

2014

Why Are We Killing Veterans? The Repugnance and Incongruity Of The U.S. Government Executing Psychologically Wounded Veterans

Joshua London

Bluebook Citation

Joshua London, Note, *Why Are We Killing Veterans? The Repugnance and Incongruity Of The U.S. Government Executing Psychologically Wounded Veterans*, 11 U. St. Thomas L.J. 274 (2014)

This Note is brought to you for free and open access by UST Research Online and the University of St. Thomas Law Journal. For more information, please contact lawjournal@stthomas.edu.

NOTE

WHY ARE WE KILLING VETERANS? THE REPUGNANCE AND INCONGRUITY OF THE U.S. GOVERNMENT EXECUTING PSYCHOLOGICALLY WOUNDED VETERANS

JOSHUA LONDON*

*“The painful paradox is that fighting for one’s country
can render one unfit to be its citizen.”¹*

INTRODUCTION

The United States government trains some of the most effective killers the world has ever seen and, understanding the psychological costs, sends them to face the horrors of war. These experiences can result in the returning veteran being far different from the young soldier that left home. The person who returns has been programmed—programmed to react to perceived threats automatically and with overwhelming force; to end human life without hesitation; to handle weapons; and to excel in a system that

* Joshua London, Esq., received his *Juris Doctor* from the University of St. Thomas School of Law in 2014. Mr. London is an Associate Attorney at Brockton D. Hunter, P.A., and also serves as the Operations Officer of the Veterans Defense Project, a non-profit organization founded to advocate for the vigorous legal defense of military veterans facing criminal charges. In his position, Mr. London played an essential role in editing and publishing the legal treatise *The Attorney’s Guide to Defending Veterans in Criminal Court*, a comprehensive manual of the art and science of defending criminally involved combat veterans with PTSD, TBI, substance abuse, or other service-related disorders. That treatise brings together preeminent experts from the fields of law, medicine, social work, psychology, and psychiatry to provide practitioners with the knowledge and tools to provide effective, vigorous representation of veteran-defendants.

I would like to express my deep gratitude to Brock Hunter and Ryan Else, my mentors, colleagues, and dear friends. Working with Brock and Ryan, I have seen what it means to truly devote your time, resources, and soul to a worthy cause and community. Thank you for accepting me into the brotherhood of attorneys that fights to defend our nation’s warriors. Additional thanks to Ryan Else for developing the framework for this manuscript and allowing me to run with it.

1. Jonathon Shay, M.D., Ph.D., *No Sugar Coating: Combat Trauma and Criminal Conduct*, in *THE ATTORNEY’S GUIDE TO DEFENDING VETERANS IN CRIMINAL COURT* 70 (Brockton D. Hunter, Esq., & Ryan C. Else, Esq., eds., 2014).

values the appearance of strength and courage. Many of these warriors experience traumatizing events in combat that remain embedded in their psyche for years to come. Like each of their predecessors, the Iraq and Afghan Wars have been accompanied by a tidal wave of invisible psychological and physiological wounds that, too often, manifest in the form of abnormal behavior that is unfit for civilized communities and unfit for peace. In those suffering most severely, symptoms of a psychological injury can conspire with deadly training to create the perfect storm.

What should happen when the storm culminates in a veteran causing the death of another person? This article will demonstrate why a veteran-defendant who has committed a capital crime should not be subject to the death penalty when his conduct can be linked to a service-connected disorder. Part I begins with a brief history of combat trauma in modern warfare and offers a basis for the assumption underlying the premise of this article—that Post-Traumatic Stress Disorder (“PTSD”) and Traumatic Brain Injury (“TBI”) can cause their host to engage in violent criminal behavior. Part II argues that the systematic indoctrination of military culture, values, and skills—referred to as the Military Total Institution—lays the groundwork for later aberrant behavior. Part III discusses the landmark U.S. Supreme Court decision in *Porter v. McCollum*, which held that a veteran-defendant’s combat service is a necessary component of a fair sentencing procedure,² and provides a brief overview of trends in the criminal justice system favoring special treatment for military veterans.

After laying out the military and psychological components that can lead to criminality and providing a snapshot of the rapidly evolving veterans justice landscape, Part IV details the three schools of thought on why and when a defendant’s military service should bar the death penalty: (1) in recognition of the veteran’s service to our country; (2) to account for the mental and emotional toll of combat exposure; and (3) because the government shares responsibility for creating the psychological state that led to criminal behavior, it lacks moral standing to pursue a purely punitive sanction. Finally, Part V proposes a legislative solution that would preclude the death penalty if the defendant served in the military, sustained a valid psychological injury (such as PTSD or TBI), and that injury contributed to the commission of a capital crime. Using the framework established by the Supreme Court in *Atkins v. Virginia* and *Roper v. Simmons*, Part V analyzes the propriety and desirability of a categorical exclusion.³ “[T]he injustice and immorality of executing a single . . . veteran who has PTSD and/or TBI at the time of the crime outweighs any conceivable benefit from preserving

2. See *Porter v. McCollum*, 558 U.S. 30 (2009).

3. *Atkins v. Virginia*, 536 U.S. 304 (2002); *Roper v. Simmons*, 543 U.S. 551 (2005).

the ability to execute those whose crimes are unrelated to military service and injury.”⁴

I. SERVICE-RELATED INJURY AND ILLNESS INCREASING VETERANS’ PROPENSITY TO ENGAGE IN CRIMINAL ACTIVITY

In 2008, the *New York Times* reported that 121 veterans of the Iraq and Afghan Wars had committed or been charged with killing another person on American soil.⁵ Undoubtedly, as the wars now wind down, that number has increased. History illustrates, and the medical community’s advanced understanding of the brain confirms, that service-related traumas cause identifiable psychological and physiological changes in the way people perceive and react to environmental stimuli. Notwithstanding what we might like to believe about ourselves, every person is susceptible to trauma-induced mental injuries. Stated plainly, by no fault of their own, those suffering from these injuries are more likely to engage in criminal behavior.

A. PTSD and Criminal Behavior

The link between combat and post-traumatic stress disorder (“PTSD”) is as old as war itself. Stories dating back to ancient Greece recount the traumatizing effects of combat. Three thousand years ago, in Homer’s *Iliad*, Achilles expressed deep sorrow over the loss of his friend, Patroclus, and his feeling of betrayal at the hands of his commander Agamemnon.⁶ The constellation of his experiences led Achilles to proclaim hopelessness for the chance of or desire for survival.⁷ The story of Achilles’ psychological unraveling during the Trojan War has drawn parallels to the experiences of many modern combat veterans.⁸ The first American medical accounts of the psychological reaction to combat exposure appeared during the Civil War, when the Surgeon General of the Union Army employed the term “nostal-

4. Hal S. Wortzel, M.D., & David B. Arciniegas, M.D., *Combat Veterans and the Death Penalty: A Forensic Neuropsychiatric Perspective*, 38 J. AM. ACAD. PSYCHIATRY LAW 407, 412 n.3 (2010).

5. Deborah Sontag & Lizette Alvarez, *Across America, Deadly Echoes of Foreign Battles*, N.Y. TIMES, Jan. 13, 2008, available at http://nytimes.com/2008/01/13/us/13vets.html?pagewanted=all&_r=0.

6. See JONATHAN SHAY, M.D., PH.D., *ACHILLES IN VIETNAM: COMBAT TRAUMA AND THE UNDOING OF CHARACTER* 49–51 (1994).

7. *Id.*

8. ERIC T. DEAN, JR., *SHOOK OVER HELL: POST-TRAUMATIC STRESS, VIETNAM, AND THE CIVIL WAR* 46–69 (1997) (discussing combat trauma experienced by soldiers during the Civil War).

gia” to describe the breakdown of soldiers after battle.⁹ Others referred to the condition as “irritable heart” or “soldier’s heart.”¹⁰

During the First World War, soldiers who exhibited anxiousness, trembling, crying, exaggerated startle reactions, disorganization, catatonic stupor, or depression were said to suffer from “shell shock.”¹¹ The term derived from the belief that the soldiers were affected by a physical malady from the concussive force exerted from the use of heavy artillery.¹²

By the Second World War, experts recognized that these symptoms were the result of psychological, rather than physical, injuries. The military leadership tried to limit the number of psychological casualties by screening draftees for signs of a predisposition for mental illness.¹³ As a result, more than 1.6 million draftees were turned away.¹⁴ Nonetheless, over 1.3 million service members developed mental illness during the war,¹⁵ and approximately 504,000 men—“enough to man fifty divisions”—“were lost from America’s combat forces due to psychiatric collapse.”¹⁶ The failed screening effort demonstrated that everyone is vulnerable to the stressors of combat. In fact, a “World War II study of [U.S.] Army combatants on the beaches of Normandy found that after [sixty] days of continuous combat, 98% of the surviving soldiers [became] psychiatric casualties.”¹⁷ “[T]he remaining 2% were identified as ‘aggressive psychopathic personalities.’”¹⁸

Vietnam presented a different type of conflict, both on the battlefield and at home. Service members faced grueling “guerilla” fighting, and those who survived returned home to an ungrateful American public. The combination of these experiences amplified the rates of psychological injuries. Despite the influx, PTSD was not formally recognized until 1980—seven years after the last American troops withdrew from Vietnam.¹⁹ Dr. Mathew Friedman, Executive Director of the National Center for PTSD, described

9. S.L. Baker, *Traumatic War Disorders*, in *COMPREHENSIVE TEXTBOOK OF PSYCHIATRY 1830* (H.I. Kaplan et al. eds., 3d ed., Williams & Wilkins ed., 1980).

