Psychiatric Diagnoses in Sexual Harassment Cases

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Forty-four women and three men who were plaintiffs in sexual harassment and sexual discrimination cases were evaluated by experts for the plaintiffs and by the author, an expert in these cases, for the defense. There were considerable differences in the diagnostic assessments. Some reasons for these differences and their implications for forensic evaluations are discussed.

Sexual harassment is defined by Title VII of the 1964 Civil Rights Act, which was amended in 1972,[1] as involving unwelcome sexual advances, requests for sexual favors, and other verbal or physical conduct of a sexual nature, when submission to such conduct is made a condition of an individual's employment or promotion (*quid pro quo*) or such conduct interferes with an individual's performance or creates a hostile work environment.

Sexual discrimination, which is also subsumed under Title VII, involves discriminatory acts based on gender. These acts must create economic disadvantages to the individual.

Both sexual harassment and sexual discrimination can have significant psychological consequences.[2] The medical expert is often called in order to assess the psychiatric consequences of these actions. This paper compares the diagnostic assessment of experts for the plaintiffs and for the defense.

Method

In this study 44 female and three male plaintiffs were evaluated by various consultants for the plaintiff before being evaluated by the defense. The plaintiff examiners consisted of 27 psychiatrists. Of these, one plaintiff was evaluated and treated by two psychiatrists with a third providing a second opinion; a second plaintiff was evaluated and treated by two psychiatrists and a psychologist; a third, by a psychiatrist and family physician. In two cases, the psychiatrist worked with the psychologist. Family physicians functioned as examiners for two men, while a master's-level therapist was the examiner for a third. Other plaintiff examiners consisted of 10 family practitioners, and 18 master's- or doctoral-level counselors or psychologists.

In each case, the author evaluated the plaintiff in a psychiatric examination requested by the defense. Before the ex-

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amination, the author reviewed the results of psychometric tests (MMPI-2, Rorschach, Thematic Apperception Test, Sentence Completion, Beck Depression Inventory, and Shipley Hartford), which were performed by the same licensed consulting psychologist for the defense, a man with 30 years' experience conducting psychological testing for both plaintiff and defense in both criminal and civil cases.

The author's psychiatric examination investigated broad areas of the plaintiffs' developmental and genetic histories as well as vocational and social histories and mental status examination. Topics covered in the history included family history; history of physical, emotional, or sexual abuse; religious preference, if any; family and plaintiff histories of medical, psychiatric, chemical dependency, legal or work problems; education; adolescence; vocational history; social history; background of the current legal complaint; effects of the alleged harassment/discrimination; emotional connections between events of the alleged harassment/discrimination and the past; plaintiff's perceived role, if any, in the work problems; effects of the litigation process; and other life stressors.

Results

The diagnoses given the plaintiffs by experts for the plaintiff and defense are shown in Table 1. The majority of plaintiffs were given one diagnosis by plaintiff expert and multiple diagnoses by the defense. The plaintiffs' expert diagnoses included one of the diagnoses given by the defense expert in 14 of the 47 cases.

Discussion

There are many possible reasons for discrepancies in diagnosis among experts, who have been subject to criticism for bias and inaccuracy.[3] In this series, several explanations seem pertinent. First, there were differences in training experiences between the groups. Second, in-depth historical information was not obtained by plaintiff examiners. This was either because other diagnoses were not considered to be relevant for the litigation or treatment modality used, because the emphasis was on the treatment of acute symptoms, or because an in-depth interview approach was not possible or considered to be necessary. The lack of depth of examination by plaintiff examiners is best illustrated in the case of the first male plaintiff who was provided his diagnosis and a disability leave after the first 15-minute office visit.

Third, the plaintiff's presentation to his or her own examiner may have been more acute and/or exaggerated than that made to the defense expert. Fourth, there are inherent potential biases in conducting plaintiff versus defense evaluations, even though ideally the side requesting the evaluation should not affect the results. Fifth, examiners may have unconscious or conscious biases.[3] Sixth, there may be malingering, which is difficult for any examiner to detect.

