

A Practitioner's Guide to Defending Capital Clients Who Have Mental Disorders and Impairments

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ACKNOWLEDGEMENTS

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PREFACE

This manual is a companion to *A Practitioner's Guide to Defending Capital Clients Who Have Mental Retardation*, revised and published by the International Justice Project in 2006. We have deliberately limited our discussion of intellectual impairments in this manual in the belief that readers should consult the companion volume if their clients have intellectual impairments of any kind, regardless of whether they are believed to meet the criteria for exemption from capital punishment under *Atkins v. Virginia*.¹ As the Supreme Court observed in *Tennard v. Dretke*, intellectual disabilities of any kind are “inherently mitigating.”²

This volume draws on material that the authors first published elsewhere, in articles in *Capital Report* (a publication of the National Legal Aid and Defender Association Death Penalty Litigation Section), *The Champion* (the monthly magazine of the National Association of Criminal Defense Lawyers), *Hofstra Law Review*, and the *Guide to Mental Health Mitigation* (published by the Capital Resource Project and Federal Death Penalty Resource Counsel Project). We have written new sections, revised and rewritten existing material, and often melded material first developed in multiple articles and training presentations. Our hope is that the finished product combines in a single volume a useful overview of this important subject.

This manual focuses on the issues arising solely in the representation of persons with mental disorders and impairments in death penalty cases. It does not address the legal excuses for criminal responsibility, the various affirmative defenses such as not guilty by reason of insanity or diminished capacity, available in both capital and non-capital contexts. Clearly, the assertion of such defenses implicates myriad strategic considerations in death penalty cases—most notably, how to resolve the inherent conflict between offering mental health evidence as an excuse in the first phase of a trial and then, if it is rejected for that purpose, arguing that the same evidence is not an excuse, but a reason to spare an individual's life. In most jurisdictions, insanity defenses may also expose the client to early discovery of defense work product and a wide-ranging evaluation by a prosecution expert. It is simply beyond the scope of this manual to discuss these complex legal and strategic questions. Instead, the manual focuses on the issues unique to capital cases (especially mitigation evidence). Competency questions are addressed because of the unusual ways in which they implicate every phase of capital litigation.

We are indebted to many colleagues around the country who have contributed to the capital defense community's understanding of mental health issues. To list them all would be impossible, but we must acknowledge a small number whose contribution has been immense and particularly significant to the authors of this manual: lawyers John H. Blume, Mark E. Olive, and Denise Young; mitigation specialist Scharlette Holdman; neuropsychologist Dale Watson; and psychiatrists Richard G. Dudley, Jr., and George Woods. We are also grateful for the assistance of two British law student

¹ 536 U.S. 304 (2002).

² 542 U.S. 274, 287 (2004).

interns from Warwick University, Faye Lawson and Benjamin Morris. Their research assistance and constructive feedback have made a valuable contribution in the final months of preparing the manual for publication.

This manual is a brief introduction to a complex subject. It is our hope that it will help practitioners who encounter clients with mental disorders and impairments to be thoughtful and empathetic in deciding how those issues affect capital defense representation.

The authors also wish to acknowledge the support and assistance of the projects and agencies with which they are affiliated. Richard Burr is an attorney in Houston, Texas, who serves as a Federal Death Penalty Resource Counsel. David Freedman is based in Little Rock, Arkansas, and consults on mental health issues with the Capital Resource Counsel Project. Russell Stetler is based in Oakland, California, and serves as National Mitigation Coordinator for the federal death penalty projects. Kathy Wayland is a clinical psychologist who works as a mitigation specialist with the Habeas Corpus Resource Center in San Francisco, California. The opinions expressed in this manual are strictly those of the authors.

The International Justice Project (IJP) wishes to thank Matthew Cross for his tireless research and his efforts in the compilation of the guide. The IJP also wishes to thank Joanne Cecil for her invaluable assistance in the editing of the guide.

This guide can be downloaded from the Federal Death Penalty Resource Counsel and the Habeas Assistance and Training Project website at: <http://www.capdefnet.org/> and is also available from the International Justice Project.

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CHAPTER 1:

DEATH IS DIFFERENT: MENTAL HEALTH ISSUES IN CAPITAL CASES

Including:

- Mental illness in the capital client population;
- Roles of mental health experts in capital cases;
- Mental disorders and client relationships;
- Mental disorders and capital jurors; and
- Observing clients over a long, stressful time.

In upholding the modern American death penalty, the Supreme Court nonetheless recognized “that the punishment of death is different in kind from any other punishment imposed under our system of criminal justice.”³ Likewise, the representation of individuals facing capital punishment is different from any other variety of legal representation.⁴ One commentator recently described capital defense representation as the “cardiac surgery of legal representations.”⁵ The stakes involve life and death. The litigation involves expertise outside the scope of non-capital criminal defense practice, including skill in developing and presenting both mental health evidence and other mitigation evidence. The complexity and potentially lethal consequences of the litigation not only require specialized expertise and skills, but a substantial investment of time in building a relationship of trust with clients and investigating evidence relevant to both guilt and penalty.

The complexity and high stakes of capital defense representation require a team of lawyers and non-lawyers. *ABA Guidelines* 4.1 and 10.4 mandate no fewer than two qualified attorneys, at least one investigator, and at least one mitigation specialist, with the additional proviso that the team should include “at least one member qualified by training and experience to screen for the presence of mental or psychological disorders or impairments.” The Commentary to the *ABA Guidelines* clarifies that the individual qualified to screen for mental disorders may be one of the four core team members or an additional person.⁶ The *ABA Guidelines* set the standard of representation at every stage. As noted in Guideline 1.1.B: “These Guidelines apply from the moment the client is taken into custody and extend to all stages of every case in which the jurisdiction may be entitled to seek the death

³ *Gregg v. Georgia*, 428 U.S. 153, 188 (1976).

⁴ See American Bar Association, *Guidelines for the Appointment and Performance of Defense Counsel in Death Penalty Cases* (rev. 2003), 31 HOFSTRA L. REV. 913 (2003). (Hereinafter, ABA GUIDELINES.)

⁵ Fox, L.J., *Capital Duties and Ethical Guidelines: Mutually Reinforcing Responsibilities*, 36 HOFSTRA L. REV. 775, 777 (2008).

⁶ The Commentary also makes the point that the defense team may need to screen not only the client, but also members of his family, for mental disorders and impairments. ABA GUIDELINES, at 1003.

penalty, including initial and ongoing investigation, pretrial proceedings, trial, post-conviction review, clemency proceedings and any connected litigation.”⁷

MENTAL ILLNESS IN THE CAPITAL CLIENT POPULATION

The Commentary to ABA Guideline 4.1 notes that “mental health issues are so ubiquitous in capital defense representation that the provision of resources in that area should be routine.”⁸ It is worth taking a moment to consider how this situation came about.

We know the pervasiveness of mental health issues in the modern (that is, post-*Furman*) capital client population in part because the law has required capital defense counsel to investigate the lives of each individual client. By contrast, it is striking that we know so little about the mental health and individual biographies of the thousands of prisoners executed in the pre-*Furman* era. A prominent historian of the death penalty in New York, Scott Christianson, has documented the cursory comments of the Lunacy Commissions that were charged with evaluating condemned prisoners prior to execution. In the 1940s, one such commission evaluating a seventeen-year-old convicted of assaulting and murdering two girls, ages six and eight, recorded its results as follows:

Comments or test findings: “Cynical attitude. Silly cooperation and quite efficient effort.”

Impression: “Normal level of intelligence. Anomalous character; intensive volitional and emotional reactions. Poverty of sentiment, purpose and ambition. Peculiar sexual reaction degenerating into chaotic sex. A readiness of psychoneurotic episodes from trivial causes.”⁹

Such superficial assessments offered little insight into the individuals who were put to death and merely reinforced a demonic portrait of the perpetrators as nothing more than monsters guilty of unspeakable offenses.

When the U.S. Supreme Court considered post-*Furman* capital statutes in 1976, it specifically rejected mandatory schemes that denied jurors the opportunity to extend mercy based on the uniqueness of the individual who had committed the crime. In *Woodson v. North Carolina*, the Court made individualized consideration a constitutional requirement:

A process that accords no significance to relevant facets of the character and record of the individual offender or the circumstances of the particular offense

⁷ See also Freedman, E.M., *The Revised ABA Guidelines and the Duties of Lawyers and Judges in Capital Post-Conviction Proceedings*, 5(2) J. APP. PRACTICE & PROCESS 325 (2003).

⁸ ABA GUIDELINES, at 957.

⁹ Christianson, S., *CONDEMNED: INSIDE THE SING SING DEATH HOUSE* (NYU Press 2000).

excludes from consideration in fixing the ultimate punishment of death the possibility of compassionate or mitigating factors stemming from the diverse frailties of humankind. It treats all persons convicted of a designated offense not as uniquely individual human beings, but as members of a faceless, undifferentiated mass to be subjected to the blind infliction of the death penalty.¹⁰

In *Gregg v. Georgia*, the Court quoted with approval the outline of statutory mitigating factors drafted in the American Law Institute's Model Penal Code in 1962.¹¹ These included extreme mental or emotional disturbance and impaired capacity to appreciate the criminality of conduct or to conform conduct to the requirements of law as a result of mental disease or defect or intoxication. The framework of the Model Penal Code's mitigating factors was adopted in the vast majority of capital statutes throughout the country, thus focusing defense counsel's attention on mental health issues as soon as these statutes took effect.¹²

The period of the modern U.S. death penalty has also been a time of significant change in the provision of mental health services. Gone are the days of the insane asylums, where the mentally ill were warehoused and forgotten. Advances in neurochemistry and pharmacology in the 1950s brought the hope of managing mood and psychotic disorders with outpatient drug therapy, utilizing newly discovered "tranquilizers" like meprobamate (Miltown) and antipsychotic agents like chlorpromazine (Thorazine). The number of patients in public psychiatric hospitals plummeted from over 565,000 in 1955 to some 70,000 in 1995.¹³ In theory, community mental health services were to provide the care and supervision needed to make psychopharmaceutical therapy effective, but the defunding of community

¹⁰ *Woodson v. North Carolina*, 428 U.S. 280, 303 (1976).

¹¹ *Gregg*, 428 U.S. at 193-4, n. 44.

¹² See, for example, the statutory lists in ALA. CODE § 13A-5-51-52 (1975); ARIZ. REV. STAT. ANN. § 13-703-G (2007); ARK. CODE ANN. § 5-4-605 (2007); CAL. PENAL CODE § 190.3 (West 2007); COLO. REV. STAT. ANN. § 18.1.3-1201(4) (West 2007); FLA. STAT. ANN. § 921.141(6) (West 2007); 720 ILL. COMP. STAT. ANN. 5 § 9-1.c (West 2007); IND. CODE § 35-50-2-9.c (West 2007); KAN. STAT. ANN. § 21-4626 (2006); KY. REV. STAT. ANN. § 532.025(2)(b) (West 2007); LA. CODE CRIM. PROC. ANN. art. 905.5 (2007); MD. CODE ANN., CRIM. LAW § 2-203(h)(2) (West 2007); MISS. CODE ANN. § 99.19.101(6) (West 2007); MO. ANN. STAT. §565.032.3 (West 2007); MONT. CODE ANN. § 46.18.304 (2007); NEB. REV. STAT. § 29-2523(2) (2007); NEV. REV. STAT. ANN. § 200.035 (West 2007); N.H. REV. STAT. ANN. § 630.5.VI (2008); N.J. REV. STAT. ANN. § 2C:11-3.c(5) (2008); N.M. STAT. ANN. § 31-20A-6 (West 2007); N.Y. PENAL LAW § 125.27.9 (McKinney 2007); N.C. GEN. STAT. ANN. § 15A-2000(f) (West 2007); OHIO REV. CODE ANN. § 2929.04(B) (West 2008); OKLA. UNIF. JURY INSTRUCTIONS - CRIM. § 4-79 (West 2007); 42 PA. CONS. STAT. ANN. § 9711(e) (West 2007); S.C. CODE ANN. § 16-3-20(C)(b) (2007); TENN. CODE ANN. § 39-13-204(j) (West 2007); UTAH CODE ANN. § 76-3-207(4) (West 2007); VA. CODE ANN. § 19.2-264.4.B (West 2007); WASH. REV. CODE ANN. § 10.95.070 (West 2008); WYO. STAT. ANN. § 6-2-102(j) (2007); 18 U.S.C.A. § 1392(a) (2008).

¹³ Torrey, E.F., *OUT OF THE SHADOWS: CONFRONTING AMERICA'S MENTAL ILLNESS CRISIS* (John Wiley & Sons 1996).

services and the limitations of the drugs themselves resulted in jails and prisons becoming the principal mental health providers to the poor.¹⁴

In July 1999, the Justice Department released the first comprehensive study of the rapidly growing number of emotionally disturbed people in the nation's jails and prisons, finding 283,000 inmates with mental illness (about 16 percent of the incarcerated population generally) in 1998.¹⁵ Other studies suggested that more than 50 percent of prison and jail inmates had had some form of psychiatric disorder during their lifetime, while nearly 15 percent had been estimated to have severe disorders (such as schizophrenia, bipolar disorder, or major depression).¹⁶

Human Rights Watch issued a report in 2003 generally endorsing the Justice Department estimates (200,000 to 300,000 mentally ill prisoners), but estimating that 70,000 inmates were psychotic on any given day, with little or no meaningful treatment and a likelihood that they would be viewed as a disciplinary problem within the prisons. The report described the resulting deterioration:

They huddle silently in their cells, mumble incoherently, or yell incessantly. They refuse to obey orders or lash out without apparent provocation. They beat their heads against cell walls, smear themselves with feces, self-mutilate, and commit suicide.¹⁷

In September 2006, the Bureau of Justice Statistics released a new report, indicating that at midyear 2005, *more than half* of all prison and jail inmates in the United States had a mental health problem. The dramatic difference between the 1999 and 2006 estimates derived from methodology. In 1999, BJS counted only those inmates who had been diagnosed and treated within the preceding twelve months, but in 2005 they counted not only those with a documented *history* (i.e., clinical diagnosis or treatment) but also those whose reported *symptoms* in the preceding twelve months

¹⁴ See Kupers, T., PRISON MADNESS: THE MENTAL HEALTH CRISIS BEHIND BARS AND WHAT WE MUST DO ABOUT IT (Jossey-Bass 1999). The soaring use of prescription antidepressants outside the prison walls raises other concerns for capital litigators. According to the Centers for Disease Control and Prevention, the new varieties of antidepressants such as Prozac and Paxil have become the most prescribed drugs in the United States, constituting 118 million of 2.4 billion drugs prescribed in visits to physicians and hospitals in 2005: CNN, 'CDC: Antidepressants most prescribed drugs in U.S.,' July 9, 2007, available at <http://www.cnn.com/2007/HEALTH/07/09/antidepressants/index.html>. Since this increase results in part from aggressive pharmaceutical marketing to consumers, there is a concern that jurors will not appreciate the mitigating significance of a diagnosis of major depression because so many Americans use these medications.

¹⁵ See Butterfield, F., *Prisons Brim With Mentally Ill, Study Finds*, N.Y. TIMES, July 12, 1999, A10.

¹⁶ See Freedman, D., *Mental Health and Indigent Defense*, v:2 THE SPANGENBERG REPORT 1 (June 1999), citing Teplin, L.A., *Psychiatric and Substance Abuse Disorders among Male Urban Jail Detainees*, 84:2 AMERICAN JOURNAL OF PUBLIC HEALTH 290 (1994); Teplin, L.A., et al., *Prevalence of Psychiatric Disorders among Incarcerated Women*, 53 ARCHIVES OF GENERAL PSYCHIATRY 505 (1996); Robins, L.N., et al., *Lifetime Prevalence of Specific Psychiatric Disorders in Three Sites*, 41 ARCHIVES OF GENERAL PSYCHIATRY 949 (1984); and Lamb, H.R., & Weinberger, L.E., *Persons with Severe Mental Illness in Jails and Prisons: A Review*, 49:4 PSYCHIATRIC SERVICES 483 (1998).

¹⁷ Human Rights Watch, 'Ill Equipped: U.S. Prisons and Offenders with Mental Illness,' available at www.hrw.org/reports/2003/usa1003.

met the criteria in the *Diagnostic and Statistical Manual of Mental Disorders IV-TR*. The data came from personal interviews with jail inmates in 2002 and state and federal sentenced prisoners in 2004. The estimated numbers are staggering: 705,600 inmates in state prisons, 70,200 inmates in federal prisons, and 479,900 inmates in local jails.¹⁸ Since these estimates included all prisoners, it can safely be assumed that the prevalence of mental disorders and impairments in the violent offender population is even higher.¹⁹

ROLES OF MENTAL HEALTH EXPERTS IN CAPITAL CASES

It is essential for counsel and the defense team not only to build a foundation of trust with the client before involving experts in the case, but also to develop an independently corroborated multi-generational²⁰ social history that will highlight the complexity of the client's life and identify multiple risk factors and mitigation themes. In the paradoxical universe of mitigation investigation, it is often unclear whether a particular fact will be viewed as aggravating or mitigating. Once information is determined to be reliable and credible, it must still be contextualized in order to understand its significance. Involving experts before these ambiguities have been resolved can be dangerous, and the choice of expert may inadvertently prematurely focus the mitigation case too narrowly. Also, mental health experts need the social history information to enable them to conduct a thorough evaluation, if that is their assignment. Mental health experts are neither all-purpose generalists nor interchangeable. They represent many different disciplines (e.g., psychiatry, neurology, psychology, neuropsychology, pharmacology, and addiction medicine), and they have specialized knowledge and experience based on their research and

¹⁸ Bureau of Justice Statistics, 'Special Report: Mental Health Problems of Prison and Jail Inmates,' available at www.ojp.usdoj.gov/bjs/pub/pdf/mhppji.pdf. Some research suggests that even this study may underestimate current and lifetime psychiatric illness among inmates. A Connecticut study, for example, found two of three jail inmates met the criteria for at least one lifetime psychiatric disorder: see Trestman, R.L., Ford, J., Zhang, W., & Wiesbrock, V., *Current and Lifetime Psychiatric Illness Among Inmates Not Identified as Acutely Mentally Ill at Intake in Connecticut's Jails*, 35 J. AM. ACAD. PSYCHIATRY LAW 490 (November 4, 2007). An Illinois study of juveniles in detention found that nearly two-thirds of males and three-quarters of females met diagnostic criteria for one or more psychiatric disorders: see Teplin, L.A., Abram, K.M., McClelland, G.M., Mericle, A.A., Duncan, M.K., & Washburn, J.J., *Psychiatric Disorders of Youth in Detention*, JUVENILE JUSTICE BULLETIN (U.S. Dept. of Justice, Office of Juvenile Justice and Delinquency Prevention, April 2006).

¹⁹ Haney, C., *The Social Context of Capital Murder: Social Histories and the Logic of Mitigation*, 35 SANTA CLARA L. REV. 547; Lewis, D.O., et al., *Psychiatric, Neurological, and Psychoeducational Characteristics of 15 Death Row Inmates in the United States*, 143 AM. J. PSYCHIATRY 838.

²⁰ See *Supplementary Guidelines for the Mitigation Function of Defense Teams in Death Penalty Cases*, 36 HOFSTRA L. REV. 677 (2008) (*Hereinafter*, SUPPLEMENTARY GUIDELINES.) Guideline 5.1.B: "Life history includes... multi-generational family history; genetic disorders and vulnerabilities, as well as multi-generational patterns of behavior." Guideline 10.11.E.2.a. notes the need to find witnesses who know the "client's family, extending at least three generations back." See also Commentary to ABA Guideline 10.7: "A multi-generational investigation extending as far as possible vertically and horizontally frequently discloses significant patterns of family dysfunction and may help to establish or strengthen a diagnosis or underscore the hereditary nature of a particular impairment." ABA GUIDELINES, at 1025.

clinical practices. Familiarity with cultural norms for the community in which the client grew up is critical.²¹ Administrative issues—such as fees, terms of payment, and the expert's ability to dedicate adequate attention to the case in a timely fashion—should also be clearly addressed at the outset.²²

Another question that needs to be addressed before retaining any mental health expert is what role the expert is going to play.²³

Consultant

A mental health expert might, for example, join the capital defense team as a *consultant*, whose job is just to help develop themes to integrate the first and second phases of the trial (e.g., to explain the connection between the client's behavior in the capital crime and his or her mental infirmities).²⁴ A consultant might also be called upon to decode and deconstruct prior mental health evaluations of the client: to look beneath the labels at the clusters of symptoms that were detected and to suggest alternative hypotheses for explaining those behaviors or traits.

Quasi-therapeutic intervention

Another role for a mental health consultant is quasi-therapeutic intervention: to assist the legal team in dealing with the client. The expert might provide insight into team interactions with the client and suggest ways to make the team work better with the client. The mental health consultant might assist the client in enduring the stress of a capital trial, even advising when medication might be indicated. The consultant might play an integral role in helping the client to maintain appropriate decorum in the courtroom or to help counsel explain the cultural and psychological underpinnings of behavior that might be easily misinterpreted by jurors. Finally, the expert might help counsel to recognize the client's self-destructive behaviors, and help the team to address those risks.

²¹ See Dudley Jr., R.G., & Leonard, P.B., *Getting It Right: Life History Investigation as the Foundation for a Reliable Mental Health Assessment*, 36 HOFSTRA L. REV. 963, 978 (2008): "An important qualification of mental health experts in capital trials is ethno-cultural competence. Institutions in general, and the field of mental health in particular, have been slow to recognize the needs and perspectives of non-white, non-mainstream patients."

²² *Id.*, at 976.

²³ The role of the expert will affect the extent to which any contact with the client is privileged and therefore whether the client's disclosures to the expert will be confidential.

²⁴ See also Commentary to ABA Guideline 10.4: ". . . counsel should structure the team in such a way as to distinguish between experts who will play a 'consulting' role, serving as part of the defense team covered by the attorney-client privilege and work product doctrine, and experts who will be called to testify, thereby waiving such protections." (Citation omitted.) ABA GUIDELINES.

Fact gatherer

Another role for a mental health expert is as a *fact gatherer*, an investigator with specialized expertise, someone who can elicit sensitive information that the client (or family members) won't disclose to others on the team. The expert may be a skilled listener or a highly trained interviewer. The goal may be just to elicit the information, or to evaluate the credibility and reliability of disclosures. A clinician with expertise in sexual trauma, for example, might be skilled not only in eliciting the client's most shameful secrets, but also in identifying the indicia of reliability when disclosures come. Another fact-gathering role is the assessment of intellectual functioning—or other neuropsychological deficits which affect behavior and potentially diminish culpability—through testing. Or the expert might serve as a skilled observer, whose job would be to describe psychiatric symptomatology more richly and systematically than the team's lay observers.

Testifying expert

In some cases, fact gatherers may become *testifying experts*—the storytellers who will narrate and interpret the client's life history for the sentencing jury. This narration may or may not include a diagnosis of the client's mental disorders. Many clients have more than one mental disorder, and it is important to convey to jurors all the signs and symptoms of the co-occurring disorders. It is also important to avoid a battle of the experts over diagnostic labeling when jurors' potential empathy will stem not from the label, but from an understanding of how the damaged brain of the client affects his perception of the world and reading of social cues. There may be an attempt to explain why the crime occurred. Other testifying experts may simply be teaching witnesses, called to explain the nature and consequences of a client's disorder(s) or impairment(s).²⁵ Whether they are teaching witnesses or experts who testify directly about their assessment of the capital client, it is imperative that they avoid technical jargon (sometimes known as “psychobabble”) and instead use language that will be understood by jurors, judges, and everyday people.²⁶

Defining the expert's role will help counsel to identify who the expert should be, but the unique needs of the individual case will also dictate what type of expertise is needed and what subspecialty or subspecialties, if any, fits the unique needs of the case. If the role involves fact gathering, it is particularly important also to consider how the expert will relate to and connect with the client. How will the expert's age, race, ethnicity, gender, sexual orientation, and personality affect rapport with the client? If the role involves testimony, the key question is who will be most credible and persuasive to the fact-finders in the case. Another consideration is how the

²⁵ See Dudley & Leonard, *supra*, n.21, at 976-977, concerning the need for collaboration with the testifying expert to ensure that the testimony is credible, comprehensible, and integrated into the overall mitigation themes. Moreover, “No expert witness for the defense wants to be surprised on the stand by information defense counsel withheld or failed to provide,” such as reports or data available to the prosecution and its experts. Careful preparation for cross-examination is crucial.

²⁶ *Id.* at 977.

expert's qualifications will look to a reviewing court. Counsel must also conduct a thorough investigation of the expert's background and prior testimony in anticipation of cross-examination.

Mental health experts consulted in capital cases are asked to address a wide range of referral questions.²⁷ They are not simply called upon to "evaluate" the client. When experts are retained, it is essential to be clear and explicit about the absolute confidentiality of the consultation and the precise referral question or questions to be addressed. The legal issues that might be addressed range from all the questions traditionally implicated in non-capital cases to those unique to capital sentencing. The traditional questions in forensic mental health include competency to stand trial and to aid and assist counsel, responsibility (not guilty by reason of insanity, diminished capacity, extreme emotional disturbance, etc.), mental status at the time of the offense (including capacity to premeditate, deliberate, and form specific intent), capacity to make a knowing and intelligent waiver of rights (including *Miranda* rights, right to counsel, right to be present, right to trial and appeal, right to testify), and the voluntariness and reliability of all statements to law enforcement. These questions pertain not only to the capitally charged offense, but also to all prior offenses, including all convictions by negotiated dispositions involving waivers. This is relatively familiar territory for most lawyers and many experts, and involves clearly articulated legal standards. But developing mitigating evidence is quite different.

It is incumbent upon capital counsel to educate experts to be sure that they understand that mitigating evidence relating to mental conditions is defined by what it is *not*. Mitigation is *not* a defense to prosecution. It is not an excuse for the crime. It is not a reason the client should "get away with it." Instead, it is evidence of a disability or impairment or condition which inspires compassion, but which offers neither justification nor excuse for the capital crime. Unlike the insanity and competency requirements, mitigation need not involve a mental "disease" or "defect." Mitigation does not require a diagnosis. The expert who assists a capital defense team is not there for either the traditional forensic purpose (assessing competency and/or responsibility) or for the routine goals of a clinician (diagnosis in order to prescribe treatment). If the expert testifies, it may simply be to help jurors appreciate the world as the client experiences it.

Mitigation is the biography of mental disability and impairment. It is the explanation of what influences converged in the years, days, hours, minutes, and seconds leading up to the capital crime, and how information was processed in a damaged or traumatized brain. It may be explanatory (why did this crime happen), or simply a basis for mercy (is the individual's disability, or capacity for change through treatment, inherently mitigating), but it is never an excuse.

²⁷ The referral question can best be framed only after a thorough social history investigation has been completed, and it is important that mental health experts understand that a social history is a key component of a reliable assessment. *Id.* at 975.

MENTAL DISORDERS AND CLIENT RELATIONSHIPS

Mental illness or impairment can also interfere with the capital defense team's effort to establish a relationship of trust. As the Commentary to ABA Guideline 10.5 (Relationship with the Client) notes:

Many capital defendants are... severely impaired in ways that make effective communication difficult: they may have mental illnesses... that make them highly distrustful or impair their reasoning and perception of reality; they may be mentally retarded or have other cognitive impairments that affect their judgment and understanding; they may be depressed and even suicidal; or they may be in complete denial in the face of overwhelming evidence. In fact, the prevalence of mental illness and impaired reasoning is so high in the capital defendant population that "[i]t must be assumed that the client is emotionally and intellectually impaired." There will also often be significant cultural and/or language barriers between the client and his lawyers. In many cases, a mitigation specialist, social worker or other mental health expert can help identify and overcome these barriers, and assist counsel in establishing a rapport with the client. (Citation omitted.)²⁸

Mentally ill clients can be self-destructive.²⁹ Their paranoia may prevent them from accepting sound legal advice about the wisdom of a plea offer. They may fear the shame and stigma of mental retardation, even when the diagnosis could save them from execution.³⁰ Cultural context also affects how clients and their family members perceive and discuss the symptoms of mental disorders and impairments, and behaviors must always be assessed in the context of ethnocultural norms. Individuals with serious mental illness or certain neurological damage so frequently deny their conditions that there is a clinical term, anosognosia, for the denial, which may itself be symptomatic.³¹

²⁸ ABA GUIDELINES, at 1007-1008.

²⁹ About 12 percent of the post-*Furman* executions have involved "volunteers" who waived their appeals and sought to be executed (112 of 1,099 executions through the end of 2007). See Death Penalty Information Centre, available at <http://www.deathpenaltyinfo.org>. Professor John Blume analyzed 106 volunteer executions through the end of 2003 and found that nearly 88 percent had struggled with mental illness and/or substance abuse, including 14 with schizophrenia, others with delusions, 23 with depression or bipolar disorder, and 10 with Posttraumatic Stress Disorder. At least 30 had previously attempted suicide. Blume's study was based on published opinions, media coverage, and a survey of counsel who had represented the inmates. Blume, J., *Killing the Willing: "Volunteers," Suicide and Competency*, 103 MICH. L. REV. 939 (March 2005). The experience of being condemned by society and stigmatized in the media exacerbates preexisting depression to such a degree that even among the wrongfully convicted there have been at least two *post-exoneration* suicides. See Rimer, S., *Life After Death Row*, N.Y. TIMES MAGAZINE, December 10, 2000, 100-109. For a brilliant study of the general phenomenon of suicide, see Jamison, K.R., NIGHT FALLS FAST: UNDERSTANDING SUICIDE (Alfred A. Knopf 1999).

³⁰ See Edgerton, R.B., THE CLOAK OF COMPETENCE (University of California Press 1993).

³¹ See Amador, X., I'M NOT SICK, I DON'T NEED HELP! (Vida Press 2007).

Capital prosecution is itself often an overwhelming stressor for clients. When they learn that they may face a trial in which jurors could decide whether they will be executed or sent to prison to die a natural death without possibility of release, they are stunned. They typically go through a process that is strikingly similar to the stages of grief classically described by Elisabeth Kübler-Ross in her discussion of responses to a diagnosis of terminal illness: denial, anger, bargaining, depression, acceptance.³² They frequently say that they would rather die than go to prison without hope of parole. Virtually all capital clients at the outset want to cling to the hope that the charges are all a bad dream and they will somehow go away. Clients' family members often respond similarly. They just cannot accept that their loved one could be guilty of the charged crime, or that his only options may be execution or a life without parole sentence. In many ways, building a relationship of trust with a capital client involves working through the stages of denial, anger, and depression toward negotiation and acceptance. But the stress of the charge itself means that the defense team must be vigilant for signs of suicidality and decompensation.

MENTAL DISORDERS AND CAPITAL JURORS

In the capital context, mental illness can be powerful mitigation when jurors understand empathetically the disabilities, brain damage, and tormented psyches of a convicted killer. The most robust empirical investigation of how jurors make their decisions in death penalty cases has been carried out by the Capital Jury Project, a consortium of university-based researchers established in 1991 with support from the National Science Foundation.³³ The CJP has carried out structured interviews of three to four hours duration with more than 1,200 jurors who have served in 353 capital trials in fourteen states. Some returned death verdicts; others voted for life sentences. CJP findings have been reported in more than forty scholarly articles. In one report for example, Professor. Stephen P. Garvey found mental illness highly mitigating.³⁴

Another CJP researcher, Professor Scott Sundby, however, noted how jurors show skepticism toward defense experts, who appear to be “hired guns” unless their opinions are supported by contemporaneous information from lay witnesses.³⁵ According to Professor Sundby:

If the expert performs as a soloist, presenting theories unsupported by facts established by more credible persons who are free of any suspicions attached to experts, the testimony is likely to be discounted at best or have a negative spillover effect at worse [sic]. If, on the other hand, the expert takes the role of

³² Kübler-Ross, E., *ON DEATH AND DYING* (Macmillan, 1969).

³³ See School of Criminal Justice, University at Albany (New York), ‘Capital Jury Project,’ available at <http://www.albany.edu/scj/CPRIjuryproj.htm>.

³⁴ Garvey, S.P., *Aggravation and Mitigation in Capital Cases: What Do Jurors Think?* 98 COLUM. L. REV. 1538 (1998)

³⁵ Sundby, S., *The Jury as Critic: An Empirical Look at How Capital Juries Perceive Expert and Lay Testimony*, 83 VA. L. REV. 1109 (1997): two-thirds of the witnesses jurors thought “backfired” were defense experts.

accompanist and helps harmoniously explain, integrate, and provide context to evidence presented by others, the jury is far more likely to find the expert's testimony useful and reliable.³⁶

It is important to corroborate expert testimony through records and witnesses who can show the impact of impairments and disorders on a client's functioning long before the capital offense.³⁷ The witnesses identified in the life-history investigation may include historical experts—that is, professionals who encountered the client or his family in the developmental years and who provide the insights of objective third parties to the onset of intellectual impairments, psychological disorders, or family dysfunction.³⁸

There is also a risk that mental illness will inspire fear, rather than compassion, and become an excuse to kill (“surgery to excise the cancer”) instead of a basis for reduced moral blame and mercy. As Professor Craig Haney has pointed out, “Human beings react punitively toward persons whom they regard as defective, foreign, deviant, or fundamentally different from themselves. Sobering histories recount the ways in which ‘scientific’ attempts to prove defect or deviance have served as a prelude to mistreatment and extermination.”³⁹

The empirical studies disclose three principal concerns affecting jurors' sentencing determinations: the nature of the capital offense itself (how bad they perceive it to be), the defendant's likelihood of being violent in the future (how dangerous he will be), and the defendant's remorse.⁴⁰ Addressing future dangerousness is particularly

³⁶ *Id.* at 1144.

³⁷ See Dudley & Leonard, *supra*, n.21, at 979: “It is particularly important to seek out medical and health care providers who evaluated the defendant prior to his entry into the criminal justice system. A common tactic of the state is to attack defense mental health issues as fabricated excuses for the client's criminal behavior. Therefore, mental health conditions that pre-existed the crime are more credible than newly diagnosed conditions. Life history documents and lay witnesses provide additional depth of understanding about the pre-existing condition and add to the credibility of the claim.”

³⁸ During the operative years of the New York death penalty statute (1995 to 2004), for example, the Capital Defender Office offered the testimony of historical experts in several cases. A school psychologist who had tested a client routinely as part of mandated triennial review for Special Education explained the significance of his borderline intellectual functioning (FS IQ 76-81): *People v. George Davis Bell* (Ind. 128-97, Judge Cooperman, Queens County, N.Y., 1999). In another case, a different school psychologist explained the impact of learning disabilities (at age eleven, reading just above a second grade level; at fourteen, just above fourth grade; and at seventeen, just above fifth grade): *People v. José J. Santiago* (Ind. 1210/99, Judge Bristol, Monroe County, N.Y., 2000). In a third case, a psychiatrist had treated the client's mother after her suicide attempt when the client was nine—thirty years before the capital trial. From the records, the psychiatrist testified to the history of mood disorders and suicidality in the maternal lineage, as well as family dysfunction, including fights over promiscuity, gambling, and drinking. From her current perspective, the psychiatrist opined about the devastating impact on the children of the mother's mood disorder, suicidality, and psychiatric removal from the family: *People v. John F. Owen* (Ind. 547-99 cons. with 414-99, Judge Egan, Monroe County, N.Y., 2001).

³⁹ See Haney, C., *Violence and the Capital Jury: Mechanisms of Moral Disengagement and the Impulse to Condemn to Death*, 49 STAN. L. REV. 801, 814 (July 1997).

⁴⁰ Blume, J.H., Johnson, S.L., & Sundby, S.S., *Competent Capital Representation: the Necessity of Knowing and Heeding What Jurors Tell Us about Mitigation*, 36 HOFSTRA L. REV. 1035 (2008), citing

important when there is evidence of brain damage or mental disorders, so that jurors will understand how the client is likely to function in a highly structured prison environment and whether his disorder can and will be treated effectively.

OBSERVING CLIENTS OVER A LONG, STRESSFUL TIME

Capital defense representation is of longer duration than most non-capital criminal defense representation. Death-sentenced prisoners typically spend over a decade from sentencing to execution, and many have been on death row for more than twenty years.⁴¹ At the trial level, a defense team typically spends over a year in the representation; from the initial meeting immediately following the stressful moment of arrest through the ordeal of trial itself. Post-conviction teams may represent a client for years. Team members observe and interact with clients through stressful times, including the roller coaster ride of legal developments, the milestones of everyday life that have profound personal significance to clients (weddings, births and deaths of loved ones), anniversary dates of the capital offense and arrest, losses (divorce, break-ups, unexpected deaths), and violence and conflict in the custodial environment. This longitudinal observation may be critical in compiling an accurate overview of the client's functioning.

Defense team observations of client behaviors over the life of the case can assist the mental health expert whose contact with the client is less extensive. Psychologist and mitigation specialist Deana Logan has provided an exhaustive list of noteworthy behaviors,⁴² including:

1. Reality confusion (hallucinations: hearing voices, "seeing things," olfactory, tactile, and gustatory false sensations; illusions: such as misperception of harmless image as threatening; phobias: irrational fears, such as fear of leaving one's cell; disorientation: seeming confused about people and surroundings; delusions: consistent false beliefs, such as lawyers out to get him, guard in love with him, food being poisoned);

Constanzo, M., & Constanzo, S., *Jury Decision Making in the Capital Penalty Phase*, 16 LAW & HUM. BEHAV. 185, 188-89 (1992); Geimer, W.S., & Amsterdam, J., *Why Jurors Vote Life or Death: Operative Factors in Ten Florida Death Penalty Trials*, 15 AM. J. CRIM. L. 1, 46 (1989); Blume, J.H., Garvey, S.P., & Johnson, S.L., *Future Dangerousness in Capital Cases: Always "At Issue,"* 86 CORN. L. REV. 397, 398 (2001); Garvey, S.P., *The Emotional Economy of Capital Sentencing*, 75 N.Y.U. L. REV. 26, 59 (2000); Sundby, S., *The Jury and Absolution: Trial Tactics, Remorse and the Death Penalty*, 83 CORN. L. REV. 1557 (1998); Eisenberg, T., Garvey, S.P., & Wells, M.T., *Mitigation Means Having to Say You're Sorry: The Role of Remorse in Capital Sentencing*, 83 CORN. L. REV. 1599, 1617 (1998).

⁴¹See Death Penalty Information Center, 'Time on Death Row,' available at <http://www.deathpenaltyinfo.org/article.php?&did=1397>, citing Bureau of Justice Statistics data showing the average interval between sentencing and execution is 145 months.

⁴²See Logan, D.D., *Learning to Observe Signs of Mental Impairment*, 19:5-6 CALIFORNIA ATTORNEYS FOR CRIMINAL JUSTICE, FORUM 40 (1992).

2. Speech and language problems (incoherence, neologisms, and illogicality: nonsensical speech, including new word formations and non sequiturs; poverty of speech and thought: half answers, whether monosyllabic or lengthy but empty; distractibility: changing subjects midsentence; tangentiality: irrelevant answers; derailment: slipping off track from one oblique thought to another; circumstantiality: long-winded and tedious; loss of goal; perseveration: persistent, inappropriate repetition; pressured speech: rapid, racing speech; blocking: mind goes blank mid-thought; paraphasia: substitution of inappropriate words; slurring; monotone; stilted speech; micrographia; hypergraphia; dyslexia);
3. Memory and attention issues (amnesia; confabulation: filling in details of faulty memory; hypermnesia: extraordinary ability to recall; limited attention span; selective inattention on emotionally charged issues);
4. Medical complaints (hypochondria; self-mutilation; accident-proneness; insomnia; hypersomnia; anorexia and changes in eating habits; blurred vision; hearing problems; ringing in ears; headaches; dizziness; nausea; fatigue; loss of control of bodily functions);
5. Inappropriate emotional tone (anxiety; suspicion; depression; hostility; irritability; excitement; flat affect; emotional lability; inappropriate laughter);
6. Personal insight and problem solving difficulties (self-esteem too high or too low; frustration; denial of mental problems; difficulty planning; difficulty changing plans when necessary; impaired ability to learn from mistakes);
7. Problems related to physical ability (agitation; hypervigilance; psychomotor retardation; slow reactions in movements or while answering questions; clumsiness; tension); and
8. Unusual social interactions (isolation/estrangement; difficulty perceiving social cues; suggestibility; emotional withdrawal; disinhibition).

The Commentary to ABA Guideline 10.15.1 (Duties of Post-Conviction Counsel) in fact has a section entitled “Keeping the Client Whole”:

Even if their executions have been safely stayed... the mental condition of many capital clients will deteriorate the longer they remain on death row. This may result in suicidal tendencies and/or impairments in realistic perception

and rational decision-making. Counsel should seek to minimize this risk by staying in close contact with the client.⁴³

This section of the Guidelines closes with the somber observation that *Ford v. Wainwright*, the case exempting the insane from execution, was “heavily based on notes on the client’s mental status that counsel had kept over a period of months.”⁴⁴

⁴³ ABA GUIDELINES, at 1082.