10. DARYL S. PAULSON & STANLEY KRIPPNER, *HAUNTED BY COMBAT: UNDERSTANDING PTSD IN WAR VETERANS INCLUDING WOMEN, RESERVISTS, AND THOSE COMING BACK FROM IRAQ 9* (2007).

11. M.R. TRIMBLE, *POSTTRAUMATIC NEUROSI: FROM RAILWAY SPINE TO THE WHIPLASH 98–99* (John Wiley & Sons ed., 1981).

12. BEN SHEPARD, *A WAR OF NERVES: SOLDIERS AND PSYCHIATRISTS IN THE TWENTIETH CENTURY 1–3* (2001).

13. ERIN P. FINLEY, *FIELDS OF COMBAT: UNDERSTANDING PTSD AMONG VETERANS OF IRAQ AND AFGHANISTAN 92* (2011).

14. DEAN, *supra* note 8, at 35.

15. *Id.*

16. Dave Grossman & Bruce Siddle, *Psychological Effects of Combat*, in *ENCYCLOPEDIA OF VIOLENCE, PEACE, AND CONFLICT* (2000), available at http://www.killology.com/article_psychological.htm.

17. *Id.* (citing R.L. Swank & E. Marchand, *Combat Neuroses: Development of Combat Exhaustion*, 55 *ARCHIVES OF NEUROLOGY AND PSYCHOL.* 236 (1946)).

18. *Id.*

19. See AM. PSYCHIATRIC ASS’N, *DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS 236* (3d ed. 1980).

the situation: “[Veterans] were flooding the clinics, demanding that we do something for their distress. We had no clinical terminology for what we were seeing. Their suffering was so raw.”²⁰ Although there is some disagreement over the numbers, experts estimate that, of the 3.5 million Americans who served in Vietnam, between 500,000 and 1.5 million Vietnam veterans suffered some level of PTSD.²¹

As the wars in Iraq and Afghanistan wind down, the evidence suggests that rates of PTSD will be at least as high as those of previous conflicts. In July 2012, the National Academy of Science’s Institute of Medicine (IOM) released a comprehensive report on PTSD among military and veteran populations from the Iraq and Afghan wars.²² The reports revealed that, of the 2.6 million Americans who had served in Iraq and Afghanistan up to that point, up to twenty percent—just over five-hundred thousand—are suffering from the effects of PTSD.²³ The report also acknowledges that, due to significant underreporting and delayed onset PTSD, the figures are likely higher.²⁴

The medical community’s understanding of PTSD has come a long way since its formal recognition thirty-four years ago. PTSD is triggered by a specific traumatic event—including combat—which leads to symptoms such as: persistent re-experiencing of the event; emotional numbing or avoidance of thoughts, feelings, conversations, or places associated with the trauma; and hyper-arousal, such as exaggerated startle responses or difficulty concentrating.²⁵ The most current version of the Diagnostic Statistical Manual, the DSM-V, requires, among other criteria, the presence of the following symptoms to diagnose PTSD:

- Negative alterations in cognitions and moods as evidenced by two or more of the following:
 - Inability to remember an important aspect of the traumatic event(s).
 - Persistent and exaggerated negative beliefs or expectations about one’s self, others, or the world.

20. Mark A. McCormick-Goodhart, *Leaving No Veteran Behind: Policies and Perspectives on Combat Trauma, Veterans Courts, and the Rehabilitative Approach to Criminal Behavior*, 117 PENN ST. L. REV. 895, 901–02 (2013) (citing Kate Mulligan, *For PTSD Care, It’s a Long Way from Vietnam to Iraq*, 39 PSYCHIATRIC NEWS 1, 1 (2004), available at <http://psychnews.psychiatryonline.org/doi/abs/10.1176/pn.39.9.0001>).

21. See Grossman & Siddle, *supra* note 16.

22. COMM. ON THE ASSESSMENT OF ONGOING EFFORTS IN THE TREATMENT OF POSTTRAUMATIC STRESS DISORDER, INST. OF MED. OF THE NAT’L ACADEMIES, TREATMENT FOR POSTTRAUMATIC STRESS DISORDER IN MILITARY AND VETERAN POPULATIONS: INITIAL ASSESSMENT 1 (2012) [hereinafter TREATMENT FOR PTSD].

23. See *id.* at 39.

24. *Id.* at 46.

25. *Id.* at 1.

- Persistent distorted cognitions about the cause or consequence of the traumatic event(s) that lead the individual to blame himself/herself or others.
- Pervasive negative emotional state.
- Markedly diminished interest or participation in significant activities.
- Feelings of detachment or estrangement from others.
- Persistent inability to experience positive emotions.²⁶
- Marked alterations in arousal and reactivity as evidenced by two or more of the following:
 - Irritable behavior and angry outbursts (with little or no provocation), typically expressed as verbal or physical aggression toward people or objects.
 - Reckless or self-destructive behavior.
 - Hyper-vigilance.
 - Exaggerated startle response.
 - Problems with concentration.
 - Sleep disturbance.²⁷

These changes in cognition and arousal make individuals with PTSD more likely to perceive threats in their environment and engage in violent behavior. A posting to the National Center for PTSD web page states:

Symptoms of PTSD can sometimes lead to a lifestyle that makes aggressive or criminal behavior or sudden outbursts of violence more likely to occur. Those with PTSD often suffer from bad memories of the trauma. They may be always tense and fearful. Feeling the need to be always “on guard” can cause survivors to see threats in normal situations. As a result, they may go to extremes to try to protect themselves. High levels of arousal may result in impulsive violent behavior that goes beyond what is needed to address the perceived threat.²⁸

The Institute of Medicine’s report acknowledged the long-denied connection between combat trauma and criminal behavior:

Three categories of conditions frequently co-occur with PTSD: psychiatric (depression and *substance use disorders*), medical (chronic pain, TBI, and spinal-cord injury), and psychosocial (relationship problems, difficulties in social settings, *intimate partner violence [IPV]*, *child maltreatment*, unemployment or lack of employment, homelessness, and *incarceration*) (emphasis added).²⁹

26. AM. PSYCHIATRIC ASS’N, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS 271 (5th ed., APA, 2013).

27. *Id.* at 272.

28. Nat’l Center for PTSD, *Criminal Behavior and PTSD* (2010), available at <http://www.equalaccessadvocates.com/wp-content/uploads/2012/11/PTSD-Criminal-Behavior-and-PTSD-National-Center-for-PTSD.html>.

29. TREATMENT FOR PTSD, *supra* note 22, at 10.

Today, our criminal justice system benefits from a large and rapidly growing body of evidence about PTSD and its ties to criminal behavior. As former Army scout and veterans legal advocate Brockton Hunter explains, “[W]hen we train and condition our fellow citizens in the use of violence, then send them into the horrors of war to perform unimaginable tasks, we should not be surprised when some bring their wars home with them and act out against their communities.”³⁰

B. *TBI and Criminal Behavior*

The use of advanced battlefield technologies by both American troops and enemy combatants is changing the nature of combat trauma. The wars in Iraq and Afghanistan are sending home an unprecedented number of warriors suffering from one or more Traumatic Brain Injuries (“TBI”).³¹ One major reason is that remotely detonated Improvised Explosive Devices, commonly referred to as “IEDs,” have become the primary weapon of insurgents in both wars.³² As a result, the majority of physical injuries are caused by blasts rather than gunshot.

