POST-TRAUMATIC STRESS DISORDER: A CONTROVERSIAL DEFENSE FOR VETERANS OF A CONTROVERSIAL WAR

I saw flashes, flashes like incoming round hits, like fire crackers, hearing machine guns, I heard machine guns, I heard rifle fire, I heard more explosions and I couldn’t move. I was happy because I knew I was going to die.¹

Vietnam was America’s longest² and most controversial war.³ One legacy of the Vietnam conflict is a veteran group suffering a disproportionately high rate of psychological problems and criminal encounters. The incidence of suicide,⁴ alcoholism,⁵ and mortality⁶ among Vietnam veterans is significantly greater than for veterans of other wars. Psychiatrists have attributed much of this disparity to a particular combination of psychological symptoms arising from the Vietnam experience. These symptoms are collectively known as post-traumatic stress disorder (PTSD).

Estimates vary, but as many as seventy percent of Vietnam veterans suffer from some form of PTSD.⁷ Approximately twenty-five

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¹ State v. Felde, 422 So. 2d 370, 378 (La. 1982) (testimony of accused murderer Wayne Felde).
³ Three months after the 1968 Tet offensive, the nation was split 42% opposed and 41% in favor of the war. By November 1969, however, the ratio had changed to 55% opposed and 31% in favor of the war. G. Hodgson, AMERICA IN OUR TIME 384-85 (1976).
⁴ The suicide rate for Vietnam veterans is as much as 40% higher than that of their nonveteran peers. Felde, 422 So. 2d at 377. It is 72% higher than that of the Vietnam-era veteran who did not serve in Vietnam. A Post-Vietnam Pattern?, Wash. Post, Feb. 11, 1987, at A5, col. 3.
⁵ The alcoholism rate for Vietnam veterans is 60% higher than that of World War II or Korean War veterans. Felde, 422 So. 2d at 377. See Walker, The Psychological Problems of Vietnam Veterans, 246 J. A.M.A. 781 (1981).
⁶ Vietnam veterans suffer a mortality rate 17% higher than that of Vietnam-era veterans who were not stationed in Vietnam. This includes a 93% higher automobile accident fatality rate and a 69% higher rate of accidental poisoning, mostly from drug overdoses. A Post Vietnam Pattern?, supra note 4.
percent of all men in prison are Vietnam-era veterans. As of 1981, some 30,000 such veterans were imprisoned and another 375,000 were on probation, on parole, or awaiting trial. Inasmuch as PTSD may be affecting these veterans' concept of reality, the appropriateness of PTSD as a criminal defense must be addressed.

This Note reviews the viability of PTSD as a criminal defense from several perspectives. It discusses the historical background of war-related mental disturbances, the emergence of PTSD as a recognized mental disorder, and the impact of the PTSD defense on state, federal, and military justice systems. The analysis emphasizes the relationship between PTSD and the insanity defense and considers various PTSD-related evidentiary problems.

THE VIETNAM EXPERIENCE

The post-war psychological problems plaguing the Vietnam veteran have been attributed at least partially to the unusual characteristics of the war itself. The Vietnam-era soldier was younger than combatants of previous wars and participated individually rather than as a part of a cohesive unit. Soldiers often arrived aboard commercial aircraft, joined a unit in the field for twelve or thirteen months, and then returned individually to the United States. Unit and leader loyalty consequently were limited.

8. Felde, 422 So. 2d at 377.
9. Smith, Post Traumatic Stress Disorder—An Often Overlooked Element of Trauma, TRIAL, Feb. 1984, at 92, 96. U.S. Bureau of Prisons data show that veteran inmates, unlike their nonveteran counterparts, generally have no history of prior imprisonment. This fact suggests that their criminal behavior is linked to their Vietnam experience. Id. See generally R. MASON, CHICKENHAWK (1983) (relating a former Vietnam helicopter pilot's inexplicable involvement with crime).
11. The average age of American soldiers in Vietnam was 19.2 years, whereas the average age of American soldiers in World War II was 26 years. Lyons, Vietnam Veterans Turn to Therapy, N.Y. Times, Nov. 13, 1984, at C6, col. 3.
13. Id.
The United States government’s apparent desire to contain rather than win the war, coupled with nonexistent battle lines and repetitive battles for previously seized and relinquished territory, caused soldiers to become disillusioned and uncommitted. The lack of home front support and the frustrations inherent in fighting a guerrilla war exacerbated the problem.

After surviving a Vietnam tour of duty, the Vietnam veteran did not enjoy a “cooling-off” period as had the World War II and Korean War veterans. Instead, he returned to the “hostile, critical or disinterested responses of strangers, friends and family.” The American public increasingly stigmatized veterans in light of media reports relating combatants’ mass insubordination and drug use. Public support further dwindled in the face of atrocities such as My Lai. Many veterans became embittered and began to mistrust the government that had sent them to fight such an unpopular war. This resultant mistrust of authority figures contributed to the veteran’s reluctance to seek psychological assistance.

**POST-COMBAT REACTIONS—A HISTORICAL OVERVIEW**

Despite the unique circumstances of the Vietnam conflict, postcombat reactions are not a new problem. The medical world has long recognized that combat produces dysfunctional psycholog-

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15. Returning World War II and Korean War soldiers spent several weeks on troop ships with military personnel sympathetic to their difficulties in readjusting to a civilian lifestyle after months of combat. The time aboard the ships provided time for transition between combat and civilization.
18. On 16 March 1968 an infantry company of the Americal Division assaulted the Vietnamese hamlet of My Lai, systematically killing all the inhabitants. The population consisted mainly of old men, women, and children, and the final body count was as high as 200. G. Lewy, supra note 17, at 325-26.
20. Walker, supra note 5, at 781. Of those veterans who sought assistance, the majority were misdiagnosed. See infra note 41 and accompanying text.
ical and behavioral reactions. The American recognition of combat fatigue officially dates from the Civil War, when the mental disorder was labeled “nostalgia.” Commentators attribute the relatively low psychiatric rate of the Civil War to various factors, such as fighting in the soldiers’ own country, living conditions similar to those at home, unsophisticated weaponry, and desertion as a ready alternative to fighting.

