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## PTSD AND THE LAW

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A forensic psychologist once remarked that if mental illnesses were rated on the New York Stock Exchange, PTSD would be a growth stock worth watching (Lees-Haley, 1986). Perhaps more than any other psychologic or medical disorder, PTSD has influenced, and been influenced by, the law (Stone, 1993).

*Civil Law.* The concept of mental injury as compensable entity, of which PTSD represents the culmination, has gradually emerged out of the historical context of physical injury (Scrignar, 1996). The recognition of psychologic and emotional aspects of the causation and manifestation of injury-related disorders has only been accomplished over the past century (Hoffman et al., 1992). The PTSD diagnosis represents landmark recognition that an external event can serve as the direct cause of a mental disorder. This has led one authority to state that "accurate assessment of PTSD-specific symptoms forms the basis for defining psychic injury in law ..." (Raifman, 1983, p.124). Slovenko (1994) noted that PTSD is a favored diagnosis in tort law because it is incident-specific and easy to understand, and it tends to rule out other factors potentially involved in causation. Through PTSD, plaintiffs attempt to establish that the psychologic problems they are claiming issue from an alleged traumatic event and not from a myriad of other possible sources. A diagnosis of depression, in contrast, may expose the causation issue to many etiologic considerations. Spaulding (1988) has noted that "the further from the diagnosis of PTSD the evaluator strays, the more speculative the opinion on causation will become" (p.13). Special features of PTSD also help it overcome legal barriers under workers' compensation. Whereas affective and other anxiety disorders may be argued to represent "ordinary diseases of life," the recognition that PTSD is caused by a discrete external event, e.g., a workplace accident, removes it from this exclusionary category.

Some see PTSD as threatening to overwhelm the personal injury, workers' compensation, and disability insurance litigation systems. Between 1980, when PTSD was introduced into the official psychiatric nomenclature, and 1987, the number of personal injury lawsuit filings between private parties in federal courts rose more than 50% (Olson, 1991).

Jury awards escalated dramatically during the same time period. This coincided with psychologic injury becoming more widely recognized, and with courts becoming increasingly willing to compensate for emotional distress in the absence of physical injury or impact. United States Chamber of Commerce statistics show that the number of mental stress claims recorded by employees under workers' compensation jumped nearly 800% between 1979 and 1990, making stress related disorders the nation's fastest-growing disease category (deCarteret, 1994). In a study of more than 700,000 claims filed in 11 states, the National Council on Compensation Insurance reported that the costs of stress claims averaged about 52% more than physical injury claims (Calise, 1993).

Faust and Ziskin (1988) have assailed the forensic use of PTSD on the grounds that the disorder lacks proven diagnostic reliability and validity. They opined that PTSD symptoms may have many alternate explanations and that exaggeration and malingering are ever possible, and even probable. Public skepticism has been stimulated by frivolous and sometimes well-publicized workers' compensation claims (Sparr, 1995).

*Criminal law.* Many fears have been expressed about the misuse of PTSD in criminal cases, but it is questionable whether such fears have actually come true. Appelbaum et al. (1993) carefully showed that despite early concerns, the PTSD insanity defense is raised infrequently, and, like other insanity pleas, is usually unsuccessful. It appears, however, that the primary thrust of a PTSD criminal defense has not been as an insanity plea, but instead as a factor in diminished capacity considerations, pre-trial plea bargaining, or sentencing (Sparr, 1996). In some self-defense cases, PTSD may aid a defendant in showing that a particular type of provocation to which she had become especially sensitive in light of previous traumatization caused her to feel physically threatened and evoked a reasonable self-defensive reaction. The most familiar example is so-called "battered woman syndrome" (Dutton & Goodman, 1994).

In criminal trials, PTSD is unique among mental disorders in its invocation not only by the defense but also by the prosecution. The presence of PTSD in a victim, e.g., in the form of "rape trauma syndrome" (Burgess, 1983; Frazier & Borgida, 1985), may be cited by the prosecution as evidence supporting the actual occurrence of the alleged criminal act.

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Sparr and Atkinson (1986) noted that in criminal proceedings involving pleas of not guilty by reason of insanity or by diminished capacity, establishing a valid link between PTSD and criminal behavior is an imposing task, because two levels of causation are required: first, the link between the traumatic stressor and the psychiatric symptoms, and second, the link between the psychiatric symptoms and the criminal act. In many cases, the PTSD diagnosis itself may not be questioned, but its contribution to the defendant's mental state at the time of the act may be hotly contested. Prosecutors may point to secondary factors such as financial problems, interpersonal conflicts, or drug and alcohol abuse as proximate motivations for criminal activity. Although these factors may be related to PTSD, they are not generally regarded as sufficient to relieve an individual from criminal responsibility.

Based upon a literature review, Pitman et al. (1996) summarized the factors that tend to support a PTSD-related criminal defense: (a) the act represents spontaneous, unpremeditated behavior uncharacteristic of the individual; (b) coherent dialogue appropriately related to time and place is lacking; (c) the choice of victim is fortuitous or accidental; (d) the response is disproportionate to the provocation; (e) the act is rationally inexplicable and lacks current motivation; (f) the act recreates in a psychologically meaningful way elements of the original traumatic stressor; (g) the defendant is unaware of the ways in which he has re-enacted traumatic experiences; (h) the act is precipitated by event(s) or circumstance(s) that realistically or symbolically force the individual to face unresolved conflicts; and (i) there is amnesia for the episode.