⁴⁴ *Id.*, at 1083; *Ford v. Wainwright*, 477 U.S. 399, 402 (1986).

CHAPTER 2:

SOCIAL HISTORY INVESTIGATION

Including:

- Capital client demographics;
- Methodology of social history investigation;
- Social history interviewing; and
- Capital counsel's duty to investigate social history.

CAPITAL CLIENT DEMOGRAPHICS

Differences between capital clients and their defense teams may create barriers to disclosure of sensitive life-history information quite apart from the psychological barriers that inhibit all of us from sharing shameful and sensitive personal information with inquisitive strangers. These differences often begin with race, culture, and nationality. Over three thousand prisoners are currently under sentence of death in the United States.⁴⁵ Nearly all (over 98 percent) are men, so we will use the male pronoun throughout this manual in reference to clients. The racial breakdown nationwide is roughly as follows: whites comprise the largest single group, but less than half of the total; blacks account for over 40 percent of the death row population; about 10 percent are Latino/Latina; and there are dozens of prisoners of Native American or Asian descent. Over a hundred are foreign nationals from more than two dozen different countries. Mexican nationals account for over fifty death-sentenced prisoners.

Other barriers between clients and capital defense teams typically include ethnicity, language, class, education, age, religion, politics, social values, gender, and sexual orientation. Overcoming these barriers will often mean including someone in the defense team with whom the client will feel more at ease.

Other demographic information is much less clear because confidentiality issues preclude study; but most are indigent. Many have multi-generational histories of mental illness, such as schizophrenia, bipolar disorder, and depression. Mental disorders pervade the capital client population,⁴⁶ and they often lurk undiagnosed,

⁴⁵ See Death Penalty Information Center, available at <http://www.deathpenaltyinfo.org>. This web site also links to 'Death Row USA,' published by the NAACP Legal Defense Fund, with detailed information about racial breakdowns.

⁴⁶ See Chapter 1, *supra*. See also Albernaz, A., *Study Examines Links Between Poverty and Mental Illness*, 16 NEW ENGLAND PSYCHOLOGIST 6 (July 2008), available at www.masspsy.com/leading/0506_ne_cover_study.html, reporting rates of mental illness two to nine times higher in poor communities. Similarly, British researchers in 2007 found that a significant proportion of the increased risk of psychiatric disorders among children with intellectual disabilities

including among clients who have been subjected to superficial, so-called “drive-by” evaluations in past encounters with the authorities. The key to reliable assessments is social history investigation, the meticulous biographical inquiry aimed at understanding who the client is and what in his or her background will help us to explain what happened in the alleged capital crime.

Social history investigation is multi-generational and focuses on a wide range of issues:

- a) Genetic predispositions and vulnerabilities
 - Manifested in the medical histories of parents and grandparents
- b) Family histories, including;
 - Mental illness and/or cognitive impairment of caretakers;
 - Abuse, maltreatment or abandonment;
 - Neglect, including malnutrition, anemia, poor hygiene, poor medical/dental care or premature sexualization
 - Chaos and instability, including frequent changes of address, divorce, intermittent parents, adoption and foster placements
 - Substance abuse among caretakers
 - Criminal activity among caretakers
 - Domestic violence, including physical, sexual or psychological forms
 - Tragedy in the family
 - Natural disasters
 - Death of family members or loved ones.
- c) Detailed personal histories, including;
 - Exposure to violence and trauma
 - Accidents, injuries
 - School attendance
 - Running away
 - Depression
 - Sexual disorders
 - Substance use/abuse
 - Prescribed medications
 - School performance/adjustment
 - Psychological testing
 - Evaluations
 - Therapy

may be due to their increased exposure to psychosocial disadvantage. Emerson, E., & Hatton, C., *Mental health of children and adolescents with intellectual disabilities in Britain*, BRITISH J. PSYCHIATRY (Dec. 2007).

Many clients have suicidal histories, often undiagnosed, or histories of self-destructive behaviors. Many have learning disabilities and other cognitive impairments, also often undetected and even masked by the clients' coping strategies.⁴⁷ Many are illiterate.

Many have organically based neurological deficits ranging from seizure disorders to the organic consequences of intrauterine exposure to neurotoxins or head injuries. Their brains do not work properly. We cannot understand their violence without studying brain-behavior relationships.⁴⁸

Many have physical conditions that affect cognition, such as hearing and vision impairments, or medical conditions, such as asthma, which may be stress-related or long-term consequences of abuse.⁴⁹ Others have medical illnesses with psychiatric symptoms and consequences, including AIDS, cerebral ischemia, diabetes, encephalitis, hypoglycemia, hypothyroidism, malaria, mononucleosis, systemic Lupus, etc. Among our clients' contemporaries, there are often siblings, cousins, aunts and uncles who have died of AIDS.

Abuse and trauma histories are virtually universal. The overwhelming majority of capital clients have suffered trauma, often outside the realm of ordinary human experience, whether it occurs within the home, as in incest and sexual abuse, or in the wider social setting, where growing up as an inner-city person of color often means witnessing violent death of peers and loved ones.⁵⁰ Whether they have suffered

⁴⁷ Many exhibited symptoms of psychiatric disorders in childhood that were poorly understood at the time and were instead punished as aberrant or rule-breaking behavior. See *Treating Preschoolers with Psychiatric Disorders: Experts Develop Treatment Algorithms for Nine Disorders* 24:10 HARVARD MENTAL HEALTH LETTER at 4-5 (April 2008), noting a 2005 estimate that half of all major clinical disorders start by age fourteen.

⁴⁸ See, for example, Gur, R.C., Saykin, A.J., and Gur, R.E., *Neuropsychological Assessment in Psychiatric Research and Practice*, in Michels, R., et al (eds.), PSYCHIATRY (J.B. Lippincott Company, rev. ed. 1991), ch. 72.

⁴⁹ One recent study found that children and adolescents with asthma are nearly twice as likely to suffer from anxiety and depressive disorders as their peers without asthma. See Katon, W., et al., *The Prevalence of DSM-IV Anxiety and Depressive Disorders in Youth with Asthma Compared with Controls*, 41:5 J. OF ADOLESCENT HEALTH 455 (November 2007): 16.3% of those with asthma met DSM-IV criteria within previous 12 months, compared with 8.6% of those without. Toxic stress can begin *in utero*: pregnant women with high levels of stress often have children who are more fearful and more reactive to stress. The children have a greater susceptibility to stress-related illnesses, are more likely to engage in health-damaging behaviors, and are more vulnerable to mental health problems. See National Scientific Council on the Developing Child, 'Excessive Stress Disrupts the Architecture of the Developing Brain (Working Paper #3: Summer 2005),' available at <http://www.developingchild.net>. It notes, at 2, "The neural circuits for dealing with stress are particularly malleable (or 'plastic') during the fetal and early childhood periods. Early experiences shape how readily they are activated and how well they can be contained and turned off. Toxic stress during this early period can affect developing brain circuits and hormonal systems in a way that leads to poorly controlled stress-responsive systems that will be overly reactive or slow to shut down when faced with threats through the lifespan."

⁵⁰ Studies have documented how inner-city youth are regularly and chronically exposed to high levels of violence. See, for example, Ceballos, R., Dahl, T.A., Aretakis, M.T., & Ramirez, C., *Inner-City Children's Exposure to Community Violence: How Much Do Parents Know?* 63 J. MARRIAGE &

violence or helplessly witnessed violence to others, they live with the intrusive memories and remain hyper-vigilant in the expectation that random violence may visit them again at any moment. Maltreatment may involve trauma in the form of psychological battering (i.e., rejecting, terrorizing, ignoring, isolating, and corrupting) as well as physical abuse.⁵¹

Poly-substance abuse and addiction are commonplace, often secondary to self-medication following trauma or to alleviate symptoms of mental illness. Drug and alcohol abuse, in turn, may have neurological consequences or exacerbate preexisting psychiatric vulnerabilities.⁵²

Many clients have experienced abandonment, beginning with their biological parents. They have been molded and malformed by orphanages, foster care, and a host of institutions that have failed them along the way. Prior experiences in the criminal justice system may be perceived as part of a pattern of abandonment and betrayal from the perspective of the client—or of institutional failures, from our perspective.

Clients are often difficult to interview about their own lives, and experienced capital defense counsel learn to see them as poor historians, rather than view them as uncooperative liars.⁵³ Capital counsel must learn to see client behaviors, including their inability to provide accurate personal history, as manifestations of their impairments and mental disorders, rather than as hostility or manipulation. When we see these behaviors as signals of impairments, we realize that our observations of the clients may disclose more information about them than their verbal responses to specific questions. Counsel become observational caretakers because the client's impairments will often preclude accurate memories, self-monitoring or self-disclosure.

FAMILY 927, at 933 (2001): as many as 16% of children in this study reported witnessing one person being killed by another; and Jipguep, M., & Sanders-Phillips, K., *The Context of Violence for Children of Color: Violence in the Community and in the Media*, 72:4 J. NEGRO EDUCATION 379, at 381 (2003): 74% of 2,248 inner-city elementary school children reported feeling unsafe in their neighborhoods.

⁵¹ For the many varieties of trauma affecting emotional, intellectual, and social development, see the work of Professor James Garbarino, including Garbarino, J., & Gilliam, G., UNDERSTANDING ABUSIVE FAMILIES (Lexington Books 1980); Garbarino, J., Guttman, E., & Seeley, J.W., THE PSYCHOLOGICALLY BATTERED CHILD (Jossey-Bass Publishers 1988); Garbarino, J., Kostelny, K., and Dubrow, N., NO PLACE TO BE A CHILD: GROWING UP IN A WAR ZONE (Jossey-Bass Publishers 1991); and Garbarino, J., LOST BOYS: WHY OUR SONS TURN VIOLENT AND HOW WE CAN SAVE THEM (The Free Press 1999).

⁵² See, for example, Freedman, R., *Cannabis, Inhibitory Neurons and the Progressive Course of Schizophrenia*, 165 AM. J. PSYCHIATRY 416 (April 2008).

⁵³ Clients' family members are also often poor historians for a variety of reasons. They may have their own disabilities and impairments. Others may just be guarded about sensitive issues. Others may not know all the traumas to which their children were exposed. See Ceballo et al., *supra* n.50, at 933: 44% of children reported being threatened with harm, but only 18% of their mothers believed this was the case.

METHODOLOGY OF SOCIAL HISTORY INVESTIGATION

Mitigation investigation begins with the client, but it is inevitably a multi-generational inquiry aimed at identifying the genetic predispositions and environmental influences that molded the client's life and defined his or her range of choices. The goal is to humanize and contextualize, but not to normalize, the client. That is, the goal is to present this client as a member of their human community, worthy of compassion, worthy of life. But the goal is also to show the client as someone with "diminished autonomy"—and therefore worthy of protection from the ultimate sanction of capital punishment. We diminish the client's degree of responsibility, his capacity to exercise free will, by demonstrating how his choices in life have been drastically curtailed by biological, social, and psychological influences that were not his choices.⁵⁴

It is imperative to identify the multiple risk factors in the client's life, not only to offer a more accurate and textured picture but also to anticipate rebuttal arguments comparing the client to siblings exposed to similar influences who have higher levels of functioning, and have not been charged with capital murder. (It may be useful also to look for the buffers or protective factors that have enabled siblings to overcome the forces which have overwhelmed the client.) This approach avoids the suggestion of a simplistic, deterministic approach. No one wants to suggest that any single factor in a client's background "caused" the capital crime. Professor James Garbarino provides a vivid metaphor for how risk accumulates:

Threats accumulate; support ameliorates. The presence of only one or two risk factors does not disable a child. Rather, it is the accumulation of threats that does the damage. And trouble really sets in when these threats accumulate without a parallel accumulation of compensatory "opportunity" factors. Once overwhelmed, defenses are weakened the next time the child faces threat. Children and adolescents become highly sensitive to any negative social influences around them. I look at it this way: give me one tennis ball, and I can toss it up and down with ease. Give me two, and I can still manage easily. Add a third, and it takes special skill to juggle them. Make it four, and I will drop them all. So it is with threats to development.⁵⁵

One of the most common mistakes in mitigation investigation is to narrow the focus early in the case—to define the case prematurely and narrowly in terms of a single theme. By contrast, a complex, multilayered analysis of the client's life—a social

⁵⁴ In *Eddings v. Oklahoma*, 455 U.S. 104, 116, n. 11 (1982), the Supreme Court discussed how moral blameworthiness extends beyond the individual, quoting approvingly from the *Twentieth Century Fund Task Force on Sentencing Policy Toward Young Offenders, Confronting Youth Crime* 7 (1978): "Crimes committed by youths may be just as harmful to victims as those committed by older persons, but they deserve less punishment because adolescents may have less capacity to control their conduct and to think in long-range terms than adults. Moreover, youth crime as such is not exclusively the offender's fault; offenses by the young also represent a failure of family, school, and the social system, which share responsibility for the development of America's youth."

⁵⁵ Garbarino (1999), *supra*, n.51, at 75-76.

history—helps jurors to understand the causes of the violence they examined in the guilt phase of the capital trial. As Professor Craig Haney has observed, social histories are not excuses, they are explanations.⁵⁶

A key element in social history investigation is the collection of reliable, objective documentation about clients and their families. This record gathering needs to be accomplished confidentially, using broad authorizations for release of confidential information signed by the client, parents, siblings, caretakers, and significant others. The search for records typically includes:

- Birth certificates and genealogical archives
- Prenatal, birth and pediatric charts
- Reports from physicians, hospitals, and mental health professionals
- School reports
- Social service agencies
- Juvenile courts
- Employment, Social Security, and workers compensation files
- Military records
- Marriage and divorce files
- Death and autopsy records
- Correctional, probation and parole records
- Court files and litigation records

The safest policy is to get everything, not to self-censor. A hospital may ask, for example, “Do you really want *dental* records?” What relevancy might *dental* records have to mitigation or mental health claims? In one case, defense counsel used dental records to uncover a powerful story of neglect: the client, at age eight, was taken to a hospital emergency room by a school teacher because his teeth had rotted from malnutrition and poor hygiene.

Contemporaneous records speak for themselves and are intrinsically credible. In addition, they may document events that the client and his siblings were too young to remember or too impaired to understand and record in memory. Their mitigating power is illustrated in a footnote to the U.S. Supreme Court opinion overturning the death sentence of Terry Williams in Virginia. The Court quoted verbatim from juvenile records describing Williams's home:

The home was a complete wreck... There were several places on the floor where someone had had a bowel movement. Urine was standing in several places in the bedrooms. There were dirty dishes scattered over the kitchen,

⁵⁶ Haney, *supra*, n.19 at 561: “There is increased recognition that the roots of violent behavior extend beyond the personality or character structure of those people who perform it, and connect historically to the brutalizing experiences they have commonly shared as well as the immediately precipitating situations in which violence transpires.” See also Haney, C., *Evolving Standards of Decency: Advancing the Nature and Logic of Capital Mitigation*, 36 HOFSTRA L. REV. 835, 843 (2008): “A mitigating counter-narrative that incorporates a capital defendant’s social history and immediately life-circumstances is now recognized as the centerpiece of an effective penalty phase trial.”

and it was impossible to step any place on the kitchen floor where there was no trash... The children were all dirty and none of them had on under-pants. Noah and Lula were so intoxicated, they could not find any clothes for the children, nor were they able to put the clothes on them... The children had to be put in Winslow Hospital, as four of them, by that time, were definitely under the influence of whiskey.⁵⁷

Investigating the capital client's biography is a sensitive, complex, and cyclical process. It is cyclical, rather than linear, because witnesses will need to be re-interviewed when new information has been discovered. As veteran mitigation specialist Lee Norton has observed, "The investigation is not complete until the information uncovered becomes redundant and provides no new insight. It is insufficient to talk to witnesses only once because each new individual recalls different facts and anecdotes; if an aunt provides an account of a head injury which the mother forgot to mention, it is necessary to go back to the mother to ask about it. Similarly, an interview may reveal records that must be obtained, which in turn raise new questions, questions which necessitate interviewing several witnesses again."⁵⁸

The complexity of the life-history investigation involves multi-generational evidence-gathering, tracing the client's migratory family to its roots in the rural South or from East Coast to West Coast by way of Oklahoma. The investigation encompasses all the forces that molded the client's life, both nature and nurture, the confluence and convergence of genetic predispositions and environmental influences. In the client's own generation, the investigation extends to siblings and cousins within the family, and to friends and acquaintances from every period of the client's life. Genetic predispositions are identified by carrying the investigation back in time, to include parents, aunts, uncles and grandparents, and forward if the client has children. Investigation of the client's childhood includes the climate of caregiving in the home, the quality of relationships, hygiene, nutrition, education, exposure to toxins (in the air, in the dwelling, in utero, etc.), the social and economic status of the community, cultural values, and so forth. Witnesses range from neighbors and relatives to classmates and co-workers, cellmates and army buddies, clergy and social workers, teachers and correctional staff.

SOCIAL HISTORY INTERVIEWING

Interviews are sensitive because of cultural, psychological and other barriers that must be overcome to ensure that family secrets are disclosed. Concepts of remorse and shame have great cultural variability. A sense of loyalty may also obstruct cross-cultural disclosure. Regardless of the culture, life-history investigation is invasive of

⁵⁷ *Williams v. Taylor*, 529 U.S. 362, 395 n. 19 (2000). Significantly, neither the client nor his family members could ever have provided this vivid picture, memorialized by a caseworker who was shocked by the squalor and chaos.

⁵⁸ Norton, L., *Capital Cases: Mitigation Investigations*, 16:4 THE CHAMPION 43, 45 (May 1992).

privacy—seeking the darkest, most shameful and intimate secrets of the client's family.

Life-history interviews encompass many kinds of witnesses, so there is no single technique that will be appropriate in approaching the interview. Family members will be approached differently from neutral, third-party observers of family dynamics, such as welfare caseworkers, teachers, pediatricians, and other professionals. Within the family, there will be widely varying degrees of cooperation. Witnesses will often overcome their long-established patterns of denial only as trust and rapport slowly build up.

It is always helpful to know as much as possible about witnesses before approaching them. The same barriers (e.g., race, nationality, ethnicity, culture, language, accent, class, education, age, religion, politics, social values, gender, and sexual orientation) which separate the defense team from clients may also apply to family members and other lay witnesses. We must confront our prejudices, as well as theirs—how we view the witnesses, as well as how they will see us. We must often ask whether there is someone else in the defense team who is better equipped to build a bridge to a particular witness. We must find what we do have in common with the witness and find a means of sharing whatever it is.

Sometimes friendly life-history witnesses can be interviewed by appointment, and common courtesy will dictate contacting them in advance. But reluctant witnesses find it much easier to hang up the telephone than to refuse to speak with a mitigation specialist on their doorstep. Reluctant witnesses often cancel interviews that have been set up by telephone, particularly if they are vulnerable to pressure from other members of their households or likely to contact police or prosecutors between the telephone contact and the scheduled appointment.

In order to overcome these difficulties, witnesses should always be interviewed in person. The information needed in mitigation is simply not disclosed to strangers over the telephone. Full disclosure comes only in person with great patience, using multiple one-on-one face-to-face interviews, no matter how skilled the interviewer.

Life-history witnesses should generally be interviewed in the setting which is most likely to evoke memories of the client—in the home, in the case of family members; at school, in the case of teachers; at work, if the witness is a former employer; etc. The goal of the visit is always to gather documents, snapshots, artwork, report cards, and other memorabilia, as well as to conduct the interview. The home environment or the school the client attended is itself a rich source of information about the client's social milieu.

Confidentiality and security are absolutely essential, so it will sometimes be more appropriate to interview family members one at a time in some neutral, safe setting, such as a coffee shop, church, or public place. Since the goal is to put the life-history witness at ease, it is important that the location be one where the witness is

comfortable—not a law office. Witnesses need to understand that the information they disclose will not be shared with anyone outside the legal team as the investigation proceeds.

Always ask witnesses to suggest others who may have useful information, but never let one witness control or limit our access to others. The family member who is least invested in preserving secrets is the defense team most needs to find, and concealing family members will discourage us from finding that key witness.

The key to eliciting sensitive information is patience on our part and trust on the part of the witness. Building that trust requires honesty and absolute discretion from capital defense team members. A witness needs to know that sensitive information will not be revealed to other witnesses in the course of the ongoing investigation. Promises, even small ones, must be kept. Never make promises that cannot be kept. Lee Norton has again summarized the task succinctly:

Locating lay witnesses is only half the battle. Once you have found them, you must succeed in obtaining from them the information you need. In most cases lay witnesses are initially suspicious of people asking questions about the client because, like the client, their experiences have been with individuals wanting to hurt them. Thus, time must be spent demonstrating commitment and a sincere desire to save the client's life.

One of the greatest hurdles in communicating with and gaining the trust of lay witnesses is explaining that what they may have thought was “bad” about their friend or loved one is actually helpful information. For example, descriptions of the client's inexplicable outbursts from the age of about eight when he was involved in a near-fatal car accident help the mental health experts determine the presence and etiology of brain damage. In order to gain the cooperation of lay witnesses, the defense must take the time to explain not only what information is needed, but why it is important.⁵⁹

Allow plenty of time for each interview, and understand in advance that follow-up interviews will be required. Help the witness to understand that the initial interview is only the beginning of a long process.

Family members may also share the client's cognitive or psychiatric impairments. They may abuse alcohol or other substances. There may be practiced denial of traumatic events and learned silence as to the norms of society for relatives who have been mis-socialized and corrupted as they grew up. Even absent trauma and corruption, family witnesses are often simply poor historians, flawed by their perception and insight, selective memory, biases, and inability to articulate. Finally, they have “normalized” whatever their life experience was. They do not automatically identify the signs of trauma, abject poverty or neglect that were everyday occurrences in their particular social group. One family that grew up in a

⁵⁹ *Id.* at 44.

migrant camp, for example, did not think it was noteworthy that they lived without any plumbing; but a school teacher remembered in horror the squalor of human feces in the front yard where the children played. It is important to collect all the details as the investigation proceeds, whether or not their relevance or significance is immediately apparent. Even information that may seem harmful at first may later turn out to have mitigating import when seen in a larger context.

Life-history interviewers must become skilled in reflective listening. Questions must initially be open ended, and the witnesses' words must be mirrored in follow-up questions encouraging concreteness and detail. Judgmental labeling discourages disclosure (e.g., asking a witness if the client was "abused") and should be replaced with language that permits the witness to continue elaborating. Specific follow-up questions should encompass all the possibilities suggested by the witnesses' words and consistent with the ethno-cultural context. As always, it is also important to explore with each witness strategies for corroborating what she knows: who else knows what happened, or what document would verify it. Every interview, and indeed every interviewee, is an important element in developing the full context of the client's life.

The interviewer needs to be sensitive to the re-traumatization which may occur when witnesses narrate painful memories. The combat veteran who describes to a stranger the horrific death or maiming of a comrade may re-experience painful memories in the retelling. The interviewer needs compassionate understanding of that process and should allow ample time to communicate that compassion to the witness. Follow-up contact is appropriate, to check in with the witness after intimate, humiliating, or painful revelations.

COUNSEL'S DUTY TO INVESTIGATE SOCIAL HISTORY IN CAPITAL CASES

The capital defense community has long recognized that developing mitigation evidence through life-history investigation involves hundreds of hours of work, with meticulous attention to detail, painstaking efforts to decode and decipher old records, patience and sensitivity in eliciting disclosures from both witnesses and the client. In recent years, the United States Supreme Court has acknowledged the national standards set by the capital defense community as reflected in the ABA Guidelines for the Appointment and Performance of Defense Counsel in Death Penalty Cases and rejected traditional excuses for failing to investigate mitigation. The result is an unambiguous mandate for mitigation investigation and a firm basis for counsel to seek the funding and time necessary to fulfill this mandate utilizing the services of a defense team with all the requisite skills and experience.

The single most important case was *Wiggins v. Smith*,⁶⁰ in which the Court rejected trial counsel's "strategic" decision to focus on residual doubt, after consulting a psychologist and collecting a few records from the department of social services and

⁶⁰ 539 U.S. 510 (2003).

a presentence report. The Court found that the decision “not to expand their investigation” beyond the PSI and DSS records fell short of professional standards, specifically citing the ABA Guidelines. As originally published in 1989, the Guidelines call for “efforts to discover all reasonably available mitigating evidence.” The *Wiggins* Court referred to the Guidelines as “well-defined norms” as of 2003. “Despite these well-defined norms, however, counsel abandoned their investigation of petitioner’s background after having acquired only a rudimentary knowledge of his history from a narrow set of sources.”⁶¹ The Court acknowledged the valuable work of the non-lawyer who had investigated the social history of Kevin Wiggins in post-conviction proceedings. The Court referred to the “social history” over a dozen times.⁶²

In that same year, the ABA published its revised edition of the Guidelines.⁶³ The Sixth Circuit quickly recognized the revised edition as simply “explaining in greater detail” the 1989 Guidelines on which the *Wiggins* Court relied.⁶⁴

These national standards of practice have now guided numerous courts in rejecting proffered excuses for failing to investigate mitigation. The Supreme Court rejected uninformed strategy both in *Wiggins* and in an earlier case, *Williams v. Taylor*.⁶⁵ Strategic decisions must be informed by investigation, not based on hunches and assumptions. In *Williams*, the Court found that “the failure to introduce the comparatively voluminous amount of evidence that did speak in Williams’s favor was not justified by a tactical decision to focus on Williams’s voluntary confession.”⁶⁶ That case also rejected the claim that investigation was a “two-edged sword” which would uncover bad facts as well as good in the course of Williams’s life. Indeed, Justice Rehnquist in dissent described the capital murder as “just one act in a crime spree that lasted most of Williams’s life” and noted his juvenile record from age eleven, savage beating of an elderly woman, car theft, fire setting, and stabbing during a robbery.

Attempts to blame the client for inadequate life-history investigation were rejected by the Sixth Circuit in *Hamblin v. Mitchell* and the Supreme Court in *Rompilla v. Beard*.⁶⁷ In *Hamblin*, the Sixth Circuit noted that both the ABA and judicial standards do not permit courts to excuse failure to investigate or prepare because the defendant so requested, quoting the clear language of Guideline 10.7 verbatim: “The investigation regarding penalty should be conducted regardless of any statement by the client that evidence bearing on penalty is not to be collected or presented.”

In *Rompilla*, the client’s cooperation with the mitigation investigation was “minimal” at best and obstructive at worst: he sometimes sent counsel off on wild goose chases

⁶¹ *Id.* at 523.

⁶² *Id.* at 539, 545, 546, 548, 552, and 555.

⁶³ ABA GUIDELINES.

⁶⁴ *Hamblin v. Mitchell*, 354 F.3d 482 (6th Cir. 2003).

⁶⁵ *Williams v. Taylor*, 529 U.S. 362 (2000).

⁶⁶ *Id.* at 420.

⁶⁷ *Rompilla v. Beard*, 545 U.S. 374 (2005).

pursuing false leads. *Rompilla* was reportedly “bored” by discussion of mitigation and “uninterested in helping.” In this case, counsel was faulted for failing to obtain a court file on a prior conviction that the prosecution planned to use in aggravation. That public record would have disclosed a completely different picture from what was offered by the client and his family—including a nightmarish childhood, familial mental illness, and potential mental retardation.

In both *Wiggins* and *Rompilla*, consulting mental health experts was rejected as a substitute for conducting the mitigation investigation. In *Wiggins*, counsel had consulted a forensic psychologist. In *Rompilla*, they consulted a cadre of three top mental health experts. Likewise, counsel had conducted some investigation in both cases: in *Rompilla*, they had interviewed a former wife, two brothers, a sister-in-law, and a son. Such minimal investigation fell below the national standard.

The ABA web site keeps an updated list of cases citing to the Guidelines since *Wiggins*. In addition to three cases in the U.S. Supreme Court, there have been scores of cases in the federal courts and in the highest state courts citing the Guidelines.⁶⁸

The Commentary to ABA Guideline 10.7 succinctly summarizes the parameters of the social history investigation that is required in every death penalty case.⁶⁹ The Commentary explains:

The duty to investigate exists regardless of the expressed desires of a client. Nor may counsel “sit idly by, thinking that investigation would be futile.” Counsel cannot responsibly advise a client about the merits of different courses of action, the client cannot make informed decisions, and counsel cannot be sure of the client’s competency to make such decisions, unless counsel has first conducted a thorough investigation with respect to both phases of the case.⁷⁰

Citing the need for “extensive and generally unparalleled investigation into personal and family history,” the Commentary outlines six broad areas of social history inquiry:

1. Medical history (including hospitalizations, mental and physical illness or injury, alcohol and drug use, pre-natal and birth trauma, malnutrition, developmental delays, and neurological damage);
2. Family and social history (including physical, sexual, or emotional abuse; family history of mental illness, cognitive impairments, substance abuse, or domestic violence; poverty, familial instability, neighborhood environment, and peer influence); other traumatic events such as exposure to criminal

⁶⁸ See American Bar Association, ‘Death Penalty Representation Project,’ available at <http://www.abanet.org/deathpenalty>.

⁶⁹ ABA GUIDELINES, at 1021-1026.

⁷⁰ *Id.*, at 1021 (citations omitted).

violence, the loss of a loved one, or a natural disaster; experiences of racism or other social or ethnic bias; cultural or religious influences; failures of government or social intervention (e.g., failure to intervene or provide necessary services, placement in poor quality foster care or juvenile detention facilities);

3. Educational history (including achievement, performance, behavior, and activities), special educational needs (including cognitive limitations and learning disabilities) and opportunity or lack thereof, and activities;
4. Military service (including length and type of service, conduct, special training, combat exposure, health and mental health services);
5. Employment and training history (including skills and performance, and barriers to employability);
6. Prior juvenile and adult correctional experience (including conduct while under supervision, in institutions of education or training, and regarding clinical services.⁷¹

The Commentary describes the parallel tracks of social history investigation: interviews with family members and “virtually everyone else who knew the client and his family, including neighbors, teachers, clergy, case workers, doctors, correctional, probation, or parole officers, and others” as well as the collection of records and documentary evidence “concerning not only the client, but also his parents, grandparents, siblings, cousins, and children.”⁷² The goal is a “multi-generational investigation extending as far as possible vertically and horizontally.”⁷³ The methodology requires using “all appropriate avenues including signed releases, subpoenas, court orders, and requests or litigation pursuant to applicable open records statutes” to obtain, for example, records from schools, social services, juvenile dependency and family court, medical facilities, employers, vital statistics, courts and corrections, and alcohol and drug abuse centers.⁷⁴ The Commentary concludes this discussion with a reminder of the importance of cultural context.⁷⁵

Supplementary Guidelines for the Mitigation Function of Defense Teams in Death Penalty Cases⁷⁶ have provided additional guidance on the standards of social history investigation in capital cases. Under Supplementary Guideline 5.1 (Qualifications of the Defense Team), for example, several items are noteworthy.

Supplementary Guideline 5.1.B requires staffing every case with team members:

⁷¹ *Id.*, at 1022-1023.

⁷² *Id.*, at 1024-1025 (citations omitted).

⁷³ *Id.*, at 1025.

⁷⁴ *Id.*, at 1025.

⁷⁵ *Id.*, at 1026.

⁷⁶ SUPPLEMENTARY GUIDELINES.

...with the training and ability to obtain, understand and analyze all documentary and anecdotal information relevant to the client's life history. Life history includes, but is not limited to: medical history; complete prenatal, pediatric and adult health information; exposure to harmful substances *in utero* and in the environment; substance abuse history; mental health history; history of maltreatment and neglect; trauma history; educational history; employment and training history; military experience; multi-generational family history, genetic disorders and vulnerabilities, as well as multi-generational patterns of behavior; prior adult and juvenile correctional experience; religious, gender, sexual orientation, ethnic, racial, cultural and community influences; socio-economic, historical, and political factors.

Supplementary Guidelines 5.1.C discusses expertise in social history interviewing:

Mitigation specialists must be able to identify, locate and interview relevant persons in a culturally competent manner that produces confidential, relevant and reliable information. They must be skilled interviewers who can recognize and elicit information about mental health signs and symptoms, both prodromal and acute, that may manifest over the client's lifetime. They must be able to establish rapport with witnesses, the client, the client's family and significant others that will be sufficient to overcome barriers those individuals may have against the disclosure of sensitive information and to assist the client with the emotional impact of such disclosures. They must have the ability to advise counsel on appropriate mental health and other expert assistance.

Supplementary Guideline 5.1.E relates directly to issues of mental health and trauma:

At least one member of the team must have specialized training in identifying, documenting and interpreting symptoms of mental and behavioral impairment, including cognitive deficits, mental illness, developmental disability, neurological deficits; long-term consequences of deprivation, neglect and maltreatment during developmental years; social, cultural, historical, political, religious, racial, environmental and ethnic influences on behavior; effects of substance abuse and the presence, severity and consequences of exposure to trauma.

Supplementary Guideline 10.11 (The Defense Case—Requisite Mitigation Functions of the Defense Team) is particularly concrete. Supplementary Guideline 10.11.B summarizes the parameters of social history investigation:

The defense team must conduct an ongoing, exhaustive and independent investigation of every aspect of the client's character, history, record and any circumstances of the offense, or other factors, which may provide a basis for a sentence less than death. The investigation into a client's life history must survey a broad set of sources and includes, but is not limited to: medical

history; complete prenatal, pediatric and adult health information; exposure to harmful substances *in utero* and in the environment; substance abuse history; mental health history; history of maltreatment and neglect; trauma history; educational history; employment and training history; military experience; multi-generational family history, genetic disorders and vulnerabilities, as well as multi-generational patterns of behavior; prior adult and juvenile correctional experience; religious, gender, sexual orientation, ethnic, racial, cultural and community influences; socio-economic, historical, and political factors.

Supplementary Guideline 10.11.C makes clear that there must be multiple face-to-face interviews to elicit reliable data:

Team members must conduct in-person, face-to-face, one-on-one interviews with the client, the client's family, and other witnesses who are familiar with the client's life, history, or family history or who would support a sentence less than death. Multiple interviews will be necessary to establish trust, elicit sensitive information and conduct a thorough and reliable life-history investigation. Team members must endeavor to establish the rapport with the client and witnesses that will be necessary to provide the client with a defense in accordance with constitutional guarantees relevant to a capital sentencing proceeding.

There is further discussion of the broad categories of experts who may be consulted, from mental health professionals to social scientists with expertise in a particular race, culture, ethnicity or religion, community, neighborhood, or institution.⁷⁷

The Supplementary Guidelines merely reflect the best practices developed in capital defense practice over many years. In social history investigation, these practices also draw on the multidisciplinary expertise of researchers in human development, cultural anthropology, psychology, psychiatry, and social work.⁷⁸ Mandated as a constitutional duty to develop the evidence, jurors need to make reasoned, moral decisions in capital cases. Social history investigation is also a critical component of reliable mental health assessments in these cases.⁷⁹

⁷⁷ SUPPLEMENTARY GUIDELINES, Supplementary Guideline 10.11.E1

⁷⁸ See, for example, Andrews, A.B., SOCIAL HISTORY ASSESSMENT (Sage Press, 2007).

⁷⁹ See Dudley & Leonard, *supra*, n.21; Liebert, D.S., & Foster, D.V., *The Mental Health Evaluation in Capital Cases: Standards of Practice*, 15:4 AM. J. FORENSIC PSYCHIATRY 43-64 (1994).

CHAPTER 3:

THE IMPACT OF TRAUMA ON CAPITAL CLIENTS

Including:

- Trauma and traumatic exposures;
- Prevalence of traumatic events;
- Conditional risk (non-random nature) of traumatic events;
- Cumulative risk of traumatic events;
- Trauma and its effects;
- Post Traumatic Stress Disorder;
- Risk factors for PTSD;
- The disabling effects of PTSD;
- PTSD and other psychiatric disorders;
- Consequences of trauma: beyond PTSD;
- Context of interpersonal violence;
- Coercive control;
- Traumatic bonding;
- Implications for social history investigation;
- Barriers to disclosure of traumatic experiences;
- Interviewing for traumatic experiences; and
- The great irony of trauma investigation.

Psychological trauma lies at the heart of death penalty cases. This is most immediately and obviously true because of the unspeakable grief and irrevocably altered lives that follow the loss of a loved one to homicide. But it is also an almost universal feature of the lives of capital clients. Despite the legal significance of a client's traumatic experiences, barriers to developing and presenting a capital client's trauma history are numerous, and include the too-often negative attitude of the public and fact-finders, who may have a jaded view of trauma and thus minimize or reject trauma-related information. Cynicism about the presentation of trauma and abuse histories in the capital context is perhaps most succinctly captured in the public's mind by the phrase coined by Alan Dershowitz, "the abuse excuse."⁸⁰

There is an enormous body of literature from multiple fields—epidemiology, psychology, psychiatry, developmental psychopathology and neuroscience—that clarifies the process by which exposure to psychological trauma leads to a host of

⁸⁰ DERSHOWITZ, A.M., *THE ABUSE EXCUSE: COP-OUTS, SOB STORIES, AND OTHER EVASIONS OF RESPONSIBILITY* (Little, Brown & Co. 1994): arguing that the use of abuse as a legal defense undercuts the legal system and diminishes concepts of personal responsibility. In promoting the idea that abuse is used as an excuse or evasion of responsibility, Professor Dershowitz has contributed greatly to confusion about a core principle of mitigation presentation in capital jurisprudence. Mitigation evidence is *never* a legal excuse of the capital offense. It is the explanation that jurors need to make a reasoned moral decision about whether a convicted defendant should live or die.

devastating psychological and behavioral consequences, including violence, through multiple common pathways. Central to this body of knowledge is evidence that there is a greater likelihood of psychological and emotional impairments when trauma exposure is severe, prolonged, occurs over several developmental stages, encompasses diverse forms of traumatic experiences, and is accompanied by additional psychiatric, familial, environmental and social risk factors.

Capital defense teams should keep in mind that the severity of the trauma in the lives of capital clients is often beyond the range of ordinary human experience, and it is the story of these horrific exposures that is often the most empathy-evoking mitigating evidence. Telling that story is more important than identifying a diagnostic label. Nonetheless, it is important to review current research on trauma and its diagnostic consequences to understand the depth of the psychological harm and the varieties of disorders and co-occurring disorders that are frequently present.

TRAUMA AND TRAUMATIC EXPOSURES

What is psychological trauma? The potentially devastating consequences of traumatic experiences were first recognized as part of psychiatric nomenclature in 1980,⁸¹ with the introduction of the diagnosis of Post Traumatic Stress Disorder (PTSD) in the third edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-III).⁸² PTSD has been included as a psychiatric diagnosis with each successive revision of the DSM since that time, and each version required the identification of a specific traumatic event (or events) in order to meet the first criterion (“Criterion A”) that must be satisfied in order to make the diagnosis.

Many different kinds of events fall within the rubric of “psychological trauma.” For purposes of a PTSD diagnosis, traumatic events can involve natural disasters, such as floods or earthquakes; accidental manmade disasters, such as car accidents, airplane crashes, and building collapses; deliberate manmade disasters, such as bombings, combat exposure, torture, and death camps; and violent interpersonal assault, such as rape, physical or sexual assault, physical or sexual abuse, and domestic battering.

⁸¹ As an historical footnote, the psychological consequences of exposure to traumatic events have been documented throughout history, including vivid descriptions of post-traumatic *sequelae* as early as those found in Homer's account of the Trojan War in the *Iliad*. See, e.g., Shay, J., *ACHILLES IN VIETNAM: COMBAT TRAUMA AND THE UNDOING OF CHARACTER* (Scribner 1994). Many wars have generated unique descriptors of the psychological distress following combat exposure, including “shell shock,” “combat fatigue,” and “war neurosis.” Descriptions of the effects of traumatic experiences have also been provided by pioneers in the mental health field (Sigmund Freud and Pierre Janet, among others) that included many of the symptoms of the disorder that is now recognized as PTSD.

⁸² *DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS*, Third Edition (American Psychiatric Association, 1980) (*hereinafter* DSM-III). The Diagnostic and Statistical Manual of Mental Disorders (DSM) identifies currently recognized categories of mental disorders and the criteria for diagnosing them. Published by the American Psychiatric Association, it is used worldwide by clinicians and researchers, and establishes a common understanding and language for psychiatric diagnoses. The DSM was first published in 1952 and has been revised five times since then. See Chs. 6 & 7, *infra*.

According to the current DSM-IV definition, traumatic events evoke “intense fear, helplessness or horror,” and may be experienced directly, may be witnessed, or may be experienced vicariously (*e.g.*, someone might learn about a traumatic event from a person who is close to him).⁸³ To meet criteria for a PTSD diagnosis, the trauma-related symptoms must cause “clinically significant distress or impairment in social, occupational, or other important areas of functioning.”⁸⁴

PREVALENCE OF TRAUMATIC EVENTS

When PTSD was introduced as a diagnostic category in 1980, traumatic events were described as “generally outside the range of usual human experience”⁸⁵ With the publication of the DSM-IV in 1994 that definition was dropped in recognition of research demonstrating that traumatic exposures are far more prevalent in the general population than formerly believed. While traumatic exposures in the general population are more prevalent than first believed, the traumas experienced by the capital client population, as is clear from the discussion below, stand out as both extreme (outside the range of usual experience in terms of severity and magnitude) and chronic (longstanding).

