

Author's Disclaimer: Divergent views on Posttraumatic Stress Disorder (PTSD) are underscored by recent efforts to revise the clinical diagnostic criteria. As a result of inconsistent perspectives on diagnosis or treatment, authors are hard-pressed to identify a single or perfect solution to the problem. Legal organizations may desire to approach the attorney's role in a cautious manner, limiting the attorney's response to decisional impairments that stem from PTSD symptoms. This article represents only the individual views of the author. The author was not directed to write this article in his military capacity and wrote it on his own time. By surveying assessment and counseling techniques and suggesting how attorneys might benefit from them, this article does not suggest that these approaches must or should be adopted by all attorneys providing legal services to clients. This article previews the possibilities of an enhanced client counseling role with the hope that consideration of these ideas will enrich the dialogue in the military and civilian sector on the best ways to serve clients with unique needs.

**ATTORNEYS AS FIRST-RESPONDERS: RECOGNIZING THE
DESTRUCTIVE NATURE OF POSTTRAUMATIC STRESS
DISORDER ON THE COMBAT VETERAN'S* LEGAL
DECISION-MAKING PROCESS†**

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* The term "veteran," as used in this article, refers to any person who has previously served or who is currently serving in the armed forces. Combat veterans consequently include servicemembers on active duty who have prior deployments.

† The author extends special thanks to Julia E. Urbanek, the European Medical Command, Lieutenant Colonel David T. Crawford, Todd L. Benham, Psy.D., Carol Salacka, Psy.D., MSN, Doris A. Boyd, ACSW, LCSW, Kimberly A. Hyatt, MSW, CIT, LCSW, Sandra Ward, LCSW, DCSW, Amanda Salisbury, LCSW, Brockton Hunter, Captain Greg O'Malley, Major Oren "Hank" McNelly, and Major Timothy P. Hayes.

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I. Introduction

Posttraumatic Stress Disorder (PTSD) is a stress and anxiety condition that results from exposure to an overwhelming traumatic event combined with feelings of utter helplessness.¹ At the most general level, PTSD exists when the trauma resurfaces over time in intrusive ways causing disruption in a person's thoughts and behaviors.² As a "signature" disability evaluation characterizing the Iraq and Afghanistan campaigns,³ PTSD has transformed many legal assistance and trial defense attorneys into first responders in the quest to ensure the well-being of these combat veterans.⁴ While some definitions limit the term "first responder" to emergency response personnel based on the entities

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¹ AM. PSYCHIATRIC ASS'N, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS 467–68 (text rev., 4th ed. 2000) [hereinafter DSM-IV-TR]; *infra* Part II (exploring the diagnostic criteria for PTSD); *infra* Captain Evan R. Seamone, *The Veteran's Lawyer as Counselor: Using Therapeutic Jurisprudence to Enhance Client Counseling for Combat Veterans with Posttraumatic Stress Disorder*, 202 MIL. L. REV. 185, 241–44, app. A (2009) (reprinting diagnostic criteria).

² See *infra* Part II; Seamone, *supra* note 1, app. A, at 241–42.

³ E.g., J. Ford Huffman, *True Stories of PTSD, Brain Injury Victims and Those Who Try to Help*, ARMY TIMES, http://www.armytimes.com/entertainment/books/offduty_book_battles_081409/ (last visited Dec. 18, 2009) (describing how clinicians now define the "combination of mild [Traumatic Brain Injury] with PTSD" as the "signature injury" of the wars in Afghanistan and Iraq).

⁴ In this sense, attorneys are much like Chaplains, who are also often forced to act as de facto counselors in order to compensate for the difficulty of mental health professionals in treating servicemembers with PTSD. Steven J. Danish & Bradley J. Antonides, *What Counseling Psychologists Can Do to Help Returning Veterans*, 37 COUNSELING PSYCHOLOGIST 1076, 1078 (2009).

that employ these professionals⁵ or official training completed,⁶ other definitions that consider the first responder's role cover a much broader spectrum of individuals. Just as Congress considers victim advocates first responders based on the fact that they are often the first persons to have contact with sexual assault victims,⁷ disaster planners and others recognize that attorneys sometimes serve as first responders.⁸ It is the lawyer's unique function in providing necessary legal services,⁹ or the relationship between the attorney's service and the client's relief from hardship and personal strife¹⁰ that accords this weighty title. Even those attorneys who prevent potential emergencies can nevertheless attain the status of first responder.¹¹

While mental health clinicians surely have the training to diagnose and treat combat veterans with PTSD, common obstacles prevent them from identifying and treating all servicemembers with this condition.¹² In fact, a great many Soldiers, Sailors, Airmen, and Marines are slipping

⁵ E.g., FLA. STAT. § 112.1815(1) (2009) (defining a "first responder" as "a law enforcement officer . . . , a firefighter . . . or an emergency medical technician or paramedic employed by the state or local government").

⁶ E.g., N.Y. PUB. HEALTH LAW § 3001(5) (Consol. 2009) (defining a "certified first responder" as one who has met "minimum [training] requirements" and "who is responsible for administration of initial life saving care of sick and injured persons").

⁷ E.g., National Defense Authorization Act for Fiscal Year 2006, Pub. L. No. 109-163, § 596(b)(1)(A), 119 Stat. 3136 (2006) (defining sexual assault first responders as "criminal investigators, medical personnel responsible for rape kit evidence collection, and victims advocates").

⁸ E.g., Scott Wylie, "After September 11: Disaster Preparedness: Document Protection Guidance for Lawyers and Their Clients," 44 ORANGE COUNTY LAW. 42, 44 (2002) ("Lawyers are often among the first responders after any major disaster in the United States—a fact unknown to many in our country.").

⁹ E.g., Sudha Shetty, *Equal Justice Under the Law: Myth or Reality for Immigrants and Refugees?*, 2 SEATTLE J. SOC. JUST. 565, 566–67 (2004) (recognizing that, the legal first responder has a responsibility to triage just like the medical first responder, which is satisfied in refugee cases when attorneys "assess . . . clients in . . . underserved communities where language and cultural barriers act as major barriers to accessing equal justice").

¹⁰ E.g., Nancy Cook, *Hurricane Katrina: The Storm Still Rages*, 56 R.I. B.J. 43, 43 (2008) (observing attorneys' status as first responders in the provision of various legal services to victims of Hurricane Katrina).

¹¹ See Shetty, *supra* note 9, at 566-67 (recognizing the attainment of first responder status is warranted when an attorney performs the function of "triage" in a population where existing legal problems have evaded conscious attention).

¹² Laura Savitsky et al., *Civilian Social Work: Serving the Military and Veteran Populations*, 54 SOCIAL WORK 327, 336 (2009) ("It is insufficient to assume that the care of service members, veterans, and their families will be adequately provided for by military and governmental systems.").

through the cracks.¹³ Whether an undiagnosed client's condition resulted from Delayed Onset PTSD, which was dormant for months before its symptoms surfaced,¹⁴ or the client's intentional efforts to mask her symptoms in an effort to appear strong or loyal to members of her military unit,¹⁵ these factors can easily transform her attorney into a PTSD First Responder. In these instances, first responder status arises from the legal counselor's uncommon access to the client's decision processes, personal history, and behavior, a combination of which can easily reveal PTSD symptoms or influence the client's evaluation of the attorney's advice.¹⁶ In fact, whether the visit to the lawyer's office comes as a result of domestic violence, financial issues, or abuse of controlled substances, both civilian and military attorneys will see an increasing number of PTSD victims due to the interrelationship between PTSD symptoms and these typical legal disputes.¹⁷

Many attorneys may not desire PTSD first responder status because the title implies a responsibility to "respond" to matters normally in the domain of licensed clinicians.¹⁸ Even for those few attorneys who do litigate matters facially related to PTSD, such as in the defense to a

¹³ "[A]lthough approximately 80% of Iraq and Afghanistan service members with a serious mental health disorder such as PTSD acknowledged that they had a problem, only approximately 40% stated that they were interested in receiving help." Brett T. Litz, *Research on the Impact of Military Trauma: Current Status and Future Directions*, 19 MIL. PSYCHOL. 217, 222 (2007). Of the respondents, "[o]nly 26% reported receiving formal mental health care." *Id.*

¹⁴ Delayed Onset PTSD describes a condition in which symptoms begin more than a month following the trauma. DSM-IV-TR, *supra* note 1, at 467-68. For further discussion see BRIDGET C. CANTRELL & CHUCK DEAN, *DOWN RANGE TO IRAQ AND BACK* 71-72 (2005).

¹⁵ See discussion *infra* note 54 and accompanying text.

¹⁶ See *infra* Part II.E.

¹⁷ Savitsky et al., *supra* note 12, at 329-34 (identifying, amongst other issues with obvious legal ramifications, interpersonal domestic violence, child abuse and neglect, substance abuse, and financial considerations, which could potentially lead to incarceration).

¹⁸ Such sentiments are representative of attorneys' general reluctance to transform into the role of a social worker. *E.g.*, Susan Diacoff, *Law as a Healing Profession: The "Comprehensive Law Movement,"* 6 PEPP. DISP. RESOL. L.J. 1, 59 (2006) (recognizing that "[t]he dominant, traditional approach found in the profession usually downplays, if not ignores," the client's feelings, emotions, and an attorney's involvement in addressing them"); Clare Huntington, *Repairing Family Law*, 57 DUKE L.J. 1245, 1311 (2008) (noting that "attorneys should not become therapists," even in heated family law disputes involving non-legal counseling).

criminal charge or efforts to obtain disability benefits,¹⁹ the condition is normally addressed solely through expert witnesses with the responsibility of diagnosis falling exclusively on the shoulders of the trained clinician.²⁰ The critics might argue that in those instances where PTSD is tied to the client's legal cause, the attorney meets her obligations of first response by advocating for the client's rights in a court of law. This article advocates otherwise. While PTSD sometimes falls squarely within the substantive legal matters in a case, it is more likely to arise beneath the surface, influencing the client's evaluation of the attorney's advice and the client's priorities in resolving the legal dispute. By virtue of the attorney's duties to maintain confidentiality, communicate information clearly, and maximize the client's well-being, it will forever remain the attorney's obligation to dispense legal advice independent of mental health professionals, thereby cementing the obligation of first (and sometimes only) response.²¹

At its heart, the problem is one of "framing," i.e., how lawyers perceive and identify important issues in a case.²² Inevitably, when we adopt a vantage point for viewing a legal issue or a decision, "our frames tend to focus on certain things while leaving others obscured."²³ Limited frames often and easily "force [us] to choose the wrong alternatives."²⁴

¹⁹ E.g., Rory E. Riley, *Preservation, Modification, or Transformation?: The Current State of the Department of Veterans Affairs Disability Benefits Adjudication Process and why Congress Should Modify, Rather than Maintain or Completely Redesign, the Current System*, 18 FED. CIR. B.J. 1, 9 (2008) (observing the increase in PTSD disability claims related to the campaigns in Iraq and Afghanistan and the highly complex nature of these cases).

²⁰ E.g., 38 C.F.R. § 3.159(a)(1) (2009) (articulating the VA's minimum standards for competent medical evidence from a person qualified to diagnose mental illness).

²¹ E.g., Brigid Coleman, Note, *Lawyers Who are Also Social Workers: How to Effectively Combine Two Different Disciplines to Better Serve Clients*, 7 WASH. U. J. L. & POL'Y 131, 144 (2001) (revealing that while attorneys have a duty provide clients with advice on personal courses of action, mental health providers operate from an opposing "self-determination" model that eschews an advisory role).

²² Not only is issue framing considered a "hallmark" of legal education, e.g., Adam Neufeld, *Costs of an Outdated Pedagogy? Study on Gender at Harvard Law School*, 13 AM. U. J. GENDER SOC. POL'Y & L. 511, 512-13 (2005) (observing the engrained nature of the "issue-spotter examination" in legal education), it is also indispensable in legal practice. E.g., Kathryn M. Stanchi, *Resistance is Futile: How Legal Writing Pedagogy Contributes to the Law's Marginalization of Outsider Voices*, 103 DICK. L. REV. 7, 23 (1998) ("Framing or characterizing the issue in law is an extremely important tool of advocacy because it dictates what facts are relevant, what law applies, and who wins.").

²³ J. EDWARD RUSSO & PAUL J.H. SCHOEMAKER, *DECISION TRAPS: THE TEN BARRIERS TO BRILLIANT DECISION-MAKING & HOW TO OVERCOME THEM* 19 (1989).

²⁴ *Id.* at 15.