The massive artillery bombardments of World War I often inflicted severe concussions on soldiers’ brains. Psychiatrists aptly labeled the resultant psychological breakdown “shell shock.” Psychiatrists attributed other psychiatric casualties to hysterical reactions resulting from the use of poison gas or simply from cowardice. Upon entering the war, the United States pioneered a program of forward treatment. Under this program, the military assigned a psychiatrist to each division and treated psychiatric casualties as close to the front lines as possible, with the expectation of returning as many soldiers as possible to their units.

In World War II, the United States military initially failed to apply the forward treatment techniques pioneered during World War I. Shortly after the 1942 invasion of North Africa, American combatants were evacuated for battle fatigue faster than they could be replaced. During the course of the war, the military granted 500,000 service discharges for psychiatric reasons.

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21. The Union Surgeon General, William Hammonds, first recognized this condition. In the first year of the war, 5213 cases of nostalgia were reported—2.34 cases per 1000 soldiers. This rate rose to 3.3 per 1000 by the second year. In addition, 20.8 per 1000 soldiers were discharged for “paralysis” and 6 per 1000 for “insanity.” P. Bourne, Men Stress and Vietnam 9-10 (1970) (citing Deutsch, Military Psychiatry: The Civil War, in One Hundred Years of American Psychiatry 376-77 (1944)).


23. P. Bourne, supra note 21, at 6. The presence of blood in the spinal fluid of several such casualties supported this theory. Id.

24. After the German army introduced gas warfare, the ratio of psychiatric to physical casualties in Allied ground forces exceeded two to one; that is, there were two “hysterical” reactions to every actual gas casualty. Chermol, supra note 22, at 9.


26. Id. at 13. While in use, this program returned 65% of psychiatric casualties to their units. Id. (citing Salmon, The War Neuroses and Their Lessons, 109 N.Y.J. Med. 993-94 (1919)).


rate of psychiatric casualties was as high as 101 per 1000 in some units. Not until March 1944 did psychiatrists appear regularly at the division level.

The temporal proximity of World War II to the Korean and Vietnam conflicts encouraged the military to retain the lessons learned and therefore contributed to considerably lower psychiatric casualty figures in these later wars. The relatively low psychiatric casualty rate in Vietnam reflected the quality and availability of psychiatric services, improved training, confidence in leadership, the sporadic nature of the fighting, and a twelve- to thirteen-month rotation policy. As the war grew unpopular and the military experienced severe racial and disciplinary problems, however, psychiatric casualties increased dramatically.

The psychiatric community was largely unresponsive to this trend. The original 1952 edition of the American Psychiatric Association (APA) Diagnostic and Statistical Manual of Mental Disorders (DSM I) categorized combat stress as a gross stress reaction. This categorization disappeared in the 1968 edition (DSM II).

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29. Id.
30. Id.
31. Psychiatric casualties suffered annually by U.S. armed forces averaged 37 per 1000 in Korea and 12 per 1000 in Vietnam. Id. at 15 (citing Tiffany & Allerton, Army Psychiatry in the Mid-60's, 123 AM. J. PSYCHIATRY 810-21 (1967)).
32. Id. at 18. A psychiatrist was assigned to the staff of the Chief Army Surgeon in Vietnam, every division included a psychiatrist, and both field and evacuation hospitals provided psychiatric care. Id. at 19. In October 1962, with only 8000 advisors stationed in Vietnam, the first U.S. Army psychiatrist reported for duty. Jones & Johnson, Jr., Medical and Psychiatric Treatment Policy and Practice in Vietnam, 31 J. SOC. ISSUES 49 (1975).
33. J. COLEMAN, J. BUTCHER & R. CARSON, ABNORMAL PSYCHOLOGY AND MODERN LIFE 172 (6th ed. 1980). Knowing that he could look forward to a definite end to the stressful situation appeared to make the soldier's tour more bearable. Id.
34. Conviction rates for insubordination, mutiny, and other acts involving willful refusal to perform a lawful order increased from .28 per 1,000 in 1968 to .44 per 1,000 in 1970. G. LEWY, supra note 17, at 157. Violence involving use of hand grenades against officers and noncommissioned officers, known as “fragging,” rose from 126 incidents in 1969 (.35 per 1,000) to 333 in 1971 (1.75 per 1,000). The reported deaths from these fraggings were 37 in 1969, but only 12 in 1971. Id. at 156.
35. Army neuropsychiatric cases doubled between 1965 and 1970, with the overall rate for psychiatric problems standing at 24 per 1000 in 1970. Id. at 160.
37. Id. (discussing AMERICAN PSYCHIATRIC ASS’N, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS (2d ed. 1968)).
DSM II considered combat stress only under the general heading of "adjustment reactions of adult life."\textsuperscript{38} This cursory treatment of a serious and widespread disorder indicates that the psychiatric community did not adequately address problems associated with post-combat stress reactions when the American military presence in Vietnam was at its peak.\textsuperscript{39} The medical and legal professions lacked an adequate description of PTSD symptoms that could be used to diagnose, treat, and defend veterans.\textsuperscript{40} As a result, psychiatrists frequently misdiagnosed the postwar reactions of many Vietnam veterans as psychotic, substance dependent, or fictional.\textsuperscript{41}

\textsuperscript{38} Id.

\textsuperscript{39} U.S. troop strength peaked at 542,000 in January 1969. G. Lewy, \textit{supra} note 17, at 147.