Mild TBI, or “mTBI,” is defined as an acute brain injury resulting from the discharge of mechanical energy to the head from external physical forces.³³ Essentially, a blast—usually from an IED—sends a concussive shock wave that travels through the skull, violently shaking the brain, often causing real physical damage.³⁴ Because modern military medicines and armor have drastically lowered the number of troops who die from their injuries, the current wars are often misunderstood as being less violent. Where in World War II, Korea, and Vietnam, two or three injuries occurred for every fatality, in Iraq and Afghanistan, the ratio has risen to approximately seven to one.³⁵ Because of the prevalence of gunshot wounds in previous conflicts, medicine and armor were adapted to mitigate the problem.³⁶ Today, the vital areas of the body are protected from bullets by high-tech body armor. “With the body well-protected, the 21st century will have

30. Brockton D. Hunter, Esq., *Echoes of War: Combat Trauma, Criminal Behavior, and How We Can Do Better this Time Around*, in *THE ATTORNEY’S GUIDE TO DEFENDING VETERANS IN CRIMINAL COURT* 2–3 (Brockton D. Hunter, Esq., & Ryan C. Else, Esq., eds., 2014).

31. Chrisanne Gordon, M.D., & Ronald Glasser, M.D., *Traumatic Brain Injury—The Invisible Injury*, in *THE ATTORNEY’S GUIDE TO DEFENDING VETERANS IN CRIMINAL COURT* 199 (Brockton D. Hunter, Esq., & Ryan C. Else, Esq., 2014).

32. *Id.*

33. Brigadier General Stephen N. Xenakis, M.D., *Combat Trauma in the 21st Century – An Overview of Psychological Injuries in Modern War*, in *THE ATTORNEY’S GUIDE TO DEFENDING VETERANS IN CRIMINAL COURT* 140 (Brockton D. Hunter, Esq., & Ryan C. Else, Esq., 2014).

34. *Id.* at 138.

35. Gordon & Glasser, *supra* note 31, at 200 (citing ANNE LELAND & MARI-JANA OBOROCEANU, CONG. RES. SERV., RL32492, AMERICAN WAR AND MILITARY OPERATIONS CASUALTIES: LISTS AND STATISTICS 2–3 (2010), available at <http://www.fas.org/sgp/crs/natsec/RL32492.pdf>).

36. *Id.*

to be the century of the brain because today, the body will survive injuries that nearly destroy the brain and, thus, the functionality of the person.”³⁷

Families of veterans who return with TBIs often find that the person who left for war is not the same as the one who returns. Those suffering from TBIs commonly experience memory problems, cognitive difficulties, attention impairment, fatigue, depression, anxiety, sleep disturbance, noise disturbance, lack of motivation, irritability, lack of social appropriateness, or hyper-vigilance.³⁸ In a two-part article published in *Perspectives in Psychiatric Care*, Dr. Norman Keltner, Ed.D., examined veterans returning from tours of duty with the Alabama National Guard.³⁹ Dr. Keltner observed that both alcohol abuse and post-event psychosis are disproportionately present in military personnel suffering from a war-related TBI.⁴⁰

Other studies have similarly found a direct link between the symptoms of TBIs and criminal behavior patterns. Dr. John Corrigan has performed extensive research into the simultaneous existence of substance abuse and psychiatric illness.⁴¹ Dr. Corrigan found that cognitive functions and executive functions of higher thinking are often absent or greatly reduced in individuals with a TBI.⁴² This causes increased impulsivity and, therefore, a greater propensity for aberrant actions.⁴³ Expounding on the significance of Dr. Corrigan’s research with regard to veterans, Drs. Chrisanne Gordon and Ronald Glasser stated, “This is particularly true for the soldier conditioned by fight-or-flight mechanisms of survival in war—returning home and struggling to stay contained and ‘civilized,’ especially in stressful situations.”⁴⁴

Additionally, the existence of TBI has been linked to the onset of various mental illnesses, including depression, bipolar disorder, and aggressive behavior disorders.⁴⁵ The resulting loss of executive functioning and reasoning skills leads to impulsive actions that often clash with the law or societal norms.⁴⁶

Ultimately, the influx of veterans suffering from TBI is very evident in our criminal justice system. Troops deployed in Iraq and Afghanistan are absorbing massive blows to their brains, which lead to risk-taking activities

37. *Id.* at 201.

38. *Id.* at 208.

39. Norman L. Keltner, *Biological Perspective: Traumatic Brain Injury – War Related*, 43 *PERSP. OF PSYCHIATRIC CARE* 223 (2007).

40. *Id.* at 224.

41. John Corrigan & James Deutschle, *The Presence and Impact of the Traumatic Brain Injury Among Clients in the Treatment for Co-occurring Mental Illness and Substance Abuse*, 22 *BRAIN INJURY* 223, 223–31 (2008).

42. *Id.* at 224.

43. *Id.* at 230.

44. Gordon & Glasser, *supra* note 31, at 208.

45. Warren Lux, *A Neuropsychiatric Perspective on Traumatic Brain Injury*, 44 *J. OF REHABILITATION RES. AND DEV.* 951, 951–61 (2007).

46. *Id.*

and violence due to a disconnect between the parts of the brain used for executive functioning, thinking, and “fight-or-flight” responses.

C. Substance Abuse

Just as a veteran’s traumatic combat experience(s) often cause the onset of PTSD or TBI, PTSD or TBI commonly lead a veteran to self-medicate with drugs and alcohol. Substance abuse acts to exacerbate the symptoms of the mental injury and undermines the potential for its effective treatment.⁴⁷ In addition, many experts believe the current use of prescription psychotropic medication on troops and veterans with PTSD and TBI has had a devastating adverse effect.⁴⁸ The implications of these dichotomies are readily apparent in our criminal justice system.

The traumas of war often plague service members long after they return home to their communities. Memories of trauma, terrifying nightmares, indoctrinated hyper-arousal, and survivors’ guilt make it difficult for returning warriors to cope with life after the military. Former Wing Commander in the Royal Air Force and Director of Medical Services to the British charity, Combat Stress, Walter Busuttill, M.B., Ch.B., M.Phil., MRCP, FRCPsych., explained the difficulties involved in fixing broken veterans:

PTSD commonly presents with co-morbid substance misuse disorders, especially alcohol disorders. Treatment of PTSD can be difficult, especially if the individual has been exposed to multiple traumas. These presentations are more likely to also involve co-morbid alcohol and substance misuse, including dependence, which can further complicate treatment and worsen the prognosis. Trauma-focused psychotherapies are essentially the treatment that reduces PTSD symptoms. Trauma-focused therapies will not work if information processing is impeded by illicit drug and alcohol misuse. Treatment of substance misuse must be undertaken *before* trauma focused work can be performed. Clinical services for the treatment of these co-morbid disorders must work together in order to facilitate clear smooth clinical pathways that allow thorough treatment of our combat veterans suffering from service-related injuries.⁴⁹

47. Walter Busuttill, M.B., Ch.B., M.Phil., MRCP, FRCPsych., *The Interaction of Substance Abuse and Post Traumatic Stress Disorder or Mild Traumatic Brain Injury*, in THE ATTORNEY’S GUIDE TO DEFENDING VETERANS IN CRIMINAL COURT 222 (Brockton D. Hunter, Esq., & Ryan C. Else, Esq., eds., 2014).

48. See Peter R. Breggin, M.D., *TBI, PTSD, and Psychiatric Drugs: A Perfect Storm for Causing Abnormal Mental States and Aberrant Behavior*, in THE ATTORNEY’S GUIDE TO DEFENDING VETERANS IN CRIMINAL COURT 251–263 (Brockton D. Hunter, Esq., & Ryan C. Else, Esq., eds., 2014).

49. Busuttill, *supra* note 47, at 222.

As of 2006, 1.8 million veterans (including twenty-five percent of veterans aged 18–25) met the criteria for substance abuse disorder, and eighty-one percent of veterans involved in the criminal justice system struggled with substance abuse prior to incarceration.⁵⁰ At the same time, 140,000 veterans sat in U.S. prisons, sixty percent of whom had a substance abuse problem.⁵¹ Similarly, of the 130,000 homeless American veterans, seventy-five percent were believed to suffer from some form of substance abuse disorder.⁵²

In addition, the wars in Iraq and Afghanistan have ushered in an era of psychiatric drug use to treat combat trauma like never before. Whereas in previous wars soldiers taking psychiatric drugs were rarely sent into combat, it is now common practice.⁵³ It is believed that as many as twenty percent of our combat troops are being treated with psychiatric drugs on the battlefield.⁵⁴ Nearly all those who return with a diagnosed mental injury will be prescribed psychiatric drugs for an extended period of treatment.⁵⁵

Evidence suggests that the kind of medications being used to treat PTSD and TBI can be responsible for inducing violence and suicide.⁵⁶ Dr. Peter Breggin warns that the medical community should be wary of the benefits of such treatment. As he explained, “Some of these drugs, especially antidepressants, stimulants, and benzodiazepines, closely mimic the effects of both PTSD and TBI, and are likely to worsen their condition.”⁵⁷ To illustrate this concern, Dr. Breggin points to the warning section for the FDA-approved drug, Zoloft, as found in the *Physicians’ Desk Reference* for 2009:

The following symptoms, anxiety, agitation, panic attacks, insomnia, irritability, hostility, aggressiveness, impulsivity, akathisia (psychomotor restlessness), hypomania, and mania, have been reported in adult and pediatric patients being treated with antidepressants for major depressive disorder as well as for other indications, both psychiatric and nonpsychiatric.⁵⁸

50. *Id.* (internal citations omitted).

