Vietnam on Trial: A Conceptual Framework for Presenting and Explaining PTSD in a Forensic Setting

C. Peter Erlinder, William Mitchell College of Law

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C. PETER ERLINDER

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Foreword

The Vietnam War was unlike any other war in our nation's history. The effects on the international and domestic policies of the United States were obviously profound. The deep political divisions created by the war continue to have an impact upon the way that millions of Americans view their government and themselves. For the Vietnam veteran, the impact of the Vietnam War runs far deeper than those who did not serve in the military can fully comprehend. Of the 2.5 million individuals who saw combat in Vietnam, approximately 1.5 million men and women continue to experience the psychological effects of the war.

The growing recognition of the deep seated psychic reactions to Vietnam, "The Vietnam Syndrome," has given rise to troubling questions about the source of this disorder. Why are we aware of this problem now? Were Vietnam veterans different, less tough, than veterans of other wars? Only recently have mental health professionals been able to provide some insights into why the Vietnam veteran seems to have suffered more than veterans of other wars.

As this article makes clear, Post Traumatic Stress Disorder (PTSD) has always been a consequence of war. Stephen Crane's Civil War novel, "The Red Badge of Courage," for example, indicates that psychological reactions to combat are nothing new. What is new, is the huge percentage of Vietnam combatants who suffered psychological after-effects and the delayed onset of many of the symptoms. A brief sketch of some of the differences between Vietnam and WW II illustrates some of the reasons for the intense psychic reaction to the Vietnam experience.

C. Peter Erlinder is Associate Professor of Law, William Mitchell College of Law. He was co-counsel and attorney of record in State v. Jearl Wood, one of the first successful defenses based upon PTSD. The author has consulted on numerous PTSD cases and speaks regularly to attorneys and mental health professionals on PTSD and related forensic issues.

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In Vietnam, the average soldier was 19 years old. In WW II, the average age was 26. Vietnam has accurately been labeled "our first teenage war." Many mental health professionals believe that this seven year difference is crucial in terms of the combatants' ability to successfully integrate their experiences. The average WW II soldier serving in the South Pacific saw six weeks of combat out of a three or four year tour of duty. The Vietnam soldier was exposed to hostile action for most of the 10-12 month tour of duty "in country." Thus, the exposure to combat-like situations was far more frequent for the Vietnam veteran. In WW II, the sacrifice in battle resulted in tangible results such as securing Iwo Jima or crossing the Rhine. In Vietnam, success was measured by repeated "body counts," very often in the same territory. The military objective was often not geographically strategic but, rather, was based upon the perpetual slaughter of human beings.

In WW II, a front line and a rear gave some form to the combat and an opportunity to withdraw from exposure to overt threat. In Vietnam, there were few parts of the country in which GIs could be assured of safety. Thus, the threat of combat, injury, and death were constant. Perhaps, most importantly, the "front line" could never develop, because our military was fighting an armed populace, not another conventional war machine. The most psychologically devastating result of this reality may well have been the necessity of treating all Vietnamese as possible combatants. Thus, our soldiers were encouraged, and often required, to perform acts of violence against women, children, the elderly, entire families, and villages. To survive, the American GI not only was forced to abandon the rules of war, but also the moral code that had governed behavior in the rest of life. The moral conflict, inherent in fighting that sort of war, was for many GIs, an immense weight to bear.

In addition, most combat soldiers were taken from the surroundings or stateside life, put into a year long, intense struggle for survival, and returned to the US almost overnight, without the benefit of a period of time to establish psychic decompression, moral justification, or societal support. The Vietnam warrior was forced to internalize the reactions to combat. Unlike the experience or the returning WW II "hero," no one wanted to hear of Vietnam experiences. Americans at home often directed their rage against government policy at the returning veteran who thought he had "done his duty for his country." Unlike any other returning American warriors, the Vietnam veteran struggled with the loss of comrades and innocence and memories of carnage without his community's support and without a clear reason for having sacrificed.

In studying the difficulties encountered by returning veterans in the 1960s and 1970s, mental health professionals identified and classified Post-Traumatic
Stress Disorder, a previously little known type of psychic disorder that is now recognized as an inevitable result of any highly traumatic experience. Thus, the experience or the Vietnam veteran has led to a deeper understanding of the reactions that all of us may experience following exposure to highly traumatic events. The only unusual aspect of PTSD and the Vietnam veteran is that two to three million individuals shared similar traumatic experiences: the Vietnam War itself.

Now that the effects of PTSD are understood, there are serious policy implications that confront our nation. Before we allow the government to commit young men and women to invading another nation, and to fighting an armed and hostile populace, we must understand that the costs of fighting a guerrilla war cannot be measured only in terms of deaths, physical injuries, and war-time budget figures. The real costs of trying to impose the will of the US government on independent peoples will be in excess of the apparent short term costs.

Today, a decade after Vietnam, the American people continue to bear the cost of family break-ups, substance abuse, employment problems, suicides and criminal behavior that result directly from the Vietnam War. Given this harsh legacy of the Vietnam War, we must decide whether we, as a society, are prepared to endure the costs of a Post-El Salvador or a Post-Nicaragua Stress Disorder. We, as a people, must understand that the long term costs of such military adventures can only be avoided by avoiding their source, unpopular military actions against indigenous people in their homeland.

The following article was prepared for presentation at the Third National Conference in the Treatment of Post Traumatic Stress Disorder in Baltimore, Maryland on September 25, 1984. Originally written for mental health professionals, it explores many of the issues that mental health professionals and attorneys must address in litigating PTSD cases. The conceptual context for PTSD litigation it suggests is a necessary starting point for effectively co-ordinating legal and mental health expertise in PTSD cases. The accompanying footnotes refer to a variety of additional sources that may prove helpful in applying PTSD to particular cases.

