

# Last Stand? The Criminal Responsibility of War Veterans Returning from Iraq and Afghanistan with Posttraumatic Stress Disorder

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*As more psychologically scarred troops return from combat in Iraq and Afghanistan, society’s focus on and concern for these troops and their psychological disorders has increased. With this increase and with associated studies confirming the validity of the Posttraumatic Stress Disorder (PTSD) diagnosis and the genuine impact of PTSD on the behavior of war veterans, greater weight may be given to the premise that PTSD is a mental disorder that provides grounds for a “mental status defense,” such as insanity, a lack of mens rea, or self-defense. Although considerable impediments remain, given the current political climate, Iraq and Afghanistan War veterans are in a better position to succeed in these defenses than Vietnam War veterans were a generation ago. This Article explores the prevalence and impact of PTSD, particularly in war veterans, the relevance of this disorder to the criminal justice system, and the likely evolution of related mental status defenses as Iraq and Afghanistan War veterans return from combat.*

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## INTRODUCTION

*“PTSD is the enemy within—a claymore in the mind, slowly exploding before our very eyes, but unidentified, and therefore invisible, even to those who suffer directly from its effects.”*<sup>1</sup>

After Staff Sergeant Frederick Johnson returned home from Iraq in December 2005, his method for coping with stress progressed to the ingestion of crack cocaine.<sup>2</sup> He was depressed by his separation from the only people who he believed understood his wartime experience, the other members of his military unit, the Ohio-based 373rd Medical Company.<sup>3</sup> He grappled with an emerging fear of crowds, an aversion to loud noises, and the horror of his nightmares.<sup>4</sup> These nightmares often ended with him leaping out of bed into a low-crawl position.<sup>5</sup> Fearing sleep and self-medicating with alcohol, he stayed up for days at a time.<sup>6</sup> Whether on the lookout for drugs or hunkered down alone at a corner barstool with a double shot of Remy Martin, Staff Sergeant Johnson was afraid he would become violent if he interacted with other people.<sup>7</sup> He avoided crowds, as if still in Iraq, because he remembered them as easy targets for mortar attacks.<sup>8</sup> Further, he dreaded the sound of helicopters because it reminded him of dead or wounded soldiers being flown into his medical unit.<sup>9</sup>

Staff Sergeant Johnson’s experience haunted him after his return from military service in Iraq. Unfortunately, he is not alone. The United States Army reports an avalanche in the number of Iraq War veterans with symptoms of Posttraumatic Stress Disorder (PTSD),<sup>10</sup> with one report indicating that the prevalence of PTSD among Iraq

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1. Peter Tucker, Posting of Mortardude to PTSD Quote—The Patriot Files Forum, <http://www.patriotfiles.com/forum/showthread.php?p=88091> (Mar. 28, 2005, 20:49 EST).

2. Wade Malcolm, *Iraq Vets’ Troubles Appear Long After Return*, PITTSBURGH POST-GAZETTE, Nov. 25, 2007, at A1.

3. *Id.*

4. *Id.*

5. *Id.*

6. *Id.*

7. *Id.*

8. *Id.*

9. *Id.*

10. For a general description of PTSD, see Nat’l Ctr. for PTSD, U.S. Dep’t of Veterans Affairs, *What Is PTSD?*, <http://www.ptsd.va.gov/public/pages/what-is-ptsd.asp>. While this Article focuses on the use of the insanity defense and other “mental status” defenses by Iraq and Afghanistan War veterans suffering from PTSD, there are other emerging groups of individuals with PTSD who may also be viewed sympathetically and for whom these defenses may be more accessible. For example, a recent survey conducted by the New York City Department of Health and Mental Hygiene and the federal Centers for Disease Control and Prevention found that 19% of the people directly exposed to the World Trade Center attacks on September 11, 2001, developed PTSD symptoms within five to six years after the attacks. This prevalence rate is up from 14% found in a survey done two to three years after the attacks, and it reflects a rate roughly four times the rate of PTSD typically seen among American adults. Robert M. Brackbill, James L. Hadler, Laura DiGrande, Christine C. Ekenga, Mark R. Farfel, Stephen Friedman, Sharon E. Perlman, Steven D. Stellman, Deborah J. Walker, David Wu, Shengchao Yu & Lorna E. Thorpe, *Asthma and Posttraumatic Stress Symptoms 5 to 6 Years Following*

War veterans may be as high as one in five.<sup>11</sup> Indeed, one study suggests that current figures underestimate the level of PTSD in Iraq War veterans because a lag, ranging from days to many years, occurs between the time someone experiences trauma and the time when symptoms of PTSD are reported, with projections made that ultimately 35%

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*Exposure to the World Trade Center Terrorist Attack*, 302 J. AM. MED. ASS'N 502, 511–12 (2009); see also Posting of Jennifer 8. Lee to City Room Blog, <http://cityroom.blogs.nytimes.com/2009/08/04/study-finds-post-traumatic-stress-from-911-increasing/> (Aug. 4, 2009, 16:29 EST). It should be noted that the criteria for a diagnosis of PTSD have varied somewhat since the diagnosis was initially included by the American Psychiatric Association in its *Diagnostic and Statistical Manual of Mental Disorders* in 1980, although these changes have not had any apparent impact on the judicial processing of cases involving war veterans with a diagnosis of PTSD. Indeed, it is at least arguable that while some changes have broadened the criteria, others have narrowed it. See Naomi Breslau, *The Epidemiology of Trauma, PTSD, and Other Posttrauma Disorders*, 10 TRAUMA VIOLENCE & ABUSE 198, 199 (2009) (“In the latest edition of the *DSM-IV*, the definition of traumatic events that can potentially cause PTSD—the stressor criterion—has been enlarged to include a wider range of events than the typical traumatic events of the initial definition (i.e., combat, concentration camp confinement, natural disaster, rape, or physical assault). The stressor definition . . . requires that the ‘person experienced, witnessed or was *confronted* with an event(s) that involved actual or threatened death or serious injury or a threat to the physical integrity of self and others,’ and which evoked ‘intense fear, helplessness, or horror’ (emphasis added). Learning that someone else was threatened with serious harm qualifies in the *DSM-IV* as a traumatic event. [At the same time,] *DSM-IV* introduced a new criterion, namely, the disturbance causes clinically significant distress or impairment, in recognition that distress per se and commonly experienced symptoms, such as sleep problems or concentration problems, are not equivalent to a mental disorder.”); Bruce P. Dohrenwend, J. Blake Turner, Nicholas A. Turse, Ben G. Adams, Karestan C. Koenen & Randall Marshall, *The Psychological Risks of Vietnam for U.S. Veterans: A Revisit with New Data and Methods*, 313 SCIENCE 979, 980 (2006) (noting that “[u]nlike the current DSM-IV, the diagnosis of PTSD in DSM-III-R did not require impairment by either disability in social roles or elevated psychological distress” but that other factors appear to have minimized differences in the use of the diagnosis with war veterans, and concluding that “[w]hat has been, and can still be, learned about PTSD and Vietnam veterans should be applicable to understanding the psychological risks to U.S. veterans of the war in Iraq”).

11. Charles W. Hoge, Carl A. Castro, Stephen C. Messer, Dennis McGurk, Dave I. Cotting & Robert L. Koffman, *Combat Duty in Iraq and Afghanistan, Mental Health Problems, and Barriers to Care*, 351 NEW ENG. J. MED. 13, 19 tbl.3 (2004) (employing a “broad definition” of PTSD, 18.0% of an Army study group that had been deployed to Iraq and 19.9% of a similarly deployed Marine study group met the screening criteria for PTSD; employing a “strict definition,” 12.9% and 12.2%, respectively, met the screening criteria for PTSD). A more recent study of 289,328 separated Iraq and Afghanistan veterans (41% of all eligible veterans) who have enrolled in the health care program offered by the Department of Veterans Affairs found that 21.8% of them were diagnosed with PTSD. Karen H. Seal, Thomas J. Metzler, Kristian S. Gima, Daniel Bertenthal, Shira Maguen & Charles R. Marmar, *Trends and Risk Factors for Mental Health Diagnoses Among Iraq and Afghanistan Veterans Using Department of Veterans Affairs Health Care, 2002–2008*, 99 AM. J. PUB. HEALTH 1651, 1651 (2009); see also Terry L. Schell & Grant N. Marshall, *Survey of Individuals Previously Deployed for OEF/OIF, in INVISIBLE WOUNDS OF WAR: PSYCHOLOGICAL AND COGNITIVE INJURIES, THEIR CONSEQUENCES, AND SERVICES TO ASSIST RECOVERY* 87, 88–90, 96 (Terri Tanielian & Lisa H. Jaycox eds., 2008) (conducting telephone interviews between August 2007 and August 2008 with a representative sample of 1965 troops returning from Iraq and Afghanistan, and finding that 14% met the criteria for PTSD).

(or about 300,000) of the soldiers deployed to Iraq will suffer from PTSD.<sup>12</sup> Similar concerns have been voiced about Afghanistan War veterans.<sup>13</sup>

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12. Matthew J. Friedman, *Acknowledging the Psychiatric Cost of War*, 351 NEW ENG. J. MED. 75, 76 (2004) (“[T]here is reason for concern that the reported prevalence of PTSD of 15.6 to 17.1 percent among those returning from Operation Iraqi Freedom or Operation Enduring Freedom will increase in coming years, for two reasons. First, on the basis of the findings of the Fort Devens study, the prevalence of PTSD may increase considerably during the two years after veterans return from combat duty. Second, on the basis of studies of military personnel who served in Somalia, it is possible that psychiatric disorders will increase now that the conduct of war has shifted from a campaign for liberation to an ongoing armed conflict with dissident combatants. In short, the [existing] estimates of PTSD . . . may be conservative . . .” (footnote omitted)); *see also* Schell & Marshall, *supra* note 11, at 112 (“[T]hese findings suggest that approximately 300,000 servicemembers and veterans [from the wars in Iraq and Afghanistan] have combat-related mental health problems. A similar number . . . reported a probable [traumatic brain injury] during deployment. More than two-thirds of the individuals with combat-related mental health problems did not receive minimally adequate mental health treatment in the prior year.”); Paula P. Schnurr, Carole A. Lunney, Anjana Sengupta & Lynn C. Waelde, *A Descriptive Analysis of PTSD Chronicity in Vietnam Veterans*, 16 J. TRAUMATIC STRESS 545, 551 (2003) (“Delayed onset was relatively common. Almost 40% of the sample reported that symptoms first occurred 2 or more years after entering Vietnam.”); Seal et al., *supra* note 11, at 1656 (reporting “a continued linear increase in the cumulative prevalence of new mental health diagnoses . . . when veterans were followed beyond the 2-year period of free medical care out to 4 years after their initial VA visit. . . . Solomon et al. have observed PTSD emerging in Israeli soldiers 20 years after combat stress” (footnote omitted)); James Dao, *Vets’ Mental Health Diagnoses Rising*, N.Y. TIMES, July 17, 2009, at A10 (noting that PTSD can take years to develop); Lawrence M. Wein, Op-Ed., *Counting the Walking Wounded*, N.Y. TIMES, Jan. 26, 2009, at A23 (asserting that a much longer lag time is typical while people are still in the military). Among the reasons given for delayed mental health diagnoses is “the stigma of mental illness leading to a reluctance to disclose mental health problems until problems interfere with functioning, delayed onset of military service-related mental health symptoms developing months to years following deployment, and somatization or comorbidity confounding mental health diagnosis.” Seal et al., *supra* note 11, at 1656 (footnotes omitted).

At the same time, as part of an ongoing debate, it has been countered that PTSD may be overdiagnosed in soldiers, which may result in returning veterans receiving inappropriate and ineffective treatment for mental health problems that have another cause. David Dobbs, *The Post-Traumatic Stress Trap*, SCI. AM., Apr. 2009, at 64, 64–65; *see also* B. Christopher Frueh, Jon D. Elhai, Anouk L. Grubaugh, Jeannine Monnier, Todd B. Kashdan, Julie A. Sauvageot, Mark B. Hamner, B.G. Burkett & George W. Arana, *Documented Combat Exposure of US Veterans Seeking Treatment for Combat-Related Post-Traumatic Stress Disorder*, 186 BRIT. J. PSYCHIATRY 467, 469 (2005) (“[Their] results suggest that a meaningful number of people may be exaggerating or misrepresenting their involvement in Vietnam [for the increased financial government-funded benefits that may be associated with receiving a diagnosis of PTSD], raising concerns regarding the integrity of the PTSD database . . . .”). *But see id.* at 471 (“[T]hese results should not be interpreted to deny that many combat veterans do suffer from severe and debilitating symptoms of PTSD.”). The resolution of this debate is beyond the scope of this Article, which focuses instead on the wide employment of this diagnosis and its likely impact on judicial proceedings that address a defendant’s criminal responsibility.

13. *See* Schell & Marshall, *supra* note 11, at 112; Seal et al., *supra* note 11, at 1651; Marilyn Elias, *Post-Traumatic Stress Is a War Within the Body*, USA TODAY, Oct. 27, 2008, at 7D (reporting that one out of seven service members deployed in Iraq or Afghanistan have

In addition, estimates are that 20% of soldiers and 42% of reservists returning from these wars are experiencing some form of psychological problem.<sup>14</sup> Furthermore, Army suicides—viewed by some as an indicator of pervasive PTSD problems—have more than doubled since 2001, reaching a thirty-year high in 2008, with the number of suicides in 2009 expected to be even higher, exceeding the number of American soldiers who died in combat during the same period.<sup>15</sup> Another recent report found that

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returned with symptoms of posttraumatic stress disorder (based on an April 2008 study), with a significant recent increase in the number of veterans seeking related treatment). For a review of epidemiological studies that have addressed the prevalence of PTSD among service members deployed to Afghanistan and Iraq, see Rajeev Ramchand, Benjamin R. Karney, Karen Chan Osilla, Rachel M. Burns & Leah Barnes Calderone, *Prevalence of PTSD, Depression, and TBI Among Returning Servicemembers*, in *INVISIBLE WOUNDS OF WAR*, *supra* note 11, at 35, 36–47, 60–81.

14. Charles W. Hoge, Jennifer L. Auchterlonie & Charles S. Milliken, *Mental Health Problems, Use of Mental Health Services, and Attrition from Military Service After Returning from Deployment to Iraq or Afghanistan*, 295 J. AM. MED. ASS'N 1023, 1027–28 (2009) (reporting that “19.1% of soldiers and Marines who returned from [Iraq] met the risk criteria for a mental health concern, compared with 11.3% for [Afghanistan] and 8.5%” for other deployment locations such as Kosovo and Bosnia, and 31.0% had “at least one outpatient mental health care visit within the first year postdeployment”); Seal et al., *supra* note 11, at 1651, 1654 (finding that 36.9% of separated Iraq and Afghanistan veterans enrolled in the health care program offered by the Department of Veterans Affairs received mental health diagnoses and “over 40% received mental health diagnoses or were found to have psychosocial and behavioral problems or both”); see also Robert A. Rosenheck & Alan F. Fontana, *Recent Trends in VA Treatment of Post-Traumatic Stress Disorder and Other Mental Disorders*, 26 HEALTH AFF. 1720, 1722 (2007) (finding that the number of Persian Gulf Conflict veterans treated for PTSD annually by the Veterans Health Administration from 1997 to 2005 rose from 8304 to 30,580, while the number treated for a mental health diagnosis other than PTSD rose from 21,098 to 57,453; the number of all veterans treated annually for PTSD during this time rose from 139,062 to 279,256, and non-PTSD mental health diagnoses rose from 391,205 to 546,997). Furthermore, many of these veterans experience multiple mental health problems. Seal et al., *supra* note 11, at 1652 (ascertaining that “the majority [of returning veterans with mental health problems] had comorbid diagnoses: 29% had 2 and one-third had 3 or more different mental health diagnoses”). It has also been suggested that media coverage of the wars in Iraq and Afghanistan has contributed to a recent increase in the use of treatment services for PTSD and other mental health diagnoses by veterans, including Vietnam-era veterans and Gulf Conflict veterans. See Rosenheck & Fontana, *supra*, at 1726–27; see also Dao, *supra* note 12 (“The increase in [mental health diagnoses among military veterans] accelerated after the invasion of Iraq in 2003.”).

15. Erica Goode, *Suicide's Rising Toll: After Combat, Victims of an Inner War*, N.Y. TIMES, Aug. 2, 2009, at A1; see also Lizette Alvarez, *Army and Agency Will Study Rising Suicide Rate Among Soldiers*, N.Y. TIMES, Oct. 30, 2008, at A18; Press Release, Nat'l Inst. of Mental Health, Evidence-Based Prevention Is Goal of Largest Ever Study of Suicide in the Military (July 16, 2009), available at <http://www.nimh.nih.gov/science-news/2009/evidence-based-prevention-is-goal-of-largest-ever-study-of-suicide-in-the-military.shtml> [hereinafter NIMH Press Release] (“The National Institute of Mental Health (NIMH) has announced that an interdisciplinary team of four research institutions will carry out the largest study of suicide and mental health among military personnel ever undertaken . . . . Study investigators aim to move quickly to identify risk and protective factors for suicide among soldiers and provide a science base for effective and practical interventions to reduce suicide rates and address associated mental health problems. The study is a direct response to the Army's request to NIMH to enlist

“[s]uicides among American soldiers in 2008 rose for the fourth year in a row,” with a suicide rate that “surpassed that for civilians for the first time since the Vietnam War.”<sup>16</sup>

PTSD is an anxiety disorder that typically develops after an individual experiences a life-threatening or extremely traumatic event, including—but not limited to—military combat, rape, abuse, or terrorist attack.<sup>17</sup> It is a psychological disorder that can have long-term psychological and behavioral effects, such as reliving the traumatic event, suffering recurrent distressing dreams of the event, or undergoing intense physiological distress when exposed to internal or external cues that resemble an aspect of the event.<sup>18</sup>

Because PTSD is associated with a life-threatening or highly traumatic event, war veterans who have been placed in such circumstances during combat are prime candidates for developing PTSD.<sup>19</sup> The pervasiveness of PTSD in war veterans and its impact has recently received attention from mental health professionals, military officials, and society in general.<sup>20</sup> Indeed, the Executive Director of the Iraq and

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the most promising scientific approaches for addressing the rising suicide rate among soldiers. . . . Historically, the suicide rate has been lower in the military than among civilians. In 2008 that pattern was reversed . . . . While the stresses of the current wars, including long and repeated deployments and post-traumatic stress, are important potential contributors for research to address, suicidal behavior is a complex phenomenon. The study will examine a wide range of factors related to and independent of military service, including . . . exposure to combat-related trauma . . . and overall mental health.”)

16. Lizette Alvarez, *Suicides of Soldiers Reach High of Nearly 3 Decades, and Army Vows to Bolster Prevention*, N.Y. TIMES, Jan. 30, 2009, at A19 (describing a report by the U.S. Army, which found that 20.2 of every 100,000 soldiers committed suicide). Concern about these and similar findings is so great that the National Institute of Mental Health, in direct response to a request for research assistance and \$50 million in funding from the Army, recently announced “the largest study of suicide and mental health among military personnel ever undertaken” to “enlist the most promising scientific approaches for addressing the rising suicide rate among soldiers.” NIMH Press Release, *supra* note 15. Although it is a five-year study, it is “designed to be able to identify quickly potential risk factors that can inform . . . the Army’s ongoing efforts to prevent suicide among its personnel.” *Id.* Similarly, President Obama this year “pledged \$25 billion in new [Veterans’ Affairs’] funding over the next five years to deal with emerging issues like PTSD and traumatic brain injuries among Iraq and Afghanistan veterans.” Leo Shane III, *Vets Groups Cautiously Optimistic About Obama’s Efforts*, STARS & STRIPES, Aug. 5, 2009, available at <http://www.stripes.com/article.asp?section=104&article=64030>.

17. Nat’l Ctr. for PTSD, *supra* note 10; see also *infra* Part I.A.

18. AM. PSYCHIATRIC ASS’N, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS 463–64 (4th ed. 2000) [hereinafter DSM-IV-TR].

19. *Id.* at 463.

20. See, e.g., Hoge et al., *supra* note 11, at 13; Christopher Munsey, *Armor for the Mind*, MONITOR ON PSYCHOL., Oct. 2007, at 45, available at <http://www.apa.org/monitor/oct07/armor.html>; Mike Price, *Overseas but Under Care*, MONITOR ON PSYCHOL., Oct. 2007, at 44, available at <http://www.apa.org/monitor/oct07/overseas.html>; see also Damien Cave, *A Combat Role, and Anguish, Too*, N.Y. TIMES, Nov. 1, 2009, at A1 (describing how female soldiers experience PTSD in Iraq and Afghanistan just as male soldiers do); Joe Fahy, *Combat Veterans at Risk: Concussion with Battlefield Stress Has Long-Term Effects*, PITTSBURGH POST-GAZETTE, Jan. 31, 2008, at A3; William M. Welch, *Trauma of Iraq War Haunting Thousands Returning Home*, USA TODAY, Feb. 28, 2005, at 1A.

The United States Supreme Court has added its voice to this chorus. In a recently issued

Afghanistan Veterans of America—which was founded in 2004 and is the largest group dedicated to the troops and veterans of the wars in Iraq and Afghanistan—determined that PTSD and other mental health issues are among the most pressing issues facing Iraq War veterans.<sup>21</sup>

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unanimous per curiam ruling, the Court determined, in overturning the death sentence of a Korean War veteran, that the assistance that the defendant had received from his attorney had failed to meet the constitutional requirement of effective assistance of counsel during the sentencing phase of his trial because the lawyer failed to introduce, among other things, mitigating evidence that would have indicated that he had suffered combat-related stress disorder. *Porter v. McCollum*, 130 S. Ct. 447, 448 (2009) (per curiam). The Court reasoned that this type of evidence might have swayed the jury as “[o]ur nation has a long tradition of according leniency to veterans in recognition of their service, especially for those who fought on the front lines as [the defendant] did.” *Id.* at 455; *see also id.* at 448 (“[The defendant’s] combat service unfortunately left him a traumatized, changed man.”); *id.* at 449–50 (providing an extensive discussion of the trauma the defendant experienced during the Korean War); *id.* at 450 (“After his discharge, [the defendant] suffered dreadful nightmares and would attempt to climb his bedroom walls with knives at night.”); *id.* at 450 n.4 (“Porter’s expert testified that these symptoms would ‘easily’ warrant a diagnosis of posttraumatic stress disorder (PTSD). PTSD is not uncommon among veterans returning from combat.” (citations omitted)); *id.* at 453 (“Counsel thus failed to uncover and present any evidence of [the defendant’s] mental health or mental impairment . . . or his military service.”); *id.* at 455 (“[T]he jury might find mitigating the intense stress and mental and emotional toll that combat took on [the defendant].”); Robert Barnes, *Death-Row Inmate’s Military Service Is Relevant, Justices Say*, WASH. POST, Dec. 1, 2009, at A06 (“In an unsigned opinion without dissent, the justices were strikingly sympathetic . . . . [T]he [C]ourt seemed to go out of its way . . . to express the seriousness with which it views post-traumatic stress disorder.”); Linda Greenhouse, Op-Ed, *Selective Empathy*, N.Y. TIMES.COM, Dec. 3, 2009, <http://opinionator.blogs.nytimes.com/2009/12/03/selective-empathy/> (“The most obvious [feature of this decision] was that the . . . opinion was unanimous and unsigned, labeled simply ‘per curiam,’ meaning ‘by the court.’ The Court had not heard argument in the case and never formally accepted it for decision. Evidently the justices concluded that the right decision was so obvious that they could dispense with the formality of further briefing and argument.”); David G. Savage, *Justices Rule Combat Stress Must Be Considered in Capital Cases: 1st Decision to Say Jurors Need to Hear About War Trauma*, CHI. TRIB., Dec. 1, 2009, at 13 (Monday’s decision appears to be the first in which the [C]ourt cited post-traumatic stress disorder’ from military combat as the kind of crucial evidence that calls for leniency. It comes as thousands of U.S. soldiers are being treated for the disorder from the wars in Iraq and Afghanistan.”). It should be noted, however, that concern has been raised that the Court seems to be selectively identifying surrounding circumstances that justify leniency within the criminal justice system. Greenhouse, *supra* (expressing concern “about a Supreme Court that dispenses empathy so selectively”).