51. *Id.* (internal citations omitted).

52. *Id.* (internal citations omitted).

53. See Brett J. Schneider et al., *Psychiatric Medications in Military Operations*, in *Combat and Operations Behavioral Health* 151, 154 (2011); see also *The Wounded Platoon* (PBS Frontline documentary broadcast May, 2010) (investigating the rise in PTSD in a platoon returned from Iraq).

54. Hector Morales, Deputy Dir., Pharmacoeconomic Ctr., PowerPoint: Prescription Medication Analysis & Reporting Tool (PMART), available at <http://pec.ha.osd.mil/PMART/pmart%20briefing.ppt>.

55. Breggin, *supra* note 48, at 251.

56. *Id.* at 252; see also Bart P. Billings, Ph.D., *The Over-Prescription of Psychotropic Drugs for Military Personnel*, in *THE ATTORNEY’S GUIDE TO DEFENDING VETERANS IN CRIMINAL COURT* 265–273 (Brockton D. Hunter, Esq., & Ryan C. Else, Esq., eds., 2014) (pointing out the high rates of psychotropic drug prescriptions in the military).

57. Breggin, *supra* note 48, at 252.

58. *Id.* at 258 (citing Zoloft, Physician’s Desk Reference (Thomson PDR, 2009)).

These symptoms are nearly identical to those associated with head injuries, especially PTSD. Also, a number of these symptoms are commonly recognized as causes of criminal and antisocial behavior.⁵⁹ Beyond the short term effects listed above, the use of psychiatric drugs over an extended period of time “tend[s] to produce Chronic Brain Impairment (CBI) similar or nearly identical to the trauma induced CBI.”⁶⁰ Psychiatric drug use combined with TBI or PTSD can greatly compromise “cognitive abilities, emotional stability, self-insight, and concern for self.”⁶¹ Ultimately, this means that not only do PTSD and TBI greatly increase the likelihood of engaging in criminal activity, but the treatments being administered by the Veterans Association compound the problem by further amplifying the symptoms triggering criminal behavior. Dr. Bart P. Billings, an expert in the fields of PTSD and TBI, expounded on the link between psychiatric drug use and aberrant behavior, saying:

The correlation of increased suicides, as well as homicides, in the military, and the increased use of medications, that warn about side effects of suicide, irritability, hostility, and aggressiveness, does not appear to be a coincidence, but a direct link to adverse reactions a person may experience when taking these medications.⁶²

II. THE MILITARY TOTAL INSTITUTION

In today’s military, combat training and intensive conditioning have evolved into an extremely powerful cultivation process designed to instill deep-seeded military programming. The methods of training have been carefully manipulated over time to indoctrinate recruits with mission-related values and automated reactions to perceived threats. Even those service members that never actually encounter combat are often left with psychological scars. As sociologist and Vietnam veteran Professor William “Bud” Brown explains:

In order to fully understand the complexities associated with a veteran’s risk for chronic mental health problems (e.g. PTSD) it is necessary to consider the role and function of military training and the total institution (an area that has enjoyed research immunity in the area of PTSD), contributing static variables, and the more opaque dynamic variables, which include the psychological “software” installation and manipulation procedures employed during the training processes in the military total institution.⁶³

59. *Id.* at 259; see PETER R. BREGGIN, *PSYCHIATRIC DRUG WITHDRAWAL: A GUIDE FOR PRESCRIBERS, THERAPISTS, PATIENTS, AND THEIR FAMILIES* (2013).

60. Breggin, *supra* note 48, at 262.

61. *Id.*

62. Billings, *supra* note 56, at 268.

63. William Brown, *Another Emerging “Storm”: Iraq and Afghanistan Veterans with PTSD in the Criminal Justice System*, 5 *JUST. POL’Y J.* 1, 17–18 (2008).

The lasting effect of the Military Total Institution (MTI), in itself, dramatically increases a veteran's likelihood of subsequent abhorrent behavior. The MTI starts to take effect from the very beginning, the recruiting stage.⁶⁴ The military targets "potential recruits who are more likely to be militarily adaptable—young adults."⁶⁵ These recruits enter the military with a clean slate, and are thus more amenable to conform to military culture.

Dr. Brown outlines four components that comprise the foundation of military training: obedience, discipline, survival, and sacrifice.⁶⁶ These objectives are accomplished through a systematic series of training exercises aimed at altering a recruit's natural reaction to perceived events. Where, in civilian life, people are expected to think and consider a situation before reacting, "[i]n the military, recruits are trained to react instantaneously to social stimuli they perceive as a threat."⁶⁷ Ultimately, training drills condition recruits to rely on their senses and select "fight" rather than "flight" when they perceive a hint of danger.

Trained automated reactions serve the soldier and the military well on the battlefield. But, the combination of this embedded hyper-arousal and various other deadly skills obtained through military training can come to a devastating head when the veteran returns home. For example:

Weapons training is a crucial component of military training. Military personnel sent into a combat zone are conditioned to complete the primary mission of the military during war—to defeat and kill the enemy. The more extensively one is trained in the use of weapons, the more likely those weapons will be used instantaneously in a time of threat. A threat is often defined through the perception of the individual. Individuals who have never been confronted with a life-threatening event will perceive a threatening situation differently when compared to someone who has been exposed to horrific experiences. For example, a soldier or Marine who has experienced an ambush or been involved in a firefight will respond differently to stimuli that are reminiscent of those previous events when compared to a soldier or Marine who does not share those experiences.⁶⁸

American military training has one additional feature of particular importance when considering the government's moral standing to punish

64. William B. Brown, Ph.D., *Spinning the Bottle: A Comparative Analysis of Veteran-Defendants and Veterans Not Entangled in Criminal Justice*, in *THE ATTORNEY'S GUIDE TO DEFENDING VETERANS IN CRIMINAL COURT* 112 (Brockton D. Hunter, Esq., & Ryan C. Else, Esq., eds., 2014).

65. *Id.*

66. *Id.* at 112–13.

67. *Id.* at 113.

68. *Id.* at 114; *see also* LT. COL. DAVID GROSSMAN, *ON KILLING: THE PSYCHOLOGICAL COST OF LEARNING TO KILL IN WAR AND SOCIETY* (1996) (studying "the act of killing within the Western way of war and of the psychological and sociological processes and prices exacted when men kill each other in combat").

when a mentally injured veteran commits murder: namely, its focus on overcoming the human aversion to killing. History demonstrates that humans have an innate aversion to conspecific killing—the killing of those within the same species.⁶⁹ Multiple accounts of nineteenth century warfare tell of soldiers firing their weapons harmlessly into the air rather than attempting to aim at the enemy.⁷⁰ Following the Battle of Gettysburg, thousands of muskets were found loaded with anywhere from two to ten rounds.⁷¹ Rather than fire at another person, those soldiers simply pretended to fire then loaded another ball and powder charge on top of the last, often repeating the cycle until they themselves were taken out by enemy fire.⁷²

Observing this natural inability to kill as a problem, the military developed training methods able to systematically eradicate any such aversion in new recruits. The foundation of this conditioning approach rests on (1) brutalization, (2) role-modeling, and (3) classical and operant conditioning.⁷³ The impact of military conditioning is evident from the drastic increase in soldiers' ability and willingness to fire their weapons at enemy troops. "Whereas in World War II an estimated 20% of riflemen effectively fired their weapons at the enemy, in the Korean War the percentage had risen to 55%, and by Vietnam the percentage had drastically increased to 95%."⁷⁴

The current efficacy of military training means we are sending to war the most proficient and lethal killers in our nation's history. Likewise, the warriors that return home to our communities are conditioned in a manner that makes them more dangerous, volatile, and amenable to violence than any previous generation of veterans.