Over the past decade a number of epidemiologic studies have consistently found that it is more likely than not that a given individual, over the course of his or her lifetime, will be exposed to a traumatic experience as defined in the DSM. Epidemiologic studies from the United States generally estimate that 55 to 90 percent of the population has been exposed to traumatic events.⁸⁶ The epidemiological literature demonstrating high rates of trauma exposure in the United States has been replicated in other cultures.⁸⁷ There is also evidence that refugees and people in underdeveloped

⁸³ DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS, Fourth Edition (American Psychiatric Association, 1994) (*hereinafter* DSM-IV); *see also* DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS, Fourth Edition-Text Revision (American Psychiatric Association, 2000) (*hereinafter* DSM-IV-TR).

⁸⁴ *See, e.g.*, DSM-IV-TR.

⁸⁵ DSM-III, at 236.

⁸⁶ Prevalence rates vary according to differences in definitions of trauma used, differences in sampling strategy, and differences in methods used to assess exposure to qualifying events. Despite this variability, there is general agreement in the literature (using conservative estimates) that more than half of the general population will experience a traumatic event at some point in their lives. *See* Kessler, R., & Sonnega, A., et al., *Posttraumatic Stress Disorder in the National Comorbidity Survey*, 52 ARCHIVES GEN. PSYCHIATRY, 1048 (1995); Breslau, N., *Epidemiologic Studies of Trauma, Posttraumatic Stress Disorder, and Other Psychiatric Disorders*, 47 CAN. J. PSYCHIATRY 923 (2002); McFarlane, A., *The Contribution of Epidemiology to the Study of Traumatic Stress*, 39 SOC. PSYCHIATRY & PSYCHIATRIC EPIDEMIOLOGY 873 (2004).

⁸⁷ *See* Creamer, M., et al., *Posttraumatic Stress: Findings from the Australian National Survey of Mental Health and Well-Being*, 31 PSYCHOL. MED. 1237 (2001); Norris, F., et al., *Epidemiology of Trauma and Posttraumatic Stress Disorder in Mexico*, 112 J. OF ABNORMAL PSYCHOL. 646 (2003); Zlotnick, C., & Johnson, J., et al., *Epidemiology of Trauma, Post-Traumatic Stress Disorder (PTSD) and Co-Morbid Disorders in Chile*, 36 PSYCHOL. MED. 1523 (2006).

and war-torn countries may be at even higher risk.⁸⁸ This research is particularly important given the significant number of foreign nationals currently sentenced to death.⁸⁹

Given the high likelihood of trauma exposure in the population at large, how meaningful is it to know—for example—that 55 to 90 percent of people reading this manual may have been traumatized? Does that tell us anything about any one of those individuals? What can we assume about the specific experiences of an individual (or client) or the extent to which he or she has been damaged as a result of that exposure? Should we assume that traumatic experiences are invariably psychologically damaging?

The resilience literature provides some insight about these issues. There is evidence that some people who experience traumatic events are able to cope adaptively. For example, one writer described patterns of resilience among adults who, “*in otherwise normal circumstances,*” are exposed to “*isolated and potentially highly disruptive events,*” and cited links between resilience and “*generally high functioning prior to a traumatic event.*”⁹⁰

The type of resilience discussed above rarely applies to capital clients.⁹¹ Years of experience show that most capitally charged clients were not living “in otherwise normal circumstances” at the time of their traumatic experience(s); establishing this fact and distinguishing the circumstances that shaped an individual’s specific responses should be at the core of the social history investigation. The most common traumatic events experienced by many clients (childhood victimization, physical and sexual assault, severe neglect, ongoing exposure to community violence involving witnessing of physical maiming, mutilation or death) are profoundly more than

⁸⁸ See De Jong, J., et al, *Lifetime Events and Posttraumatic Stress Disorder in Four Post-conflict Settings*, 286 JAMA 555 (2001). See also Fazel, M., et al., *Prevalence of Serious Mental Disorders in 7,000 Refugees Resettled in Western Countries: A Systematic Review*, 365 LANCET 1309 (2005).

⁸⁹ Trauma-focused mitigation investigation and mental health evaluation must be highly sensitive to a wide range of cultural issues. The DSM-IV introduced a framework for culturally sensitive assessment and included a glossary of “culture-bound syndromes.” Acknowledged in the text was the necessity to address issues that arise in applying DSM-IV criteria in a multicultural environment. Included in the description of the components of a “cultural formulation” is a systematic review of an individual’s cultural background; the role of cultural context in the expression and evaluation of symptoms and impairment; and the effect that cultural differences might have on the relationship between client and evaluator. Culture-bound syndromes (or culturally bound “idioms of distress”) were defined as recurrent, locality-specific patterns of aberrant behavior and troubling experience that may or may not be linked to a specific DSM-IV diagnosis.

⁹⁰ Bonanno, G., *Resilience in the Face of Potential Trauma*, 14 CURRENT DIRECTIONS PSYCHOL. SCI. 135 (2005) (emphasis added).

⁹¹ See also Haskett, M., et al, *Diversity in Adjustment of Maltreated Children: Factors Associated with Resilient Functioning*, 26 CLINICAL PSYCHOL. REV. 796 (2006). This study found that resilience in maltreated children was related to factors such as supportive parenting (parental affection, sensitivity, and support for a child’s autonomy; children’s positive perceptions of family coherence and stability); close attachments with peers; and strengths in the child, such as ego-control, ego-resilience, positive self esteem, and social problem solving abilities. These resilience factors are rarely seen in the life histories of capital clients.

“potentially disruptive events,” and these traumatic events (particularly chronic child abuse and community violence) are rarely “isolated” events. Finally, few of these clients would be considered “generally high functioning” or to have had the protective factors associated with resilience.

In contrast, a competent social history investigation often reveals that clients are functionally impaired and vulnerable to the effects of trauma. For many, the entire developmental course of childhood and/or adolescence was shaped by a series of profoundly traumatic events, usually within the context of destructive relationships, often at the hands of caregivers or others who should have provided safety, nurturance and protection.

CONDITIONAL RISK (NON-RANDOM NATURE) OF TRAUMATIC EVENTS

Exposure to traumatic events is not random. An understanding of this phenomenon is critical for capital defense teams as many of the risk factors for heightened exposure apply to many capitolly charged clients. Numerous factors—e.g. race, environment, socioeconomic status, education, and gender—may influence risk for exposure to traumatic events. In general, men,⁹² and especially African Americans, particularly socioeconomically disadvantaged African Americans living in urban areas,⁹³ people with lower educational levels,⁹⁴ and urban youth⁹⁵ are at heightened risk for traumatic

⁹² See Breslau, N., & Kessler, R., et al, *Trauma and Posttraumatic Stress Disorder in the Community: The 1996 Detroit Area Survey of Trauma*, 55 ARCHIVES GEN. PSYCHIATRY 626 (1998); Breslau, *supra*, n.86: noting that many studies have found higher overall exposure rates among men, including exposure to traumatic events such as accidents, assaultive violence (mugging, being assaulted or threatened with a weapon), and witnessing violence).

⁹³ See Alim, T., et al, *An Overview of Posttraumatic Stress Disorder in African Americans*, 62 J. CLINICAL PSYCHOL. 801 (2006); Selner-O'Hagan, M.B., et al, *Assessing Exposure to Violence in Urban Youth*, 39 J. CHILD PSYCHOL. & PSYCHIATRY 215 (1998): showing that results of the National Crime Victimization Survey (NCVS) conducted by the U.S. Department of Justice in 2002 showed that the overall rates of exposure to violent crimes, including sexual assault, physical assault, and robbery, were higher for African Americans than for whites, with rates of sexual assault and rape being particularly disproportionate.

⁹⁴ See Breslau, N., & Davis, G., et al, *Traumatic Events and Posttraumatic Stress Disorder in an Urban Population of Young Adults*, 48 ARCHIVES GEN. PSYCHIATRY 216 (1991); Breslau, *supra* n.86; Shalev, A., *Stress Versus Traumatic Stress: From Acute Homeostatic Reactions to Chronic Psychopathology*, in van der Kolk, B.A., McFarlane, A.C., & Weiseth, L. (eds.), *TRAUMATIC STRESS: THE EFFECTS OF OVERWHELMING EXPERIENCE ON MIND, BODY, AND SOCIETY* (The Guildford Press 1996).

⁹⁵ Urban youth are at particularly high risk for violence exposure. Studies conducted in a number of metropolitan areas, including Chicago, Detroit, Los Angeles, and New Orleans, have consistently found that approximately 25% of children have witnessed someone being shot or killed: Selner-O'Hagan, *supra*, n.93. In a study of 320 inner-city adolescents, 93% of the sample knew at least one person who had been the victim of a violent act, 79% of the sample had witnessed a violent act, and 49% of the sample had been the target of at least one violent act: Youngstrom, E., et al, *Exploring Violence Exposure, Stress, Protective Factors and Behavioral Problems Among Inner-City Youth*, 32 AM. J. COMMUNITY PSYCHOL. 115 (2003). In a representative sample of urban children, 31% of 6th grade boys and 14% of boys had had someone threaten to kill them; 42% of boys and 30% of girls had seen someone shot; and 87 to 96% of the children had witnessed arrests, heard gunfire, or seen others

exposures. These factors are often defining aspects of a client's life experiences and psychological development and are consistent with other information that shows that the population of capital charged and convicted clients is at high risk for trauma exposure.

CUMULATIVE RISK OF TRAUMATIC EVENTS

Within the population of people exposed to trauma, there is a group that has suffered from multiple exposures.⁹⁶ For example, a combat veteran may subsequently be the victim of a violent crime or witness a shooting death; someone who was repeatedly sexually assaulted during childhood may then be raped as an adult. People who have experienced multiple high magnitude exposures,⁹⁷ as will be discussed below, are at increased risk for developing profound emotional and behavioral disturbances.⁹⁸ Researchers have also found that a prior history of trauma exposure increases risk for subsequent exposure.⁹⁹ These findings suggest that people traumatized as children (as is true of many capital charged defendants) are at higher risk to be re-traumatized later in their lives. Moreover, the trauma literature clearly shows a “dose response” relationship between traumatic events and outcomes, *i.e.*, the greater the number of exposures to traumatic events, the greater the probability of negative physical and psychological health outcomes.¹⁰⁰

beaten up: Farrell, A., & Bruce, S., *Impact of Exposure to Community Violence on Violent Behavior and Emotional Distress Among Urban Adolescents*, 26 J. CLINICAL CHILD PSYCHOL. 2 (1997). In another study, 43% of urban youth aged 7-18 had witnessed a murder: Fitzpatrick, K., & Boldizar, J., *The Prevalence and Consequences of Exposure to Violence Among African-American Youth*, 32 J. AM. ACAD. CHILD & ADOLESCENT PSYCHIATRY 424 (1993).

⁹⁶ See Kessler & Sonnega, *supra*, n.86; Breslau & Davis, *supra*, n.94.

⁹⁷ The identification and assessment of the full range of traumatic exposures an individual has experienced is a critical part of a competent trauma evaluation. This involves assessment of all “Criterion A” (see, *infra*, n.112) events. See Weathers, F., & Keane, T., *The Criterion A Problem Revisited: Controversies and Challenges in Defining and Measuring Psychological Trauma*, 20 AM. J. PSYCHIATRY 107 (2007): noting that there is a continuum of stressor severity involved in traumatic events. Dimensions on which stressors vary include the complexity, frequency, and duration of the traumatic stressor; the degree of predictability or control involved; the extent of life threat; the degree of psychological or physical harm involved; and the level of interpersonal betrayal or loss. “High magnitude” traumatic events refer to events of higher order stressor severity, e.g. childhood physical or sexual abuse, combat exposure, adult physical or sexual assault, especially rape, and witnessing a mutilation or death.

⁹⁸ See Lloyd, D., & Turner, R.J., *Cumulative Adversity and Posttraumatic Stress Disorder: Evidence From a Diverse Community Sample of Young Adults*, 73 AM. J. ORTHOPSYCHIATRY 381 (2003).

⁹⁹ See Breslau, N., Davis, G.C., et al, *Risk Factors for PTSD-Related Traumatic Events: A Prospective Analysis*, 152 AM. J. PSYCHIATRY 529 (1995). See also Schumm, J., et al, *Cumulative Interpersonal Traumas and Social Support as Risk and Resiliency Factors in Predicting PTSD and Depression Among Inner-City Women*, 19 J. TRAUMATIC STRESS 825 (2006).

¹⁰⁰ See Anda, R., et al, *The Enduring Effects of Abuse and Related Adverse Experiences in Childhood: A Convergence of Evidence from Neurobiology and Epidemiology*, 256 EUR. ARCHIVES PSYCHIATRY & CLINICAL NEUROSCI. 174 (2006); Felitti, V., et al, *Relationship of Childhood Abuse and Household Dysfunction to Many of the Leading Cause of Death in Adults*, 14 AM. J. PREVENTATIVE MED. 245 (1998); Green, B., et al, *Outcomes of Single versus Multiple Trauma Exposure in a Screening Sample*, 13 J. TRAUMATIC STRESS 271 (2000).

The significance of this for social history investigation is that capital clients have often experienced multiple horrific events throughout their lives. *All* of these experiences need to be fully investigated and contextualized, as separate events and as part of a client's broader life experience and psychological development.

TRAUMA AND ITS EFFECTS

What are the psychological effects of exposure to traumatic events? PTSD is the signature psychiatric disorder that has been recognized as a consequence of exposure to traumatic events. When the American Psychiatric Association officially recognized a coherent constellation of symptoms that comprise traumatic stress reactions in 1980, it defined PTSD by three symptom clusters: (1) haunted preoccupation with the trauma, expressed in symptoms such as nightmares, intrusive thoughts, flashbacks, and physiological reactivity upon exposure to trauma reminders; (2) avoidance of stimuli associated with the trauma, expressed in symptoms such as psychic numbing, feelings of estrangement from others, decreased interest in activities, inability to feel positive emotions such as love, satisfaction or happiness; and (3) persistent hyperarousal, expressed in symptoms such as exaggerated startle responses, difficulty concentrating or sleeping, hyper-vigilance, and affective lability (irritability and anger outbursts).¹⁰¹

POST TRAUMATIC STRESS DISORDER (PTSD)

The literature suggests that despite the high prevalence of exposure to traumatic events in the general population, the number of people who develop PTSD is generally low. For example, two U.S. population-based studies (called the National Comorbidity Studies) of nationally representative samples found similar results over a ten-year period. The first study estimated the overall lifetime prevalence rate of PTSD as 7.8 percent,¹⁰² and the replication study ten years later found the lifetime prevalence rate for PTSD was 6.8 percent.¹⁰³

Thus, in light of the high prevalence of exposure to traumatic events in the community at large, it is very clear that many, in fact *most*, people that are exposed to traumatic events do not develop PTSD. Why is this relevant to social history investigation in capital cases? An understanding of the factors that put people at risk for developing PTSD is absolutely critical to understanding the effects of trauma on

¹⁰¹ DSM-III.

¹⁰² Kessler & Sonnega, *supra*, n.86.

¹⁰³ Kessler, R., & Berglund, P., et al, *Lifetime Prevalence and Age-of-Onset Distributions of DSM-IV Disorders in the National Comorbidity Survey Replication*, 62 ARCHIVES GEN. PSYCHIATRY 593 (2005). Across studies, lifetime prevalence rates of PTSD have been reported to be approximately 5–6% in men and 10–14% in women: Breslau & Kessler, *supra*, n.92; Breslau, *supra*, n. 86; Kessler & Sonnega, *supra*, n.86. *See also* Storr, C., et al., *Childhood Antecedents of Exposure to Traumatic Events and Posttraumatic Stress Disorder*, 164 AM. J. PSYCHIATRY 119 (2007).

specific clients. The capital client population typically experiences many, if not most, of the factors that increase the risk of PTSD.

Three additional points are of critical importance here. First, traumatic events are risk factors for a host of psychological difficulties, *including but not limited to* PTSD. Second, among people who suffer from PTSD, many also meet diagnostic criteria for one or more additional psychiatric disorders. Finally, for the group of people who are traumatized but do not develop PTSD, this is by no means an indication that they survived their experiences undamaged. Traumatic exposures—particularly when they are of high magnitude or there are multiple exposures—place people at risk for a complex set of psychological difficulties other than the set of symptoms that is characterized by PTSD.

In addition (and beyond the scope of this manual) there is a large and converging body of literature from neuroscience and epidemiology that indicates that exposure to stress during childhood is associated with changes in brain structure, brain chemistry, and brain function. Early childhood stress, especially when it is extreme or prolonged, can impair the development of major neuro-regulatory systems, with profound and lasting neuro-developmental and neurobehavioral consequences over the course of a lifetime.¹⁰⁴ Moreover, the developmental psychopathology literature shows that early childhood adversity and maltreatment may be associated with profound and long-lasting developmental derailment. Trauma in the developmental years may compromise a child's ability to master critical developmental milestones at particular junctures in his or her life. Thus compromised—and particularly when harm is not ameliorated—that child's ability to master later milestones is also compromised, setting the stage for a cascade of adverse events and increasing the likelihood of psychiatric distress and adult psychopathology.¹⁰⁵

Risk factors for PTSD

Trauma represents a wide range of experiences and consequences. Research on the relationship between trauma exposure and PTSD has clearly shown that the risk of developing PTSD varies according to a large number of factors. These factors include a person's prior experiences (who he was before the trauma); the nature and range of

¹⁰⁴ See Anda et al, *supra*, n.100; Nemeroff, C., et al., *Posttraumatic Stress Disorder: A State-of-the-Science Review*, 40 J. PSYCHIATRIC RES. 1 (2006); Teicher, M., *Wounds that Time Wouldn't Heal: The Neurobiology of Child Abuse*, 2 CEREBRUM 50 (2000); Teicher, M., et al., *Neurobiological Consequences of Early Stress and Childhood Maltreatment: Are results from Human and Animal Studies Comparable?*, 1071 ANNALS N.Y. ACAD. SCI. 313 (2006).

¹⁰⁵ See Cicchetti, D., & Toth, S., *A Developmental Psychopathology Perspective on Child Abuse and Neglect*, 34 J. AM. ACADEMY CHILD & ADOLESCENT PSYCHIATRY 541 (1995); Aber, J.L., Allen, J.P., Carlson, V., & Cicchetti, D., *The Effects of Maltreatment on Development During Childhood: Recent Studies and Their Theoretical, Clinical, and Policy Implications*, in Cicchetti, D., & Carlson, V. (eds.), *CHILD MALTREATMENT: THEORY AND RESEARCH ON THE CAUSES AND CONSEQUENCES OF CHILD ABUSE*, 579 (CUP 1989); Cicchetti, D., *How Research on Child Maltreatment Has Informed the Study of Child Development*, in Cicchetti & Carlson *id.*, at 377.

trauma(s) he experienced; how he responded during the traumatic experience; at what age or ages and over how many developmental periods the trauma(s) occurred; his family history of psychiatric vulnerability; his own history of cognitive or psychiatric impairments; and the nature and extent of support he received following the traumatic experience(s). All of these factors should be considered as part of a competent mitigation investigation. Several of these factors are addressed below.

Type of traumatic event

The DSM has long recognized that the effects of traumatic exposures are generally more severe and longer lasting when the stressor is “of human design” (as opposed to natural or accidental disasters). This is consistent with findings from the epidemiologic literature. Inquiry into the relationship between specific types of traumatic event and development of PTSD has shown that people exposed to combat and physical and sexual assault (especially rape) are at particular risk for developing PTSD.¹⁰⁶ PTSD has also been found to be a prevalent outcome following childhood victimization.¹⁰⁷ These findings have been replicated in a number of studies and suggest that intentional interpersonal violence constitutes a particularly potent risk factor for developing PTSD.

Social history factors

At least two meta-analyses¹⁰⁸ have been completed on the trauma literature in efforts to identify factors that predict PTSD. One found that three historical risk factors were most uniformly predictive of developing PTSD: a prior psychiatric history in the traumatized individual, a history of childhood abuse, and a family history positive for psychiatric disorder.¹⁰⁹ The other meta-analysis yielded similar results, indicating that a prior history of trauma, prior psychological adjustment problems, and a family history of psychopathology were predictive of developing PTSD.¹¹⁰

¹⁰⁶ For example, Kessler and his colleagues reported that 65% of men and 46% of women who had been raped developed a diagnosis of PTSD at some point in their lives. Kessler & Sonnega, *supra*, n.86. Breslau and her colleagues found that combat exposure, rape, and physical or sexual assault were the types of trauma with the highest risk of developing PTSD: Breslau & Kessler, *supra*, n.92.

¹⁰⁷ See Kilpatrick, D., *A Special Section on Complex Trauma and a Few Thoughts About the Need for More Rigorous Research on Treatment efficacy, Effectiveness, and Safety*, 18 J. TRAUMATIC STRESS 379 (2005).

¹⁰⁸ A meta-analysis is a review paper where the authors evaluate and combine findings from similar types of studies, using specified inclusion criteria and identified statistical methods, in an effort to identify overarching patterns in the literature.

¹⁰⁹ See Brewin, C., et al, *Meta-Analysis of Risk Factors for Posttraumatic Stress Disorder in Trauma-Exposed Adults*, 68 J. CONSULTING & CLINICAL PSYCHOL. 748 (2000), surveying results from 77 studies that involved combined sample sizes ranging from 1,000 to 11,000 subjects.

¹¹⁰ Ozer, E.J., et al, *Predictors of Posttraumatic Stress Disorder and Symptoms in Adults: A Meta-Analysis*, 129 PSYCHOL. BULL. 52 (2003), surveying results from 68 studies that included seven predictors for PTSD.

These findings have significant implications for capital cases, as experience shows that most capital defendants have at least one—and many have all three—of these risk factors. Trauma-focused investigations (like any mental health/social history investigation) must routinely and closely examine all available evidence of (1) the defendant's prior psychological functioning; (2) his prior exposures to trauma, in both childhood and as an adult; and (3) his family history of mental illness or emotional impairments.¹¹¹

Subjective experience: personal reactions and appraisals

As mentioned above, with the publication of the DSM-IV in 1994 the definition of a traumatic event (Criterion A)¹¹² was expanded to include the subjective experience of “intense fear, helplessness, and horror” during the traumatic event. Several aspects of an individual's psychological responses during traumatic events have been shown to increase that individual's risk of developing PTSD. These include the perception that one's life is in danger, dissociation during the traumatic event,¹¹³ and heightened emotional responses during the traumatic event.¹¹⁴ These findings suggest that the in-vivo appraisal and meaning of traumatic stressors play an important role as a risk factor for developing PTSD.¹¹⁵

Cumulative trauma exposures

As has been touched on above, consistent findings from the trauma literature show a dose-response relationship with respect to trauma exposure and PTSD: the risk of PTSD and its debilitating symptoms increases progressively with the total number of risk factors to which one is exposed.¹¹⁶ A competent mitigation investigation must include assessment of all “criterion A” trauma exposures, and include careful

¹¹¹ See Koenen, K., et al, *Early Childhood Factors Associated with the Development of Post-traumatic Stress Disorder: Results from a Longitudinal Birth Cohort*, 37 PSYCH. MED. 181 (2007): reporting that low IQ and chronic environmental adversity (low SES) increased risk for PTSD); childhood externalizing characteristics and family environmental stressors (maternal distress and loss of a parent) was associated with increased risk of trauma exposure and PTSD.

¹¹² “Criterion A” defines the inclusion criteria for traumatic stressors, and has been called the “gateway” to a PTSD diagnosis. A competent “criterion A” assessment involves investigation of the various types and the range of traumatic events to which an individual has been exposed and an assessment of the circumstances, effects, and responses to those exposures.

¹¹³ This is described in the trauma literature as “peritraumatic dissociation,” and might include symptoms such as feeling that one is looking down from above, has left one's body, or that time has been altered.

¹¹⁴ Ozer et al, *supra*, n.110.

¹¹⁵ A word of caution is in order here. Mitigation specialists and mental health professionals conducting trauma assessments must also consider the effects of gender when interviewing clients and family members about traumatic experiences, particularly with respect to the assessment of emotions experienced during traumatic event. This issue will be discussed at length below.

¹¹⁶ Bromet, E., et al, *Risk Factors for DSM-III-R Posttraumatic Stress Disorder: Findings from the National Comorbidity Survey*, 147 AM. J. EPIDEMIOLOGY 353 (1998).

attention to the number, type, magnitude, circumstances and dynamics of traumatic exposures for any individual client.

Social support

The presence or absence of social support has been linked to the risk of developing PTSD following exposure to traumatic events. The presence of social support is protective and lessens risk for PTSD, and the absence of social support increases risk for PTSD.¹¹⁷ Social support may be particularly important in buffering the effects of trauma for people who have experienced both child abuse and violence in adulthood.¹¹⁸ Competent social history investigation must include an assessment of the quality of interpersonal relationships and support that existed for an individual client at all stages of his life. Likewise, mitigation specialists and investigators must note those instances where social support and/or treatment were notably absent, denied, or withheld.

It can be equally important to investigate the social support network available to the client's siblings. While it is quite likely that all members of a household dominated by violence will bear some scars of the experience, it is often the case that siblings may have different levels of exposure to trauma because of birth order or other circumstances, and it is also important to know whether siblings had effective social support from outside the family.¹¹⁹ Such investigation can explain why the client might have been more traumatized, or more vulnerable to the lasting effects of trauma, than a sibling who grew up in the same household. The preparation of a chronology that summarizes the client's life history can be a very useful tool for recognizing and understanding such relationships.

Gender

Numerous studies have found that women have a greater risk of developing PTSD than men.¹²⁰ This finding persists when controlling for type of trauma, suggesting that women have a greater vulnerability to the PTSD effects of trauma.¹²¹

¹¹⁷ See Brewin et al, *supra*, n.109; Ozer et al, *supra*, n.110.

¹¹⁸ Schumm et al, *supra*, n.99.

¹¹⁹ See, e.g., Kotlowitz, A., *In the Face of Death*, N.Y. TIMES, July 6, 2003, at 32.

¹²⁰ See Breslau & Kessler, *supra*, n.92; Breslau, *supra*, n.86; Kessler & Sonnega, *supra*, n.86.

¹²¹ Breslau, *supra*, n.86. These gender differences have been observed far more often than they have been explained. Explanations have included a greater possible physiological reactivity in women, the fact that routine stressors such as poverty, discrimination and oppression may reduce women's capacity to cope with traumatic stressors, and the view that gender role socialization may increase the likelihood that women disclose symptoms and men suppress them. See Norris, F.H., et al, *Epidemiology of Trauma and Posttraumatic Stress Disorder in Mexico*, 112 J. ABNORMAL PSYCHOL. 646 (2003).

THE DISABLING EFFECTS OF PTSD

There is considerable evidence that PTSD is a chronic and disabling condition for many who suffer from this disorder. PTSD may have a duration of many years, and is more likely to be developed by people who are exposed to multiple traumas.¹²² One study reported that for at least a third of people who suffer from PTSD, it is a persistent condition lasting for many years.¹²³ Impairment resulting from PTSD involves multiple domains of psychological functioning, and many people who suffer from this psychiatric disorder have significant marital, occupational, financial, and health problems. Traumatic exposures and resulting PTSD have significant negative effects on general functioning and affect health and health care utilization. As such, PTSD poses an important economic burden on both the individual and on society.¹²⁴

PTSD AND OTHER PSYCHIATRIC DISORDERS

The fact that a client meets diagnostic criteria for PTSD should never be the end of the inquiry about mental health issues related to trauma; a competent mitigation investigation must always continue the assessment with an eye towards other symptoms and conditions associated with PTSD.

There is a substantial literature on the extent to which PTSD co-occurs with other symptoms and disorders.¹²⁵ Results consistently show that the vast majority of people who meet diagnostic criteria for PTSD also meet diagnostic criteria for one or more additional psychiatric disorders. Overall, results from a number of population-based surveys have yielded co-morbidity rates between 62 percent and 92 percent.¹²⁶ Using the more conservative estimate, this means that over 60 percent of people with PTSD suffer the effects of at least one other disorder.

Disorders that frequently co-occur with PTSD include mood,¹²⁷ anxiety,¹²⁸ and substance abuse disorders.¹²⁹ In addition, there is increasing evidence of the existence

¹²² Kessler, R., *Posttraumatic Stress Disorder: The Burden to the Individual and to Society*, 61 J. CLINICAL PSYCHIATRY (Supp. 5) 4 (2000).

¹²³ Soloman, S., & Davidson, J., *Trauma: Prevalence, Impairment, and Service, Use, and Cost*, 58 J. CLINICAL PSYCHIATRY (Supp. 9) 5 (1997).

¹²⁴ Hidalgo, R., & Davidson, J., *Posttraumatic Stress Disorder: Epidemiology and Health-Related Considerations*, 61 J. CLINICAL PSYCHIATRY (Supp. 7) 5 (2000).

¹²⁵ The existence of two or more psychiatric disorders co-occurring within an individual is described in the psychiatric literature as "co-morbidity."

¹²⁶ See Kessler & Sonnega, *supra*, n.86; Creamer et al, *supra*, n.87. For example, in the National Comorbidity Study, a representative national sample of 5877 individuals between 15 and 54 years of age, Kessler and his colleagues found that the relative odds of other psychiatric disorders are significantly elevated in people with PTSD, and that 88% of men and 79% of women with PTSD had at least one other DSM-III-R psychiatric disorder: Kessler & Berglund, *supra*, n.103. This finding has been replicated, with other authors reporting that over 89% of respondents with PTSD suffer from other psychiatric disorders: Breslau & Davis, *supra*, n.99; Creamer et al, *supra*, n.87.

¹²⁷ A disturbance in mood is the predominant feature of this category of disorders. Mood disorders include the Depressive Disorders (e.g. symptoms such as depressed mood, markedly diminished

of psychotic¹³⁰ and dissociative¹³¹ symptomatology among people who have PTSD.¹³²

interest or pleasure in daily activities, significant weight loss or weight gain, loss of energy, recurrent suicidal ideation) and the Bipolar Disorders (e.g. symptoms such as inflated self-esteem, grandiosity, flight of ideas, decreased need for sleep, distractibility). *See, e.g.*, DSM-IV-TR, at 345-48.

¹²⁸ The Anxiety Disorders include, among others, Panic Disorder, Agoraphobia, Social Phobia, Obsessive-Compulsive Disorder, Generalized Anxiety Disorder, and Acute Stress Disorder. *See, e.g.*, DSM-IV-TR, at 429-30.

¹²⁹ The essential feature of Substance Abuse Disorders is a maladaptive and repeated pattern of substance use manifested by recurrent and significant adverse consequences. *See, e.g.*, DSM-IV-TR, at 198. Substance Abuse Disorders are co-morbid with PTSD to a very high degree (Breslau, *supra*, n.86; Kessler & Sonnega, *supra*, n.86; Creamer et al, *supra*, n.87). In many cases, the substance abuse disorder may develop as an attempt to self-medicate the suffering caused by PTSD. *See* Brady, K., et al., *Comorbidity of Psychiatric Disorders and Posttraumatic Stress Disorder*, 61 J. CLINICAL PSYCHIATRY (Supp. 7) 22 at 23, 27 (2000). There is an extremely high prevalence rate of co-morbid substance abuse disorders in the highly traumatized population of capital clients. This pattern of comorbidity has significant implications for mental health evaluations. One problem that occurs has been called "diagnostic overshadowing," referring to diagnostic errors that result from mistakenly attributing signs and symptoms of one disorder or condition to another. Diagnostic overshadowing often results in the failure to identify the presence of co-occurring mental disorders. Evaluators may explain a client's behavior solely in terms of substance abuse, rather than as a consequence of substance abuse that is co-morbid with other conditions. In addition, in those relatively infrequent instances where treatment has been recommended, diagnostic inaccuracy may have resulted in a client being denied treatment for additional serious psychiatric conditions, such as PTSD, or the provision of inappropriate treatment that resulted in failed treatment outcomes.

¹³⁰ In very general terms, psychosis refers to a loss of contact with reality. Psychotic symptoms might include delusions (e.g. fixed false beliefs that are firmly held despite evidence to the contrary such as falsely believing people are out to get one, believing one is being followed or plotted against, believing others are reading one's mind or stealing one's thoughts); auditory, visual, or olfactory hallucinations (e.g. hearing, seeing, or smelling things that other people can not hear, see, or smell); paranoia and suspiciousness, or disorganized thoughts, language and behavior. The psychotic disorders include, among others, Schizophrenia, Schizoaffective Disorder, Delusional Disorder, and Brief Psychotic Disorder.

¹³¹ Dissociation describes mental states in which thoughts, emotions, sensations or memories are split off or compartmentalized. The essential feature of dissociative disorders is disruption in the usually integrated functions of consciousness, memory, identity, or perception. An example of a dissociative symptom might include losing track of the passage of time, feeling one's body does not belong to oneself, feeling that other people or the world is not real, or failure to remember important events in one's life. Extreme forms of dissociation disorders include Dissociative Identity Disorder and Depersonalization Disorder.

¹³² For example, Susanne Wicks and colleagues found that social adversity in childhood was associated with a risk of developing psychoses later in life, and that the risks increased with an increasing number of adversities, suggesting a dose-response relationship: Wicks, S., et al, *Social Adversity in Childhood and the Risk of Developing Psychosis: A National Cohort Study*, 162 AM. J. PSYCHIATRY 1652 (2005). Sareen and colleagues found a significant association between PTSD and endorsement of significant psychotic symptoms, and that co-occurrence with psychotic symptoms was marked by greater severity of PTSD symptoms and higher co-morbidity: Sareen, J., et al, *Co-Occurrence of Posttraumatic Stress Disorder with Positive Psychotic Symptoms in a Nationally Representative Sample*, 18 J. TRAUMATIC STRESS 313 (2005). Spauwen and colleagues found that exposure to traumatic events may increase the risk of psychotic symptoms, particularly in people vulnerable to psychosis: Spauwen, J., et al, *Impact of Psychological Trauma on the Development of Psychotic Symptoms: Relationship with Psychosis Proneness*, 188 BRIT. J. PSYCHIATRY 527 (2006). *See also* Van der Hart, O., et al., *Dissociation: an Insufficiently Recognized Major Feature of Complex Posttraumatic Stress Disorder*, 18 J. TRAUMATIC STRESS 413 (2005).

What are the implications of this for capital work? Quite simply: PTSD is not the end of the story; people with PTSD are at high risk for one or more additional psychiatric disorders. A careful investigation of symptoms over time is essential when developing a comprehensive trauma history and evaluation of its mental health consequences. Special focus should be placed on investigating symptoms of substance abuse, depression, anxiety, and psychotic and dissociative symptomatology. These additional symptoms can have profound effects on the mental state of a client with PTSD.¹³³ The presence of psychotic or dissociative symptomatology, in particular, may have major implications for mental state defenses and competency issues at any stage of the legal proceedings. If nothing else, a thorough understanding of a client's symptoms and impairments is essential to developing even minimal trust and communication between the client and defense team.

All too often, traditional forensic mental health evaluations generally focus simply on the question of whether or not a particular client meets diagnostic criteria for a particular psychiatric disorder. This simplistic approach can lead to an evaluation that overlooks significant psychiatric symptoms that may be sub-threshold for one or more psychiatric disorders. The result is often an incomplete and inaccurate picture of a client's mental health status, and one that dismisses or underestimates the full extent of that client's impairments. Sub-threshold symptomatology may cause or contribute to unique and potentially debilitating manifestations of PTSD and other disorders, and may be associated with significant impairment. A competent mental health evaluation must always focus on symptoms and impairment as well as on discrete disorders, as these are extremely important indicators of current and past functioning.

CONSEQUENCES OF TRAUMA: BEYOND PTSD

A correlate to the proposition that diagnosing a client with PTSD is only the beginning of the social history and psychological inquiry is the fact that if someone does not meet diagnostic criteria for PTSD, we cannot conclude that he survived his traumatic experiences without severe damage. It is the obligation of the capital defense team to understand this and to incorporate this knowledge in their social history investigation.¹³⁴ To do so effectively, it is helpful to turn to the impairments and disturbances that often accompany long-term and complex trauma exposure.

There is a complex, coherent, and consistent constellation of symptoms—not captured by the diagnosis of PTSD—frequently seen in people exposed to chronic

¹³³ Many of these symptoms also occur in those who have been exposed to traumatic events but do not currently meet full PTSD diagnostic criteria. Even absent a PTSD diagnosis consideration should be given to this spectrum of symptoms and disorders.

¹³⁴ It should also be noted that the implications of an understanding about trauma extend far beyond evidentiary presentations to a judge or jury. This understanding should be used in multiple arenas of capital defense work, including working more effectively with individual clients (*e.g.*, discussion with a despairing client who may be a potential volunteer, discussions with a client around sensitive plea negotiations).

and severe trauma. Populations studied include people who have been chronically physically or sexually abused during childhood, and people exposed to interpersonal violence in adulthood, often within the context of intimate relationships.

This constellation of symptoms has been described in the literature by various names, including “disorders of extreme stress not otherwise specific,” or DESNOS,¹³⁵ and “complex psychological trauma.”¹³⁶ Impairments are described in the following areas:

Problems with the regulation of emotion (e.g. increased anxiety and depression, difficulties with aggression and anger);

Problems with the regulation of behavior (e.g. self-destructive and impulsive behaviors);

Problems with attention or consciousness, avoidant responses (e.g. dissociative symptoms, depersonalization [an alteration in the perception of the self so that one feels detached from one's body or mental processes]);

Problems with relationships (e.g. inability to trust, fearfulness, and suspiciousness of others, idealizing or bonding with one's abuser);

Problems with a coherent sense of oneself (e.g. identity disturbances, low self esteem, feeling damaged or ineffective);

Problems interpreting one's environment and the intent and actions of others;

Problems maintaining a system of meaning (e.g. believing the future holds no promise or hope, profound feelings of despair, helplessness, and hopelessness).¹³⁷

¹³⁵ Judith Herman and her colleagues studied the complex array of symptoms associated with exposure to severe and chronic interpersonal violence under the auspices of field trials undertaken as part of the development of the DSM-IV. Following review of existing literature on victims of chronic interpersonal violence (child abuse, domestic violence, and concentration camp internment), a list of symptoms was generated and called Disorders of Extreme Stress Not Otherwise Specified (DESNOS): Herman, J., *TRAUMA AND RECOVERY* (Harper Collins 1992). The DESNOS conceptualization included seven categories of disturbance and noted symptoms of dysregulation in affective, behavioral, cognitive, and somatic domains of functioning, as well as symptoms of disturbance in interpersonal functioning (sense of identity, relationships with others, and schemas about the world). See Van der Kolk et al, *supra*, n.94; Van der Kolk, B., & Courtois, C., *Editorial Comments: Complex Developmental Trauma*, 18 J. TRAUMATIC STRESS 385 (2005); Van der Kol, B., & Roth, S., et al, *Disorders of Extreme Stress: The Empirical Foundation of a Complex Adaptation to Trauma*, 18 J. TRAUMATIC STRESS 389 (2005).

¹³⁶ Briere, J., & Spinazzolo, J., *Phenomenology and Psychological Assessment of Complex Posttraumatic States*, 18 J. TRAUMATIC STRESS 401 (2005): describing six prominent and overlapping symptom clusters, including altered self capacities; cognitive disturbances; mood disturbances; overdeveloped avoidant responses; somatoform distress; and posttraumatic stress.

¹³⁷ The World Health Organization has also recognized posttraumatic changes in psychological functioning. The 10th edition of the INTERNATIONAL CLASSIFICATION OF DISEASES (ICD-10) noted a

Many of these symptoms were included in the text of DSM-IV under “associated descriptive features” of PTSD:

Impaired affect modulation; self-destructive and impulsive behavior; dissociative symptoms; somatic complaints; feelings of ineffectiveness, shame, despair, or hopelessness; feeling permanently damaged; a loss of previously sustained beliefs; hostility; social withdrawal; feeling constantly threatened; impaired relationships with others; or a change from the individual's previous personality characteristics.¹³⁸

Knowledge of the symptoms of both PTSD and of DESNOS/complex psychological trauma should be required of anyone conducting social history investigations and evaluations in capital cases.¹³⁹ Failure to understand these symptoms and effects results all too often in misdiagnoses, including misdiagnoses of personality disorders, such as Antisocial Personality Disorder (ASPD).¹⁴⁰ A major problem leading to frequent misdiagnoses of ASPD in the capital setting is that mental health evaluators routinely ignore guidelines of the DSM that suggest the importance of understanding behavior in context in order to properly identify symptoms. For example, the DSM

diagnostic category of “lasting personality changes following catastrophic stress,” which includes “impairment in interpersonal, social and occupational functioning,” and “a hostile and mistrustful attitude towards the world, social withdrawal, feelings of emptiness and hopelessness, a chronic feeling of being ‘on the edge’ and constantly threatened, and a chronic sense of estrangement.” World Health Organization, ICD-10 (1992), at 232-233.