I. INTRODUCTION

The purpose of this article is to identify a framework for the presentation of PTSD in a forensic setting. It is not intended to address the diagnostic, treatment or ethical issues which may arise in stress cases. Rather, it will examine post traumatic stress disorder as a vehicle for explaining certain types of behavior that may have an impact on forensic issues and will identify the forensic problems peculiar to PTSD. It will outline the various applications of PTSD to legal issues and will
set out a framework that both attorneys and mental health professionals can use in presenting PTSD in the litigation context.

II. A LAWYER'S VIEW OF POST TRAUMATIC STRESS DISORDER

A. What is PTSD?

Post-Traumatic Stress Disorder is the designation assigned to a group of symptoms in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association (DSM III). Prior to 1980, when the most recent edition of the manual was published, the symptoms that are now grouped under PTSD were not included under a single diagnostic heading. The result was that prior to 1980, mental health professionals and attorneys lacked an accepted description of the symptoms now known as PTSD that could be used to diagnose and treat veterans. The absence of a recognized definition of these symptoms called into question the validity of the entire notion that reactions to traumatic events, such as combat could influence behavior long after the war. Recent research findings indicate that veterans have attempted to raise PTSD-like symptoms in criminal cases as early as the 1920s. Further, PTSD type symptoms can be seen in criminal cases following WW I, WW II, and the Korean War. Prior to 1980, however, the courts uniformly rejected defenses based upon these unexplained combat-related symptoms. Thus, the very real problems experienced by Vietnam veterans and others were often misdiagnosed, unrecognized, and untreated for almost a decade after the end of the Vietnam war. Veterans who attempted to seek help were often misdiagnosed as psychotic, substance dependent, or malingerers who suffered from a fictional malady.

PTSD, however, is far from being a fiction invented to get veterans "off the hook." While experts differ as to the incidence of PTSD in the population and its application in a particular case, there is little dispute as to the existence of stress reactions following trauma. The Veteran's Administration, for example, not only has adopted the diagnostic criteria for PTSD set out in DSM III, but has set up over 100 outreach centers which provide counseling for over 80,000 veterans who experience PTSD symptoms. PTSD is also recognized by the VA as a basis for disability claims. Both in-patient and out-patient treatment programs have been established in VA hospitals to provide treatment for veterans with symptoms of PTSD.

B. Who is affected by the Disorder?

Any principled description of Post Traumatic Stress Disorder must begin with the clear recognition that PTSD is not a new phenomenon in combat veterans, nor is it limited to veterans. A substantial body of research
exists which suggests that stress reactions among veterans have followed every major conflict in this century and, perhaps, are an unavoidable consequence of war. 11/ In addition, over the past several decades, research has indicated that reactions similar to the PTSD diagnostic criteria can be seen in such apparently diverse groups as the World War II Holocaust survivors, 12/ Hiroshima atomic blast victims, 13/ and survivors of other catastrophic events such as rape victims and battering victims. 14/ Thus, any attempt to present PTSD as a "Vietnam Veterans Problem" is clearly misplaced and tactically unwise. 15/

The fact that PTSD encompasses reactions to stressful events other than combat in Vietnam is borne out in the diagnostic criteria for PTSD in the Diagnostic and Statistical Manual of the American Psychiatric Association, which states in pertinent part:

The essential feature is the development of characteristic symptoms following a psychologically traumatic event that is generally outside the range of normal human experience. 16/

"Traumatic events" that can cause such a reaction include floods, earthquakes, car or plane accidents, bombing, torture, and, of course, combat. 17/

C. What are the Symptoms?

Following the original traumatic event, a person who suffers from PTSD may have a number of symptoms that include: self-medication through substance or alcohol abuse; 18/ memory loss; loss of sleep; nightmares reliving the original traumatic event; intrusive thoughts; exaggerated startle response; reduction in emotional response; a feeling of alienation; and "disassociative states..." during which the original event is relived and "the individual behaves as though experiencing the event of the moment." 19/ To a lay observer, these symptoms do not seem terribly surprising following a traumatic event of the magnitude described earlier. The more difficult aspect or PTSD for many to accept is that the symptoms of PTSD can occur long after the original traumatic event has ended. According to DSM III, symptoms may appear when emotional or environmental situations occur which approximate the original event. 20/ Thus, long after the original event, persons suffering from PTSD may react as though they were experiencing the original traumatic situation. 21/

D. How Can PTSD Govern Behavior?

PTSD, then, confronts attorneys and mental health professionals with a society-wide psychological condition that is unlike many more readily recognizable disorders. PTSD symptoms, for example, may mimic those of alcohol or
substance abuse. Because symptoms are episodic in nature, a client may not exhibit abnormal behavior characteristics during the lawyer-client interview, and PTSD may be overlooked. Often veterans who experience PTSD symptoms will deny a connection to Vietnam or will be unable to remember significant events which might indicate a PTSD connection.

The tendency to "reexperience" or "relive" the original event is common to those who experience PTSD symptoms after a traumatic event, whatever its source. However, for those trained in combat, a "reexperiencing" of the original event may include combat like reactions. DSM III, for example, specifically mentions "unpredictable explosions of aggressive behavior" as characteristic of war veterans with PTSD.

More recent studies have reported that this "explosive behavior" may be only one variant of the stress reactions experienced by veterans. For example, Dr. John Wilson and Dr. Sheldon Ziglebaum have suggested that at least three types of PTSD reactions can be seen in the veterans they have interviewed and treated: (1) a dissociative reaction in which the veteran behaves as he did in combat; (2) a compulsive "living on the edge" response in which the veteran repeatedly seeks out dangerous or highly stimulating situations; (3) a profound "survivor guilt" reaction which leads to intense despair, suicide attempts or attempts to get caught, punished or killed.

