Editor's Note: On 18 July 2007, the Army launched a chain-teaching program to help Soldiers and their Families identify symptoms and seek treatment for those suffering from Post Traumatic Stress Disorder (PTSD) and mild Traumatic Brain Injury (mTBI). This program recognizes the significant and genuine impact of these conditions on Soldiers, Families, and military units. It also reflects the Army's ongoing effort to identify and treat those who are experiencing PTSD and mTBI. The following article highlights an area of special concern for Judge Advocates: dealing with survivors of PTSD in the military justice system.

POST-TRAUMATIC STRESS DISORDER ON TRIAL

MAJOR TIMOTHY P. HAYES, JR.*

It has come to my attention that a very small number of [S]oldiers are going to the hospital on the pretext that they are nervously incapable of combat. Such men are cowards and bring discredit on the army and disgrace to their comrades, whom they heartlessly leave to endure the dangers of battle while they, themselves, use the hospital as a means of escape. You will take measures to see that such cases are not sent to the hospital but are dealt with in their units. Those who are not willing to fight will be tried by Court-Martial for cowardice in the face of the enemy.[1]

Every summer when it rains
I smell the jungle, I hear the planes
Can't tell no one, I feel ashamed,

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[1] Memorandum, General George S. Patton, to Seventh Army, (Aug. 5, 1943), *quoted in* Charles M. Province, *The Unknown Patton*, http://www.pattonhq.com/unknown/chap08.html (last visited Aug. 13, 2007).

Afraid someday I'll go insane . . .
Cause I'm still in Saigon . . . in my mind.[2]

I. Introduction

The above quotes from strikingly divergent sources indicate the widely differing viewpoints that are likely to be encountered when discussing the occurrence of post-traumatic stress disorder (PTSD), or as it is most commonly referred to, PTSD. An occurrence is perhaps the best way to describe PTSD at this juncture, because it is innocuous. To call it a disorder or disease, although technically correct,[3] would not satisfy those that would seek to label PTSD as an attractive excuse for criminal defendants or disgruntled Soldiers, and there are certainly individuals that continue to espouse those views.[4] As long as those people continue to be members of the jury pool, or court-martial panel population, that viewpoint must be taken into account by attorneys preparing to prosecute or defend a case where PTSD is at issue. As combat activities continue in theaters like Iraq and Afghanistan, it becomes increasingly likely that trial practitioners will have to become well-versed in understanding the complexities of PTSD as both a disorder and a defense. Therefore, the purpose of this article is to examine the current state of medical and legal understanding regarding combat-related PTSD,[5] especially when presented in courts-martial.

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[2] Samuel P. Menefee, *The "Vietnam Syndrome" Defense: A "G.I. Bill of Criminal Rights"?*, ARMY LAW., Feb. 1985, at 1 (quoting THE CHARLIE DANIELS BAND, *Still in Saigon, on* WINDOWS (Epic Records 1982)).

[3] *See* AMERICAN PSYCHIATRIC ASSOCIATION, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS 424 (4th ed. 1994) [hereinafter DSM-IV].

[4] *See, e.g.*, National Defence and Canadian Forces [CF] Ombudsman, Systemic Treatment of CF Members with PTSD Complainant: Christian McEachern, http://www.ombudsman.forces.gc.ca/rep-rap/sr-rs/pts-ssp/rep-rap-02-eng.asp (last visited August 24, 2007), where reactions to PTSD are described under the heading "Resentment towards members with PTSD." For a more reasoned and thorough discussion, *see* CHRIS R. BREWIN, POSTTRAUMATIC STRESS DISORDER: MALADY OR MYTH? (2003). *See also* GERALD ROSEN, POSTTRAUMATIC STRESS DISORDER: ISSUES AND CONTROVERSIES (2004).

[5] Although the focus of this article is combat-related PTSD, there are, of course, several other stimuli that will trigger onset of the disorder, such as domestic violence, rape, or other violent crimes, and near death experiences in accidents or natural disasters. *See, e.g.*, Edgar Garcia-Rill & Erica Beecher-Monas, *Gatekeeping Stress: The Science and Admissibility of Post-Traumatic Stress Disorder*, 24 U. ARK. LITTLE ROCK L. REV. 9 (2001).

After examining PTSD, first historically and then medically, this article will address the prevalence of PTSD within various populations. The focus of the article will then shift to its main emphasis, an analysis of PTSD within the military courtroom. This analysis will include the impact of PTSD on the accused's competency to stand trial,[6] as well as its impact on the merits of the case as a defense for lack of mental responsibility[7] or a claim of partial mental responsibility.[8] The effects of these findings will also be discussed. Finally, the article will focus on the other areas of trial where PTSD can become a factor, such as when questioning a witness suffering from PTSD[9] or when presenting PTSD as extenuation evidence during pre-sentencing.[10] The final result is a resource for judge advocates to consult when preparing for a trial that in any way involves PTSD.

II. Post-Traumatic Stress Disorder

Post-traumatic stress disorder has been documented, in some form, for as long as man has recorded his reactions to combat. As far back as ancient Hebrew civilization, Soldiers have recognized and coped with the negative mental repercussions of combat.[11] Hundreds of years later, in the Greek historian Xenophon's obituary describing the life of Clearchus, one commentator suggests that we are presented with "the first known historical case of PTSD in the [W]estern literary tradition."[12] The great Greek historian Herodotus, writing of the Battle of Marathon in 490 B.C., told of a Soldier that went permanently blind upon witnessing the death of his comrade in battle, although the blinded Soldier himself had

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[6] MANUAL FOR COURTS-MARTIAL, UNITED STATES, R.C.M. 909 (2005) [hereinafter MCM].
[7] *Id.* R.C.M. 916(k)(1).
[8] *Id.* R.C.M. 916(k)(2).
[9] *Id.* MIL. R. EVID. 104.
[10] *Id.* R.C.M. 1001(c).
[11] *See, e.g.*, *Psalms* 22:14 (King James) (where King David, a renowned warrior who lived in the 11th century B.C.E., describes his emotions in the face of his enemies as being "poured out like water" with all his "bones out of joint," with a "heart . . . like wax . . . melted in the midst of [his] bowels"). *See also Psalms* 55:3-5 (King James) (where David relates that "[b]ecause of the voice of the enemy . . . [m]y heart is sore pained within me: and the *terrors of death* are fallen upon me. Fearfulness and trembling are come upon me, and horror hath overwhelmed me" (emphasis added)).
[12] LAWRENCE A. TRITLE, FROM MELOS TO MY LAI: WAR AND SURVIVAL 56 (2000). Tritle's conclusion is suspect, in that he characterizes Xenophon's obituary as describing Clearchus as a victim of combat, when Xenophon's text actually seems to portray a heroic man fond of battle, rather than traumatized by it.

not been physically wounded.[13] The English King Alfred became so ill due to the horrors of a battle in 1003 A.D. that he vomited and was unable to lead his men.[14]

The first formal diagnosis occurred in 1678, when the Swiss coined the term "nostalgia" for a group of symptoms suffered by Soldiers that would arguably fall within the range of clinical PTSD, such as melancholy, insomnia, loss of appetite, and anxiety.[15] During the American Civil War, an Army surgeon named Dr. Jacob Mendes Decosta diagnosed many cases of tension, insomnia, and fear of returning to the front which could be manifested by paralysis, self-inflicted wounds, and increased cardiac palpitations. In 1871, Dr. Decosta labeled the condition "irritable heart" or "soldier's heart" in an article in the American Journal of Medical Sciences.[16] It was reported that veterans that had returned home would collapse due to emotional strain, even if they had shown no signs of mental illness on the battlefield.[17] Public outcry and the urging of surgeons led the United States to establish the first military hospital for the insane in 1863.[18] In the Russo-Japanese War of the early twentieth century, the Russian Army determined for the first time that mental collapse directly resulted from the stressors of combat, and that such collapses were "legitimate medical conditions"; their efforts to diagnose and especially to treat these conditions can fairly be regarded as the "birth of military psychiatry."[19]

During World War I, many attributed Soldiers' psychological injuries to higher calibers of weaponry. It was suggested that large artillery shells were causing concussions, or "shell shock" as it was then described.[20] Towards the end of the war, the medical establishment began to realize that these mental injuries had an emotional, rather than

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[13] Steve Bentley, *A Short History of PTSD: From Thermopylae to Hue, Soldiers Have Always Had a Disturbing Reaction to War*, THE VVA VETERAN, 1991, at 11-16.
[14] *Id.*
[15] *Id.*
[16] Jo Knox & David H. Price, *Healing America's Warriors, Vet Centers and the Social Contract*, http://www.vietnam.ttu.edu/vietnamcenter/events/1996_Symposium/96papers/healing.htm (citing A. Perkal, *War Related Posttraumatic Stress Disorder: A Historical Perspective*, CLINICAL NEWSLETTER (National Center for Posttraumatic Stress Disorder), 1992, at 2, (2) 19) (last visited Aug. 13, 2007).
[17] Bentley, *supra* note 13.
[18] *Id.*
[19] *Id.*
[20] *Id.*

physical, root.[21] In actuality, more American Soldiers were out of action due to psychiatric illness than died in combat.[22] The psychiatric community concluded that these injuries occurred only in "weak-minded" individuals and set out to solve the problem by screening such people out of the military before induction, to the extent they could be identified.[23]

World War II (WWII) produced psychiatric casualties in even more alarming numbers than had been experienced in World War I. One commentator asserts that, out of approximately 800,000 Soldiers that participated in direct combat, over thirty-seven percent had to be discharged for "psychiatric" reasons.[24] Regardless of the accuracy of those numbers, clearly it was not just the mentally "weak" that were susceptible to breakdowns. Regrettably, this recognition did not lead to the conclusion that such disorders were in fact mental diseases. On the contrary, the introduction and widespread use of such terms as "battle fatigue" and "mental exhaustion" reinforced the belief that a little rest would be all that was required to return the Soldier to the front.[25]

Psychiatric casualty rates remained high in the Korean and Vietnam Wars,[26] and the rates from Vietnam were possibly exacerbated by the moral questions that many American Soldiers had about the war itself.[27] No significant advances in the study or classification of the underlying causes and effects of these psychiatric injuries took place until after the Vietnam War ended. These advances followed widespread recognition of the mental trauma of Vietnam veterans, partly evidenced by the opening of over ninety counseling centers for veterans across the country by 1979.[28] Curiously, unlike in previous wars, the occurrence and frequency of reported psychiatric trauma increased as the war came to an

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[21] *Id.*

[22] *See id.* The author notes that while there were over 116,000 American deaths in Europe, there were 159,000 Soldiers out of action for psychiatric problems.

[23] *Id.* Mr. Bentley alleges that five *million* individuals were rejected for service as a result of this psychiatric screening.

[24] *Id.*

[25] *Id.*

[26] *Id.* Statistics from these wars will be examined in Section II.B of this article, *The Prevalence of Post-Traumatic Stress-Disorder in the Military*, as many of these veterans remain in the population today. *See infra* notes 50 to 72 and accompanying text.

[27] *Id.* It is conceivable that this exacerbation is due to the Soldiers' inner conflicts about the justification of the war, or the unpopularity of the war could have encouraged Soldiers to come forward about their trauma, or both.

