Behavioral Sciences and the Law, Vol. 12, 215–234 (1994)

Posttraumatic Stress Disorder Among Battered Women: Analysis of Legal Implications

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The diagnosis of posttraumatic stress disorder (PTSD) has recently been applied to the psychological experiences of victims of intimate violence, including physical and sexual assault. The use of trauma theory to explain battered women's responses to violence has laid a foundation for expert testimony on PTSD, where relevant, within more general testimony concerning partner violence. This article discusses the relevance of the PTSD diagnosis within the legal context for explaining battered women's responses to violence.

The diagnosis of posttraumatic stress disorder (PTSD) originally was developed to characterize the psychological responses of some veterans to combat experiences. Later the diagnosis was used to describe the psychological impact of natural disasters and rape (Davidson & Foa, 1993; Figley, 1985; Van der Kolk, 1987). More recently, it has been applied to the psychological experiences of victims of spouse or partner violence, including physical and/or sexual assault (Browne, 1992; Dutton, 1992b; Goodman, Koss & Russo, 1993b; Walker, 1992).

The use of trauma theory to explain battered women's responses to violence has laid a foundation in legal proceedings for expert testimony on PTSD. Increasingly, research on PTSD has been introduced into expert testimony in criminal defense cases involving battering victims (typically women, accused of killing their abusive partners (Blackman, 1986; Maguigan, 1991)), civil actions brought by battered women against their batterers (alleging negligent or intentional infliction of emotional distress (Kohler, 1992)), criminal prosecution of domestic violence perpetrators (Schneider, 1991; Bowman, 1992), and marital dissolution and child custody proceedings involving persons in a battering relationship (Cahn, 1991).

This article outlines and critically evaluates the use of the PTSD diagnosis to explain, within the legal context, battered women's response to violence. We begin with a description of the diagnosis and its application to the experience of domestic violence victims. We then move to an analysis of PTSD applied to expert testimony

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CCC 0735–3936/94/030215–20

in litigation involving battered women. We conclude that PTSD is clearly relevant to some aspects of battered women's litigation, but not universally so.

PTSD DIAGNOSIS

PTSD is described in the revised third edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-III-R; American Psychiatric Association, 1987) as a set of "characteristic symptoms following a psychologically distressing event that is outside the range of usual human experience ... [and that] would be markedly distressing to almost anyone" (p. 247). This characterization makes clear that the responses comprising the diagnosis of PTSD are not based on prior emotional difficulties; rather, PTSD presumes a set of normal responses to an abnormal event or set of events.

Traumatic Stressor

According to DSM-III-R, the "most common traumata" that produce PTSD are actual or threatened harm to one's self, spouse, relatives or close friends; sudden destruction of one's home or community; or witnessing harm to another as the result of an accident or physical violence (American Psychiatric Association, 1987, pp. 247–48). Traumatic events may be experienced alone (e.g., rape or assault) or in the company of others (e.g., military combat), and may include natural disasters (e.g., floods, earthquakes), accidents (e.g., automobile collisions, airplane crashes), and deliberately caused disasters (e.g., bombing, torture, death camps) (American Psychiatric Association, 1987, p. 248).

The DSM-IV draft criteria eliminate the requirement that the event be outside the range of usual human experience and instead characterize a traumatic event as one in which "the person has experienced, witnessed, or been confronted with an event or events that involve actual or threatened death or serious injury, or a threat to the physical integrity of oneself or others" and where the person's response has been "intense fear, helplessness, or horror" (American Psychiatric Association, 1993). This definition recognizes that a number of traumatic events that potentially can lead to PTSD are not "outside the range of usual human experience", given the frequency with which they occur (e.g., victimization by violence).

Green (1990) describes several dimensions of the traumatic event, itself, that have been associated with the development of PTSD. These include threat to life and limb, severe physical harm or injury, receipt of intentional injury/harm, exposure to the grotesque, violent/sudden loss of a loved one, witnessing or learning of violence to a loved one, learning of exposure to a noxious agent, and causing death or severe harm to another.

Davidson and Foa (1993) propose a trauma continuum. At one end of the continuum lie extreme traumatic events likely to produce PTSD in most individuals, regardless of other factors. At the other end of the continuum lie events which, though minimally stressful to most people, could lead to PTSD in the presence of multiple predisposing factors. These authors conclude that most instances of PTSD will follow an event that is neither minimally stressful nor maximally traumatic

and that the occurrence of PTSD is mediated by internal and external factors separate from the event itself.

Symptomatology

PTSD Diagnostic Criteria

To be diagnosed with PTSD, a trauma victim must demonstrate symptoms that match DSM-III-R criteria (American Psychiatric Association, 1993) in each of three symptom clusters: intrusive symptoms, avoidance symptoms, and arousal symptoms. Intrusive symptoms are those through which the trauma is relived. Examples include nightmares, vivid recollections, hallucinations or flashbacks, severe distress at exposure to events that symbolize or resemble an aspect of the traumatic event, and intense fear of a recurrence of the trauma.