As one might expect, these reactions may lead to behavior that has a wide range of legal implications for veterans. Some authorities have suggested that 25% to 30% of Vietnam veterans who experienced heavy combat have been arrested on criminal charges. In addition, high suicide rates, substance abuse, marital difficulties, and employment problems, all of which have legal implications, occur more frequently among Vietnam veterans who saw heavy combat than among the general population.

For attorneys, probably the most important conclusion that can be drawn from these studies is that PTSD can affect virtually every aspect of a veteran/client's behavior. Additionally, the effects may be subtle, and, if Wilson and Ziglebaum's suggestions are correct, the effects of PTSD on veterans may not appear to be related to combat at all. For attorneys untrained in psychology or psychiatry, this implies a duty to examine with care a client's psychological history for a PTSD connection, even when the relationship is not readily apparent.

E. PTSD Differs Conceptually from other Disorders

PTSD differs conceptually from other disorders in that PTSD is a psychological condition brought about by
factors external to the person who experiences symptoms. The importance of this fact is that, unlike many other psychological disorders, it is possible to point to specific events to establish a logical or a causal link to client behavior. 37/ As a result, once PTSD is found to be a factor in client behavior, it may be possible to describe in a systematic and logical manner the events that brought about the acts in question. 38/ This means that PTSD requires far less of the "leap of faith" based upon expert opinion than do some other psychological disorders. Perhaps most importantly, and perhaps because PTSD is brought about by external factors, many health professionals agree that PTSD is highly amenable to treatment. 39/ Thus, it is possible to explain a client's behavior in a specific setting as a reaction to certain conditions without also requiring the conclusion that the client is beyond treatment or that the behavior will necessarily recur. 40/

III. PTSD AS A FORENSIC ISSUE

Post Traumatic Stress Disorder has been used in both civil and criminal cases in which the state of mind of a particular individual or a member of a group is relevant to a legal issue. It has been accepted by courts in more than 20 states and several federal districts. 41/

A. Civil Damages

In a civil context, PTSD-related issues typically arise in the proof of damages sustained by an individual following a particularly traumatic incident. Cases involving PTSD have included plaintiffs who were survivors of both man-made and natural catastrophes. In this context PTSD may be presented as a way of allowing the court to take into consideration the psychological harm sustained by an individual in assessing the damages arising from a particular event.

B. Criminal Prosecutions

In a criminal context, Post Traumatic Stress Disorder has been used by both prosecutors and defense attorneys to assist in establishing the state of mind of an individual at a particular time. In situations where consent has been advanced as a defense in rape cases, prosecutors have attempted to introduce Post Traumatic Stress Disorder to corroborate a prosecution witness's testimony that she had been raped and to rebut the assertion by the defense that the sexual conduct was consensual. 42/ In such situations, the success of the prosecution often depends upon a battle of oaths between the accused rapist and the alleged victim. Thus, the existence of Post Traumatic Stress Disorder symptoms has been advanced as a way of allowing either the judge or the jury to conclude that the alleged victim's testimony is credible.
C. Criminal Defense

Defense attorneys have also found that PTSD can be helpful in explaining the state of mind of particular clients. 43/ Post Traumatic Stress Disorder has provided the basis for testimony regarding the mental state of those accused of both violent and nonviolent offenses, 44/ and it has been used in cases involving both male and female defendants. 45/ While no precise figures are available, it appears that Post Traumatic Stress Disorder is being advanced in criminal cases with increasing frequency under theories of insanity, diminished capacity, self-defense, or as a basis for a conviction for a lesser included offense. Since the state of mind of a defendant is an integral part of every criminal prosecution, it is logical that defense attorneys would introduce evidence of thought disorders, such as PTSD, to attempt to establish that defendants were not legally responsible for their acts or that they had a mental state which would result in less than criminal culpability or, following conviction, that the existence of a psychological disorder be taken into consideration by the court in assessing proper punishment. PTSD has most often been the basis for expert testimony in defending battered women in self-defense cases and Vietnam veterans in criminal responsibility defenses.

IV. A CONCEPTUAL FRAMEWORK FOR INTRODUCING PTSD IN A FORENSIC SETTING

The most important aspect of any case involving PTSD is properly preparing the case prior to trial. Given the role of expert witnesses in judicial proceedings and the peculiarities of Post Traumatic Stress Disorder, it is possible to develop a step by step approach that can be applied to most cases in which PTSD is likely to be at issue. I again must emphasize that I make no attempt to address the diagnostic or treatment issues which may be attendant to the procedure that I will describe. Rather, I will begin with the assumption that a diagnosis of PTSD has already been made. However, since the accuracy of the diagnosis is a predictable issue in litigation, some of the techniques suggested may assist in providing a basis for a more accurate and more confident diagnosis. Much of this paper will refer to PTSD in cases involving Vietnam veterans. However, the same techniques are appropriate in other cases in which PTSD is an issue.

A. What is Unique About PTSD as a Forensic Issue?

Because PTSD is a psychological disorder which is attributable to identifiable incidents external to the individual, it is possible and necessary to describe very logically, and in great detail, the factors which compel the conclusion that PTSD is a factor in client behavior. If the diagnosis is accurate, a mental health professional should be able to look to objective data from
before and after the traumatic event which would lead to the conclusion that Post Traumatic Stress Disorder is present. If expert witnesses testify to opinions that a factfinder cannot test empirically, it's unlikely that the testimony will carry much weight.

B. A Framework for Explaining the Diagnosis

In order to demonstrate to a factfinder that the conclusion regarding PTSD is correct, it is necessary to examine closely three well-defined time periods that are related to the onset of PTSD:

(a) the time period preceding the traumatic event

(b) the traumatic event itself

(c) the time period following the traumatic event in which behavioral changes can be observed.