[28] Menefee, *supra* note 2, at 3.

end.[29] Additionally, during the same period, there were a number of catastrophic events such as acts of terrorism, natural disasters, and plane crashes. Mental health professionals working with victims of these disasters noted almost identical symptoms among this population as those complained of by Vietnam veterans.[30] The medical community began to consider "battle fatigue" and other stress reactions as a certifiable, clinical diagnosis. After extensive research by veterans groups and recommendations by mental health workers, the 1980 update to the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM-III)[31] included a new category of illness: post-traumatic stress disorder.[32] The most recent update in 1994, DSM-IV, continues to list post-traumatic stress disorder as a mental disorder.[33] A text revision occurred in 2000 which did not affect the PTSD criteria.[34]

A. Post-Traumatic Stress Disorder from a Medical Perspective

> Post-Traumatic Stress Disorder (PTSD) is a debilitating condition that follows a terrifying event. Often, people with PTSD have persistent frightening thoughts and memories of their ordeal and feel emotionally numb, especially with people they were once close to. PTSD, once referred to as shell shock, was first brought to public attention by war veterans, but it can result from any number of traumatic incidents. These include kidnapping, serious accidents such as car or train wrecks, natural disasters such as floods or earthquakes, violent attacks such as mugging, rape, or torture, or being held captive. The event that triggers it may be

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[29] Jim Goodwin, *The Etiology of Combat-Related Post-Traumatic Stress Disorder*, *in* POST-TRAUMATIC STRESS DISORDERS: A HANDBOOK FOR CLINICIANS 1-18 (1987), *available at* http://home.earthlink.net/~dougyelmen/readjust.html (last visited Aug. 13, 2007).

[30] *Id.*

[31] AMERICAN PSYCHIATRIC ASSOCIATION, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS 236 (3d ed. 1980) [hereinafter DSM-III].

[32] Goodwin, *supra* note 29.

[33] DSM-IV, *supra* note 3, at 424.

[34] *See* AMERICAN PSYCHIATRIC ASSOCIATION, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS 468 (4th ed. 2000 Text Revision) [hereinafter DSM-IV-TR].

> something that threatened the person's life or the life of someone close to him or her.[35]

That, in laymen's terms, is an accurate description of PTSD. The DSM-IV criteria, which are provided in their entirety at Appendix A, are summarized below:

(1) A traumatic event that involved death or serious injury to self or others and included a response of intense fear, helplessness, or horror;
(2) The traumatic event distressingly recurs in recollections (such as images and thoughts), dreams, actions (including hallucinations and dissociative flashbacks), or intense responses or physiological reactions to certain cues;
(3) Persistent avoidance of trauma-associated stimuli and numbing of responsiveness as evidenced by at least three listed indicators (such as detachment and diminished interest);
(4) Persistent symptoms of increased arousal (such as insomnia, angry outbursts, and hypervigilance);
(5) The existence of these indicators for more than one month; and,
(6) The disturbance causes significant distress or impairment.

The diagnosis may be acute or chronic, depending on whether the symptoms endure for less or more than three months, respectively, and may be labeled "with delayed onset" if the symptoms do not appear until at least six months after the traumatic event.[36] There are numerous associated features such as depressed mood, somatic or sexual dysfunction, guilt or obsession, and addiction.[37] Diagnosis can be difficult because several disorders, such as major depressive disorder, obsessive-compulsive disorder, and schizophrenia, have similar or identical symptoms.[38] Additionally, PTSD is more common in people with a history of those disorders.[39]

Although the precise cause is unknown, several factors may contribute to a person acquiring PTSD, such as psychological, genetic,

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[35] Posttraumatic Stress Disorder, http://www.psychnet-uk.com/dsm_iv/posttraumatic_stress_disorder.htm [hereinafter Posttraumatic Stress Disorder] (last visited Aug. 13, 2007).
[36] DSM-IV-TR, *supra* note 34, at 468.
[37] *Id*. at 465.
[38] *Id.* at 467.
[39] *Id.* at 465.

physical, and social factors.[40] Individuals with a strong support network may be less likely to develop PTSD than those with poor support systems.[41] According to the National Center for PTSD, a division of the Department of Veterans Affairs, treatment of reported PTSD is often accomplished via individual or group therapy, medication, or both.[42] Therapy can include psychotherapy, exposure therapy, other less common treatments, or some combination of those methods.[43] Beneficial medications include antidepressants, mild tranquilizers, and antipsychotics.[44]

Some panel members may continue to doubt the authenticity of PTSD in a particular case, or as a mental disorder in general, despite its universal acceptance by the medical community as presented by expert testimony. In such cases, magnetic resonance images (MRIs) could possibly be used to illustrate the difference between a veteran suffering from PTSD and one who is not afflicted with the disorder. Such a comparison is provided at Appendix B.[45] Similar MRIs presented in a court-martial as verifiable scientific evidence of a mental disorder (or perhaps of a lack thereof) could be highly persuasive to a panel for either the defense or the prosecution. However, despite the existence of at least five published studies linking PTSD to reduced hippocampal size within the brain,[46] the reduction in size is relatively small—five to twenty percent[47]—and many PTSD patients have no or very minimal reduction in hippocampal size.[48] Therefore, MRIs are not used to diagnose or

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[40] *Id.* at 466.
[41] *Id*.
[42] *Treatment of PTSD - (National Center for PTSD)*, http://www.ncptsd.va.gov/ncmain/ncdocs/fact_shts/fs_treatmentforptsd.html (last visited Aug. 13, 2007).
[43] *Id.*
[44] *See* Posttraumatic Stress Disorder, *supra* note 35.
[45] Images found at Appendix B were reproduced from http://www.news-leader.com/apps/pbcs.dll/article?AID=/20050927/LIFE04/509270313 (last visited Nov. 1, 2005); *see also, e.g.*, Tamara v. Gurvits et al., *Magnetic Resonance Imaging Study of Hippocampal Volume in Chronic, Combat-Related Posttraumatic Stress Disorder*, 40 BIOL. PSYCHIATRY 1091 (1996).
[46] PTSD, http://www.lawandpsychiatry.com/html/ptsd.html (citing N. Schuff et al.,. *Reduced Hippocampal Volume and n-acetylaspartate in Post Traumatic Stress Disorder*, 821 ANNALS N. Y. ACAD. SCI. SUPP. PSYCHOBIOLOGY OF POSTTRAUMATIC STRESS DISORDER 516 (1997)) [hereinafter PTSD] (last visited Aug, 13, 2007). *See also* J. Douglas Bremner, *Neuroimaging Studies in PTSD*, NC-PTSD CLINICAL Q. (National Center for PTSD, White River Junction, Vt.), Fall 1997, at 70-71, 73, *available at* http://www.ncptsd.va.gov/ncmain/nc_archives/clnc_qtly/V7N4.pdf?opm=1&rr=rr249&srt=d&echorr=true.
[47] *See* PTSD, *supra* note 46.
[48] *Id.*

determine the severity of PTSD, but could be used to illustrate and verify the occurrence of PTSD within a particular individual. The ramifications of the resulting images should be carefully considered when contemplating an MRI request.[49]

B. The Prevalence of Post-Traumatic Stress Disorder in the Military

It is worth noting that the overall prevalence of PTSD in the general population is estimated to be anywhere from one to fourteen percent.[50] This statistic, although imprecise, helps put military PTSD statistics in context. One researcher has concluded that roughly one-third of combat veterans become affected by PTSD, and probably a higher proportion of prisoners of war.[51] The earliest statistical analysis of PTSD prevalence among war veterans involves Soldiers from WWII and Korea who are generally the oldest veterans still alive today. One study found the current prevalence of PTSD in veterans of those two wars, who had not previously sought psychiatric treatment, to be nine and seven percent, respectively; among those that *had* sought psychiatric treatment previously, thirty-seven percent of the WWII veterans and eighty percent of the Korean War veterans were currently suffering from PTSD.[52] Another study found that fifty-four percent of a group of psychiatric patients who had seen combat in WWII met the PTSD criteria, whether or not they had sought treatment for PTSD, and twenty-seven percent were continuing to suffer from PTSD at the time of the study.[53]

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[49] For example, the accused is not likely to have a pre-PTSD MRI of his brain, so his PTSD MRI would have to be compared to a non-PTSD individual's MRI, or simply explained by an expert, or both. However, the previous statistics have shown the likelihood that the accused's MRI will not reveal any significant reduction in hippocampal size. Such an MRI, if introduced into evidence, may persuade some panel members not to accept other PTSD evidence presented through expert or lay testimony.

[50] Garcia-Rill & Beecher-Monas, *supra* note 5, at 17 (citing Naomi Breslau & Glen Davis, *Posttraumatic Stress Disorder in an Urban Population of Young Adults: Risk Factors for Chronicity*, 149 ARCHIVES GEN. PSYCH. 671 (1992)). *See also* Ronald C. Kessler, *Posttraumatic Stress Disorder: The Burden to the Individual and to Society*, 61 J. CLIN. PSYCHIATRY 4, 6 (2000) (citing a lifetime prevalence of only one to two percent).

[51] Garcia-Rill & Beecher-Monas, *supra* note 5, at 17 (citing R.A. KULKA ET AL., TRAUMA AND THE VIETNAM WAR GENERATION 53 (1990)).

[52] Matthew J. Friedman et al., *Post-Traumatic Stress Disorder in the Military Veteran*, 17-2 PSYCH. CLIN. OF N. AM. 265, 267 (1994) (citing D. Blake et al., *Prevalence of PTSD Symptoms in Combat Veterans Seeking Medical Treatment*, J. TRAUM. STRESS 315 (1990)).

[53] Friedman et al., *supra* note 52, at 267 (citing J. Rosen et al., *Concurrent Posttraumatic Stress Disorder in Psychogeriatric Patients*, 2 J. GERIATRIC PSYCH. NEUROL. 65 (1989)).

