

Combat Veterans and the Death Penalty: A Forensic Neuropsychiatric Perspective

Hal S. Wortzel, MD, and David B. Arciniegas, MD

With our nation's present conflicts, a new generation of veterans are returning home, many of whom have substantial psychopathology and are encountering significant barriers in accessing care. Headlines from around the nation reflect that some of these wounded warriors go on to commit offenses that are potentially punishable by death. Existing circumstances speak to the urgency with which the subject of combat veterans with post-traumatic stress disorder (PTSD), traumatic brain injury (TBI), or both facing capital crimes ought to be addressed. This publicity has led to a recent call for a legislatively or judicially enacted, narrow, categorical exclusion for combat veterans who were affected by either PTSD or TBI at the time of their capital offenses. In the present article, we illustrate the reality that combat veterans who commit capital offenses may face execution, summarize legal arguments offered in favor of a categorical exclusion, and provide a neuropsychiatric perspective on PTSD, TBI, and aggression, to help inform further dialogue on this weighty subject.

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In a law review article, Giardino¹ argues, from the legal perspective, that combat veterans with post-traumatic stress disorder (PTSD) or traumatic brain injury (TBI) at the time of their offenses should not be subject to capital punishment. The argument offered is an interesting one that addresses an important topic and warrants further consideration. For a veteran with genuine combat sequelae of PTSD and perhaps TBI, capital punishment for crimes that may be legitimately connected to service-related injuries clearly represents a deplorable outcome. Given that as a nation we have the ability to prevent such an outcome, it is incumbent on us to give the matter of capital punishment for combat veterans serious consideration. However, in considering Giardino's position, including the call for a categorical exclusion for

combat veterans who have either PTSD or TBI at the time of their capital offenses, a more precise examination predicated on the behavioral neuroscience of PTSD, TBI, and aggressive behavior becomes essential. In the present article, we illustrate the reality that some combat veterans are facing execution, summarize the legal arguments offered by Giardino,¹ and provide a neuropsychiatric perspective on PTSD, TBI, and aggression to help inform further dialogue.

Veterans Facing Capital Punishment

The potential for combat veterans with serious neuropsychiatric illness at the time of their capital offenses to be sentenced to death is very real. Manuel "Manny" Babbitt was executed by the state of California in 2005, after spending 18 years on death row for the murder of a 78-year-old woman that occurred during a break-in.² Mr. Babbitt served in Vietnam and was exposed to combat. While fighting in the prolonged siege on Khe Sanh, he was wounded by rocket fragments striking his head and hand, and eventually received a Purple Heart (while on death row) for his wounds. Reports from family suggest that Mr. Babbitt had severe PTSD, experiencing flashbacks during which he would run for cover from bombs. Reportedly, the nature and extent of Mr.

Dr. Wortzel is Assistant Professor, Veterans Integrated Service Network (VISN) 19, Mental Illness Research, Education, and Clinical Center (MIRECC), Denver, VA, and the Neurobehavioral Disorders Program and Division of Forensic Psychiatry, Department of Psychiatry, University of Colorado, Denver, CO. Dr. Arciniegas is Director of the Neurobehavioral Disorders Program and an Associate Professor of Psychiatry and Neurology, School of Medicine, University of Colorado, Denver, CO. The opinions offered in this article do not necessarily reflect that of the Veterans Administration or the VISN 19 MIRECC. Address correspondence to: Hal S. Wortzel, MD, VISN 19 MIRECC, 1055 Clermont Street, Denver, CO 80220. E-mail: hal.wortzel@ucdenver.edu.

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Babbitt's mental illness was not conveyed to jurors during trial. Some of them have since indicated that they would never have supported a death sentence if such mitigating evidence had been presented.²

Louis Jones, Jr., was executed by the U.S. government on March 18, 2003, for the 1995 rape and murder of a young servicewoman. Mr. Jones had sought clemency on the basis that he was exposed to nerve gas while serving in the first Gulf War and that such exposure contributed to his violent behavior. He was a decorated former member of the U.S. Special Forces. His defense team at trial argued that Jones had PTSD related to his front-line duties in Iraq as well as action in Grenada, where he parachuted in under fire.