Furthermore, in criminal defense cases, a logical link must be established between the criminal conduct and PTSD.

VERIFICATION AND CORROBORATION OF PTSD DIAGNOSIS WITH AN EYE TOWARD TRIAL. THE NEED FOR OBJECTIVE DATA.

Often, it is possible to rely on patient-reported information to develop a working hypothesis with regard to the diagnosis. However, if forensic issues are likely to arise, such patient-reported data are probably not sufficient to sustain the opinion through skillful cross examination. An expert who relies upon client reported data should be aware that a healthy skepticism exists in litigation for potentially self-serving client behavior or statements. As a result, it is absolutely necessary to verify every major fact upon which the mental health expert relies in making the diagnosis. This involves considerable research into the client's history and may involve accumulation of medical records, school records, reports from any friends, family members or acquaintances, and any other objective records which support the existence of facts reported by the client. These reports are essential to help reduce the likelihood that the events upon which the opinion is based were created. This list should not be thought of as exhaustive; resourcefulness in verifying client data on a case by case basis will certainly be the most effective procedure.

A. Behavior Prior to the Traumatic Experience

Since observable changes in behavior are clearly part of the diagnostic criteria in DSM-III, and because it may be argued that post-trauma symptoms were actually
based on other pre-existing disorders, it is necessary to
document a client's history as thoroughly as possible.
This investigation should include inspecting all hospital
and medical records, military or veteran records when
applicable, records from educational institutions,
juvenile records and criminal records, where applicable,
and any other source of written records which may reflect
reports of client behavior. Interviews with family,
friends and acquaintances are invaluable in developing an
understanding of the client's behavior prior to the onset
of symptoms and may provide corroboration for client-
reported information.

B. Describing the Traumatic Event

The importance of developing a detailed description
of the traumatic event which precipitated the stress
reactions cannot be overemphasized. It is absolutely
essential to document thoroughly the precise nature of
the experience as seen through the eyes of the client.
Such an inquiry may be difficult and painful for the
client, and objective data may be difficult to accumu-
late. However, since it is necessary for a fact finder
to conclude that the traumatic event was beyond "normal
human experience," and because, at least in criminal
cases, it may be necessary to demonstrate that subsequent
behavior is related to the traumatic incident, a thorough
investigation of the emotional and environmental stimuli
associated with the traumatic event must be undertaken.
In the case of victims of crime or disaster, it may be
possible to accumulate data from reports made at the
scene by police officers or by others acting in an offi-
cial relief capacity. Reports made to others, and par-
ticularly reports which are recorded and made contem-
poraneous with the event, carry in the law a greater
measure of reliability than subsequent reports of the
event made when a reason to fabricate may exist.

An extremely important source of information for
verifying the traumatic event may be the reports of oth-
ers who experienced or witnessed the event. In criminal
cases involving Vietnam veterans, for example, reports
which have proved most successful are those in which the
Vietnam experience of the defendant was described in
great detail by either the defendant or by those who
served with the defendant. In at least one case, a jury
found that a Vietnam veteran was not responsible for his
actions without having heard any testimony from the
defendant. In People v. Jearl Wood, testimony of the Viet-
nam experience came solely from people who had served
with the defendant in Vietnam. The effect of this tes-
timony was to help the jury understand and experience the
events which were at the heart of the trauma and which
might be the sort that would cause subsequent behavioral
psychological reactions.
C. Behavior Following the Traumatic Incident

The Diagnostic and Statistical Manual sets forth diagnostic criteria for Post Traumatic Stress Disorder which requires an examination of the client's behavior for a period following the traumatic incident. Like the testimony regarding pre-trauma client behavior, reported data are likely to be suspect in a litigation proceeding. Therefore, it would be most helpful to verify reports of client behavior from other sources. In this respect, hospital records, school records, reports from friends, employment records, and other sources of data recorded at the time of onset of symptoms would be helpful. Of course, it is only after presenting this description of symptomology to a court that the basis for a diagnosis can effectively be explained. In cases in which a diagnosis of PTSD has been made, a detailed analysis of the relationship between client behavior and the diagnostic criteria in DSM-III pinpoint the behavioral characteristics reported by the client, and especially those reported by others, that are consistent with the diagnostic criteria in DSM III.

VI. PTSD: Making the Link to Criminal Behavior

In cases in which PTSD is advanced as part of a defense theory, the issue most often is whether the post-traumatic stress disorder so impaired functioning that the defendant was unable to form the mental state necessary to be held criminally liable. The same procedures are generally applicable to both self defense and responsibility.

A. PTSD as a Logical Explanation for Irrational Acts

In this context, it is absolutely imperative for the mental health professional to examine carefully all of the details about the incident in question. If Post Traumatic Stress Disorder is, in fact, the precipitating cause of the client's behavior, it should be possible to point to specific aspects of the traumatic experience that have brought about the subsequent traumatic reaction. A common feature of cases in which juries have acquitted Vietnam veterans has been drawing a direct link between the behavior on trial and the behavior of the individual in the traumatic situation in Vietnam. Moreover, women's self defense cases are usually built around the reasonableness of a woman's violent act in light of prior traumatic incidents. In these cases, a detailed analysis of battering incidents and their effect on the woman's perceptions of threat are essential. 46/

B. Supporting the Conclusion that PTSD Gave Rise to the Behavior in Question.

In one case, experts explained that the location of a shooting incident was so similar to the site of a
battle and that, combined with other stressful events, such as the loss of a spouse, a relation back to the original experience occurred, which caused the ensuing shooting incident. In another case, industrial plant conditions combined with other ideational factors caused a relation back to situations similar to the experience in Vietnam. The relationship between the experience in Vietnam and the behavior at issue required a detailed description of the exact experiences which occurred in the plant and in Vietnam. Particularly in cases in which PTSD is called upon to explain client conduct in criminal cases, establishing this logical link between the behavior complained of and the behavior during the original trauma is absolutely essential.

