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ARTICLES

DIAGNOSING LIABILITY: THE LEGAL HISTORY OF POSTTRAUMATIC STRESS DISORDER

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This Article examines the origins of the unique relationship between the psychiatric diagnosis Posttraumatic Stress Disorder (PTSD) and the law and considers the implications of that relationship for contemporary uses of the diagnosis in legal settings. PTSD stands apart from all other diagnoses in psychiatry's standard classification system, the Diagnostic and Statistical Manual of Mental Disorders (DSM), and is the focus of significant controversy within psychiatry, because its diagnostic criteria require a determination of causation. By diagnosing a person with PTSD, a clinician necessarily assigns responsibility to a specific event or agent for causing the person's symptoms, a practice more commonly associated with law. In short, the diagnosis uniquely medicalizes liability. The law has turned to PTSD, on the erroneous assumption that its location in the DSM signifies that it is well-settled science, to serve as a mechanism to resolve difficult problems in assessing legal responsibility. These uses include determining whether a criminal complainant is credible and when emotional distress from another's negligence is sufficient in itself to serve as a basis for liability. However, by adopting PTSD's conceptualization of causation of psychological injury, courts unknowingly delegate normative determinations of liability to psychiatry broadly and to the individual psychiatrists who

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present PTSD evidence at trial. This Article argues that the legal system should consider PTSD's origins and its persistent controversies as part of a broader reexamination of the role of the diagnosis in the law.

“[A]s soon as you accepted that the man's break down was a consequence of his war experience rather than of his own innate weakness, then inevitably the war became the issue.”¹

I. INTRODUCTION

The psychiatric diagnosis Posttraumatic Stress Disorder (PTSD) is powerful on many levels. The term permeates our culture, and the very mention of it can evoke imagery of the horrors of war, genocide, child abuse, and epic disasters. Affixing the label of PTSD to an individual suggests that the person was once mentally healthy and, as a result of a distinct and horrific experience, is now psychologically damaged and scarred. The person “reexperiences” the event through frightening symptoms such as flashbacks, fear, anxiety, avoidance, and nightmares. It is the diagnosis that attaches to psychological injuries—that is, a mental disorder attributable to an external cause. And, for all of these reasons, it is a diagnosis that appears uniquely suited for aiding the determination of liability in court.

PTSD has generated much attention and controversy within both law and psychiatry in large part because it contains elements of two fields that do not always fit together easily. PTSD stands apart from all other diagnoses in the American Psychiatric Association's (APA) standardized classification, the *Diagnostic and Statistical Manual of Mental Disorders (DSM)*, because it has a determination of causation built into the definition,² whereas other listings are agnostic as to the etiology of disorders. That is, although PTSD's listing has the typical descriptive cluster of symptoms found in all psychiatric diagnoses, its criteria also require a diagnostician to assign the cause of such symptoms to a specific external event or other source, known as the “A Criterion,”³ a practice more commonly associated with the law.⁴ In short, the diagnosis medicalizes liability.

This Article traces the historical origins of the unique relationship between PTSD and the law and explores the implications of such relationship for contemporary uses of the diagnosis in legal settings. Part II examines the early conceptualizations of psychological injury within medicine and the relationship of those theories to questions of legal responsibility from the late nineteenth to mid-twentieth centuries. It reviews

1. PAT BARKER, REGENERATION 115 (1991) (Barker's fictionalized account of World War I British military psychiatrist W. H. R. Rivers).

2. See AM. PSYCHIATRIC ASS'N, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS 467–68 (4th ed., text rev. 2000) [hereinafter DSM-IV-TR] (listing “expos[ure] to traumatic event” among diagnostic criteria for Posttraumatic Stress Disorder).

3. The name “A Criterion” results from the fact that the requirement of an external traumatic cause appears in subsection A of the DSM's PTSD criteria. DSM-IV-TR, *supra* note 2, at 467.

4. See Gillian Mezey & Ian Robbins, *Usefulness and Validity of Post-Traumatic Stress Disorder as a Psychiatric Category*, 323 BRIT. MED. J. 561, 562 (2001) (attributing criticism of PTSD diagnosis to its unique status as the only compensable psychiatric disorder).

the history of PTSD's forerunners—railway spine, shell shock, and traumatic neurosis—and demonstrates that a link to external causes, often with an association with liability questions, has been a key attribute of these diagnoses, even though the specific symptomatology and theories of the precise causal mechanisms at work have differed significantly over time. Part II then considers the parallel developments in the law regarding liability for psychological injuries during this same period.

Part III recounts the campaign for the inclusion of PTSD in the *DSM* and the unusual place of the diagnosis, and specifically the A Criterion, within the APA's classification system. The diagnosis first appeared in the third edition of the *DSM* in 1980 as a result of heavy lobbying by Vietnam veterans' groups who saw it as a mechanism to legitimate the extreme symptoms of veterans, enabling them to receive care and benefits for combat-related mental illnesses.⁵ However, the APA subsequently loosened the diagnostic criteria to reflect use of the diagnosis for people experiencing a wide range of life experiences, and the diagnosis became ubiquitous in personal injury litigation and widely used in criminal law as well. Although psychiatry broke away from the psychoanalytic and other psychodynamic theories of the origins of mental disorders in the rest of the *DSM-III*, PTSD represented a rooting in the past, both for the patients and for the field.

This historical discussion serves as the backdrop for Part IV of this Article, which explores the uses of PTSD in the legal context and considers how PTSD, as one group of commentators put it, "acquired [its] own legal currency."⁶ This Part focuses on two particular uses of the diagnosis to address problems of establishing liability: (1) proving that a criminal complainant or civil plaintiff was subjected to an alleged trauma to prove criminal or civil liability for such trauma; and (2) enabling personal injury plaintiffs to pursue "stand-alone" claims for psychological injuries. Part IV also examines the minimal evidentiary limitations that courts impose on such uses.

Part V returns to psychiatry and reviews two key controversies concerning PTSD that challenge many of the core assumptions upon which the APA based its recognition of the disorder: (1) the validity of the A Criterion and the causal relationship between events and symptoms; and (2) the extent to which PTSD is a "construct" rather than a "scientific discovery." This discussion concludes that the inherent complexities of both the formation of emotional responses to life events and the development of psychiatric diagnoses preclude any simple "resolution" of these debates.

Part VI concludes the Article by reviewing the lessons for law from PTSD's history and by considering the implications for the role of PTSD evidence in litigation specifically and for the relationship between the law and psychiatry on a broader level. Medical diagnoses are largely the result of "negotiations" among various institutions and stakeholders rather than being pure scientific "discoveries." The history of PTSD's negotiations reveals a particularly prominent role for legal interests. From the late

5. See AM. PSYCHIATRIC ASS'N, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS 236, 237 (3d ed. 1980) [hereinafter *DSM-III*] (showing inclusion of Posttraumatic Stress Disorder in a chapter on anxiety disorders generally); Wilbur J. Scott, *PTSD in DSM-III: A Case in the Politics of Diagnosis and Disease*, 37 SOC. PROBLEMS 294, 309 (1990) (attributing the inclusion of PTSD in *DSM-III* to the collaboration between key psychiatrists and the Vietnam veteran community).

6. Stuart A. Greenberg et al., *Unmasking Forensic Diagnosis*, 27 INT'L J.L. & PSYCHIATRY 1, 10 (2004).

nineteenth century to the publication of *DSM-III*, medicine produced various diagnostic labels for psychological injuries, particularly those for which individuals sought compensation or other legal benefit. Psychiatry thus addressed socio-legal needs as well as medical needs when it established PTSD. The law has turned to PTSD and its unique linking of an identifiable event and psychiatric symptoms to serve as a mechanism to resolve difficult problems in assessing legal responsibility, such as determining whether a criminal complainant is credible and when emotional distress from negligence is sufficient in itself to serve as a basis for liability.

However, most courts that admit evidence of PTSD for such purposes impose minimal scrutiny to the diagnosis. Rather, the fact of PTSD's location within the *DSM* (coupled with courts' misplaced assumptions about the *DSM* itself) has led most courts to grant PTSD the status of well-settled science. Courts are likely unaware of PTSD's legal origins, the persistent controversies within psychiatry and psychology about the theoretical underpinnings of the diagnosis, and the complicated notion of "causation" within contemporary psychiatry. All of this suggests that courts should exercise caution before permitting the diagnosis to serve as evidence in a determination of liability.

Accordingly, the legal system should consider PTSD's historical development and contemporary controversies as part of a broader reexamination of the role of the diagnosis in the law. By adopting PTSD's particular (and unsettled) conceptualization of the causation of psychological injury, courts may unknowingly delegate the normative determinations of legal responsibility to psychiatry broadly and to the individual psychiatrists who present PTSD evidence at trial. Such uses recast PTSD as essentially a legal tool, potentially undermining its clinical function in aiding those who have experienced the horrors of war, assault, and disaster.

II. THE PSYCHIATRIC FORERUNNERS OF PTSD AND PARALLEL DEVELOPMENTS IN LAW

Although the term "posttraumatic stress disorder" was first coined in the 1970s during the development of the diagnosis that eventually appeared in the third edition of the *DSM*, the direct lineage of the term extends to at least the late nineteenth century.⁷ As PTSD's history reveals, the link between medical concepts of psychological injury and legal notions of responsibility is not of recent origin but was present from the earliest conceptualizations of such injuries. Thus, it is impossible to talk of PTSD and its forerunners apart from broader socio-political attempts to attach legal responsibility for psychological injuries to identifiable sources.

A. *Early Medical Conceptualizations of Psychological Injury*

The history of psychiatry reflects a wide range of theories on the origins of mental illness. Some have thought that the symptoms of mental instability originate from spirits, humors, vapors, or demons.⁸ The notion that an exogenous event could alter one's behavior, thinking, and beliefs—that one could sustain a psychological *injury*—is

7. ALLAN YOUNG, *THE HARMONY OF ILLUSIONS: INVENTING POST-TRAUMATIC STRESS DISORDER* 5 (1995).

8. See generally ROY PORTER, *MADNESS: A BRIEF HISTORY* 1–61 (2002).

of more recent origin, and has always been controversial. Freud and other followers of his theories were significant proponents of the notion that one's prior life experiences, particularly negative ones, can have lasting influence on one's psyche.⁹ Although Freud himself later altered these theories to give fantasy a more prominent role, the essential notion of a lasting emotional reaction to a specific event has persisted to this day.

PTSD is often associated with exposure to combat, and indeed military psychiatry is where many of the concepts of PTSD found their origins during the First World War.¹⁰ However, the story of PTSD in fact begins with the railways.¹¹ Prior to the spread of the railways, and the accompanying spate of railway accidents, traumatic injuries were not commonly the subject of either everyday conversation or litigation.¹² The word "trauma" was, until the late nineteenth century, a term associated exclusively with physical wounds.¹³ John Erichsen, a British surgeon and academic, is often credited with being the first to apply the term to psychiatric injuries¹⁴ in his book, *On Railway and Other Injuries of the Nervous System*, first published in 1866.¹⁵ Erichsen theorized that railway injuries from "Jars, Shakes, Shocks, or Concussions" to the spinal cord could cause injuries (specifically, lesions) that could have several manifestations, including "cerebral" changes affecting memories, thoughts, temper, and sleep.¹⁶ Erichsen did not and could not explain the specific causal mechanism in place leading to so-called "railway spine,"¹⁷ but his work led to that of others who more thoroughly developed the association between railway injuries and nervous system disorders.¹⁸

9. See YOUNG, *supra* note 7, at 36–38 (describing Freud's belief that hysterical attacks are caused by the failure to discharge emotion attached to prior traumatic experiences).

10. Two scholars, a historian and an anthropologist, have produced excellent and highly regarded historical analyses of the early development of PTSD. See generally BEN SHEPHARD, *A WAR OF NERVES: SOLDIERS AND PSYCHIATRISTS IN THE TWENTIETH CENTURY* (2000); YOUNG, *supra* note 7.

11. In this important respect, the origins of PTSD share a critical link with the development of American tort law and its conceptualizations of liability. Jennifer B. Wriggins, *Torts, Race, and the Value of Injury, 1900–1949*, 49 HOW. L.J. 99, 108 (2005) ("Railroad injuries in the mid and late nineteenth century spurred the development of tort doctrine and tort practice.").

12. SHEPHARD, *supra* note 10, at 16.

13. YOUNG, *supra* note 7, at 13; see also RUTH LEYS, *TRAUMA: A GENEALOGY* 19 (2000) (linking psychical "trauma" to the term's original use to describe a surgical wound); Scott Baldwin et al., *The Creation, Expansion, and Embodiment of Posttraumatic Stress Disorder: A Case Study In Historical Critical Psychopathology*, 3 SCI. REV. MENTAL HEALTH PRAC. 33, 43 (2004) (explaining psychological trauma as a metaphor for literal physical trauma).

14. YOUNG, *supra* note 7, at 13; see also Edward M. Brown, *Regulating Damage Claims for Emotional Injuries Before the First World War*, 8 BEHAV. SCI. & L. 421, 421–22 (1990) (discussing Erichsen's description of a disorder afflicting railway accident victims who show no obvious physical injury); Flora V. Woodward Tibbits, *Neurasthenia, the Result of Nervous Shock, as a Ground for Damages*, 59 CENT. L.J. 83, 85 (1904) (discussing Erichsen's etiology of "traumatic neurasthenia").

15. JOHN ERICHSEN, *ON RAILWAY AND OTHER INJURIES OF THE NERVOUS SYSTEM* (1866).

16. *Id.* at 94, 96–99. Another nineteenth century proponent of the theory of actual physical damage to the nervous system (in his case, lesions) as the cause of traumatic neurosis was Berlin neurologist Hermann Oppenheim. See *infra* notes 36–38 and accompanying text for a discussion of Oppenheim's study.

17. ERICHSEN, *supra* note 15, at 94 (conceding that, how the injuries to the spine "directly influence its action I cannot say").

18. BARBARA YOUNG WELKE, *RECASTING AMERICAN LIBERTY: GENDER, RACE, LAW AND RAILROAD REVOLUTION, 1865–1920*, at 154–56 (2001); YOUNG, *supra* note 7, at 14–15.

Erichsen developed his theory and diagnostic term with litigation specifically in mind.¹⁹ At the time, British and American societies were confronting the impact of industrialization, and particularly railways, on society. Railway accidents were “frequent, terrifying and highly publicized instances of the capacity of industrial technology to maim and kill.”²⁰ A significant number of railway accidents led to claims for compensation.²¹ However, in a number of these cases, railways were able to escape with little or no financial liability where, notwithstanding the presence of negligence, the physical injuries were minimal.²² Accordingly, Erichsen, who testified frequently on behalf of patients in these cases, developed his theory of railway spine to decrease the “discrepancy of surgical opinion” regarding those who exhibited symptoms that arose after the accident, and when it had been assumed that there had been no injury.²³ These symptoms included “headache, confusion of thought, loss of memory, disturbance of the organs of sense, [and] irritability of the eyes and ears.”²⁴ His work initially had an enormous impact on litigation against the railways, resulting in large damages awards and settlements.²⁵

Medicine did not uniformly embrace Erichsen’s theories and, given the financial impact on the railways and the lack of empirical basis for railway spine, they provoked swift criticism.²⁶ One of his most prominent critics was Herbert Page, a physician who, not surprisingly, did consulting work for a railway.²⁷ Page immediately challenged the causal assumptions underlying Erichsen’s theory of traumatic railway injuries. He rejected Erichsen’s purely somatic hypothesis in favor of one that included a potential causal role for fear in the mix, thus recharacterizing the symptoms as psychosomatic.²⁸ He referred to the condition as “nervous shock,” and concluded that it arose only in those with a preexisting “nervous temperament.”²⁹

19. ERICHSEN, *supra* note 15, at 2–3; WELKE, *supra* note 18, at 150–51; Brown, *supra* note 14, at 423.

20. Brown, *supra* note 14, at 423; *see also* WELKE, *supra* note 18, at 139–46 (describing American society’s fear in reaction to frequent railway accidents and their media coverage in the late nineteenth century).

21. Brown, *supra* note 14, at 423.

22. *See id.* (explaining a legal defense that sometimes prevented railway employees from collecting damages against their employers before the advent of workers’ compensation laws).

23. ERICHSEN, *supra* note 15, at 3–4.

24. *Id.* at 119.

25. Brown, *supra* note 14, at 424; *see* WELKE, *supra* note 18, at 162–63 (discussing corporate doctors and lawyers who blamed Erichsen for his pro-plaintiff bias and for huge damage awards in American courts).

26. *See* WELKE, *supra* note 18, at 153 (discussing the mobilization of railway doctors against Erichsen and his conclusions about railway spine); Brown, *supra* note 14, at 424 (explaining that railway spine theory was vulnerable to criticism because of vague diagnoses and victims who recovered after settled cases).

27. YOUNG, *supra* note 7, at 16–17; Brown, *supra* note 14, at 425–26.

28. Brown, *supra* note 14, at 425–26; *see also* WELKE, *supra* note 18, at 154–55 (explaining Page’s argument against Erichsen’s theory of injury to the spinal cord); YOUNG, *supra* note 7, at 16–17 (describing Page’s emphasis on mental factors, including fear, in the onset of symptoms); J. David Kinzie & Rupert R. Goetz, *A Century of Controversy Surrounding Posttraumatic Stress-Spectrum Syndromes: The Impact on DSM-III and DSM-IV*, 9 J. TRAUMATIC STRESS 159, 160 (1996) (describing Page’s rejection of Erichsen’s theory of injury to the spinal cord and his belief that mental factors contribute to the disorder).

29. Brown, *supra* note 14, at 425–26.

In his criticism, Page specifically raises the specter of malingering—the exaggeration or falsification of symptoms³⁰—in light of the potential for compensation for railway injuries made possible by the passage in England in 1864 of an amendment to the Campbell Act, allowing recovery for railway injuries.³¹ Page, among others, suspected that desire for compensation played some role in the development and persistence of symptoms, even in unconscious ways.³² The resistance by doctors associated with the railways to permitting recovery of compensation for injuries that were not obviously physical was unrelenting, and some turned their criticism specifically to the doctors who diagnosed such conditions, who, they claimed, were responsible for the role of “suggestion” in the persistence of symptoms.³³ Those arguing a purely psychological (or “hysterical”) origin for lasting symptoms also challenged Erichsen and other proponents of such conditions in the courtroom,³⁴ and had some success in limiting the railways’ exposure for such claims.³⁵

The debate regarding diagnoses such as “railway spine” soon spread beyond Britain. In Germany in the 1880s, neurologist Hermann Oppenheim developed the term “traumatic neurosis,” and saw a key role for direct neuropathological injury in its onset.³⁶ His theory, like Erichsen’s, developed as a result of work treating individuals who developed a range of symptoms after railway and other industrial accidents.³⁷ Unlike Erichsen, however, he also saw a significant etiological role for “the psyche: terror, emotional shock.”³⁸

Across the Channel in France, neurologist Jean-Martin Charcot was also interested in the development of traumatic syndromes. Charcot focused entirely on the causal impact of fear in creating symptoms even in the absence of any spinal injury or

30. The current edition of the *DSM* defines malingering as the “intentional production of false or grossly exaggerated physical or psychological symptoms, motivated by external incentives” including “obtaining financial compensation.” *DSM-IV-TR*, *supra* note 2, at 739.

31. See YOUNG, *supra* note 7, at 17 (attributing to Page the contention that railway accident victims could not think of injuries in isolation from their monetary significance).

32. SHEPHARD, *supra* note 10, at 16; WELKE, *supra* note 18, at 167–68; YOUNG, *supra* note 7, at 17; see also Brown, *supra* note 14, at 426–27 (describing the attempts of Erichsen’s critics to define objective symptoms that could distinguish malingering).

33. WELKE, *supra* note 18, at 166, 168.

34. See *id.* at 163–64 (describing the cottage industry that arose among anti-Erichsen expert medical witnesses).

35. SHEPHARD, *supra* note 10, at 16.

36. See *id.* at 98 (discussing the development of Oppenheim’s theory that “actual physical damage to the brain and nervous system” caused victims’ symptoms); WELKE, *supra* note 18, at 156 (attributing to Oppenheim the term “traumatic neurosis,” a phrase indicating chronic nervous system disorders could be “produced by the stresses of modern industrial life itself”); Paul Lerner, *From Traumatic Neurosis to Male Hysteria: The Decline and Fall of Hermann Oppenheim, 1889–1919*, in *TRAUMATIC PASTS: HISTORY, PSYCHIATRY, AND TRAUMA IN THE MODERN AGE, 1870–1930* 140, 144 (Mark S. Micale & Paul Lerner eds., 2001) [hereinafter *TRAUMATIC PASTS*] (indicating Oppenheim’s theory that “traumatic neurosis” was caused, in part, by minute lesions in the brain or nervous system, which lead a victim’s nervous system to deteriorate).

37. Lerner, *supra* note 36, at 144.

38. *Id.* at 145 (translating HERMANN OPPENHEIM, *DIE TRAUMATISCHEN NEUROSEN NACH DEN IN DER NERVENKLINIK DER CHARITÉ IN DEN LETZEN 5 JAHREN GESAMMELTEN BEOBACHTUNGEN* (1889)).

lesions.³⁹ This interest grew out of his close study of “hysteria,” and he opined that Oppenheim’s descriptions of “traumatic neuroses” were essentially indistinguishable from hysteria, as he had classified it.⁴⁰ He suspected that traumatic experiences often accounted for hysteria in men.⁴¹ In an argument that would foreshadow controversies arising a century later about PTSD, Charcot challenged the creation of traumatic neurosis as an “entity” aside from hysteria, distinguished only by having a specific origin, such as fear or fright.⁴² The term “traumatic hysteria” soon found use not only to explain the unusual symptoms experienced by those who had been exposed to an event but also to bring more credibility to the concept of “hysteria” generally, which had become a disparaging term by this time, used primarily to describe a “condition” (or perhaps simply malingering) displayed by overdramatic women.⁴³

Oppenheim resisted Charcot’s linking of post-traumatic responses with hysteria.⁴⁴ He was concerned that Charcot’s use of the term “traumatic hysteria” suggested too strong a role for the individual’s thoughts and ideas and raised the specter of malingering.⁴⁵ Oppenheim’s theories were eventually rejected by the German psychiatric establishment, in part because they had been successfully used to support compensation claims brought by railway and factory workers and because (unlike Page, for example) he did not suggest a significant role for individual predisposition in the onset of these neuroses.⁴⁶ Although Oppenheim is regarded as only a minor player in the development of modern notions of posttraumatic psychological injury (in fact, his name is nearly forgotten), his conceptualization of “traumatic neurosis” had a more lasting impact than the theories of any of his contemporaries, and, as we shall see, that term played an increasingly important role in personal injury litigation in the twentieth century.⁴⁷

39. See YOUNG, *supra* note 6, at 19 (detailing Charcot’s theory that fear produced traumatic symptoms during a self-induced hypnotic state).

40. *Id.* at 20; see also WELKE, *supra* note 18, at 156 (discussing the emergence of labels, including Oppenheimer’s “traumatic neurosis” and Charcot’s “traumatic hysteria,” used to describe the same psychological ailment).

41. See SHEPHARD, *supra* note 10, at 9 (noting Charcot’s belief that male hysteria was “usually traumatic in origin”); Kinzie & Goetz, *supra* note 28, at 161 (noting Charcot’s belief that “much of male hysteria was traumatic hysteria”).

42. YOUNG, *supra* note 7, at 20 (quoting JEAN-MARIN CHARCOT, CLINICAL LECTURES ON DISEASES OF THE NERVOUS SYSTEM DELIVERED AT THE INFIRMARY OF LA SALPÊTRIÈRE 224–25 (New Sydenham Soc’y 1899)).

43. Brown, *supra* note 14, at 426. See generally IAN HACKING, REWRITING THE SOUL: MULTIPLE PERSONALITY AND THE SCIENCES OF MEMORY 185–88 (1995); EDWARD SHORTER, FROM PARALYSIS TO FATIGUE: A HISTORY OF PSYCHOSOMATIC ILLNESS IN THE MODERN ERA 112–17 (1992).

44. Lerner, *supra* note 36, at 145. Erichsen similarly disagreed with Charcot on this point, in part because he could not fathom the notion that men could be “hysterical.” WELKE, *supra* note 18, at 173–74.

45. Lerner, *supra* note 36, at 145.

46. *Id.* at 151–52. Many were also concerned that the application of his theory to war neuroses would have an impact on Germany’s army during World War I. See, e.g., *id.* at 157 (noting Oppenheim’s theory became regarded as “a threat to national health and strength” because its application would create significant pension obligations to soldiers diagnosed with traumatic neurosis).

47. Paul Lerner & Mark S. Micale, *Trauma, Psychiatry, and History: A Conceptual and Historiographical Introduction*, in TRAUMATIC PASTS, *supra* note 36, at 1, 13–15.

Work on the psychological impact of accidents continued with a number of researchers in Europe and the United States at the turn of the twentieth century.⁴⁸ American neurologist George Miller Beard first suggested the diagnosis of “traumatic neurasthenia,” the symptoms of which resemble those of railway spine.⁴⁹ The term “neurasthenia” had been around for a few decades, and it was regarded as being more legitimate than hysteria, although its symptoms were vague and not well defined.⁵⁰ It was seen as a condition caused by “the stresses of advanced civilization,” and, for that reason, many readily accepted a causal link with industrial accidents.⁵¹ Beard asserted that neurasthenia had a physical cause (as Erichsen had claimed was true for railway spine) and “defined as ‘disease’ what before had been seen as self-willed, and in the process shifted causation away from the individual to modern civilization.”⁵²

Many of those examining these questions of psychological injury turned their focus to the role of memory in the emergence of psychological symptoms—the “pathogenic memory” or “traumatic memory”⁵³—and such “traumatic remembering” is a core concept of PTSD.⁵⁴ Sigmund Freud’s original theories about traumatic memory (developed in conjunction with Josef Breuer) tied pathology to a patient’s memory of a traumatic event.⁵⁵ The pathological mechanism was thought to stem from a patient’s inability to “discharge” his emotional reactions to the event, forcing the nervous system to “manage a sudden surge of excitation.”⁵⁶ Memories of these events then became isolated from a person’s consciousness and could no longer be reached.⁵⁷ The key to treatment, therefore, was to bring such traumatic memories to the surface and verbalize them through “abreaction”⁵⁸ to achieve “catharsis,”⁵⁹ so that the memories would lose their “pathogenic power.”⁶⁰ Freud’s “seduction theory” suggested that psychoneurosis stemmed from early childhood trauma, generally sexual abuse, whereas “actual neurosis” emerged from trauma later in life.⁶¹ He later abandoned the theory to place more emphasis on the role of early fantasy in the development of neuroses.⁶²

48. Brown, *supra* note 14, at 427.

49. WELKE, *supra* note 18, at 157–58.

50. Brown, *supra* note 14, at 427; *see also* Kinzie & Goetz, *supra* note 28, at 162 (describing neurasthenia as a common diagnosis in the 1900s for “nonspecific emotional” injuries caused by traumatic events).

51. Brown, *supra* note 14, at 427; *see also* WELKE, *supra* note 18, at 157–58 (discussing Beard’s theory that nervousness was caused by “noises that were necessary accompaniments of civilization”).

52. WELKE, *supra* note 18, at 159.

53. YOUNG, *supra* note 7, at 25, 39.

54. *Id.* at 34.

55. LEYS, *supra* note 13, at 19–20; YOUNG, *supra* note 7, at 36.

56. YOUNG, *supra* note 7, at 36.

57. *Id.* at 37.

58. *Id.* at 38.

59. SHEPHARD, *supra* note 10, at 13.

60. YOUNG, *supra* note 6, at 37; *see also* SHEPHARD, *supra* note 10, at 13 (describing Freud’s treatments resulting in the restoration of a patient’s mental state).

61. YOUNG, *supra* note 6, at 37–38.

62. *Id.* at 38. With that shift came the accompanying shift from abreaction to psychoanalysis. *Id.*; *see also* John P. Wilson, *The Historic Evolution of PTSD Diagnostic Criteria: From Freud to DSMV-IV*, 7 J. TRAUMATIC STRESS 681, 683–84 (1994) (explaining the external pressures influencing the underpinnings of

The theories of pathogenic memory advanced by Freud, Breuer, and French psychologist Pierre Janet⁶³ in the years leading up to the First World War began to displace the approaches to psychological injury described by Erichsen, Page, Beard, and Charcot.⁶⁴ Interest in pathogenic memory in particular became strong during the war, when there was horror on a scale (both in terms of frequency and degree) that was previously unfathomable, at a time when clinicians in many countries were exploring these new notions of memory and consciousness.⁶⁵ Suddenly, the countries involved in the fighting had thousands of emotionally-wounded soldiers and little plan to address the widespread epidemic.⁶⁶

The British military establishment set a number of distinct labels to diagnosis the psychiatric conditions seen in officers and enlisted men during this time.⁶⁷ The most prominent and lasting was “shell shock,”⁶⁸ which, like Erichsen’s original conceptualization of railway spine, was based upon an assumption that the symptoms’ primary origin was a neurological injury from a specific event, such as the discharge of an explosive in very close proximity.⁶⁹ Shell shock soon became a blanket synonym for all war neuroses, particularly in light of the challenge of differentiating among the various conditions as they appeared in different individuals and a lack of a uniform classification system (or “nosology”) in psychiatry or neurology at that time.⁷⁰ There is no indication that military psychiatrists followed anything resembling diagnostic criteria or shared a common understanding of how to differentiate among these various diagnoses.⁷¹

The controversy continued regarding whether individual disposition played a role in the development of these conditions.⁷² Some physicians concluded that “inborn

Freud’s seduction theory to include “the role of fantasy”). Although Freud’s impact on the development of PTSD cannot be underestimated, his rejection of the seduction theory has led present-day proponents of the trauma theory (and repressed memory theory) of child sexual abuse to revile him. LEYS, *supra* note 13, at 18–19.

63. Janet’s writings on dissociation have played a key role in contemporary conceptualizations of PTSD and particularly the theory of “traumatic” and “narrative memory.” LEYS, *supra* note 13, at 105 (internal quotation marks omitted).

