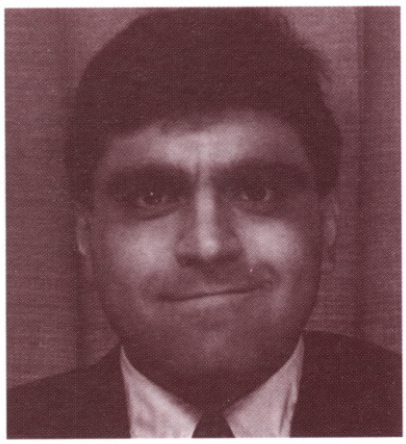
Criminal Law

Post-traumatic stress disorder: the legal view

by Sandeep Savla



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On researching the subject of post-traumatic stress disorder ('PTSD') as a defence in criminal proceedings, the dearth of published material seemed apparent. Despite this, I will suggest in this short article that PTSD may be used as a potent criminal defence. More specifically, this article will consider how the PTSD defence can be cogently argued before the criminal courts and, for that purpose, the manner in which medical experts should be asked to structure their reports.

When arguing PTSD as a defence in criminal proceedings, the defence has to be fitted into the structure of the criminal law as it presently exists. Therefore, PTSD has to be brought within the three defences of insanity, diminished responsibility or automatism. The focus of this article is non-insane automatism, but it is as well to consider all three defences.

INSANITY

The basis of the insanity defence is to be found in the M'Naghten Rules ((1843) 10 Cl & F 200). The test for insanity arising from the M'Naghten Rules may be summarised as follows.

(1) Everyone is presumed sane unless proved otherwise.

(2) It is a defence to a criminal prosecution for the accused to show that he or she suffered from a defect of reason due to a disease of the mind. The defendant must show that he or she did not know the nature or quality of the act, or did not know that what he or she was doing was wrong.

The phrase 'disease of the mind' refers to something 'internal' and, according to the House of Lords case of *R v Sullivan* [1984] AC 156, it must affect the faculties of reason, memory and understanding. The insanity defence is not really applicable to PTSD because the case of *R v Quick* [1973] QB 910 held that the application of an external factor, such as violence, would not constitute a disease of the mind. A defendant who suffered from a traumatic event would be relying on an external cause and therefore could not rely on the insanity defence.

DIMINISHED RESPONSIBILITY

Section 2 of the *Homicide Act* 1957 reduces the offence of murder to manslaughter if, at the time of the offence, the defendant was suffering from an abnormality of mind. That abnormality of mind must have substantially impaired his or her responsibility for the killing. Strictly speaking, medical experts should confine themselves to the first part of s. 2: in other words, they should consider whether the defendant was suffering from an abnormality of mind.

Most psychiatrists see abnormality of mind as being any mental state that meets current recognised diagnostic criteria, for instance the criteria in the fourth edition of the *Diagnostic and Statistical Manual* (DSM IV) (American Psychiatric Association, 1994). However, what we are actually concerned with is the legal definition of abnormality of mind and, according to *R v Byrne* [1960] 2 QB 396, that equates to a state of mind so different from that of an ordinary person that the reasonable person would term it absurd.

PTSD within the context of diminished responsibility has taken on renewed importance in cases of battered women who have killed their husbands. In these cases, the triggering event for the commission of the act may be quite minor, so that provocation could not be argued. However, it may be possible to show that a woman who has been exposed to violence 'over time' is suffering from PTSD, so as to rely on the diminished responsibility defence.

AUTOMATISM

This brings me to the main focus of the present article. 'Automatism' refers to an act that is beyond a person's control because there is no direction from the mind. Automatism has been divided by the court, in *R v Kemp* [1957] QB 399, into sane and insane automatism and this approach was approved in *Bratty v AG for NI* [1963] AC 386. Automatism that is derived from an external force is deemed to be sane and the defence may then be put before the jury. The defence results in a complete acquittal for the defendant. By contrast, where there is an internal cause, this is the legal equivalent of insanity (see above).

While most mental states have an internal cause, PTSD is derived from an external trauma. PTSD as a defence is therefore most likely to succeed when argued under the head of 'non-insane automatism'. Here the accused only bears the burden of adducing evidence and the burden of disproving non-insane automatism is then borne by the Crown.

The significance of PTSD as a possible defence first appears in the case of *R v T* [1990] Crim LR 256, decided at Snaresbrook Crown Court by Southan J. T was charged with robbery and assault occasioning actual bodily harm. She had injured a victim with a Stanley knife after a disagreement. On arrest, she was passive and indifferent, and in interview she could only recollect some events. T was examined by a doctor in Holloway Prison seven days later and he found that

her hymen had been ruptured and was bleeding. T complained that she had been raped three days prior to the arrest. T was then examined on a number of occasions by a psychiatrist, who diagnosed PTSD to the extent that she was in a dissociative state at the time that she had committed the offence.

Southan J held that rape could have an appalling effect on any young woman, however well balanced she normally was. PTSD involving a normal person in an act of violence was not to be considered a disease of the mind (within the M'Naghten Rules), even if there was a delay before the dissociation manifested itself.

This case may be contrasted with the Canadian case of *R v Rabey* (1978) 79 DLR (3d) 414. In that case, the defence of non-insane automatism was not accepted in respect of the psychological blow caused by the break-up of a relationship with a girlfriend. The Ontario Court of Appeal rejected this psychological blow as one of the ordinary stresses and disappointments of life (at 435). It is clear, therefore, that the defence of PTSD will be approached with some caution and that the triggering event for the PTSD must have a traumatic effect on a normally well-balanced person.