Other combat veterans have been convicted of capital crimes and sentenced to death, sometimes under circumstances involving misconduct on the part of prosecutors. Gary B. Cone, a decorated Vietnam War Veteran, was convicted of murder and sentenced to death for killing an elderly couple. The defense team argued that Mr. Cone was using methamphetamine and had a psychosis brought on by PTSD secondary to his honorable service in Vietnam. The trial prosecutor called the claim of drug addiction "baloney" and argued that Mr. Cone was a cold and deliberate killer. It turned out that the prosecution had withheld important evidence in support of his reported substance abuse and intoxication at the time of the criminal act, including witness statements suggesting that Mr. Cone had been "drunk or high."^{3,4}

James Floyd Davis sits on death row in North Carolina for a workplace shooting wherein he shot and killed three people. He served two tours in Vietnam, suffered hearing loss, and carries a piece of shrapnel in his leg to this day. He received commendations for his service, including the Good Conduct Medal. Following his military service, Mr. Davis struggled with his mental health, was diagnosed with schizophrenia and depression, and was thought to have PTSD. He recently received his military medals, including a Purple Heart, while awaiting execution on death row.⁵ George Page, also a Vietnam Veteran with PTSD, was on death row in North Carolina until a stay was granted on February 25, 2004, just two days before he was scheduled for execution. Mr. Page reportedly has a long and complex mental health history involving PTSD, bipolar mood disorder, and suicide attempts. Advocates in-

dicating that he was never afforded the opportunity to have an evaluation or testimony by a PTSD expert and that the jury lacked vital information in making their life-or-death determination.^{6,7}

Recent history clearly indicates that combat veterans, including those who have the physical and psychological wounds of war, may commit capital crimes and be sentenced to death. This risk seemingly extends to combat veterans with severe, combat-related neuropsychiatric illness. In addition, even when there are prominent mitigating circumstances related to military service and neuropsychiatric impairment, such information may never be heard by juries because of actions or inactions on the part of defenders, prosecutors, and courts. With our nation's present conflicts, a new generation of veterans are returning home, many of whom have substantial psychopathology and are encountering significant barriers in accessing care.⁸⁻¹⁰ Even those who undergo screening for such injuries after returning home may have their disorders remain undetected.¹¹ Headlines from around the nation clearly reflect that some of these wounded warriors go on to commit offenses that are potentially punishable by death. *The New York Times*, in January of 2008, reported 121 cases of veterans of Iraq and Afghanistan who had been charged with killings after their return.¹² The existing circumstances speak to the urgency with which the subject of combat veterans with PTSD and/or TBI who are tried for capital crimes ought to be addressed.

Giardino's Argument and Commentary

In brief, Giardino¹ argued that the combination of combat training and exposure and either PTSD or TBI, is a powerful mitigating factor that sufficiently diminishes culpability such that capital punishment is not an appropriate penalty. Defendants in capital cases already enjoy relatively wide latitude in the introduction of mitigating evidence. However, as the cases described herein illustrate, the ability to introduce mitigating evidence is not always realized and, even when effectively presented to juries, such evidence may not have its intended effect. Because mitigating evidence based on neuropsychiatric findings may be undervalued, misunderstood, or possibly even treated as an aggravating factor by juries, Giardino called for a legislatively or judicially enacted, narrow, categorical exclusion from the death penalty

for combat veterans who had either PTSD or TBI at the time of their capital offenses.

