I. Introduction

The Vietnam War was a conflict in many ways unlike anything American soldiers had ever seen before. It was an unfamiliar kind of war, fought in unfamiliar terrain, for an objective that was all too often unclear to those asked to fight it. Young men were flown into battle and asked to fight alongside fellow soldiers and under commanding officers whom they had never before met. They were often exposed to extraordinary brutality, committed both by the enemy and sometimes even by their own comrades. And when they returned home, these soldiers were faced with a disinterested, if not hostile, public.

These factors combined to result in a staggering amount of psychological trauma among the soldiers returning home from Vietnam. As will be discussed, many of the survivors of this war began to psychologically reexperience the worst parts of their military service. Relatedly, they often became isolated, irritable, and unable to integrate back into society. Many returning soldiers even committed suicide, while many others committed criminal acts. The latter group, some of them suffering from what was then called “Vietnam Syndrome,” often attempted to use the impact of the Vietnam War on them to explain, justify, or mitigate their criminal acts, with differing levels of success.

However, it was not until 1980 that the American Psychiatric Association officially recognized Vietnam Syndrome—or as it came to be known, post-traumatic stress disorder (“PTSD”)—as a psychological illness.
been estimated that up to seventy percent of the soldiers who survived Vietnam suffered some form of PTSD as a result of the war.\(^7\)

Several decades of relative peace pushed the subject of combat-related PTSD as a criminal defense to the background of the criminal law. However, as soldiers serving overseas in Iraq and Afghanistan continue to return home, they are likely to confront some of the same issues and problems as their predecessors in Vietnam did upon their return. By 2009, over one-third of war veterans from Iraq and Afghanistan enrolling in the veterans’ health system after 2001 received a diagnosis revealing at least one mental health issue.\(^8\) Like the soldiers in Vietnam, the military personnel in Iraq and Afghanistan are fighting a difficult war that has posed severe challenges and exposed them to traumatic events for which they were often ill-prepared.\(^9\)

Additionally, the current prolonged nature of the conflicts, resulting in multiple and lengthy deployments, continues to burden the psyche of these soldiers.\(^10\) And like their predecessors in Vietnam, today’s military personnel will return home to a public deeply divided on the moral justification and effectiveness of their mission.\(^11\)

This Article will examine the current interplay between PTSD and the criminal law. In Part II, the historical development of PTSD as a psychiatric diagnosis will be explored, as well as the nature of the disorder as it is currently defined. In Part III, the possible ways in which PTSD could lead a veteran to commit criminal acts will be discussed. Finally, in Part IV, defenses potentially available to these veterans, the difficulties faced by someone with PTSD pursuing these defenses, and strategies that may enhance the likelihood of a successful defense will be outlined.

II. PTSD Described

A. Historical Background

Though Vietnam brought the issue of combat-related stress disorders into the national consciousness, the apparent revelation that soldiers often experience severe psychological reactions to combat is not a new one.\(^12\) As early as the Civil War, it was acknowledged that intense combat could lead


\(^9\) See Hafemeister & Stockey, supra note 5, at 99-102, 105-07; F. Don Nidiffer, Evolution of Combat-Related Post Traumatic Stress Disorder, 29(1) DEV. MENTAL HEALTH L. 1, 10-12 (2010).

\(^10\) See Dao, supra note 8; Tramontin, supra note 6, at 30-32.

\(^11\) At one point, over sixty percent of Americans surveyed believed that the Iraq War was not worth fighting. The views on the war in Afghanistan have been significantly more positive, with fifty-five percent of Americans at the same time believing that we should continue our military operations in that country. Michael A. Fletcher & Jon Cohen, Poll Finds Support for Obama’s War Views, WASH. POST, Dec. 16, 2008, at http://www.washingtonpost.com/wp-dyn/content/story/2008/12/15/ST2008121503327.html.

\(^12\) Nidiffer, supra note 9, at 4 (tracing history of documented combat-related, PTSD-like symptoms back to 1900 B.C.).
to psychiatric symptoms. At the time, soldiers exhibiting symptoms of PTSD after battle were diagnosed with “nostalgia,” or “soldier’s heart.” This diagnosis encompassed symptoms of hyperalertness, dizziness, and chest pain, which were thought at the time to be caused by a heart condition. However, psychological symptoms of battle did not become a widespread issue until World War I, during which numerous veterans were diagnosed with “neurasthenia” or “shell shock.” Psychiatrists often attributed the sudden change in behavior among those afflicted to exposure to toxic gasses, to differences in atmospheric pressure, or to simple cowardice.

The 1940s brought another war and yet another new term for the severe psychological reaction experienced by soldiers exposed to combat trauma. In World War II, large numbers of soldiers were diagnosed with “battle fatigue.” Over the course of the war, the various military branches granted more than 500,000 discharges for psychiatric reasons. At one time during the North African phase of the war, American soldiers were being evacuated for battle fatigue faster than they could be replaced.

The military response to this mental health crisis was a divided one. On the one hand, by the end of World War II the army had begun to dispatch psychiatrists to the battle arena to deal with mental health issues before they became disabling. On the other hand, many in the military publicly expressed their views that these psychological problems were nothing more than cowardice. The most famous example of this came when General George S. Patton visited an army hospital and encountered a soldier with shell shock. Upon hearing that the soldier had a nervous condition, Patton called him a “yellow coward,” began slapping him, and threatened to shoot the patient if he did not return to the front lines.

Despite the widespread occurrence of battle fatigue, the psychiatric community was slow to respond to the emergence of this mental health crisis. The first edition of the American Psychiatric Association’s (“APA”) Diagnostic and Statistical Manual of Mental Disorders (“DSM-I”), published in 1952, did not recognize post-traumatic stress disorder or its many precursors as a psychiatric condition. Instead, the DSM-I lumped combat stress into its description of gross stress reactions. The second edition of this manual (“DSM-II”) was published in 1968, in the midst of the Vietnam War.
War. The DSM-II took a step forward and removed combat stress from the category of gross stress reactions. But instead of recognizing it as a mental disorder, the DSM-II placed combat stress under the general heading “adjustment reactions of adult life.”

At the same time that the DSM-II was being finalized, however, the Vietnam War was escalating. While the combat stresses of World War I and World War II had resulted in a number of psychiatric casualties, the unique characteristics of the Vietnam War increased the proportion of soldiers with severe psychological reactions to unprecedented levels. Unlike prior wars, the soldiers in Vietnam functioned primarily as individuals, and not as part of a cohesive unit. This loss of unit cohesiveness (and an associated decrease of belief in the wisdom of their commanding officers) left soldiers more vulnerable to the psychological trauma experienced during this war.

Additionally, during the Vietnam War, there were no front and rear lines; the combat zone came to surround the soldiers virtually anywhere they were and at all times. Furthermore, because combatants are not clearly identified in this type of warfare, soldiers found it difficult to know who was a friend and who was an enemy. As a result, many soldiers assumed a hyper-vigilant or “survivor mode” state of mind where they attempted to be constantly aware of their surrounding environment in order to anticipate and react to potential attacks and threats.

By the time that the third edition of the Diagnostic and Statistical Manual (“DSM-III”) was published in 1980, the specter of post-traumatic stress disorder loomed too large to ignore. By the early 1980s, between thirty and seventy percent of Vietnam veterans were exhibiting psychological symptoms as a result of combat trauma. As a result, veterans’ groups put a tremendous amount of pressure on the APA to recognize combat fatigue as a legitimate psychological ailment.