64. SHEPHARD, *supra* note 10, at 13.

65. YOUNG, *supra* note 7, at 41–42.

66. *Id.*

67. The diagnostic labels included “hysteria,” “neurasthenia,” and “disordered action of the heart.” YOUNG, *supra* note 7, at 50–52; *see also* SHEPHARD, *supra* note 10, at 58, 65–66 (discussing “soldier’s heart,” a diagnosis similar to disordered action of the heart). Some historians have traced the use of the term “soldier’s heart” to the American Civil War. *E.g.*, WILBUR J. SCOTT, VIETNAM VETERANS SINCE THE WAR: THE POLITICS OF PTSD, AGENT ORANGE, AND THE NATIONAL MEMORIAL 29 (Univ. of Okla. Press 2004). The final classification was “not yet diagnosed (nervous)” (often known by its acronym “NYD [N]”), which was intended to serve as an interim label, but in practice was often the only “diagnosis” applied. YOUNG, *supra* note 7, at 52–53 (emphasis omitted).

68. Cambridge psychologist C. S. Myers is credited with coining this term in a 1915 article, although it is possible that the term was already in use in the military by that time. SHEPHARD, *supra* note 10, at 1.

69. YOUNG, *supra* note 7, at 50–51. *See supra* notes 16–24 and accompanying text for a discussion for Erichsen’s original conceptualization.

70. *Id.* at 60.

71. *Id.* at 61.

72. SHEPHARD, *supra* note 10, at 110–112; YOUNG, *supra* note 7, at 54–55.

timidity or neuropathic disposition” explained why some soldiers and not others developed these conditions.⁷³ Many army psychiatrists assumed that a combination of “flawed heredity and constitution” accounted for the cause of most war neuroses.⁷⁴ The issues raised in those debates are echoed in the contemporary controversies about the interaction of the psychological and physiological (such as the endocrine system) in the symptoms of PTSD and the role of preexisting psychopathology in those who develop PTSD.⁷⁵ Most physicians at the time were not particularly concerned with identifying the specific causal mechanisms of these conditions since the treatments employed did not depend upon such understanding.⁷⁶

However, the adoption of shell shock was a considerable change for the military, which had previously attached a label of “cowardice” to such symptoms.⁷⁷ And the fact that one in six who received the diagnosis was an officer made it a nearly “respectable” condition.⁷⁸ The British military did attempt initially to distinguish between a reaction properly classified as a “wound” incurred in battle and a mere “breakdown,” which carried far more of a stigma.⁷⁹ If the shell shock was not linked to a specific shell explosion, the soldier was labeled as “sick,” not “wounded,” and such designation precluded a pension award.⁸⁰

By 1916, several military doctors concluded that the symptoms classified as shell shock did not necessarily depend upon a person’s proximity to an explosion for the cause, but, in fact, may have a gradual onset or cause due largely to “emotions of extreme and sudden horror and fright”⁸¹ or “sudden psychic shock.”⁸² Furthermore, a great number of soldiers were claiming to have the condition by name.⁸³ Thus, the psychiatrists rejected the label “shell shock” and officially replaced it with “war neuroses,” or “functional nervous disorders.”⁸⁴ But the term was not easily discarded, as it made a lasting impression upon soldiers and the general public as a “neutral, physical label for a psychological condition.”⁸⁵

W.H.R. Rivers, who was a Royal Army Medical Corps officer and psychiatrist in Great Britain who served for a time as a psychiatrist in Craiglockhart Military Hospital

73. YOUNG, note 7, at 54 (quoting Frederick Mott, *The Lettsomian Lectures on the Effects of High Explosives upon the Central Nervous System*, 187 THE LANCET 331, 331 (1916)); see also SHEPHARD, *supra* note 10, at 30 (discussing Mott’s views that predisposition affected post-war psychological impact).

74. YOUNG, *supra* note 7, at 55.

75. SHEPHARD, *supra* note 10, at 111–12, 125.

76. YOUNG, *supra* note 7, at 55. These conditions were generally treated with rest, hypnosis, diet, and electricity. *Id.* at 55–56.

77. SHEPHARD, *supra* note 10, at 28.

78. *Id.* at 73–75.

79. *Id.* at 28–29.

80. *Id.* at 29.

81. *Id.* at 31 (quoting CHARLES A. MYERS, SHELL SHOCK IN FRANCE, 1914–1918, at 36 (1940)).

82. *Id.*; see also YOUNG, *supra* note 7, at 60 (explaining how one-third of soldiers described symptoms that appeared gradually and without memorably significant events).

83. SHEPHARD, *supra* note 10, at 29.

84. *Id.* at 31.

85. *Id.*

in Scotland, was one of the early developers of what came to be known as PTSD.⁸⁶ He was notable for his “humane treatments” and for his use of abreaction-based treatments resembling what we would now call psychotherapy.⁸⁷ He theorized, drawing largely on the work of Freud, that the symptoms of war neuroses, particularly in officers, came from the repression of fear.⁸⁸ Thus, the key to treatment was to reverse the repression of traumatic memories by confronting them directly.⁸⁹

Freud revisited the question of traumatic memory himself shortly after the war ended, and it is clear from these writings that he had not entirely abandoned the notion that external events can produce neuroses.⁹⁰ He noted similarities between war trauma and others and concluded that all traumatic neuroses were based upon fear (in psychoneurosis, however, the origin of the fear was sexual conflict).⁹¹ In both contexts, repression operated as a psychological defense.⁹² He regarded an injury to the “organ of the mind” from trauma that was unexpected⁹³ as one that was functional, not psychological.⁹⁴ His most significant contribution, and one we can see in the development of PTSD specifically, is the notion of an initial “traumatic blow” to the “protective shell of the ego,” which was then followed by psychological consequences.⁹⁵ Although Freud’s writings do not, as a whole, provide an entirely coherent theory of traumatic psychological injury, it is his ideas that have made the most significant indelible impact on contemporary psychological conceptualizations of PTSD.⁹⁶

As the war progressed with an unexpectedly high number of apparent psychological casualties, it became particularly important for the military to be able to

86. YOUNG, *supra* note 7, at 42–44.

87. *Id.* at 42, 56; *see also id.* at 69–70 (distinguishing Rivers’s “painless talking cure” from “physical suffering” inflicted by Lewis Yealland’s and others’ electrotherapy treatments).

88. *Id.* at 65–66; SHEPHARD, *supra* note 10, at 87–88. Rivers was not strictly a “Freudian,” but he did adopt many of Freud’s ideas and approaches. SHEPHARD, *supra* note 10, at 87; YOUNG, *supra* note 7, at 65–66.

89. *See* SHEPHARD, *supra* note 10, at 87–88 (noting River’s method of treatment of war neuroses involved allowing the patient to “confront the memories” so that he could “reduce the horror”); YOUNG, *supra* note 7, at 67 (noting that Freud and Rivers agreed that treating anxiety neurosis required addressing the traumatic memory); *see also* SCOTT, *supra* note 67, at 30 (noting Freud’s suggested method for treating war neurosis was psychoanalysis).

90. LEYS, *supra* note 13, at 21–23; Wilson, *supra* note 62, at 685.

91. SIGMUND FREUD, BEYOND THE PLEASURE PRINCIPLE 6–7 (James Strachey trans., rev. ed. 1961) (1950); YOUNG, *supra* note 7, at 78–79.

92. Wilson, *supra* note 62, at 685.

93. SHEPHARD, *supra* note 10, at 108.

94. Wilson, *supra* note 62, at 686.

95. Kinzie & Goetz, *supra* note 28, at 162; *see also* LEYS, *supra* note 13, at 23 (describing the term “traumatic” as “an experience which within a short period of time presents the mind with an increase of stimulus too powerful to be dealt with or worked off in the normal way”); SHEPHARD, *supra* note 10, at 107–08 (describing trauma as an outside excitation powerful enough to break through the shield which protects the brain from stimuli that will surely result in exhaustive defensive measures); Wilson, *supra* note 62, at 686–87 (explaining that “both the traumatic stressors and secondary ones can overwhelm the now depleted ego-defenses, thereby setting-up the possibility of long-term post-traumatic stress disorder and other co-morbid conditions”).

96. *See* LEYS, *supra* note 13, at 18, 25–27 (noting that Freud is “a founding figure in the history of the conceptualization of trauma”).

distinguish those with true war neuroses from those who were malingering.⁹⁷ Taking a cue from the literature developed to weed out individuals with mere “compensation neurosis” among those filing claims against railways for injuries,⁹⁸ military doctors consulted books that described mechanisms to identify those who might be feigning a neurosis to avoid further combat duty and to distinguish between true hysteria and mere malingering.⁹⁹

Once the war was over, concern shifted to reabsorbing these emotionally damaged soldiers into civilian society. More than 160,000 former British service members had received an award or were drawing a pension for a psychiatric injury.¹⁰⁰ In the United States, more than one-third of military hospitalizations at the end of the war were for psychiatric conditions.¹⁰¹ Psychiatrists noted that some men recovered quickly upon return to civilian life, whereas others continued to struggle with symptoms.¹⁰² Psychiatrists began to draw a distinction between “true” and “false” war neuroses, with the former appearing only in those who had “a minimal predisposition” and the latter appearing in those with a predisposition that indicated that the war was not the true cause of the neurosis.¹⁰³ Those with the “false” label were simply neurotics whose breakdown was inevitable.¹⁰⁴ The British government attempted unsuccessfully to convince psychiatrists to assign specific veterans to each class for purposes of limiting the pension awards.¹⁰⁵

In 1941, Abram Kardiner, an American psychoanalyst, published *The Traumatic Neuroses of War*, a detailed study of the long-term psychological impact of combat on World War I veterans.¹⁰⁶ He noted that there were also soldiers whose breakdowns did not occur until after they returned home and then persisted for many years.¹⁰⁷ His book remained a “bible” for those studying war neuroses through the 1970s, when the

97. SHEPHARD, *supra* note 10, at 113–14.

98. See *infra* notes 163–67 and accompanying text for a discussion of examples of how feigning a neurosis had been used to exacerbate legal claims or increase recovery.

99. YOUNG, *supra* note 7, at 57–59.

100. SHEPHARD, *supra* note 10, at 144.

101. *Id.* at 153.

102. *Id.* at 150–51.

103. *Id.* at 151.

104. See *id.* (indicating that those with “false” neuroses had predispositions).

105. *Id.* at 158. Some raised the concern that the pension awards actually inhibited recovery or encouraged the reporting of symptoms. *Id.* at 151. Based upon these assumptions, France did not award any pensions to those with war neuroses. *Id.* at 152. Similarly, as the number of psychiatric casualties increased, German psychiatrists began to attribute the symptoms to malingering to avoid combat or to obtain pensions and employed “treatments” that were particularly brutal. HERB KUTCHINS & STUART A. KIRK, MAKING US CRAZY: DSM: THE PSYCHIATRIC BIBLE AND THE CREATION OF MENTAL DISORDERS 103–104 (1997).

106. ABRAM KARDINER, THE TRAUMATIC NEUROSES OF WAR (1941); SHEPHARD, *supra* note 10, at 154–55; Kinzie & Goetz, *supra* note 28, at 165. The other influential works from this period include Roy Grinker and John Spiegel’s *War Neuroses and Men Under Stress*, both published in 1945 and also heavily influenced by Freudian theory. SHEPHARD, *supra* note 10, at 331. See generally ROY R. GRINKER & JOHN P. SPIEGEL, MEN UNDER STRESS (1945); ROY R. GRINKER & JOHN P. SPIEGEL, WAR NEUROSES (1945).

107. SHEPHARD, *supra* note 10, at 152.

diagnosis of PTSD was first discussed and formulated.¹⁰⁸ He urged quick intervention after men first exhibited symptoms to prevent the adaptive responses manifested as aversion and avoidance.¹⁰⁹ He theorized that a complex “physio-neurosis,” a series of adaptive responses, accounted for the symptoms occurring in war neurotics.¹¹⁰

In the late 1930s, with the Second World War looming, the British Ministry of Pensions was the driving force behind the renewed debate on war neuroses. There were still a great number of World War I veterans receiving (or claiming) benefits due to a psychiatric disorder based upon the prior war.¹¹¹ The Ministry’s resident psychiatrist, Dr. Francis Prideaux, argued that many soldiers had incorrectly received diagnoses linked to exposure to battle, and that the men’s predispositions, not traumatic experiences, were the key causal agents for most war neuroses.¹¹² He was successful in convincing other psychiatrists and bureaucrats of his view, but the debate left unresolved the question of how to differentiate between those very few soldiers who did deserve pensions and the vast majority who would only be encouraged to break down by the availability of a pension.¹¹³ Eventually, the British government decided not to award any pensions for war-related psychoneurosis until after the war had concluded.¹¹⁴

Given the assumption that predisposition was the single most significant factor in who ended up with a war neurosis, the British and American armies attempted to screen recruits for psychiatric disorders during World War II.¹¹⁵ However, by the end of the war, perhaps due to the utter failure of this approach, American military thinking had shifted from an assumption that preselection screening could keep out those men vulnerable to psychoneurosis to the view that “every man has his breaking point” and factors other than predisposition (including leadership) played a role in the cause of some men’s breakdowns.¹¹⁶ However, the military did not remove soldiers with apparent psychological injuries from service. Rather, in 1943, American military leadership determined that all psychiatric casualties should be given an initial diagnosis

108. YOUNG, *supra* note 7, at 89 (explaining that Kardiner’s book is “routinely cited as a landmark in the history of the posttraumatic disorders” and was used in creating “the symptom list for post-traumatic stress disorder”).

109. SHEPHARD, *supra* note 10, at 156.

110. *Id.*

111. *Id.* at 165.

112. *Id.* at 165–66. He also specifically rejected the possibility of a delayed onset of neuroses after seven years had elapsed from the date of exposure. *Id.* at 166.

113. *Id.* at 166–67.

114. *Id.* at 167 (noting that one of the “main legac[ies] of the First World War [was] an official determination that quasi-medical words like ‘shell-shock’ should never be used, that the whole question of psychoneurosis should be both recognized and played down and that few pensions should be paid”).

115. *Id.* at 187–90, 197–201.

116. *Id.* at 326; *see also* Kinzie & Goetz, *supra* note 28, at 168–69 (indicating that although some individuals had predispositions to mental illness, “even persons with sound personalities would break if the stress was high enough”).

of only “exhaustion,”¹¹⁷ or “combat fatigue,” which would be treated with brief rest not far from the front.¹¹⁸

Research interest in trauma-induced psychopathology waned significantly until the final years of the Vietnam War.¹¹⁹ However, well before that time, there was an emerging consensus that there could be a causal role for the “fright” and “shock” during severe accidents or other intense events that lead to injuries to the nervous system.¹²⁰ These discussions were framed around notions of responsibility; that is, whether an external event or agent could cause such symptoms and the role of the individual’s predisposition in whether the person developed the condition.¹²¹

B. *Legal Mechanisms for Psychological Injury Claims*

Given that during the first decades of the twentieth century there were at least some segments of medicine that accepted that external events could lead to psychological injuries, it followed that attorneys and plaintiffs would seek to assign legal responsibility for such injuries to the persons who were responsible for the precursor events as a means to recover compensation. Despite Herbert Page’s attempt to stem the tide of these claims for posttraumatic psychological injuries, his work and that of his contemporaries served as the foundation for refining the theories that served as a basis for the recovery of emotional damages, at least in cases where physical damages had also been sought.¹²²

The history of the recovery for mental injuries, however, is one of a tension between those who asserted that such injuries were real and could be traced to specific stressors, and those who were more skeptical of such claims and argued that such recoveries should be permitted only where the possibility of recovery for meritless claims could be minimized. Reflecting the concern in the British military with

117. SHEPHARD, *supra* note 10, at 216–17.

118. SCOTT, *supra* note 67, at 30–31; YOUNG, *supra* note 7, at 92. Military psychiatrists started treating soldiers with “narco-analysis,” administering high dosages of barbiturates, especially sodium amytal and pentothal, to not only calm the patient but to encourage the soldier to access and recount repressed memories of painful events as a form of drug-aided abreaction. SHEPHARD, *supra* note 10, at 208–210, 214–15; YOUNG, *supra* note 6, at 92.

119. YOUNG, *supra* note 7, at 85; *see also* LEYS, *supra* note 13, at 15 (characterizing the history of trauma as one “marked by an alternation between episodes of forgetting and remembering,” in which “it took the experience of Vietnam to ‘remember’ the lessons of World War II”).

120. WELKE, *supra* note 18, at 154–56. The various terms referring to disorders resulting from “fright” or “shock” were often used interchangeably and their exact boundaries were not always well defined. *See* WELKE, *supra* note 18, at 156. For example, in a 1904 article, one legal commentator referred to railway spine as the “traumatic” form of neurasthenia, and indicated that it was the form of “most importance from a legal aspect, as railway accidents often cause it, and suits for damages often result. . . . Many cases are said to be much improved or cured by the award of substantial damages.” Tibbits, *supra* note 14, at 85.

121. Historian Barbara Young Welke has analyzed in detail the role of gender, both implicit and explicit, in the development of modern conceptualizations of psychological injuries during this period. In particular, she has noted that the role of predisposition was minimized by Erichsen, Beard, and others specifically because it was assumed that “normal” men, who comprised a significant number of those with symptoms of traumatic neurosis, were not generally at risk of developing nervous conditions, and therefore the cause of such conditions must be some external force. WELKE, *supra* note 18, at 171–202.

122. Brown, *supra* note 14, at 428, 433.

separating the truly neurotic from the merely malingering so as to not deplete the ranks, legal systems have similarly sought rules and standards that offered a way to distinguish the claims of those seeking compensation through a specious claim.

As the American tort system came under increasing demand to address traumatic injuries from the industrial age, especially railways, courts immediately reacted with skepticism to notions of a “pure” emotional injury.¹²³ By the turn of the twentieth century, courts permitted recovery for emotional distress injuries as part of “pain and suffering” or “loss of enjoyment of life” damages in tort claims, but only where such distress was incidental to the primary physical injury,¹²⁴ as so-called “parasitic damages.”¹²⁵ Some courts and commentators simply expanded notions of what constituted “bodily harm” and did not make a specific distinction for injuries that were psychological in nature.¹²⁶

However, courts were far more reluctant to permit claims to proceed that were based upon assertions of emotional injury alone, particularly for mere negligence.¹²⁷ Courts largely followed the lead of Lord Wensleydale’s 1861 ruling in the House of Lords: “Mental pain or anxiety the law cannot value, and does not pretend to redress, when the unlawful act complained of causes that alone.”¹²⁸ American courts expressed their resistance by raising concerns about malingering, a potential explosion of litigation,¹²⁹ or an assumption that people with normal constitutions (and particularly, men) could not be “shocked” into a mental disorder (and tortfeasors should not have to bear responsibility for compensating women’s overemotional reactions).¹³⁰

123. WELKE, *supra* note 18, at 205–207; Richard Abel, *General Damages Are Incoherent, Incalculable, Incommensurable, and Inegalitarian (But Otherwise a Great Idea)*, 55 DEPAUL L. REV. 253, 303 (2006); William L. Prosser, *Intentional Infliction of Mental Suffering: A New Tort*, 37 MICH. L. REV. 874, 875, 877 (1939).

124. RESTATEMENT (SECOND) OF TORTS § 905 (1965); *see, e.g.*, *Sarauw v. Oceanic Navigation Corp.*, 622 F.2d 1168, 1175 (3d Cir. 1980), *vacated and remanded* 451 U.S. 966 (1981) (holding that no plain error occurred when the court allowed the jury to assess as separate components pain and suffering, loss of enjoyment of life, and permanent disability).

125. MARTHA CHAMALLAS & JENNIFER B. WRIGGINS, *THE MEASURE OF INJURY: RACE, GENDER, AND TORT LAW* 38 (2010); Prosser, *supra* note 123, at 875, 880.

126. John J. Kircher, *The Four Faces of Tort Law: Liability for Emotional Harm*, 90 MARQ. L. REV. 789, 832–33 (2007) (quoting RESTATEMENT (THIRD) OF TORTS: LIABILITY FOR PHYSICAL HARM § 4 cmt. d (Proposed Final Draft No. 1, 2005)).

127. Brown, *supra* note 14, at 428–30; Prosser, *supra* note 123, at 874 (“‘Mental anguish’ has been an orphan child.”).

128. *Lynch v. Knight*, (1861) 11 Eng. Rep. 577 (H.L.) 598; *see also* *Victorian Rys. Comm’rs v. Coultas*, (1888) 13 A.C. 222 (P.C.) 226 (Eng.) (holding that Plaintiff’s shock-induced mental and physical injuries caused by a near-collision with a train were too remote to be compensable).

129. *See Mitchell v. Rochester Ry. Co.*, 45 N.E. 354, 354–55 (N.Y. 1896), *overruled by Battalla v. State*, 176 N.E.2d 729 (N.Y. 1961); WELKE, *supra* note 18, at 207–08, 210.

130. *See Ward v. W. Jersey & Seashore R.R. Co.*, 47 A. 561, 562 (N.J. 1900), *overruled in part by Falzone v. Busch*, 214 A.2d 12 (N.J. 1965); CHAMALLAS & WRIGGINS, *supra* note 125, at 90; WELKE, *supra* note 18, at 210; Abel, *supra* note 123, at 303–04; Martha Chamallas & Linda K. Kerber, *Women, Mothers, and the Law of Fright: A History*, 88 MICH. L. REV. 814, 829 (1990). Implicit in this skepticism as well is an assumption that emotional harm, as opposed to bodily injury or property damage, was not of sufficient value to warrant legal protection. CHAMALLAS & WRIGGINS, *supra* note 125, at 37–38. Tort law generally recognizes a rule that permits a plaintiff to recover for all damages flowing from a tortfeasor’s wrongdoing, even if the plaintiff’s injury (physical or mental) is far greater than that of the average person with a latent or underlying

Courts developed a range of “bright-line” rules to control the circumstances under which one could recover for psychic harm as the sole or primary injury.¹³¹ Some of these rules limited the underlying theory of liability of the particular tort. Assault has traditionally permitted recovery for psychological harm even in the absence of physical contact, but only where the tortfeasor is found to have intentionally put the plaintiff in fear or apprehension of injury.¹³² Intentional infliction of emotional distress was first recognized as a tort in the United Kingdom at the end of the nineteenth century in a case in which the defendant told the plaintiff, as a joke, that her husband had been seriously injured in an accident.¹³³ The ensuing shock produced “serious and permanent physical consequences,” and the court permitted recovery on the assumption that this was a claim for physical injury even if the origin was a psychological shock.¹³⁴

In the United States, the tort of intentional infliction of emotional distress was slow to develop outside of the very specific and narrow context of claims against common carriers, innkeepers, and telegraph companies, or for the mistreatment of dead bodies.¹³⁵ It was not until the middle of the twentieth century that the American Law Institute’s *Restatement of Torts* made reference to the tort,¹³⁶ and some courts interpreted it to limit recovery to instances where the tortfeasor “subjects another to the mental suffering incident to serious threats to his physical well-being.”¹³⁷ In 1965, the *Restatement (Second) of Torts* permitted recovery for intentional conduct that resulted in “bodily harm”; however, such recovery was premised on the plaintiff’s ability to prove that her emotional distress was “severe” and the defendant’s conduct was “extreme and outrageous.”¹³⁸ If the conduct was sufficiently atrocious, a court could assume that there would be some psychological injury, diminishing concerns about malingering or unexpectedly strong reactions.¹³⁹

vulnerability; the so-called “eggshell plaintiff” rule requires a defendant to “take” his plaintiff as he “finds him.” Joseph H. King, Jr., *Causation, Valuation, and Chance in Personal Injury Torts Involving Preexisting Conditions and Future Consequences*, 90 YALE L.J. 1353, 1360–61 (1981). Courts may deny liability for emotional distress entirely as one way to limit the application of this rule to claims for psychological injury for “eggshell plaintiffs.” Cf. CHAMALLAS & WRIGGINS, *supra* note 125, at 112 (noting that in highly unusual cases involving public policy concerns such as racial prejudice, it may be justifiable to use the doctrine of proximate cause to cut off liability for emotional harm).

131. Abel, *supra* note 123, at 303–04.

132. Kircher, *supra* note 126, at 790.

133. *Wilkinson v. Downton*, (1897) 2 Q.B. 57 (Eng.); *see also* Kircher, *supra* note 126, at 795 (noting that the theory of intentional infliction of emotional distress can be traced to *Wilkinson v. Downton*, which did not explicitly name the tort but allowed recovery for the emotionally distressed plaintiff).

134. *Wilkinson*, 2 Q.B. at 58–59; Kircher, *supra* note 126, at 796.

135. Kircher, *supra* note 126, at 796–98.

136. *Id.* at 797; *see also* Prosser, *supra* note 123, at 874 (acknowledging the creation of a new tort yet to be named).

137. Kircher, *supra* note 126, at 798 (citing RESTATEMENT OF TORTS § 46 (Supp. 1948)).

138. RESTATEMENT (SECOND) OF TORTS § 46 cmt. k (1965); Kircher, *supra* note 126, at 800–01; Prosser, *supra* note 123, at 879 (noting that the character of the conduct ensures that genuine harm occurred and warrants redress).

139. RESTATEMENT (SECOND) OF TORTS § 46 cmt. k (explaining a court may assign liability without evidence of bodily harm if conduct is extreme and outrageous); Kircher, *supra* note 126, at 800 (noting “the defendant’s extreme and outrageous conduct alone tends to prove the severity of the distress,” eliminating a need for proof of any physical symptoms).

Recovery for emotional distress where a negligent, as opposed to intentional, act caused no other injury—the “stand-alone” tort of “Negligent Infliction of Emotional Distress”—has been recognized by courts only within the last fifty years or so.¹⁴⁰ Courts’ reluctance to permit stand-alone claims for emotional distress can be generally traced, not only to concerns about malingering or exaggeration and the great difficulty in quantifying emotional distress,¹⁴¹ but also to an assumption that if the only resulting harm is emotional the defendant’s negligence did not rise to a level that should trigger liability of any kind.¹⁴² The *Restatement* also reasoned that any emotional injury that would occur in the absence of physical injury would be “‘so temporary, so evanescent and so relatively harmless’ that the task of compensating for it would unduly burden defendants and the courts.”¹⁴³ Some courts thought that an emotional injury itself was “too remote” from the original accident to be compensable.¹⁴⁴ As a result of these views, a strange body of case law developed, with a significant number of different approaches. One high court referred to this as “one of the most disparate and confusing areas of tort law,” characterized by “inconsistency and incoherence.”¹⁴⁵

Although American law generally did not recognize claims based solely on emotional distress damages due to negligence until recently,¹⁴⁶ courts developed a variety of exceptions and requirements to permit some recovery, while retaining broader limitations on the claims.¹⁴⁷ The “impact rule” required a plaintiff to show some kind of initial physical contact or injury in order to recover for emotional distress, and denied recovery for the physical consequences of an initial emotional shock.¹⁴⁸

140. Kircher, *supra* note 126, at 807–08.

141. *Payton v. Abbott Labs*, 437 N.E.2d 171, 178 (Mass. 1982); *see also* Herbert F. Goodrich, *Emotional Disturbance as Legal Damage*, 20 MICH. L. REV. 497, 504 (1922) (identifying courts’ prior reluctance to assign liability because of “danger of fraud through simulated injuries”); Kircher, *supra* note 126, at 808 (quoting *W. PAGE KEETON ET AL., PROSSER AND KEETON ON THE LAW OF TORTS* § 10, at 360–61 (5th ed., 1984)) (identifying the danger of falsified claims as a point of concern for courts in assigning liability for emotional distress).

142. *Payton*, 437 N.E.2d at 178–79; *see* Goodrich, *supra* note 141, at 504–05 (indicating that when conduct is intentional no impact is necessary for defendant’s liability for emotional distress); Kircher, *supra* note 126, at 808 (quoting *KEETON ET AL., supra* note 141) (identifying potential triviality of emotional harm and the potential for an undue burden on defendant points to caution for courts); Prosser, *supra* note 123, at 878 (“There has been much more readiness to grant a remedy where mental suffering is inflicted intentionally than where it is the result of mere negligence.”).

143. *Payton*, 437 N.E.2d at 178 (quoting *RESTATEMENT (SECOND) OF TORTS* § 436A cmt. b).

144. Tibbits, *supra* note 14, at 87 (citing *Ewing v. Pittsburgh, C., C. & St. L. Ry. Co.*, 23 A. 340, 341 (Pa. 1892), *overruled by* *Niederman v. Brodsky*, 261 A.2d 84 (Pa. 1970)).

145. *Camper v. Minor*, 915 S.W.2d 437, 440 (Tenn. 1996).

146. *See, e.g.*, *RESTATEMENT (SECOND) OF TORTS* § 313(1) (stating that if an actor’s negligent conduct creates an unreasonable risk of bodily harm or emotional disturbance, but results in only emotional disturbance, the actor is not liable).

147. Kircher, *supra* note 126, at 810 (stating that these limitation were due to “judicial concern over the genuineness of claims for negligently caused emotional distress”).

148. *CHAMALLAS & WRIGGINS, supra* note 125, at 40–45; Kircher, *supra* note 126, at 810–11; Tibbits, *supra* note 14, at 86. A handful of states still follow the rule. Kircher, *supra* note 126, at 810 n.113. In the nineteenth century, some courts recognized limited claims for “fright” or “shock” as a basis to recover for the psychological injuries on a theory of negligence, but only where there was an accompanying physical injury. *Chamallas & Kerber, supra* note 130, at 819–23. Several scholars have noted that the shaping (and limits) of such legal claims were often gender-based. *See, e.g.*, *CHAMALLAS & WRIGGINS, supra* note 125, at 37–47

Later, several courts required evidence that the alleged emotional distress had some kind of physical manifestation—such as insomnia, nightmares, weight loss, irritability, fatigue, and extreme nervousness¹⁴⁹—even where the emotional distress itself was severe.¹⁵⁰ This requirement imposed a kind of objective proof on mental distress claims so that they more closely resembled claims for physical injury. The “physical manifestation” rule was an alternate means to recover for emotional distress when there was no accompanying physical injury at the time of the accident.¹⁵¹ Usually neither of these standards required showing an extensive physical injury or manifestation but both ensured that plaintiffs could not recover for purely psychic injuries (assuming that such a dichotomy could be drawn and understood).¹⁵²

Some states limited negligence-based emotional distress recovery to people who were within the “zone of danger” of the event; that is, someone who was sufficiently close to the accident to be at risk of physical injury, even if none resulted.¹⁵³ This requirement limited recovery by “bystanders,” generally family members who learn of the death or serious injury of a loved one, and was sometimes linked with the “impact rule.”¹⁵⁴ And some courts permitted recovery by a bystander who was not in the zone of danger (i.e., fearing for own safety) so long as the person had a “close relationship” with the person actually injured.¹⁵⁵ A few courts eliminated all limitations on negligent infliction of emotional distress claims on the assumption that concerns about severity

(noting that the defendants in the first emotional distress cases were women, forging an early connection between women and fright-based injury); WELKE, *supra* note 18, at 211–34 (describing the role of miscarriage in the legal recognition of the right to recover for harm resulting from nervous shock).