Of the over one and one-half million American troops that served in the Korean War, almost 200,000 saw combat. Of those that saw combat, almost one-quarter were psychiatric casualties.[54] In Vietnam, although almost three million American troops served, it has been difficult to estimate the number of troops that actually saw combat given the nature of the fighting.[55] However, the Vietnam conflict was the first to fuel widespread statistical tracking of PTSD affliction among its veterans. One study concluded that approximately 480,000 troops became afflicted with PTSD as a result of their Vietnam experience, and another 350,000 acquired partial PTSD.[56] Of those 830,000 veterans with some form of PTSD, only about 55,000 had filed a claim, and only half of those have been certified by adjudication boards.[57] Estimates vary significantly, with some authorities contending that the prevalence of PTSD in Vietnam veterans is as high as seventy percent.[58]

Perhaps the most reliable study of Vietnam veterans estimated current prevalence of PTSD, at the time of the study, to be over fifteen percent in males and over eight percent in females.[59] Within that group, current PTSD was much higher in veterans with "high war-zone exposure": over thirty-five percent of men and over seventeen percent of women.[60] The prevalence of PTSD over the course of a lifetime for Vietnam veterans was estimated at over twenty-five percent for both men and women.[61] The same study notes that Vietnam veterans were less likely to be married but more likely, if married, to be divorced or have marital problems.[62] Of more significance to this article, one-quarter of the male Vietnam veterans afflicted with PTSD had engaged in *thirteen* or more violent acts in the previous year, and half had been arrested or

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[54] Bentley, *supra* note 13. The author notes that the chances of being a psychiatric casualty in Korea was 143 percent greater than the chances of being killed in combat.
[55] *Id.*
[56] *Id.* (citing R. A. KULKA, TRAUMA & THE VIETNAM WAR GENERATION: REPORT OF FINDINGS FROM THE NATIONAL VIETNAM VETERANS READJUSTMENT STUDY (1990)). "Partial" PTSD is undefined.
[57] *Id.* (data on claims and adjudications through July 1990).
[58] Michael J. Davidson, *Post-Traumatic Stress Disorder: A Controversial Defense for Veterans of a Controversial War*, 29 WM. & MARY L. REV. 415 (1988) (citing John Wilson & Sheldon Zigelbaum, *The Vietnam Veteran on Trial: The Relation of Post-Traumatic Stress Disorder to Criminal Behavior*, 1 BEHAV. SCI. & L. 70 (1983)).
[59] Friedman et al., *supra* note 52, at 266 (citing KULKA, *supra* note 56).
[60] *Id.*
[61] *Id.*
[62] *Id.* at 268.

incarcerated multiple times as an adult.[63] Even after the first Gulf War—a popular, brief, and successful endeavor—PTSD rates were almost ten percent among male veterans and almost twenty percent among female veterans.[64]

Of most interest to current military trial practitioners are the emerging statistics from the conflicts in Iraq and Afghanistan. The only comprehensive study to date has estimated the risk for depression, anxiety, or PTSD among Iraq veterans to be eighteen percent, and the risk among Afghanistan veterans to be eleven percent.[65] A study conducted before these conflicts commenced found that at least six percent of all U.S. active duty service members receive treatment for some form of mental disorder every year.[66]

Clearly, not every combat veteran will suffer from clinically diagnosed PTSD during their lifetime. There are many risk factors to weigh. These include pre-military factors such as education, economic deprivation, and history of abuse, prior psychiatric disorders, or behavioral problems; wartime factors such as high exposure to combat or being wounded or injured in combat; and post-military factors such as social support, coping skills, and physical disabilities resulting from combat, reminding the veteran of his or her traumatic experience.[67] Social support includes the various benefits a veteran with PTSD might receive from agencies like the Department of Veterans Affairs (VA). The VA recently announced that over 215,000 veterans received PTSD benefit payments in 2004 at a cost of $4.3 billion, a jump of over 150 percent in five years.[68] These increases do not even factor in Iraq and

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[63] *Id.* These astounding figures were culled from the National Vietnam Veterans' Readjustment Study which was ordered by Congress in 1983, *supra* note 56. *See also* http://www.ncptsd.va.gov/ncmain/ncdocs/fact_shts/fs_nvvrs.html?opm=1&rr=rr45&srt=d&echorr=true (last visited Aug. 14, 2007).

[64] *Id.* at 267 (citing unpublished data from 1993).

[65] Charles W. Hoge et al., *Combat Duty in Iraq and Afghanistan, Mental Health Problems, and Barriers to Care*, 351 NEW ENG. J. MED. 13 (2004).

[66] *Id.*

[67] Friedman et al., *supra* note 52, at 268-270. One study conducted by the Center for the Study of Traumatic Stress, an arm of the Uniformed Services University of Health Sciences, has found that a severely wounded veteran is not more likely to suffer from PTSD than a combat veteran who was not severely wounded. *See* Deborah Funk, *Study: PTSD Not More Likely in Severely Wounded Vets*, ARMY TIMES, Feb. 20, 2006, at 28.

[68] Shankar Vedantam, *A Political Debate on Stress Disorder*, WASH. POST, Dec. 27, 2005, at A01.

Afghanistan veterans, but reflect a growing number of Vietnam veterans seeking treatment.[69]

The preceding statistics illustrate that military trial practitioners are likely to encounter PTSD in some fashion in future trials involving combat veterans. This is due primarily to the vast number of participants in recent campaigns in Iraq and Afghanistan, but also due to the intensity, and perhaps the unpredictability, of those campaigns. As one expert has noted, "[t]here is no front line in Iraq,"[70] recognizing that combat support or combat service support Soldiers on a compound or in a convoy may be as susceptible to attack as the combat arms Soldiers that are on patrol. Others are quick to note that "[b]eing in the war zone does not constitute exposure to trauma . . . [i]t is just stressful."[71] While it is true that many, if not most, veterans will experience "[r]eadjustment and reintegration issues"[72] not amounting to PTSD, those veterans are not likely to commit court-martial offenses, or their readjustment/reintegration issues will not rise to the level of a legal defense. However, given the significant percentage of veterans who will return from deployment with PTSD or PTSD-like symptoms, the likelihood of PTSD evidence in future proceedings must be acknowledged and addressed. Therefore, the focus of this article now shifts to the potential impacts of PTSD upon those proceedings, beginning with a brief review of three seminal PTSD cases.

In *United States v. Cartagena-Carrasquillo*,[73] the defendant was convicted of cocaine trafficking after his PTSD evidence was excluded by the trial judge. This exclusion was one basis of his appeal. Mr. Lugo-Lopez,[74] a Vietnam veteran, had been diagnosed with PTSD and had spent time in a mental hospital for schizophrenia, albeit over ten years before his conviction.[75] Despite these favorable facts for the defense, they were undone by the psychiatrist's report, which noted a "significant" mental disease.[76] The trial judge found this characterization

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[69] *Id.*
[70] Shankar Vedantam, *Veterans Report Mental Distress*, WASH. POST, Mar. 1, 2006, at A01 (quoting Colonel Charles W. Hoge, Walter Reed Army Institute of Research).
[71] *Id.* (quoting Harvard University psychologist Richard J. McNally).
[72] *Id.* (quoting Michael J. Kussman, Principal Deputy Undersecretary for Health, Department of Veterans Affairs).
[73] 70 F.3d 706 (1st Cir. 1995).
[74] *Id*. at 709 (Mr. Lopez was one of three co-defendants in this case).
[75] *Id*. at 712.
[76] *Id.*

did not rise to the level of severe mental disease or defect required by the statute,[77] and excluded the evidence.[78] The appeals court found no abuse of discretion and affirmed.[79]

Robert Garwood was another Vietnam veteran who claimed, before recognition of PTSD as a mental disorder, that his combat experience as a Prisoner of War (POW) reduced him to a dissociative state.[80] He was charged with aiding the enemy[81] in a much-publicized case following his return from Vietnam several years after the war had ended. He alleged that he was literally beaten into insanity.[82] However, the Government presented contradictory evidence in the form of a psychiatric evaluation.[83] Most damning, other POWs testified that he had interrogated and guarded them, and even assaulted one.[84] Garwood was convicted and did not raise the insanity issue on appeal.[85] This is perhaps the most notorious case in which an insanity defense has been arguably concocted to avoid criminal responsibility. Defense counsel may need to distinguish *Garwood* from an accused's case, especially for older panel members that may recall its facts.

Finally, in *United States v. Correa*,[86] twelve months after his conviction of several offenses by a general court-martial, Correa underwent a psychiatric evaluation that determined he suffered from PTSD as a result of his combat duty in Vietnam.[87] Correa argued on appeal that his charges should be dismissed based on this diagnosis, but his conviction was affirmed. The Court of Military Review found "no evidence that would have alerted the trial judge to a potential insanity" defense.[88] The only abnormality manifested by Correa was repeated criminal behavior, which "cannot be the sole ground for a finding of mental disorder."[89] This case stands for the general proposition that a

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[77] 18 U.S.C. § 17 (2000). *See also* Part IV.A.1, *infra* notes 129 to 173 and accompanying text, for a closer study of the "severity" requirement.
[78] *Cartagena*, 70 F.3d. at 710.
[79] *Id*. at 712.
[80] United States v. Garwood, 16 M.J. 863 (N.M.C.M.R. 1983).
[81] UCMJ art. 104 (2005).
[82] *Garwood*, 16 M.J. at 867.
[83] *Id.*
[84] *Id.*
[85] United States v. Garwood, 20 M.J. 148 (C.M.A. 1985).
[86] 21 M.J. 719 (C.M.R. 1985).
[87] *Id.* at 719-20.
[88] *Id.* at 720.
[89] *Id.* (quoting United States v. Frederick, 3 M.J. 230, 234 (C.M.A. 1977)).

case of PTSD diagnosed after trial will not disturb the findings of the trial court, where there was no evidence of PTSD presented or indicated at trial.[90] The accused must show a lack of capacity to stand trial, or a lack of mental responsibility for the crime.

III. Capacity to Stand Trial

The Rules for Courts-Martial (RCMs) mandate that Soldiers may not be tried by court-martial if they are *presently* suffering from a mental disease or defect which renders them "mentally incompetent" to the extent that they are unable to understand the proceedings, or to conduct or intelligently cooperate in their defense.[91] Mental capacity focuses on the accused's mental state at the time of *trial*, whereas mental responsibility, the subject of Part IV of this article, concerns the accused's mental state at the time of the *offense*. Simply put, a finding of lack of capacity means no trial, while a finding of lack of mental responsibility means not guilty. Clearly, the same mental disease or defect could render a person incapable of standing trial, or not responsible for a crime, or both. Regarding capacity, unless the accused establishes sufficient evidence to the contrary, they are presumed to have the requisite mental capacity to stand trial.[92]

It follows then that a defense counsel (or any party) attempting to prove lack of capacity should first be prepared to establish, by a preponderance of the evidence,[93] that the accused is mentally incompetent due to a mental disease or defect from which he is presently suffering. Following that proffer, the moving party carries the same burden to prove that the lack of competency has rendered the accused either unable to understand the court proceedings or unable to conduct or intelligently cooperate in his defense. Each of these areas, while not defined in the RCMs, has been examined to some degree by military courts.

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[90] *See infra* note 238 for a discussion of the due diligence exception to this rule; *see also* Thompson v. United States, 60 M.J. 880 (N-M. Ct. Crim. App. 2005) (appellant became mentally incompetent while on appellate leave; court ordered proceeding stayed until appellant could competently assist in his appeal).
[91] MCM, *supra* note 6, R.C.M. 909(a).
[92] *Id.* R.C.M. 909(b).
[93] *Id.* R.C.M. 909(e)(2).