Avoidance symptoms are those through which the victim attempts to insulate himself or herself from internal and external reminders of the trauma so as to avoid becoming emotionally overwhelmed (Goodman, Koss & Russo, 1993a). Examples include avoidance of environmental stimuli—including people, places, and activities—associated with the trauma, avoidance of thoughts or feelings associated with the trauma (sometimes leading to a general numbing of responsiveness and a restricted range of affect), inability to recall aspects of the trauma (e.g., psychogenic amnesia), and feelings of detachment from others. Intrusion and avoidance phases tend to alternate within each individual, although the time length of each phase and the timing of the cycles vary from individual to individual (Herman, 1992; Horowitz, 1975, 1976, 1980).

Finally, arousal symptoms include sleep problems, irritability, concentration difficulties, hypervigilance, and an exaggerated startle response.

Comorbidity

Although the depressive and anxiety disorders are separate disorders distinct from PTSD, many of the symptoms of these disorders overlap significantly with those of PTSD. Specifically, many of the avoidance symptoms of PTSD, such as social withdrawal and general emotional numbing, overlap with symptoms associated with depressive disorders, and a number of the arousal symptoms overlap with those of anxiety disorders. Furthermore, these disorders, as distinct diagnostic entities, are commonly found as comorbid conditions among trauma victims with PTSD diagnoses (American Psychiatric Association, 1987; McGrath, Keita, Strickland, & Russo, 1990).

A Related Diagnosis: Acute Stress Disorder

A new diagnosis, Acute Stress Disorder (American Psychiatric Association, 1993), has been proposed for DSM-IV. This diagnosis represents a pattern of response similar to that proposed for Posttraumatic Stress Disorder but with greater emphasis on the dissociation present during or immediately after the traumatic experience. Further, the duration of overall symptoms must be more than 2 days but less than 4 weeks. The Acute Stress Disorder diagnosis will assist in recognizing the acute

reactions of trauma victims, including battered women, during an acute physically or sexually abusive episode, *per se*, as well as shortly following.

Mediating and Moderating Influences

Even devastating, extremely traumatic events do not lead to PTSD in all persons exposed to them (Breslau, Davis, Andreski, & Peterson, 1991; Green, 1982). Whether a particular traumatic event will produce PTSD in a given individual is thought to depend on a number of factors. These include characteristics of the traumatic event (e.g., severity, presence of death threat) (Kilpatrick *et al.*, 1989; Riggs, Kilpatrick, & Resnick, 1992; Buydens-Branchey, Noumair, & Branchey, 1990; Houskamp & Foy, 1992); characteristics of the recovery environment (e.g., level of social support, response of institutional systems) (Harvey, 1992); and predisposing characteristics of the individual (e.g., psychological vulnerability) (Davidson & Foa, 1993; Green, Wilson & Lindy, 1985).

THE DIAGNOSIS OF PTSD IN BATTERED WOMEN

Although PTSD has long been used to explain trauma victims' responses to a broad range of traumatic conditions and events, its application to battered women is relatively recent. There are several reasons for this delayed application of the concept to battered women. First, early empirical work on PTSD focused almost exclusively on the psychological consequences of combat; only later did research expand to include the psychological impact of natural diasters and, still later, the effects of interpersonal violence (Herman, 1992).

Second, all but the most severe forms of domestic violence were perceived until recently as normal, or at least normative: that is, the phenomenon was not considered "outside the range of usual human experience" (Dutton, 1992a; Koss *et al.*, in press). Further, even when the occurrence of domestic violence was recognized, its psychological sequelae, as experienced by its victims, were not thought to be "markedly distressing to almost anyone", as required by DSM-III-R for a PTSD diagnosis.

Third, especially within the legal system, battered women are often considered to be as violent, or at least as culpable, as their male partners (Saunders, 1986). For example, judges often use a mutual restraining order against a battered woman (Pagelow, 1992) even when her abusive partner has not filed a petition requesting it.

Fourth, the psychological problems experienced by battered women frequently have been portrayed as causes, rather than effects of battering (Schechter, 1982). This tendency made feminist scholars and clinicians initially reluctant to apply any clinical diagnosis that might be construed as additional grounds for treating battered women as the authors of their own misfortune (Dutton, 1992a).

Finally, the complex array of psychological distress and physical symptoms often experienced by battered women and other female crime victims (Koss & Heslet, 1992; Kilpatrick & Resnick, 1993; Herman, 1992) has sometimes been mistaken by clinicians and researchers for problems unrelated to the exposure to violence. Only recently have an array of psychological problems been recognized as complex

sequelae to chronic traumatic events (Herman, 1992) or as associated features of PTSD (Kilpatrick & Resnick, 1993). For example, based on a national probability sample of 2,009 women, Kilpatrick and Resnick (1993) determined that "irrespective of PTSD status, being a crime victim increased the risk of both serious alcohol and serious drug use problems" (p. 134). Without this sort of recognition, the alcohol and drug problems of battered women might not be linked, where appropriate, to their histories of abuse.

Domestic Abuse as a Traumatic Event

As noted above, DSM-III-R describes the most common traumata as including actual or threatened harm to one's self, relatives or close friends, or the witnessing of harm to another (American Psychiatric Association, 1987, p. 247–48). Physical and psychological harm to one's self and the witnessing of harm to others are common features of battering relationships (Browne, 1993; Dutton, 1992a), which may include physical, sexual, and psychological abuse.

