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POTENTIAL FACTORS INFLUENCING ATTITUDES TOWARD VETERANS WHO COMMIT CRIMES: AN EXPERIMENTAL INVESTIGATION OF PTSD IN THE LEGAL SYSTEM

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ABSTRACT

Research has shown that veterans with PTSD report more acts of violence than those without PTSD. As such, it is important to study factors that may impact legal attitudes toward veterans with PTSD, especially in regards to the use of PTSD as a defense. In the present study, participants read documents detailing a case in which a veteran was charged with murder. Two factors were manipulated: when the defendant was diagnosed with PTSD and what type of military event caused the PTSD. Results revealed that these factors did not impact guilt judgments but did impact other perceptions of the defendant.

INTRODUCTION

On August 16, 2008, Jessie Bratcher killed the man he thought raped his girlfriend. Bratcher was a member of the Oregon Army National Guard and had been previously deployed to Iraq for 11 months. During this deployment, he sustained injuries from a roadside bomb and his best friend was killed. As a result, he developed posttraumatic stress disorder (PTSD). After he returned home, his girlfriend said that she was raped by a local man, Jose Ceja Medina, whom Bratcher then confronted. Medina claimed it was consensual sex. Bratcher fired a gun at Medina, shooting him 10 times in the back as he turned to run. During the trial, Bratcher claimed that he experienced flashbacks to Iraq during the shooting. Several months later, Bratcher was found guilty but insane—he would not be sentenced to prison for the murder (Sullivan, 2009).

Bratcher is not the only veteran with PTSD who has returned to the United States and committed a serious crime. In recent years, there have been numerous trials of veterans who have committed murder, attempted murder, robbery, and kidnapping, although exact numbers are unclear (Wood, 2012). Some, like Bratcher, receive a relatively light sentence or no sentence at all. However,

others, such as Nicholas Horner, who killed two people and injured a third during a PTSD episode, do not receive any leniency for their crimes; Horner was sentenced to life in prison (Lawrence & Rizzo, 2012).

With the withdrawal of troops from Iraq and Afghanistan, an influx of veterans will be returning to the United States. Although most veterans will re enter civilian life successfully, the United States Department of Veterans Affairs believes that 11-20% of these veterans either have developed or will develop PTSD (“How common is PTSD,” 2007). Although it is important to note that research does not imply a direct link between PTSD and most violent behavior (Brown, 2012), if past trends continue, at least some of these veterans will go on to commit violent crimes. As such, it is important to study the public’s views of veterans with PTSD, especially in terms of criminal involvement. More specifically, do people tend to consider PTSD to be a valid legal defense and what factors may make the diagnosis seem more or less legitimate—a topic that has not been studied to date.

Aggression, PTSD, and the Legal System

Research has found that veterans with PTSD self-report higher levels of hostility, aggression, and more numerous acts of violence than veterans without PTSD (Begic & Begic, 2001; Lasko, Guruits, Kuhne, Orr, & Pitman, 1994). Additionally, the National Vietnam Veterans Readjustment study found that half of a sample of Vietnam veterans with PTSD had been arrested at least once and also reported an average 13 acts of violence in the previous year (Kulka, et al., 1990).

If an individual with PTSD commits a crime, the diagnosis can be relevant at several different stages of the legal process, including whether the defendant meets the legal definition for insanity or whether the prosecutors choose to plea-bargain instead of going to trial. A PTSD diagnosis also can be introduced during the sentencing phase after a defendant is found guilty in an effort to secure a lighter sentence. According to research in the area of attribution theory (Heider, 1958; Weiner, 1986), people are less punitive toward individuals who commit criminal acts if they consider the crime to be caused by factors outside the individual’s control (Aspinwall, Brown, & Tabery, 2012; Templeton & Hartnagel, 2012; Unnever, Cochran, Cullen, & Applegate 2010). As such, it seems reasonable to presume that people would be less punitive toward an individual with PTSD compared to one without PTSD as this diagnosis provides an external factor upon which to place blame for the event. Research has supported this idea by showing that PTSD is considered to be one of the more valid excuses for committing a crime (Heath, Stone, Darley, & Grannemann, 2003). It is unclear, however, why some veterans with PTSD may be more likely to receive plea bargains or sentencing leniency while other veterans with PTSD do not.

