendations, and prognosis can be an invaluable service in the attempt to clarify the complex allegations found in sexual harassment cases.

As with other controversial social issues, however, it is a rare member of our profession who has not developed an opinion regarding the issue of sexual harassment. Even those who have not been personally involved in such cases often have strong feelings regarding one of the many issues raised by allegations of sexual harassment. Given this atmosphere, providing a credible, objective assessment of sexual harassment claims is a challenge.

This challenge is well illustrated by a 1994 study that compared the results of forensic examinations by the plaintiff's experts in 47 sexual harassment cases with the results of the authors' examina-

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tions, which were conducted for the defense.[2] Seventeen cases were assigned the diagnosis of posttraumatic stress disorder (PTSD) by plaintiff's experts, and only 3 cases had a primary or associated diagnosis of personality disorder. In contrast, the defense expert diagnosed PTSD in only 3 cases, and personality disorders in 35 cases. Diagnostic differences along these lines are common in such cases and, to a large degree, reflect the influence of bias.

Succumbing to personal biases can discredit the psychiatric profession as well as one's own reputation. Biased assessments cast doubt on the validity of all psychiatric testimony. Further, such assessments appear to validate the stereotype of a "hired gun," an expert witness who sells testimony instead of time.[3] Finally, whether biased toward plaintiff or defense, assessments that ignore or distort factual data may ultimately harm the litigant, because they are much easier to discredit in court. Unbiased assessments can protect both plaintiffs and defendants.

The ethical standards delineated by the American Academy of Psychiatry and the Law (AAPL) require that forensic psychiatrists strive for objectivity and honesty.[4] To adhere to this standard, especially in cases in which partisan and inflammatory issues such as sexual harassment are raised, forensic psychiatrists are ethically obligated to be aware of sources of possible bias and not let them influence their opinions.

Bias is inherent in all human endeavors. Certain biases inherent in the nature of forensic evaluation, and therefore present in cases of sexual harassment, include: (1) advocacy bias inherent in the legal system[2, 5]; (2) personal or professional bias (economic gain, status, reputation, media exposure); (3) diagnostic bias favoring defense or plaintiff[6, 7]; (4) bias due to role conflict between treating clinician and forensic evaluator.[8]

Many of these influences have been addressed by the ethical guidelines adopted by the AAPL[4, 9] and by recommendations regarding procedural guidelines in forensic evaluations.[10–12] Sexual harassment cases, however, activate biases specific to this type of case.[6] For example, the bias due to role conflict between treating clinician and forensic evaluator, which is generic to forensic evaluation, is complicated further in sexual harassment cases. The appropriate patient-oriented bias of the clinician may be even more pronounced in clinicians who treat patients with histories of sexual harassment. Treatment recommendations are to accept such patients' versions of events not only as "therapeutic" or narrative truth, but as literal truth, to avoid causing "second injury."[13–18] Such patient-oriented stances are incompatible with providing the more critical assessments required in a forensic examination.

Biases activated in sexual harassment cases that create problems specific to the forensic assessment of sexual harassment include: (1) sociopolitical biases; (2) bias due to lack of knowledge regarding sexual harassment; (3) bias due to formal psychiatric training; (4) gender bias; and (5) diagnostic bias.

One author has noted, in regard to the forensic evaluation of PTSD, that "Qualification as an expert witness is not generic but rather issue specific. Licensure

as a physician who practices psychiatry, or even a board certification in psychiatry, should not, in and of itself, result in qualification as an expert on PTSD" (pp. 6, 7).[19] In applying this concept to sexual harassment evaluations, qualified experts should be familiar with sexual harassment law and the data regarding sexual harassment, as well as its sociopolitical background. In addition, to counter gender and training issues, they must have expertise in women's psychology and in stress/trauma and trauma responses. Biases related to these issues may be specific to sexual harassment assessments, but we are no less obligated to be aware of them and address them if we hope to offer credible forensic evaluations.

Sociopolitical Biases

Sexual harassment is a relatively new social issue that grew out of the civil rights' and women's movement of the 1960s and 1970s.[20] Because of its historical association with these two powerful ideological movements, the issue of sexual harassment arouses strong feelings in individuals with differing opinions regarding aspects of civil rights and feminism. Court cases have provided the legal definitions of sexual harassment, and as cases continue to be heard, sexual harassment law continues to evolve.[21, 22] However, the complex nature of human relationships and sexual behavior defies the development of social or legal formulas. Efforts to define when conduct is offensive and when offensive conduct is illegal cannot help but be grounded in sociopolitical viewpoints, thus creating a potential source of bias in the forensic evaluation of sexual harassment claims.

To address these kinds of issues, the forensic examiner must be familiar with the definitions of sexual harassment based on the case law. Sexual attraction is a natural outgrowth of people working together and is in no way illegal. As many as 70 percent of all male and female workers have either dated or married someone they met in the workplace (p. 3/9).[23] Sexual harassment is unwanted, nonmutual, unacceptable conduct. Sexual attraction and sexual harassment are not related. Sexual harassment is distinct from other acceptable behaviors that occur in a workplace because it lacks the elements of choice and mutuality inherent in a normal relationship. In addition, it is a type of coercion that relies on the power of the perpetrator to affect a victim's economic status and does not necessarily involve physical force.