\textsuperscript{41} Erlinder, \textit{supra} note 40, at 28. In 1976, a psychological study reported that 77% of Vietnam veterans admitted to VA hospitals were misdiagnosed as schizophrenic. J. Brende & E. Parsons, \textit{Vietnam Veterans} 76 (1985). PTSD is easily confused with schizophrenia, antisocial personality disorder, and an atypical psychosis (hysterical neurosis). Walker & Cavenar, Jr., \textit{Vietnam Veterans: Their Problems Continue}, 170 J. NERVOUS & MENTAL DISEASE 174, 175 (1982).
POST-TRAUMATIC STRESS DISORDER

The 1980 edition of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM III) recognized PTSD as a subcategory of anxiety disorders. DSM III characterized PTSD as the development of specific symptoms following a psychologically traumatic event that is beyond the range of usual human experience. PTSD is not limited to veterans; it may develop in victims of traumatic events such as rape, assault, airplane crashes, and torture. The traumatic event, or "stressor," is defined as an event that would generate symptoms of distress in virtually anyone exposed to it.

For Vietnam veterans, PTSD symptoms include combat flashbacks, intense memories or recurrent dreams of the traumatic event, or the feeling that the stressor is reoccurring. The PTSD diagnostic criteria include a numbing of responsiveness to the outside world, evidenced by diminished interest in significant activities, feelings of detachment or estrangement, or repressed emotions. The criteria also require that at least two of the following symptoms be new developments in the patient's behavior after encountering the stressor: hyperalertness, sleep disturbance, survivor guilt, memory impairment, avoidance of activities reminiscent of the trauma, and intensification of symptoms after exposure to stimuli resembling the stressor.

A few Vietnam veterans have reported flashbacks in which they re-live traumatic events and behave accordingly. These flashbacks may occur immediately after the traumatic event or not until years later. A flashback can last for several minutes or several days. Associated symptoms include depression, anxiety, and unpredict-

42. American Psychiatric Ass'n, Diagnostic and Statistical Manual of Mental Disorders (3d ed. 1980) [hereinafter DSM III].
43. Id. at 236-38.
44. Id. at 236.
45. Id. at 236.
46. Walker, supra note 5, at 782. Spouses of veterans have reported that their husbands scream or strike them while asleep. Id.
47. DSM III, supra note 42, at 238.
48. Id.
49. Id.
50. Id. at 236. See also Wilson & Zigelbaum, supra note 7, at 73-74.
able explosions of aggressive or impulsive behavior involving sudden trips, unexplained absences, or changes in lifestyle. Psychologists have observed several patterns of psychic-state responses in the PTSD sufferer.

**PTSD AND THE INSANITY DEFENSE**

PTSD may affect the sufferer's understanding of reality, his perception of surrounding circumstances, and his reaction to otherwise normal events. These symptoms raise questions concerning the PTSD victim's ability to possess the requisite criminal intent and whether PTSD can qualify as an insanity type defense. Insanity defenses, however, have been subject to frequent criticism.

Although PTSD has received a mixed reception in the legal community, it has achieved some success as a legal defense. Vietnam veterans have used PTSD successfully as an insanity defense against charges of murder, attempted murder, kidnapping, and other crimes.

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51. DSM III, supra note 42, at 237.
52. Wilson & Zigelbaum, supra note 7, at 72-73. PTSD may be divided into the following nine subsyndromes: depression and suicidal, isolation and withdrawal, sensation seeking, paranoid, profound psychic numbing, alienation and cynicism, problem with intimacy, fusion of stress syndrome with pre-morbid disposition syndrome, and prosocial-humanitarian. Id.
55. 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. Viet War Trauma Grows as Defense in Criminal Cases, supra note 54, at 1, col. 6.
58. PTSD Successful in Insanity Defense, VETERANS RIGHTS NEWSLETTER, July-Aug. 1983, at 1 (citing People v. Parish, No. 82-32052 (Cir. Ct. Genesee County Mich. Mar. 4,
and drug smuggling. PTSD has also been used to mitigate sentences in convictions for crimes such as drug dealing, manslaughter, assault with intent to commit murder, and even tax fraud. In light of the relative rarity of the insanity defense in general and the unlikelihood of its success, the success of PTSD as an insanity defense is intriguing.

To determine whether an accused was insane at the time he committed an offense, courts commonly apply one of three tests—the M'Naghten rule, the irresistible impulse addition to the M'Naghten rule, and some version of the American Law Institute (ALI) Model Code definition of insanity. The M'Naghten rule, also known as the “all or none” rule, requires a finding that


61. People v. Saldivar, 113 Ill. 2d 256, 497 N.E.2d 1138 (1986) (PTSD used as a mitigating factor to reduce sentence to statutory minimum).


64. The insanity defense is used less than once in every 1000 criminal cases. Only 4 to 5% of these cases result in a verdict of innocent by reason of insanity. T. BLAU, THE PSYCHOLOGIST AS EXPERT WITNESS 87 (1984). The National Commission on the Insanity Defense reported that the insanity plea was used rarely and that acquittals were extremely rare. NATIONAL COMM'N ON THE INSANITY DEFENSE, MYTHS & REALITIES: A REPORT OF THE NATIONAL COMMISSION ON THE INSANITY DEFENSE 14 (1983). As an illustration, in Virginia less than 1% of the felony cases involve the insanity defense, and acquittals number no more than 15 per year. Id. at 15.

65. See M'Naghten’s Case, 10 Cl. & Fin. 200, 8 Eng. Rep. 718 (1843).


68. T. BLAU, supra note 64, at 84.
a person suffers from a disease that renders cognition and volition clearly defective. The irresistible impulse addition to the M'Naghten rule adopted an additional volition test. Under this standard a party is considered insane if he knew what he was doing and that it was wrong, but his actions were beyond his control due to the presence of some mental disease.

In 1961, the ALI adopted a new definition of legal insanity as part of its Model Penal Code. The ALI definition expanded the M'Naghten rule by inquiring whether the accused understood the criminal nature of his act and whether he was able to conform his conduct to legal requirements.