As it is the case that PTSD symptoms are known to be relatively easy to fake (Hall & Hall, 2007), it is possible that people do not view all cases of PTSD as equally legitimate. This ease of faking is not known just to experts; rather, media coverage has made the possibility of veterans faking their symptoms known to the general public. For instance, a recent article in the Los Angeles Times (and later picked up by outlets such as The Washington Post) focused on the rise

in claims of PTSD by veterans and featured several interviews with experienced psychologists who stated that they believed a significant portion of veteran patients were malingering (exaggerating or fabricating their symptoms) in order to earn disability benefits (Zarembo, 2014). It is important to note that while some studies have found support for the notion that a large percentage of veterans may be exaggerating their symptoms (e.g., Freeman, Powell, & Kimbrell, 2008), others dispute these claims (e.g., Marx, et al., 2012). Regardless, it is possible that the sentencing differences experienced by veterans who use a PTSD defense may have to do with whether people viewed the diagnosis as legitimate.

One factor that could be influential in judgments of legitimacy concerns the timing of the diagnosis. If PTSD was diagnosed before the crime (as in the case of Bratcher, detailed in the outset of this article), it may seem more legitimate to potential jurors that PTSD was, in fact, accurately diagnosed. If PTSD was diagnosed after the crime (as in the case of Horner, who was found guilty; King, 2009), people may be suspicious that the veteran is faking a diagnosis in order to receive a benefit (in this case, a lighter sentence, similar to the example above in which veterans allegedly fabricated their symptoms to earn disability benefits).

The type of combat a veteran experienced may also influence attitudes toward a PTSD diagnosis. Previous research has examined whether witnessing a combat related trauma (e.g., seeing a fellow soldier injured) is sufficient to produce PTSD or if one needs to actively engage in violence (e.g., killing an enemy combatant). For instance, a study on Vietnam veterans revealed that witnessing the deaths of others was not sufficient on its own to produce symptoms of PTSD, while killing others had a strong direct effect on developing the disorder (Fontana & Rosenheck, 1999). A more recent study on soldiers returning from the Gulf War revealed a strong effect of killing on PTSD symptoms, even after controlling for witnessing combat deaths in general (Maguen et al., 2011). Other studies have found similar results (e.g., Van Winkle & Safer, 2011), with a study on combat medics showing that witnessing soldiers being killed no longer related to PTSD symptoms once “attempting to kill” another person was entered into the regression model (Pitts et al., 2014). A study on veterans returning from Iraq and Afghanistan found that those who reported killing were twice as likely to fall into the “high symptom” category of PTSD compared to those who had not killed (Maguen et al., 2013). In other words, research supports the notion that actually killing while deployed as opposed to witnessing the death of a fellow soldier or civilian, may not only be more likely to produce symptoms of PTSD, but also symptoms that are more severe. Again, given media coverage regarding the legitimacy of PTSD diagnoses when there is a benefit to the individual (McVay, 2014; Sisk, 2017; Zarembo, 2014), it is possible that people may be skeptical of the diagnosis when used as a criminal defense and therefore look for more convincing evidence that the PTSD diagnosis is valid (i.e., how much trauma the individual actually experienced).

Present Study

The purpose of the present research is to determine whether two specific factors have the potential to impact attitudes: 1) the timing of diagnosis, in terms of whether the veteran was diagnosed before or after committing a crime and 2) the type of combat experienced, in terms of whether the veteran developed PTSD after engaging in combat, as opposed to witnessing an

event. Specifically, we hypothesize that individuals will express more lenient attitudes toward those veterans diagnosed prior to committing the crime (with an exception for the responses concerning the likelihood of successful rehabilitation, given that those individuals already diagnosed would likely be seen as undergoing treatment and therefore rated as less likely to benefit from rehabilitation compared to those diagnosed after the crime). We also hypothesize that individuals will be more lenient toward those veterans who actively engaged in combat, as people may view engaging in versus witnessing combat as more likely to produce a legitimate case of PTSD.

