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Forensic Psychiatric Expertise: Posttraumatic Stress Disorder

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SUMMARY

Introduction This article presents our experiences in the field of forensic post-traumatic stress disorder (PTSD).

Objective The study examined parameters of 30 patients with PTSD who were the subject of forensic expertise (PTSDF) and in 30 patients with PTSD who were not (PTSDN).

Methods Clinical research and the battery of tests (Impact of Event Scale – IES, Mississippi Scale, and list of symptoms of PCL-M) covered a total of 60 male subjects with a verified diagnosis of PTSD. The study involved socio-demographic variables, catastrophic experience, enduring personality change after catastrophic experience (EPCACE), comorbidity disorders and non-material damage.

Results In terms of respondents' average age, years of education, marital status, time of military engagement, there were no statistically significant differences between PTSDF and PTSDN groups. In terms of EPCACE statistically significant differences were found in both PTSDF and PTSDN groups. Among PTSDF respondents (N=30) EPCACE was verified in 83.33% (N=25), and among PTSDN in 23.33% (N=7) ($p<0.05$). In terms of comorbidity disorders and the parameter of non-material damage no statistically significant differences were found either in PTSDF or PTSDN group.

Conclusion In terms of EPCACE there were statistically significant differences both in PTSDF and PTSDN group. Forensic and psychiatric meaning of PTSD encompasses a number of complex elements on which forensic expert opinion depends, while the existence of PTSD diagnosis itself does not affect creation of opinions. The study should serve to identify methodological and conceptual problems in the field of forensic aspects of PTSD.

Keywords: post-traumatic stress disorder; expertise; non-material damage

INTRODUCTION

Forensic psychiatric exploration of post-traumatic stress disorder (PTSD) is an important chapter in psychiatry. Exploration of a constellation of extreme traumatic experiences and mental disorders after traumatic experiences and their perception for the needs of the court dates back to much earlier times. Hamilton's text published in 1904, emphasising in the title "for judicial use", points out that, in addition to doctors and lawyers, it is also intended for the use in the courts. Numerous studies report a positive correlation between PTSD and increased use of alcohol, drugs and other medications [1, 2]. Brown and Wolfe in their study of subjects with clinically verified PTSD, 46% were those who used psychoactive substances [3]. There are numerous papers which mention that induction of psychosis is possible by means of PTSD or dissociative state after trauma, which in the later symptoms of PTSD have a significant role [4, 5]. In general, PTSD has serious effects on almost all spheres of life and work, while the specific impact of a high level of depression, suicidal tendencies and excessive alcohol use show that trauma can have long-term late effects, which is important for forensic psychiatric considerations [6, 7]. The diagnosis of anxiety, stress-related and somatoform disorders (labelled from F40-48 to ICD-10) does not in itself constitute grounds for incompetence or significantly reduced mental capacity. In most of entities of this group in principle there is "no alienation from reality", which significantly influences the opinion of experts for this diagnostic category. When it comes to certain entities in the group F40-48 to ICD-10 things can stand differently, especially when it comes to PTSD with a wide range of possible complications, late and lasting changes.

The relationship of PTSD and crime can be multidirectional. A criminal act may happen due to PTSD, but also PTSD may be the result of crime. When the crime is a consequence of PTSD it is usually related to the presence of dissociative phenomena ("flashbacks") with an additional contribution to a series of secondary contributing ("trigger") factors such as interpersonal conflicts, financial problems, previous motivation for criminal activity, etc., as well as the presence of "constellation" or "complication" factors. Very rarely the criminal act is a direct result of PTSD as a diagnostic category. PTSD as a result of actions evolves and can be present in the victim, but can be also present in the perpetrator (when crime is stressful for the offender and when it precedes PTSD). Forensic significance of PTSD results from a specific, typical symptoms and reactions, possible com-

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plications of PTSD, and late and lasting effects of PTSD and their manifestations. Depending on the degree of disorders changes, forensic psychiatric significance in the field of criminal or civil law also fluctuates. For a crime (offence against the law) related to the "complication" factor with PTSD (for example, excessive use of alcohol that developed on the basis of the underlying PTSD) the role of this factor in the mental domain is also considered [3, 4].