The PTSD Defense Under State Law

A substantial minority of the states use some version of the ALI insanity definition, and a few states employ the irresistible impulse test, but the majority of state courts follow the stricter M'Naghten insanity standard. Regardless of the standard applied, PTSD should prove a legitimate defense. The veteran who believes he is again in combat and attacks one whom he believes to be an enemy soldier is insane under the M'Naghten right-wrong test. This veteran is also insane under the ALI standard due to his incapacity to appreciate the criminality of his conduct. The PTSD defense could also frustrate the prosecutor's attempt to

69. Id. The M'Naghten test requires that "[t]o establish a defense on the ground of insanity, it must be clearly proved that, at the time of the committing of 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 what he was doing was wrong." Id.


71. MODEL PENAL CODE § 4.01.

72. T. Blau, supra note 64, at 84. The Model Penal Code states: "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 the law." MODEL PENAL CODE § 4.01.

73. T. Blau, supra note 64, at 84-86.

74. Id.

75. Id.


77. Id at 87-88.
prove sufficient mens rea or specific intent and would prove beneficial to the convicted PTSD sufferer seeking a sentence reduction or post-conviction hearing.

The PTSD defense has been successful in states that apply various insanity standards. A Louisiana court, using a M'Naghten modified insanity test, acquitted a former Marine of murder in State v. Heads. The accused had experienced extensive combat as a point man in long-range reconnaissance patrols in Vietnam. After returning home he suffered a flashback following a stressful marital breakup and killed his brother-in-law. The defense convinced the jury that Head's combat flashback had destroyed his ability to distinguish right from wrong. The defense successfully argued that the stress of losing his family, coupled with the similarity of the shooting scene to Vietnam, caused the normally law-abiding veteran to go "on automatic" and revert to combat-like behavior.

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78. Id. at 88.
82. See Erlinder, supra note 40, at 33-35 (discussing Heads).
83. Wilson & Zigelbaum, supra note 7, at 73-74. Heads, reportedly perceiving his brother-in-law as a Viet Cong, pulled a rifle from his car, shot the victim through the eye and then "stalked the ranch house as though it were a straw hooch." War Echoes in the Courts, NEWSWEEK, Nov. 23, 1981, at 103.
84. War Echoes in the Courts, supra note 83, at 103.
85. Erlinder, supra note 40, at 34.
In *State v. Wood*, an Illinois jury applied the ALI standard and found that an ex-Marine who had suffered a PTSD flashback was not guilty of attempted murder by reason of insanity. Wood claimed that the physical similarities of his factory workplace and his artillery base in Vietnam initiated a flashback that culminated in the shooting of his foreman. At the time of the shooting, counsel argued, Wood was reliving Vietnam.

A Michigan court, using a modified ALI standard, also found a Vietnam veteran not guilty by reason of insanity. In *People v. Parish*, the accused had seized his sister-in-law and her husband and forced them at knife-point to take him to his estranged wife and children. Despite conflicting expert testimony about Parish’s condition, the jury acquitted him of the kidnapping charge.

In *Commonwealth v. Mulcahy*, a Marine veteran was convicted of a lesser included offense. Charged with murdering a stranger over a dispute with a bar waitress, Mulcahy claimed he could not remember shooting his victim. The defense presented a videotape of Mulcahy reliving his Vietnam trauma while under sodium

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86. Erlinder, *supra* note 40, at 35-37 (citing *State v. Wood*, No. 80-7410 (Cir. Ct. Cook Cty Ill. May 5, 1982)).

87. The jury’s verdict of “not guilty by reason of insanity” did not specify whether the verdict was rendered because the defendant could not “substantially appreciate the criminality of his acts” or because he could not “conform his conduct to the law.” Erlinder, *supra* note 40, at 36-37.

88. The heat and humidity, the assembly plant’s floor (metal matting floor) and the loud noises resembled Wood’s former artillery base in Vietnam. *Vietnam Vet Acquitted of Shooting*, *supra* note 57, at 19.


91. *Id.*


93. *Id.*
pentathol. The videotape established that at the time of the shooting, Mulcahy believed he was experiencing a rocket attack in Long Binh, Vietnam. The court found Mulcahy guilty only of manslaughter.

**The PTSD Defense in the Federal Courts**

Prior to Congress’ October 12, 1984, enactment of the Insanity Defense Reform Act of 1984, the vast majority of federal courts followed the ALI standard. The 1984 Act worked three changes on the insanity defense in the federal courts. First, the federal system now limits the insanity defense to severe mental diseases or defects. The mental defect must be of such severity as to make the accused “unable to appreciate the nature and quality or the wrongfulness of his acts.” Second, the 1984 Act eliminates the volitional portion of the cognitive-volitional test and the diminished-responsibility defense. This change effectively resurrects the M’Naghten rule in the federal courts. Federal defendants who appreciate the wrongfulness of their acts but lack the capacity to conform their conduct to the requirements of the law therefore will not be able to use the insanity defense. Finally, the 1984 Act places on the defendant the burden of proving his insanity by clear and convincing evidence.

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94. Id. at 26, col. 3.
95. Id.
98. 18 U.S.C. § 20(a) (Supp. III 1985). The statute reads, in part, “[I]t is an affirmative defense . . . that, at the time of the commission of the acts constituting the offense, the defendant, as a result of a severe mental disease or defect, was unable to appreciate the nature and quality of the wrongfulness of his acts. Mental disease or defect does not otherwise constitute a defense.” Id.
100. Diminished responsibility, also known as partial insanity, allows the trier of fact to consider the defendant’s impaired mental state in mitigation of sentence and degree of offense. It does not, however, rise to the level of insanity. BLACK’S LAW DICTIONARY 412 (5th ed. 1979).
101. Lefcourt & Becker, supra note 97, at 358.
At least three federal district courts and one federal appeals court have held that the insanity standard is substantive in nature and cannot be applied retroactively. 103 Courts have also held that shifting the burden of proof from the prosecution to the accused is substantive, therefore prohibiting retroactive application. 104 In addition, courts have held that the Act’s assignment of the burden of proof does not violate the fifth amendment’s due process clause. 105 Federal courts, in deciding United States v. Pricket 106 and United States v. Mest, 107 held that the Act’s prohibition of expert testimony on the ultimate legal issue of insanity may be applied retroactively without violating the ex post facto clause. 108