By focusing on the ultimate legal issues in a case, lawyers may fail to consider less obvious issues that are nevertheless still related to the legal problem.²⁵ In the context of PTSD, this Ultimate Legal Issue frame concerns itself with expert testimony on the causal link between PTSD and military service or the client's past behavior but leaves little room for considerations of how PTSD might influence the client's legal decisions during legal counseling.²⁶ The resulting lack of concern for or knowledge of the effects of this disorder create a substantial risk that the attorney will be misled into believing that a client with PTSD either does not have the disorder or is not impaired by it.²⁷ Through this limited frame, even a well-meaning attorney can unknowingly contribute to the aggravation of a client's condition while believing she has fully satisfied her professional responsibilities.²⁸ In fact, attorneys who fail to

²⁵ The prioritization of ultimate legal issues, combined with lack of training on the intersection of mental health and client counseling, generates insensitivity to underlying mental health issues. *See, e.g.*, Judy H. Kluger et al., *The Impact of Problem Solving on the Lawyer's Role and Ethics*, 29 *FORDHAM URB. L.J.* 1892, 1918 (2002) (comments of Susan Hendricks) (observing that defense attorneys do not routinely attend training in "types of mental illness and their treatment" and, if polled "on their own knowledge of [mental health] issues, . . . a proud and significant percentage would tell you that they do not need to know about these topics because they are attorneys, defense attorneys, not social workers"); *id.* (observing that lack of knowledge of mental health issues "mak[es] it harder for [these same attorneys] to meet their ethical obligations to counsel clients fully").

²⁶ In criminal practice, the ultimate PTSD issue is normally limited to severity of the condition and the impact of the condition on the client's understanding of the charged criminal conduct. *E.g.*, Major Timothy P. Hayes, Jr., *Post-Traumatic Stress Disorder on Trial*, 191 *MIL. L. REV.* 67, 85–100 (2007) (describing standards for lack of mental responsibility or partial mental responsibility negating specific intent). In disability cases, the ultimate PTSD issue concerns the question of whether the onset of the condition is related to the client's military service. *E.g.*, Heathcote W. Wales, *Causation in Medicine and Law: The Plight of Iraq Veterans*, 35 *NEW. ENG. J. ON CRIM. & CIV. CONFINEMENT* 376–89 (2009) (describing the evidentiary hurdles posed by the causation requirements in establishing service connection for mental illness, including PTSD); *VETERANS BENEFITS MANUAL* 146–168 (Barton F. Stichman & Ronald B. Abrams eds., 2007) (describing a complex series of special considerations that apply to the evaluation of PTSD disability claims).

²⁷ *E.g.*, Rebecca J. Covarubias, *Lives in Defense Counsel's Hands: The Problems and Responsibilities of Defense Counsel Representing Mentally Ill or Mentally Retarded Capital Defendants*, 11 *SCHOLAR* 413, 443 (2009) (observing that counsel are often unable to discover a client's mental condition because "the attorney does not know how to identify the symptoms"); *see also* Evelyn Lundberg Stratton, *Solutions for the Mentally Ill in the Criminal Justice System*, 32 *CAPITAL U. L. REV.* 90, 102 (2004) (noting that the attorney's "perceptions are more accurate to the extent that he is trained and knows how to look for distortions in viewing and interpreting even simple behavior").

²⁸ Consider, for example, the trial defense counsel who advises an active duty servicemember regarding nonjudicial punishment. The attorney may believe that the

acknowledge their clients' PTSD symptoms or counter the effects of stress responses can cause harm beyond their clients' legal cause. Chief among other potential harms, the compounded stress of litigation alone can increase the risk of suicidal behavior.²⁹

Although this article considers many statistics, it is particularly noteworthy that the number of Soldiers who lost their lives to suicide in recent years, at times, topped the number of Soldiers killed in action,³⁰ with 2009 marking the highest number of suicide deaths to date.³¹ In the

issue is isolated, and fail to detect a pattern of conduct related to symptoms of PTSD. If the client continues to engage in risky behavior related to symptoms of the untreated condition, the recidivism could lead to a discharge under other than honorable conditions that eliminates or substantially limits his ability to receive necessary medical treatment upon separation, even if he is diagnosed with PTSD at the time. *E.g.*, 38 C.F.R. § 3.12(b) (2009) (barring eligibility for veterans' benefits under several circumstances related to misconduct or characterization of discharge unless the veteran was "insane at the time of committing the offense"); Brittany Cvetanovich & Larkin Reynolds, Note, *Joshua Omvig Veterans Suicide Prevention Act of 2007*, 45 HARV. J. ON LEGIS. 619, 634 (2008) ("Receiving a less-than-honorable discharge, even for offenses linked to PTSD (such as drug abuse, being absent without leave, and assault), renders a veteran ineligible to receive medical benefits."); Amy N. Fairweather, *Compromised Care: The Limited Availability and Questionable Quality of Health Care for Recent Veterans*, 35 HUM. RTS. 2, 24 (2008) (observing the "limited eligibility for federal benefits" and a "particularly cruel outcome for many veterans who suffer from PTSD and are kicked out of the military for behavior stemming from their combat injury"). All the while, the attorney, who had no knowledge of PTSD symptoms, could go on thinking that she did everything within her power and responsibility to assist the client when she counseled him on the legal issues related to the initial minor infraction.

²⁹ Savitsky, *supra* note 12, at 333 ("When mental health issues are not addressed, the results may be deadly."); *id.* ("Without treatment and support, PTSD-related stress may lead to divorce, substance abuse, family violence, unemployment . . . and other related issues that can have a lasting, detrimental effect on family life and society."). *See generally* Cvetanovich & Reynolds, *supra* note 28, at 620 ("Numerous studies have linked suicide to PTSD and other mental illnesses.").

³⁰ *E.g.*, Chuck Crumbo, *Military Moms Meet on Somber Occasion; Gold Star Mother Chapter Opens in Columbia*, HERALD (Rock Hill, S.C.), Aug. 2, 2009, at 28 (observing that, in 2008, "[t]hrough mid-July, 129 soldiers had died from suicide, exceeding the combat death toll").

³¹ Compare Grace Vuoto, *Wounds of War; Army Suicides at Record Pace*, WASH. TIMES, July 2, 2009, at B02 (predicting a suicide rate in which "the tally for 2009 will likely eclipse last year's total of 140 suicides, the highest rate since the Pentagon began recording suicide rates 28 years ago"), with Mark Mueller & Tomäis Dinges, *The Wounds Within: Suicide in the Military*, STAR LEDGER (Newark, N.J.), Nov. 22, 2009, at 1 (noting that by October 2009, the Marine Corps matched its prior year's suicide record of forty-two and by 16 November 2009, the Army had matched its own record of 140 cases); *see also* Elizabeth A. Stanley & Amishi P. Jha, *Mind Fitness: Improving Operational Effectiveness and Building Warrior Resilience*, 8 JOINT FORCE Q. 144, 144 (2009) (noting "the growing number of suicides, with the Marine Corps experiencing

same year, litigation in the Ninth Circuit Court of Appeals highlighted the Veterans Administration's (VA) statistics showing that eighteen veterans take their lives each day, with another one thousand, solely under the care of the VA, attempting suicide each month.³² Considering that legal problems have been ranked as the second risk factor for suicide, next to relationship problems at home and during military operations, the attorney's office or courtroom may be no different from the front line of a major disaster for a traditional first responder.³³ Even a civilian who has never deployed to combat will face harmful stress responses to litigation, which can sometimes last for months, causing lack of sleep, depression, and other undesirable symptoms.³⁴ For a population already susceptible to taking their own lives due to PTSD, clients who suffer from PTSD will face heightened stress and anxiety. This requires the attorney to know even more about the influence of PTSD on a client, even if such knowledge serves the limited purpose of informing an attorney when referral for diagnosis is more appropriate.

The PTSD First Responder frame proposed by this article considers PTSD's effects on a client's decision-making before, and in addition to, consideration of the substantive legal issues in the case. At a minimum, knowledge of PTSD symptoms will enable the attorney to identify the need for referral. Furthermore, conscious awareness of the many ways in which PTSD can distort legal advice will enable the attorney to anticipate conditions that are likely to aggravate PTSD symptoms or the need for additional measures to improve the client's evaluation of legal information.³⁵ This article, which is the first in a series,³⁶ will provide an overview of major decisional impairments and how they can be identified during the course of legal counseling. Whether solutions to these problems originate with the attorney, a mental health provider, or the collaboration of both professionals, only this new perspective will

more suicides in 2008 than since the war began and the Army logging its highest monthly total in January 2009 since it began counting in 1980").

³² See, e.g., Bob Egelko, *Federal Court Hears Vets' Appeal on Mental Health*, S.F. CHRON., Aug. 13, 2009, at A7 (revealing Veterans Administration statistics that "reported 18 suicides a day among veterans and 1,000 suicide attempts a month among the 30 percent of veterans under VA care").

³³ Savitsky et al., *supra* note 12, at 333 ("The leading suicide risk factors were problems with relationships at home and in combat, followed by legal actions . . .").

³⁴ E.g., Larry J. Cohen & Joyce H. Vesper, *Forensic Stress Disorder*, 25 L. & PSYCHOL. REV. 1, 17-19 (2001) (describing harmful symptoms of this litigation-induced disorder).

³⁵ See generally Seamone, *supra* note 1 (providing further analysis of possible measures individual attorneys can take to improve client counseling).

³⁶ *Id.*

meet the unique demand for “interdisciplinary” and “collaborative” action to address the mental health needs of a growing population of combat veterans.³⁷

II. PTSD and Its Influence on Client Decisions

Posttraumatic Stress Disorder is a condition caused by an overwhelming traumatic event that “distressingly recurs” in various manifestations leading to impairment lasting more than a month.³⁸ Although the Text Revision of the *Diagnostic and Statistical Manual of Mental Disorders IV* (DSM-IV-TR) recognizes PTSD as a “stress disorder,” the condition “contains the components of both stress and anxiety.”³⁹ Anxiety is most apparent in the “chronic feeling of dread, apprehension, and hypervigilance” experienced by victims of PTSD.⁴⁰ A synopsis of the seventeen diagnostic criteria is provided in the Appendix to the second article in this series.⁴¹ Traumatic combat experiences that commonly result in PTSD include:

[W]itnessing the violent death of a buddy or valued leader, being responsible for the death of unarmed children, failing to save a buddy from death or serious injury, friendly fire, witnessed atrocities, or surviving an unexpected assault in which many friendly casualties were suffered, such as a vehicle-borne IED attack or a large ambush.⁴²

³⁷ Savitsky et al., *supra* note 12, at 337. In a recent task force report on the Army’s medical evaluation process, General (Ret.) Frederick Franks, Jr., recognized attorneys and paralegals as “stakeholders in the disability evaluation system” and emphasized how all stakeholders must endeavor “never [to] leave a fallen comrade,” even in addressing potential unseen injuries like PTSD or TBI.” GENERAL (RET.) FREDERICK FRANKS, JR., I WILL NEVER LEAVE A FALLEN COMRADE: FINAL TASK FORCE RECOMMENDATIONS TO BETTER FULFILL THE ARMY’S DUTY IN MEB/PEB 1, 27 (29 Apr. 2009).

³⁸ DSM-IV-TR, *supra* note 1, at 467–68.

³⁹ ASHLEY R. HART II, AN OPERATOR’S MANUAL FOR COMBAT PTSD: ESSAYS FOR COPING 6 (2000).

⁴⁰ *Id.*

⁴¹ Seamone, *supra* note 1, app. A, at 241–42.

⁴² William P. Nash, *Combat/Operational Stress Adaptations and Injuries*, in COMBAT STRESS INJURY: THEORY, RESEARCH, AND MANAGEMENT 33, 51 (Charles R. Figley & William P. Nash eds., 2007) [hereinafter COMBAT STRESS INJURY].

This information is significant considering 39% of Afghanistan and 95% of Iraq veterans reported “seeing dead bodies or remains” and 43% of Afghanistan and 86% of Iraq veterans reported “knowing someone seriously injured or killed.”⁴³ While “the symptoms of PTSD are part of the *normal reaction* to trauma,”⁴⁴ the symptoms translate into Acute Stress Disorder when experienced for four weeks, Acute PTSD when they last beyond four weeks, and Chronic PTSD when they persist beyond three months.⁴⁵

Among veterans, reactions to trauma differ. Approximately one-third of those with PTSD “can begin to move on within the first year of treatment.”⁴⁶ More specifically, “half the vets with PTSD are likely to recover within two years while another 20 to 30 percent will recover within five years.”⁴⁷ In a great majority of cases, veterans experience the first signs of symptoms three to four months after redeploying from combat, which would qualify as Delayed Onset PTSD.⁴⁸ When left untreated, PTSD can lead veterans to behave irresponsibly, impulsively, violently, and self-destructively, which has created significant concern for their own well-being and the well-being of others.

The Army’s interest in PTSD is necessarily high, due to the increasing number of Soldiers diagnosed with the disorder. In the five years between 2003 and 2008, the Army saw more than 28,000 Soldiers diagnosed with PTSD, with a jump from 6800 cases in 2006 to

⁴³ LAURIE B. SLONE & MATTHEW J. FRIEDMAN, *AFTER THE WAR ZONE: A PRACTICAL GUIDE FOR RETURNING TROOPS AND THEIR FAMILIES* 23 (2008) (“Frequent Combat Experiences Reported by Members of the U.S. Army and Marines”). A detailed breakdown can be found in Charles W. Hoge et al., *Combat Duty in Iraq and Afghanistan, Mental Health Problems, and Barriers to Care*, 351 *NEW ENG. J. MED.* 13, 18 tbl.2 (2004) (accounting for “Combat Experiences Reported by Members of the U.S. Army and Marine Corps After Deployment to Iraq or Afghanistan”).

⁴⁴ Albert “Skip” Rizzo et al., *Virtual Reality Applications for the Treatment of Combat-Related PTSD*, in *COMBAT STRESS INJURY*, *supra* note 42, at 183, 184.