21. *Cf.* Posting of Terrell Frazier to Iraq and Afghanistan Veterans of America, <http://iava.org/blog/president-signs-ndaa-includes-critical-provisions-new-veterans> (Oct. 28, 2009) (“Today, Iraq and Afghanistan Veterans of America (IAVA), the nation’s first and largest non-partisan, nonprofit organization representing veterans of the wars in Iraq and Afghanistan, applauded President Obama for signing the National Defense Authorization Bill (NDAA) which includes several of IAVA’s top legislative priorities. The legislation: 1. Requires mandatory, face to face, confidential mental health screenings for every returning servicemember. 2. Increases the number of mental health providers in the military. . . . IAVA Executive Director Paul Rieckhoff stated: ‘Today, the President signed a critical piece of legislation that will save lives and go a long way in helping our nation’s troops and veterans. For years, IAVA has led the fight for improved mental health care for troops and veterans. *This bill will help to reduce*

The occurrence of PTSD among these war veterans has potential legal implications. Because such veterans may be especially susceptible to PTSD symptoms—such as dissociation, exaggerated startle response, irritability, and impulsive behavior<sup>22</sup>—that may be linked to violent acts and related criminal behavior, a diagnosis of PTSD may be the foundation for efforts to negate criminal culpability by asserting a related “mental status defense.”<sup>23</sup>

When PTSD was first used as a basis for insanity defenses, in the wake of the relatively unpopular Vietnam War, these defenses enjoyed little success.<sup>24</sup> However, following the more broadly supported recent conflicts in Iraq and Afghanistan, along with society’s increased understanding of this disorder’s impact on an individual’s thoughts and behavior, PTSD may now be enjoying a warmer welcome in judicial arenas.

This Article will explore the use of PTSD as part of an insanity defense or when raised in conjunction with other arguments made by a defendant to avoid or reduce criminal culpability. In addition, amenability to the “PTSD defense” will be compared to the reception received by two other “defenses” that focus on the effects of traumatic experiences, namely, Battered Spouse Syndrome (BSS) and Urban Survival Syndrome (USS). Finally, the implications of using PTSD as a defense for Iraq and Afghanistan War veterans will be discussed.

Because modern medicine has increased the likelihood that seriously wounded armed forces personnel will survive their injuries,<sup>25</sup> and because of a greater recognition of and concern about PTSD, there are more opportunities and increased calls to study the prevalence of PTSD in combat veterans, the psychological and behavioral impact of PTSD on them, and the relevance of PTSD as the basis for a criminal defense in the legal system.

## I. OVERVIEW OF PTSD AND PREVALENCE IN WAR VETERANS

### A. PTSD Diagnosis Generally

In 1980, in response to pressure from Vietnam War veterans groups, the American Psychiatric Association (APA) added the diagnosis of PTSD to its third edition of the *Diagnostic and Statistical Manual of Mental Disorders (DSM)*.<sup>26</sup> As explained below, according to the APA’s most recent iteration of the fourth edition of the *DSM*, the *DSM-IV-TR*, the criteria for PTSD include exposure to a life-threatening or other traumatic event, a subjective response involving fear, helplessness, or horror, and

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*stigma and finally get our heroes the services and support they desperately need.*” (emphasis in original)).

22. See *DSM-IV-TR*, *supra* note 18, at 463–68.

23. “Defense” is a term that is utilized in a relatively generic sense throughout this Article to encompass both affirmative defenses (e.g., the insanity defense) and rebuttals to evidentiary showings that must be made by the prosecution (e.g., the defendant lacked the requisite *mens rea* for the crime).

24. See *infra* Part II.C.

25. Manav Tanneeru, *Advances Helping More Soldiers Survive Attacks*, CNN.COM, Nov. 13, 2006, <http://www.cnn.com/2006/US/11/13/war.wounded/index.html>.

26. CHRISTOPHER SLOBOGIN, ARTI RAI & RALPH REISNER, *LAW AND THE MENTAL HEALTH SYSTEM: CIVIL AND CRIMINAL ASPECTS* 20 (5th ed. 2008).



symptoms from each of the following symptom clusters: intrusive recollections, avoidant/numbing symptoms, and hyperarousal symptoms.<sup>27</sup> The diagnosis also depends on the duration of the symptoms and their impact on the individual's daily functioning.<sup>28</sup>

Under the *DSM-IV-TR*, a person may be suffering from PTSD if "the person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others" and "the person's response involved intense fear, helplessness, or horror."<sup>29</sup> The diagnosis also requires that the traumatic event be consistently psychologically re-experienced, with "(1) recurrent and intrusive distressing recollections of the event," "(2) recurrent distressing dreams of the event," "(3) acting or feeling as if the traumatic event were recurring,"<sup>30</sup> "(4) intense psychological distress" when exposed to "cues that symbolize or resemble an aspect of the traumatic event," or "(5) physiological reactivity" after exposure to "cues that symbolize or resemble an aspect of the traumatic event."<sup>31</sup>

The *DSM-IV-TR* also requires the presence of at least two persistent symptoms of increased arousal that were not present before the traumatic event. Examples include: "difficulty falling or staying asleep," "irritability or outbursts of anger," "difficulty concentrating," "hypervigilance," and "exaggerated startle response."<sup>32</sup> Other characteristic symptoms include "persistent avoidance of stimuli associated with the trauma and a numbing" of the person's "general responsiveness."<sup>33</sup>

Finally, these symptoms must persist for more than one month and they must cause "clinically significant distress or impairment in social, occupational, or other important areas of functioning."<sup>34</sup> In other words, these symptoms cannot be fleeting and must cause a significant disruption in the individual's day-to-day functioning. If an individual experiences symptoms for only a short period of time following a traumatic event, or the person's functional abilities are not significantly impaired, a diagnosis of PTSD may not be warranted.

Although traumatic experiences may be relatively infrequent, when they do occur they can significantly alter a person's life. While it is uncertain whether these reactions to a traumatic experience will occur for any given individual, there are three variables that appear to influence their manifestation: (1) "the traumatic nature of the incident" itself; (2) the character and personality of the person exposed to the trauma and concurring events in that individual's life; and (3) the support the individual receives from others before, during, and after the event.<sup>35</sup>

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27. *DSM-IV-TR*, *supra* note 18, at 467–68.

28. *Id.*

29. *Id.* at 467.

30. This feeling of recurrence can include reliving the experience, illusions, hallucinations, and disassociation though episodic flashbacks.

31. *DSM-IV-TR*, *supra* note 18, at 468.

32. *Id.*

33. *Id.*

34. *Id.*

35. DAVID KINCHIN, A GUIDE TO PSYCHOLOGICAL DEBRIEFING: MANAGING EMOTIONAL DECOMPRESSION AND POST-TRAUMATIC STRESS DISORDER 11 (2007).

Moreover, PTSD victims suffer associated behavioral, emotional, and social disturbances.<sup>36</sup> One of the most distressing PTSD symptoms reported is a sensation that the person is reliving the traumatic event, which can occur during nightmares or daytime flashbacks.<sup>37</sup> In the most severe cases, the mental images become so vivid that the individual starts to behave as if he or she were back in that earlier situation where the trauma initially occurred.<sup>38</sup> This experience may last a few seconds or a few days, and it is usually triggered by a sensory perception associated with the original trauma, such as a familiar sound or smell.<sup>39</sup> Although individuals with PTSD may be aware of the flashback and their response, they still may not be able to control these actions.<sup>40</sup>

PTSD can also be depicted in terms of the chemical process that takes place in the brain. When an individual experiences a highly traumatic event, the body undergoes a physiological change, that is, a stress response.<sup>41</sup> This stress response begins in the reticular activating system and then progresses to the hypothalamus.<sup>42</sup> The hypothalamus, in turn, signals the pituitary gland to secrete a hormone called adrenocorticotrophic hormone (ACTH).<sup>43</sup> This hormone generates adrenaline,<sup>44</sup> which triggers rapid heartbeat, desensitization, and hyperalertness.<sup>45</sup> Although this is a natural response to a stressful situation, individuals with PTSD may experience a stress response every time there is a reminder of the earlier stressful event.<sup>46</sup> Indeed, they can be so vulnerable to this reoccurrence that even relatively unrelated or minor events sometimes set this response in motion.<sup>47</sup> Additionally, individuals with PTSD can become so concerned about its reoccurrence that they undergo essentially constant stress, which can have permanent deleterious effects on the brain.<sup>48</sup>

Recent studies involving Magnetic Resonance Imaging (MRI) indicate that people who suffer from PTSD may have smaller or damaged hippocampi, parts of the brain that are involved in memory and emotional experience.<sup>49</sup> Damage to this area could

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36. See DSM-IV-TR, *supra* note 18, at 465; KINCHIN, *supra* note 35, at 24.

37. KINCHIN, *supra* note 35, at 24.

38. *Id.*

39. *Id.*

40. *Id.*

41. ROBERT M. SAPOLSKY, STRESS, THE AGING BRAIN, AND THE MECHANISMS OF NEURON DEATH 11 (1992); Edgar Garcia-Rill & Erica Beecher-Monas, *Gatekeeping Stress: The Science and Admissibility of Post-Traumatic Stress Disorder*, 24 U. ARK. LITTLE ROCK L. REV. 9, 18 (2001).

42. Garcia-Rill & Beecher-Monas, *supra* note 41, at 18.

43. *Id.*

44. *Id.*

45. *Id.* at 13, 16, 18, 27, 27 n.58.

46. *Id.* at 16–17.

47. *See id.* at 17.

48. *See id.* at 18 (“The occasional stress response is not going to do any harm, but, if you are under continuous stress, high circulating levels of glucocorticoids may lead to the shrinking of dendrites, probably wherever there are glucocorticoid receptors in the brain.”); *id.* at 18 n.34 (“Receptors are like ‘locks’ which are opened by neurotransmitter and hormonal ‘keys,’ leading to the opening of channels, ‘doors’ in the cell membrane.”).

49. See J. Douglas Bremner, *Hypotheses and Controversies Related to Effects of Stress on the Hippocampus: An Argument for Stress-Induced Damage to the Hippocampus in Patients with Posttraumatic Stress Disorder*, 11 HIPPOCAMPUS 75, 76 (2001); Kim Felmingham, Leanne

impair one's ability to store and recall information, as well as one's ability to manage fear responses.<sup>50</sup> Consequently, this damage could impact an individual's ability to react appropriately to environmental stimuli<sup>51</sup>—specifically, in relation to PTSD, an individual may overreact or respond violently to what he or she perceives as a threat, and this reaction may result in the individual harming another person and lead to criminal charges.

In recent years there has been an increase in the diagnosis of PTSD, which at least one commentator, David Kinchin, a noted author and PTSD trainer, attributes to an increased exposure to violence or reports of violence, the wider impact of natural disasters, and other traumatic events that have become more prevalent.<sup>52</sup> He asserts that as the world has become more intertwined, the scope of exposure to traumatic situations and life stressors has grown.<sup>53</sup>

PTSD, however, is not a new phenomenon, particularly among soldiers. Related identified disorders have existed, albeit under different names, from at least the time of the American Civil War.<sup>54</sup> Indeed, a variety of names have been employed across this time span for psychological disorders that manifest symptoms similar to PTSD. Soldiers returning from war have suffered disorders referred to as Soldier's Heart, Railway Spine, Shell Shock, War Neurosis, Combat Fatigue, and Battleshock.<sup>55</sup> However, it was not until the Korean and Vietnam conflicts that PTSD really began to gain the attention of mental health professionals and others.<sup>56</sup>

Current estimates are that about 7.7 million American adults are affected by PTSD,<sup>57</sup> with the sources of PTSD including natural disasters and violent accidents.

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M. Williams, Thomas J. Whitford, Erin Falconer, Andrew H. Kemp, Anthony Peduto & Richard A. Bryant, *Duration of Posttraumatic Stress Disorder Predicts Hippocampal Grey Matter Loss*, 20 NEUROREPORT 1402, 1402 (2009); Tamara V. Gurvits, Martha E. Shenton, Hiroto Hokama, Hirokazu Ohta, Natasha B. Lasko, Mark W. Gilbertson, Scott P. Orr, Ron Kikinis, Ferenc A. Jolesz, Robert W. McCarley & Roger K. Pittman, *Magnetic Resonance Imaging Study of Hippocampal Volume in Chronic, Combat-Related Posttraumatic Stress Disorder*, 40 BIOLOGICAL PSYCHIATRY 1091, 1092 (1996); Matthew Tull, *The Effect of PTSD on the Brain: The Size of the Hippocampus Differs Between People With and Without PTSD* (Jan. 25, 2009), <http://ptsd.about.com/od/symptomsanddiagnosis/a/hippocampus.htm>.

50. See Tull, *supra* note 49.

51. See *id.*

52. David Kinchin, *What Is Post Traumatic Stress Disorder?*, <http://www.burnsurvivorsttw.org/articles/ptsd1.html>; see also Meredith L. Mealer, April Shelton, Britt Berg, Barbara Rothbaum & Marc Moss, *Increased Prevalence of Post-Traumatic Stress Disorder Symptoms in Critical Care Nurses*, 175 AM. J. RESPIRATORY & CRITICAL CARE MED. 693, 693–96 (2007).

53. Kinchin, *supra* note 52.

54. KINCHIN, *supra* note 35, at 13–14.

55. *Id.* at 13.

56. Terri Tanielian, Lisa H. Jaycox, David M. Adamson & Karent N. Metscher, *Introduction*, in *INVISIBLE WOUNDS OF WAR*, *supra* note 11, at 3, 4; see also KINCHIN, *supra* note 35, at 13.

57. NAT'L INST. OF MENTAL HEALTH, U.S. DEP'T OF HEALTH & HUMAN SERVS., *ANXIETY DISORDERS* 8 (2009), available at <http://www.nimh.nih.gov/health/publications/anxiety-disorders/index.shtml>. Additionally, “[i]n recent studies among incarcerated populations, PTSD has been found in approximately 48% of female inmates and 30% of male inmates.” CLAUDIA BAKER & CESSIE ALFONSO, NAT'L CTR. FOR PTSD, PTSD AND CRIMINAL BEHAVIOR (2009), <http://www.ptsd.va.gov/public/pages/ptsd-criminal-behavior.asp>.

Furthermore, the APA has determined that 8% of the American population that suffers from PTSD (i.e., over 600,000 Americans) will experience its effects throughout their lifespan.<sup>58</sup>

Although the rate of PTSD in the general American population is a matter of concern, the prevalence of PTSD in combat veterans is even higher.<sup>59</sup> Approximately one of eight veterans is returning with symptoms of PTSD after military service in Iraq.<sup>60</sup> As noted earlier, other reports estimate that the prevalence of PTSD among Iraq War veterans in particular is one in five, with others estimating that at least 300,000 (out of 1.6 million) service members who served in Iraq or Afghanistan have shown signs of PTSD.<sup>61</sup> Just as the Vietnam War placed PTSD on the radar of mental health professionals, the Iraq War, and increasingly the Afghanistan War, may raise awareness of, encourage research on, and increase sensitivity to the impact of this disorder on military veterans—leading to a greater appreciation of the psychological battles these veterans face when they return home.<sup>62</sup>

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58. DSM-IV-TR, *supra* note 18, at 463, 466.

59. *Id.* at 466 (“Community-based studies reveal a lifetime prevalence for Posttraumatic Stress Disorder of approximately 8% of the adult population in the United States. . . . Studies of at-risk individuals (i.e., groups exposed to specific traumatic incidents) yield variable findings, with the highest rates (ranging between one-third and more than half of those exposed) found among survivors of rape, military combat and captivity, and ethnically or politically motivated internment and genocide.”); Erin M. Gover, Comment, *Iraq as a Psychological Quagmire: The Implications of Using Post-Traumatic Stress Disorder as a Defense for Iraq War Veterans*, 28 PACE L. REV. 561, 565–66 (2008) (“[T]he American Psychiatric Association concluded that eight percent of the American population suffers from PTSD that will have lifetime prevalence, with the highest rates among those who have served in military combat.” (citation omitted)). However, research suggests that the leading cause of PTSD is not military combat, but rather auto accidents. Press Release, Am. Psychological Ass’n, Motor Vehicle Accidents Are Leading Cause of Posttraumatic Stress Disorder, According to New Book (Dec. 7, 2003), available at [http://www.apa.org/releases/accidents\\_ptsd.html](http://www.apa.org/releases/accidents_ptsd.html) (citing EDWARD B. BLANCHARD & EDWARD J. HICKLING, AFTER THE CRASH: PSYCHOLOGICAL ASSESSMENT AND TREATMENT OF SURVIVORS OF MOTOR VEHICLE ACCIDENTS (2003)).

60. Hoge et al., *supra* note 11, at 19 tbl.3; see also Associated Press, *1 in 8 Returning Soldiers Suffers from PTSD*, MSNBC.COM, June 30, 2004, <http://www.msnbc.msn.com/id/5334479>.

61. See generally Seal et al., *supra* note 11, at 1651 (finding that 21.8% of separated Iraq and Afghanistan veterans who enrolled in the health care program offered by the Department of Veterans Affairs were diagnosed with PTSD); Elias, *supra* note 13 (reporting that approximately one out of seven service members deployed in Iraq or Afghanistan have returned with symptoms of posttraumatic stress disorder based on an April 2008 study, with a significant recent increase in the number of veterans seeking related treatment); Editorial, *PTSD and the Purple Heart*, N.Y. TIMES, Jan. 12, 2009, at A22; Wein, *supra* note 12; Gregg Zoroya, *A Fifth of Soldiers at PTSD Risk: Rate Rises with Tours, Army Says*, USA TODAY, Mar. 7, 2008, at 11A.

62. See generally Ira K. Packer, *Post-Traumatic Stress Disorder and the Insanity Defense: A Critical Analysis*, 11 J. PSYCHIATRY & L. 125, 125–26 (1983) (“The difficulty that many Vietnam veterans have experienced upon their return to the United States has been documented by a number of researchers . . . . The American Psychiatric Association in *DSM-III*, has recognized this constellation of difficulties as a psychiatric disorder, calling it post-traumatic stress disorder (PTSD) . . . . [M]uch of the publicity about PTSD has focused on Vietnam veterans and attorneys have begun to use it as a defense in criminal cases.” (citations omitted));

*B. PTSD and the Vietnam War Veteran*

The Vietnam War was arguably the first time that the United States military fully acknowledged the existence and impact of PTSD.<sup>63</sup> This war, in which approximately 58,000 American soldiers died, was a contentious and controversial endeavor.<sup>64</sup>

Various features of this war increased the likelihood that the soldiers involved would develop PTSD. For instance, the war presented the American military with a relatively new kind of warfare—guerrilla warfare.<sup>65</sup> The very nature of guerrilla warfare expands the number of combatants placed in danger, encompassing both soldiers directly involved in the fighting and those working in what had traditionally been a relatively removed and safe logistical capacity.<sup>66</sup> During the Vietnam War, there were no front and rear lines; the combat zone came to surround the soldiers virtually anywhere they were in that country at all times.<sup>67</sup> Furthermore, because combatants are not clearly identified in this type of warfare, soldiers found it difficult to know who

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Gover, *supra* note 59, at 566 (claiming that evaluations of PTSD in military personnel are becoming more sophisticated as they evolve to take into account the “environment, the person’s emotional responses, what type of military activities they participated in and the dimensions of the [military] mission itself”); Sami Bég, *Mental Problems Plague Returning Troops: Nearly One-Third of Veterans Can’t Leave Trauma Behind, New Study Suggests*, ABC NEWS.COM, Mar. 12, 2007, <http://abcnews.go.com/Health/story?id=2944619&page=1> (noting the increasing attention being given to the prevalence of PTSD, with one-sixth of the 100,000 troops returning from Iraq and Afghanistan treated at Veterans Affairs facilities between 2001 and 2005 diagnosed with PTSD; the personal effects and impact of the disorder, including an increased risk of suicide; and a lack of adequate resources being in place to help troops with returning mental conditions).

63. See Rosenheck & Fontana, *supra* note 14, at 1720 (“The Department of Veterans Affairs (VA) bears specific responsibility for providing mental health services to veterans with military-related mental health problems. The VA responded to the needs of 3.1 million Vietnam Theater veterans by establishing more than 200 storefront community-based outreach programs . . . in the 1970s and 1980s and an array of more than 140 specialized PTSD treatment programs, alongside its network of general mental health programs.”); see also SLOBOGIN ET AL., *supra* note 26, at 20 (“[I]n 1980, in response to pressure from Vietnam veterans groups, the APA added a Posttraumatic Stress Disorder categorization to the DSM.”); Friedman, *supra* note 12, at 75 (“The rigorous evaluation of war-related psychiatric disorders is relatively new, having begun with the National Vietnam Veterans Readjustment Study. This national epidemiologic survey of male and female veterans of Vietnam was conducted in the mid-1980s. The veterans were therefore assessed 10 to 20 years after their service in Vietnam. The prevalence of current PTSD was 15 percent among men and 8 percent among women. The lifetime prevalence of PTSD was higher — 30 percent among male veterans and 25 percent among female veterans.”).

64. See Marc Pilisuk, *The Legacy of the Vietnam Veteran*, 31 J. SOC. ISSUES 3, 3–12 (1975).

65. *Id.*

66. See Dohrenwend et al., *supra* note 10, at 979 (“[E]stimates of the percentage of veterans exposed to combat dangers increase when Vietnam is recognized as a ‘war without fronts’ rather than a conventional war. Kolko, for example, reports that 50% of soldiers were considered ‘combat forces,’ and Baskir and Strauss conclude that about 1.6 million of the 2.15 million men that they estimate were assigned to tours in Vietnam itself ‘served in combat.’” (citations omitted)).

67. *Id.*; Chester E. Sigafos, *A PTSD Treatment Program for Combat (Vietnam) Veterans in Prison*, 38 INT’L J. OFFENDER THERAPY & COMP. CRIMINOLOGY 117, 118 (1994).

was friend or foe.<sup>68</sup> For example, Vietnamese “civilians” could turn out to be Viet Cong operatives.<sup>69</sup> Hence, many soldiers assumed a hypervigilant or “survivor mode” state of mind in which they attempted to be constantly aware of their surrounding environment in order to anticipate and react to potential attacks and life-threats.<sup>70</sup> Unfortunately, many times this mode did not “turn off” when the soldiers returned home.<sup>71</sup> As a result, many veterans manifested enduring psychological problems after returning to civilian life.<sup>72</sup>

It has been estimated that there are between 500,000 and 1.5 million Vietnam veterans in the United States who have suffered from PTSD,<sup>73</sup> with the lifetime prevalence of PTSD among Vietnam veterans 30.9% for men and 26.9% for women.<sup>74</sup>

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68. Sigafos, *supra* note 67, at 118.

69. *Id.* The Viet Cong was a guerrilla faction of the Vietnamese communist movement. Merriam-Webster Online Dictionary, <http://www.merriam-webster.com/dictionary/vietcong>.

70. Sigafos, *supra* note 67, at 118; *see also* John P. Wilson & Sheldon D. Zigelbaum, *The Vietnam Veteran on Trial: The Relation of Post-Traumatic Stress Disorder to Criminal Behavior*, 1 BEHAV. SCI. & L. 69, 73 (1983) (defining “survivor mode,” which is characterized by “an altered state of consciousness, hyperaltness, [and] hypervigilance”).