VII. POST-CONViction STRATEGIES

For veterans convicted of offenses before the inclusion of PTSD in the DSM III in 1980, it is unlikely that PTSD was ever raised either as a defense or at sentencing. 47/ For these veterans, or for those convicted after 1980 who had attorneys unfamiliar with PTSD, strategies must be devised to raise PTSD in a context that will allow the criminal justice or penal system to take PTSD into account in determining the appropriate disposition of the case. Although there are no reliable figures on the number of Vietnam veterans who are incarcerated, the estimates range from a low of 49,000 to as many as 125,000. 48/ When the number of veterans on parole, probation or awaiting trial are added to those figures, the size of the problem is readily apparent. 49/

Currently, few programs exist for incarcerated veterans to receive counseling or treatment for PTSD while incarcerated. 50/ A notable exception is the Veterans In Prison Project administered by the Veterans Administration hospital in Brentwood, California 51/ and efforts by the Wisconsin Public Defender's Office to provide a veteran liaison to identify veterans and help arrange treatment or counseling. 52/ A study of incarcerated veterans in Massachusetts found that they were far less likely to have had criminal backgrounds than the general prison population, and that they experienced fewer adjustment problems in the institution. 53/ In the absence of an institutional diagnosis, screening and treatment programs, however, it is not at all certain that incarcerated veterans will be able to identify their own difficulties as PTSD related, or that they will receive counseling. 54/ Without such intervention, there is little to insure that PTSD related criminal problems will not be repeated. The best response to this state of affairs is for attorneys and mental health professionals to develop strategies that will allow the corrections system, or the judiciary, to respond to the needs of veterans. These strategies include presenting PTSD in parole hearings, in motions to reduce sentence, or even in post conviction petitions.
A. Parole Hearings

An example of the sort of petition that might be submitted in support of a parole plan that takes PTSD into account was prepared by attorneys from the Veteran's Law Center in a Virginia murder case. 55/ In a well-documented presentation, the petition makes the important point that, had PTSD been understood at the time of the offense, the outcome of the trial might have been different. 56/ In addition, it sets forth a description of PTSD with supporting footnotes, a complete history of the client, a description of the homicide incident, the client's prison history and a parole plan. 57/ The petition is supported by a psychiatrist's report which makes the PTSD diagnosis, and includes a treatment plan, military records, family history, and post-Vietnam history. 58/

B. Sentencing

An example of a successful motion to reduce sentence may be found in US v Krutschewski. 59/ The defendant in Krutschewski 60/ was convicted of multiple drug-related charges and was sentenced to consecutive 5-year terms and a fine of $60,000. 61/ The Vietnam Veterans of America, as amicus curiae, file a memorandum in support of the motion that persuasively set forth the argument that, in the case of a veteran defendant, an "appropriate" sentence must take both military service and PTSD into account as substantial mitigating factors. 62/ The trial judge in Krutschewski was empowered to hear the defendant's petition for a modification of sentence pursuant to Rule 35 of the Federal Rules of Criminal Procedure. 63/ The success of the petition is demonstrated by the fact that the order issued by the court in response to the motion allowed the defendant to be paroled prior to serving the minimum one third of his sentence. Usually, a defendant must serve one-third of his sentence before a court will consider parole. 64/

Since Krutschewski was a federal prosecution, Rule 35 provided the legal basis for filing the petition for a reduction in sentence. It should also be noted that Krutschewski was a case in which PTSD had been raised both at trial and at sentencing. 65/ Thus, unlike many cases involving veterans, the relationship between PTSD and the criminal conduct had already been established. 66/

In jurisdictions in which procedural devices analogous to Rule 35 exist, petitions which include diagnosis and treatment plans similar to the Veteran's Law Center petition mentioned earlier may have value. In many jurisdictions, however, procedural mechanisms, such as Rule 35, which would allow reconsideration of sentences or determinations of liability, may not be available. 67/
However, many jurisdictions require courts to consider factors in mitigation and aggravation in reaching a sentencing decision. 

Arguably, a failure to consider PTSD as a factor either in determining liability or in sentencing may contravene the procedural rights of the defendant. An example of a case in which this strategy was successfully employed is State v Dobbs. In Dobbs, attorneys for the defendant argued that failure to take PTSD into account in sentencing required a new sentencing hearing. Following that hearing, the defendant's sentence was reduced from seven-and-one-half years of hard labor to the three years already served.

C. Post-Conviction Petitions

A possible strategy for allowing the court to consider the impact of PTSD in liability and sentencing may exist in creative uses of post-trial petitions or habeas corpus petitions. One potential basis for raising PTSD in a post-conviction context arises from the relatively recent inclusion of PTSD in the DSM III. The certification of PTSD as an identifiable psychological disorder may be presented in the nature of newly discovered evidence. Like a blood sample or fingerprint that defies classification until science develops to understand its significance, the relationship between PTSD and criminal behavior could not have been introduced until after PTSD was identified.