*Forensic evaluation of PTSD.* Psychiatric researchers are now required to determine the presence or absence of diagnostic criteria in a systematic, reliable manner by means of structured interview instruments. Because the need for reliability in the medicolegal setting is equally great, forensic evaluations call for a similar approach. Simon et al. (1995) offer a series of specifically articulated guidelines for the forensic assessment of PTSD, including the psychiatric examination of adults, adolescents, and children, forensic psychologic assessment, and evaluation of the troublesome issue of malingering. Wilson and Keane (1997) have assembled treatises on state-of-the-art PTSD psychometric instruments.

The current diagnostic criteria for PTSD include physical manifestations, e.g., specific physiologic reactivity and exaggerated startle response. Pitman and Orr (1993) have proposed that the laboratory measurement of these criteria "has the potential to redeem the PTSD diagnosis from its current subjectivity and to help separate the wheat from the chaff in the forensic evaluation of PTSD claims" (p. 40). As with psychometric tests, however, they note that psychophysiological test results do not stand on their own but serve as only one component of a comprehensive forensic psychiatric evaluation.

Pitman et al. (1996) have summarized common errors leading to the forensic overdiagnosis of PTSD, which include: (a) failure to separate expectable emotional distress

from mental disorder; (b) application of fewer criteria than are required for the proper diagnosis; (c) failure to consider the contribution of earlier, unrelated traumatic events to the evaluatee's illness, with resulting false attribution to the traumatic event being litigated; (d) failure to diagnose pre-existing psychopathology; (e) failure to identify a positive family history of mental disorder that may point to another etiology; and (f) failure to entertain differential diagnoses. Common errors leading to the forensic underdiagnosis of PTSD include: (a) characterization of PTSD symptoms as mere understandable, normal reactions to the traumatic event; (b) basing opinion on inadequate, open-ended interviews without an adequate attempt to explore details of the traumatic event and subsequent symptomatology; (c) idiosyncratic thresholds for diagnosis; (d) failure to acknowledge that the diagnosis of PTSD may be made despite the presence of major vulnerability factors; (e) mistaking predisposition for pre-existing psychopathology; (f) false attribution of the evaluatee's symptoms to other life events; (g) espousal of narrow or outdated theories of etiology which may play on popular prejudices, e.g., all mental illness results from early childhood experience, or all mental illness is inherited; and (h) failure to consider relevant, supportive PTSD literature.

*Expert PTSD testimony.* Legal advocates seem to have a thirst for expert psychiatric and psychologic testimony and sometimes attempt to push such experts beyond the limits of their knowledge (Sparr & Boehnlein, 1990). This state of affairs emphasizes the need for quality assurance (American Psychiatric Association, 1997; Hoffman, 1997) and ethical standards (Appelbaum, 1997) in forensic psychiatric assessments. Mental health professionals who render testimony on either a willing or unwilling basis can avoid problems if they stick to describing the evaluatee's history, signs and symptoms, diagnostic conditions, and mental disabilities and leave the judge and jury to weigh these in the context of legal standards. The expert should not attempt to resolve questions of damages, competence, or criminal responsibility.

Scientific courtroom testimony, including psychiatric evidence, is governed by expert witness rules that revolve around three issues. First, courts are concerned with reliability, particularly because they have long experience with a litigant's ability to find experts to support virtually any position. Second, courts are concerned with the "aura of special reliability and trustworthiness" that surrounds an expert's testimony. Third, courts fear that courtrooms will be overrun by experts. Expert testimony has added substantially to the length and cost of trials. Some courts will resist allowing it unless they are convinced it will aid the trial process (Murphy, 1992). Prior to 1993, the general legal standard for the admissibility of scientific evidence was that it "be sufficiently established to have gained general acceptance in the particular field in which it belongs" (Frye v. United States, 1923). However, in *Daubert v. Merrill Dow* (1993), the U.S. Supreme Court held that the Frye rule had been superseded by the Federal Rules of Evidence (see also Marwick, 1993; Steinberg, 1993). The

Court handed down a strict interpretation of these rules as they pertain to "scientific knowledge." It assigned the job of determining the reliability of proffered scientific testimony to the trial judge and offered five guidelines for making such a determination: (1) whether the theory or technique can be (and has been) tested; (2) whether it has been subjected to peer review and publication; (3) its known or potential error rate; (4) the existence and maintenance of standards controlling its operation; and (5) whether it has attracted widespread acceptance within a relevant scientific community (the former Frye rule).

The material in the abstracts and citations that follow demonstrate the degree to which the study of PTSD has advanced since the disorder's introduction in 1980. It behooves psychiatrists and clinical psychologists who plan to testify about PTSD to be familiar with scientific advances in the field, and about current standards for PTSD's assessment. They should also consider how well the testimony they plan to present meets these standards, lest they be surprised to find their expert opinions ruled inadmissible in court.