Another case of PTSD being used as a defence by arguing non-insane automatism may be found in the literature: Wright et al report the case of a police officer who raised the PTSD defence before a jury by arguing non-insane automatism (see 'Automatism revisited: post-traumatic automatism as a defence to a serious criminal charge' (1995) 35 Med Sci Law 327). The police officer was hit on the face by a man he was arresting and was rendered unconscious. When he recovered he hit the handcuffed man with his truncheon. In a case where a conviction seemed a foregone conclusion, psychiatric evidence was obtained about three traumatic events that the defendant had suffered:

(1) The defendant had been in the Royal Navy for 12 years and in 1965 he was caught by a booby trap in Malaya and rendered unconscious.

(2) The defendant had been a passenger in a train crash in 1968, when three people had been killed in his compartment.

(3) Finally, in 1987 the defendant had suffered a whiplash injury in a car accident.

There was no past history of mental disorder. In interview, the police officer said that, when he recovered from being hit in the face, he saw bright lights and stars and had a dazed feeling. The casualty officer who saw the police officer recorded in his notes that the police officer seemed very taken aback by the fact that he had been struck in the face. The psychiatric evidence stated that the police officer had been suffering from a temporary injury to the brain, which brought on post-traumatic amnesia. Evidence was given by witnesses at the trial as to the fact that the police officer had been knocked out for four to five minutes and the police officer himself had no memory of the act. This seemingly 'open and shut case' led to two hung juries and, in this writer's submission, shows the potential of the PTSD defence.

ROLES OF SOLICITOR AND PSYCHIATRIST

These two cases suggest an important way forward in the assertion of the PTSD defence. It is clear that the opinion of the expert psychiatrist is important. The opinion of the expert is admissible to furnish the court with scientific information which is likely to be outside the experience of the judge and jury (see *R v Turner* [1975] QB 854). The rule is that the expert is prohibited from giving his or her opinion on the ultimate issue: the job of the psychiatrist, then, is to educate the judge and jury about PTSD. In seeking to do this, it is advisable that the following approach be followed:

(1) The psychiatrist should review the pre-traumatic state in detail and form a view on the traumatic event itself. He or she should contrast the pre-traumatic status and post-traumatic behaviour of the defendant.

(2) Both cases above show that the defendant's account alone will not be sufficient. There should be interviews with independent persons to strengthen the connection between the traumatic event and the behaviour relating to the alleged offence.

(3) The diagnosis should be made by the psychiatrist on the basis of a detailed account of the symptoms and, if possible, with reference to DSM IV.

(4) It is important to recognise that many people survive extraordinary trauma, so the psychiatrist should link the particular trauma to the commission of the particular act that constitutes the crime (see Ashtead, 'PTSD and the Criminal Law' in *PTSD: Explaining, Understanding, Treating* (Mole Conferences, November 1997)).

In *R v T* there was independent evidence of a physical nature to indicate the traumatic event and, in the subsequent case, the witnesses and the casualty officer provide independent corroborative evidence.

It would appear, then, that when solicitors are faced with a defendant who is disorientated at the time of the commission of the offence, it may be possible to obtain psychiatric evidence to link the commission of the crime with a previous traumatic event.

OVERCOMING OBJECTIONS

The Law Commission, in its report dealing with PTSD in the civil context, identified three possible difficulties (see Law Commission, 'Liability for Psychiatric Illness', Consultation Paper No. 137, HMSO 1995, p. 51-57).

First, judges may be wary of flooding courts with PTSD defences. Doctors are increasingly willing to support PTSD claims and the concept of PTSD seems to be expanding. 'Acute stress disorder', for instance, is new to DSM IV and was added to describe acute reactions to extreme stress. It has also been suggested that there is evidence to support the existence of a more complex stress reaction occurring in victims of prolonged, repeated and inter-personal violence and victimisation. However, all the legitimate diagnoses of psychiatric conditions must today meet the diagnostic criteria which are contained in the classificatory system in DSM IV. Any discrepancy between the particular diagnosis and the classificatory systems can be probed in cross-examination, as can a failure to rule out alternative causes.

The second possible objection is fraudulent and exaggerated claims. It is argued that claimants may be able to fake the symptoms of a psychiatric illness and that they may be able to exploit legitimate differences of opinion within the medical profession. However, although no physical tests exist with which to ascertain an assertion of PTSD, there are a number of psychological tests. These psychological tests may help to distinguish long-standing character problems and dysfunctions from illness or injury of a sudden onset. The psychological tests are objective and given by computer and these tests are then complemented by clinical evaluation and corroborative interviews with family members.

The third and final objection is one of conflicting medical opinions. There is disagreement among mental health professionals concerning the presence or absence of a mental disorder following trauma. It is clear that there is a fluidity of psychiatric thinking here and there may be a judicial perception that mental health professionals may agree to a legally predetermined position. Nonetheless, there is no reason why courts cannot weigh evidence here as in other cases.

CONCLUSION

It would seem that there is no reason why the courts should not accept the defence of PTSD in criminal proceedings. What is required is a careful strategy to present expert evidence. Expert evidence must be supported with independent corroborative interviews from family members to establish the pre-traumatic status, evidence from witnesses who were present at the scene of the crime and evidence from independent witnesses, including those who may have examined the defendant shortly after the commission of the crime. While all these types of evidence may not be present, the more evidence that can be found the stronger the defence. Although the scope of the defence is not clear, what does appear from the cases discussed above is that PTSD put forward as 'non-insane automatism' may be more readily available than is presently thought.

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Although the author's interest is in financial crime, this article arose from his involvement in a series of criminal cases that involved psychiatric defences. He is grateful to the participants at the Conference on Criminal Law and Psychiatry held at Whipps Cross Hospital, London, on 21 March 1998, for their comments and suggestions.