⁴⁵ ERIC NEWHOUSE, *FACES OF COMBAT PTSD & TBI: ONE JOURNALIST’S CRUSADE TO IMPROVE TREATMENT FOR OUR VETERANS* 18–19 (2008).

⁴⁶ *Id.* at 12; Rizzo et al., *supra* note 44, at 184–85 (observing “[t]he majority of trauma victims naturally recover as indicated by a gradual decrease in PTSD symptom severity over time”).

⁴⁷ NEWHOUSE, *supra* note 45, at 19 (citing an interview with Dr. Matthew Friedman, Executive Director of the Veterans’ Administration National Center for PTSD).

⁴⁸ *E.g.*, CANTRELL & DEAN, *supra* note 14, at 71–72. Delayed Onset PTSD describes symptoms that begin more than a month after the trauma. NEWHOUSE, *supra* note 45, at 19.

approximately 10,000 cases in 2007.⁴⁹ In general, between 15% and 40% of combat veterans develop PTSD.⁵⁰ The incidence of PTSD is even higher among those who have deployed multiple times.⁵¹ Multiple deployments, in fact, account for practically half of Iraq and Afghanistan combat veterans.⁵² True PTSD figures are expected to be higher than the current estimates⁵³ because many combat veterans intentionally mask their symptoms,⁵⁴ live in denial,⁵⁵ or remain unaware of their symptoms until long after experiencing the traumatic event.⁵⁶ While the military's medical institutions have incorporated cutting-edge clinical treatments⁵⁷ and developed methods to reduce the stigma of help-seeking behavior,⁵⁸

⁴⁹ Pauline Jelinek, *Wartime PTSD Cases Jumped Roughly 50% in 2007*, May 27, 2008, http://www.huffingtonpost.com/2008/05/27/wartime-ptsd-cases-jumped_n-103779.html.

⁵⁰ Rachel Dekel & Zahava Solomon, *Secondary Traumatization Among Wives of War Veterans with PTSD*, in *COMBAT STRESS INJURY*, *supra* note 42, at 137, 138.

⁵¹ NEWHOUSE, *supra* note 45, at 18 (“Soldiers on their third/fourth deployments are at particular risk of reporting mental health problems.”); Danish & Antonides, *supra* note 4, at 1082 (“With increased deployments, the likelihood of greater levels of PTSD, depression, and TBI increases.”).

⁵² *E.g.*, Dan Heilman, *Returning Veterans with Post Traumatic Stress Disorder Present Unique Challenges for the Criminal Justice System*, MINN. LAW., Oct. 27, 2008 (observing “[w]e’ve had 1.7 million people deployed in Iraq and Afghanistan, and almost half of them have gone back more than once”). It is not uncommon now to encounter military members who have deployed five times. *E.g.*, Savitsky et al., *supra* note 12, at 327; Danish & Antonides, *supra* note 4, at 1082 (“As of August 2008, one third of those deployed have served at least two tours in a combat zone, more than 70,000 have been deployed three times, and more than 20,000 have been deployed at least five times.”).

⁵³ *E.g.*, Rand Center for Military Health Policy Research, *Research Highlights: Invisible Wounds: Mental Health and Cognitive Care Needs of America’s Returning Veterans* (2008), at 3 (“Our survey found that only 53% of returning troops who met the criteria for PTSD or major depression sought help from a provider for these conditions in the past year.”).

⁵⁴ *E.g.*, Covarubias, *supra* note 27, at 442 (observing that “[m]entally ill individuals often choose to hide their symptoms because of the stigma associated with their illness”). For a survey of leading reasons why servicemembers with PTSD refuse to obtain the services they so desperately need, see Litz, *supra* note 13, at 222–23.

⁵⁵ *E.g.*, George W. Reilly, *Second Wind Foundation Offers New Help for PTSD Sufferers*, PROVIDENCE J. (Rhode Island), Feb. 4, 2008, at C-06 (“Many veterans either do not recognize the signs of PTSD or are in denial out of fear of being stigmatized.”).

⁵⁶ *E.g.*, Wales, *supra* note 26, at 374 (“[M]any service members will not be symptomatic, or aware that they are symptomatic, until sometime after leaving active duty.”).

⁵⁷ *See infra* Parts II.E.1–3 (discussing various therapies including Virtual Reality Therapy).

⁵⁸ “[O]ur American, and especially our military, culture can make it difficult to admit that you have psychological pain and even more difficult to seek mental health treatment if you do need help.” SLONE & FRIEDMAN, *supra* note 43, at 137. Soldiers may “fear that they will be labeled as weak or ‘mental,’ or that others will think less of them because they have sought professional assistance.” *Id.* In an effort to combat these perceptions,

the time has come to better address the impact of PTSD in the provision of legal services.

A. Inevitably, Military and Civilian Lawyers Will Serve a High Proportion of Clients with PTSD

Attorneys working in the fields of legal assistance and criminal justice will inevitably see clients who have PTSD because the condition often leads to marital discord⁵⁹ and criminal behavior.⁶⁰ Within the military household, spouses witness as their combat veteran counterparts become less engaged and more withdrawn.⁶¹ Research reveals that

the Army has launched a number of efforts. Changes in security clearance protocols now recognize that it is perfectly normal for a Soldier to seek mental health counseling in relation to combat experiences. *E.g.*, Editorial, *Army is Tracking Stress Disorders in the Field*, MIAMI HERALD (Sun. ed.), July 27, 2008 (recognizing that “[t]he pentagon no longer treats visits to a counselor as an adverse factor in giving security clearances”). Furthermore, general officers, such as General Carter Ham, Commander of the Army’s European Command, and Major General David Blackledge, have publicly shared their own experiences recovering from PTSD in an effort to demonstrate that this condition can influence just about anyone, and help is necessary to combat its negative effects. *E.g.*, Editorial, *A Four-Star General Admits to Suffering from PTSD*, REG.-GUARD (Eugene, Ore.), Dec. 1, 2008, at PA8 (describing General Ham’s experience); Editorial, *Marching Toward Wellness*, WASH. TIMES, Dec. 3, 2008, at B01 (describing Major General Blackledge’s experiences). Some military programs even permit servicemembers to receive mental health treatment at primary care facilities to avoid the stigma of going to a mental health center for treatment. *E.g.*, Less Spivey, *New Approach to PTSD Offers Service Members Greater Privacy, Reduced Stigma*, U.S. DEP’T OF DEF., MIL. HEALTH SYS., July 15, 2009, <http://www.health.mil/Press/Release.aspx?ID=822> (describing a pilot program instituted at Lackland Air Force Base). Despite these efforts, some Soldiers are still reluctant to seek help for their symptoms because they “fear that psychological problems can’t be fixed or believe they should just be able to get over it on their own.” SLONE & FRIEDMAN, *supra* note 43, at 137–38.

⁵⁹ *E.g.*, Lynne Gold-Bilin & Jonathan W. Gould, *Post Traumatic Stress Disorder and the Practice of Family Law*, 19 J. AM. ACAD. MATRIMONIAL L. 17, 31 (2004) (“As troops return from such hotspots as Iraq and Afghanistan, the issue of PTSD will become more important to the family law attorney.”).

⁶⁰ *E.g.*, Casey T. Taft et al., *Risk Factor for Partner Violence Among a National Sample of Combat Veterans*, 73 J. CONSULTING & CLIN. PSYCHOL. 151 (2005) (observing significant rates of partner violence among combat veterans as high as one third); Savitsky et al., *supra* note 12, at 329 (“[I]nability to moderate aggression postdeployment may result in misplaced, inappropriate aggression and lead to family violence.”).

⁶¹ KEITH ARMSTRONG ET AL., *COURAGE AFTER FIRE: COPING STRATEGIES FOR TROOPS RETURNING FROM IRAQ AND AFGHANISTAN AND THEIR FAMILIES* 31 (2006) (observing that avoidance is a common symptom of PTSD which affects all members of the family by causing them to feel rejected); *see also* Dekel & Solomon, *supra* note 50, at 137, 141 (“[W]ives of PTSD veterans report greater spousal conflict, less intimacy, less cohesion,

military wives can actually develop conditions that mirror their husbands' PTSD symptoms as a result of constant exposure to anxious reactions or physical violence.⁶² As a result of these complications, a 2006 study indicated that nearly 20% of servicemembers planned on separation or divorce.⁶³

The link between PTSD and criminal activity is also well documented.⁶⁴ Commonly, veterans with the disorder knowingly participate in dangerous behavior in attempts to recreate the rush of combat.⁶⁵ This could include anything from driving at extremely fast speeds,⁶⁶ to provoking road rage,⁶⁷ and starting fist-fights.⁶⁸ While the

and less martial satisfaction than wives of non-PTSD veterans, as well as more verbal and physical violence by their husbands.”)

⁶² *E.g.*, Dekel & Solomon, *supra* note 50, at 137 (“[W]ives of traumatized veterans are one of the various groups of persons who have been identified as suffering psychological consequences of traumatic events which they did not experience at first hand, but through their close proximity to a direct victim.”). The authors note that secondary traumatization of wives may result in the “transmission of nightmares, intrusive thoughts, flashbacks, and other symptoms.” *Id.* at 138.

⁶³ U.S. DEP’T OF DEF. TASK FORCE ON MENTAL HEALTH, AN ACHIEVABLE VISION: REPORT OF THE DEPARTMENT OF DEFENSE TASK FORCE ON MENTAL HEALTH 36 (2007). In a related statistic, “The yearly divorce rate in the U.S. Army nearly doubled for enlisted personnel and tripled for officers between 2001 and 2004.” Danish & Antonides, *supra* note 4, at 1082. *See also* HART, *supra* note 39, at 10 (“Many combat veterans report some initial difficulty in adjustment but develop severe problems later in life when there are other psychosocial complications which include increased responsibility at work, family dynamic issues such as divorce, separation, and challenging teenagers for example.”). The return to the household after redeployment often leads to such a response. *Id.*

⁶⁴ “Estimates put the number of service veterans under some form of correctional supervision at more than 500,000.” Rhonda McMillion, *Sending in Reinforcements: A New ABA Group Will Coordinate Efforts to Bolster Legal Services for Veterans*, A.B.A. J., Apr. 2009, at 62, 62; *see also* Heilman, *supra* note 52 (observing “About 600,000 of those people have PTSD and TBI . . . and less than half of them get the help they need. Those are the ones who end up in the criminal courts.”); C. Peter Erlinder, *Post-Traumatic Stress Disorder, Vietnam Veterans and the Law: A Challenge to Effective Representation*, 1 BEHAV. SCI. & L. 25, 30 (1983) (“Some authorities have suggested, that 25% to 30% of Vietnam veterans who saw heavy combat have been arrested on criminal charges.”).

⁶⁵ *E.g.*, CANTRELL & DEAN, *supra* note 14, at 32–33. *See also* Larry R. Decker, *Combat Trauma: Treatment From a Mystical, Spiritual Perspective*, J. HUMANISTIC PSYCHOL. 30, 32 (2007) (“Many combat veterans found war to be the most meaningful experience of their lives and frequently long for a return to the intensity of the horror.”).

⁶⁶ CANTRELL & DEAN, *supra* note 14, at 32.

⁶⁷ *Id.* at 33.

⁶⁸ Heilman, *supra* note 52 (recounting the story of a combat veteran who “gets in fights in bars because he can’t stop wanting to fight”). Early studies of Vietnam veterans revealed

use of illegal narcotics can also supply a desired adrenaline rush that simulates combat, drug abuse is also common among those who desire to escape feelings of guilt or shame over losses they suffered in combat.⁶⁹ Ultimately, criminal activity can result from

- (1) Overreaction to danger cues;
- (2) Behavioral re-experiencing while in a dissociative state;
- (3) Stimulation-seeking behavior to overcome numbness and emotional nonreactivity; and
- (4) Engaging in dangerous behavior to alleviate survivor guilt.⁷⁰

The above “flashback” scenario in number two, which is commonly cited in legal publications, is quite possible⁷¹ but hardly demonstrates all possible criminal manifestations of PTSD. For many of these reasons, “military trial practitioners are likely to encounter PTSD in some fashion in future trials involving combat veterans.”⁷²

B. The Effects of PTSD on the Attorney-Client Relationship Have Been Neglected in Legal Discussions

While PTSD can be addressed from several perspectives, this article is concerned with a single dimension of the disorder—its effects on the

that those with PTSD “reported an average of 20 acts of violence in the past year compared to less than one act reported by combat veterans without PTSD.” Matthew Jakupcak et al., *Anger, Hostility, and Aggression Among Iraq and Afghanistan War Veterans Reporting PTSD and Subthreshold PTSD*, 20 J. TRAUMATIC STRESS 945, 946 (2007). Like the earlier studies, more recent ones confirm that “symptoms of PTSD are associated with anger, hostility and aggression among Iraq and Afghanistan war veterans.” *Id.* at 947–50.