The high frequency of personality disorder diagnoses found by the defense raises many questions. In all cases in which the diagnosis was made, the life history provided support for it. Perry[4] has found that there is low reliability of

Table 1
Expert Diagnoses Given

Plaintiff Expert Diagnosis	Defense Expert Diagnoses
Women	
1 PTSD	AD; P.D.
2 PTSD; AD	BD; PD; substance abuse
3 PTSD	dysthymia; PD; substance abuse
4 No diagnosis	AD; PD
5 PTSD	AD; CD; PD
6 BD (treating practitioner) PTSD (expert)	BD; PD
7 AD	AD; PD; substance abuse; CD
8 AD	AD; PD; CD
9 MD; PTSD; general anxiety	AD; PD; substance abuse
10 MD; PTSD	Atypical Depression; panic disorder; PD
11 AD	AD; PD
12 AD	MD
13 PTSD	AD; PD; substance abuse
14 AD	AD; PD
15 MD	PD
16 MD; PTSD	MD; PD
17 MD	AD; PD
18 MD; PTSD	Dysthymia; alcohol abuse; PD
19 AD	Schizophrenia; PD; chronic PTSD
20 PTSD; MD	AD; PD
21 MD	PD
22 MPD	PD
23 PTSD	Schizophrenia; PD
24 MD	MD; PD
25 MD	Delusional disorder; PD
26 PTSD	PD
27 AD	Dysthymia; PD
28 AD	AD; CD; PD
29 PTSD	MD; PD
30 Depression; BD; PD	MD; PD
31 AD; PTSD	PD
32 AD	No psychiatric diagnosis
33 PTSD	No psychiatric diagnosis
34 PTSD	PTSD; schizophrenia; PD
35 AD	PD
36 MD and "possible PD"; AD; MD	Dysthymia; CD; PD
37 AD	No diagnosis
38 AD; somatoform disorder; personality traits	AD; PD; PTSD
39 Schizoaffective; PD	BD
40 PD	No diagnosis
41 No diagnosis since 1991	AD in 1991; not seen since
42 Delusional disorder; borderline intellectual functioning	No diagnosis
43 Somatoform disorder; MD; PD	MD
44 AD, resolved in 1991	MD, 1991
Men	
1 "Stress and depression"	PD; alcohol abuse, AD, malingering
2 MD	MD
3 Alcohol, other substance abuse; personality traits	Alcohol, cocaine abuse; MD; PD

AD = adjustment disorder; BD = bipolar disorder; CD = conversion disorder; MD = major depression; PD = personality disorder; PTSD = posttraumatic stress disorder; MPD = multiple personality disorder.

agreement between instruments currently available, and that "personality patterns are best revealed by the recurring patterns one finds when taking a systematic history." [4] There are also traditional caveats about making personality disorder diagnoses in individuals who are actively engaged in litigation or who feel that they have been acutely victimized, although the validity scales on the MMPI-2, especially the F scale,[5-8] are helpful in determining acute versus chronic disturbance as well as malingering. Moreover, all of the plaintiffs who were diagnosed by the defense examiner as having personality disorders had elevations above 70 on Scale Four ("psychopathic deviate") on the MMPI-2 except for one female and one male plaintiff, whose MMPI-2s both were malingered. In one woman and one man, who were diagnosed by the defense examiner to have certain personality traits, the plaintiff examiner diagnosed personality disorder.

Some plaintiff examiners resist making a personality disorder diagnosis, arguing that its presence is irrelevant to the issue of emotional harm arising from sexual harassment in the workplace. These examiners prefer to assess the effectiveness of the plaintiff's preexisting coping style and defensive structure in containing symptomatology arising from workplace (and other concurrent) stressors. If the examiner determines that the work environment stress transcended the coping mechanisms of the plaintiff, an Axis I diagnosis is usually made. Such an approach, however, risks overlooking the possible role of the plaintiff's behavior in provoking or exacerbating workplace interpersonal problems.

The use of the posttraumatic stress disorder (PTSD) diagnosis in tort claims is a source of ongoing controversy.[9, 10] The difficulties in the use of this diagnosis are particularly evident in sexual harassment cases. First, because most of the early work on PTSD as a diagnosis involved studies of combat veterans,[11] there is reason to question whether the syndrome, as defined by DSM-III-R[14] is applicable to victims of sexual harassment. Second, many of the symptoms of PTSD are difficult to verify and relatively easy to malinger. Third, in order to qualify for the diagnosis, the plaintiff must establish that the work environment qualifies as a stressor under Criterion A of the DSM-III-R.