This pressure corresponded with increased attention being paid to the plight of Vietnam veterans in both popular culture and the media. Films like Apocalypse Now, The Deer Hunter, and Coming Home portrayed stress reactions in soldiers and the inability of Vietnam veterans to readjust to life as a civilian after experiencing the horrors of war. The criminal actions of Vietnam vets with PTSD were also being increasingly reported. For example, in 1978, John Coughlin, a Vietnam veteran who had been awarded a Bronze Star and two Purple Hearts began firing a shotgun at a police station in Quincy, Massachusetts, screaming “The gooks are everywhere, the gooks are here! Kill them! Kill them!”


See Samuel P. Menefee, The “Vietnam Syndrome” Defense: A “G.I. Bill of Criminal Rights”?, The Army Lawyer, Feb. 1985, at 1. Court officials were convinced not to pursue prosecution after a psychiatrist provided a diagnosis of “traumatic war neurosis.” Coughlin was sent to Bridgewater State Hospital for observation, and subsequently received treatment.

26 Davidson, supra note 17, at 419.
27 Id. at 420.
28 See Horowitz & Solomon, supra note 1, at 9.
29 For instance, while it is uncertain whether a reaction to a traumatic experience, such as exposure to combat, 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. DAVID KINCHIN, A GUIDE TO PSYCHOLOGICAL DEBRIEFING: MANAGING EMOTIONAL DECOMPRESSION AND POST-TRAUMATIC STRESS DISORDER 11-13 (2007).
As a result of these developments and the efforts of war veteran movements, the DSM-III officially recognized PTSD as a distinct psychological disorder for the first time.\textsuperscript{33} Despite the original emphasis on combat experiences, since PTSD has been recognized as a specific disorder there have been substantial discussions regarding the applicability of PTSD to various other groups of individuals, such as rape victims, abused children, and inner-city youth.\textsuperscript{34} These discussions have cast more light on the disorder and may assist in stimulating increased acceptance of PTSD. Since the publication of the DSM-III, the validity of PTSD as a psychological disorder has not been seriously challenged, and the fourth edition of the \textit{Diagnostic and Statistical Manual} ("DSM-IV"), both as initially published and as revised, left the DSM-III’s description of PTSD almost untouched.\textsuperscript{35} PTSD remains a recognized psychiatric disorder under current APA diagnostic criteria.

\section*{B. Diagnosis}

In 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 and symptoms from each of the following symptom clusters: intrusive recollections, avoidant/numbing symptoms, and hyper-arousal symptoms.\textsuperscript{36} The diagnosis also depends on the duration of the symptoms and their impact on the individual’s daily functioning.\textsuperscript{37}

The first integral requirement for any PTSD diagnosis is the occurrence of a psychologically traumatic event that triggers the condition.\textsuperscript{38} To qualify as a triggering event under the DSM-IV, the event must be “beyond the range of usual human experience.”\textsuperscript{39} The hallmark of this requisite triggering event is that it “would generate symptoms of distress in virtually anyone exposed to it.”\textsuperscript{40} These triggering events can include, but are not limited to, combat situations.\textsuperscript{41} Traumatic events such as rape, abuse, assault, and car crashes can also qualify as triggering events under the DSM-IV-TR.\textsuperscript{42} However, a psychologically traumatic event is not by itself a sufficient basis for a PTSD diagnosis. The second prerequisite to a diagnosis is that the individual persistently recall that traumatic event long after it has ended.\textsuperscript{43} This recall can manifest itself in a number of different ways. Perhaps the most common means by which trauma is re-experienced among individuals with PTSD is through nightmares or other recurrent distressing dreams of the event.\textsuperscript{44} However, individuals with PTSD may suffer from a more intrusive form of recall following the

\textsuperscript{33} See Davidson, \textit{supra} note 17, at 421; Dohrenwend et al., \textit{supra} note 31.
\textsuperscript{35} \textsc{American Psychiatric Association, Diagnostic and Statistical Manual of Mental Disorders} 469 (4th ed. 2000).
\textsuperscript{36} \textsc{American Psychiatric Association, Diagnostic and Statistical Manual of Mental Disorders: DSM-IV-TR 463-68 (4th ed., text revision, 2000)} [hereinafter DSM-IV-TR].
\textsuperscript{37} Id.
\textsuperscript{38} Id.
\textsuperscript{39} Id.
\textsuperscript{40} Id. See Davidson, \textit{supra} note 17, at 421.
\textsuperscript{41} DSM-IV-TR, \textit{supra} note 36, at 463-68.
\textsuperscript{42} Id. at 469.
\textsuperscript{43} Id.
\textsuperscript{44} Id.
occurrence of internal or external stimuli that remind them of their traumatic experience, which causes them to experience various related psychological symptoms. For some individuals these stimuli can cause a dissociative episode in which they feel or behave as if the traumatic event were in fact recurring.

These occurrences have an effect on the chemistry of the brain. The significance of a psychologically traumatic event is that it creates a stress response in the individual experiencing it. Each person’s brain has certain predetermined biological responses to stress. When an ordinary individual comes in contact with a stressor, it triggers a “chain reaction of hormone activity” that eventually reaches the adrenal gland—a gland that secretes hormones and helps regulate the body’s stress response. The gland produces two classes of hormones, adrenaline and glucocorticoids, which act quickly on the organs to increase heartbeat, alertness, and muscle function. In ordinary individuals, these chemicals are only triggered when the brain perceives a significant threat or traumatic event. However, one of the hallmarks of PTSD is that the sufferer continues to reexperience the traumatic event long after it is over. Because the PTSD sufferer is continually reminded of the initial stressor, the entire hormonal process is repeated within his body every time the person reexperiences the trauma. Over time, while the adrenaline produced as a result of these stress responses dissipates, the glucocorticoids begin to build up in the bloodstream, causing “feedback inhibition.” Essentially, the brain becomes more and more predisposed to the release of these chemicals during stressful events, leading to a feedback loop. Both glucocorticoids and adrenaline have harmful, deleterious effects upon the brain with continued exposure. Hence, individuals who suffer from PTSD experience a constant physiological reaction to stress that alters the chemical composition of the brain.

Over time, this repeated exposure to hormones associated with stress responses causes a number of definable and diagnosable symptoms. The authoritative list of these diagnostic criteria appears in the revised fourth edition of the Diagnostic and Statistical Manual of Mental Disorders (“DSM-IV-TR”) published by the APA. The DSM-IV-TR requires the manifestation of three separate sets of symptoms for a diagnosis of PTSD.

First, the individual must persistently reexperience the traumatic event in any one of a number of ways, as discussed above. Second, the individual must persistently avoid stimuli associated with the trauma. These avoidance behaviors can range from general to specific. Among the more general avoidance behaviors listed by the DSM-IV are a generally diminished interest in significant activities, a feeling of detachment from others, and a restricted range of feelings. The individual may also perform avoidance behavior specific to the initial trauma. For example, the PTSD sufferer may make a conscious effort to avoid thoughts, places, activities, and people that cause him to remember the initial trauma. This distinction could determine how an individual copes with...
his or her diagnosis and what activities he or she is able to confront.

Third, the disorder must manifest itself in persistent symptoms of increased arousal. These arousal symptoms include difficulty falling asleep, increased irritability and anger, difficulty concentrating, hypervigilance, and an exaggerated response when startled. Assuming that all three categories of symptoms are present, and assuming that the symptoms persist for a period longer than a month, a diagnosis of PTSD is warranted.