Physical abuse may consist of an entire range of behaviors including single slaps, repeated beatings, stabbings, or shootings (Browne, 1993) which may result in multiple injuries to the face, head, neck, breast, or abdomen (Randall, 1990). Physical violence has been reported to occur in all forms of intimate relationships, including marital (Straus & Gelles, 1990), same-sex (Island & Letellier, 1991; Renzetti, 1992), college (Kiernan & Taylor, 1990; Pedersen & Thomas, 1992; Riggs, 1993; Stets & Pirog-Good, 1989; White & Koss, 1992) and high school (Bergman, 1992) couples. Further, in one study that compared battered women seeking help from a mental health clinic with those who had been charged with homicide-related crimes against their abusers, both groups were found to have experienced high rates of punching (67% vs. 88%, respectively), kicking (47% vs. 48%), strangling (55% vs. 61%), and prior use of gun (39% vs. 20%) or knife (27% vs. 13%) (Dutton, Hohnecker, Halle, & Burghardt, in press). Battered women also may be forced by their abusers to abuse others, such as their children (Herman, 1992).

Sexual abuse, another form of trauma experienced by women in intimate relationships, has gone largely unrecognized. Between 32% and 61% of physically battered women have also been sexually abused by their male partners (Dutton *et al.*, in press; Shields, Resick, & Hanneke, 1990; Walker, 1984). Sexual abuse also occurs among those who have not been physically abused by their partners (Finkelhor & Yllo, 1985; Russell, 1982). Further, for approximately 26% of rape victims in one study, the perpetrator was identified as a husband or male lover (George & Winfield-Laird, 1986). Finally, both high school (Bergman, 1992) and college (Finley & Corty, 1993; Koss, 1992; Koss, Gidycz, & Wisniewski, 1987; Mills & Granhoff, 1992; Ogletree, 1993; Stets & Pirog-Good, 1989) students have reported sexual abuse by their male dating partners.

Threats of violence are also a common feature of battering relationships. Indeed, batterers often use threats as a means of exercising extensive coercive control over their victims, placing the victims in a virtual "state of siege" since they may feel that they need to remain on guard continually. A batterer may explicitly threaten to kill or assault the woman or her children, family or friends. A batterer may threaten to abandon the woman, leave her in financial ruin, or, by means of a legal custody battle or kidnapping, take the children so that she may never see them again. Battered

women may literally be held captive by their abusers, not allowed to leave the house or even a given room. Batterers may also hold their victims accountable to them for their every move—for example, by requiring them to report odometer readings, account for time to the minute, or ask permission before leaving the house. Sometimes the behavior of batterers toward their victims can even be compared to the torture of hostage victims (Graham, Rawlings & Rimini, 1988; Scrignar, 1988).

Finally, batterers also threaten battered women in more subtle ways, such as the capricious enforcement of petty rules or subtle gestures or silences that unmistakably signal his potential for violence to the woman who is well-practiced in reading the batterer's behavior (Dutton, 1992a,b; Herman, 1992). Over time, the batterer's behavior forms a cohesive pattern of coercive control that varies across batterers as to the specific configuration of "verbal abuse, threats, psychological manipulation, control over economic resources, physical battering, and sexual coercion that defines the pattern" (Buel, 1993, p. 6).

PTSD Symptomatology in Battered Women

Studies focusing on the psychological sequelae of violence and abuse in intimate relationships have found that battered women are often diagnosed with PTSD. In the past decade, researchers and women's advocacy groups have highlighted the prevalence of serious domestic violence (see Browne, 1993 for a review) and studies have documented high rates of PTSD among battered women, for example, 31% to 60% (Cimino & Dutton, 1991; Gleason, 1993; Houskamp & Foy, 1991) of battered women seeking help from domestic violence programs while living at home and 40% to 89% (Gleason, 1993; Kemp, Rawlings, & Green, 1991; West, Fernandez, Hillard, & Schoof, 1990) of those living in a battered women's shelter met PTSD criteria. When the trauma is a sexual assault, the rate of PTSD among victims has been shown to range from 35% (community sample) to 60% (agency-referred sample) one month postrape; even when the postrape period extended to 15 years, the rate of PTSD remained at 12.5% to 16.5% (Kilpatrick & Resnick, 1993). Today, there is little question that some, although not all, women who have been physically and/or sexually assaulted by their partners experience aftereffects that make PTSD an appropriate diagnosis for them (Herman, 1992).

Critique of the PTSD Diagnosis As Applied to Battered Women

Advantages

The PTSD diagnosis has a number of important advantages for characterizing a portion of the experience of some battered women. First, the diagnostic entity of PTSD is a parsimonious frame for describing some of the psychological sequelae of battering because it integrates a number of disparate symptoms and at the same time differentiates them from other psychological difficulties (McCann & Pearlman, 1990; Murran & Motta, 1993). As a framework that establishes a relationship between previously isolated symptoms, the PTSD diagnosis provides a context for theoretical model development (Goodman *et al.* 1993b). Behavior (e.g., anger, social withdrawal, hypervigilance) that may have been erroneously attributed to other fac-

tors (e.g., personality disorders) can, where appropriate, be more accurately understood in the context of a traumatic reaction to a history of battering and abuse.

Second, recognizing some of battered women's reactions as PTSD enables health professionals to borrow from the rich and rapidly developing body of empirical and theoretical literature on PTSD in other populations in order to aid battered women (Goodman *et al.*, 1993b). Understanding battered women's reactions to violence within this broader context can potentially help to combat the gender bias often associated with domestic violence.