149. Kircher, *supra* note 126, at 812–13.

150. CHAMALLAS & WRIGGINS, *supra* note 125, at 94; *see also* *Camper*, 915 S.W.2d at 442 (compiling cases evidencing such a rule); *Fortes v. Ramos*, No. CIV. A. 96-5663, 2001 WL 1685601, at *4 (R.I. Ct. App. 2001) (detailing Rhode Island’s treatment of the physical manifestation requirement). It is not surprising that nightmares were among the physical manifestations that could serve as a basis for recovery of psychological injuries as they had long been associated with traumatic neurosis. The “Battle Dream” generated medical interest during World War I, and it was considered the “most characteristic symptom of war neurosis.” SHEPHARD, *supra* note 10, at 92; *see also* BARKER, *supra* note 1, at 26. Freud in particular noted the role of traumatic experience with dreams. Rather than representing the fulfillment of fantasy, which was the case with most dreams, he claimed that the recurring dream of trauma was the result of a fixation with the event leading to a compulsion to repeat the experience. JONATHAN LEAR, FREUD 154–56 (2005); SHEPHARD, *supra* note 10, at 107 (citing FREUD, *supra* note 91, at 7, 13).

151. *Camper*, 915 S.W.2d at 442. In *Kaufman v. Western Union Telegraph Co.*, 224 F.2d 723 (5th Cir. 1955), the Fifth Circuit’s approach was to be flexible regarding whether the “physical injury” that was required in any event preceded or came after the emotional injury. *Id.* at 731. In that case, the shock from a false death notice came first and led to an increase in the plaintiff’s blood pressure. *Id.* at 725–26. There were a few cases, however, to the contrary. *See* Tibbits, *supra* note 14, at 88–89 (discussing three cases in which plaintiffs were permitted recovery for “nervous shock” in the absence of physical injury causing such shock).

152. *See Camper*, 915 S.W.2d at 442 (stating that the physical manifestation test was formulated in part due to the belief that physical impact requirements block many worthy claims for relief based solely on emotional damages).

153. CHAMALLAS & WRIGGINS, *supra* note 125, at 113; Kircher, *supra* note 126, at 815.

154. Kircher, *supra* note 126, at 815–16, 823.

155. *Nielson v. AT&T Corp.*, 597 N.W.2d 434, 442 (S.D. 1999); *Dillon v. Legg*, 441 P.2d 912, 920–21 (Cal. 1968).

and malingering were best left to be addressed by defendants through the adversarial process.¹⁵⁶

Faced with this well-entrenched judicial hostility toward recovery for emotional distress and psychological injuries, many lawyers evoked quasi-medical concepts, such as “traumatic neurosis,” in an attempt to bring legitimacy to their clients’ claims for such injuries.¹⁵⁷ In practice, traumatic neurosis was not a clinical diagnosis per se, but rather a term generally reserved to describe psychological injuries in the context of personal injury litigation or claims for industrial and other occupational accidents.¹⁵⁸ One psychiatrist described the condition in 1959 as being “the total neurotic reaction to a physical injury or, occasionally, near-injury,” which “may take many forms, e.g., conversion hysteria, anxiety reaction, obsessive-compulsive reaction, reactive depression, and other less well-defined symptom complexes.”¹⁵⁹ By the time of the development of the *DSM-III* in the 1970s, it does not appear that the term was in wide use in litigation. One psychiatrist wrote an article in 1971 calling on attorneys to pursue more claims based upon traumatic neurosis, characterizing such conditions as being “[r]elatively [u]ntried in the [c]ourts.”¹⁶⁰ He attributed the reluctance of attorneys to bring such claims, in part, to their “orientation . . . toward factual proof,”¹⁶¹ lack of objective tests to confirm such condition, and fear “of treading in the uncharted waters of traumatic neurosis.”¹⁶²

By the middle of the twentieth century, some cases referred to “compensation neurosis.”¹⁶³ Like “traumatic neurosis,” it was not a recognized clinical term, but rather was a shorthand label for a subtype of traumatic neurosis that arose when there was the possibility of recovering compensation through a claim or litigation.¹⁶⁴ Although it was

156. See Kircher, *supra* note 126, at 816–18 (discussing cases that held no physical injury was required for plaintiffs to recover for emotional distress).

157. The “traumatic” conditions such as “traumatic hysteria,” “traumatic neurasthenia,” and particularly “traumatic neurosis” eclipsed “railway spine” in litigation claims. See *supra* notes 26–52 and accompanying text for a discussion of the evolution of these terms.

158. Kenneth M. Cole, Jr., *Workmen’s Compensation—Damages—Compensation Neurosis Held Compensable*.—*Miller v. United States Fid. & Guar. Co.*, 99 So. 2d 511 (La. App. 1957), 37 TEX. L. REV. 361, 361 (1959); Kinzie & Goetz, *supra* note 28, at 165–66; see also Hubert Winston Smith, *Relation of Emotions to Injury and Disease: Legal Liability for Psychic Stimuli*, 30 VA. L. REV. 193, 304 (1944) (explaining that this term has little relevance given the current state of science); Hubert Winston Smith & Harry C. Solomon, *Traumatic Neuroses in Court*, 30 VA. L. REV. 87 (1943) (asserting that the common prerequisites for an official diagnosis are lacking for neuroses); Jay Ziskin, *New Terminology for the “Traumatic Neurosis” Case: Challenging the Plaintiff’s Psychiatrist*, 32 DEF. L.J. 72, 73 (1983) (stating that the American Psychiatric Association never recognized traumatic neurosis).

159. Cole, *supra* note 158, at 361 (citing Smith & Solomon, *supra* note 158, at 92–95).

160. Lester Keiser, *Traumatic Neurosis; A Common Problem Relatively Untried in the Courts*, 17 MED. TRIAL TECH. Q. 1, 1 (1971).

161. *Id.* at 4 (emphasis omitted).

162. *Id.* at 6.

163. Kinzie & Goetz, *supra* note 28, at 171–72; see also Smith & Solomon, *supra* note 158, at 148 (rejecting the notion of “compensation neurosis” as being medically distinct from traumatic neurosis; it is only one part of the total reaction to the event).

164. Cole, *supra* note 158, at 361–62. A highly publicized 1961 study suggested some legitimacy to the claim that a plaintiff’s symptoms improved after the resolution of a legal claim for recovery from psychological injuries. Henry Miller, *Accident Neurosis (pts. 1 & 2)*, 1961 BRIT. MED. J. 919–25, 992–98.

generally a pejorative term, some psychiatrists used it to draw a distinction from true malingering and regarded it as the mechanism through which the possibility of secondary gain could unconsciously aggravate the primary traumatic neurosis, similar to Herbert Page's theories published in the 1880s.¹⁶⁵ In fact, in the workers' compensation realm—which generally permitted a more liberal approach to causation and traumatic neurosis than did tort law¹⁶⁶—some awards were expressly based upon “compensation neurosis.”¹⁶⁷

Therefore, in the century prior to PTSD's recognition by the APA, courts permitted individuals to recover for psychological injuries only to a very limited degree. The limitations imposed by courts on such recovery reflected the contemporaneous theories of psychological injuries during this period and raised many of the same debates, such as the distinction between the emotional and the physical, the role of individual predisposition, the impact of litigation on the development and persistence of symptoms, and concerns of malingering. These same themes later emerged during the debate leading to (and resulting after) the recognition of PTSD by the psychiatric establishment.

III. THE DEVELOPMENT OF THE PTSD DIAGNOSIS IN THE *DSM*

Although some psychologists and psychiatrists advanced theories of psychological injury in the nineteenth century, the notion of psychopathology attributable to a specific external cause did not take root in mainstream psychiatry until it was embodied in the American Psychiatric Association's psychiatric classification system in the *Diagnostic and Statistical Manual of Mental Disorders*. Early editions of the *DSM* included some references to psychological reactions to stress. However, it was through the addition of PTSD in the *DSM*'s third edition—with criteria that required a clinician to identify a specific event as a cause of symptoms—that psychiatry unambiguously recognized a particular mental disorder as an injury attributable to exogenous forces, initially the horrors of war and later a wide range of distressing events.

A. *The Campaign for PTSD in DSM-III*

There is a striking irony in the history of psychiatry and the Vietnam War. In 1967, some in the United States military claimed that the “incidence of neuropsychiatric illness”¹⁶⁸ in Vietnam was markedly lower as compared to prior wars,

165. Cole, *supra* note 158, at 361. See *supra* notes 27–35 and accompanying text for a discussion of Page's theories.

166. Brown, *supra* note 14, at 431–32.

167. See *Thompson v. Ry. Exp. Agency*, 236 S.W.2d 36, 39 (Mo. Ct. App. 1951) (noting that a psychoneurosis can be the basis of a workers' compensation award so long as a causal link to a workplace accident has been made); *Bailey v. Am. Gen. Ins. Co.*, 279 S.W.2d 315, 316 (Tex. 1955) (sustaining cause of action for “anxiety reaction” in a workers' compensation case); Cole, *supra* note 158, at 361 (asserting that compensation neurosis was “tolerate[d]” in courts); Ramon A. Von Drehle, *Workmen's Compensation-Neuroses Unaccompanied by Physical Trauma Held Compensable*, 34 TEX. L. REV. 496, 497 (1956) (describing awards of workers' compensation for psychoneurosis when there is a direct link with an accident).

168. SHEPHARD, *supra* note 10, at 340.

and were confident that the problem of combat-induced psychoneurosis had been resolved.¹⁶⁹ However, the war later served as the catalyst for bringing the notion of psychopathology induced by an identifiable external cause into the mainstream of both psychiatry and law. Once the lens of PTSD was in place, those initially optimistic assessments seemed sharply out of focus. The 1990 Vietnam Veterans Study concluded that between twenty-five and thirty-three percent of those who served in Vietnam met the criteria for PTSD at some point, and that, as of the date of the study, fifteen percent still met the criteria.¹⁷⁰

The formal recognition of PTSD occurred at a time when American psychiatry was particularly concerned with diagnostic labels as it sought to overhaul its classification system. The APA published the first *DSM* in 1952 to create a standardized classification of diagnoses for use by clinicians.¹⁷¹ Prior to the release of the *DSM*, there were only a limited number of clinical psychiatric labels, which were generally limited to major mental illnesses seen in large public asylums.¹⁷²

After World War II, the spread of psychoanalytically-inclined psychiatry resulted in a great many more people being treated in the community who did not have the severe mental illnesses of those in the hospitals, creating a need for a broader range of diagnostic labels. Although the first edition of the *DSM* made significant strides towards addressing that need, it did not reflect a large consensus of psychiatrists.¹⁷³ The notion of “diagnostic criteria” was not in keeping with the psychodynamic approach that dominated American psychiatry at this time.¹⁷⁴

The *DSM-I* did not include a term such as “traumatic neurosis” to reflect specific trauma-induced disorders.¹⁷⁵ Although it did include the diagnosis of “gross stress reaction,” described as a “transient,” situational personality disorder, this was essentially a short-term reactive disorder and not indicative of any underlying neurosis or psychosis.¹⁷⁶

169. *See id.* (noting that an Army researcher stated “psychiatric casualties need never again become a major cause of attrition in the United States military in a combat zone”).

170. *Id.*

171. AM. PSYCHIATRIC ASS’N, DIAGNOSTIC AND STATISTICAL MANUAL: MENTAL DISORDERS (1st ed. 1952) [hereinafter *DSM-I*]; SHEPHARD, *supra* note 10, at 363.

172. *DSM-I*, *supra* note 171, at v–vi; EDWARD SHORTER, A HISTORY OF PSYCHIATRY: FROM THE ERA OF THE ASYLUM TO THE AGE OF PROZAC 298 (1997); *see also* SHEPHARD, *supra* note 10, at 363 (describing the prior status of diagnostic terminology).

173. YOUNG, *supra* note 7, at 98; *see also* *DSM-III*, *supra* note 5, at 1 (reporting a new method of peer revision). Many of the labels were either a reflection of Adolf Meyer’s biopsychosocial theory of mental disorder or based upon Freudian psychoanalytic practice. SHORTER, *supra* note 172, at 299.

174. YOUNG, *supra* note 7, at 93.

175. The initial diagnostic system established by the military had a category for “psychoneurotic disorders,” but not a disorder specifically linked with exposure to trauma. YOUNG, *supra* note 7, at 93.

176. YOUNG, *supra* note 7, at 107; *see* SCOTT, *supra* note 67, at 32 (noting that the editors of *DSM-I* thought the disorder was “temporary” and normally disappeared in the absence of combat); SHEPHARD, *supra* note 10, at 364.

DSM-I defined the disorder as follows:

000-x81 Gross stress reaction

Under conditions of great or unusual stress, a normal personality may utilize established patterns of reaction to deal with overwhelming fear. The patterns of such reactions differ from those of

The second edition of the *DSM* was published in 1968, during the height of the Vietnam War,¹⁷⁷ and its editors aimed to be consistent with the *International Classification of Diseases*.¹⁷⁸ The edition dropped “gross stress reaction” as a distinct diagnosis, and the editors suggested that the associated symptoms could be subsumed into the category “transient situational disturbances,”¹⁷⁹ which consisted of “acute reaction[s] to overwhelming environmental stress” in adults “without any apparent underlying mental disorders.”¹⁸⁰ The symptoms would “usually recede as the stress diminishes” provided that the patient had “good adaptive capacity.”¹⁸¹ The subcategory of “[a]djustment reaction of adult life” encompassed “[f]ear associated with military combat and manifested by trembling, running and hiding.”¹⁸² However, reflecting the hold that psychoanalytic schools maintained on American psychiatry, the broad notion of “neurosis,” with its primary symptom being anxiety, remained in the manual,¹⁸³ in a category separate from the “transient situational disturbances.”¹⁸⁴

Thus, during the Vietnam War there was no diagnosis specifically tied to either combat or trauma, perhaps because that generation of *DSM* editors had not treated those with war neurosis.¹⁸⁵ The term “combat fatigue,” a holdover from World War II, was sometimes used to describe the psychological effects of combat on soldiers, but it was not regarded as a true diagnostic label.¹⁸⁶ This lack of a specific term equivalent to “shell shock” or “war neurosis” meant that, as veterans began to seek treatment and compensation for their persistent psychiatric difficulties, there was no diagnosis that

neurosis or psychosis chiefly with respect to clinical history, reversibility of reaction, and its transient character. When promptly and adequately treated, the condition may clear rapidly. It is also possible that the condition may progress to one of the neurotic reactions. If the reaction persists, this term is to be regarded as a temporary diagnosis to be used only until a more definitive diagnosis is established.

This diagnosis is justified only in situations in which the individual has been exposed to severe physical demands or extreme emotional stress, such as in combat or in civilian catastrophe (fire, earthquake, explosion, etc.). In many instances this diagnosis applies to previously more or less “normal” persons who have experienced intolerable stress.

The particular stress involved will be specified as (1) combat or (2) civilian catastrophe.

DSM-I, *supra* note 171, at 40.

177. AM. PSYCHIATRIC ASS’N, *DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS* (2d ed. 1968) [hereinafter *DSM-II*].

178. *Id.* at vii; see *International Classification of Diseases*, WORLD HEALTH ORG., <http://www.who.int/classifications/icd/en> (last visited Nov. 14, 2011).

179. SCOTT, *supra* note 67, at 33; see *DSM-II*, *supra* note 177, at 48–49 (identifying “[a]djustment reaction of adult life” as a category of “[t]ransient situational disturbances”).

180. *DSM-II*, *supra* note 177, at 48.

181. *Id.* at 48; YOUNG, *supra* note 7, at 107.

182. *DSM-II*, *supra* note 177, at 49; see Wilson, *supra* note 62, at 690–91 (noting the “simplicity and inadequacy of these examples,” particularly in light of the significant number of high-profile traumatic events that had occurred since the publication of *DSM-I* and the extensive research on psychological responses by that time).

183. SHORTER, *supra* note 172, at 299.

184. *DSM-II*, *supra* note 177, at 39–41.

185. SCOTT, *supra* note 67, at 33; SHEPHARD, *supra* note 10, at 364.

186. See SHEPHARD, *supra* note 10, at 349 (stating that combat fatigue, or combat exhaustion, was seen as a character or behavioral disorder, not actually a disease).

clearly captured their symptomatology. This created a substantial barrier to receiving medical care or benefits from the Veterans Administration (VA), since such care and benefits were available only for “service-connected” injuries.¹⁸⁷ If the symptoms did not appear until at least a year after the veteran’s discharge, the VA would not consider them to indicate a service-connected condition.¹⁸⁸ In the absence of a recognized diagnosis to capture the cluster of symptoms (and delayed onset) exhibited by many soldiers and veterans, military and VA psychiatrists diagnosed them with “character disorders” or schizophrenia, ruling out any “service-connected” disability compensation.¹⁸⁹ Therefore, the veterans and their advocates made it a goal to see that the next edition of the *DSM* included a diagnosis that would remedy this problem.¹⁹⁰

The push to introduce a diagnosis that captured combat-related psychopathology began with a small organization called Vietnam Veterans Against the War, which held “rap groups” of veterans in New York City.¹⁹¹ The organization began working with two prominent psychoanalysts, Chaim Shatan and Robert Jay Lifton.¹⁹² These discussions led to the founding of the National Veterans Resource Project.¹⁹³ The successful efforts to alter the listing of homosexuality in the then-draft edition of *DSM* signaled to the veterans and their supporters that any *DSM* listing could be the focus of debate and advocacy.¹⁹⁴ One major target of the advocacy for specialized treatment of Vietnam veterans was the VA, which was still oriented towards serving the veterans of World War II, as were other major institutions serving veterans (congressional committees and organizations like the Veterans of Foreign Wars).¹⁹⁵ The advocates’

187. *See id.* at 365 (explaining that the VA used the *DSM-II* nomenclature which contained no diagnoses for “war-related trauma”). In an interview by Wilbur Scott, Chaim Shatan stated that he suspected that gross stress reaction was dropped specifically to reduce the potential financial liability of the VA. SCOTT, *supra* note 67, at 32 n.15. However, Scott’s research did not uncover any specific reason for the omission of the diagnosis. *Id.*

188. SCOTT, *supra* note 67, at 52.

189. SHEPHARD, *supra* note 10, at 350 (discussing abnormal official statistics reflecting increases in diagnoses of character disorders, and noting that the Army did not consider those disorders psychiatric diseases); Scott, *supra* note 5, at 298 (noting that many VA physicians concluded that veterans who appeared to be “agitated by their war experiences, or who talked repeatedly about them, suffered from a neurosis or psychosis whose origin and dynamics lay outside the realm of combat”).

190. *Id.* at 365.

191. SHEPHARD, *supra* note 10, at 355–56; *see* SCOTT, *supra* note 67, at 14–15 (referring to the groups also as “rap sessions”). Sociologist Wilbur Scott’s thoroughly researched history of the efforts of veterans’ rights advocates to gain recognition of PTSD, *Vietnam Veterans Since the War* (originally published as *The Politics of Readjustment*), is regarded by many as the leading authority on this episode. *See* Baldwin et al., *supra* note 13, at 40 (noting that Scott’s body of work, including *Vietnam Veterans Since the War*, provides “one of the most detailed examinations” of the subject matter).

192. SCOTT, *supra* note 67, at 6; SHEPHARD, *supra* note 10, at 355–56.

193. SCOTT, *supra* note 67, at 46; SHEPHARD, *supra* note 10, at 357.

194. *See* SCOTT, *supra* note 67, at 58 (indicating the homosexuality entry challenge created a large number of inquiries regarding revisions in *DSM-II* diagnoses list).

195. *See id.* at 52–54 (describing initial statutory efforts to introduce treatments specific to Vietnam veterans); SHEPHARD, *supra* note 10, at 361–62 (detailing how the VA overcame political pressure to help Vietnam veterans and the efforts of advocates to effect change).

primary objective was to ensure that Vietnam veterans with continuing psychological difficulties could obtain health care and benefits from the agency.¹⁹⁶

Shatan initially coined the missing diagnosis as “post-Vietnam syndrome,”¹⁹⁷ which he described as cluster of delayed-onset symptoms such as alienation, guilt, rage, the feeling of being scapegoated, and psychic numbing.¹⁹⁸ Shatan made no secret of his political goals with the diagnosis: “This is an opportunity to apply our professional expertise and anti-war sentiments to help some of those Americans who suffered most from the war.”¹⁹⁹

In making the case for Post-Vietnam Syndrome, Shatan and Lifton drew from post-war psychiatric literature about the Holocaust and Hiroshima.²⁰⁰ In these contexts as well, the issues of psychological impact and compensation were closely tied. The West German government had a program to compensate concentration camp survivors, but only if a causal nexus could be established between the person’s experience and the psychiatric symptoms that persisted.²⁰¹ Around this time, Jewish psychoanalysts felt pressure to present research that, contrary to the claims of German psychiatrists, the psychological effects of trauma could last well beyond the traumatic event.²⁰² Such persistent symptoms were classified as “survivor syndrome,” which was characterized by feelings of guilt as well as “depression, anxiety and nightmares.”²⁰³ As with the psychiatrists working with the veterans, those psychiatrists had taken on the dual roles of medical professionals and advocates.²⁰⁴

The timing of the campaign for the new diagnosis was significant. The *DSM-III*, which was finally published in 1980, embodies and reflects a revolution in psychiatry.²⁰⁵ Specifically, it represents a power shift within psychiatry from those

196. KUTCHINS & KIRK, *supra* note 105, at 100, 108–09.

197. SCOTT, *supra* note 67, at 43.

198. *Id.* at 43 (referencing Chaim Shatan, *Post-Vietnam Syndrome*, N.Y. TIMES, May 6, 1972, at 35).

199. ETHAN WATTERS, *CRAZY LIKE US: THE GLOBALIZATION OF THE AMERICAN PSYCHE* 114 (2010).

200. SHEPHARD, *supra* note 10, at 361.

201. *Id.* at 359–60.

202. *Id.* at 360.

203. *Id.*

204. *Id.* at 360–61 The potential legal implications of the recognition of the unique psychiatric impact on veterans was apparent from early on in the advocacy. A public defender in New York representing a Vietnam veteran in a destruction of property case tried unsuccessfully to assert a defense based upon “traumatic war neurosis.” SCOTT, *supra* note 67, at 58. The judge denied the defense on the basis that the diagnosis did not appear in the *DSM-II*. *Id.* The attorney appealed to Spitzer directly to find out if the *DSM-III* would reintroduce a diagnosis such as traumatic war neurosis and Spitzer informed him that “no change was planned.” *Id.* Noted attorney William Kunstler contacted Shatan in 1973 because he hoped to present a “post-Vietnam syndrome” defense for eight clients (known as the “Gainesville 8”) who were facing charges for planning to blow up the 1968 Democratic and Republican conventions. *Id.* at 47. The defendants were acquitted but apparently used no such defense. John Kifner, *Defense is Short in Veterans Trial*, N.Y. TIMES, Aug. 29, 1973, at 18; John Kifner, *8 Acquitted in Gainesville of G.O.P. Convention Plot*, N.Y. TIMES, Sept. 1, 1973, at 1.

205. See generally KUTCHINS & KIRK, *supra* note 105, at 1–16. See SHORTER, *supra* note 172, at 300–302 (explaining how DSM-III marked the shift from using clinical criteria to using fixed scientific criteria to diagnose psychiatric conditions); Isaac R. Galatzer-Levy & Robert M. Galatzer-Levy, *The Revolution in Psychiatric Diagnosis: Problems at the Foundations*, 50 PERSP. BIO. & MED. 161, 161 (2007) (stating that

following psychoanalytic theory, which had dominated psychiatry (particularly in the United States for the previous half-century), to those associated with so-called biological psychiatry, which regards all psychiatric illness as having origins in brain chemistry and development.²⁰⁶ The editors of *DSM-III* aimed to create a common language for not only clinicians but also for researchers to describe mental disorders in a way that did not require one to subscribe to any particular theoretical orientation.²⁰⁷ One of the editors' key objectives was to address the twin problems of the reliability (the extent to which examiners apply the same diagnosis to a set of symptoms) and validity (the extent to which a diagnosis reflects a "real" condition) in psychiatric diagnosis.²⁰⁸

In a new approach, the editors adopted the basic framework of early twentieth century German psychiatrist Emil Kraepelin, considered to be the father of psychiatric nosology,²⁰⁹ in rejecting any diagnosis that did not have a basis in empirical findings. Each disorder was assigned a set of specific criteria to be used to assess patients and to assign diagnoses. Previously, the *DSM* had included only vague, brief descriptions of each disorder.²¹⁰ The classifications and criteria ultimately adopted in the *DSM-III* would be the result of field trials.²¹¹ To underscore the scrubbing of all whiffs of Freudianism, notions of the "unconscious" (and other invisible mechanisms) would be absent from the manual,²¹² and the editors were careful to note that the term "neurotic disorder" did not implicate any "special etiological process."²¹³

At first, the lead editor of the *DSM-III*, Robert Spitzer, rejected the call for the new "post-combat disorder" diagnosis as unnecessary based upon the recommendations of other researchers studying the psychological problems of Vietnam veterans; a campaign to reverse this position was underway soon thereafter.²¹⁴ The advocates' key ally within the psychiatric establishment was psychoanalyst Mardi Horowitz, who had by this time developed an extensive theory, based largely upon the work of Freud,

DSM-III "not only revolutionized psychiatric diagnosis" but also "transformed and dominated American psychiatry").

206. SHEPHARD, *supra* note 10, at 363–64 (providing historical examples of biological manifestations of psychological illness); SHORTER, *supra* note 172, at 239, 300–02 (summarizing trend in 1970s toward biological psychiatry).

207. YOUNG, *supra* note 7, at 94, 99.

208. STUART A. KIRK & HERB KUTCHINS, THE SELLING OF DSM: THE RHETORIC OF SCIENCE IN PSYCHIATRY 28–32 (1992); Alix Spiegel, *The Dictionary of Disorder: How One Man Revolutionized Psychiatry*, THE NEW YORKER, Jan. 3, 2005, at 56, 57–58.

209. See YOUNG, *supra* note 7, at 95–96, 99 (describing Kraepelin's pioneering work with psychiatric nosology).

210. See SHORTER, *supra* note 172, at 301–02 (noting the increased length and detail of *DSM-III* as compared to previous *DSM* editions).

211. *DSM-III*, *supra* note 5, at 4–5; SHORTER, *supra* note 172, at 302; YOUNG, *supra* note 7, at 95.

212. YOUNG, *supra* note 7, at 100.

213. *DSM-III*, *supra* note 5, at 9–10 (emphasis omitted); see also SHORTER, *supra* note 172, at 304 (explaining that the editors of *DSM-III* differentiated between "neurosis" and a "neurotic process" in order to appease major interest group of psychoanalysts). Apparently, *DSM-III* retained the term "neurosis" (which Spitzer had attempted to strike out) only as a compromise to the psychoanalytic camp, who otherwise would have refused to approve the new manual. Spiegel, *supra* note 208, at 60–61.

214. SCOTT, *supra* note 67, at 60–61; YOUNG, *supra* note 7, at 109–10.

Kardiner, and others, about “stress response syndromes.”²¹⁵ Horowitz described a number of different reactions to traumatic stress, including avoidance of things associated with the events (including memories) and “intrusive” effects when the memories nonetheless caused a reexperiencing of the events, both of which Kardiner had described in his studies of World War I veterans.²¹⁶ Although the number of acute psychiatric casualties initially appeared to be lower in Vietnam,²¹⁷ some officials noted the impact of “stress” on soldiers during their one-year stints.²¹⁸ Towards the end of the war, Horowitz predicted a high incidence of delayed-onset psychiatric reactions or “stress response syndromes” by soldiers.²¹⁹

The advocates of the new diagnosis were careful not to limit it to combat reactions, but rather applied it to a broad category of individuals exposed to “trauma.”²²⁰ In their work with the APA, they revised the name of the proposed diagnosis to “catastrophic stress disorder,” with a sub-type of “post-combat stress reactions.”²²¹ The symptom list for the initial formulation of PTSD developed by Shatan, Lifton, and Horowitz²²² was largely taken from Abram Kardiner’s *The Traumatic Neuroses of War*.²²³ Together, these psychiatrists refined a “unitary kind of ‘trauma’” that was ultimately embodied in the diagnostic criteria of PTSD.²²⁴ It drew heavily on Freudian theory about the emotional impact of repressed memories of earlier traumatic events:²²⁵ the pathogenic memory.²²⁶ They expressly stated that there were

215. SHEPHARD, *supra* note 10, at 367; *see also* SCOTT, *supra* note 67, at 62 (describing Horowitz’s role with Vietnam Veterans Working Group).

216. Kinzie & Goetz, *supra* note 28, at 172. *See supra* notes 106–10 and accompanying text for a discussion of Kardiner’s work regarding the long-term psychological impact of war.

217. SCOTT, *supra* note 67, at 33.

218. *See* SHEPHARD, *supra* note 10, at 349 (describing how Army physicians in Vietnam measured the effects of stressful military activities).

219. *See generally* Mardi J. Horowitz & George F. Solomon, *A Prediction of Delayed Stress Response Syndromes in Vietnam Veterans*, 31 J. SOC. ISSUES 67 (1975). The delay was attributed to the widespread use of both illicit drugs, such as heroin, as well as tranquilizers, such as chlorpromazine, both widely available. SHEPHARD, *supra* note 10, at 351–53.

220. *See* SHEPHARD, *supra* note 10, at 366 (noting that “Shafton, Lifton and their allies” began to look at post-combat disorder as a sub-class of a more general phenomenon, and thus began reviewing “literature of catastrophes in general”).