⁶⁹ HART, *supra* note 39, at 11 (“Nearly seventy percent of veterans with combat PTSD also have other diagnosable mental health problems. The two most prominent are affective disorder and substance abuse.”). Such substance abuse normally includes pain killers, alcohol, and marijuana, all of which are abused to meet the “expectation that the intoxicant will create a change in mood.” *Id.*

⁷⁰ Constantina Aprilakis, Note, *The Warrior Returns: Struggling to Address Criminal Behavior by Veterans with PTSD*, 3 GEO. J. L. & PUB. POL’Y 541, 553 (2005).

⁷¹ *E.g.*, Erlinder, *supra* note 64, at 33–35 (discussing a Louisiana trial in which a long-range reconnaissance veteran successfully argued temporary insanity to a murder charge based on a PTSD flashback episode where he went into a defensive mode as if in combat).

⁷² Hayes, *supra* note 26, at 78.

attorney-client relationship. More specifically, what obligation does an attorney have to ensure that a client with PTSD fully considers available options and makes informed decisions, especially if that client is suffering from distorted thinking or other adverse effects of the disorder? The resolution of this question extends beyond interviewing and reaches the counseling strategies the attorney adopts throughout the entire legal process.

The considerations addressed in this article are intended for all lawyers who regularly deal with criminal and family law. Although defense counsel and legal assistance attorneys are the only Army attorneys authorized to form attorney-client relationships,⁷³ prosecutors may also benefit from these suggestions to the extent that they interview and counsel victims or witnesses who suffer from the disorder.⁷⁴

To date, like civilian scholars, military legal institutions have focused almost exclusively on the substantive legal issues surrounding PTSD.⁷⁵ They have paid surprisingly little attention to the manner in which this widespread disorder impairs client decisions and limits attorneys in their roles as effective counselors. On occasion, military appellate courts have addressed the obligations of attorneys to investigate the possibility that a client has PTSD⁷⁶ or their obligation to present

⁷³ U.S. DEP'T OF ARMY, REG. 27-26, RULES OF PROFESSIONAL CONDUCT FOR LAWYERS R. 1.13(b) (1 May 1992) [hereinafter AR 27-26] ("An Army lawyer shall not form a client-lawyer relationship or represent a client other than the Army unless specifically assigned or authorized by a competent authority.").

⁷⁴ E.g., Deborah Epstein et al., *Transforming Aggressive Prosecution Policies: Prioritizing Victims' Long-Term Safety in the Prosecution of Domestic Violence Cases*, 11 AM. U. J. GENDER SOC. POL'Y & L. 465, 474 (2003) ("One study of victims involved in the criminal court system found that almost 40% met formal diagnostic criteria for PTSD. Victims experiencing PTSD may have extreme difficulty concentrating, feel constantly on guard or jumpy, and experience unpredictable outbursts of rage."). See also Hayes, *supra* note 26, at 101-02 (discussing attempts to discredit witnesses at courts-martial based on their diagnoses of PTSD).

⁷⁵ E.g., Captain Daniel E. Speir, *Application and Use of Post-Traumatic Stress Disorder as a Defense to Criminal Conduct*, ARMY LAW., June 1989, at 17; Samuel P. Menefee, *The "Vietnam Syndrome" Defense: A "G.I. Bill of Criminal Rights"?*, ARMY LAW., Feb. 1985, at 1. For example, in the most recent *Military Law Review* article focusing on PTSD, the author's "main emphasis" was "an analysis of PTSD within the military courtroom." Hayes, *supra* note 26, at 69. This article supplements that common objective with an analysis of PTSD *within the attorney's office*.

⁷⁶ E.g., *United States v. Ashby*, No. NMCCA 2000000250, 2007 CCA LEXIS 235, at *37-49 (N-M. Ct. Crim. App. June 27, 2007) (addressing the claim that defense counsel were ineffective when "they failed to recognize, secure, and present evidence and expert testimony concerning the impact that post-traumatic stress disorder (PTSD) and/or acute

evidence of PTSD during the course of a court-martial.⁷⁷ However, such opinions are limited to claims of ineffective assistance of counsel⁷⁸ and fail to offer needed guidelines for attorneys who desire to overcome the negative effects of PTSD during the course of the legal representation.

C. Veterans' Treatment Courts Provide Necessary Lessons for Attorneys Representing Combat Veterans

The influx of veterans in need of mental health services has been recognized as an epidemic in many cities, calling for drastic measures.⁷⁹ In some states, for example, public service announcements targeted to law enforcement officers provide education about the link between PTSD and criminal behavior.⁸⁰ As part of a coordinated response,

stress disorder (ASD) had upon the appellant's ability to form the specific intent required for [the charged offenses]").

⁷⁷ *E.g.*, United States v. Green, No. NMCCA 200600843, 2007 CCA LEXIS 413, at *6–8 (N-M. Ct. Crim. App. Sept. 27, 2007) (addressing the claim that the defense counsel failed to introduce evidence of PTSD beyond the accused Marine's statement that he was taking medication for PTSD).

⁷⁸ *E.g.*, *id.*

⁷⁹ Observers note that returning Iraq and Afghanistan veterans have placed a greater tax on the criminal justice system because of the unique aspects of these conflicts. *E.g.*, Robert T. Russell, *Veterans Treatment Court: A Proactive Approach*, 35 NEW ENG. J. ON CRIM. & CIV. CONFINEMENT 357, 357 (2009) ("With the increase of [Afghanistan and Iraq] veterans with serious needs in our criminal justice system, comes the need for the system to develop innovative ways of working to address these issues and needs."). For example, in the advent of effective life-saving measures, far more Soldiers have survived to return home with serious mental health complications from their combat injuries. *E.g.*, ILONA MEAGHER, MOVING A NATION TO CARE: POST-TRAUMATIC STRESS DISORDER AND AMERICA'S RETURNING TROOPS, at xxi (2007):

[I]n today's theaters of war, where troops are dealing with extended and multiple deployments, twenty-four hour operations with no opportunity to unwind, sleep deprivation, ever changing mission goals and guerilla warfare conditions where enemies and civilians blend together, it has been estimated that cases of PTSD may be higher than in past conflicts.

See also Candice M. Monson et al., *Cognitive Processing Therapy for Veterans with Military-Related Posttraumatic Stress Disorder*, 74 J. CONSULTING & CLIN. PSYCHOL. 898, 898 (2006) ("[R]esearch with active duty personnel in Iraq and Afghanistan suggests that we are creating a new generation of veterans with high levels of PTSD and related mental health symptoms.").

⁸⁰ *E.g.*, Christopher Hawthorne, *Bringing Baghdad into the Courtroom: Should Combat Veterans be Part of the Criminal Justice Equation*, 24 CRIM. JUST. 4, 6 (2009) (describing the ten-minute Video Public Service Announcement, "Beyond the Yellow Ribbon:

legislators have increasingly recognized the need to respond to the unique circumstances facing combat veterans. In California⁸¹ and Minnesota,⁸² for example, statutes require courts to incorporate veteran status in criminal sentences. The diversionary provisions of these programs recognize that treatment for PTSD often provides a meaningful alternative to incarceration.

In January 2008, the first Veterans' Treatment Court was established in Buffalo, New York, in the chambers of Judge Robert T. Russell.⁸³ Observing that veteran-offenders represented a majority of cases on his criminal docket, Judge Russell developed a specialized program to address their unique concerns.⁸⁴ Diagnosis and treatment for PTSD was a large part of this specially-tailored program, which combined the efforts of prosecutors, defense attorneys, and mental health professionals.⁸⁵ In a span of months, similar veterans' courts began in eight other jurisdictions,⁸⁶ including Wisconsin,⁸⁷ Oklahoma,⁸⁸

PTSD and Veterans," created by the Norfolk County District Attorney's Office in Clinton, Massachusetts, "which explains to law enforcement the 'natural reactions to unnatural events' that cause post-combat trauma in veterans").

⁸¹ CAL. PENAL CODE § 1170.9 (LexisNexis 2009). This legislation "lets judges depart from presumptive prison sentences in cases involving veterans with PTSD, and, when suitable, order treatment in lieu of jail time." Heilman, *supra* note 52.

⁸² MINN. STAT. § 609.115 (LexisNexis 2009). Under this legislation, "If the defendant is a veteran and has been diagnosed as having a mental illness, the court may consult with the federal or state Department of Veterans Affairs to determine treatment options in lieu of or along with a jail sentence." Heilman, *supra* note 52.

⁸³ Russell, *supra* note 79, at 364.

⁸⁴ *Id.* at 363:

As presiding judge over Buffalo's Drug Treatment and Mental Health Treatment courts, I noticed that many of the participants on my docket had something in common—They were veterans. In fact, it was the noticeable rise in the numbers of veterans on the city treatment dockets that ultimately led to the advent of a specialized Veterans Treatment Court.

⁸⁵ Judge Russell observes the dramatic change in traditional courtroom roles. "To facilitate the veterans' progress in treatment, the prosecutor and the defense counsel shed their traditional adversarial courtroom relationship and work together as a team." *Id.* at 365.

⁸⁶ Mary Ellen Schneider, Broadcast, *Treatment Courts Aimed at Getting Vets Back on Track* (Int'l Med. News Group Broadcast, June 26, 2009).

⁸⁷ E.g., Jane Pribek, *Reaching Out to Returning Vets: Veterans' Treatment Court Moves Forward in Wisconsin*, WIS. L. J. (Milwaukee, Wis.), Feb. 2, 2009 (describing the Wisconsin Veterans Intervention Program).

⁸⁸ Editorial, *Helping Vets*, TULSA (OKLA.) WORLD (Final ed.), Dec. 10, 2008, at A22.

California,⁸⁹ and Alaska,⁹⁰ with the prospect of thirty states planning future initiatives⁹¹ and federal legislation to fund such programs.⁹²

Despite the difference between military courts and civilian criminal courts,⁹³ veterans' treatment court programs offer several important lessons to the military legal system and attorneys representing combat veterans. First, by requiring judges, prosecutors, and defense attorneys to learn more about psychological aspects and interventions tailored to PTSD, these programs confirm the need for lawyers to adopt a specialized approach to cases involving PTSD.⁹⁴ Attorneys in these courts cannot effectively advise their clients without knowledge of

⁸⁹ Hawthorne, *supra* note 80, at 12.

⁹⁰ Editorial, *supra* note 88, at A22.

⁹¹ Schneider, *supra* note 86.

⁹² *E.g.*, Services, Education, and Rehabilitation for Veterans Act, H.R. 7149, 110th Cong. § 2 (2008) (proposing federal funding for veterans treatment courts throughout the nation).

⁹³ Foremost, on active duty, narcotics pose special dangers due to operational conditions, including access to weapons and multimillion dollar equipment. *E.g.*, Murray v. Haldeman, 16 M.J. 74, 78 (C.M.A. 1983):

The increased incidence of drug abuse in the Armed Forces poses a substantial threat to the readiness and efficiency of our military forces. Unlike the civilian population, the military forces are charged with the responsibility of continuously protecting the nation's interests both on the domestic and international level. Widespread use of marijuana, hashish and other drugs can have a serious debilitating effect on the ability of the Armed Services to perform their mission.

Additionally, the structure of the court-martial systems makes it far less likely that a court-martial could implement probationary terms or monitor the treatment of a particular Soldier. Military scholars observe that even though "probation is the most common criminal sentence adjudged today," "a military judge or panel is not authorized to adjudge probation." Major Tyesha E. Lowery, *One "Get out of Jail Free" Card: Should Probation be an Authorized Courts-Martial Punishment?*, 198 MIL. L. REV. 165, 166-67 (2008). Commanders have articulated the major reason for this limitation: "[O]ur legal system is pretty efficient in comparison to the civilian system. From flash to bang—it's pretty quick. The overhead [i.e., manpower required to supervise the Soldier] would be debilitating. We don't have the overhead to monitor Soldiers." *Id.* at 197-98 (citing Interview with Colonel David Clark, Commander, Training Support Brigade, Fort Sam Houston, Tex. (Feb. 29, 2008)).

⁹⁴ *E.g.*, Pribek, *supra* note 87 (recognizing that veterans' treatment court programs require "a comprehensive training program for defense attorneys, prosecutors, judges, [and others]," focused on "the effects of PTSD, and how to effectively interact with veterans with it, and other service-related disorders").

rehabilitative options.⁹⁵ These programs also signify that PTSD requires modification of procedures in the way cases are handled and a modification of traditional courtroom relationships.⁹⁶ Because these new programs exist mainly to address the specialized needs of Iraq and Afghanistan combat veterans, they signify that our current legal assistance and criminal practice may benefit from similar considerations. Ultimately, these new programs signify the need for the attorney's further education about PTSD.