According to Giardino's argument, the Supreme Court's reasoning behind its *Atkins v. Virginia*¹³ and *Roper v. Simmons*¹⁴ decisions, creating categorical exclusions from the death penalty for the mentally retarded and juveniles, respectively, can be applied to combat veterans who have PTSD, TBI, or both. The Court's rationale in *Roper*¹⁴ may be viewed as a two-step analysis, with the first step involving a consideration of evolving standards of decency and societal mores. Giardino argues in support of an evolving societal sentiment that combat veterans suffering from service-related neuropsychiatric injuries deserve to be treated differently in criminal courts. He points to the recent trends involving diversion programs and veterans courts in several states and cities across the nation. The trend clearly has momentum, with new veteran courts^{15,16} coming into existence even since his recent publications. Another clear indication of the evolving sentiment is a major change in policy at the Veterans Administration (VA), where new initiatives have been launched for outreach and service to justice-involved veterans. While the subpopulation of veterans who have been charged with crimes was largely ignored in the not-too-distant past, the VA now officially recognizes that many veterans of Iraq and Afghanistan are arrested for a variety of offenses, some of which may be related to extended periods of battle readiness and combat exposure during multiple deployments and to maladaptive coping with the return to civilian life.¹⁷ The VA's Uniform Mental Health Services Package now calls not only for assistance for veterans re-entering the community from state and federal prisons, but also for outreach efforts to veterans who are interfacing with jails, courts, and law enforcement and for education to these agencies regarding mental health problems relevant to veteran populations, such as PTSD and TBI. Giardino writes:

From magnetic yellow ribbons on cars to broad campaign promises to take care of our veterans, it appears that popular sentiment backing those combat veterans who have served in Iraq and Afghanistan favors helping them with any service-related injuries they may have incurred. This sentiment indicates that a significant number of Americans would support, or at least tolerate, a narrow categorical exclusion from the death penalty for combat veterans who committed capital offenses while suffering from service-related PTSD or TBI [Ref. 1, pp 2990–1].

The second step in the *Roper* Court's analysis involves consideration of whether the death penalty

constitutes disproportionate punishment of a class of offenders, with a survey of the mitigating factors applicable to that class of offenders and the likelihood that sentencers would appropriately recognize the mitigating value of such evidence. Giardino contends:

The Court should find that both PTSD and TBI symptoms significantly affect judgment so as to render combat veterans suffering from those conditions similar to, if not less culpable than, the mentally retarded and juveniles. The symptoms of PTSD and TBI are similar to mental retardation and juvenile status in that the abilities to appreciate the wrongfulness of one's conduct and to conform one's behavior to the requirements of the law are significantly diminished. The Court should also examine the role that government-sponsored military training plays in diminishing culpability in combat veterans, especially those with PTSD or TBI, to find further support for a categorical exclusion. . . . Finally, the Court should consider the more fundamental question of whether the government should be in the business of putting to death the volunteers they have trained, sent to war, and broken in the process. The Court should find that it is unconscionable for the government to sentence soldiers and veterans to death for criminal actions that would likely not have happened but for their military service [Ref. 1, pp 2993–4].

The state's role in damaging some of these individuals appears to be a salient feature of this proposed class of capital defendant. Some defendants would almost certainly not have engaged in criminal behavior but for their service-related injuries. However, the question also arises of whether some of the individuals who would fall under such a categorical exclusion were "broken" before their service and whether they would have engaged in violent acts regardless of military experiences. Problematic from the neuropsychiatric perspective is Giardino's likening of the combat veteran with TBI or PTSD to either a juvenile or a person with mental retardation. In addition, not all crimes of aggression (including murder) are alike, and certain acts of violence would be difficult to connect cogently with military training, combat exposure, PTSD, or TBI. On the other hand, the cognitive, emotional, and behavioral sequelae experienced by the combat veteran with PTSD and/or TBI may be substantial and demand attention in capital cases.