71. Sigafos, *supra* note 67, at 118.

72. *Id.*

73. *See* J. Ingram Walker & Jesse O. Cavenar, *Vietnam Veterans: Their Problems Continue*, 170 J. NERVOUS & MENTAL DISEASE 174, 174 (1982); *see also* Schnurr et al., *supra* note 12, at 551 (“Among Vietnam veterans who had ever developed full or partial PTSD, only one in five reported no symptoms in the prior 3 months when assessed 20-25 years after their Vietnam service. Over half said they had symptoms every month in the 5 years prior to being interviewed, which is noteworthy because only slightly more than 20% currently had full or partial PTSD. Failing to meet current diagnostic criteria was not equivalent to being symptom-free.”). The 1988 National Vietnam Veterans Readjustment Survey estimated that 30.9% of Vietnam veterans had developed PTSD at some point in their lifetimes. Dohrenwend et al., *supra* note 10, at 979. A recent reappraisal of this study generated somewhat smaller prevalence rates but concluded that “the Vietnam War took a severe psychological toll on U.S. veterans.” *Id.* at 982. In 2005, 189,309 Vietnam veterans sought treatment for PTSD from the Veterans Health Administration alone, more than doubling the 91,043 seeking treatment in 1997. Rosenheck & Fontana, *supra* note 14, at 1722. Some of those veterans were diagnosed years ago; some were new diagnoses. *Id.* at 1721–22. Media coverage of the wars in Iraq and Afghanistan may be partially responsible for this increase in requests for treatment. *Id.* at 1727; *see also* Richard Robbins, *More Vietnam Vets Seeking PTSD Help*, PITTSBURGH TRIBUNE-REVIEW, Oct. 11, 2009, [http://www.pittsburghlive.com/x/pittsburghtrib/news/s\\_647506.html](http://www.pittsburghlive.com/x/pittsburghtrib/news/s_647506.html); Libby Lewis, *Iraq War Stirs Memories for Vietnam Vets*, NPR, Sept. 25, 2007, available at <http://www.npr.org/templates/story/story.php?storyId=14529768> (reporting that in 2003, more than 153,600 Vietnam veterans sought treatment for PTSD).

74. RICHARD A. KULKA, WILLIAM E. SCHLENGER, JOHN A. FAIRBANK, RICHARD L. HOUGH, B. KATHLEEN JORDAN, CHARLES R. MARMAR & DANIEL S. WEISS, *TRAUMA AND THE VIETNAM WAR GENERATION: REPORT OF FINDINGS FROM THE NATIONAL VIETNAM VETERANS READJUSTMENT STUDY* 63, 267 (1990); *see also id.* at 51 (“The results are striking. A disturbingly large proportion of Vietnam theater veterans have PTSD today.”); *id.* at 53 (examining the current prevalence of either partial or full PTSD syndrome, finding that a total of 830,000 Vietnam theatre veterans “have trauma-related symptoms that may benefit from professional treatment”); Dohrenwend et al., *supra* note 10, at 979 (“In 1988, the National Vietnam Veterans Readjustment Study (NVVRS) of a representative sample of 1200 veterans estimated that 30.9%

Studies have found that many of these veterans have experienced “clinically significant stress reaction symptoms.”<sup>75</sup> Such symptoms include intrusive recollections or recurrent dreams of events, distress caused by exposure to certain events or symbols, continued efforts to avoid thoughts and feelings, feelings of detachment, a restricted range of affect, insomnia, a sense of a foreshortened future, hypervigilance, and concentration problems.<sup>76</sup>

It is, however, the propensity of combat veterans with PTSD to commit crimes that makes this diagnosis particularly germane in the legal arena. Surveys conducted in the early 1980s indicated that Vietnam War veterans in the United States suffering from PTSD displayed a high rate of criminal behavior compared to that of the general population.<sup>77</sup> Approximately 10,000 of the 71,000 inmates in the Federal Bureau of

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had developed posttraumatic stress disorder (PTSD) during their lifetimes and that 15.2% were currently suffering from PTSD. . . . We used military records to construct a new exposure measure and to cross-check exposure reports in diagnoses of 260 NVVRS veterans. . . . According to our fully adjusted PTSD rates, 18.7% of the veterans had developed war-related PTSD during their lifetimes and 9.1% were currently suffering from PTSD 11 to 12 years after the war . . . .”); Donna M. Shaw, Cynthia M. Churchill, Russell Noyes, Jr. & Paul L. Loeffelholz, *Criminal Behavior and Post-Traumatic Stress Disorder in Vietnam Veterans*, 28 *COMPREHENSIVE PSYCHIATRY* 403, 403 (1987) (“The combat environment of Vietnam was overwhelming . . . . Nearly half of the veterans who saw combat were found to have some difficulty with unresolved war experiences and 20% to 43% were diagnosed as having post-traumatic disorder.”); *id.* at 408 (“[V]eterans who developed PTSD reported higher risk assignments, higher levels of subjective stress, more frequent thoughts of death, lower unit morale, and more involvement in violence.”); Daniel S. Weiss, Charles R. Marmar, William E. Schlenger, John A. Fairbank, B. Kathleen Jordan, Richard L. Hough & Richard A. Kulka, *The Prevalence of Lifetime and Partial Post-Traumatic Stress Disorder in Vietnam Theater Veterans*, 5 *J. TRAUMATIC STRESS* 365, 365, 372 (1992) (finding that an additional 22.5% of the males and 21.2% of the females that were Vietnam theater veterans have experienced partial PTSD in their lifetimes, and “that of the 1.7 million veterans who ever experienced significant symptoms of PTSD after the Vietnam war, approximately 830,000 (49%) still experience clinically significant distress and disability from symptoms of PTSD[, with t]he contribution of partial PTSD represent[ing] an estimated additional 350,000 veterans”). Another account asserts that 480,000 of those returning from Vietnam (15.2% of men and 8.1% of women) had PTSD, with 168,000 Vietnam veterans still having it. Posting of Bob Krause to Iowa Veterans Blog, <http://iowavetsblog.blogspot.com/search?q=168%2C000+Vietnam+veterans> (Oct. 20, 2008, 21:08 EST).

75. KULKA ET AL., *supra* note 74, at 267 (“These findings mean that over the course of their lives, more than half of male [Vietnam] theater veterans and nearly half of female [Vietnam] theater veterans have experienced clinically significant stress reaction symptoms. This represents about 1.7 million veterans of the Vietnam war.”); *see also* Ronald C. Kessler, Amanda Sonnega, Evelyn Bromet, Michael Hughes & Christopher B. Nelson, *Posttraumatic Stress Disorder in the National Comorbidity Survey*, 52 *ARCHIVES GEN. PSYCHIATRY* 1048 (1995).

76. Sigafos, *supra* note 67, at 117.

77. *See* Wilson & Zigelbaum, *supra* note 70, at 82 (“[T]he results of this study have extended growing research literature on PTSD among Vietnam veterans by exploring the relationship between combat role factors, exposure to stressors in Vietnam, and pre-morbid personality traits to criminal behavior. . . . [O]ur results . . . indicated that there was a significant relationship between combat role factors, exposure to stressors in Vietnam, and criminal behavior after returning home from the war. . . . [A]mong Vietnam veterans with PTSD what predisposes the onset of a criminal act is a changed psychological state of being that we have termed the survivor mode of functioning which operates as a behavioral defense mechanism. In

Prisons in 1992 were military service veterans, and approximately 10% of these incarcerated veterans likely suffered from combat-induced PTSD.<sup>78</sup> Similarly, in 2004, state prisons held 127,500 veterans,<sup>79</sup> accounting for approximately 10% of the entire prison population.<sup>80</sup>

Thus, incarceration may be a particularly likely occurrence for veterans suffering from psychological disorders such as PTSD. The National Vietnam Veterans Readjustment Study of 1988 found that 480,000 of the veterans returning from Vietnam had developed PTSD by the time the study was conducted, with almost half (around 240,000) arrested or jailed at least once, 35% more than once, and 11.5% convicted of a felony.<sup>81</sup> Other studies confirmed that higher crime rates existed for Vietnam War veterans suffering from PTSD.<sup>82</sup>

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this psychological state the veteran responds to conscious or unconscious manifestations of the anxiety disorder by reverting to the class of behaviors learned in combat which were connected with survival. In this altered state of being, the individual may then commit a violent or non-violent crime depending on predominant symptom dynamics of PTSD *and* the idiosyncratic nature of his experiences in the war.” (emphasis in original)). For a typology of what led veterans of the war in Vietnam with PTSD to engage in criminal behavior, see Bruce Pentland & James Dwyer, *Incarcerated Viet Nam Veterans*, in *THE TRAUMA OF WAR: STRESS AND RECOVERY IN VIET NAM VETERANS* 403, 407–10 (Stephen M. Sonnenberg et al. eds., 1985) (“We have conceptualized three categories of behavior which lead to the incarceration of most veterans: 1) conscious flashback behavior, 2) unconscious flashback behavior (or the ‘blind flashback’), and 3) action junkie behavior.”).

78. Sigafos, *supra* note 67, at 118.

79. MARGARET E. NOONAN & CHRISTOPHER J. MUMOLA, U.S. DEP’T OF JUSTICE, BUREAU OF JUSTICE STATISTICS SPECIAL REPORT: VETERANS IN STATE AND FEDERAL PRISON, 2004, at 9 tbl.1 (2007).

80. *Id.* at 1.

81. See KULKA ET AL., *supra* note 74, at 186–87 (“[Male Vietnam theater veterans] with PTSD were . . . especially prone to active forms of expressing their hostility (over 40 percent scoring in the highest category) and to violent behavior (averaging 13.31 violent acts in the past year compared with only 3.54 among those without PTSD). Almost half of these (45.7 percent) had been arrested or jailed more than once—one-fourth of these (11.5 percent) convicted of a felony—compared with only 11.6 percent of those without a stress disorder.”); see also Posting of Bob Krause, *supra* note 74.

82. Wilson & Zigelbaum, *supra* note 70, at 77 (survey of Vietnam combat veterans that included a measure to assess the presence and severity of PTSD and their post-Vietnam legal problems, including whether they had been arrested, acquitted, or convicted of any of nineteen criminal offenses); Gover, *supra* note 59, at 570 (citing Michael J. Davidson, Note, *Post-Traumatic Stress Disorder: A Controversial Defense for Veterans of a Controversial War*, 29 WM. & MARY L. REV. 415, 415 (1988)); see also C. Peter Erlinder, *Paying the Price for Vietnam: Post-Traumatic Stress Disorder and Criminal Behavior*, 25 B.C. L. REV. 305, 306 (1984) (“[M]any attorneys may fail to recognize that various client problems ranging from criminal charges and substance abuse, to family problems and employment disputes may be related to PTSD and to service in Vietnam.”); *id.* at 311 (“Some authorities have suggested, that twenty-five to thirty percent of Vietnam veterans who saw heavy combat have been arrested on criminal charges.” (citing Schultz, *Trauma, Crime and the Affirmative Defense*, 11 COLO. LAW. 2401, 2401 (1982))); Pentland & Dwyer, *supra* note 77, at 406 (“[C]urrent data indicate that Viet Nam veterans (those who actually saw service in Viet Nam) constitute five to 10 percent of the population of state prisons.” (citations omitted)); *id.* (“We hypothesize that . . . many Viet Nam veterans in prison are there, at least in part, because of stressors related to the Viet Nam combat and homecoming experience. It is our observation that many of these veterans have not



*C. PTSD and Military Training*

Military training and combat, of course, encourage violent and aggressive behavior.<sup>83</sup> However, such behavior off the battlefield, if unjustified, can result in the individual running afoul of the criminal justice system and lead to the imposition of criminal sanctions.<sup>84</sup> At least some of this criminal behavior can be attributed to the impact of PTSD.<sup>85</sup>

Indeed, the training used to prepare soldiers for combat may account in part for this scenario. To enhance their combat performance, military training imbues soldiers with a unique mind-set to almost instinctively confront and react to combat situations.<sup>86</sup> Further, soldiers are conditioned to survive harsh, threatening, and violent environments.<sup>87</sup> They are taught to attack an enemy target dispassionately, quickly, and without hesitation. To function effectively within a military unit, a soldier must learn to suppress various normal instincts, such as flight in the face of a threat.<sup>88</sup>

In fact, after World War II, a prominent military historian, S.L.A. Marshall, studied military veterans and, specifically, how ready they had been to fight.<sup>89</sup> Marshall determined that as few as 15% of them would consciously fire their weapon at the enemy during combat.<sup>90</sup> After this study, Marshall recommended to the Army that its training programs needed to seek “any and all means by which we can increase the ratio of effective fire when we have to go to war” and to break down the typical “inner and usually unrealized resistance toward killing a fellow man.”<sup>91</sup> Marshall’s

worked through these experiences, and until they do we believe that they will remain the ‘outlaw casualties’ of that war.”); Thomas Yager, Robert Laufer & Mark Gallops, *Some Problems Associated with War Experience in Men of the Vietnam Generation*, 41 ARCHIVES GEN. PSYCHIATRY 327, 331 (1984) (“[A]rrests were . . . more than four times more prevalent among heavy combat veterans than among men who were exposed only to light combat or none at all.”); H. Dondershine, *The Veteran and the Criminal Process: Three Subtypes of Post-Traumatic Stress Disorder Associated with Criminal Behavior* 4 (1983) (unpublished manuscript, on file with the Department of Psychiatry, Stanford University Medical School). *But see* Shaw et al., *supra* note 74, at 408 (“[C]riminal behavior leading to imprisonment in [Vietnam] veterans did not appear to be a consequence of PTSD. PTSD was no more prevalent among incarcerated veterans than it was among a control group of unincarcerated veterans.”).

83. See William E. Calvert & Roger L. Hutchinson, *Vietnam Veteran Levels of Combat: Related to Later Violence?*, 3 J. TRAUMATIC STRESS 103, 104 (1990) (stating that in military performance, the more aggression a soldier shows, the more the soldier is rewarded).

84. *Id.*

85. See Barry L. Levin, *Defense of the Vietnam Veteran with Post-Traumatic Stress Disorder*, 46 AM. JUR. TRIALS 441, § 5 (1993); Lizette Alvarez & Dan Frosch, *A Focus on Violence by G.I.’s Back from War*, N.Y. TIMES, Jan. 2, 2009, at A1 (“For the past several years . . . the number of servicemen implicated in violent crimes has raised alarm.”).

86. See Levin, *supra* note 85.

87. *Id.*

88. *Id.*

89. DAVE GROSSMAN, ON KILLING 3–4 (1995); Anthony E. Giardino, *Combat Veterans, Mental Health Issues, and the Death Penalty: Addressing the Impact of Post-Traumatic Stress Disorder and Traumatic Brain Injury*, 77 FORDHAM L. REV. 2955, 2963 (2009).

90. S.L.A. MARSHALL, MEN AGAINST FIRE 36–43, 64–84 (1964); Giardino, *supra* note 89, at 2963; see also GROSSMAN, *supra* note 89, at 4.

91. MARSHALL, *supra* note 90, at 23, 79; Giardino, *supra* note 89, at 2963.

suggestions were not only implemented, but also extremely effective. By the Vietnam War, 90% or more of soldiers would consciously fire their weapon at the enemy.<sup>92</sup>

The goal of getting American soldiers to more readily kill other human beings was achieved by combining stimulus response training and psychological inoculation.<sup>93</sup> Modern military training involves, among other things, operant conditioning to break down soldiers' innate psychological resistance to killing, to desensitize them to the act of killing, and to reflexively take another's life when a given set of circumstances exist.<sup>94</sup> The objective is to develop instant, unhesitating obedience to a superior's orders to ensure that commands and responsibilities are carried out in combat without question.<sup>95</sup> Positive and negative reinforcement techniques, such as rewards and punishments, are utilized to condition (i.e., make automatic) these behaviors.<sup>96</sup>

This training can also result in the soldier becoming less focused on human suffering and more attuned to accomplishing an assigned military objective (e.g., repelling an enemy's attack).<sup>97</sup> Moreover, to survive in battle, a soldier must remain hypervigilant and be ready to immediately spring into action.<sup>98</sup>

This mindset, however, can be dangerous to society once a soldier's tour of duty is over.<sup>99</sup> A body of evidence demonstrates that while the military successfully trains soldiers in how to survive in combat and complete a mission, the conditioning associated with this training often remains intact even after the soldier's tour of service is completed.<sup>100</sup>

Not only does combat training involve psychological conditioning, but almost all soldiers learn a skill set that includes hand-to-hand combat and how to use weapons. For example, veterans may receive specialized training in explosives, infiltration, and detecting enemy activity.<sup>101</sup> Although these skills can be essential to fulfill military objectives, they may also be inappropriate once the veteran returns to civilian life.<sup>102</sup> Civilians do not operate in a combat environment and rarely need to be wary of life-threatening situations on a daily basis. Indeed, when veterans return home they may have trouble adjusting to the absence of constant threats.<sup>103</sup>

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92. GROSSMAN, *supra* note 89, at 251; Giardino, *supra* note 89, at 2963.

93. GROSSMAN, *supra* note 89, at 81–82, 252–55; Giardino, *supra* note 89, at 2964. *See generally* BRUCE K. SIDDLE, SHARPENING THE WARRIOR'S EDGE (1995) (discussing modern combat training methods); Mark S. Martins, *Deadly Force Is Authorized, but Also Trained*, ARMY LAW., Sept.–Oct. 2001, at 1, 3–5, 8–9, 15.

94. *See* GROSSMAN, *supra* note 89, at 81–82, 177–78, 251–64; MARSHALL, *supra* note 90, at 36–43; 50–84; Giardino, *supra* note 89, at 2964; *see also* Levin, *supra* note 85.

95. Levin, *supra* note 85; *see also* GROSSMAN, *supra* note 89, at 81–82, 251–64.

96. GROSSMAN, *supra* note 89, at 82, 177–78, 253.

97. Levin, *supra* note 85.

98. *Id.*

99. *Id.*

100. *Id.* It is beyond the scope of this Article to address why, if soldiers are required to undergo psychological change to withstand the horrors of war and accomplish military objectives, soldiers are not similarly conditioned by the military to transition them back to civilian life.

101. Sigafos, *supra* note 67, at 117.

102. *Id.*

103. *See* Levin, *supra* note 85; *see also* Sigafos, *supra* note 67, at 118.

It is not surprising that when soldiers return home from combat, they may experience psychological problems, not only from past combat exposure, but also from trying to reintegrate into civilian life. Soldiers are trained to think and act in a manner necessary for survival on the battlefield, but they may not be well prepared for their return to life beyond the military. Furthermore, returning veterans may have become accustomed to the emotional highs and lows that accompany a combative environment.<sup>104</sup> In light of their training and psychological orientation, as well as the horrors of war and the threat of death or injury they experienced, it is no wonder that some veterans undergo significant psychological problems when they return home.<sup>105</sup>

The impact of modern military training may be particularly apparent when a combat veteran suffering from PTSD commits an act of violence.<sup>106</sup> This act may have involved a reflexive response due to the veteran's PTSD, with the PTSD altering the judgment and decision making of the veteran.<sup>107</sup> The veteran's ability to fully appreciate the nature or wrongfulness of the violent act or, in certain cases, to conform his or her conduct to the requirements of the law, may as a result have been impaired.<sup>108</sup> Thus, veterans who have been through modern military training and who are suffering from combat-related PTSD may be less culpable than other individuals committing similar crimes.<sup>109</sup>

#### *D. PTSD and the Iraq and Afghanistan War Veteran*

PTSD continues to be a problem for many veterans returning home from war. Iraq and Afghanistan War veterans returning home have exhibited PTSD symptoms, with some having engaged in related dangerous coping mechanisms.<sup>110</sup>

As during the Vietnam War, soldiers in Iraq and Afghanistan have faced surprise attacks and constant threats of bodily harm. But these wartime theaters also present some added novel threats that stem from changes in warfare technology. Military officers, among others, have commented on how the terrorist warfare being employed by the Iraqi insurgents is relatively unique.<sup>111</sup> These reports indicate that the nature of the enemy's action evolved: enemy forces moved away from small-unit infantry engagements toward more hit-and-run attacks that used improvised explosive devices, mortars, or rocket-propelled grenades.<sup>112</sup>

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104. See Levin, *supra* note 85; see also Sigafos, *supra* note 67, at 118.

105. See Levin, *supra* note 85; see also Sigafos, *supra* note 67, at 117–18.

106. See Levin, *supra* note 85; see also Michael J. Davidson, Note, *Post-Traumatic Stress Disorder: A Controversial Defense for Veterans of a Controversial War*, 29 WM. & MARY L. REV. 415, 424–29 (1988).

107. See Levin, *supra* note 85; Davidson, *supra* note 106, at 424–29.

108. See Levin, *supra* note 85; Davidson, *supra* note 106, at 424–29.

109. See Levin, *supra* note 85; Davidson, *supra* note 106, at 424–29.

110. See *supra* notes 1–25 and accompanying text.

111. Jim Garamone, *Number of Attacks in Iraq Constant, Enemy Tactics Change*, AM. FORCES PRESS SERV., Oct. 6, 2003, <http://www.defenselink.mil/news/newsarticle.aspx?id=28370>; see also Friedman, *supra* note 12, at 76 (noting, in 2004, concern that rates of PTSD among veterans of Iraq and Afghanistan “will increase now that the conduct of war has shifted from a campaign for liberation to an ongoing armed conflict with dissident combatants”).

112. Garamone, *supra* note 111.

During a press briefing, Army Lieutenant General Ricardo Sanchez stated that “what we all need to understand is that (with) some of these improvised explosive devices, all that is required is someone with a paper bag or a plastic bag to drop it as a walk-by. . . . I think what it requires is for us to remain vigilant constantly . . . .”<sup>113</sup> Another commanding general, Army Lieutenant General Raymond Odierno, distinguished this warfare and its impact from that faced in World War II, in which troops spent a lot of time in contact with the enemy but were pulled out of the fighting periodically for rest and relaxation.<sup>114</sup> He noted: “Here, we don’t do that. [Troops] are out there consistently every single day. So you have to be mentally and physically tough . . . [a]nd different things affect you.”<sup>115</sup>

Compounding the stress stemming from the nature of the warfare in Iraq and Afghanistan has been the psychological toll associated with the “long and repeat deployments” of troops in these prolonged conflicts.<sup>116</sup> General George W. Casey Jr., the Army’s Chief of Staff, recently stated that “the mental effects of repeated deployments—rising suicide rates in the Army, mild traumatic brain injuries, post-traumatic stress—had convinced commanders ‘that we need a program that gives soldiers . . . better ways to cope.’”<sup>117</sup>

Like Vietnam, soldiers in Iraq and Afghanistan found themselves in a foreign country engaged in, at least for Iraq, a fairly controversial war.<sup>118</sup> However, unlike their Vietnam War counterparts, returning Iraq and Afghanistan War veterans have generally enjoyed the support and admiration of the country upon their return.<sup>119</sup>

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113. *Id.*

114. Jim Garamone, *Troops Continue to Adapt to Enemy Tactics in Iraq*, AM. FORCES PRESS SERV., May 31, 2007, <http://www.globalsecurity.org/military/library/news/2007/05/mil-070531-afps02.htm>.

115. *Id.*

116. Dao, *supra* note 12 (“[There is] a growing body of research showing that the prolonged conflicts, where many troops experience long and repeat deployments, are taking an accumulating psychological toll.”); *see also* Bob Herbert, Op-Ed., *War’s Psychic Toll*, N.Y. TIMES, May 19, 2009, at A25 (asserting that multiple tours, longer deployments, common redeployment to combat, and infrequent breaks between deployments have “sacrific[ed] the psychological well-being of these [soldiers]”).

The Iraq War may have triggered an increase in mental health problems for several reasons. First, waning public support and lower morale among troops may predispose returning veterans to mental health problems, as occurred during the Vietnam era. Second, the insurgency in Iraq has had no definable “front-line,” characterized by unexpected threats to life such as roadside bombs and improvised explosive devices. Finally, multiple and more-lengthy deployments and heightened media attention may contribute to a steady increase in new mental health disorders. Seal et al., *supra* note 11, at 1656 (citations omitted).