D. Certain Attributes of Law Practice Will Aggravate a Client's PTSD

As long as attorneys practice criminal and family law, they will serve clients with PTSD. Common issues within these two practice areas can aggravate the client's symptoms, trigger anxious responses, or produce other obstacles in client representation.⁹⁷ Psychologists have shown that "the litigation process itself" or "the issues underlying the litigation" often produce(s) negative effects on a person similar to post-traumatic stress.⁹⁸ "Forensic stress disorder" (FSD), which contains many of the same diagnostic criteria as PTSD,⁹⁹ manifests symptoms that include obsessive thinking, panic attacks, fear, and "intrusive thoughts of the legal case [that] can invade daily activities and disrupt evening dreams."¹⁰⁰ However, the symptoms of FSD normally persist six months

⁹⁵ E.g., Bruce J. Winick & David B. Wexler, *The Use of Therapeutic Jurisprudence in Law School Clinical Education: Transforming the Criminal Law Clinic*, 13 CLIN. L. REV. 605, 613 (2007) ("The criminal defense lawyer . . . must possess the psychological skills necessary to understand when the client's problem is the product of alcoholism or substance abuse, mental illness, or some behavioral disorder, all of which may respond to treatment or rehabilitation in an appropriate community program."); Kluger et al., *supra* note 25, at 1918 (recognizing that "problem-solving courts," like veterans' treatment courts, "are . . . changing the parameters with respect to client counseling" by requiring attorneys to develop expertise in alcoholism, substance abuse, and mental illness for the purpose of fulfilling "ethical obligations") (comments of Susan Hendricks).

⁹⁶ E.g., Russell, *supra* note 79, at 365 (recognizing that veterans' treatment courts require both prosecutors and attorneys to "shed their traditional adversarial courtroom relationships and work together as a team").

⁹⁷ E.g., Katrina J. Eagle & Steve R. Binder, *Veterans Facing Criminal Charges: How a Community of Professionals Can Serve Those Who Served Our Country*, 16 NEV. LAW. 16, 16 (2008) ("The veteran's trauma is compounded by the threat of a criminal charge and punishment for the offense.").

⁹⁸ Cohen & Vesper, *supra* note 34, at 2.

⁹⁹ *Id.* at 17–19 (describing diagnostic criteria for FSD).

¹⁰⁰ *Id.* at 5; see also Bruce Winick, *Therapeutic Jurisprudence and the Role of Counsel in Litigation*, 37 CAL. W. L. REV. 105, 109 (2001) ("Criminal and similar kinds of legal

or less following the conclusion of the legal action.¹⁰¹ Importantly, the client who is already suffering from PTSD prior to litigation is far more likely to experience acute stress reactions to litigation, which can “lead to an inability to manage the uncertainty and frustration of the legal process.”¹⁰²

Yet another complication may occur when the client’s PTSD is related to the charged offense or the charged offense involves a traumatic event powerful enough to cause PTSD independently. For example, “the act of killing another human being, even under circumstances that render the homicide a criminal offense, carries a high risk that the perpetrator will experience a severe case of PTSD.”¹⁰³ The link between PTSD and the subject matter in a criminal trial will inevitably lead to additional impediments in the attorney-client relationship:

The avoidance of the triggers by the defendant who has self-inflicted PTSD will be severely tested by defense counsel who must actively implore the defendant to revisit the circumstances of the charged crime and discuss in detail with counsel the defendant’s thoughts, feelings, and recollections of the homicide or violent assault. Additionally, the accused is forced throughout the pretrial and trial stages of a criminal prosecution to relive, often as a passive spectator, the traumatic experience of the crime through the testimony of witnesses, photographs, exhibits, and legal arguments. All of these circumstances, routine to the criminal trial process, have the potential to stimulate and aggravate the accused’s PTSD.¹⁰⁴

proceedings are intensely stressful and can create feelings of fear, anxiety, and depression.”).

¹⁰¹ Cohen & Vesper, *supra* note 34, at 4 (“Although litigants may suffer symptoms found in individuals diagnosed with acute or posttraumatic stress disorder, the psychological disturbance for litigants usually abates within six months after the legal case has concluded.”).

¹⁰² *Id.* at 14 (“[I]ndividuals who witnessed violent or life threatening-events as well as those people who were involved in traumatic accidents prior to litigation experience acute stress reactions.”).

¹⁰³ J. Vincent Aprile II, *PTSD: When the Crime Punishes the Perpetrator*, 23 CRIM. JUST. 39, 39 (2009).

¹⁰⁴ *Id.* at 40.

The common danger posed to the attorney-client relationship in each of these situations is the effect of compounded trauma.

The convergence of traumatic events can easily aggravate clients' symptoms in a variety of ways and can seriously impede effective communication. Attorneys who wish to limit psychological harm during client counseling commonly emphasize simple alterations to their standard approach. Among immigrants applying for asylum or victims of domestic violence, for example, it is valuable to assist clients in regaining a sense of lost control. An attorney can do this by empowering clients to set the time of, the location of, and the content to be discussed during meetings involving sensitive issues.¹⁰⁵ As one researcher recommends:

To avoid or reduce retrauma, try to reverse the dynamics of the trauma in your work with your client. . . . The question is how the lawyer can help [the client] regain some control . . . It may be as simple as giving the client power to make some decisions in the representation. Tell her you are going to talk about this matter and you know how difficult it is. Ask her *when* she would like to talk about it. Or, when she decides she is ready to talk about it, offer breaks to give her the opportunity to decide how she tells you about it, and how long the sessions are. . . [L]isten deeply, use her own words back, try to authentically understand her story.¹⁰⁶

These alterations to client counseling can produce positive effects during litigation by increasing the client's comfort level with disturbing issues. However, it is doubtful that these measures, alone, would effectively

¹⁰⁵ *E.g.*, Diacoff, *supra* note 18, at 55:

Lawyers working with traumatized clients can help reverse the effects of trauma, by using excellent interpersonal skills. For example, if the client was raped and experienced degradation and humiliation, the lawyer can provide the client with an additional measure of respect, autonomy, and control. The attorney can ask the client when and for how long she wants to talk about the event, listen well, and treat her with respect.

¹⁰⁶ Symposium, *Stress, Burnout, Vicarious Trauma, and Other Emotional Realities in the Lawyer/Client Relationship: A Panel Discussion*, 19 *TOURO L. REV.* 847, 860-61 (2004) (comments of Professor Peters).

assist a client forced to confront a particularly traumatic issue, such as an individual who, as part of his trial, must view photographs of the Iraqi child he accidentally shot while deployed. These simple suggestions also fail to address the client who, as a result of PTSD, desires to forfeit legal rights or an important defense as an outgrowth of self-hatred. In these examples, and countless others, the attorney must be prepared to consider how these issues could complicate the client's decision-making process and evaluation of legal advice.

E. The Attorney's Basic Understanding of PTSD and Treatment Approaches

An attorney who does not understand how PTSD affects a client is helpless to prevent its symptoms from infecting the attorney-client relationship.¹⁰⁷ Oftentimes, “[c]lients who have experienced trauma also have difficulty during trial preparation, exhibiting patterns of forgetfulness and avoidance.”¹⁰⁸ These common problems can impede attorney-client communication, and thus effective representation, if the attorney does not anticipate and counteract them. In this context, “it would behoove lawyers to understand basic psychological concepts, not so that we may become therapists, but so that we might be better legal counselors.”¹⁰⁹

Where trauma is common, attorneys have recognized the need to undergo specialized training to effectively represent clients with PTSD. Such training necessarily includes

¹⁰⁷ *E.g.*, SANFORD M. PORTNOY, *THE FAMILY LAWYER'S GUIDE TO BUILDING SUCCESSFUL CLIENT RELATIONSHIPS* 19 (2000) (“Obviously the first step in management of your client is recognition of what needs to be managed.”); Covarrubias, *supra* note 27, at 443 (observing that counsel are often unable to discover a client's mental condition because “the attorney does not know how to identify the symptoms”); *see also* Evelyn Lundberg Stratton, *Solutions for the Mentally Ill in the Criminal Justice System*, 32 CAPITAL U. L. REV. 90, 102 (2004) (noting that the attorney's “perceptions are more accurate to the extent that he is trained and knows how to look for distortions in viewing and interpreting even simple behavior”).

¹⁰⁸ Lynette M. Parker, *Increasing Law Students' Effectiveness When Representing Traumatized Clients: A Case Study of the Katharine & George Alexander Community Law Center*, 21 GEO. IMMIGR. L.J. 163, 171 (2007).

¹⁰⁹ Marjorie A. Silver, *Love, Hate, and Other Emotional Interference in the Lawyer/Client Relationship*, 6 CLIN. L. REV. 259, 275 (2000); *see also* Erlinder, *supra* note 64, at 26 (recognizing that “few attorneys are likely to recognize that a wide range of client problems from criminal charges and substance abuse to family problems and employment disputes may be related to PTSD . . .”).

mechanisms . . . to interview and prepare a client's case with minimal retraumatization, . . . techniques for working with emotional clients . . . ways to keep a client focused or to re-focus a client who is avoiding talking about his or her traumatic experience . . . [and] techniques for building trust with clients who have suffered trauma.¹¹⁰

While such attorney training may exceed even the subject matter required for many masters' level psychology students,¹¹¹ it is nevertheless necessary "to fulfill the duty of care which requires lawyers to obtain specialized training in order to provide zealous representation to their clients."¹¹² Learning about PTSD, therefore, requires far more than reviewing a handy copy of the *Diagnostic and Statistical Manual of Mental Disorders*. It requires further understanding of the many ways in which PTSD manifests in a client's behavior.

Lack of trust of others and self-destructive tendencies, which are common characteristics of PTSD, can seriously affect legal representations. As one researcher notes, "Since self-abuse is common among trauma victims, you may see it acted out in the form of settlement suggestions that are self-defeating or self-destructive behaviors such as not showing up for court appearances."¹¹³ Attorneys must be prepared to explore aspects of the client's legal decision-making process—objectives, prioritization of issues, and the weighing and balancing of decisions—to identify the presence of otherwise unseen distorting forces. In the strategic vernacular, the attorney must endeavor to get inside the

¹¹⁰ Parker, *supra* note 108, at 182.

¹¹¹ *Id.* at 190 ("The area of trauma, PTSD, and vicarious trauma is a specialized course not necessarily taken by all psychology master students.").

¹¹² *Id.* at 167. Others, such as Professor Erlinder, recognize the attorney's duty to learn about PTSD for service to all clients in general:

PSTD can affect virtually every aspect of a veteran/client's behavior. Additionally, the effects may be subtle, and the . . . effects may not appear to be related to combat at all. For attorneys untrained in psychology or psychiatry, this implies a duty to examine a veteran client's psychological history for a PTSD connection with particular care, even when the relationship is not readily apparent.

Erlinder, *supra* note 64, at 30.

¹¹³ PORTNOY, *supra* note 107, at 31.

client's defective OODA loop, and counter it with in a way that permits effective evaluation of legal options.¹¹⁴

Too often, combat veterans who experience a traumatic event suffer from shattered beliefs about the world around them.¹¹⁵ Before the overwhelming event, the client, like all functioning adults, likely operated from five "fundamental assumptions common to all people at all times":

- (1) [T]he world is benevolent;
- (2) the world is meaningful;
- (3) the self is worthy;
- (4) [I am safe and my life] will not be snuffed out in the next few seconds; and
- (5) a moral order exists in the universe that discriminates right from wrong.¹¹⁶

The traumatizing event has the effect of challenging one or more of these assumptions, often resulting in destruction of the capacity for trust.¹¹⁷

¹¹⁴ The term "OODA loop" originated with Air Force strategist Colonel R. Boyd. John R. Boyd, *Patterns of Conflict*, lecture notes (1986), available at <http://www.d-n-i.net/boyd/pdf/poc.pdf>. As an acronym for the repeated steps "Observe, Orient, Decide, and Act," the OODA loop relates to accurate "situational awareness." Doug Richardson, *Network-Centric Warfare: Revolution or Passing Fad?*, 28 *ARMADA INT'L* 62, 62 (2004). The victorious force will be triumphant over its opposition because it has a faster and more continuous OODA loop. *Id.* See also Zheyao Li, Note, *War Powers for the Fourth Generation: Constitutional Interpretation in the Age of Asymmetric Warfare*, 7 *GEO. J.L. & PUB. POL'Y* 373, 399 & n.144 (2009). Colonel Boyd's theory has been applied in varied contexts including the portrayal of the United States in the media. *E.g.*, Newt Gingrich & Mark Kester, *A Security Strategy of Transforming Societies: From Stabilizing to Transforming Societies as the Key to American Security*, 28 *FLETCHER F. WORLD AFF.* 5, 11 (2004). In the context of combating PTSD's many distortions, the attorney can effectively neutralize the client's distorted thinking and prevent complications throughout the litigation if she routinely checks for signs of PTSD and then intervenes promptly after spotting the signs.

¹¹⁵ *E.g.*, Nash, *supra* note 42, at 53 (recognizing that traumatic stress has the ability to "shatter necessary and deeply held beliefs"); Decker, *supra* note 65, at 31 (observing that "[t]he very nature of trauma is such that it attacks our basic beliefs and challenges our processes of accommodation and assimilation" and that "most trauma survivors' beliefs (including combat veterans') are deconstructed and set into disarray").

¹¹⁶ Nash, *supra* note 42, at 53. In this recognition, Nash recounts the three core fundamental assumption recognized by Dr. Janhoff-Bulman, and adds the additional two fundamental assumptions based on his clinical experience. See generally RONNIE JANHOFF-BULMAN, *SHATTERED ASSUMPTIONS: TOWARD A NEW PSYCHOLOGY OF TRAUMA* (1992).