1. Recently Discovered Evidence

This theory provided the basis for a post-conviction petition filed in a ten-year-old murder conviction in Arizona. In State v Jensen, an unreported opinion, the Arizona Supreme Court granted the defendant's petition for post-conviction relief on the issue of PTSD as recently discovered evidence. The case was remanded to the trial court for a hearing as to whether the failure to introduce PTSD at trial in 1973 would have had an effect upon the verdict or the sentence. In that hearing the defense introduced testimony establishing that he suffered from PTSD at the time of the offense. Further, the defense introduced testimony from several experts tending to show that, prior to the publication of DSM III in 1980, a competent attorney would not have been able to establish the relationship between Vietnam service and criminal conduct. In addition, there was some indication that experts who testified at the original trial perceived psychological abnormalities related to Vietnam service. However, they were not able to explain the relationship between the Vietnam experience and the defendant's behavior at the time of the original proceeding.
2. Ineffective Assistance of Counsel

Convictions of veterans that occurred after the promulgation of PTSD by the American Psychiatric Association in which counsel failed to raise PTSD may be attacked on grounds that competent counsel should have investigated or presented PTSD. 83/ It can be argued that attorneys who represent veterans fail to provide adequate representation if they fail to explore such a widespread disorder as PTSD. The competency-of-counsel argument was successful in overturning a 1979 conviction that was, the subject of another unreported opinion. In State v Cohea, a California appellate court granted a new trial based upon the defendant's assertion that the attorney at the previous trial in which the defendant had been convicted of murder had failed to explore the implications of his Vietnam experience. 84/ In 1983, the defendant was found guilty of manslaughter, a lesser offense in a jury trial in which PTSD was advanced to explain the defendant's behavior during the criminal act. 85/

VIII. PREPARING TO LITIGATE PTSD-RELATED ISSUES

In thinking about Post Traumatic Stress Disorder in the forensic context, it is extremely important for mental health professionals to remember that, although attorneys often deal with questions that involve litigation, they rarely deal with issues that have psychological or psychiatric implications. Attorneys receive no training that will assist them in understanding the methodology used by mental health professionals. The result is that, in cases involving PTSD or other psychological disorders, it may be necessary for mental health professionals to educate attorneys in the proper presentation and preparation of these psychological issues. The most successful presentation of Post Traumatic Stress Disorder usually results from a collaboration between the mental health professional and the attorney in order to establish a clear understanding of the legal, ethical, and psychological issues which are implied in the case. The following is a checklist of issues which should be addressed either by the mental health professional, the attorney, or both, when the introduction of any testimony regarding PTSD or other psychiatric issues may arise in a forensic context.

A. Preparing to Testify

1. Independently verify all of the data upon which the diagnosis is based.

2. The attorney should explain all of the testimony that is expected to be introduced at trial. The mental health expert should understand the testimony of opposing experts and obtain copies of those reports, if possible.
3. The attorney should explain the exact legal issues upon which the expert testimony bears. It is only by understanding the underlying legal issues, and what each side must prove in relation to those issues, that an expert will be able to understand the nature of the questions advanced by either advocate.

4. Prepare in detail testimony with the attorney. The attorney should be able to provide a list of questions for direct testimony. In addition, the PTSD expert may suggest to the attorney questions which will help explain PTSD. Since questioning on direct testimony requires open-ended questions, it will be helpful for the PTSD expert and the attorney to know in advance the sequence and thrust of the questions.

5. Prepare for cross-examination by having another attorney cross-examine the PTSD expert as if it were an actual trial. In every case there are at least two points of view and this "testing" in a trial-like setting will help the PTSD expert clarify the potential problems in the case.

6. Make certain to ask the attorney about the discovery rules which apply to the particular case. Discovery rules require that each side disclose to the other certain reports and failure to do so may cause some testimony to be excluded. Make certain, before embarking on the case, that the experts understand which reports are likely to be introduced into evidence and which reports may have to be disclosed to the opposing counsel. Once the expert has reached a diagnosis that is based on a "reasonable professional certainty," it would be best to stick to that diagnosis and allow the factfinders to assess how that diagnosis fits with the other evidence they have heard.

Make the attorney aware of any contradictions or difficulties that arise in reaching the diagnostic conclusion. Often, such apparent contradictions may be explained in a more thorough development of the facts. For example, in the case of People v Jearl Wood the assessment of Mr. Wood was based upon his "confession" that he had put a gun to the head of the victim. However, the prosecution's witness established at trial that the victim and Mr. Wood never got any closer than approximately twenty feet from each other. The result was that when properly explained, the "confession" supported the contention that the client was not fully aware of his conduct at the time the shooting occurred.

B. Once the Trial Begins

1. Once the trial has begun, inquire of the attorney about everything that has preceded your testimony to fully understand what the factfinder knows about the case and about your area of expertise prior to your testimony.
Failure to do this may result in talking above or beneath the level or understanding already garnered in court.

2. If, during the course or testimony, your memory fails, do not hesitate to ask for notes which may refresh your recollection. The law makes allowances for failure of memory on the witness stand, and anything from a newspaper report to handwritten notes to reports can be viewed to refresh "recollection." Reading from the report, however, is usually not acceptable unless the precise language in the report is important.

3. Find out as much about both attorneys as possible. Very often the "human" enterprise of litigation is affected by the relationships that exist in the trial itself. Try to assess beforehand how your method of explaining your diagnosis is likely to affect the persons in the proceedings.

4. Use visual aids when possible to help the factfinder follow your explanation. Large photographic blow-ups of DSM III, photographs, tape recordings, slides, movies, diagrams, and models are all usually admissible to help illustrate your testimony. Most successful PTSD cases have made use of these aids to help judges and juries experience the conditions which gave rise to PTSD and to understand the relationship to DSM III.

C. Educating the Attorney and the Court

One of the most crucial aspects of presenting PTSD at trial is establishing that Post Traumatic Stress Disorder is sufficiently recognized in the profession to be a valid diagnostic technique. Because most attorneys are not trained in the behavioral sciences, and because very few cases ever directly involve psychological testimony, few attorneys are prepared to adequately present to the court the scientific foundation for PTSD. As a result, it may be necessary for you to educate the attorney as well as the judge about the existence of PTSD and the scientific underpinnings for the diagnostic criteria mentioned in the DSM.