In sexual harassment cases, the use of the PTSD diagnosis in particular is noteworthy, because it is the only DSM-III-R diagnosis that can potentially establish causality.[12] If causality can be established and attributed to the work environment, the claim for emotional damages may be significant. Even if the work environment could be established as a qualifying Criterion A stressor, according to Breslau and Davis,[13] only about 25 percent of individuals exposed to a qualifying stressor actually develop PTSD. Obviously 75 percent of such exposed individuals do not. Realistically then, the number of individuals developing true PTSD from such an environment would be predicted to be small.

In 18 cases in this series, the plaintiffs' examiners made the diagnosis of PTSD

without referring to the PTSD criteria as delineated by DSM-III-R. However, in the opinion of the defense examiner, only two of the 38 plaintiffs qualified for the diagnosis, and these two plaintiffs had chronic PTSD, which was related to rapes occurring in adolescence rather than to the present work environment. Other problems that must be resolved with respect to the PTSD diagnosis in sexual harassment cases involve whether the stressor, as defined in Criterion A, must be "outside the natural experience of individuals" as currently defined by DSM-III-R[14] or whether stressors that are more commonplace or subjective can give rise to the syndrome.[19] As PTSD is currently defined, examples of such stressors include natural disasters, active military combat, and rape. In the opinion of the defense examiner, none of these women who were diagnosed as having PTSD caused by the work environment met the DSM-III-R criteria for PTSD for two reasons. First, the work environment could not be established as a stressor that rose to the level of that described under Criterion A. To date, the literature has not described cases in which the work environment conditions have qualified as a Criterion A stressor. Second, none of the women had the symptom picture of PTSD as defined by DSM-III-R.

Tanay[16] suggests that the proper role of the examiner may be simply to establish whether "psychic injury" has occurred, rather than to emphasize how that "injury" is labeled diagnostically. However, as Sparr and Boehnlein[10] stress, it is important to make the PTSD diagnosis only when it can be substantiated, because "the PTSD diagnosis may elicit more sympathy for, and identification with, the patient because of perceived external causation as opposed to internal causation (e.g., personal weakness) in the case of depression, anxiety, or adjustment disorder." The DSM-IV Draft Criteria,[17] finalized in March 1993, redefined the Criterion A stressors to include witnessing, experiencing, or confronting "an event or events that involve actual or threatened death or serious injury, or a threat to the physical integrity of oneself or others," with the response involving "intense fear, helplessness, or horror." It will be interesting to see how the final version of DSM-IV will address the issues of defining the stressor criterion and the cohesiveness and validity of the syndrome characteristics.[3, 15]

One issue that impacts the use of PTSD as well as other diagnoses in sexual harassment cases involves unique countertransference reactions of evaluators on either side. On the one hand, plaintiff examiners may overemphasize Axis I conditions while minimizing or omitting Axis II conditions. Possible reasons for this may include a desire to assist or to protect the plaintiff, identification with the plaintiff, anger toward the defendant, or a desire to affirm sociopolitical beliefs. On the other hand, defense examiners may overemphasize Axis II diagnoses while minimizing Axis I diagnoses for the same reasons on the opposite side, namely, a desire to assist or to protect the defendant, identification with the defendant, anger toward

the plaintiff, or a desire to affirm sociopolitical beliefs. Furthermore, the examiner for either side may wish consciously or unconsciously to discredit the opposing examiner or attorney.

Other countertransference issues relate to the granting of medical leaves of absence and disability. As described by Feldman-Schorrig,[18] many plaintiffs, especially those with personality disorders, exaggerate symptoms, often for secondary gain reasons such as monetary rewards and leaves of absence from work or disability. These plaintiffs may exert considerable pressure upon medical and mental health providers to remove them from the negative work environment. Some countertransference problems include, first, the provider wanting to be relieved of the pressure which the plaintiff is generating through calls, frequent office visits, and letters. The office notes of 16 of the 38 plaintiffs in this series showed evidence of this kind of pressure. Second, the provider unconsciously may identify with the plaintiff and want to rescue the latter from a perceived unjust situation. One family physician's notes mentioned her own experiences of sexual harassment. Removing the plaintiff from the work situation affects not only the evaluation or treatment process, but also the litigation process.[10] Moreover, granting a medical leave of absence or a disability for emotional reasons in a characterologically disordered plaintiff strengthens the tendencies of the plaintiffs to exaggerate symptoms and externalize blame for his or her life's problems.