METHOD

Participants

Participants were 103 students from a Midwestern university. The median age was 19 ($M = 18.98$, $SD = 1.16$). Fifty-four percent of participants were female. The participants were recruited from psychology classes and were given course credit for participating.

Procedure

Participants came to the lab in groups of one to four and were told that the purpose of the study was to understand criminal judgments. Participants were then given court documents to read (adapted from Hodson, Hooper, Dovidio, & Gaertner, 2005) that described the murders of two men. The participants were told that the crime and documents were real, although they were actually fictional. The first two documents were witness statements that described two men being shot in their front yards by a man who got into his car and left the scene. The statements described the license plate number of the car in which the defendant left after the shooting.

The next document was a statement from a detective, who described going to the house to which the license plate was registered and arresting the defendant. The next document was an evaluation of the defendant written by a psychologist and stated that the defendant was a veteran who had PTSD. This document was manipulated to assess the variables of interest. Specifically, participants were randomly assigned to read that the defendant was diagnosed with PTSD six months before the shooting (“before” condition) or that he was diagnosed with PTSD after the shooting (“after” condition; see Appendix). Additionally, some participants read that there was a bombing of the veteran’s base that killed his bunkmate (“witness” condition) while others read that the veteran also shot two enemy intruders after being instructed to lock down the perimeter in addition to the bombing (“engaged” condition; see Appendix). The next document for all conditions was a statement from the veteran stating that he shot the two men, but did not know why. The final document was an agreement from the psychologist that he would testify that the veteran had PTSD, indicating that the defense was attempting to use the PTSD diagnosis as an explanation for the crime. All documents were created to appear official, complete with names, addresses, and official seals.

Participants then answered a series of questions (also adapted from Hodson, Hooper, Dovidio, & Gaertner, 2005) designed to assess their attitudes toward the veteran. These questions included

“is the defendant guilty or innocent,” “how guilty is the defendant,” and “what sentence would you give this defendant.” Participants also were asked general questions about their perceptions of the defendant, which are detailed in the results section.

A manipulation check was included after the documents that asked when the defendant was diagnosed with PTSD (before or after the crime) and what traumatic event was the trigger (a bombing, a shooting, or both). Data collected from participants who did not correctly answer the manipulation check questions ($n = 9$ for timing of diagnosis; $n = 22$ for traumatic event) were not included in the analyses for which that information was relevant. We also asked participants whether they had served in the military (no participants indicated they had done so).

RESULTS

Judgments of Guilt

Pearson’s chi square analyses were conducted to assess whether timing of diagnosis or degree of combat experienced influenced the verdicts of “guilty” versus “not guilty.” Results showed that participants were equally likely to find the veteran “guilty” regardless of whether they were told he was diagnosed with PTSD before the crime (75%) or after the crime (73%), $\chi^2 (1, N = 87) = .04, ns$. Results also showed that participants were equally likely to find the veteran “guilty” regardless of whether they were told the veteran witnessed combat (69%) versus actively engaged in combat (77%), $\chi^2 (1, N = 79) = .60, ns$.

A 2 (timing of diagnosis) \times 2 (degree of combat) analysis of variance (ANOVA) was conducted on participants’ continuous ratings of guilt (1 to 9 scale). No significant effects were found for timing of diagnosis, $F(1, 67) = .08, ns$, degree of combat, $F(1, 67) = 1.44, ns$, or their interaction, $F = .01$. In other words, contrary to expectations, participants rated the veteran as equally guilty regardless of when he was diagnosed or whether he actively engaged in combat versus witnessed a bombing. See Tables 1 and 2 for means and standard deviations.

Table 1.

Means and Standard Deviations for Timing of Diagnosis Conditions

Variable	Before	After
How Guilty	5.95 (1.94)	5.79 (1.89)
Sentence Length	4.03 (2.51)	3.68 (1.98)
Likelihood of Successful Rehabilitation*	6.19 (1.58)	7.06 (1.41)
Deserving of Reduced Sentence	7.28 (1.47)	7.00 (2.17)
Control over Actions	5.20 (1.60)	4.89 (1.84)
Sorry for Defendant	7.01 (1.78)	7.15 (1.76)
Persuasiveness of Defense	6.67 (1.69)	6.62 (1.89)

Note. * $p < .05$

Table 2.