In practice, forensic significance of PTSD can be observed in a narrow and broad sense. Under PTSD (according to ICD-10) we mean a disorder with a maximum duration of two years (forensic significance of PTSD in the narrow sense), while the consequences of PTSD in the form of EPCACE after a catastrophic experience with a duration of over two years are seen as the forensic significance of PTSD in a broader sense. We must keep in mind possible symptoms associated with PTSD, which have such a quality that they can be classified as a separate entity (associated with anxiety, depression, etc.) and other affiliated separate entities (comorbidity) [5]. The simplest psychiatric assessment is when PTSD exists in isolation without associated symptoms and without comorbidity, which in practice is rarely encountered. Accountability of perpetrators can in this case be reduced, and very rarely is significantly reduced. More complex psychiatric examination is when PTSD is accompanied by associated symptoms, which is often encountered in practice. The responsibility of the perpetrators can then be reduced to a range of significantly reduced, with incompetence not being excluded, even though it is rare. The most complicated psychiatric assessment is when with PTSD one or more other diagnostic categories are present, each of which presents itself as a separate entity. The responsibility of perpetrators can then be significantly reduced, with incompetence not being excluded. PTSD is of great forensic importance especially in the post-war period. Specific constellations during and after the war include analysis of all relevant coincidental interaction factors in determining this significance. It is very important in PTSD to properly evaluate the relationship between traumatic stress disorder and psychiatric symptoms, as well as the correlation between psychiatric symptoms and a criminal act. It is important to differentiate between health consequences of catastrophic events of war with PTSD and without PTSD. War veterans with PTSD are at a higher risk of dermatological, gastrointestinal, ophthalmic, endocrine and cardiovascular diseases, when compared to veterans without PTSD [5, 6]. Forensic significance of PTSD can be seen in specific constellations such as PTSD-suicide, PTSD-homicide, PTSD-alcohol offences. The triad PTSD-alcohol-homicide can sometimes be present. Since alcohol lowers the threshold of tolerance to frustration and encourages aggression, constellation of the aforementioned triad should always properly appreciate the influence of all relevant factors. Particularly significant is the relationship of PTSD with comorbidity. The most common comorbid diagnoses with PTSD are mood disorders (depression), use of psychoactive substances (drugs) and other anxiety conditions. There is also a problem of "overlapping" of symptoms. According to the national comorbidity examination data in the United States, 59% of men and 44% of women with PTSD show criteria for 3 or more other psychiatric diagnoses. Studies have shown that in 80% of individuals diagnosed with PTSD, one or two more psychiatric disorders are also diagnosed, most commonly depression or anxiety states, neurosis or organic mental disorder. It is therefore necessary to consider the importance of crime related to PTSD in the context of the abovementioned relation of PTSD with comorbidity [7]. Forensic significance of PTSD in the broad sense is an analysis of EPCACE (lasting longer than two years). As EPCACE entity has its own peculiarities (according to ICD-10), forensic psychiatric process establishes all elements necessary for expertise. Usually, constellation factors have an impact and may reduce the ability of understanding actions and management practices [8, 9].

Criminal legal significance

PTSD is an entity that may be present before and/or after the crime, separately in the victim or perpetrator, or both, and it may also be present in the witness in the proceedings. Sometimes both the perpetrator and the victim have verified PTSD in the time before the offence was committed and/or after the offence was committed. Then you have to look at both sides and determine the elements related to the emergence and impact of PTSD during the offence. If there are reasons for it, possible impact of the victim in this work will also be analysed.

Psychiatric expertise of victims in criminal proceedings should answer the following questions: Can a victim of such behaviour (in time before the start of the act) initiate the act, or direct it in any direction, or act on its implementation, and also if he/she can have an active role in the segments of the act, etc.? Can mental state of the victim in terms of present PTSD affect the behaviour of perpetrators of crimes. Criminal act depends on the characteristics of perpetrators, victims and other factors. Homicide can be affected by emotional and social relationships, victim in the act of murder can play an active role; homicide can be triggered by provocative conduct of the victim. Usually relationships between victims and perpetrators are „burdened" with the past (earlier disagreements) when the motives for murder can be drawn from such relations.

Psychiatric expertise of the witness is to answer the question whether the testimony can be taken as reliable. This depends on the state of his mental health during temporae criminis and in time of giving evidence in court. People with PTSD can be reliable witnesses, if they had a neat observation at tempore criminis and reproduction of the observed in the time of giving evidence in court, otherwise they may give completely false statements.