¹³⁸ DSM-IV-TR, at 465. Findings from the DSM-IV field trial and from subsequent studies have provided additional empirical support that adaptation to chronic interpersonal violence constitutes a complex, coherent, and consistent pattern of symptoms in both adults and children. See Ford, J., & Kidd, P., *Early Childhood Trauma and Disorders of Extreme Stress as Predictors of Treatment Outcome with Chronic Posttraumatic Stress Disorder*, 11 J. TRAUMATIC STRESS 743 (1998); Roth, S., et al, *Complex PTSD in Victims Exposed to Sexual and Physical Abuse: Results from the DSM-IV Field Trial for Posttraumatic Stress Disorder*, 10 J. TRAUMATIC STRESS 539 (1997); Van der Kolk & Courtois, *supra*, n.135; Van der Kolk et al, *supra*, n.94; Zlotnick, C., & Zakriski, A., et al, *The Long-Term Sequelae of Childhood Sexual Abuse: Support for a Complex Posttraumatic Stress Disorder*, 9 J. TRAUMATIC STRESS 195 (1996).

¹³⁹ De Jong and his colleagues conducted a study of DESNOS symptoms in non-Western samples (Ethiopia, Algeria and Gaza) and found cultural differences in symptom expression. These authors argue that exposure to extreme traumatic stress results in universal symptoms found across cultures (e.g. difficulty modulating emotion and anger, a symptom of the psychobiological process of affect dysregulation) as well as culturally-specific symptoms (e.g. suicidal ideation was much lower in these samples, which may be attributed to the fact that suicide is taboo in both the Islamic and Coptic religions; the emotions of guilt and shame following exposure to events may be more applicable in some cultures than in others). De Jong, J., Komproe, I., & Spinzola, J., et al, *DESNOS in Three Postconflict Settings: Assessing Cross-Cultural Construct Equivalence*, 18 J. TRAUMATIC STRESS 13 (2005). This discussion highlights the critical need for culturally sensitive investigation.

¹⁴⁰ Antisocial Personality Disorder (ASPD) is described in the DSM-IV-TR as a pervasive pattern of disregard for, and violation of, the rights of others that begins in childhood or early adolescence and continues into adulthood. Symptoms include failure to conform to social norms, deceitfulness, impulsivity or failure to plan ahead, reckless disregard for safety of self or others, consistent irresponsibility, and lack of remorse.

notes, “when personality changes emerge and persist after an individual has been exposed to external stress, a diagnosis of PTSD should be considered,” and cautions:

...[C]oncerns have been raised that the diagnosis [of ASPD] may at times be misapplied to individuals in settings in which seemingly antisocial behavior may be part of a protective survival strategy... [I]t is helpful for the clinician to consider the social and economic context in which the behaviors occur.¹⁴¹

An evaluator might decide that behaviors signify “irritability and aggressiveness” (a symptom of ASPD) and miss the fact that the behaviors in question are a consequence of the hyper-arousal component of PTSD.¹⁴² Similarly, an evaluator might decide that behaviors signify “lack of remorse” (a symptom of ASPD), and miss the fact that the behaviors in question are a consequence of the psychic numbing component of PTSD.¹⁴³ Finally, an evaluator might decide that behaviors signify “reckless disregard for safety of self and others” (a symptom of ASPD) and miss the fact that the behaviors in question reflect the DESNOS symptom (and description of associated features of PTSD noted in the DSM-IV) of dysregulated affect and behavior.

The potential for misdiagnoses of ASPD is particularly great when the trauma history has not been sufficiently investigated, such that the capital defense team lacks information that would allow them to properly contextualize their clients' actions and behaviors, misinterpreting or dismissing them as symptoms of intentional conduct-disordered¹⁴⁴ or antisocial behavior, rather than as trauma responses.

CONTEXT OF INTERPERSONAL VIOLENCE

¹⁴¹ DSM-IV-TR, at 704. In order to make the diagnosis of ASPD an individual must show evidence of behavioral dysfunction in childhood prior to age 15. Often ASPD misdiagnoses are rendered in situations where there has been no social history investigation of a client's childhood behavior and functioning or there is no evidence of conduct problems in childhood.

¹⁴² This is a core symptom category of PTSD that results in symptoms such as difficulty falling asleep, exaggerated startle response, hypervigilance, difficulty concentrating or “irritability or outbursts of anger.”

¹⁴³ This is a core symptom category of PTSD that results in symptoms such as avoidance of thoughts, feelings, or conversations related to the trauma, feelings of detachment or estrangement from others, and a “restricted range of affect.”

¹⁴⁴ Conduct Disorder in a condition that is diagnosed in childhood or adolescence, and is described as a “repetitive and persistent pattern or behavior in which the basic rights of others or major age-appropriate societal norms or rules are violated.” DSM-IV-TR. Symptoms are grouped into four categories, including aggression, property loss or damage, deceitfulness or theft, and serious violation of rules. Mischaracterizations of client behaviors frequently occur in death penalty cases, where a client's behavior is taken out of context and labeled “conduct-disordered.” One common example involves a child who leaves home to escape physical or sexual abuse and is labeled a “runaway” (a symptom of conduct disorder). Another example involves a child who has not attended school to hide symptoms of abuse (or to care for younger siblings because an alcoholic or depressed parent is disabled) and is labeled a “truant,” another symptom of conduct disorder.

Just as behaviors must be understood in context for an accurate evaluation of symptoms, an understanding of the context in which interpersonal violence often occurs is also necessary.¹⁴⁵ Recognizable—indeed, predictable—patterns of behavior are seen across situations involving interpersonal violence, particularly when that violence is extensive, ongoing, and involves relationships with an imbalance of power, such as that involved between parent and child or in relationships involving intimate partner violence. In her seminal book on the effects of severe, prolonged and sustained trauma, *Trauma and Recovery*, Judith Herman labeled this “captivity” and provided a succinct description of the dynamics in which chronic abuse occurs:¹⁴⁶

[C]hronic childhood abuse takes place in a familial climate of pervasive terror, in which ordinary caretaking relationships have been profoundly disrupted. Survivors describe a characteristic pattern of totalitarian control, enforced by means of violence and death threats, capricious enforcement of petty rules, intermittent rewards, and destruction of all competing relationships through isolation, secrecy and betrayal.¹⁴⁷

An understanding of the dynamics of violent relationships helps to inform the investigation of issues involving psychological trauma and relationships with clients and their family members. These dynamics are most relevant for clients who have been abused as children, have been victims of ongoing violence in institutional settings, or have been victims of domestic battering. An understanding of these dynamics provides insight about the experiences of clients and their sometimes seemingly inexplicable responses to others, including members of the defense team (*e.g.*, inability to trust or disclose, suspicion of defense team members, the persistent belief that the defense team is not acting in his or her best interest, increasing anxiety, vulnerability and agitation as the defense team gains intimate knowledge about his or her life). This knowledge can assist interviewers with the often delicate process of obtaining trust, maintaining rapport, and dealing with the inevitable challenges that are encountered in the ongoing relationship between client and defense team members. It also helps them understand how aspects of the attorney-client relationship (the imbalance of power, the client's dependency on the defense team) can trigger profound emotional responses that often reflect the devastating interpersonal *sequelae* of chronic and untreated child maltreatment.

¹⁴⁵ Other contextual factors that are beyond the scope of this chapter are also of great importance in developing and presenting a comprehensive narrative of a client's life history. These include, among others, neighborhood effects; cultural factors; and the multi-generational psychiatric and social history of the client's family.

¹⁴⁶ In this quote Herman is describing ongoing child abuse, but the dynamics described have also been seen in the other situations involving “captivity,” including domestic violence and abuse within institutional or internment settings.

¹⁴⁷ HERMAN, *supra*, n.135, at 77.

COERCIVE CONTROL

There is a coherent set of strategies that are used to exert control, induce fear, and undermine the sense of autonomy and will in victims living in a situation “which brings the victim into prolonged contact with the perpetrator.”¹⁴⁸ These dynamics have been called “coercive control,”¹⁴⁹ “captivity,”¹⁵⁰ and “psychological battering.”¹⁵¹

“Coercive control” can be summarized as comprising the four key issues which will be described below: isolation; domination and destruction of autonomy; a climate of terror (fear arousal and maintenance); and the demand for collusion/illusion of participation.¹⁵² The following description of these concepts and their effects on trauma survivors is not meant to be comprehensive, but simply to provide a general idea of the various types of recognized abusive strategies and some of their potentially devastating effects on many capital clients and their families.¹⁵³

Isolation

Isolation constitutes the undermining or destruction of attachments, either from the external social world or from one's internal sense of self. Children may be prevented from engaging in appropriate peer activities, forced to dress differently or inappropriately (e.g., to attend school in tattered or urine-soaked clothes because of neglect), may be scapegoated within the family, or may be subjected to frequent

¹⁴⁸ *Id.*, at 74. An understanding of the dynamics of abusive relationships has been derived from clinical work with people living in situations of “captive subjugation,” including the treatment of hostages, brainwashed prisoners, people interned in concentration camps, victims of intimate partner violence, and chronic childhood maltreatment (verbal, physical and sexual abuse).

¹⁴⁹ Okun, L., *WOMAN ABUSE: FACTS REPLACING MYTHS* (State University of New York Press 1986).

¹⁵⁰ HERMAN, *supra*, n.135.

¹⁵¹ Garbarino et al (1988), *supra*, n.51.

¹⁵² See, for example, descriptions of “coercive control” (Okun, *supra*, n.149; Stark, E., *COERCIVE CONTROL: THE ENTRAPMENT OF WOMEN IN PERSONAL LIFE* (Oxford University Press 2007); “psychological battering,” (Garbarino et al (1988), *supra*, n.51); and “captive subjugation” (HERMAN, *supra*, n.135). While authors describe these issues somewhat differently depending on the population they are describing (e.g. adults versus children) the underlying dynamics of the various conceptualizations are very similar.

¹⁵³ There is evidence that emotional forms of coercion and torture are psychologically devastating, and are as damaging—if not more so—than physical coercion and torture. Many clinicians and researchers who work with victims of domestic battering report that survivors consistently say that the psychological battering they experienced is more distressing than individual acts of violence (Walker, L., *THE BATTERED WOMAN* (Harper & Row 1979); Okun, *supra*, n.149; Stark, *supra*, n.152. Basoglu and colleagues reported that “cruel, inhuman, and degrading” treatment during captivity, such as psychological manipulation and humiliation, is not substantially different from physical torture in the severity of psychological suffering experienced or in the underlying mechanisms of traumatic stress and long-term psychological outcomes: Basoglu, M., Livanou, M., & Crnobaric, C., *Torture vs. Other Cruel, Inhuman, and Degrading Treatment: Is the Distinction Real or Apparent?* 64 ARCHIVES OF GEN. PSYCHIATRY, 277 (2007).

humiliation (*e.g.*, be given “nicknames” like “worthless,” “zero,” “no name”). They may be forced to renounce ideals or values of importance to them (*e.g.*, an adolescent may turn to religion as a source of solace and be attacked for his beliefs). When considered outside the context of abusive relationships, some of these acts on the part of the caregiver may seem mundane. However, contextualized as part of the larger picture of coercive control, they may have enormous psychological significance.

A key task of child development is to develop a coherent and positive sense of self, and to competently embed oneself in a larger social world. Isolation prevents a child from adaptively engaging in the myriad of seemingly routine daily interactions that form the basis of social competence. These are the building blocks needed to develop a sense of social belonging and social confidence, and to reinforce relatedness with others. When core attachment relationships become primary sources of danger, disillusionment, and betrayal, the victim may lose (or never develop) hope and a sense of trust in the social world. His or her perceptions of reality may be systematically undermined (*e.g.*, a sexually abused child may be told the abuse is for his or her own good or is dictated by the bible), thus making it difficult to develop accurate perceptions of oneself and others. An abused child may reach adulthood with no expectations of healthy relationships, no beliefs that others are trustworthy, and no sense that he or she is worthy of humane treatment.

Domination and the destruction of autonomy

Violent relationships are often characterized by the absolute, arbitrary, and capricious exercise of power.¹⁵⁴ Examples might include sleep deprivation (*e.g.*, waking someone up in the middle of the night to force them to do household tasks), withholding food, or control over basic physical functions (*e.g.*, controlling use of toilet facilities, grooming, or hygiene). The effects of this can be devastating, particularly for a child. The will of the perpetrator is frequently asserted without regard for the victim's needs, desires, perceptions, aspirations and goals. Speaking one's thoughts or expressing emotions that are appropriate to the situation at hand may be the catalyst for a physical or psychological attack.

A key task of child development is to develop social competence and mastery, and an increasing ability to function autonomously. Repeated experiences with the arbitrary enforcement of power may undermine a child's ability to operate independently and confidently. It may also impair his ability to negotiate the world around him or develop a belief that he has any influence over his own circumstances and his treatment by others.

¹⁵⁴ See Judith Herman's description of the perpetrator's "inconsistent and unpredictable outburst of violence" and "capricious enforcement of petty rules," HERMAN, *supra*, n.135, at 77.

Climate of Terror / Fear Arousal and Maintenance

A climate of fear and terror is often established by threats, surveillance, and degradation. For example, the perpetrator may drive wildly when drunk, leading others to feel their lives are in danger; he or she may suddenly and without provocation threaten and carry out physical assaults. As context, consider a time when your life was in danger and you thought you were going to die or be seriously injured, and imagine living with that level of fear. Actual violence is not needed to instill fear; the mere threat of violence is sufficient, especially when it is clear that the perpetrator has the power to carry out those threats. Living in a state of fear narrows one's focus to basic survival, keeps one focused on the person who induces that state of fear, and profoundly distracts one from engaging in normal developmental tasks. Daily life may be dictated and punctuated by the need to focus on the perpetrator's demands and leave the survivor in states of sickening anticipation and dread. Evidence suggests that persistent states of hyper-arousal literally recondition the nervous system and change "set points" for arousal.

Demand for Collusion / Illusion of Participation

As Judith Herman has noted, "Once a perpetrator has succeeded in establishing day-to-day bodily control of the victim, he becomes a source not only of fear and humiliation but also of solace. The hope of a meal, a bath, a kind word, or some other ordinary creature comfort can become compelling to a person long enough deprived."¹⁵⁵ When arbitrary and capricious control is exerted over the victim of chronic interpersonal violence, he or she often becomes focused on the perpetrator, who may be perceived as omnipotent. The perpetrator may demand expressions of loyalty, allegiance, respect, gratitude, and unconditional acceptance of the status quo. This dynamic is particularly destructive from the perspective of childhood psychological development. For example, a sexually abused child may be forced to "participate" in sexual acts, creating the illusion that he or she is complicit. This can systematically undermine a child's ability to accurately assess issues of responsibility and lead him/her to confuse the role of victim and perpetrator. This dynamic can also fundamentally undermine a victim's capacity to assess accurately the motivations of others, and may lead to inordinate interpersonal difficulties in accurately perceiving and relating to people in a position of authority.

TRAUMATIC BONDING

Why do people remain in abusive relationships or family systems? Why do they continue to enter new abusive relationships? Why is disclosure of abuse so difficult? Why do abuse victims frequently protect their abusers? A seeming contradiction about psychological trauma is that abusive and exploitive relationships, particularly

¹⁵⁵ *Id.*, at 78.

when they are longstanding, can result in extremely powerful and seemingly inexplicable emotional ties, including intense bonds of loyalty expressed by victims towards abuse perpetrators. This phenomenon has been described as “traumatic bonding” and has been particularly noted in family and relationship systems involving violence.¹⁵⁶ Common to these extremely destructive relationship patterns are unequal power dynamics, the exploitation of trust by caregivers or those in positions of power, and the fact that the abuse and exploitation generally occurs on an intermittent basis.¹⁵⁷

The systematic and sustained use of coercive control methods serves to break down a victim's psychological strength and resistance, may lead to emotional dependence on the perpetrator, to a view of him or her as omnipotent, and to a drastically reduced sense of self-worth and efficacy. Persistent and sustained states of helplessness, hopelessness, and heightened and extreme emotional responses may result. These coercive strategies are most effective in exerting their destructive effects when they are random, unpredictable, and intermittently interspersed with kindness and loving behavior. Indeed, it is the intermittent nature of the abuse that is most responsible for undermining a victim's sense of autonomy and breaking down psychological resistance. These dynamics are particularly acute when they are experienced by children, who are by definition dependent on caregivers to provide nurturance, guidance and support. They can profoundly shape a child's most basic schemas of self and others, and result in profoundly negative expectations about the possibility for safety, emotional sustenance and support in interpersonal relationships.

¹⁵⁶ Dutton, D., & Painter, S., *Traumatic Bonding: The Development of Emotional Attachments in Battered Women and Other Relationships of Intermittent Abuse*, 6 VICTIMOLOGY 139 (1981); Painter, S., & Dutton, D., *Patterns of Emotional Bonding in Battered Women: Traumatic Bonding*, 8 INT'L J. WOMEN'S STUD. 363 (1985).

¹⁵⁷ Decades of research from the attachment literature shows that the quality of relationship between parent and child has enormous implications for virtually every aspect of a child's development and functioning throughout life. Secure attachment in early years provides the foundation for healthy development of affect regulation, self-identity, and schemas about relationships. More recently, convergent data from clinical and pre-clinical studies provides insight about the neuroscience of attachment. Interactions between caregiver and infant structure brain development and growth, and shape the neural substrate for early social and emotional learning. Abuse, neglect, under-stimulation, and prolonged shame increase stress hormones that are toxic to the brain and impair the child's ability to regulate impulses and affect, which are central to success in forming attachments and negotiating the social world. See Carlson, E., *A Prospective Longitudinal Study of Attachment Disorganization/Orientation*, 69 CHILD DEVELOPMENT 1107 (1998); Cozolino, L., *THE NEUROSCIENCE OF HUMAN RELATIONSHIPS: ATTACHMENT AND THE DEVELOPING SOCIAL BRAIN* (W.W. Norton 2006); Kandel, E., *Biology and the Future of Psychoanalysis: A New Intellectual Framework for Psychiatry Revisited*, 156 AM. J. PSYCHIATRY 505 (1999); Perry, B., *THE BOY WHO WAS RAISED AS A DOG AND OTHER STORIES FROM A CHILD PSYCHIATRIST'S NOTEBOOK: WHAT TRAUMATIZED CHILDREN CAN TEACH US* (Basic Books 2006); Schore, A., *AFFECT REGULATION AND THE ORIGIN OF THE SELF: THE NEUROBIOLOGY OF EMOTIONAL DEVELOPMENT* (Lawrence Erlbaum Associates, 1994); Sroufe, A., *Attachment and development: A Prospective, Longitudinal Study from Birth to Adulthood*, 7 ATTACHMENT AND HUMAN DEVELOPMENT 349 (2005); Teicher, *supra*, n.104; Teicher et al, *supra*, n.104.

IMPLICATIONS FOR SOCIAL HISTORY INVESTIGATION

As is clear from the above, a competent social history investigation must thoroughly explore *all* of an individual client's trauma exposures. It is likely that he or she will have suffered multiple and possibly repeated traumatic experiences, very possibly in numerous contexts. An individual client may have been exposed to physical abuse, sexual abuse, community violence, institutional violence, combat, a natural disaster, and one or more motor vehicle accidents. Further, the physical and sexual abuse history of that client might include numerous incidents of abuse over several developmental periods by multiple perpetrators, and the community violence exposure may have spanned a number of years. A competent social history investigation requires close examination of each event (or series of events), including the circumstances of each trauma, the sequelae, the interaction or overlap with other disorders and disabilities, and the factors that shaped the client's response and recovery (or disability). As noted above, the frequency of victimization and range of traumatic experiences will most likely increase the range of post-traumatic symptomatology and the level of impairment.

Development of a full understanding of Criterion A exposures requires extensive documentary evidence, investigation of a client's cultural and institutional history, multiple interviews with an individual client, and multiple interviews with family members, friends, peers, and teachers (among others). Mental health evaluations that consist of a two- or three-hour interview of the client by a court-appointed mental health professional, relying largely on client self report, conducted in a hostile setting (e.g., a jail), without sufficient time to develop rapport, fall far below the necessary standard of care. In the typical scenario where this has occurred, the mental health evaluator operated with little or no historical information or documentary evidence, and with little or no information about the client's family, neighborhood, community, and institutional history. In many cases, there was no attempt to corroborate or assess the minimal information disclosed by the client to the evaluator. The result is a substandard, incomplete, unreliable mental health assessment without depth or context, which rarely touches the surface of the trauma history. Thus, even when a client is forthcoming with respect to his trauma history, the resulting information may be easily attacked or minimized by the prosecutor as self-serving and lacking in corroboration. This is particularly distressing given the consistent finding by experienced capital practitioners that many of their clients have suffered multiple and repeated trauma exposures throughout their lives, often far more severe than they themselves reveal. Moreover, many clients' traumatic experiences have occurred within their own families or communities, increasing both the obstacles to data collection and the need for informed and sensitive investigation.

BARRIERS TO DISCLOSURE OF TRAUMATIC EXPERIENCES

There is a range of factors operating as barriers to disclosure of traumatic experiences, especially in the context of legal investigations. Most often these barriers

arise (or are encountered) during interviews with either the client himself or life-history witnesses (*e.g.*, siblings or other family members), hence the need to devote the time to establish a rapport with the client and the client's family. Differences of race, gender, age, ethnicity, class, education, religion, sexual orientation, and language may come into play, hence the requirement for culturally competent interviews. Obstacles to disclosure may be attributable to the nature of traumatic memory, the skills/techniques of the interviewer, distrust/suspicion of the interviewee, or the longstanding effects of the trauma itself. Following is a partial list of barriers to obtaining thorough and credible trauma/social history information:

Psychological

- Unreliable memories of the subject—either old in time (simply forgotten), revisionist, repressed, or the fragmented memories of a trauma victim
- Psychic numbing or flooding
- Confidentiality concerns—*i.e.*, fear that disclosed information will be repeated to others (especially family members)
- Reluctance to revisit painful experiences
- Normalizing or minimizing one's traumatic experiences
- Embarrassment, shame, humiliation or guilt around specific issues or events
- Fear of being judged (for the trauma or his response to it)
- Fear of being dismissed, disbelieved, doubted—risk that the interviewer will not be respectful of experiences/feelings that have great significance (positive or negative) to the subject
- The subject's sense of responsibility for (or complicity in) his own victimization
- Desire to safeguard his personal privacy, or the privacy/dignity/reputation of the family
- Distrust of strangers, especially those associated (at least in the mind of the witness) with lawyers or the legal/judicial system; distrust of people generally

Familial

- Family members' anger at the subject (for causing this whole mess and causing intrusions on the family)
- Traumatic bonding, *i.e.*, life-long social conditioning to keep "family matters" within the family
- Protection of loved ones/family members—*e.g.*, abusive spouses, fathers, brothers, etc.
- Questions/subject areas touching on the misdeeds or inaction (complicity) of family members
- Fear of backlash/retaliation/disapproval of those associated with the trauma, especially perpetrators (who may still have connections with, or even live with, the subject)—possibility of re-victimization for disclosing

Cultural

- Cross-cultural distrust (sometimes compounded by language barriers)
- Communication barriers encountered because of language differences
- Communication barriers posed by use of interpreters
- Colloquial language that differs from region to region
- Different cultural norms around talking with people outside the family or disclosure of traumatic material
- The male ethos of appearing strong, not vulnerable or helpless (certainly not victimized)
- Lack of trust of authority, including attorneys and mental health experts
- Cultural variability in the expression of mental health symptoms
- Cultural differences in the language for mental health symptoms
- Cultural stigma about mental health issues

Institutional

- History of institutional abuse/trauma
- Fears about confidentiality and possible victimization
- Fear about immigration status
- Re-traumatization around process of visitation and interviews
- Presence of jailor or guards
- Fear that custody staff or other inmates will know that the client is meeting with expert witnesses or mitigation specialists
- Subject's fear that his victimization experiences will become public record, *i.e.*, discussed at trial or in a published legal opinion

Legal

- Insensitivity, pushiness, arrogance or sense of entitlement (to the subject's information) conveyed by the interviewer
- Use of a checklist (rather than open-ended questions) to obtain information
- Use of labels to obtain information (*e.g.*, "were you physically abused?" "Sexually abused?")
- Failure to use open-ended questions, instead asking questions that require a "yes" or "no" answer (*e.g.* "did you ever feel afraid of your father," versus "tell me about a time when you were afraid of what your father might do")
- Lack of understanding about trauma on part of interviewer
- Failure of the interviewer to establish a rapport with the subject
- Insufficient time to obtain information (*e.g.*, expectation that the information will be readily disclosed in a short period of time)
- Failure of interviewer to establish a framework for the process and answer questions/doubts about how personal/traumatic history or family dynamics are relevant to the legal case – either (1) "How can that information help?" or (2) "Why should I spill my guts to someone I don't even know?"

- Failure of the interviewer to convey to the subject that he will not be judged and that the information will be viewed with compassion
- Obvious reactions of the interviewer to the information received, broadcasting or suggesting surprise, disbelief, horror, pity, or disapproval

INTERVIEWING FOR TRAUMATIC EXPERIENCES

Investigation of traumatic events and other highly sensitive life experiences requires highly specialized knowledge and skills. By virtue of the mandate to investigate and present the “diverse frailties of humankind,” life history investigation in capital cases can often lead the capital defense team into areas that are potentially experienced as invasive and intrusive. It requires skilled interviewing of clients, family members, and others on a variety of subjects that are highly sensitive, may be cognitively or emotionally difficult to recall, and the telling or retelling of which may be accompanied by overwhelming affect. These issues are intensified greatly when the task at hand is to interview witnesses about their own and others’ painful or deeply buried histories of exposure to traumatic events. In many cases, the witness being interviewed (*e.g.*, siblings and other family members) may have been a victim or witness to the same or similar traumatic events or be implicated in the client’s trauma (as often happens in cases of multi-generational and systemic child abuse).

Rapport between interviewer and subject is a necessary, though by no means a sufficient, condition for disclosure to occur. Interviewers must be highly knowledgeable in their understanding of trauma dynamics in order to recognize the psychological meaning of the complex dynamics involved in interpersonal—often familial—violence. Given the nature of traumatic experience and barriers to disclosure, there is a need for multiple, repeated interviews over time. Interviewers must be conscious of the possibility of re-traumatization during interviewing. They must have skills to avoid or minimize this possibility and knowledge of how to respond to witnesses who are flooded and overwhelmed during interviews. Interviewers must be aware that clients often disclose traumatic material in small increments, and be able to judge the client’s limits and allow him to discuss at a pace that is psychologically tolerable. They must have the skill and patience to pace themselves, to gauge the pace at which disclosure can occur, and to remain focused on the central goals of trauma interviews: (1) to maintain trust, rapport and cooperation with those being interviewed; (2) to effectively obtain information; and (3) to avoid or minimize re-traumatization.

Most clients represented by capital litigators are male, and special issues may arise with respect to interviewing men about psychological trauma. By virtue of differences in gender role socialization, women may be more likely than men to acknowledge vulnerability associated with traumatic events. Men, on the other hand, may be far less likely to acknowledge or articulate feelings of vulnerability (such as intense fear, helplessness or horror), especially to strangers or in hostile environments. Their reluctance to disclose weaknesses, real or perceived, may be a

deeply engrained aspect of social conditioning.¹⁵⁸ In seeking to elicit highly sensitive historical information, effective interviewers (whether attorneys, mitigation specialists, or mental health professionals) must be keenly aware of obstacles to disclosure generally, and must also be cognizant of the particular concerns or barriers to disclosure facing individual clients.

In addition, trauma-focused and other mitigation interviews with capitolly charged defendants—most of them men—takes place, by definition, in jails and prisons. The price of acknowledging vulnerability in such settings—apart from issues of gender role socialization—may be perceived to be, and may actually be, enormous. Disincentives to disclosing fear or weakness may be powerful. Clients may be intimidated by signs of institutional power; they may struggle to avoid issues which have humiliated them in the past; their avoidance symptoms may be exacerbated by the conditions of confinement. Those who have suffered abuse in institutional settings may be re-traumatized by specific triggers around interviews (*e.g.*, body cavity searches prior to visits with defense team members or mental health evaluators). These considerations have important implications for mitigation investigations, and illustrate the critical importance of the need for highly skilled interviewers, the importance of establishing trust and rapport, and of the need for multiple interviews over time.

THE GREAT IRONY OF TRAUMA INVESTIGATION

The experience of seasoned capital defense practitioners has consistently shown that people who are capitolly charged and convicted are most often young, male, people of color, and people exposed to poverty. The trauma literature demonstrates that men, young people, minorities, and people of lower socioeconomic status are among those at highest risk for exposure to traumatic experiences. People who are at risk for cumulative traumatic exposure include people traumatized as children and people who are disenfranchised by virtue of race and class. People who are at risk for developing PTSD, a severe and disabling condition, include those with prior psychiatric histories, with childhood maltreatment histories, and with family histories of psychiatric difficulties. People who are at risk for developing complex PTSD are those who have had multiple interpersonal victimization experiences, including extensive histories of childhood victimization. Taken together, the above characterizes the large majority of those who are capitolly charged and convicted.

Experienced capital defense teams understand the great irony of trauma investigation: common symptoms of severe trauma are themselves barriers to disclosure of

¹⁵⁸ As a practical matter, when interviewing men, it may make less sense to ask how they “felt” in response to a horrific event than to ask what they were thinking (*e.g.* in my clinical experience, men who will not say “I was terrified,” will say “I thought I was going to be killed,” or “I thought my friend was going to die,” thus describing fear or horror in cognitive terms) or asking them what was going on with them physically (again, men who might not describe the emotion of fear, helplessness or horror might say “my heart was racing,” “my palms were sweating,” “my hands were clenched,” “I felt a knot in my gut,” “I felt like I was going to throw up”, etc.)

traumatic events and their aftermath. Mitigation investigation related to psychological trauma must therefore be informed by the trauma literature, including an understanding of the factors that increase risk, knowledge of trauma and its effects, and an understanding of the dynamics of interpersonal violence. This base of knowledge informs investigation and interviewing strategies with clients and family members, and provides a framework for presenting the psychological significance of this information to fact finders. It also informs work with clients and their families.

CHAPTER 4:

THE BRAIN AND ITS RELATIONSHIP TO BEHAVIOR

Including:

- Biology of the brain;
- Overview of brain structure;
- Some key neurochemicals;
- Some key regions of the brain; and
- Sources of brain damage relevant to social history investigation.

The adult human brain, of course, results from an extended developmental process that begins during the third week of gestation, just after conception. The precursor cells that initiate the developmental process that leads to the adult brain are present just after conception, which helps explain why some disorders and diseases, such as fetal alcohol spectrum disorders, begin *in utero*.

The vulnerability of the developing brain has been eloquently summarized by two leading authorities on neurotoxicity:

The developing brain is inherently much more susceptible to injury caused by toxic agents than is the brain of an adult. This susceptibility stems from the fact that during the nine months of prenatal life, the human brain must develop from a strip of cells along the dorsal ectoderm of the fetus into a complex organ consisting of billions of precisely located, highly interconnected, and specialized cells. Optimum brain development requires that neurons move along precise pathways from their points of origin to their assigned locations, that they establish connections with other cells, both nearby and distant, and that they learn to communicate with other cells via such connections. All these processes have to take place within a tightly controlled time frame, in which each developmental stage has to be reached on schedule and in the correct sequence.

Because of the extraordinary complexity of human brain development, windows of unique susceptibility to toxic interference arise that have no counterpart in the mature brain, or in any other organ. If a developmental process in the brain is halted or inhibited, there is little potential for later repair, and the consequences can therefore be permanent...

The human brain continues to develop post-natally, and the period of heightened vulnerability therefore extends over many months, through infancy and into early childhood. Although most neurons have been formed by the

time of birth, growth of glial cells and myelination of axons continues for several years.¹⁵⁹

BIOLOGY OF THE BRAIN

Brain cells, known as neurons, begin to coalesce and develop into the central nervous system at approximately the end of the first month of gestation; this process of coalescing and developing of neurons into the central nervous system lasts until the sixth month of pregnancy. Each neuron has an axon that transmits information to other neurons and a dendritic tree which integrates information coming into the neuron from thousands of other neurons. Each dendritic tree can have several thousand branches, each connecting to other neurons, muscles or glands at a synapse. A synapse is the junction between one neuron and the next, and also between a neuron and muscle. These three components form the primary structural building blocks of the brain.

Information is transferred across the synaptic gap by means of neurotransmitters, which are chemical agents that pass across the synaptic gap between neurons. Axons are covered by a fatty tissue sheathing, known as myelin, which facilitates passage of electrical signals. The linkages between neurons change over time by a constantly occurring, natural process of reorganization, with some connections being culled and new ones being built. Similarly, neurotoxic exposure or any of a number of injuries or insults to the brain can cause permanent damage to the connections within the brain's structures. Thus, injury or damage to any of these component parts of the brain might result in behavioral abnormality.

The central nervous system comprises the spinal cord and brain; the peripheral nervous system comprises the nerves that run throughout the rest of the body, carrying information back and forth from the body to the brain. Most of the attention here is on the central nervous system except for instances where symptoms are most easily seen in the peripheral nerves.

A way of viewing the brain-behavior relationship is that the normally functioning brain creates an action (e.g., speaking, moving, acting, thinking), interprets the response in the environment to that action, and then adjusts or acts again as that sensory information comes back into the brain. In the scientific literature, sensory input caused by our own actions is termed refference; sensory input caused by the external environment is termed exafference. As refference or exafference comes back to the brain through the senses, the person adapts to that new information and adjusts. For instance, if you feel hungry, a sensation triggered by the central nervous system, you might go to your refrigerator and open the door. Depending on what you see, you might eat something. If you open the refrigerator and it is empty, you might look somewhere else for food. This is a sensory-environment feedback loop.

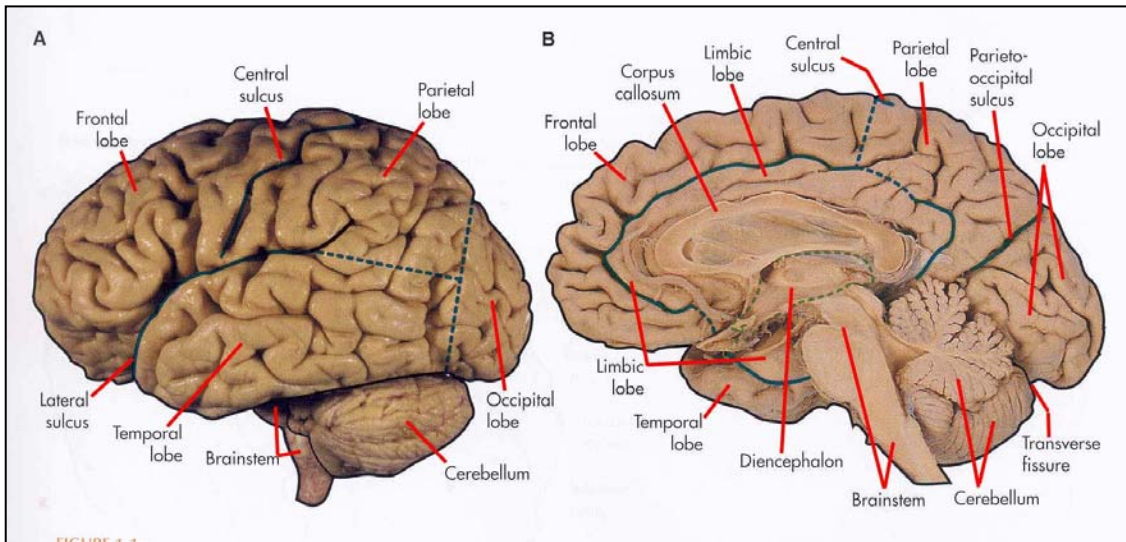
¹⁵⁹ Grandjean, P., & Landrigan, P., *Developmental Neurotoxicity of Industrial Chemicals*, LANCET, November 8, 2006, at 1-2 (citations omitted).

As common as this process is, happening for even the most minute of actions, it is also extremely complex. Every behavior involves this complex neurochemical and neuroelectrical process that draws on many parts of the brain. It is less the size of the brain (an average adult brain weighs 1,400 grams) than the complexity of the connections among the various parts of the brain that allows the normal human to function and behave. Although too complicated to address here, an overview of how the brain performs, especially this conception of a never-ending interaction between the organism and its environment, is the scientific basis for nearly all mitigation evidence and social history investigation in one way or another.

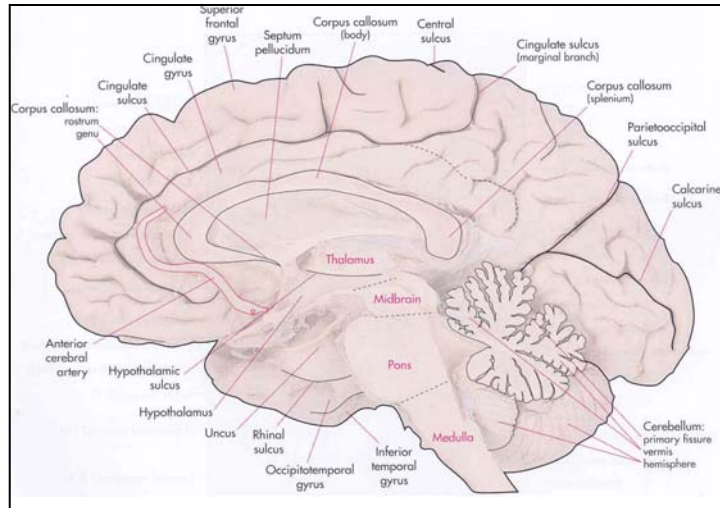
The reason to have some insight into the complexity of this process is that at every point, a minor defect or impairment can result in dramatic behavioral maladaptation. Physical, chemical, or electrical impairments in the brain can so dramatically alter this process as to lead to seriously disordered behavior.

Although different areas of the brain are said to control various functions, it is still important to remember throughout this discussion that the brain works as an integrated system: the various pieces of the brain reach out to and connect with the entire organism and other parts of the brain, processing information both coming in and going out through an intensely complex array of interactions within the brain.

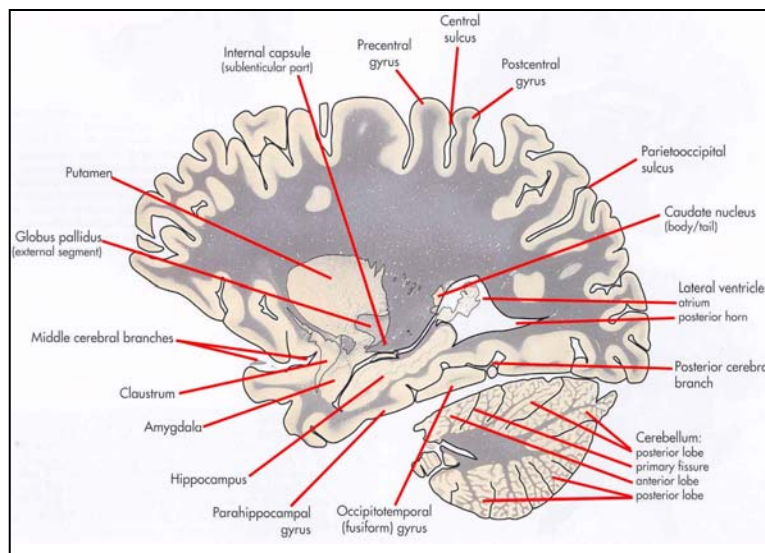
Below are some overview images showing the various sections of the brain.



Lateral and medial view of brain. Reprinted with permission from NOLTE & ANGEVINE, THE HUMAN BRAIN IN PHOTOGRAPHS AND DIAGRAMS (2nd ed., St. Louis, Mosby, 2000),1 ©



Medial view of sagittally hemisected brain. Reprinted with permission from NOLTE & ANGEVINE, THE HUMAN BRAIN IN PHOTOGRAPHS AND DIAGRAMS (2nd ed., St. Louis, Mosby, 2000), 8 ©



View passing longitudinally through the hippocampus. Reprinted with permission from NOLTE & ANGEVINE, THE HUMAN BRAIN IN PHOTOGRAPHS AND DIAGRAMS (2nd ed., St. Louis, Mosby, 2000), 94 ©

OVERVIEW OF BRAIN STRUCTURE

The medial views of the brain (above) show many primary parts of the brain. The hindbrain consists of the brain stem, cerebellum and the pons. These are the oldest (in an evolutionary sense) parts of the brain, and link the rest of the nervous system to the brain. They play important roles in the most primitive functions of the brain (e.g., blood pressure, respiration, heart beat, posture mediation, motor reflexes, coordination and modifying output from other parts of the brain), control alertness, and have some role in sensory processing and perception.

Just above the hindbrain are a series of structures that play critical roles in memory, sensory perception, motor function, arousal, attention, autonomic functions, emotional expression and seem to play the central role in integrating the flow of information within the brain (thalamus and hypothalamus). Also in this area are the basal ganglia, which are the base of the cerebrum, the most evolved and largest part of the brain. Memory, learning, cognitive flexibility, emotional state and mood disorders occur when there is damage in this region. These behavioral changes can also result from disruptions to the control and flow of information. The basal ganglia affect complex motor functions and reach from the cerebrum to the frontal lobes. The corpus callosum (above the basal ganglia) connects the left and right hemispheres of the brain and is crucial to the communication between the hemispheres.