In *United States v. Proctor*,[94] the Court of Military Appeals (COMA) affirmed a trial judge's holding that an accused suffering from pedophilia and a personality disorder had the necessary mental capacity to stand trial because the accused had coherent ideas and control of his mental faculties as well as sufficient memory, intelligence, and ability to express himself.[95] Therefore, even presuming the accused suffered from a personality disorder that could be considered a mental disease or defect,[96] he was still able to cooperate intelligently in his defense. Previously, the Court of Military Review had noted that RCM 909 required that the accused

> must be able to comprehend rightly his own status and condition in reference to such proceedings; that he must have such coherency of ideas, such control of his mental faculties, and such power of memory as will enable him to identify witnesses, testify in his own behalf, if he so desires, and otherwise properly and intelligently aid his counsel in making a rational defense . . . .[97]

Further, the Supreme Court has held that the language of the rule means that the accused "has sufficient present ability to consult with his lawyer with a reasonable degree of rational understanding—and . . . a rational as well as factual understanding of the proceedings against him."[98]

If the accused's mental capacity becomes an issue at any point before or after referral, to include post-trial, any party, be it the convening authority, investigating officer, panel members, counsel, or the military judge, can request a mental capacity inquiry.[99] The standard for ordering this inquiry, commonly referred to as a sanity board, is fairly low.[100]

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[94] 37 M.J. 330 (C.M.A. 1993).
[95] *Id.* at 334.
[96] There is a dearth of case law examining the sufficiency of a mental disease or defect as it affects mental capacity as opposed to mental responsibility, but the *Proctor* court did approve the trial judge's expansive definition of mental disease or defect regarding capacity as analogous to their holding in *United States v. Benedict*, 27 M.J. 253, 259 (C.M.A. 1988), that psychosis was not required to assert an affirmative defense based on lack of mental responsibility. *See Proctor*, 37 M.J. at 336.
[97] United States v. Williams, 17 C.M.R. 197, 204 (C.M.A. 1954).
[98] Dusky v. United States, 362 U.S. 402, 402 (1960).
[99] MCM, *supra* note 6, R.C.M. 706(a).
[100] *See* United States v. Kish, 20 M.J. 652, 654-55 (A.C.M.R. 1985).

Any request that "is not frivolous and is made in good faith" should be granted.[101]

A. Sanity Board

The sanity board, like the request preceding it, can come at any stage of the court-martial proceedings.[102] The request should include the underlying facts and basis of the belief or observation regarding mental capacity.[103] In some cases, a mental evaluation may have already been performed, and the trial counsel may wish to argue that this evaluation constituted an adequate substitute for a sanity board.[104] However, trial practitioners should be wary about summarily concluding that any prior mental evaluation is an adequate substitute for a requested sanity board.[105]

If the convening authority or military judge orders the sanity board,[106] a board consisting of one or more persons will be convened.[107] Typically, the commander of the medical treatment facility will appoint the members to the board. The members must all be either a physician or clinical psychologist.[108] At least one member of the board should be a psychiatrist or clinical psychologist.[109] The order for the board must contain the reasons for doubting the mental capacity of the accused or

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[101] *See* United States v. Nix, 36 C.M.R. 76, 79-80 (C.M.A. 1965).
[102] MCM, *supra* note 6, R.C.M. 706(b).
[103] *Id.* R.C.M. 706(a).
[104] *See* United States v. Jancarek, 22 M.J. 600 (C.M.A. 1986) (holding that a prior mental evaluation was an adequate substitute for a sanity board where the substance of the evaluation included a forensic mental evaluation by a professional).
[105] *See* United States v. Collins, 41 M.J. 610 (Army Ct. Crim. App. 1994) (holding that a prior mental evaluation does not equate to a sanity board *per se*. The substance of the evaluation must be assessed. Here, the evaluation was not administered with a view towards court-martial, so it was not a satisfying forensic examination).
[106] The convening authority orders a sanity board before referral. After referral, the military judge will order the inquiry; however, the convening authority may order the inquiry before any hearing commences, if the judge is not reasonably available. *See* MCM, *supra* note 6, R.C.M. 706(b).
[107] *Id.* R.C.M. 706(c)(1).
[108] *Id.*
[109] *Id. See also* United States v. Best, 61 M.J. 376, 387 (2005). (There is not a per se conflict if a member of the sanity board has treated or diagnosed the accused on a prior occasion, as long as his prior contact does not materially limit his ability to "objectively participate" in the sanity board.)

other reasons for the request.[110] The board must specifically answer four questions.[111] The board must then conclude whether or not the subject is presently suffering from a mental disease or defect rendering him incapable of understanding the court-martial proceedings or unable to conduct or cooperate in his defense.[112] The board can, and often does, consist of only one member. A reasonable amount of time to conduct the examination can be considered excusable delay when performing speedy trial calculations.[113]

When the sanity board has concluded, it submits written findings to the ordering officer, the accused's commander, the Article 32 investigating officer (if any), all counsel, the convening authority, and, after referral, the military judge.[114] Upon receipt of the report, further action may be suspended, the charges may be dismissed, administrative separation action may be taken, or the charges may be referred to court-martial.[115] The practical effects of an incompetency finding will be discussed in the next section, but for now we will discuss what happens when the convening authority refers the case to trial, either due to a finding of competence by the sanity board or because the convening authority disagreed with the board's finding of incompetence.

Once the case has been referred to trial, the sanity board is revisited. If the board found the accused to be mentally incompetent to stand trial because he suffered from a mental disease or defect such as PTSD, but the convening authority disagreed as evidenced by the referral, the military judge is required to conduct an in-court hearing to determine mental capacity to his or her own satisfaction.[116] At this point, the accused's mental competency becomes an interlocutory question of fact.[117] Trial cannot proceed if it is "established by a preponderance of the evidence that the accused is presently suffering from a mental disease

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[110] *See* MCM, *supra* note 6, R.C.M. 706(c)(2).
[111] *Id.* (listing the four questions the board must answer at a minimum).
[112] *Id*. At this point, it is important to note that sanity boards can also be directed to address the accused's mental responsibility, instead of, or in addition to, their mental capacity. The procedure is the same for both, although the findings will be different. Further discussion of mental responsibility is reserved for Part IV of this article.
[113] *Id*. R.C.M. 707(c)(1) discussion.
[114] *Id*. R.C.M. 706(c)(3)(A). The defense counsel will receive the full report, while the trial counsel will receive a sanitized version that serves to protect the accused's Article 31, UCMJ rights.
[115] *Id*. R.C.M. 706(c)(3) discussion.
[116] *Id*. R.C.M. 909(d).
[117] *Id*. R.C.M. 909(e)(1).

or defect rendering him or her mentally incompetent.[118] In making this determination, the military judge is not bound by the rules of evidence except with respect to privileges."[119] The judge can hear testimony from any or all of the sanity board members. If the judge finds the accused to be mentally incompetent, the proceedings are halted and the judge must report his or her finding to the general court-martial convening authority (GCMCA).[120]

Of course, a sanity board may not be requested or even contemplated until after referral. In fact, it may so happen that the accused does not show any symptoms of PTSD or other mental disease or defect until his trial is already underway. Or perhaps a sanity board found the accused to be competent, but the accused's condition subsequently deteriorated to the point that one or more parties feel that his capacity is again in question. In such cases, the parties are not without recourse. Either party may request a capacity determination hearing at any time before or after referral, and the judge may also conduct a hearing *sua sponte*.[121] Again, if the judge determines the accused to be mentally incompetent, the trial is stopped and his findings are reported to the GCMCA.[122]

B. Practical Effects of Incompetency Findings

At this point in the proceedings the GCMCA has received a report of the accused's mental incompetency to stand trial, either pre-referral from the sanity board, or post-referral from the military judge. In the former case, he or she can still refer the case to trial or pursue other options previously discussed. In the latter case, the GCMCA is out of options and must commit the accused to the custody of the Attorney General.[123]

The Attorney General is required to hospitalize the accused under Title 18 of the United States Code.[124] If the accused sufficiently recovers so that he or she has gained the capacity to stand trial, the Attorney General shall transfer custody of the accused back to the GCMCA.[125]

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[118] *Id*. R.C.M. 909(e)(2).
[119] *Id*.
[120] *Id*. R.C.M. 909(e)(3).
[121] *Id*. R.C.M. 909(d).
[122] *Id*. R.C.M. 909(e)(3).
[123] *Id*. R.C.M. 909(f).
[124] 18 U.S.C. § 4241(d) (2000). *See also* UCMJ art. 76b (2005).
[125] MCM, *supra* note 6, R.C.M. 909(f).

The GCMCA can then refer the case to trial, at which time the military judge will conduct another competency hearing. If, after hospitalization,[126] there is no improvement in the accused's mental capacity, the Attorney General will take action in accordance with Title 18 of the United States Code.[127] If the PTSD-affected Soldier has been declared competent to stand trial, there are still other options available to his or her counsel, which will now be discussed in detail.

IV. Lack of Mental Responsibility

If a Soldier's PTSD has not rendered him or her incompetent to stand trial, he or she is not without recourse. It may be that the effects of the disorder were greater at the time of the crime than at the time of trial, or perhaps he or she has since sought and received counseling or medication that have helped to control the disorder. In such cases, the defense counsel may be able to assert a defense of lack of mental responsibility. Such a defense, if proven and accepted by the judge or panel, could be a complete defense to the criminal conduct. There are two permutations to the mental responsibility defense, lack of mental responsibility and partial mental responsibility, and each will be discussed in turn.

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[126] The discussion accompanying RCM 909(f) notes that the initial period of hospitalization should not exceed four months under 18 U.S.C. § 4241(d). If, however, there is a substantial probability that the accused will regain capacity to stand trial in the near future, hospitalization may be continued for an additional reasonable period of time.

[127] 18 U.S.C. § 4246, part of the Insanity Defense Reform Act of 1984, directs that a person hospitalized for lack of mental capacity to stand trial may not be released, even if charges have subsequently been dismissed due to incapacity, if he or she continues to suffer from a mental disease or defect that would create a substantial risk of bodily injury to another person or serious damage to property if the person was released. This risk is determined via a hearing following a psychiatric or psychological examination. If the court finds clear and convincing evidence of such a substantial risk, custody should be remanded to the Attorney General, who shall release the accused to his or her state of domicile or trial provided that state will accept responsibility for the person. In any event, hospitalization will continue until such time as a periodic reevaluation determines that there is no longer a substantial risk of bodily harm to others or serious damage to property if the person is released. There is also a provision for conditional release under prescribed medical, psychiatric, or psychological care or treatment. *See* 18 U.S.C. § 4246(e)(2).

A. Affirmative Defense

The RCMs describe the lack of mental responsibility as follows:

> It is an affirmative defense to any offense that, at the time of the commission of the acts constituting the offense, the accused, as a result of a severe mental disease or defect, was unable to appreciate the nature and quality or the wrongfulness of his or her acts. Mental disease or defect does not otherwise constitute a defense.[128]

This definition requires a two-part analysis. First, the accused suffered from a severe mental disease or defect at the time of the crime. Simply put, when the crime was committed, he or she had a severe mental disorder, typically as defined within the DSM-IV. Second, the disorder rendered the accused mentally incapable of appreciating the nature and quality, or the wrongfulness, of his actions. In the most basic terms, the disorder made him unable to understand what he was doing, or that what he was doing was wrong. The courts have broken this definition into these two elements as well, and examined them at length. Following an analysis of those judicial examinations is a review of the burden of proof for this defense.