Sexual harassment can result in significant stress and stress-related symptoms or disorders. Unbiased assessments of any situation in which stress and stress responses are alleged must consider both the nature and the effects of that particular stressor. In sexual harassment cases, this requires familiarity with the definition of sexual harassment (the stressor) and the available data regarding the occurrence and effects of sexual harassment. Familiarity with this database can assist forensic examiners in neutralizing their own sociopolitical biases.

Whether the events in question constitute sexual harassment is ultimately the decision of the court. Nevertheless, since the effects of sexual harassment can differ

from those of other types of stressors, and the nature of the stressor is a key factor in assessing its effects on any individual, forensic examiners must be able to make a reasonable determination. This enables examiners to provide accurate assessments of the psychological effects of those events, divorced from their ideological beliefs regarding this complex issue.

Bias Based on Lack of Knowledge

One frequent source of bias in the assessment of sexual harassment claims arises from a lack of familiarity regarding its occurrence and effects in the workplace. The position that any personal comment made by a male coworker toward a woman in the workplace is sexual harassment demonstrates unfamiliarity with the definition of sexual harassment. However, the position that sexual harassment is not a legitimate problem in the workplace and does not result in significant consequences is also an uninformed opinion, which equally reflects bias. Studies of sexual harassment and women's responses to it indicate that sexual harassment is a significant problem that can have serious effects on the psychological and physical health of women.

Studies consistently demonstrate that women experience sexual harassment more often than men.[24–35] Substantial rates of sexual harassment are reported, as are associated stress reactions, negative effects on women's job performances, and other emotional, behavioral, and health-related sequelae. The U.S. Merit Systems Protection Board conducted the largest of these surveys, which in 1994 found that 44 percent of women and 19 percent of men reported that they had experienced some form of unwanted sexual attention during the preceding two-year period.[35] The overwhelming majority of people reporting such experiences are women, and the majority of alleged harassers are men.

These studies also reveal that such experiences typically consist of a cumulative series of escalating and varied incidents, rather than a single discrete overwhelming assault that would arouse a reasonable fear of severe physical harm, violation, or death. The studies indicate that the less severe forms of sexual harassment, such as sexual innuendo, touching, and flirtatious remarks, are the more prevalent behaviors. Women who appear to be at greatest risk are those who work exclusively or mostly with men and who are supervised by men.

Adequate education may resolve the biases that influence assessments when forensic psychiatrists believe that any male female workplace interaction constitutes a form of sexual harassment or when they are skeptical regarding the prevalence and seriousness of this problem.

Gender Bias

The fact that sexual harassment is overwhelmingly an experience of women, however, raises gender issues that are unique to this type of assessment and that contain the potential of significant bias. One type of gender bias derives from the traditional intrapsychic orientation of psychiatric training. The emphasis on intrapsychic factors in the assessment of emotional disturbances has resulted in the

deemphasis of the social context in which all psychiatric disorders evolve. Some psychodynamically trained psychiatrists have a tendency, at least initially, to view a woman's allegations of abuse as the product of intrapsychic fantasy. In addition, this focus necessarily directs a forensic examiner's scrutiny toward the individual's contribution to her problems rather than evaluating the effects of external events.

Most clinicians would acknowledge that external circumstances and existing social arrangements affect social identities and psychological status. However, the serious development of a psychology of women, which takes such external factors into account, has emerged only recently. The new models of women's psychology explore women's development as a process distinct from that of men and challenge the more traditional psychological theories regarding women's psychological development and mental health. In addition, these researchers have explored the responses of women to events that occur primarily to women in a male-dominated society. Their theories and models are supported by a growing amount of research and clinical experience.[36–41]

The cornerstone of the new psychology of women is an appreciation of the power and importance of relationships in women's lives in establishing and maintaining normal psychological development, self-esteem, and mental health. In contrast, the more traditional psychology often interprets the importance of relationships for women in terms of dependency, a negative value. The new theories also recognize that the subordinate status of women in our social, economic, and institutional structures are embedded in the relationships of people within those structures. This subordinate status results in the devaluation of women, expressed implicitly and explicitly through social structures and relationships. In addition, it has resulted in women's consistent internalization of their devalued status and many of the social values that perpetuate a subordinate social status as normative.

Studies indicate that many women report physical or psychological distress associated with experiences of sexual harassment.[9, 10, 13, 14, 24, 42–47] Sexual harassment has not been proven to cause any specific mental disorder; however, reported responses are consistent across studies. Associated diagnoses include PTSD or other anxiety disorders, adjustment disorders, and mood disorders such as major depression or dysthymia. This is the same spectrum of disorders found in all types of stress and trauma experiences. The severity of the response, as in other types of stress/trauma responses, is directly related to the severity of the harassment.

The new models of women's psychology add a different perspective to understanding why the psychological conflicts created by sexual harassment can have significant consequences for women. Sexual harassment threatens important relationships within women's lives, both in the workplace and in the home. In addition, as these relationships deteriorate (deemed a form of failure, for which women are often assigned and accept responsibility), women experience a paral-

lel deterioration in self-esteem. A woman's decreasing effectiveness can then activate internalized social devaluations, causing further deterioration in function, coping, and self esteem and further increases in stress.