## SELECTED ABSTRACTS

APPELBAUM, P.S., JICK, R.Z., GRISSO, T., GIVELBER, D., SILVER, E., & STEADMAN, H.J. (1993). **Use of posttraumatic stress disorder to support an insanity defense.** *American Journal of Psychiatry*, 150, 229-234. **OBJECTIVE:** The authors examine the allegation that the diagnosis of PTSD is frequently abused in the legal system as the basis for a defense of not guilty by reason of insanity. **METHOD:** Data for the investigation were drawn from a study of insanity pleas gathered from court records in 49 counties in eight states. Data on the 28 insanity plea defendants for whom PTSD was diagnosed before or immediately after trial were compared with data on 8,135 defendants whose insanity pleas were based on other diagnoses. **Results:** Insanity pleas by defendants with diagnoses of PTSD constituted only 0.3 percent of the cases. There were few significant differences between the two groups on demographic variables, psychiatric histories, previous involvement in crime, or current charges. The defendants with PTSD were more likely to have been married, less likely to have been arrested as juveniles, and less likely to have been detained after trial. **CONCLUSIONS:** Contrary to previously expressed concerns, PTSD was infrequently associated with an insanity defense in the cases in this study. In the cases in which pleas based on PTSD were used, they were no more likely to succeed than pleas based on any other diagnosis. Defendants with PTSD-related insanity defenses differed little from other insanity defendants, contradicting the stereotype of the person who is driven by PTSD to commit crimes. The data do not support fears of widespread misuse of the diagnosis of PTSD in connection with the insanity defense.

BURGESS, A.W. (1983). **Rape trauma syndrome.** *Behavioral Sciences and the Law*, 1, 97-113. Abstracted in *PTSD Research Quarterly*, 3, (3) 1992.

FAUST, D. & ZISKIN, J. (1988). **The expert witness in psychology and psychiatry.** *Science*, 241, 31-35. According to the authors the involvement of psychologists and psychiatrists within the legal

## LEGAL CASES

Frye v. United States, 293 F. 2d 1013 (D.C. Cir. 1923).

Daubert v. Merrill Dow Pharmaceuticals, 113 S. Ct. 2786 (1993).

## REFERENCES

CALISE, A. (1993, August 30). **Workers' compensation mental-stress claims in decline.** *National Underwriter*, 8, 3, 31.

DECARTERET, J.C. (1994). **Occupational stress claims: effects on workers' compensation.** *American Association of Occupational Health Nurses Journal*, 42, 494-498.

OLSON, W.K. (1991). *The Litigation Explosion*. New York, NY: Dutton.

WILSON, J.P. & KEANE, T.M. (Eds.) (1997). *Assessing psychological trauma and PTSD*. New York: Guilford Press.

arena continues to grow rapidly but remains highly controversial. Extensive research on clinical judgment provides a scientific basis for clarifying the growing disputes about the values of such professional activities. The authors state that studies show that professionals often fail to reach reliable or valid conclusions and that the accuracy of their judgments does not necessarily surpass that of laypersons, thus raising substantial doubt, according to Faust and Ziskin, that psychologists or psychiatrists meet legal standards for expertise. Factors that underlie the research findings and implications for court-room testimony are discussed.

FRAZIER, P. & BORGIDA, E. (1985). **Rape trauma syndrome evidence in court.** *American Psychologist*, 40, 984-993. The authors state that the use of expert psychological testimony on rape trauma syndrome in court is a relatively new phenomenon, although the basic scientific and legal questions that arise in regard to its admissibility are also associated with the admission of any type of expert psychological testimony. This article describes rape trauma syndrome, reviews pertinent case law, and examines the evidence in light of three criteria for the admission of expert testimony — scientific status, helpfulness to the jury, and potential prejudicial impact. Research issues pertaining to the admissibility of rape trauma syndrome evidence are also raised.

HOFFMAN, B.F. (1997). **Courts and torts: the psychiatrist preparing for trial.** *Canadian Journal of Psychiatry*, 4, 497-501. To outline how a psychiatric expert can do an impartial assessment and medicolegal report and then give an effective presentation in court that can sustain cross-examination. **METHODS:** The legal principles of litigating emotional trauma are reviewed, including proving causation, characterizing emotional suffering, assessing disability, and determining a realistic prognosis. **RESULTS:** Psychiatrists must understand the interplay of legal and psychiatric principles when they are asked to assess litigants who are suing for monetary compensation for a widening range of emotional

injuries resulting from motor vehicle accidents, slips and falls, incest and sexual abuse of children, discrimination, unlawful dismissal, malpractice, human-made disasters, product liability, and intentional torts, to name a few. **CONCLUSION:** The psychiatrist can prepare his or her attitude, knowledge, and skills to give a presentation in court that will be credible, trustworthy, and dynamic. With adequate preparation, the psychiatric expert can bring an informed psychiatric perspective to the court that will have a significant impact on the outcome of the judicial deliberations.