1. Severe Mental Disease or Defect

The Military Judges' Benchbook,[129] in the instruction for the lack of mental responsibility defense, attempts to define a severe mental disease or defect in the negative. It is not "an abnormality manifested only by repeated criminal or otherwise antisocial conduct or by nonpsychotic behavior disorders and personality disorders."[130] This assertion that recidivism or a significant personality disorder does not qualify an accused as suffering from a severe mental disease or defect is borne out in case law as well.[131] More important to this analysis, what would

[128] MCM, *supra* note 6, R.C.M. 916(k)(1).
[129] U.S. DEP'T OF ARMY, PAM 27-9, MILITARY JUDGES' BENCHBOOK (15 Sept. 2002).
[130] *Id*. at 820.
[131] *See, e.g.*, United States v. Freeman, 357 F.2d 606, 625 (2d Cir. 1966) (holding that repeated criminal behavior "cannot be the sole ground for a finding of mental disorder"); United States v. Cartagena-Carrasquillo, 70 F.3d 706, 712 (1st Cir. 1995) (stating that

constitute such a disorder? Answering this question is the most difficult hurdle to clear for the counsel representing or prosecuting a Soldier suffering from PTSD, at least with regard to the defense of lack of mental responsibility.

Determining whether PTSD constitutes a severe mental disease or defect is a question that can be broken into two parts. First, does PTSD qualify as a mental disease or defect?[132] Second, if so, what would constitute a severe enough case of it to warrant a finding of lack of mental responsibility? Both of these questions have been fairly answered in case law.

The first federal case to make the argument that PTSD could be a qualifying mental disease or defect was *United States v. Long Crow*.[133] Alvin Long Crow was a Native American living on a reservation in South Dakota who, after consuming eight or more beers as well as liquor, got in a fight at his son's birthday party and then left to retrieve a metal baseball bat and a .22 caliber rifle.[134] He returned to the party and opened fire, injuring four people. A licensed clinical psychologist diagnosed Long Crow with "mild severity Post Traumatic Stress Disorder"[135] as well as alcohol abuse and personality disorder. No indication was given as to how Long Crow acquired PTSD. However, the psychologist, Dr. Bickart, concluded that Long Crow was competent to stand trial and was not insane at the time of the offense.[136]

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even "significant" cases of PTSD and schizophrenia did not rise to the level of severe mental disease or defect).

[132] At lease one commentator has argued that the definition of "severe mental disease or defect" found in RCM 706 and in DA Pam. 27-9 is unsupported by statute and case law and is thus invalid. *See* Major Jeremy A. Ball, *Solving the Mystery of Insanity Law: Zealous Representation of Mentally Ill Servicemembers*, ARMY LAW., Dec. 2005, at 1, 17-19. I have chosen to limit my focus to a discussion of how a case of PTSD may meet the RCM 916(k)(1) criteria as it is currently interpreted in order to best assist today's military justice practitioner, despite the sound arguments presented by Major Ball in his article. Nevertheless, I commend Major Ball's article to an attorney involved in a PTSD case, as it provides insightful practical advice in such areas as requests for instruction and eliciting expert testimony. *See* Ball, *supra*, at 19. Further, although sparingly but appropriately cited, I have consulted Major Ball's article frequently and with appreciation as a resource to help refine or expand the analysis contained in this article.

[133] 37 F.3d 1319 (8th Cir. 1994).

[134] *Id*. at 1321.

[135] *Id.* at 1322.

[136] *Id.*

Needless to say, Long Crow's attorney did not seek to introduce Dr. Bickart's diagnosis into evidence. Long Crow asserted at trial that after firing the first shot he blacked out,[137] and to support his theory called a different psychologist to testify. The new psychologist, Dr. Dame, never clinically examined Long Crow, but testified based on general expertise and courtroom observations.[138] Somehow, Dr. Dame was able to assert that if he were treating Long Crow, he would consider a PTSD diagnosis, and it was his belief that Long Crow appeared to be suffering from PTSD at the time of the offense.[139]

Recognizing that the defense held the burden of proving a severe mental disease or defect by clear and convincing evidence,[140] the trial judge refused to submit instructions to the jury regarding this defense for lack of sufficient evidence, and the jury found Long Crow guilty on three of five counts and the court sentenced him to ten years in prison.[141] The Eighth Circuit Court of Appeals reviewed *de novo* the judge's decision not to submit the instruction, as a matter of law.[142]

The only evidence of PTSD considered by any court was Long Crow's claim that he blacked out and Dr. Dame's testimony based on in-court observation and personal expertise. The Appeals Court found no evidence in the record as to the severity of Long Crow's PTSD, if in fact he had it at all. Most important was this language from the Eighth Circuit:

> We have found no cases that treat PTSD as a severe mental defect amounting to insanity, and Long Crow has cited none. Although we do not reject the possibility that PTSD could be a severe mental disorder in certain instances, there is no evidence that Long Crow suffered a severe case.[143]

The most helpful case for the defense counsel trying to make an argument for PTSD causing a lack of mental responsibility, *United States*

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[137] *Id.*
[138] *Id.*
[139] *Id.*
[140] *See* Part IV.A.3, *infra* notes 198 to 224 and accompanying text, for further discussion on the burden of proof.
[141] *Long Crow*, 37 F.3d at 1322.
[142] *Id.* at 1323.
[143] *Id.* at 1324.

v. Rezaq,[144] cites favorably the *Long Crow* case. Omar Mohammed Ali Rezaq, also known as Omar Marzouki or Omar Amr, is a Palestinian who was a member of a terrorist organization.[145] In 1985, Rezaq and two accomplices boarded an Air Egypt flight in Athens. After takeoff, the three hijacked the plane. Their leader, Salem, was killed and an Egyptian air marshal was wounded during the initial takeover.

After the gun battle and death of Salem, Rezaq took over the leadership of the hijacking and, as planned, ordered the pilot to fly the plane to Malta. Once the aircraft landed, Rezaq identified and separated the Israeli and American hostages from the rest of the passengers. When he was denied a requested refueling, Rezaq began shooting the Israelis and Americans. He shot five in all, wounding three and killing two. Then, in a tempting yet tragic case for aggravation evidence,[146] Egyptian forces stormed the plane in spectacularly inept fashion. They fired at random and employed explosives which caused the aircraft to burst into flames, killing fifty-seven passengers and the third hijacker. Rezaq was injured and captured.[147]

Rezaq was tried in Malta for murder, attempted murder, and hijacking. He pled guilty and was sentenced to twenty-five years in prison.[148] Incredibly, he was released after only seven years confinement and allowed to board a plane for Ghana, where he was detained for several months before being allowed to fly to Nigeria. In Nigeria, he was detained and transferred to U.S. custody and sent to the United States, where he was indicted and tried for air piracy in U.S. District Court.[149]

At his U.S. trial, Rezaq invoked the insanity defense and presented evidence that he suffered from PTSD.[150] He called as witnesses his family members and three psychologists, and offered his own testimony. Rezaq identified several traumatic events that may have triggered his

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[144] 918 F. Supp. 463 (D.D.C. 1996).
[145] United States v. Rezaq, 134 F.3d 1121, 1126 (3d Cir. 1998), *cert. denied*, 525 U.S. 834 (1998). The underlying facts of the case are best presented in this appeal. However, Rezaq appealed on grounds unrelated to the insanity defense, so, although the case was affirmed, the appellate decision is not important to this discussion.
[146] MCM, *supra* note 6, R.C.M. 1001(b)(4).
[147] *Rezaq*, 134 F.3d at 1126.
[148] *Id.*
[149] *Rezaq*, 918 F. Supp. at 463.
[150] *Rezaq*, 134 F.3d at 1126.

alleged PTSD. He spent much of his adolescence in a refugee camp in Jordan and later in Lebanon, where he was active in revolutionary organizations for several years.[151] He alleged to have seen the killings of hundreds of refugees as well as the extermination of entire village populations, in addition to a near-death experience of his own in a car bombing.[152] His family asserted that when he was in Jordan he was "normal, friendly, and extroverted, but when he returned from Lebanon he was pale, inattentive, prone to nightmares, antisocial, and had lost his sense of humor."[153] The defense psychologists identified these changes as "symptomatic of PTSD, and, based on their examination of Rezaq and on the testimony of other witnesses, they concluded that Rezaq was suffering from PTSD when he committed the hijacking."[154]

The Government countered with two of its own experts, who testified that the symptoms alleged by Rezaq "were not as intense as those usually associated with PTSD, and that Rezaq was able to reason and make judgments normally at the time he hijacked the plane."[155] In other words, even if Rezaq suffered from PTSD, it was not a severe case. The jury sided with the Government and rejected Rezaq's insanity defense. He was found guilty of aircraft piracy, sentenced to life imprisonment, and ordered to pay over $250,000 in restitution to the victims.[156]

Before the case got to the jury, however, Judge Lamberth considered a government motion to preclude the defense from offering evidence to prove the affirmative defense of insanity.[157] After first citing the affirmative defense of insanity,[158] the court concluded that the seminal question in determining whether to allow the introduction of the PTSD evidence was whether Rezaq's case of PTSD was sufficiently "severe" to constitute an affirmative defense.[159] Judge Lamberth noted that a court's "severity" analysis

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[151] *Id.*
[152] *Id.*
[153] *Id.* at 1127.
[154] *Id.*
[155] *Id.*
[156] *Id.*
[157] United States v. Rezaq, 918 F. Supp. 463, 466 (D.D.C. 1996).
[158] *Id.* at 467 (citing 18 U.S.C. § 17(a) (2000), which is identical in all substantive portions to RCM 916(k)(1), *supra* note 128).
[159] *Rezaq*, 918 F. Supp. at 467.

> consists of more than locating the magical word "severe" in the diagnosis. Rather, section 17(a) contemplates a more thoroughgoing approach, in which a court reviews the diagnosis for overall indications of the severity of defendant's mental disease or defect. The mere presence of the word "severe" in a diagnosis that suggests a mild condition will not constitute a defense under section 17(a). Similarly, the absence of the word "severe" will not necessarily mean that the condition diagnosed does not meet the standards of section 17(a).[160]

The court noted that, in considering the admissibility of evidence regarding an insanity defense, a liberal approach should be taken.[161] After reviewing the defense evidence, the court determined that Rezaq's diagnosis met the test of insanity.[162] One psychologist, Dr. Dondershine, had diagnosed a severe case of PTSD and depression that left Rezaq "seriously impaired."[163] Dr. Dondershine testified that, during the offense, Rezaq's "personality was fragmenting and the parts—perception, reason, judgment, contemplation of right and wrong, and assessment of consequences—were no longer fully [operative]."[164] A second defense expert, Dr. Wilson, also concluded that Rezaq suffered from PTSD and major depression at the time of the hijacking, and was therefore unable to understand that his conduct was wrongful.[165] Dr. Wilson described Rezaq's mental state during the commission of the offense as "fragile, vulnerable, and unstable."[166] A third defense expert diagnosed Rezaq with chronic PTSD which resulted in an inability to appreciate the wrongfulness of his acts.[167] Judge Lamberth did not find this diagnosis and supporting summary of Rezaq's condition to meet the test for a severe disease or defect, but when taken as a whole, the sum of the expert testimony satisfied the test.[168] The judge therefore found the

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[160] *Id*. at n.6.
[161] *Id.* at 467 (citing several cases, most notably United States v. Smith, 507 F.2d 710, 711 (4th Cir. 1974), holding that "[A] trial judge should permit 'an unrestricted inquiry into the whole personality of defendant' and should 'be free in his admission of all possibly relevant evidence'").
[162] *Id.*
[163] *Id.*
[164] *Id.*
[165] *Id.* at 468.
[166] *Id.*
[167] *Id.*
[168] *Id.*

evidence relevant, and more probative than prejudicial,[169] thus allowing the jury to hear the evidence. First though, Judge Lamberth noted that Federal Rule of Evidence 704(b) would preclude the experts from testifying to ultimate issues of fact such as Rezaq's ability or inability to appreciate the wrongfulness of his actions.[170] While he considered that portion of their testimony in motions hearings, the judge limited the expert's testimony before the jury to only the severity of Rezaq's illness.[171]