In order to examine the impact of PTSD in the war veteran population, it is important to understand how prevalent PTSD is in America. Currently there are about 7.7 million American adults affected by PTSD. Such individuals have experienced PTSD symptoms following such traumatic events as natural disasters and violent accidents. The APA has determined that 8% of the American population that suffers from PTSD (over 600,000 Americans) will experience its effects throughout their lifespan.

III. The Relationship Between PTSD and Criminal Behavior

While PTSD can be diagnosed through observation of physiological and psychological symptoms, it is important to remember that not all PTSD sufferers present these symptoms in the same way. Two PTSD sufferers may exhibit completely different sets of physiological symptoms and avoidance behaviors and still have the same disorder, so long as those symptoms and behaviors are among those catalogued in the DSM-IV. Reactions may be influenced by the actual traumatic event or an individual’s support system or other coping strategies.

In 1983, John P. Wilson and Sheldon D. Zigelbaum identified no fewer than nine different paradigm reactions among Vietnam veterans with PTSD. These typologies run the gamut from the isolation and withdrawal syndrome, in which the sufferer withdraws from society and avoids human contact, to the protosocial-humanitarian syndrome, in which the sufferer transforms his guilt into altruism toward himself and others. A full description of the various typologies is beyond the scope of this Article. However, Wilson and Zigelbaum identified three typologies that closely correspond to criminal behavior in PTSD sufferers: dissociative reaction, sensation-seeking syndrome, and depression-suicidal syndrome.

A. Dissociative Reaction

Perhaps the most well-publicized symptom of PTSD for those who have been in combat situations occurs when the sufferer lapses into what is known as a dissociative state. Individuals experiencing a dissociative state believe they are in another setting or environment and grossly misconstrue what is occurring. Such individuals are not cognizant of the character of their actions or the need for them, and thus they are not capable of knowing their nature, quality, or wrongfulness. A dissociative reaction is typically triggered by environmental stimuli that mimic the environment in which the original stressors were experienced by the sufferer. Once the sufferer encounters the stimuli, the person enters into what some call

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59 Id.
60 Id.
62 Id.
63 DSM-IV-TR, supra note 36, at 463-68.
“survivor mode.” In this state, he or she will experience typical physiological symptoms of PTSD such as hyperalertness, hypervigilance, and excessive autonomic nervous system arousal. In addition, a PTSD sufferer in such a situation will revert back to the use of conditioned skills and basic cognitive function learned before the stressful event that triggered the disorder. This individual will also perceive situations in a similar way to his or her perceptions at the time that the psychological trauma that triggered the condition occurred. Such an individual is often described as “going on automatic.”

In a civilian, this “automatic” state may present as nothing more than a zombie-like numbness. But in a combat veteran, reverting to an automatic state carries far greater dangers. A soldier will ordinarily receive countless hours of ritualized training on the operation of a firearm, hand-to-hand combat, and the use of stealth as part of his or her military training. When put into a dissociative state, this veteran may lapse into a search-and-destroy mentality in which his or her automatic reaction is to find and kill any perceived source of danger.

For example, State v. Heads involved a former Marine who had participated in over thirty long-range reconnaissance missions in Vietnam. After his discharge, this Marine used the same tactics that he had utilized on those patrols—stealth and ambush—to fatally shoot his brother-in-law. The defendant testified that he looked across a foggy field, and then immediately perceived himself as being back in Vietnam. After the flashback, Heads had only limited recollection of what followed. In this case, the defendant was convicted of murder at his first trial, but was granted a new trial after a series of appeals.

Similarly, People v. Wood illustrates another example of a veteran reverting to past combative situations in a dissociative, yet criminal manner. Mr. Wood, a Vietnam veteran employed in a factory, faced charges of attempted murder after shooting the factory foreman following an argument. At trial, Wood’s PTSD diagnosis, as well as the history of his Vietnam combat activities, was introduced into evidence. In addition, the defense introduced testimony and audiotape recordings to show the likeness between factory noises and the noises heard by Wood while deployed in Vietnam. Arguing that he reacted to an auditory perception that he was back in Vietnam, Wood received a verdict of not guilty by reason of insanity.

B. Sensation-Seeking Syndrome

Another way in which PTSD can manifest itself in criminal behavior is through the sensation-seeking syndrome. Veterans with this typology of the disorder often seek out activities that offer a level of danger similar to their combat experiences in an effort to maintain control over their surroundings. In such instances, war veterans with PTSD tend

70 See Gover, supra note 7, at 126; Wilson & Zigelbaum, supra note 4, at 72-73.
71 Wilson & Zigelbaum, supra note 4, at 72-73.
72 Id.
73 Id.
76 See Davidson, supra note 17, at 425 (discussing Heads).
77 Id.
78 Id.
80 People v. Wood, No. 80-7410 (Cir. Ct. of Cook Co., Ill., May 5, 1982).
82 Id.
83 Id.
84 Id.
85 See Wilson & Zigelbaum, supra note 4, at 74.
to find civilian life unstimulating and may seek out dangerous and sensational activities or events as part of a compulsive desire for re-exposure to trauma.\textsuperscript{87} These activities may be legal ones, such as skydiving, gambling, or flying, or they may be illegal, such as dealing in or smuggling illegal drugs.\textsuperscript{88} The sensation-seeking behavior is undertaken by the PTSD sufferer for two primary reasons. First, the activities generate an optimal level of arousal intended to make the actor feel more alive.\textsuperscript{89} Second, the sensation-seeking activity recreates the psychological elements faced by the veteran in combat, thus enabling the actor to achieve mastery over the unconscious trauma experienced during the war.\textsuperscript{90} By compulsively repeating life-or-death encounters similar to those faced in combat, the actor can reaffirm that he or she is still alive.\textsuperscript{91}

One of the most prominent uses of this syndrome in criminal law was the trial of Michael Tindall.\textsuperscript{92} Tindall was brought up on charges of smuggling illegal drugs from Morocco to Massachusetts aboard a boat.\textsuperscript{93} At trial, Tindall asserted a defense of PTSD, arguing that the horrors of Vietnam had left him dependent on stressful situations to cope with his PTSD. Tindall, who had been a helicopter pilot while in Vietnam, viewed the smuggling trip as “just another combat mission.”\textsuperscript{94} His psychiatrist testified that “he was recreating the same situation he was able to cope with and master in Vietnam. He needed it to feel alive. The excitement, the thrill, the risk . . . paralleled his experience in Vietnam.”\textsuperscript{95} These psychological manifestations allow defense attorneys to employ related strategies to defend their war veteran clients’ actions and potentially mitigate their culpability.