Depending on the extent of the trauma suffered and the intensity of the disorder, the client's new assumptions could unknowingly or intentionally sabotage his well-being. Clients may desire to use litigation to punish themselves as an outgrowth of the belief that they do not deserve to live happy lives when, for example, their subordinates died at their hands. Much like a capital client may initially be inclined not to offer evidence in mitigation, the PTSD client may desire a self-defeating result.¹¹⁸

An understanding of defeated beliefs and distrusting predispositions is only one component of PTSD awareness. Another component involves knowledge of the physiological dimension, including the events that trigger anxious responses, the duration of hyper-aroused states, and the limitations of comprehension that result from such states. Veterans with PTSD respond differently to external stimuli based on their unique circumstances. A loud noise, the sound of a helicopter, the smell of oil or gas, or even the sight of children in a crowd may all be triggers.¹¹⁹ Other common examples include the anniversary of traumatic events¹²⁰ or news of the deaths of military service members in Iraq or Afghanistan.¹²¹

A response to a triggering event causes a physiological response in which "adrenaline . . . becomes a neurotransmitter which overrides the decision making and executive processes of [the] cerebral cortex, or smart brain."¹²² While it is possible to decrease a response in the

¹¹⁷ Nash, *supra* note 42, at 53–54.

¹¹⁸ See A.B.A. GUIDELINES FOR THE APPOINTMENT AND PERFORMANCE OF DEFENSE COUNSEL IN DEATH PENALTY CASES cmt. to Guideline 10.5 (rev. ed. 2003).

¹¹⁹ *E.g.*, ARMSTRONG ET AL., *supra* note 61, at 17. In the most general terms, "Triggers can come through any of the senses and include sounds, sights, tastes, and smells." *Id.*

¹²⁰ *E.g.*, *id.* at 17–18:

An anniversary date of a traumatic event can also bring back thoughts, feelings, and physical reactions related to the trauma. For instance, a veteran may experience an "anniversary reaction" or an increase in posttraumatic stress symptoms at Thanksgiving, as she recalls a mortar blast that happened on Thanksgiving Day, killing one of her buddies. Anniversary reactions can cause intense peaks in anxiety or depression and may occur even before [the Soldier] consciously remembers that a particular traumatic event even happened on that date.

¹²¹ *Id.* at 17.

¹²² HART, *supra* note 39, at 17.

beginning stages using relaxation techniques, the lack of effective and early intervention usually leads to a period of heightened arousal that lasts between three-and-a-half to four days.¹²³ In such a state, concentration and communication become impaired and intrusive thoughts increase.¹²⁴

Even though PTSD causes severe debilitating effects, effective treatment is often possible. Approximately 50% of veterans treated for PTSD recover within two years, and between 20% and 30% more may recover within five years.¹²⁵ Effective treatment normally involves a combination of medication and psychotherapy.¹²⁶ In 2004, the Department of Defense collaborated with the Department of Veterans Affairs to create the *VA/DoD Clinical Practice Guideline for the Management of Post-Traumatic Stress*.¹²⁷ The *Guideline* recommends three primary options for the clinical treatment of PTSD, which include (1) Exposure Therapy (ET), (2) Cognitive Processing Therapy (CPT), and (3) Eye Movement Desensitization Reprocessing (EMDR).¹²⁸ Attorneys should be familiar with the mechanics of these therapies because a client's reactions to issues raised in therapy can easily influence legal counseling. Furthermore, knowledge of specific treatment techniques will enable attorneys to explore ways that clinicians might address the client's negative reactions to legal issues in a case.

¹²³ *Id.* ("It will typically take an individual three and a half to four days before the adrenaline is exhausted within the body.").

¹²⁴ Clinicians sometimes refer to this heightened state of arousal as a "wild ride" because it generates a physiological response that often leaves the client with continuous "strong urges to fight or flee," and uncomfortable nervous shaking. *Id.*

¹²⁵ NEWHOUSE, *supra* note 45, at 19

¹²⁶ *E.g.*, SLONE & FRIEDMAN, *supra* note 43, at 164 ("Typical PTSD treatment usually involves assessment, [educating the patient about the disorder], and, depending on the severity and the particular set of symptoms, therapy, medication, or both."); NEWHOUSE, *supra* note 45, at 223 ("Most conventional modes of treatment, including those used by the VA, involve a combination of group therapies, cognitive behavioral therapies, and/or medicines to realign the chemistry of the brain."); HART, *supra* note 39, at 76-79 (describing the effects of various medications and highlighting the fact that "[m]edication for combat PTSD is utilized because of changes in the biological functioning of the individual exposed to trauma").

¹²⁷ U.S. DEP'T OF VETERANS AFFAIRS & DEP'T OF DEF., VA/DOD CLINICAL PRACTICE GUIDELINE FOR THE MANAGEMENT OF POST-TRAUMATIC STRESS (2004) [hereinafter VA/DOD PRACTICE GUIDELINE].

¹²⁸ *Id.* at I-18 (strongly recommending EMDR, PE, CPT, and Stress Inoculation).

1. *Exposure Therapy*

Exposure therapy is based on the theory that a patient with PTSD will benefit from re-experiencing trauma in a controlled environment where his or her fears can be explored with the guidance of a nonthreatening clinician.¹²⁹ In a very real way, lawyers engage in exposure therapy when they take reluctant clients or witnesses to visit a courtroom and sit in the witness chair to aid in easing the anxiety of providing live testimony. Some clinicians have hailed exposure therapy as the most effective among the treatment choices.¹³⁰

Prolonged Exposure (PE) is a popular and effective method in which patients “vividly imagine” traumatic events, by speaking or writing about them, often in the first-person, present tense format, with a focus on “the most distressing aspects.”¹³¹ Patients then revisit their accounts, which are either written or recorded, and observe subtle differences in the way the event is recounted over time.¹³² By revisiting the event with the guidance of the clinician, the patient is able to develop more accurate statements or images over time. Studies reveal that PE can have as much as a 70% success rate in reducing PTSD symptoms

¹²⁹ E.g., William P. Nash & Dewleen G. Baker, *Competing and Complementary Models of Combat Stress Injury*, in *COMBAT STRESS INJURY*, *supra* note 42, at 65, 73 (“[Exposure] treatments all make use of controlled reexperiencing of traumatic cures both in imagination and in real life in order to facilitate desensitization and extinction of conditioned fear responses.”).

¹³⁰ E.g., Editorial, *Virtual Reality Brings Therapy to PTSD Patients*, U.S. Dep’t of Def., MIL. HEALTH SYS., June 10, 2008, <http://www.health.mil/Press/Release.aspx?ID=238> (relating the comments of Dr. Greg Reger, Clinical Psychologist, Telehealth and Technology Center of the Defense Center of Excellence, who states, “The standard-of-care treatment for PTSD is exposure therapy”).

¹³¹ Allison G. Harvey et al., *Cognitive Behaviour Therapy for Posttraumatic Stress Disorder*, 23 *CLIN. PSYCHOL. REV.* 501, 502 (2003).

¹³² Nash & Baker, *supra* note 129, at 73 (“In PE, for example, traumatized individuals are asked to record on audiotape the story of their traumatic experiences in detail and in the present tense. They are then asked to listen to these tapes on a daily basis while practicing relaxation techniques.”). Exposure can be real, rather than imagined. The practice of “in vivo” exposure calls for patients to participate in an event that they had previously been avoiding. In one example, veterans who feared the presence of helicopters based on their combat experiences reduced these fears over time by riding in helicopter flights with the supervision of their therapists. *See generally* Raymond M. Scurfield et al., *An Evaluation of the Impact of “Helicopter Ride Therapy” for In-Patient Vietnam Veterans with War-Related PTSD*, 157 *MIL. MED.* 67 (1992).

after nine sessions of treatment.¹³³ Attorneys should seek to learn whether a client is receiving exposure therapy treatment at the time of legal counseling. By synchronizing calendars with the clinician, the attorney can avoid scheduling meetings close in time to the days when the client will revisit vivid traumatic experiences.

Another form of clinician-supervised exposure therapy includes Virtual Reality (VR) Therapy, which exposes veterans to computer-simulated images that resemble their own traumatic experience.¹³⁴ Virtual environments commonly depict streets, homes, and scenes encountered in Iraq.¹³⁵ In some pilot programs, clinicians can reproduce smells common to combat environments and other effects that make the experience extremely realistic.¹³⁶ Virtual Reality programs are not yet mainstream, but attorneys in the near future may represent clients undergoing PE or VR clinical trials during the course of the representation.

2. Cognitive Behavior Therapy

Cognitive Behavior Therapy (CBT) involves clinical exploration of the link between the client's distorted thoughts and his maladaptive behavior.¹³⁷ During CBT, a therapist helps the client explore these links by making the client complete charts and other written assignments.¹³⁸

¹³³ E.g., Edna B. Foa & Shawn P. Cabill, *Matching Survivors to the Appropriate Modality*, in TREATING TRAUMA SURVIVORS WITH PTSD 34, 53 (Von Rachel Yehuda ed., 2002).

¹³⁴ See generally Rizzo et al., *supra* note 44. As of June 2009, "There [were] about 40 Virtual Iraq systems in Defense Department and Veterans affairs hospitals and clinics," with the Air Force and Navy operating most of the active duty systems. Geoff Ziezulewics, *Military Uses Virtual Therapy to Help Troops Heal Wounds*, STARS & STRIPES (Mideast ed.), June 29, 2009, at 3, available at <http://www.stripes.com/article.asp?article=63509§ion=104>.

¹³⁵ E.g., Ziezulewics, *supra* note 134, at 2 (reproducing photographs from the University of Southern California's Institute of Creative Technologies).

¹³⁶ E.g., *id.* at 4 (noting that during the use of the virtual simulations, "the smell of fire, diesel, cordite, body odor and burning rubber are also used to facilitate memory recall and emotional processing").

¹³⁷ SLONE & FRIEDMAN, *supra* note 43, at 165 ("CBT involves working with your cognitions, or thoughts, to change your emotions, thoughts, and behaviors.").

¹³⁸ See generally MICHAEL A. TOMPKINS, USING HOMEWORK IN PSYCHOTHERAPY: STRATEGIES, GUIDELINES, AND FORMS 1-6 (2004) (describing the nature of psychotherapy homework and its many benefits); DAVID D. BURNS, THE FEELING GOOD HANDBOOK, at xxxiii-xxxvi (rev. ed. 1999) (describing how he and his patients are able to understand

The goal is to assist the client in challenging faulty assumptions or beliefs and to permit the client to adopt corrected beliefs.¹³⁹ Scholars describe a “feedback loop” that explains how unchecked thoughts can result in ongoing impairments:

In the case of painful feelings, a negative feedback loop can be set up in which an uncomfortable feeling itself becomes an “event,” the subject of further thoughts, which produce more painful feelings, which become a larger event inspiring more negative thoughts, and so on. The loop continues until you work yourself into a rage, an anxiety attack, or a deep depression.¹⁴⁰

Cognitive Behavior Therapy practitioners use a common three-column “A-B-C Worksheet” to identify the interrelationship of thoughts, situations, and feelings.¹⁴¹ The first column, which represents “the activating event,” requires the patient to identify an event that triggers an undesired emotional response. The second column represents the “belief” underlying the emotion. The third column represents the “consequence” of the trigger and resulting belief, which is the emotion or feeling that is generated. In Figure 1 below, a hypothetical Soldier, Specialist Tracy Melvin, was initially traumatized by the detonation of an improvised explosive device that seriously injured a fellow Soldier. The event occurred near a schoolyard. Recently, her response to seeing a group of children was fear that an attack similar to the one she witnessed in combat was about to take place, even though she was nowhere near a combat zone.¹⁴²

the application of psychological concepts at a personal level when they put pen to paper and provide individualized information).

¹³⁹ *E.g.*, DENNIS GREENBERGER & CHRISTINE A. PADESKY, MIND OVER MOOD: CHANGE HOW YOU FEEL BY CHANGING THE WAY YOU THINK 109 (1995) (describing the value of considering alternative and balanced thoughts and how consideration of such thoughts provides new insights and feelings).

¹⁴⁰ MATTHEW MCKAY ET AL., TAKING CONTROL OF YOUR MOODS AND YOUR LIFE: A THOUGHTS AND FEELINGS WORKBOOK 18 (1997).

¹⁴¹ PATRICIA A. RESICK ET AL., COGNITIVE PROCESSING THERAPY VETERAN/MILITARY VERSION: THERAPISTS MANUAL 63 (Dept. Veterans Affairs 2007) [hereinafter CPT THERAPISTS MANUAL] (describing how the worksheets help patients to “see the connection between . . . thoughts, and feelings following events”).

¹⁴² *E.g.*, ARMSTRONG ET AL., *supra* note 61, at 17 (observing that “[b]eing around children who remind you of kids in the war zone” is a specific reminder “that may trigger responses for returning veterans”).

A-B-C Sheet		
Date: _____ Patient # _____		
<u>Tracy Melvin</u>		
ACTIVATING EVENT	BELIEF	CONSEQUENCE
A	B	C
<p>“Something happens”</p> <p><i>I walk by a group of school children on post</i></p>	<p>“I tell myself something”</p> <p><i>These kids have an IED or this is an ambush</i></p>	<p>“I feel something”</p> <p><i>Confused</i></p> <p><i>Scared</i></p>
Is it reasonable to tell yourself “B” above? _____		
What can you tell yourself on such occasions in the future? _____		

Fig. 1 “A-B-C Worksheet”

Because it is sometimes difficult to identify underlying feelings and Soldiers with PTSD often experience emotions first, without seriously considering their thoughts,¹⁴³ the patient might complete the “B” column as the final step for the worksheet.