Of interest to both the prosecutor and the defense counsel, the *Rezaq* case established that a severe case of PTSD can in fact be a qualifying mental disease or defect that would support an insanity defense. Rezaq's PTSD-based insanity defense made it to the jury, where, unfortunately for him, it was rejected.[172] Thus, the summit not yet scaled: How does the defense counsel convince the fact-finder that her client's case of PTSD is not only a valid defense, or even a plausible defense, but a complete defense? The factors that Judge Lamberth considered in *Rezaq*[173] may be the most helpful currently reported. A diagnosis of a serious impairment in judgment would be beneficial to the defense, as would a diagnosis of a fragmented personality or a vulnerable or unstable mental state. Conceivably, these diagnoses could manifest themselves in several ways, such as witnesses' observations of unusual or unclear speech patterns, irrational decision-making, or perhaps extremely heightened and varied emotions. Eyewitness testimony to that effect could lead an expert to diagnose a severe case of PTSD; then it would normally be up to the trier of fact to determine whether the accused's PTSD was so severe that he or she was unable to appreciate the nature and quality, or the wrongfulness, of his acts. But, as we shall see, in military courts the defense expert has even more latitude, which may prove to be the extra boost needed to help the military defense counsel scale the PTSD summit.

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[169] *Id.*
[170] *Id.* at n.8.
[171] *Id. See infra* Part IV.A.2 for a discussion of how this evidentiary rule is relaxed in courts-martial. *See infra* notes 193-197 and accompanying text.
[172] *Rezaq*, 134 F.3d at 1126.
[173] *Rezaq* was affirmed on appeal by the Third Circuit on unrelated grounds. *See* United States v. Rezaq, 134 F.3d 1126 (3d Cir. 1998), *cert. denied*, 525 U.S. 834 (1998).

2. Appreciation of Nature and Quality or Wrongfulness

This second element of the insanity defense has only been analyzed in case law; it has not been defined by statute, by the Manual for Courts-Martial, the Military Judges' Benchbook, or legislative history.[174] The most insightful military case on point is *United States v. Martin*.[175] The facts of the case are not important to this analysis,[176] but the Court of Appeals for the Armed Forces (CAAF) did provide helpful examination of the key terms of the second element of the defense: "appreciate," "nature and quality," and "wrongfulness."

To "appreciate" is not merely to know that a fact is true, but also to incorporate an understanding of the significance or importance of that fact.[177] The *Martin* court recognized that an understanding of the "moral or legal import of behavior" was required.[178] This is key language because "import" would seem to signify an understanding of the consequences of your actions, which should make the case for a lack of mental responsibility easier to prove. Even if an accused knew what he was doing, for example shooting a weapon, if he did not understand what the results of his actions would be—perhaps the death of an innocent bystander—then this failure to understand the consequences of his actions may amount to a lack of mental responsibility under *Martin*.[179]

The terms "nature and quality" and "wrongfulness" are less satisfactorily defined by the *Martin* court; in fact, one could argue that CAAF only muddied the waters.[180] The simplest definition is that the accused either did not know what she was doing, or, since the element is disjunctive, that she did not know what she was doing was wrong.[181] For example, an accused on trial for choking his wife might have thought he was choking a member of the Iraqi Republican Guard with whom he was engaged in combat. Alternatively, knowing he was choking his wife, he did not know it was wrong because he thought he had been ordered to, be it by a superior being or a superior officer. The CAAF recognized that "wrongfulness" has been understood to include not only the illegality of

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[174] Ball, *supra* note 132, at 20.
[175] 56 M.J. 97 (2001).
[176] Major Martin did not have PTSD, but bipolar disorder. *Id.* at 100.
[177] *See, e.g.*, BLACK'S LAW DICTIONARY 97 (17th ed. 1999).
[178] *Martin*, 56 M.J. at 108.
[179] *Id.*
[180] *See* Ball, *supra* note 132, at 21.
[181] WHARTON'S CRIMINAL LAW § 101, at 17 (15th ed. 1993).

the act, but also the immorality of the act,[182] as defined by society, the individual, or both.[183]

United States v. Thomas[184] is an example of a military case in which a severe mental disease or defect did not amount to a lack of mental responsibility defense because it did not meet the requirements of this second element. Frederick Thomas was a Sailor who kidnapped his wife and son, eventually killing his son. A sanity board determined that, during his rampage, he was under the influence of a brief psychotic disorder amounting to a severe mental disease or defect, but that he was able to appreciate the nature and the wrongfulness of his conduct.[185] A civilian forensic psychiatrist concurred with these findings and additionally diagnosed significant symptoms of obsessive compulsive disorder and depression.[186] The accused pleaded guilty to the premeditated murder of his son, Freddy, as well as to other charges and specifications. Thomas entered into a stipulation of fact, stating that despite being under the influence of this psychotic episode amounting to a severe mental disease or defect, he "consciously and deliberately determined he would kill Freddy first and then kill himself."[187] During his providence inquiry, Thomas testified that although his psychotic episode led him to believe, incorrectly, that he was surrounded by state troopers, highway patrolmen, and SWAT[188] teams, he intended to kill his son and did not believe that he had a legal or moral defense for doing so.[189]

The *Thomas* case demonstrates that the defense must prove both distinct elements of R.C.M. 916(k)(1). The *Thomas* court held that it is not ineffective assistance of counsel to allow your client to plead guilty if one but not both elements can be proven.[190] Also noteworthy is its

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[182] *Martin*, 56 M.J. at 109.
[183] *See* Ball, *supra* note 132, at 22 (citing United States v. Danser, 110 F. Supp. 807, 826 (S.D. Ind. 1999) and United States v. Segna, 555 F.2d 226 (9th Cir. 1977), for the proposition that wrongfulness could include the subjective belief that the act did not violate the accused's own conscience).
[184] 56 M.J. 523 (N-M. Ct. Crim. App. 2001).
[185] *Id.* at 525.
[186] *Id.*
[187] *Id.* at 526 (citing Prosecution Exhibit 1 at 8-9).
[188] SWAT is an acronym for Special Weapons and Tactics. RANDOM HOUSE WEBSTER'S UNABRIDGED DICTIONARY 1920 (2d ed. 1998).
[189] *Thomas*, 56 M.J. at 526-28 (the accused stated that he killed his son to mercifully spare him the pain of being shot to death by the perceived law enforcement personnel).
[190] *Id.* at 531.

holding that a failure to raise both of the elements at trial constitutes waiver.[191] Thomas appealed on the grounds that his counsel should have made a more thorough evaluation of the psychiatric evidence with an eye towards pursuing an insanity defense. The court held that his counsel, in procuring a civilian forensic psychiatrist and foregoing the two experts provided by the government, and then ending his inquiry when the psychiatrist sided with the sanity board, was not ineffective. The fact that the defense presented no evidence at the guilty plea of the accused's failure to appreciate the nature and quality or wrongfulness of his actions, compared with ample evidence to the contrary, precluded Thomas from alleging these matters on appeal absent new evidence.[192]

For military counsel, the most important aspect of this second element of the insanity defense may be how it is presented to the trier of fact. As previously noted, the *Rezaq* court recognized that Federal Rule of Evidence (FRE) 704(b) would preclude an expert from testifying to ultimate issues of fact such as an accused's ability or inability to appreciate the nature and quality or the wrongfulness of his actions.[193] However, Military Rule of Evidence (MRE) 704 contains no such limitation. Rather, it allows that "testimony in the form of an opinion or inference otherwise admissible is not objectionable because it embraces an ultimate issue to be decided by the trier of fact."[194] So, unlike other federal courts, courts-martial allow defense experts to conclude in their testimony that the accused was not only laboring under a severe mental disease or defect, but was unable to appreciate the nature and quality or the wrongfulness of his actions. The CAAF, then known as the COMA, noted in *United States v. Combs*[195] that the MREs "liberally allow for expert testimony to assist the trier of fact."[196] Previously, the court had noted that the proper standard for admitting such expert testimony was "helpfulness, not absolute necessity."[197] Even if military fact-finders can conclude for themselves whether or not the accused knew what he was doing, or that what he was doing was wrong, if expert testimony will be

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[191] *Id.* at 532.
[192] *Id.*
[193] The expert could testify that the accused suffered from a severe mental disease or defect, but would not be able to conclude in his or her testimony that, because of that disease or defect, the accused did not subjectively appreciate his actions, or that they were wrong. *See* United States v. Rezaq, 918 F. Supp. 463, 468 n.8 (D.D.C. 1996).
[194] MCM, *supra* note 6, MIL R. EVID. 704.
[195] 39 M.J. 288 (C.M.A. 1994).
[196] *Id.* at 292.
[197] United States v. Meeks, 35 M.J. 64, 68 (C.M.A. 1992).

helpful in making that conclusion, the military judge should allow the testimony. Needless to say, eliciting such testimony from a qualified expert can powerfully affect the panel members, going a long way toward meeting the defense's burden of clear and convincing evidence.

3. Clear and Convincing Burden on Defense

The defense of mental responsibility is the only affirmative defense in the RCMs requiring the accused to prove the defense by clear and convincing evidence.[198] In fact, only one other defense puts the burden of proof on the accused at all.[199] At first glance, it may seem inapposite to put a burden of proof on a defendant in a criminal case under any circumstance, as such a practice would offend traditional notions of due process. However, the Supreme Court decided this issue over fifty years ago in *Leland v. Oregon*.[200] Mr. Leland was tried and convicted of killing a fifteen year-old girl. At trial, he unsuccessfully presented an insanity defense. Oregon state law at that time required the defendant to prove his insanity beyond a reasonable doubt.[201] Leland appealed on the grounds that this burden of proof violated his due process rights. The Court held, however, that this burden did not "violate generally accepted concepts of basic standards of justice."[202] The standard announced was whether assigning this particular burden to the defendant "offends some principle of justice so rooted in the traditions and conscience of our people as to be ranked as fundamental."[203] Certainly, if assigning the insanity burden to the accused under the beyond a reasonable doubt standard was held constitutional, then the RCM's clear and convincing evidence standard, a lower threshold, is constitutionally sound as well.