III. *PORTER v. MCCOLLUM* AND THE RAPIDLY CHANGING VETERANS JUSTICE LANDSCAPE

A. *The Case*

In 2009, the United States Supreme Court reinforced the impact of a defendant's military service at the sentencing phase of a criminal prosecution. In *Porter v. McCollum*, the Court overturned George Porter's death penalty sentence due to his attorney's failure to present evidence of his

69. See Paul Roscoe, *Intelligence, Coalition Killing, and the Antecedents of War*, 109 AM. ANTHROPOLOGIST 485, 488 (2007); Ashley Montagu, *The Nature of Human Aggression* (2006); Nikolas Tinbergen, *On War and Peace in Animals and Man*, 160 SCIENCE 1411 (1968); Gwynne Dyer, *War: The Lethal Custom* (1985); and Grossman, *supra* note 68.

70. Ardant Du Picq, *Battle Studies* (1946); Grossman, *supra* note 68.

71. Grossman, *supra* note 68, at 21–24 (citing F.A. Lord, *Civil War Collector's Encyclopedia* (1976)) (reporting 90% of the muskets recovered after the Battle of Gettysburg were loaded more than once; 12,000 were loaded with more than one round, 6,000 of those were loaded with three or more rounds).

72. Grossman, *supra* note 68, at 21–24.

73. Hunter, *supra* note 30, at 43.

74. *Id.* (citing Grossman, *supra* note 68, at 189; Lt. Col. Dave Grossman & Loren W. Christiansen, *On Combat* 78 (2008)).

service in the Korean War and resulting combat trauma.⁷⁵ In fact, it held that a defense attorney's failure to present his client's military service record as mitigating evidence at his sentencing for two murder convictions was ineffective assistance of counsel under the *Strickland* standard.⁷⁶ In effect, the Court recognized that veterans deserve special treatment under the law to the extent that a sentencing hearing does not meet the minimum standards of fairness if the defendant's service record is not made available to the sentencer.

Porter joined the United States Army at the age of sixteen.⁷⁷ Only months after his enlistment, he found himself on the Korean Peninsula as a member of Baker Company, 1st Battalion, 23rd Infantry Regiment, 2nd Division of the Army.⁷⁸ Almost immediately, Porter was thrown into some of the most intense and important battles of the Korean War: Kunu-Ri and Chipyeong-Ni.⁷⁹ In these battles, he sustained wounds for which he would later be awarded Purple Hearts.⁸⁰ For his courageous service in Korea, Porter was also awarded the Korean Service Medal with three Bronze Service Stars and the Combat Infantryman's Badge.⁸¹

After leaving the Army in 1953, family members reported Porter was never able to regain his footing. The Supreme Court's opinion recognized his struggles:

After his discharge, he suffered dreadful nightmares and would attempt to climb his bedroom walls with knives at night. Porter's family eventually removed all of the knives from the house. According to Porter's brother, Porter developed a serious drinking problem and began drinking so heavily that he would get into fights and not remember them at all.⁸²

In July 1986, Porter faced the end of his tumultuous romantic relationship with Evelyn Williams.⁸³ After threatening to kill Evelyn, Porter left

75. *Porter*, 558 U.S. at 30.

76. *Id.*; See *Strickland v. Washington*, 466 U.S. 668, 687 (1984) (creating a two-part test to determine whether a convicted defendant's claim that counsel's assistance was so defective as to require reversal of a conviction . . . First, the defendant must show that counsel's performance was deficient. This requires showing that counsel made errors so serious that counsel was not functioning as the 'counsel' guaranteed the defendant by the Sixth Amendment. Second the defendant must show that the deficient performance prejudiced the defense. This requires a showing that counsel's errors were so serious as to deprive the defendant of a fair trial, a trial whose result is reliable).

77. Linda McDermott, Esq., *Porter v. McCollum: The Story that Almost Went Untold*, in *THE ATTORNEY'S GUIDE TO DEFENDING VETERANS IN CRIMINAL COURT* 516 (Brockton D. Hunter, Esq., & Ryan C. Else, Esq., eds., 2014).

78. *Id.*

79. *Id.* at 516–17.

80. *Id.* at 516.

81. *Id.*

82. *Porter*, 558 U.S. at 35–36.

83. *Id.* at 31.

town.⁸⁴ He returned only a few months later, in October, to learn that Evelyn was involved with another man, Walter Burrows.⁸⁵ In *The Attorney's Guide to Defending Veterans in Criminal Court*, George's appellate attorney, Linda McDermott, described the events that followed:

George was beside himself with frustration and grief and became obsessed with Evelyn. George met Evelyn on October 8th in an attempt at reconciliation. Evelyn told George she no longer wanted a relationship and after the meeting George spent the evening drinking in various lounges. Over the course of the night George told a friend that she would soon be reading about him in the newspaper. He later stole another friend's gun and, at 5:30 a.m. on October 9th, George found himself at Evelyn's house. Walter Burrows was there too. Within minutes Williams and Burrows had been shot and killed.⁸⁶

Porter pleaded guilty to the charges and was sentenced to death.⁸⁷ At a post-conviction hearing the judge held that Porter was not prejudiced by his attorney's failure to introduce evidence of his combat service.⁸⁸ The appeal that followed was similarly unsuccessful.⁸⁹

More than twenty years after he was condemned to die for his crimes, the Supreme Court reversed the decisions of the state courts and the Eleventh Circuit Court of Appeals, sparing Porter's life. The opinion stated that if the jury had been presented with evidence of Porter's combat experiences, it likely would have impacted their decision to impose the death penalty:

It is . . . unreasonable to conclude that Porter's military service would be reduced to "inconsequential proportions," simply because the jury would also have learned that Porter went AWOL on more than one occasion. Our Nation has a long tradition of according leniency to veterans in recognition of their service, especially for those who fought on the front lines as Porter did. Moreover, the relevance of Porter's extensive combat experience is not only that he served honorably under extreme hardship and gruesome conditions, but also that the jury might find mitigating the intense stress and mental and emotional toll that combat took on Porter.⁹⁰

84. McDermott, *supra* note 77, at 514.

85. *Id.*

86. *Id.*

87. *Porter*, 558 U.S. at 32.

88. *Id.* at 36.

89. *Id.* at 37.

90. *Id.* at 43 (internal citations omitted).

B. Recent Trends toward Disparate Treatment for Veterans Charged with Criminal Offenses

Porter provided a substantial endorsement of a legal trend that was already well under way. Even before *Porter*, states had begun codifying veteran sentencing statutes and implementing veterans treatment courts. However, pre-*Porter* examples of special treatment for veterans were all too rare and the movement's growth was glacial. Fortunately, national and state authorities have responded strongly to the Supreme Court's recognition that an individual's military service unmistakably impacts his or her right to fair sentencing. The decision was followed by amendments to the United States Sentencing Guidelines, an increase in state laws accounting for military service in criminal proceedings, and a vast expansion of the use of veterans treatment courts throughout the country.

When our nation sends young men and women to prepare for and fight wars, it is, as San Diego Prosecutor William C. Gentry eloquently articulated, "[u]nleashing certain things in a human being we don't allow in civic society, and getting it all back in the box can be difficult for some people."⁹¹ Unfortunately, our criminal justice system has not historically accorded veterans the "leniency" that the *Porter* court referred to. On the contrary, in many cases, it appears military service was treated as an aggravating factor at sentencing. A report by the Bureau of Justice Statistics analyzing data as of 2004 showed that, of defendants charged with the same crime, "veterans had shorter criminal records than nonveterans in State prisons, but reported longer prison sentences and expected to serve more time in prison than nonveterans. . . . On average veterans expected to serve 22 months longer than nonveterans."⁹² This represents just one of many disconcerting ways in which American military veterans have been mistreated throughout history.

Thankfully, advances in medical understanding of military-related disorders and increasing societal awareness have broken that historical trend. In 2006 and 2008, California⁹³ and Minnesota⁹⁴ passed laws designed to ensure that a veteran's service and resulting psychological injuries are taken into account at sentencing. In *Porter*, the Supreme Court pointed to these pioneering statutes as extrinsic evidence that not only is military service relevant at sentencing, but juries cannot make an informed decision at sentencing without it.⁹⁵

Following *Porter*, the United States Sentencing Commission amended Sentencing Guideline § 5H1.11 in 2010 to state that, "[m]ilitary service

91. Sontag & Alvarez, *supra* note 5.

92. MARGARET NOONAN & CHRISTOPHER MUMOLA, BUREAU OF JUSTICE STATISTICS SPECIAL REPORT, VETERANS IN STATE AND FEDERAL PRISON 1 (2004).