It is important that attorneys understand the significance of the Diagnostic and Statistical Manual published by the American Psychiatric Association and to understand what the American Psychiatric Association is, and how the DSM is used. In addition, it may be helpful to refer them to some of the work regarding reactions to trauma by such researchers as Drs. Figley, Wilson, Egen-dorf, Lifton, and others. It also may be helpful for judges and attorneys to understand that Post Traumatic Stress Disorder has been recognized as a service-connected disability for Vietnam veterans. Mental health professionals should be prepared to direct attorneys to the relevant literature to help them establish with the
court that PTSD is recognized by a substantial proportion of the profession and is referred to in a growing body of literature. This will establish that Post Traumatic Stress Disorder like other sorts of psychological disorders, is not a "figment of the imagination."

Conclusion

It is important to emphasize that the suggestions made in this paper are intended to serve as a vehicle for raising the PTSD issue before the trial or appellate court. They are premised on the assumption that a just result can occur only after the court has had an opportunity to have a full description of all of the factors related to an offense. In a very real sense, veterans and others affected by PTSD who have not had that fact presented either at trial or sentencing have not had their day in court. The above suggestions for raising PTSD-related issues on behalf of a client should not, however, at this time be considered definitive. Attorneys should consider other theories, or undertake legislative action to ensure that psychological evaluations and PTSD treatment be made available to all Vietnam veteran defendants.

FOOTNOTES


Diagnostic criteria for Post-Traumatic Stress Disorder:

A. Existence of a recognizable stressor that would evoke significant symptoms of distress in almost anyone.

B. Reexperiencing of the trauma as evidenced by at least one of the following:

(1) recurrent and intrusive recollections of the event
(2) recurrent dreams of the event
(3) sudden acting or feeling as if the traumatic event were reoccurring, because of an association with an environmental or ideational stimulus.

Numbing of responsiveness to, or reduced involvement with, the external world, beginning some time after the trauma, as shown by at least one of the following:

(1) markedly diminished interest in one or more significant activities
(2) feeling of detachment or estrangement from others
(3) constricted affect

D. At least two of the following symptoms that were not present before the trauma:

(1) hyperalertness or exaggerated startle response
(2) sleep disturbance
(3) guilt about surviving when others have not, or about behavior required for survival
(4) memory impairment or trouble concentrating
(5) avoidance of activities that arouse recollection of the traumatic event
(6) intensification of symptoms by exposure to events that symbolize or resemble the traumatic event

2. The original edition of the Diagnostic and Statistical Manual, published during the period of the Korean War, included a diagnostic category for "Gross Stress Reaction" that referred to combat as a precipitating factor. American Psychiatric Ass'n, Diagnostic & Statistical Manual of Mental Disorders 40 (1st ed. 1952). "Gross Stress Reaction" was dropped in the 1968 edition of the Manual, and the symptoms were categorized under "Transient Situational Disturbances." For a review of the development of the two previous editions, see Spitzer, Introduction to American Psychiatric Ass'n, Diagnostic & Statistical Manual of Mental Disorders (3d ed. 1980).

3. Id.


6. Rating Practices and Procedures, Veterans Administration Memorandum PG 21-1 Sec. 0-12 at 1-3 (revised June 30, 1981). See also 38 C.F.R. Sec. 4.132 (1y_).


supra note 18, at 236.

11. For an historical review of reports of psychiatric disorders arising from combat, see Note, Post Traumatic Stress Disorder — Opening Pandora's Box, 17 New Eng. L. Rev. 91, 92–99 (1981).


17. Id.

18. Id at 237.

19. Id. at 236–237.

20. Id. at 237.

21. Id. at 236–237.

22. In People v Wood, the defendant sought treatment for alcoholism only to find that the source of the alcohol abuse was an attempt to self medicate the effects of PTSD. See also Diagnostic & Statistical Manual (3d ed. 1980), supra note 1, at 237; Walker, Vietnam Combat Veterans with Legal Difficulties: A Psychiatric Problem, 138 Am. J. Psychiatry 1384 (1981)

23. For example, in at least two of the cases that are the subject of this article, People v Wood 80–7410 (Cir. Ct. Cook County Ill., May 5, 1982) and State v Heads, No 106, 126 (1st Jud. Dist. Ct. Caddo Parish, Oct. 10, 1981), the attorneys representing the veteran defendants were unaware that PTSD could be a factor in client behavior. In Heads, the connection was made only after an earlier conviction had been reversed on appeal. In Wood, a one line notation in a hospital record from a year before the offense mentioned, "patient reports nightmares about Vietnam." That notation led counsel to begin exploring the client's military history. In both cases, had counsel not investigated the client's service history and reactions after Vietnam, the connection would
probably never have been made.

24. This problem is not limited to the attorney-client setting. Veterans have developed a mistrust of authority figures, and a "chip-on-the-shoulder" attitude often sets up an "adversarial relationship even in a treatment context." Walker & Cavenar, supra note 4, at 175. The description of PTSD in DSM III also makes it clear that memory impairment is characteristic of the disorder, Diagnostic & Statistical Manual (3d ed. 1980), supra note 1, at 236.