Additionally, more recent cases address PTSD-afflicted veterans who—following their return from tours in Iraq and Afghanistan—committed complex bribery, drug, and theft offenses. For example, John Brownfield, who once served as a U.S. Air Force firefighter in both Afghanistan and Iraq, pleaded guilty to accepting bribes in a public capacity for selling illegal contraband to federal prison inmates while employed as a corrections officer.\textsuperscript{96} Former Army Sergeant Patrick Lett, after serving for seventeen years and completing two tours of duty in Iraq, returned a decorated veteran,\textsuperscript{97} yet pleaded guilty to selling narcotics in 2004.\textsuperscript{98} And Timothy Oldani, a member of the U.S. Marine Corps reserves, pleaded guilty to conspiracy to steal military optics from the Marines and illegally export them from the United States via eBay sales.\textsuperscript{99}

Along with Tindall, these cases illustrate a few key differences between PTSD sufferers displaying the sensation-seeking typology and those suffering from dissociative reactions. First, the criminal acts undertaken by sensation-seeking actors are typically non-violent in nature. In contrast, crimes committed by those in dissociative states are usually violent as a result of the actor reverting back to his or her combat training. Second, an individual displaying the sensation-seeking typology is capable of

\textsuperscript{87} Stephen Joseph et al., \textit{Impulsivity and Posttraumatic Stress}, 22 \textit{PERSONALITY & INDIVIDUAL DIFFERENCES} 279, 279 (1997).
\textsuperscript{88} Id.
\textsuperscript{89} Id.
\textsuperscript{90} Id.
\textsuperscript{91} Id.
\textsuperscript{93} See Menefee, supra note 32, at 21 (discussing Tindall).
\textsuperscript{94} Id.
\textsuperscript{95} Id.
\textsuperscript{98} Efrati, supra note 96.
substantial premeditation. The mechanics of a drug smuggling operation are myriad and challenging, and require a substantial amount of thinking and planning. In contrast, an individual acting within a dissociative state is typically experiencing things “in the moment,” and is unable to formulate complex plans or schemes.

C. Depression-Suicide Syndrome

A third typology relevant to criminal behavior is the depression-suicide syndrome. Sufferers of this syndrome are typically wracked with survivor guilt, hopelessness, despondency, and a deep depression. PTSD sufferers with this typology often feel that they should have died in combat, and experience a deep sense of helplessness at the hands of fate or the government that deployed them. If the actor is subject to stresses in his day-to-day life that are beyond his control, he will typically experience suicidal urges. These urges may be translated into criminal behavior when the actor begins to subconsciously act out his anger through criminal acts. These acts may be undertaken with the subconscious aim of being shot by law enforcement officers (commonly referred to as “suicide by cop”).

State v. Gregory offers a potential example of such behavior. Gregory, a Vietnam veteran, entered a bank wearing military decorations and carrying two M-16 automatic rifles. He took the adult males in the bank hostage, firing 250 rounds of ammunition into the air for five hours. Gregory was apprehended by law enforcement personnel without anyone being harmed. Though Gregory was initially convicted of eight counts of kidnapping and assault, the conviction was overturned on appeal. Among the evidence was testimony that Gregory’s actions were an attempt at “passive suicide” because he felt guilty for surviving an ambush in Vietnam.

No matter the manner in which these veterans attempt to take their own lives, army suicides—considered a significant indicator of pervasive PTSD problems—have more than doubled since 2001, reaching a twenty-seven-year high in 2007.

IV. Strategies Available to Criminal Defendants with PTSD

A. Not Guilty by Reason of Insanity

The most common defense argued by defendants with PTSD is not guilty by reason of insanity. Though, as discussed below, there are several variations of the legal test for insanity, the crux of such a defense is that the actor should not be held criminally responsible for his or her actions because of a mental disorder. The likelihood of success of such a defense will vary greatly depending on the

100 Wilson & Zigelbaum, supra note 4, at 74-75.
101 Id. at 75.
102 Id.
103 Id.
104 Id.
105 Id.
107 See Criminal Behavior and PTSD, supra note 82.
108 Id.
109 Id. Additionally, there was testimony from a psychiatrist “that the defendant’s behavior in the bank was an attempt to recreate an ambush situation.” This behavior may also fall within the sensation seeking syndrome discussed earlier.
110 See Marilyn Elias, Post-traumatic Stress Is a War Within for Military and Civilians, 1 USA TODAY, Oct. 27, 2008, http://www.usatoday.com/news/health/2008-10-26-PTSD-main_N.htm (reporting that one out of seven service members deployed in Iraq or Afghanistan have returned with symptoms of post-traumatic stress disorder based on an April 2008 study, with a significant recent increase in the number of veterans seeking related treatment). See also Erica Goode, After Combat, Victims of an Inner War, N.Y. TIMES, Aug. 2, 2009, http://www.nytimes.com/2009/08/02/us/02suicide.html (noting that “from January and mid-July [2009], 129 suicides were confirmed or suspected, more than the number of American soldiers who died in combat during the same period).
strictness of the test and the nature of the defendant’s presentation of his or mental disorder.

Currently, about half of the states in America utilize the M’Naghten Test to assess the sanity of a defendant, although other insanity test formulations do exist. For example, under the “Product Test,” no one shall be held criminally accountable for an act that was the “offspring and product of mental disease.” Alternatively, under the American Law Institute (ALI) “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 of the nature of his or her act and that such an act was wrong. The “Control Test” is also called the “Irresistible Impulse Test” in some jurisdictions.

1. The M’Naghten Test

The M’Naghten test takes its name from the famous English case of the same name. That case involved the trial of Daniel M’Naghten, who attempted to murder the Prime Minister but mistakenly shot his secretary instead. To the dismay of many in England, M’Naghten was acquitted under an insanity defense. In response, the House of Lords was asked to articulate the controlling rule for the insanity test. This test requires that:

[T]o establish a defense on the ground of insanity, it must be clearly proved that, at the time of committing the act, the party accused was laboring 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.

The fundamental question under the M’Naghten test was whether at the time of the offense the defendant was capable of distinguishing right from wrong. This test is widely employed in the United States today.

This test, strict though it is, does provide some prospect for relief for those PTSD sufferers who commit crimes while in a dissociative state. The defining characteristic of the dissociative state is that the actor is reexperiencing the traumatic event or events that triggered his or her PTSD. For a soldier who received his or her trauma in combat, that reexperience will likely manifest itself as wartime combat. Usually, a veteran in a dissociative state will perceive himself as being back in wartime, and any persons around him will be perceived as enemy combatants. Because the veteran has been conditioned to kill enemy soldiers in a combat situation, he or she will think that committing a violent act is the “right” thing to do. Thus, assuming that the defendant is in a true dissociative state, he or she should be able to satisfy the M’Naghten test.

Multiple defendants have been able to successfully assert an insanity defense in a M’Naghten jurisdiction in just the situation described above. For example, the defendant in State v. Heads was able to successfully plead insanity after shooting his brother-in-law while in a dissociative state, even though he was in a M’Naghten jurisdiction. Similarly, the defendant in New Jersey v. Cocuzza assaulted with a piece of wood several police officers who were following him. He presented evidence that he thought the police

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113 RICHARD J. BONNIE, ANNE M. COUGHLIN, JOHN C. JEFFRIES, JR., & PETER W. LOW, CRIMINAL LAW 533 (2d ed. 2004).
114 Id.
115 Id. It should be noted that the ALI test contains both knowledge and control prongs, with either potentially serving as the basis for a successful insanity defense.
116 Id.
117 Gover, supra note 7, at 570 (discussing M’Naghten’s Case, (1843) 8 Eng. Rep. 718 (H.L.)).
118 Id. at 570-71.
119 Id. at 571.
120 Wilson & Zigelbaum, supra note 4, at 73.
121 Id.
122 See Davidson, supra note 17, at 425.
officers were enemy soldiers, and this evidence was corroborated by the fact that he was holding the piece of wood like a rifle.124 He was found not guilty under the M’Naghten test.125

PTSD sufferers with sensation-seeking syndrome or depression-suicide syndrome, on the other hand, do not fare so well under this system. Because the criteria for insanity are the inability to know the nature and quality of the act or the inability to distinguish right from wrong, virtually anyone committing a crime as a result of one of these two syndromes will be prevented from asserting an insanity defense in a jurisdiction with the M’Naghten test.