A pivotal question in the use of the PTSD insanity defense before a federal court is whether PTSD qualifies as a severe mental disease or defect under the 1984 Act. Congress’s purpose in imposing the severity requirement was to ensure that nonpsychotic behavior disorders or neuroses such as inadequate personality, immature personality, and pattern of antisocial tendencies would not suffice as defenses. 109 Congress also intended to exclude voluntary drug or alcohol abuse as a valid defense, even though such abuse might have prevented an accused from appreciating the nature and quality of his conduct. 110

The federal courts have not determined a standard for the severity requirement. 111 As a minimum, however, a PTSD dissociative

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104. Mest, 789 F.2d at 1073 n. 3.
107. 789 F.2d 1069 (4th Cir.).
108. Id. at 1071. Limiting expert testimony with respect to a defendant’s mental state does not require any less testimony for conviction, but merely changes the style of question and answer that may be used. Id.
111. In United States v. Duggan, 743 F.2d 59 (2d Cir. 1984), the accused was charged with weapons smuggling. The defense claimed that the accused suffered from PTSD as a result of
state should qualify as a severe mental defect or disease given that the individual's cognitive abilities are completely altered. A dissociative state can be triggered by common stimuli such as the sound of helicopters flying nearby, the smell of urine, the smell of diesel fuel, tree lines, the sound of popcorn popping, loud noises, the sight of Vietnamese people, or the sound of rain.\footnote{112} During a flashback, a PTSD victim is likely to function in a survivor mode, which is characterized by altered consciousness, hyperactivity, and excessive automatic nervous system arousal.\footnote{113} Typically, during a flashback a PTSD victim displays survival skills and cognitive capacities acquired in combat.\footnote{114}

\textit{State v. Cocuzza}\footnote{115} exemplifies the PTSD dissociative state defense. The defendant was acquitted under the M'Naghten insanity test after he had assaulted several policemen with a log.\footnote{116} The Vietnam combat veteran had suffered a flashback in which he believed himself in Vietnam and saw the police officers as enemy soldiers.\footnote{117} Police officers testified that the defendant had carried the log as if it were a rifle, ignored their orders, and appeared to be in a drunken and incoherent rage as he attacked.\footnote{118} Medical experts testified that Cocuzza knew the nature and quality of his conduct only in the sense that he was aware that he was attacking someone. He did not know that his acts were wrong, however, because he believed he was attacking enemy soldiers.\footnote{119}

\begin{footnotes}
\item[113] Wilson & Zigelbaum, \textit{supra} note 7, at 73.
\item[114] \textit{Id}.
\item[117] Ford, \textit{supra} note 115, at 440.
\item[118] \textit{Id.} at 439.
\item[119] \textit{Id.} at 440.
\end{footnotes}
The PTSD Defense in Military Tribunals

In military tribunals, the PTSD defense has seen little use, and appellate decisions addressing PTSD have been few. The best known case involved the highly publicized court martial of Marine Private First Class Robert Garwood. Garwood was charged with treasonous conduct in aiding North Vietnamese forces during the Vietnam conflict. He pleaded PTSD unsuccessfully as a partial defense, arguing that his North Vietnamese captors had tortured and brutalized him to the point that he experienced a dissociative reaction. Garwood contended that this reaction negated his perceptive and controlling faculties of mental responsibility and rendered him insane under the test used by the Armed Forces. A government psychiatrist testified that Garwood "possessed the mental capacity to appreciate the criminality of his actions and to conform his conduct to the requirements of the law." The court-martial therefore rejected Garwood's PTSD defense. The U.S. Navy-Marine Corps Court of Military Review sustained the trial court's

120. Telephone interview with Major Dale Marvin, Army Defense Appellate Division, Judge Advocate General Corps (Nov. 1986); telephone interview with Lieutenant Chris Hayes, Appellate Defense Division, Navy-Marine Corps Appellate Review Activity (Feb. 11, 1987) (one case pending at the trial court level); letter from Captain W.B. Steinbach, United States Coast Guard (Jan. 28, 1987) (PTSD has never been raised as a criminal defense in any Coast Guard court-martial).


122. In 1979, Garwood returned from Vietnam and was charged with desertion, solicitation of U.S. troops in the field to defect and to refuse to fight, communication and holding intercourse with the enemy, and misconduct as a prisoner of war. 16 M.J. at 866. The court-martial found Garwood guilty of assault and of holding intercourse and communication with the enemy. Id.

123. 16 M.J. at 867. See generally United States v. Frederick, 3 M.J. 230 (C.M.A. 1977) (court rejected M'Naghten/irresistible-impulse standard and adopted ALI test). Under Frederick, an individual is not responsible for his criminal behavior "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 the law." Id. at 234. For a history of the insanity defense in the military, see Trant, The American Military Insanity Defense: A Moral, Philosophical, And Legal Dilemma, 99 Mil. L. Rev. 1 (1983).

124. 16 M.J. at 867.

125. Id.
decision, and Garwood’s appellate defense did not raise the PTSD issue.

The PTSD defense was raised again in United States v. Correa. The accused had experienced extensive combat as well as various emotional stresses during his twenty-month Vietnam duty. He married a Vietnamese woman and endured the deaths of several close friends, including an officer who died in his arms. Correa’s court-martial offenses occurred while he was stationed at the Defense Language Institute, in California and in Vietnam-like Honduras, following a period of marital discord and alcohol related problems. Twelve months after Correa’s conviction at court martial, Government psychiatrists diagnosed him as suffering from PTSD as a result of Vietnam combat. Supported by this new information, Correa appealed his conviction to the Army Court of Military Review.