25. Id.
26. Id.
27. Id. at 237.
28. See Wilson, supra note 13; Dondershine, supra note 8.
29. Wilson, supra note 30, at 8.
30. Id. at 9.
31. Id. at 11.
32. Schulz, supra note 4, at 2401; Dondershine, supra note 8, at 4.
33. The suicide rate among Vietnam Veterans is 23% higher than the same age group in the general population.
35. See supra text accompanying notes 29-31.
36. See infra notes 83-85.
37. For a discussion of the importance of making the specific connections between the Vietnam experience and the conditions that brought about the criminal behavior, see the discussion of the Heads and Wood cases at notes 81-128. See also Jack The Vietnam connection: Charles Heads' Verdict, 9 Crim. Def. No. 1 at 7 (1980)
39. See J. Wilson, Towards An Understanding of
Post-Traumatic Stress Disorder Among Vietnam Veterans (testimony before US Senate Subcommittee on Veteran's Affairs, May 21, 1980, Wash. DC). In its first year of operation, for example, the Veterans Outreach Program reached some 80,000 veterans and provided successful treatment in 60% of the cases. Wilson, supra note 7.

40. The importance of this aspect of PTSD is apparent when treatment programs are suggested in lieu of incarceration or other punishment. See Erlinder, infra note 41.


42. See Burgess, Rape Trauma Syndrome, Behavioral Sciences & the Law, Vol. 1, No. 3 (1983) at 97. See also State v Middleton, 648 P.2d 1296 (Or. Ct. App. 1982); State v Marks, 647 P.2d 1292 (Kan. 1982); State v Mackie, 622 P.2d 673 (Mont. 1981); State v LeBrun, 587 O.2d 1044 (Or. Ct. App. 1978); Minn. v Saldana, 324 N. W.2d 227 (Minn. 1982); People v Matthews, 154 Cal. Rptr. 628 (1979).

43. See Raifman, Problems of Diagnosis and Legal Causation in Courtroom Use of Post-Traumatic Stress Disorder, Behavioral Sciences & Law, Vol. 1, No. 3 (1983) at 112.


45. See Raifman, supra note 43 at 118. See also Ibn-Tamas v US, 407 A2d 626 (D.C Cir 1979). See generally Burgess supra note 44.

46. See Erlinder, supra note 41, supra.

47. See supra discussion accompanying note 41.


49. As of 1974, 37,000 veterans were on parole, 250,000 veterans were on probation, and 87,000 veterans were awaiting trial. Presidential Review Memorandum on Vietnam Era Veterans, H.R. Rep. No. 38, 96th Cong., 1st Sess. 32 (1979).
50. See May, supra note 48 at 6.

51. Telephone interview with Mr. Bruce Pentland, Director, Veterans in Prison Project (Mar. 8, 1983).

52. Telephone interview with Mr. David Niblack, Esq., Madison, Wis., Wis. State Public Defender (Mar. 9, 1983).

53. See May, supra note 48, at 6

54. Id.


56. Id. at 1.

57. Id. at 3-17, 28-34.

58. Id. at 37.


62. Supra note 59, at 3.


64. Id.

65. Id.

66. Id.

67. In Illinois, for example, the trial court loses jurisdiction 30 days after the last action taken. Ill. Rev. Stat. Ch. 110A Sec. 606 (Smith Hurd 1982). As a result, motions for modification of sentence or for a new trial may not properly be heard in the trial court after that time. See People ex rel Carey v Scotillo, 84 Ill. 20170, 417 N.E.2d, 356 (1981), and People v Carter, 91 Ill. App. 3d 635, 415 N.E.2d 17 (1980).

69. In some cases, failure to consider evidence of medical or physical condition when presented to the court has constituted grounds for a new hearing as to sentence. See infra notes 70-71 and accompanying text.


71. Id.

72. Telephone interview with Barry Levin, Esq., Los Angeles, Cal., attorney for Mr. Dobbs (Jan. 31, 1984).

73. Some suggested uses of habeas petitions may be found in Note, Post Traumatic Stress Disorder - Opening Pandora's Box, 17 New Eng. L. Rev. 115-117 (1979). However, these focus primarily on fitness issues which may not be relevant to PTSD cases. See III. Ann. Stat. Ch. 38 Sec. 122-1 at supra. (Smith-Hurd 1982) for an example of post conviction remedies.

74. For example of successful post-conviction cases, see supra notes 76-84 and accompanying text.

75. See notes 76-84 and accompanying text.

76. For example, in State v Jensen, the trial court granted the defendant's post conviction petition based directly upon such an analysis. No. CR-75687 (Super. Ct., Maricopa Co., Ariz., Feb. 17, 1984)(Cantor, J). Following a hearing which lasted several days, the trial court entered the following findings of fact and conclusion of law:

The Court finds that more probably than not the verdict or sentence might have been different if the records of the defendant, the diagnostic category of PTSD and the research as to this disorder had been presented to the jury in 1973.

Therefore, the Court makes the following conclusions of law:

Pursuant to Rules of Criminal Procedure, Rule 32.1, the Court finds that newly-discovered material facts exist; that the Court has considered the following:

The probability of such facts, if introduced, would have changed the verdict, finding or sentence; the diligence which would have been required to discover and produce the evidence; that the petitioner acted with promptness in commencing a proceeding after discovery of such new facts; that for the foregoing reasons,

The Court finds that the conviction and sentence should be vacated. Id.


80. Supra note 76. The author was called as an expert witness for the defense to describe how PTSD has been used in other cases. The hearing was held on January 16-19, 1984 and resulted in the conviction and sentence being vacated. See supra note 76.

81. Supra note 76.

82. Id.

83. Failure to introduce relevant evidence is often subject to constitutional challenge as a denial of effective assistance. Ill. Ann. Stat. ch. 38 122-1 (Smith-Hurd 1982). See also People v. Edmonds, 78 Ill. App. 393, 398 N.E.2d 230 (1979) and People v. Brown, 35 Ill. App. 3d 315, 343 N.E.2d 525 (1976). While, as a matter of law, PTSD has probably not become so widely known that an attorney can be held liable for failing to present a PTSD defense, the issue may provide a basis for presenting evidence of PTSD to the trial court.