93. CAL. PENAL CODE § 1170.9 (2014).

94. MINN. STAT. § 609.115(10) (2008).

95. *Porter*, 558 U.S. at 43–44 n.9.

may be relevant in determining whether a departure is warranted, if the military service, individually or in combination with other offender characteristics, is present to an unusual degree and distinguishes the case from the typical cases covered by the guidelines.”⁹⁶ Currently, there are a total of five states with veterans sentencing statutes.⁹⁷ Even more states impose a duty on the court, the Veterans Association, or community corrections officers to inquire about the veteran’s service, inform him of the services available, or consider his service-related disorder in constructing a treatment plan.⁹⁸

Perhaps most impressive is the explosion of veterans treatment courts across the United States. In December 2011, *The Atlantic* reported that nearly eighty veterans courts had sprung up across the country over the previous four years, and twenty more were expected to open by the end of the year.⁹⁹ By mid-2012, 168 veterans treatment courts were in operation and 7,724 veterans had been admitted to programs in those courts.¹⁰⁰

The broad implication of this rapidly growing trend is that the criminal justice system views veterans with a service-related disorder differently than other offenders. More narrowly, it shows courts and legislators systematically implementing three mitigating factors related to military services: (1) recognition of service, (2) impact of mental and emotional stress, and (3) government’s role in creating the veteran’s psychological state. As drafter of the Minnesota veterans sentencing statute and author of *The Attorney’s Guide to Defending Veterans in Criminal Court*, Brockton Hunter stated:

This multi-state and federal push for such sentencing mitigation guidelines shows that the public’s focus has shifted towards placing a higher priority on the treatment of a veteran’s service-related impairment and away from a strictly punitive approach to veteran defendants. It seems that, amidst the recent wars in Iraq and Afghanistan, the American public and the policy-makers working on their behalf have made an affirmative decision not to

96. U.S. SENTENCING GUIDELINES MANUAL § 5H1.11 (2010).

97. CAL. PENAL CODE § 1170.9; MINN. STAT. § 609.115(10); NEV. REV. STAT. § 176.015 (2014); N.H. REV. STAT. ANN. § 651:4-b (2014); R.I. GEN. LAWS § 12-29-5 (2014).

98. CAL. PENAL CODE § 1449 (2014); VA. CODE ANN. § 2.2-2001.1 (2014); IOWA CODE § 356.6A (2014); KY. R. CRIM. PRO. 4.06; KY. REV. STAT. § 431.515 (2014); MINN. STAT. § 243.251 (2014).

99. Kristina Shevory, *Why Veterans Should Get Their Own Courts*, THE ATLANTIC (Dec. 2011), <http://www.theatlantic.com/magazine/archive/2011/12/why-veterans-should-get-their-own-courts/8716/>.

100. JIM MCGUIRE ET AL., AN INVENTORY OF VA INVOLVEMENT IN VETERANS COURTS, DOCKETS AND TRACKS 5–7 (2013), available at <http://www.justiceforvets.org/sites/default/files/files/An%20Inventory%20of%20VA%20involvement%20in%20Veterans%20Courts.pdf>.

repeat the mistakes made when the Vietnam generation of veterans first came into contact with the criminal justice system.¹⁰¹

Fortunately, the movement against strictly punitive treatment of psychologically injured veterans continues to make strides. On April 7, 2014, a landmark bill passed through the California Assembly that requires judges in First-Degree Murder cases to consider a veteran-defendant's service-connected trauma in deciding between imposing the death penalty or life in prison.¹⁰² The bill amends California Penal Code Section 190.3 to read, "In determining the penalty, the trier of fact shall consider . . . whether the defendant was, or currently is, a member of the United States military and whether the defendant may be suffering from sexual trauma, traumatic brain injury, post-traumatic stress disorder, substance abuse, or mental health problems as a result of that service."¹⁰³ Not only did the bill pass the California assembly, but it did so by an impressive 73–0 vote. While this bill does not preclude the death penalty when such trauma is present, the overwhelming support exhibited by the California legislature is symbolic of our society's discomfort for executing wounded warriors. And while the amendment is a valuable start, we can do better.

IV. MILITARY SERVICE AS A MITIGATING FACTOR AND GOVERNMENT'S SHARED RESPONSIBILITY FOR THE CAPITAL CRIMES OF VETERANS WITH SERVICE-CONNECTED DISORDERS

The Supreme Court's landmark decision in *Porter v. McCollum* reinforced and enhanced the "long tradition of according leniency to [military] veterans in recognition of their service."¹⁰⁴ Legal practitioners and medical experts weighing in on the issue offer a variety of justifications for affording such special treatment. The *Porter* Court emphasized its belief that veterans should be treated differently "in recognition of their service" and "the intense stress and mental and emotional toll" combat often causes.¹⁰⁵ The former theory reflects the Court's, along with the American public's, gratitude to individuals who shoulder the burdens assumed by all who represent and protect our nation. The latter refers to the psychological effects of war discussed in Part I of this article. As a result of their decision to serve, many will encounter emotional stressors unparalleled in any other human experience. Those who face combat are likely to see tested the limits of what the human psyche can bear.

101. Brockton D. Hunter & Ryan C. Else, *Legal Strategies for Defending the Combat Veteran in Criminal Court*, in THE ATTORNEY'S GUIDE TO DEFENDING VETERANS IN CRIMINAL COURT 429, 429 (Brockton D. Hunter, Esq., & Ryan C. Else, Esq., eds., 2014).

102. A.B. 2098, 2013-2014 Leg., Reg. Sess. (Cal. 2014).

103. *Id.*; CAL. PENAL CODE § 190.3. This bill's language was modified subsequently when it passed the California Senate.

104. *Porter*, 558 U.S. at 43–44.

105. *Id.*

Accounts from individuals who served in our most recent conflicts in Iraq and Afghanistan reveal that an overwhelming percentage of these veterans have experienced highly stressful combat-related events. From 2008 to 2010, Dr. Brown conducted comprehensive interviews with 78 veteran-defendants and 162 additional veterans in sixteen states who served in Iraq or Afghanistan.¹⁰⁶ The compelling results of that study speak to the prevalence of the “emotional toll” factor emphasized by the *Porter* Court. The participants’ responses showed:

- 88.5% witnessed dead bodies or human remains
- 21.4% participated in handling or uncovering human remains
- 83.8% witnessed the death or serious injury of an American soldier
- 40.2% were themselves injured or wounded in combat
- 31.2% directly caused the death of an enemy combatant
- 20.9% directly caused the death of a civilian
- 12.8% were directly responsible for the death of a child¹⁰⁷

The DSM-V provides a list of representative events considered sufficient to produce PTSD.¹⁰⁸ The first experience on that list is “exposure to war as a combatant.”¹⁰⁹ The numbers provided by Dr. Brown’s study clearly demonstrate why.

The *Porter* decision stood for the proposition that exposure to these traumatic experiences has a tendency to mitigate the veteran-defendant’s culpability, separating them from others guilty of the same offense.¹¹⁰ The death penalty is an exceptional measure reserved for only the most culpable and egregious offenders. An established link between a veteran-defendant’s service-connected disorder and his crime of conviction, in itself, removes such a defendant from this “most culpable” category. Penalty of death, therefore, is not an appropriate option.

A third and perhaps most comprehensive basis for granting service members special treatment reflects the notion that government is often responsible for the circumstances that lead veterans to criminality—the “shared responsibility theory.” Professor Youngjae Lee recently explained that this reasoning does not purport to reduce the veteran’s culpability, “but instead centers around the State’s involvement in the production of their criminality.”¹¹¹ The shared responsibility theory is grounded in two underlying facts of the state-soldier relationship. First, the government knowingly places service members in situations—be it combat, intensive training, or combat-related circumstances—that exponentially increase the likelihood of

106. Brown, *supra* note 64, at 128–30.

107. *Id.*

108. AM. PSYCHIATRIC ASS’N, *supra* note 26, at 274–75.

109. *Id.*

110. *Porter*, 558 U.S. at 43–44.

111. Youngjae Lee, *Military Veterans, Culpability, and Blame*, 7 CRIM. L. & PHIL. 285, 300 (2013).

sustaining mental or emotional damage.¹¹² The second aspect is akin to indirect fault as the *respondeat superior*, because a soldier acting in the interests of the military acts as an extension of the government itself.¹¹³ Thus, when a soldier in combat commits an act of violence, the government is guilty of the same. And, except in a limited number of extraordinary circumstances, a soldier commits acts of violence only in response to the government's command to do so. Taken together, "[i]f the soldiers, while working as agents of the State in places and situations designated by the State as their mission sites" develop mental or emotional injuries, "which drive them toward criminal activities post-deployment, the State's standing to condemn their behavior is undermined because the State itself has caused the conditions leading to the crimes."¹¹⁴

For reasons unstated in his article, Professor Lee limits his analysis to cases involving veterans with PTSD.¹¹⁵ It is important to recognize, however, that the shared responsibility theory logically extends to non-PTSD service-related disorders, including TBIs. In his 2009 (pre-*Porter*) article, Anthony Giardino advocated for the creation of a categorical death penalty exemption for combat veterans with PTSD or TBI.¹¹⁶ In distinguishing combat veterans from civilians suffering from similar afflictions, Giardino points out that veterans "would not have service-related PTSD or TBI *but for government action* in the form of training them to kill and sending them to war."¹¹⁷ As with Professor Lee's, Giardino's position is a poignant one—to a large degree, this article is an extension of what he proposed in 2009.¹¹⁸ Again, however, the focus of his proposed exemption, combat veterans with PTSD and TBI, is too narrow. If the primary mitigating factors are the government's contributory role and the resulting psychological effects, then it is unfair to overlook service-members impacted by events outside Giardino's definition of combat.