PTSD, TBI, and Aggression

A crucial question in considering this matter is whether the combination of military training, combat exposure, and PTSD and/or TBI yield a neuropsychiatric profile that diminishes culpability, either

by interfering with the ability to appreciate the wrongfulness of one's actions or by reducing the ability to conform one's behavior to the requirements of the law. In many instances, this constellation of experiences and injuries will have precisely that effect. Giardino reviews the literature that suggests a role in diminished culpability for each of these independent circumstances. Combat training certainly involves indoctrination and conditioning designed to bypass the individual's prohibition against killing under certain circumstances, and combat exposure is very likely to have an added desensitizing effect in the violation of normal social and moral prohibitions.¹ However, the extent to which military personnel are exposed to combat training and actual combat is highly variable. To what extent is a physician who enters the military as an officer trained to kill? If that doctor is subsequently on base during an attack, is he then a combat veteran who has been primed to bypass the normal restraints against killing?

Certainly, as Giardino argues, both PTSD and TBI carry implications for an individual's judgment and behavior. The argument that this constellation of factors, combining combat training, combat experience, and PTSD and/or TBI is unique to this proposed class of offender¹ seems valid and in many instances would result in a neuropsychiatric status warranting diminished culpability. Many in this proposed class of offender are likely to have had a series of experiences (military training and combat) and traumatic exposures (psychological and/or biomechanical) with direct implications relating to aggression and behavioral control.

Much of the neurobiological research into PTSD and TBI suggests combinations of bottom-up and top-down regulatory deficits in neural networks.¹⁸ Bottom-up deficits involve increased and maladaptive affective input from the limbic system. Key structures implicated in this process include the hippocampus and the amygdala, which are susceptible to damage in both conditions. The hippocampus is involved in stress responses, declarative memory, and fear conditioning. While many structural imaging findings have been reported in PTSD, reduced hippocampal volume is among the most reproducible.¹⁹ The amygdala is crucial to limbic system function, playing a central role in emotional processing. Top-down controls are in large part provided by the prefrontal cortex, including the medial prefrontal cortex (mPFC) and the anterior cingulate cortex (ACC).

The mPFC is linked to the limbic system and the amygdala and is thought to exert inhibitory control over emotional reactivity and stress responses.¹⁹

In fact, volumetric findings in both the hippocampus and the prefrontal cortex have been reported specifically in veterans with PTSD. Vythilingam *et al.*²⁰ reported a significantly smaller volume of the hippocampal head in Gulf War veterans with PTSD compared with that in healthy civilians. Geuze *et al.*²¹ reported decreased cortical thickness in the bilateral superior and middle frontal gyri, the left inferior frontal gyrus, and the left superior temporal gyrus in veterans with PTSD compared with that in veterans without PTSD matched for age, year, and region of deployment. Collectively, the existing PTSD imaging literature suggests the hippocampus, amygdala, and prefrontal cortex (including mPFC and ACC) as sites of interest in understanding the symptomatology of PTSD. Furthermore, Solomon *et al.*²² argue that PTSD is not a "monolithic disorder" and offer evidence that symptom clusters may differ among different populations and that hyperarousal symptomatology may serve as the psychological "engine" behind PTSD in war veterans. Anger, related to hyperarousal and conceptually (and perhaps neurobiologically) overlapping with aggression in many ways, may be a salient feature of postwar adjustment for returning veterans and is often a crucial feature of their clinical presentations.

The frontal and temporal lobes are particularly susceptible to injurious forces acting on the brain during biomechanical trauma.²³⁻²⁶ This regional susceptibility has been demonstrated in pre-imaging autopsy-based research revealing typical patterns of contusions after injury^{24,25} and in studies utilizing modern-day imaging techniques, such as voxel-based morphometry.^{27,28} Neuroanatomic vulnerability to TBI also extends to white matter, which connects various cortical areas with one another, as well as with deep brain nuclei, and is particularly susceptible to the shearing and straining forces produced in TBI. TBI also disrupts the structure and function of the major modulatory neurotransmitter systems that support the function of the frontal and temporal lobes (see Arciniegas and Silver^{29,30} and Bales³¹ for reviews). These combinations of structural and neurochemical changes produced by TBI increase the likelihood of clinically significant post-traumatic disturbances in frontally mediated cognition, emotion, and behavior. Notably, similar top-down and bot-

tom-up control systems have also been postulated to underlie the neurobiology of aggression,³² and these overlapping neurobiological underpinnings are likely to explain, at least in part, the substantial body of literature articulating associations between aggression and both PTSD and TBI.