Means and Standard Deviations for Type of Combat Experienced Conditions

Variable	Witness	Engaged
How Guilty	5.52 (1.72)	6.09 (2.00)
Sentence Length	3.72 (2.27)	3.70 (2.15)
Likelihood of Successful Rehabilitation	7.07 (1.36)	6.32 (1.61)
Deserving of Reduced Sentence	7.02 (1.83)	7.23 (1.85)
Control over Actions	5.02 (1.71)	5.07 (1.73)
Sorry for Defendant	6.69 (1.88)	7.32 (1.65)
Persuasiveness of Defense*	5.92 (2.00)	7.07 (1.50)

Note. * $p < .05$

Sentencing

A 2 (timing of diagnosis) \times 2 (degree of combat) analysis of variance (ANOVA) was conducted on participants' sentencing recommendations. Participants were given options ranging from 0 years (coded as 1) to life in prison (coded as 9), with the midpoint being 15 years in jail (coded as 5). No significant effects were found for timing of diagnosis, $F(1, 66) = .89$, *ns*, degree of combat, $F(1, 66) = 1.11$, *ns*, or their interaction, $F = 1.71$.

Perceived Success of Rehabilitation

Participants were asked to rate the likelihood of successful rehabilitation of the defendant if treatment were offered, with responses ranging from 1 (not likely to be successful) to 9 (very likely to be successful). A 2 \times 2 ANOVA revealed a main effect for timing of diagnosis, $F(1, 67) = 4.97$, $p = .03$, $\eta_p^2 = .07$. Consistent with our hypotheses, participants who read the veteran was diagnosed with PTSD *after* he committed the crime ($M = 7.06$, $SD = 1.41$) believed that successful rehabilitation was more likely than participants who read that the defendant was diagnosed with PTSD *before* he committed the crime ($M = 6.19$, $SD = 1.58$). There was a trend, $F(1, 67) = 3.74$, $p = .06$, $\eta_p^2 = .05$, such that participants who read that the veteran witnessed combat judged the veteran as having a better chance at successful rehabilitation ($M = 7.07$, $SD = 1.36$) than did participants who read that the defendant actively engaged in combat ($M = 6.32$, $SD = 1.61$) although this difference did not reach statistical significance. There was no interaction, $F(1, 67) = .04$, *ns*.

Reduced Sentence

Participants were asked to indicate if the veteran should later be offered a reduced sentence for good behavior, with responses ranging from 1 (not at all) to 9 (very much so). A 2 \times 2 ANOVA did not yield a significant main effect for either timing of diagnosis, $F(1, 67) = .02$, *ns*, or degree of combat, $F(1,67) = 1.67$, *ns*, but did reveal an interaction, $F(1,67) = 4.20$, $p = .04$, $\eta_p^2 = .06$. Of veterans who were diagnosed prior to the crime, those veterans who actively engaged in combat were rated as more deserving of having their sentence reduced in the future for good behavior

compared to those who simply witnessed combat ($M_s = 7.67$ vs. 6.58 , $SD_s = 1.31, 1.55$), $t(35) = 2.27$, $p = .03$. Of veterans who were diagnosed after the crime, there was no difference between those individuals who engaged in combat ($M = 6.70$, $SD = 2.27$) and those who witnessed combat ($M = 7.43$, $SD = 2.03$), $t(32) = .96$, ns .

Control over Actions

Participants were asked to indicate how much control the veteran has over his daily actions on a scale from 1 (no control) to 9 (all control). A 2×2 ANOVA yielded no significant effects for timing of diagnosis, $F(1,67) = .47$, ns , degree of combat, $F(1, 67) = .01$, ns , or their interaction, $F = .06$.