221. SCOTT, *supra* note 67, at 64.

222. SHEPHARD, *supra* note 10, at 367.

223. YOUNG, *supra* note 7, at 89, 91.

224. SHEPHARD, *supra* note 10, at 367.

225. KUTCHINS & KIRK, *supra* note 105, at 114; *see also* Marilyn L. Bowman, *Problems Inherent to the Diagnosis of Posttraumatic Stress Disorder*, in *PSYCHOLOGICAL INJURIES AT TRIAL* 820, 821 (Izabela Z. Schultz & Douglas O. Brady eds., 2003) (Am. Bar Ass’n CD-ROM) (describing the relationship between Freud’s theory regarding “conflict-laden early experiences” and modern views of adult emotional disorders); Mardi J. Horowitz, *Introduction* to *ESSENTIAL PAPERS ON POSTTRAUMATIC STRESS DISORDER* 1, 3 (Mardi J. Horowitz ed., 1999) (explaining that posttraumatic symptoms derive from the Freudian theory of shock mastery); Wilson, *supra* note 62, at 691 (noting that the PTSD diagnostic criteria in *DSM-III* reflect Freud’s observations about the impact of trauma on human emotion, cognitive processes, ambition, relationships, and “physiological functioning”).

226. *See supra* notes 53–66 and accompanying text for a discussion of theories that indicate the pathogenic memory plays a role in psychoneurosis.

no predisposing factors, other than the exposure to the traumatic event.²²⁷ However, this description contained more etiology than the editors could tolerate. They responded that but for the link with a specified event the symptoms could be found in other conditions, and therefore the diagnosis was unnecessary.²²⁸

The sole empirical support for the proposed diagnosis that Shatan and Lifton could offer was anecdotal evidence that some VA doctors had been noting “traumatic war neurosis” on patient charts for years in the absence of a recognized diagnosis.²²⁹ Although this was not the type of empirical data that Spitzer aspired to have as the sole basis for the *DSM-III* diagnoses,²³⁰ these case histories had a significant impact on Nancy Andreasen, the chair of the *DSM-III* Committee on Reactive Disorders and a psychiatrist within the APA mainstream who had worked on the psychological impact of trauma, specifically with burn victims.²³¹ However, what was perhaps more convincing for those within the APA was the “moral” case for including the diagnosis.²³² By adopting the diagnosis, the psychiatric establishment would help eliminate one of the key barriers to veterans’ access to compensation and health care for their mental troubles. To do otherwise would leave the responsibility on the shoulders of the veterans themselves.²³³

The final name and criteria for PTSD emerged from the Committee on Reactive Disorders, and it largely followed the recommendation of Lifton, Shatan, and others on the working group that had developed the “catastrophic stress disorder” diagnosis, changing little other than the name of the diagnosis and eliminating the “post-combat” subtype.²³⁴ It was placed within the “Anxiety Disorders,”²³⁵ and its “essential feature” was described as “the development of characteristic symptoms following a psychologically traumatic event that is generally outside the range of usual human experience.”²³⁶ The “characteristic symptoms” were “reexperiencing the traumatic event; numbing of responsiveness to, or reduced involvement with, the external world;

227. SHEPHARD, *supra* note 10, at 367; SCOTT, *supra* note 67, at 64.

228. YOUNG, *supra* note 7, at 110.

229. SCOTT, *supra* note 67, at 34, 62–63; *see also* YOUNG, *supra* note 7, at 111 (noting the significance of the Vietnam War in defining PTSD in the *DSM-III*).

230. KUTCHINS & KIRK, *supra* note 105, at 114; *see also* Thomas Maier, *Post-Traumatic Stress Disorder Revisited: Deconstructing the A-Criterion*, 66 *MED. HYPOTHESES* 103, 103–104 (2006) (noting that although PTSD did not emerge from a traditional “Popperian view of scientific progress,” it is a good example of a “paradigm shift” as that term was used by Thomas Kuhn to describe “how scientific progress is never exclusively guided by empiric observations, but by theoretical concepts derived from highly selective observations”).

231. *See* SCOTT, *supra* note 67, at 61–63 (indicating that a working group advocating for a category of “combat-induced disorder” felt “that they had won Andreasen over” with regard to their views).

232. YOUNG, *supra* note 7, at 114; *see also* KUTCHINS & KIRK, *supra* note 105, at 116 (explaining that approval of PTSD was based largely on “demonstrating that victims suffer from impairments even if they do not show signs of debilitating physical trauma”).

233. YOUNG, *supra* note 7, at 114 (stating that failing to put PTSD in the *DSM-III* would mean “denying medical care and compensation” to veterans and that “[a]cknowledging PTSD would be a small step toward repaying a debt” to young soldiers who sacrificed their youth in Vietnam).

234. SCOTT, *supra* note 67, at 66.

235. *DSM-III*, *supra* note 5, at 225.

236. *DSM-III*, *supra* note 5, at 236.

and a variety of autonomic, dysphoric, or cognitive symptoms.”²³⁷ The criteria differentiated between “acute” PTSD, with an onset within six months of the trauma and a duration of less than six months, and “chronic or delayed” PTSD, which had either or both an onset of more than six months or duration longer than six months.²³⁸ In short, the diagnosis appeared to provide the veterans precisely what they needed to pursue claims for compensation and care.

B. *The A Criterion*

The publication of the diagnostic criteria for PTSD in the *DSM-III* marked a significant moment in the history of both psychiatric diagnosis and legal claims for psychological injuries. PTSD provided psychiatry with a means to classify a psychological injury that developed “in normal people . . . following an extremely traumatic event.”²³⁹ Accordingly, unlike the remainder of *DSM-III* diagnoses, the criteria for PTSD were not “atheoretical,” as that term is employed in psychiatric nosology.²⁴⁰ Specifically, the list of diagnostic criteria for the disorder includes the “A Criterion” (also commonly referred to as the “stressor criterion”), which, in *DSM-III*, is described as “a recognizable stressor that would evoke significant symptoms of distress in almost everyone.”²⁴¹ As described in the explanatory text, the diagnosis required the prior occurrence of a specific etiological event “outside the range of usual human experience” that would create “significant symptoms of distress in most people.”²⁴² In other words, the diagnosis itself contains a theory of the etiology of the symptoms. Robert Spitzer has acknowledged this to be the case: “[A] key distinguishing feature of PTSD is that it is not agnostic to etiology. Unlike virtually all diagnoses in the [*DSM*], PTSD rests on the assumption of a specific etiology, whereby a distinct set of events (criterion A) is assumed to be the uniformly most potent contributor to outcome.”²⁴³

237. *Id.* The text also states that “[p]reexisting psychopathology apparently predisposes to the development of the disorder.” *Id.* at 237. This language regarding predisposition seems at variance with Scott’s description of the committee report that was the basis for the final diagnosis, but he provides no explanation for its inclusion in the *DSM-III*.

238. *DSM-III*, *supra* note 5, at 238. There is no reference in the main text to the concept of “traumatic neurosis” or any other similar diagnostic labels that had been used (and were still in use) to describe psychological injuries. Baldwin et al., *supra* note 13, at 41. This is likely because the term was never accepted as part of any official psychiatric nosology.

239. Rachel Yehuda & Alexander C. McFarlane, *Conflict Between Current Knowledge About Posttraumatic Stress Disorder and Its Original Conceptual Basis*, 152 *AM. J. PSYCHIATRY* 1705, 1706 (1995).

240. “Atheoretical” refers to an absence of an assigned specific theory for the cause of a mental disorder. See Dorthe Berntsen et al., *Contrasting Models of Posttraumatic Stress Disorder: Reply to Monroe and Mineka*, 115 *PSYCHOL. REV.* 1099, 1099–1100 (2008) (discussing how the PTSD diagnosis formed an exception to the absence of etiology throughout *DSM-III*); YOUNG, *supra* note 7, at 115 (providing a further explanation of the term “atheoretical” in this context and his application of the term to PTSD and the *DSM*).

241. *DSM-III*, *supra* note 5, at 238.

242. *Id.* at 236.

243. Robert L. Spitzer et al., Editorial, *Revisiting the Institute of Medicine Report on the Validity of Posttraumatic Stress Disorder*, 49 *COMPREHENSIVE PSYCHIATRY* 319, 319 (2008); see also *DSM-III*, *supra* note 5, at 7 (“*DSM-III* is atheoretical with regard to etiology”); Gerald M. Rosen & Scott O. Lilienfeld, *Posttraumatic Stress Disorder: An Empirical Evaluation of Core Assumptions*, 28 *CLINICAL PSYCHOL. REV.* 837, 839 (2008) (reiterating that the “core assumption” of PTSD is the causal connection between a traumatic event and the ensuing series of reactions).

Similarly, the Institute of Medicine's recent analysis of PTSD observed that "the necessary cause of PTSD is by definition a traumatic event."²⁴⁴

The A Criterion has been described as the "gatekeeper"²⁴⁵ and the "defining feature"²⁴⁶ of the diagnosis because the "DSM theory of PTSD" is that "time and causality move *from* the traumatic event *to* the other criterial features."²⁴⁷ Absent "the event," the symptomatology would be assigned a different diagnosis. Once the event is identified and deemed to fit within the A Criterion definition of "traumatic," the symptoms are transformed into markers of PTSD.²⁴⁸ *DSM-III* also set forth a specific list of symptoms or reactions to the A Criterion event, and it distinguished between reactions that had an onset soon after the event and those that were latent, occurring more than six months after the event.²⁴⁹ A key feature in the symptom cluster described in *DSM-III* is the role of memory and dissociative experiences such as "flashbacks."²⁵⁰ In other words, the past remains very much in the person's present and is the subject of "persistent reexperie[n]g."²⁵¹

The new diagnosis therefore "violated basic guidelines about theory and research that had been established for the DSM-III," and, most notably, the editors' attempts "to eliminate etiology from their description of disorders."²⁵² At the time of the first iteration of PTSD, there was a controversy over whether the event, as opposed to a person's predisposition, should be regarded as the primary cause of the symptoms.²⁵³ PTSD, as it finally appeared, reflected a break from the way traumatic neurosis and

244. Spitzer et al., *supra* note 243, at 319 (quoting INST. OF MED., POSTTRAUMATIC STRESS DISORDER: DIAGNOSIS AND ASSESSMENT 23 (2006)).

245. Robert I. Simon, *Forensic Psychiatric Assessment of PTSD Claimants*, in POSTTRAUMATIC STRESS DISORDER IN LITIGATION: GUIDELINES FOR FORENSIC ASSESSMENT 41, 57 (Robert I. Simon ed., 2d ed. 2003) [hereinafter PTSD IN LITIGATION].

246. YOUNG, *supra* note 7, at 120.

247. *Id.* at 115.

248. YOUNG, *supra* note 7, at 120; Baldwin et al., *supra* note 13, at 44.

249. *DSM-III*, *supra* note 5, at 238–39.

250. Edgar Jones et al., *Flashbacks and Post-Traumatic Stress Disorder: The Genesis of a 20th-Century Diagnosis*, 182 BRIT. J. PSYCHIATRY 158, 160 (2003). The term "flashback" was not directly mentioned in the *DSM-III*, but was included as a synonym for some PTSD symptoms in the *DSM-III-R*. *Id.*

251. AM. PSYCHIATRIC ASS'N, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS 250 (3d ed. rev. 1987) [hereinafter DSM-III-R]; see Jones et al., *supra* note 250, at 160 (stating that soldiers were "reliving episodes from . . . active service"). This is at variance from the notion of the transformation of repressed memories into internal conflicts as a result of subsequent events in the person's life. See Jones et al., *supra* note 250, at 160 (discussing the idea that "certain experiences, which are neither salient nor meaningful when they occur, acquire an emotional potency or importance by an additional piece of information" and, in a sense, "a normal recollection of an event becomes transformed into a disturbing and highly significant memory").

252. KUTCHINS & KIRK, *supra* note 105, at 114. Strictly speaking, the category of "Substance Use Disorders" could arguably include a link to causation since the category "deals with behavioral changes associated with more or less regular use of substances that affect the central nervous system." *DSM-III*, *supra* note 5, at 163; Correspondence from David Rubin to Deirdre M. Smith, Prof. of Law and Glassman Scholar, University of Maine School of Law (July 29, 2010) (on file with author). However, psychiatry does not appear to regard such association as having a basis in a "theory," in the same respect as PTSD's link with traumatic events.

253. Berntsen et al., *supra* note 240, at 1100.

similar conditions were viewed in that the persistence of the symptoms was not regarded as being due to an individual's inability to adapt.²⁵⁴ The drafters of PTSD considered what they assumed to be the legal implications of this debate; as Horowitz later recalled: "If trauma were the main cause of symptoms, the institutions or people responsible for causing or not preventing the traumatic events could be held legally responsible for damage to victims."²⁵⁵

The explanatory text accompanying the original PTSD criteria provided several examples of the kinds of traumatic events that meet the A Criterion (rape, military combat, floods, earthquakes, plane crashes, torture), and notes: "The disorder is apparently more severe and longer lasting when the stressor is of human design."²⁵⁶ One psychiatrist explained the rationale for this observation as follows: "Stressors caused by man appear to have a greater traumatic impact than natural events. The injured person usually feels that a manmade stressor is preventable, whereas natural disasters are unavoidable acts of God. Feelings of rage, retribution, and vengeance are commonly experienced."²⁵⁷ In other words, categories of trauma for whom another person (whether natural or corporate) could be *held responsible* were assumed to be most likely to result in reactions like PTSD.

Notions about legal obligation thus drove the specific criteria of PTSD. In order for the veterans to be able to claim entitlement to "service-connected" benefits the proponents of the diagnosis concluded that such "connection" to military service needed to be built into the diagnosis. By framing the condition as it did, the *DSM-III* made it unquestionably clear that those who were previously psychiatrically healthy could suffer severe functional limitations as a result of being exposed to traumatic stress that was not of their own making. Thus, we see a diagnosis that embodies a shift of responsibility from one to another, or at least away from the patient. Without such a feature embodied in A Criterion, PTSD would have emerged in 1980 looking like all of the other *DSM-III* diagnoses, or more likely, it would not have emerged at all since its symptoms overlap with other disorders in the manual.

With a diagnosis built around their experiences, veterans were indeed more successful in obtaining not only health coverage and disability benefits but also validation from the United States Government itself that they had endured an experience that transformed a "normal" person into one who was ill and in need of care and compassion. With PTSD cast as it was, there was little room for debate that its occurrence in Vietnam veterans was "service-connected," and therefore the veterans with such diagnosis would be among those receiving "top priority" care and compensation.²⁵⁸ Once PTSD was accepted for inclusion in the DSM, the veterans advocacy groups took the next step and successfully lobbied the Senate Veterans Affairs Committee to issue a report authorizing the VA to recognize and compensate PTSD in Vietnam veterans.²⁵⁹

254. *Id.*

255. Horowitz, *supra* note 225, at 1.

256. *DSM-III*, *supra* note 5, at 236.

257. Simon, *supra* note 245, at 57.

258. YOUNG, *supra* note 7, at 113.

259. YOUNG, *supra* note 7, at 114.

There have been two revisions to the A Criterion since its initial inclusion in the *DSM-III* in 1980. In 1987, with the publication of the revised edition of the Third Edition, *DSM-III-R*, the APA revised the criterion as follows:

The essential feature of this disorder is the development of characteristic symptoms following a psychologically distressing event that is outside the range of usual human experience . . . [and] would be markedly distressing to almost anyone

The most common traumata involve either a serious threat to one's life or physical integrity; a serious threat or harm to one's children, spouse, or other close relatives and friends; sudden destruction of one's home or community; or seeing another person who has recently been, or is being, seriously injured or killed as the result of an accident or physical violence. In some cases the trauma may be learning about a serious threat or harm to a close friend or relative, e.g., that one's child has been kidnapped, tortured, or killed.²⁶⁰

This revision moved some of the explanatory description into the criterion itself (with minor rewording), and provided a list of examples of the kinds of events that would be considered "outside the range of human experience" and "markedly distressing to almost anyone."²⁶¹ The aim of this revision was to address the problem of different individuals having different "stress thresholds."²⁶² The editors had hoped that providing the list of examples would clarify that the A Criterion stressors were "at the extreme end of the stress continuum," since it was assumed that the more "severe and life-threatening" events would be more likely to produce psychopathology such as PTSD.²⁶³

The APA revised the diagnostic criteria for PTSD for a second time in 1994.²⁶⁴ For the *DSM-IV*, the APA divided the A Criterion into two parts:

- A. The person has been exposed to a traumatic event in which both of the following were present:
 - (1) the person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others
 - (2) the person's response involved intense fear, helplessness or horror.²⁶⁵

These changes broadened the criterion to allow a wider range of events and experiences to qualify for the criterion and also introduced a subjective component.²⁶⁶

260. *DSM-III-R*, *supra* note 251, at 247–48.

261. *Id.* at 247.

262. Wilson, *supra* note 62, at 694.

263. *Id.* Wilson was on the committee that recommended the revisions.

264. AM. PSYCHIATRIC ASS'N, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS 427–29 (4th ed. 1994) [hereinafter *DSM-IV*].

265. *Id.* at 427–48. The *DSM-IV* also added a new disorder, "Acute Stress Disorder," which was also premised on the occurrence of a traumatic event, but, unlike PTSD, could be diagnosed within four weeks after the traumatic event to classify an individual's immediate emotional reaction. *Id.* at 429–32; see also KUTCHINS & KIRK, *supra* note 105, at 117–18 (providing an overview of the new Acute Distress Disorder diagnosis).

266. See Naomi Breslau & Ronald C. Kessler, *The Stressor Criterion in DSM-IV Posttraumatic Stress Disorder: An Empirical Investigation*, 50 *BIOLOGICAL PSYCHIATRY* 699, 700, 703–704 (2001) (concluding that there was "no doubt that the intent [of the revision of Criteria A in the *DSM-IV*] was to enlarge the variety

DSM-IV eliminated the “normative criterion of the ‘average’ person,” by removing the reference to “almost anyone.”²⁶⁷ The revisions also removed the reference to the event being “markedly distressing” to the average person without specifying when such distress occurs—whether at the time of the event or in the recollection of it.²⁶⁸

There was also no longer a reference to events being “outside the range of usual human experience.”²⁶⁹ This revision ostensibly conformed the language of the criteria to its use in practice.²⁷⁰ Clinicians frequently disregarded the original phrasing in that they did not attempt to determine the actual frequency of such events or the appropriate context for such analysis.²⁷¹ For example, among Vietnam veterans, exposure to death and dismemberment was not unusual. Sexual assault is not infrequent, particularly in certain cultures or locations.²⁷² And clinicians did not hesitate to diagnose PTSD in war veterans or rape survivors. However, some commentators have claimed that the *DSM-IV* revision to the A Criterion resulted in a substantial increase in people diagnosed with PTSD.²⁷³

The revisions to PTSD and the A Criterion did not silence the critics within psychiatry who questioned the validity and utility of having a disorder in the *DSM* linked categorically to a specific and identifiable cause rather than being no more than a set of frequently coexisting symptoms. In fact, the expanded range of potential stressor events, coupled with the contemporaneous increase in the forensic use of PTSD as discussed in the next Part, only served to fuel the debate.

of experiences that can be used to diagnose PTSD” and that “the population’s total life experiences that can be used to diagnose PTSD has increased materially by 59.2%”); Maier, *supra* note 230, at 105 (discussing changes in PTSD diagnosis from *DSM-III* to *DSM-VI*); Simon, *supra* note 245, at 57 (discussing new language in *DSM-IV* diagnosis).

267. Simon, *supra* note 245, at 59. Compare *DSM-IV*, *supra* note 264, at 427 (requiring “the person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others”), with *DSM-III*, *supra* note 5, at 238 (requiring “[e]xistence of recognizable stressor that would evoke significant symptoms of distress in almost everyone”). Some studies suggest that clinicians generally waived that requirement even prior to the amendment. YOUNG, *supra* note 7, at 124.

268. YOUNG, *supra* note 7, at 124–25. Freud and others made a link between the experience of fear at the time of the event and the causation of traumatic neurosis. *Id.* at 125.

269. KUTCHINS & KIRK, *supra* note 105, at 118 (quoting *DSM-III-R*, *supra* note 251, at 247).

270. See YOUNG, *supra* note 7, at 127 (comparing *DSM-III-R*’s literal meaning of traumatic event and actual diagnostic practice of PTSD). This revision is somewhat similar to the distinction between intentional infliction of emotional distress and negligent infliction of emotional distress, where the former was more readily accepted by courts because it required a showing of conduct so “extreme and outrageous” that the plaintiff’s resulting emotional distress was not suspect. See *supra* notes 127–56 and accompanying text for a discussion of emotional injury and liability.

271. See YOUNG, *supra* note 7, at 127.

272. KUTCHINS & KIRK, *supra* note 105, at 118.

273. *Id.* at 121. One study suggested a fifty percent expansion in those diagnosed after this revision. LISA APPIGNANESI, MAD, BAD AND SAD: A HISTORY OF WOMEN AND THE MIND DOCTORS 427 (2007); JUDITH HERMAN, TRAUMA AND RECOVERY: THE AFTERMATH OF VIOLENCE—FROM DOMESTIC ABUSE TO POLITICAL TERROR 427 (rev. ed. 1997) (1992). Harvard psychiatrist Judith Herman, one of the leading figures in the effort to apply the PTSD diagnosis to women who had experienced sexual assault, sexual abuse, domestic violence, and other forms of violence, served on the APA committee that advanced the amendments. HERMAN, *supra*, at 426–27.

IV. PTSD AND QUESTIONS OF LIABILITY

Once the psychiatric establishment fully embraced the concept of a psychological injury by adopting PTSD in *DSM-III*, attorneys began to explore potential uses of this diagnosis in a wide range of settings in which the key question was how to assign responsibility, whether civil or criminal. In some respects, this was the continuation of the strategy used with the nonclinical term “traumatic neurosis,” but it came at a time when there was also a turning point in law regarding the role of psychiatric diagnosis in legal proceedings. This change was due in large part to the fact that *DSM-III* was the first edition of the manual to have widespread use beyond the psychiatric profession. Psychiatric diagnosis itself had a new and central role in litigation that touched on mental issues, and the *DSM-III*'s code-like structure and ostensible “scientific” basis eased the way for the diagnoses themselves to be evidence in litigation.

As noted in Part III, the *DSM-III* marked a revolutionary moment in the history of psychiatry.²⁷⁴ Beginning with that edition, the *DSM* had remarkable impact. It is referred to by some as a “bible,”²⁷⁵ by others as a “consensus document.”²⁷⁶ It is used universally throughout the psychiatric profession in the United States and in a great deal of the rest of the world.²⁷⁷ However, its true power comes from its wide adoption outside of the mental health profession, in a range of institutional, educational, and administrative settings. The legal system is one such institution that has widely incorporated use of the *DSM*.²⁷⁸ Philosopher Ian Hacking, who writes about the interactions between science (including psychiatry) and the wider culture, observes that, although we assume that the classifications we create merely reflect what is there, such classifications in fact shape the systems that use them and the people within that system, creating a “looping effect.”²⁷⁹ PTSD's influence on the legal system serves as an example of this effect.

Although the APA certainly was aware that recognition of PTSD would yield immediate benefits for countless Vietnam veterans, the editors of *DSM-III* apparently anticipated the appeal the manual as a whole would hold for the legal system. Near the

274. KUTCHINS & KIRK, *supra* note 105, at 5.

275. *Id.*

276. Renee L. Binder & Dale E. McNiel, *Some Issues in Psychiatry, Psychology, and the Law*, 59 HASTINGS L.J. 1191, 1197–98 (2008); see also Abilash Gopal & Harold Bursztajn, *On Skepticism and Tolerance in Psychiatry and Forensic Psychiatry*, PSYCHIATRIC TIMES, Apr. 15, 2007, at 2 (noting that some “ill-trained attorneys” erroneously believe that the *DSM* is the “bible of psychiatry” or that psychiatry “can be practiced from a cookbook”).

277. See KUTCHINS & KIRK, *supra* note 105, at 10–12 (remarking that every mental health professional owns a copy of the *DSM*, and the *DSM* has had a broad impact on other sectors of life); SHORTER, *supra* note 172, at 302 (noting that, by the early 1990s, the *DSM* had been translated into more than twenty languages and it was being used widely in France and Germany; “[t]he appearance of *DSM-III* was thus an event of capital importance not just for American but for world psychiatry”).

278. KUTCHINS & KIRK, *supra* note 105, at 11–12; see also Greenberg et al., *supra* note 6, at 7 (noting that the *DSM* “has become a forensic mantra”).

279. Ian Hacking, *Kinds of People: Moving Targets*, 151 PROC. BRIT. ACAD. 285, 285–86 (2006); see also YOUNG, *supra* note 7, at 107 (explaining that diagnostic technologies like the *DSM-III* “are an integral part of the historical formation of some of the disorders (including PTSD) that they now identify and represent”).

end of his introduction to *DSM-III*, lead editor Robert Spitzer included a brief paragraph titled “Cautions,” which stated:

The purpose of *DSM-III* is to provide clear descriptions of diagnostic categories in order to enable clinicians and investigators to diagnose, communicate about, study, and treat various mental disorders. The use of this manual for non-clinical purposes, such as determination of legal responsibility, competency or insanity, or justification for third-party payment, must be critically examined in each instance within the appropriate institutional context.²⁸⁰

However, the nonclinical and nonresearch uses of *DSM-III*, and specifically PTSD, were soon widespread in the legal system with scant little of the critical examination urged by Spitzer. Indeed, perhaps in response to this trend, the editors’ caution has grown more emphatic with each new edition of the *DSM*, to little avail.²⁸¹

PTSD has had many applications in the law in a wide range of contexts, including criminal law (with respect to defenses and sentencing)²⁸² and workers’ compensation.²⁸³ However, the discussion here will focus on two contexts in which courts have permitted PTSD, and particularly the A Criterion, to take a critical role in establishing liability: (1) to prove that a criminal complainant or civil plaintiff was subjected to a traumatic event, such as child sexual abuse; and (2) in tort cases, to establish liability for stand-alone claims for emotional distress. As one psychiatrist noted, PTSD is particularly powerful in legal settings because it “carries a legal and moral implication that someone else is responsible for an event so overwhelming that anyone could develop a potentially severe psychiatric disorder as a result.”²⁸⁴ Such

280. *DSM-III*, *supra* note 5, at 12.

281. Greenberg et al., *supra* note 6, at 6.

282. *See, e.g.*, *Coggin v. State*, 745 P.2d 1182, 1184–85 (Okla. Crim. App. 1987) (describing expert testimony offered by defendant, which indicated that the night of the murder certain events had “triggered a ‘flashback’ to Vietnam which put the appellant in a disassociative state” and the defendant “did not remember stabbing the victim”); *State v. Miller*, No. 48316, 1984 WL 6384, at * 2 (Ohio Ct. App. Dec. 20, 1984) (describing expert testimony offered by defendant that the victim’s attack “caused [defendant] to flash back to Vietnam” and he had no memory of the murder); *see also* Daniel W. Shuman, *Persistent Reexperiences in Psychiatry and Law*, in *PTSD IN LITIGATION*, *supra* note 245, at 1, 9 (noting various uses of PTSD as a criminal defense strategy); Michael J. Davidson, *Post-Traumatic Stress Disorder: A Controversial Defense for Veterans of a Controversial War*, 29 WM. & MARY L. REV. 415, 422–40 (1988) (discussing use of PTSD as defense in criminal prosecutions involving Vietnam veteran defendants); John O. Lipkin et al., *Post-Traumatic Stress Disorder in Vietnam Veterans: Assessment in a Forensic Setting*, 1 BEHAV. SCI. & L. 51, 63–64 (1983) (discussing connection between criminal behavior and PTSD symptoms).

283. PTSD resulted in an expansion of recovery of workers’ compensation benefits for employees who demonstrated psychological injuries from their workplaces. Much like the veterans who asserted “service-connected” injuries arising from their combat, employees attempted to analogize their workplace to traumatic stressors and to seek compensation for work-related mental injuries. *See generally*, Izabela Z. Schultz, *Psychological Causality Determination in Personal Injury and Workers’ Compensation Contexts*, in *PSYCHOLOGICAL INJURIES AT TRIAL*, *supra* note 229, at 102. In one remarkable case, the Supreme Court of Arizona permitted a police officer to pursue a workers’ compensation claim for PTSD, resulting from an incident in which he was shot nearly twenty-four years prior to the 1984 filing date. *Henry v. Indus. Comm’n of Ariz.*, 754 P.2d 1342, 1344–45 (Ariz. 1988). The court permitted such a claim on the basis that PTSD was “not diagnosable” in 1960 when the incident occurred. *Id.*

284. Liza H. Gold, *PTSD in Employment Litigation*, in *PTSD IN LITIGATION*, *supra* note 245, at 163, 164.

power is particularly apparent in these two contexts because the fact of the *medical* diagnosis is assigned a role in the determination of *legal* liability.

A. *The Fact of the Traumatic Event*

With the recognition of PTSD by the APA, Vietnam veterans began using the diagnosis in the criminal law as part of defenses or in seeking lighter sentences. However, PTSD's impact in criminal settings attracted more notice when prosecutors began using the diagnosis in criminal trials for sexual assault and child sexual abuse. Prosecutors have long faced "distinctive evidentiary problems" when prosecuting child sexual abuse cases because generally the only witness is the child complainant.²⁸⁵ The child may be particularly young or inarticulate, either of which could implicate problems of competency or credibility. Similarly, in rape prosecutions, the key factual disputes often turn on the credibility of the complainant.²⁸⁶ In both cases, there is often little other evidence to corroborate the complainant's allegations. The recognition of PTSD by the APA suggested new potential strategies to address these challenges.

Soon after the release of *DSM-III*, prosecutors sought to offer testimony through psychological experts centered on the theory and criteria of PTSD to opine that the complainant's behavior was consistent with having been sexually abused or assaulted, and, from that assessment, to opine that the complainant in fact had been sexually abused²⁸⁷ or assaulted.²⁸⁸ PTSD and the "traumatic stress model" of child sexual abuse were useful due to "the unequaled etiological significance [PTSD] placed on 'outside' (external to psyche) trauma."²⁸⁹ Such experts generally employed the criteria or general concept of PTSD, but some also used terms such as "child sexual abuse accommodation syndrome" (CSAAS)²⁹⁰ or "rape trauma syndrome" (RTS).²⁹¹ Such uses of the *DSM* and PTSD were met with fierce resistance from defense attorneys, and courts struggled with the question of whether to admit such evidence and for what

285. Lisa R. Askowitz & Michael H. Graham, *The Reliability of Expert Psychological Testimony in Child Sexual Abuse Prosecutions*, 15 CARDOZO L. REV. 2027, 2033 (1994).