These theories also explain why psychological conflicts created by sexual harassment can result in responses that may appear paradoxical. The formal reporting of sexual harassment claims is limited to about 10 percent or less of total incidents reported in studies and surveys.[14, 15, 17, 23, 29, 35, 46] In addition, women may comply with harassing behaviors before objecting to it. Both of these phenomena are understandable as the direct result of the conflicts sexual harassment presents specific to women's psychology. They are a function of the value women place on preserving relationships, as well as the social disapproval and discomfort typically experienced by women when they display anger or engage in direct confrontations. The Supreme Court's acknowledgment that voluntary participation does not imply welcomeness of action,[48] a significant criterion in the determination of whether a behavior is sexual harassment, was the legal acknowledgment of these aspects of women's psychology.

The presentation of women who claim to have experienced sexual harassment is frequently noted to be unstable, histrionic, and paranoid.[14, 18, 43, 49] These extreme presentations have often been interpreted solely as a cause of work-related problems. The new theories of women's psychology allows forensic examiners to consider the possibility that these presentations may result from an experience that threatens financial well-being, activates internalized prejudices, and threatens important relationships in a woman's life. Given the increasing evidence of the validity of these models, forensic assessments must take this theoretical framework into account to minimize the gender biases inherent in the more traditional psychological theories.

Another type of gender bias is inherent in the issue of sexual harassment itself. A large and consistent body of literature on sexual harassment reveals a significant gender gap in the perception of offensive behaviors.[17, 35, 46, 50] The gap is particularly large with respect to the less explicit behaviors, which are the most common forms of harassment. Some of the gender differences in perception of sexual harassment are consistent with gender-related cultural beliefs regarding normal behavior and the psychology of men and women. These beliefs, often referred to as cultural myths, are consistent across various forms of victimizing sexual behaviors toward women. Since men have traditionally been the gender of majority in both the psychiatric and legal professions, the potential influence of this particular form of gender-based difference in perception of sexual harassment claims is significant.

The acknowledgment of gender bias in the perception of sexual harassment was recognized legally by the Ninth Circuit Court in the case of *Ellison v. Brady*.[51] This decision established the "reasonable woman" standard as the appropriate legal criterion for determining whether sexual harassment had occurred. The court al-

lowed that the "sex blind reasonable person standard tends to be male biased and tends to systematically ignore the experience of women." The court noted that in evaluating the seriousness of harassment, the focus should be on the perspective of the victim because "[c]onduct that many men consider unobjectionable may offend many women." Although the reasonable person standard was later reinstated by the Supreme Court,[52] we as forensic psychiatrists must remain aware of this gender gap in the perception of sexual harassment to correct for our own gender biases.

One explanation of the gender gap in the perception of sexual harassment is the fact that women are far more likely than men to experience sexual harassment as well as other forms of sexual victimization.[33, 39, 44, 53] The prevalence of these experiences in women was influential in the Ninth Circuit Court's decision, which noted that because women are more likely to be victims of sexual assault, they have a "stronger incentive to be concerned with sexual behavior."

Extrapolating from these statistics of the incidence of sexual victimization, another potential source of gender bias, termed "victim bias," becomes apparent. The percentage of forensic examiners who have personal histories of victimization should roughly approximate the percentage of people who have had such experiences in the general population. Studies consistently indicate these percentages to be 5 to 10 percent of men and 20 to 25 percent of women.[17, 53, 54] This extrapolation is supported by a study of professional women in general[55] and psychologists in particular.[56] Conscious or unconscious bias is likely to be present in forensic evaluations performed by examiners with histories of victimization. These individuals may overidentify with a claimant if they have been victims of harassment or sexual abuse. Conversely, they may condemn or disbelieve a litigant as a result of their own defenses.

Gender has been a central organizing feature of human cultures throughout history, and it is an integral part of our social structures. The influence of gender can never be completely neutralized in any social or professional relationship. However, the more we are aware of the ways gender can influence forensic assessments in sexual harassment cases, the more we can use a knowledge of women's psychology and social experiences to balance the influence of gender bias in such cases.

Diagnostic Bias

Psychiatric diagnoses used in sexual harassment cases must also be subject to scrutiny for potential bias. The terms used to describe any type of problem are unavoidably influenced by the values and judgments of the group who defined them. This results in inherent bias in their use. Since the psychiatric definitions forensic evaluators use have been defined by a predominantly male profession, gender differences in diagnosis create another source of bias in gender-specific issues such as sexual harassment.

Personality disorders diagnoses have come under scrutiny for this type of bias. The study comparing plaintiff and defense experts diagnoses[2] demonstrated

that a line is clearly drawn between the diagnosis of PTSD and personality disorders. The bias of advocacy is a significant factor in the explanation of these results. However, the influence of gender bias in diagnosis is also a significant factor, given the fact that the majority of individuals given personality disorder diagnoses are women.

