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Combat-related PTSD in military court: A diagnosis in search of a defense ☆

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ABSTRACT

As more veterans return from Iraq and Afghanistan, Posttraumatic Stress Disorder (PTSD) often returns with them. As a result, PTSD has quickly become the most prevalent mental disorder diagnosis among active duty United States (U.S.) military. Although numerous studies have not only validated PTSD but have chronicled its negative behavioral impact, it remains a controversial diagnosis. It is widely diagnosed by all types of mental health professionals for even minimal trauma, and DSM-IV PTSD criteria have wide overlap with other mood and anxiety disorders. This, however, has not stopped PTSD from being used in civilian courts in the U.S. as a mental disorder to establish grounds for mental status defenses, such as insanity, diminished capacity, and self-defense, or as a basis for sentencing mitigation. Not surprisingly, PTSD has recently found its way into military courts, where some defense attorneys are eager to draw upon its understandable and linear etiology to craft some type of mental incapacity defense for their clients. As in the civilian sphere, this has met with mixed success due to relevance considerations. A recent court-martial, *U.S. v. Lawrence Hutchins III*, has effectively combined all the elemental nuances of PTSD in military court.

1. Introduction

The military Manual for Courts-Martial (MCM) allows for (a) mental status defenses, such as lack of mental responsibility, which is an affirmative defense and (b) "partial mental responsibility," which is a non-affirmative defense (Manual for Courts-Martial United States, 2012a). An affirmative defense relieves a defendant of liability even though the plaintiff or prosecution has proven all elements of the offense. In the United States, in civilian jurisdictions, "partial mental responsibility" is usually called diminished capacity.

This article examines the inclusion of post-combat, military-related Posttraumatic Stress Disorder (PTSD) as a consideration in litigation strategy by military defense attorneys. The putative influence of PTSD on a defendant's criminal intent has been a central issue at several recent military court-martials. In fact, it is apparent that this question, which surfaced after previous armed conflicts (e.g., Vietnam), has not entirely been put to rest in that these recent trials have once again tested the limits of PTSD as a mental incapacity defense, and have even raised the question of whether repetitive stress can lead to the perception of the need to kill proactively (Berger, McNiel, & Binder, 2012; Hafemeister & Stockey, 2010; Sparr & Atkinson, 1986; Sparr, Reaves, & Atkinson, 1987).

PTSD is now by a wide margin the most common compensable mental disorder and the prevalence of PTSD-based service connected disability has increased at an alarming rate. Between 1999 and 2010, the number of veterans who receive service-connected disability for PTSD increased from 120,265 to 501,280 (Department of Veterans Affairs, 2011). Returning veterans from wars in and around Afghanistan (Operation Enduring Freedom) and Iraq (Operation Iraqi Freedom) have likely contributed substantially to the increase. The recent Department of Veterans Affairs (DVA) regulation liberalizing evidentiary criteria for PTSD claims is likely to further accelerate both the rate of PTSD claims and awards (Department of Veterans Affairs, 2010a). Under the new rule, the Veterans Administration (VA) no longer requires the corroboration of a stressor related to hostile military or terrorist activity, if a VA evaluator confirms that the stressful experience recalled by the veteran adequately supports the PTSD diagnosis and the veteran's symptoms appear to be related to the claimed stressor. Previously, claims adjudicators were required to seek corroboration that a veteran actually experienced a stressor related to hostile military activity (Department of Veterans Affairs, 2010b).

This article will first address the increasing diagnostic prevalence of PTSD, and then discuss problems with the diagnosis itself, before addressing the medico-legal issues in military court. Using a recent case illustration, it will show how PTSD factored into defense strategy in four alternative ways and how each concept ultimately had to be discarded.