The reason for this is self-evident. Though a sensation-seeking PTSD sufferer may be compelled to commit a certain crime, this compulsion does not remove the knowledge of the nature of the act or that the crime is wrong.126 Indeed, many people with sensation-seeking syndrome choose to fulfill their need for danger through legal outlets like skydiving for this very reason.127 Similarly, though a veteran with depression-suicide syndrome may be driven to commit armed robbery by a subconscious desire to act out against the government, this does not change the fact that the defendant knows that a bank robbery is occurring and robbing banks is against the law.128 Indeed, the defendant’s knowledge of the wrongfulness of the act is often the motivating factor behind the crime, since the defendant’s intent is not to profit but rather to get arrested or killed for breaking the law.129

In a M’Naghten test jurisdiction, therefore, only those PTSD sufferers who commit crimes while in dissociative states are likely to gain acquittal through an insanity defense.

2. The ALI Test

While a majority of jurisdictions use the M’Naghten test for insanity, a substantial minority use the test put forth by the ALI in the Model Penal Code. This test incorporates both the M’Naghten rightfulness/wrongfulness distinction and an additional volitional component. Under this test, “[a] person is not responsible for criminal conduct if at the time of such 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 law.”130

The ALI test provides two opportunities for a PTSD defendant to assert a plea of not guilty by reason of insanity. The first section of the test dealing with the defendant’s ability to appreciate the criminality of his or her conduct is merely a codification of the M’Naghten rule, and is resolved as discussed above. However, the ALI test also involves a volitional component—where the defendant may assert a plea of not guilty by showing that he or she lacked substantial capacity to conform his or her conduct to the requirements of the law. Under this test, a defendant who understands the criminality of his conduct may still be able to prevail in an insanity defense if the defendant can show that he or she was unable to control his actions as a result of PTSD.

For PTSD sufferers whose crimes occurred during a dissociative reaction, this second prong may be slightly preferable to the narrower M’Naghten rule, simply because it provides a jury with an alternative way to find the defendant insane. The real difference, however, is for PTSD defendants who suffer from either sensation-seeking syndrome or depression-suicide syndrome. Under the M’Naghten test, these defendants could be essentially barred from even asserting an insanity defense, as no reasonable jury could find that they were unaware of the

124 Id.
125 Id.
126 Wilson & Zigelbaum, supra note 4, at 74.
127 Id.
128 Id.
129 Id. at 75.
130 MODEL PENAL CODE § 4.01 (1962) (emphasis added).
wrongfulness of their actions. The volitional prong of the ALI test provides defendants a way to get their evidence past the “velvet rope”—the burden of production requirement that requires a judge to disallow the defense if there is insufficient evidence supporting it—and in front of a jury, who can then weigh the evidence for themselves. If the evidence of insanity under such a syndrome is particularly strong, a jury may even acquit under such a theory.

Thus, for example, the drug-smuggling defendant in *Tindall* was able to present evidence of his sensation-seeking syndrome to the jury under the ALI test, and was subsequently acquitted of drug smuggling charges.\(^{131}\) While a plea of not guilty by reason of insanity may be a tough case to make for sufferers of sensation-seeking syndrome or depression-suicide syndrome, it at least gives those with serious afflictions the opportunity to make their argument to a jury.

**B. Unconsciousness**

Virtually all jurisdictions recognize unconsciousness, sometimes called “automatism,” as a defense to criminal conduct.\(^ {132}\) This defense is based upon the criminal law’s requirement of *actus reus*—that the crime involved a voluntary act.\(^ {133}\) An individual who commits a crime when unconscious cannot be said to have voluntarily committed the act, and thus he or she cannot be found guilty.\(^ {134}\) Unlike an insanity defense, a successful unconsciousness defense results in a full acquittal for a criminal defendant (without the hospitalization that is typically required at least initially for the insanity acquittee).\(^ {135}\) While not technically an insanity defense, the unconsciousness defense bears mentioning in a discussion of PTSD because a dissociative state may be construed as unconsciousness, depending on the facts of the case.

The ALI states that a defendant is not guilty unless “his liability is based on conduct that includes a voluntary act or the omission to perform an act of which he is physically capable.”\(^ {136}\) Examples of involuntary acts include reflexes, convulsions, movements during sleep, conduct under hypnosis, and “a bodily movement that otherwise is not a product of the effort or determination of the actor, either conscious or habitual.”\(^ {137}\)

While this defense will be of no use to defendants presenting with sensation-seeking syndrome or depression-suicide syndrome, it is at least theoretically applicable to PTSD defendants who commit crimes while under the influence of a dissociative reaction. Because those individuals are said to be “on automatic,” and to have reverted back to their conditioned training, an argument can be made that they are acting unconsciously within the meaning of the defense.

However, as a general matter, the unconsciousness defense is seldom used by criminal defendants, and PTSD sufferers are no different.\(^ {138}\) One can understand why by looking at the type of proof necessary for the assertion of this defense, especially relative to the type of proof necessary for the insanity defense. Practically, in order to persuade a jury, the defendant will have to provide some plausible reason for his or her unconsciousness. In the examples listed above, for example, a defendant may have to introduce evidence that he or she is a sleepwalker, or that he or she was placed under hypnotic suggestion shortly before the crime was committed.

In the case of a PTSD sufferer, the source of the unconsciousness is the disorder itself, so, just as in other insanity tests, the defendant will have to introduce evidence of a

\(^{131}\) *Menefee*, *supra* note 32, at 21.

\(^{132}\) *Gover*, *supra* note 7, at 578.

\(^{133}\) *Id.*

\(^{134}\) *Id.*

\(^{135}\) *Id.*

\(^{136}\) MODEL PENAL CODE § 2.01 (1962).

\(^{137}\) *Id.*

\(^{138}\) *Gover*, *supra* note 7, at 578.
prerequisite mental disorder. Additionally, it is difficult to conceptualize an individual who is both unconscious and who simultaneously appreciated the wrongfulness of his or her conduct. A defendant’s unconsciousness necessarily means that he or she is incapable of understanding that his or her actions are wrong—indeed, the unconscious defendant is often not capable of understanding his or her actions at all.

So, as a practical matter, assertion of an unconsciousness defense requires proof of everything required for an insanity defense, plus the additional burden of proving true automatism. This additional burden may prove significant. It would be plausible for a juror to believe that the defendant did not appreciate the wrongfulness of his or her actions—for example, because he or she thought he or she was rightfully killing an enemy soldier—while still believing that the defendant retained sufficient control over his or her bodily movements to negate a defense of automatism. While there may be strategic reasons to assert unconsciousness rather than insanity—for one, as noted, a defendant acquitted under the former defense will not have to be committed to a psychiatric facility—these advantages are usually outweighed by the additional burden placed on the defendant: it is limited to those who experience dissociative states as a PTSD symptom and it is, with the exception of a few cases, rarely successful. Consequently, the unconsciousness defense will likely remain a little-used part of the PTSD defendant’s toolbox.