286. See Richard Klein, *An Analysis of Thirty-Five Years of Rape Reform: A Frustrating Search for Fundamental Fairness*, 41 AKRON L. REV. 981, 1016–17 (2008) (explaining that a major reform in rape prosecutions deals with "weaknesses in the prosecutor's case arising from victim conduct which appears to be inconsistent with that of an individual who had just been sexually assaulted").

287. Askowitz & Graham, *supra* note 285, at 2046; see also SUSAN A. CLANCY, *THE TRAUMA MYTH: THE TRUTH ABOUT THE SEXUAL ABUSE OF CHILDREN—AND ITS AFTERMATH* 100–101 (2009) (discussing the introduction of sexual abuse as a traumatic event in order to conceptualize the harm endured by a victim as a form of PTSD).

288. Klein, *supra* note 286, at 1016–17.

289. CLANCY, *supra* note 287, at 101.

290. See, e.g., *Allison v. State*, 353 S.E.2d 805, 807–08 (Ga. 1987) (admitting testimony from an expert on child sexual abuse syndrome who discussed the behavioral characteristics and the stages an alleged victim goes through), *superseded by statute*, GA. CODE ANN. § 17-7-110 (West 2011), *as recognized in* *Park v. State*, 495 S.E.2d 886 (Ga. Ct. App. 1987).

291. *People v. Taylor*, 552 N.E.2d 131, 132 (N.Y. 1990); Ann Wolbert Burgess, *Rape Trauma Syndrome*, 1 BEHAV. SCI. & L. 97, 98 (1983); see also *State v. Allewalt (Allewalt II)*, 517 A.2d 741, 754 (Md. 1986) (Eldridge, J., dissenting) (reviewing the origin of the term "rape trauma syndrome" and noting that it is recognized as "a sub-category of post-traumatic stress disorder in which the triggering trauma is rape").

purposes. A significant body of case law, with a wide variety of approaches, developed in the first twenty years after PTSD was recognized.

The least controversial use of such PTSD evidence is on rebuttal to rehabilitate the complainant after impeachment by offering possible alternative reasons (based upon the diagnoses) for the person to have acted in a manner that, on the surface, would appear to be inconsistent with being a victim of rape or sexual abuse.²⁹² Courts have been significantly more conflicted, however, on the issue of whether to admit during a prosecutor's case in chief expert testimony that the complainant had PTSD symptoms for the purposes of establishing that the person had been a victim of rape or abuse.²⁹³ The prosecution would offer an expert to testify that the alleged victim displayed "typical" or hallmark symptoms of these syndromes indicating that the victims had experienced trauma consistent with that alleged by the prosecution.²⁹⁴

Courts have been sharply divided on the admissibility of such evidence.²⁹⁵ One court that upheld the admission of such evidence concluded that, since the incidence of PTSD in an individual "indicates that she might have been sexually abused," such evidence is probative of one of the central questions in these cases, even if the evidence is not being offered in response to an issue raised by the defense.²⁹⁶ Other courts that have admitted such evidence reasoned that it was not being admitted to prove that a crime had been committed but rather only to help the jury understand the behavior of sexually abused children²⁹⁷ or to negate suggestions or defenses of consent.²⁹⁸ The excluding courts' concern with admitting PTSD testimony for such purposes, even if not articulated precisely this way, essentially stems from the role of the A Criterion—that the application of the diagnosis to an individual appeared to represent a *clinical* opinion that the person had in fact been exposed to a traumatic event.²⁹⁹

292. See *State v. Alberico*, 861 P.2d 192, 207 (N.M. 1993) (explaining that nearly all jurisdictions have concluded that PTSD evidence is appropriate to explain a victim's behavior that is inconsistent with having been raped); *Taylor*, 552 N.E.2d at 138 (concluding that jurors can be assisted by evidence of RTS to dispel common misconceptions about rape).

293. Askowitz & Graham, *supra* note 285, at 2048–51.

294. See Burgess, *supra* note 291, at 110 (recounting a Montana Supreme Court case where evidence of the complainant's symptoms of rape trauma syndrome was found to be probative and helpful to the jury to resolve); *Alberico*, 861 P.2d at 207–08 (holding that the prosecution's introduction of expert testimony to show that a crime had been committed was proper).

295. See *Allewalt II*, 571 A.2d at 751 (finding PTSD expert testimony is admissible by distinguishing it from RTS testimony, which most courts find inadmissible); *Chapman v. State*, 18 P.3d 1164, 1172 (Wyo. 2001) (stating that although most courts find testimony about PTSD to be sufficiently reliable to warrant admission, the purposes for which this testimony may be admitted remains a subject for debate). See generally Missy Thornton, *State v. Chauvin: Determining the Admissibility of a Post-Traumatic Stress Syndrome Diagnosis as Substantive Evidence of Sexual Abuse*, 78 TUL. L. REV. 1743 (2004) (discussing split among both federal and state courts on whether expert witness testimony about PTSD to establish the trauma in fact occurred is admissible).

296. *Alberico*, 861 P.2d at 207–09.

297. *E.g.*, *Chapman v. State*, 18 P.3d 1164, 1172 (Wyo. 2001).

298. *State v. Huey*, 699 P.2d 1290, 1294 (Ariz. 1985).

299. See *State v. Chauvin*, 846 So. 2d 697, 707–08 (La. 2003) (stating that the method of diagnosing a person with PTSD is designed for therapeutic purposes and is not reliable as a fact-finding tool); *People v. Taylor*, 552 N.E.2d 131, 138–139 (N.Y. 1990) (finding the therapeutic nature of RTS makes it unreliable when introduced to prove a crime took place); *State v. Black*, 745 P.2d 12, 18 (Wash. 1987) (holding that RTS

The various judicial opinions in the litigation of a Maryland rape case, *Allewalt v. State*,³⁰⁰ exemplify the key arguments in this debate. In the 1983 trial, during which the defendant asserted a consent defense, the trial court permitted the state to offer rebuttal testimony of a forensic psychiatrist.³⁰¹ The psychiatrist had examined the complainant and concluded that she had the symptoms of PTSD.³⁰² The trial court admitted the testimony after conducting a voir dire examination of the expert, concluding that PTSD “has been around for a long time,” is “nothing new,” and was “recognized” within psychiatry.³⁰³ The trial court reasoned that the witness would “assist [the] jury in making a determination as to [the complainant’s] state of mind at the time of the event on the basis of post event findings.”³⁰⁴ However, on cross-examination, the psychiatrist conceded that in developing his opinion about whether the complainant had PTSD, he assumed that she had in fact been raped by the defendant: “I think it is more important that the individual reporting, that is the patient or person you are evaluating, believes that it took place. But . . . the whole diagnosis is predicated on the assumption that some traumatic incident occurred.”³⁰⁵ The psychiatrist also opined that none of the complainant’s other circumstances (i.e., a history of depression and “marital and domestic problems”) would account for her symptoms.³⁰⁶

An intermediate appeals court reversed the conviction on the basis that the expert testimony was improperly admitted because its prejudicial effect outweighed the probative value, which was quite small in light of the fact that the assumption the rape had taken place rendered the expert’s conclusions unreliable in establishing that she had not consented to the sexual encounter.³⁰⁷ The appellate court was also concerned that the testimony appeared to be bolstering the credibility of the complainant: “By stating that a rape *could* cause the disorder, an expert implicitly verifies the victim’s claim that rape *did* cause it.”³⁰⁸

expert testimony is not a scientifically reliable means of proving rape occurred because the diagnosing individual is not concerned with the accuracy of the victim’s description of the event); *People v. Bledsoe*, 681 P.2d 291, 301 (Cal. 1984) (noting that RTS testimony is not scientifically reliable because it is not based on a narrow set of criteria and its purpose is to help a victim of trauma, not to prove the trauma occurred). The opinion is “clinical” in the sense that it is based upon an examination of the person for purposes of making a medical assessment.

300. (*Allewalt I*) 487 A.2d 664 (Md. Ct. Spec. App. 1985), *vacated*, 517 A.2d 741 (Md. 1986).

301. *Allewalt I*, 487 A.2d at 665–66.

302. *Id.* at 666.

303. *State v. Allewalt (Allewalt II)*, 517 A.2d 741, 743 (Md. 1986).

304. *Id.*

305. *Allewalt I*, 487 A.2d at 666 (omission in original) (quoting cross-examination testimony).

306. *Id.*

307. *Id.* at 669–70. Other courts have also excluded similar evidence on the basis that jurors would be confused by the evidence or the defendant would be unfairly prejudiced, and based their rulings on rules similar to Federal Rule of Evidence 403. *See, e.g.*, *People v. Taylor*, 552 N.E.2d 131, 138–39 (N.Y. 1990) (excluding RTS expert testimony because it might create an inference in the minds of jurors that rape occurred, which presents undue prejudice against the defendant). Federal Rule of Evidence 403 provides: “Although relevant, evidence may be excluded if its probative value is substantially outweighed by the danger of unfair prejudice, confusion of the issues, or misleading the jury, or by considerations of undue delay, waste of time, or needless presentation of cumulative evidence.” FED. R. EVID. 403.

308. *Allewalt I*, 487 A.2d at 670.

The Court of Appeals of Maryland, in a sharply divided opinion, reversed and reinstated the conviction.³⁰⁹ The majority specifically noted the diagnostic criteria for PTSD and concluded that the psychiatrist was “acting well within the field of his special training and experience” when he opined, *as part of the diagnostic process*, that the alleged victim had experienced a sexual assault.³¹⁰ In other words, arriving at an opinion about the occurrence of a trauma was simply part of what the PTSD criteria required. The majority concluded that the appellate court had imposed too high a standard on the admission of such testimony. Rather, it reasoned, this was simply another form of expert testimony as to causation of symptoms, which is generally admissible.³¹¹ The majority reviewed the competing line of cases on the issue of admitting PTSD (or RTS) testimony in the prosecution of rape cases and concluded that the testimony of the expert was sufficiently limited to warrant its admission at trial:

Just as a jury can understand that evidence of the complainant’s hysteria shortly following an alleged sexual assault tends to negate consent, so a jury, with the assistance of a competent expert, can understand that a diagnosis of PTSD tends to negate consent where the history, as reviewed by the expert, reflects no other trauma which in the expert’s opinion could produce that *medically recognized disorder*.³¹²

The concurring justice opined that there was some role for a forensic psychiatrist to offer testimony about PTSD generally (since it would not be within the general knowledge of the fact-finder), but thought that courts should draw the line at permitting a psychiatrist to opine that the witness had PTSD resulting from the alleged crime.³¹³ The author of the dissenting opinion, however, reasoned that “[b]ecause post-traumatic stress disorder is not a fact-finding tool, but a therapeutic tool useful in counseling, and the relevant scientific literature does not even purport to claim that the disorder is a scientifically reliable means of providing that a rape occurred,” the testimony should not have been admitted.³¹⁴ He also thought that there was no way to guard against the jury concluding that the expert had reached a conclusion about the alleged victim’s credibility and using the testimony to reach their conclusions about that issue.³¹⁵

Courts across the country debated the admissibility of such evidence for several years after the first reported cases, and apparently the consensus of the courts at present is to admit PTSD (or related syndrome) evidence in sexual assault cases, generally with a limiting instruction to jurors regarding the appropriate use of the evidence.³¹⁶ The

309. *Allewalt II*, 517 A.2d at 752.

310. *Id.* at 746–47.

311. *Id.* at 746–48.

312. *Id.* at 751 (emphasis added). The court noted that there was a “nice question” that was “[l]urking” in the case, which was whether a defendant could offer testimony of the absence of PTSD as evidence of consent. *Id.*

313. *Id.* at 759–61 (McAuliffe, J., concurring).

314. *Id.* at 755 (Eldridge, J., dissenting) (citations omitted) (internal quotation marks omitted); *see also* *People v. Bledsoe*, 681 P.2d 291, 300–01 (Cal. 1984) (concluding that evidence that a witness suffers from rape trauma syndrome is inadmissible to show that the witness was raped).

315. *Allewalt II*, 517 A.2d at 755–58 (Eldridge, J., dissenting).

316. Klein, *supra* note 286, at 1019 (discussing the trend of courts finding expert RTS testimony as relevant and appropriate); *see, e.g.*, *People v. Baenziger*, 97 P.3d 271, 275 (Colo. App. 2004) (“It has been repeatedly held that rape trauma syndrome evidence is reasonably reliable.”); *People v. Nelson*, 804 N.Y.S.2d

admissibility of PTSD or CSAAS evidence in child sexual abuse prosecutions, however, remains varied from state to state.³¹⁷ Some courts that have rejected RTS or CSAAS have done so largely because, unlike PTSD itself, they are not found in the *DSM*,³¹⁸ or because such terms have assumptions about the specific cause of the symptoms built into the names of the terms.³¹⁹

The use of PTSD evidence to prove the fact of the traumatic event is not limited to the criminal context. In civil cases, although a plaintiff may offer evidence of PTSD for the purportedly limited purpose of proving the extent of her damages, the nature of PTSD and its A Criterion suggests a finding of liability as well. Some plaintiffs suggest that their PTSD symptoms are probative of whether they had in fact been subjected to trauma.³²⁰ For example, if someone displays symptoms of PTSD, such evidence could be persuasive on the question of whether she did in fact experience sexual harassment. Courts have been less wary of its use in civil cases as compared with criminal prosecutions, but some have expressed concern about the potential inferential leap invited by such evidence and put strict limitations on the extent of an expert's testimony.³²¹

The A Criterion in the civil context raises the same problem of circularity as seen in the sexual abuse and rape cases. Clinicians cannot apply the PTSD diagnostic criteria without opining about the nature, extent, or even the existence of a reported or purported stressor event. Although a doctor setting a broken leg may refer to the fact of a motor vehicle collision in her report, whether or not a collision occurred has no bearing on whether the doctor concludes that the leg is broken. By contrast, the A Criterion *requires* an assessment of the stressor event on the part of the clinician to determine whether it met whatever the A Criterion required at that time. The existence of such a clinical determination cannot be deemed insignificant since the APA has amended the diagnostic criteria specifically (and more than once) to define who can be diagnosed with the disorder.

If a psychiatrist cannot in fact diagnose a person as having PTSD without making a determination as to whether a stressor event satisfying the A Criterion occurred, then

373, 373–74 (N.Y. App. Div. 2005) (ruling that RTS evidence was properly admitted in part because the court provided a limiting instruction).

317. Dyane L. Noonan, Note, *Where Do We Go From Here? A Modern Jurisdictional Analysis of Behavioral Expert Testimony in Child Sexual Abuse Prosecutions*, 38 SUFFOLK U. L. REV. 493, 494–95 (2005).

318. *E.g.*, *State v. Alberico*, 861 P.2d 192, 212 (N.M. 1993).

319. *See State v. Roles*, 832 P.2d 311, 318 n.4 (Idaho Ct. App. 1992) (noting that the term RTS is much more inflammatory than the term PTSD); *State v. Gettier*, 438 N.W.2d 1, 5–6 (Iowa 1989) (finding no error in admitting evidence where an expert testified to PTSD instead of the more prejudicial term, RTS).

320. *See, e.g.*, *Martin v. Cavalier Hotel Corp.*, 48 F.3d 1343, 1358 (4th Cir. 1995) (upholding admission of expert psychological testimony opining that the plaintiff's symptoms "were consistent with those of someone who had been sexually assaulted"), *overruled*, *Pa. State Police v. Suders*, 542 U.S. 129 (1994).

321. *See, e.g.*, *Isely v. Capuchin Prov.*, 877 F. Supp. 1055, 1067 (E.D. Mich. 1995) (holding that an expert on PTSD may only testify to her theories and opinions of the syndrome and whether the plaintiff's behavior is consistent with someone who is suffering from PTSD); *Garcia v. Los Banos Unified Sch. Dist.*, No. 1:04-CV-6059-SMS, 2007 WL 715526, at *3–5 (E.D. Cal. Mar. 8, 2007) (denying defendant's motion to exclude PTSD testimony from plaintiff's expert but cautioning plaintiff's counsel to ask only about the diagnosis, causation, and extent of harm, rather than the underlying events in that sexual harassment case).

there is considerable question as to whether psychiatrists can testify in the more theoretically limited role that some courts assign in terms of rehabilitating victims who have been impeached or in cases in which the occurrence of the stressor event is a central controversy. This problem is not unique to the A Criterion since several other PTSD criteria also tie back to the supposedly traumatic “event.” For example, if a person is “re-experiencing” an event, there is an explicit assumption that the person previously “experienced” the event that now arises in intrusive thoughts and nightmares. Similarly, if someone is avoiding something, such avoidance is a “symptom” only if it is associated with an identified traumatic event.³²² These symptoms each link to the diagnostician’s initial assessment of the fact of “the event.”

Use in criminal and civil cases as proof of the occurrence of the traumatic event is based upon an assumption that a psychologist or psychiatrist, employing specialized skills, can attribute an individual’s symptoms to a specific event, isolated from the “myriad other sources encountered in life.”³²³ Thus, although the courts that found PTSD evidence to be potentially useful to fact finders claimed that they were not admitting expert testimony to bolster the credibility of the plaintiff or complainant, there can be little doubt that the evidence potentially has such effect.³²⁴ Given the central role of credibility in these cases and the challenge of reconciling competing stories, it is not difficult to imagine that a fact finder receiving the testimony of a mental health professional would, notwithstanding any limiting instruction, give it great weight as a measure of the truthfulness of the plaintiff-complainant’s allegations.³²⁵

B. Tort Liability for Psychological Injury

As noted above, courts have been far less reluctant to admit PTSD in civil claims than in criminal cases. The diagnosis offers plaintiffs “a significant benefit” when

322. PTSD’s connection to memory raises the prospect of treating or perhaps even preventing PTSD using memory dampening techniques. If this is the case, this raises the possibility that plaintiffs are expected to mitigate their damages, shifting responsibility for PTSD back to the plaintiffs. See Adam J. Kolber, *Therapeutic Forgetting: The Legal and Ethical Implications of Memory Dampening*, 59 VAND. L. REV. 1561, 1592–95 (2006). For a broader discussion of the question of mitigation of psychological injuries, see generally Lars Noah, *Comfortably Numb: Medicalizing (and Mitigating) Pain-and-Suffering Damages*, 42 U. MICH. J.L. REFORM 431, 448–79 (2009).

323. Ralph Slovenko, *Introduction to PTSD IN LITIGATION*, *supra* note 245, at xix, xxiv.

324. One court excluded PTSD evidence in a sexual harassment case in part out of concern that the expert witness had drawn his own conclusions about whether the rape had occurred and therefore his testimony would constitute improper bolstering of the plaintiff’s credibility, or, at the very least, would appear to do that. *Spencer v. General Electric Co.*, 688 F. Supp. 1072, 1077 (E.D. Va. 1988), *overruled in part by* *Pesso v. Montgomery Gen Hosp.*, No. 98-1978, 1999 U.S. App. LEXIS (4th Cir. May 24, 1999), and *Ellis v. Director, CIA*, No. 98-2481, 1999 U.S. App. LEXIS 21638 (4th Cir. Sept. 10, 1999).

325. See Christopher Slobogin, *Psychological Syndromes and Criminal Responsibility*, 6 ANN. REV. L. & SOC. SCI. 109, 118–19 (2010) (reviewing studies regarding the impact of RTS testimony on juror decision-making). Indeed, one court that concluded that PTSD should be admissible in sexual abuse prosecutions declined to draw distinctions among the various purported uses of the evidence. *State v. Alberico*, 861 P.2d 192, 210–12 (N.M. 1993). The court reasoned that there was no “logical difference” between using such evidence to explain a complainant’s behavior, to opine as to the complainant’s credibility, or to provide a specific opinion as to the “causality” of the complainant’s symptoms in relation to sexual abuse. *Id.*

proving causation and the extent of emotional injuries in tort cases,³²⁶ and its potential use in personal injury litigation is apparent.³²⁷ Articles appeared in legal publications assessing the potential impact on personal injury claims by the diagnosis,³²⁸ particularly after the 1994 revisions of the A Criterion.³²⁹ A psychiatrist observed that, by virtue of the A Criterion, “an external injury is by definition the explicit cause of this disorder,” which then operates to support “legal arguments regarding single and proximate causation of harm.”³³⁰ A forensic psychologist observed that PTSD is the “most common courtroom diagnosis” in claims of psychological injury.³³¹ One defense attorney cautioned others that any PTSD claims they encounter must be “fleshed out as soon as possible and attacked immediately.”³³²

The APA’s recognition of PTSD had a significant impact on the determination of liability for psychological injuries and, in the words of one group of commentators, “transformed and expanded the horizons of tort litigation, resulting in the recognition of a host of new claims tied to the diagnosis.”³³³ It has had this effect in several ways that will be briefly reviewed here.

The *DSM-III* appeared at a time when courts were grappling with the issue of whether and under what circumstances to permit recovery for emotional injuries, as described earlier in Part II. Although some courts permitted recovery for “traumatic neurosis,” the notion of compensating for emotional injuries remained controversial. Many courts continued to apply the “impact rule” or the “physical manifestation” rule to limit damages for psychological injuries.³³⁴ With PTSD now listed in the definitive authority on mental disorders, however, several courts began to build their legal standard for negligent infliction of emotional distress around whether the emotional

326. Richard L. Newman & Rachel Yehuda, *PTSD in Civil Litigation: Recent Scientific and Legal Developments*, 37 JURIMETRICS J. 257, 258 (1997); see, e.g., *Allewalt v. State (Allewalt I)*, 487 A.2d 664, 667–70 (Md. Ct. Spec. App. 1985) (explaining how PTSD testimony is useful in civil cases arising out of rape for establishing damages and evaluating compensable injuries), *vacated*, 517 A.2d 741 (Md. 1986).

327. See, e.g., *Alphonso v. Charity Hosp. of La. at New Orleans*, 413 So. 2d 982, 987 (La. Ct. App. 1982) (affirming \$50,000 emotional distress award that was based upon PTSD diagnosis resulting from sexual assault in hospital).

328. See, e.g., Ziskin, *supra* note 158, at 73 (noting that all claims for “traumatic neurosis” would be cast using PTSD, “which appears to cover most of the cases formerly called traumatic neurosis”).

329. See, e.g., KUTCHINS & KIRK, *supra* note 105, at 122 (explaining how changes in PTSD diagnoses were recognized by an audience that included non-psychotherapists); Paul R. Lees-Haley, *DSM-IV Alert: Changes Important to Claims Evaluation*, FOR THE DEF., June 1995, at 29, 30 (noting that problem of PTSD for defense attorneys may become worse under the *DSM-IV* revisions); Mark I. Levy, *Stressing the Point: Post Traumatic Stress Disorder Claims*, FOR THE DEF., Nov. 1995, at 27, 27 (observing that PTSD claims were “growing by leaps and bounds” and resulting in particularly large awards, especially in employment cases).

330. Gold, *supra* note 284, at 164.

331. Albert M. Drukteinis, *Understanding and Evaluating Mental Damages*, PSYCHIATRIC TIMES, Apr. 15, 2007, available at <http://www.psychiatrictimes.com/display/article/10168/55241>.

332. James T. Brown, *Compensation Neurosis Rides Again: A Practitioner’s Guide to Defending PTSD Claims*, 63 DEF. COUNS. J. 467, 482 (1996).

333. Greenberg et al., *supra* note 6, at 7 (internal quotation marks omitted).

334. E.g., *Chappetta v. Bowman Transp., Inc.*, 415 So. 2d 1019, 1022–23 (La. Ct. App. 1982).

injury was “medically diagnosable,” often using PTSD expressly or impliedly as the basis for evaluating whether specific claims met that standard.³³⁵

Some courts concluded that psychiatry had sufficiently progressed to the point where there was less reason to be concerned regarding the validity of such claims.³³⁶ For example, in 1983, the Supreme Court of Missouri in *Bass v. Nooney Co.*³³⁷ was influenced by the “prevailing” belief among courts that “the development of psychiatric tests and refinement of diagnostic techniques have enabled science to establish with reasonable medical certainty the existence and severity of psychic harm” and “mental trauma.”³³⁸ Accordingly, the court’s new legal standard included the requirement that “the emotional distress or mental injury must be medically diagnosable and must be of sufficient severity so as to be medically significant.”³³⁹ The dissent was less certain that the new standard was workable: “What does ‘medically significant’ mean in a courtroom?”³⁴⁰

Similarly, the Supreme Court of Tennessee dispensed with that state’s “physical manifestation” rule in *Camper v. Minor*,³⁴¹ a personal injury case in which PTSD was the primary basis of the claim for damages, and instead imposed the requirement that claims of negligent infliction of emotional distress “be supported by expert medical or scientific proof.”³⁴² A Louisiana appeals court reached a similar conclusion and allowed an award for emotional injury damages to stand because the plaintiff suffered from “more than fright[.]. . . there was sufficient proof of emotional injury, *post-traumatic stress disorder*, to support the Trial Judge’s award of damages.”³⁴³

335. See *Jarrett v. Jones*, 258 S.W.3d 442, 449 (Mo. 2008) (holding that plaintiff’s PTSD was sufficient to establish that his emotional injury was “medically diagnosable and of sufficient severity to be medically significant”); *Hamilton v. Nestor*, 659 N.W.2d 321, 329–30 (Neb. 2003) (holding that although plaintiff did suffer diagnosable and medically significant emotional distress, it was not of sufficient severity to be actionable); *Johnson v. Ruark Ob/Gyn*, 395 S.E.2d 85, 97 (N.C. 1990) (finding that severe emotional distress must be generally recognized and diagnosed by medical professionals); *Hegel v. McMahon*, 960 P.2d 424, 431 (Wash. 1998) (holding that “nightmares, sleep disorders, intrusive memories, fear, and anger” would be sufficient to satisfy the “objective symptomatology” requirement for negligent infliction of emotional distress, but only if they “constitute a diagnosable emotional disorder” such as PTSD).

336. *Molien v. Kaiser Found. Hosps.*, 616 P.2d 813, 821 (Cal. 1980), *abrogated by Burgess v. Superior Court*, 831 P.2d 1197 (Cal. 1992); Noah, *supra* note 322, at 437–39. The dissent in that case specifically disputed that psychiatry had “become better equipped to evaluate the traumatic effects of psychic stimuli.” *Molien*, 616 P.2d at 825 (Clark, J., dissenting).

337. 646 S.W.2d 765 (Mo. 1983)

338. *Bass*, 646 S.W.2d at 769; see also *Paugh v. Hanks*, 451 N.E.2d 759, 765 (Ohio 1983) (criticizing the persistence of the physical manifestation rule because it “completely ignores the advances made in modern medical and psychiatric science”).

339. *Bass*, 646 S.W.2d at 772–73. A 1971 Georgetown Law School student piece was one of the authorities upon which the court derived its “medically diagnosable” standard. Comment, *Negligently Inflicted Mental Distress: The Case for an Independent Tort*, 59 GEO. L.J. 1237 (1971).

340. *Bass*, 646 S.W.2d at 781 (Donnelly, J., dissenting).

341. 915 S.W.2d 437, 446 (Tenn. 1996).

342. *Camper*, 915 S.W.2d at 439, 446.

343. *Id.* at 1023 (emphasis added). One notable implication of the increased use of PTSD in making emotional distress, such as to “medically diagnosable” standards, was the prospect of extensive discovery of a plaintiff’s mental health history or a requirement to submit to an independent psychiatric examination on the theory that such plaintiff has waived the psychotherapist-patient privilege. See generally Deirdre M. Smith, *An*

Some of the changes to PTSD's A Criterion actually paralleled or even influenced the evolution in the legal standards for recovering for emotional distress. For example, many courts expanded the rules for liability to "bystanders" to include recovery for merely observing or encountering a trauma occurring to a family member.³⁴⁴ Similarly, the revisions to the A Criterion in *DSM-IV* included extending "eligibility" for the diagnosis to one who "witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others."³⁴⁵ Indeed, at least one court cited specifically to that amended diagnostic language in deciding where to draw the line in allowing recovery for negligent infliction of emotional distress claims.³⁴⁶ Another court held, for purposes of summary judgment, that an expert witness's opinion that the plaintiff had PTSD "as a direct and proximate result of being personally involved in a collision that resulted in the death of a child" was sufficient to generate a factual issue as to causation.³⁴⁷

Not all courts embraced PTSD as a measure of the advancement of psychiatry's role in law, and some explicitly rejected legal standards for recovery based upon the presence of a psychiatric diagnosis such as PTSD.³⁴⁸ The Supreme Court of Alaska, for example, reasoned that including a requirement of standard such as that in *Bass*—that the distress be "medically diagnosable or objectifiable"—would usurp the jury's function in determining the severity of the emotional distress as a question of fact.³⁴⁹

The recognition of PTSD also did not silence the concerns about malingering in claims for psychological injuries; indeed, malingering has been a central issue with PTSD, perhaps more than any other diagnosis, due to the strong association with litigation.³⁵⁰ Although studies have documented the incidence of malingering, no

Uncertain Privilege: Implied Waiver and the Evisceration of the Psychotherapist-Patient Privilege in the Federal Courts, 58 DEPAUL L. REV. 79 (2008).

344. *E.g.*, Clohessy v. Bachelor, 675 A.2d 852, 865 (Conn. 1996); Cameron v. Pepin, 610 A.2d 279, 284 (Me. 1992); Gates v. Richardson, 719 P.2d 193, 199 (Wyo. 1986).

345. *DSM-IV*, *supra* note 264, at 427; *see also* Baldwin et al., *supra* note 13, at 42 (noting that *DSM-IV* expanded the qualifications for PTSD to include one who "'witness[ed]'" or "'learned about'" a threat to a loved one's life).

346. Marzolf v. Stone, 960 P.2d 424, 429, 429 & n.2 (Wash. 1998) (citing *DSM-IV*, *supra* note 264, at 429, and permitting recovery for family member who observed an injured family member at the scene of an accident). In an article titled *Compensation Neurosis Rides Again* defense attorney James T. Brown wrote: "PTSD[] is demonstrating an ability to influence the current tort system, both economically and doctrinally. The diagnosis is being used to erode traditional legal restrictions and barriers to recovery." Brown, *supra* note 332, at 467.