MURPHY, S. (1992). **Assisting the jury in understanding victimization: Expert psychological testimony on battered woman syndrome and rape trauma syndrome.** *Columbia Journal of Law and Social Problems*, 25, 277-312. This article proposes a test for admission of psychological testimony that would enhance juror understanding of women's experiences, while effectively limiting value-laden judgments that unduly prejudice juries. Part II of this Article examines the evidentiary treatment of expert testimony both prior and subsequent to the adoption of the Federal Rules of Evidence, and assesses the continuing viability and value of some older evidentiary doctrines. Part III examines the insanity defense, the oldest field of psychological expert testimony, and explores how the law has grappled with scientific determinations in that area. This section then addresses courts' experience with psychological testimony on battered woman syndrome and rape trauma syndrome. Part IV explores the most recent trend in these cases, and suggests a method of treating psychological evidence based on that analysis.

PITMAN, R.K. & ORR, S.P. (1993). **Psychophysiological testing for post-traumatic stress disorder: Forensic psychiatric application.** *Bulletin of the American Academy of Psychiatry and the Law*, 21, 37-52. The validity of the PTSD diagnosis is limited by both the illusory objectivity of the traumatic event and the subjectivity of the ensuing syndrome. These limitations are especially problematic in the forensic setting. Psychophysiological measurements may strengthen PTSD's forensic value by offering a more objective assessment technique for cases that find their way into the courtroom. Based upon the results of published research studies conducted in a range of military and civilian, PTSD and non-PTSD subjects, psychophysiological data can provide evidence helping to establish or refute the presence of the DSM-III-R PTSD arousal criteria, as well as aid psychiatric experts in estimating the probability of the disorder's presence in a given claimant. Psychophysiological testing should be viewed as one component of a multimethod forensic psychiatric evaluation for PTSD. It is likely that it will soon be offered and, given current legal standards, admitted as evidence in civil and criminal litigation.

PITMAN, R.K., SPARR, L.F., SAUNDERS, L.S., & MCFARLANE, A.C. (1996). **Legal issues in posttraumatic stress disorder.** In B.A. van der Kolk, A.C. McFarlane, & L. Weisaeth (Eds.), *Traumatic stress: The effects of overwhelming experience on mind, body, and society* (pp. 378-397). New York: Guilford Press. Perhaps more than any other psychological or medical disorder, post-traumatic stress disorder (PTSD) has influenced, and been influenced by, the law. Non-psychiatric incentives such as the prospect of financial gain or avoidance of criminal punishment, present in all civil and criminal legal systems, have cast a shadow over the validity of the PTSD diagnosis and delayed its acceptance into diagnostic systems in psychiatry. Since this acceptance, however, PTSD has exerted a dramatic impact on forensic psychiatry and the law. In civil law, the PTSD diagnosis represents landmark recognition that an external event can serve as the

direct cause of a mental disorder. In criminal trials, PTSD is unique among mental disorders in its invocation by both prosecution and defense. The dissociative "flashback" experience has opened a new dimension in insanity and related criminal defenses, insofar as a non-psychotic defendant with PTSD may be alleged to have briefly lost contact with reality and become "temporarily insane." The presence of PTSD in a victim may be cited by the prosecution as "syndrome evidence" supporting the occurrence of a criminal act such as rape. PTSD is also occasionally invoked as grounds for civil commitment. This chapter provides an overview and discussion of civil and criminal legal issues in PTSD. It also discusses forensic psychiatric evaluation and testimony in this new and rapidly developing area of forensic psychiatry.

SAVODNIK, I. (1991). **The concept of stress in psychiatry.** *Western State University Law Review*, 19, 175-189. The author contends that the nature of stress-related diagnoses within psychiatry has taken on enormous proportions in the last decade considering the large number of worker compensation cases that continue to be filed. A number of important questions arise regarding this issue and the answers may provide some surprising insights into the entire complex of claims, beliefs and expectation on the part of everyone involved. What is stress? What is a psychiatric disorder? Are psychiatric disorders medical disorders? What is the nature of diagnosis in psychiatry and how does it differ from diagnosis in the rest of medicine? What is the role of psychological tests in psychiatric diagnosis? These and other questions are addressed in this article.

SCRIGNAR, C.B. (1996). *Post traumatic stress disorder: Diagnosis, Treatment, and Legal Issues* (3rd ed.). New Orleans: Bruno Press. This book comprehensively summarizes knowledge about the epidemiology, etiology, diagnosis, and treatment of PTSD. One section is devoted to legal issues. Basic information is provided about how to conduct a forensic evaluation and how to serve as an expert witness. Separate chapters explore personal injury litigation and workers' compensation claims. Two additional chapters address issues related to plaintiffs and to defendants. A closing chapter presents information about PTSD in criminal trials. Overall, the book is an excellent single introductory source for mental health professionals who are preparing to testify about PTSD in a legal setting. [PPS]

SIMON, R.I. (Ed.) (1995). *Posttraumatic stress disorder in litigation: Guidelines for forensic assessment*. Washington: American Psychiatric Press. The articles presented in this book stem from a standards development conference on the forensic assessment of claimants. One chapter discusses new research and its implications for the diagnosis of PTSD. Another chapter elaborates on the development of guidelines for the forensic psychiatric examination of the PTSD claimant. A related chapter sets out standards for the evaluation of malingering in PTSD and provides indicators of genuine and malingered PTSD. Guidelines for the examination of PTSD in children also are provided. These and other issues are richly discussed in this publication. This book will be of much interest to a multidisciplinary audience. [Adapted from Text]