Recent observations on the diagnostic category of "borderline personality disorder" have noted that this category is particularly judgment laden and sometimes frankly punishing.[57] Women who receive a diagnoses of borderline personality disorder find that their credibility is automatically suspect. They are frequently accused of manipulative behavior and malingering.[58] They are suspected of "hypersensitivity" and distortion. One author has suggested that the term borderline has become so prejudicial that it should be abandoned altogether (p. 123).[57]

Recent research has found a well-documented association between the diagnosis of borderline personality disorder and a history of childhood abuse.[57, 59–61] This information takes on new significance when considered in cases of revictimization such as sexual harassment. Research findings also indicate that women with previous histories of victimization have been found to be at greater risk for all forms of revictimization, a phenomenon referred to as the "sitting duck syndrome."[62] Women who have a history of victimization are at greater risk for sexual harassment and may even be selected as targets by harassers.[18]

The constellation of personality traits, coping patterns, and responses associated with borderline personality disorder are not infrequently found in women claiming sexual harassment. These are women who often have difficulty assessing the trustworthiness of others and who may be slow to recognize and deal effectively with critical early boundary violations. They are often inappropriate or provocative themselves in ways that they do not recognize. Given the studies regarding the increased occurrence of revictimization in this population; however, the association between such a personality organization and reports of sexual harassment is not surprising nor unexpected.

Further complicating these assessments, women with such histories tend to have more severe reactions to less severe forms of victimization, particularly sexual victimization.[33, 57, 63] For these women, even mild forms of sexual harassment may precipitate severe symptoms, including those of PTSD, even if their earlier coping responses have been adequate or good.[18] In addition, preexisting posttraumatic stress disorders or personality disorders can be exacerbated by sexual harassment. Once a diagnosis of personality disorder is given, however, its inherent bias often leads forensic examiners to assume that the claimant's current emotional state and level of functioning are the cause rather than the result of the workplace situation or that reports of harassment are distorted or fabricated.

The question of perceptual distortion is clearly relevant in the assessment of sexual harassment claims, whether due to "hypersensitivity" of a woman with a borderline personality disorder or the impaired reality testing of a woman with an

underlying psychosis. One approach to avoiding the bias of assuming distortion due to a diagnostic label is to frame this issue as one of the likelihood of distortion due to any cause. Evidence of misinterpretation of comments and reports, prior unsubstantiated claims of inappropriate behavior, or prior psychosis might be evidence favoring an assessment of distortion or misinterpretation. The use of psychological testing can also be valuable in making a determination of distortion, as well as in the detection of malingering, a possibility that must be considered in any forensic examination.

In cases of sexual harassment, the diagnosis of a personality disorder focuses attention on the claimant's coping patterns and interpersonal difficulties, making it a preferred defense diagnosis. Forensic examiners must endeavor to avoid allowing the bias of a personality disorder diagnosis to substitute for the careful evaluation of reported events and a claimant's responses to them. The data on the association of trauma, personality disorder, and revictimization reveal that women with previous histories of victimization often have both patterns of personality consistent with personality disorder diagnoses and experiences of revictimization.

A diagnosis of PTSD also carries inherent bias. PTSD is a diagnosis that lends itself well to litigation. Unlike other DSM diagnoses, PTSD contains within its criteria the causative trauma, making it a diagnosis that is seen as incident specific. As one author has commented, "by giving diagnostic credence and specificity to the concept of psychic harm, PTSD has become the lightning rod for a wide variety of claims of stress related psychopathology in the civil arena. PTSD posits a straightforward causal relationship that plaintiff's lawyers welcome" (p. 29).[64] In sexual harassment litigation, a diagnosis of PTSD focuses attention on the event and not the individual, making it a preferred plaintiff's diagnosis.

There has been an explosion of all types of litigation associated with the diagnosis of PTSD.[59, 64] It is common however, to find that a PTSD diagnosis has been inaccurately made in forensic cases, which raises the issue of whether bias has influenced the assignment of this diagnosis in such instances. The inaccurate use of a PTSD diagnosis can arise out of a forensic examiner's ignorance. Some psychiatrists erroneously believe that any psychiatric disturbance that occurs after a traumatic experience qualifies as PTSD. However, an expert's feelings regarding the "victims rights movement" can result in the avoidance or misapplication of the PTSD diagnosis as well. The diagnosis of PTSD provides forensic experts with "a scientific rationale to support the sociopolitical ideology of victimization and to justify the growing recognition of victims' rights" (p.24).[64]

The influence of bias should be suspected when an examiner assigns a diagnosis of PTSD in cases in which the claimant's symptoms do not meet the DSM-IV diagnostic criteria. Bias may also be present when the forensic examiner asserts that the cause of PTSD is limited to the event in question when other factors, such as present or past history of trauma and other psychosocial

stressors, have not been assessed. Finally, the assertion by an expert that a legitimate diagnosis of PTSD implies a definable cause of PTSD, referred to as syndrome evidence, similarly must be examined for bias.

To counter the biases inherent in the PTSD diagnosis, forensic examiners must be experienced in the diagnosis and treatment of trauma and trauma-related responses. The DSM-IV diagnostic criteria for PTSD have been extensively evaluated and validated. These criteria must be met for this diagnosis to be accurately assigned. An evaluation of a case in which a potential diagnosis of PTSD exists should also include an assessment of the traumatic stressor, the response to that stressor, and the vulnerabilities of the individual. When such an assessment is made and when the criteria for PTSD are applied appropriately, the potential for a biased use of the diagnosis is diminished.