Third, because PTSD describes a set of expected or normal responses to an abnormal event, a PTSD diagnosis should not carry the stigma often associated with other psychological disorders. On the contrary, it places battered women in the company of war veterans, former hostages, plane crash victims, and other trauma survivors who typically are perceived as innocent victims of tragic circumstances. Even so, battered women have been further stigmatized, particularly within the legal system when, for example, they are ruled as unfit parents because of their PTSD diagnosis and forced to give up custody of their children to the battering partner.

Limitations

The PTSD diagnosis also has significant limitations, even considering that it characterizes only a subset of some battered women's experiences (Dutton, in press; Larsen, 1992).

One relatively superficial limitation is the DSM-III-R definition of traumatic events as those "outside the range of usual human experience" (American Psychiatric Association, 1987, p. 247). The DSM-III-R definition can be read to exclude partner violence, given its prevalence among women in this country (Goodman *et al.*, 1993b). An integrative analysis of the most prominent studies in the field suggests that between 21% and 34% of women in this country will be physically assaulted by an intimate adult partner (Browne, 1993), thus indicating that such assaults are hardly unusual. This problem is less serious when the word "usual" in the PTSD definition is understood to mean "normal" rather than "typical." Further, the DSM-IV draft criteria (American Psychiatric Association, 1993) modify the stressor criteria referred to earlier to include "actual or threatened death or serious injury, or a threat to the physical integrity of oneself or others" (American Psychiatric Association, 1993, p. K:8), thus largely resolving the problem.

A more profound limitation of the PTSD diagnosis is that inclusionary criteria for PTSD are structured to describe most clearly situations in which the primary stressor is no longer present. Women faced with ongoing threat or danger may not fit neatly into this picture (Herman, 1992). Studies show that during and immediately following an assault, women experience reactions of shock, denial, withdrawal, confusion, psychological numbing, fear, and dissociation including partial amnesia (Browne, 1987; Koss *et al.*, in press; Spiegel, 1993; Walker, 1984). These reactions may precede PTSD symptoms which emerge only once the ongoing threat of danger ceases.

Similarly, the PTSD diagnosis captures the psychological sequelae of a single traumatic event or a circumscribed set of events better than it does chronic abusive conditions such as ongoing battering (Dutton, 1992a,b; Herman, 1992). For example, identifying symptoms which were "not present before the trauma" (American

Psychiatric Association, 987, p. 250) presents a particular challenge when physical and/or sexual abuse has been present during most of a long-term relationship extending over many years, or when domestic violence is superimposed upon previous traumas (e.g., prior physical or sexual abuse by former partner, date rape, or even experiences such as accidents or natural disasters) especially when they have occurred early in the life of the victim (e.g., childhood sexual or physical abuse, tragic loss of parent).

Although a PTSD diagnosis accounts for many of the psychological sequelae manifested by victims of partner violence, it currently excludes certain posttraumatic symptoms that may be prevalent in battered women, especially those whose abuse has been chronic. These include the multiplicity of symptoms, somatization, and alterations in affect regulation and consciousness that frequently result from being subjected "to totalitarian control over a prolonged period (months to years)" (Herman, 1992, p. 121). Herman (1992) recently proposed an alternative diagnosis, Disorder of Extreme Stress Not Otherwise Specified (DESNOS), that would incorporate these symptoms.

Finally, PTSD does not account for battered women's psychological reactions to violence in yet another way. The psychological impact of violence and abuse on women's lives is not limited to descriptions of clinical diagnosis (e.g., PTSD); it also includes changes to women's cognitions (Blackman, 1989; Janoff-Bulman, 1992; McCann & Pearlman, 1990) and psychological reactions that, despite their level of intensity, do not meet criteria for clinical diagnoses. Cognitions that may be transformed as a result of partner violence include perceptions of safety or vulnerability (Janoff-Bulman, 1992), expectations regarding future violence (Dutton, in press), views of oneself (Peterson & Seligman, 1983), perceptions of the ability to control violence (Foa, Zinbarg, & Rothbaum, 1992), perceptions of available alternatives; level of tolerance for abuse (Blackman, 1989), and beliefs about the trustworthiness and powerfulness of others (McCann & Pearlman, 1990). In Herman's (1992) DESNOS, these are categorized as changes in self-perception, perceptions of perpetrator, relations with others, and systems of meaning. Transformations in these cognitive domains are not necessarily pathological; they often represent generalizations or accurate reappraisals based on actual prior experience with violence and abuse (Dutton, in press). Similarly, while intense reactions of fear/terror or anger/rage, alone, do not constitute a clinical diagnosis they are not only predicable psychological sequelae of victimization, but may be relevant to litigation as well.

PTSD IN LITIGATION INVOLVING BATTERED WOMEN

Expert testimony concerning the nature and extent of domestic violence and women's reactions to it (Dutton, in press) has been admitted in the courtroom in both criminal and civil cases (Harvard Law Review, 1993; Maguigan, 1991). Depending upon the scope of testimony ruled admissible (see Maguigan, 1991 for review issues concerning admissibility by state), expert testimony in the courtroom may be used to explain both domestic violence and its effects, both generally and in a particular battered woman's violent situation. In the latter case, expert testimony would refer to a woman's particular domestic violence history and her unique configuration

of responses to it. This kind of testimony, of course, would require an individual face-to-face evaluation of the battered woman and a review of documents specific to her case.