The cerebral cortex is the outer layer of the brain and appears to be involved in mediating most complex behaviors.

The frontal lobes compose about a third of total brain area in humans. Just behind the frontal lobes is the motor cortex, which controls complex motor activity and reflexes. Just behind the motor cortex is the parietal lobe, which includes the somatosensory cortex. The back of the brain holds occipital lobes.

Occipital lobes: The occipital lobes are involved in visual perception, recognition of emotional state, inability to recognize objects, inability to recognize faces or emotional content of faces.

Parietal lobes: The parietal lobes are responsible for processing touch and the integration of visual, tactile and auditory input. These lobes also relate to drawing, writing and constructional tasks.

Temporal lobes: The temporal lobes contain the primary auditory functions, but also play a critical role in language formulation and comprehension.

Frontal Lobes: The frontal lobes control executive functions: inhibition of movement and behavior, judgment, planning, assessing options and consequences, intentionality, complex decision making. Executive functions are sometimes defined as real-world

adaptability. They are the newest evolutionary part of the brain and have the greatest number of connections to other parts of the brain. The frontal lobes are also involved in motor functions, language processing, and mental flexibility (initiating, stopping and adjusting behavior). The frontal lobes are the part of the brain that most distinguishes humans from other mammals.

Limbic System: The major structures of the limbic system are the hippocampus, the amygdala and the uncus. In brief, the limbic system has everything to do with emotional responses to sensory stimuli, links perception and memory, encodes visual and auditory sensations into the memory, encodes emotional tags onto memories, retrieves memories, and originates protective drive states (fear, fight or flight, autonomic responses to perceived danger).

All of these parts of the brain rely on neurochemical and neuroelectric mechanisms to communicate and interact. This makes the neurochemicals of the brain crucial to the normal functioning of the organism. When a signal is sent from one part of the brain or body to another, it is transmitted by electrical activity through nerves or neurons, but where the message needs to be continued on to the next nerve, muscle or neuron, the signal is converted to a chemical (in the brain, a neurotransmitter) and passed on (across the synaptic gap), where it is re-converted to an electrical signal by the next neuron. For even the most minor or common action, this process occurs.

As mentioned above, disruptions in chemical or electrical systems in the central nervous system, including overabundance, or undersupply, of neurochemicals, can result in seriously disordered behavior. Thus, an overview of the chemical systems and the primary pathways these neurochemicals move through is critical to our understanding of how the brain functions.

SOME KEY NEUROCHEMICALS

Some key neurochemicals that are recognized to affect behavior directly are:

Serotonin (5-HT): This is ubiquitous in the brain, although receptors are more densely distributed in basal ganglia, amygdala and hippocampus. Accumulation of serotonin may be involved in impulse control disorders. It also appears involved in psychotic disorders and depression.

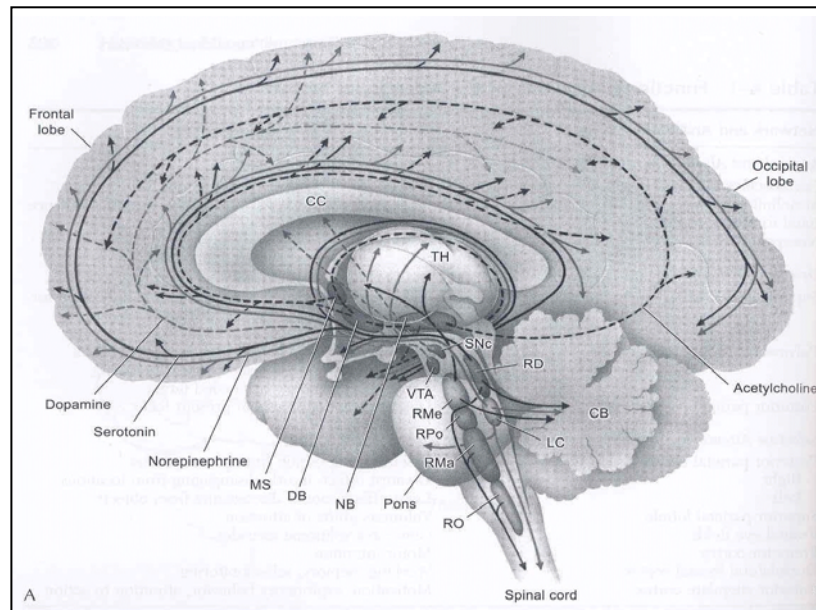
Dopamine: Dopamine is especially prominent in the limbic system and basal ganglia (e.g., death of dopamine neurons in the basal ganglia appears to cause Parkinson's disease). It has a role in

regulating neuroendocrine secretions, regulation of locomotor activity, emotion and affect. Dopamine receptors are the primary target for many antipsychotic medications known as neuroleptics. Note that the primary dopamine pathway runs through the frontal lobes.

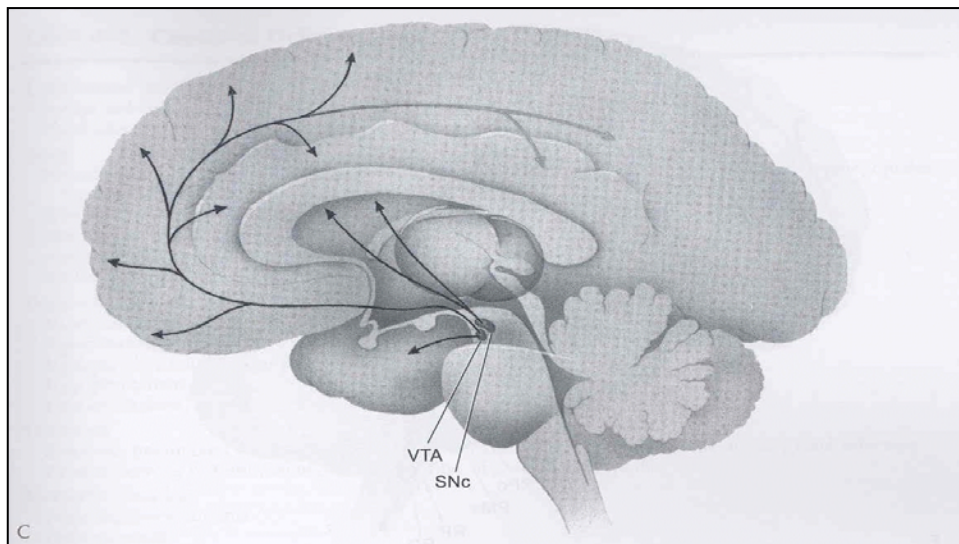
Glutamate: Especially prominent in the frontal lobes. Glutamate is regarded as an excitatory neurotransmitter. When dopamine is reduced, glutamate pathways become hyperactive.

Acetylcholine: This is especially prominent in the limbic system (especially the hypothalamus) and reaches into the frontal lobes. Cholinesterase inhibitors administered directly to the brain cause otherwise docile animals to exhibit aggressive and predatory behavior.

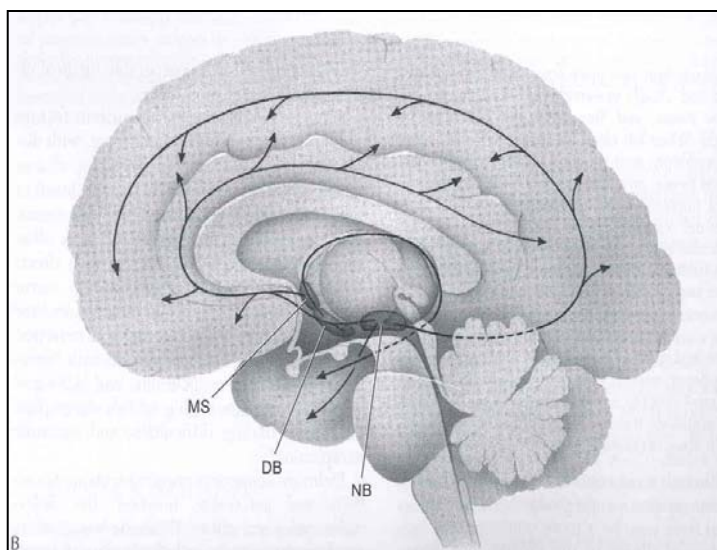
GABA: Also ubiquitous in the brain and central nervous system, GABA (*gamma aminobutyric acid*) is especially prominent in the frontal lobes. GABA is generally an inhibitory neurotransmitter, but it also plays a role in stimulating brain maturation.



Neurochemical pathways in the brain. Reprinted with permission from DEVINSKY & D'ESPOSITO, NEUROLOGY OF COGNITIVE AND BEHAVIORAL DISORDERS (Oxford University Press, 2004), 106 ©



Dopamine pathway. Reprinted with permission from DEVINSKY & D'ESPOSITO, NEUROLOGY OF COGNITIVE AND BEHAVIORAL DISORDERS (Oxford University Press, 2004), 107 ©



Acetylcholine system. Reprinted with permission from DEVINSKY & D'ESPOSITO, NEUROLOGY OF COGNITIVE AND BEHAVIORAL DISORDERS (Oxford University Press, 2004), 106 ©

SOME KEY REGIONS OF THE BRAIN

The Frontal Lobes

Elkhonon Goldberg, a well-known neurologist has written: “The frontal lobes are to the brain what a conductor is to an orchestra, a general to an army, the chief executive officer to a corporation. They coordinate and lead other neural structures in concerted action. The frontal lobes are the brain’s command post.”¹⁶⁰ This is why so much attention in capital cases focuses on the functioning of the frontal lobes. The frontal lobes perform the tasks with which the law is most concerned.

The neural developmental process in humans leaves the frontal lobes till last. Thus, myelination (the process by which the connective structures of the neurons are coated with myelin to allow for proper electrical conduction) does not complete in the frontal lobes until early adulthood (around age eighteen to the early twenties). Until completed, the frontal lobes do not work efficiently or properly (hence, the erratic and disinhibited behavior of teenagers).

The frontal lobes appear highly involved when a person is given a novel stimulus, but when that stimulus is repeated (e.g., when a person is familiar with a task), the frontal lobes no longer activate.

Current research has identified seven frontal-cortical circuits. These circuits are basically information/stimuli loops within the frontal lobes that take in information from all regions of the brain, evaluate it, and send output signals back. The circuits are the mechanism by which the frontal lobes regulate behavior. Dysfunction in one of these loops causes very specific behavioral deficits, although your task is really to document frontal lobe damage rather than specific damage to a loop. Nevertheless, the importance of the seven loops helps to explain why people with frontal lobe damage do not all exhibit exactly the same behaviors. Variations in behavior will occur depending on which loops or portions of the brain the loop incorporates have suffered damage or are no longer functioning properly.¹⁶¹

Similarly, some psychiatric illnesses appear to be circuit related as well (for instance, mania and psychosis).

In terms of behavior, it is clear that frontal lobe dysfunction is related to attention and working memory, difficulty shifting attention from one stimulus to another, reduction of memory span, deficits in the ability to self-monitor, diminished planning and problem solving ability, inflexibility in thinking, inhibition of behaviors, and visuospatial impairments.

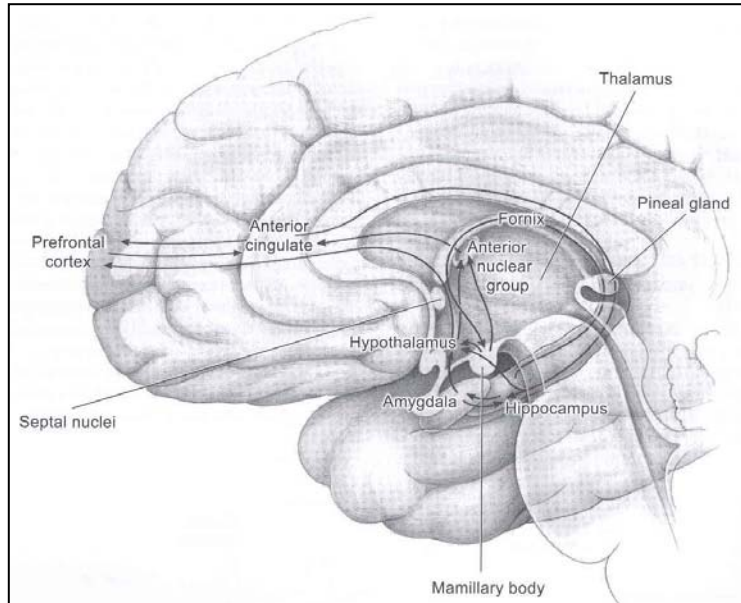
¹⁶⁰ Goldberg, E., *THE EXECUTIVE BRAIN: FRONTAL LOBES AND THE CIVILIZED MIND* (OUP 2001), at 2.

¹⁶¹ Lichter, D.G., & Cummings, J.L., *FRONTAL-SUBCORTICAL CIRCUITS IN PSYCHIATRIC AND NEUROLOGICAL DISORDERS* (The Guildford Press 2001).

The Limbic System

The components of the brain that make up the limbic system are, in an evolutionary sense, some of the oldest in the brain. The limbic system helps to regulate emotion, memory, motivation, instinctual behaviors and social relations, and therefore, disorders or damage which make this system unbalanced can have dramatic behavioral manifestations. The limbic system is also physically and chemically “wired” to the frontal lobes.

The hippocampus and amygdala are particularly important in the coding and retrieval of memories, including emotional memories. That means that this region of the brain is especially affected by exposure to traumatic events. Brain imaging of people with PTSD suggests that they have decreased hippocampal volume (smaller brain mass) and excessive amygdala activation. This likely explains the persistent fight-or-flight responses and the host of other behavioral changes seen in people with PTSD.



Principal structures of the limbic system. Reprinted with permission from DEVINSKY & D'ESPOSITO, *NEUROLOGY OF COGNITIVE AND BEHAVIORAL DISORDERS* (Oxford University Press, 2004), 334 ©

The hippocampus is one of the locations where perception and memory interact. The hippocampus is involved in memory storage and temporal dating of the memory.

Verbal memory, visual memory, auditory memory, recognition, and recall all appear to rely on a properly functioning hippocampus. With chronic depression and chronic stress, there is neuronal atrophy in the hippocampus, with disorders of focus, concentration, and memory.

The amygdala is involved in object recognition and sense of smell, and it provides an emotional tag to the memory that is stored. It is also directly involved in many core survival mechanisms. Perhaps more importantly for trauma and behavior though, the amygdala is critical for fear conditioning, such that threatening stimuli are coded in the amygdala and re-exposure to them prompts heightened response. The amygdala also plays a critical role in determining the emotional content of visual information and interacts with the frontal lobes in responding to that stimulus.

SOURCES OF BRAIN DAMAGE RELEVANT TO SOCIAL HISTORY INVESTIGATION

Finally, there are four typical sources of brain damage to consider in the social history investigation:

1. *Genetic predispositions:* We are learning more about how to recognize diseases which have genetic components to them, and some central nervous system illnesses are now well-recognized to have genetic components (e.g., schizophrenia, mood disorders, alcoholism). These must be proven by multi-generational family history and record gathering which can be used to demonstrate the patterns of illness across the generations.
2. *In utero injury:* Innumerable injuries or illnesses can occur during gestation, some of which cause developmental changes, others of which cause malformation of the central nervous system. For clients with little or no prenatal care, records that document such problems may be limited, but certain types of exposure to toxins (e.g., alcohol, pesticides, metals) can be proven by careful interviewing and record gathering.
3. *Physical injury:* Both intentional and unintentional injuries are quite common. Again, medical record availability will depend on access to health care, but interviewing will certainly assist in obtaining corroborative information on physical injuries.
4. *Toxicological injury:* This includes intentional and unintentional exposure to chemicals or agents that alter central nervous system function (e.g., lead, alcohol). Exposures may be community-wide or individual.

CHAPTER 5:

BROKEN BRAINS AND NEUROLOGICAL DISORDERS

Including:

- Fetal Alcohol Spectrum Disorders;
- Pesticide exposure;
- Metal exposure;
- Learning disabilities/language deficits;
- Traumatic Brain Injury;
- Temporal Lobe Epilepsy;
- Degenerative Basal Ganglia Disorders; and
- Autism Spectrum Disorders.

FETAL ALCOHOL SPECTRUM DISORDERS (FASD)

Maternal alcohol consumption during pregnancy has important negative consequences for fetal development. Research suggests that there is no safe level of consumption, although as with most toxins, increased dose leads to increased neurological deficits. The range of permanent effects constitutes the Fetal Alcohol Spectrum Disorders (FASD) including Fetal Alcohol Syndrome (FAS), Alcohol-Related Neurodevelopmental Disorder (ARND), and Fetal Alcohol Effect (FAE). FAS results from intrauterine exposure to alcohol (which is exposure to alcohol in the uterus), and has well-recognized central nervous system, physiological, cognitive and behavioral symptoms. FAE is a related syndrome. Originally thought to be less severe than FAS, it is now thought to be different only in the expression of the facial stigmata of FAS. FAS can result from maternal drinking of approximately two drinks per day while pregnant, although no intake of alcohol during pregnancy is considered to be without consequences for the developing fetal brain. FAS is also associated with failure to thrive in infancy and family history will assist in identifying patterns in the family which support a hypothesis of intrauterine alcohol exposure.

FAS is a leading cause of mental retardation and cognitive impairment. Approximately half of FAS children are mentally retarded, but nearly all have serious cognitive, attention and behavioral problems. Autopsy findings have indicated significantly reduced brain size in FAS, as documented in newborns as well as older children and adults. FAS children have extreme difficulty with:

1. Abstract reasoning and judgment
2. Executive functions (ability to coordinate, plan and carry-out appropriate responses)

3. Perceiving social cues
4. Processing speeds and diminished attention
5. Learning
6. Inhibition of impulses

Although first observed in childhood, these functional deficits persist throughout life and appear to worsen over time when untreated or undiagnosed.

FAS also has three areas that serve as physical markers: (1) intrauterine and/or postnatal growth retardation; (2) central nervous system impairment; and (3) a pattern of facial characteristics that includes short palpebral fissures (eye slits), elongated midface, flattened philtrum, thin upper lip, flattened maxilla, epicanthal folds, and minor ear anomalies. Some of these features may occur in normal people, but it is the pattern that defines FAS. Some of the facial patterns do not persist beyond adolescence, changed by pubescent growth. Other physical symptoms that are common (but not always present) in FAS include heart defects, minor hand anomalies, malformed or misaligned teeth, myopia and hearing loss.

People with FAE will likely not have the facial pattern associated with FAS, but may have equally serious behavioral and cognitive symptoms. FAE is likely caused by intrauterine exposure to alcohol in smaller dosages than in FAS or possibly varying amounts of alcohol at specific gestational periods during pregnancy.

Factual development of FASD requires assessment of the physiological, cognitive and behavioral patterns that are markers of intrauterine exposure to alcohol both at the time of trial and, more usefully, in social and family history records. It is particularly important to note in the records patterns of family substance use as well as alcohol related deaths. Similarly, records may contain crucial information on developmental milestones, physiological symptoms noted in childhood and early photographs that will show facial patterns of abnormalities that have disappeared in adulthood. Because photographic evidence is relatively rare in pediatric records, it is crucial to find family albums, preschool and church pictures, and other nonstandard sources of documentary evidence. In addition to records, it is important to find percipient witnesses to discuss the client's mother's alcohol intake during pregnancy. Many witnesses may be reluctant to discuss these facts, but you must get them. Although the client's siblings may be helpful, better witnesses on this issue are the people who went out drinking with the client's mother or caretakers who were present when she came home from drinking.

Physical and sexual abuse are also strongly associated with FASD—meaning that those with FASD report exceptionally high rates of being abused. This may make the investigation more difficult because of the need to gather evidence of abuse, often

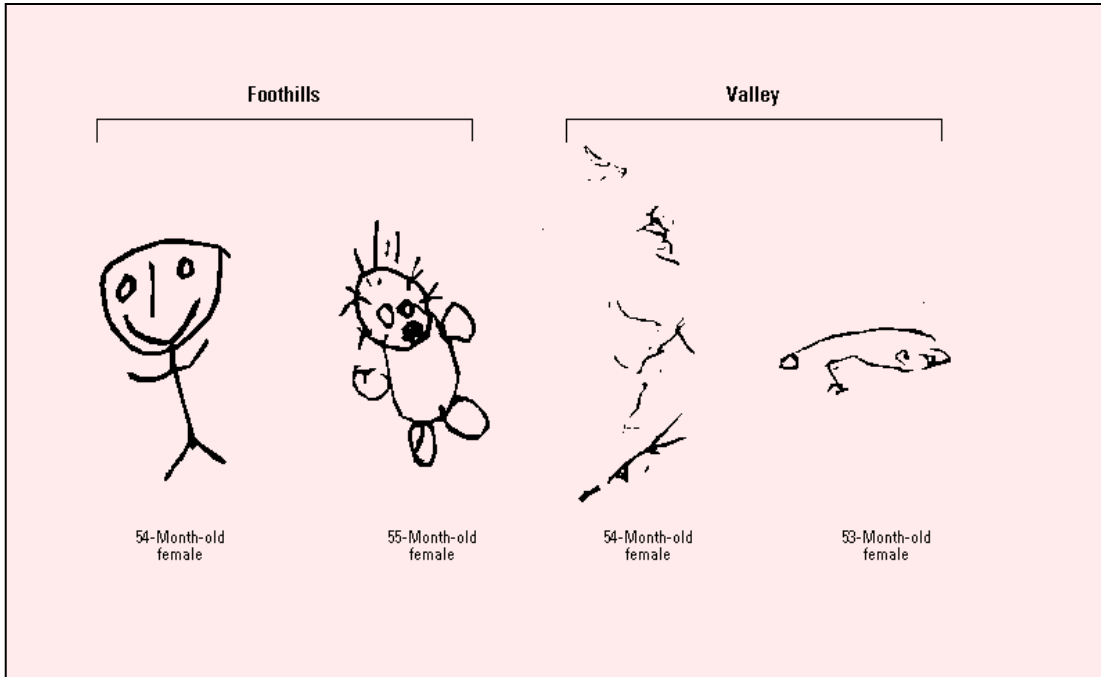
committed by the same witnesses (*e.g.*, caregivers who become frustrated with your client's disabilities).

MRI imaging and autopsy findings seem to indicate that intrauterine exposure to alcohol damages the corpus callosum, basal ganglia, hippocampus, and cerebellum, although imaging research on FASD is relatively new. Neuropsychological testing has demonstrated cognitive impairments as well as consistently reduced frontal lobe function greater than that explained by reduced IQ.

FASD will ultimately be an explanatory model that can help the jury understand the client. Defense teams must be prepared to deal with the common response that: "well, my mother drank while pregnant with me..." The answer to this will have to be developed during the social history investigation as to how FASD related to other deficits that the client experienced and other problems the client's mother may have had that enhanced the impairment the client suffered. Nevertheless, FASD is a causal explanation that shows that the origins of the client's impaired functioning rests in the family and social dynamics in which he was conceived and raised and over which he had no control.

PESTICIDE EXPOSURE

The widespread use of pesticides in urban and rural areas has made exposure to these neurotoxins an issue in many cases. A pesticide is a poisonous compound whose purpose is to control or destroy any pest. In general, pesticides kill insects by attacking the central and/or peripheral nervous systems. There are three primary classes of insecticides in use throughout the world: organochlorines, organophosphates and carbamates. Almost every pesticide affects the central and/or the peripheral nervous system directly or indirectly. Pesticides work by interrupting or destroying the interactive processes of the nervous system, including functioning of the neurochemical and neuroelectric systems of the brain. The mechanisms by which pesticides disrupt normal functioning are slightly different for each class of pesticide and as a result exposure to each class has slightly different short- and long-term consequences and symptoms.



Drawing of age-matched children, comparing pesticide exposed children (on right) to non-exposed children (on left), controlling for socio-demographic factors. Drawings on left by less exposed children; drawings on right from highly exposed children. Reprinted with the permission of EHP: E. A. Guillette, M. M. Meza, M. G. Aquilar, A. D. Soto, & E. Garcia, 106(6) Environmental Health Perspectives 347 (1998).

At sufficiently high dose levels, pesticide-induced effects may result in transient changes or permanent neuronal dysfunction. Environmental exposures, like exposure to pesticides, are part of the explanation and etiology of neurological impairment, dysfunction and behavior changes. Pesticide exposure alters the way in which the client's brain works and may lead to otherwise inexplicable behaviors. Pesticide exposure evidence also fills out the social history picture of the client's life to differentiate him as an individual, and to provide necessary information to any mental health experts.

In young children, from *in utero* to adolescence, the human body is less able to process pesticides compared to adults experiencing the same exposure. The absorption in children is more than 70 percent compared to absorption in adults of 30 percent of the chemical agent. In addition, because the central nervous system is not fully developed until after adolescence, exposures prior to and during adolescence alter the development and functioning of the brain to a greater degree. The enhanced susceptibility of the young human brain to damage from these chemicals has been well-recognized by toxicologists for decades.

Symptoms that result from exposure depend upon a number of factors:

1. Type of exposure (which specific toxic agent)
2. Quantity of exposure (duration of exposure)

3. Quality of exposure (how much was ingested, absorbed, or inhaled)
4. Individual susceptibility (physiological, genetic and psychiatric vulnerability and predispositions)

Investigating pesticide exposure issues requires detailed information on each type of compound a client was exposed to, how often the exposure occurred, the context of the exposure (in a field picking crops or playing in a hazardous waste site), and the observed symptoms they experienced. Clients and their families are rarely able to identify the specific compounds to which they were exposed. Much of this information will, by necessity, come from percipient witnesses, for instance, farm owners who purchased and arranged for spraying of fields in which the client worked. However, in addition to the social and family history records and interviews, it is important to search for local, county, state and federal regulatory agency records (e.g., EPA, HUD, Fire Departments, departments of pesticide regulation), local newspapers, civil suits against local industries, local medical clinics and medical professionals, and local agriculture extension departments of local universities.

Overall, symptom patterns to investigate include:

Physiological	Cognitive	Behavioral
Eye twitching; Eyelid twitching; Pinpoint pupils (constriction); Skin rashes; Nausea; Vomiting; Diarrhea; Abdominal pain; Weakness in extremities or generalized; Eye irritation and redness; Headaches; Dizziness; Sweating; Salivation; Chest tightness; Blurred vision; Pressure in the head; Muscle twitches or tremors; Aching in joints; Unconsciousness.	Reduced vigilance; Attention deficits; Psychomotor retardation; Impaired memory function; Reduced comprehension; Depression; Confusion; Speech difficulty (slurring); Difficulty formulating thoughts; Intelligence decline; Excessive dreaming; Developmental delays; Developmental retardation; Cognitive deficits; Brain function decrease.	Depression; Mental confusion; Slowing of performance; Impairment of judgment; Schizophrenic-like reactions; Irritability; Temper outbursts; Aggressive behavior not previously observed; Belligerence not previously observed; Psychosis; Hyper-excitability; Emotional lability; Anxiety; Paranoia; Increased excitability and agitation; Extreme/disproportionate response to stimuli.

Pesticides, like almost all neurotoxic agents, cause both short-term (acute) and long-term (chronic) central nervous system damage. Acute exposure refers to a poisoning event where the individual suffers immediate symptoms. Chronic exposure generally refers to a sub-symptomatic exposure that repeats or extends over time. It is possible that a person can be repetitively acutely exposed as well. Acute exposure may place the brain in a state of “uncontrollable” over-stimulation or over-excitation. This may cause short-term physiological and behavioral changes, as well as permanent brain dysfunction.

A number of additional issues arise when investigating exposure to pesticides. First, most of the research that has been done to date has examined single exposures to a single pesticide, rather than the typical real-world exposure to numerous types and kinds of pesticides at once. Many of these compounds interact with one another in the human body and cause a toxicity as much as a thousand times as great as either compound alone. For instance, while malathion is considered comparatively safe, when exposed to malathion and parathion at the same time, the effect of the malathion is enhanced nearly 400 times because parathion inhibits the enzymes that break down malathion in the human body.

Second, the severity of symptom patterns (including brain dysfunction) may also be potentiated by other injuries or impairments to the brain. For instance, physical child abuse that results in brain trauma appears to potentiate the effect of neurotoxic agents like pesticides. In effect, more than simply being an additional injury on a list, pesticides potentiate the existing damage, resulting in a significantly more impaired functioning.

Third, kindling effects refer to a sort of priming that occurs when a person is exposed to pesticides for a period of time, then removed from the exposure and subsequently re-exposed. Because pesticides cause chemical and electrical changes in the brain, it appears that upon re-exposure, the brain quickly returns to its familiar response, which may be more severe than the current exposure level would suggest. This is a kindling effect.

Finally, after sufficient factual development, it is possible to use neurological and neuropsychological tests to assess the impact of pesticide exposure. Neuropsychological batteries have been developed to specifically test for neurotoxic exposures. The World Health Organization has published a recommended battery for assessing neurotoxic exposure. These batteries utilize existing neuropsychological tests, but the examiner should have specialized training to interpret the tests for neurotoxicity. Similarly, the neurologic examination is not especially different for assessing neurotoxicity (although some additional types of tests may be indicated, such as nerve conductance testing), but the examiner should have experience and training to assess the results.

METAL EXPOSURE

Mercury, lead, cadmium, arsenic, selenium, manganese, and aluminum, all metals, are widely used in common products. Exposure to each of them may cause serious cognitive and behavioral problems that persist throughout life after exposure. As a result of their widespread use, people come into contact with these metals quite frequently, usually at very low doses. For some, a low level dose-exposure appears to have no measurable, lasting effect. However, for all metals at high levels of exposure, and for lead and mercury at any exposure level, significant cognitive and behavioral effects will be observed. Significant exposure to lead or mercury *in utero* or in early childhood can cause mental retardation as well.

Symptoms Associated with Metal Exposure

Acute Exposure Symptoms	Chronic Exposure Symptoms
Abdominal colic; Constipation; Vomiting; Headache; Lightheadedness; Dizziness; Forgetfulness; Anxiety; Depression; Irritability; Muscle and joint pain; Seizure; Coma; Increased intra-cranial pressure; Parathesia; Nightmares; Confusion; Emotional lability; Mood swings.	Persistent cognitive deficit; Decline in IQ score; Impaired attention; Decline in visuo-spatial functioning; Impaired memory; Reduced reaction time; Impaired executive functioning; Mood alterations.

Lead

Recent research indicates that there is no safe level of lead exposure. With even the smallest amounts, at 1 microgram per deciliter of blood, ingestion in childhood results in lifelong decreases in IQ and increases in behavior problems.

Lead has been recognized as causing neurological damage for at least 150 years, yet industry was slow to remove lead from places which exposed people to lead's dangers. Lead water pipes were used until the 1920s, lead paint was used in

household indoor paint until the 1960s, it was used in cans for food and drinks until the 1970s, and in gasoline well into the 1970s. Lead persists in the soil of many urban neighborhoods in significant amounts. Lead is still found in solder, batteries, paint, pipes, ceramic glazes, and roofing materials. Lead is still used in many folk remedies in some Asian and Latino communities. Lead exposure disproportionately affects poor and urban people.¹⁶² Although its use is now limited in many products, lead is still extensively used in industrial production.

Lead crosses the placental barrier and poses a threat to normal development *in utero*. As with other neurotoxic agents, children are more susceptible to exposure and symptoms because of a combination of behaviors and the developmental stages of the brain. Children often put things in their mouths and chew on things that adults may not (e.g., lead paint chips which have a sweet taste). Once exposed, lead is stored in skeletal bones.

Even at exceptionally low levels of exposure, lead exposure has been associated with:

- Decreased IQ and cognitive functioning
- Heightened distractibility and shortened attention span
- Impulsivity
- Inability to inhibit inappropriate responses to stimuli
- Poor vigilance
- Inability to follow simple and complex sequences of directions
- Deficits in changing response strategy

These impairments, which often begin in childhood from lead exposure, persist across the lifespan of the exposed person. Lead has a diffuse affect on the central nervous system, reducing synaptic counts, neuron density, mitochondrial membrane development, and neurotransmitter and enzyme function. As a result, low level lead exposure, even without overt symptoms, can result in cognitive, developmental, and behavioral deficits and delays.

Almost all jurisdictions (county or local) have lead abatement programs. These programs are usually an excellent source of community exposure information. Some of these programs have created zip-code based exposure risk maps that are very helpful exhibits.

Mercury

Mercury is commonly used in batteries, paint, radios, thermometers, calculators, cosmetics, jewelry, dental care (although, rarely in the United States currently), and various manufacturing processes. Mercury was also used widely in the United States

¹⁶² Brody, D.J., et al, *Blood lead levels in the US population: Phase 1 of the Third National Health and Nutrition Examination Survey (NHANES III, 1988 to 1991)* 272:4 JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION 277 (1994).

as a fungicide for many years to treat seeds (in some countries it is still in use). Exposure to mercury is also common for people whose diets are high in fish as a result of the bio-accumulation of mercury in fish which passes onto humans on ingestion. Methyl mercury, one of two types of mercury (the other being inorganic mercury), is extremely damaging to the brain because a large amount of ingested, inhaled or absorbed mercury crosses the blood-brain barrier and builds up in the brain, with approximately 10 percent of methyl mercury body burden being found in the brain. As with lead, there is really no safe level of exposure although EPA currently uses an exposure limit of 0.1 microgram per kilogram of weight per day.

Mercury appears to be the only metal that biomagnifies, meaning higher in the food chain shows higher amounts of mercury per body weight and heightened effects. Mercury is also quite mobile, carried in water, air and soil. Epidemiological evidence of the effects on humans comes from two large scale poisoning incidents (Minamata, Japan, 1953 to 1959; and Iraq, 1971).

Methyl mercury also crosses the placental barrier and children are at heightened risk for symptoms and exposure. Children who are exposed (unlike adults) show language and memory deficits. Acutely exposed adults also have certain hallmark symptoms that involve peripheral neuropathy, muscle tremoring, gait disturbance and ataxia, visual field constriction and hearing loss.

Like lead, mercury causes a variety of long-term problems:

- Decreased IQ and cognitive functioning
- Gait and balance problems
- Impulsivity and agitation
- Inability to inhibit inappropriate responses to stimuli
- Poor vigilance
- Inability to follow simple and complex sequences of directions
- Deficits in changing response strategy
- Mood swings

Childhood and *in utero* exposure effects persist across life-span. *In utero* exposure in humans has been associated with severe developmental abnormalities, including neurological abnormalities, delays in developmental milestones, sensory and behavioral maladjustment that persists. An extensive literature on human methyl mercury exposure and outcomes exists for both acute and chronic exposures.

Testing for Metals

First, it is important to develop facts from independent sources that effectively prove the quality and quantity of the exposure before considering medical testing for metals. Second, neuropsychological testing should first be performed to identify the consequences of exposure. Neuropsychological batteries have been developed to test

specifically for neurotoxic exposures. These batteries utilize existing neuropsychological tests, but the examiner should have specialized training to interpret the tests for neurotoxicity. Since the evidence sought for mitigation is both the fact of exposure and the behavioral and cognitive symptoms, it is never sufficient, and often not even useful, to use medical tests to quantify exposure. However, in some cases, when carefully considered with appropriate experts and based on overwhelmingly strong neuropsychological and corroborative factual evidence, quantifying exposure may incrementally add to a mitigation case.

For lead, it is possible to use long-bone x-ray techniques to assess quantity of lead exposure that occurred earlier in life. If the exposure is very close in time to when you test, blood-lead levels can be helpful.

For mercury and lead, a pattern of deficits has been identified that can be observed with MRI imaging. For lead, diffuse neuronal damage is expected which suggests functional as well as structural imaging. For mercury, the key areas of the brain damaged by methyl mercury appear to be the visual cortex, cerebellar vermis and hemispheres, and the postcentral cortex.

ORGANIC SOLVENTS

Industrial solvents are ubiquitous. The term “organic solvents” refers to a group of chemical compounds or mixtures that are used for extracting, dissolving or suspending non-water soluble materials. Solvents are used in many manufacturing processes, as well as in dyes, polymers, plastics, textiles, inks and pharmaceuticals. These solvents have been known since the early 1970s to be neurotoxic, meaning that they have been known since then to cause damage to the central (brain) and peripheral nervous systems.

Studies of chronic exposure in workers has demonstrated that organic solvents cause peripheral neuropathy, which are disorders of the peripheral nervous system, and mild toxic encephalopathy that persists for many months and years following the cessation of exposure. Chronic exposure has also been shown to cause neurobehavioral changes in workers, including impaired judgment, impaired concentration and impaired memory. Chronically exposed workers have been shown to experience fatigue, irritability, memory impairments, sustained alteration in mood, emotional instability, diminished impulse control, and deterioration in cognitive functioning.

These effects are caused by the pharmacological properties of solvents in the human body. Research on the behavioral sequelae of solvent exposure began in the 1950s, beginning with studies on the psychological functioning of exposed subjects. In the 1960s, this research was extended to examine in a systematic manner the behavioral consequences observed in both chronically and acutely exposed workers. Evidence from this early work has been confirmed over decades of continuing research. Additionally, research over this period has examined the effect of specific solvents in

the human body as well as potentiating effects from multiple, simultaneous exposures.

Solvents as a class have some common effects in the human body because of the mechanism of action in the body. The somatic and mental changes noted above occur as the result of degeneration of the myelinated nerve fibers and axonal swelling. In brief, solvents deteriorate the functioning of the central and peripheral nervous system by breaking down the integrity of the system at its smallest component parts. The deterioration in central nervous system function is often permanent and irreversible. Further, solvents preferentially accumulate in lipid-rich tissues, including the central nervous system, which both explains the significant effect in the central nervous system and results in accumulation in the body.

Toluene

Toluene inhalation is well documented to cause dysfunction of the central nervous system. The exposed worker will experience impaired cognitive and neuromuscular function. Chronic exposure to toluene results in permanent damage. The sequelae include ataxia, tremors, seizure activity, paranoid psychosis, hallucinations, nystagmus and impaired speech, hearing and vision. These changes can range from mild alterations to severe depending on dose. These effects were well documented by the 1960s. Toluene, found in numerous consumer products such as glue and gasoline, is one of the toxic agents that causes brain damage when people “huff” substances.

Benzene

Benzene is an extremely toxic solvent. In the early 1970s, the National Institute for Occupational Safety and Health (NIOSH) had already promulgated standards to minimize and control worker exposure to benzene. One strategy they recommended was to stop using Benzene in favor of other less toxic solvents. Another recommended strategy was that workers be given personal protective equipment, such as respirators and skin protection. Inhalation of Benzene fumes is more significant than skin contact, although both pose a serious risk. Benzene's toxicity was first noted in the medical literature in the 1920s and 1930s. These included reports of deaths from acute exposure and physiologic symptoms of chronic exposure. By the 1950s, the effects of inhalation were well-documented to include giddiness, headache, nausea, depressed respiration, ataxia and in severe cases, seizures and loss of consciousness.

Chloroform

Chloroform targets the central nervous system, having a depressive effect. Exposure results in ataxia, decreased coordination and an anesthetic effect. In fact, chloroform

has been used historically as an anesthetic for surgery. Chronic inhalation results in decreased concentration, depression, irritability, and possible psychotic episodes including hallucinations. The neurotoxicity of chloroform is well documented beginning in the 1940s.

Chorotheane (TCE)

Chorotheane exposure has permanent effects on the central and peripheral nervous system. The sequelae of such exposure include fatigue, ataxia, difficulty concentrating, memory impairments and increased irritability and anxiety. Employers are required to use mechanical and educational methods to reduce worker exposure to TCE because of its known toxicity. As with Benzene, these methods are recommended to include substituting another, less toxic solvent for TCE, and requiring engineering and personal protective equipment. Knowledge of TCE's toxicity has also been known for decades.

Acetone

Acetone is also quite toxic. The sequelae of exposure are similar to those of other solvents. Exposed workers first report lightheadedness and headache. Acetone also causes declines in neurological and neurobehavioral functioning. One unique feature of acetone is that it potentiates the effect of other solvents when inhaled and contacted together. Thus, the effect of Benzene, in the case of hand washing with Benzene and Acetone (a common industrial practice), is enhanced when contacted along with Acetone. These effects were well known by the 1970s.

Hexane

Hexane is known to result in severe peripheral neuropathy. Exposure is most commonly by inhalation. Sequelae of chronic exposure include weakness, numbness, an anesthetic effect, and motor system dysfunction. Hexane exposure can result in a permanent decrease in electrical velocity within nerves, a slowing of normal processing. Research documenting the short and long-term effects of worker exposure to Hexane was being published in the 1970s.

Xylene

Xylene exposure can result in memory impairments, decreases in reaction time, and ataxia. Research also indicates numerous physiologic effects and pronounced neurologic effects from chronic exposure. These effects may include hyper-reactivity to stimuli, loss of motor function, and behavioral alterations. Repeated, low-level

exposure can cause permanent impairments. These effects were widely recognized by the 1970s.