In cases of sexual harassment, a thorough forensic assessment involves evaluation of the nature of the sexual harassment. An analysis of the severity and type of ensuing psychiatric responses must include the specifics and chronicity of the alleged harassment, how the claimant perceived and experienced it, and the past history of the person being harassed. The subjective experience of perception of life threat, potential for physical violence, extreme fear, and personal helplessness are significant in determining whether an event is experienced as traumatic. The severity of the stress of sexual harassment is also influenced by its pervasiveness in the workplace, the institutional response to reports of the harassment, and the amount of retaliation against and ostracism of the individual who reports it. Other factors that affect responses are include the predictability, duration, and ambiguity of the harassment, the power differential between the harasser and the victim, and the harasser's ability to directly affect the victim's status. Finally, the availability of support inside and outside the workplace to the victim is a highly significant factor in the assessment of stress.

Given the subjective experience of a traumatic stressor, an individual may develop a variety of disorders. Although most individuals have some psychological response to trauma, even under the most horrendous circumstances, most people do not develop PTSD. The lifetime incidence of individuals exposed to trauma who develop PTSD is 24 percent, although this can vary with the type of trauma experienced. Studies indicate that with the exception of sexual assault, which is associated with the highest rates of subsequent PTSD, even extremely traumatic events usually do not lead to more than 50 percent of the exposed population developing PTSD.[59, 65, 66]

The most common forms of sexual harassment involve the less severe behaviors of touching, suggestive comments, and the like, as opposed to physical assault or rape. An individual would be unlikely to develop PTSD as a response to these forms of sexual harassment, although mood or other anxiety disorders could result from these experiences. Indeed, a very profound response such as PTSD to minimally severe stressors raises the issues of malingering and the individ-

ual's susceptibility to psychiatric morbidity.[59] Vulnerable individuals, however, such as those with preexisting psychiatric disorders or personality disorders, are widely acknowledged to develop severe responses even to minor stressors. When a victim of harassment has a prior history of rape, incest, or childhood sexual abuse, even the mildest forms of sexual harassment can be extremely damaging, and the presentation of such individuals on evaluation is often more complex as well as more severe.

The bias of a "causally obvious" PTSD diagnosis in these individuals can lead the forensic examiner to believe that sexual harassment is the proximate cause of their psychiatric problems. As in any type of PTSD litigation, this is not necessarily true. The less severe the stressor and the more severe the reaction, the more significant these other vulnerabilities may be in the genesis of the psychiatric problems being assessed, including PTSD. In addition to preexisting psychiatric disorders, these vulnerabilities include previous or concurrent trauma. The questions that must be addressed to assess proximate cause in such cases are whether the PTSD (1) is a new disorder caused by recent trauma; (2) is a previously undiagnosed PTSD caused by earlier, unrelated trauma; (3) has been precipitated by recent trauma but caused by a previous trauma, which is more likely if the previous trauma is of greater magnitude that recent trauma; or (4) has been caused by interactions of both recent and previous trauma.[67]

Other sources of psychosocial stress that create vulnerabilities in the individual and that must be assessed, but that may be overlooked by limiting assessment of proximate cause to a PTSD diagnosis, include the effects of: (1) litigation, commonly acknowledged to be extremely stressful[6, 49, 46, 68–70]; (2) retaliation, which may be distinct clinically and legally from the harassment; (3) underlying medical conditions or medications, which may cause psychological symptoms; and (4) the use of drugs or alcohol, often found in individuals responding to stress.

The fact that women who have previously been victimized have more severe reactions to all forms of repeated victimization, and that such women are frequently involved in cases of sexual harassment, adds a further challenge in avoiding diagnostic bias. To label such claimants as borderline without evaluating whether they may have experienced sexual harassment is an error of bias. The assignment of an overly simplistic PTSD diagnosis, which implies single external causality without thoroughly assessing the stressor, the vulnerabilities of the individual, and other sources of possible stress, is equally an error of bias. Familiarity with data regarding trauma, trauma responses, and responses to sexual harassment can help forensic examiners avoid some of these diagnostic biases found in sexual harassment cases.

Another form of diagnostic bias can be significant in the area of evaluation of functional impairment and potential for recovery. Although the Supreme Court has ruled that a woman who experiences sexual harassment is not required to be psychologically damaged to have a legitimate legal claim,[52] the assessment of such damage is still a critical factor in

litigation. The extent of psychiatric injury is one of the most important factors considered in the determination of damages. The bias of certain diagnostic categories can influence an assessment when the forensic examiner assumes that an individual's psychiatric diagnosis equates with functional impairment.

Psychiatric diagnoses are not implicitly associated with any specific level of functioning, impairment, or level of recovery. Further, no matter what psychiatric diagnosis may be present, rarely is an individual either mentally or physically totally disabled. A careful assessment of the claimant's personality, behavior, and functioning both before and after the occurrence of the incidents in question is required to make an accurate assessment of impairment. In addition, prognostic assessments, also critical in the consideration of damages, should be based on the forensic examiner's knowledge of the natural history of any psychiatric illness and knowledge of the effects of rehabilitation and treatment.