347. Jarrett v. Jones, 258 S.W.3d 442, 449 (Mo. 2008).

348. *See, e.g.*, Chizmar v. Mackie, 896 P.2d 196 (Alaska 1995) (rejecting requirement of medical diagnosis in claims of emotional distress); Fortes v. Ramos, No. CIV. A. 96-5663, 2001 WL 1685601, at *4-9 (R.I. Super. Ct. Dec. 19, 2001) (reviewing Rhode Island's physical manifestation requirement and its underlying principles).

349. *Chizmar*, 896 P.2d at 205. However, among the reasons that the jury would have had sufficient basis to award the plaintiff damages was that she "presented medical testimony that she suffered from post-traumatic stress disorder." *Id.*

350. Phillip J. Resnick, *Guidelines for Evaluation of Malingering in PTSD*, in PTSD IN LITIGATION, *supra* note 245, at 187, 188. Defense-oriented commentators have attempted to resurrect notions of "compensation neurosis" to suggest that the secondary gain from alleging a potential traumatic stressor are the

empirical research has established a specific link between PTSD-related malingering and the prospect of compensation.³⁵¹ However, the diagnostic criteria are readily available, and some court opinions have noted incidents of coaching by attorneys.³⁵² The *DSM-IV*'s addition of a subjective element in the A Criterion made the issue all the more acute.³⁵³ Indeed, the *DSM-IV* includes a comment directed specifically at PTSD: "Malingering should be ruled out in those situations in which financial remuneration, benefit eligibility, and forensic determinations play a role."³⁵⁴ This caveat is not directed at other diagnoses and did not appear in other editions.³⁵⁵ This reflects psychiatry's own acknowledgment of the unique link between that diagnosis and determinations of compensation.

C. Evidentiary Limitations on PTSD Evidence

The key mechanism in law to determine what a fact finder may consider in making determinations of liability (or resolving other legal controversies) is the body of relevant evidence law. Thus, questions of whether and where a fact finder may consider PTSD in assigning criminal or civil liability necessarily implicates the rules of evidence, particularly those pertaining to relevance and expert testimony. However, perhaps because courts have regarded PTSD as being a medical (and therefore "scientific") diagnosis uniquely suited for aiding in determinations of liability, courts have generally leaned in favor of putting such evidence in the hands of fact finders.

Evidence of PTSD is generally offered through expert witnesses, whether they are treating clinicians who describe their diagnostic impressions of their patients or forensic examiners retained by one of the parties to evaluate an individual and render an opinion on a specific issue tied to the civil or criminal litigation. Accordingly, the admissibility of PTSD evidence directly implicates the rules regarding the admissibility of expert opinion evidence. A comprehensive examination of the various rules governing the admissibility of evidence of PTSD and other mental disorders is beyond the scope of this Article,³⁵⁶ but a few of the particular admissibility issues that PTSD evidence implicates will be addressed.

real causes of the plaintiff's symptoms, even in the absence of intentional mendacity. *E.g.*, Brown, *supra* note 332, at 468–69.

351. See Resnick, *supra* note 350, at 187 (asserting that financial gain is primary motivation to malingering); Simon, *supra* note 245, at 81–82 (noting that secondary gain may be one of several factors in maintaining PTSD symptoms); Richard A. Bryant & Allison G. Harvey, *The Influence of Litigation on Maintenance of Posttraumatic Stress Disorder*, 191 J. NERVOUS & MENTAL DISEASE 191 (2003) (noting the "widely held view" that PTSD is "often mediated by compensation factors").

352. Some national service organizations reportedly distributed the PTSD criteria to Vietnam veterans, which could have made malingering easier. Resnick, *supra* note 351, at 195. See also Nelsen v. Research Corp. of Univ. of Haw., 805 F. Supp. 837, 844–445 (D. Haw. 1992) (finding lack of candor on part of plaintiff alleging PTSD for, among other things, reviewing diagnostic criteria for disorder before reporting the full range of symptoms).

353. See Resnick, *supra* note 351, at 187 (noting that PTSD diagnoses are made "almost entirely" on subjective symptoms, and that the accessibility of *DSM-IV*'s criteria makes malingering easier).

354. *DSM-IV*, *supra* note 264, at 427 (emphasis omitted).

355. Gerald M. Rosen & Steven Taylor, *Pseudo-PTSD*, 21 J. ANXIETY DISORDERS 201, 201–02 (2007).

356. For an overview of the applicable rules and case law, see generally DANIEL W. SHUMAN, PSYCHIATRIC AND PSYCHOLOGICAL EVIDENCE (3d ed. 2005); David Faust et al., *The Admissibility of*

The *DSM-III* was published only five years after Congress enacted the Federal Rules of Evidence, which evidenced a shift towards a bias of admissibility of a wide range of relevant evidence, including opinion testimony.³⁵⁷ In 1993, the year before the *DSM-IV* was released with its broader A Criterion, the United States Supreme Court issued its opinion in *Daubert v. Merrill Dow Pharmaceuticals, Inc.*,³⁵⁸ which, along with the follow-up cases in the following few years, significantly revised the approach federal and many state courts took to the admissibility of most kinds of scientific and other expert testimony.³⁵⁹ The Court ruled that the federal common law *Frye* test for determining the admissibility of expert testimony—whether the basis for the opinion enjoyed “general acceptance” in the relevant scientific community³⁶⁰—did not survive the enactment of the Federal Rules of Evidence with their “‘liberal thrust’ . . . and their ‘general approach of relaxing the traditional barriers to opinion testimony.’”³⁶¹ Rather, the Court held, courts should serve as “gatekeepers” of the admissibility of such evidence and consider a range of factors (rather than prerequisites) in assessing the reliability and relevance of the proffered expert testimony.³⁶²

Most psychiatric evidence generally fared well under *Frye* as being “generally accepted.”³⁶³ The courts that reached such conclusions with respect to PTSD often based them primarily on the fact that PTSD had been included in the *DSM*.³⁶⁴ In theory, “abandonment of the *Frye* ‘general acceptance’ test” by the federal courts and the states that followed *Daubert*’s lead should have precluded granting any kind of “immunity from judicial scrutiny” to the *DSM* generally or PTSD specifically.³⁶⁵ However, few courts have used *Daubert* or other evidence rules to limit the admissibility of PTSD testimony, or indeed most other forms of clinical psychiatric evidence,³⁶⁶ and it appears that the controversies in the psychiatric and related medical

Behavioral Science Evidence in the Courtroom: The Translation of Legal to Scientific Concepts and Back, 6 ANN. REV. CLIN. PSYCHOL. 49 (2010).

357. Shuman, *supra* note 282, at 5–6.

358. 509 U.S. 579 (1993).

359. See generally *Daubert*, 509 U.S. at 579 (abandoning “general acceptance” test, and prescribing trial court judges to assess admissibility of expert testimony on the scientific techniques and methodologies used); *Gen. Elec. Co. v. Joiner*, 522 U.S. 136 (1997) (reinforcing *Daubert*’s principle of an independent judicial reasonableness evaluation of the conclusion, methodologies, and facts in expert admissibility determinations by prescribing an abuse-of-discretion standard of review on appeal); *Kumho Tire Co. v. Carmichael*, 526 U.S. 137 (1999) (extending the *Daubert* analysis to nonscientific areas of expertise).

360. *Frye v. United States*, 293 F. 1013, 1014 (D.C. Cir. 1923).

361. *Daubert*, 509 U.S. at 588–89 (quoting *Beech Aircraft Corp. v. Rainey*, 488 U.S. 153, 169 (1988)) (internal quotation marks omitted).

362. *Id.* at 592–97.

363. Christopher Slobogin, *Psychiatric Evidence in Criminal Trials: To Junk or Not to Junk?*, 40 WM. & MARY L. REV. 1, 34 (1998).

364. See, e.g., *People v. Taylor*, 552 N.E.2d 131, 134–35 (N.Y. 1990) (“[T]he diagnostic criteria for posttraumatic stress disorder that are contained in DSM III-R have convinced us that the scientific community has accepted that rape as a stressor can have marked, identifiable effects on a victim’s behavior . . .”).

365. Shuman, *supra* note 282, at 6.

366. See Slobogin, *supra* note 325, at 118–24 (discussing psychological syndrome evidence specifically and concluding that courts “seldom examine closely all four of the evidentiary components described here (materiality, probative value, helpfulness, and prejudice)”; Slobogin, *supra* note 363, at 27 (noting a

or academic literature over the validity and reliability of this diagnosis have not had any significant impact on its use in courts. Courts also seem to be unconcerned with the fact that the PTSD criteria, including the A Criterion, were revised three times in fourteen years.

Courts have been somewhat more willing to play the role of “gatekeeper” for the use of PTSD and related diagnoses by prosecutors in sexual abuse and rape cases since such use directly implicates questions of the reliability of the testimony. Nonetheless, many courts provide fairly cursory analyses before admitting PTSD-based evidence. In 2001, the Supreme Court of Wyoming, applying *Daubert*, appeared to conclude that the broader question of admissibility of PTSD testimony in sex abuse cases was by then resolved.³⁶⁷ In an appeal of a sexual abuse conviction, the defendant argued that the trial court erred in allowing the state to offer a psychiatrist’s testimony that the complainant had PTSD on the basis that “the theory of PTSD related to child sexual abuse is not sufficiently developed to permit an expert to formulate a reasonable opinion on the subject.”³⁶⁸ The court rejected those arguments, noting first that PTSD’s inclusion in the *DSM* was in itself evidence that it had “achieved acceptance in the fields of psychiatry and psychology.”³⁶⁹ Further, the court reasoned, “the PTSD diagnosis appears to be grounded in basic behavioral psychology.”³⁷⁰ More significantly, by that time, the diagnosis had been “widely, although not universally, accepted by other jurisdictions as a reliable form of expert testimony in this context,” although the specific purpose for which it could be offered was still subject to some controversy.³⁷¹

Another example of a court applying little scrutiny to the reliability of PTSD evidence as proof of sexual abuse is a 1993 opinion of the Supreme Court of New Mexico, *State v. Alberico*.³⁷² The court concluded: “We hold that PTSD testimony is grounded in valid scientific principle.”³⁷³ The inclusion of PTSD in *DSM-III* was a large part of that determination because the court reasoned that “[t]he existence of DSM III-R and its general acceptance in psychology indicate that PTSD has been exposed to objective scientific scrutiny and empirical verification.”³⁷⁴ The court also accepted the State’s argument that trained psychologists could “isolate the cause of the symptoms because different stressors manifest themselves in different symptoms.”³⁷⁵ The court thought that the “current state of the technique” of the diagnosis of PTSD had advanced sufficiently since the time of earlier decisions to permit experts to testify

“mammoth study,” which demonstrated that “courts ignore [*Frye* and *Daubert*] when psychiatric testimony is at issue”).

367. See *Chapman v. State*, 18 P.3d 1164, 1173 (Wyo. 2001) (applying *Daubert* and stating that “[t]he pivotal question in determining the admissibility of PTSD testimony in sexual assault cases is the testimony’s relevance to the issues in the case”).

368. *Id.* at 1169.

369. *Id.* at 1171.

370. *Id.* at 1172.

371. *Id.*

372. 861 P.2d 192, 206–08 (N.M. 1993).

373. *Alberico*, 861 P.2d at 208.

374. *Id.*

375. *Id.* at 209.

that the complainant's PTSD symptoms were consistent with having been sexually abused.³⁷⁶

By contrast, some courts have declined to admit PTSD evidence specifically due to concerns about its reliability for purposes of proving that a trauma had occurred and have held that the fact PTSD is included in the *DSM* does not end the analysis required under *Daubert's* "gatekeeping" standard.³⁷⁷ The Supreme Court of Washington held that it was improper to admit expert testimony on rape trauma syndrome, regardless of whether it was described as PTSD, on the basis that it was not a scientifically reliable method of determining whether a rape had occurred and it amounted to an expert opinion on the guilt of the defendant and the credibility of the plaintiff.³⁷⁸ Similarly, the Louisiana Supreme Court concluded: "[I]t is widely accepted that PTSD has not been proven to be a reliable indicator that sexual abuse is the trauma underlying the disorder or that sexual abuse has even occurred."³⁷⁹

The concept of the "traumatic memory" underlying PTSD also led to the theory of the "repressed memory" of a traumatic event that could be subsequently "recovered" through psychotherapy.³⁸⁰ This theory became a central issue in several lawsuits in which adults claimed to have recovered memories of childhood abuse and then sought compensation.³⁸¹ A federal district court considered the reliability of evidence of PTSD and repressed memory in *Isely v. Capuchin Province*.³⁸² Relying largely on the reasoning in *Alberico* and the extensive work of the plaintiff's expert witness—who

376. See *id.* at 209 (finding testimony, which indicated that psychologists have ability to isolate the cause of different symptoms, more persuasive than "judicial determinations of validity based on evidence that [was] many years old"); *id.* at 213 (holding that it was not an abuse of discretion for the trial court to admit expert testimony on PTSD because the expert testimony was convincing based on the validity of the science and contradictory case law was based on out-dated scientific evidence).

377. See, e.g., *State v. Chauvin*, 846 So. 2d 697, 705, 709 (La. 2003) (holding expert testimony inadmissible due to a lack of showing reliability and accuracy of PTSD evidence, and noting that despite PTSD being catalogued in the *DSM*, evidence that trial court performed its "gatekeeping" function was still necessary).

378. *State v. Black*, 745 P.2d 12, 19 (Wash. 1987).

379. *Chauvin*, 846 So. 2d at 707–08 (concluding that the diagnostic criteria for PTSD was intended to be used for dealing with the aftermath of severe traumatic events, not for providing clinical and forensic tools). In civil cases as well, courts restricted the admissibility of PTSD evidence to prove that a plaintiff had experienced a traumatic event. In *Spencer v. General Electric Co.*, 688 F. Supp. 1072 (E.D. Va. 1988), a federal district court (applying *Frye* in a pre-*Daubert* case) excluded the plaintiff's proffered psychological expert who would have testified that the alleged victim in the underlying sexual harassment case suffered from PTSD and therefore some kind of trauma must have occurred for such symptoms to be present, and that the only stressors in her life that could have caused such symptoms were the alleged rape and harassment. *Id.* at 1074. The court reasoned that "[e]vidence of PTSD occasioned by rape . . . is not a scientifically reliable means of proving that a rape occurred." *Id.* at 1075–76.

380. See RICHARD J. McNALLY, REMEMBERING TRAUMA 8–11 (2003) (discussing the evolution of repressed memory theory throughout the development of the current PTSD diagnosis); Richard J. McNally, *Progress and Controversy in the Study of Posttraumatic Stress Disorder*, 54 ANN. REV. PSYCHOL. 229, 241–44 (2003) (discussing the debate surrounding the validity of repressed memory theory); Steven Taylor & Gordon J.G. Asmundson, *Posttraumatic Stress Disorder: Current Concepts and Controversies*, 1 PSYCHOL. INJ. & L. 59, 67–69 (2008) (discussing the controversy surrounding whether repressed memories exist in PTSD patients).

381. SHEPHARD, *supra* note 10, at 390.

382. 877 F. Supp. 1055 (E.D. Mich. 1995).

had, among other things, served on the committees that revised Criterion A in *DSM-III-R* and *DSM-IV*—the court concluded that the expert “has met the foundational requirements to testify regarding PTSD and repressed memory.”³⁸³ The court further ruled that it would permit the expert to “not only testify as to her theories and opinions concerning PTSD and repressed memory, but also . . . to testify as to whether [the plaintiff’s] behavior is consistent with someone who is suffering repressed memory or post-traumatic stress disorder.”³⁸⁴ Although the court ruled that she could not go further and testify expressly that she *believed* the allegations, the court drew a very fine distinction there.³⁸⁵

In civil cases in particular, courts have grappled with the respective roles of the court, the fact finder, and the expert witness in applying the A Criterion to the issues presented at trial, particularly since the determination of the A Criterion so closely resembles the fact finding of causation typical in many trials.³⁸⁶ These questions are particularly apparent in cases where the court or a party raises questions about whether the forensic examiners or clinicians strictly adhered to the *DSM* criteria, including the A Criterion, when assigning PTSD diagnoses.³⁸⁷ Generally, courts do not exclude testimony on such basis, concluding that the issue goes to the weight rather than the admissibility of the testimony.³⁸⁸

For example, in *Bachir v. Transoceanic Cable Ship Co.*,³⁸⁹ the defendant filed a post-verdict motion to set aside an award to a former cook employed on a ship for damages resulting from an accident in which he tripped and fell over some pipes.³⁹⁰ A neuropsychiatrist had testified at trial that the plaintiff had PTSD as a result of the accident, which satisfied the “traumatic event” (i.e., A Criterion) requirement of the *DSM-IV*’s criteria for PTSD.³⁹¹ Although the defense offered contradictory expert testimony on the issue of whether such incident could trigger PTSD, the trial court

383. *Isley*, 877 F. Supp. at 1066.

384. *Id.* at 1067.

385. *Id.*

386. *Compare* Marzolf v. Stone, 960 P.2d 424, 429 (Wash. 1998) (determining that the court has the authority to determine the sufficiency of emotional trauma to impose liability on a defendant), *and* Nelsen v. Research Corp. of Univ. of Hawaii, 805 F. Supp. 837, 844 (D. Haw. 1992) (determining that the court has the ultimate authority to determine if an individual meets the criteria for PTSD), *with* *Bachir v. Transoceanic Cable Ship Co.*, No. 98 Civ. 4625(JFK), 2002 WL 413918, at *8 (S.D.N.Y. Mar. 15, 2002) (determining that it is the jury’s task to weigh and assess the credibility of expert witnesses regarding psychiatric testimony).

387. Apparently, it is not uncommon for treating or evaluating clinicians to vary from following the *DSM* criteria for PTSD and other disorders. See Robert I. Simon, *Preface* to PTSD IN LITIGATION, *supra* note 245, at xv (“In litigation, it is quite common to find the diagnosis of PTSD made without any attempt to follow the diagnostic criteria for this disorder.”). Cf. Owen Whooley, *Diagnostic Ambivalence: Psychiatric Workarounds and the Diagnostic and Statistical Manual of Mental Disorders*, 32 SOC. HEALTH & ILLNESS 452, 458 (2010) (finding that “[t]o carve a space of autonomous practice psychiatrists develop a series of workarounds to insulate their practice from [a] literal, reductionist application of the DSM”).

388. See *Lingo v. Burle*, No. 4:06-CV-1392 CAS, 2008 WL 1914148, at *3 (E.D. Mo. Apr. 25, 2008) (denying a defendant’s motion to exclude expert testimony based on the fact that courts “rarely exclude an expert from testifying under *Daubert* for failure to adhere to the DSM”).

389. No. 98 Civ. 4625(JFK), 2002 WL 413918 (S.D.N.Y. Mar. 15, 2002).

390. *Bachir*, 2002 WL 413918, at *1.

391. *Id.* at *8.

dismissed the post-trial challenge to the admissibility of the evidence as going only to “weight and credibility” and therefore an issue for the jury to decide.³⁹²

Some courts, however, have applied more scrutiny to plaintiffs’ experts’ opinions where they appear to stray from the *DSM* criteria, and at least one even substituted its own assessment. In the bench trial opinion in *Nelsen v. Research Corp. of the University of Hawaii*,³⁹³ another injury-at-sea case, the district court made a specific factual finding that, despite the plaintiff’s treating psychiatrist’s testimony to the contrary, the underlying incident at issue in that case—an on-board flood on a research vessel due to a faulty bilge pump—did *not* meet the A Criterion as it appeared in the *DSM-III-R*.³⁹⁴ Accordingly, for this reason, it was not “reasonably foreseeable” that the plaintiff would develop PTSD and he was not entitled to compensation for his psychological injury.³⁹⁵

*Alvarado v. Shipley Donut Flour & Supply Co., Inc.*³⁹⁶ is one of the few federal court opinions in civil cases demonstrating close scrutiny of PTSD testimony under a *Daubert* analysis, but the result may have been due to the apparent overreaching by the plaintiffs and their expert.³⁹⁷ The federal district court excluded plaintiffs’ expert testimony in an employment discrimination claim brought by twelve employees.³⁹⁸ The psychologist retained by the plaintiffs examined all twelve and diagnosed *each* of them with PTSD.³⁹⁹ The district court conducted a close review of the psychologist’s techniques under *Daubert* and concluded that they fell far short of being sufficiently reliable for admission.⁴⁰⁰ Among the deficiencies noted were a failure to use any of the standardized diagnostic instruments available for PTSD evaluations and the *absence* of Criterion A1, the traumatic event.⁴⁰¹ The judge further noted that the expert’s conclusion that all fifteen of the original plaintiffs had PTSD was highly suspect, given studies suggesting that the post-trauma incidence is closer to ten to fifteen percent.⁴⁰²

392. *Id.* at *8–9 (holding that the question of whether the incident at issue in the litigation was severe enough to satisfy the PTSD A Criterion was a matter for the jury, and that the plaintiff’s expert testimony was properly admitted despite indications that he did not follow the *DSM* criteria when diagnosing plaintiff with PTSD); *see also* *S.M. v. J.K.*, 262 F.3d 914, 921–22 (9th Cir. 2001) (concluding that the fact that the plaintiff’s psychiatrist did not follow the PTSD criteria in effect at the time of the examination only indicated the “range where experts might reasonably differ, and where the jury must decide among the conflicting views” (quoting *Kumho Tire Co. v. Carmichael*, 526 U.S. 137, 153 (1999))).

393. 805 F. Supp. 837 (D. Haw. 1992).

394. *Nelsen*, 805 F. Supp. at 843–44; *see also* *Perkins v. Gen. Motors Corp.*, 709 F. Supp. 1487, 1495–96 (W.D. Mo. 1989) (rejecting plaintiff’s psychological expert’s testimony that plaintiff had PTSD as a result of the alleged sexual harassment because “the stressor essential for the diagnosis does not exist”).

395. *Nelsen*, 805 F. Supp. at 844–46. Although the court concluded that the plaintiff was entitled to some compensation for his depression following his discharge from employment by the defendant, he was not otherwise entitled to compensation for a psychological injury. *Id.* at 845–46. The court also appeared to discount the experts’ assessment of PTSD since one of them had furnished the plaintiff with the *DSM-III-R* criteria before he was evaluated. *Id.* at 844–45.

396. Civil Action No. H-06-2113, 2007 WL 4480134 (S.D. Tex. Dec. 18, 2007).

397. *Alvarado*, 2007 WL 4480134, at *3–7.

398. *Id.* at *7.

399. *Id.* at *1.

400. *Id.* at *3–7.

401. *Id.* at *4–6.

402. *Id.* at *6.

In short, with few exceptions, courts generally do not use rules of evidence as a basis to restrict PTSD-based expert testimony. Rather, reasoning that due to its inclusion in *DSM* PTSD is a “medically recognized disorder,”⁴⁰³ courts regard it as relevant, useful, and appropriate for fact finders to employ, even when making essential determinations of liability, and rely upon the adversarial process to flesh out the limitations of such evidence.⁴⁰⁴

There are several other possible reasons for courts’ inclination (implicitly or explicitly) to use PTSD in liability determinations. Courts and attorneys are drawn to the *DSM* perhaps because the diagnostic criteria bear some resemblance to legal criteria, with “prongs” and categorical criteria. Courts may place significant weight on the identification of psychiatric disease by doctors because they are doctors, ascribing to them a special power to detect disease and malingering.⁴⁰⁵ Courts may simply use PTSD as a stand-in for a broader legal rule regarding recovery for psychological injuries.⁴⁰⁶ Regardless of the specific reasoning, however, there is little indication that courts consider or acknowledge PTSD’s development and long-standing association with assigning legal responsibility when deciding to admit such evidence.

V. PTSD’S PERSISTENT CONTROVERSIES

As demonstrated in Part IV, many courts assume that PTSD represents a well-settled scientific fact and, therefore, a reliable tool for fact finders to use when making liability determinations. However, during the three decades since the *DSM-III*’s publication, the controversy over the diagnosis has not diminished and has perhaps intensified as a result of the extensive study of PTSD that took place only *after* the diagnosis was officially established.⁴⁰⁷ Robert Spitzer, *DSM-III*’s lead editor, noted

403. *Attewalt v. State (Allewalt II)*, 517 A.2d 741, 751 (Md. 1986).

404. *See, e.g., Jarrett v. Jones*, 258 S.W.3d 442, 449 (Mo. 2008) (allowing expert testimony of PTSD to show causation).

405. *See* Lars Noah, *Pigeonholing Illness: Medical Diagnosis as a Legal Construct*, 50 HASTINGS L.J. 241, 270 (1999) (stating that some courts have allowed tort plaintiffs to be awarded damages on the basis of a PTSD diagnosis and that psychiatric testimony that the plaintiff suffers from a diagnosable mental illness may provide some reassurance of legitimacy); Deirdre M. Smith, *Who Says You’re Disabled? The Role of Medical Evidence in the ADA Definition of Disability*, 82 TULANE L. REV. 1, 43–47 (2007) (explaining that courts’ reliance on expert medical testimony in disability cases results from the “central role” society accords physicians in deciding who is truly disabled).

406. Noah, *supra* note 405, at 270–71 (“It may be . . . that courts have accepted general evidence concerning PTSD as a nosological entity to support a doctrinal expansion of emotional distress claims, recognizing that stressful events can cause serious psychological injuries even without physical manifestations, in which case the accuracy of individual diagnoses arguably becomes less important.”). British commentators have suggested the development of legal standards that follow more closely the current understanding of PTSD, while noting that “policy reasons and not medical evidence . . . inform the law of psychiatric injury.” Marios C. Adamou & Anthony S. Hale, *PTSD and the Law of Psychiatric Injury in England and Wales: Finally Coming Closer?*, 31 J. AM. ACAD. PSYCHIATRY & L. 327, 331–32 (2003).

407. *See* Gerald M. Rosen et al., Editorial, *Problems with the Post-Traumatic Stress Disorder Diagnosis and its Future in DSM-V*, 194 BRIT. J. PSYCHIATRY 3, 3–4 (2008) (noting that “since its inception in 1980 little about PTSD has gone unchallenged”); Rosen & Lilienfeld, *supra* note 243, at 853 (stressing “that most every core assumption underlying the diagnostic construct [of PTSD] has met with questionable support, if not falsification”); Yehuda & McFarlane, *supra* note 239, at 1705 (noting the “competing agendas” and “theoretical inconsistencies” that emerged in the years after the inclusion of PTSD in the *DSM-III*); Taylor &

recently that, since PTSD's introduction "no other . . . diagnosis, with the exception of Dissociative Identity Disorder (a related disorder), has generated so much controversy in the field as to the boundaries of the disorder, diagnostic criteria, central assumptions, clinical utility, and prevalence in various populations."⁴⁰⁸ The large-scale epidemiological studies of PTSD have revealed strikingly diverse conclusions, putting some trauma researchers on the defensive regarding the validity of the diagnosis itself.⁴⁰⁹ The original questions raised about PTSD have not been answered in the eyes of many in psychiatry, including, perhaps most centrally, whether it is a normal reaction to an extraordinary event.⁴¹⁰

PTSD has been subjected to particular scrutiny within behavioral science in part because of the use of the diagnosis, or at least the term, in the courts and the broader culture.⁴¹¹ Many psychiatrists and psychologists have been struck by the widespread adoption of PTSD as "a household word and courtroom plea."⁴¹² Forensic psychiatrist Roger Pitman observed: "Perhaps more than any other psychological or medical disorder, [PTSD] has influenced, and been influenced by, the law. . . . [It] has become the most important diagnosis in the forensic psychology of personal injury."⁴¹³ Former APA President Alan Stone has been highly critical of PTSD's widespread adoption, particularly in personal injury law:

Asmundson, *supra* note 380, at 65–66 (finding criterion for traumatic stressor to be too liberal in some instances, such as viewing of film *The Exorcist* being classified as a traumatic stressor for individual who developed PTSD-like symptoms afterwards). Cf. CHRIS R. BREWIN, POSTTRAUMATIC STRESS DISORDER: MALADY OR MYTH? 25–28 (2003) (examining historical divergence in diagnosis of diseases similar to PTSD).

408. Robert L. Spitzer et al., *Saving PTSD from Itself in DSM-V*, 21 J. ANXIETY DISORDERS 233, 233 (2007).

409. YOUNG, *supra* note 7, at 130–33; *see also* LEYS, *supra* note 13, at 6–7 ("[T]he very terms in which PTSD is described tend to produce controversy.").

410. Yehuda & McFarlane, *supra* note 239, at 1705–07.

411. *See* APPIGNANESI, *supra* note 273, at 427–28 (explaining that when the criteria delineating what qualified as PTSD were broadened, the diagnosis rate rose by half); SHEPHARD, *supra* note 10, at 355, 385–87 (stating that the mental health field's adoption of PTSD as "scientific truth" and the ensuing media attention led to an "infinite" amount of literature on the subject); SHORTER, *supra* note 172, at 290 (noting that after entry into popular culture, PTSD was "trivialized . . . as a way of psychologizing life experiences"); Baldwin et al., *supra* note 13, at 45–48 (questioning legitimacy of popular concern about American citizens developing psychological injuries from learning about the September 11, 2001 terrorist attacks with an absence of such concern in following the Japanese attack on Pearl Harbor); Rachel Yehuda & Alexander C. McFarlane, *PTSD is a Valid Diagnosis: Who Benefits from Challenging Its Existence?*, 26 PSYCHIATRIC TIMES, no. 7, July 9, 2009, at 31, available at <http://www.psychiatrictimes.com/display/article/10168/1426957> (suggesting that some psychiatrists are bothered by PTSD due to their "resentment that some persons fake [PTSD] symptoms for secondary gain" or that some patients cease treatment as soon as they are awarded compensation).

412. Paul R. McHugh & Glenn Treisman, *PTSD: A Problematic Diagnostic Category*, 21 J. ANXIETY DISORDERS 211, 212 (2007). One psychiatrist commented that the concepts "traumatic" and "stress" for PTSD have become so non-specific as to be almost meaningless, and suggested that a more accurate term is "Post Something Really Horrible Disorder." Chris Cantor, *Post-Traumatic Stress Disorder's Future*, 192 BRIT. J. PSYCHIATRY 394, 394 (2008).