SLOVENKO, R. (1994). **Legal aspects of post-traumatic stress disorder.** *Psychiatric Clinics of North America*, 17, 439-446. The legal requirements for compensable injury in civil law gradually have loosened over the years from the physical effects of direct injury to include the emotional effects of direct injury, the emotional effects of witnessing injury to others, the emotional effects of knowing of injury to others, and a person's fear that he or she may

become ill at a later date. Although a psychiatric diagnosis is not required to bring action, post-traumatic stress disorder (PTSD) has become the favored diagnosis in cases of emotional distress. Also, in criminal law, defenses based on PTSD have become increasingly common, being used as the standard defense in selected situations. The limits of the use of PTSD as a defense remain to be clarified; differing judgments have been made in similar cases by different courts.

SPARR, L. F. (1996). **Mental defenses and posttraumatic stress disorder: Assessment of criminal intent.** *Journal of Traumatic Stress*, 9, 405-425. The author declares that since its formal introduction into psychiatric nomenclature more than a decade ago, the diagnosis of PTSD has become firmly entrenched in the legal landscape. In part, this is because PTSD seems easy to understand. It is one of only a few mental disorders for which the psychiatric Diagnostic and Statistical Manual (DSM) describes a known cause. Since the diagnosis is usually based on patients' self-report, however, it creates the possibility of distortion aimed at avoidance of criminal punishment, and, as a result, has achieved mixed success as a criminal defense. When providing expert testimony, mental health witnesses must take care to distinguish between mere PTSD and a causal connection between PTSD and the criminal act in question. PTSD has not only been used to abrogate or diminish responsibility, but also to arrange pre-trial plea bargaining agreements or play a role in sentencing determinations. The author explores various uses and potential abuses of PTSD in criminal jurisprudence and offers suggestions regarding retrospective PTSD assessment.

SPARR, L.F. (1995). **Post-traumatic stress disorder: Does it exist?** *Neurologic Clinics*, 13, 413-429. The author notes it is easy for lawyers, lay people, and psychiatrist alike to confuse legal notions of mental disability ("stress" cases) that confer eligibility for monetary benefit with the DSM-III-R psychiatric disorder, PTSD. This is because the lay-legal concept of stress borrows heavily from the psychiatric concept, which isolates and identifies a specific event (stressor) and an emotional reaction or series of reactions (symptoms) related to that event. Some observers, however, note that many policies underlining the provision of monetary benefits are independent of, and sometimes opposed to, therapeutic and research purposes of a medical diagnosis. In many legal cases, especially in those involving workers' compensation litigation, the decision as to whether or not a particular stress is detrimental is determined on moral or ethical grounds. For example, if an individual can establish that he or she was treated unfairly, then it is argued that the experience was stressful and psychiatrically harmful. Even some psychiatrists who conduct disability examinations may endorse this idea by ignoring requisite criteria and regarding any emotional disturbance that follows an untoward external event as tantamount to PTSD. The author observes that the fact that stress is not a moral or ethical term and has no inherent moral meaning is often obscured in legal debate.

SPARR, L.F. & ATKINSON, R.M. (1986). **Posttraumatic stress disorder as an insanity defense: medicolegal quicksand.** *American Journal of Psychiatry*, 143, 608-613. The authors note a growing awareness of PTSD has led to recent use of the disorder as a legal defense against criminal responsibility for both violent and nonviolent crimes. Diagnosis of PTSD is difficult because the symptoms are mostly subjective, often nonspecific, usually well publicized, and, therefore, relatively easy to imitate. Accurate psychiatric testimony in such cases requires diligent searching for collateral sources of information. The authors argue that the insanity defense is appropriate only in the rare instance that a dissociative episode related to PTSD directly leads to criminal activity.

SPARR, L.F. & BOEHNLEIN, J.K. (1990). **Posttraumatic stress disorder in tort actions: forensic minefield.** *Bulletin of the American Academy of Psychiatry and the Law*, 18, 283-302. The authors discuss PTSD as a basis for personal injury litigation. Three case examples raise issues related to: (1) the controversy surrounding expansion of tort liability, (2) the courtroom use of psychiatric nomenclature as represented in the DSM (e.g., PTSD), and (3) ethical concerns regarding psychiatric expert witnesses. Psychiatrists became easy targets when problems related to personal injury "stress" cases developed. A careful analysis, however, demonstrates that the issues are complex and multifaceted. For example, tort liability expansion was primarily instituted to compel a greater provision of liability insurance, not to reward stress claims. The increasing use of psychiatry's DSM in the courtroom has occurred despite explicit precautions against forensic application. Finally, the need for psychiatric expert witnesses has increased because courts have gradually usurped some psychiatric clinical prerogatives and because there has been a trend toward greater consideration of emotional pain and suffering. Although psychiatric expert witnesses have not been beyond reproach, critics have attempted to impeach the entire psychiatric profession for the questionable actions of the minority. The authors provide a detailed analysis of current problems, offer suggestions for improvement, and provide an educational counterpoint to the "hysterical invective" that often greets psychiatric testimony.