The final assessment of permanent impairment for any psychiatric disorder rests on obtaining appropriate treatment, which requires an assessment of the claimant's motivation for recovery and willingness to enter treatment. Even minimal impairment may lead to permanent disability when the claimant is not motivated to recover. An assessment of motivation for recovery and treatment is critical and extremely difficult in the setting of litigation, where the secondary gain of having more severe symptoms and impairment may result in a better financial outcome.

In cases in which a claimant is found to have a preexisting psychiatric disorder, the influence of diagnostic bias can become intertwined with the influence of advocacy bias, resulting in the discrepancies seen between plaintiff and defense experts diagnostic assignments. The forensic examiner must determine whether the preexisting problems are related to the symptoms or impairment in question, whether the stress of the sexual harassment has aggravated, accelerated, or reactivated an individual's preexisting disorder, or whether there is no relationship between the preexisting diagnosis and present symptoms. The existence of a preexisting diagnosis does not serve as a substitute for a complete evaluation or imply that a complete evaluation is not needed. The influence of advocacy bias can result in a forensic examiner using or avoiding various diagnoses, such as personality disorders or PTSD, which themselves reflect certain biases in terms of vulnerabilities, responsibility, proximate cause, function, impairment, and ultimately legal damages.

Attorneys take a keen interest in the assessment of a preexisting diagnosis because it is so important in the court's assessment of damages. In cases in which preexisting Axis I or II diagnoses have been legitimately interpreted as having created vulnerabilities to the stress of sexual harassment, the issue of prognosis and long term impairment can be argued by either plaintiff or defense attorneys to their advantage. An attorney's obligation is to use the information gathered from the forensic evaluation to provide his or her client with a vigorous defense. It is

certainly appropriate for a forensic examiner to assist the attorney in doing so when asked for advice regarding the use of the assessment or weaknesses in an opposing assessment. The forensic examiner's obligation, however, is to provide the most knowledgeable, accurate assessment without regard to whether the retaining attorney is representing the plaintiff or the defense. The forensic examiner is ethically obliged to be an advocate for that assessment, not for the attorney or the attorney's client.

Conclusion

It is appropriate that an assessment of the biases that occur in the evaluation of cases of sexual harassment return ultimately to the bias of advocacy. As Bernard Diamond pointed out, it is impossible ever to completely neutralize bias in forensic assessments due to the adversarial nature of litigation.[5] Such biases are difficult enough to address in forensic evaluations in general. When we add the challenge of neutralizing the biases that arise in the context of a controversial issue such as sexual harassment, providing a balanced forensic evaluation becomes even more difficult.

Sexual harassment claims raise biases beyond those inherent in general forensic exams. These biases arise from a complicated interaction between psychiatric training and diagnoses, social politics, and gender issues. The only way to effectively address biases that affect our ability to provide accurate assessments in sexual harassment claims is to ground our assessments in our expertise in forensic ethics, procedures, and available data on trauma, trauma responses, women's psychology, and sexual harassment itself. Evaluations that lack such informed bases undermine the credibility of both expert testimony and forensic psychiatrists and ultimately can cause significant harm to a claimant or defendant. Unbiased assessments can be invaluable in assisting both the claimant and defendant in protecting their rights, as well as the judge or jury in sorting through complicated and controversial evidence. Balance in the forensic evaluation of sexual harassment cases is a difficult goal to achieve, but one that is well worth our efforts.

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References

1. Jackson M: Sex harassment and the bottom line. The Bergen Record, April 14, 1998, p A13
2. Long BL: Psychiatric diagnoses in sexual harassment cases. Bull Am Acad Psychiatry Law 22:195–203, 1994
3. Gutheil TG: The Psychiatrist as Expert Witness. Washington DC: American Psychiatric Press, 1998
4. American Academy of Psychiatry and the Law: Ethics Guidelines for the Practice of Forensic Psychiatry (adopted 1987, revised 1989, 1991, and 1995). Bloomfield, CT: AAPL, 1995
5. Diamond BL: The fallacy of the impartial expert. Archives of Criminal Psychiatry 3:221–36, 1959
6. Simon RI: The credible forensic psychiatric evaluation in sexual harassment litigation. Psychiatr Ann 26:139–48
7. Feldman-Schorrig S, McDonald J: The role of the forensic examiner in the defense of sexual