The CAAF explored the clear and convincing evidence burden for the insanity defense in *United States v. Dubose*.[204] Lance Corporal Dubose was a troubled young man who made a pipe bomb, intending to kill himself. However, members of his unit found and disassembled the

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[198] MCM, *supra* note 6, R.C.M. 916(b).
[199] *Id.* The defense of mistake of fact as to age in a prosecution for carnal knowledge requires the accused to prove the defense by a preponderance of the evidence.
[200] 343 U.S. 790 (1952).
[201] OR. COMP. LAWS § 26-929 (1940). The defendant's current burden of proof in Oregon is a preponderance of the evidence. *See* OR. REV. STAT. § 161.055(2) (2003).
[202] *Leland*, 343 U.S. at 799.
[203] *Id.* at 798 (quoting Snyder v. Massachusetts, 291 U.S. 97, 105 (1934)).
[204] 47 M.J. 386 (1998).

bomb before it exploded.[205] At his court-martial, Dubose was found guilty of manufacturing and possessing the bomb among other charges, but not guilty of attempted murder or assault. Dubose raised the defense of lack of mental responsibility and presented four witnesses, including three experts, to prove the defense; nonetheless, a military judge found him mentally responsible for his acts.[206] Dubose appealed on the grounds that he had presented clear and convincing evidence of a severe mental disease or defect that rendered him unable to appreciate the nature and quality or wrongfulness of his conduct.[207]

The Navy-Marine Court of Criminal Appeals held that the defense of lack of mental responsibility required "clear and convincing objective evidence, not merely subjective medical opinion . . . ."[208] The CAAF, holding that the service court had improperly applied the standard of proof by interjecting the word "objective,"[209] pronounced that "[a]ll relevant evidence, whether 'objective' or 'subjective,' must be considered by the lower court in its review of sufficiency. There is no premium placed on lay opinion as opposed to expert opinion, nor on 'objective' as opposed to 'subjective' evidence."[210] This is an important ruling for the defense counsel that may have plentiful subjective evidence in the form of expert testimony that her client's disorder meets the insanity criteria, but a dearth of objective evidence of the disorder, such as testimony from a squad member that the accused was acting strangely.

Revisiting the *Long Crow* case,[211] this clear and convincing burden of proof for the affirmative defense of lack of mental responsibility appears to be the standard for a jury instruction on the insanity defense as well. There, the Eighth Circuit noted that generally, "the evidence to support a theory of defense need not be overwhelming; a defendant is entitled to an instruction on a theory of defense even though the evidentiary basis for that theory is 'weak, inconsistent, or of doubtful

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[205] *Id.* at 387.
[206] *Id.*
[207] *Id.*
[208] United States v. Dubose, 44 M.J. 782, 784 (N-M. Ct. Crim. App. 1996).
[209] *Dubose*, 47 M.J. at 388.
[210] *Id.* at 389.
[211] United States v. Long Crow, 37 F.3d 1319 (8th Cir. 1994); *see supra* notes 133 to 143 and accompanying text.

credibility.'"[212] However, the court went on to note that, as the defendant bears the burden of proof to establish insanity by clear and convincing evidence, "this statutorily imposed higher burden of proof calls for a correlating higher standard for determining the quantum of evidence necessary to entitle a defendant to such an instruction."[213] Thus, the wary defense counsel should not expect just any evidence to suffice in procuring a jury instruction. In *Long Crow*, the accused's own testimony and the testimony of one psychologist observing the trial, where there was no clinical diagnosis of PTSD admitted at trial, was held to be insufficient to merit a jury instruction.[214]

This same burden of proof applies not only to the affirmative defense of lack of mental responsibility, but also to the defense of partial mental responsibility. Though not a complete defense, partial mental responsibility may be offered to prove that the accused lacked the state of mind necessary to form the requisite specific intent for the alleged crime. This defense could be appropriate for an accused suffering from PTSD as discussed briefly below.

B. Partial Mental Responsibility and Negating Specific Intent

Partial mental responsibility is sparingly described in the RCMs as "[a] mental condition not amounting to a lack of mental responsibility."[215] The discussion sheds a little more light, if not on the meaning of partial mental responsibility, then at least on its admissibility: "Evidence of a mental condition not amounting to a lack of mental responsibility may be admissible as to whether the accused entertained a state of mind necessary to be proven as an element of the offense."[216] As an example, for a charge of assault in which grievous bodily harm is intentionally inflicted, evidence of a traumatic episode of severe PTSD could be admitted to prove that the accused could not have formed the specific intent to inflict grievous bodily harm. The accused may still be

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[212] *Long Crow*, 37 F.3d at 1323 (quoting Closs v. Leapley, 18 F.3d 574, 580 (8th Cir. 1994)).
[213] *Id. See also* Anderson v. Liberty Lobby, Inc., 477 U.S. 242, 253 (1986) ("a higher burden of proof should have a corresponding effect on the judge when deciding to send the case to the jury").
[214] *Long Crow*, 37 F.3d at 1324.
[215] MCM, *supra* note 6, R.C.M. 916(k)(2).
[216] *Id.* R.C.M. 916(k)(2) discussion.

guilty of a lesser form of assault. To glean any more knowledge on the subject, it is necessary to turn to case law.

One of the seminal cases in the partial mental responsibility arena is *Ellis v. Jacob*.[217] Staff Sergeant Ellis was charged with the premeditated murder of his son. Colonel Jacob was the trial judge at his court-martial. Ellis submitted a motion requesting the introduction of expert opinion evidence to rebut the element of specific intent.[218] Ellis's theory was not one of insanity, but that extreme sleep deprivation prevented him from forming the specific intent necessary to kill his son. Judge Jacob denied the motion, and Ellis appealed. The COMA held that while Ellis could not present the expert testimony as an affirmative defense, he was entitled to present the evidence to support his claim that he lacked specific intent to kill.[219]

Although today's practitioner may see this holding as fairly intuitive given the language of RCM 916(k)(2) and its accompanying discussion, the 1984 edition of the *Manual for Courts-Martial*,[220] in effect at the time of this ruling, specifically prohibited the admission of partial mental responsibility evidence to negate the state of mind element of an offense.[221] In effect, *Ellis v. Jacob* and its progeny[222] overruled that prohibition, and President Bush removed it in 2004 as reflected in the 2005 *Manual for Courts-Martial*. It is important to note, however, that while the doctrine of partial mental responsibility was once considered an affirmative defense,[223] these cases and the updated *Manual for Courts-Martial* have not served to restore the doctrine to that position.[224]

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[217] 26 M.J. 90 (C.M.A. 1988).

[218] Premeditated murder requires a specific intent to kill a person. *See* MCM, *supra* note 6, pt. IV, ¶ 43c(2)(a).

[219] *Ellis*, 26 M.J. at 93-94.

[220] MANUAL FOR COURTS-MARTIAL, UNITED STATES (1984).

[221] *Id.* R.C.M. 916(k)(2) ("A mental condition not amounting to a lack of mental responsibility under subsection (k)(1) of this rule is not a defense, nor is evidence of such a mental condition admissible as to whether the accused entertained a state of mind necessary to be proven as an element of the offense.").

[222] *See, e.g.*, United States v. Berri, 33 M.J. 337, 344 (C.M.A. 1991) (holding that the trial judge erred by not instructing the panel to consider expert evidence possibly negating specific intent).

[223] *See* United States v. Frederick, 3 M.J. 230 (C.M.A. 1977) (holding that partial mental responsibility was an affirmative defense).

[224] There was some debate on that point. *See* Ball, *supra* note 132, at 29 n.306 (noting that some scholars saw this line of cases as resurrecting partial mental responsibility as an affirmative defense). However, the change to RCM 916(k)(2) effectively extinguished

It survives only to the extent that it allows an accused to present evidence of a mental condition, not amounting to a severe disease or defect, to rebut evidence that he harbored a specific intent to commit the crime. This will not be a complete defense, but may, for example, turn a charge of murder into involuntary manslaughter.

C. Practical Effects of Lack of Mental Responsibility Findings

Although partial mental responsibility is not a defense and will therefore serve only to potentially negate an element of a crime, a finding of complete lack of mental responsibility, unlike a finding of lack of capacity, will excuse the criminal conduct. Whereas capacity is established at a sanity board and finally determined by the GCMCA or the military judge, the lack of mental responsibility is determined by the fact-finder, during deliberations on findings.[225] Significantly, a finding of lack of capacity is frequently revisited and could eventually change if the accused's mental condition improves. A finding of lack of mental responsibility, because it applies to the accused's state of mind at the time of the crime, is a once and final determination. If the accused has made significant progress since the crime, hospitalization may not even be necessary, although continued therapy could be required. If hospitalization is ordered, the patient's status will be monitored for signs of recovery that could result in eventual discharge.[226]

V. Other Occasions for Post-Traumatic Stress Disorder Evidence at Trial

There are at least two other instances in which PTSD could play a role in courts-martial proceedings. The first is the examination of a witness who has suffered or is suffering from PTSD. The second is during sentencing. While neither is explored at length here, with the number of combat veterans in the ranks steadily increasing, corresponding increases of combat veterans in the courtroom are a foregone conclusion, some percentage of which will undoubtedly suffer from PTSD.

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that debate. For a fuller treatment of partial mental responsibility, *see* Ball, *supra* note 132, at 27-32.

[225] MCM, *supra* note 6, R.C.M. 921(c)(4).

[226] *See* 18 U.S.C. § 4246(e)(2) (2000).

A. Impeaching Witnesses

While not previously discussed, the criminally accused is not the only person in the courtroom that could be suffering from PTSD. Any of the attorneys, panel members, paralegals, witnesses, or even the military judge may be recovering from their experiences in combat. To be sure, the crime victims may also suffer from PTSD, be it combat-related or due to the crime to which they fell victim. How information is elicited from these witnesses could prove to be the most pivotal aspect of the case.

The questioning of witnesses is governed by the MREs.[227] These rules require that witnesses have personal knowledge of the matter in question.[228] Their credibility may be attacked by any party.[229] Witnesses that have suffered from or currently suffer from PTSD, be they an eyewitness to the crime, the victim of the crime, or a sentencing witness, warrant special consideration. It may be that they were suffering from PTSD at the time they witnessed or were victim of the crime, or during the time they formed an opinion of the accused for sentencing purposes. It is also possible these witnesses are suffering from PTSD during the trial. In some cases, a witness may fall into more than one category.

First, consider the witness who suffered from PTSD during the event about which they are testifying. While being careful not to offend the witness and alienate the judge or panel, it may be wise to inquire about the witness's disorder, especially as it might effect his perception and judgment. Perhaps the witness has acquired a heightened sensitivity to violence as a result of experiences in combat, which may lead the panel to believe that the accused's actions were not as egregious as the witness has described them. A mild case of PTSD in a witness, reported and treated, may not be worth delving into. In any case, the best course of action is to inquire into the matter in pre-trial interviews. Then, if necessary, a professional examination of the witness, as well as an examination of her medical records, may be in order. It may even be helpful to have the examining professional provide expert testimony on the effects of PTSD on the witness's perception and recollection of the event in question.

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[227] MCM, *supra* note 6, MIL. R. EVID. 601-615.
[228] *Id.* MIL. R. EVID. 602.
[229] *Id.* MIL. R. EVID. 607.

A witness suffering from PTSD at the time of trial but not at the time of the alleged crime may be less helpful. Unless the witness is suffering from such a severe case that he can be declared incompetent to be a witness,[230] it will likely be of no use to point out his disorder to the panel. In fact, it may do more harm than good for the defense if the panel links the witness's PTSD to the accused's conduct. However, a sentencing witness with PTSD may draw further attention towards, and credibility to, the accused's case of PTSD, which could be harmful or beneficial to either party, depending on the relative severity of each case. For example, if the accused's case of PTSD is less severe than the witness's case, the accused will likely engender less sympathy than she otherwise might have, and vice versa.

