

CASE REPORT**PSYCHIATRY & BEHAVIORAL SCIENCE**

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Posttraumatic Stress Disorder and Diminished Criminal Responsibility as “New Evidence” in Criminal Revision Procedures

ABSTRACT: Posttraumatic stress disorder (PTSD) may affect victims of crime, but may also be reported by offenders. In the postappeal phase, offenders may claim to suffer from chronic PTSD and argue that this indicates diminished criminal responsibility at the time the index crime was committed. As members of a Dutch criminal cases review commission, we recently encountered two cases in which PTSD was presented as new evidence that would justify a reopening of the case. In this article, we argue that such claims are problematic in that clinical decision making resulting in a PTSD diagnosis adheres to quite different standards than those dictating forensic fact-finding. The two cases illustrate the difference between criminal and clinical fact-finding.

KEYWORDS: forensic science, posttraumatic stress disorder, psychiatry, psychology, expert-witnesses, behavioral science

Posttraumatic stress disorder (PTSD) is a complex compilation of complaints, ranging from intrusive memories, nightmares, hypervigilance, and irritability to dissociative symptoms and feelings of detachment, in reaction to an experienced or witnessed traumatic event (1). It is easy to understand how a crime victim may develop PTSD when he/she experiences a violent crime as traumatic. However, offenders may also report PTSD. Committing a crime may be experienced as highly traumatic by perpetrators and so they may develop PTSD in response to their own violence (2). In this contribution, we describe two cases in which yet a different type of PTSD claim was brought forward by convicts.

The context of these cases is the postappeal phase in which convicted perpetrators may file a request to the Dutch Supreme Court to reopen their case on the grounds that there is new evidence uncovered posttrial that casts doubts on their conviction. According to the Dutch Code of Criminal Procedure, a revision of formally irrevocable judgments is possible when a so-called *novum* is uncovered—a novel finding that might have led to a different verdict, had it been known to the lower or appeal courts. When the Supreme Court accepts the presence of a *novum* in a case, it will grant the request for revision and refer the case to a court of appeal that will retry the case. A criminal cases review commission may inform the Supreme Court whether the evidence presented by the convicted person really has the potential of being a *novum* (3,4).

Below, we describe two cases in which a diagnosis of PTSD was proffered as new evidence to the criminal case review

committee of which two of us (ER and HM) are members. In both cases, the convicted perpetrator claimed that he committed a crime *as a result of prior traumatization*. Thus, the perpetrator claimed to suffer from PTSD at the time of the crime and this psychiatric syndrome would have caused him to behave violently. Although the legal background of both cases is the Dutch inquisitorial system, we believe that the problems that arise when PTSD is presented as legal evidence have broader relevance.

Case 1

In 2012, a 26-year-old policeman was sentenced to 18 years imprisonment for a murder that he had committed in 2010. He kidnaped a 12-year-old girl and brought her to his home, where he first raped and then killed her. He buried her body in his garden. A few days later, he was arrested, and the body was detected, as was other technical evidence that linked the policeman to the crime. In 2014, his lawyer filed a request to the criminal case review commission, in which a PTSD diagnosis was presented as a potential *novum* that would require further investigation so as to examine possibilities for reopening the case of his client. Briefly, the argument was that in 2013, while in prison, a psychologist had administered a Structured Interview for DSM-IV Axis I Disorders (SCID-I) and a Dutch version of the Post Traumatic Stress Symptom Scale–Self-Report Version (PSS-SR) to his client (5,6). On the basis of these instruments, the psychologist concluded that the convict “meets all DSM-IV criteria for PTSD (.). He suffers from chronic PTSD as the complaints exist since 2007.” The psychologist argued that the confrontation with violence and death during his career as a policeman had resulted in PTSD symptoms. During the initial trial and the appeal trial, the judges had not taken into consideration the issue of PTSD. The lawyer argued that this was a grave omission because the PTSD of his client should have been a

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central topic. Thus, adverse experiences during his work as a policeman had caused the PTSD and this, in turn, had undermined his criminal responsibility when he committed the crime.

Case 2

A 35-year-old man was sentenced to 18 years imprisonment in 2001 for manslaughter. He had broken into the home of his former employer, but was caught in the act by the employer's wife. He repeatedly stabbed the woman, consequently killing her. During the psychiatric evaluation, the perpetrator was diagnosed with an antisocial, narcissistic, and borderline personality disorder. This diagnosis resulted in a so-called partial responsibility verdict and a consequent combination of imprisonment and incarceration in a forensic psychiatric clinic. In 2014, while incarcerated in a forensic clinic, the convict was evaluated psychiatrically once more. In addition to the Axis II diagnoses, he was now also diagnosed with depression, drug addiction, and PTSD. The underlying trauma was the death of a friend at the age of five and repeated sexual abuse, also during childhood. According to the clinicians, the convict suffered from various PTSD symptoms such as intrusive memories, flashbacks, physical agitation, avoidance, detachment, sleep disturbance, irritability, hypervigilance, and concentration problems. Crucially, the diagnostic team members opined that his victim, who caught him in the act of burglary, startled the convict. He panicked, automatically went into a reliving of childhood maltreatment, and in that state, mindlessly kept stabbing his former employer's wife, according to the defense. The lawyer of this convict filed a request to the criminal cases review committee arguing that the diagnosis of PTSD was a potential novum. In his view, his client should have been declared completely (rather than partially) criminally irresponsible, resulting in a sentence to a treatment program instead of imprisonment.