C. Persuading a Jury

The greatest obstacle facing most PTSD defendants is not their ability to convince judges to permit them to mount a defense, but their ability to convince jurors to accept that defense. Unfortunately, PTSD presents a unique problem for the criminal defendant, namely, that the best evidence of PTSD usually comes from the afflicted individual’s description and recollection of his or her experiences. In the context of a criminal prosecution, where the defendant has an incentive to fabricate or exaggerate the symptoms of PTSD, this can lead jurors to be skeptical of such a diagnosis. Additionally, mental health professionals’ and attorneys’ ignorance of the complexities of PTSD may add to juror confusion.

Most jurors’ concerns about an insanity defense based on PTSD can be separated into three categories: (1) concern about the validity of PTSD as a psychiatric condition, (2) concern about malingering, and (3) concern about causation. Each of these concerns will be examined below, as well as potential ways to assuage them.

1. Concerns about Validity

Some jurors are likely to express skepticism at a claim of PTSD, no matter how much evidence there is, based on a fundamental mistrust of the diagnosis as a whole. These jurors’ concerns often echo those of General Patton: these jurors may believe that PTSD sufferers merely suffer from cowardice, or are trying to blame their problems on a non-existent condition.

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139 Id.
140 Id.
142 Gover, supra note 7, at 578.
143 See Martha Deller, Veteran’s Lawyers Seek to Use Post-Traumatic Stress Disorder as a Defense in Capital Murder Trial, THE FORT WORTH STAR-TELEGRAM, Apr. 21, 2010, http://www.star-telegram.com/2010/04/21/2133255/veterans-lawyers-seek-to-use-post.html (describing the difficulties of pleading a PTSD defense for veteran criminals). According to Shad Meshad, founder of the National Veteran’s Foundation, PTSD as a criminal defense is “starting to get attention.” Id. Meshad voiced concerns that when defense attorneys fail to understand the subtle nuances of a PTSD defense “they get eaten alive by prosecutors.” Id.
For instance, in *State v. Sturgeon*, a man was charged with murder after shooting four people in what he claimed was a flashback. During closing argument, the prosecutor openly ridiculed the defendant’s alleged disorder, telling the jury “Ladies and gentlemen, we’ve got the Rambo defense going here. He assumed the ‘tactical defense position’—give me a break!” The jury evidently believed that, despite his claims, the defendant should be held responsible for his actions and ultimately convicted the defendant of murder.

While this skepticism was undoubtedly a problem in the 1970s and early 1980s when most of the criminal cases involving the Vietnam Defense took place, it is less likely to be a problem today. For one thing, PTSD has now been recognized as a mental disorder by the APA for thirty years. While jurors may have been willing to dismiss the diagnosis of PTSD as a fad or novelty three decades ago, they are more likely to accept it as common practice now. Furthermore, the national discourse on PTSD came to the fore frequently after the September 11 terrorist attacks. The extensive media coverage of the attacks, and of the survivors’ reactions to those attacks, has had a “galvanizing effect” that has made PTSD a household word. This increased familiarity is likely to make jurors more sympathetic to a defendant claiming PTSD than they formerly would have been, and more likely to accept PTSD as a valid psychiatric condition. This growing awareness may ultimately translate into society being more willing to take a PTSD diagnosis into account when assessing criminal responsibility and punishment.

### 2. Concerns about Malingering

A more pressing problem with convincing jurors may be their concerns over malingering. Unfortunately, this is a problem endemic to the nature of PTSD. Because the most psychologically valuable evidence for diagnosis comes from interviews with the defendant, there will always be an incentive for a defendant to lie about the disease to escape punishment. Many observers have noted the relative ease with which a defendant can fake PTSD.

This skepticism may be warranted in some cases. For example, in *People v. Lockett*, a defendant asserted a PTSD-based insanity defense after being charged with eighteen counts of robbery. The defendant in this case, Samuel Lockett, claimed that he had been exposed to psychological trauma while serving in the Air Force during the Vietnam War. Lockett was examined by three separate psychiatrists, and he vividly recounted to each of them his experiences of “ongoing stress, being under fire, witnessing fellow soldiers being impaled or blown apart by land mines, having to carry parts of bodies to record a body count.” Based on these descriptions and Lockett’s agitated demeanor during the interviews, all three psychiatrists found he was unable to appreciate the wrongfulness of his conduct due to PTSD. When the prosecutors examined Lockett’s military records, however, they discovered that he had never actually served in Vietnam; he was stationed as an accountant at Randolph Air Force Base in Texas for the

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145 Id.
146 Id.
148 Id.
150 See Gover, * supra* note 7, at 582; Slovenko, * supra* note 147, at 421.
152 Id. at 804.
153 Id. at 804-05.
duration of the war. The court set aside his insanity defense because it was obtained through fraud, and Lockett was subsequently convicted.

Former Oregon Army National Guard soldier Jessie Bratcher's 2009 criminal trial provides an example of how the prosecution may try to undermine a veteran's PTSD defense to a jury. Oregon charged Bratcher with the brutal shooting murder of Jose Ceda Medina after Bratcher suspected that Medina was the father of his fiancée's child. However, Bratcher also suffered from PTSD after a military tour in Iraq, where he survived a Humvee crash and watched a close friend die. Veterans' Administration evaluations ultimately found Bratcher 100 percent disabled by PTSD. However, the prosecution sought to undermine this diagnosis by highlighting factual discrepancies in Bratcher's psychological records: Bratcher's poor performance on memory tests, allegations that he exaggerated facts, Bratcher's reporting every symptom of traumatic brain injury, and Bratcher's description of flashbacks that never occurred were all presented by the prosecution. One juror's concern "was that PTSD would be used as an excuse for murder."

Despite the prosecution's efforts to disprove Bratcher's PTSD to a jury, the defense presented a forensic psychologist to testify that Bratcher's military training led him to respond automatically to anticipated threats and "overkill them." Additionally, jurors heard related testimony from a platoon sergeant, as well as a state hospital expert. Although the jurors ultimately found Bratcher guilty, they also found he committed the crime while insane due to PTSD.

The Lockett and Bratcher cases are useful reminders that no matter how detailed a defendant's description of his experiences in combat may be, without sufficient corroboration, such a description may be considered suspect by a jury. Thus, the best strategy for a defendant attempting to use PTSD as a defense is to present extrinsic evidence of both the trauma that triggered the condition and the after effects. If the defendant is able to call members of his or her military company to testify to the horrors that they observed simultaneously with the defendant, it may go a long way toward curing the fears of jurors that the defendant is merely faking. Similarly, if the defendant can produce unbiased witnesses to testify to a change in personality after returning from combat, the defendant is far more likely to persuade a jury that he or she really has PTSD. Ideally, the defendant would be able to provide such evidence both for a period long before the crime was committed (when he or she would have had little incentive to fake PTSD) and for a period shortly before the crime was committed (to demonstrate that the defendant was still suffering from the condition at the time of the offense).