117. Benedict Carey, *Army Will Train Soldiers to Cope with Emotions*, N.Y. TIMES, Aug. 18, 2009, at A1.

118. *See* S. Anthony Higgins, *Post-Traumatic Stress Disorder and Its Role in the Defense of Vietnam Veterans*, 15 LAW & PSYCHOL. REV. 259, 262 (1991); Dana Milbank & Claudia Deane, *Poll Finds Dimmer View of Iraq War: 52% Say U.S. Has Not Become Safer*, WASH. POST, June 8, 2005, at A1.

119. Friedman, *supra* note 12, at 76 (“There are obviously important distinctions between the period after the Vietnam War and the present. Americans no longer confuse war with the

Surveys indicate that although the Iraq and Afghanistan Wars have increasingly been compared to the Vietnam experience, there still appears to be support at home for these returning veterans. For example, although one poll found that nearly six in ten Americans said the war in Iraq was not worth fighting,<sup>120</sup> and more than four in ten believed the United States' presence in Iraq was becoming analogous to Vietnam,<sup>121</sup> the troops nevertheless continue to be viewed positively and have the support of Americans.<sup>122</sup>

As will be discussed, the different perceptions of this war and the increased understanding of PTSD may enable Iraq and Afghanistan veteran defendants suffering from PTSD to better employ this diagnosis as a basis for reducing or avoiding criminal culpability.

## II. THE INSANITY DEFENSE AND PTSD WAR VETERANS

### A. *The Insanity Defense in General*

*Black's Law Dictionary* defines the insanity defense as "an affirmative defense alleging that a mental disorder caused the accused to commit the crime."<sup>123</sup> The first recorded insanity defense acquittal occurred in 1505.<sup>124</sup>

While the insanity defense is by no means a new concept, it has evolved over time. Today, different jurisdictions recognize different insanity tests.<sup>125</sup> Moreover,

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warrior; those returning from Iraq or Afghanistan enjoy national support, despite sharp political disagreement about the war itself."); *see also* Anna Badkhen, *Some Vets View Day With Pride, Resentment*, BOSTON GLOBE, Nov. 12, 2007, at B1 ("As troops who have served in Iraq and Afghanistan observe Veterans Day today, they will be cheered by a supportive nation and a government that has developed an elaborate network of benefits and services to ease their transition to civilian life. Celebrating also, Vietnam War veterans like Charles S. Brown, 57, will look on with a mix of pride and resentment."); Paul Harris, *Bush: Our Shame Over Army Hospitals—As the Row Over Filthy Conditions at a Top US Military Ward Costs Two Army Chiefs Their Jobs, The President Vows to Help Veterans*, THE OBSERVER (England), Mar. 4, 2007, at 34 ("In contrast to some reactions during the Vietnam war, veterans of Iraq and Afghanistan are almost universally regarded as returning heroes, even by staunch critics of the conflicts.").

120. Milbank & Deane, *supra* note 118.

121. *Id.*

122. Friedman, *supra* note 12, at 76.

123. BLACK'S LAW DICTIONARY 865 (9th ed. 2009).

124. PETER W. LOW, JOHN CALVIN JEFFRIES, JR. & RICHARD J. BONNIE, THE TRIAL OF JOHN W. HINCKLEY, JR.: A CASE STUDY OF THE INSANITY DEFENSE 8 (1986). Although this may reflect the first recorded instance, it has been asserted that reference to the insanity defense can be found in the Talmud. *See* DONALD H. J. HERMANN, THE INSANITY DEFENSE: PHILOSOPHICAL, HISTORICAL AND LEGAL PERSPECTIVES 18–19 (1983) ("It is an ill thing to knock against a deaf mute, an imbecile or a minor; he that wounds them is culpable, but if they wound others they are not culpable." (citing THE MISHNAH 342–43 (Herbert Danby trans., Oxford Univ. Press 1967))). It has also been contended that the defense is consistent with the writings of Plato and Aristotle. *Id.* at 19–20. Finally, it has been stated that explicit recognition of the insanity defense is found in Justinian's codification of Roman law in the sixth century A.D. *Id.* at 20.

125. *See* Clark v. Arizona, 548 U.S. 735, 749 (2006) ("Even a cursory examination of the traditional Anglo-American approaches to insanity reveals significant differences among them, with four traditional strains variously combined to yield a diversity of American standards.").

jurisdictions often have different views regarding which mental disorders make a defendant eligible for the defense.<sup>126</sup>

Dramatically different opinions exist as to whether the insanity defense should be read broadly to include a wide range of mental disorders or whether its availability should be limited or abolished from the legal system. Proponents of the defense argue that a relatively wide range of mental disorders should be able to provide a basis for this defense.<sup>127</sup> Abolitionists, on the other hand, generally believe that individuals, regardless of their mental condition, should be held accountable for their wrongful behavior.<sup>128</sup>

Modern formulations of the insanity defense are generally derived from the House of Lords' formulation in *M'Naghten's Case*.<sup>129</sup> The *M'Naghten* Rule (sometimes

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126. See RICHARD J. BONNIE, ANNE M. COUGHLIN, JOHN C. JEFFRIES, JR. & PETER W. LOW, *CRIMINAL LAW* 531 (2d ed. 2004); see also CHARLES PATRICK EWING, *INSANITY: MURDER, MADNESS, AND THE LAW*, at xxi (2008) ("Ironically, mental disease and mental defect are terms that often have not been defined by the law."); WAYNE R. LAFAVE, *CRIMINAL LAW* 377 (4th ed. 2003) ("There has never been a clear and comprehensive determination of what type of mental disease or defect is required to satisfy the *M'Naghten* test."); LOW ET AL., *supra* note 124, at 20 ("There has been over the years considerable debate about what kinds of mental conditions should qualify as a 'mental disease or defect' for this purpose. Some have contended that the concept should be limited to the kinds of gross disturbance of mental functioning commonly referred to as psychoses. Others have taken the position that the requirement of a 'mental disease or defect' should not operate as an independent limitation on the availability of the insanity defense. Most views, however, fall somewhere in between these two extremes.").

127. See BONNIE ET AL., *supra* note 126, at 532; see also LAFAVE, *supra* note 126, at 377 ("[I]t would seem that any mental abnormality, be it psychosis, neurosis, organic brain disorder, or congenital intellectual deficiency (low IQ or feeble-mindedness), will suffice if it has caused the consequences described in the second part of the test." (italics in original)); cf. LOW ET AL., *supra* note 124, at 3 ("Proposals to broaden the [insanity] defense compete with calls for its abolition."). For additional articles supporting the insanity defense, see Stephen J. Morse, *Excusing the Crazy: The Insanity Defense Reconsidered*, 58 S. CAL. L. REV. 777 (1985); Daniel J. Nusbaum, Note, *The Craziest Reform of Them All: A Critical Analysis of the Constitutional Implications of "Abolishing" the Insanity Defense*, 87 CORNELL L. REV. 1509 (2002); Jenny Williams, Comment, *Reduction in the Protection for Mentally Ill Criminal Defendants: Kansas Upholds the Replacement of the M'Naughten Approach with the Mens Rea Approach, Effectively Eliminating the Insanity Defense* [State v. Bethel, 66 P.3d 840 (Kan. 2003)], 44 WASHBURN L.J. 213 (2004). Other commentators have critiqued efforts to abolish the insanity defense. See Rita D. Buitendorp, Note, *A Statutory Lesson from "Big Sky Country" on Abolishing the Insanity Defense*, 30 VAL. U. L. REV. 965 (1996).

128. BONNIE ET AL., *supra* note 126, at 532; 1 WORKING PAPERS OF THE NATIONAL COMMISSION ON REFORM OF FEDERAL CRIMINAL LAWS 251 (1970) ("A number of informed observers believe that it is therapeutically desirable to treat behavioral deviants as responsible for their conduct rather than as involuntary victims playing a sick role."). Among the articles that have criticized the insanity defense, see Joseph Goldstein & Jay Katz, *Abolish the "Insanity Defense"—Why Not?*, 72 YALE L.J. 853, 853 (1963).

129. *M'Naghten's Case*, (1843) 8 Eng. Rep. 718 (H.L.); see also BONNIE ET AL., *supra* note 126, at 535; EWING, *supra* note 126, at xviii ("Modern insanity law . . . dates most directly to *M'Naghten's Case* . . ."); LAFAVE, *supra* note 126, at 376 ("The *M'Naghten* test (sometimes with slight variations) has become the predominant rule in the United States.").

referred to as a “cognitive test” because of its emphasis on assessing the defendant’s cognitive capacity)<sup>130</sup> states that, to establish an insanity defense:

[I]t must be clearly proved that, at the time of the committing of the act, the party accused was labouring under such a defect of reason, from disease of the mind, as not to know the nature and quality of the act he was doing; or if he did know it, that he did not know he was doing what was wrong.<sup>131</sup>

Like all American iterations of the insanity test, this standard requires, as a foundational prerequisite for the defense to succeed, that a mental disorder existed at the time of the offense.<sup>132</sup> Whether this requirement is articulated as a “disease of the mind,” “defect in reasoning,” “mental disease,” or “mental disease or defect,” most American jurisdictions recognizing the insanity defense employ it.<sup>133</sup> Consequently, for a PTSD-afflicted veteran to successfully raise an insanity defense, the court must first recognize PTSD as constituting the requisite mental disorder.<sup>134</sup>

Although some variation of the original *M’Naghten* Test is employed in about half of the states,<sup>135</sup> other insanity test formulations exist. For example, under the “Product Test,” no one shall be held criminally accountable for an act that was the “offspring or product of mental disease.”<sup>136</sup> Alternatively, under the “Control Test,” a defendant may be exculpated if the defendant was unable to control his or her behavior as the result of a mental disorder, even if the defendant was aware that such an act was wrong.<sup>137</sup> The “Control Test” is also called the “Irresistible Impulse Test” in some jurisdictions.<sup>138</sup>

130. See LAFAVE, *supra* note 126, at 376 (“Taken literally, the *M’Naghten* rule appears to refer to a certain mental disability which must produce one of two conditions, both of which are defined in terms of lack of cognition.”). Note, however, that the United States Supreme Court recently distinguished the two prongs of the *M’Naghten* test by describing the prong that addresses whether the defendant was able to understand what he or she was doing as an assessment of the defendant’s “cognitive capacity,” while the prong that addresses whether the defendant was able to understand that his or her action was wrong is characterized as an assessment of the defendant’s “moral capacity.” *Clark v. Arizona*, 548 U.S. 735, 747 (2006). Not surprisingly, this terminology is increasingly being employed. See EWING, *supra* note 126, at xviii (“The two ‘prongs’ of the *M’Naghten* standard—(1) inability to know the nature and quality of the act and (2) inability to know that the act was wrong—respectively deal with what have been referred to as cognitive incapacity and moral incapacity.”).

131. *M’Naghten’s Case*, 8 Eng. Rep. at 722.

132. See LOW ET AL., *supra* note 124, at 20 (“[A]ll formulations of the insanity defense require as a threshold condition that the defendant be suffering from a ‘mental disease or defect.’”).

133. Gover, *supra* note 59, at 570–75.

134. See *infra* Part II.B.

135. See BONNIE ET AL., *supra* note 126, at 540–41; see also LAFAVE, *supra* note 126, at 376–77 (“The *M’Naghten* test . . . remains the rule in more than thirty of the states, occasionally supplemented with a test for loss of volitional control” (footnotes omitted)). Jurisdictions vary on whether the defendant must be unable to “know” or “appreciate” the nature or wrongfulness of his or her conduct. BONNIE ET AL., *supra* note 126, at 540–41.

136. *State v. Jones*, 50 N.H. 369, 398 (1871).

137. EWING, *supra* note 126, at xviii (“[U]nder the ‘irresistible impulse’ standard an accused was insane if found, by reason of mental illness, ‘unable to adhere to the right even though he knew the act was wrong.’”); LAFAVE, *supra* note 126, at 389 (“Broadly stated, [the commonly

Finally, the Model Penal Code (MPC) combines aspects of the *M'Naghten* and Control Tests, providing that a person is not responsible for criminal conduct if, “[a]t the time of [the] conduct as a result of mental disease or defect he lacks substantial capacity either to appreciate the criminality . . . of his conduct or to conform his conduct to the requirements of [the] law.”<sup>139</sup> This test thus permits a defendant to establish insanity either via a cognitive element (the defendant “lacks substantial capacity . . . to appreciate the criminality . . . of his conduct”) or a volitional element (the defendant “lacks substantial capacity . . . to conform his conduct to the requirements of [the] law”).<sup>140</sup>

Although at one time quite popular, the MPC test suffered extensive criticism in the late 1970s and early 1980s.<sup>141</sup> After the acquittal of John Hinckley, the MPC approach was viewed as making the insanity defense too available, and many jurisdictions altered their insanity test.<sup>142</sup> As a result, the MPC no longer represents the majority

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(but unfortunately) termed ‘irresistible impulse’ test] requires a verdict of not guilty by reason of insanity if it is found that the defendant had a mental disease which kept him from controlling his conduct. Such a verdict is called for even if the defendant knew what he was doing and that it was wrong . . .”).

138. See, e.g., Stephen J. Morse, *Excusing and the New Excuse Defenses: A Legal and Conceptual Review*, 23 CRIME & JUST. 329, 360 (1998); see also *Bennett v. Commonwealth*, 511 S.E.2d 439, 447 (Va. Ct. App. 1999) (“The irresistible impulse defense is available when ‘the accused’s mind has become “so impaired by disease that he is totally deprived of the mental power to control or restrain his act”’ (citation omitted)). But see LAFAVE, *supra* note 126, at 389 (criticizing the use of the phrase “irresistible impulse” when what more precisely is being determined is whether the defendant “had a mental disease which kept him from controlling his conduct”).

139. MODEL PENAL CODE § 4.01(1) (2001).

140. *Id.*

141. RICHARD J. BONNIE, JOHN C. JEFFRIES, JR. & PETER W. LOW, A CASE STUDY IN THE INSANITY DEFENSE: THE TRIAL OF JOHN W. HINCKLEY, JR. 18 (3d ed. 2008) (“The Model Penal Code has had an enormous impact on the development of American criminal law in many areas, and its insanity test was especially influential. By 1980, the Model Code insanity defense had been adopted . . . in more than half the states. . . . [In addition, it] had been adopted by all of the federal courts of appeal.”); *id.* at 21 (“Signs of dissatisfaction with the prevailing approach to the insanity defense began to emerge in the late 1970’s. . . . The simmering debate about the insanity defense took on national proportions in reaction to the *Hinckley* trial [in 1982].); *id.* at 127 (“Because the Model Penal Code insanity defense was employed in the *Hinckley* trial [and its highly controversial and much criticized acquittal of John Hinckley by reason of insanity]—and was then the governing criterion in a majority of states and in the federal courts—subsequent proposals to modify the defense have focused on the Model Code.”).

142. See BONNIE ET AL., *supra* note 126, at 540. In 1981, John W. Hinckley shot and wounded President Regan, along with three others. Applying the MPC test, the jury returned a verdict of not guilty by reason of insanity. This acquittal upset the American public, and the insanity defense, especially the volitional component of the test, underwent harsh scrutiny. See *id.*; see also BONNIE ET AL., *supra* note 141, at 121–30; EWING, *supra* note 126, at xix (“In the wake of the Hinckley verdict, Congress narrowed the substantive federal insanity defense by deleting reference to volitional incapacity . . . .”); Christian Breheny, Jennifer Groscup & Michele Galietta, *Gender Matters in the Insanity Defense*, 31 LAW & PSYCHOL. REV. 93, 95–96 (2007). But cf. LAFAVE, *supra* note 126, at 400 (“The Model Penal Code formulation has rightly been praised as achieving the two important objectives of a test of responsibility: (1) giving expression to an intelligible principle; and (2) fully disclosing that principle to the jury.”).



approach; many states no longer allow volitional impairment to be an independent basis for an insanity acquittal.<sup>143</sup> However, approximately twenty states retain the MPC insanity test and one state, New Hampshire, employs the Product Test.<sup>144</sup>

The fact that different jurisdictions employ different versions of the insanity test has important implications for defendants with PTSD who become embroiled in the criminal justice system as a result of their psychiatric disorder. When individuals psychologically relive a traumatic situation, they may be cognitively aware of their actions but unable to control their behavior.<sup>145</sup> Hence, such individuals may be eligible for acquittal in a jurisdiction that has retained the volitional component of the insanity defense, but face conviction in a state that does not recognize this basis for an insanity defense.

Another key variable associated with whether a PTSD-based insanity defense is likely to be successful—and that also varies across jurisdictions—is the assignment of related evidentiary burdens at trial (generically referred to as the “burden of proof”). All states place a “burden of production” on the defendant to show that sufficient evidence exists to permit the defendant to initially raise an insanity defense.<sup>146</sup> Two-

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143. BONNIE ET AL., *supra* note 126, at 540. Similarly, Congress, in response to the Hinckley verdict, eliminated the volitional element of the insanity defense under federal law and made the insanity defense available to a defendant charged with a federal crime only if “the defendant, as a result of a severe mental disease or defect, was unable to appreciate the nature and quality or the wrongfulness of his acts.” Insanity Defense Reform Act of 1984, 18 U.S.C. § 17 (2006); *see also* BONNIE ET AL., *supra* note 126, at 541. In addition, four states have abolished the insanity defense altogether. *Clark v. Arizona*, 548 U.S. 735, 752 (2006).

144. *Clark*, 548 U.S. at 751 (“Fourteen jurisdictions, inspired by the Model Penal Code, have in place an amalgam of the volitional incapacity test and some variant of the moral incapacity test, satisfaction of either . . . being enough to excuse. Three States combine a full *M’Naghten* test with a volitional incapacity formula. And New Hampshire alone stands by the product-of-mental-illness test.” (footnotes omitted)); BONNIE ET AL., *supra* note 126, at 540–41 (“About 20 states retain the Model Code formula, and a few states use *M’Naghten* together with some variation of the ‘irresistible impulse’ test. Only New Hampshire uses the ‘product’ test.”).

145. *See, e.g.*, KINCHIN, *supra* note 35, at 24; Gover, *supra* note 59, at 566–67 (explaining how people with PTSD often believe they are in combat and react with violence as in a combat situation).

146. The “burden of proof” is the obligation to prove the assertions presented in a legal action. It can be broken into two components: the burden of production and the burden of persuasion. BLACK’S LAW DICTIONARY 223 (9th ed. 2009).

The “burden of production” usually lies with the party who initiated the proceedings and must be met to enable the case to go forward. The failure to do so will result in a legal action being summarily dismissed by the judge and thus will not reach the fact finder (the jury or judge if there is no jury) for a verdict. For example, the government in a criminal case will typically have to show probable cause that the defendant committed the charged criminal act at an arraignment or before a grand jury before the case can be brought to trial. Similarly, the defendant may have to show some evidence supporting an affirmative defense, such as insanity, before it can be pursued at trial. *See* 21B CHARLES A. WRIGHT & KENNETH W. GRAHAM, JR., FEDERAL PRACTICE AND PROCEDURE § 5142 (2d ed. 2005).

In contrast, the “burden of persuasion” focuses on who has the ultimate obligation to convince the fact finder that the facts as stated are true and support a given outcome. *Id.* Thus, for example, the prosecution must prove each and every element of a charged offense beyond a reasonable doubt before a criminal conviction can be obtained. *See* BLACK’S LAW DICTIONARY

thirds of the states, however, also place on the defendant the burden of persuasion (i.e., what must be shown to obtain the desired outcome).<sup>147</sup> The associated evidentiary standard for the burden of persuasion is usually a preponderance-of-the-evidence standard.<sup>148</sup> This means that supporting evidence, when weighed against evidence to the contrary, must be found to be more probably true than not. Hence, even if a diagnosis of PTSD is recognized as a valid foundation for the insanity defense under a state's test and some evidence exists regarding the requisite linkage of the mental disorder to a cognitive or volitional impairment, states vary as to whether the prosecution or the defendant bears the burden of persuasion, a difference that can lead to dramatically different trial outcomes.<sup>149</sup>

As a result of these variations, the likelihood of PTSD constituting the requisite foundation for an insanity defense will differ from jurisdiction to jurisdiction. Theoretically, however, at least in those states with a broadly formulated insanity standard, it should be possible for a defendant to use a PTSD finding as a basis for an insanity defense. Nevertheless, PTSD has only received limited acceptance as a valid foundation for such a defense.

### B. PTSD and the Insanity Defense

When individuals suffering from PTSD commit crimes, there is uncertainty and controversy over whether they should be held criminally responsible for their actions. Criminal culpability will vary depending on the jurisdiction's applicable insanity test and the nature and severity of the individual's PTSD.<sup>150</sup>

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223 (9th ed. 2009); 21B CHARLES A. WRIGHT & KENNETH W. GRAHAM, JR., FEDERAL PRACTICE AND PROCEDURE § 5142 (2d. ed. 2005).

147. BONNIE ET AL., *supra* note 141, at 133 ("Today, in two-thirds of the states recognizing the [insanity] defense, the defendant bears the burden of persuading the jury that she or he was in fact insane . . ."); BONNIE ET AL., *supra* note 126, at 541 ("All states place the burden of producing sufficient evidence to raise the defense on the defendant. In two-thirds of the states, the defendant also bears the burden of persuasion . . ."); LAFAVE, *supra* note 126, at 414 ("There is a general presumption of sanity, and thus the initial burden (called the burden of going forward) is on the defendant to introduce evidence creating a reasonable doubt of his sanity. As to the burden of convincing the jury (called the burden of persuasion), some states require the defendant to prove insanity by a preponderance of the evidence, while others require the prosecution to prove sanity beyond a reasonable doubt."); *see also supra* note 130. Like the majority of states, when a defendant is being prosecuted under federal law, the burden lies with the defendant to prove the affirmative defense of insanity. Insanity Defense Reform Act of 1984, 18 U.S.C. § 17 (2006).

148. 1 BARBARA E. BERGMAN & NANCY HOLLANDER, WHARTON'S CRIMINAL EVIDENCE § 2:15 (15th ed. 1997); BONNIE ET AL., *supra* note 141, at 133. *But see id.* ("Under the new federal statute, the defendant bears a more demanding burden. As that statute states: 'The defendant has the burden of proving the defense of insanity by clear and convincing evidence.'" (footnote omitted)).

149. *See generally* BONNIE ET AL., *supra* note 141, at 133; LAFAVE, *supra* note 126, at 414.

150. Alternatively, in extreme cases, if an individual can establish an absence of control over his or her actions, the PTSD defendant may be able to employ an automatism defense. *See Gover, supra* note 59, at 577–78. Although not technically the equivalent of an insanity defense, it can be employed when the individual had no conscious perception of what was occurring. *See id.* In general, it may be invoked when a defendant has committed a crime while sleepwalking or while experiencing an uncontrollable physical reaction, such as a seizure. *See id.* at 577–79. The

As discussed, one hurdle that a defendant who asserts he or she suffered from PTSD must overcome is establishing that the PTSD constitutes the requisite mental disorder. All four accepted variations of the insanity test require a prerequisite showing that the defendant's actions were the result of a "mental disease."<sup>151</sup> Hence, this is a threshold requirement under all insanity tests, and criminal behavior is excused only if it can be attributed to a mental disorder.<sup>152</sup>

It is generally agreed that this requirement will typically be met only by a psychotic disorder.<sup>153</sup> Limiting the insanity defense to psychotic disorders is intended to prevent defendants with a relatively minor psychological impairment from employing the defense to avoid being held accountable for criminal behavior.<sup>154</sup>

As a "psychotic disorder" generally refers to mental conditions that involve a "gross impairment in reality testing,"<sup>155</sup> the majority of PTSD diagnoses will be ineligible for an insanity defense as not meeting the "mental disease" threshold requirement.<sup>156</sup> The mental impairment associated with PTSD may be relatively mild<sup>157</sup> and not involve

automatism defense may be appropriate when an individual suffers PTSD symptoms that include a physiological reaction to external or internal cues or after experiencing dissociative flashback episodes and reenactments. *See id.*

151. The *M'Naghten* Test requires a defect in reasoning from a "disease of the mind." BONNIE ET AL., *supra* note 141, at 11 (citing *M'Naghten's Case*, (1843) 8 Eng. Rep. 718, 722 (H.L.)). The MPC requires that the defendant suffer from a "mental disease or defect." MODEL PENAL CODE § 4.01(1) (2001). The Product Test holds that the act must be "the offspring and product of mental disease." BONNIE ET AL., *supra* note 141, at 17 (citing *State v. Jones*, 50 N.H. 369 (1871)). Finally, the Control Test requires that the person's inability to control behavior be the result of "mental disease." BONNIE ET AL., *supra* note 126, at 563–64. In addition, under the federal test, the defendant's inability to appreciate the nature and quality or the wrongfulness of his or her acts must be the result of a "severe mental disease or defect." 18 U.S.C. § 17.