Another factor that may influence the granting of disability or extended leaves of absence may be the gender of the examiner, although, because of the small sample size of this study, no definite conclusions can be drawn. In this series, 9 of 14 disabilities granted to the female plaintiffs were granted by female examiners. Of these, 5 were given the diagnosis of adjustment disorder, 3 were given the diagnosis of PTSD, and one was diagnosed with depression. A 10th plaintiff was recommended for disability by her male psychiatrist after the plaintiff was hospitalized for a manic episode, whereas another male psychiatrist granted a disability to a woman in whom he diagnosed bipolar disorder but who had never been hospitalized for a manic episode. An 11th plaintiff was diagnosed by her male family physician as having an adjustment disorder and granted a disability without any input from the mental health profession. The twelfth was granted disability at her request by her female master's level therapist; no diagnosis was given. A 13th female plaintiff was granted a disability by her female psychiatrist for a major depression and personality disorder. When this physician left on a leave of absence, her male psychiatric colleague reversed the disability and diagnosed an adjustment disorder. The company's female psychiatrist was consulted for a second opinion, denied the disability, and diagnosed major depression. Another male psychiatrist granted disability to a woman whom he diagnosed as having PTSD. One male plaintiff was granted disability by his male family physician on the basis of "stress and depression" related to lit-

igation and past sexual harassment by the female defendant, who had left the company over a year before the plaintiff was granted the disability. The second male plaintiff was granted disability by his master's level therapist.

Some plaintiffs do have a valid claim for significant emotional damages that are causally linked to the work environment. In this series, for example, one plaintiff, who had been diagnosed by her male treating psychiatrist as having an adjustment disorder, was diagnosed by the author as having a serious major depression that was attributable exclusively to the work environment. Immediate removal from the work environment was recommended by the author; and the potential for damages was considerable, because the plaintiff was judged to be at high risk for a psychotic decompensation. However, in the opinion of the defense expert, the work environment did not qualify as a Criterion A stressor, and the plaintiff did not have the syndrome of PTSD.

Feldman-Schorrig and McDonald[18] have described other difficulties that may impact the psychiatrist's diagnoses in sexual harassment evaluations for the plaintiff or defendant.

> Detailed information must be gathered by the clinician to determine whether the plaintiff may be pursuing an exaggerated or false claim of harassment due to the presence of one or more extraneous factors such as (1) characterologic hypersensitivity to sexual cues, (2) operation of a repetition compulsion, (3) presence of a personality disorder, (4) displacement of anger toward a currently abusive partner or spouse, (5) wish to avenge a perceived but unrelated wrong, and (6) an expectation of financial reward.

Although repetition compulsion, displacement, and preexisting personality do not negate legal causality, these dynamics can affect both the plaintiff's perceptions in the work environment (and thus influence the claim of damages) as well as motivate the plaintiff's pursuit of litigation. In all of the female plaintiffs diagnosed with personality disorders, the five psychological dynamics listed above were key factors both in perception of damages and in litigation. The dynamics operative in the first male plaintiff's pursuit of litigation were a desire to deflect attention away from his performance problems at work (including drinking on the job) and an expectation of financial reward, both of which in the opinion of the defense motivated his conscious exaggeration of psychological symptoms. The dynamics operative in the case of the second male plaintiff included displacement of anger directed toward an ex-spouse and a current spouse whom he was divorcing during the time of the work difficulties. The third man sought inpatient chemical dependency treatment for a relapse for which he blamed the company. Just before this hospitalization, the company had confronted him about financial improprieties for which he was ultimately terminated.

These issues emphasize important ethical questions. One issue, which has been well addressed in the literature, concerns the potential hazards that psychiatrists face when they attempt to function both as treater and forensic expert.[20–25] Another question arises when nonpsychiatric treaters both medical

and nonmedical are asked to render an expert opinion on the mental health of a plaintiff. These individuals are open to attack by opposing counsel who questions their qualifications for testifying as an expert in these cases. This question, which has both ethical and financial implications, also raises the issue of the appropriateness of these practitioners' providing medical mental health disabilities and leaves of absence for plaintiffs who are either currently involved or not involved in litigation. Many of these practitioners acknowledge that their plaintiffs are functioning adequately socially and are capable of functioning vocationally, but they are disabled from working for the employer against whom the litigation is directed. In the future, employers and insurers pressed by the costs of extended disabilities granted by these practitioners for "stress" and other mental health reasons increasingly may require psychiatric second opinions early in the disability or leave process.

Acknowledgements

The author thanks Seymour Halleck, MD, Phillip Resnick, MD, Ben Bursten, MD, and Jonas Rappeport, MD, for their assistance in preparing this article.

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