The Army Court of Military Review, in an opinion reflecting its lack of understanding of the PTSD defense, held that the evidence was insufficient to raise the issue of insanity. Instead, the court reasoned that Correa’s involvement in criminal incidents was not unusual given his voluntary intoxication and his failure to control

126. Id.
129. Correa’s combat awards included the Silver and Bronze Stars, the Purple Heart, and the Vietnamese Cross of Gallantry with Palm. List of Army Medals Awarded to Walter Correa, Motion To Admit Defense Appellate Exhibits A-D, Correa, 21 M.J. 719 (No. CM 446255).
131. While at the Defense Language Institute, Correa threatened to kill a fellow soldier and made financial claims for an unauthorized housing allowance. Supplement to Petition for Grant of Review, at 5, Correa 21 M.J. 719 (No. CM 446255) [hereinafter Supplement]. Correa admitted that he knew right from wrong when he accepted the housing allowance, but insisted that he had difficulty acting according to what was right due to his Vietnam combat mentality. Clinical Report, supra note 130, at 6.
132. Correa threatened a soldier with his pistol while he was engaged in a drunken altercation over local women. Clinical Report, supra note 130, at 5. Correa also flew into a rage and threatened to shoot a soldier who reprimanded him for being too boisterous during a truck ride. Supplement, supra note 131, at 5-7.
133. Correa, 21 M.J. at 719. Correa’s symptoms met all four main criteria for PTSD and twelve of twelve subcriteria in three areas. Clinical Report, supra note 130, at 6. Correa regressed back to a Vietnam mentality but did not experience any flashbacks. Id. at 4-5.
134. 21 M.J. at 721.
his temper. Rejecting the PTSD defense, the court relied heavily on the fact that twelve years had elapsed between Correa’s combat duty and his first PTSD-related offense. Psychiatric evaluations indicated, however, that during this period Correa had continually displayed symptoms of PTSD. The court also asserted that Correa’s criminal behavior may have been related directly to his alcohol problem, but it failed to recognize the connection between alcohol abuse and PTSD.

Finally, the court noted that even if Correa had been a victim of PTSD, the expert testimony presented by the defense failed to show that PTSD satisfied the prerequisites for legal insanity. Although three mental health professionals had diagnosed Correa as suffering from PTSD, none of them had characterized PTSD as a

135. 21 M.J. at 720-21. During the evening of the Honduran barroom altercation, Correa had consumed four cans of beer, twelve double shots of alcohol, and four single shots. Clinical Report, supra note 130, at 5.


Clinicians with extensive experience working with combat veterans have found that although PTSD victims may appear to function symptom free for a number of years following combat, on closer examination they frequently exhibit subtle symptoms of PTSD. Lipkin, Scurfield & Blank, supra note 10, at 56. According to the American Psychiatric Association diagnostic manual, “[i]t is not unusual . . . for the symptoms to emerge after a latency period of months or years following the trauma.” DSM III, supra note 42, at 237. A 1982 study of active-duty Vietnam veterans indicates that 3.4% of the group suffered from “chronic” PTSD (that is, they had experienced PTSD in Vietnam and continued to experience it) and 1.7% of the group suffered from “delayed” PTSD (they had not experienced PTSD in Vietnam but currently were suffering from it). Stretch, Incidence & Etiology of Post-Traumatic Stress Disorder Among Active Duty Army Personnel, 16 J. APPLIED SOC. PSYCHOLOGY 464, 473 (1986). Some psychiatrists hypothesize that the delayed effect occurs because veterans block out the war experience. The residual effects of the trauma return when veterans must deal with close relationships with others, such as family members. Lyons, supra note 11, at C6. Emotional stress tends to contribute to the initiation of PTSD reactions. Erlinder, supra note 40, at 34.


mental disease or defect. Furthermore, the court noted that one of these experts had described PTSD as an “unresolved grief reaction.” In light of *DSM III*’s recognition of PTSD as a mental disease or defect, the court’s reasoning here ignores the current thinking regarding PTSD.

The latest military appellate decision to deal with PTSD is *United States v. Hagen*. Hagen, an Army sergeant, was convicted of larceny, sale, attempted sale, and conspiracy to sell government explosives and ammunition. A post-trial sanity board unanimously determined that Hagen had not possessed sufficient mental capacity to understand the nature of the proceedings against him and therefore had been unable to cooperate intelligently in his defense. Based on these findings as well as evidence that Hagen suffered from PTSD, Hagen’s counsel requested a rehearing.

The U.S. Army Court of Military Review conceded that Hagen suffered from PTSD but nonetheless affirmed the verdict and the sentence. The court relied on Hagen’s confession that his motive had been profit, on two pretrial sanity evaluations finding him competent to stand trial, on Hagen’s apparently coherent testimony and unimpaired memory at trial, and on the fact that the board had made its finding of PTSD impairment a full year after Hagen’s trial.

Although even such renowned warriors as Audie Murphy have reportedly suffered PTSD-like symptoms following combat experiences, the military has continued to be skeptical of the PTSD

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139. *Id.*
140. *Id.*
142. *Id.*, slip op. at 1, 2.
143. *Id.*, slip op. at 3.
144. *Id.*
145. *Id.*, slip op. at 5.
146. *Id.*
147. *Id.*
148. *Id.*, slip op. at 6.
149. Audie Murphy, America’s most decorated World War II hero, reportedly was plagued by war-related nightmares and could not sleep without a loaded German pistol under his pillow. Hendin & Haas, *Vietnam Veterans’ Trauma*, N.Y. Times, Nov. 11, 1984, at E21, col. 3.
defense. Such skepticism may be attributed to a self-perpetuating masculine image\textsuperscript{150} that views soldiers who do not react well to combat as weak or cowardly\textsuperscript{151} or to a military reluctance to grant a potential judicial carte blanche to its many combat veterans.