152. *See* BONNIE ET AL., *supra* note 141, at 20 ("[A]ll formulations of the insanity defense require as a threshold condition that the defendant be suffering from a 'mental disease or defect.'").

153. *See* BONNIE ET AL., *supra* note 126, at 551.

154. *See generally* Packer, *supra* note 62.

155. *See* DSM-IV-TR, *supra* note 18, at 297. *See generally id.* at 467 (discussing psychotic disorders).

156. *Cf.* Debra D. Burke & Mary Anne Nixon, *Post-Traumatic Stress Disorder and the Death Penalty*, 38 HOW. L.J. 183, 183 (1994) ("An extreme case of post-traumatic stress disorder ('PTSD') may be argued as the basis for an insanity defense from criminal responsibility."); Henry F. Fradella, *From Insanity to Beyond Diminished Capacity: Mental Illness and Criminal Excuse in the Post-Clark Era*, 18 U. FLA. J.L. & PUB. POL'Y 7, 52–53 (2007) ("Extreme cases of Posttraumatic Stress Disorder (PTSD) may serve as the qualifying 'mental disease or defect' for an insanity defense. Of course, to do so effectively in the overwhelming majority of courts in the United States, the disorder would have to render the defendant unable to substantially appreciate the wrongfulness or criminality of his or her actions."). *See generally* Packer, *supra* note 62, at 126 (noting that not all psychiatric disorders listed in the *DSM-IV-TR* qualify for the insanity defense, including disorders such as tobacco dependence and antisocial personality disorder, with the latter specifically excluded from consideration for an insanity defense by the Model Penal Code).

157. *See* DSM-IV-TR, *supra* note 18, at 466 (stating that the "predominance" of experiencing the symptoms may vary); Psych Central, *Posttraumatic Stress Disorder (PTSD) Symptoms*, <http://psychcentral.com/disorders/sx32.htm> (discussing the many different ways that PTSD symptoms may manifest themselves); *see also* Dobbs, *supra* note 12, at 65 (citing experts

delusions or dissociation. In addition, although the severity of the symptoms experienced by a given individual may vary over time,<sup>158</sup> the “mental disease” requirement will only generally be met if the PTSD caused a severe psychiatric impairment at the time of the offense.<sup>159</sup>

Nevertheless, some of the symptoms associated with a diagnosis of PTSD may be viewed as constituting a psychotic disorder.<sup>160</sup> For example, PTSD may result in a gross impairment in reality testing,<sup>161</sup> especially when the disorder leads the individual to believe that he or she is reliving a traumatic event or otherwise perceives the surrounding environment to be substantially different (and often more threatening) from that which actually exists.<sup>162</sup> Consequently, PTSD-afflicted veterans experiencing delusions or dissociative states may be able to meet this threshold requirement for the insanity defense.

In addition, not only has PTSD been receiving more attention and validation as a mental disorder, but its origins in a given individual can be established on a relatively reliable basis, in part because, before the diagnosis can be assigned, there must be “exposure to an extreme traumatic stressor.”<sup>163</sup> This requirement may help counter the

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who assert that “[t]he diagnostic criteria for PTSD . . . represent a faulty, outdated construct that has been badly overstretched so that it routinely mistakes depression, anxiety or even normal adjustment for a unique and especially stubborn ailment”).

158. DSM-IV-TR, *supra* note 18, at 466 (“The symptoms of the disorder . . . may vary over time. . . . In some cases, the course is characterized by a waxing and waning of symptoms.”).

159. *See* LOW ET AL., *supra* note 124, at 128–30 (noting that Congress in 1984 enacted legislation “requiring a ‘severe’ mental disease” in an effort to narrow the scope of the insanity defense); *id.* at 20 (“Some have contended that the concept [of ‘mental disease’ required for a successful insanity defense] should be limited to the kinds of gross disturbance of mental functioning commonly referred to as psychoses.”); Packer, *supra* note 62, at 126 (“In cases of mild impairment [associated with PTSD], a label of ‘mental disease’ would not be warranted, though it might be applicable in cases of severe impairment.”).

160. *See generally* BONNIE ET AL., *supra* note 141, at 20 n.r (“According to the glossary of the fourth edition of the Diagnostic and Statistical Manual of the American Psychiatric Association (DSM-IV) the meaning of the term ‘psychotic’ varies somewhat in relation to particular disorders. However, the ‘narrowest definition’ is restricted to delusions or prominent hallucinations in the absence of insight into their pathological nature. Conceptually, the term refers to a ‘gross impairment in reality testing’: When there is gross impairment in reality testing, the individual incorrectly evaluates the accuracy of his or her perceptions and thoughts and makes incorrect inferences about external reality, even in the face of contrary evidence. The term psychotic does not apply to minor distortions of reality that involve matters of relative judgment.”).

161. *See* Toni Luxenberg & Patti Levin, *The Role of the Rorschach in the Assessment and Treatment of Trauma*, in *ASSESSING PSYCHOLOGICAL TRAUMA AND PTSD* 190, 201 (John P. Wilson & Terence M. Keane eds., 2d ed. 2004) (“Numerous studies have shown problems in reality testing in traumatized individuals.”).

162. *See* DSM-IV-TR, *supra* note 18, at 822 (defining “dissociation” as “[a] disruption in the usually integrated functions of consciousness, memory, identity, or perception of the environment. The disturbance may be sudden or gradual, transient or chronic.”); Gover, *supra* note 59, at 567.

163. *See* DSM-IV-TR, *supra* note 18, at 463; *see also* Heathcote W. Wales, *Causation in Medicine and Law: The Plight of the Iraq Veterans*, 35 *NEW ENG. J. ON CRIM. & CIV. CONFINEMENT* 373, 385–86 (2009) (describing how most diagnoses of PTSD can be traced to at least one highly traumatic event). *But see* Richard J. McNally, *Progress and Controversy in the*

concerns of skeptics of its use in conjunction with the insanity defense as defendants making this claim must generally show they have been exposed to or witnessed a life-threatening or other traumatic event, with the evidence of this event often readily subject to verifiable proof (e.g., exposure to combat or other life-threatening situations). It provides a relatively objective means of verifying the validity of the claimed disorder.<sup>164</sup>

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*Study of Posttraumatic Stress Disorder*, 54 ANN. REV. PSYCHOL. 229, 231 (2003) (“Despite references to life threat and injury, *DSM-IV* significantly broadens the definition of a traumatic stressor. For example, a person who merely learns about someone else being threatened with harm qualifies as having been exposed to trauma and is therefore eligible for a PTSD diagnosis (assuming fulfillment of symptomatic criteria). . . . No longer must one be the direct (or even vicarious) recipient of trauma; merely being horrified by what has happened to others now counts as a PTSD-qualifying event.”).

164. See generally Gover, *supra* note 59, at 568–69 (laying out the ways that a defendant can prove he or she has PTSD). However, there is considerable controversy regarding the validity of PTSD diagnoses in general and within the military and concerns have been expressed that such claims may be feigned to gain benefits that may be associated with such a diagnosis. For example, from a clinical perspective, an individual making such a claim may find it more personally acceptable to view the course of one’s life as negatively altered by an external event rather than admit to what may be a more personal flaw. Concerns have also been expressed that some clinicians do not adequately assess an individual’s self-described symptoms before assigning a diagnosis, for example by failing to employ a relatively time-consuming but evidence-based assessment instrument such as the Clinician Administered Post Traumatic Stress Disorder Scale. Concerns have also been expressed that PTSD is over diagnosed within the Veterans’ Administration, with calls to eliminate reliance on what is perceived to be the relatively unreliable traumatic stressor event requirement and focus instead shifted to the symptoms specific to a PTSD diagnosis, such as whether the person is re-experiencing the prior traumatic event. E-mail from Mary Tramontin, Clinical Psychologist, PTSD Clinic/Traumatic Stress Studies Program, James J. Peters Veterans Affairs Medical Center, to Thomas Hafemeister, Director of Legal Studies, Institute of Law, Psychiatry, and Public Policy, University of Virginia (Oct. 15, 2009, 08:50 EST) (on file with author); see also Frueh et al., *supra* note 12, at 467, 470 (pointing to potential problems with overdiagnosis of PTSD based on their study in which they found a significant number of veterans diagnosed with PTSD had exaggerated their combat exposure in Vietnam, noting that “[t]he financial incentive to present as psychiatrically disabled with PTSD within the US Veterans Affairs healthcare system is significant[, as v]eterans may obtain monetary compensation if they are rated as ‘service-connected’ for PTSD”); Paul R. McHugh & Glenn Treisman, *PTSD: A Problematic Diagnostic Category*, 21 J. ANXIETY DISORDERS 211, 212 (2007) (“[M]ental health professionals have overworked [the PTSD] theme and led themselves into diagnostic and therapeutic practices that now confound the discipline. Specifically, those who promote PTSD have (1) disregarded time-honored lessons about traumatic stress reactions; (2) permitted political and social attitudes to sway their judgments and alter their practices; (3) dispensed with diagnostic fundamentals and so made claims that are regularly (and embarrassingly) misleading; and (4) slighted other explanations and treatments for patients with trauma histories.”); McNally, *supra* note 163, at 229, 234 (discussing the problem of increased claims of PTSD within the military and asserting that “[a]s many as 94% of veterans with PTSD apply for financial compensation for their illness, and the incentive to do so is strong, especially for those with limited occupational opportunities” (citations omitted)); Robert L. Spitzer, Michael B. First & Jerome C. Wakefield, *Saving PTSD from Itself in DSM-V*, 21 J. ANXIETY DISORDERS 233, 234, 236 (2007) (arguing that “a large part of the problem with PTSD concerns the expansion of the PTSD construct of trauma” and suggesting that the definition of trauma for PTSD after DSM-IV should be tightened).

Nonetheless, even if a defendant pursuing a PTSD-based insanity defense can establish in a given case the existence of the requisite mental disorder at the time of the offense, the defendant must also show that the mental disorder had the required incapacitating effect (i.e., there must be a connection between the disorder and the criminal act).<sup>165</sup> If the mental disorder did not have the “specified incapacitating effects at the time of the offense,” the insanity defense will fail.<sup>166</sup> Some individuals with PTSD will indeed have episodes when they lose touch with reality and during which they commit a criminal act.<sup>167</sup> However, for most individuals with PTSD, this disorder is not the source of the criminal behavior, at least from the viewpoint of the criminal justice system.<sup>168</sup>

In addition, most insanity defenses are limited to cognitive impairments, namely, that the defendant, as a result of the disorder, was either unable to appreciate the nature and quality of the act or the wrongfulness of the act.<sup>169</sup> Even if PTSD is linked to a criminal act, such individuals may still know what they are doing (e.g., that they are attacking another individual) and know that they are engaging in a wrongful act (e.g., that they are not acting in self-defense). This knowledge will defeat an insanity defense claim in jurisdictions that employ an insanity test limited to “cognitive” impairments.<sup>170</sup>

Even under a cognitive test, however, individuals with PTSD may successfully employ the insanity defense if they exhibit the PTSD symptom of dissociation.<sup>171</sup> As one commentator notes, “[i]f [a person’s] crime [was] one of violence, such as murder or assault, and he indeed believed that he was in combat in Vietnam, then it could reasonably be concluded that he did not know his actions were wrong as he believed he was attacking or killing the enemy.”<sup>172</sup> During such a dissociative state, these individuals believe they are in another setting or environment and grossly misconstrue what is occurring.<sup>173</sup> These individuals are neither cognizant of the character of their actions nor the need for them, and thus they do not know the nature and quality of the

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165. BONNIE ET AL., *supra* note 126, at 552.

166. *Id.*

167. Packer, *supra* note 62, at 128.

168. *See id.*; *see also* Gover, *supra* note 59, at 569 (noting that even if an individual has experienced a war-based trauma and asserts that the “trauma sufficiently qualifies for an insanity defense, diminished capacity, self-defense, unconsciousness and so on,” ultimately, it is up to the fact finder to determine if the trauma experienced was sufficient “to cause the [PTSD] symptoms purported, and thus affect the mens rea to the extent necessary to reduce culpability”).

169. BONNIE ET AL., *supra* note 126, at 540 (“The sole criterion in about half the states is whether the defendant was unable to ‘know’ or ‘appreciate’ the nature or wrongfulness of the conduct.”); LAFAVE, *supra* note 126, at 369 (“[U]nder the prevailing *M’Naghten* rule . . . the defendant cannot be convicted if, at the time he committed the act, he was laboring under such a defect of reason, from a disease of the mind, as not to know the nature and quality of the act he was doing; or, if he did know it, as not to know he was doing what was wrong.”).

170. *See* Cristie L. March, *The Conflicted Treatment of Postpartum Psychosis Under Criminal Law*, 32 WM. MITCHELL L. REV. 243, 254–55 (2005) (describing the cognitive tests, which require that the defendant did not know, or did not appreciate, the wrongfulness of his or her actions at the time of the crime because of mental disease or disorder).

171. *See* Gover, *supra* note 59, at 573.

172. Elizabeth J. Delgado, Comment, *Vietnam Stress Syndrome and the Criminal Defendant*, 19 LOY. L.A. L. REV. 473, 483 (1985).

173. *Id.* at 476.

wrongfulness of their actions.<sup>174</sup> As the cognitive prong is utilized in most courts where the insanity defense is recognized, establishing that the individual with PTSD experienced a dissociative state, or some other symptom that rendered the defendant incapable of knowing the nature and quality of his or her action or of knowing right from wrong, is likely to be extremely important to the defendant's case.<sup>175</sup>

The PTSD insanity defense may be most readily available in those states that also employ some iteration of the Control Test. This volitional test allows veterans who can show they were unable to control their actions as a result of PTSD to assert an insanity defense, even though they knew the nature and quality of what they were doing or that what they were doing was wrong.<sup>176</sup> Although less than half of the states in the United States utilize this test,<sup>177</sup> where it is employed a person who is driven by delusions or hallucinations, and who has suffered a loss of control and is unable to restrain his or her behavior as a result, can qualify for the insanity defense despite knowing what he or she was doing and that such behavior was wrong at the time of the offense.<sup>178</sup>

The Control Test does require the judicial fact finder to speculate as to whether the individual could have acted differently than he or she did, and whether the mental disorder prevented the defendant from exercising the degree of choice about his or her behavior that other individuals can normally exert.<sup>179</sup> Nevertheless, deficits in impulse control have been found in individuals who suffered childhood trauma, particularly when they experienced multiple or repeated traumas.<sup>180</sup> Similarly, if war veterans

174. *Id.*

175. *See, e.g., Clark v. Arizona*, 548 U.S. 735, 748–56 (2006). As discussed earlier, under the *M'Naghten* test the defendant can qualify for the insanity defense if the defendant did not know the nature and quality of the act *or* did not know that the act was wrong. The United States Supreme Court in *Clark v. Arizona*, however, held that a state does not violate the federal constitution when it narrows its definition of insanity to focus only on whether as a result of mental disease or defect the defendant was unable to understand that the act was wrong. *Id.*

176. *See supra* notes 137–38 and accompanying text.

177. *Clark*, 548 U.S. at 751 (“Fourteen jurisdictions . . . have in place an amalgam of the volitional incapacity test and some variant of the moral incapacity test, satisfaction of either . . . being enough to excuse. Three States combine a full *M'Naghten* test with a volitional incapacity formula.”); BONNIE ET AL., *supra* note 126, at 540 (“About 20 states retain the Model Code formula [which contains both a cognitive and the Control Test], and a few states use *M'Naghten* together with some variation of the “irresistible impulse” test[, which is a variation on the Control Test].”).

178. *See* BONNIE ET AL., *supra* note 126, at 540.

179. *See* Stephen J. Morse, *Thoroughly Modern: Sir James Fitzjames Stephen on Criminal Responsibility*, 5 OHIO ST. J. CRIM. L. 505, 518 (2008) (describing the fact finder's analysis under the Control Test); Richard E. Redding, *The Brain-Disordered Defendant: Neuroscience and Legal Insanity in the Twenty-First Century*, 56 AM. U. L. REV. 51, 81–82 (2006) (same).

180. Kathleen M. Heide & Eldra P. Solomon, *Biology, Childhood Trauma, and Murder: Rethinking Justice*, 29 INT'L J.L. & PSYCHIATRY 220, 221 (2006) (“Traumatic stress caused by child neglect and/or abuse compromises homeostasis and leads to a constellation of long-term biological changes involving the nervous and endocrine systems. . . . When confronted with stressful situations, Type III trauma survivors often have difficulty accessing higher cortical centers, the areas of the brain essential for thinking logically and formulating appropriate decisions. Instead, their responses are driven by limbic and brain stem activity, often resulting in socially inappropriate behaviour. This primitive response mode results in a variety of problems including difficulty regulating affective impulses and inappropriate expression of anger.”).

“relive” a traumatic event, they may lose control over their actions and act impulsively.<sup>181</sup> This may satisfy the Control Test in those jurisdictions that recognize it, leading to a successful PTSD insanity defense.

Notwithstanding the potential for a successful PTSD-based insanity defense under either a cognitive or a volitional test, additional factors may impede its application. For example, not all individuals exposed to a potentially life-threatening or otherwise traumatic event develop PTSD symptoms, let alone experience symptoms that manifest themselves in criminal behavior at a subsequent time.<sup>182</sup>

Responses to traumatic events vary with the individuals involved and are dependent on a range of personal and environmental factors.<sup>183</sup> Two factors are particularly influential: the intensity of the traumatic event encountered and the resources available to help the person cope with the stress associated with the event.<sup>184</sup> However, it may be difficult to objectively measure just how “severe” the stress associated with an event is. Moreover, the requisite resources needed to cope with this stress will tend to vary with each individual involved. Thus, it can be difficult to discern who is suffering from PTSD and to what degree, and how the symptoms were manifested at the time of the criminal offense.

In general, a PTSD diagnosis is neither a necessary nor a sufficient condition for determining an individual to be not guilty by reason of insanity. People with PTSD suffer a broad range of impairments and it is usually only in rare instances that they

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181. C. Peter Erlinder, *Post-Traumatic Stress Disorder, Vietnam Veterans and the Law: A Challenge to Effective Representation*, BEHAV. SCI. & L., Summer 1983, at 25, 29 (“This tendency to ‘reexperience’ or ‘relive’ the original event is common to those who experience PTSD symptoms after a traumatic event whatever its source. However, for those trained in combat, a ‘reexperiencing’ of the original event may include combat-like reactions. DSM-III, for example, specifically mentions ‘unpredictable explosions of aggressive behavior’ as characteristic of war veterans with PTSD.” (citations omitted)); Wilson & Zigelbaum, *supra* note 70, at 73 (“[I]f the individual is placed in a situation which is perceived as threatening . . . a dissociative reaction may occur as a response . . . . In this dissociative state the veteran is likely to function predominately in the survivor mode by behaving as he did in combat in Vietnam.” (emphasis in original)).

182. See generally KULKA ET AL., *supra* note 74, at xxvii (“The majority of Vietnam theater veterans have made a successful reentry into civilian life and currently experience few symptoms of PTSD or other readjustment problems.”); *id.* at 77 (“[T]hese results are consistent with a model of PTSD that posits a role for individual vulnerability . . . and a role for exposure to environmental factors . . . in determining who . . . develops PTSD.” (emphasis in original)); Packer, *supra* note 62, at 133 (“Those experiencing [PTSD] range broadly in degree of functional impairment. In rare instances some of these individuals may experience brief psychotic or dissociative states, during which time they appear to be reliving or reenacting the traumatic episodes.”).

183. See Eric G. Benotsch, Kevin Brailey, Jennifer J. Vasterling, Madeline Uddo, Joseph I. Constans & Patricia B. Sutker, *War Zone Stress, Personal and Environmental Resources, and PTSD Symptoms in Gulf War Veterans: A Longitudinal Perspective*, 109 J. ABNORMAL PSYCHOL. 205, 205 (2000).

184. Stevan E. Hobfoll, Charles D. Spielberger, Shlomo Breznitz, Charles Figley, Susan Folkman, Bonnie Lepper-Green, Donald Meichenbaum, Norman A. Milgram, Irwin Sandler, Irwin Sarason & Bessel van der Kolk, *War-Related Stress: Addressing the Stress of War and Other Traumatic Events*, 46 AM. PSYCHOLOGIST 848, 848–49 (1991).



experience dissociative or psychotic states during which their connection to reality is severely impaired.<sup>185</sup> If an individual is experiencing only mild PTSD symptoms without a dissociative or psychotic state, then a PTSD diagnosis does not warrant a finding of legal insanity,<sup>186</sup> although the diagnosis may have other implications for a determination of criminal responsibility.<sup>187</sup>

One concern that may arise in discussing a PTSD-based insanity defense is that it may be overused.<sup>188</sup> However, one study ascertained that insanity pleas from defendants diagnosed with PTSD constituted only 0.3% of the cases where the insanity defense was raised.<sup>189</sup> Additionally, the study found that PTSD insanity pleas were no more likely to succeed than insanity pleas based on other psychiatric diagnoses.<sup>190</sup> Hence, there should be no fear that recognizing the validity of PTSD-based insanity defenses in some cases will open the floodgates for insanity pleas.

*C. Case Law on PTSD as the Basis for an Insanity Defense for Vietnam War Veterans*

Although many of the symptoms associated with PTSD have no doubt existed from time immemorial, after the PTSD diagnosis was included for the first time in the third edition of the APA's *Diagnostic and Statistical Manual* in 1980, defense attorneys hoped that a PTSD diagnosis might increasingly supply a credible foundation for an insanity defense, especially when the defendant had not previously committed a violent crime or manifested a psychiatric disorder.<sup>191</sup>

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185. *See id.* at 850.

186. *See* 75A AM. JUR. 2D *Trial* § 1071 (2007) (“A court may properly refuse to charge upon the [insanity defense] where there is no proof of insanity offered by the defense or disclosed by the circumstances established by the prosecution . . . .”); *id.* § 1071, n.3 (“The defendant’s testimony that he ‘blacked out’ after firing a shot, coupled with a nondiagnosing physician’s testimony that the defendant appeared to have been suffering from post-traumatic stress disorder (PTSD) during the commission of the crime, was insufficient to warrant an instruction on the insanity defense, because even if PTSD could in severe cases amount to insanity, the trial record contained no evidence as to the severity of any mental defect.” (citing *U.S. v. Long Crow*, 37 F.3d 1319 (8th Cir. 1994))).

187. For example, it may be germane to whether the defendant had the necessary state of mind for a given offense, is entitled to assert that he or she acted in self-defense, or should receive a reduced sentence because his or her state of mind constitutes mitigating evidence. *Gover, supra* note 59, at 575–81; *infra* Part III.

188. *Gover, supra* note 59, at 581. *See generally supra* note 164.

189. Paul S. Appelbaum, Rose Zoltek Jick, Thomas Grisso, Daniel Givelber, Eric Silver & Henry J. Steadman, *Use of Posttraumatic Stress Disorder to Support an Insanity Defense*, 150 AM. J. PSYCHIATRY 229, 231 (1993).

190. *Id.* at 232.

191. *See* Michael J. Davidson, Note, *Post-Traumatic Stress Disorder: A Controversial Defense for Veterans of a Controversial War*, 29 WM. & MARY L. REV. 415, 422 n.55 (1988) (“In its first five years of use, the PTSD defense has helped at least 250 Vietnam veterans get shorter sentences, treatment instead of jail, or acquittals.”); *Gover, supra* note 59, at 562 (“[The] use [of PTSD] as a defense rose dramatically when the American Psychiatric Association officially recognized it as a mental disorder in 1980.” (citation omitted)).