2. PTSD prevalence

After three decades of research, the definitive answer regarding the prevalence of PTSD in the military is still lacking but point prevalence rates have ranged from 2–17% and lifetime prevalence from 6–31% (Dohrenwend et al., 2006; Kulka et al., 1990; Richardson, Frueh, & Acierno, 2010). Studies of veterans from the combined conflicts in Iraq

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and Afghanistan report a PTSD point prevalence from 4–17.1% (Hoge, Auchterlonie, & Milliken, 2006; Hoge et al., 2004; Seal, Bertenthal, Miner, Sen, & Marmar, 2007). Various factors have affected these rates, including combat role and cultural background, as well as methodological issues such as sampling strategies, measures, and diagnostic criteria.

In addition to service connected disability claims, the United States Army reports an avalanche in the number of Iraq war veterans with PTSD, with one report indicating that the prevalence of PTSD among these veterans may be as high as 20% (Hoge et al., 2004). This may in part be related to the persistent and ongoing fear of hostile or terrorist activities in Iraq. Friedman (2004) suggested that the current figures underestimate the level of PTSD in Iraq war veterans because a lag ranging from days to many years occurs between the time someone experiences trauma and the time when symptoms of PTSD are reported. Projections have been made that ultimately 35% (or about 300,000) of the soldiers deployed to Iraq will suffer from PTSD. Similar concerns have been voiced about Afghanistan war veterans (Schell & Marshall, 2008).

3. Problems with the PTSD diagnosis

Amid the reports of increased incidence of PTSD in war veterans, concern has been voiced about the validity of the PTSD diagnosis itself. Many observers have noted that PTSD diagnostic criteria are not particularly objective and defining symptoms are nonspecific (Atkinson, Henderson, Sparr, & Deale, 1982; Barglow, 2012; Brewin, 2003; McHugh & Treisman, 2007; Rosen & Lilienfeld, 2007). For example, problems with attention, concentration, and "insomnia" are common to thirty-two other diagnostic classifications and another hallmark of PTSD, irritability, is common to twenty-three others (Sparr, Scott, Fergueson, Gannon, & Newman, 2011). In one sample of outpatients with PTSD seeking treatment, 98% had another Axis I psychiatric diagnosis (Brown, Campbell, Lehman, Grisham, & Mancill, 2001). This has raised the concern that PTSD, at least on some occasions, is simply an amalgam of other disorders. When formulated, PTSD was defined in the Diagnostic and Statistical Manual of Mental Disorders, Third Edition (American Psychiatric Association, 1980) as a disorder that arose from a specific set of traumatic stressors. As a result, the origins of the PTSD definition are related to a specific etiology (criterion A), but studies have shown that the disorder can develop after a variety of non-life threatening events (e.g., divorce, financial difficulties) that are excluded from criteria A (Rosen, Spitzer, & McHugh, 2008; Spitzer, First, & Wakefield, 2007). Bodkin, Pope, Detke, and Hudson (2007) have postulated that symptoms of PTSD are not necessarily caused by trauma. In their study, 103 outpatients presenting for pharmacological treatment of depression were also examined for symptoms of PTSD. Two blind raters subsequently judged whether subjects' experiences met DSM-IV (American Psychiatric Association, 1994) criteria for trauma (criterion A). Among 54 subjects scored by both raters as having experienced trauma, 42 (78%) met all other criteria for PTSD. Among 36 subjects scored by both raters as not having experienced trauma, 28 displayed all other DSM-IV criteria for PTSD — also a rate of 78%. Bodkin et al. concluded that this equivalence suggests that in a treatment-seeking population, caution should be exercised in attributing PTSD symptoms to trauma. In short, this and other studies have shown that criterion A events alone are neither necessary nor sometimes even sufficient to produce PTSD symptoms. Instead, they appear to represent high magnitude stressors that are otherwise indistinct from the full range of stressors that can have an impact on an individual and create risk of psychiatric morbidity (Rosen et al., 2008).