3. Concerns about Causation

In the end, it is not sufficient to merely prove that the defendant has PTSD and committed a crime. If this were true, then a diagnosis of

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\text{id. at 806-07.}
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\text{id.}
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\text{id. Bratcher was initially denied benefits as his PTSD symptoms were deemed “too mild.” id.}
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\text{id. Specifically, the District Attorney alleged that Bratcher had never fired a weapon in Iraqi combat, had never been shot at on his first patrol, and the only body he viewed in Iraq was that of his friend. id.}
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\text{id. Such a finding allowed hospital treatment in lieu of jail time. id.}
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PTSD would essentially function as a “get out of jail free card,” allowing any sufferer to commit crimes with impunity. To make out a valid defense, the defendant must demonstrate a causal link between the two.\textsuperscript{164} In the final analysis, this causal link will almost always be the most difficult element to establish.\textsuperscript{165}

For example, failure to establish a causal link was the defendant’s Achilles’ heel in \textit{State v. Simonson}.\textsuperscript{166} In that case, the defendant, Clifford Simonson, was tried and convicted of murdering two of his supervisors at his place of employment.\textsuperscript{167} Simonson did not dispute that he had killed the victims. Instead, he argued that he had developed PTSD while stationed in Vietnam years earlier, and the disorder rendered him legally insane at the time of the shooting.\textsuperscript{168} During his case in chief, Simonson called numerous co-workers and family members who testified to his erratic behavior after returning from Vietnam.\textsuperscript{169} These character witnesses uniformly testified that the defendant could not have been in his right mind when he shot the victims.\textsuperscript{170} Simonson also called two psychologists who worked primarily with Vietnam veterans, both of whom testified that he suffered from PTSD.\textsuperscript{171}

However, on rebuttal the State called several of Simonson’s co-workers, who testified that Simonson had bragged that “he could shoot anyone he wanted because everyone would think he was crazy due to his being previously stationed in Vietnam.”\textsuperscript{172} Another co-worker testified that Simonson had told him he was going to kill one of his supervisors mere minutes before the crime was committed.\textsuperscript{173} Based on this testimony, the jury determined that the PTSD did not cause his criminal acts and convicted Simonson of murder.\textsuperscript{174}

\textit{Simonson} illustrates the fundamental difficulty of establishing a causal link between the PTSD diagnosis and the crime committed. The two psychologists who testified on Simonson’s behalf were probably right; Simonson probably did have PTSD as a result of his tour in Vietnam.\textsuperscript{175} But even though Simonson most likely had PTSD, and even though Simonson committed a violent crime, the State’s evidence clearly showed that Simonson did not commit his violent crime while suffering from a PTSD dissociative flashback. Ultimately, although a diagnosis of PTSD can be established through extrinsic evidence and witnesses’ descriptions, the causal link between the disorder and the crime can often only be demonstrated by the defendant’s own testimony.

\textit{State v. Felde} provides another excellent example of the difficulties of establishing a causal link between PTSD and a violent crime. In this case, the defendant, Wayne Felde, was a Vietnam veteran who had recently escaped from prison, when he was arrested for public intoxication by a police officer.\textsuperscript{176} While being driven to the police station, Felde pulled a concealed firearm and

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\bibitem{165} This causation can be difficult to establish as, even though someone may suffer from PTSD, the defendant still has the task of illustrating a link between the PTSD and the crime at the time the crime occurred. In \textit{Martinez v. State}, for example, the court determined that PTSD did not cause nor explain the defendant’s actions of repeatedly stabbing the victim and engaging in a conspiracy to conceal the murder. 663 S.E.2d 675 (Ga. 2008).
\bibitem{166} \textit{State v. Simonson}, 669 P.2d 1092 (N.M. 1983).
\bibitem{167} \textit{Id.} at 1093-94.
\bibitem{168} \textit{Id.}
\bibitem{169} \textit{Id.} at 1097.
\bibitem{170} \textit{Id.}
\bibitem{171} \textit{Id.}
\bibitem{172} \textit{Id.} at 1094.
\bibitem{173} \textit{Id.}
\bibitem{174} \textit{Id.}
\bibitem{175} Many of the behaviors described by Simonson’s character witnesses, particularly his wife, are indicative of PTSD. The evidence established that Simonson had become an alcoholic after returning, was “jumpy,” suffered from nightmares, and often complained of men coming to get him. \textit{Id.} at 1097.
\bibitem{176} Menefee, \textit{supra} note 32, at 10.
\end{thebibliography}
attempted to shoot himself.\textsuperscript{177} When one of the officers intervened, the gun went off and the officer was killed.\textsuperscript{178} At trial, Felde asserted a defense of not guilty by reason of insanity. Felde was examined by several psychiatrists, all of whom agreed that he had PTSD. Even the prosecuting attorney did not dispute that Felde had PTSD.\textsuperscript{179}

Where the prosecutor differed from Felde’s psychiatrist was in the determination of whether Felde’s PTSD caused him to shoot the police officer. Specifically, the prosecutor questioned whether Felde was in a dissociative state at the time of the shooting.\textsuperscript{180} During closing argument, the prosecutor held up a picture of the crime scene and asked the jury, “does this look like a war scene at night or does that look like a police car with a siren on top on a four lane highway in Shreveport Louisiana . . . Does this look like anything you see in Vietnam? Or does that look like a ride back to the penitentiary?”\textsuperscript{181} Ultimately, the jury sided with the prosecutor and convicted Felde of first degree murder. When deliberating on the appropriate penalty, the jury indicated in no uncertain terms both that they thought that Felde suffered from PTSD, and that they also thought he was aware of the wrongfulness of his conduct:

We, the Jury, recognize the contribution of our Viet Nam veterans and those who lost their lives in Viet Nam. We feel that the trial of Wayne Felde has brought to the forefront those extreme stress disorders prevalent among thousands of our veterans. . . . Through long and careful deliberation, through exposure to all the evidence, we felt that Mr. Felde was aware of right and wrong when Mr. Thompkins’ life was taken. However, we pledge ourselves to contribute whatever we can to best meet the needs of our veterans.\textsuperscript{182}

For an individual who has committed a crime while in a dissociative state, establishing a causal link is difficult, but not impossible. The strongest point indicating a causal link is often not a piece of evidence, but rather a lack of it. For example, if the crime is committed without a clear motive, a jury is much more likely to find that it was committed while in a dissociative state.\textsuperscript{183} In both \textit{Simonson} and \textit{Felde}, the defendants’ motives gave the juries good reasons to be skeptical of their insanity claims. In \textit{Simonson}, the defendant had a well-known conflict with one of the victims, who was his supervisor at the plant.\textsuperscript{184} Similarly, in \textit{Felde} the prosecutor put forth a reasonable alternative theory for why the defendant engaged in the shooting: he did not want to return to prison.\textsuperscript{185}

If the defendant does have a motive to commit the crime, then his or her best bet for an acquittal is to show through witnesses to the crime that the defendant acted in an unusual way that was suggestive of a dissociative state.\textsuperscript{186} So, for example, the fact that the defendant was holding a log like a rifle just before assaulting someone may convince a jury that the defendant was acting under the belief that he or she was in combat at the time of the crime.\textsuperscript{187} Alternatively, if the defendant can provide strong evidence that would explain why he or she reverted to a dissociative state, it can help persuade the jury of the defendant’s insanity.

In \textit{People v. Wood}, discussed earlier, the defendant was found not guilty after explaining that the conditions at the time of the crime were similar to the regular

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\textsuperscript{177} Id.
\textsuperscript{178} Id.
\textsuperscript{179} During his closing argument, the prosecutor stated, “I don’t argue for a moment that he . . . doesn’t have a form of post-traumatic stress disorder, like thousands of others.” \textit{Felde}, 422 So. 2d at 388.
\textsuperscript{180} Id.
\textsuperscript{181} Id.
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\textsuperscript{182} Id. at 380 n.9.
\textsuperscript{183} Menefee, supra note 32, at 15.
\textsuperscript{184} 669 P.2d at 1094
\textsuperscript{185} 422 So. 2d at 388.
\textsuperscript{186} Menefee, supra note 32, at 15.
\textsuperscript{187} Id.
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Specifically, the shooting occurred on a hot and humid night, and the area where the shooting occurred had a grated metal floor similar to the floor at the artillery base where the defendant was stationed in Vietnam.