SPAULDING, W.J. (1988). **Compensation for mental disability.** In J.O. Cavenar (Ed.), *Psychiatry* (Vol. 3, pp. 1-27). Philadelphia: Lippincott. The author states that mental disability, by definition, is a disadvantage but it also is a legal basis for compensation intended to mitigate that disadvantage. This chapter examines the three principal systems for compensating mental disability: tort damages for psychic trauma injuries, worker's compensation awards for occupational stress, and Social Security disability benefits based on mental impairments. While worker's compensation grew out of the tort remedy, and Social Security disability benefits grew out of worker's compensation, all three forms of compensations have undergone parallel changes with respect to mental disability. In all three systems mental disability claims have become both more numerous and more readily accepted.

STONE, A.A. (1993). **Post-traumatic stress disorder and the law: Critical review of the new frontier.** *Bulletin of the American Academy of Psychiatry and the Law*, 21, 23-36. Since its debut in the psychiatric nomenclature in 1980, post-traumatic stress disorder (PTSD) has had a dramatic impact on criminal and civil jurisprudence. PTSD has created a cottage industry among both criminal and negligence attorneys and mental health practitioners. The diagnosis first achieved public notoriety when it was introduced as a new basis for the insanity defense. More recently "syndrome evidence" of the subtypes and variations of PTSD has encroached on the substantive criminal law of self-defense. In addition, the diagnosis may have an impact on such traditionally legal and factual determinations as the credibility of witnesses and may undermine conservative tort doctrine that attempts to cabin psychic injury. The emerging legal area of victims' rights has been strengthened and paradoxically divided by PTSD. Yet the newly defined disorder of PTSD has not borne such a heavy forensic burden easily. Indeed the diagnosis poses for psychiatry some of the very problems it supposedly solves for legal purposes, including the illusory objectivity of the causative traumatic event and the expert's dependence upon the victim's subjective and unverifiable reports of symptomatology for the diagnosis.

## ADDITIONAL CITATIONS

### Annotated by the Editors

American Psychiatric Association resource document on peer review of expert testimony (1997). *Journal of the American Academy of Psychiatry and the Law*, 25, 359-373.

Describes the problems of how psychiatrists who provide expert testimony are perceived in popular, medical, and legal domains. Criticisms center around lack of competence and ethical misconduct. Voluntary peer review of testimony is recommended as a possible solution, and suggestions are made for implementation.

APPELBAUM, P.S. (1997). **A theory of ethics for forensic psychiatry.** *Journal of the American Academy of Psychiatry and the Law*, 25, 233-247.

This article offers a justification for a set of principles that constitute the ethical underpinnings of forensic psychiatry. The two principles on which that effort rests are truth-telling and respect for persons. Psychiatrists cannot simply rely on general medical ethics, embedded as they are in the doctor-patient relationship — which is absent in the forensic setting.

DUTTON, M.A., GOODMAN, L.A. (1994). **Posttraumatic stress disorder among battered women: Analysis of legal implications.** *Behavioral Sciences and the Law*, 12, 215-234.

Demonstrates that the diagnosis of PTSD has recently been applied to the psychological experiences of victims of intimate violence, including physical and sexual assault. The use of trauma theory to explain battered women's responses to violence has laid a foundation for expert testimony on PTSD. This article discusses the relevance of the PTSD diagnosis within the legal context for explaining battered women's responses to violence.

HOFFMAN, B.F., ROCHON, J.P., & TERRY, J.A. (1992). *The emotional consequences of personal injury: A handbook for psychiatrists and lawyers.* Toronto: Butterworth.

Assessed 400 litigants who were suing for emotional damages due to motor vehicle accidents and other forms of civilian trauma. Approximately 70% had evidence of continuing physical injuries to account for some of the physical and emotional symptoms. The most common DSM-III-R diagnoses were psychiatric condition affecting physical illness (50%), major depression (24%), somatoform disorder (11%), and PTSD (8%).

LEES-HALEY, P.R. (1986). **Pseudo post-traumatic stress disorder.** *Trial Diplomacy Journal*, 9, 17-20.

Argues that some trauma victims are inappropriately diagnosed as having PTSD when they actually have "pseudo-PTSD," a condition the author proposes is caused by factors that are unrelated to the original trauma. These factors include personal characteristics, post-traumatic life events, and treatments intended to alleviate PTSD symptoms.

MARWICK, C. (1993). **What constitutes an expert witness?** *Journal of the American Medical Association*, 269, 2057.

Reviews antecedents of a landmark civil case seeking to keep "junk science" from influencing deliberations on a variety of vital matters in the nation's courtrooms. He shows how the American Medical Association and its journal, *JAMA*, have each joined with several other scientific groups in filing amicus curiae briefs as the US Supreme Court considers the case of *Daubert v Merrill Dow Pharmaceuticals Inc.* The questions are: When is expert scientific testimony to be allowed in court to be heard and

weighed by a jury? When and on what grounds is it to be ruled out? For the first time, the Court will try to define criteria judges should use to decide on admitting testimony by expert witnesses.

RAIFMAN, L.J. (1983). **Problems of diagnosis and legal causation in courtroom use of post-traumatic stress disorder.** *Behavioral Sciences and the Law*, 1, 115-130.