The information identified on the A-B-C Worksheet presents a foundation upon which clinicians can build to further explore the connection between thoughts, feelings, and situations. In more detailed thought records, patients rate the intensity of their thoughts by percentage from zero to one-hundred.¹⁴⁴ They, likewise, identify statements that challenge or balance the initial responses, and re-rate the intensity of their original feelings after considering alternative viewpoints.¹⁴⁵

¹⁴³ *E.g., id.* at 101 (describing how Soldiers with PTSD often use “emotional reasoning,” in which they “reason things out based on how [they] feel”).

¹⁴⁴ *E.g.,* MCKAY ET AL., *supra* note 140, at 42 (reproducing a completed “Thought Journal”); GREENBERGER & PADESKY, *supra* note 139, at 100–01 (same).

¹⁴⁵ *E.g.,* GREENBERGER & PADESKY, *supra* note 139, at 100–01.

Specialist Melvin’s thought above (“These kids have an IED or this is an ambush,”) can represent three of eight types of distorted thinking—“overgeneralization,” “catastrophizing,” or “magnifying”—which are defined in Figure 2, below.¹⁴⁶

1. **Filtering:** You focus on the negative details while ignoring all the positive aspects of a situation.
2. **Polarized Thinking:** Things are black or white, good or bad. You have to be perfect or you’re a failure. There’s no middle ground, no room for mistakes.
3. **Overgeneralization:** You reach a general conclusion based on a single incident or piece of evidence. You exaggerate the frequency of problems and use negative global labels.
4. **Mind Reading:** Without their saying so, you know what people are feeling and why they act the way they do. In particular, you have certain knowledge of how people think and feel about you.
5. **Catastrophizing:** You expect, even visualize, disaster. You notice or hear about a problem and start asking, “What if?” “What if tragedy strikes?” “What if it happens to you?”
6. **Magnifying:** You exaggerate the degree or intensity of a problem. You turn up the volume on anything bad, making it loud, large, and overwhelming.
7. **Personalization:** You assume that everything people do or say is some kind of reaction to you. You also compare yourself to others, trying to determine who is smarter, more competent, better looking, and so on.
8. **Shoulds:** You have a list of ironclad rules about how you and other people should act. People who break the rules anger you, and you feel guilty when you violate the rules.

Fig. 2. Eight Forms of Distorted Thinking

Distorted thoughts commonly associated with PTSD, and which could influence legal representation, include the following:

- “It’s not worth my time and energy to plan for the future because I may be redeployed”,¹⁴⁷
- “I never think beyond today, much less tomorrow or

¹⁴⁶ MCKAY ET AL., *supra* note 140, at 32 (“Summary”). These eight patterns represent most of the dysfunctional thoughts exhibited by patients, although they might go by different names. Elsewhere, for example, polarized thinking has been called “All-or-nothing thinking” and “Magnifying” has been called “Overfocusing on the Negatives.” *E.g.*, STEVEN TAYLOR, CLINICIAN’S GUIDE TO PTSD: A COGNITIVE BEHAVIORAL APPROACH 193 (2006) (“Handout 10.1, Cognitive Distortions Associated with PTSD”).

¹⁴⁷ ARMSTRONG ET AL., *supra* note 61, at 132.

- the next day. I won't live much longer."¹⁴⁸
- "Grieving means I'm weak."¹⁴⁹
 - "If I move on with my life, I will stop thinking about those I lost."¹⁵⁰

With knowledge of such limitations, the client can conduct further self-analysis, acting as a personal scientist, to substitute dysfunctional thoughts with more productive ones.¹⁵¹ The process can work equally well in permitting the client to evaluate errors in the interpretation of legal advice.

Cognitive Processing Therapy (CPT) is an adaptation of CBT which combines traditional exercises with an element of exposure therapy. During CPT, the patient revisits a traumatic experience by writing about it over the course of time, evaluates changes in the descriptions of the event, and explores the feelings and beliefs related to the changing descriptions.¹⁵² Success rates for CBT treatment of PTSD have been consistently high, leading many clinicians to suggest that CBT represents one of the most successful approaches to the clinical treatment of PTSD.¹⁵³

3. Eye Movement Desensitization Reprocessing

Eye Movement Desensitization Reprocessing (EMDR) Therapy is an eight-phase treatment which combines visualization techniques with optical stimulation. Based on the recognition that PTSD affects the two hemispheres of the brain,¹⁵⁴ EMDR requires the clinician to move a

¹⁴⁸ *Id.*

¹⁴⁹ *Id.* at 119.

¹⁵⁰ *Id.*

¹⁵¹ *E.g.*, Harvey et al., *supra* note 131, at 503 ("Cognitive restructuring involves teaching patients to identify and evaluate the evidence for negative automatic thoughts as well as helping patients to evaluate their beliefs about the trauma, the self, the world, and the future.").

¹⁵² VA/DoD PRACTICE GUIDELINE, *supra* note 127, at I-21.

¹⁵³ SLONE & FRIEDMAN, *supra* note 43, at 165 ("Cognitive Behavioral Therapy . . . has been shown to be the most effective treatment for PTSD. In fact, CBT has been designated the treatment of choice in all evidence-based clinical practice guidelines for the treatment of PTSD published to date.").

¹⁵⁴ HART, *supra* note 39, at 30:

finger back and forth across the patient's field of vision to promote an exchange of information across the left and right hemispheres.¹⁵⁵ This stimulation normally occurs while the patient considers a selected unsettling image related to a traumatic experience.¹⁵⁶ At a neurological level, "[i]t is thought that this technique allows the emotional response of these traumatic and pictorial memories to be reduced to just a flashbulb memory, a picture with an emotional response no longer, but rather just a feeling of sadness and a sense of loss."¹⁵⁷

Therapists repeat this process and deal with newly emerged images and statements, comparing levels of emotional distress.¹⁵⁸ In the process above, the "desensitization" component of EMDR represents the visualization of the target image and its transformation into new images and sensations.¹⁵⁹ The "reprocessing" component occurs when "clients generally report new memory associations and change of

Recent research has shown that when individuals are traumatized, there appears to be marked lateralization of activity in the right hemisphere. There is also a decrease in activation or stimulation to a part of the brain in the left hemisphere responsible for language . . . There appeared to be a decrease in oxygen utilized by this part of the brain in the left hemisphere during the activation of a traumatic memory.

¹⁵⁵ E.g., Harvey et al., *supra* note 131, at 512 (discussing patients' visual "tracking" of the therapists movements while focusing attention on traumatic events); Howard J. Lipke & Allan T. Botkin, *Case Studies of Eye Movement Desensitization and Reprocessing (EMDR) with Chronic Post-Traumatic Stress Disorder*, 29 PSYCHOTHERAPY 591, 591 (1992):

EMDR calls for the patient to visualize the most distressing moment of a traumatic incident and the concomitant physical distress while . . . repeating the [associated] negative self-statement . . . [Next], the patient is asked to follow, with his or her eyes, the therapist's finger as it rapidly moves back and forth a distance of approximately 12 inches across the patient's field of vision approximately 12 inches from the face. Twelve to 24 back-and-forth eye movements are made at a rate of two complete cycles per second. When the movements are completed the patient is asked to "blank" the scene out of mind and take a deep breath.

¹⁵⁶ Commander Mark C. Russell, *Treating Combat-Related Stress Disorders: A Multiple Case Study Using Eye Movement Desensitization and Reprocessing (EMDR) with Battlefield Casualties from the Iraq War*, 18 MIL. PSYCHOL. 1, 3 (2006).

¹⁵⁷ HART, *supra* note 39, at 31.

¹⁵⁸ *Id.*

¹⁵⁹ Russell, *supra* note 156, at 3.

somatic/emotional content and valence as well as insights and shifts of cognitive content.”¹⁶⁰

An applied example involves a Marine, who had been medically evacuated for shrapnel wounds received in Iraq. This patient experienced deep feelings of sadness in response to witnessing a fellow Marine (and new father) mutilated by the same RPG attack that injured him.¹⁶¹ His target image was “his buddy’s horrific death,” accompanied by the thoughts, “He will never see his family,” and “I might not ever see my family again.”¹⁶² During the first eye movements, the patient recalled more details about the events leading to the explosion accompanied by the new thought, “I am going to die.”¹⁶³

As eye movements continued, the scene again transformed into an unrelated vision of “an elderly ‘ragtag’ civilian soldier armed with an AK-47 exiting a car shooting,”¹⁶⁴ then to a positive one—“rolling into south Baghdad and being greeted by what appeared to be starving children who were smiling.”¹⁶⁵ The patient now visualized an occasion when he handed a boy food, and the boy responded, “America OK.”¹⁶⁶ This new image was associated with feelings that he was a hero.¹⁶⁷ After observing these developments, the therapist had the patient return to the target image of friend’s severed torso. While there were still feelings of loss, resonance between the target image and the new, more positive one finally resulted in concluding thoughts that “His family will be taken care”¹⁶⁸ of and “he won’t see his family again, but I survived and will be back with them tomorrow.”¹⁶⁹ After the “exhausting” EMDR session, the patient reported that he was able to sleep well “for the first time in a long time.”¹⁷⁰

Soldiers undergoing EMDR therapy have similar experiences to the Marine in the above example. In explaining how she did not initially know what to expect, a patient related her response to the eye

¹⁶⁰ *Id.*

¹⁶¹ *Id.* at 8.

¹⁶² *Id.*

¹⁶³ *Id.*

¹⁶⁴ *Id.*

¹⁶⁵ *Id.*

¹⁶⁶ *Id.*

¹⁶⁷ *Id.*

¹⁶⁸ *Id.* at 9.

¹⁶⁹ *Id.*

¹⁷⁰ *Id.*

movements: “It was amazing what came out, things from Iraq, things from Bosnia, and things from my childhood.”¹⁷¹ It is said that treatment such as this “can bring out [encoded] memories, strip them of their emotional content, and store them away again in a less threatening form,” thus completing a formerly blocked process of experiencing.¹⁷² While some clinicians may be skeptical of EMDR, based on its dissimilarity to standard psychological approaches, organizations of mental health professionals have endorsed EMDR as a legitimate treatment tool because of its high success rates in the treatment of combat veterans with PTSD.¹⁷³ Clinicians may be able to modify EMDR treatment to address a client’s litigation-related fears at the attorney’s request.

With the availability of treatments including PE, CPT, and EMDR, most combat veterans are expected to improve with effective treatment.¹⁷⁴ Attorneys should endeavor to learn: (1) the type of technique the client is using during the legal representation and how far along he is; (2) whether the client unsuccessfully attempted treatment in the past with a different technique; and (3) the types of relaxation methods the clinician has demonstrated to the client or which the client has been practicing to limit the adverse effects of the disorder. Once aware of the techniques a client has been practicing, the attorney can work with clinicians to tailor complementary exercises that address the effects of Forensic Stress Disorder or triggers unique to the legal representation.

III. Fostering Productive Relationships with Mental Health Professionals

While the diagnosis and treatment of mental health conditions are functions of licensed mental health professionals, attorneys must

¹⁷¹ NEWHOUSE, *supra* note 45, at 247 (describing the experiences of Heather Kryszak).

¹⁷² *Id.* at 252 (describing Dr. Shapiro’s theory).

¹⁷³ *E.g.*, Russell, *supra* note 156, at 2 (observing positive treatment recommendations from the International Society for Traumatic Stress Studies, the U.S. DVA/DoD, The American Psychiatric Association, and the Israeli National Counsel for Mental Health).

¹⁷⁴ Regardless of whether a client is undergoing CPT, EMDR, or PE therapy, the recommended treatment lasts approximately twelve weeks. *E.g.*, Kent A. Corso et al., *Helping Military Personnel and Recent Veterans Manage Stress Reactions*, 31 J. MENTAL HEALTH COUNSELING 119, 119 (2009) (observing that “effective treatment protocols are rigorous and time-consuming—as much as 12 weeks of 60-90 minute sessions”). In line with this protocol, for example, the Army’s CPT program consists of twelve sessions. *See generally* CPT THERAPISTS MANUAL, *supra* note 141.

nevertheless deal with the impact of a client's mental health conditions in fulfilling their legal duties.¹⁷⁵ Overlap between the psychological and legal spheres is inevitable as mental health providers also face the patient's legal issues from the therapist's couch.¹⁷⁶ Despite some incongruence between professional approaches and standards of professional responsibility between disciplines, there is a necessity for collaboration in the best interests of a client with a mental illness like PTSD.¹⁷⁷

There are legitimate concerns that may prevent full collaboration. A common issue in cross-disciplinary work is child abuse reporting requirements: "[A]ttorney confidentiality and privilege differ from social worker confidentiality and privilege in that the mandatory child abuse reporting statute abrogates both privilege and confidentiality with respect to social workers, but not with respect to attorneys."¹⁷⁸ In such situations, the attorney and clinician can establish measures to ensure that their different sets of professional responsibilities are met. They can generally develop procedural safeguards, such as (1) educating the client about different professional duties; (2) requiring consent from the client to share certain information; and (3) using "shadow files, in which protected information is kept apart from other case information."¹⁷⁹ Criminal attorneys can also request the clinician as a consultant to the defense team in order to limit the possibility that certain communications will be disclosed.¹⁸⁰ An active duty client who is already in treatment

¹⁷⁵ E.g., PORTNOY, *supra* note 107, at 19 & 158.