Giardino's categorical death penalty exemption applies to a veteran "only if he or she has taken fire from or fired at an enemy force."¹¹⁹ On the other hand, his reasoning is grounded chiefly in the effects of modern military training, PTSD, and TBI.¹²⁰ While exchanging fire with enemy combatants certainly is the primary cause and increases the likelihood of

112. *Id.*

113. *Id.*

114. *Id.* at 301.

115. *See id.*

116. *See* Anthony E. Giardino, *Combat Veterans, Mental Health Issues, and the Death Penalty: Addressing the Impact of Post-Traumatic Stress Disorder and Traumatic Brain Injury*, 77 *FORDHAM L. REV.* 2955 (2009).

117. *Id.* at 2961 (emphasis added).

118. *Id.* at 2988–89.

119. *Id.*

120. *Id.* at 2967–80.

incurring psychological injuries, if such an injury is sparked by a different military experience, the shared responsibility element is no less present.

Consider two examples. First, a soldier deployed to Iraq at the height of the war to serve in a combat support hospital. Seven days a week, for months at a time, he is forced to endure a never-ending exposure to the death and gruesome injuries of American troops. Never himself placed in harm's way, but nonetheless unable to escape the cries of pain and sadness that plague his memory for the rest of his life. On the other hand, even soldiers who make it through a deployment without ever having to face the horrors of war can develop significant psychological injuries.

Imagine an infantryman deployed to South Korea in the late 1980s. By this point, North Korean troops had become a formidable opponent consisting of hundreds of thousands of troops. The soldier was part of a small unit described as a "trip-wire" force in case the North Koreans invaded the South. Essentially, he would have understood that if an invasion ever did take place, he and his comrades were there to fight and be slaughtered. And, with some regularity, the alarms would sound, he would prepare to do his job—he would prepare to die—only to learn that it was a drill or false alarm. It would not be surprising if after returning home, that soldier struggled with the hyper-arousal symptoms of PTSD due to his military service. Does the government share any less of the blame for this type of veteran's psychological injuries? Of course not.

The question presented by the shared responsibility theory is not whether the government has standing to prosecute and sentence veteran-defendants who commit capital offenses. Of course, even where the government's actions contribute to the commission of such a crime, it will be necessary to protect public safety by isolating the veteran-offender from other potential victims. Instead, the theory poses a challenge to the state's moral standing to pursue a strictly *punitive* sentence.¹²¹ Beyond merely asking, "does someone who committed these acts deserve to die?" it requires the question, "can the government rightfully serve as his executioner?" The issue is one of blameworthiness. Where the government intentionally and knowingly cultivates in an individual a psychological state that directly contributes to his or her subsequent criminal conduct, it cannot turn around and punish the resulting unlawful conduct.

Unequivocally, therefore, the government has no moral standing to end the life of a person whose service-related disorder contributed to the commission of a crime. If the purpose of maintaining the death penalty as an option is to deter crime and punish those responsible for the most heinous acts, the State cannot reasonably invoke those grounds when it contributes to the mental state of a veteran at the time he or she commits a capital offense.

121. Lee, *supra* note 111, at 300; Hunter & Else, *supra* note 101, at 428.

V. THE PROPOSED CATEGORICAL EXCLUSION

Because the death penalty is not an appropriate consequence for military veterans suffering from a service-related disorder at the time of their offense, a prudent legal response requires the creation of a narrow categorical exclusion. Categorical exclusions are necessary because those determining the sentence may not, in their own discretionary role, give deference to some forms of mitigating evidence regarding certain offenders.¹²² Supreme Court decisions contemplating categorical death penalty exclusions have consistently recognized that mitigating evidence based on psychology or psychiatry are undervalued and misunderstood by the sentencing bodies.¹²³ Only a categorical exclusion can protect against the devaluation and discounting of valid service-related mental health disorders existing at the time a capital crime was committed, a factor that unquestionably mitigates the defendant's culpability and the government's standing to execute.¹²⁴

The proposal is a bill put before the U.S. legislature that would amend 18 U.S.C.A. § 3592¹²⁵ to bar the death penalty when three factors are satisfied: (1) the defendant served in the United States military, (2) the defendant's service caused him to suffer from a mental health or physical cognitive disorder, and (3) there is a causal connection between the defen-

122. See, e.g., *Roper*, 543 U.S. at 573; *Atkins*, 536 U.S. at 320–21; Christopher Slobogin, *Mental Disorder as an Exemption from the Death Penalty: The ABA-IRR Task Force Recommendations*, 54 *CATH. U. L. REV.* 1133 (2005); Ronald J. Tabak, *Executing People With Mental Disabilities: How We Can Mitigate an Aggravating Situation*, 25 *ST. LOUIS U. PUB. L. REV.* 283, 287–89 (2006).

123. *Roper*, 543 U.S. at 564–79; *Tennard v. Dretke*, 542 U.S. 274, 288–89 (2004); *Atkins*, 536 U.S. at 317–21.

124. Shortly after Anthony Giardino's article was published, Drs. Hal S. Wortzel, M.D., and David B. Arciniegas, M.D., published a piece in *The Journal of the American Academy of Psychiatry and the Law*, supporting the proposed exclusion from a neurological perspective, stating:

There are compelling arguments, from a neuropsychiatric perspective, to consider the combat veteran who is genuinely affected by certain PTSD and/or TBI sequelae at the time of a criminal offense to be treated as a distinct class of offender. In most such instances, the facts surrounding the wounded warrior's military experiences and service-related injuries ought to be considered mitigating in the sentencing of the offender. At the same time, Giardino's proposed categorical exclusion is actually quite broad, potentially covering hundreds of thousands of returning service men and women. Because of this breadth, there would probably be instances in which individuals "broken" long before their military service are offered protection from punishment for their criminal acts by this categorical exclusion. It could be argued that the injustice and immorality of executing a single combat veteran who has PTSD and/or TBI at the time of the crime outweighs any conceivable benefit from preserving the ability to execute those whose crimes are unrelated to military service and injury. Neuroscience cannot inform society on how to balance these risks. However, the tragedy of the wounded combat veteran who faces execution by the nation he has served seems to be an avoidable one, and we, as a society, should take action to ensure that it does not happen. Giardino's argument is a poignant one, and its intentions are meritorious. With the combined expertise of the legal and neuropsychiatric realms, an optimized version of the proposed categorical exclusion may emerge.

Wortzel & Arciniegas, *Combat Veterans and the Death Penalty*, *supra* note 4.

125. 18 U.S.C.A. § 3592 (West) (laying out mitigating and aggravating factors to be considered in determining whether a sentence of death is justified).

dant's service-connected disorder and the offense of conviction. Accordingly, the burden would be placed on the defendant to prove each of these elements by a preponderance of the evidence. If the trier of fact believes it is more-likely-than-not that each element was present when the crime was committed, the death penalty would be off the table. This amendment provides four valuable improvements to the law. It would: (1) reflect the national consensus that has developed regarding the impropriety of putting to death this category of offenders; (2) recognize that the penological goals of the death penalty are not served by executing these offenders; (3) acknowledge the significant mitigating nature of service-related mental health disorders in veterans who have also been trained to kill by the government; and (4) "address the unacceptable risk that a sentencer could disregard mitigating evidence of military training, PTSD, and TBI to impose a death sentence where it is unwarranted."¹²⁶

A. *A Categorical Exemption is Supported by the Atkins and Roper Framework*

The framework for categorical death penalty exclusions created by the Supreme Court in *Atkins v. Virginia* and *Roper v. Simmons* supports the creation of the exemption argued for herein.¹²⁷ Although *Atkins* and *Roper* only purport to provide the considerations for judicially enacted death penalty exclusions, the determinative considerations are equally applicable in the legislative setting. In 2002, the Supreme Court stated that it is unconstitutional to impose the death penalty on a mentally retarded person.¹²⁸ In 2005, the Court similarly held it is unconstitutional to execute a juvenile offender.¹²⁹ Ultimately, the Court established a two-part test to analyze whether the death penalty is an appropriate punishment for a specific class of offenders under the Eighth Amendment's prohibition of cruel and unusual punishment.¹³⁰

1. *Objective Evidence of Societal Discontent for Executing Veterans*

First, the Court evaluates whether putting to death certain offenders constitutes punishment that is "graduated and proportioned to [the] offense" and within the boundaries of the "evolving standards of decency that mark the progress of a maturing society."¹³¹ To make this determination, the Court examines "objective evidence of contemporary values."¹³² Evidence

126. Giardino, *supra* note 116, at 2988.

127. See *Atkins*, 536 U.S. 304; *Roper*, 543 U.S. 551.

128. *Atkins*, 536 U.S. at 321.