The Aspen Neurobehavioral Conference Consensus Statement on violence³³ may be useful in considering the unique profile of the combat veteran with PTSD and/or TBI. The statement notes that all human behavior is variably governed by the interaction of numerous factors, including genes, early life experience, acquired brain damage, learned behavior patterns, and situational contingencies. PTSD and TBI appear to cause neurobiological dysfunction that threatens the capacity to inhibit violent behavior. While it is crucial to appreciate that illness is not destiny and that many pre-injury and postinjury psychosocial factors are at play in any individual who exhibits violent behavior toward others,³³ in the case of many combat veterans with either PTSD or TBI, a host of pre-injury and postinjury conditions (many of which are directly related to military service and training) may further predispose to violent behavior.

Unfortunately, there is no report in the medical or scientific literature of a study that has effectively tested this hypothesis. One could argue that the increased rates of suicide among veterans and the frequency with which veterans are incarcerated for violent crimes are both indicative of the multifactorial formula at work in the aggression of combat veterans, as described earlier.³⁴ Perhaps the closest we have to evidence on this possibility derives from an epidemiological investigation comparing an index Brigade Combat Team (BCT) out of Fort Carson, Colorado, which was associated with eight homicides in 12 months, with a similar BCT. Not surprisingly, results suggest that the violence resulted from the interaction of multiple factors. However, a very notable finding was that the index unit experienced a significantly higher level of combat intensity, as determined by combat death rates and post-deployment behavioral health diagnoses, suggesting a possible association between increasing levels of combat exposure and more negative behavioral outcomes.³⁵

A major challenge involved in carving out a categorical exclusion surrounds the wide variability of the clinical phenomenon of aggression. For instance, one form of aggression, observed not only among persons with TBI but also in those with other severe

neurological disorders,³⁶ is organic aggressive syndrome (OAS).³⁷ This syndrome is characterized by aggression that is reactive (provoked by seemingly trivial stimuli), nonreflective (unplanned), nonpurposeful (serves no clear aim or objective), explosive (occurs suddenly and without any apparent build-up), periodic (prolonged periods of relative calm punctuated by aggressive outbursts), and ego-dys-tonic (the individual feels bad about the behavior).³⁶ This type of post-traumatic aggression is relatively uncommon and is generally observed among persons who are severely neurologically compromised. In such instances, causative relationships between injury and behavior are relatively straightforward.

However, common experience reveals that people who show aggression do not typically present with OAS. As aggressive behavior becomes more discordant with the organic aggressive profile, clinical judgments regarding direct associations and causal relationships between injuries and actions become exceedingly difficult. Reid and Thorne³⁸ offer typologies of violence that are useful constructs for illustrating this point. For instance, aggressive acts that are composed of purposeful, instrumental violence probably fall at the opposite end of the spectrum of aggression from OAS. In purposeful, instrumental violence, the aggressive behavior is used consciously as a means to achieve gainful ends or to intimidate or manipulate another person into some desired behavior. Included in this category of aggressive behavior is violence for revenge or violence for hire.³⁸ It is unclear when, if ever, culpability for violence of this kind would be mitigated by a neuropsychiatric condition, such as PTSD or TBI.