Sorry for Defendant

Participants were asked to indicate how sorry they felt for the veteran on a scale from 1 (not at all sorry) to 9 (very sorry). A 2×2 ANOVA did not yield a significant main effect for timing of diagnosis, $F(1,67) = .96$, ns , or degree of combat, $F(1, 67) = 2.32$, ns , but did reveal an interaction, $F(1,76) = 5.69$, $p = .02$, $\eta_p^2 = .08$. Of veterans who were diagnosed prior to the crime, participants indicated feeling more sorry for those who actively engaged in combat compared to those who simply witnessed combat ($M_s = 7.58$ vs. 5.96 , $SD_s = 1.41, 1.94$), $t(35) = 2.02$, $p = .006$. Of veterans who were diagnosed after the crime, there was no difference in ratings between those individuals who engaged in combat ($M = 7.00$, $SD = 1.89$) and those who witnessed combat ($M = 7.36$, $SD = 1.60$), $t(32) = .58$, ns .

Persuasiveness of Defense

Finally, participants were asked to indicate how persuasive the PTSD defense was on a scale ranging from 1 (not persuasive) to 9 (very persuasive). A 2×2 ANOVA revealed no main effect for timing of diagnosis, $F(1, 66) = .01$, ns . There was a main effect for degree of combat experienced, $F(1, 66) = 7.12$, $p = .01$, $\eta_p^2 = .10$, such that participants who read the veteran experienced combat ($M = 7.07$, $SD = 1.50$) found the PTSD defense to be more persuasive than participants who read that the defendant witnessed combat ($M = 5.92$, $SD = 2.00$). There was no interaction, $F(1,66) = .003$, ns .

DISCUSSION

Although previous research has shown that PTSD is relevant in the legal system, to date no research has investigated whether specific factors related to the diagnosis may impact people's attitudes. The results of the present study reveal that, in short, the timing of the diagnosis—and whether the veteran witnesses versus engages in combat—were not found to influence judgments of guilt or recommended sentence length. Importantly, however, the perceived likelihood of successful rehabilitation appears to be influenced by these factors; participants in the present study believed that a veteran who was diagnosed with PTSD after he committed the described crime was more likely to successfully rehabilitate than a defendant who was diagnosed before he committed the crime. It may be the case that when the diagnosis is relatively recent, participants

believe that therapy will be more successful in subduing the condition than it would be if the defendant had already been diagnosed. Although not significant, there was a trend that the veteran who witnessed combat versus actively engaged in it also was seen as having greater potential success at rehabilitation. Perhaps people view killing another human being as more difficult to overcome versus simply watching violence unfold, as in the case of a bomb exploding.

Additionally, results of the current study show that the defense was seen as more persuasive if the PTSD developed as a result of engaging in the trauma firsthand instead of as a result of passively witnessing a trauma. Logically, it makes sense that the trauma would be more impactful if the individual were more active in the experience, and that a more impactful trauma would lead to more severe PTSD. It may be the case that participants viewed PTSD that developed after active engagement as being more severe or valid, which therefore translated to a more persuasive defense. It is important to note, however, that according to the most recent version of the DSM (American Psychiatric Association, 2013), witnessing an event is considered a valid trigger for PTSD.

Overall, the results from the current study provide a mostly positive impression concerning people's views toward veterans with PTSD. For instance, in terms of guilt and sentencing, it was not the case that participants were suspicious of PTSD diagnoses that occurred after a crime was committed, as results showed that veterans who were diagnosed after the crime versus before were not more likely to be judged guilty or given a longer sentence. However, it is important to note that we did not specifically hypothesize that no difference would be found between conditions for the judgments of guilt and sentencing and that these statements are therefore post hoc interpretations. As such, future research should attempt to explore these findings further. Additionally, although participants found a PTSD defense to be less persuasive if the veteran had witnessed trauma versus actually engaged in it, this did not translate to a harsher sentence, meaning that individuals may still consider witnessing a trauma to be a legitimate cause of PTSD.

Although this study provides novel insight into how people view veteran PTSD diagnoses, especially in terms of legal factors, there are several limitations. First, the crime described in the court documents was both serious (murder) and committed against a stranger. It may be the case that the PTSD diagnosis in general seemed more legitimate, given the otherwise unexplainable motivation for the crime. Additionally, given the number of participants who failed the manipulation check regarding whether the veteran witnessed or engaged in combat, it is possible that a more obvious manipulation in this area would produce stronger effects. Finally, participants were asked to indicate whether they found the defendant either "guilty" or "not guilty" but were not given other options that may have provided more nuanced insight into people's perceptions of PTSD, such as second degree murder or voluntary manslaughter.