Currently, occupational health regulations, promulgated by both state and federal agencies, require safety equipment for workers who come in contact with solvents. The first line of safety equipment is mechanical, including proper ventilation and filtering systems. Workers must also be given personal protective equipment, including respirators to protect against inhalation and covering for skin to protect against absorption. Living near industrial plants will also expose people to solvents, usually through inhalation but also through contamination of groundwater and soil.

Testing for solvent exposure is similar to that for pesticides. A pattern of neuropsychological deficits can be observed on testing. Similarly, investigative approaches to suspected solvent exposure are similar to pesticide and metal exposure investigation.

LEARNING DISABILITIES/LANGUAGE DEFICITS

Language and learning impairments may seem minor compared to other forms of mitigation, but when present, they have an enormous impact on how the client has experienced the world, how others have perceived him and the likelihood of psychiatric and behavioral problems. Possibly more importantly, language and learning deficits are likely to be the first hint of neurological problems. During client interviews with your client, the defense team should be paying careful attention to how the client talks, the types of information he seems able to integrate into other concepts and his ability to express ideas. Many language and learning impairments will be recognizable as small or peculiar language usage, speech oddities, repetition in speech patterns, or a need to discuss the same concept repeatedly.

Language and learning impairments often begin in childhood. Language-impaired children have long been recognized to be at increased risk for psychiatric disorders. Further, significant overlap exists between observed behavior problems in childhood and language and learning deficits.

Language and learning problems usually reflect broader brain functioning impairments. These problems usually involve receptive language, the way in which words are heard and understood; expressive language, the way in which concepts are formed and how words are articulated; and language processing in the brain, cognition or comprehension. These types of deficits may be the easiest to observe. Paying careful attention to how the client speaks and responds may provide the first hints as to how he functions.

Empirical research indicates that about one third of children referred by teachers or parents for psychiatric evaluation specifically because of observed behavior problems actually suffered from unsuspected language and learning deficits. Although sent for

intervention because of acting out, assessment disclosed that these children had learning and language deficits that caused the behavior problems and which could be treated.

In the studies, when mothers did not know that their children had a language problem, they rated their own children higher on delinquency scales. Where the language impairment was known, the behaviors appeared less significant to the child's mother. When the language impairment was not known to the teachers, they tended to rate children who have language and learning impairments as having severe behavior problems, including considering them to be aggressive, inattentive and overactive.

Other research demonstrates that children who refuse to go to school were significantly more likely than controls to have language and learning disabilities. These findings demonstrate the co-occurrence of school refusal and language and learning impairments. Longitudinal studies of children referred for language deficits have found a long-term increase in anxiety, attention and social relations behavior problems, but not in conduct disturbance or anti-social behavior. These problems often persist into adulthood and will help to explain how the client saw himself. Even individuals who no longer have apparent language problems may have internalized beliefs based on growing up with these impairments.

All of this research points to the importance in how children are perceived: as delinquent and aggressive or with a treatable neurological condition. It also points to the very real need to undertake extensive investigation, especially if the client at first blush appears to have behaviors that constitute conduct disorder. When not aware of the language and learning deficits, teachers and parents appear to hold children responsible for negative behavioral problems. This finding tends to support to the hypothesis that language and learning deficits may underlie attention, delinquency, truancy and aggressive acts as identified by teachers and parents. These are the "bad acts" that constitute conduct disorder but may in fact be symptoms of neurological dysfunction.

Approximately 13 percent of state prisoners and 7 percent of federal prisoners self-report having speech or learning problems. A much higher percentage of juvenile delinquents (35 percent) are estimated to have learning disabilities. Social and family records (especially school records) and neuropsychological testing are crucial for identifying language and learning deficits.

TRAUMATIC BRAIN INJURY

Traumatic brain injury (TBI, sometimes referred to as closed head injury) refers to a specific type of injury that is quite common in the United States. Somewhere around 1.5 million people seek medical care each year for head injury. TBI generally refers to a blow to the head that does not pierce the skull, although fracturing may occur. The most common forms of TBI result in diffuse damage to the brain where the force

of injury causes a shearing effect or bruising as the brain collides with the inside of the skull.

The DSM-IV-TR does not contain a diagnostic category for TBI, although there is a related category, post-concussive syndrome, which was studied for inclusion but determined to be insufficiently supported by empirical research.

Determining whether someone has suffered traumatic brain injury depends on four criteria: (1) loss of consciousness for a period of time; (2) present or past loss of memory for events either just before and/or just after the injury; (3) an alteration in mental state following the injury; and (4) focal neurological impairment (i.e., focused in a specific region of the brain), which can be either permanent or transient.

The problem in many cases is that insufficient documentation exists to satisfy these four criteria. Record gathering is essential since any delayed reporting of severity will be challenged. However, most of our clients will have suffered what is termed "mild" TBI and will not have sought medical care following head injury because: (1) the injury resulted from physical abuse which the care-taker is trying to keep from public view; (2) access to medical care was limited and/or ability to pay for care was limited and therefore not sought; (3) the injury occurred during substance use and was not reported or was discounted because of the presence of substances; (4) the client had insufficient social support and was unable to get to a doctor or did not recognize and was not told the severity of the injury until later; or (5) the client simply did not go to the doctor. However, if contemporaneous documentation exists, here are the most common techniques for assessing the four critical factors:

1. Level of Consciousness:

The standard technique for assessing a person's level of consciousness at the time of an accident is the Glasgow Coma Scale (GCS). Total score ranges from 3 to 15 based on whether the person's eyes are open, open in response to verbal command, open in response to pain, or not responsive; whether the person can move in response to verbal command or level of response to a variety of painful stimuli; and whether the person can verbally respond to simple orientation questions. Alteration in the level of consciousness rather than a specific cut-off on the GCS should be noted, but a GCS score between 13 and 15 is indicative of mild traumatic brain injury.

2. Loss of Memory

The duration of loss of memory is much less important than whether or not any occurred. It is often difficult to assess this since the evaluator usually has little external information about the incident and has no way to assess confabulation or missing details.

3. Change in Mental Status

The obvious signs are disorientation or confusion, but may range across a fairly broad spectrum of problems. Most commonly, emergency response personnel simply ask the brain-injured person for a self-assessment. Sometimes the alterations are severe and persistent, most apparent in mood, affect and behavior.

4. Neurological deficits

Assessed by neurologic and/or neuropsychological evaluation. Lack of specific deficits may describe the severity of the injury, not determine the presence or absence of injury.

One key to proving TBI’s importance to a client’s life is to document the behavior patterns exhibited before and after the event. Social and family history investigation should be geared (on this issue) to documenting very specific *changes* in emotion, responses to stimuli and behavior. To do so requires a clear picture of how the client was before the injury and the course of changes in behavior that stem from the injury.

Common Symptoms of TBI:

Physical	Behavioral
Headaches; Dizziness; Nausea; Vertigo; Noise intolerance; Sleep disturbance; Blurred or double vision; Physical or mental fatigue; Decline in coordination/motor function; Enhanced startle response.	Memory impairment; Slowed mental processing; Difficulty maintaining train of thought; Diminished concentration; Increased distractibility; Emotional lability; Anxiety; Depression; Substance use; Libido changes; Low frustration tolerance/agitation; Poor impulse control; Disinhibition.

Adapted from Murrey¹⁶³

Along with behavior changes, people with TBI are significantly more likely to use substances, to be diagnosed with psychiatric illnesses such as depression, post-traumatic stress disorder, and anxiety, and to have decreased adaptive functioning as evidenced by a noted decline compared to pre-injury ability. Depending on the region of the brain affected, there may also be other problems, such as movement disorders, speech or vision problems, cognition impairments or executive function deficits. Not all regions of the brain will be affected by an injury, thus a person could very likely maintain full cognitive function while losing executive function.

¹⁶³ Murrey, G.J., THE FORENSIC EVALUATION OF TRAUMATIC BRAIN INJURY (CRC 2000).

A favorite approach of prosecutors is to suggest that since the TBI occurred some amount of time earlier, the client should be over it. With treatment and extensive rehabilitative services, the majority of TBI patients appear to recover most functioning. It is therefore crucial to investigate whether the client had access to the services that would have assisted in recovery. Research indicates that psychiatric symptoms associated with TBI persist in about half of people with TBI. Approximately 25 percent of TBI cases meet the criteria for PTSD six months following the incident. TBI is strongly associated with substance use, especially alcohol. However, nearly half of people were intoxicated at the time of injury, so it is important to establish onset of substance abuse or changes in usage. The effect of substances on an injured brain may also be enhanced compared to non-injured users. Behavioral effects from TBI also persist and may be permanent (up to thirty years).¹⁶⁴ It is estimated that around 15 percent of mild TBI patients have long-term symptoms.

Evidence or reports of TBI do not change the approach to testing discussed below. Neuropsychological and neurology examinations are still necessary. It is essential that the expert have evidence to substantiate the TBI prior to testing and interpreting testing data. Some additional tests, following administration of standard testing, may be indicated based on social and family history information.

TEMPORAL LOBE EPILEPSY

Temporal lobe epilepsy (TLE) is a rare condition in which seizure activity originates in the amygdala, uncus and hippocampal regions of the temporal lobe. There is abnormal electrical activity in the temporal lobe. Approximately 0.2 percent of people are thought to have TLE and the condition is very difficult to diagnose. The seizures are rarely, if ever, 'grand mal' and are more typically partial seizures involving just a portion of the brain. The behaviors associated with TLE make it very appealing as a mitigating circumstance, although proving its presence remains difficult.

Behavior changes brought about by seizure activity are usually described in relation to the seizure itself: the ictal state (during seizure), postictal (the days and weeks following seizure); and interictal (the period between seizures which defines baseline functioning). Seizures may be known only to the individual who suffers them; symptoms include headache, visual aura, confusion or loss of consciousness.

The observable behaviors of the ictal state and the postictal state are very similar, and include non-reflex movement without volition (chewing, swallowing, rubbing the hands, walking or running), hypoactivity and drowsiness, depression with flat affect, confusion (including confusion about the period of seizure), emotional lability, memory dysfunction, increased anxiety, altered social interactions and psychosis. Typically, psychosis begins after a number of years of seizure activity and onset may follow two to seventy-two hours after seizure.

¹⁶⁴ Bernstein, D.M., *Recovery from mild head injury*, 13(3) BRAIN INJURY 151 (1999).

Interictal behavior, that is the “normal state” behaviors that are brought on by seizure activity, include psychosis, paranoia, intrusive and repetitive thoughts, dissociative fugue states, increased aggression, mood changes, anxiety and a feeling of impending disaster, hallucinations (vivid sensory experiences), feelings of déjà vu, and somatic problems.

Other common interictal symptoms are: hypermoralism (religious conversions, great attention to rules, inability to distinguish major and minor infractions, a desire to punish offenders, metaphysical interests), verbosity and tangentiality (pedantic, constant talking with a tendency towards explaining every detail, speech which branches away from a direct line of thought, excessive background information), hypergraphia (extensive and detailed writings, diaries containing details of everyday events, autobiographical writing), heightened emotionality, periodic elation or euphoria (sometimes viewed as grandiosity), depression, irritability, altered sexual interest and libido, obsessionalism (ritualized behaviors, compulsion to detail, excessive orderliness), dependence, humorlessness, and passivity.¹⁶⁵

Diagnosis of TLE, as with all conditions, must first look to historical information such as brain injury, gestational toxicity, birth complications, childhood infections, delayed milestones, learning disabilities or endocrine disruption (e.g., exposure to toxins). It is difficult to diagnose TLE because the patterns of symptoms shown by sufferers are not always the same. Additionally, some of the symptoms resemble psychiatric illnesses and some of the symptoms also respond to psychiatric medication. Thus, a person experiencing psychosis as a result of TLE may be misdiagnosed and prescribed an antipsychotic medication, and antipsychotic medication will be beneficial in reducing the psychotic symptoms even though the cause of the symptoms has not been identified.

Testing with EEG can be uncertain unless seizure activity occurs during the test. Since the seizure activity originates in the deep structures of the brain, nasopharyngeal leads that are placed well inside the nasal passages are necessary. However, placing the leads into the nasal passages can be very uncomfortable and upsetting for many clients and counsel should be sure to prepare the client carefully for the discomfort. Functional imaging may be useful, although it remains uncertain.

DEGENERATIVE BASAL GANGLIA DISORDERS

Parkinson's, Huntington's, Wilson's and Fahr's Diseases are all degenerative disorders of the basal ganglia. These are all diseases that progressively affect the deep structures of the brain, primarily the basal ganglia. Each is associated with movement disorders as well as cognitive and psychiatric symptoms. Each is also an inherited, degenerative disorder, meaning that familial patterns will be observed and that over time the symptoms worsen significantly. No current treatment can halt or reverse the

¹⁶⁵ Bear, D., *The temporal lobes: An approach to the study of organic behavior changes*, in Gazzaniga, M., (ed.), *HANDBOOK OF BEHAVIORAL NEUROLOGY* (1979).

progressive decline in functioning, and end-stage for these diseases is a near total inability for self-care. For this manual's purposes, the four conditions are considered as a group, although it is important to remember that each disease has specific symptoms. The four diseases are similar but not identical.

The basal ganglia connect to the thalamus and frontal lobes. These connections mean that damage or impairment of the basal ganglia can result in a variety of disease symptoms. The most easily recognized are the movement disorders (chorea, dystonia, myoclonus, parkinsonism); however, basal ganglia diseases are also accompanied by mood disorders (depression, bipolar and/or suicidal thoughts), dementia, and personality change (irritability, aggression or apathy), often including violent homicidal and suicidal behavior (apathy and aggression are not usually seen in the same patient). Psychosis can also occur, with hallucinations and delusions.

In the early stages of these diseases, people show marked increases in hostility, irritability and disinhibited aggression, and behaviors such as assault, arson, and homicide are often found. Irritability can take different forms. One form is an increase in the baseline level of irritability punctuated by more severe outbursts. The irritable responses become exaggerated in intensity and duration. In another form, people are not necessarily irritable in general, but become agitated when their requests are not met immediately, no matter how inappropriate. These people often "perseverate relentlessly on a single desire or idea and become progressively more irritable when it is not indulged."¹⁶⁶ Personality changes may present prodromally.

In addition, sexual disinhibition, hypersexuality, and paraphilias are commonly observed. These personality changes have been shown to often lead to marital breakdown, in which the reasons for separation mainly relate to aggressive, violent, and abusive behavior associated with the disease.¹⁶⁷

Interestingly, Gulf War Syndrome (GWS) affects the basal ganglia in much the same way as Huntington's Disease, although it is not degenerative. GWS's behavioral symptoms are almost identical to those found in the basal ganglia disorders.

Although treatment is not available to reverse the degeneration, it is possible to effectively manage the behavioral manifestations. Improvement in irritability can usually be seen if the person is relieved of responsibilities and where unexpected changes are minimized. Underlying causes or triggers of outbursts can be removed at least to some degree. These triggers are usually such things as hunger, pain, frustration with failing abilities, or minor unexpected changes in routine. Since

¹⁶⁶ Ranen, N.G., *Huntington's Disease*, in Lauterbach, E.C., (ed.) *PSYCHIATRIC MANAGEMENT IN NEUROLOGICAL DISEASE* (American Psychiatric Pub. 2000).

¹⁶⁷ *Id.* Lauterbach, E.C., et al, *Neuropsychiatric correlates and treatment of lenticulostratial diseases: A review of the literature and overview of research opportunities in Huntington's, Wilson's, and Fahr's diseases* 10(3) *J. NEUROPSYCHIATRY & CLIN. NEUROSCIENCE* 249 (1998); Harper, P.S., *HUNTINGTON'S DISEASE* (W.B. Saunders Co. 1994).

incarceration may accomplish much of this, the behavioral aspects of these diseases can be easily managed.

AUTISM-SPECTRUM DISORDERS

Autism is a neurological disease that affects a person's ability to communicate, to form relationships and interact with others appropriately, and to respond appropriately to the immediate environment. It is a disease which is increasingly diagnosed: between 1987 and 1998, California experienced a 273 percent increase in annually reported cases and the increase cannot be explained only by changing reporting criteria. Autism-spectrum (from high-functioning to severely disabled) disorders are an important cause of mental retardation, although high functioning autistic people and people with Asperger's Disorder are likely to have IQ scores well above 70. Most capital cases in which autism will be an issue are likely to involve high-functioning autism (HFA) or Asperger's Disorder.

Although still debated among experts, for this manual's purposes, these will generally be considered as autism-spectrum disorders (ASD) except where noted. Oftentimes, High-Functioning Autism and Asperger's are considered the same disorder. However, they are separate diagnostic disorders in the DSM-IV-TR and are distinguished based on whether early cognitive and language impairments are present (they are present in autism, not in Asperger's) and whether there is inappropriate interest in parts of objects (autism) or all encompassing pursuit of an interest to which the individual devotes inordinate amounts of time. The DSM-IV-TR notes that differentiating these two conditions may be difficult.

Autism is a developmental and behavioral disorder that is diagnosed (*see* DSM-IV-TR for complete diagnostic criteria and for Asperger's criteria) based on:

1. Impairments in social interaction: impairment in the use of non-verbal behaviors such as eye contact, facial expressions, posture or gestures related to social interaction; failure to develop age-appropriate relationships with peers; lack of social or emotional reciprocity; or a lack of seeking to share enjoyment or interests with others.
2. Impairments in communication: delay in normal developmental milestones related to language; impairment in ability to initiate or maintain conversations; stereotyped or repetitive use of language; developmentally inappropriate or non-varied play or interaction.
3. Restricted repetitive and stereotyped patterns of behavior: preoccupation with a pattern of behavior that is abnormal in intensity or focus; inflexible adherence to non-functional routines or rituals; repetitive or stereotyped motor mannerisms; or persistent preoccupation with parts of objects.

4. Onset prior to three years of age.

The skill or behavior is not described as totally absent, but rather impaired. Thus, at any level of the functioning spectrum of ASD, portions of the skill or behavior may be present; but if impaired significantly, the criteria may be met.

Higher functioning people with ASD may focus repetitively on a specific element of their world, such as the type of car driven by every person they know or about how weather maps are made and what they mean. High functioning people with ASD may have extensive knowledge on a single or handful of topics and the breadth of the details known on this subject may at first appear very impressive. It is important to probe this knowledge to see how broad it is and whether the preoccupation with a single or handful of subjects has interfered with the person's ability to understand the larger meaning or context of the subject matter, as in an inability to see the forest for the trees. Thus, a knowledge of the kings and queens of England may on its face appear impressive, but a high functioning person with ASD will likely have a limited ability to explain the processes by which power and political intrigue have shaped the passing of the crown.

Investigation of ASD requires historical records and interviews of percipient witnesses who can describe the behaviors of your client in detail. Because onset is at a very young age, it will be important to investigate early childhood thoroughly in an effort to document behaviors specific to a client's developmental progress. Even without being able to substantiate the onset prior to age three (average age of diagnosis for ASD is six years old), the pattern of behaviors and the symptoms related to ASD are potentially powerful mitigation evidence.

Since ASD likely includes impairment in nonverbal behavior, this is the first line of investigation. Odd movements or postures or gestures during client interviews should be noted. Similarly, odd use of words, repetitive behaviors or comments and inappropriate or odd responses to simple emotional discussion may become apparent. Errors in word meaning and impaired usage of words in proper social context usage are often seen as well. Although rare in the capital client population, the Asperger's child may be exceptionally verbally precocious.

Some of the behaviors of ASD often appear to be obsessive-compulsive disorder (OCD) because of the repetitive nature of the some of the signs and symptoms. Since people with ASD often display ritualistic and repetitive behaviors, this may appear at first to be OCD. The behaviors of attention deficit disorder (ADD or ADHD) also overlap to some degree with ASD and should be differentiated. Similarly, ASD can often be mistaken for schizotypal or schizoid personality disorder in its lack of empathy, impaired social skills and inappropriate social interactions. ASD symptoms are often more severe in these terms than schizoid personality symptoms. The significance of differentiating them is that ASD is a clear neurological disorder, with a number of potential causes while schizoid personality disorder is a personality

disorder that is likely to be used to describe the negative quality of a client's character rather than as a disabling condition affecting him.

ASD may help to explain behaviors that the prosecution views as evidence of conduct disorder. For example, ASD symptoms in childhood usually include tantrums and emotional volatility. ASD may affirmatively explain that the cause of these behaviors is not volitional or bad temper foretelling future criminal activity, but rather a specific neurological disease. Additionally, behaviors often seen in childhood include sleep disorders (trouble getting to sleep, staying asleep, getting enough sleep) and serious difficulties interacting with others such that children with ASD often are very isolated, even from family members with whom they live.

ASD can help explain the cause of unusual or odd behaviors manifested throughout a client's life. Documenting the pattern of behavior over time is essential. Further, people with ASD respond well to highly structured and predictable environments—it is one of the keys to treatment and remediation—and this argument may be especially helpful in demonstrating the appropriateness of a life sentence.

Substantial evidence supports the conclusion that people with ASD have executive functioning deficits. Many people with ASD appear to perseverate more and have difficulty with cognitive flexibility and planning on neuropsychological tests of executive function. Research suggests that executive function deficits are common features of those with ASD but not necessarily causative of ASD.

Brain imaging research suggests that people with ASD have brain abnormalities in the amygdala and hippocampus and frontal regions; however, there is no evidence to support a role for functional imaging in the clinical diagnosis of ASD.

CHAPTER 6:

THE HISTORY OF THE DSM: A KEY TO MULTI-GENERATIONAL INVESTIGATION

Including:

- The Diagnostic and Statistical Manual of Mental Disorders (DSM);
- Dates and defining features of the DSMs;
- Changing conceptions and the emergence of the multiaxial diagnostic scheme;
- The multiaxial scheme beginning with DSM-III;
- The fourth (and current) edition of the DSM; and
- Changes in the DSM-IV.

Life-saving mitigation evidence never requires a diagnosis. Instead, it requires a narrative that helps jurors, judges, or prosecutors develop empathy by understanding how a capital client experiences the world. The mitigation narrative is a life story that begins before the client had the capacity to make any choices or decisions, his DNA encoded by parents he didn't choose, exposed *in utero* to substances and trauma, and raised in a neighborhood that continued to deny him safety and health. When clients have a diagnosable mental disorder, it remains essential to translate the diagnosis into a vivid picture of the symptoms that illustrate what is wrong. When there is a documented history of mental disorders, it is essential to probe beyond the outmoded language of diagnoses past, to deconstruct the labels, in order to see what signs, symptoms, and behaviors were present. In the modern era, the key to deconstructing diagnoses lies in the Diagnostic and Statistical Manual of Mental Disorders, or DSM.

THE DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS (DSM)

First published in the aftermath of the Second World War, the DSM is the official manual that has been used by mental health providers to define and delineate psychiatric disorders in the U.S. for the last half century. Five successive editions of this manual, each incorporating substantive changes in diagnostic criteria or in text language used to discuss the disorders, have been published since the initial inception of the DSM in 1952. An understanding of the history and background of changes to the DSMs is critical for accurately interpreting and understanding multi-generational records in death penalty cases.

Many attorneys are involved with experts who rely on the DSM as part of the basis for their conclusions on a range of issues, from mental health defenses to state of mind or competency issues to mitigating factors. This is especially the case in post-conviction death penalty litigation, where multiple prior mental health evaluations and previous diagnoses have often been rendered, for the client and/or family

members. (See chapter 10.) Even in pretrial work, psychiatric evaluations obtained in the multi-generational fact-gathering process may occur over decades, and may span various editions of the DSM. In order to understand fully these prior diagnoses, it is important to have an historical awareness of the context in which prior diagnoses were rendered. This is critical to understanding the complex, often multi-generational mental health background of clients and their families. Thus, a competent, current, and accurate mental health evaluation of a particular client may require a critique of prior evaluations and diagnoses. It is important to know at what point in time the DSM was consulted, in order to understand the theories and theoretical assumptions reflected in the formulation of prior diagnoses.

DATES AND DEFINING FEATURES OF THE DSMs

DSM-I

1952 Approximately 100 diagnoses included; based in part on theoretical views that mental illness was caused by an interaction between biology and environment; disorders often termed “reactions.”

DSM-II

1968 Etiology (cause) of disorder promised; approximately 180 diagnoses included; based in part on psychoanalytic theoretical view, certain disorders labeled “neuroses” (anxiety or other symptoms caused by unconscious conflict) or “psychophysiologic” (physical symptoms caused by emotional factors and involving a single organ system—e.g., backache, tension headache).

DSM-III

1980 Approximately 260 diagnoses included; attempt to provide an atheoretical, non-etiological (non-causal) based diagnostic scheme; introduction of five-axial system; introduction of operational criteria for diagnosis of mental disorders.

DSM-III-R*

1987 Results consistent with DSM-III in attempt to provide atheoretical diagnostic scheme with distinct operational criteria; attempt to provide multiple ways to reach a diagnosis, rather than having each decision based on a rigid set of criteria (i.e., change from a “monothetic” to a “polythetic” diagnostic scheme).

DSM-IV

1994 Approximately 300 diagnoses included; attempt to base changes on a more solid base of empirical support, with process dictated by literature reviews, data re-analyses, and extensive field trials.

DSM-IV-TR*

2000 In anticipation of the fact that the next major revision (i.e., DSM-V) will not appear until 2011 or later, a text revision was published to maintain the currency of the text in terms of empirical literature; changes confined to the descriptive text and a few criteria sets.

* "R" denotes revised edition; "TR" denotes text revision.

RELEVANCE OF HISTORICAL INFORMATION ABOUT DIAGNOSTIC SCHEMES TO DEATH PENALTY LITIGATION

Changes in the DSM over time, with simultaneous changes in views of mental illness, have significant implications for mental health record review in death penalty cases. These changes underscore the importance of looking behind the historical labels to try to detect the signs and symptoms that prompted the evaluation. When there is no diagnostic history, it may be because some disorders were recognized belatedly in the DSM. The following examples illustrate these points.

(i) *Denial of depression in childhood*

Not until the late 1970s and early 1980s did depression emerge as a diagnosis to be seriously considered in the assessment of mentally ill children. In fact, there was a psychoanalytically based belief that children could not be depressed. According to psychoanalytic theory, depression was the product of a persecutory superego, and could not occur in pre-adolescents, who supposedly lacked mature superego structures. This view has changed dramatically, as psychoanalytic thought no longer holds hegemony in mental health practice. There is currently a consensus of opinion that children can in fact, and frequently do, exhibit symptoms of depressive disorders.

Consider the situation of a death row client who attempted suicide multiple times as a child in the late 1960s and early 1970s, and who exhibited many of the cognitive and vegetative symptoms (i.e., concentration difficulties, sleep or appetite disturbance) of the phenomenon we now call depression. Even if this client had been brought to the attention of mental health professionals during

childhood, the chances of professionals recognizing his or her mental illness were at best substantially reduced, due to prevailing theoretical conceptions of diagnosis and mental illness as related to children.

(ii) *Changed delineation of bipolar versus schizophrenic symptoms*

Another illustration of the importance of an historical viewpoint involves the changed delineation of symptoms of bipolar disorder versus schizophrenia from the DSM-II to the DSM-III. Given the increase in the specificity required to meet diagnostic criteria from the II to the III (discussed in more detail later on in this chapter), some patients diagnosed with a psychotic (thought) disorder in the DSM-II scheme were diagnosed with a mood (affective) disorder in the DSM-III. Thus, the significant distinction between a mood disorder and a psychotic disorder (both of which may share features of psychotic symptoms) may be masked in diagnoses rendered at this important diagnostic junction. This is important because the distinctive diagnoses may provide different explanations for the same behavior. Also, accurate diagnosis has enormous implications for whether medication is indicated, the choice of medication, and the type of treatment modality.

(iii) *Post Traumatic Stress Disorder*

A final example involves the now universally recognized diagnosis of post traumatic stress disorder (included in the DSM as of 1980). Since its inclusion in the DSM-III, there has been a wealth of empirical data supporting the existence of this disorder. In addition, many of the central features of post traumatic stress disorder (PTSD) were identified more than fifty years ago. However, the diagnosis of PTSD was not officially recognized until publication of the DSM-III. Records prior to that time, as in the case of a death row inmate severely and chronically traumatized as a child, may include vivid descriptions of symptoms we now associate with PTSD. Nevertheless, while there may be clear and convincing descriptions in pre-1980 records consistent with this disorder as we now recognize it, there was no official recognition of the disorder at that time.

One conclusion from these examples is that we need to review prior mental health records not only for diagnostic conclusions, but also for descriptions of symptoms. At the time the symptoms were noted, there may have been no way in which to understand their importance in terms of today's diagnostic categories. It is therefore of vital importance to pay retrospective attention to symptoms in the context of the revised DSM.

CHANGING CONCEPTIONS AND THE EMERGENCE OF THE MULTIAXIAL DIAGNOSTIC SCHEME

Prior editions of the DSM, particularly the earlier versions (I and II), were shaped by the prevailing theoretical orientations of the time. Not surprisingly, the characterization of mental disorders was similarly affected.

For example, the DSM-I (1952) was in part based on the “psychobiologic” orientation of Adolf Meyer, who, representing a social-Darwinian theoretical framework, viewed mental illness as a maladaptive attempt to adapt to a changing psychosocial environment. Thus, in the DSM-I, many disorders were characterized in terms of a “reaction” to the social environment.

While the DSM-II purported to eschew theory-based definitions of psychopathology (mental disease or disorder), its diagnostic scheme was characterized in part by psychoanalytic terms and concepts. One category of diagnoses in the DSM-II was termed “neuroses.” This category of disorder is essentially theoretically based, and is derived from a Freudian perspective suggesting that mental diseases or disorders are caused by the tension between unconscious conflicts and the defense mechanisms generated to resolve these conflicts. For example, the DSM-II conceptualizes “depressive neurosis” as an “excessive reaction of depression due to an internal conflict or to an identifiable event such as the loss of a love object or cherished possession.”

In many respects, the DSM-III represented a radical departure from its predecessors. Designed to be theoretically neutral in order to increase its utility for clinicians of different theoretical viewpoints, disorders were largely defined without reference to etiology (causes). An additional defining feature of the third edition of the DSM included introduction of a complex (multi-axial) system of diagnoses, which attempted to simultaneously consider such diverse factors as:

- Axis I:* identification of major (traditional) mental illness
- Axis II:* identification of longstanding and enduring personality traits and/or maturational delays
- Axis III:* identification of medical illnesses that may affect psychological functioning
- Axis IV:* identification of environmental and psychosocial stressors that may influence psychological functioning
- Axis V:* delineation of a longitudinal context within which to appraise psychological functioning

The introduction of this multiaxial system constituted a significant change in diagnostic thought. The multiaxial scheme, in effect, indicated that a complex range of variables was involved in accurate diagnosis. It also represented an apparent rejection of a strictly medical model in favor of a diagnostic scheme that acknowledged the interplay of various factors—psychological, maturational, enduring, medical, environmental—in the conceptualization and assessment of psychopathology.

THE MULTIAXIAL SYSTEM BEGINNING WITH DSM-III

Axis I—Includes the “clinical syndromes,” i.e., the major mental disorders. This axis comprises what most people think of as mental illnesses. It is composed of approximately fifteen categories of mental disorders, each comprising a distinct group or class of mental illness (e.g., mood, anxiety, psychotic, or dissociative disorders). Each group or class (e.g., mood disorders/anxiety disorders) contains distinct disorders (e.g., major depressive disorder, bipolar I and II disorders, etc/panic and anxiety disorders, phobias, PTSD) which make up that group.

Axis II—Includes longstanding and enduring personality traits and maturational/developmental deficits and delays. Personality traits are “enduring patterns of perceiving, relating to, and thinking about the environment and oneself,” and are exhibited in a range of important social and personal contexts. It is only when personality traits are inflexible, maladaptive and cause either significant functional impairment or subjective distress that they constitute an actual disorder. The essence of maturational/developmental delays is a disturbance in the acquisition of “cognitive, language, motor, or social skills.” Such disturbances may be pervasive (as with mental retardation), involve delays or deficits in specific skills (reading, arithmetic, language), or involve qualitative distortions in multiple areas of normal development (autism).

Axis III—Includes physical disorders and medical conditions that may affect psychological functioning.

Axis IV—Includes psychosocial stressors that may influence psychological functioning; they are rated on a five-point scale from “mild” (relationship breakup) to “catastrophic” (death of a child or spouse).

Axis V—Includes the delineation of a longitudinal context (known as the Global Assessment of Functioning [GAF]) within which to appraise psychological functioning. Social, psychological and occupational functioning is rated on a 100-point scale of mental illness which includes 90 (absent or minimal symptoms, “good functioning in all areas”), through 50 (serious symptoms, “suicidal ideation, severe obsessional rituals... serious impairment in some functioning”) to 20-10 (“persistent danger of severely hurting self or others... persistent inability to maintain minimal personal hygiene [smears feces]... serious suicidal acts with clear expectation of death”).

Another major change in the DSM-III was the use of operational criteria to define mental disorders. As an illustration, compare the descriptions of manic depression in the DSM-II and III:

DSM-II: Manic-Depressive Illness, Manic Type

These disorders are marked by severe mood swings and a tendency to remission and recurrence... This disorder consists exclusively of manic episodes. These episodes are characterized by excessive elation, irritability, talkativeness, flight of ideas, and accelerated speech and motor activity...

DSM-III: Manic-Depressive Illness, Manic Type

Diagnostic criteria for a manic episode:

- A. One or more distinct periods with a predominantly elevated, expansive, or irritable mood. The elevated or irritable mood must be a predominant part of the illness and relatively persistent, although it may alternate or intermingle with depressive mood.
- B. Duration of at least one week (or any duration if hospitalization is necessary), during which, for most of the time, at least three of the following symptoms have persisted (four if the mood is only irritable) and have been present to a significant degree;
 - 1) increase in activity (either socially, at work, or sexually) or physical restlessness;
 - 2) more talkative than usual or pressure to keep talking;
 - 3) flight of ideas or subjective experience that thoughts are racing;
 - 4) inflated self-esteem (grandiosity, which may be delusional);
 - 5) decreased need for sleep;
 - 6) distractibility, i.e., attention is too easily drawn to unimportant or irrelevant external stimuli;
 - 7) excessive involvement in activities that have a high potential for painful consequences which is not recognized, e.g., buying sprees, sexual indiscretions, foolish business investments, reckless driving.
- C. Neither of the following dominates the clinical picture when an affective syndrome is absent (i.e., symptoms in criteria A and B above);
 - 1) preoccupation with a mood-incongruent delusion or hallucination;
 - 2) bizarre behavior.

- D. Not superimposed on either Schizophrenia, Schizophreniform Disorder, or a Paranoid Disorder.
- E. Not due to any Organic Mental Disorder, such as Substance Intoxication.

The above comparison illustrates a major difference between the DSM-II and III: the third edition of the DSM spelled out detailed criteria for inclusion and exclusion of mental disorders. For example, the above illustrates that particular criteria must be present to render a diagnosis of manic-depression, and also shows that other diagnoses must be ruled out. This extensive use of inclusion and exclusion criteria was initiated with the DSM-III, and was unique to diagnostic schemes in the U.S. at that time.

THE FOURTH (AND CURRENT) EDITION OF THE DSM

In 1994, the American Psychiatric Association published the fourth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV).¹⁶⁸

Work on the DSM-IV began in May of 1988, when the Board of Trustees of the American Psychiatric Association (APA) appointed a task force to begin the revision process. One of the driving forces dictating the timing of the revision was the scheduled publication of the tenth edition of the World Health Organization's International Classification of Diseases (ICD-10). As is true of previous editions of the DSM, both the timing of publication of the DSM-IV and descriptions of diagnostic categories were designed to be consistent with the publication of the ICD-10, the international counterpart of the American DSM, pursuant to a treaty agreement with the World Health Organization to maintain a coding and terminological consistency with the ICD.

An effort was made to provide a strong base of empirical support for changes made in the DSM-IV. A central organizing principle governing the DSM-IV revision process was the requirement that final decisions not rely exclusively on the consensus of committees of "experts," but be more comprehensively informed by, and based on, empirical data. This requirement was in part to address concerns about the expert opinion consensus process that dictated earlier editions of the DSM, a process that had resulted in criticisms that diagnostic categories were in part arbitrary and "unscientific."

Accordingly, thirteen work groups were formed to guide discussion and decisions about potential DSM-IV changes in diverse classes of disorders. Work groups studied thirteen individual classes of clinical disorders, each of which included a range of diagnostic entities within its particular class. For example, the mood disorders work

¹⁶⁸ This was actually the fifth version of the DSM, if one counts the DSM-III and DSM-III-R separately; but the 1994 publication was officially known as the DSM-IV.

group considered major depression, bi-polar disorders, dysthymia, and cyclothymia, among other disorders in this class; the psychotic disorders work group considered, among others, schizophrenia, schizophreniform disorder, schizoaffective disorder, and delusional disorder; the anxiety disorder work group considered post-traumatic stress disorder, obsessive compulsive disorders, phobias, and other disorders in the anxiety disorder class.

Work groups were charged with the task of following a three-step process for consideration of changes from the DSM-III-R. First, extensive reviews of the literature were conducted on the diagnostic categories under consideration for change. The purpose of this step was to provide explicit documentation of the nature and extent of empirical support for any substantive revisions, additions, or deletions in the DSM-IV.

Second, data re-analyses were conducted. The purpose of this step was to insure that decisions about changes were based on input from multiple research programs and sites, so as to minimize the potential bias of conclusions based on findings from a limited number of research sites. Finally, field trials were conducted on a variety of existing diagnoses. Field trials involved multiple sites across the country for each diagnostic category studied, and were performed on a range of disorders, including antisocial personality disorder, post-traumatic stress disorder, major depression, dysthymia, schizophrenia, and the disruptive behavior disorders. The purpose of the field trials was to provide a basis of scientific support (i.e., reliability and validity data) which could be used to support, or to obviate, proposed changes in specific diagnostic categories.

The final DSM-IV included, among other changes, the deletion of several previous diagnoses, the addition of several new diagnoses, changes in criteria sets for several existing diagnoses and changes in the rating scales and foci of several axes. Additional changes included efforts to make the DSM more sensitive to the multicultural issues inherent in diagnosis, with a text section added to reflect specific known cultural features, an appendix outlining issues related to cultural formulation, and a glossary of culture-bound syndromes.

The DSM-IV is composed of sixteen major classes of mental illnesses, within which particular disorders are subsumed. For example, the class of mood disorders includes such disorders as major depression, bipolar I and II, and dysthymia; the class of anxiety disorders includes, among others, PTSD, obsessive-compulsive disorder, and phobic disorders (e.g., simple phobia, social phobia, and agoraphobia).

Individual disorders are placed in a particular class of mental illness on the basis of shared phenomenological features. That is, two disorders within the same class of mental illness may share a predominant emotion or behavioral symptom, may respond similarly to medication, may be genetically linked, and/or may consistently occur together with other disorders. For example, PTSD and Panic Disorder with Agoraphobia (PDWA) are both in the anxiety disorder class of mental illness, and

share similar emotional, behavioral, and physiological symptoms. These disorders have in common a predominant emotion (fear); a similar behavioral-pattern (phobic avoidance of feared situations, people or events); and similar physiological responses (increased autonomic arousal when confronted with anxiety-provoking or feared stimuli). Additionally, a similar mode of psychotherapy (behaviorally based “exposure therapy”) has been effective for some patients in reducing distress significantly for both disorders. Finally, evidence suggests a possible biomedical and/or psychophysiological link between PTSD and PDWA, as both disorders occur together with depressive disorders and respond similarly and positively to a certain class of drugs.

The purpose of grouping disorders on the basis of shared features was to facilitate the process of “differential diagnosis,” the term used to describe the hierarchical decision-making process required to differentiate a particular disorder from other disorders which have one or more similar presenting features. For example, Attention Deficit Hyperactivity Disorder (a disruptive behavior disorder), Major Depression (a mood disorder) and Post-traumatic Stress Disorder (an anxiety disorder) may all share characteristics of concentration difficulty and agitated behavior. To determine whether these characteristics are symptoms of a particular disorder, and, if so, to identify that disorder, a careful evaluation of present symptoms, as well as a careful history are needed.

The description of particular disorders occurs through clearly specified “criteria sets” which outline such factors as the type, number, duration, and severity of symptoms required to warrant a diagnosis. A wealth of additional information is provided in the text that accompanies criteria set definitions. One area of further information detailed in the text includes factors predisposing individuals to particular disorders, e.g., family history, exposure to extremely stressful environmental events, and in-utero exposure to trauma and/or toxins. Additional information might also address the nature, subtypes and specific course of particular disorders, e.g., age of onset (early vs. late); mode of onset (abrupt vs. insidious); severity of disorder (mild, moderate or severe); and chronicity and duration of the disorder (episodic vs. continuous, single event vs. recurring episodes, or full vs. partial remission).