\section*{Evidentiary Considerations}

\textit{Expert Testimony}

The prerequisites for the use of expert testimony vary with each jurisdiction, but generally the subject matter of the expert’s testimony must be so distinctly related to a scientific or professional area or occupation that knowledge of it is beyond the ken of laymen.\textsuperscript{152} The trial judge may allow expert testimony even if the jurors have some generalized knowledge of the subject, provided, however, such testimony would be useful.\textsuperscript{153} The expert testimony need only be relevant, probative, and helpful to the trier of fact.\textsuperscript{154} Additionally, the witness must demonstrate the requisite skills, knowledge, or experience to qualify as an expert.\textsuperscript{155}

\begin{enumerate}
\item \textsuperscript{151} An extreme example of military intolerance for warrior weakness is General George Patton’s face-slapping incident involving an apparently shell-shocked soldier in World War II.
\begin{quote}
When asked what his trouble was, the man replied, [sic] “It’s my nerves,” and began to sob. The General then screamed at him. “What did you say?” He replied, “It’s my nerves, I can’t take the shelling anymore.” He was still sobbing. The General then yelled at him. “Your nerves, Hell, you are just as [sic] goddam coward, you yellow son of a bitch.” He then slapped the man and said, “Shut up that Goddam crying. I won’t have these brave men here who have been shot seeing a yellow bastard sitting there crying.”
\end{quote}
\item \textsuperscript{152} C. McCormick, \textit{McCormick on Evidence} § 13 (3d ed. 1984).
\item \textsuperscript{153} \textit{Id.} \textit{See} Fed. R. Evid. 702 (expert testimony permitted if specialized knowledge will “assist the trier of fact to understand the evidence or to determine a fact in issue”).
\item \textsuperscript{154} Raifman, \textit{Problems of Diagnosis and Legal Causation in Courtroom Use of Post-Traumatic Stress Disorder}, 1 Behav. Sci. & L. 115, 127 (1983).
\item \textsuperscript{155} \textit{Id.}\
\end{enumerate}
The Insanity Defense Reform Act of 1984 amended the federal rules concerning admissibility of expert testimony. The new rule prohibits an expert witness from expressing an opinion or making an inference as to whether a defendant possessed a certain mental state. This rule, which restricts expert testimony to the presentation and explanation of diagnoses—for example, a description of the characteristics and severity of a mental disease or defect—was designed to eliminate confusion created by conflicting expert testimony on the ultimate issue of insanity to be decided by the trier of fact. The limitation applies not just to the insanity plea but to any ultimate determination of mental state that is relevant to the legal issue to be proved. A jury, however, may now specifically find a defendant “not guilty only by reason of insanity.”

Courts increasingly have been called on to determine the proper qualifications for experts offering testimony concerning PTSD. In Allewalt v. State, a Maryland court held that in order to qualify as an expert, a witness had to possess “such a degree of knowledge as to make it appear that his opinion is of some value whether such knowledge has been gained from observation or experience, standard books, maps of recognized authority, or any other reliable sources.”

Rule 702, which is followed by federal, military, and most state courts, dictates broad criteria for expert witness qualification. The rule is loosely phrased to allow qualification not only through

157. The rule provides:

[n]o expert witness testifying with respect to the mental state or condition of a defendant in a criminal case may state an opinion or inference as to whether the defendant did or did not have the mental state or condition constituting an element of the crime charged or of a defense thereto.

Fed. R. Evid. 704(b).
159. Id. at 231, reprinted in 1984 U.S. Code Cong. & Admin. News at 3413. Examples include premeditation in a homicide case and lack of disposition in entrapment. Id.
162. Id. at 669 (quoting Radman v. Harold, 279 Md. 167, 170, 367 A.2d 472, 474 (1976)).
scientific or technical knowledge, but also through specialized knowledge held by "skilled" witnesses.\textsuperscript{164} The rule thus recognizes that a witness may gain expertise by experience as well as through formal training or education.\textsuperscript{165} This expanded definition should allow the qualification of counselors and social workers as experts in PTSD.

Despite such broad criteria, however, the United States Court of Appeals for the Fifth Circuit upheld a trial court's refusal to qualify a witness as a PTSD expert because he was not a trained physician.\textsuperscript{166} In \textit{United States v. Crosby},\textsuperscript{167} the United States District Court for the Eastern District of Louisiana refused to qualify a counselor from a storefront veterans' counseling service as an expert in diagnosing PTSD because it determined that only a qualified physician could make such a diagnosis.\textsuperscript{168} Although the witness held a master's degree in social work, the lower court also refused to qualify him as an expert because it held that sociology was irrelevant.\textsuperscript{169} The court of appeals upheld the trial court's decision as within the judge's discretionary power.\textsuperscript{170}

In situations similar to that in \textit{Crosby}, state court determinations of expert qualification have varied with each judge. In \textit{State v. Sharp},\textsuperscript{171} a Louisiana court permitted a Veterans Administration counselor to testify as an expert in social work dealing with veterans suffering from emotional problems. The court accepted the counselor's testimony concerning conversations with the defendant about his battlefield experiences.\textsuperscript{172} Psychologists testified as experts in \textit{State v. Pettit}\textsuperscript{173} and \textit{State v. Simonson},\textsuperscript{174} and a

\begin{footnotesize}
\textsuperscript{164} 56 F.R.D. 183, 282 (note to Fed. R. Evid. 702).
\textsuperscript{165} United States v. Johnson, 575 F.2d 1347, 1361 (5th Cir.), cert. denied, 440 U.S. 907 (1978).
\textsuperscript{166} United States v. Crosby, 713 F.2d 1066 (5th Cir.), cert. denied, 464 U.S. 1001 (1983).
\textsuperscript{167} Id.
\textsuperscript{168} Id. at 1076-77.
\textsuperscript{169} Id. at 1076 n.10.
\textsuperscript{170} Id. at 1077.
\textsuperscript{171} 418 So. 2d 1344 (La. 1982).
\textsuperscript{172} Id. at 1347 n.4.
\textsuperscript{173} 104 Idaho 601, 661 P.2d 767 (1983).
\textsuperscript{174} 100 N.M. 297, 669 P.2d 1092 (1983).
\end{footnotesize}
neuropharmacologist testified about a veteran’s drug problems in State v. Cone.\textsuperscript{175}