129. *Roper*, 543 U.S. at 574–75; U.S. CONST. amend. VIII.

130. *Atkins*, 536 U.S. at 564–79; *Roper*, 543 U.S. at 311–21.

131. *Atkins*, 536 U.S. at 311, 341 (internal citations omitted).

132. *Id.* at 312 (internal citations omitted); *Roper*, 543 U.S. at 594 (internal citations omitted).

of discomfort with and intolerance for the execution of a certain class of offenders weighs in favor of a categorical exclusion.¹³³ The Court views the strongest objective evidence to be legislation enacted by the various states.¹³⁴

With regards to the present proposal, there is extremely strong “objective evidence” that “contemporary values” and societal mores support the adoption of the categorical death penalty exclusion proposed above. To date, a total of five states have enacted veterans sentencing statutes¹³⁵ and even more impose a duty on the court, the Veterans Association, or community corrections to inquire about the veteran’s service, inform him of the services available, or consider his service-related disorder in constructing a treatment plan.¹³⁶ In 2010, the United States Sentencing Commission amended Sentencing Guideline § 5H1.11 to consider a defendant’s military service as a likely mitigating factor at the penalty phase of criminal prosecutions in federal court.¹³⁷ Furthermore, *Porter* officially established military service as a mitigating factor at sentencing in a death penalty case.¹³⁸ The holding effectively highlighted the Court’s own discomfort with, and intolerance for, executing a veteran whose combat trauma led him down a path ending in violence.

In addition to the strong evidence offered by the movement toward legislative and judicial changes, academics and professionals with expertise on relevant topics agree on the mitigating nature of combat trauma and military service.

2. *Subjective Factors Affecting the Proportionality of the Death Penalty*

Second, in ruling on the propriety of a proposed exclusion, the framework instructs the Court to “determine, in the exercise of [its] own independent judgment, whether the death penalty is a disproportionate punishment for [a class of offenders].”¹³⁹ This second step allows the Court to weigh in with its own judgment on relevant subjective factors. *Atkins* and *Roper* focused specifically on three such considerations: (1) penological goals of punishment, (2) specific mitigating factors that may entitle a class of offenders to a categorical exclusion, and (3) whether or not there is an unac-

133. *Atkins*, 536 U.S. at 310.

134. *Id.* at 312 (internal citations omitted).

135. *See, e.g.*, CAL. PENAL CODE § 1170.9; MINN. STAT. § 609.115(10); NEV. REV. STAT. § 176.015; N.H. REV. STAT. ANN. § 651:4-b; R.I. GEN. LAWS § 12-29-5.

136. CAL. PENAL CODE § 1449; VA. CODE ANN. § 2.2-2001.1; IOWA CODE § 356.6A; KY. R. CRIM. PRO. 4.06; KY. REV. STAT. § 431.515; MINN. STAT. § 243.251.

137. U.S. SENTENCING GUIDELINES MANUAL § 5H1.11.

138. *Porter*, 558 U.S. at 43–44.

139. *Roper*, 543 U.S. at 564; *see Atkins*, 536 U.S. at 312–13.

ceptable likelihood that a sentencer could disregard those mitigating factors to still arrive at a sentence of death.¹⁴⁰

Each of the three subjective factors comprising the second prong of death penalty exclusion analysis strongly supports the creation of a categorical exclusion for qualifying veteran-defendants. First, none of the penological goals of the death penalty are served by executing those who suffer from a psychological injury incurred as a result of his or her service to our country. Neither retributive nor deterrence based justifications for the death penalty make sense in this context. The retributive goals are negated by both the mitigating nature of military service and the government's lack of moral standing to punish. The impaired judgment and automated responses that accompany PTSD, TBI, and substance abuse related disorders negate the argument that this type of offender will consider the possibility of facing the death penalty and curb his violence.

Second, specific mitigating factors that distinguish troops and veterans with a service-connected disorder further tip the scales in favor of creating a categorical exclusion. The symptoms of PTSD and TBI, and the manner in which veteran-defendants incur those disorders, mitigate their culpability as much as, if not more than, the conditions excluding juveniles and the mentally handicapped.

Third, the Nation's volatile relationship with our troops and the vast misunderstanding of the mitigating nature of combat trauma illustrate an unacceptable risk that a sentencer will overlook the role a service-connected disorder played in the underlying crime, and thus may impose the death penalty. Unfortunately, as discussed in Part III above, sentencing bodies have historically demonstrated this type of oversight with some regularity. In fact, the evidence suggests that misunderstanding of service-connected disorders and a sentencer's personal feelings on war have even resulted in military service and psychological injuries being treated as aggravating factors.¹⁴¹ As Giardino points out, the unacceptable risk that a veteran-defendant's service-related disorder will be disregarded or mistreated is exacerbated further by the declining representation of veterans in the judicial and political system.¹⁴² *Porter* illustrates that this is simply too serious a problem to rely on a defense bar so inadequately informed on service-related issues.

140. Giardino, *supra* note 116, at 2983–84.

141. See *supra* Parts I–III's discussion of past legal and medical mistreatment of psychologically injured veterans.

142. Giardino, *supra* note 116, at 2994 (citing Michael S. Woodson, Stand for the Troops, *SFTT Special Report: A Combat Vet Needed for the Supreme Court*, DEFENSEWATCH, July 12, 2005, <http://www.sftt.org/cgi-bin/csNews/csNews.cgi?command=viewone&id=19&database=DefenseWatch%202005%20A.db>; Military Officers Association of America, *Declining Military Experience in Congress*, http://www.moaa.org/lac/lac_resources/lac_resources_tips/lac_resources_tips_decline.htm (last visited Mar. 31, 2009); U.S. Census Bureau, *People: Veterans*, http://factfinder.census.gov/jsp/saff/SAFFInfo.jsp?_pageId=tp12_veterans (last visited Mar. 31, 2009)).

Finally, analysis of the current proposition would be incomplete without the consideration of a fourth factor—government’s shared responsibility for the veteran-defendant’s criminal behavior. As discussed at length in Part IV above, the State is completely without moral standing to impose purely punitive criminal consequences against a person who, but for their military training and service, would not have committed a criminal offense. The most dramatic and glaring example of this paradox is when the State imposes the death penalty on a veteran suffering from a service-connected disorder at the time of his offense.

CONCLUSION

The majority of our nation’s returning veterans will leave the military stronger and wiser from their experiences. But as has been the case with each of America’s past wars many will struggle to reintegrate in society, saddled with heavy psychological and emotional burdens. This time around, it should not surprise us when the highly combustible combination of military indoctrination and extreme trauma results in violent behavior, including murder.

Today, legal trends reflect a growing distaste for the government seeking retribution against service members and veterans whose criminal behavior is a product of their service. Of course, it will continue to be necessary to protect our communities by isolating individuals who have shown themselves to be a source of danger. However, the government acts beyond its moral standing when it imposes purely punitive consequences for behavior it is directly responsible for creating.

When death is on the line, the reasoning underscoring the wrongfulness and incongruity of imposing retributive sentencing measures on psychologically injured veterans is at its zenith. Weighing the penological impetus for the death penalty against the government’s shared responsibility and the effects of PTSD and TBI, it is clear that executing this type of veteran-defendant is unjustifiable and unacceptable. Due to common fundamental misunderstandings regarding the mitigating nature of service-related traumas, a categorical exclusion is necessary to prevent their mistreatment at sentencing.

All relevant factors support the creation of a categorical death penalty exclusion for service members and veterans suffering from a service-related mental injury when they commit the underlying capital offense: the American public overwhelmingly shares the belief that service-related psychological injuries mitigate a veteran’s culpability for abhorrent behavior; legal frameworks provided by the judiciary for considering a categorical exclusion from the death penalty strongly support the creation an exemption under the circumstances discussed herein; neuroscience confirms that PTSD and TBI drastically enhance the likelihood of criminality; and, most importantly, the government is largely responsible for causing these injuries.