Below, we review the various ways in which PTSD may be utilized in expert testimony regarding battered women, and discuss some of its limitations within the legal context. We begin with a discussion of expert testimony in general and then turn to a discussion of expert testimony with regard to specific elements of substantive law.

General Issues

There are a number of overarching or general issues commonly addressed in expert testimony across most or all of the various types of legal cases (e.g., criminal, civil tort, marital dissolution and/or child custody and visitation, failure to protect, neglect, or child abuse) regardless of the specific legal elements of substantive law in a particular type of legal action. These issues can be addressed in a specific case based on an individual evaluation of a particular battered woman and/or on information derived from relevant literature by asking the following (Dutton, in press): (1) What is the nature and extent of violent and abusive behavior, including the psychology of the domestic violence perpetrator? (2) What are the strategies used by battered women for responding to violence and abuse, namely what efforts do they use to avoid abuse, escape, or protect themselves and their children? (3) What is the psychological impact on battered women and their children (or other family members) that results from living with violence and abuse (including the broad range of possible psychological sequelae of abuse described earlier)? (4) How does the context in which a battered woman lives (e.g., socioeconomic status; presence of children and others for whose care the battered woman may be responsible; cultural background, race, or ethnicity; urban, rural, or suburban residence; homelessness; educational background and employment status; physical limitations and health status; sexual preference; age; immigration status etc.) affect each of these categories: (a) the risk of exposure to violence, (b) the strategies used to respond to violence and abuse, and (c) the psychological impact of victimization by domestic violence?

The information obtained in response to these questions can inform the factfinder about "puzzling" aspects (Maguigan, 1991) of battered women's behavior (e.g., why she didn't leave, call the police, or tell anyone or someone in particular about the violence; why she left the children with the batterer; why she appeared to be angry and/or seemingly unafraid in public). Moreover, the responses to these questions assist the factfinder in deconstructing myths and stereotypes concerning both battered women (e.g., all battered women are helpless; an economically independent woman cannot be battered or she would leave; owning a firearm is inconsistent with being a battering victim; a woman who is physically larger than her partner is not at risk for battering; women with a history of alcohol or drug use, promiscuity or prostitution, who have a criminal record, or have been trained as police officers cannot be considered "legitimate" battered women) and violent perpetrators (e.g., men who are known by their friends to be calm and peaceful do not batter their partners; professional, educated, prominent community leaders do not batter their intimate partners; all batterers are alcoholic or all alcoholics are batterers). Without providing adequate information to address these issues in a particular case, such

myths and stereotypes can be used to attack a battered woman's credibility and/or to imply culpability in her own victimization.

It should be noted from the start, however, that in spite of commonalities, not all battered women's experience with abuse is alike and certainly not all battered women respond to violence in the same manner (Mahoney, 1992). The inevitable variability in women's response to violence must be understood alongside the common features of victimization.

Even though the physical, sexual, and psychological abuse defining domestic violence often results in serious psychological symptoms, including those of PTSD, such is not always the case. When PTSD is not diagnosed in a particular battered woman, it does not mean that testimony concerning domestic violence, or even the psychological sequelae to it, is not useful. It may mean that while PTSD is not applicable, other aspects of the battered woman's psychological or strategic response to violence are relevant.

Further, when only partial symptoms of PTSD are present (e.g., posttraumatic stress syndrome (Blank, 1992)) or when PTSD was present at some point, but not currently, testimony concerning the battered woman's response to violence may still be relevant. Particular PTSD symptoms, but not the full spectrum of the diagnostic category may be adequate, and even most on point, for addressing a specific legal question. Further, the full range of PTSD diagnostic criteria is not required for explaining the battered woman's behavior most of the time.

Nature and Extent of Domestic Violence

An issue which sometimes arises in cases involving domestic violence is the issue of corroboration of a victim's testimony concerning violence in her relationship, especially when other available evidence (e.g., police reports, hospital records, witness statements) is unavailable or inconclusive.

PTSD, when diagnosed as relating to the violence and abuse of a particular battering relationship, may be offered to corroborate a battered woman's testimony, depending upon the limits of admissibility. In a clinical context, when PTSD specific to a particular traumatic event or experience is identified, the existence of the stressor is presumed; its probative value, however, is less clear (Simon, in press).

A caution should be noted, however, about the use of PTSD to corroborate the occurrence of violence. The presence of PTSD is not necessary to demonstrate that the traumatic event in question actually occurred since not all trauma victims develop PTSD and since PTSD symptoms, even where present, diminish or abate over time. Thus, a serious risk of utilizing the presence of PTSD as an indicator that domestic violence occurred is the unintended effect of establishing it as a threshold criterion. To illustrate, in one case where "there was conflicting testimony of alleged domestic abuse" and expert opinions indicated that the battered woman "did not show signs of battered woman syndrome", the court ruled that "no domestic abuse had occurred" (Bjerke v. Bacon, 1993 p. 31). In sum, although the presence of PTSD may be construed as support for an allegation of prior domestic violence, the absence of PTSD does not likewise indicate that such violence has not occurred.

Strategies for Responding to Violence and Abuse

Expert testimony regarding the battered woman's prior attempts to avoid abuse, escape, or protect herself and her children from ongoing and future violence is commonly offered in cases involving domestic violence. The often asked questions — "Why didn't she just leave?" "Why did she return home after having separated?" "Why didn't she call the police?" "Why didn't she tell anyone about the violence?" — are sometimes used to suggest that the strategies a battered woman used in her attempts to protect herself from her batterer should have been different and would have resulted in her safety.