During a PTSD-linked dissociative state the defendant may have reacted as he or she would have responded to the initial traumatic event.<sup>192</sup> The dissociative state may be triggered by various environmental stimuli and may be accompanied by flashbacks, which in turn could trigger attacks on others by the defendant.<sup>193</sup> The defendant may neither be responsible for nor able to control these dissociative states.<sup>194</sup>

Extreme instances of PTSD may provide the basis for an insanity defense.<sup>195</sup> Such instances can constitute the requisite mental disorder that renders individuals unable to control their behavior or leaves them unable to cognitively appreciate the nature or wrongfulness of their actions.<sup>196</sup>

In one case where an individual with PTSD was able to successfully raise an insanity defense, a Vietnam War veteran was charged with armed robbery for holding up a gun shop and taking semiautomatic weapons and ammunition.<sup>197</sup> He was apprehended in a field where he had fired one of the guns into an abandoned building. When questioned by police, he was unable to explain the motivation for his behavior and his memory of the incident was patchy.<sup>198</sup> Although he was wary about discussing his experience in Vietnam, he recollected one battle where he had assaulted an enemy bunker and killed enemy troops. He revealed that he had been thinking about his experiences earlier in the day before the robbery occurred.<sup>199</sup>

A forensic psychologist examined him and determined that the veteran had PTSD. The psychologist further determined that, at the time of the offense, the defendant was in an altered state of consciousness (i.e., a dissociative state), did not have the “ability to appreciate the wrongfulness of his behavior,” and “lacked the ability to conform his conduct to the requirements of the law.”<sup>200</sup> The defendant was subsequently found not guilty by reason of insanity.<sup>201</sup>

In a Louisiana case, the defendant, a Vietnam War veteran, was charged with murdering his sister-in-law’s husband.<sup>202</sup> During the crime, the defendant, in search of his estranged wife, broke into his sister-in-law’s house and fired a loaded pistol.<sup>203</sup> After firing all the bullets in the pistol, he grabbed a rifle from the trunk of his car and continued the assault.<sup>204</sup> The defendant was convicted of murder at his first trial but was granted a new trial after a series of appeals.<sup>205</sup>

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192. See *supra* text accompanying notes 12, 23, 29–33; see also *supra* note 22 and accompanying text.

193. See *supra* text accompanying notes 12, 23, 29–33; see also *supra* note 22 and accompanying text.

194. Harold V. Hall & Frederick L. Hall, *Post-Traumatic Stress Disorder as a Legal Defense in Criminal Trials*, 5 AM. J. FORENSIC PSYCHOL. 45, 48 (1987).

195. See Fradella, *supra* note 156, at 53; *supra* Part II.B.

196. See Fradella, *supra* note 156, at 53.

197. Packer, *supra* note 62, at 128–30.

198. *Id.* at 128.

199. *Id.* at 129.

200. *Id.*

201. *Id.*

202. *State v. Heads*, 370 So. 2d 564, 566 (La. 1979), *vacated*, *Heads v. Louisiana*, 444 U.S. 1008 (1980).

203. *Id.*

204. *Id.* at 566.

205. *State v. Heads*, 385 So. 2d 230, 231 (La. 1980).

Between his first and second trial, the APA recognized PTSD as a diagnostic category, providing the basis for a PTSD-linked defense at his second trial.<sup>206</sup> Evidence at this proceeding established that the defendant did not have a prior criminal record, documented his combat history in Vietnam, and indicated his difficult adjustment upon return.<sup>207</sup> After hearing expert testimony that the defendant “had experienced at least one ‘dissociative state’” since his return home from Vietnam, as well as testimony regarding the Vietnam-like conditions present at the scene of the crime, and “the emotional threat” the defendant felt at “losing his wife and family,” the jury returned a verdict of not guilty by reason of insanity.<sup>208</sup>

In an Illinois case, the defendant was “charged with attempted murder” when he shot his foreman “after a dispute at work.”<sup>209</sup> The defendant had no criminal record and had served in Vietnam. After hearing testimony about the symptoms of PTSD and the defendant’s prior diagnosis of PTSD, the defendant’s work environment (which included tape recordings that showed a similarity between the noises in the factory and noises the defendant heard during combat), the defendant’s military service (including combat duty in Vietnam), and recent events in the defendant’s life (including the death of his brother), the jury in this case also returned a verdict of not guilty by reason of insanity.<sup>210</sup>

Despite the fact that these defendants were war veterans who successfully invoked their PTSD diagnosis as a basis for an insanity defense, their cases are not the norm.<sup>211</sup> For example, in *State v. Simonson*,<sup>212</sup> the defendant was tried and convicted of murdering two of his supervisors at his place of employment. The defendant argued that he had acquired PTSD from serving in Vietnam and was rendered legally insane at the time of the shooting.<sup>213</sup> Despite testimony from psychologists—who primarily worked with Vietnam veterans—establishing that the defendant suffered from PTSD, conflicting state evidence established that the defendant did not commit his violent crime during a PTSD dissociative flashback.<sup>214</sup> After considering the evidence, the jury rejected the insanity defense, and the defendant received a pair of life sentences with the conviction affirmed on appeal.<sup>215</sup>

An attempt to employ PTSD as a basis for an insanity defense for a Vietnam veteran also failed in *State v. Felde*.<sup>216</sup> Felde, the defendant and a Vietnam War veteran, claimed that he was attempting to shoot himself while in police detention.<sup>217</sup> When one of the officers driving Felde to a police station intervened, the gun went off and killed

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206. Erlinder, *supra* note 181, at 33–34.

207. *Id.* at 34.

208. *Id.*

209. *Id.* at 35 (citing *People v. Wood*, No. 80-7410 (Cir. Ct. of Cook County Ill. 1982)); *see also* BAKER & ALFONSO, *supra* note 57.

210. Erlinder, *supra* note 181, at 35–36; *see also* BAKER & ALFONSO, *supra* note 57.

211. *See, e.g.*, Packer, *supra* note 62, at 125.

212. 669 P.2d 1092, 1094 (N.M. 1983).

213. *Id.* at 1094–97.

214. *See id.* at 1094, 1097.

215. *Id.* at 1094, 1098.

216. 422 So. 2d 370 (La. 1982).

217. *Id.* at 375.

one of the officers.<sup>218</sup> Felde pled that he was not guilty by reason of insanity because he suffered from PTSD at the time of the shooting.<sup>219</sup> Despite agreement among several expert witnesses that Felde suffered from PTSD, the jury convicted Felde because they concluded that he was aware of the wrongfulness of his actions at the time they were committed.<sup>220</sup>

The outcomes in these two cases constitute the more prevalent disposition of PTSD insanity defenses raised by war veterans.<sup>221</sup> The defense has tended to be more successful for veterans who could show they were experiencing a dissociative state and committed crimes as if they were on “autopilot,” although this is not characteristic of most individuals suffering PTSD.<sup>222</sup> But even if the insanity defense is not widely available to war veterans (although as will be discussed, the insanity defense may be more available to veterans of Iraq and Afghanistan<sup>223</sup>), there may be alternative options

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218. *Id.*

219. *Id.* at 376.

220. *See id.* at 376–78; Samuel P. Menefee, *The “Vietnam Syndrome” Defense: A “G.I. Bill of Criminal Rights”?*, ARMY LAW., Feb. 1985, at 1, 13.

221. For other sources where assertions were unsuccessful that a PTSD diagnosis provided the basis for a defense for a Vietnam War veteran, see, for example, *United States v. Cartagena-Carrasquillo*, 70 F.3d 706 (1st Cir. 1995); *United States v. Murphy*, No. 07-cr-00133-LTB, 2008 WL 4696068 (D. Colo. Oct. 22, 2008); *Taus v. Senkowski*, 293 F. Supp. 2d 238 (E.D.N.Y. 2003); BAKER & ALFONSO, *supra* note 57 (Although the decision was overturned on appeal, a defendant was found guilty at trial of kidnapping and assault, notwithstanding that the defendant was a Vietnam combat veteran who had entered a bank “dressed in a suit with his military decorations pinned on it and armed with two M-16 automatic rifles, the weapon used by U.S. forces in Vietnam. He announced that he was not robbing the bank, let the women and children go, and took the remaining occupants hostage. Over a five-hour period, [the defendant] fired over 250 rounds of ammunition into the air and at inanimate objects before the police apprehended him without serious injury to anyone. . . . The examining psychiatrist determined that [the defendant] had been one of very few survivors of an ambush in Vietnam, and the psychiatrist testified that the defendant’s behavior in the bank was an attempt to recreate an ambush situation. Also, his behavior was viewed as an attempt at passive suicide in order to relieve the intense guilt he felt about having survived the ambush in Vietnam when so many others perished.”); Daniel E. Speir, *Application and Use of Post-Traumatic Stress Disorder as a Defense to Criminal Conduct*, ARMY LAW., June 1989, at 17, 18.

222. *See Packer, supra* note 62, at 129–30 (“[The Vietnam veteran’s] behavior was understood as a reenactment, in an altered state of consciousness, of a traumatic experience in Vietnam. . . . Had he committed an offense in a normal state of consciousness . . . his reaction to the stresses of Vietnam would not have provided sufficient basis for exculpation.”); *id.* at 133 (“[D]iagnosing an individual as experiencing a PTSD is neither a necessary nor a sufficient condition for determining that individual’s sanity at the time of the commission of an offense. Those experiencing this disorder range broadly in degree of functional impairment. In rare instances some of these individuals may experience brief psychotic or dissociative states, during which time they appear to be reliving or reenacting the traumatic episodes. Under such conditions the individual’s contact with reality is impaired and he or she would be considered legally insane. However, if the individual is not experiencing such a state, then the fact that he or she manifests symptoms of a stress disorder is not sufficient to warrant a finding of insanity.”).

223. *See discussion infra* Part IV. In addition, as discussed *supra* note 20, the United States Supreme Court’s apparent endorsement of the view that PTSD in war veterans provides a basis

available for veterans who have run into trouble with the law and want their diagnosis of PTSD taken into account.

### III. BEYOND THE INSANITY DEFENSE

#### A. PTSD and Other Bases for Avoiding or Reducing Culpability

Even though PTSD generally will not satisfy the mental disorder threshold for the insanity defense, a PTSD diagnosis may still enable defendants to avoid or reduce their criminal culpability by supporting an assertion that either they did not possess the requisite mens rea or they were acting in self-defense. These arguments have not only been raised by defendants with PTSD, but also by defendants with other similar mental states such as Battered Spouse Syndrome (BSS) and Urban Survival Syndrome (USS).

BSS and USS have been asserted to provide a legal justification for a defendant's conduct or to negate the prosecution's effort to establish that the defendant had the mens rea—that is, the state of mind—required for a criminal conviction.<sup>224</sup> Like PTSD, BSS and USS are attributed to severe stress-inducing environments that are unlike those that the average person experiences. All three “defenses”<sup>225</sup> attempt to explain the defendant's actions by focusing on prior violence and threatening environments to which the defendant was subjected.

Hence, if the legal system accepts BSS or USS, this can serve as a benchmark for the potential utilization of PTSD to mitigate the culpability of Iraq and Afghanistan War veterans charged with a crime. As mental health professionals and society gain greater understanding of the psychological disruption that can result from exposure to violence and threatening environments, wider acceptance of PTSD as a basis for reducing the criminal culpability of war veterans may emerge.<sup>226</sup>

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for affording them greater leniency in criminal justice proceedings could similarly have the effect of making the insanity defense more available to them in general. *See* Porter v. McCollum, 130 S. Ct. 447, 455 (2009).

224. *See* discussion *infra* Parts III.C, III.E.

225. Technically, a claim that a defendant lacked mens rea because of a mental disorder is not a defense per se, but a rebuttal to the prosecution's required showing that all the elements of a charged crime were present. *See* Clark v. Arizona, 548 U.S. 735, 766 (2006) (“[A] defendant is innocent unless and until the government proves beyond a reasonable doubt each element of the offense charged, including the mental element or *mens rea*.” (citations omitted)).

226. For example, early in 2009 the federal Department of Veterans Affairs (VA) launched a program, Veterans Justice Outreach Initiative, that involves “training 145 specialists at its hospitals nationwide to help veterans who are in jails, awaiting trial or serving misdemeanor sentences,” who will “report to a civilian court on an accused veteran's medical history—and available VA benefits or programs that might help,” with prosecutors and judges determining “whether and how to use that information when deciding if a veteran should undergo treatment instead of incarceration.” P. Solomon Banda, *Troubled Veterans Get a Hand: VA Offers Legal Alternatives to Those Accused of Crimes*, WASH. POST, Aug. 7, 2009, at A19, available at <http://www.washingtonpost.com/wp-dyn/content/article/2009/08/06/AR2009080603757.html>. In addition, “patterned after drug courts,” the VA “is participating in 10 ‘veterans courts’ to help former service members accused of crimes get into treatment programs, in exchange for reduced sentences or dismissed charges[, with m]ore than 40 such courts . . . planned across the country.” *Id.* In 2002, prior to the Iraq War, but using the most recent figures available, “veterans accounted for roughly 10 percent of the nation's jail and prison population.” *Id.*

## 1. Mens Rea

With regard to mens rea, the American justice system attempts to impose proportionately greater sanctions on offenders who are more blameworthy. Often, culpability is based on the defendant's mental state, or mens rea, when the illegal act was committed. Mens rea requirements distinguish among individuals who intentionally, knowingly, recklessly, or negligently broke the law, according to the Model Penal Code (MPC).<sup>227</sup> Because the American legal system is committed to individualized justice, an accidental act, for example, should not be punished as harshly, if at all, as an intentional act.<sup>228</sup>

Under a scenario germane to this Article, an individual is confronted with a situation that reminds him or her of a traumatic event or causes him or her to relive a traumatic event that invoked PTSD. During this episode, the individual—believing that he or she needs to respond or act in a certain manner—may commit a crime, but lack the requisite criminal intent associated with the criminal charge. In such a situation, the individual may be able to argue that he or she did not form the requisite mens rea and thus should have the criminal charges dropped or mitigated.

Under the MPC, “[e]vidence that the defendant suffered from a mental disease or defect is admissible whenever it is relevant to prove that the defendant did or did not have a state of mind that is an element of the offense.”<sup>229</sup> About one-fourth of the states have adopted a rule similar to this provision and admit evidence of a mental disorder when a subjective inquiry is conducted regarding the defendant's mens rea.<sup>230</sup> Additionally, approximately one-third of the states will admit such evidence when the offense requires a specific intent.<sup>231</sup>

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227. MODEL PENAL CODE § 2.02(1) (“Except as provided in Section 2.05, a person is not guilty of an offense unless he acted purposely, knowingly, recklessly or negligently, as the law may require, with respect to each material element of the offense.”). Although many states have adopted the mens rea categories of the Model Penal Code, other states employ different terms to categorize the state of mind a defendant must possess to be guilty of a given crime. *See generally* Kenneth W. Simons, *Should the Model Penal Code's Mens Rea Provisions Be Amended?*, 1 OHIO ST. J. CRIM. L. 179 (2003); *see also* Jean K. Gilles Phillips & Rebecca E. Woodman, *The Insanity of the Mens Rea Model: Due Process and the Abolition of the Insanity Defense*, 28 PACE L. REV. 455 (2008).

228. *See* Taryn F. Goldstein, Comment, *Cultural Conflicts in Court: Should the American Criminal Justice System Formally Recognize a “Cultural Defense”?*, 99 DICK. L. REV. 141, 143 (1994).

229. MODEL PENAL CODE § 4.02(1) (2001).

230. BONNIE ET AL., *supra* note 126, at 608. A “subjective inquiry” examines an individual's judgment or opinion about a phenomenon, while an “objective inquiry” focuses on what is directly observable (i.e., it is not dependent on the individual's “state of mind” or subjective impression).

231. *Id.* at 608–09. The mens rea requirements for some crimes are subjective and require an examination of the *defendant's* intent at the time of the offense. The mens rea requirements for other crimes are typically “objective” and require an examination of what a *reasonable person* would have intended under these or similar circumstances (i.e., an “objective” test), regardless of whether the defendant actually intended the harm or knew that harm would likely result. INSTITUTE OF LAW, PSYCHIATRY & PUBLIC POLICY, *BASIC FORENSIC EVALUATION: PRINCIPLES AND PRACTICE* ch. 5, p. 7 (Oct. 2008). A “specific intent” crime focuses on whether the

Indeed, it has been argued that it is unfair to define mens rea in subjective terms and then not to allow the defendant to introduce evidence to support a claim that he or she did not have the requisite state of mind.<sup>232</sup> However, it is worth noting, for example, that the Virginia Supreme Court has ruled that when “determining criminal responsibility a [defendant] is either legally insane or sane; there is no sliding scale of insanity,” and that “[u]nless [the] accused contends that he was [legally insane] when he acted, his mental state is immaterial to the issue of specific intent.”<sup>233</sup>

## 2. Self-Defense

PTSD may also have implications for a defendant’s claim that he or she acted in self-defense.<sup>234</sup> According to the MPC, “the use of force upon or toward another person is justifiable when the actor believes that such force is immediately necessary for the purpose of protecting himself against the use of unlawful force by such other person on the present occasion.”<sup>235</sup>

For example, when individuals are confronted with a situation reminiscent of the event that led to their PTSD, they may believe that they must take steps to “defend” themselves. Veterans with PTSD may under these circumstances assume a “survival mode” in which they believe, regardless of the actual reality, that it is necessary to use force for self-protection.<sup>236</sup> A dissociative state may not even exist, but a veteran suffering from PTSD might simply overreact to surrounding events and stimuli because of their PTSD.<sup>237</sup> The PTSD can cause the veteran to view the threat and danger posed by the other person to be far greater than is actually the case.

If the self-defense test used in that jurisdiction assesses the threat level from the defendant’s perspective (i.e., a subjective test is employed), the veteran with PTSD may have a valid self-defense claim under these circumstances.<sup>238</sup>

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defendant personally had the mental state that constitutes an element of a crime.

232. Richard J. Bonnie & Christopher Slobogin, *The Role of Mental Health Professionals in the Criminal Process: The Case for Informed Speculation*, 66 VA. L. REV. 427, 477 (1980).

233. *Stamper v. Commonwealth*, 324 S.E.2d 682, 688 (Va. 1985).

234. Gover, *supra* note 59, at 580.

235. MODEL PENAL CODE § 3.04 (2001).

236. Gover, *supra* note 59, at 581.

237. *See id.*

238. *See generally* John F. Wagner Jr., Annotation, *Standard for Determination of Reasonableness of Criminal Defendant’s Belief, for Purposes of Self-Defense Claim, That Physical Force Is Necessary—Modern Cases*, 73 A.L.R.4th 993 (1989). In some states, however, “the requisite reasonableness of a criminal defendant’s belief that the use of physical force in self-defense was necessary is determined under an objective standard,” that is, the defendant “must have an objectively reasonable belief, in light of the surrounding circumstances, that the use of force was necessary to avert death or serious bodily harm” (i.e., the belief of a reasonable person). *Id.* § 3 (referring to the test applied in *United States v. Peterson*, 483 F.2d 1222 (D.C. Cir. 1973)). In contrast, under the subjective test, the fact finder is to determine whether the “circumstances were sufficient to create in this defendant’s mind an honest and reasonable belief that . . . force was necessary.” *Id.* § 4 (referring to the test applied in *State v. Leiholm*, 334 N.W.2d 811 (N.D. 1983)).

*B. Cases Where PTSD Has Been Used to Negate the Culpability of a War Veteran*

Recent cases illustrate that some courts are willing to consider PTSD evidence when it is used to support a claim of self-defense or to rebut the prosecution's claim that the defendant had the requisite mens rea for a charged crime.<sup>239</sup>

In one Florida case, PTSD evidence was permitted on the question of self-defense in a prosecution for attempted second-degree murder where the defendant was a war veteran.<sup>240</sup> An appellate court held that because in Florida a defendant's perceptions are relevant when assessing whether the defendant acted in self-defense, evidence could be introduced in an attempt to explain how PTSD affects an individual's perceptions.<sup>241</sup>

Similarly, a Washington appellate court, after noting that mental health professionals recognize a link between PTSD and diminished culpability, ruled that it was inappropriate to exclude expert testimony regarding a murder defendant's claimed inability to form specific intent due to PTSD.<sup>242</sup> The court determined that the expert's testimony indicated that the defendant suffered from PTSD and, as a result, may have experienced a flashback during her struggle with the victim.<sup>243</sup> If such was the case, the court concluded, PTSD would have impaired the defendant's ability to act with the intent required for a conviction and this evidence would have helped the jury determine whether the defendant was capable of forming the "requisite specific intent to murder" the victim.<sup>244</sup>

This "defense," however, may not necessarily exonerate the defendant from all criminal liability as there may be a lesser-included offense (e.g., breaking and entering) for which the prosecution needs only to establish the existence of an objective or general intent to obtain a conviction.<sup>245</sup> Nevertheless, a mens rea approach may be more generally available to a defendant than the insanity defense as the defendant claiming a lack of mens rea is not limited to when the PTSD induced a psychotic state—as is typically required for an insanity defense—but can include various other

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239. Combat-related PTSD may also be invoked as a mitigating factor in sentencing. See Christopher Hawthorne, *Bringing Baghdad into the Courtroom: Should Combat Trauma in Veterans Be Part of the Criminal Justice Equation?*, 24 CRIM. JUST. 4, 12 (2009) ("Given the unpopularity of the insanity defense, PTSD and the defendant's combat experience generally show up in the sentencing phase of a criminal trial. In fact, most of the Vietnam-era cases dealing with PTSD involved reductions in sentences, usually in state courts."); see also *Porter v. McCollum*, 130 S. Ct. 447 (2009); discussion *supra* note 20. However, PTSD as a mitigating factor at sentencing is beyond the scope of this Article.

240. *State v. Mizell*, 773 So. 2d 618, 619 (Fla. Dist. Ct. App. 2000).

241. *Id.* at 620 ("Defense counsel proposed to offer expert trial testimony from . . . a licensed clinical psychologist."); *id.* at 621 ("[W]e hold that PTSD evidence is relevant on the question of self-defense.").

242. *State v. Bottrell*, 14 P.3d 164, 165–66 (Wash. Ct. App. 2000).

243. See *id.* at 170.

244. *Id.* As discussed, in a specific intent crime, the prosecution must prove that the defendant committed the crime with the requisite intent or purpose, which is usually listed in the statute establishing that a given act is a punishable crime. In this case, the defendant may not have been capable of forming the requisite malice aforethought or intent for the established crime of murder. *Id.* at 165–66; see also BLACK'S LAW DICTIONARY 882 (9th ed. 2009).

245. *Higgins*, *supra* note 118, at 272–73.



PTSD symptoms.<sup>246</sup> Although a mens rea “defense” will not necessarily result in an acquittal, it can result in less severe punishment, such as a lighter sentence or probation.<sup>247</sup>

Although PTSD has not been widely accepted or applied as a basis for an insanity defense (particularly for Vietnam War veterans),<sup>248</sup> courts may be more amenable to testimony establishing the existence of this mental disorder in conjunction with these alternative “defenses.” For example, the Supreme Judicial Court of Massachusetts—after reviewing the totality of the circumstances and hearing evidence that the defendant was wounded on two occasions in the Vietnam War, was treated for shell shock, and suffered severe reactions to loud noises—determined that justice would best be served by changing the verdict from first-degree to second-degree murder.<sup>249</sup> Although a PTSD-based insanity defense was not specifically alleged, the Massachusetts Supreme Court, in reducing the charge, took testimony regarding the defendant’s Vietnam War service, injuries, and psychological trauma, as well as other mitigating factors, into consideration.<sup>250</sup>

Additionally, in a Wisconsin case, the defendant, a Vietnam War veteran accused of murdering his wife, asserted that he lacked mental responsibility for the crime.<sup>251</sup> The Supreme Court of Wisconsin concluded that he should be given a new trial because testimony indicated he had some mental or emotional problems and thus the issue of mental responsibility should be explored further.<sup>252</sup> The court determined that the evidence provided, which included testimony from six experts in mental health, weighed “quite heavily” in favor of the defendant on the mental responsibility question, and that it was likely that there had been a miscarriage of justice.<sup>253</sup>

These cases illustrate that a diagnosis of PTSD—when supported by findings that the disorder impacted a defendant’s cognitive and emotional state and causes him or her to react to a situation differently than would otherwise be expected—can result in the culpability of war veterans being negated or diminished. These rulings have likely implications for the Iraq and Afghanistan War veterans suffering from PTSD. With the advances in the recognition and treatment of PTSD, as well as the increased support for these soldiers and veterans, these defenses are likely to be increasingly available to Iraq and Afghanistan War veterans.