D. Judicial Sentencing and PTSD

When a jury does convict a military veteran, the critical issue of sentencing comes into play. A recent United States Supreme Court decision recognized that military service and its potential PTSD consequences are significant enough to affect the results of a capital sentencing hearing, placing a new onus on defense attorneys to ascertain whether their clients may be experiencing a psychiatric disorder after serving. Additionally, some federal judges at the district court level encourage sentencing leniency for veterans convicted of crimes.

1. Porter v. McCollum: The Significance of PTSD in Capital Sentencing

With respect to capital crimes, the United States Supreme Court ruled unanimously that attorneys representing clients facing the death penalty are required to present evidence of post-traumatic stress disorder when it is available. In Porter v. McCollum, George Porter Jr. received convictions in 1987 for the murder of his former girlfriend, Evelyn Williams, and her new boyfriend, Walter Burrows. Porter represented himself for part of the trial and ultimately proffered a guilty plea for the crimes. However, Porter relied on a court-appointed attorney, Sam Bardwell, for advocacy at his sentencing hearing. Though Porter served on the front lines during the Korean War and was a decorated military veteran, Bardwell neglected to present any evidence of Porter’s military experience to the jury. In fact, Bardwell never obtained Porter’s school, medical, or military records, merely presenting Porter’s ex-wife as his sole witness.

In its 15-page per curiam opinion, the Supreme Court found Bardwell’s preparation “not even cursory” and that his decisions “did not reflect reasonable professional judgment.” The Court determined that Porter’s Sixth Amendment right to counsel was violated by the representation he received at the sentencing hearing. In the opinion, the Court recognized various state provisions “where the jury might find mitigating the intense stress and mental and emotional toll that combat took on Porter.” Notably, the Court wrote: “[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 Porter did.”

Porter represents the Supreme Court’s recognition that PTSD in the context of military service has the potential to provide invaluable

188 Id. (discussing People v. Wood (Cir. Ct. Cook Co., Ill., May 5, 1982)).
189 Id.
192 Id.
194 See Savage, supra note 191.
195 See Liptak, supra note 193.
196 Id.
197 Id.
198 Id. at 14 n.9 (noting California and Minnesota state statutes that allow special hearing procedures for veterans convicted of crimes when they allege PTSD or mental health defenses).
199 Id. at 14.
mitigating evidence where a veteran defendant faces a capital sentence. Where the Court articulates the history of leniency to veterans and explains the prejudice that defendants face without the disclosure of such evidence, such a ruling places a burden on the defense bar to ascertain clients' military background and subsequent related issues when defending them in capital cases.

2. Other Judicial Sentencing Considerations Involving PTSD

Though Porter requires consideration of PTSD issues in capital sentencing matters, judges in non-capital cases may consider criminal defendants’ military backgrounds, as well as mental and emotional issues, when determining prison sentences. As a result, many veterans are now receiving sentences involving probation and psychological care instead of jail time.

One federal judge has not only taken a lenient stance when sentencing military veterans, but also is an advocate for military veterans facing federal sentencing. Judge John L. Kane, a Colorado federal judge, sentenced military veteran John Brownfield to five years of probation and ordered him to undergo a psychiatric evaluation for the crime of accepting a bribe as a public official. Both the prosecutor and defense counsel originally recommended one year in prison. Yet Judge Kane insisted instead on a sentence of probation, noting in his sentencing memorandum that Brownfield “returned from the war, but never really came home.”

Significantly, Judge Kane published the Brownfield sentencing memorandum and provided copies to the United States Sentencing Commission, explaining that “this case involves issues the Sentencing Guidelines do not address regarding the criminal justice system’s treatment of returning veterans who have served in Afghanistan and Iraq.” Judge Kane explained his decision to place Brownfield on probation: “[i]t would be a grave injustice to turn a blind eye to the potential effects of multiple deployments to war zones on Brownfield’s subsequent behavior. A lengthy sentence of probation requiring effective treatment as determined by qualified experts ensures that these factors are adequately addressed.”

Judge Kane’s Brownfield memorandum underscores the growing importance of PTSD and military service as potential mitigating information for veterans facing federal sentencing. If allowed under the United States Sentencing Guidelines as potential mitigating factors, they would offer certain veterans an invaluable opportunity to reduce their sentences by demonstrating past service and present mental health issues.

While there currently are twenty-one specialized veterans’ courts in operation in the United States at the state level, there are no existing specific provisions allowed for veterans at the federal level. Although Booker recognizes that the federal Sentencing Guidelines are merely advisory in nature, they are persuasive and there are currently no clear provisions allowing for military service or PTSD resulting from service to warrant a sentencing departure.

This may soon change, owing to proposed revisions to the guidelines allowing “federal judges to consider criminal defendants’


See Efrati, supra note 96.
Id.
Id.
military service, age, and mental and emotional conditions in determining more lenient prison sentences."^208 Unless Congress blocks the changes, set to take effect November 1, 2010, this update to the federal Sentencing Guidelines may allow for more lenient federal sentences for military veterans.^209

V. Conclusion

Fortunately for the members of our armed services, the United States went through a long period of relative peace after the Vietnam War. Limited skirmishes in Panama, Somalia, Kosovo, and Iraq during the 1980s and 1990s involved relatively small numbers of troops and few casualties. Unfortunately for attorneys representing veterans with PTSD, this long period of peace has left the question of the applicability of criminal defenses for such individuals in a state of stasis.

As the case law currently stands, PTSD sufferers face a mixed bag when it comes to the viability of defenses based on their mental disorder. Those individuals who commit crimes while in a dissociative state should have at least one viable available defense regardless of the jurisdiction in which they are tried. While these individuals may face significant hurdles in their attempts to persuade a jury of their insanity, particularly with respect to the necessary causal link between their disorder and their crime, they would at least be able to present their defense to the jury in almost every situation. PTSD sufferers manifesting the sensation-seeking or the depression-suicide typologies face a much more arduous road. In a jurisdiction applying the M’Naghten test, these defendants have almost no chance of successfully asserting an insanity defense. While these defendants may not fare much better in an ALI jurisdiction, the added volitional component should at the very least allow them to present evidence of their insanity to the jury.

With respect to post-conviction sentencing, PTSD is a critical consideration that may affect the outcome of a defendant’s sentence. The Supreme Court recognized that a defendant’s veteran status and subsequent PTSD issues are factors a defense attorney must present to a jury during capital sentencing hearings. Porter ultimately acknowledges that juries may sentence a defendant differently with the knowledge of a defendant’s military service and the psychological after-effects of combat. This decision places an added responsibility on the defense bar to ensure that they know their clients’ military backgrounds and the possible mental health issues resulting from this service. Even in non-capital situations, judges are reducing sentencing based on military service and the toll it takes on America’s veterans. Proposed changes to the federal Sentencing Guidelines will specifically provide for possible federal sentencing reductions based on factors such as military service and its potential mental and emotional burdens.

Because of the viability of certain PTSD-based defenses for military veterans, as well as the possibility of sentencing mitigation, lawyers should apprise themselves of their clients’ military experience and mental health background so as to protect and best advocate for the best interests of their clients.


^209 Id.