PTSD can be relevant to the issues of the battered woman's strategies for responding to violence and abuse, although an explanation for these strategies more often rests solidly on other factors (e.g., the nature of the violence itself, economic resources, outcome of prior attempts in responding to the violence). Nevertheless, a battered woman's diagnosis of PTSD may be relevant for explaining both why she did not take various actions as well as why certain strategies were used.

The cluster of avoidance symptoms that are part of the PTSD diagnosis help to explain why battered women may not engage in attempts to protect themselves in ways others might expect (e.g., calling police, telling others, going to a shelter). When a battered woman's psychological response to violence includes denial, numbing, or minimization of the effects of abuse, she is less likely to acknowledge the abuse to herself, name it for others, or seek help in responding to it. For example, if a battered woman has had a pregnancy terminated as a result of a beating by her partner, she may be unable to report the pregnancy or its termination to her physician even when asked specifically about a prior pregnancy. To do so would be to admit the reality of her situation. For some women, accepting the psychological reality that an intimate partner has engaged in life threatening behavior is not automatic.

Intrusive symptoms of PTSD help to explain a woman's seemingly "unnecessary" attempts to protect herself. Intrusion symptoms of PTSD may be triggered by a batterer's behavior even when he is not engaging in actual threatening behavior at that moment. That is, given exposure to violent behavior in the past, certain behaviors such as specific verbal responses (e.g., yelling obscenities that had previously been paired with violence) or gestures (e.g., pounding fist on table) may trigger a PTSD reaction, even when there is no actual danger. Intrusive symptoms may lead a battered woman to believe that she must take immediate action to protect herself (e.g., threaten with a weapon, fight back, call police). Her subjective experience (e.g., PTSD symptomology) in this example would have been jointly determined by her prior experience with actual violence and by the immediate "triggering" behaviors.

PTSD resulting from a violent experience unrelated to a woman's current partner (e.g., violence in a previous marriage, prior rape, abuse by a parent) could be triggered by that partner even though he or she was not the original, or the most serious, perpetrator, or, in some cases, ever a perpetrator. It is important that these examples be distinguished from two other types of cases, one in which a battered woman's perception of danger is based on actual cues learned to be discriminative of violence or abuse from prior violent episodes with that same person. The second type of case is when a PTSD reaction may exacerbate an independently existing perception

of real danger, even if she is also diagnosed with PTSD related to domestic violence with this partner.

Psychological Impact of Violence and Abuse

Exposure to domestic violence and abuse may or may not result in psychological reactions diagnosed as clinical symptoms. When clinical symptoms are evident, they may or may not include those found in the diagnosis of PTSD. Nonetheless, when PTSD is diagnosed for a particular battered woman, its relation to domestic violence is important to understand. PTSD may either be caused exclusively by a history of violence and abuse by an intimate partner or by a combination of events including, but not limited to, domestic violence. Predisposing factors (e.g., history of child abuse) may increase the risk for development of PTSD later in life, but do not negate the influence of the current traumatic stress (e.g., battering).

One of the clearest indicators that PTSD is etiologically linked to domestic violence can be found through a close examination of the intrusion symptoms of PTSD. Each of the five symptoms indicated within the category of intrusion symptoms refer to reactions linked directly to a specific traumatic event or reminders of that event—in this case, one or more instances of violence and abuse. Some of these symptoms are "recurrent or intrusive distressing recollections . . .or dreams . . .acting or feeling as if the traumatic event were recurring, physiological reactivity upon exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event" (American Psychiatric Association, 1987, p. 250; American Psychiatric Association, 1993, p. K:8). Specific details of the cognitive representation of, affect surrounding, and physiological reaction to specific events, persons, or situations are important in substantiating that intrusion symptoms are present and that they are linked to the domestic violence.

Another indication that a diagnosis of PTSD is linked specifically to the trauma of domestic violence may derive from three of the seven PTSD avoidance symptoms: (1) "efforts to avoid thoughts, feelings or conversations associated with the trauma", (2) "efforts to avoid activities, places, or people that arouse recollections of the trauma," and (3) an "inability to recall an important aspect of the trauma" (American Psychiatric Association, 993, p. K:8). Like the intrusive symptoms above, these avoidance symptoms are specific to particular events, persons, or situations.

The remaining avoidance and arousal symptoms are not linked in content, but are linked temporally, to a specific traumatic event. When the occurrence of domestic violence is relatively short-term and recent, determining the onset of these symptoms may provide another causal link to domestic violence. That is the symptoms *per se*—"difficulty falling or staying asleep . . . difficulty concentrating . . .irritability or outbursts of anger . . . feeling of detachment or estrangement from others . . .or markedly diminished interest or participation in significant activities (American Psychiatric Association, 1993, pp. K:8–9)—do not refer to a specific traumatic event. They are, however, considered to be caused by exposure to the traumatic event and thus emerge subsequent to it. When domestic violence escalates in severity and frequency over time, it may be more difficult to determine the exact onset of these symptoms since they also may develop over time.