Further enhancing the likelihood that these various mental status defenses will be accepted when presented on behalf of Iraq or Afghanistan War veterans suffering from PTSD is that “[s]ince the 1980s, the introduction [and acceptance] of expert testimony

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246. *Id.*

247. *Id.* at 273.

248. *See supra* Part II.C.

249. *Commonwealth v. Vanderpool*, 328 N.E.2d 833, 835 n.2, 837–38 (Mass. 1975).

250. *See id.* at 838. Other mitigating circumstances taken into account were “that all those involved in the [incident] were under the influence of alcohol,” that the defendant’s intention in approaching the victim was to resolve a conflict and not to intensify it, and that there was a lack of premeditation on the defendant’s behalf. *Id.* at 837.

251. *Kemp v. State*, 211 N.W.2d 793, 794–95 (Wis. 1973).

252. *Id.* at 799.

253. *Id.* at 797, 799. Further information regarding the final disposition of this case has not been reported.

that a defendant . . . suffers from a psychological ‘syndrome’ has increased.”<sup>254</sup> As will be discussed, courts have become more amenable to considering evidence that certain “syndromes,” including Battered Spouse Syndrome (BSS),<sup>255</sup> show that the defendant was acting in self-defense or did not possess the requisite criminal mens rea.<sup>256</sup> However, other “syndromes,” including the Urban Survival Syndrome (USS), have not been as successful as the basis for a criminal defense, with courts generally rejecting their admission into evidence.<sup>257</sup>

### C. Battered Spouse Syndrome

Battered Spouse Syndrome (BSS) has been defined as “a series of common characteristics that appear in [spouses] who are abused physically and psychologically over an extended period of time by the dominant . . . figure in their lives.”<sup>258</sup> This syndrome, like PTSD, can alter an individual’s perception of the surrounding environment and cause the individual to react unexpectedly to certain cues or events that are perceived to be threatening.<sup>259</sup> Because BSS can alter perceptions of reality

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254. Joe W. Dixon & Kim E. Dixon, *Gender-Specific Clinical Syndromes and Their Admissibility Under the Federal Rules of Evidence*, 27 AM. J. TRIAL ADVOC. 25, 25 (2003).

255. Battered Spouse Syndrome was originally and is still often referred to as “Battered Woman Syndrome.” See LENORE E. A. WALKER, *THE BATTERED WOMAN SYNDROME* (3d ed. 2009). To indicate that violence in relationships can target both men and women, as well as both unmarried and married partners, the more frequently used phrase today to describe this violence is “intimate partner violence.” See CENTERS FOR DISEASE CONTROL AND PREVENTION, *INTIMATE PARTNER VIOLENCE* (2009), <http://www.cdc.gov/violenceprevention/pdf/IPV-FactSheet.pdf>; see also WALKER, *supra*, at 5 (“[T]he limited available research suggest that while there may be some differences in same sex violence from male to female heterosexual violence, its use to obtain power and control over one’s partner is still primary.”). However, the phrase “Intimate Partner Violence Syndrome” has not been employed, most likely because research on the existence of a syndrome and its impact has largely been confined to women who were victims of this violence. The phrase “Battered Spouse Syndrome” is used throughout the remainder of this Article because it seems to be more frequently employed in recent judicial rulings and because it is gender-neutral, although it fails to encompass unmarried intimate partners, who may also, it can be argued, be subject to this violence and manifest a similar syndrome.

256. See Dixon & Dixon, *supra* note 254, at 26–27.

257. See *infra* Part III.E.

258. State v. Kelly, 478 A.2d 364, 371 (N.J. 1984). See generally *Developments in the Law: Legal Responses to Domestic Violence*, 106 HARV. L. REV. 1498, 1575 (1993) (“Much of the current debate about the criminal law’s treatment of women who kill their abusers focuses on the use of expert testimony about the psychological effects of battering that are collectively known as the ‘battered woman syndrome.’”); *id.* at 1578 (“‘Battered woman syndrome’ is a descriptive term that refers to the effects of physical or psychological abuse on many women. It describes a ‘pattern of responses and perceptions presumed to be characteristic of women who have been subjected to continuous physical abuse by their mate.’” (quoting Regina A. Schuller & Neil Vidmar, *Battered Woman Syndrome Evidence in the Courtroom*, 16 LAW & HUM. BEHAV. 273, 274 (1992))).

259. See David L. Faigman, Note, *The Battered Woman Syndrome and Self-Defense: A Legal and Empirical Dissent*, 72 VA. L. REV. 619, 627 (1986) (“[T]he battered woman is reduced to a state of fear and anxiety . . . and her perception of danger extends beyond the time of the battering episodes themselves. A ‘cumulative terror’ consumes the woman and holds her

and induce certain behaviors, this diagnosis has been thoroughly studied and its application sought within the criminal justice system.<sup>260</sup> Testimony related to this disorder is typically presented at trial when a battered woman claims she injured or killed her spouse in self-defense.<sup>261</sup>

For example, in 1981, the Georgia Supreme Court recognized the scientific foundation of BSS as sufficiently established to permit related expert testimony to be admitted into evidence to assist a jury evaluating a defense based on this syndrome.<sup>262</sup> In a 1997 ruling, the court added that evidence of BSS can be used to show “that the defendant had a mental state necessary for the [self-]defense . . . justification [for the crime, even] though the actual threat of harm [to the defendant did] not immediately precede the homicide.”<sup>263</sup>

In the latter case, the defendant had been convicted of voluntary manslaughter for shooting her husband.<sup>264</sup> The defendant testified that her husband had not only “beat[en] her repeatedly,” but also “held a gun to her head and threatened to kill her and abscond with her child.”<sup>265</sup> She had called the police about a dozen times and left her husband twice. On the day of the shooting, her husband was upset with her because she had been out visiting friends, subsequently hitting her in the face.<sup>266</sup>

The Georgia Supreme Court determined that testimony regarding these incidents provided adequate evidence that the defendant had been psychologically traumatized by these beatings and that she lived in a fear-invoking environment.<sup>267</sup> Thus, the court ruled, the jury should have been instructed on BSS and its implications for self-defense and that in the future a jury instruction “be given in all battered person syndrome cases, when authorized by the evidence and requested by defendant, to assist the jury in evaluating the battered person’s defense of self-defense.”<sup>268</sup>

BSS received further support when the Supreme Court of New Jersey reversed a conviction of reckless manslaughter after it held that BSS testimony was admissible on

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in constant fear of harm.” (citations omitted)); *id.* at 628 (“[T]he battered woman’s knowledge of the batterer’s history of violence shapes her perception of harm. A woman’s experience in the recurring cycles of violence puts her in constant fear of what appears to her as imminent harm.”); *see also* WALKER, *supra* note 255, at 44 (“When domestic violence events occur and reoccur, the woman recognizes the man’s escalating anger and she becomes physiologically aroused with fear that activates the autonomic nervous system to release its neurotransmitters and hormones that produce hyperarousal. . . . and then, to psychologically escape using a variety of methods including minimization or denial of the danger from the particular incident, depression, dissociation, or even repression and forgetting.”); *id.* at 68 (“The analysis of the data obtained from the women who participated in this research indicated that BWS existed as a subcategory of PTSD.”).

260. *See* Faigman, *supra* note 259, at 626–30 (discussing research on battered woman syndrome and describing its use in criminal trials); *Developments*, *supra* note 258, at 1578–88.

261. *See* Faigman, *supra* note 259, at 619.

262. *Smith v. State*, 277 S.E.2d 678, 683 (Ga. 1981).

263. *Smith v. State*, 486 S.E.2d 819, 822 (Ga. 1997) (quoting *Chapman v. State*, 386 S.E.2d 129, 131 (Ga. 1989)).

264. *Id.* at 820.

265. *Id.*

266. *Id.* at 821.

267. *Id.* at 823.

268. *Id.* The court also crafted what such a jury instruction might look like. *Id.*

the issue of self-defense.<sup>269</sup> The court noted the prevalence of domestic violence in America (citing studies that report that over one million women are beaten in this country every year) and the increased attention that BSS has received.<sup>270</sup>

A BSS expert at trial had explained the long-standing, deep-seated fear of severe bodily harm and isolation that results from being a battered spouse.<sup>271</sup> The expert had been prepared to testify that the defendant, who had stabbed her husband with scissors after seven years in an abusive relationship, suffered from BSS and to explain how this affected her perception of her environment and shaped her behavior at the time of the stabbing.<sup>272</sup> The Supreme Court of New Jersey ultimately held that the expert's testimony could be relevant to a claim of self-defense and would have aided the jury "in determining whether, under the circumstances, a reasonable person would have believed there was imminent danger to her life."<sup>273</sup>

The acceptance of BSS as a defense may have direct implications for PTSD-linked determinations of criminal culpability. For example, researchers are becoming increasingly aware of the development of PTSD in women who are the victims of domestic violence,<sup>274</sup> with symptoms exhibited by battered women consistent with a *DSM-IV-TR* PTSD diagnosis.<sup>275</sup> Research also indicates that the extent, type, and severity of the abuse correlate with the severity of the PTSD disorder, with women who experience the most severe or life-threatening abuse displaying more symptoms of PTSD.<sup>276</sup> Unfortunately, these victims of domestic violence are often only treated for depression, with their PTSD symptoms overlooked and, consequently, untreated.<sup>277</sup>

As may be the case with regard to mental status defenses raised on behalf of Iraq and Afghanistan War veterans, the timing of efforts to invoke defenses based on BSS evidence was vital to their acceptance. Initial attempts to introduce BSS evidence in criminal proceedings were concurrent with efforts to secure parity and respect for the rights of women in the United States.<sup>278</sup> In 1979, Lenore Walker authored her seminal work, *The Battered Woman*, which was followed five years later by her publication of *The Battered Woman Syndrome*.<sup>279</sup> By that time, tremendous strides had been made in

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269. State v. Kelly, 478 A.2d 364, 382 (N.J. 1984).

270. *Id.* at 369–73.

271. *Id.* at 372–73.

272. *Id.*

273. *Id.* at 377.

274. Loring Jones, Margaret Hughes & Ulrike Unterstaller, *Post-Traumatic Stress Disorder (PTSD) in Victims of Domestic Violence: A Review of Research*, 2 TRAUMA VIOLENCE, & ABUSE 99, 99–100 (2001).

275. *See id.* at 100; *see also* WALKER, *supra* note 255, at 68 ("The analysis of the data obtained from the women who participated in this research indicated that BWS existed as a subcategory of PTSD.")

276. Jones et al., *supra* note 274, at 100.

277. *Id.* at 112. The undertreatment of PTSD in war veterans has also had negative effects, including an increase in suicide. *See supra* notes 14–21 and accompanying text; *see also* Hoge et al., *supra* note 14, at 13.

278. Janet C. Hoefel, *The Gender Gap: Revealing Inequities in Admission of Social Science Evidence in Criminal Cases*, 24 U. ARK. LITTLE ROCK L. REV. 41, 43 (2001).

279. *Id.* at 42–43. For additional background, *see* LENORE E. WALKER, *THE BATTERED WOMAN* (1979) and WALKER, *supra* note 255.

“exposing the problem of domestic violence” in America.<sup>280</sup> Parallel to these developments, BSS was soon admitted into a number of courtrooms across the United States and ultimately changed the landscape of self-defense law for spouses, particularly women, who struck back at their batterers.<sup>281</sup>

#### *D. Implications of BSS for PTSD-Based Defenses*

Just like BSS, the timing of the introduction of the PTSD defense for war veterans was critical. However, with regard to PTSD, the timing was unfavorable. As discussed, the formal recognition of PTSD emerged shortly after the Vietnam War ended in 1975.<sup>282</sup> But while the BSS defense was raised at a time of considerable public sympathy for individuals who suffered from BSS, initial attempts to employ a PTSD defense occurred when there was wide-spread negativity about soldiers who had fought in this unpopular war.<sup>283</sup> Whereas veterans of prior “victorious” wars—such as World War II—were welcomed home with parades, Vietnam War veterans were perceived as coming home in “defeat” and were more likely to encounter antiwar protests and marches.<sup>284</sup>

For example, one study conducted during the 1970s found a shift in the perceptions of Americans about the military participants in warfare.<sup>285</sup> Comparing perceptions from 1961 to those in 1971, it was determined that war participants were more likely to be associated with brutality and violence, regardless of the political leanings of the respondent.<sup>286</sup> Hence, the general perception of Vietnam War participants was not a positive one and, unlike the battered spouse, they were probably less likely to invoke sympathy from judges and juries, even though both groups of individuals, arguably, had undergone traumatizing “combat” experiences.

A BSS defense may have also received a more sympathetic response from judges and jurors because the defendants in these cases often attacked individuals who had verbally or physically battered them, with the result that the attacked “victims” may have been perceived as getting their “just deserts.” Combat veterans with PTSD were more likely to have harmed a relatively innocent individual, further limiting the willingness of jurors and judges to reduce or negate the defendant’s culpability.<sup>287</sup>

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280. Hoeffel, *supra* note 278, at 43.

281. *Id.* at 43–44.

282. *See supra* note 26 and accompanying text.

283. *See Higgins, supra* note 118, at 262. Soldiers were unpopular, not just because they participated in the war, but because of specific incidents and stereotypes that emerged from Vietnam. *See id.* The My Lai Massacre and the image of drug-crazed soldiers killing civilians (whether or not this picture was accurate), along with a frequently held sense that the war was unjustified and unwarranted, left many in society with little sympathy for a veteran struggling to adjust to life back home. *See id.* at 262–63.

284. *See id.*

285. David L. Cole, *Perceptions of War and Participants in Warfare: A Ten-Year Replication*, 10 J. PEACE RES. 115 (1973).

286. *Id.* at 116.

287. *See supra* note 209 and accompanying text (two supervisors at the defendant’s place of employment were killed), and *supra* notes 216–20 and accompanying text (an arresting police officer was killed). In addition, it should be noted that in one of the discussed cases where a PTSD-based insanity defense was successfully raised on behalf of a Vietnam War veteran, the

*E. Urban Survival Syndrome*

In light of the success of the BSS defense, attorneys attempted to incorporate other “syndromes” into a defense. One such effort involved what was characterized as Urban Survival Syndrome (USS).<sup>288</sup> In 1993, Damien Osby killed Willie and Marcus Brooks in Fort Worth, Texas.<sup>289</sup> Osby was African-American. According to the defendant, the two victims had repeatedly harassed and threatened him and his family. Osby believed that the only way to escape serious harm or even death was to kill them first.<sup>290</sup>

At trial, defense counsel noted that Osby lived in an inner-city neighborhood with one of the highest violent crime rates in the country and argued that residents of that neighborhood quickly learned that they were at great risk of being killed in this “war zone.”<sup>291</sup> Counsel further argued that as a result of his routine exposure to violence in this neighborhood, Osby had been conditioned to believe that he needed to use lethal force to defend himself from these two men and, as a result, his action was reasonable under the circumstances.<sup>292</sup> Despite this argument, Osby was convicted of two counts of murder and was sentenced to life in prison.<sup>293</sup>

In another famous case in which USS was raised as a defense, Torino Roosevelt Boney, also an African-American, shot another man in the head in Washington, DC.<sup>294</sup> His attorney claimed at his trial in 1994 “that poor urban areas foster a cycle of violence and despair among black men.”<sup>295</sup> This cycle was asserted to result in individuals being conditioned to respond with violence to the daily threats they encountered—a response so entrenched that ultimately “a look, a bump or a glance [could] lead[] to extreme violence.”<sup>296</sup> Despite this argument, the jury convicted Boney.<sup>297</sup>

These USS cases illustrate that even when some support for a “syndrome” defense exists within the *DSM-IV-TR*, such a defense will not necessarily be successful.<sup>298</sup> For

trial focused on the defendant’s robbery of a gun shop where no one was injured and his subsequent firing of guns into an abandoned building. *See supra* notes 197–201 and accompanying text.

288. *See* Patricia J. Falk, *Novel Theories of Criminal Defense Based Upon the Toxicity of the Social Environment: Urban Psychosis, Television Intoxication, and Black Rage*, 74 N.C. L. REV. 731, 738–41 (1996) (“Defendants in four cases, all unreported, have utilized urban psychosis or a variation thereof as a theory of defense.”); Demetra L. Liggins, Note, *Urban Survival Syndrome: Novel Concept or Recognized Defense?*, 23 AM. J. TRIAL ADVOC. 215 (1999); Wally Owens, Note, *State v. Osby, The Urban Survival Defense*, 22 AM. J. CRIM. L. 809 (1995).

289. BONNIE ET AL., *supra* note 126, at 456; *see also* Falk, *supra* note 288, at 740–41; Owens, *supra* note 288, at 809–11.

290. BONNIE ET AL., *supra* note 126, at 456.

291. *Id.*

292. *See id.*

293. *Id.*

294. Lisa Weintraub, *Inner-city Post-traumatic Stress Disorder*, 25 J. PSYCHIATRY & L. 249, 262 (1997).

295. *Id.* (internal quotations omitted).

296. *Id.* (quoting Greg Seigle, *Union Station Killer Gets 10-Year Minimum*, WASH. TIMES, June 10, 1994, at C10).

297. *Id.*

298. *Id.*

example, the *DSM-IV-TR* provides for a possible connection between urban violence and PTSD when it lists the traumatic events that must have been experienced before individuals may be assigned a diagnosis of PTSD, including (1) experiencing, (2) witnessing another individual experience, or (3) learning that a family member or other close associate has experienced actual or threatened death or serious injury.<sup>299</sup> Living in disadvantaged neighborhoods with high crime rates increases the likelihood that an individual will experience such violent and traumatic life experiences.<sup>300</sup> According to proponents of USS, the daily experience of racial segregation and violence found in many inner cities may cause a mental state—namely, USS—that is the equivalent of the mental state resulting from undergoing a traumatic combat experience.<sup>301</sup> Nevertheless, the “USS defense” has gained little traction.

Moreover, one commentator argues that the legal system should not encourage such defenses even though many inner-city defendants can meet the criteria for a PTSD diagnosis.<sup>302</sup> She asserts that this defense perpetuates negative stereotypes about racial minorities and contends that efforts should be devoted instead to seeking to prevent these symptoms from arising.<sup>303</sup>

There may be another reason why this defense has not taken hold in the United States. Like PTSD defenses for Vietnam War veterans, the timing of the introduction of USS to the legal system may have impeded its success. When it was first presented to the courts in the 1990s, crime rates in the United States were rising and national policy was focused on the punishment and deterrence of crime. According to the United States Department of Justice, the rate of violent crimes (rape, robbery, aggravated assault, and homicide) reached an all-time high in the late eighties and early nineties,<sup>304</sup> with urban crime a particular concern.<sup>305</sup> Hence, judges, juries, and the general public may not have been willing to embrace this new defense that seemed to excuse and hold blameless the behavior associated with urban crime.

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299. See *DSM-IV-TR*, *supra* note 18, at 463 (establishing that for a PTSD diagnosis there must be “the development of characteristic symptoms following exposure to an extreme traumatic stressor involving direct personal experience of an event that involves actual or threatened death or serious injury, or other threat to one’s physical integrity; or witnessing an event that involves death, injury, or a threat to the physical integrity of another person; or learning about unexpected or violent death, serious harm, or threat of death or injury experienced by a family member or other close associate”); see also Dean G. Kilpatrick, Kenneth J. Ruggiero, Ron Acierno, Benjamin E. Saunders, Heidi S. Resnick & Connie L. Best, *Violence and Risk of PTSD, Major Depression, Substance Abuse/Dependence, and Comorbidity: Results from the National Survey of Adolescents*, 71 *J. CONSULTING & CLINICAL PSYCHOL.* 692, 692 (2003) (finding that interpersonal violence increases the risk of PTSD in adolescents).

300. George W. Clarke, *Urban Survival Syndrome: A New Defense*, 30 *LAW ENFORCEMENT Q.* 16, 17 (2001).

301. See Weintraub, *supra* note 294, at 250.

302. *Id.* at 251.

303. *Id.*

304. U.S. DEP’T OF JUSTICE BUREAU OF JUSTICE STATISTICS, CRIME AND VICTIMS STATISTICS (2008), <http://www.ojp.usdoj.gov/bjs/cvict.htm>.

305. U.S. DEP’T OF JUSTICE NAT’L INST. OF JUSTICE, FIGHTING URBAN CRIME: THE EVOLUTION OF FEDERAL-LOCAL COLLABORATION 4–5 (2003), <http://www.ncjrs.gov/pdffiles1/nij/197040.pdf>.

## IV. IMPLICATIONS FOR “PTSD DEFENSES” RAISED ON BEHALF OF IRAQ AND AFGHANISTAN WAR VETERANS

In the wake of the Iraq and Afghanistan Wars, America has seen an increasing number of its soldiers return home with battle scars, both physical and psychological.<sup>306</sup> One news account reports that a study recently released by the United States Army found that the Army’s mental health screening methods “substantially underestimate[d] the mental health [problems]” of Iraq War veterans.<sup>307</sup> Furthermore, with over 1.5 million American troops returning from these wars, America is faced with an unprecedented number of war veterans who suffer from PTSD.<sup>308</sup>

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306. See Tanneeru, *supra* note 25.

307. See Malcolm, *supra* note 2 (internal quotation marks omitted); see also DEP’T OF DEFENSE TASK FORCE ON MENTAL HEALTH, AN ACHIEVABLE VISION: REPORT OF THE DEPARTMENT OF DEFENSE TASK FORCE ON MENTAL HEALTH, ES-1 (2007), <http://www.health.mil/dhb/mhtf/MHTF-Report-Final.pdf> (“[T]he [existing] system is being challenged by emergence of two ‘signature injuries’ from the current conflict – post-traumatic stress disorder and traumatic brain injury. . . . New demands have exposed shortfalls in a health care system that in previous decades had been oriented away from a wartime focus. Staffing levels were poorly matched to the high operational tempo even prior to the current conflict, and the system has become even more strained by the increased deployment of active duty providers with mental health expertise. As such, the system of care for psychological health that has evolved over recent decades is insufficient to meet the needs of today’s forces and their beneficiaries, and will not be sufficient to meet their needs in the future.”); Hoge et al., *supra* note 14, at 1031 (relying on the U.S. Department of Defense’s mandatory Post-Deployment Health Assessment (PDHA) screen, the authors concluded that the “mental health portion of the PDHA screening provides an indicator of deployment-related mental health concerns on a population level but may have limited utility in predicting which individuals will use services, at least as the screening is being used now, immediately on return from deployment.”); Charles S. Milliken, Jennifer L. Auchterlonie & Charles W. Hoge, *Longitudinal Assessment of Mental Health Problems Among Active and Reserve Component Soldiers Returning from the Iraq War*, 298 J. AM. MED. ASS’N 2141, 2141 (2007) (noting that their previous article describing the “the Department of Defense’s (DoD’s) screening efforts to identify mental health concerns among soldiers and Marines as they return from Iraq and Afghanistan using the Post-Deployment Health Assessment (PDHA). . . . raised concerns that mental health problems might be missed because of the early timing of this screening” and that “[b]ased on these preliminary data, the DoD initiated a second screening similar to the first, to occur 3 to 6 months after return from deployment”). Responding to claims that the military does not adequately monitor and screen its soldiers for mental health problems following combat, on March 4, 2009, Congress introduced a bill to require the Department of Defense to adopt a program of professional and confidential screenings to detect mental health injuries acquired during military deployment and to ultimately reduce the incidence of suicide among veterans. Veterans Mental Health Screening and Assessment Act, H.R. 1308, 111th Cong. (2009) (referred to the Subcommittee on Armed Services and to the Committee on Veterans’ Affairs). Similarly, the Army recently announced plans to require all 1.1 million of its soldiers to complete a \$117 million intensive training program, the first of its kind in the military, to develop and enhance emotional resiliency to “head off the mental health problems, including depression, post-traumatic stress disorder and suicide, that plague about one-fifth of troops returning from Afghanistan and Iraq.” Carey, *supra* note 117.