Psychiatric expertise perpetrators of felonies with PTSD are performed in order to assess the capability of understanding the acts and management of procedures of temporae criminis. It is necessary to differentiate between parts of the offence connected with PTSD, parts in connection with morbid structure, analyze exogenous

provoking ("trigger") factors, and assess their motivation to act. In the dynamics of the offence difference must be observed between psychological and psychopathological processes. Present motivation refers to the psychological motives of the dynamics of offence. Unfortunately, when it comes to PTSD, psychological and psychopathological processes are largely intertwined, so an expert has a difficult task when he needs to assess the risk or consequences that result from the disorder itself. Experiences such as dissociative "flashbacks" of PTSD open a new dimension of observance of relationships when considering accountability, because these states fall into a category that can be treated as "temporary mental disorder" that in accordance with the law can result in incompetence.

Psychiatric expertise of PTSD associated with comorbidity disorders is of particular significance. PTSD associated with depression, personality disorders, alcoholism and other addictions, psychotic reactions, presents a better foundation for a much easier and faster development of conditions for delinquent and criminal behaviour. The core of the influences of common disorders associated with PTSD (alcoholism, drug addiction) affects the nervous system, so it disturbs logical thinking and rational behaviour by launching aggressive tendencies. Under such circumstances even a harmless situation may cause an uncontrolled turn which can result in murder or other felony. Exceptional significance is that of comorbidity of PTSD with psychotic disorders or diseases.

David and his associates mention 40% of veterans with resulting PTSD in hospital treatment showing proven psychotic symptoms [9, 10].

Forensic importance of consequences of PTSD in the form of EPCACE include among other things analysis of inflexible and poorly adaptive patterns of behaviour, changes in interpersonal, social and occupational functioning, recording of characteristics of individuals who previously did not exist (such as alienation, helplessness, vulnerability, social withdrawal, hostility attitude toward the environment, etc.) In the forensic psychiatric process determined are all elements and specific characteristics necessary for expertise. Usually "complication" factors for EPCACE may have a significant impact on the ability of understanding the acts and management practices. Criminogenic circuit which is in post-war conditions frequently encountered includes EPCACE, alcohol (or poly-addictions), unemployment, and aggression. It is necessary to clearly differentiate between "enduring personality changes after catastrophic experience" and other permanent personality changes. Characteristic impulsive and aggressive behaviour may be present in EPCACE, which can be dangerous to the victim-offender relationship, because a small provocation by the victim or even absence of it may result in disproportionate response by the offender with an uncertain outcome. Offenders with EPCACE are often characterised by diminished mental capability, rarely by complete mental responsibility, and very rarely by substantially reduced responsibility, and only exceptionally by incapability [11, 12].

Civil legal significance

Overall capacity (person's ability to perform legal actions to protect its rights and interests) when it comes to PTSD in most cases it is completely preserved (full legal capacity), can be significantly compromised or incompletely preserved (partial legal capacity), whereas in complex cases it can be absent (individuals with PTSD may be incapable for doing business). In practice, in cases of PTSD with comorbidity legal capacity may be questioned. In any such case it is necessary to appreciate the impact of individual elements and give an opinion based on the total impression of business skills in general. When a person with PTSD and with effects of the excessive use of alcohol or drugs is an immediate threat to their own rights and interests of others, he or she is in part deprived of legal capacity. When a person with PTSD or the consequences of PTSD is not able to care about their rights and interests, he or she is completely deprived of legal capacity (which is in practice very rare).

Expertise of contractual ability and validity of the contract (specific legal capacity) in patients with PTSD is a voluntary assessment of vocational and intellectual functions (reasoning ability) in "temporae acti". The expert needs to express opinion on the mental health of people "in tempore acti" for sales contracts, contracts of gift, lifelong care or other.

Testator capacity (specific business capability) can rarely be questioned with PTSD, except when in "tempore acti" any associated symptoms of PTSD have the quality of those upon which the other entity with the same symptoms would surely bring testator capacity into question. Since for this specific business capacity quantum of smaller capacity is sufficient, reasoning ability is crucial, and this ability is usually preserved with PTSD.