Reviews issues in the forensic use of the PTSD diagnosis, including prior vulnerability, stressor identification, symptom assessment, intervening posttraumatic factors, and criminal responsibility. Although some of the author's concerns about validity have been addressed in the 15 years since the article was published, this is a good introductory source for learning about the forensic application of PTSD.

STEINBERG, C.E. (1993). **The Daubert decision: An update on the Frye rule.** *Newsletter of the American Academy of Psychiatry and the Law*, 8, 66-69.

Briefly describes the background and content of a Supreme Court decision regarding the presentation of expert scientific testimony in court. The new, more liberal, decision is based on the Federal Rules of Evidence and allows expert testimony that is not "generally accepted": "if scientific, technical, or other specialized knowledge will assist the trier of fact to understand the evidence or to determine a fact in issue, a witness qualified as an expert by knowledge, skill, experience, training, or education, may testify thereto in the form of an opinion or otherwise."

### VA Cooperative Study #420: Group Treatment of PTSD

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In 1995, Dr. Matt Friedman and I received approval from the VA Cooperative Studies program to conduct a multisite randomized clinical trial of group psychotherapy for treating PTSD in male Vietnam veterans, VA Cooperative Study (CS) #420. Treatment research has been an ongoing activity at the National Center for PTSD since we opened in 1989. In 1993, we began discussing using our resources to plan a large-scale PTSD treatment study because we felt that a multisite study would be needed in order to have a sufficient number of participants. Late in 1993 we submitted a planning request to the VA Cooperative Studies Program and were fortunate to receive the Program's support in planning a trial. We officially submitted a proposal in the summer of 1995 and were notified of approval in November of that year. Funding began in 1996. We are now enrolling the second of the three cohorts of men we plan to run in the study.

The planning process was made exciting and enjoyable by the strength of the team that designed and implemented the study. Matt and I were able to assemble a group of experts who have great research and clinical experience in both PTSD and multisite trials. Dr. David Foy led a team that developed Trauma Focus Group Therapy. TFGT is intended to capitalize on the group for support in helping the veteran get through the exposure work. Each partici-

pant receives two in-group exposure sessions, which are audiotaped, and is asked to do at least 8 additional exposures as part of the weekly homework that is assigned throughout treatment. TFGT also includes relapse prevention training for PTSD symptoms, anger management, psychoeducation, and coping skills training. Tracie Shea was charged with the task of developing a non-trauma-focused group therapy that would control for the nonspecifics of therapy so that we could attribute any observed effectiveness of trauma-focused therapy to its active ingredients. The comparison therapy also had to be credible to both patients and therapists. Looking to what was being delivered in VA, it was clear that dealing with current social problems was the single most common activity, and so Tracie and her team developed Present Centered Group Therapy (PCGT) to focus on current interpersonal problems while avoiding trauma processing.

In addition to Drs. Foy and Shea, people who contributed significantly to the planning process included Drs. Terry Keane, Charlie Marmar, Daniel Weiss, Bruce Rounsaville, Phil Lavori, Frank Hsieh, Bob Rosenheck, and Ray Scurfield, as well as Mr. Fred Gusman. Drs. Shirley Glynn, Melissa Wattenberg, Beth Stamm, and Joe Ruzek, along with Ms. Sherry Riney and Mr. Joe Rudolph, contributed to the implementation. Matt and I think they have helped us design a treatment that is appropriate for VA patients in the context of the VA system.

CS #420 is a randomized clinical trial designed to assess the efficacy of TFGT, relative to PCGT, for treating war-zone-related PTSD in male Vietnam veteran outpatients. TFGT and PCGT treatment are delivered in weekly group therapy sessions for 30 weeks according to the manuals first-authored by David Foy and Tracie Shea, respectively. All sessions last 1.5-hours, except for exposure sessions, which last 2 hours. Monthly 1.5-hr group booster sessions are delivered for the 5 months following active treatment; 15-minute booster phone calls also are delivered monthly during this period for the TFGT condition. All participants receive case management throughout the study.

Participants are 360 male veterans with PTSD due to service in the Vietnam theater. These men were targeted because they represent 90% of the veterans who receive PTSD treatment in the VA. Interviewers who are blind to participants' treatment condition perform assessments at study entry, the end of treatment (7 months), and the end of booster sessions (12 months). In addition, two-thirds of participants will be assessed at 18 months and one-third will be assessed at 24 months following study entry. Participants complete self-reported questionnaires monthly during the 7 months of active treatment.

Four domains are being assessed: (a) psychological factors, including PTSD, substance abuse, and distress; (b) psychosocial function, including an individual's work status, marital functioning, social/interpersonal functioning, legal status, and quality of life; (c) self-reported physical health status; and (d) utilization of physical and mental health services. PTSD symptom severity as measured on the National Center

for PTSD's Clinician Administered PTSD Scale is the primary outcome measure.

The group-based design creates significant challenges because it delays treatment for subjects who have been admitted to the study. Since both TFGT and PCGT are group rather than individual therapies, it is necessary at each study site to accrue 12 subjects for a cohort before treatment can begin. The 12 subjects are then randomized to either TFGT ( $N = 6$ ) or PCGT ( $N = 6$ ). There will be three cohorts per site. Each successive cohort begins active treatment one month after the preceding cohort has begun booster sessions.