413. Roger K. Pitman et al., *Legal Issues in Posttraumatic Stress Disorder*, in PSYCHOLOGICAL INJURIES AT TRIAL, *supra* note 229, at 861, 861–63; *see also* Landy F. Sparr & James K. Boehnlein, *Posttraumatic Stress Disorder in Tort Actions: Forensic Minefield*, 18 BULL. AM. ACAD. PSYCHIATRY & L. 283, 283 (1990) ("[PTSD] as the basis for a tort claim is a union of forensic problem children.").

No diagnosis in the history of American psychiatry has had a more dramatic and pervasive impact on law and social justice

. . . .

By giving diagnostic credence and specificity to the concept of psychic harm, PTSD has become the lightning rod for a wide variety of claims of stress-related psychopathology in the civil arena.

. . . The recognition of this disorder by the medical community changed the nature of personal injury litigation.⁴¹⁴

Several psychiatrists and psychologists, even those with forensic training and experience, raised questions early on regarding the ways that PTSD found its way into the courtroom. In 1983, Lawrence Raifman, with training in both law and psychology, questioned the use of PTSD in legal settings and argued that PTSD's underlying conceptual problems made it a particularly poor fit for answering legal questions, whether they arise in criminal or in civil matters.⁴¹⁵ He was particularly concerned that the misuse he observed in just the first few years of the diagnosis's official existence would eventually lead to "skepticism and possible stigmatization of PTSD complainants," which would "threaten the credibility and validity of the diagnostic entity."⁴¹⁶

There is no dispute within psychiatry that many people who experience serious and distressing events may have resulting long-term psychological symptoms, some quite severe.⁴¹⁷ However, the specific conceptualization of PTSD as a stand-alone diagnosis with a defined set of symptoms has brought widespread attention and scrutiny within psychiatry.⁴¹⁸ Two key questions linger that have direct implications for the legal uses described in the prior Part: the validity of the A Criterion and the extent to which PTSD is a construct rather than a "scientific discovery."

A. *Revisiting the A Criterion*

The most significant area of dispute within psychiatry regarding PTSD is, as has been the case since the publication of *DSM-III*, the precise role of the A Criterion, or underlying stressor event, in the development of a person's PTSD symptoms.⁴¹⁹

414. Alan A. Stone, *Post-Traumatic Stress Disorder and the Law: Critical Review of the New Frontier*, 21 BULL. AM. ACAD. PSYCHIATRY & L. 23, 23, 29, 34 (1993).

415. Lawrence J. Raifman, *Problems of Diagnosis and Legal Causation in Courtroom Use of Post-Traumatic Stress Disorder*, 1 BEHAV. SCI. & L. 115, 119–29 (1983).

416. *Id.* at 126.

417. See Rosen & Lilienfeld, *supra* note 243, at 838 (stating that even though PTSD may not be entirely valid as a diagnosis, the "serious and often disabling" symptoms associated with it are not imaginary).

418. SHEPHARD, *supra* note 10, at 390–91 (PTSD's "theoretical underpinning . . . [is] unravelling").

419. Miranda Van Hooff et al., *The Stressor Criterion-A1 and PTSD: A Matter of Opinion?*, 23 J. ANXIETY DISORDERS 77, 77 (2009); Frank W. Weathers & Terence M. Keane, *The Criterion A Problem Revisited: Controversies and Challenges in Defining and Measuring Psychological Trauma*, 20 J. TRAUMATIC STRESS 107, 107–12 (2007). For examples of literature applying the varying views on this dispute, see Naomi Breslau & Glenn C. Davis, *Posttraumatic Stress Disorder: The Stressor Criterion*, 175 J. NERVOUS & MENTAL DISEASE 255, 259–62 (1987) (classifying stressors as extraordinary and ordinary); Meaghan L. O'Donnell et al., *Criterion A: Controversies and Clinical Implications*, in CLINICIAN'S GUIDE TO POSTTRAUMATIC STRESS DISORDER 51, 60–67 (Gerald M. Rosen & B. Christopher Frueh eds., 2010) [hereinafter CLINICIAN'S GUIDE TO

Controversies regarding the A Criterion are often directly related to the increasing use of the diagnosis in civil litigation as a theory of recovery and the role of the diagnosis in the determination of legal causation.⁴²⁰ In a recent editorial co-authored by Robert Spitzer, three psychiatrists observed that the diagnosis's narrow focus on a single specific event may lead clinicians to "ignore crucial pathogenic features," remarking that, "[u]nfortunately, what may be best for a lawsuit is not necessarily best for the patient."⁴²¹

The determination of causation as required by the A Criterion raises questions of bias and skewed subjective assessment on the part of both the clinician and the patient, decreasing the validity and reliability of PTSD diagnoses.⁴²² Several studies have suggested a significant potential role for bias on the part of clinicians when diagnosing PTSD.⁴²³ Research has indicated that PTSD is a diagnosis that may be particularly susceptible to "confirmatory" bias, in that a clinician who is aware of a person's experience (or allegation) of a potentially qualifying stressor may be more likely to assume that the person does have lasting symptoms from such an event (particularly if the distress from the trauma has led to the initiation of litigation).⁴²⁴ In one study of forty-seven sexual harassment cases in which a plaintiff was subjected to forensic psychiatric evaluations by examiners retained by either the plaintiff or defense attorneys, seventeen plaintiffs received PTSD diagnoses from plaintiffs' examiners but only three plaintiffs received PTSD or chronic PTSD diagnoses from defense examiners.⁴²⁵ Some courts have suggested in specific cases that the forensic examiners

PTSD] (separating A Criterion into narrow and broad definitions to analyze how diagnosis changes with definitional change). The other PTSD criteria are the subject of dispute as well, but I will focus here only on the A Criterion since that is the one that most clearly implicates legal questions. See *Preface to POSTTRAUMATIC STRESS DISORDER: ISSUES AND CONTROVERSIES*, at xi–xii (Gerald M. Rosen ed., 2004) [hereinafter PTSD: ISSUES AND CONTROVERSIES] (listing current disputes involving PTSD's criteria).

420. See Landy F. Sparr & Roger K. Pitman, *PTSD and the Law*, in *HANDBOOK OF PTSD: SCIENCE AND PRACTICE* 449, 454 (Matthew J. Freidman et al. eds., 2007) (attributing the "geometric increase" in PTSD-based civil claims to the expansion of the *DSM-IV*'s criteria for PTSD); Pitman et al., *supra* note 413, at 861 ("Non-psychiatric incentives (e.g., the prospect of financial gain or avoidance of criminal punishment), which are 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.").

421. Rosen et al., *supra* note 407, at 4.

422. William J. Koch et al., *Empirical Limits for the Forensic Assessment of PTSD Litigants*, 29 L. & HUM. BEHAV. 121, 128–29 (2005).

423. E.g., Bowman, *supra* note 225, at 826–39; see also Olav Nielssen, et al., *The Reliability of Evidence About Psychiatric Diagnosis After Serious Crime: Part I. Agreement Between Experts*, 38 J. AM. ACAD. PSYCHIATRY & L. 516, 523 (2010) (finding lower reliability for PTSD in criminal forensic settings than for any other tested diagnosis, and attributing the findings, in part, to the fact that "it is difficult, with the current diagnostic criteria, to make the diagnosis in a reliable way in legal settings").

424. Bowman, *supra* note 225, at 826–39; see also William J. Koch, *Posttraumatic Stress Disorder Following Motor Vehicle Accidents: Clinical Forensic Guidelines*, in *PSYCHOLOGICAL INJURIES AT TRIAL*, *supra* note 229, at 794, 803–04 (noting confirmatory bias following motor vehicle accidents generally); Gerald M. Rosen, *The Aleutian Enterprise Sinking and Posttraumatic Stress Disorder: Misdiagnosis in Clinical and Forensic Settings*, 26 PROF. PSYCHOL. RES. & PRAC. 82, 84–85 (1995) (using marine disaster as case study and finding confirmatory bias among survivors).

425. B.L. Long, *Psychiatric Diagnoses in Sexual Harassment Cases*, 22 BULL. AM. ACAD. PSYCHIATRY & L. 195, 196–97 (1994).

may have (perhaps even intentionally) attempted to support the plaintiffs' claims when diagnosing plaintiffs with PTSD.⁴²⁶

There are also concerns about the heavy reliance during the diagnostic process on subjective reporting by the patient of both the stressor event and the resulting reactions, as well as the subjective impressions of the diagnostician.⁴²⁷ One study documented low inter-rater reliability in determining whether specific events met the A Criterion and noted that "interpreting Criterion-A1 is a highly subjective process influenced not only by the personal experience of the victim but also the experiences and mindset of those who rate them."⁴²⁸ The researchers raised the question that courts struggled with in the personal injury cases in which the evaluator determined that the event at issue met the requirements of being a "stressor."⁴²⁹ They questioned how a clinician conducting a diagnostic evaluation could "define a stressor as 'traumatic' without relying on [her] own subjective interpretation of the definition of Criterion-A1."⁴³⁰ The widespread use has resulted in "conceptual bracket creep," meaning that clinicians are continuously broadening the categories of events that qualify for the criterion, thereby diminishing the significance of the criterion in the process.⁴³¹

Even aside from these concerns about bias and subjective assessment, a number of studies have raised questions about the core assumption of PTSD (and its particular use in the legal context): that the symptoms of PTSD (that is, anxiety, poor sleep, irritability, flashbacks, and so forth) were in fact *caused* by a traumatic event. In a 2007 study, a group of researchers concluded that symptoms of PTSD were of equal prevalence among subjects divided into groups of those who identified as being "traumatized, non-traumatized, [or] equivocal."⁴³² The researchers noted that "the diagnosis of posttraumatic stress disorder may harbor an uncertain theory of etiology within its name," which suggests caution due to the "practical importance, as psychotherapy may be structured, research studies designed, and legal compensation awarded on the basis of an unexamined assumption that symptoms of PTSD are caused by specific traumatic events."⁴³³ This study also refers to research noting the presence

426. See, e.g., *Alvarado v. Shipley Donut Flour & Supply Co., Inc.*, Civil Action No. H-06-2113, 2007 WL 4480134, at *6 (S.D. Tex. Dec. 18, 2007) (excluding evidence of forensic psychologist who diagnosed all twelve plaintiffs with PTSD); *Nelsen v. Res. Corp. of Univ. of Haw.*, 805 F. Supp. 837, 844–45 (D. Haw. 1992) (discounting plaintiff's experts' PTSD diagnosis because one of them had provided him with the *DSM* criteria before evaluations by the others); *Perkins v. Gen. Motors Corp.*, 709 F. Supp. 1487, 1495 (W.D. Mo. 1989) (excluding PTSD evidence in a sexual harassment case on the basis that it appeared to be the "current diagnosis of choice with [the plaintiff's] psychologists and they fit their patient to that diagnosis"); see also Pitman et al., *supra* note 413, at 875 (stating that bias can arise when diagnosing PTSD because of "sympathy" or "antipathy" the diagnostician may hold toward a patient's status as a victim).

427. Roger K. Pitman & Scott P. Orr, *Forensic Laboratory Testing for PTSD*, in *PTSD IN LITIGATION*, *supra* note 245, at 207, 207.

428. Van Hooff et al., *supra* note 419, at 85.

429. See *supra* notes 367–79 and accompanying text for a discussion regarding the judicial scrutiny of stressors and their use in diagnosing PTSD.

430. Van Hooff et al., *supra* note 419, at 78.

431. McNally, *supra* note 380, at 231; Van Hooff et al., *supra* note 419, at 77.

432. J. Alexander Bodkin et al., *Is PTSD Caused by Traumatic Stress?*, 21 J. ANXIETY DISORDERS 176, 176 (2007).

433. *Id.* at 181.

of PTSD symptoms after “sub-threshold traumatic events,” including divorce, money problems, and the death of livestock.⁴³⁴ These findings suggest that the mere presence of PTSD symptoms may serve as an imprecise or perhaps even improper proxy for legal standards that are based upon the severity of an underlying event.

Some psychological researchers theorize that it is not entirely accurate to state that the A Criterion event caused the PTSD symptoms to develop because the primary determining factor in whether someone develops such symptoms is the way in which the person recalls the event. One group has suggested that a person’s “memory of a stressful event, rather than the event itself, is the key to PTSD.”⁴³⁵ Thus, it is the way a person organizes and accesses the memory of an event that is most determinative of whether PTSD symptoms will develop.⁴³⁶ It is widely understood by psychologists that certain individuals are predisposed to develop PTSD in response to particular events⁴³⁷ and that individuals have widely varying responses to threatening events.⁴³⁸ This suggests that any individual who develops PTSD had a preexisting, yet latent, condition, and that PTSD reflects merely a triggering of such condition.⁴³⁹ Thus, the causal relationship between the stressor event and PTSD symptoms is not one of “mechanistic linear causality but of dynamic interaction,” and therefore is far more complex than was originally assumed.⁴⁴⁰

The implications of these findings could be significant for the legal context, and at least one court has raised such questions. After a bench trial, the court in *Burns v. Republic Savings Bank*⁴⁴¹ concluded that one cannot readily determine where causation from the event ends and where perception and memory of the event begins.⁴⁴² The court rejected the plaintiff’s forensic expert who had opined that the plaintiff had

434. *Id.*; see also Harold Merskey & August Piper, *Posttraumatic Stress Disorder Is Overloaded*, 52 CAN. J. PSYCHIATRY 499, 499–500 (2007) (arguing that PTSD is diagnosed in a great number of cases where there has been no actual traumatic experience).

435. Berntsen et al., *supra* note 240, at 1104. Indeed, such a view is more consistent with Freud’s initial conceptualization of traumatic neurosis. LEYS, *supra* note 13, at 20.

436. David C. Rubin et al., *Memory In Posttraumatic Stress Disorder: Properties of Voluntary and Involuntary, Traumatic and Nontraumatic Autobiographical Memories in People with and Without Posttraumatic Stress Disorder*, 137 J. EXPERIMENTAL PSYCHOL.: GEN. 591, 594 (2008) (“[P]roperties of the memory of the event rather the A1 and A2 criteria of the event itself will predict PTSD symptoms. Thus, individual differences factors influencing the availability of the memory (such as personality and temperament) will have a well-specified role to play.” (citation omitted)); see also Bowman, *supra* note 225, at 824–25 (noting that pre-event “traits” appear to contribute more significantly to the development of PTSD than the severity of the traumatic event itself); YOUNG, *supra* note 7, at 136, 141 (noting that some non-combat war veterans, after hearing of others’ traumatic experiences, will “remember” false events).

437. Bowman, *supra* note 225, at 825–26; Horowitz, *supra* note 225, at 9.

438. Bowman, *supra* note 225, at 821–23.

439. See Bowman, *supra* note 225, at 833 (“The clinical model for PTSD is biased by simple dose-response thinking, as if humans and flat-worms had their well-being and behavior equally totally determined by external events.”); John A. Call, *Liability for Psychological Injury: Yesterday and Today*, in PSYCHOLOGICAL INJURIES AT TRIAL, *supra* note 229, at 40, 52–53 (citing studies associating PTSD with “childhood behavior problems, dysfunctional families, physical abuse, current unemployment, genetic predisposition, and experience with previous traumas”).

440. Berntsen et al., *supra* note 240, at 1105.

441. 25 F. Supp. 2d 809 (N.D. Ohio 1998).

442. *Burns*, 25 F. Supp. 2d at 822 n.7.

depression resulting from PTSD, and concluded instead that she had a “depressive episode . . . caused, at least in part, by [the plaintiff’s incorrect] *perception* that she had been treated unfairly and discriminated against.”⁴⁴³

PTSD was originally conceptualized as a “natural process of adaptation to extraordinarily adverse situations” that arose in “normal people.”⁴⁴⁴ The dispute over the validity of this assumption has social and political dimensions as well as legal ones.⁴⁴⁵ The veterans’ campaign for PTSD’s recognition emphasized that the disorder was one caused entirely by their combat experiences.⁴⁴⁶ However, subsequent research pointed to several “risk factors,” and such findings “are inconsistent with the notion that traumatic events are the primary cause of symptoms and challenge the idea of PTSD as a typical stress response.”⁴⁴⁷ Some psychologists, particularly within the field of traumatology, resist such arguments, as they seem to redirect “blame” to the “victim”⁴⁴⁸ and challenge the “every person has a breaking point” notion that led to the development of PTSD for veterans as a service-connected event.⁴⁴⁹

Commentators have also suggested that events are “traumatic” in part due to a person’s experience with society’s response to the event, and that certain events will have less effect as traumatic stressors “as society begins to supply victims with social

443. *Id.* at 821–22 (emphasis added). Although the “eggshell plaintiff” rule would nonetheless allow recovery of any damages that could be found to flow from the tortfeasor’s actions (assuming such calculation can be made), it would not implicate essential questions of liability.

444. Yehuda & McFarlane, *supra* note 239, at 1706; *see also* McNALLY, *supra* note 380, at 87 (characterizing original view of PTSD as a “normal response to an abnormal stressor”).

445. Yehuda & McFarlane, *supra* note 239, at 1706.

446. *See supra* Part III.A for a discussion of how veterans of the Vietnam War were largely responsible for the official recognition of PTSD.

447. Yehuda & McFarlane, *supra* note 239, at 1707–08; *see also* McNally, *supra* note 380, at 237–39 (noting that the risk of developing PTSD symptoms is influenced by genetic and other vulnerability factors); Simon, *supra* note 245, at 59 (citing studies that have identified risk factors for exposure to traumatic events); Taylor & Asmundson, *supra* note 380, at 60 (emphasizing the important role played by risk factors in the development of PTSD).

448. *See* McNALLY, *supra* note 380, at 89 (noting that some “people” are offended by risk factor research because “it entails blaming victims for their plight”). Some researchers have alleged that the link between PTSD and its political and legal uses has inhibited scientific debate on the validity of the diagnosis. Editorial, *Challenges to the PTSD Construct and its Database: The Importance of Scientific Debate*, 21 J. ANXIETY DISORDERS 161, 161–62 (2007); *see also* Maier, *supra* note 230, at 105 (“[I]t is still difficult and sometimes even impossible to mention other influencing factors, especially in psychotherapies or in litigation contexts. This is not helpful for the further development of therapeutic and preventive interventions in PTSD.”); Van Hooff et al., *supra* note 419, at 85 (“[D]iscussions about PTSD are often polarized because of the role this diagnosis plays in determining causation, and hence negligence, in many litigation settings.”).

449. One reviewer theorizes several reasons why the clinical model and *DSM* criteria continue to be based upon a dose-response, event-causative model, including the fact that the model was based upon those who sought treatment; that individuals “make errors in reasoning about the causes and meanings of emotional arousal”; and clinicians “may fear being accused of ‘blaming the victim’ in looking at factors beyond the event. . . . This fear represents a shift away from a scientific approach to PTSD to a moralistic model.” Marilyn Laura Bowman, *Individual Differences in Posttraumatic Distress: Problems with the DSM-IV Model*, 44 CAN. J. PSYCH. 21, 27 (1999). She also suggests that “the *DSM* model for PTSD developed partly in response to advocacy groups attempting to normalize the condition of people with certain experiences.” *Id.* at 29.

support services.”⁴⁵⁰ For example, some attribute the widespread PTSD and other readjustment problems in Vietnam veterans to the hostile and unsupportive society they encountered upon their return. In fact, some studies have found that those with milder physical injuries are at a greater risk of developing PTSD because of the limited psychological support they received after a traumatic event.⁴⁵¹

In addition to these studies evaluating the validity of the A Criterion generally, several studies have specifically concluded that the diagnosis cannot be reliably used to determine whether the person has been subjected to trauma, particularly in cases of child abuse.⁴⁵² A group of legal and psychological commentators concluded, based upon their review of the current literature, that psychologists and psychiatrists have no skills grounded in “specialized knowledge” to identify whether a child has been a victim of sexual abuse, and there is no scientific basis for child abuse syndrome evidence.⁴⁵³

Given the controversies over the A Criterion—that it is unique, often disregarded, and seems to encourage use (and misuse) in legal settings—some psychiatrists have raised the question of whether, after thirty years, psychiatry should simply jettison the A Criterion or even the entire diagnostic category of PTSD.⁴⁵⁴ However, the APA is unlikely to take steps that could be interpreted as a denial of the “close relationship of trauma and disorder.”⁴⁵⁵

450. Raifman, *supra* note 415, at 129. It has even been suggested that “[a]s with other medical diagnoses oriented to legal consequences, PTSD will—in the future—no longer be a medical syndrome.” *Id.*

451. Simon, *supra* note 245, at 60.

452. Askowitz & Graham, *supra* note 285, at 2047–48. Some have specifically criticized its use on the basis that child sexual abuse did not meet the A Criterion because it often occurs over time. *E.g.*, David Finkelhor, *Early and Long-Term Effects of Child Sexual Abuse: An Update*, 21 PROF. PSYCHOL. RES. & PRAC. 325, 328–29 (1990); *see also* William J. Koch et al., *Empirical Limits for the Forensic Assessment of PTSD Litigants*, 29 L. & HUMAN BEHAV. 121, 136–40 (2005) (discussing how documentation of the trauma experienced from sexual abuse, which rarely occurs, is critical to a careful forensic assessment of the Criterion A status); Steve Herman, *Improving Decision Making in Forensic Child Sexual Abuse Evaluations*, 29 L. & HUMAN BEHAV. 87, 107 (2005) (“The current finding of low overall accuracy in clinician judgments about unconfirmed allegations of child sexual abuse is consistent with the almost universal consensus among top scientific experts that these evaluations currently have no firm scientific basis.”). *See generally* CLANCY, *supra* note 287.

453. GARY B. MELTON ET AL., *PSYCHOLOGICAL EVALUATIONS FOR THE COURTS: A HANDBOOK FOR MENTAL HEALTH PROFESSIONALS AND LAWYERS* 516 (3rd ed. 2007); *see also* Daniel W. Shuman, *The Diagnostic and Statistical Manual of Mental Disorders in the Courts*, 17 BULL. AM. ACAD. PSYCH. L. 25, 28 (1989) (noting that child abuse accommodation syndrome, although often the subject of expert psychological testimony, is not consistent with the diagnostic criteria for PTSD and not supported by scientific literature).

454. *E.g.*, Gerald M. Rosen et al., *Afterword: PTSD's Future in the DSM: Implications for Clinical Practice*, in CLINICIAN'S GUIDE TO PTSD, *supra* note 419, at 263, 264–65; Olav Nielssen & Matthew Large, *Post-Traumatic Stress Disorder's Future*, 192 BRIT. J. PSYCH. 394, 394 (2008); *see also* Maier, *supra* note 230, at 105 (arguing that since the criterion has little use in the clinical setting, it should be eliminated from the diagnosis); Rosen & Taylor, *supra* note 355, at 206 (discussing how PTSD would be diagnosed if the field of traumatology were to do away with the A Criterion); Yehuda & McFarlane, *supra* note 416 (noting that “the existence of PTSD is being called into question”).

455. Maier, *supra* note 230, at 106; Yehuda & McFarlane, *supra* note 411 (arguing that, although original assumptions PTSD was based on have been proven incorrect, the diagnosis should be retained since it has been “on-target in so many ways for so many trauma survivors”). Such a step would likely render the diagnosis superfluous: How can something be *post*-traumatic if the precursor was irrelevant?

Indeed, in 2010, the APA working group released its proposal for yet another revision to PTSD in the *DSM-V*, which would retain the A Criterion but would modify it once more:

A. The person was exposed to one or more of the following event(s): death or threatened death, actual or threatened serious injury, or actual or threatened sexual violation, in one or more of the following ways:

1. Experiencing the event(s) him/herself
2. Witnessing, in person, the event(s) as they occurred to others
3. Learning that the event(s) occurred to a close relative or close friend; in such cases, the actual or threatened death must have been violent or accidental
4. Experiencing repeated or extreme exposure to aversive details of the event(s) (e.g., first responders collecting body parts; police officers repeatedly exposed to details of child abuse); this does not apply to exposure through electronic media, television, movies, or pictures, unless this exposure is work related.⁴⁵⁶

Additionally, Criterion A2, which was added in 1994 to describe the subjective reaction of the patient to the traumatic event, would be eliminated from the criteria.⁴⁵⁷

This proposal aims to “tighten[] up the A1 criterion to make a better distinction between ‘traumatic’ and events that are distressing but which do not exceed the ‘traumatic’ threshold” by restricting the types of events that can serve as a basis for a PTSD diagnosis to three: actual or threatened death, serious injury, or sexual violation.⁴⁵⁸ The “threat to physical integrity” category would be removed, eliminating the application of the A Criterion to many events currently considered to be potential stressors, including sexual harassment.⁴⁵⁹ The ambiguous term “confronted with” included in the *DSM-IV* revision would be replaced by a list of specific ways that the person was “exposed” to such events.⁴⁶⁰ Finally, with the elimination of Criterion A2—now deemed to be of “no utility”—the subjective reaction of the individual would be irrelevant to the diagnostic process.⁴⁶¹ None of these changes, however, addresses the

456. AM. PSYCHIATRIC ASS’N, *G 05 Posttraumatic Stress Disorder*, DSM-5 DEVELOPMENT, <http://www.dsm5.org/ProposedRevisions/Pages/proposedrevision.aspx?rid=165> (last visited Nov. 14, 2011) (citation omitted). One reason for this new language is in response to the findings of Van Hooff et al., *supra* note 419, at 82, about the low inter-rater reliability in terms of meeting the A Criterion when the event was witnessed by the patient, rather than directly experienced.

457. See *supra* notes 264–73 and accompanying text for a discussion of the 1994 DSM-IV revisions to the diagnostic criteria for PTSD.

458. AM. PSYCHIATRIC ASS’N, *supra* note 456 (follow “Rationale” tab). The use of the term “event(s)” in the proposed A Criterion revision suggests that, for the first time, diagnosticians could assign the cause of a person’s PTSD to more than one distinct event.

459. In an influential article, psychologists Claudia Avina and William O’Donohue suggest that “threat to physical integrity” in the *DSM-IV*’s Criterion A1 potentially extends to sexual harassment in three ways: “(1) by threatening the victim’s financial well-being, (2) by threatening the victim’s physical boundaries, and (3) by threatening the victim’s control over situations that she should legitimately be able to have some control.” Claudia Avina & William O’Donohue, *Sexual Harassment and PTSD: Is Sexual Harassment Diagnosable Trauma?*, 15 J. TRAUMATIC STRESS 69, 73 (2002).

460. Compare *DSM-IV*, *supra* note 264, at 427, with AM. PSYCHIATRIC ASS’N, *supra* note 461.

461. AM. PSYCHIATRIC ASS’N, *supra* note 456 (follow “Rationale” tab).

fundamental criticisms of the A Criterion and the role of causation in diagnosing PTSD.⁴⁶²

The research findings with respect to the uncertain reliability of the diagnosis of PTSD and the uncertain validity of the disorder itself underscore the dangers of admitting PTSD evidence in legal proceedings, particularly for the purpose of proving that a traumatic event occurred. Not only is the A Criterion itself the subject of a great deal of scientific debate as to its utility and validity, there is little to no research to support many of the PTSD-related theories that have found their way into trials, such as the existence of “typical” or “hallmark” symptoms that are reliable indicators that a person has been subjected to a particular kind of trauma, such as child sexual abuse or rape, or has repressed memories of a trauma. To be sure, PTSD does have many defenders within psychiatry and psychology who offer responses to many of the key challenges to PTSD’s validity.⁴⁶³ However, even they are likely to concede that there is nothing resembling a scientific consensus within psychiatry about the core assumptions of PTSD as a stand-alone diagnostic category.⁴⁶⁴

Perhaps of most significance to the applicability of PTSD in legal contexts, these debates regarding PTSD and particularly the A Criterion exemplify the broader debate within psychiatry regarding the uncertain role of the concept of “causation” in that field. “Causation” has an unquestionably central operation in law, which uses the terms “legal cause” and “proximate cause” to construct normative rules to assign legal responsibilities between and among parties to a controversy. Such assignment is one of the core functions of law, particularly of litigation. However, causation has a far more uncertain—and some would argue nonexistent—role in contemporary psychiatry, which classifies and treats mental disorders based largely upon symptomatology without regard to etiology. Indeed, the role of “causes” of mental illness was the essential dispute between those within psychiatry who based their understanding of mental disorder upon psychoanalytic and other psychodynamic theories, and those who assumed that there were biological bases (even if they had not yet been precisely isolated) for most psychopathology.⁴⁶⁵ PTSD’s A Criterion, with its roots in the former, is an outlier (and some would say a relic) within contemporary psychiatry’s *DSM*.

B. PTSD as a Construct

Courts’ use of a PTSD diagnosis as discussed in Part IV implicates the scientific basis of that diagnosis. However, science has an uncertain role in PTSD. The scores of empirical findings that emerged after the diagnosis had been in place for many years led the *American Journal of Psychiatry*, the official publication of the American Psychiatric Association, to title a 1997 editorial “What is PTSD?” in light of research

462. Rosen et al., *supra* note 454, at 268 (“[T]he new working proposal for Criterion A does not resolve any of the core issues that constitute the ‘Criterion A problem’”).

463. See generally BREWIN, *supra* note 407.

464. *Id.* at 1–3.