¹⁷⁶ See generally Anthony Bertelli, *Should Social Workers Engage in the Unauthorized Practice of Law*, 8 B.U. PUB. INT. L.J. 15 (1998) (identifying inevitable legal overlap in the functions of mental health providers who treat low-income populations).

¹⁷⁷ Veterans' treatment courts have recognized this overwhelming benefit and structured their programs accordingly. See *supra* Part II.C.

¹⁷⁸ Jacqueline St. Joan, *Building Bridges, Building Walls: Collaboration Between Lawyers and Social Workers in a Domestic Violence Clinic and Issues of Client Confidentiality*, 7 CLIN. L. REV. 403, 430-31 (2001). The Army rule is no different. See U.S. DEP'T OF ARMY REG. 608-18, THE ARMY FAMILY ADVOCACY PROGRAM app. G-4 (30 Oct. 2007) ("A military lawyer has no obligation to make a report of spouse or child abuse that comes to his or her attention as a result of privileged communication unless the communication clearly contemplates the commission of a future crime.").

¹⁷⁹ St. Joan, *supra* note 178, at 440. See also Paula Galowitz, *Collaboration Between Lawyers and Social Workers: Re-Examining the Nature and Potential of the Relationship*, 67 FORDHAM L. REV. 2123, 2147-53 (1999) (discussing various methods to remove impediments to collaboration between lawyers and social workers).

¹⁸⁰ See MANUAL FOR COURTS-MARTIAL, UNITED STATES, R.C.M. 703(d) (2008) (providing standards for the appointment of an expert consultant). See generally Major Will A. Gunn, *Supplementing the Defense Team: A Primer on Requesting and Obtaining*

may pose fewer concerns, as his records are likely releasable to the command upon request, creating concerns only with new information related to the representation not yet revealed in medical files.¹⁸¹ In each situation, the growing scholarship on interdisciplinary practice in children's law, elder law, and mental health law provides a range of safeguards to protect the client.¹⁸²

Simply from the perspective of limited resources, it is infeasible to expect that the attorney will have access to a mental health provider during all client counseling sessions.¹⁸³ Accordingly, the collaborative process is often incremental and iterative. In her role as first responder to the cognitive problems presented by legal issues, the attorney conducts triage: she evaluates the client's behavior, seeks feedback from mental health personnel or resources, and considers how to compensate for the client's decisional impairments.

An attorney representing a client already in treatment for PTSD should endeavor to learn whether the client is using EMDR, CPT, or PE methods and how such treatment might complicate legal counseling sessions scheduled close in time. With knowledge of the client's legal concerns and aspects of litigation that will pose the greatest amount of stress on the client, the attorney should consider how the mental health professional can address legal stressors with therapeutic intervention. If, for example, a client is already using A-B-C worksheets as part of a CPT regimen, attorneys could also use the worksheets to assist in identifying distorted litigation-related thoughts.¹⁸⁴ Even where a clinician is unable

Expert Assistance, 39 A.F. L. REV. 143 (1996) (providing practical guidance on how to meet R.C.M. 703(d)'s requirements).

¹⁸¹ See, e.g., SLONE & FRIEDMAN, *supra* note 43, at 142 (discussing accessibility of Soldiers' medical records, especially relating to mental health treatments for PTSD). There are so many exceptions to the military's psychotherapist-patient privilege established by Military Rule of Evidence 513 that defense counsel have been cautioned not to expect protection of client communications with mental health providers. E.g., Lieutenant Colonel R. Peter Masterton, *The Military's Psychotherapist-Patient Privilege: Benefit or Bane for Military Accused?*, ARMY LAW., Nov. 2001, at 21–22.

¹⁸² E.g., ABA COMM. ON L. & AGING & AM. PSYCHOLOGICAL ASSN., ASSESSMENT OF OLDER ADULTS WITH DIMINISHED CAPACITY: A HANDBOOK FOR LAWYERS 3 (2005) (LEXIS Course No. SM054) (exploring various alternatives that will not compromise the attorney's role or violate the client's best interests).

¹⁸³ E.g., Coleman, *supra* note 21, at 142 (identifying common limitations on multidisciplinary legal teams including coordination difficulties and "time pressure[s]").

¹⁸⁴ See *supra* Part II.E.2 (reviewing key attributes of the A-B-C Worksheet). Similar collaboration between the attorney and clinician has been proposed by forensic psychologist Astrid Birgden, who envisions cross-disciplinary application of a

to address uniquely legal concerns, an attorney can still work with the provider to modify client counseling on sensitive legal topics or plan responses to a client's stress responses in the legal office.¹⁸⁵

Whether the attorney explores mental health concerns in relation to a specific case or in an effort to address all potential cases involving PTSD, the first responder frame requires interaction with healthcare providers to improve the quality of client counseling.

IV. Conclusion

This article has introduced a new perceptual frame for attorneys representing combat veterans. From this vantage point, the attorney acknowledges her role as a potential first responder to PTSD. She accepts the fact that, for many reasons, a client may be suffering from this disorder without having been diagnosed or treated; she recognizes that, as a lawyer representing the combat veteran, she has an obligation to act in the best interests of her client.¹⁸⁶ While the PTSD First Responder frame does not require the attorney to don a lab coat and prescribe medication, it does require knowledge of PTSD symptoms as

psychological technique by an attorney and mental health professional. Astrid Brigden, *Dealing With the Resistant Criminal Client: A Psychologically-minded Strategy for More Effective Legal Counseling*, 38 CRIM. L. BULL. 225, 237 (2002) ("A joint defense attorney and mental health professional strategy is proposed to maximize cooperation in the resistant client; the attorney applies motivational techniques [during three stages of the counseling process] while the mental health professional applies cognitive behavioral intervention and relapse prevention at the [other two additional] stages."). In this joint model, "[t]echniques previously designed for the mental health professional regarding motivating change and techniques for the defense attorney regarding enhanced decision-making are combined." *Id.* at 238–39 & 238 tbl.4 (depicting attorney and mental health professionals' respective roles).

¹⁸⁵ *E.g.*, Christina A. Zawisza & Adela Beckerman, *Two Heads are Better Than One: The Case-Based Rationale for Dual Disciplinary Teaching in Child Advocacy Clinics*, 7 FL. COASTAL L. REV. 631, 679–80 (2006) (identifying several crucial ways social workers and other mental health professionals can assist attorneys in meeting their duties, including overcoming barriers to effective communication during client counseling); Seamone, *supra* note 1 (addressing enhanced counseling methods that permit attorneys to effectively represent servicemembers with PTSD).

¹⁸⁶ Few can doubt the fundamental proposition that "[a]ll attorneys have an ultimate responsibility to act in the best interests of their clients." Christopher J. Mealing & Donald Stepler, *Court Annexed Arbitration—The Northern Kentucky Experience*, 81 K.Y. L.J. 1155, 1163 (1993). *See, e.g.*, *Friedman v. Comm'r of Pub. Safety*, 473 N.W.2d 828, 834–35 (Minn. 1991) (addressing the attorney's obligation to maximize an alcoholic client's well-being by exploring treatment options for his condition).

they relate to a client's participation in the legal representation. Without such knowledge the attorney will be unable to see signals that the client suffers from a decisional impairment as a result of these symptoms. Like a medical first responder, the veterans' attorney should conduct triage.¹⁸⁷

In line with the prevailing research, the attorney need not presume that every combat veteran who visits her office is afflicted with PTSD.¹⁸⁸ When the attorney pays conscious attention to the subtle indicators of potential problems, the need for further analysis will be evident. Sometimes the cues will be obvious. In military settings, if a client is wearing a Combat Infantryman Badge, a Marine Combat Aircrew Badge, a Combat Action Badge, a Combat Medical Badge, a ribbon or medal with a "V" device, or other signs of engagements with an enemy,¹⁸⁹ these visual indicators provide conversational starting points for the attorney. In civilian settings, other casual questions probing prior or multiple deployments can easily serve the same function. Missed appointments or problems keeping track of information can also be signals.¹⁹⁰ Ultimately, in every scenario, aside from considering the legal questions presented by a case, veterans' counsel should first consider the foundational questions of whether the client is capable of understanding their advice and whether some sort of corrective action will be necessary for successful client counseling on the legal issues or the client's well-being in general.

While this first responder frame surely requires education in areas that are unfamiliar to many attorneys, the legal profession imposes an ethical obligation to gain knowledge necessary to the effective representation of a client.¹⁹¹ Veterans' treatment courts may become the

¹⁸⁷ Shetty, *supra* note 9, at 566–67.

¹⁸⁸ See *supra* Part II (discussing the prevalence of PTSD in combat veterans and the fact that a majority of veterans will not have this condition). The population of veterans facing legal problems will likely contain a higher percentage of veterans with PTSD than the entire veteran population. *Id.*

¹⁸⁹ For example, the combination of a deployment patch and indicators of service in the Explosive Ordnance Disposal military occupational specialty would suggest, at the least, that the servicemember has had increased exposure to traumatic combat events. The same can be said of flight surgeons or others who are charged with treating combat injuries.

¹⁹⁰ *E.g.*, ARMSTRONG ET AL., *supra* note 61, at 142 (describing common signals, such as problems organizing information).

¹⁹¹ *E.g.*, MODEL RULES OF PROF'L CONDUCT cmt. to R. 1.1 (2006) ("A lawyer can provide adequate representation in a wholly novel field through necessary study or consultation with a lawyer of established competence in the field in question."); AR 27-26, *supra* note

first to develop a formal PTSD training regimen for attorneys,¹⁹² but historic parallels can also be drawn to criminal and civil cases involving DNA analysis. For the most part, attorneys are normally unprepared to evaluate the merits and validity of cases involving DNA.¹⁹³ Yet, they must nevertheless engage in extensive study to meet their legal duties in these cases.¹⁹⁴ In the context of PTSD, attorneys have even more incentive to learn about the related scientific issues, if for no reason other than the fact that this unseen condition may be lurking in the backdrop of any case involving a combat veteran. Attorneys working on cases involving PTSD and DNA also share important limitations. The similarities continue. Just as learned criminal law attorneys must reserve laboratory analysis for the forensic serologist, veterans' counsel must also reserve formal diagnosis and treatment for the licensed clinician. In either case, the attorney must have independent knowledge of scientific principles and the ability to effectively incorporate them in legal analysis.

73, cmt. to R. 1.1 (same). In cases involving the representation of children, for example, courts have imposed supplemental rules requiring attorneys to become conversant in psychology and the clinical assessment of their clients. Zawisza & Beckerman, *supra* note 185, at 679.

¹⁹² See *supra* Part II.C.

¹⁹³ E.g., Steve Lash, *Require "DNA 101" for Lawyers, Justices Urged*, CHI. DAILY LAW BULL., Oct. 14, 2005, at 1 (reporting the efforts of the American Bar Association to "urge[] the justices to require that defense attorneys either understand DNA and other biological evidence or consult with experts" to prevent wrongful convictions); Myrna S. Raeder, *Cost-Benefit Analysis, Unintended Consequences, and Evidentiary Policy: A Critique and Rethinking of the Application of a Single Set of Evidence Rules to Civil and Criminal Cases*, 19 CARDOZO L. REV. 1585, 1589 (1998) (identifying a pervasive "math phobia" in the legal profession and observing that "the discomfort some feel with the *Daubert* standard (requiring the court to determine the reliability of new technological advances) stems from the inability of many trial lawyers and judges to understand hard science").

¹⁹⁴ E.g., Gregory W. O'Reilly & Allan Sincov, *Forensic DNA Case Evaluation and Litigation*, 28 LITIG. 43, 43 (2001) (noting that "the two most important skills necessary in trying DNA cases are to learn the science well enough that you can not only cross-examine a[n] . . . expert but also explain the technology to a lay jury"). Joelle Anne Moreno, *Beyond the Polemic Against Junk Science: Navigating the Oceans that Divide Science and Law with Justice Breyer at the Helm*, 81 B.U. L. REV. 1033, 1081 (2001) ("Legal scholars and practitioners who must assess the quality of scientific evidence must also acquire a basic understanding of core statistical concepts."). Professor Moreno identifies the need for scientific sophistication by identifying several common errors that attorneys must correct from the misuse of terminology to the misunderstanding of scientific methodology. *Id.* at 1064–81.

This new frame for client counseling and case evaluation comes at an opportune time for attorneys serving servicemembers. Combat veterans with PTSD who find themselves in a criminal defense attorney or a family law attorney's office are usually experiencing the direct results of their symptoms. They come to attorneys for advice, guidance, and solutions to very real and immediate problems. The ramifications of their legal problems may have lifetime or life-ending implications. In many cases, such as the common scenario where a veteran is reluctant to seek help, the attorney's office is the frontline in the fight for effective representation. Whether in the form of referral or through enhanced counseling techniques, military and civilian attorneys owe it to their clients to intervene early and meaningfully.