PTSD in a Legal Context

The attempts of the defense lawyers in both cases to relate a diagnosis of PTSD to the crimes of their clients are surrounded by four problems. First, methods that are used to arrive at a psychiatric diagnosis such as PTSD do not possess laser accuracy. For example, the PSS-SR has a test-retest stability of around 0.80 and a specificity in the range of 0.75–0.80 (7,8). Likewise, the interrater agreement (in terms of Cohen's kappa) of the SCID-1 is 0.77 (9). For clinical purposes, these diagnostic accuracy statistics are good, but in the legal context, where solid evidence is required, they leave room for the possibility of a false positive, that is, a convict who is erroneously diagnosed with PTSD.

Second, and related to the previous point, in neither case, clinicians ruled out malingering of PTSD symptoms by the convicts. The DSM 4 (APA, 1994, p. 739) explicitly warned that "Malingering should be ruled out in those situations in which financial remuneration, benefit eligibility, and forensic determinations play a role (10)." Studies have shown that it is relatively easy to fake PTSD symptoms, yet detection can be enhanced with so-called Symptom Validity Tests (SVTs) (11–13). Still, detection of malingered PTSD is a challenging task, even for professionals. Recent findings show that of 178 forensic psychiatrists only seven were confident that they can actually detect malingered PTSD symptoms. Furthermore, 59% stated that the PTSD diagnosis was greatly overdiagnosed in forensic setting (14). More generally, it is not surprising that clinicians are hesitant to assess for fabrication of symptoms, due to the serious legal

consequences that might follow if the assessment raises doubts about a patient's report and/or the hostile reactions from patients (15,16). In the cases described above, the clinicians did not use any SVTs, although it would have been easy to do so.

A third issue pertains to chronology. Even if one assumes that false positives and malingering of PTSD can be ruled out in both cases, and that the two convicts genuinely suffered from PTSD, the question arises what the origins of their PTSD are. Epidemiological studies showed that almost 70% of people experience a traumatic event during their lives (17). However, traumatic exposure will lead PTSD in only 10% of cases (18). This indicates that the majority of people will have some kind of a traumatic experience to report. However, the causal link between that specific event and the reported symptoms is difficult to establish. Furthermore, PTSD is almost three times more frequent in offenders than in the general public (19,20). Thus, PTSD may develop because perpetrators are traumatized by their own violence and/or by their incarceration (2,21). In these scenarios, PTSD is irrelevant to the issue of criminal responsibility because the symptoms develop after the crime.

A fourth issue is whether PTSD undermines criminal responsibility. Even if one would assume that the convicts in both cases suffered from PTSD when they committed their crimes, the essential question is whether PTSD negates their responsibility. A dubious assumption on the part of the lawyers in both cases is that suffering from PTSD makes a perpetrator criminally less or not responsible. To the best of our knowledge, there is no empirical evidence suggesting that PTSD per se undermines the ability of an individual to oversee the consequences of his/her own actions. Admittedly, the DSM-5 states that the PTSD patient may experience "dissociative reactions (e.g., flashbacks) in which the individual feels or acts as if the traumatic event(s) were recurring." In extreme cases, such reaction may be accompanied by a "complete loss of awareness of present surroundings" (p. 271) (1). However, this description specifically alludes to anxious behavior similar to that displayed during traumatization. It does not imply the notion that traumatized individuals may, due to PTSD, act violently as if they were trying to escape a traumatic situation. Taking into account the paucity of research looking into the impact of particular PTSD symptoms on criminal behavior (22), such notion is not supported by empirical data. Ultimately, defense lawyers are not bound by science. However, by emphasizing the invalidating effect of PTSD on criminal responsibility, they may expose other actors in the legal arena (e.g., forensic psychologists, but also judges) to unfounded claims. We seek to warn against the convincing effect of repeated claims, even unfounded ones (23).

Importantly, the lawyers in both cases failed to specify a scenario that would help to understand how the alleged PTSD of their clients contributed to the murder and manslaughter. It is possible to imagine a scenario in which a perpetrator is provoked such that a dissociative state is triggered (2). However, in the two cases described above the crimes were self-initiated rather than provoked.

Clinical Diagnosis Versus Legal Evidence

Posttraumatic stress disorder stands out between the numerous other syndromes described in various versions of the DSM in that PTSD is one of the few diagnoses of which the DSM specifies the causal pathway. Most other definitions of psychiatric disorders included in the DSM are silent about potential causes. For example, the DSM-5 dictates nothing about how one can

develop an anxiety disorder, a psychotic disorder, or an obsessive-compulsive disorder.

The defense lawyers in both cases seemed to assume that a PTSD diagnosis actually validates reports of prior traumatization in their clients. However, a diagnosis of PTSD does not imply that the patient has experienced a trauma him/herself. It suffices to witness a trauma, or even to learn that a traumatic event has occurred to a person close to the patient (22). But even when a patient reports exposure to a traumatic event, this would still be a self-reported trauma, which will generally be taken seriously by the clinician. A PTSD diagnosis does not require a clinician to engage in fact-finding to establish that the self-reported trauma did, indeed, occur. Such investigation would even be considered counterproductive and detrimental for the patient–clinician working relation (24).

Conclusion

Although acceptance of self-reported trauma may work well in therapy, in the criminal justice arena, the diagnosis cannot be relied upon to decide that there actually was a trauma (25). Hence, some authors have argued that the diagnosis should be avoided altogether in criminal proceedings (26). Others go as far as to propose that clinicians should by definition not act as experts in legal proceedings (27). Such proposals seek to avoid that assumptions made leniently in a therapeutic context too easily get translated into “facts” in legal proceedings.

The cases as described in this contribution are summaries of the case descriptions published on the website of the Dutch Supreme Court (28). The requests of the lawyers in these cases to accept PTSD as new legal evidence and to examine the possibilities for reopening the cases of their clients was denied by the criminal case review commission.

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