308. Gover, *supra* note 59, at 566; Elias, *supra* note 13.



A series of studies have highlighted the failure to identify the prevalence of mental health problems in general and PTSD in particular among both soldiers serving in Iraq and Afghanistan and veterans returning to the United States,<sup>309</sup> how exposure to combat significantly increases these problems,<sup>310</sup> how fewer than forty percent of veterans with a mental health problem seek care,<sup>311</sup> and that there are numerous barriers to obtaining this treatment.<sup>312</sup>

These accounts have not only brought combat-related PTSD to the public's attention, they illustrate just how common and under-treated this mental disorder is in the returning troops. Just as the Vietnam War introduced the diagnosis of PTSD to the public and the legal system, the Iraq and Afghanistan Wars may further the understanding of PTSD and serve as an additional catalyst for the acceptance of PTSD defenses in the legal system.<sup>313</sup> Although only time will tell how PTSD diagnoses in Iraq and Afghanistan War veterans play out in the legal arena, the dispositions of their Vietnam counterparts and of the BSS and USS defenses not only suggest some of the impediments they may face but also provide some instances where a PTSD or a related "syndrome" defense has been successful.

In addition, there are already a few cases involving veterans of the Iraq and Afghanistan Wars where PTSD issues have been raised, albeit with mixed results. For example, in 2008 in *Martinez v. State*,<sup>314</sup> the Supreme Court of Georgia, notwithstanding its previously discussed acceptance of the BSS defense,<sup>315</sup> held that the defendant did not show his attorney had provided ineffective assistance in deciding

309. See, e.g., Malcolm, *supra* note 2; see also DEP'T OF DEF. TASK FORCE ON MENTAL HEALTH, *supra* note 307, at ES-1; Schell & Marshall, *supra* note 11, at 96.

310. Hoge et al., *supra* note 11, at 13.

311. *Id.*

312. *Id.*

313. It should be noted that the mental status defenses addressed in this Article (with the exception of the somewhat mischaracterized "mens rea defense") are affirmative defenses that ultimately must be raised and pursued by the defense. A defendant may choose not to pursue such a defense for a number of reasons, including a desire to avoid the stigma often associated with claiming and being found to have a mental disorder, a desire (sometimes unfounded) to assume responsibility for an otherwise criminal act, or a recognition that unsuccessfully raising such a defense may lead a jury or judge to impose harsher sanctions on the defendant. In addition, the consequences of a successful insanity defense may be more deleterious for the defendant than a criminal conviction. See Christian Breheny, Jennifer Groscup & Michelle Galieta, *Gender Matters in the Insanity Defense*, 31 LAW & PSYCHOL. REV. 93, 98 (2007).

[R]esearch has shown that 11% of all felony arrests resulted in imprisonment while 67% of unsuccessful insanity pleas resulted in the same. . . .

. . . .

Another common misconception is that insanity defendants "go free" after being adjudged [not guilty by reason of insanity]. . . . However, in reality, society's condemnation of the mentally ill often leads to greater punishment. Empirical data has shown that a defendant who successfully pleads insanity is often detained for a significantly longer terms [sic] than if the defendant had not utilized an insanity plea.

*Id.* (citations omitted).

314. 663 S.E.2d 675 (Ga. 2008).

315. See *supra* notes 262–68 and accompanying text.

to forgo an insanity defense based on defendant's alleged PTSD.<sup>316</sup> In this case, Alberto Martinez, who served in the infantry in Iraq, was found guilty of murder and various related offenses in connection with a fatal stabbing shortly after he returned from a six-month deployment to Iraq in 2003.<sup>317</sup> Notwithstanding the defendant's assertion that his PTSD caused him to suffer delusions and compulsions, the court determined that it was not unreasonable for his counsel to decide against employing a PTSD-based insanity defense.<sup>318</sup>

In support of its ruling, the court focused on various facts of the case. The evidence showed that the defendant was joined in his attack on the victim by two other men; that Martinez and one of the other men attempted to hide the victim's body in the woods; that Martinez and the other men drove to a convenience store where they purchased lighter fluid and matches, following which they returned to the body and set it on fire; and that Martinez returned to the crime scene several days later and subsequently decided to bury the body.<sup>319</sup>

Despite Martinez's claim that he did not remember stabbing the victim, it is not surprising that the court concluded that counsel's decision not to pursue a PTSD-based insanity defense on Martinez's behalf was reasonable.<sup>320</sup> In support of its ruling, the court noted that (1) counsel had read the reports on defendant's mental state, conferred with the defendant and his wife, considered information Martinez provided, and spoke with people treating veterans with PTSD about how the disorder would fit with Martinez's defense; (2) the defense was difficult to reconcile with their assertion that Martinez was not the one who fatally stabbed the victim; (3) Martinez was not prepared to admit that he had committed the gruesome acts; and (4) the defense could not explain why Martinez had attempted to cover up his actions.<sup>321</sup>

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316. *Martinez*, 663 S.E.2d at 679.

317. *Id.* at 677.

318. *Id.* at 679.

319. *Id.* at 677.

320. *See id.* at 677–79.

321. *Id.* at 678–79. Although beyond the scope of this Article, and not addressed in the ruling by the Supreme Court of Georgia, a question remains whether a defendant's attorney can raise (or not raise) an insanity defense contrary to the wishes of the defendant. The United States Supreme Court in *Indiana v. Edwards*, 128 S. Ct. 2379 (2008), held that a trial court judge can disregard a defendant's expressed desire to proceed *pro se* if the judge determines that the defendant is incompetent to represent himself, notwithstanding that the judge has also ruled that the defendant is currently competent to stand trial. *Id.* at 2387–88. The Court embraced this relatively paternalistic approach to protect the dignity of a defendant with a "severe mental illness." *See id.* at 2387. By extension, it could be argued that a defendant's attorney, as an officer of the court, could raise (or not raise) an insanity defense contrary to the wishes of his or her client if the attorney believes that this trial strategy is in the best interests of the defendant, although it is likely that the attorney would need the blessing of the court before pursuing this strategy. Such a course of action, however, has the potential to be contrary to the expectation of the defendant who expects the attorney to honor the defendant's trial-related requests and raise issues regarding the defense attorney's ethical obligation to a client. *Compare* MODEL RULES OF PROF'L CONDUCT R. 1.2(a) (2009) ("[A] lawyer shall abide by a client's decisions concerning the objectives of representation . . ."), *and* MODEL RULES OF PROF'L CONDUCT R. 1.14(a) (2009) ("When a client's capacity to make adequately considered decisions in connection with a representation is diminished, whether because of minority, mental impairment or for some other

Another case involved Ricardo Cortez, who after serving two tours of duty in Iraq, shot his wife, killing her and their unborn child.<sup>322</sup> The defense argued that Cortez was suffering from PTSD at the time of the offense.<sup>323</sup> Despite expert testimony and the defendant's claim that he was not guilty by reason of insanity, Cortez was found guilty of murder by a jury on November 13, 2008, and sentenced to life plus eighty years.<sup>324</sup> In a local editorial, it was contended that the correct verdict was reached in that Cortez was "an abusive, jealous husband . . .," but also hoped "that the public doesn't dismiss Post Traumatic Stress Disorder as easily as the jury did last week when they sent Cortez to prison for the rest of his life."<sup>325</sup>

Although neither of these verdicts embraced the use of PTSD testimony, there are indications that PTSD diagnoses are coming to have a greater impact on the criminal trials of Iraq and Afghanistan veterans. For example, in one case that was reported in *The New York Times*, Sergeant Archie O'Neil, on the eve of his second deployment to Iraq, fatally shot his mistress at their home after she threatened to kill several of his family members while he was gone.<sup>326</sup> During Sergeant O'Neil's military trial, his lawyer argued that the defendant suffered from PTSD and was not guilty by reason of insanity as "the ravages of war" provided the "trigger" for the killing.<sup>327</sup> A military jury convicted Sergeant O'Neil of murder but declined to impose the maximum sentence of life imprisonment, considering it too harsh.<sup>328</sup>

The jury verdict in this case suggests that the views regarding veterans with PTSD may be softening, and such veterans may receive a warmer welcome in the judicial system.<sup>329</sup> And with at least 121 Iraq and Afghanistan War veterans known to be involved in homicides as of the beginning of 2008, embracing the use of PTSD evidence in their defense has important implications for the outcomes of these trials, the veterans involved, and the legal system.<sup>330</sup> Perhaps reflecting this change in

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reason, the lawyer shall, as far as reasonably possible, maintain a normal client-lawyer relationship with the client."), *with* MODEL RULES OF PROF'L CONDUCT R. 1.14(b) (2009) ("When the lawyer reasonably believes that the client has diminished capacity, is at risk of substantial physical, financial or other harm unless action is taken and cannot adequately act in the client's own interest, the lawyer may take reasonably necessary protective action, including consulting with individuals or entities that have the ability to take action to protect the client . . .").

322. David Young, *Cortez: Life Plus 80 Years*, GREELEY TRIB. (Colo.), Nov. 14, 2008, available at <http://www.greeleytribune.com/article/20081114/NEWS/811149988/1002/NONE>.

323. *Id.*

324. *Id.*

325. *Misunderstood Mental Illness Is Brought to Light During Cortez Trial*, GREELEY TRIB. (Colo.), Nov. 19, 2008, available at <http://www.greeleytribune.com/article/200811199986>.

326. Deborah Sontag & Lizette Alvarez, *Across America, Deadly Echoes of Foreign Battles*, N.Y. TIMES, Jan. 13, 2008, at A1.

327. *Id.*

328. *Id.* ("A second jury, however, convened only for sentencing, voted the maximum penalty, life without parole. The case is on appeal.")

329. See e.g., Young, *supra* note 322 (reporting that the public defender who represented Ricardo Cortez, an Iraq veteran whose PTSD-based insanity defense in the murder of his estranged wife was rejected by a jury, told the sentencing judge that "as more soldiers come back from Iraq and Afghanistan, we will be seeing this more and more"); see also *Porter v. McCollum*, 130 S. Ct. 447 (2009); discussion *supra* note 20.

330. Sontag & Alvarez, *supra* note 326 ("The New York Times found 121 cases in which

perspective, the reporters who compiled this tabulation asserted that “these killings provide a kind of echo sounding for the profound depths to which some veterans have fallen, whether at the bottom of a downward spiral or in a sudden burst of violence.”<sup>331</sup>

Indeed, the Iraq and Afghanistan Wars have several features that may result in PTSD-related defenses raised by the veterans of these wars gaining greater acceptance. For one, PTSD appears to be more pervasive in Iraq and Afghanistan War veterans than even among Vietnam War veterans.<sup>332</sup> This may result in mental health professionals and society, and subsequently the judicial system, becoming more (1) aware of related symptoms; (2) likely to recognize the validity of the diagnosis and the impact of PTSD on human behavior, even when criminal behavior is involved; and (3) willing to take it into account when assessing criminal responsibility and punishment.<sup>333</sup> Also, treatment protocols to address PTSD continue to improve, decreasing the potential for a long-term, chronic threat from such defendants and

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veterans of Iraq and Afghanistan committed a killing in this country, or were charged with one, after their return from war. In many of those cases, combat trauma and the stress of deployment—along with alcohol abuse, family discord and other attendant problems—appear to have set the stage for a tragedy that was part destruction, part self-destruction.”)

331. *Id.*; see also Associated Press, *W. Pa. Soldier to Claim Insanity in Shootings*, CENTRE DAILY TIMES (Pa.), Aug. 12, 2009, available at [http://www.centredaily.com/news/local/crime\\_courts/story/1446845.html](http://www.centredaily.com/news/local/crime_courts/story/1446845.html) (reporting that a “troubled Iraq war veteran” home from the Army on medical leave and whose “family contends his actions were fueled by post-traumatic stress disorder” is pursuing an insanity defense in response to capital charges that he fatally shot a clerk and a bystander while robbing a Subway sandwich shop and taking about \$130); R. Norman Mood, *Afghanistan Vet’s Shooting Trial Postponed*, FLA. TODAY, Mar. 30, 2009, available at <http://www.tcpalm.com/news/2009/mar/30/afghanistan-vets-shooting-trial-postponed/> (providing an account of an Army veteran in Florida without a criminal record who had completed combat missions in Afghanistan but who suffered from PTSD, according to family members, when he shot at his wife and then confronted responding police officers; his attorney has filed notice that he intends to rely on an insanity defense at trial); Michelle Tan, *Report: Accused GIs Were ‘at Risk’*, ARMY TIMES, July 26, 2009, available at [http://www.armytimes.com/news/2009/07/army\\_carson\\_072609w/](http://www.armytimes.com/news/2009/07/army_carson_072609w/) (“Intense combat experiences, prior criminal behavior, substance abuse and barriers to seeking mental health care all contributed to a ‘cluster’ of murders or attempted murders allegedly committed by soldiers from the same Fort Carson, Colo., brigade, Army leaders said July 15.”).

332. Elias, *supra* note 13. As discussed in this Article, the higher prevalence of PTSD in Iraq and Afghanistan War veterans may be explained by the difference between the Iraq and Vietnam theaters. See *supra* Part I.D. Although there was guerilla warfare and essentially no front lines in either war, the Iraq and Afghanistan Wars involve an enemy that could be anywhere or anyone, and strike at anytime through the use of make-shift explosives, car bombs, rocket-propelled missiles, or suicide bombers. Ann Hubbard, *A Military-Civilian Coalition for Disability Rights*, 75 MISS. L.J. 975, 986 (2006). Also, more advanced weapons, including mortar attacks, are more widely used in these wars. See *id.* Additionally, because of the changes in combat technology and, ironically, improved medical technology, more soldiers are returning to the United States with severe injuries. Although these soldiers are more likely to physically survive these attacks, their experiences may create psychological problems—including PTSD—that can haunt them for the rest of their lives. Phillip Carter & Owen West, *Iraq 2004 Looks Like Vietnam 1966—Adjusting Body Counts for Medical and Military Changes*, SLATE, Dec. 27, 2004, <http://www.slate.com/id/2111432/>.

333. Welch, *supra* note 20.

enhancing the likelihood of their rehabilitation.<sup>334</sup> Additionally, the stigma of a PTSD diagnosis appears to be diminishing for Iraq and Afghanistan War veterans, particularly in contrast to their Vietnam counterparts.<sup>335</sup> This may make these veterans more willing to raise a PTSD-linked defense, as well as reduce the criminal justice system's reluctance to recognize these defenses.<sup>336</sup>

Further, because the mainstream media has widely covered the psychological impact of the combat experience of Iraq and Afghanistan War veterans, the American public is more educated about and sympathetic to the "emotional fallout" and the invisible psychological "scars of war."<sup>337</sup> For example, a number of media outlets have highlighted the findings that approximately twenty percent of veterans report serious mental problems, including PTSD and depression, upon returning home from Iraq and Afghanistan and that these veterans have been taking their lives at twice the rate of the American population in general.<sup>338</sup>

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334. See Friedman, *supra* note 12, at 76.

335. Welch, *supra* note 20. *But see* Friedman, *supra* note 12, at 76–77 (discussing perceived stigmatization in soldiers and Marines returning from Operation Iraqi Freedom and Operation Enduring Freedom).

336. At the same time, considerable stigma still tends to surround all diagnoses of a mental disorder, including PTSD, among soldiers and military veterans, which continues to impede their willingness to seek related mental health care. E-mail from Mary Tramontin, *supra* note 164 ("Many returning service members are young and developmentally at odds with the patient role and seek to normalize their experiences; they are aware of the stigma attached to mental health treatment, especially if they are seeking careers in law enforcement; military cultural factors affect help seeking behaviors; and for PTSD, the core symptom of avoidance also serves to keep them out of treatment. Finally, the most effective evidence based treatments for PTSD that are short-term and recovery oriented are not widely disseminated, meaning that most community practitioners and VA clinicians will not have these in their repertoire. There is a lot of untreated, and even undiagnosed, combat PTSD out there. One of my colleagues and I looked at a very small sample of treatment completers and found that the only significant variable was age—the older (mid 40's on) OEF/OIF returnees were more likely to stay in and finish a treatment protocol.").

337. See Lizette Alvarez, *Army Data Show Rise in Number of Suicides*, N.Y. TIMES, Feb. 6, 2009, at A12; Goode, *supra* note 15; *Vet Suicide on the Rise*, ONLINE NEWS HOUR, Nov. 10, 2008, [http://www.pbs.org/newshour/forum/health/july-dec08/vetsuicide\\_11-10.html](http://www.pbs.org/newshour/forum/health/july-dec08/vetsuicide_11-10.html); *see also* Steven Leser, *Iraq War—Pardon the Troops Accused of Crimes*, OPEDNEWS.COM, Dec. 24, 2006, [http://www.opednews.com/articles/opedne\\_steven\\_1\\_061224\\_iraq\\_war\\_\\_\\_pardon\\_th.htm](http://www.opednews.com/articles/opedne_steven_1_061224_iraq_war___pardon_th.htm) ("We all need to come together to support the Iraq war veterans who come home . . . in every way. That includes understanding that we put them in a terrible situation and that it is completely understandable for anyone to break and commit crimes in that situation.").

338. See Armen Keteyian, *Suicide Epidemic Among Veterans*, CBS NEWS.COM, Nov. 13, 2007, [http://www.cbsnews.com/stories/2007/11/13/cbsnews\\_investigates/main3496471.shtml](http://www.cbsnews.com/stories/2007/11/13/cbsnews_investigates/main3496471.shtml); *Study: Suicide Risk Double Among Male U.S. Veterans*, CNN.COM, June 11, 2007, <http://edition.cnn.com/2007/HEALTH/06/11/vets.suicide/index.html>; *Veteran Suicides on the Rise* (NBC Nightly News broadcast Dec. 12, 2007), available at <http://www.msnbc.msn.com/id/21134540/vp/22218515/#22218515>. It has also been determined that incarcerated veterans are at greater risk of suicide than either veterans or incarcerated inmates in general. Hal S. Wortzel, Ingrid A. Bingswanger, C. Alan Anderson & Lawrence E. Adler, *Suicide Among Incarcerated Veterans*, 37 J. AM. ACAD. PSYCHIATRY & L. 82, 82 (2009).

Support for the role of these combat troops and continued media attention to their psychological problems may make veterans of the Iraq and Afghanistan Wars relatively sympathetic criminal defendants, unlike their Vietnam War counterparts, and result in their being viewed as analogous to the relatively sympathetic battered spouse who assaults an abusive spouse. However, a factor that may limit sympathy for these defendants is that—unlike BSS defendants—they are more likely to have attacked a relatively “innocent” bystander who was not responsible, at least in part, for the defendant’s psychological disorder but just happened to be present during a PTSD-related event.<sup>339</sup>

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339. In addition, it should be noted that raising a PTSD-related defense on behalf of an unpopular Iraq or Afghanistan War soldier or veteran may undercut the good will that might otherwise be available for this “defense” in general. For example, there are some indications that Maj. Nidal Malik Hasan may have been suffering from PTSD at the time he killed thirteen individuals at Fort Hood on November 5, 2009. Robert D. McFadden, *12 Killed, 31 Wounded in Rampage at Army Post; Officer Is Suspect*, N.Y. TIMES, Nov. 6, 2009, at A1. A diagnosis of PTSD is not limited to individuals who have personally experienced or witnessed “an extreme traumatic stressor,” but can also include individuals who have “learn[ed] about unexpected or violent death, serious harm, or threat of death or injury experienced by a family member or other close associate.” DSM-IV-TR, *supra* note 18, at 463. As a psychiatrist in the military, he provided counseling services to soldiers returning from Iraq and Afghanistan with PTSD. It has been suggested that he was personally experiencing considerable stress at the time of the Fort Hood shootings. Scott Shane & James Dao, *Tangle of Clues About Suspect at Fort Hood*, N.Y. TIMES, Nov. 15, 2009, at A1 (“Whatever led Major Hasan to act, it is clear that he felt under intense pressure. He had told family members for years about his fears of being sent to war, and his work at Walter Reed Army Medical Center had exposed him daily to the horrors combat could produce.”); *see also* Richard Boudreaux, *Fort Hood Shooting Suspect Endured Big Pressure, Uncle Says*, L.A. TIMES, Nov. 8, 2009, <http://www.latimes.com/news/nationworld/world/la-fg-fort-hood-suspect-uncle8-2009nov08,0,1886826.story> (reporting conversations his uncle had had with Maj. Hasan a year earlier) (“[T]he major seemed more afflicted by his caseload of physically disabled and traumatized war veterans. ‘He didn’t have time even to breathe. . . . Too much pressure, too many patients, not enough staff.’ He would say, ‘I don’t know how to treat them or what to tell them,’ because he didn’t have enough time. They just kept coming one after the other. ‘Sometimes he cried because of what happened to them. How young they are, what’s going to happen to the rest of their lives. They’re going to be handicapped; they’re going to be crazy.’”); Shari Roan, *Fort Hood Tragedy Rocks Military as It Grapples with Mental Health Issues*, L.A. TIMES, Nov. 9, 2009, <http://www.latimes.com/news/nationworld/nation/la-sci-fort-hood-psych9-2009nov09,0,4570410.story> (“The factors that may have led to Hasan’s alleged actions are not yet clear. What is clear is that no one is immune to mental health problems: Doctors have slightly higher suicide rates than does the general population.”). It might be argued that his clients constituted “close associates” and in the course of exploring the traumatic events they had undergone, he too developed PTSD. In light of the adverse reaction to these shootings, however, raising a PTSD-related defense on his behalf would likely not be well received by the general public. *See* Shane & Dao, *supra* (“In his weekly address, President Obama vowed on Saturday that the administration would discover the full story of the massacre. . . . Mr. Obama said investigators would also look for any missteps. ‘If there was a failure to take appropriate action before the shootings, there must be accountability,’ he said.”); *see also* Benedict Carey, Damien Cave & Lizette Alvarez, *For Therapists in the Military, Painful Stories*, N.Y. TIMES, Nov. 8, 2009, at A1 (“Many of the patients who fill the day are bereft, angry, broken. Their experiences are gruesome, their distress lasting and the

## CONCLUSION

As more psychologically scarred troops return from combat, society's focus on and concern for these troops and their psychological disorders has increased. With this increase and with associated studies confirming the validity of the PTSD diagnosis and the genuine impact of PTSD on the behavior of veterans, greater weight may be given to the premise that PTSD is a mental disorder that provides grounds for a "mental status defense," such as insanity, a lack of mens rea, or self-defense. Although considerable obstacles remain, given the current political climate, Iraq and Afghanistan War veterans are in a better position to successfully pursue these defenses than Vietnam War veterans were a generation ago, a development that may make these defenses more available for all defendants with a PTSD diagnosis.

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process of recovery exhausting. The repeated stories of battle and loss can leave the most professional therapist numb or angry. And hanging over it all, for psychiatrists and psychologists in today's military, is the prospect of their own deployment—of working under fire in Iraq or Afghanistan, where the Pentagon has assigned more therapists to combat units than in previous wars. That was the world that Maj. Nidal Malik Hasan, an Army psychiatrist, inhabited until Thursday, when he was accused of one of the worst mass shootings ever on a military base in the United States, an attack that killed 13 and left dozens wounded. Five of the dead were fellow therapists, the Army said.”).