Two therapists lead each group. To participate in the study, therapists had to be masters- or doctoral-level clinicians with prior experience in treating PTSD in a group format. We did not require them to have formal training in exposure techniques, or even cognitive-behavioral therapy. Our approach to handling the problem of therapist effects, which often comes up in psychotherapy research, was to randomize therapists. We plan to examine how therapist preferences and expertise, as well as protocol adherence, relate to participants' outcomes. All sessions are videotaped, and supervision based on the tapes is provided by Dr. Shirley Glynn at the West Los Angeles VA (TFGT) and Dr. Melissa Wattenberg at the Boston VA Outpatient Clinic (PCGT). Drs. Charlie Marmar and Daniel Weiss also are rating adherence according to a protocol developed by a team led by Dr. Bruce Rounsaville.

Case management is delivered according to a manual developed by Dr. Beth Stamm and colleagues. Case management serves as a point of individual contact for each participant so that adequate monitoring of clinical status is ensured and assistance with additional services that may be needed (e.g., medical, legal, financial) is provided. Dr. Phil Massad at the White River Junction VA supervises the 20 case managers.

Ten VA sites across the country were chosen to participate in the study: Boston, Providence, West Haven, Miami, New Orleans, Minneapolis, Seattle, San Francisco, Menlo Park/San Jose, and San Diego. Dr. Stamm coordinates the study for us. She is assisted in this enormous task by Joe Rudolph.

To our knowledge, CS #420 is one of the largest psychotherapy studies that the VA has ever funded. A large and complicated study like CS #420 could not be planned or run in any cost-effective manner without the support of the research infrastructure provided by the program. Data collection is targeted to finish early in the year 2000. We are looking forward to learning the results of our study and share our findings with others at that time.

## PILOTS UPDATE

It has been more than three years since we last updated the *PILOTS Database User's Guide*, and there have been a lot of changes in the database since then. The PILOTS database is no longer part of the Combined Health Information Database. The Dartmouth College Library Online System (DCLOS), which replaced CHID as the principal means of access to PILOTS, offered a quick and simple command-driven approach to searching our database. While it is still the best interface to the database for those performing complex searches, those whose information needs are not so complex can choose to use the graphic interface provided by the Dartmouth College Information System (DCIS). Both DCLOS and DCIS are now available to users of the World Wide Web, with access and instructions provided at the National Center's Web site.

The existence of the World Wide Web, and the rapidly-changing environment in which the PILOTS database—like all other information products and services—exists, requires us to rethink our plans for future editions of the *PILOTS Database User's Guide*. Printed publications are expensive to produce and distribute, and become obsolete very rapidly. It is difficult to estimate the quantity that will be needed, and cumbersome to store excess copies. Although we shall produce a printed version of the new *User's Guide*, we do not intend to print more copies than will be needed for an initial distribution to National Center staff members, VA medical libraries, Vet Centers, and specialized VA PTSD treatment programs.

We shall turn to the National Technical Information Service (NTIS) for public distribution of the printed *User's Guide*. NTIS will keep a single master copy, producing copies in microfiche or xerographic form as needed. These will be available for purchase from NTIS.

We shall also offer an alternative form of print-on-demand distribution, free of charge. We intend to produce the *PILOTS Database User's Guide* in portable document format (PDF), which may be viewed on our Web site or downloaded from it. Like other PDF documents on our Web site—including this and other issues of the *PTSD*

*Research Quarterly*—it will be an exact replica of the original printed document. To read it on a computer monitor, or to print it on a PostScript printer, a copy of the Adobe Acrobat Reader is needed. (This software program is widely available, free of charge, in versions for almost every computer platform. For those who have not got it already, our Web site offers a link to the publisher's site from which it can be downloaded.) And for those whose computers or terminals will not support PDF documents, we shall post a plain-text (ASCII) version as well.

We shall continue to maintain a hypertext version of the *User's Guide* on our Web site, which can be revised whenever changing Internet conditions or new database features make it appropriate to do so. The biggest change will be the inclusion of the entire Thesaurus—the annotated list of descriptors used in searching the database for material on a specific subject. The hierarchical listing of descriptors is a table of the terms we use to describe the subject content of each publication we index, arranged to show the relationships between broader and narrower terms. The alphabetical index explains the way that the PILOTS database uses each descriptor, and provides extensive cross references from the terms a user might have in mind to the appropriate descriptors. Thus those users who depend on our Web site for instructions on using the database will have access to the same help in planning their searches as those who have got the printed *User's Guide*.

These plans are subject to change, either in response to changes in the Internet environment or as a result of feedback from readers of this column and other users of the PILOTS database. We shall be working on the new *User's Guide* during the next several months; the sooner we receive any comments or suggestions, the better chance they have of influencing the outcome of our work.

Even before the new *User's Guide* is completed, we have begun to implement the changes in the PILOTS Thesaurus that we described in our last "PILOTS Update" column. We have posted a new hierarchical listing of descriptors on our Web site, and we invite you to download a copy to replace the listing on pp. 29-45 of the *PILOTS Database User's Guide*, 2d edition.

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