CHANGES IN THE DSM-IV

Changes to the axes

DSM-IV included a number of conceptually distinct changes. Revisions were made in the content of two axes within the multiaxial system as the learning, communication and motor skills, and pervasive developmental disorders were moved from Axis II to Axis I. Another change involved the designation of Axis III as relating to “general medical” conditions rather than only “physical” conditions, in order to deemphasize the somewhat inaccurate distinction between “organic”

(brain or biological) and “psychological” factors that was implicit in the DSM-III-R. Very minor changes were made in Axes IV and V regarding the specification of psychosocial stressors and general psychological functioning.

Changes to the criteria sets and disorders

With respect to major mental illnesses (Axis I) and enduring personality traits (Axis II), modifications included, among other things:

- (i) *Changes in the names of major diagnostic classes and disorders.* For example, there is no longer a class of disorders known as “organic mental syndrome and disorders.” The rationale for this change was that this category, as employed in DSM-III and DSM-III-R suggested a deceptive distinction between disorders caused by psychiatric (mental, emotional or behavioral) versus organic (brain or biological) factors. This change reflected the influence of findings from neuroscience and neurology that many mental disorders are in fact brain disorders;

Of additional interest is the fact that the name of a disorder which has received much public and media attention, Multiple Personality Disorder, was changed to “Dissociative Identity Disorder.” This change was based in part on the recognition that distinct personality entities (e.g., the “Three Faces of Eve”) are *per se* less common than the presence of different and dissociated personality states (e.g., passive, aggressive, gregarious, etc.);

- (ii) *Changes in diagnostic criteria for particular disorders.* These are similar to the changes in criteria discussed *supra* in relation to Manic Depressive Disorder, Manic Type. (Changes in the criteria for PTSD are discussed at length in our chapter on trauma.)
- (iii) *The creation of several new diagnoses*, such as bipolar II (a change which reflected the awareness of the complexity and variability of mood disorders), acute stress disorder, and several new childhood disorders; and
- (iv) *The deletion of some diagnoses*, including “self-defeating personality disorder.”

The DSM-IV also lists certain syndromes in an appendix with recommendations for further study, such as post-concussional disorder and mixed anxiety-depressive disorder. Additional axes are also proposed for study, and certain disorders are delineated as subsumed by other diagnoses. In addition, developers of the DSM-IV

placed greater emphasis on the importance of variables such as culture and gender in the development and expression of mental illness

The DSM-IV-TR, published in 2000, included no changes in diagnostic criteria for various disorders. The goal of its publication was to include findings from the empirical literature so as to ensure that text discussions were both accurate and comprehensive.

It is the nature of science, including psychiatry, to improve over time, to move in the direction of greater accuracy, without ever claiming to have attained perfection. The dean of a major medical school famously tells incoming first-year students, "Half of what we teach you here is wrong; unfortunately, we don't know which half." Diagnoses recorded today based on the criteria of the DSM-IV-TR may well have to be revised when the DSM-V appears in the future. Diagnoses under past DSM schemes need careful deconstruction today. Even with the increased empirical foundation of the current DSM-IV-TR, diagnostic impressions are invariably limited by the completeness of the data available and the evaluator's opportunity for longitudinal observation. All these considerations underscore the importance of looking beyond the diagnoses of capital clients for the signs, symptoms, and behaviors that reflect their disorders and impairments, the everyday limitations and disabilities that can evoke empathy from fellow humans.

CHAPTER 7:

BEYOND THE DSM'S DIAGNOSTIC CATEGORIES

Including:

- Conceptual issues in diagnostic nomenclature: normality versus abnormality;
- Consistency of diagnostic conclusions: the concept of reliability;
- The relationship of diagnosis to reality: the concept of validity;
- Symptom constellation versus disease entity;
- Categorical versus dimensional approaches;
- Dimensionality in mitigation; and
- Co-occurring disorders.

CONCEPTUAL ISSUES IN DIAGNOSTIC NOMENCLATURE: NORMALITY VERSUS ABNORMALITY

The detailed criteria for inclusion and exclusion represent an important methodological improvement, but there remain underlying questions of great magnitude and significance as we review the half-century evolution of the DSM. At the heart of evolving conceptual changes is a core question: What is abnormal behavior? Does a diagnostic scheme require agreement among diagnosticians about normality, and if so, who should decide, and how should concepts of normality and abnormality be defined? One discussion of this issue identifies the question in the following way: "In the case of physical illness, the norm is structural and functional integrity of the body; here the boundary lines between normality and pathology are usually (but by no means always) clear. On a psychological level, however, we have no 'ideal model' or even 'normal model' of human functioning to use as a base of comparison."¹⁶⁹

Cultural and sociopolitical values and concerns are strongly implicated in this question, and some have argued that what is deemed "abnormal" behavior is simply deviation from mainstream societal norms and expectations. For example, an often noted illustration of this view was the characterization of homosexuality as a mental disorder in the DSM-I and II. In the DSM-I, published in 1952, homosexuality was listed as a sexual deviation involving "pathological behavior" in the section labeled sociopathic personality disturbance. In the DSM-II, published in 1968, homosexuality was no longer listed under the category of sociopathic personality disturbances, but remained listed as a sexual deviation. Following challenge by clinicians and gay-rights activists, the labeling of same-sex relationships as a mental disorder was eliminated with the 1980 publication of the DSM-III.

¹⁶⁹ Coleman, J.C., Butcher, J.N., & Carson, R.C., *ABNORMAL PSYCHOLOGY AND MODERN LIFE* (Scott, Foresman & Co. 7th ed. 1984).

Another example of the interplay between diagnostic nomenclature and sociocultural labels was the diagnosis of “self-defeating personality disorder” proposed for inclusion in the DSM-III-R. This proposed diagnosis included criteria such as “chooses people and situations that lead to disappointment, failure, or mistreatment even when better options are clearly available; rejects... the attempts of others to help...; following positive personal gains... responds with depression, guilt or a behavior that produces pain...; incites angry or rejecting responses from others...” A group of clinicians and feminists fiercely contested this proposed constellation of symptoms. The basis of the debate on this proposal was the argument that the “symptoms” identified would label as mental illness the predictable responses of individuals—often women—exposed to the real and common social phenomenon of interpersonal violence. The “compromise” position reached was to include this diagnostic entity in an appendix in the DSM-III-R labeled “Needing Further Study.” This proposed disorder was dropped from the DSM-IV because of insufficient empirical evidence supporting its existence.

The preceding examples illustrate the (now fairly uncontroversial) viewpoint that delineation of mental illnesses or disorders should not, among other things, reflect societal/cultural disapproval of non-mainstream lifestyles, or pathologize predictable coping and behavioral responses to societal ills.

It is acknowledged, however, that definitional problems are an inherent part of any effort to clearly define behavior as abnormal. For example, the DSM-IV notes that “the concept of mental disorder, like many other concepts in medicine and science, lacks consistent operational definition that covers all situations...” In the DSM-IV, each of the mental disorders is conceptualized as “a clinically significant behavioral or psychological syndrome or pattern that occurs in an individual and that is associated with present distress (e.g., a painful symptom) or disability (i.e., impairment in one or more important areas of functioning) or with a significantly increased risk of suffering, death, pain, disability, or an important loss of freedom.”

As will be discussed below, efforts to avoid arbitrary delineations of mental disorders rely heavily on concepts of reliability and validity, and on increasing scientific support for existing criteria sets.

CONSISTENCY OF DIAGNOSTIC CONCLUSIONS: THE CONCEPT OF RELIABILITY

Will two clinicians who evaluate the same mentally ill patient reach the same diagnostic opinion as to the nature of the disorder? A commonly accepted tenet in the mental health field is that diagnostic agreement is an important requirement of an adequate diagnostic scheme. That is, a necessary, though not sufficient component of an adequate classification scheme is the ability of clinicians to agree that the presence of a symptom or set of symptoms will lead to a diagnosis that a certain illness or disorder exists. In diagnostic language, this is the concept of “reliability.”

In this context, reliability refers to the extent to which different observers can agree that their observations conform to a certain diagnostic category. If this is not the case, it suggests that classification criteria are not precise enough to determine whether the disorder is present. Clearly, if imprecision and inconsistency were to characterize diagnostic decisions, a strong suspicion would be raised about the arbitrary nature of these decisions. This would call the diagnostic scheme into question, create considerable confusion and disagreement over the legal ramifications of diagnoses, and play havoc with decisions about means and methods of treatment.

As noted earlier, a driving force in changes in the DSM over time has been the effort to increase reliability in diagnosing clinicians. There is empirical evidence that acceptable levels of reliability have been obtained for many, but not all, categories of mental disorders.¹⁷⁰

THE RELATIONSHIP OF DIAGNOSIS TO REALITY: THE CONCEPT OF VALIDITY

Is a particular diagnosis reflective of a phenomenon in the real world? As illustration, do the symptoms of depression as described in the DSM represent something real that characterizes a certain group of people? If we know that someone has had difficulties in concentration, has had sleep or appetite disturbance, has been “down in the dumps,” has contemplated suicide, has been feeling worthless and hopeless, has lost interest in sex, work, relationships—does that help us differentiate that person from someone who is not “depressed”? In diagnostic literature, this is the concept of “validity.” The concept of validity requires that a classification meaningfully tell us something that is significant and true about the entity or person being classified. Using the example presented above, if someone is diagnosed with depression, this should allow us to make certain inferences about that person’s emotions, cognitions and behavior, and these inferences should allow us to differentiate that person from someone who is not depressed. Clearly, if a diagnostic scheme lacks validity, that diagnostic scheme has no meaningful lessons to tell us about human functioning and behavior.

It is important to recognize that because changes in the DSMs were guided by an effort to strengthen its empirical base, with the goal of increasing reliability and validity, evaluations conducted under older versions of the DSM, particularly DSM-I and II may carry a greater likelihood of misdiagnosis, inaccurate diagnosis, or failure to identify the existence of particular mental disorders.

¹⁷⁰ Grove, W., *The Reliability of Psychiatric Diagnosis* in Last, C.G., & Herzen, M. (eds.), *ISSUES IN DIAGNOSTIC RESEARCH* (Plenum Press 1987), at 99-119. See also Matarazzo, J.D., *Psychological Assessment Versus Psychological Testing: Validation from Binet to the School, Clinic, and Courtroom*, 45 *AM. PSYCHOLOGIST* 999 (1990).

SYMPTOM CONSTELLATION OR DISEASE ENTITY?

What is the nature of a mental disorder? For example, does a “mental disorder” imply that a disease entity is present, does it refer to a cognizable constellation of symptoms, or is it simply an expression of a single symptom? Analogous examples from the field of medicine may serve to illustrate these questions. Conceptual distinctions can be drawn among the conditions of cancer, versus cerebral palsy, versus a broken bone. That is, cancer is a diagnosis which implies an underlying disease entity, cerebral palsy syndromes are “not a diagnosis per se, but provide a useful therapeutic classification for children with static spastic paresis, incoordination, or involuntary movements...”;¹⁷¹ a broken bone is a condition resulting from trauma to the body. As noted in a standard psychiatric text, “Implicit in the classification of mental disorders into various categories is the assumption that separate disease entities underlie the various manifestations of psychopathology.”¹⁷² However, writing about the DSM-IV, others have noted that some diagnoses “are well enough understood to be called established diseases... but most disorders defined in the DSM-IV are syndromes... and still other diagnoses... are no more than single symptoms.”

CATEGORICAL VERSUS DIMENSIONAL APPROACHES

With *Atkins v. Virginia*,¹⁷³ the United States Supreme Court extended a categorical protection to those prisoners who meet the criteria for mental retardation. These prisoners have been deemed so disabled as to require exemption from the capital punishment sentencing scheme altogether. But the Court has also recognized in at least three ineffective counsel cases¹⁷⁴ that even individuals who do not meet the strict criteria for exemption lie close enough on a spectrum of disability that their limited intellectual functioning also constitutes powerful mitigation.

The spectrum of disability that characterizes limited intellectual functioning has also been recognized by researchers in the mental health field. As noted in a discussion on the classification of mental disorders, “intelligence is a multifactorial construct with a variety of complexly interacting etiologies that is best described as a continuous variable... there does not appear to be a discrete break in its distribution that would provide a qualitative distinction between normal and pathologic intelligence.”¹⁷⁵

¹⁷¹ Berkow, R., & Fletcher, A.J., *THE MERCK MANUAL OF DISORDERS AND THERAPY* (Merck 1987), at 2110.

¹⁷² Kaplan, H.I., & Sadock, B.J., *THE COMPREHENSIVE TEXTBOOK OF PSYCHIATRY, THE CLASSIFICATION OF MENTAL DISORDERS* (vol. 1) (Williams & Wilkins 5th ed. 1989).

¹⁷³ 536 U.S. 304 (2002).

¹⁷⁴ *Williams v. Taylor*, 529 U.S. 362 (2000); *Wiggins v. Smith*, 539 U.S. 510 (2003); *Tennard v. Dretke*, 542 U.S. 274 (2004).

¹⁷⁵ Widiger, T.A., & Frances, A.J., *Toward a Dimensional Model for the personality disorders* in Costa, P.T., & Widiger, T.A. (eds.), *PERSONALITY DISORDERS AND THE FIVE-FACTOR MODEL OF PERSONALITY* (American Psychological Association 2nd ed. 2002).

Although considerable thought and research support a selection of an IQ of 70-75 as providing a meaningful and reasonable point at which to characterize lower levels of intelligence as resulting in clinically significant impairment and the possible need for clinical intervention, this point of demarcation does not distinguish the presence versus absence of an underlying pathology. It is only one point along a continuous distribution of cognitive functioning. In addition, there are persons with IQs below 70 for whom a qualitatively distinct physical disorder is evident, such as Down's or Fragile X Syndrome, that can often be traced to a specific biological event.

The 2002 report of the President's Commission on Special Education also addressed the dimensionality of mental retardation, in this instance in the educational context. Speaking of mental retardation and other developmental disorders, the report noted that there are objective criteria for identifying the disorders, but continued, "However, the model for identification is like that used for obesity or hypertension, not measles or meningitis. The disorder is always a matter of degree on a dimension, not a disorder that you have or do not have, and identification is ultimately a judgment based on the need for services."¹⁷⁶

Indeed, the need for services and the availability of funding for these services have always influenced the legal criteria for mental retardation. When the first Diagnostic and Statistical Manual (DSM) was published by the American Psychiatric Association in 1952, the degrees of intelligence defect used the same nomenclature as in later editions (mild, moderate, or severe) but very different numerical cutoffs:¹⁷⁷

	DSM-I (1952)	DSM-III (1980)
Mild	70 to 85	55 to 70
Moderate	50 to 70	35 to 49
Severe	below 50	20 to 34

In effect, the definition of mild (compared to severe) mental retardation was changed from sub-average intellectual functioning falling one standard deviation below the mean to two standard deviations. This adjustment sharply reduced the population eligible for services: a full scale score of 80 on the Wechsler IQ test ranks in the ninth percentile, whereas a score of 70 ranks in the second.

In *Williams v. Taylor*, one of the five categories of mitigating evidence which trial counsel had failed to introduce was borderline mental retardation¹⁷⁸ and Williams'

¹⁷⁶ In October 2001, President Bush established the President's Commission on Excellence in Special Education to recommend reforms to improve the educational performance of children with disabilities. On July 9, 2002, the Commission issued its report, A NEW ERA: REVITALIZING SPECIAL EDUCATION FOR CHILDREN AND THEIR FAMILIES, available at the Department of Education's web site at <http://www.ed.gov/inits/commissionsboards/whspecialeducation>, at Section 2: Assessment and Identification, 21.

¹⁷⁷ American Psychiatric Association, DIAGNOSTIC AND STATISTICAL MANUAL, MENTAL DISORDERS (1952), at 23-24; American Psychiatric Association, QUICK REFERENCE TO THE DIAGNOSTIC CRITERIA FROM DSM-III (1980), at 25-26.

¹⁷⁸ *Williams*, 529 U.S. at 372, n.4.

failure to advance beyond sixth grade in schooling.¹⁷⁹ In *Wiggins v. Smith*, limited intellectual capacity,¹⁸⁰ also characterized as borderline retardation¹⁸¹ and reflecting a full scale IQ of 79,¹⁸² is part of what the Court found to be powerful mitigation which the jury should have heard about.¹⁸³ In *Tennard v. Smith*, the Court characterized “impaired intellectual functioning” as “inherently mitigating.”¹⁸⁴

The Court's recognition of dimensionality in the area of mitigation is not new at all. Its most eloquent discussion, in fact, came a quarter century ago in *Eddings v. Oklahoma*.¹⁸⁵ While it declined then to exempt from execution an individual who was only sixteen years old at the time of the crime, the Court noted:

But youth is more than a chronological fact. It is a time and condition of life when a person may be most susceptible to influence and to psychological damage. Our history is replete with laws and judicial recognition that minors, especially in their earlier years, generally are less mature and responsible than adults... Even the normal 16-year-old customarily lacks the maturity of an adult. In this case, Eddings was not a normal 16-year-old; he had been deprived of the care, concern, and paternal attention that children deserve. On the contrary, it is not disputed that he was a juvenile with serious emotional problems, and had been raised in a neglectful, sometimes even violent, family background. In addition, there was testimony that Eddings' mental and emotional development were at a level several years below his chronological age. All of this does not suggest an absence of responsibility for the crime of murder, deliberately committed in this case. Rather, it is to say that just as the chronological age of a minor is itself a relevant mitigating factor of great weight, so must the background and mental and emotional development of a youthful defendant be duly considered in sentencing.¹⁸⁶

The reference to mental age "several years below his chronological age" is another way of describing low intellectual functioning, which is assessed in relation to age peers.

Neuroscientific research in the intervening quarter century since *Eddings* “has provided further evidence that the human brain continues to develop as individuals reach their early twenties.”¹⁸⁷ For example, maturational processes such as the increase

¹⁷⁹ *Id.*, at 396.

¹⁸⁰ *Wiggins*, 539 U.S., at 516.

¹⁸¹ *Id.*, at 518.

¹⁸² *Id.*, at 523.

¹⁸³ *Id.*, at 526.

¹⁸⁴ *Tennard*, 542 U.S., at 287.

¹⁸⁵ 455 U.S. 104 (1982).

¹⁸⁶ *Id.*, at 115-6.

¹⁸⁷ See Begley, S., *Getting Inside a Teen Brain*, NEWSWEEK, Feb. 28, 2000, at 58-59, reporting findings of Jay Giedd of the National Institute of Mental Health (corpus callosum, the cable of nerves connecting the right and left hemispheres, “continues growing into your twenties”) and Elizabeth Sowell of UCLA's Lab of Neuro Imaging (frontal lobes—responsible for such “executive functions as self-control, judgment, emotional regulation, organization and planning—undergo the greatest change

and subsequent elimination ("pruning") of the brain's gray matter may not be completed until late adolescence. Research shows that myelination, the process by which the brain's white matter, or "insulation," refines the operation of neural networks regulating behavior, continues into the early twenties. Further, the brain myelinates from the more primitive to the more complex areas, with the frontal lobes being the last part of the brain to undergo this process. As the frontal lobes are the part of the brain that govern impulsivity, judgment, planning for the future, and ability to anticipate consequences, this research shows that neurodevelopmentally adolescents are less able to control and plan their behavior than are adults:

[B]rain scan techniques have demonstrated conclusively that... phenomena observed by mental health professionals in persons under eighteen that would render them less morally blameworthy for offenses have a scientific grounding in neural substrates.¹⁸⁸

Taken together, brain anatomy data indicate that people are not biologically prepared to exercise mature emotional and behavioral control under they reach adulthood.

In the case of both age and intellectual functioning, the law has drawn a variety of bright lines. There is a minimum age to operate a motor vehicle, to vote, to drink alcohol, to serve in the armed forces, to serve as President of the United States, or to be eligible for execution.¹⁸⁹ Numerous state and federal statutes have defined intellectual disabilities for purposes of benefits and protections. These bright-line tests provide a clear answer to some questions: a fifteen-year-old may not drink alcohol and a 29-year-old may not be elected president, regardless of their individual reputations for maturity and wisdom. The tests exclude or include individuals in particular legal categories. But they often tell us nothing beyond that legal fact. They tell us which individuals meet certain criteria for exclusion, but they tell us nothing about the individual characteristics of those who are not excluded.¹⁹⁰

Age is more than a chronological fact, and intellectual functioning is more than an IQ score. The individual who has attained the minimum age to be served alcohol does not automatically drink responsibly. The individual whose IQ is in the 80s has an intellectual handicap, even if she does not meet the criteria for mental retardation. (And a generation earlier, when the criteria were different, she would have qualified!)

between puberty and young adulthood). See also Giedd, J.N., et al, *Brain development during childhood and adolescence: a longitudinal MRI study*, 2:10 NATURE NEUROSCIENCE 861 (1999); and Sowell, E., et al, *In vivo evidence for post-adolescent brain maturation in frontal and striatal regions*, 2:10 NATURE NEUROSCIENCE 859 (1999).

¹⁸⁸ 'Declaration of Ruben C. Gur, Ph.D., in *Patterson v. Texas*, Petition for Writ of Certiorari to U.S. Supreme Court,' available at <http://www.abanet.org/crimjust/juvjus/Gur%20affidavit.pdf>.

¹⁸⁹ See *Roper v. Simmons*, 543 U.S. 551 (2005), exempting from execution individuals who were under 18 years of age at the time of the capital offense.

¹⁹⁰ See Pollet, S.L., *Defining Adolescence and the End of Childhood in Family Court*, N.Y. LAW JOURNAL, Aug. 18, 2003, at 4, 6. Quoting Mylniec, Pollet notes that "the law recognizes rigid demarcations between adulthood and childhood based on age. The age at which a child legally becomes an adult may vary from 14 to 21 for a particular event." See also Mylniec, W.J., *A Judge's Ethical Dilemma: Assessing a Child's Capacity to Choose*, 64 FORDHAM L. REV. 1873 (1996).

In medicine, the dimensionality of many disorders is well understood by physicians and patients alike. Obesity is well defined (body mass index of 30 or more), but the overweight individual (body mass index = 25.0 to 29.9) who does not quite meet the criteria for obesity is still at risk for heart disease, certain cancers, type 2 diabetes, stroke, arthritis, breathing problems, and psychological disorders (such as depression). Hypertension also has clear definition (blood pressure of 140 or more, over 90 or more). Borderline elevation (130-139 over 85-89) still puts the patient at risk to damage arteries, heart and kidneys, or suffer atherosclerosis or stroke. Large-scale epidemiologic studies have increased our awareness of the dimensional relationship between blood pressure and risk, and led to continual downward adjustments of readings considered to be problematic.¹⁹¹

DIMENSIONALITY IN MITIGATION

In mitigation, the dimensionality of human frailty means that categorical compassion (protection from execution for people with mental retardation or teenagers below a certain age) merely anchors one end of a spectrum. Those who are nearer that end are still very disadvantaged, even when they are outside the exempt category. They are functioning with brains that are damaged or not yet fully developed. They are behaving impulsively not by choice but because their regulatory apparatus is not working. We can all glimpse in the mirror of our own lives or those of our children how that impulsivity takes hold, and this glimpse, in turn, helps us to understand in our imagination how these capital clients see and experience the daunting world around them. It is a glimpse at once of frailty and kinship.

The mental health field has long recognized the importance and role of dimensionality in the expression of mental disorders. Physical disorders and diseases often have a specific, discrete event, pathogen or lesion, a core pathophysiology, and an associated array of signs and symptoms that mark the disorder as a discrete clinical condition. In contrast, mental disorders are often characterized by an “extraordinary and obstinate heterogeneity,” whose richness is best captured on a dimensional model:

...[W]e have overwhelming evidence that... disorders of behavior are, with minimal exception, the products of countless discrete, dimensional, interactive, and sequential influences: biological, psychosocial, and sociocultural; historic and current; “hardware” (i.e., innate brain characteristics and any acute or persistent physical insults to the central nervous system) and “software” (i.e., the “programs” and data loaded into that hardware system from birth to present); planned and accidental, including

¹⁹¹ See *The Seventh Report of the Joint National Committee on Prevention, Detection, Evaluation, and Treatment of High Blood Pressure*, J. AM. MEDICAL ASS'N (May 21, 2003), recommending a more aggressive approach to the diagnosis and management of hypertension and defining as prehypertensive systolic BP readings of 120 or more and diastolic BP readings of 80 or more.

random bad luck... To anticipate that the outcomes of these multiple, complexly interwoven and... highly idiosyncratic antecedent processes... will fall out naturally into neat; digital packages of the kind envisaged by a... [categorical] diagnostic system is to strain the limits of credibility.¹⁹²

Co-occurring disorders

As is evident from the above, it is often more common for patients to exhibit co-occurring diagnoses than to meet criteria for a single diagnosis only.¹⁹³ Anecdotal experience with many clients on death row suggests that this tendency towards co-occurrence, which is prevalent in the general population, is even more pervasive in capably charged and convicted clients. The heightened vulnerability of this group may be understood in the context of the psychological literature on risk factors and resilience, which shows that exposure to adversity is not evenly distributed across the population¹⁹⁴. For example, children with competent and effective parents are exposed to fewer adverse life events than are children with less effective parents. Moreover, the accumulation of concurrent risk exposures is strongly related to poor outcomes on multiple measures of development. Severe marital discord, low socio-economic status, overcrowded living conditions, paternal criminality, maternal psychiatric disorder, and out-of-home placement are all variables associated with child psychiatric disorder.

Children exposed to two of these factors have a fourfold risk of developing a psychiatric disorder compared to children exposed to just one; with exposure to more than two of these factors, as is true for many capably charged clients, the risk is exponentially increased.¹⁹⁵

Research also shows that for certain patients, symptom remission is relatively rare. Again, this finding is true for clinical populations, where (in contrast to capably charged and convicted clients) there is a greater likelihood of family support and access to psychopharmacologic treatment and other clinical interventions to address psychiatric difficulties. Given a very vulnerable population, it is likely that the general problems with symptom remission may be greatly exacerbated.

¹⁹² Carson, R.C., *Dilemmas in the Pathway of the DSM-IV*, 100:3 J. ABNORMAL PSYCHOLOGY 302 (1997).

¹⁹³ Widiger, T.A., & Clark, L.A., *Toward DSM-V and the Classification of Psychopathology*, 126:6 PSYCHOLOGICAL BULLETIN 946 (2000).

¹⁹⁴ See Masten, A.S., *Ordinary Magic: Resilience Processes in Development*, 56:3 AM. PSYCHOLOGIST (2001) for a discussion of factors associated with risk and adversity exposure and resilience.

¹⁹⁵ See Rutter, M., Cox, A., Tupling, C., Berger, M., & Yule, W., *Attainment and Adjustment in Two Geographical Areas: The Prevalence of Psychiatric Disorder*, 126 BRITISH J. OF PSYCHIATRY 493 (1975); Rutter, M., Yule, B., Quinton, D., Rowlands, O., Yule, W., & Berger, M., *Attainment and Adjustment in Two Geographical Areas: Some Factors Accounting for Area Differences*, 126 BRITISH J. OF PSYCHIATRY 520 (1975); both in Rutter, M., *Protective Factors in Children's Responses to Stress and Disadvantage* in Kent, M.W., & Wolf, J.E. (eds.), *PRIMARY PREVENTION OF PSYCHOPATHOLOGY: SOCIAL COMPETENCE IN CHILDREN* (University Press of New England 1979), at 51-53.

In the current DSM, criteria have been set to establish or rule out particular diagnoses (e.g., does the person meet five of nine possible symptoms, or three of seven, or two of five, etc?). While empirical data provided the basis for decisions about criteria for some of the disorders, later research has sometimes shown that the criteria would have been different if the data had been collected in different settings, suggesting how arbitrary these decisions can be.¹⁹⁶ The heterogeneity of mental disorders is a problem of such magnitude that the developers of the DSM-V face important decisions about whether to include alternative criterion sets for different ethnic, gender and cultural groups.¹⁹⁷

The problem of how to identify the boundaries between what is viewed as normal and what is considered abnormal is also seen in the addition of new diagnoses to subsequent editions of the DSM: the purpose of most new additions is to fill in the holes and gaps along the boundaries of existing categories,¹⁹⁸ i.e., to describe a clinical problem which appears to occur on a continuum between an existing category of mental disorder and normal functioning.¹⁹⁹ For example, recurrent brief depressive disorder is major depression with shorter episodes; acute stress disorder is PTSD with a shorter duration; mixed anxiety-depressive disorder describes sub-threshold cases of mood and anxiety disorders; binge eating disorder concerns sub-threshold cases of bulimia nervosa; bipolar II disorder fills in gaps between bipolar I and cyclothymia; and mild neurocognitive disorder concerns sub-threshold cases of dementia, delirium, or amnesic disorder. In each of these cases, the attempt was to capture clinically significant phenomena that signaled psychiatric difficulty but did not meet diagnostic criteria for an established disorder.

Dimensional approaches to the classification of mental disorders have gained support among some clinicians and researchers because of the recognition that many patients meet criteria for a number of different mental disorders. For example, the average number of personality disorder diagnoses is often greater than four,²⁰⁰ and patients may meet criteria for as many as seven, eight, nine, and even eleven personality disorder diagnoses.²⁰¹ Not surprisingly, the personality disorder diagnosis most frequently given is “Personality Disorder Not Otherwise Specified.”

¹⁹⁶ Widiger & Frances, *supra*, n.175.

¹⁹⁷ Widiger & Clark, *supra*, n.193.

¹⁹⁸ *Id.*

¹⁹⁹ Thus, the number of diagnoses in the DSM has grown from approximately a hundred in the original edition (1952) to roughly three hundred in the latest (1994).

²⁰⁰ Skodol, A.E., Rosnick, L., Kellman, H.D., Oldhan, J., & Hyler, S.E., *Validating a Structured DSM-III-R Personality Disorder Assessments with Longitudinal Data*, 43:6 AM. J. PSYCHIATRY 1297; Widiger, T.A., Trull, T.J., Hurt, S., Clarkin, J., & Frances, A., *A Multidimensional scaling of the DSM-III Personality Disorders*, 44 ARCHIVES OF GEN. PSYCHIATRY 557 (1987); and Costa, P.T., & Widiger, T.A., *Introduction: Personality Disorders and the Five-Factor Model of Personality* in Costa & Widiger, *supra*, n.175.

²⁰¹ Widiger & Frances, *supra*, n.175.

Ironically, the theory underlying the personality disorder category is that there is a clearly defined personality to be described (“persons have only one personality”).²⁰² While the categories as described in the DSM provide vivid and clear images of various personality disorders, when, as frequently occurs, the patient is not a prototypical type, the diagnosis is misleading and stereotypical, and fails to capture the complexity that actually exists.²⁰³ While the personality disorders are particularly problematic, the “Not Otherwise Specified” category is the most frequently provided diagnosis in general clinical practice,²⁰⁴ presumably because diagnostic nomenclature in its current form is inadequate in its ability to classify actual clinical phenomena under the time constraints of typical clinical practice.

Depression has been described clearly by physicians since antiquity, but it may also be a condition best understood using a dimensional approach. In depression the debate over categorical versus dimensional models can be traced back for almost a century.²⁰⁵ The current focus of the discussion is whether subclinical forms of depression lie on a continuum with clinical cases, or whether subthreshold and clinical cases represent qualitatively distinct phenomena. A considerable body of data shows there are significant links between subclinical and full syndromal forms of depression, indicating that depressive syndromes occur on a continuum, i.e., that major depression as articulated in the DSM-IV may be a diagnostic convention imposed on a continuum of depressive symptoms of varying severity and duration.²⁰⁶

Observations of the longitudinal course of mental disorders reveal that the interweaving of some disorders is so frequent and pervasive that there is a basis to consider them alternative manifestations of a single disorder rather than co-occurring disorders. For example, about 75 percent of patients with dysthymic disorder have a lifetime history of suffering from major depression. As noted by leading researchers in this area:

How reasonable is it to consider these individuals as having two distinct disorders rather than a single disorder with more chronic and more episodic manifestations?

Such a view would be analogous to a chronic physical disorder (e.g., arthritis, asthma, or diabetes) in which acute exacerbations occur from time to time. That some individuals do not have acute exacerbations (i.e., do not have major depressive episodes within dysthymia) or that others suffer primarily from

²⁰² Widiger, T.A., *Mental Disorders As Discrete Clinical Conditions: Dimensional Versus Categorical Classification* in Turner, S.M., & Hersen, M. (eds.), *ADULT PSYCHOPATHOLOGY AND DIAGNOSIS* (John Wiley & Sons 3rd ed. 1997).

²⁰³ To address this problem, some current research proposes adoption of a dimensional, five-factor model of personality disorders.

²⁰⁴ Widiger & Clark, *supra*, n.193.

²⁰⁵ Shankman, S.A., & Klein, D.N., *Dimensional Diagnosis of Depression: Adding the Dimension of Course to Severity, and Comparison to the DSM*, 43:6 *COMPREHENSIVE PSYCHIATRY* 420 (2002).

²⁰⁶ Kendler, K.S., & Gardner, C.O., *Boundaries of Depression: An Evaluation of DSM-IV Criteria*, 155:2 *AM. J. PSYCHIATRY* 172 (1998); Shanklin & Klein, *id.*

relatively discrete episodes is not an argument against this view. Rather, it speaks simply to the longitudinal heterogeneity of clinical presentation, which is likely as common among psychological disorders as physical illness.²⁰⁷

The dissociative disorders represent another cluster of conditions whose diagnosis is so subtle that clinicians, required to indicate a diagnosis if only for billing purposes, most frequently make the vaguest choice: "Not Otherwise Specified." A more precise diagnosis will require not only longitudinal observation, but also a meticulously documented social history. "Not Otherwise Specified" may in reality refer to many possibilities, from Post Traumatic Stress Disorder to Dissociative Identify Disorder or even Schizoaffective Disorder.

In the context of mitigation (as opposed to treatment), diagnostic precision is less significant than a rich and detailed inventory of symptoms, a carefully chronicled phenomenology of the client's mental anguish. Mitigation is an area where the law does not ask what mental disease or defect affects an individual's present functioning or mental state at the time of the offense. Instead, the law asks how individual frailties manifested over the course of a lifetime, whether through co-occurring mental disorders or chronic and episodic manifestations of one disorder.

Diagnostic debate often overshadows the tragic reality that two clinical snapshots may both reflect symptoms of frailty which should inspire compassion or mercy. Just as youth is still mitigating beyond statutory cut-offs and sub-average intellectual functioning is mitigating whether it measures one or two standard deviations on the spectrum of cognitive disability, so too are the waxing and waning symptoms of mental and emotional distress, even when there is diagnostic ambiguity. It is the symptoms themselves that are capable of evoking empathy and kinship, by providing context, explanation, and insight into the world as the capital client experiences it.

²⁰⁷ Widiger & Clark, *supra*, n.193, at 956.

CHAPTER 8:

AN OVERVIEW OF CLINICAL DISORDERS COMMON TO CAPITAL CLIENTS

Including:

- Schizophrenia and other psychotic disorders;
- Mood disorders;
- Anxiety disorders;
- Dissociative disorders;
- Substance-related disorders; and
- Dual diagnosis (substance use and psychiatric disorders).

It is conceptually useful to separate psychiatric disorders from neurological or medical disorders, although they certainly overlap and co-occur. This chapter will survey the clinical disorders most frequently found in the capital client population: psychotic and delusional disorders, mood disorders and dissociative disorders, as well as the substance-related disorders. All these disorders are reported on Axis I in the DSM, and the reader is referred to the DSM-IV-TR for details of diagnostic criteria and further discussion.

SCHIZOPHRENIA AND OTHER PSYCHOTIC DISORDERS

Schizophrenia is a major psychotic disorder, most typically characterized by the presence of a number of symptoms including thought disorder, hallucinations, delusions, loose associations, flat or inappropriate affect, disorganized behavior, and impaired cognitive abilities, including deficits in attention, concentration, motivation and/or judgment.²⁰⁸ Essential to understanding schizophrenia is that it is a psychotic disorder defined by the loss of attachment to reality, such that individuals cannot assess the accuracy of their own thoughts, perceptions and feelings about the real world and typically lack insight into their own illness.²⁰⁹ Although exceedingly rare (approximately 0.5 percent of people have the disorder), a pervasive mythology has built up around schizophrenia in the popular imagination.²¹⁰

No single symptom is itself pathognomonic of schizophrenia. Diagnosis requires recognition of heterogeneous symptom patterns associated with impaired occupational or social functioning. The symptoms of schizophrenia are generally

²⁰⁸ Heinrichs, R.W., *The primacy of cognition in schizophrenia*, 60(3) AM. PSYCHOLOGIST 229 (2005).

²⁰⁹ Cummings, J.L., & Mega, M.S., *NEUROPSYCHIATRY AND BEHAVIORAL NEUROSCIENCE* (Oxford University Press 2003).

²¹⁰ Messias, E.L., Chen, C., & Eaton, W.W., *Epidemiology of Schizophrenia: Review of Findings and Myths*, 30 PSYCHIATRIC CLINICS OF NORTH AMERICA 323 (2007).

discussed in two categories, positive symptoms (referring to an excess or distortion of normal function) and negative symptoms (referring to a diminution or loss of normal function).²¹¹ These symptoms often fluctuate in severity over time.

Positive Symptoms	Negative Symptoms
Delusions (unfounded/unrealistic beliefs); Unusual thought content (fantastic or bizarre); Hallucinations (in any sensorium); Suspiciousness/persecution; Grandiosity (exaggerated self-opinion); Disorganized speech (language or thought); Grossly disorganized behavior.	Affective flattening; Emotional withdrawal; Lack of spontaneity; Reduced thought/speech productivity; Disturbance of volition; Poor rapport/lack of empathy; Poverty of speech.

Schizophrenia can be summed up as “a neurological disorder manifested by behavioral, neuropsychological, neuroimaging, and neuroanatomic alterations.”²¹²

DEVELOPMENT OF SCHIZOPHRENIA

The onset of schizophrenia is typically between the ages of fifteen and twenty-four years old. Men appear more likely to be diagnosed with schizophrenia in this young adult period, and women experience a second incidence peak between the ages of fifty-five and sixty-four.²¹³ However, perhaps as early as three years of age, certain signs and symptoms may begin to appear. Research indicates that those at high risk to develop schizophrenia are identifiable by deficits in developmental milestones, cognitive functioning, neurological and motor development, school achievement, social interactions, and psychological functioning.²¹⁴ This period of development of symptoms is termed the prodromal phase, which is a slow and steady increase in symptoms and severity of symptoms towards active phase schizophrenia. Some people have abrupt onset of psychotic symptoms, while others have a slow progression towards psychosis. The majority of people with schizophrenia diagnoses also have acute phases of illness mixed with periods of stability or remission, often described as waxing and waning of symptoms.

All of these changes are important for the social and family history investigation. Although onset of the first psychotic episode is important, the investigation should

²¹¹ See Kay, S.R., Fiszbein, A., & Opier, L.A., *The positive and negative syndrome scale (PANSS) for schizophrenia*, 13(2) SCHIZOPHRENIA BULLETIN 261 (1987). The PANSS was conceived as an operationalized, drug-sensitive 30-item instrument with balanced representation of positive and negative symptoms and which gauges their relationship to one another and to global psychopathology.

²¹² Cummings & Mega, *supra*, n.209, at 181.

²¹³ *Id.*

²¹⁴ *Id.*

seek evidence of the prodromal period. The waxing and waning of symptoms will likely mean that different witnesses have different experiences with the client, and will likely have seen him in different phases of the illness. This is also important for correct diagnosis, and a careful timeline must be created to document the pattern of illness.

Similarly important for the investigation is the substantial research on genetic predisposition to schizophrenia. Part of the factual development will necessarily look for multi-generational patterns of mental illness in the client's family. If a single parent has been diagnosed with schizophrenia, the average risk of a child developing the disorder is 13 percent; that risk ranges as high as 35 percent if additional biological family members have the disease.²¹⁵ Nevertheless, although at heightened risk, not every biologically related family member will develop recognizable symptoms. No single gene accounts for the vulnerability to schizophrenia, and current research focuses on the interaction of multiple genes of small effect with environmental factors in production of the disorder.

Although more rarely, schizophrenia does begin in childhood for some people. Childhood onset of schizophrenia seems to begin gradually, often preceded by developmental disturbances and lags in speech and language. Children with schizophrenia often have visual or auditory hallucinations and may have paranoid and bizarre beliefs. Other symptoms seen in childhood include problems paying attention, impaired memory and reasoning, speech impairments, inappropriate or flattened affect, inappropriate expression of emotion, poor social skills, and depressed mood. Such children may laugh at a sad event, make poor eye contact, and show little body language or facial expression. Misdiagnosis of schizophrenia in children is common.

Some research suggests that the brains of teens with early onset schizophrenia appear to be progressively damaged by what researchers call a "back-to-front wave" of neuronal damage. This loss of working brain tissue begins in the back of the brain (in the perception processing areas), and over about five years reaches to the frontal areas (executive functioning). Longitudinal research suggests that children who later develop schizophrenia have neuromotor, receptive language and cognitive developmental delays starting, in some cases, as early as three years of age. These children also had emotional and interpersonal problems, but at similar rates to children who developed other psychiatric illnesses.²¹⁶ Brain imaging research has found that over time (measured longitudinally between ages four and twenty-two), childhood-onset schizophrenics have a significant loss of total brain volume, driven by drops in frontal gray matter and total gray matter, compared to healthy controls.²¹⁷

²¹⁵ Gottesman, I., & Moldin, S., *SCHIZOPHRENIA AND GENETIC RISKS: A GUIDE TO GENETIC COUNSELING* (National Institute of Mental Health 2nd ed. 1998).