harassment cases. J Psychiatry Law 20:5–33, 1992
8. Strasburger LH, Gutheil TG, Brodsky A: On wearing two hats: role conflict in serving as both psychotherapist and expert witness. Am J Psychiatry 154:448–56, 1997
9. American Psychiatric Association: The Principles of Medical Ethics with Annotations Especially Applicable to Psychiatry. Washington, DC: APA, 1995
10. Simon RI, Wettstein RM: Toward the development of guidelines for forensic psychiatric examinations. J Am Acad Psychiatry Law 25: 17–30, 1997
11. Benedek EP: Forensic aspects of sexual harassment: serving as an expert witness, providing courtroom testimony, and preparing legal reports, in Sexual Harassment in the Workplace and Academia. Edited by Shrier DK. Washington, DC: American Psychiatric Press, 1996, pp 113–32
12. Benedek EP, Voigt CJ, Heisel DE: Brief personal reflections on sexual harassment. Psychiatr Ann 26:128–31, 1996
13. Sherer A: Psychiatric assessment: a semistructured interview, in Sexual Harassment in the Workplace and Academia. Edited by Shrier DK. Washington, DC: American Psychiatric Press, 1996
14. Charney DA, Russell RC: An overview of sexual harassment. Am J Psychiatry 151:10–17, 1994
15. Institute for Research on Women's Health: Sexual Harassment and Employment Discrimination Against Women. Bethesda, MD: Feminist Institute Clearing House, 1988
16. Pendergrass VE, Kimmel E, *et al*: Sex discrimination counseling. Am Psychol 31:36–46, 1976
17. Koss MP, Goodman LA, Browne A, *et al*: No Safe Haven. Washington, DC: American Psychological Association, 1994
18. Shrier DK, Hamilton JA: Therapeutic interventions and resources, in Sexual Harassment in the Workplace and Academia. Edited by Shrier DK. Washington, DC: American Psychiatric Press, 1996, pp 95–112
19. Shuman DW: Persistent reexperiences in psychiatry and law: current and future trends in posttraumatic stress disorder litigation, in Posttraumatic Stress Disorder in Litigation. Edited by Simon RI. Washington, DC: American Psychiatric Press, 1995, pp 1–11
20. MacKinnon C: Sexual Harassment in the Workplace. New Haven, CT: Yale University Press, 1979
21. Shrier DK: Introduction and brief overview, in Sexual Harassment in the Workplace and Academia. Edited by Shrier DK. Washington, DC: American Psychiatric Press, 1996, pp 1–20
22. Fitzgerald LF, Swan S, Magley VJ: But was it really sexual harassment?: legal, behavioral, and psychological definitions of the workplace victimization of women, in Sexual Harassment: Theory, Research and Treatment. Edited by O'Donohue W. Boston: Allyn and Bacon, 1997, pp 5–28
23. Petrocelli W, Repa BK: Sexual Harassment on the Job (ed 2). Berkeley, CA: Nolo Press, 1995
24. Gutek B: Sex and the Workplace. San Francisco, CA: Jossey-Barr, 1985
25. Klein F: The 1988 Working Women Sexual Harassment Executive Report. Cambridge, MA: Klein Associates, 1988
26. Sandroff R: Sexual harassment in the Fortune 500. Working Women Magazine, 13:69–73, 1988
27. Lenhart SA, Klein F, Falcao P, *et al*: Gender bias against and sexual harassment of AMWA members in Massachusetts. J Am Med Womens Assoc 46:121–5, 1991
28. Fitzgerald LF, Ormerod AJ: Breaking silence: the sexual harassment of women in academia and the workplace, in Psychology of Women: A Handbook of Theories and Issues. Edited by Denmark FI, Paludi MA. Westport, CT: Greenwood Press, 1993, pp 553–82
29. Center for Women Policy Studies: Harassment and Discrimination of Women in Employment. Washington, DC: Author, 1981
30. Culbertson AL, Rosenfeld P, Newell LE: Sexual Harassment in the Active Duty Navy: Findings from the 1991 Navy-Wide Survey. San Diego, CA: Navy Personnel Research and Development Center, 1993
31. Gutek BA, Koss MP: Changed women and changed organizations: consequences of and coping with sexual harassment. J Vocational Behav 42:28–48, 1993
32. Nina Burleigh and Stephanie B. Goldberg, Breaking the silence: sexual harassment in law firms. 75 ABA J 46 (1989)
33. Bernstein AE, Lenhart SA: The Psychodynamic Treatment of Women. Washington, DC: American Psychiatric Press, 1993
34. Gruber JE: An epidemiology of sexual harassment: evidence from North America and Europe, in Sexual Harassment: Theory, Research and Treatment. Edited by O'Donohue W. Boston: Allyn and Bacon, 1997, pp 84–95
35. U.S. Merit Systems Protection Board: Sexual Harassment in the Federal Workplace. Wash-