Further research is needed to better understand the factors that may influence people's judgments regarding veterans with PTSD. Some factors to be investigated in future studies include those related to the type of crime (e.g., burglary, white collar crimes; stranger versus relative) and those related to the individual (such as differences between an enlisted individual versus an

officer or a male perpetrator versus a female perpetrator). Additionally, it may be beneficial to have a condition in which the individual engages in combat but does not witness the bunkmate killed to determine whether any effects seen are due to the veteran having killed another individual or to the veteran having experienced two traumatic events (i.e., witnessing his bunkmate killed and killing enemy combatants). Finally, although the purpose of the current study was to focus on factors related to the PTSD diagnosis in a veteran sample, future research could attempt to determine whether these factors (e.g., timing of the diagnosis) are relevant to a non-veteran population. It is important to note, however, that a study that directly compares veterans with PTSD to a “control” condition of nonveterans with PTSD would likely face a confound regarding the causal event—e.g., combat versus, for instance, a car accident. As such, the current research focused on the factors that influence the believability of a PTSD diagnosis solely in veterans and did not attempt to compare findings to nonveterans.

Although certainly not all veterans who have PTSD commit crimes, and an even smaller percentage commit crimes as severe as murder, these findings are important, especially given the increased number of veterans returning from the recent wars. First, the results provide evidence that people may be willing to welcome veterans with PTSD who commit crimes back into society—for instance, across conditions, participants responded with an average of 6.6 out of 9 when asked about the veteran’s likelihood of successful rehabilitation if he were to receive treatment. Additionally, approximately 25% of participants found the veteran “not guilty.” Given that he confessed to shooting the two men, it is likely that this “not guilty” vote was due to people’s consideration of the PTSD diagnosis. Finally, it is important for both prosecution and defense attorneys to have a greater understand of the factors that may make people more or less sympathetic to these veterans and for researchers to continue to provide insight into how people view PTSD diagnoses and what factors may influences these viewpoints. This research serves as the first step in this important process.

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APPENDIX

Subset of Psychological Evaluation Regarding Before and After Condition

VA Boston Healthcare System
Brockton Division
940 Belmont Street
Brockton, MA 02301

May 28, 2011

TO SUFFOLK COUNTY PROSECUTION SERVICE:

Re: Mr. Todd Parker

In November of 2010, Todd Parker returned from his second deployment in Afghanistan. He had joined the Army right after high school because he didn't know what he would want to study in college. His first tour was 11 months long and was in Camp Baharia in Iraq. He returned home for one year and four months before deploying the second time. His second tour was one year long and was located in Kabul, Afghanistan.

I had been conducting therapy sessions with Mr. Parker since he returned, so for about six months before the shootings. (Note: "After" condition read: I was asked to assess the mental competency of Mr. Parker, and thus have met with him 4 times since he was arrested.) My assessment was that he met the diagnosis for posttraumatic stress disorder according to the criteria set forth in the DSM-IV-TR.

Subset of Psychological Evaluation Regarding Witnessing versus Engaging in Combat

Mr. Parker has identified his primary traumatic stressor. On September 4, 2010, Mr. Parker was stationed temporarily at Camp Bastion in Afghanistan. Shortly after 10pm, the base was bombed by outside forces. Approximately five insurgents, armed with rocket-propelled grenades and explosive vests, entered the premises, with one entering the specific building where Mr. Parker was sleeping. The insurgent threw a grenade into the building and then ran outside. Mr. Parker's bunkmate, who was outside their bedroom at the time, was killed in the explosion; Mr. Parker discovered his body as he ran from his room.

The below sentences were included for the "engaged" condition:

Mr. Parker's platoon leader then instructed him and nearby soldiers to chase the insurgents out of the area. Mr. Parker grabbed his gun and ran outside. Once there, he encountered an insurgent who had his gun drawn. Mr. Parker fired and hit him in the chest. A second insurgent ran at Mr. Parker and was only a few steps away when Mr. Parker shot him in the head.

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