The PTSD diagnosis also has been criticized because it is thought to rely excessively on clinical judgment and patient report (Nielssen & Large, 2008; Scott & Stradling, 1994). This in turn suggests that the diagnosis might be susceptible to patients' attempts to deceive. A 1994 study by Lees-Haley and Dunn reported that 86% of untrained subjects could discern which symptoms on a checklist to endorse to qualify for a PTSD DSM-IIIR (American Psychiatric Association, 1987) diagnosis. Pressure for a PTSD diagnosis may arise when patients are involved in personal injury or workers' compensation claims. Unlike depression or other psychiatric diagnoses that can be caused by multiple factors unrelated to a legal claim, a PTSD diagnosis is said to be incident-specific, which supposedly determines causation. This apparent connection was noted after PTSD was first included in the DSM-III in 1980 and personal injury lawsuits in federal court increased more than 50% in the next decade (Olson, 1991).

4. Malingered PTSD

There have been numerous anecdotal studies, but statistics indicating prevalence, incidence, and base rates of malingering in military populations are unknown. A retrospective analysis of 116 consecutive disability pension examinations for combat-related PTSD found that 25.4% of the 63 claimants who were diagnosed with PTSD were suspected of malingering based on MMPI-II validity indicators (Morel, 1996; Morel, 2010). In a study of veterans diagnosed with chronic PTSD and subsequently referred to a VA residential treatment clinic, Freeman, Powell, and Kimbrell (2008) found clear evidence of symptom exaggeration on objective testing of 53% of the veterans. Frueh et al. (2005) examined the military personnel records of 100 consecutive patients assessed for PTSD in a Veterans Administration (VA) hospital who had reported war-related trauma in Vietnam. When the investigators attempted to validate self-reports of stressor exposure, the corroboration rate was only 41% even though 94% had received a PTSD diagnosis. Furthermore, 7% of the entire sample had no evidence in their files of having served in Vietnam, and of these, 2% apparently never served in the military. Responding to this and similar studies, McNally and Frueh (2012) decried the fact that clinicians who evaluate veterans for service-connected disability pensions within the Department of Veterans Affairs (DVA) are rarely able to use recommended best practices to assess PTSD.

Knoll and Resnick (2006) have listed clinical indicators of malingered combat-related PTSD, and Hall and Hall (2006) have presented an extensive overview of forensic and diagnostic considerations in detecting authentic PTSD. Unfortunately, there is no definitive way to uncover malingering because at the present time there is no method or single instrument that is universally recognized as being the best detection tool. Although there are scores of tests available to assist in the detection of malingering, in general, only a few have been validated. Tests that have been shown to be among the most reliable for the general detection of malingering are the Structured Interview of Reported Symptoms [SIRS] (Rogers, Bagby, & Dickens, 1992) and the Minnesota Multiphasic Personality Inventory-2 [MMPI-2] (Butcher, Dahlstrom, Graham, Tellegen, & Kaemmer, 1989; Keane, Malloy, & Fairbank, 1984). The Miller Forensic Assessment of Symptoms Test [M-FAST] (Jackson, Rogers, & Sewell, 2005) and Trauma Symptom Inventory [TSI] (Briere, 1995; Elhai et al., 2005) have received the most validation for detecting malingered PTSD (Knoll & Resnick, 2006). New versions of these tests are the Minnesota Multiphasic Personality Inventory-2-Restructured Form [MMPI-2-RF] (Ben-Porath & Tellegen, 2008), the Structured Interview of Reported Symptoms-2 [SIRS-2] (Rogers, Sewell, & Gillard, 2010), and the Trauma Symptom Inventory-2 [TSI-2] (Briere, 2011).

5. PTSD as a criminal defense

As PTSD has aged as an official psychiatric diagnosis, its forensic face has changed as well. Initial enthusiasm for PTSD as a criminal defense has waned, and initial fears of misuse have not materialized. Instead, the uses of PTSD as a criminal defense have been primarily as an occasional factor in pre-trial plea-bargaining and diminished capacity considerations at trial, and as a mitigating factor in post-trial sentencing