Expert Evaluation of non-material damage in people with PTSD and permanent consequences of PTSD is frequent in the post-war period. Expert Evaluation of non-material damages includes assessed suffered pain, fear, mental suffering (mental pain), reduction of general life activity and disfiguration. Physical pain and disfiguration are estimated as a result of hurt, if it exists with PTSD. Assessment of suffered fear and mental suffering is essential for PTSD. Psychological suffering is estimated based on specific emotional reactions to individuals with PTSD. Disorders of interpersonal, occupational and social functioning of EPCACE must be analyzed in the context of estimates for the expertise of general life activity. Assessment of suffered fear and physical suffering (mental pain) in patients with EPCACE is to be done by a psychiatrist. Thus, the assessment of general life activities in persons with EPCACE must be in the domain of psychiatrists. The primary fear implies a vital threat at the moment of catastrophic experience. Secondary fear then generally follows in the form of concern for the outcome of treatment, increases in the intervals with the emergence of flashbacks, and reduces in the majority of EPCACE over time. The fear leaves permanent sequels, in the case of EPCACE.

Disorders of interpersonal and social functioning of the EPCACE must be analyzed in the context of the estimates for the expertise of general life activities [12].

Expert Evaluation of associated craniocerebral injuries and other injuries with PTSD are common in post-war period (with prisoners, inmates, soldiers). Differentiation between symptoms of EPCACE (F62.0) and organic personality change (F07.0) in cases of comorbidity of these two entities is very difficult, sometimes impossible. To give a final opinion on the lasting effects of PTSD or a craniocerebral injury associated with PTSD a sufficient period of time (usually two to four years) should pass [13, 14].

Expert Evaluation of the ability to marry a person with PTSD is rare, while persons with a diagnosis of EPCACE (F62.0) due to the specificity of this entity can often be the subject of this testimony. Family Law, by considering and analyzing "misleading characteristic of the spouse" includes the possibility of annulment of marriage, among other things, in cases of "permanent, serious or dangerous diseases." Enduring personality changes can be serious in a way that they endanger the life of the patient, or paralyze life considerably, and may be hazardous to the environment or health or life of the spouse, and by definition are permanent, so EPCACE could be the reason for the annulment of marriage [12, 15]. Expert Evaluation of eligibility to get the right to raise children in divorce proceedings are tough when it comes to PTSD, and especially delicate when it comes to EPCACE. A multidisciplinary team should assess the marital situation and mental state of both parents (rarely is disorder present in only one parent!) [7, 16].

OBJECTIVE

The study examines the parameters in 30 patients with PTSD who are the subject of forensic expert opinion (PTSDF) and in 30 patients with PTSD who are not (PTSDN). Examined are socio-demographic variables, catastrophic experiences, EPCACE, associated disorders and non-material damage.

METHODS

Clinical research and the battery of tests included a total of 60 male subjects with a verified diagnosis of PTSD. Respondents, in accordance with ethical principles, consented to participate in the study. Respondents were administered the following questionnaires: the Impact of Event Scale (Impact of Event Scale – IES) [18]; Mississippi Scale for PTSD caused by war (Mississippi Scale for Combat-related PTSD) [19] and the adapted List of symptoms for PTSD-Military Version (PTSD Symptom Checklist – Military Version, PCL-M). In all subjects the diagnosis of PTSD was determined according to the criteria of ICD-10 classification. History of the disease, findings and opinions, complete medical records and confirmation from the unit (about wounding, capturing, etc.) were used. Statistical analysis: Results of data analysis were calculated using the Statistical Package for Social Sciences (SPSS 18.0) for Windows. We applied the Kruskal-Wallis and Mann-Whitney U-test with significance at $p<0.05$.

RESULTS

Sociodemographic variables and catastrophic experiences are presented in Table 1. In terms of average age of respondents, years of education, marital status, time of military engagement in PTSDF and PTSDN groups there were no statistically significant differences. All respondents have included at least one extreme catastrophic experience. In the PTSDF respondents 13.33% of all respondents (N=4) confirmed the existence of a single catastrophic experience, while 36.67% (N=11) confirmed the presence of two disastrous experiences, and 26.67% (N=8) confirmed the presence of three disastrous experiences, while 23.33% (N=7) of subjects confirmed 4 or more catastrophic events. Results for the PTSDN group had no significant deviations compared to the PTSDF group, and no statistically significant differences between the groups.