465. For a more detailed discussion of the use and conceptualization of “causation” within law and psychiatry respectively, see Deirdre M. Smith, *The Disordered and Discredited Plaintiff: Psychiatric Evidence in Civil Litigation*, 31 CARDOZO L. REV. 749, 755–71 (2010).

that challenged some of the basic assumptions upon which the diagnosis had been based, and to conclude that the question “has no one answer.”⁴⁶⁶

This observation reflects the broader dispute within psychiatry regarding whether PTSD was a “discovery” or a “product” of psychiatric discourse.⁴⁶⁷ One of the core assumptions of PTSD is that the symptoms included in the *DSM* diagnosis represent “the way” that trauma (or at least certain types of trauma) can lead to psychopathology.⁴⁶⁸ Thus, the argument goes, PTSD is a disorder that was finally “recognized” by the APA in 1980, but it had in fact been in existence for decades, centuries, or longer.⁴⁶⁹ However, many who have noted PTSD’s conspicuously “political” origins question how organizing and lobbying could have resulted in the “discovery” of a new disease in an ostensibly science-driven document such as the *DSM-III*.⁴⁷⁰ They challenge the notion that PTSD can be understood to exist apart from the APA determination through a show of hands in the late 1970s and that the cluster of symptoms constitutes a singular disorder. The implications of this debate go to the essential validity of using a unique diagnostic label to classify all psychological symptoms that are determined to be in reaction to identifiable events.⁴⁷¹

A group of psychologists offering a critical historical analysis of PTSD explained why the origins of the diagnosis have become the focus of such a contentious debate:

[I]f one can demonstrate that a disorder shows up repeatedly across time and across cultures, one has evidence that the disorder is a state of nature rather than a social and cultural artifact due to social mores and conventions. Conversely, when disorders come and go we typically suspect that their instability is indicative of a social rather than natural basis.⁴⁷²

Along these lines, many in the field of traumatology or who otherwise work regularly with PTSD attempt to point to the timelessness of the condition, stating that it

466. Editorial, *What is PTSD?*, 154 AM. J. PSYCH. 143, 144 (1997).

467. YOUNG, *supra* note 7, at 121; Patrick J. Bracken, *Post-Modernity and Post-traumatic Stress Disorder*, 53 SOC. SCI. & MED. 733, 735–36 (2001).

468. See WATTERS, *supra* note 119, at 4 (listing some of the cultural assumptions that lie behind Western ideas of mental health); Gerald M. Rosen et al., *Searching for PTSD’s Biological Signature*, in CLINICIAN’S GUIDE TO PTSD, *supra* note 419, at 97, 97 (noting that the goal of medical nosology, including psychiatric classification, is to “reflect[] the true state of affairs in nature”); Bracken, *supra* note 467, at 733 (“Most of those who research and write about PTSD appear confident that the syndrome captures something fundamental about the way in which human beings deal with trauma.”).

469. LEYS, *supra* note 13, at 3; Jones et al., *supra* note 250, at 158 (noting that some scholars claim to identify PTSD symptoms in the *Iliad* and seventeenth century writings); Donna Trembinski, *Comparing Premodern Melancholy/Mania and Modern Trauma: An Argument in Favor of Historical Experiences of Trauma*, 14 HIST. OF PSYCHOL. 80, 80 (2011).

470. SHORTER, *supra* note 172, at 304–05; Jerry Lembcke, *The “Right Stuff” Gone Wrong: Vietnam Veterans and the Social Construction of Post-Traumatic Stress Disorder*, 24 CRITICAL SOC. 37, 38 (1998).

471. In 2000, a resolution proposed in the Royal College of Psychiatry in the United Kingdom that would have stated that the body “believes that PTSD is largely a fictional condition” was defeated only narrowly. Bowman, *supra* note 225, at 821; see also Celia Hall, *Stop Cashing In On Stress, Says Psychiatrist*, THE DAILY TELEGRAPH (July 4, 2000), <http://www.telegraph.co.uk/news/newstoppers/politics/health/1346618/stop-cashing-in-on-stress-says-psychiatrist.html> (criticizing the “compensation culture” created by psychoanalysis and lawyers through the application of PTSD to everyday experience).

472. Baldwin et al., *supra* note 13, at 37.

is essentially the same disorder once diagnosed as shell shock.⁴⁷³ However, a number of scholars, both within and outside of the field, conclude otherwise. For example, one study of World War I military pension records found that there were virtually no complaints of what would now be referred to as “flashbacks,” the classic dissociation symptom of the PTSD experienced by Vietnam veterans; in fact, a significant number of soldiers receiving compensation for war neurosis or shell shock would not have met the current PTSD criteria if it were in place at the time.⁴⁷⁴ Moreover, cross-cultural studies of PTSD have revealed “remarkable deviations from the PTSD symptom list.”⁴⁷⁵ Medical anthropologist Allan Young concluded from his study of the development of PTSD that the diagnosis “is not timeless, nor does it possess an intrinsic unity.”⁴⁷⁶ Rather, he observed, “it is glued together by the practices, technologies, and narratives with which it is diagnosed, studied, treated, and represented and by the various interests, institutions, and moral arguments that mobilized these efforts and resources.”⁴⁷⁷

As an alternative to proving the “timelessness” of PTSD, several researchers have attempted to locate a precise biological cause or indicator of PTSD to establish the elusive independent validity of the diagnostic category.⁴⁷⁸ Since 1980, numerous papers have attempted to align the diagnosis with the “new” biological psychiatry.⁴⁷⁹ Many researchers hope to identify specific psychobiologic responses or “biomarkers” to PTSD to improve the reliability of diagnoses. Finding these biological markers, the hallmarks of a “naturally occurring and inevitable phenomenon,” has become a key object of traumatologists.⁴⁸⁰ The expectation is that finding physiological indicators of the disorder will put an end to the controversies within psychiatry and allow the diagnosis (and presumably the entire field of traumatology) to receive broader

473. See, e.g., BREWIN, *supra* note 407, at 25–28 (detailing similarities between symptoms of PTSD and symptoms of shell shock).

474. Jones et al., *supra* note 250, at 160–61. One theory to account for the incidence of “flashbacks” in the later twentieth century is that the symptom is derived from the cinematic technique. *Id.* at 162. See also Baldwin et al., *supra* note 13, at 40 (noting the “discontinuity” of the conceptualization of PTSD over time).

475. WATTERS, *supra* note 199, at 102; see also Derek Summerfield, *Cross-Cultural Perspectives on the Medicalization of Human Suffering*, in PTSD: ISSUES AND CONTROVERSIES, *supra* note 419, at 233, 233–44 (noting that Western medicalization of distress has resulted in a wide range of symptoms being attributed to PTSD).

476. YOUNG, *supra* note 7, at 5.

477. *Id.*

478. YOUNG, *supra* note 7, at 105–06; Rosen et al., *supra* note 468, at 98; see also Baldwin et al., *supra* note 13, at 38 (“[P]hysiological differences between persons with a diagnosis of PTSD compared with those without the diagnosis ha[ve] been used rhetorically to champion the ‘reality’ of PTSD and to discredit critics.”); LEYS, *supra* note 13, at 254 (noting that the “plausibility” of trauma theories would be “enormously enhanced” if they were “supported by neurobiological evidence”).

479. SHEPHARD, *supra* note 10, at 388–90; see also Taylor & Asmundson, *supra* note 380, at 63–64 (reviewing various studies examining potential neurobiological and behavioral-genetic causes of PTSD). Much research has focused on the potential role of hormones such as cortisol or norepinephrine. APPIGNANESI, *supra* note 273, at 436–37.

480. Baldwin et al., *supra* note 13, at 48–49; see also Yehuda & McFarlane, *supra* note 411 (noting the progress made in identifying biomarkers for PTSD and that “[s]oon it will be more difficult . . . to dismiss the ‘validity’ of the PTSD diagnosis”).

acceptance,⁴⁸¹ including within the legal realm specifically.⁴⁸² Most recently, a study claims to have identified a neurological abnormality in veterans with PTSD through magnetoencephalography (MEG) scans.⁴⁸³ However, no consensus has emerged on any biomarkers for PTSD,⁴⁸⁴ and thus far not one has been identified for diagnostic purposes.⁴⁸⁵

The debate regarding PTSD's origins, however, fails to note that PTSD is not unique in its "constructed" evolution; rather, such evolution is perhaps simply more conspicuous than in other diagnoses. PTSD provides an example of medical historian Edward Shorter's theory of the "symptom pool," the mechanism through which the mind experiences and explains a reaction within the person's cultural context at a particular time and place.⁴⁸⁶ A patient's unconscious "striving for recognition and legitimization of internal distress" may lead the unconscious to manifest such distress through means that will lead to such result.⁴⁸⁷ The patient is not alone in this process. Through "illness negotiation" with a physician, the two "shape each other's perceptions of the behavior" with the backdrop of what has been recognized as a "legitimate disease category," thereby leading to "scientific validation" of the patient's experience.⁴⁸⁸

This dynamic is particularly powerful with psychiatric diagnoses.⁴⁸⁹ "Hysteria," a psychosomatic illness in which individuals experience paralysis or the sudden loss of the ability to speak, hear, or see, was the "archetypal disorder of the Victorian era"; however, such symptoms are rarely encountered today.⁴⁹⁰ Similarly, the symptoms of World War I veterans' "shell shock" are quite different from those reflected in the current diagnostic criteria of PTSD (which themselves have undergone substantial

481. Baldwin et al., *supra* note 13, at 49.

482. Two excellent, recent works, Adam J. Kolber, *The Experiential Future of the Law*, 60 EMORY L.J. 585, 609–22 (2011), and Betsy J. Grey, *Neuroscience and Emotional Harm in Tort Law: Rethinking the American Approach to Free-Standing Emotional Distress Claims*, in 13 LAW AND NEUROSCIENCE: CURRENT LEGAL ISSUES 2010, at 203, 204–06 (Michael Freeman ed., 2011), explore the potential impact of emerging technological advances for identifying biological markers for PTSD and other psychological injuries on legal decision-making in the future.

483. See Katie Drummond, *Neuroscientists Say Brain Scans Can Spot PTSD*, WIRED.COM (Jan. 22, 2010, 8:00 A.M.), <http://www.wired.com/dangerroom/2010/01/brain-biomarker-could-be-the-key-to-ptsd-diagnosis> (study indicating that new brain imaging technology permitted researchers to spot specific brain biomarkers, allowing them to diagnose PTSD with ninety percent accuracy).

484. Baldwin et al., *supra* note 13, at 49–52 (critiquing various psychophysiological studies).

485. See Pitman & Orr, *supra* note 427, at 207 (noting that diagnosis of PTSD continues to rely on "the veracity of the complainant").

486. SHORTER, *supra* note 43, at 2–4; WATTERS, *supra* note 199, at 32.

487. WATTERS, *supra* note 199, at 32 (noting that "[t]his sort of cultural molding . . . happens imperceptibly and follows a large number of cultural cues that patients simply are not aware of").

488. *Id.* at 33.

489. *Id.* at 60 (noting that there is "[a] pervasive mistaken assumption in the mental health profession: that mental illnesses exist apart from and unaffected by professional and public beliefs and the cultural currents of the time").

490. *Id.* at 72; see also WELKE, *supra* note 18, at 158 (noting that "neurasthenia" was regarded as "America's primary mental disorder" at the turn of the twentieth century and had become "a household word").

revision since *DSM-III*).⁴⁹¹ What PTSD and its forerunners have in common then is not their symptomatology, their theoretical underpinning, or their treatment, but rather their *utility* outside of the clinical setting. This commonality suggests a particularly strong role for the symptom pool, but PTSD is by no means the only diagnosis that developed in this fashion.

Indeed, it would be accurate to say that *all* of the *DSM* is infused with the policy choices made by those in positions of authority to decide the parameters of what is a mental “disorder.”⁴⁹² The diagnostic categories in the *DSM* do not, for the most part, “reflect a coherent progression of empirical research,” but rather, are, “at best, a categorization of the pain, suffering, or distress.”⁴⁹³ The development of medical diagnoses generally reflects “negotiation,” rather than discovery, and the resulting classifications “serve to rationalize, mediate, and legitimate relationships between individuals and institutions in a bureaucratic society.”⁴⁹⁴ And the legal system is one of the players in such negotiations, particularly with respect to psychiatric diagnoses, given the extensive association of psychiatry with the legal system throughout the twentieth century.⁴⁹⁵ The demands the legal system brings to these negotiations often include consistency, certainty, and reliability and, more generally, the ability to aid in the resolution of legal questions and problems.⁴⁹⁶ *DSM-III*, at least on its face, appeared to satisfy all of these demands,⁴⁹⁷ and thus it should not be surprising that PTSD—which purported to provide consistent, certain, and reliable answers on the causation of injury—found a central place in litigation so quickly. Therefore, that PTSD is a “construct” is simply a given. It is remarkable, rather, because of the manifestly socio-political and *legal* origins of this particular psychiatric construct and, accordingly, the implications of such origins for its use in determining liability in legal settings.

The construct-versus-discovery argument itself has implications for the role of PTSD in law. As discussed above, many courts and legislatures have framed legal standards or requirements directly or indirectly around PTSD on the assumption that it

491. Bracken, *supra* note 467, at 735. One analysis of the shifting criteria of PTSD noted eleven distinct changes to the diagnosis in the *DSM-III-R* and fifteen changes to the *DSM-IV* criteria, all in the space of fourteen years. These changes were so significant that a great number of patients who met the criteria under one would not meet the criteria under another, and that, under the current version, two patients without any overlapping symptoms could have the same PTSD diagnosis. KUTCHINS & KIRK, *supra* note 105, at 124.

492. Daniel W. Shuman, *Softened Science in the Courtroom: Forensic Implications of a Value-Laden Classification*, in DESCRIPTIONS AND PRESCRIPTIONS: VALUES, MENTAL DISORDERS, AND THE DSMs 217, 224-25 (John Z. Sadler ed., 2002); Elizabeth C. Cooksey & Phil Brown, *Spinning on Its Axes: DSM and the Social Construction of Psychiatric Diagnosis*, 28 INT’L J. HEALTH SCI. 525, 548-49 (1998).

493. Greenberg et al., *supra* note 6, at 5, 12.

494. Charles E. Rosenberg, *Framing Disease: Illness, Society, and History*, in FRAMING DISEASE: STUDIES IN CULTURAL HISTORY, at xii, xxi (Charles E. Rosenberg & Janet Golden eds., 1992) [hereinafter FRAMING DISEASE]; see also GEOFFREY C. BOWKER & SUSAN LEIGH STAR, SORTING THINGS OUT: CLASSIFICATION AND ITS CONSEQUENCES 47 (2000) (noting the “multitude of local political and social struggles and compromises that go into the constitution of a ‘universal’ classification” such as the *DSM* or the International Classification of Diseases).

495. Janet A. Tighe, *The Legal Art of Psychiatric Diagnosis: Searching for Reliability*, in FRAMING DISEASE, *supra* note 494, at 206, 207-08.

496. *Id.* at 215-16, 219.

497. See *id.* at 217 (noting that *DSM-III* was the most technologically sophisticated edition of the *DSM*).

represents an advancement in scientific understanding of the psychological impact of traumatic events.⁴⁹⁸ A few courts, by contrast, have dismissed the diagnosis as a mere “human construct,” using the term to signify that “PTSD” is nothing more than a label.⁴⁹⁹ However, in making either assumption, these courts fail to recognize the complexity not only of psychopathology itself, but of our very understanding and explication of mental disorders and, indeed, all medical diagnoses.

VI. CONCLUSION – THE LESSONS OF PTSD’S LEGAL HISTORY

At the time of PTSD’s recognition by the APA, few within the psychiatric establishment raised concerns about recognizing, treating, and compensating the psychological injuries of the people who fought a violent and controversial war. However, since that time, PTSD’s association with law, and particularly with compensation, has led to a backlash against the diagnosis. Many psychiatric and legal commentators regard it as a medical term co-opted by the legal profession and its clients to be a mechanism either to acquire undeserved compensation or to evade personal responsibility.⁵⁰⁰ As a result, the very real psychological impact of horrific events is often minimized and claims of psychological injuries continue to be regarded with suspicion.

Some commentators from within psychiatry who have expressed particular skepticism about the role of PTSD in legal settings urge a decoupling of legal and medical notions of causation embodied in PTSD. The assignment of responsibility to a source is the purview of law, not psychiatry. Regardless of the particular school or theory, psychiatry has always seen the workings of the psyche as being far more complex than the liability questions raised in most civil and criminal cases resolved by non-expert fact finders. Those within psychiatry who criticize the legal system for taking PTSD and running with it,⁵⁰¹ however, fail to acknowledge that PTSD and the legal conceptualizations of emotional injuries share a common past and have evolved

498. See, e.g., Edgar Garcia-Rill & Erica Beecher-Monas, *Gatekeeping Stress: The Science and Admissibility of Post-Traumatic Stress Disorder*, 24 U. ARK. LITTLE ROCK L. REV. 9, 37–39 (2001) (noting that “PTSD . . . is based on solid science and should be admissible under *Daubert*”).

499. E.g., *Spencer v. Gen. Elec. Co.*, 688 F. Supp. 1072, 1075–76 (E.D. Va. 1988) (noting that “PTSD is simply a diagnostic category created by psychiatrists; it is a human construct, an artificial classification of certain behavioral patterns”), *overruled in part* by *Pesso v. Montgomery Gen Hosp.*, No. 98-1978, 1999 U.S. App. LEXIS (4th Cir. May 24, 1999), and *Ellis v. Director, CIA*, No. 98-2481, 1999 U.S. App. LEXIS 21638 (4th Cir. Sept. 10, 1999).

500. See, e.g., Brown, *supra* note 332, at 468 (stating that “symptoms of PTSD can be easily coached and simulated,” and that some “individuals and their counsel take advantage of these ploys”); Derek Summerfield, *The Invention of Post-Traumatic Stress Disorder and the Social Usefulness of a Psychiatric Category*, 322 BRIT. MED. J. 95, 96 (2001) (“Once it becomes advantageous to frame distress as a psychiatric condition people will choose to present themselves as medicalised victims rather than as feisty survivors. . . . There is a veritable trauma industry comprising experts, lawyers, claimants, and other interested parties . . .”). For an example of such backlash in the popular culture, see generally ALAN M. DERSHOWITZ, *THE ABUSE EXCUSE: AND OTHER COP-OUTS, SOB STORIES, AND EVASIONS OF RESPONSIBILITY* (1994).

501. See, e.g., Maier, *supra* note 230, at 105 (“The legal system . . . , which is based on strictly causal thinking, gratefully picked up the diagnosis and has built in the meantime a whole industry of victimology on PTSD.” (emphasis omitted)).

together.⁵⁰² Where physicians have built a theory of causation into the “signs and symptoms” themselves, it is not so simple to suggest that “the physician delineates signs and symptoms; the legal system decides on compensation.”⁵⁰³ Jerome Wakefield and Allan Horwitz, two noted scholars of the development and implications of psychiatric diagnoses, recently observed of PTSD: “No other psychiatric diagnosis involves issues where drawing boundaries is not just a matter of diagnostic convenience but also of justice and injustice.”⁵⁰⁴ The line between law and medicine is not merely blurred in PTSD; it is absent.

PTSD’s inextricable relationship to notions of causation and responsibility does not, however, mean that the legal system should utilize it freely. In fact, PTSD’s distinctly *legal* history suggests that the law should in fact apply far greater scrutiny to the role of PTSD in litigation than it does for other psychiatric diagnoses. The studies that have called into question the original theoretical assumptions of PTSD and the problems inherent in the A Criterion demonstrate that courts should be reluctant to allow a PTSD diagnosis to be assigned legal significance in itself. Permitting PTSD to play a central role in legal settings risks conflating the unsettled psychiatric conceptualization of “causation” with the questions of legal or proximate cause reserved for fact finders.⁵⁰⁵

Although unquestionably infused with policy choices, psychiatric diagnoses were developed to serve that profession’s clinical and research needs. Law, by contrast, serves distinctly normative goals through the development of legal rules or standards, which determine the framework to allocate responsibility based upon policy determinations reached by “lawmakers” (generally legislators and judges) applying their notions of “justice.”⁵⁰⁶ When courts employ legal standards that incorporate conceptualizations of “diagnosable” conditions, they are thereby assuming something *legally* significant about the thresholds the psychiatric profession chooses to set.⁵⁰⁷ However, courts do not acknowledge or understand the construction of psychiatric

502. In this regard, PTSD can be seen as a “co-production” of psychiatry and law, to borrow a concept from noted science and technology studies scholar Sheila Jasanoff. Sheila Jasanoff, *The Idiom of Co-Production*, in STATES OF KNOWLEDGE: THE CO-PRODUCTION OF SCIENCE AND SOCIAL ORDER 1, 2 (Sheila Jasanoff ed., 2004) (“Briefly stated, co-production is shorthand for the proposition that the ways in which we know and represent the world (both nature and society) are inseparable from the ways in which we choose to live in it.”). I am appreciative of Allan Young for bringing this term to my attention in our correspondence.

503. Kinzie & Goetz, *supra* note 28, at 166.

504. Jerome C. Wakefield & Allan V. Horwitz, *Normal Reactions to Adversity or Symptoms of Disorder?*, in CLINICIAN’S GUIDE TO PTSD, *supra* note 419, at 33, 42.

505. See Shuman, *supra* note 282, at 7 (“Both *Daubert* and the DSM make clear that it is not appropriate to assume that a psychiatric diagnosis is relevant to, let alone dispositive of, an issue in a case.”).

506. To be sure, PTSD is not unique in this respect since law has certainly relied upon the presence of a “diagnosable” mental disorder in other contexts, particularly with respect to preventative detention laws. For example, people are subject to involuntary commitment, only where an examiner has found the presence of a mental illness. Similarly, sexually violent predator laws universally require a finding of a mental disorder as well as a history of sexual violence in order to detain a person. Several conceptualizations of the insanity defense require the presence of a mental disease or defect in addition to specific cognitive or volitional impairments. MELTON ET AL., *supra* note 453, at 210–12.

507. Shuman, *supra* note 282, at 10 (“[T]he role of PTSD in litigation turns, in part, on diagnostic nomenclature that psychiatry largely controls . . .”).

disease and the limitations of using psychiatric labels outside of clinical and research settings.⁵⁰⁸ Linking PTSD—with its built-in clinical determination of causation—to legal standards effectively delegates to the psychiatric profession determinations of legal responsibility.⁵⁰⁹

Accordingly, although PTSD is now commonplace in the legal system, this Article suggests that courts and other legal policymakers consider PTSD's legal history as part of a reexamination of the roles that law has assigned to the diagnosis. PTSD evidence arises in a wide range of legal contexts, including workers' compensation claims, criminal defenses and sentencing, and explaining the extent of a personal injury plaintiff's emotional distress damages, and there are varying degrees of danger of misuse in each of these settings. However, the uses described in Part II—where a fact finder is permitted to use PTSD's construction of causation to make a finding of civil or criminal liability—likely pose a greater danger of courts unknowingly permitting a policy-driven diagnosis to influence a legal outcome.

Courts should also be cognizant of the fact that laypersons lack the tools to understand the limitations of this diagnosis and may misapprehend the significance of the diagnostic label. PTSD evidence, like any other expert opinion testimony, should not be exempt from the application of the rules of evidence, particularly *Daubert* scrutiny. It represents precisely the kind of expert opinion that is often presented as the *ipse dixit* conclusion of a treatment provider or forensic examiner that *Daubert* and its progeny warn are of little use to lay fact finders who cannot evaluate the reliability of the testimony for themselves.⁵¹⁰ It is unlikely that the typical cross-examination of a forensic examiner can bring out the full extent of the construction of trauma and psychological injury embodied in the diagnosis, the role of the diagnostician's own value judgments about causation in applying the diagnosis, and the overall complexity of the psychological mechanisms involved in mental disorders, including PTSD.

Using PTSD as the stand-in for severe emotional distress or proof of a traumatic event asks fact finders to distill an elaborate and poorly understood psychological process into simple determinations of liability. A PTSD diagnosis provides fact finders “a semantic handle for the complexity inherent in diagnostic issues,”⁵¹¹ particularly since jurors (like all of us) are drawn to “simple causal explanations.”⁵¹² Nonetheless, the widespread use of the term, particularly in the wider culture, has rendered it loaded,

508. See Sparr & Pitman, *supra* note 420, at 454 (“Beyond its significance as an apparent solution to the legal problem of causation, PTSD's greatest importance is that it seems to make scientific and objective matters that the court once considered too subjective for legal resolution.” (citation omitted)). See generally Greenberg et al., *supra* note 6 (critiquing the forensic use of *DSM* diagnoses).

509. See *Smith v. Schlesinger*, 513 F.2d 462, 477 (D.C. Cir. 1975) (“[P]sychiatric judgments may disguise, wittingly or unwittingly, political or social biases of the psychiatrist; and excessive reliance on diagnoses will pre-empt the primary role of legal decision-makers.”).

510. See, e.g., *Gen. Elec. Co. v. Joiner*, 522 U.S. 136, 146 (1997) (“[N]othing in either *Daubert* or the Federal Rules of Evidence requires a district court to admit opinion evidence that is connected to existing data only by the *ipse dixit* of the expert.”); see also *Smith*, *supra* note 465, at 810–15 (discussing some of the unique dangers of admitting psychiatric evidence, particularly *DSM* diagnoses).

511. Greenberg et al., *supra* note 6, at 10.

512. CHAMALLAS & WRIGGINS, *supra* note 130, at 125 n.25 (citing NEAL FEIGENSON, *LEGAL BLAME: HOW JURORS THINK AND TALK ABOUT ACCIDENTS* 51–52 (2000)); see also Sparr & Pitman, *supra* note 420, at 454 (commenting that “PTSD posits a straightforward causal relationship that plaintiffs' lawyers welcome”).

diluted, and confused, and it risks being a misleading and unreliable tool in the hands of lay fact finders for purposes of assigning legal responsibility or assessing harm.⁵¹³ Indeed, encouraging challenges to PTSD to be played out in front of the fact finder may even undermine a plaintiff's claim for emotional distress damages or a complainant's allegation of sexual assault where the fact finder then links the problems of the diagnosis with the legitimacy of such claims and allegations; such a result would hardly be just.

It is important to emphasize here that scrutinizing the use of a PTSD diagnosis as evidence of liability does not require us to discount or diminish the recognition of and compensation for the events that can give rise to such liability, ranging from the horrors of combat, to the exploitation of children, to discrimination in workplaces, to the negligent operation of automobiles. Rather, this argument urges that determinations of liability for such actions must remain within the legal system without overreliance on psychiatry, and that legal barriers to recovery should be removed through legal mechanisms such as legislation, judicial opinions, and rules, rather than through the adoption of psychiatric standards of causation. PTSD may serve several important roles within psychiatry, including those which do not require any particular level of scientific reliability, such as to validate a person's reactions to an event or to encourage a person to pursue treatment. But psychiatric diagnoses are not fact-finding tools and have no place in litigation for such purpose.

One could certainly say that PTSD has provided important roles in legal contexts by, for example, enabling Vietnam veterans to receive critical benefits and health care for psychological injuries after exposure to a horrific and arguably unjust war. But such arguments are based upon a misplaced assumption that psychiatry was the proper route to fix the problem of compensation standards for veterans. The fault was with the VA and Congress for failing to provide compensation in the absence of a targeted diagnosis and for relying upon psychiatry to dictate compensation determinations in the first place. Courts repeat such mistakes by looking to psychiatry to fix problems with legal standards when they create legal rules such as "medically diagnosable" requirements to recover emotional distress damages.⁵¹⁴ Although psychiatry may have created a diagnosis that is intertwined with legal concepts, the law should not implement legal standards that are intertwined with psychiatric concepts without first considering the full implications of doing so.⁵¹⁵

PTSD has served as a critical mechanism in law for other important purposes, such as the recognition that misconceptions about sexual assault victims can skew the results in prosecutions. It has also played a role in the erosion of the rigid mind-body dichotomy in personal injury law to permit expanded recovery for psychological injuries in tort actions. The problems in the legal systems that PTSD has been used to

513. Noah, *supra* note 405, at 243 (noting that when legal institutions "rely heavily on clinical judgments" it can in turn "distort the diagnostic process").

514. See ROBIN FELDMAN, *THE ROLE OF SCIENCE IN THE LAW*, at xi (2009) ("We continually look to science to rescue us from the discomfort of difficult legal decisions . . .").

515. Maintaining a clearer demarcation between the legal and medical judgments not only protects the legal system from unintentionally delegating policy-making to medicine, it also protects medicine from the influence of the law. See Noah, *supra* note 410, at 244 (arguing that "legal institutions should better insulate the diagnostic enterprise by delinking their decisions from clinical judgments").

remedy should not go unaddressed. Rather, courts should use legal tools to dispel such misperceptions about sexual assault so that they do not interfere with fact-finding in such cases.⁵¹⁶ For example, “rape shield” laws such as Federal Rule of Evidence 412 limit a defendant’s ability to exploit common (yet wrong) assumptions about the role of a woman’s sexual “predisposition” in sexual assault cases.⁵¹⁷ Also, courts should allow compensation of psychological injuries through testimony of plaintiffs and their mental health providers who can describe symptoms and treatment for such injuries without being obliged to convey the impression that the cluster of symptoms signals something transformative in the person. Indeed, the American Law Institute’s forthcoming *Restatement (Third) of Torts* permits recovery for emotional injury without any requirement for a medical diagnosis.⁵¹⁸

Although PTSD, given its well-documented legal and political origins, may offer perhaps the most stark example of how psychiatric diagnoses can reflect legally-significant assumptions, we must also recognize that all psychiatric diagnoses reflect assumptions and conclusions about human behavior and emotion that reflect the time when they were developed. Indeed, unlike many legal rules, such framing can shift quite rapidly, with diagnoses being added, removed, or revised, within just a few years of the prior conceptualizations.⁵¹⁹ If the law decides to address problems of justice by looking to psychiatry or other branches of medicine and science for solutions, it must only do so with a full appreciation and understanding of the origins and limitations of the concepts it seeks to adopt. Absent such acknowledgement, together with a determination that such concepts are in fact appropriate to import into law, the legal system simply delegates juridical authority to those fields.

516. MELTON ET AL., *supra* note 453, at 226.

517. FED. R. EVID. 412.

518. The *Restatement (Third) of Torts* includes Section 46, which provides as follows:

An actor whose negligent conduct causes serious emotional disturbance to another is subject to liability to the other if the conduct: (a) places the other in immediate danger of bodily harm and the emotional disturbance results from the danger; or (b) occurs in the course of specified categories of activities, undertakings, or relationships in which negligent conduct is especially likely to cause serious emotional disturbance.

RESTATEMENT (THIRD) OF TORTS: LIAB. FOR PHYSICAL & EMOTIONAL HARM § 46 (Tentative Draft No. 5, 2007); *see also* CHAMALLAS & WRIGGINS, *supra* note 125, at 95 (noting “[t]he Restatement’s emphasis [is] on the relational context in which the tort is committed,” not “on the categorization of the injury marks”).

519. *See, e.g.*, JONATHAN M. METZL, *THE PROTEST PSYCHOSIS: HOW SCHIZOPHRENIA BECAME A BLACK DISEASE* (2009) (discussing the radical re-conceptualization of the diagnosis of schizophrenia in the United States in 1950s and 1960s).