Somewhere on the middle of this proposed spectrum of aggressive behavior is targeted but impulsive violence, wherein unplanned aggressive behavior is directed at a specific person in response to a perceived threat.³⁸ Common clinical experience suggests that violence of this type is far more common among neurobehaviorally impaired PTSD patients and TBI survivors, particularly among those with generalized impairments of impulse control (i.e., disinhibited behavior) and those with comorbid severe cognitive impairments, depression, mania, anxiety, or psychosis. However, aggression of any kind may also arise in the absence of such neuropsychiatric conditions as a function of problems that bear no direct relation to a neuropsychiatric injury *per se*, including states of intoxication, premorbid personality traits and disor-

ders (especially antisocial, borderline, and narcissistic), or as a premeditated, purposeful, instrumental violent act. Attribution of aggressive behavior to PTSD or TBI (i.e., impaired impulse control resulting from neuropsychiatric illness) rather than to purposeful, instrumental violence must be undertaken with caution and only after careful consideration of the totality of the circumstances surrounding such acts, including (but not limited to) specific details of the neuropsychiatric condition, psychosocial factors in existence before and after the event, the context in which the particular violent act occurred, potential precipitants, and possible objectives.

Because there are so many factors at play in any individual and in any act of violence, it becomes essential to consider specific details pertaining to a capital case more carefully. In fact, our justice system typically recognizes and respects the need for individual attention to and consideration of specific circumstances, particularly in highly complex cases; therein lies a potential problem with the categorical exclusion proposed by Giardino.¹ For instance, consider a combat veteran with a history of mild TBI who returns home and commits a murder. This vague picture, full of uncertainties, would fall under the proposed exclusion. Starting with the question of TBI, an important point of clarification from Giardino's argument is essential. TBI is a historical diagnosis, based on an event, not on current symptoms. Presumably, Giardino intends to include in his categorical exclusion those combat veterans who have active sequelae of TBI at the time of a capital offense. Even with this clarification, a categorical exclusion remains tricky.

Fill in the story of the combat veteran who commits a murder with these details. The returning veteran served as a cook and sustained a mild TBI in his only combat exposure. The only persistent sequelae from this injury after a few months is headache. Upon returning home, he becomes involved in drug trafficking and commits a planned execution-style killing of a material witness in an associate's criminal case. Obviously, this scenario is not representative of most capital cases involving combat veterans. Nor is it likely to represent the type of defendant or crime Giardino seeks to exclude with the proposed categorical exclusion. Nevertheless, the exclusion proposed has the potential to capture many instances of violence with no meaningful neuropsychiatric relation-

ship to the perpetrator's military experience or service-related injury.

Conclusions

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 woman. 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.

Alternatively, the dilemma articulated herein may be more simply construed as yet another indication of the unfeasible nature of our present capital punishment system, featuring pitfalls inherent in the near-impossible balancing act that affects all capital cases. The American Law Institute (ALI) recently released a study indicating that decades of experience have proven the capital punishment system incapable of reconciling the twin goals of individualized determinations regarding who should be executed and the need for systemic justice.^{39,40} The ALI concludes:

[T]he longstanding recognition of these underlying defects in the capital justice process, the inability of extensive constitutional regulation to redress those defects, and the im-

mense structural barriers to meaningful improvement all counsel strongly against the Institute's undertaking a law reform project on capital punishment. . . . Rather, these conditions strongly suggest that the Institute recognize that the preconditions for an adequately administered regime[n] of capital punishment do not currently exist and cannot reasonably be expected to be achieved [Ref. 40, p 49].

Add the complex neuropsychiatric nuances frequently present in capital cases (whether they involve veterans or not) with the competing needs of justice, and it becomes increasingly clear that the potential for error in these life-or-death decisions achieves unacceptable levels. The execution of a combat veteran who had service-related neuropsychiatric injuries at the time of the offense is, in truth, emblematic of the pervasive problems with the system as a whole; the obvious injustice and emotional valence surrounding the wounded warrior turned capital defendant may best illustrate these systemic defects and serve as an impetus to much needed change.

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