B. Sentencing

Until there is a landmark military case in which an accused's PTSD is accepted by the panel as a complete defense for his criminal conduct, the sentencing phase of the trial will continue to be the most likely and useful venue for PTSD evidence. This evidence will probably be received as extenuation evidence.[231] Matters in extenuation allow the defense counsel to present evidence that "serves to explain the circumstances surrounding the commission of an offense, including those reasons for committing the offense which do not constitute a legal justification or excuse."[232] Perhaps the defense counsel was unsuccessful in persuading the panel to find her client not guilty for lack of mental responsibility, or was unable to argue successfully that her client lacked the ability to form the specific intent to commit the crime.[233] In such cases, the defense counsel may still be able to negotiate a reduced sentence for her client by presenting sentencing evidence that the accused's PTSD did have an effect on his actions and judgment, for which leniency would be appropriate.

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[230] For example, when questioning a witness about a horrific and unjustified killing he witnessed in a combat zone, the witness could conceivably become so distraught that he is unable to appreciate his current surroundings or understand the nature of the proceedings. For the legal standard for competency, *see* MCM, *supra* note 6, MIL R. EVID. sec. VI.

[231] *Id.* R.C.M. 1001(c)(1)(A).

[232] *Id.*

[233] Yet another possibility is that the counsel was successful in proving a lack of specific intent, but his client was convicted of a lesser included offense.

The most advantageous tactical decision may be to avoid all mention of the client's PTSD until the sentencing phase of the trial.[234] This strategy was examined by the Navy-Marine Court of Military Review in *United States v. Lewis*.[235] Seaman Recruit Lewis, prior to her conviction on four counts of communicating a threat, had been diagnosed with three different personality disorders. However, these disorders were not presented as evidence until after findings were announced.[236] She appealed her conviction on the grounds that the military judge should have ordered a sanity board upon receipt of evidence of her personality disorders during presentencing. The service court affirmed the conviction, noting that the RCMs require the accused to give notice of her intent to rely on the defense of lack of mental responsibility before the beginning of a trial on the merits.[237] Like other affirmative defenses, the insanity defense is generally waived if not raised before findings.[238] Once the tactical decision has been made to forego an insanity defense, the accused cannot reopen the door to the defense by her presentation of extenuation evidence in sentencing, although she is not foreclosed from presenting such evidence.[239] Of course, if the accused's capacity to understand the proceedings becomes an issue during the sentencing phase, a sanity board could then be appropriate.

Finally, a statement by the accused (sworn or unsworn), or a sworn statement by a relative or unit member, describing how PTSD has affected the accused both before and after the criminal conduct, may garner sympathy from a panel.[240] A rising number of panel members are likely to have combat experience, thereby increasing their familiarity with and appreciation of PTSD and its effects. That is not to say,

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[234] *Id.* R.C.M. 1001(c)(1) (allowing extenuation evidence to be presented even if the evidence was not offered prior to findings).
[235] 34 M.J. 745 (N-M. Ct. Crim. App. 1991).
[236] *Id.* at 752.
[237] *Id.* at 750 (citing MCM, *supra* note 6, R.C.M. 701(b)(2)).
[238] *Id.* (citing MCM, *supra* note 6, R.C.M. 905(e)). Of course it may be true that, despite due diligence on the part of the defense counsel, the accused's insanity did not become readily apparent, or was not firmly established, until after the conclusion of the trial. In such a case, it may be possible to raise the issue after trial. *See* United States v. Harris, 61 M.J. 391 (2005) (holding that newly discovered evidence after trial which established that the accused was bipolar justified a new trial).
[239] *See* MCM, *supra* note 6, R.C.M. 1001(c)(1)(A)-(B).
[240] Testimony from the accused may also have the unintended effect of demonstrating the need for a sanity board. *See, e.g.*, United States v. Estes, 62 M.J. 544 (Army Ct. Crim. App. 2005) (stating that appellant's unsworn testimony led the Army Court of Criminal Appeals to grant his request for an additional sanity board).

however, that a panel dominated by combat veterans is more or less likely to return a sympathetic sentence. Those without combat experience may doubt the authenticity of PTSD, while combat veterans may be repelled by the fact that the accused is using his reactions to his combat experience, which may have been less severe than theirs, as an excuse for his conduct. Care should be taken during voir dire to determine the members' standing on this controversial issue. Each individual member should be polled to discreetly determine if his or her combat experience, or lack thereof, will have a positive or negative impact on the member's perception of PTSD in general, and of the accused and his situation in particular. More personal questions may be better suited to a written questionnaire. Suggested defense-oriented PTSD voir dire questions that could be tailored to suit either side are provided at Appendix C.

VI. Conclusion

Ultimately, gaining an acquittal due to insanity in a PTSD case is a high hurdle to clear. Therefore, a decision to proceed on a PTSD-based insanity defense must be carefully weighed and discussed with the accused in light of the relevant case law. The accused must recognize that his chances for success when raising PTSD as a defense are slim. Nevertheless, the wary trial counsel must acknowledge the possibility that a severe case of PTSD could legally excuse criminal conduct, or negate the specific intent necessary to commit the conduct. Although this could result in hospitalization for the client if the PTSD persists despite treatment, it is the correct result if the accused was unable to appreciate the nature and quality, or wrongfulness, of his conduct. If the accused suffers from a less than severe case of PTSD, this diagnosis may still result in a conviction for a lesser offense or reduced punishment when presented as extenuation evidence. In any event, the proper recognition and consideration of PTSD in the proceedings will only help to ensure that justice is served.

Appendix A

DSM-IV Criteria for Posttraumatic Stress Disorder[241]

Diagnostic criteria for 309.81 Posttraumatic Stress Disorder

A. The person has been exposed to a traumatic event in which both of the following have been present:

(1) the person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others

(2) the person's response involved intense fear, helplessness, or horror. **Note:** In children, this may be expressed instead by disorganized or agitated behavior

B. The traumatic event is persistently reexperienced in one (or more) of the following ways:

(1) recurrent and intrusive distressing recollections of the event, including images, thoughts, or perceptions. **Note:** In young children, repetitive play may occur in which themes or aspects of the trauma are expressed.

(2) recurrent distressing dreams of the event. **Note:** In children, there may be frightening dreams without recognizable content.

(3) acting or feeling as if the traumatic event were recurring (includes a sense of reliving the experience, illusions, hallucinations, and dissociative flashback episodes, including those that occur upon awakening or when intoxicated). **Note:** In young children, trauma-specific reenactment may occur.

(4) intense psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event

(5) physiological reactivity on exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event

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[241] DSM-IV-TR , *supra* note 34 , at 467-68.

C. Persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness (not present before the trauma), as indicated by three (or more) of the following:

(1) efforts to avoid thoughts, feelings, or conversations associated with the trauma

(2) efforts to avoid activities, places, or people that arouse recollections of the trauma

(3) inability to recall an important aspect of the trauma

(4) markedly diminished interest or participation in significant activities

(5) feeling of detachment or estrangement from others

(6) restricted range of affect (e.g., unable to have loving feelings)

(7) sense of a foreshortened future (e.g., does not expect to have a career, marriage, children, or a normal life span)

D. Persistent symptoms of increased arousal (not present before the trauma), as indicated by two (or more) of the following:

(1) difficulty falling or staying asleep

(2) irritability or outbursts of anger

(3) difficulty concentrating

(4) hypervigilance

(5) exaggerated startle response

E. Duration of the disturbance (symptoms in Criteria B, C, and D) is more than one month.

F. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

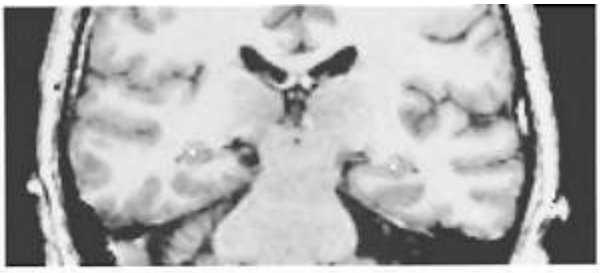
Specify if:
Acute: if duration of symptoms is less than 3 months

Chronic: if duration of symptoms is 3 months or more

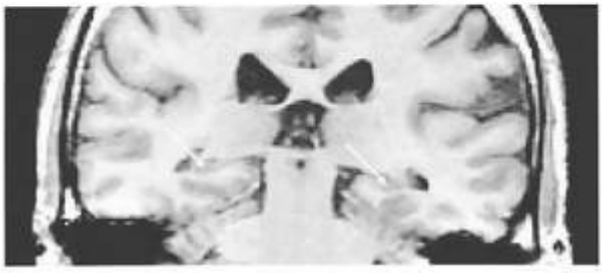
Specify if:
With Delayed Onset: if onset of symptoms is at least 6 months after the stressor

Appendix B

Magnetic Resonance Images



MR Image From Non-PTSD Veteran



MR Image From PTSD Veteran

Magnetic Resonance Images show the difference between the brain of a Soldier with post-traumatic stress disorder and one without. In PTSD, scientists believe that stress hormones like adrenaline scorch a painful event deep into the person's long-term memory.

Pictures and commentary derived from the following online article: http://www.news-leader.com/apps/pbcs.dll/article?AID=/20050927/LIFE04/509270313/1035

Appendix C

Suggested PTSD Voir Dire Questions

Ladies and Gentlemen, the defense of lack of mental responsibility will be presented in this case. The accused will attempt to prove that at the time of the offense, he suffered from a severe case of Post-Traumatic Stress Disorder. Further, he will assert that his PTSD made him unable to intend, understand, or appreciate his actions. PTSD is a mental disease listed in the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders. PTSD is basically a debilitating condition that results from a terrifying event.

1. Have you or anyone you are close to known or met people that suffered from combat-related PTSD, whether clinically diagnosed or not?

2. Do you believe a veteran with combat-related PTSD should be able to receive veteran's benefits for that diagnosis in the same manner, if perhaps not to the same degree, as a veteran with physical injuries?

3. Would you be surprised to learn that someone with a mental disorder like PTSD could often appear perfectly normal to a casual observer in many situations?

4. Would you be surprised to learn that the severity of a mental disorder like PTSD could change with time, therapy, medication, or outside factors?

5. Would you be surprised to learn that someone could have such a severe case of PTSD that they would be unable to intend, understand, or appreciate their actions?

6. Do you think it is possible for you to find that someone committed a crime but should not be found guilty because he was not mentally responsible at the time?

If the Military Judge allows individual voir dire:

7. SGM Smith, what types of symptoms would you expect a Soldier with PTSD to exhibit?

8. COL Wright, some of the symptoms of PTSD include detachment, irritability, anxiety, depression, anger, fear, guilt, insomnia, obsession, and addiction. Recognizing that almost every Soldier will experience some type of readjustment "pains" post-deployment, have you seen any of these symptoms in any of your Soldiers? To such a degree that it is possible they suffered from PTSD?

9. MAJ Sanchez, what would you do with a Soldier who came to you and stated that he believed he might have PTSD? If that Soldier later committed some type of misconduct, would you consider the possibility that his PTSD, if properly diagnosed, could have played a part in the misconduct? Do you think it could have been the primary cause?