Enduring personality changes, associated disorders and non-material damage parameters are presented in Table 2. In terms of EPCACE, in PTSDF and PTSDN groups statistically significant differences were found. In PTSDF respondents (N=30) for which the relevant court order appointed an expert in regard to war damage 83.33% (N=25) were verified with EPCACE, while in PTSDN respondents EPCACE was verified in 23.33% (N=7). In terms of associated disorders and parameters for non-material damage, in PTSDF and PTSDN groups statistically significant differences were found. In 66.66% (N=20) of all (N=30) PTSDF respondents verified were associated disorders: personality disorders, depression, alcoholism, addiction and psychotic reactions, while in 73.33% (N=22) of all (N=30) PTSDN respondents verified were comorbidity disorders. Among the examined parameters of non-material damages, there

Table 1. Sociodemographic variables and catastrophic experiences

Variables		Number of patients	
		PTSPV group	PTSPN group
Age (years)	18–25	2 (6.67%)	1 (3.33%)
	26–35	11 (36.67%)	10 (33.33%)
	36–45	8 (26.66%)	10 (33.33%)
	≥46	9 (30.00%)	9 (30.00%)
Education (years)	4–8	10 (33.33%)	9 (30.00%)
	9–12	18 (60.00%)	20 (66.66%)
	≥13	2 (6.67%)	1 (3.33%)
Marital status	Married	24 (80.00%)	20 (66.66%)
	Unmarried	6 (20.00%)	10 (33.33%)
Military involvement (months)	0–3	2 (6.67%)	1 (3.33%)
	4–12	2 (6.67%)	3 (10.00%)
	13–24	2 (6.67%)	2 (6.67%)
	25–36	7 (23.33%)	6 (20.00%)
	≥37	17 (56.67%)	18 (60.00%)
Catastrophic experience (number)	1	4 (13.33%)	5 (16.66%)
	2	11 (36.67%)	10 (33.33%)
	3	8 (26.67%)	7 (23.33%)
	≥4	7 (23.33%)	8 (26.67%)

Table 2. Enduring personality changes, associated disorders and non-material damage parameters

Parameters	Number of patients	
	PTSPV group	PTSPN group
Enduring personality changes*	25 (83.33%)	7 (23.33%)
Associated disorders**	20 (66.66%)	22 (73.33%)
Impairment of general life activities (general viability)	24 (80.00%)	21 (70.00%)
Suffered fear and physical suffering	24 (80.00%)	23 (76.66%)
Physical pain and disfiguration	5 (16.66%)	4 (13.33%)
Craniocerebral injury	3 (10.00%)	2 (6.66%)

* $p<0.05$
** Personality disorders, depression, alcoholism, substance abuse, psychotic reactions

were differences but they were not statistically significant. In PTSDF respondents impairment of general life activities was verified in 80.0% (N=24), while in the PTSDN group it was for 70.0% (N=21). In terms of fear and suffered psychological suffering (mental pain) representation of PTSDF was found in 80.0% (N=24) subjects, and in the PTSDN group 76.66% (N=23). In a small number of PTSDF respondents, 16.66% (N=5) had physical pain and disfiguration, while in the PTSDN group 13.33% (N=3). In our material, 10.0% (N=3) had craniocerebral injuries associated with PTSD, while in the PTSDN group 6.66% (N=2).

DISCUSSION

As confirmed by our experience, individuals with PTSD often appear in cases of consequential non-material damage. The study included demographic variables, catastrophic experiences, exploration and analysis of aspects of personality and inflexible and poorly adaptive patterns of behaviour, changes in social, occupational and interpersonal functioning, recording of characteristics of individuals which previously did not exist (such as alienation, helplessness, vulnerability, social withdrawal, hostile attitude toward the environment, etc.) and consequently the associated disturbances, parameters of non-material damage in the form of reductions of general viability and suffered fear and mental suffering in PTSDF and PTSDN groups. The results which revealed a high level of association between comorbidity disorders and non-material damage parameters in the form of reductions of general viability and suffered fear and physical suffering in the PTSDF group are consistent with previous studies [15, 19-22].