Other state courts have interpreted expert qualifications more narrowly. In Wilburn v. State,\textsuperscript{176} an Arkansas court held that a social worker who directed a veterans’ counseling service was not qualified to testify whether the defendant was under the influence of an extreme emotional disturbance during counseling.\textsuperscript{177} In a North Carolina case,\textsuperscript{178} the court held that a Vietnam veteran could not testify about his own dissociative episodes since he had not qualified as an expert and the defense had not presented expert testimony showing that the witness suffered from PTSD.\textsuperscript{179} In State v. Felde,\textsuperscript{180} the court held that the testimony of a former operating room nurse about the type of wounds sustained by veterans was irrelevant, and that a person who researched complaints from Vietnam veterans did not qualify as an expert on the effects of Agent Orange.\textsuperscript{181} Furthermore, the court did not allow the researcher to testify about his own Vietnam adjustment problems.\textsuperscript{182}

\textit{Combat Film Footage}

Film footage of Vietnam may prove useful in assisting the trier of fact to appreciate the trauma of combat fully. As with still photographs, film footage arguably is admissible as a graphic portrayal of oral testimony.\textsuperscript{183} The proponent may establish its reliability and accuracy through testimony that the film accurately reproduces the event as the witness perceived it.\textsuperscript{184} Films made by or depicting activities of the accused and films of events in which the

\begin{footnotes}
\item[175] 665 S.W.2d 87, 92 (Tenn.), \textit{cert. denied}, 467 U.S. 1210 (1984).
\item[176] 289 Ark. 224, 711 S.W.2d 760 (1986).
\item[177] \textit{Id.} at 224-5, 711 S.W.2d at 761.
\item[178] State v. Avery, 315 N.C. 1, 337 S.E.2d 786 (1985). The defendant, while being treated for PTSD, donned his Army fatigues and assaulted an office complex with several weapons and firebombs. \textit{Id.} at 789. He struck a nurse on the head with the butt of a rifle, shot four people, charred four separate areas of the building, and then shot himself in the head with a .22 caliber pistol. \textit{Id.} at 789-90.
\item[179] \textit{Id.} at 801-02.
\item[180] 422 So. 2d 370 (La. 1982).
\item[181] \textit{Id.} at 386-87.
\item[182] \textit{Id.} at 386.
\item[183] C. \textsc{McCor\textsc{m}ick}, \textit{supra} note 152, \S\ 214 at 671.
\item[184] \textit{Id.}
\end{footnotes}
accused participated are particularly relevant and have strong prospects for admission. In *State v. James*, the Louisiana Court of Appeals held that the trial judge had discretion to disallow the introduction of a commercially produced film. The court noted that the accused did not appear in the film, the film did not show combat in which the defendant had participated, and the film’s possible prejudicial effect outweighed any potential probative value.

**Intoxication**

An issue requiring expert testimony may arise when a defendant who asserts a PTSD defense was also intoxicated at the time of the incident. If voluntary intoxication is seen as the cause of the attack, then the PTSD defense may fail. In *Commonwealth v. Plank*, the court refused to allow a defendant charged with rape to present an insanity defense based on his chronic alcohol abuse. The court held that if the "defendant drank voluntarily, the insanity defense is barred because appellant induced the infirmity."

In *Norris v. State*, a drunken Vietnam veteran stabbed a party host following an argument. A psychiatrist testifying for the accused stated that even though Norris was intoxicated, he was experiencing a PTSD-related flashback when the stabbing occurred. The government psychiatrist, however, testified that alcohol, combined with the amount of valium Norris had taken, could have precipitated the stabbing regardless of any flashback. The appellate court upheld Norris’ conviction for aggravated assault.
A plausible means of circumventing the voluntary intoxication bar to the PTSD defense is to argue that drinking problems themselves are caused by PTSD. This "involuntary intoxication" argument may be cast in terms of self-medication of symptoms\(^\text{194}\) and/or PTSD-generated psychological need.\(^\text{195}\) Empirical data of widespread alcohol problems among Vietnam veteran defendants\(^\text{196}\) lend support to this theory.

**CONCLUSION**

American society and the criminal justice system have recognized, belatedly, that a large number of Vietnam veterans are suffering adverse psychological reactions as a result of their experiences in Vietnam.\(^\text{197}\) This recognition, coupled with the nation's recovery from the Vietnam experience, has resulted in growing sympathy in society for the problematic veteran.\(^\text{198}\) This is equally true in the courtroom.\(^\text{199}\) Sympathy and sensitivity toward the problems of the Vietnam veteran may even filter into the military tribunal as the notion of PTSD gains credibility. For many veterans, these steps are long overdue. Progress has been halting, however, especially in light of the recent tightening of legal insanity standards following the insanity acquittal of John Hinkley.\(^\text{200}\)

Like any other insanity defense, PTSD is vulnerable to abuse.\(^\text{201}\) Nevertheless, PTSD diagnostic criteria are sufficiently well defined to enable courts to prevent its manipulation in most cases. One can only hope that the popular distaste for insanity pleas will not de-

\(^{194}\) See J. Goodwin, *supra* note 112 at 121.

\(^{195}\) Id.

\(^{196}\) See *supra* note 5 and text accompanying note 110.


\(^{199}\) "Those people are combat veterans and hero types,' states Elliot Milstein, an American University law professor and co-director of the National Veterans' Law Center. 'Juries and judges tend to be sympathetic.'" Burke, *supra* note 54, at 26, col. 2.

\(^{200}\) See Lefcourt & Becker, *supra* note 97, at 355.

prive Vietnam veterans suffering from PTSD of a legitimate judicial defense.

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