ington, DC: U.S. Government Printing Office, 1995
36. Miller JB: Toward a New Psychology of Women. Boston: Beacon Press, 1976
37. Gilligan C: In a Different Voice. Cambridge, MA: Harvard University Press, 1982
38. Chodorow N: The Reproduction of Mothering: Psychoanalysis and the Sociology of Gender. Berkeley, CA: University of California Press, 1978
39. Unger R, Crawford M: Women and Gender: A Feminist Psychology (ed 2). New York: McGraw Hill, 1996
40. Braude M, editor: Women, Power and Therapy. New York: Haworth Press, 1988
41. Miller JB, Stiver IP: The Healing Connection: How Women Form Relationships in Therapy and Life. Boston: Beacon Press, 1997
42. Crull P: Stress effects of sexual harassment on the job: implications for counseling. Am J Orthopsychiatry 52:539–44, 1982
43. Hamilton JA, Alagna SW, King LS, *et al*: The emotional consequences of gender-based abuse in the workplace: new counseling programs for sex discrimination, in Women, Power and Therapy: Issues for Women. Edited by Braude M. New York: Haworth Press, 1987, pp 155–82
44. Fitzgerald LF, Ormerod AJ: Perceptions of sexual harassment: the influence of gender and context. Psychol Women Q 15:281–94, 1991
45. Lenhart S: Physical and mental health aspects of sexual harassment, in Sexual Harassment in the Workplace and Academia. Edited by Shrier DK. Washington, DC: American Psychiatric Press, 1996
46. Siegel DL: Sexual Harassment: Research and Resources. New York: National Council for Research on Women, 1995
47. Kilpatrick DG, Dansky BS: Effects of sexual harassment, in Sexual Harassment: Theory, Research and Treatment. Edited by O'Donohue W. Boston: Allyn and Bacon, 1997, pp 152–74
48. Meritor Savings Bank v. Vinson, 477 U.S. 57 (1986)
49. Berger MA: Litigation on Behalf of Women: A review for the Ford Foundation. New York: Ford Foundation, 1980
50. Hotelling K, Zuber BA: Feminist issues in sexual harassment, in Sexual Harassment: Theory, Research and Treatment. Edited by O'Donohue W. Boston: Allyn and Bacon, 1997, pp 99–111
51. Ellison v. Brady, 924 F.2d 872 (9th Cir. 1991)
52. Harris v. Forklift Systems, Inc., 114 S. Ct. 367 (1993)
53. Finkelhor D: Current information on the scope and nature of child sexual abuse. Future Child 4:31–53, 1994
54. Rose DS: Sexual assault, domestic violence, and incest, in Psychological Aspects of Women's Health Care. Edited by Stewart DE, Stotland NL. Washington, DC: American Psychiatric Press, 1993, pp 447–83
55. Elliott DM, Briere J: Sexual abuse trauma among professional women: validating the Trauma Symptom Checklist-40 (TSC-40). Child Abuse Negl 16:391–8, 1992
56. Pope KS, Feldman-Summers S: National survey of psychologists' sexual and physical abuse history and their evaluation of training and competence in these areas. Prof Psychol Res Pract 23:353–61, 1992
57. Herman J: Trauma and Recovery. New York: Basic Books, 1992
58. Feldman-Schorrig S: Factitious sexual harassment. Bull Am Acad Psychiatry Law 24:387–92, 1996
59. Simon RI: Toward the development of guidelines in the forensic examination of posttraumatic stress disorder claimants, in Posttraumatic Stress Disorder in Litigation: Guidelines for Forensic Assessment. Edited by Simon RI. Washington, DC: American Psychiatric Press, 1995, pp 31–84
60. van der Kolk B: The complexity of adaptation to trauma: self-regulation, stimulus discrimination, and characterological development, in Traumatic Stress: The Effects of Overwhelming Experience on Mind, Body, and Society. Edited by Van der Kolk B, McFarlane AC, Weisaeth L. New York: Guilford Press, 1996, pp 182–213
61. Zanarini MC, editor: Role of Sexual Abuse in the Etiology of Borderline Personality Disorder. Washington, DC: American Psychiatric Press, 1997
62. Kluft RP: Incest and subsequent revictimization: the case of therapist-patient sexual exploitation, with a description of the sitting duck syndrome, in Incest-Related Syndromes of Adult Psychopathology. Edited by Kluft RP. Washington, DC: American Psychiatric Press, 1990, pp 263–88
63. McFarlane AC, Yehuda R: Resilience, vulnerability, and the course of posttraumatic reactions, in Traumatic Stress: The Effects of Overwhelming Experience on Mind, Body, and Society. Edited by Van der Kolk B, McFarlane AC, Weisaeth L. New York: Guilford Press, 1996, pp 155–77

64. Stone AA: Post-traumatic stress disorder and the law: critical review of the new frontier. Bull Am Acad Psychiatry Law 21:23–36, 1993
65. Kilpatrick DG, Resnick HS: Posttraumatic stress disorder associated with exposure to criminal victimization, in Posttraumatic Stress Disorder, DSM-IV and Beyond. Edited by Davidson JR, Foa EB. Washington, DC: American Psychiatric Press, 1993
66. Green BL: Recent research findings on the diagnosis of posttraumatic stress disorder: prevalence, course and morbidity, in Posttraumatic Stress Disorder in Litigation: Guidelines for Forensic Assessment. Edited by Simon RI. Washington, DC: American Psychiatric Press, 1995, pp 13–29
67. Kleinman SB: Trauma-induced psychiatric disorders and civil law, in Principles and Practice of Forensic Psychiatry. Edited by Rosner R. New York: Chapman and Hall, 1994, pp 242–7
68. Schafran LH: Sexual harassment cases in the courts, or therapy goes to war: supporting a sexual harassment victim during litigation, in Sexual Harassment in the Workplace and Academia. Edited by Shrier DK. Washington, DC: American Psychiatric Press, 1996, pp 133–52
69. Lenhart SA, Shrier DK: Potential costs and benefits of sexual harassment litigation. Psychiatr Ann 26:132–8, 1996
70. Binder RL: Sexual harassment: issues for forensic psychiatrists. Bull Am Acad Psychiatry Law 20:409–18, 1992