To retrospectively determine the catastrophic experience before the advent of post-traumatic symptoms, we used the certificate (in units) or existing medical records. Based on the length of military engagement it can be concluded that the majority of respondents were exposed to multiple war traumas for a long time. Only 13.33% (N=4) of the respondents in the PTSDF group had only one catastrophic event. Analysis of EPCACE and associated disorders has special significance for the results of psychiatric evaluation. Obvious differences in terms of EPCACE in PTSDF and PTSDN groups were statistically significant (Table 2) but we could not compare them with similar studies because other studies had not been carried out. Out of all PTSDF respondents (N=30) 83.33% (N=25) were verified with EPCACE, while in PTSDN 23.33% (N=7) were verified with EPCACE, which supports the thesis that PTSDF respondents frequently have EPCACE (which is understandable since these are required by a court assessment of non-material damage). Despite confirmed differences in terms of EPCACE, in our test material, no difference was found in associated disorders (personality disorders, depression, alcoholism, addiction and psychotic reactions). Complication factors for EPCACE have a significant impact on the assessment of general viability. In PTSDF respondents the impairment of general life activities was verified for 80.0% (N=24), while in the PTSDN group 70.0% (N=21). Within the mental suffering of PTSD associated with injuries and/or disabilities, among other things, we appreciated suffering due to the disruption of continuity of ordinary life activities, pain due to treatment and during treatment and suffering due to long-term harm. In terms of fear and suffered psychological suffering (mental pain) representation of PTSDF was found in 80.0% (N=24) of subjects in the group, and PTSDN in 76.66% (N=23). A small number of PTSDF respondents (16.66%) (N=5) had coexisting physical pain and disfiguration, while in the PTSDN group 13.33% (N=3). In our material 10.0% (N=3) had craniocerebral injuries associated with PTSD, while in the PTSDN group 6.66% (N=2). Additional elements which were examined: fear resulting from mental suffering, physical pain and disfiguration, as well as craniocerebral injury; these results corresponded to those of previous studies [1, 3, 6, 15, 23, 24, 25].

Differentiation of symptoms of EPCACE (F62.0) and organic personality changes (F07.0) in cases of comorbidity of these two entities is very difficult (sometimes impossible!). Interweaving of affective, cognitive, behavioural and other disorders in these entities makes it highly difficult to make the differentiation. Development of services of Telepsychiatric system monitoring of catastrophic consequences of the experiences and implementation of Telepsychiatry in the judiciary sphere will contribute to the quality of perception of a wide range of forensic aspects of PTSD and EPCACE domains [11, 26, 27].

CONCLUSION

In terms of EPCACE for PTSDF and PTSDN groups statistically significant differences were found. In terms of average age of respondents, years of education, marital status, time of military engagement, associated disorders and parameters for non-material damage in PTSDF and PTSDN groups statistically significant differences were not found. The patient with PTSD requires involvement of a number of mechanisms in order to ward off further (secondary) traumatization, which is done to prevent criminal behaviour. Psycho-socio-therapeutic interventions, in particular adequate treatment and educational activities within the wider social environment, and the use of Telepsychiatry, significantly contribute to the prevention of criminogenic factors and antisocial behaviour.

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Судскопсихијатријска вештачења посттрауматског стресног поремећаја

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КРАТАК САДРЖАЈ

Увод Рад представља властита искуства у домену вештачења посттрауматског стресног поремећаја (ПТСП).

Циљ рада Истраживање испитује параметре код 30 испитаника са ПТСП који су предмет вештачења (ПТСПВ) и 30 испитаника са ПТСП који то нису (ПТСПН).

Методе рада Клиничким истраживањем и батеријом тестова (Скала утицаја догађаја – *IES*; Мисисипи скала; Листа симптома *PCL-M*) обухваћено је укупно 60 испитаника мушког пола с потврђеном дијагнозама ПТСП. Испитиване су социодемографске варијабле, катастрофични доживљаји, трајне промене личности (ТПЛ), удружени поремећаји и нематеријална штета.

Резултати У погледу просечне старости испитаника, година школовања, брачног стања и времена војног ангажовања између ПТСПВ и ПТСПН групе није било статистички значајних разлика. У погледу ТПЛ утврђене су статистички значајне разлике ($p<0,05$). ТПЛ је потврђен код 25 испитаника групе ПТСПВ (83,33%) и седам испитаника групе ПТСПН (23,33%). У погледу удружених поремећаја и параметра нематеријалне штете нису уочене статистички значајне разлике између две посматране групе испитаника.

Закључак У погледу ТПЛ утврђене су статистички значајне разлике између ПТСПВ и ПТСПН групе. Судскопсихијатријско значење ПТСП обухвата низ сложених елемената од којих зависи мишљење вештака, док егзистирање дијагнозе ПТСП, само по себи, не утиче на доношење мишљења. Истраживање би требало да послужи у препознавању методолошких и концептуалних проблема у домену форензичких аспеката ПТСП.

Кључне речи: посттрауматски стресни поремећај; вештачење; нематеријална штета