In some cases, PTSD resulting from domestic violence may exist alongside another condition, also resulting from domestic violence or unrelated to it. These other

diagnoses may include a neuropsychological condition (e.g., Post Concussion Syndrome resulting from head trauma), the symptoms of which are similar to those of PTSD. Additionally, at the time of the onset of domestic violence, a battered woman may already be experiencing PTSD related to a prior trauma (e.g., childhood sexual abuse, previous rape, natural disaster). Further, another psychological disorder (e.g., Major Depressive Disorder, Generalized Anxiety Disorder) may predate the onset of domestic violence or it may be a concurrent effect of it. In sum, a diagnosis of PTSD does not presume a completely healthy individual untouched by prior adversity (Simon, in press), nor that it alone represents the entire spectrum of psychological sequelae to abuse.

Explaining "Puzzling" Aspects of Battered Women's Behavior

Symptoms of PTSD may also be important in explaining other "puzzling" aspects of the battered woman's behavior thought to be relevant to the legal questions at issue. For example, in some homicide cases, the battered woman may repeatedly shoot or stab the batterer even though he is incapacitated or even dead. One argument made is that such behavior suggests that the battered woman, therefore, is "cold-blooded," revengeful, or has premeditated the killing. One alternative and often more plausible explanation relevant to PTSD is that certain features of a traumatic stress reaction (e.g., intrusive symptoms, numbing or dissociative avoidance symptoms of PTSD), have left the battered woman unable clearly to calculate the minimum level of force necessary to provide protection. When a battered woman is experiencing intrusive symptoms, she may respond not only to the actual behavior of the batterer at that moment, but also to the "experience" of abuse relived in her mind and body.

Another puzzling aspect of battered women's behavior is that at times, they appear to act as if nothing is wrong. This can occur either in or outside the presence of the batterer (e.g., on the dance floor, at a social engagement, in the couple's home). Although there may be a number of explanations, an important one relies on the avoidance symptoms of PTSD to understand the battered woman's conscious and unconscious efforts to avoid thinking, feeling, or acting as if the violence had occurred. Thus, her apparently "normal" behavior may camouflage the violence to herself as well as to others.

Intrusive symptoms of PTSD resulting from domestic violence may be triggered by police interrogation or other questioning. When law enforcement officers or other male authority figures use raised voices, intimidation, aggressive gestures or similar acts, they may trigger feelings or memories associated with previously occurring trauma of domestic violence. Thus, a battered woman's response to these persons may be similar to the way she responds to her abuser. For example, she may comply even with suggestions of having engaged in behavior she did not (e.g., "false confessions"); she may become angry and risk arrest herself; or, she may withdraw and say very little about the circumstances of the events, even when such statements would be helpful to her.

Addressing myths and stereotypes of battered women

A final use of PTSD is to address myths and stereotypes about both battering victims and their abusers. Battered women do not conform to a stereotypic image; rather, they vary dramatically from each other (e.g., based on such factors as physical size, social class and available economic resources, social support, children, prior history, employment and educational level, minority class membership etc.). Some have argued that when a women does not fit the stereotypic image of a battered woman (e.g., when she is physically large, economically independent, skilled at operating a firearm, or able to exhibit anger toward the batterer in public) she cannot have been battered. Or, when the evidence of battering is clear (e.g., through hospital or police records), the woman is often blamed for her own victimization in some way. For example, when a woman does not fit the stereotype of a "good woman" (e.g., when she has been or is a prostitute, has a history of alcohol and drug use, or has a criminal record), she may be considered to "deserve" the battering, even if she did not cause it.

In some cases, PTSD may be relevant for deconstructing the battered woman stereotype, thus enabling the factfinder to reasonably weigh the relevant information to determine a battered woman's role in the legal issue at hand (e.g., criminal charge, custody determination, tort claim). For example, an angry woman defies the stereotype of a battered woman, and unless the factfinder understands that expressions of "irritability and outbursts of anger" (American Psychiatric Association, 1987, p. 250) are not only "normal" reactions to trauma, such a presentation may be inappropriately judged. Further, certain avoidance responses characteristic of PTSD (e.g., "efforts to avoid thoughts or feelings associated with the trauma" (American Psychiatric Association, 1987, p. 250)) may be facilitated by a battered woman's excessive use of alcohol and/or drugs, regardless of when her substance abuse began. Finally, a battered woman's behavior may be understood as indicative of a serious mental disorder—i.e., that she is, after all, just "crazy," not battered. When PTSD symptoms are severe, the trauma victim may not be capable of adequately functioning for a period of time. A combination of severe intrusive reactions, severe hypervigilance, and intense physiological reactivity may lead untrained or inexperienced professionals and lay persons alike to attribute these differences to a mental illness, thereby failing to connect such behavior to a severe victimization history.

Issues Specific to Substantive Law

In addition to the overarching issues described above, expert testimony is also offered to address specific issues of substantive law defined by the particular type of legal case at hand—e.g., criminal, tort, child custody, failure to protect, or child abuse.

Criminal cases

In criminal self-defense cases, PTSD may be relevant to the key legal elements of "reasonableness," "imminence," and "equal force" (Maguigan, 1991). For example, both intrusion and arousal symptoms of PTSD may help explain why it was reasonable, when it was not otherwise apparent, for a battered woman to perceive herself to be in danger. That is, her experience of "acting or feeling as if the traumatic event were recurring" (American Psychiatric Association, 1993, p. K:8), "physiologi-

cal reactivity (e.g., sweating, heart palpitations or racing) upon exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event" (American Psychiatric Association, p. K:8), or an "exaggerated startle response" may contribute to a battered woman's "reasonable" perception that she was in great danger. Differences in "subjective" and "objective" standards of reasonableness, which vary from state to state, must also be considered (Maguigan, 1991).

Another legal element of self-defense, "imminence" of the threat to which the woman was responding, may also be addressed by the presence of certain PTSD symptoms, including an exaggerated startle response, physiologic arousal, and "reliving" the trauma (e.g., acting or feeling as if the traumatic event were recurring). These symptoms or reactions are sudden; for example, the heart is pounding, hyperventilation or dizziness begins. The reaction is now, not merely remembered. In these examples, the PTSD victim's immediate reaction becomes an understandable response. Accounts of Vietnam veterans taking cover in their own backyard upon hearing a plane overhead is a related type of example.

A cautionary comment should be made here: Battered women are often taking natural and reasonable action to protect themselves. In some cases, experts need not, and should not, resort to mental illness diagnoses, including PTSD, in order to explain battered women's behavior (Bowker, 1993). When a battered woman's reaction to violence is framed as a "syndrome" or "disorder," the unintended result may be that the expert witness constructs an image of pathology or diminished capacity when it may be not only inaccurate, but indeed the opposite of what is intended (Dutton, in press). Thus, it should be stated that for many women the perception of reasonableness of danger is based not on symptoms of PTSD, but on a finely-tuned, acquired ability to recognize such danger, based on repeated opportunities to do so often over a lengthy period of time. Moreover, the perceived need to act immediately may reflect the battered woman's recognition that she cannot stop the violence once it begins and, thus, must act to protect herself (and/or her children) when she has the opportunity to do so.

Some battered women are coerced by various threats to engage in unlawful behavior for which they are criminally charged. Even when explicit force or threat of force is not immediately present during the commission of a crime, many of the intrusion symptoms of PTSD (with the exception of dreams) may operate to place the battered women in a psychological reality in which she feels forced to engage in such behavior. Thus, for example, intrusive recollections of prior abusive events, feeling as if the violence were recurring, or reacting with psychological distress or physiological reactivity to internal or external cues of the abuse may effectively provide the coercion necessary to obtain compliance to a batterer's demands, even without the immediate use of violence.

Civil Tort Cases

In civil tort cases brought by domestic violence victims against their batterers, PTSD may be useful in expert testimony offered in support of a claim of intentional infliction of emotional distress. In such testimony, the expert may address the liability phase issues of intent—i.e., whether the violence and/or abuse was "extreme and outrageous" (Restatement 2d on Torts, 1992) and whether the victim suffered as a result of it. An expert witness may also provide testimony relevant to the damages phase

of the legal action, where an evaluation of the posttraumatic effects of domestic violence for a particular battered woman is necessary.

Child custody

Testimony concerning PTSD in cases of child custody may be used to substantiate a presumption against a parent who has engaged in domestic violence; to challenge the allegation that the battered woman is an unfit parent; to argue for sole custody of a child; or to negate charges of failure to protect, neglect, or child abuse. Of course, a battered woman's diagnosis of PTSD does not automatically lead to a favorable disposition in child custody cases, nor should it. However, the symptoms of PTSD resulting from domestic violence that jeopardize a battered woman's parental rights (e.g., failure to protect a child from an abusive parent due to avoidance symptoms, angry outburst toward a child) can be expected to diminish or cease altogether once violence and abuse are no longer a threat.

Consideration should also be given to the notion that challenges to child custody and visitation arrangements are sometimes made by an abusive parent as a means of continuing the abusive control exercised over the battered woman. It is thus necessary to determine the extent to which behavior alleged against a battered woman may require explanation through the construct of PTSD (or any other psychological mechanism) or is more accurately characterized as a misrepresentation by a battering partner who continues the cycle of power and control through the child custody litigation.

Failure to protect/child abuse

In cases where a battered woman is charged with failure to protect, neglect, abandonment, or child abuse, PTSD may be used in expert testimony to explain a mother's behavior in the context of an abusive family environment. A battered woman's inability to stop a batterer's violent or abusive behavior may have placed a child at risk or resulted in actual physical or sexual abuse to a child. Although a child in this case clearly requires adequate protection, the problem may better be addressed by understanding the maltreatment of the child in the overall context of domestic violence.

Beyond the fear engendered by domestic violence, PTSD may be relevant to a battered woman's failure to protect her child. A battered woman whose avoidance symptoms are severe may fail to acknowledge the extent of risk to the child and thus not attempt to provide adequate protection, assuming it was possible to do so. This may be especially true when the abuse to the child occurs outside the presence of the mother and the denial of that possibility may be easier.

Sometimes battered women abuse or even kill their own children. There are many possible explanations for this behavior, but PTSD may be relevant in some cases. For example, in cases of severe PTSD, both the battered woman's rage and use of alcohol or drugs to numb her own feelings of victimization may contribute to her harming her own children.

CONCLUSION

PTSD can be an important explanatory construct in legal issues involving battered women. PTSD is not an excuse for bad behavior. It can, however, assist a psychological expert witness in illuminating for the factfinder a more complete understanding of a battered woman's actions within the legal context in question. Without the benefit of such information, the factfinder may unintentionally mislabel, misconstrue, or misunderstand numerous aspects of a battered woman's situation, including her behavior.

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