²¹⁶ Cannon, M., et al, *Evidence for early-childhood, pan-developmental impairment specific to schizophreniform disorder*, 59 *ARCHIVES OF GENERAL PSYCHIATRY* 449 (2002).

²¹⁷ Gogtay, N., Giedd, J., & Rapoport, J.L., *Brain development in healthy, hyperactive, and psychotic children* 59 *ARCHIVES OF NEUROLOGY* 1244 (2002).

The more common pattern of onset is one of an extended prodromal period, with a psychotic incident in the late teens to late twenties. After onset of the first psychotic episode, the acute phase of illness, a period of stabilization and finally a stable period often follow. The acute phase is marked by florid symptoms (hallucinations and/or delusions) and severely disorganized thinking. During stabilization, positive symptoms typically decrease in severity. Symptoms in the stable phase are less severe, sometimes not present, although non-psychotic symptoms such as depression or anxiety may appear. In addition, more negative symptoms may appear in later stages, and the negative symptoms of schizophrenia account for a significant degree of the morbidity associated with this disorder.

Trauma and psychosis

Current research indicates that the risk for psychosis is significantly increased by childhood maltreatment.²¹⁸ Studies demonstrate that up to 98 percent of adults with severe mental illness have a history of child abuse,²¹⁹ and researchers have described a biological mechanism by which trauma may trigger or cause psychosis and worsen the outcome in those who are already vulnerable to psychosis.²²⁰

A number of hypotheses for the relationship have been suggested, including that physiological changes to the brain and central nervous system brought about by physical and sexual abuse (especially the effects on the developing brain of childhood trauma) worsen the course and accelerate the onset of psychosis. In addition, people with major mental illnesses, such as schizophrenia, have a significantly higher risk of being abused. Finally, people with PTSD are prone to developing the positive symptoms of psychosis.²²¹ In studies of people with schizophrenia, those who have a history of childhood abuse are more likely to develop the positive symptoms of schizophrenia.²²² Similarly, people with PTSD are more likely to have the positive symptoms of schizophrenia (delusions, hallucinations, and bizarre behavior in the absence of formal thought disorder).²²³ Finally, people with severe mental illnesses are significantly more likely to have PTSD compared to the general population.²²⁴

²¹⁸ Keshevan, M., Kennedy, J., & Murray, R. (eds.), *NEURODEVELOPMENT AND SCHIZOPHRENIA* (Cambridge University Press 2004).

²¹⁹ Mueser, K., et al, *Trauma and Posttraumatic Stress Disorder in Severe Mental Illness*, 66(3) *JOURNAL OF CONSULTING & CLINICAL PSYCHOL.* 493 (1998).

²²⁰ Larkin, W., & Morrison, A., *TRAUMA AND PSYCHOSIS* (Routledge 2006); Spauwen, J., et al, *Impact of psychological trauma on the development of psychotic symptoms: relationship with psychosis proneness*, 88(6) *BRITISH JOURNAL OF PSYCHIATRY* 527 (2006).

²²¹ Seedat, S., et al, *Linking Posttraumatic Stress Disorder and Psychosis: A Look at Epidemiology, Phenomenology, and Treatment*, 191(10) *JOURNAL OF NERVOUS & MENTAL DISEASE* 675 (2003).

²²² Ross, C.A., et al, *Childhood Abuse and the Positive Symptoms of Schizophrenia*, 45(5) *HOSPITAL AND COMMUNITY PSYCHIATRY* 489 (1994).

²²³ Butler, R.W., et al, *Positive Symptoms of Psychosis in Posttraumatic Stress Disorder*, 39(10) *BIOLOGICAL PSYCHIATRY* 839 (1996).

²²⁴ Mueser, K.T., et al, *Interpersonal Trauma and Posttraumatic Stress Disorder in Patients with Severe Mental Illness: Demographic, Clinical, and Health Correlates*, 30(1) *SCHIZOPHRENIA BULLETIN* 45 (2004).

Thus, although the precise biological pathways remain uncertain, it is clear that the association between childhood abuse and more severe positive symptoms of schizophrenia is a strong one; that people with schizophrenia are significantly more likely than the general population to have been physically and sexually abused; and that the symptom patterns of PTSD and the prodromal period of schizophrenia may manifest through similar symptomatology.

Beyond myths and stereotypes

The popular image of schizophrenia is of someone wandering the streets aimlessly, mumbling or talking incoherently, dirty and unkempt, and acting quite bizarrely. It is exceedingly unlikely that this is how a client will present. In an acute phase of illness disorganized, tangential thinking, periods of distraction or what appear to be short fugue states (which may be auditory or visual hallucinations) may be observed. In an acute state, a person with schizophrenia might not be able to differentiate hallucinatory voices as such. In a less severe state, the schizophrenic client may still experience auditory hallucinations but can recognize them as such. A schizophrenic client may also experience unusual physical sensations or somatic delusions. Speech patterns may be odd or even incomprehensible in acute stages, presenting as rambling and unedited commentary that sometimes seems pointless or unfiltered skipping from thought to thought. The client may explain this as his brain moving faster than he can talk and he may have a self-perception of enhanced mental acuity. At the same time, he may be easily distracted and unable to differentiate important from unimportant stimuli. Sometimes the symptoms of a formal thought disorder are confusing to defense team members, and may seem like lack of interest in the agenda for a legal interview, or as evidence of uncooperative behavior, belligerence, or arrogance. Rather, these are important symptoms of severe psychopathology of which the capital defense team will need to take note.

The team will also want to listen carefully for delusional and especially paranoid delusional thinking. Delusions are fixed false beliefs that usually involve a misinterpretation of perceptions or experiences. As such, they often incorporate a kernel of truth. Some delusions may be very complex and some appear at first to be at least partially accurate reflections of the client's current life. To be delusional, these thoughts may, but do not need to be, completely implausible. For example, they may be bizarre ("a spaceship from Mars will be coming for me") or non-bizarre ("the jail is poisoning my food"). Since the symptoms of schizophrenia include abnormal perceptions and sensations, the client may struggle to explain his experience of the world, and this experience may understandably be radically different from that of defense team members.

Anosognosia is the clinical term for lack of awareness of one's own illness (or lack of insight). This is a critical concept for understanding schizophrenia, and also for developing techniques for working with a schizophrenic client. Somewhere between

60 and 80 percent of people with schizophrenia deny being mentally ill. This lack of insight is thought to be a neurological/neuropsychological deficit, and is associated with a host of negative outcomes. For example, it predisposes the individual to non-compliance with treatment, is predictive of higher relapse rates and increased numbers of involuntary hospitalizations, predicts poorer psychosocial functioning, and has a less favorable prognosis. Clients with anosognosia often show a pronounced and driven compulsion to disprove any suggestion that they are mentally ill. This obviously presents significant challenges in defense teams' relationships with such clients. Lack of insight need not be comprehensive. Some people with schizophrenia will be aware of one component of illness but not others. As noted above, lack of insight appears to be related to neuropsychological impairments rather than denial or defensiveness.²²⁵

Confronting a client's delusions is pointless and is highly likely to be counter-productive to his interests. Sometimes, the defense team's frustration with a client's inability to acknowledge seemingly obvious facts or their frustration with the client's tendency to turn simple facts into convoluted conspiracies, creates a desire to confront the delusional nature of the client's beliefs. This desire comes from our own confusion about how mental illness works. It is critical that we not forget that symptoms of mental illness represent disease states which the client cannot "think" his way out of. Confrontation of a client's beliefs will invariably create a breakdown in the relationship and likely push the client towards incorporating the defense team into his delusional system of beliefs. Instead, it is important to listen to the client carefully, demonstrate an understanding of his concerns, empathize with how difficult daily life is (especially living with delusional beliefs), and build trust that the team will work together with him to address these problems.²²⁶

Diagnostic criteria for schizophrenia

As with all psychiatric disorders, social history investigation is a critical part of determining whether the diagnostic threshold for particular mental disorders, as established by DSM-IV-TR, has been met. The DSM-IV-TR Criteria for Schizophrenia are:

- A. Characteristic symptoms: Two (or more) of the following, each present for a significant portion of time during a 1-month period (or less if successfully treated):
 - 1) Delusions
 - 2) Hallucinations
 - 3) Disorganized speech (e.g., frequent derailment or incoherence)

²²⁵ Amador, X., & Shiva, A.A., *Insight into Schizophrenia*, 10(3) CIVIL RIGHTS LAW JOURNAL 401 (2000).

²²⁶ See Amador, *supra*, n.31.

- 4) Grossly disorganized or catatonic behavior
- 5) Negative symptoms, i.e., affective flattening, avolition, or anhedonia

Note: Only one Criterion A symptom is required if delusions are bizarre or hallucinations consist of a voice keeping a running commentary on the person's behavior or thoughts, or two or more voices conversing with each other.

- B. Social/occupational dysfunction: For a significant portion of the time since the onset of the disturbance, one or more major areas of functioning such as work, interpersonal relations, or self-care are markedly below the level achieved prior to the onset (or when the onset is in childhood or adolescence, failure to achieve expected level of interpersonal, academic, or occupational achievement).
- C. Duration: Continuous signs of disturbance persist for at least six months. This six-month period must include at least one month of symptoms (or less if successfully treated) that meet Criterion A (i.e., active-phase symptoms) and may include periods of prodromal or residual symptoms. During these prodromal or residual periods, the signs of disturbance may be manifested by only negative symptoms or two or more symptoms listed in Criterion A present in attenuated form (e.g., odd beliefs, unusual perceptual experiences).
- D. Schizoaffective and Mood Disorder exclusions: Schizoaffective Disorder and Mood Disorder with Psychotic Features have been ruled out because either 1) no Major Depressive, Manic, or Mixed Episodes have occurred concurrently with the active-phase symptoms; or 2) if mood episodes have occurred during active-phase symptoms, their total duration has been brief relative to the duration of the active and residual periods.
- E. Substance/general medical condition exclusion: The disturbance is not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition.
- F. Relationship to a Pervasive Developmental Disorder: If there is a history of Autistic Disorder or another Pervasive Developmental Disorder, the additional diagnosis of Schizophrenia is made only if prominent delusions or hallucinations are also present for at least one month (or less if successfully treated).

DSM-IV-TR subtypes include paranoid type, disorganized type, catatonic type, and residual type.

Schizophrenia research has dramatically advanced in recent years both by brain imaging and careful empirical study. Findings have shown alterations in the prefrontal cerebral cortex, cerebellum and temporal cortex. This research points to a dysfunction of the pathways connecting the cerebral cortex, the thalamus and the cerebellum that leads to thought disorder and behavioral symptoms. According to this model, multiple different factors including genetic predisposition and environment contribute to neural dysfunction, the cognitive dysfunction emerges, and the person begins to have symptoms. Neuroimaging studies correlate abnormalities of brain frontal and mesolimbic regions in schizophrenic subjects with deficits in emotional processing and sensory hallucinations.²²⁷

Other neurological abnormalities such as perioral dyskinesias (involuntary tic-like movements around the mouth) and dystonic posturing (unnatural positioning) that are often seen in schizophrenia may indicate a malfunction of the basal ganglia and thalamus. Frequent blinking and grimacing are also believed to be related to hyperactivity of the dopaminergic system, a critical neurotransmitter system involved in schizophrenia. Another well-documented neurological deficit associated with schizophrenia is olfactory dysfunction, which is related to damage to brain pathways also involved in emotional response and the experience of pleasure.

National Institute of Mental Health scientists have reported that the excess dopamine activity found in schizophrenia may be driven by a defect in the prefrontal cortex, the brain's executive control center.²²⁸ This would tend to confirm the primary role that frontal lobe dysfunction plays in behavioral abnormalities seen in schizophrenia.

Schizophrenia is a severe mental illness, and as is true of many, if not most, mental disorders, it frequently does not occur alone. Many people with schizophrenia have co-morbid or co-occurring mental health disorders and problems, and also suffer depression, suicidal ideation and attempts, anxiety, substance use and report being victims of violence at rates higher than non-mentally ill people.

Working with schizophrenia issues

Treatment issues are first and foremost litigation issues. Although difficult, capital defense teams have to assess the effect on litigation of numerous issues such as motions to gain appropriate treatment for the client, to oppose forced medication, for appointment of a non-testifying expert who will assist the team in illness management and client relations, or for extensions of time because of the special needs of the client and the effect of his mental illness on defense team functioning, investigation and preparation.

²²⁷ Sawa, A., & Snyder, S.H., *Schizophrenia: Diverse approaches to a complex disease* 296 SCIENCE 692 (26 April 2002).

²²⁸ Meyer-Lindenberg, A., et al, *Reduced prefrontal activity predicts exaggerated striatal dopaminergic function in schizophrenia*, 5(3) NATURE NEUROSCIENCE 267 (2002).

Some of these motions will not be likely to prevail, but filing the motion may be useful as a litigation strategy to educate the judge, gain needed assistance or time, or simply to establish a way of talking about the client's mental illness in court that he can agree with rather than oppose.

One issue is whether to seek medication for the client. To assist in this decision, it is helpful to be informed about current antipsychotic medications that are commonly used to treat schizophrenia. In the 1950s, chlorpromazine and other drugs (e.g., haloperidol) were discovered to be beneficial in ameliorating the positive symptoms of schizophrenia and allowing patients to live moderately well in the community. Chlorpromazine and similar psychopharmacologic agents represented the first generation of antipsychotic medications (and are sometimes called "neuroleptics"). The side effects were quite serious, causing Parkinson's-like symptoms because neuroleptics block dopamine receptors. First generation neuroleptics are often referred to as "conventional" or "typical" medications.

In the 1990s, a second generation of antipsychotic medication came into widespread use, the "atypical" or "novel" antipsychotics. Some medications of this type include clozapine (trade name: Clozaril), risperidone (trade name: Risperdal), olanzapine (trade name: Zyprexa), quetiapine (trade name: Seroquel), and ziprasidone (trade name: Geodon). The atypicals have reported to have fewer and less debilitating side effects as measured by extrapyramidal symptoms, and to relieve both the positive and negative symptoms of schizophrenia. However, while initially hailed as major improvements, recent research calls the efficacy of the second generation drugs into question. Reservations about the efficacy of atypical antipsychotics include research showing no differences in patient perception of quality of life when administered this class of medication compared to the first generation of drugs, and concerns about weight gain and potentially serious metabolic side effects.

Other psychotic disorders

Along with schizophrenia, a number of other psychotic and delusional disorders are recognized. Rather than discuss each in detail, what follows is simply some definitional information that may help direct further research if these diagnoses appear in client records. Once again, the place to start is the DSM-IV-TR.

Delusional Disorder is characterized by at least one month of non-bizarre delusions without other active-phase symptoms of schizophrenia. Delusional disorder is a less severe illness in terms of number of symptoms, but may be no less debilitating to the client.

Brief Psychotic Disorder is characterized by symptoms that last more than one day but less than one month. Some people have unsuccessfully tried to argue that the nature of a crime is proof that the client suffered a brief

psychotic disorder at the time of the offense. This argument is unlikely to succeed unless based almost entirely on collateral sources of information.

Schizophreniform Disorder has the same symptom pattern as schizophrenia but diagnoses people whose symptom persistence does not meet the duration requirements. The course of illness is shorter than in schizophrenia and there is no need to show changes in social functioning. Duration of schizophreniform illness is longer than brief psychotic disorder but shorter than schizophrenia.

Schizoaffective Disorder requires that all the criteria of schizophrenia and major depression, manic or mixed episode, are met during the same period of illness. As noted in DSM-IV-TR, distinguishing between schizoaffective and schizophrenia and mood disorders can be quite difficult. The difference is essentially the duration of mood symptoms (in schizophrenia, they are of shorter duration).

Psychotic Disorder not Otherwise Specified is for people who have psychotic presentations but do not meet the criteria for any other illness.

Psychotic disorder due to a medical condition includes: dementia, delirium, brain tumor or certain illnesses which have delusional and/or hallucinatory features.

Psychotic disorder due to substances may result from either prescribed medication or illicit drugs which can cause psychosis—for instance, phencyclidine (PCP) is recognized to mimic schizophrenic psychosis.

Each of these has psychotic symptoms, as does schizophrenia, although, by definition, the clinical presentations differ.

MOOD DISORDERS

Mood disorders consist of a number of psychiatric illnesses, including major depression, bipolar I and II disorder, dysthymia, and cyclothymia. Mood disorders are characterized by wide variability in the course, severity, chronicity, and features associated with specific mood episodes. Each of the mood disorders requires significant impairment in normal functioning and is marked by significant behavioral symptoms.

Major depressive disorder

Depression is a major cause of disability and suicide in the United States. According to the DSM-IV-TR, the lifetime risk for Major Depressive Disorder in community samples varies from 10 to 25 percent for women and 5 to 12 percent for men. For

some people, major depression—the most severe form of the illness—is a chronic illness. Onset of major depression can be at any age. Depression may result from a combination of early life experiences, genetic predisposition, and environmental factors. Early life events such as physical or sexual abuse significantly increase the likelihood that a person will develop major depression. Depression has a strong familial pattern (genetic predisposition).

Associated with depression are disturbances in a number of neurotransmitter systems, including MAOA (monoamine), norepinephrine and serotonin. The research evidence and symptom patterns suggest that each of these systems is involved in major depression. It appears that major depression is best understood as a common endpoint for a variety of underlying problems.

The essential feature of a major depressive episode is a period of at least two weeks during which there is either depressed mood or the loss of interest and pleasure in almost all activities. Depression has numerous additional somatic and cognitive markers, including irritability, a sense of helplessness and hopelessness, attention and concentration impairments, suicidal thoughts, fatigue, and sleep and appetite disturbances. Similarly, a host of physical symptoms often accompanies depression, including headaches, gastrointestinal problems, lethargy, and general body aches and pains.

Severe major depression may have psychotic features. The DSM-IV-TR criteria for major depressive disorder include two possible types: single episode or recurrent. The criteria are essentially the same, except for the presence of a single episode versus presence of two or more episodes, and the symptoms must not be better accounted for by, or superimposed on, schizophrenia, schizoaffective disorder, schizophreniform disorder, delusional disorder, or psychotic disorder. There must be an absence of any manic episode as well. Finally, the severity and context of the depression have to be determined.

The DSM-IV-TR Criteria for Major Depressive Episode are:

- A. Five (or more) of the following symptoms have been present during the same two-week period and represent a change from previous functioning; at least one of the symptoms is either (1) depressed mood or (2) loss of interest or pleasure. Note: do not include symptoms that are clearly due to a general medical condition, or mood-incongruent delusions or hallucinations.
 - 1) Depressed mood most of the day, nearly every day, as indicated by either subjective report (e.g., feels sad or empty) or observation made by others (e.g., appears tearful). Note: In children and adolescents, can be irritable mood.

- 2) Markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day (as indicated by either subjective account or observation made by others).
 - 3) Significant weight loss when not dieting or weight gain (e.g., a change of more than 5% of body weight in a month), or decrease or increase in appetite nearly every day. Note: In children, consider failure to make expected weight gains.
 - 4) Insomnia or hypersomnia nearly every day.
 - 5) Psychomotor agitation or retardation nearly every day (observable by others, not merely subjective feelings of restlessness or being slowed down).
 - 6) Fatigue or loss of energy nearly every day.
 - 7) Feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick).
 - 8) Diminished ability to think or concentrate, or indecisiveness, nearly every day (either by subjective account or as observed by others).
 - 9) Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide.
- B. The symptoms do not meet the criteria for a Mixed Episode.
- C. The symptoms cause clinically significant distress or impairment in social, occupational, or some other important areas of functioning.
- D. The symptoms are not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition (e.g., hypothyroidism).
- E. The symptoms are not better accounted for by bereavement, i.e., after the loss of a loved one, the symptoms persist for a period of longer than two months or are characterized by marked functional impairment, morbid preoccupation with worthlessness, suicidal ideation, psychotic symptoms, or psychomotor retardation.

As major depressive disorder is frequently a recurrent disorder, it is particularly important to include developmental and longitudinal assessment of the disorder as part of a comprehensive social history investigation. Identification of familial patterns of depression is also critical, given the highly heritable nature of this disorder.

A difficult aspect of presenting major depression in litigation tends to be convincing the fact-finder that, in this particular client, the condition was severe and significantly different from the sad feelings everyone has experienced at some point in time. Fact-finders may minimize or fail to grasp the severity of this disorder. Thus, depression

generally tends to be a difficult diagnosis from which to explain criminal behaviors. Whether it can be made the centerpiece of a mitigation case or not, however, major depression is very important in helping defense teams figure out how to work with a client, how to explain specific behavioral symptoms the jury or judge may observe (e.g., flat affect may be interpreted as lack of remorse) and how to assess the client's ability to participate in his defense.

Bipolar disorder

Sometimes referred to as manic depression, bipolar disorder affects approximately 1 to 3 percent of people in the United States, and its symptom pattern has been described consistently for centuries. Subtle variations and complex behavior patterns make it difficult to diagnose at times and even more difficult to predict the course and outcome.

Bipolar is a serious but treatable disease of the brain that causes extreme shifts in mood, energy and functioning. Men and women are equally likely to develop this disabling illness that typically emerges in adolescence or early adulthood. However, new research suggests that childhood onset is more common than previously thought, although often misdiagnosed because the adult criteria do not accurately describe the behavioral symptoms experienced by children. Cycles, or episodes, of depressive and/or manic symptoms typically recur if untreated and may become more frequent, often disrupting work, school, family and social life.

A number of different symptom patterns make up various types of bipolar disorder, but essentially they contain periods of *mania* (abnormally and persistently elevated or irritable mood that lasts at least a week and includes grandiosity, decreased need for sleep, pressured talking, flights of ideas, distractibility, increased goal directed activity, excessive involvement in pleasurable activities *and* social or occupational impairment) or *hypomania* (abnormally and persistently elevated or irritable mood that lasts at least four days and includes grandiosity, decreased need for sleep, pressured talking, flights of ideas, distractibility, increased goal directed activity, excessive involvement in pleasurable activities *without* social or occupational impairment), usually intermixed with depression. (The patterns of symptom expression vary as to how often each of the manic and depressive states occur and last, and it is possible to have bipolar without having a major depressive episode). The DSM-IV-TR differentiates Bipolar I disorder from Bipolar II disorder. The former is characterized by one or more manic or mixed episodes, usually accompanied by major depressive disorder. The latter is characterized by one or more major depressive episodes accompanied by at least one hypomanic episode.

Again, social history information and descriptions of the following types of symptoms over time will assist in diagnosis:

Manic Symptoms	Depressive Symptoms
<p>Severe changes in mood—either extremely irritable or overly silly and elated; Overly inflated self-esteem; grandiosity; Increased energy; Decreased need for sleep—ability to go with very little or no sleep for days without tiring; Increased talking—talks too much, too fast; changes topics too quickly; cannot be interrupted; Distractibility—attention moves constantly from one thing to the next; Hypersexuality—increased sexual thoughts, feelings, or behaviors; use of explicit sexual language; Increased goal-directed activity or physical agitation; Disregard of risk—excessive involvement in risky behaviors or activities.</p>	<p>Persistent sad or irritable mood; Loss of interest in activities once enjoyed; Significant change in appetite or body weight; Difficulty sleeping or oversleeping; Physical agitation or slowing; Loss of energy; Feelings of worthlessness or inappropriate guilt; Difficulty concentrating; Recurrent thoughts of death or suicide.</p>

Bipolar disorder may wax and wane over time. As with major depression, longitudinal evidence of mania and depression are an important part of developing the symptom picture, and collateral witnesses to the behavioral symptoms are critical as people suffering from these disorders are often unaware of how unusual their behavior is (especially during the manic phases of the illness).

The medications which have been found to help control bipolar disorder include mood stabilizers, antidepressants, and anti-psychotic medicines. Mood stabilizers include lithium, divalproex sodium (Depakote) and carbamazepine (Tegretol). In high doses these medications can stop mania. They are also used to minimize or prevent episodes of mania or depression. The medications must be taken continuously and usually for life.

Antidepressants include fluoxetine (Prozac), sertraline (Zoloft), paroxetine (Paxil), bupropion (Wellbutrin), nefazodone (Serzone), venlafaxine (Effexor), and others. These medications should generally be used along with mood stabilizers. It is generally not appropriate to take antidepressants without mood stabilizers. Antidepressants are used mainly to treat acute major depression rather than bipolar generally. Once the depressive episode is controlled, mood stabilizers may be recommended to prevent future depression.

Surprisingly, electroconvulsive therapy (ECT, previously known as electroshock) has once again become a common and apparently successful tool in the treatment of

bipolar disorder. More traditional therapy (cognitive-behavioral) has also proven useful in treating bipolar disorder.

Bipolar disorder can be important as a mitigating factor because it may explain a variety of otherwise negative appearing behaviors: grandiosity, irresponsibility, oversexualization, engaging in risky behaviors that seem to show disregard of self or others.

ANXIETY DISORDERS

These disorders are a set of conditions that include: panic attacks, post-traumatic stress disorder, obsessive-compulsive disorder, generalized anxiety and acute stress disorder. Panic attacks are present in many of the anxiety disorders. A panic attack is defined by a discrete period of intense fear or discomfort in the absence of any real danger that is accompanied by a number of somatic (physiological) or cognitive symptoms. These conditions are included here because they have important effects on behavior and are often quite disabling.

Although not fully understood, current research points to the hippocampus and the amygdala as critical to the neuroanatomy of fear and anxiety. As discussed above in chapter four, the amygdala plays an essential role in the acquisition of conditioned fear and the expression of innate and learned fear responses. Through connections to other parts of the brain, the amygdala has a role in automatic and involuntary behavioral responses, which triggers fight or flight responses. Direct electrical stimulation of the amygdala precipitates fearful and panic-like responses.

Additionally, the amygdala and hippocampus connect to the cortex and are involved in the elaboration of contextual information, interpreting the environments associated with conditioned responses, and storing this information in memory. This is one of the important feedback loops that appears to exert an inhibitory effect on the amygdala. Therefore, dysfunction of the prefrontal cortex would lead to a disinhibition of the amygdala.

As with all the other conditions discussed in this manual, the key issue for mitigation related to anxiety disorders is to establish through the social and family history investigation the onset and course of the illness. This will allow the capital defense team both to tell the story of how this illness shaped the client's life, as well as develop the facts necessary to substantiate the diagnosis.

Post-Traumatic Stress Disorder (PTSD)

One of the anxiety disorders frequently encountered in capital defendants is post-traumatic stress disorder. One long term consequence of trauma (see chapter three) can be PTSD. Chronic or single incident trauma must be documented in order to find

PTSD. Inversely, the experience of trauma does not mean the client suffers from PTSD. Current research suggests that approximately 25 percent of people exposed to a life-threatening experience will develop PTSD.²²⁹ However, for those who do develop PTSD, and do not receive treatment, symptoms of PTSD will be long-lasting. The essential features of PTSD result from changes that occur following the exposure to a life threatening event. Thus, the DSM-IV-TR criteria begin with a direct personal experience of an event that actually does, or is perceived to, threaten the life of the person and then move to persistent behavioral changes:

- A. The person has been exposed to a traumatic event in which both of the following were present:
 - 1) The person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others
 - 2) The person's response involved intense fear, helplessness, or horror. [Note: In children, this may be expressed instead by disorganized or agitated behavior.]

- B. The traumatic event is persistently re-experienced in one (or more) of the following ways:
 - 1) Recurrent and intrusive distressing recollections of the event, including images, thoughts or perceptions. [Note: In young children, repetitive play may occur in which themes or aspects of the trauma are expressed.]
 - 2) Recurrent distressing dreams of the event. [Note: In children, there may be frightening dreams without recognizable content.]
 - 3) Acting or feeling as if the traumatic event were recurring (includes sense of reliving the experience, illusions, hallucinations, or dissociative flashback episodes, including those that occur on awakening or when intoxicated). [Note: In young children, trauma-specific reenactment may occur.]
 - 4) Intense psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event.
 - 5) Physiological reactivity on exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event.

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

²²⁹ Carlson, E., TRAUMA ASSESSMENTS (Guilford Press 1997).

- 1) Efforts to avoid thoughts, feelings, or conversations associated with the trauma.
 - 2) Efforts to avoid activities, places, or people that arouse recollections of the trauma.
 - 3) Inability to recall an important aspect of the trauma.
 - 4) Markedly diminished interest or participation in significant activities.
 - 5) Feeling of detachment or estrangement from others.
 - 6) Restricted range of affect (e.g. unable to have loving feelings).
 - 7) Sense of foreshortened future (e.g., does not expect to have a career, marriage, children, or a normal life span).
- D. Persistent symptoms of increased arousal (not present before the trauma), as indicated by two (or more) of the following:
- 1) Difficulty falling or staying asleep.
 - 2) Irritability or outbursts of anger.
 - 3) Difficulty concentrating.
 - 4) Hypervigilance.
 - 5) Exaggerated startle response.
- E. Duration of the disturbance (symptoms in B, C, and D) is more than one month.
- F. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

The key features described here must be proven before a diagnosis of PTSD can be made. It is not enough that the traumatic event is documented. To be diagnosed with PTSD, the client must meet these criteria. The investigative efforts should be geared towards uncovering the behavioral and psychological changes brought about by the exposure to trauma even if the client does not currently meet these criteria.

DISSOCIATIVE DISORDERS

Dissociative disorders refer to a state in which the individual's normally integrated mental functions of consciousness, memory, identity and/or perception are disrupted or severed from each other. Dissociation is a criterion subset for a number of other psychiatric disorders such as the dissociative response to trauma, but a "Dissociative Disorder" diagnosis is found only when dissociative symptoms occur outside the presence of those conditions.

Dissociation is often described by those who have experienced it as a floating above and/or looking down on oneself (depersonalization) or as a feeling that one's

surroundings and the events are unreal (derealization). It may also be experienced as an absence, a period for which there is no memory or explanation (amnesia). A client who describes an experience in any of these ways is likely describing dissociation. It is essential to determine whether the dissociation is caused by an underlying psychiatric illness or meets the criteria for Dissociative Disorder by means of a thorough social and family history investigation.

A common misunderstanding of dissociation is that the dissociated person is unable to act or do things, but a better description is that the person has an absence from conscious awareness of his actions. This has been termed “dissociated control,” a state in which the person can perform learned tasks that require little executive functioning, like dialing a phone number, but those actions take place outside the full functioning of the cognitive system.

This concept may help to explain, for example, cases where a client maintains he knows nothing about the offense but physical evidence appears to strongly implicate him. Some experts have opined that a client experienced dissociation at the time of the offense based on clinical interviewing in which the client appeared unable to recall any specific details of the offense. On cross-examination and in rebuttal through prosecution witnesses, this opinion is nearly impossible to sustain credibly if the opinion is based solely on clinical interview of the client. As with other conditions, it is crucial to establish the reliability of this assertion through collateral sources, for instance, through witnesses who spoke with the client while he dissociated, by a history of dissociation—preferably documented by a mental health expert prior to the initiation of litigation, and by documenting specific events that trigger dissociation in the client and which occurred at the time of the offense.

Even with substantial evidence of dissociation, the rebuttal argument is that each action the client took leading up to and during the offense is evidence of volition. This type of rebuttal evidence is sometimes called “forensic behavioral analysis” and consists of a prosecution expert performing a narrative crime reconstruction for the jury. Some prosecution experts have used this technique with great effectiveness, recasting the dissociated control behaviors, which are properly considered avolitional, as intentional, planning activity.

Dissociation as a useful concept in capital defense settings is probably most useful when attached to an underlying psychiatric condition that causes it (e.g., trauma) rather than as a stand-alone explanation for behavior.

SUBSTANCE-RELATED DISORDERS

Alan Leshner, former Director of the National Institute on Drug Abuse, concluded in 1997: “Addiction is a brain disease.” Drug use changes the functioning of the brain: the brains of drug users are different from the brains of non-users. The craving and dependence observed with repetitive use results from specific pathways in the brain.

Addiction and use are not the same, of course, since addiction refers to someone who has a compulsion to continue use.

Addiction is a disease of compulsion, and is therefore not voluntary. Addiction is defined by a loss of control, where the user does it despite the negative consequences that coincide with use. Craving is another component of addiction wherein getting/using the drug consumes the addicts' thoughts. Craving is dysphoric, agitating, and feels very bad. Addiction is a chronic, relapsing disease. The natural history of the disease is illustrated by the progressive loss of control over use, so the loss of control occurs more rapidly as the disease progresses.

Nearly all substances of abuse work on the same pathway in the brain, with some important differences discussed below: the mesolimbic reward system. Long-term use of nearly all substances causes pervasive changes in both brain function and brain structure, including changes in metabolic activity, neurochemical receptor activity and availability, and responsiveness to stimuli.

Drugs and alcohol have long been associated with violent crime, but most people continue to view substance use as a willful act that simply makes worse whatever other crimes are associated with being on drugs. Surveys have indicated that nearly 80 percent of incarcerated people have used drugs or alcohol, many of them during the time of their offense.²³⁰ The litigation strategy for explaining substance use must dually explain that the client's substance use began for a reason other than self-enjoyment and that once begun, addiction processes took away the volitional nature of the use. Substantial scientific evidence exists to indicate:

1. many people who later become addicted are introduced to substance use by an older sibling or peer, oftentimes in the context of physical or sexual abuse;
2. many people with otherwise untreated or under-medicated psychiatric illness, language or learning disabilities, exposure to violence, brain dysfunction or numerous medical conditions, self-medicate with illicit drugs, prescribed medication and/or alcohol in an effort to control their emotional experience of the world; and,
3. once initiated, drugs and/or alcohol alter the way in which the brain functions; all of them create short-term alterations in function, but each also (to a varying degree) causes changes in brain function and/or brain structure that persists across life-span.

The first task of investigating substance use is to obtain a very detailed drug history: when the client began use of any drug or alcohol, who introduced the client on that first occasion, when and how much of each substance was used, how often, where did

²³⁰ National Center on Addiction and Substance Abuse at Columbia University, *BEHIND BARS: SUBSTANCE ABUSE AND AMERICA'S PRISON POPULATION* (1998).

the client obtain it, what was the quality or purity of the substance, how did the client deal with periods of withdrawal or inability to procure. It is important to obtain extensively detailed information of the client's substance use over the course of his life following that first use.

In addition to creating a substance use timeline, it is important to develop a parallel timeline of childhood abuse, trauma exposure, mental illness and brain injury symptoms to explore onset and course of mental illness in relation to substance use. The client's self-report of the temporal relationship between substance use and onset of mental illness or brain dysfunction cannot be relied on, but it is useful to start with the client and then develop collateral evidence. Most people underreport their own substance use, and capital clients are often poor historians in general.

Because substance use has been demonstrated to be strongly linked to parental and familial use, it is also necessary to develop information on the multi-generational use of substances within the family that may have an environmental and/or genetic influence on the client's use.

Substance abuse is strongly associated with childhood abuse, neglect and trauma. People who suffer abuse, neglect and/or trauma are significantly more likely to use drugs and alcohol. The leading view as to why this is suggests that people seek to self-medicate the symptoms that follow such trauma or seek to avoid every day life and dealing with the consequences and experience of the abuse. Especially in cases where treatment for the trauma was not available, it is more likely that the traumatized person will seek a means for dealing with the day-to-day consequences of trauma and abuse. The critical task for the investigation is to demonstrate that the onset of the substance use followed the trauma.

DSM-IV-TR defines intoxication and abuse of each kind of substance (a different criteria set for each type of substance which can be abused or to which a person can become dependent—see DSM-IV-TR for each set of criteria). All of the important substances that people use (see below) have the capacity to create dependence. The common criteria across all substances are that the person have recently used the substance, that the use causes significant impairment or distress, that the person experiences repeated social or interpersonal problems as a result of the use, and that the person experiences some sort of craving (physiological or not) to seek continuing use.

Most drug use researchers consider the notion of physiological dependence versus psychological dependence to be an obsolete distinction based on a decades old lack of understanding about how substance use alters brain function. The hallmark of this approach depended on the presence of withdrawal symptoms when a person was detoxified. However, it is now generally accepted that all major substances of abuse produce withdrawal symptoms and all have specific effects within the brain when a person goes through the detoxification process. Evidence of withdrawal is very important to corroborate use and to assess the extent of addiction. Along with

documenting use patterns, it is important to document the onset of withdrawal symptoms when developing the substance use history (especially if part of the mitigation case relates to substance use at the time of the offense or time of arrest).

Methamphetamine

Methamphetamine is a stimulant drug that became significantly cheaper and easier to use in the early 1980s. It can be smoked, injected or ingested. Acute effects of methamphetamine last between four and twenty-four hours (depending on dose and quality). Like all stimulant drugs, methamphetamine forces the release of the body's own natural stimulants without reason or demand from the body, that is, without reasonable need for the energy. Methamphetamine's principal biochemical action on the brain is to mimic and increase the effects of epinephrine (adrenaline) and to prompt the massive release of dopamine into the brain.

Methamphetamine damages dopamine terminals and transporters in the brain, causing a dysregulation of the dopamine system. This appears to be most significant in the orbitofrontal cortex. Current research suggests that this dysregulation explains both the loss of control and the craving pattern associated with methamphetamine use. Chronic use causes frontal lobe brain damage (reduced neuronal activity and density).

The initial effect of the release of excess stimulating chemicals is euphoric. However, activation of the sympathetic nervous system produces a "fight or flight" behavior pattern in which intoxicated individuals misinterpret, overreact, and misjudge stimuli. Methamphetamine keeps the chemicals circulating by blocking the normal re-absorption, so the stimulant effects are both exaggerated and prolonged.

High doses or prolonged use of methamphetamine can cause toxic psychosis. These symptoms are almost always the result of high potency methamphetamine used either intravenously or by inhalation (smoking) and occur more often among chronic users. Psychosis occurs when the vague drug-induced fears crystallize into a fixed delusional system. Typically, the psychosis includes delusions and/or hallucinations occurring in the absence of intact reality testing, sometimes with disorganization of speech and behavior. The delusions (erroneous beliefs involving distortion or exaggeration of thought) suffered by methamphetamine users are paranoid delusions, meaning that the individual believes he is being watched, persecuted, or attacked when he is not. The auditory hallucinations (distortions or exaggeration of perception) most often reported are vague noises, voices, and occasional conversations with the voices. Speech is pressured, tangential, and fragmented reflecting internal disorganization.

Amphetamine psychosis can be expected to have several substantive effects on behavior; these can include euphoria or affective blunting, changes in sociability, hypervigilance, interpersonal sensitivity, anxiety, tension, or anger, stereotyped (repetitive) behaviors, impaired judgment, or impaired social or occupational

functioning. Cognitive abilities are similarly affected, with effects including paranoia and hallucinations, compounding the severe irritability and poor impulse control. As a consequence of the drug-induced psychotic state, the individual is unable to separate fact from fantasy (psychosis), and is subject to irrational fear (paranoia) that can trigger responsive (and impulsive) behavior from him. Events occur, and behaviors are seen that would not occur if it were not for methamphetamine intoxication.

Even in very low doses, methamphetamine produces a variety of significant physiological responses that are a consequence of the increase of epinephrine (adrenaline) in the system: pulse and blood pressure increase; the pupils dilate, and finally, body temperature rises. Methamphetamine increases motor and speech activity as well as nervousness and irritability. Alertness and excitement increase, and consequently, in high doses the drug produces prolonged periods of wakefulness, even when the individual is physiologically exhausted.

Methamphetamine-impaired neuropsychological function does not appear to recover following an extended period of abstinence: the damage caused by chronic methamphetamine use is permanent.

Phencyclidine (PCP)

PCP is a dissociative anesthetic agent developed in the late 1950s as a surgical anesthetic (it was subsequently banned from use). PCP has come in and out of widespread use a number of times in the last three decades. It is commonly used with other substances (e.g., marijuana is sometimes dipped in PCP). It is generally reported that people use PCP to achieve the feelings of numbness and dissociation (e.g., as a self-medication). Ketamine, another dissociative anesthetic drug, works in much the same way as, and with similar effects to, PCP.

PCP intoxication causes a psychosis that is indistinguishable from schizophrenia. Psychosis is the threshold effect of PCP and people who are intoxicated with PCP are often unpredictable and volatile. In some people, PCP acts as a sedative, although for most people it causes an extreme agitation.

Along with psychosis, low doses of PCP cause mood fluctuations, distortions in thinking, memory loss, impaired judgment, agitation, impaired perception, disorientation and hallucinations. Psychosis can last from approximately twenty-four hours up to six weeks from low dose usage of PCP.

Chronic use of PCP causes permanent alterations in mood and behavior as well as in brain functioning. PCP binds to opioid receptors which are very prevalent (high density of receptors) in the hippocampus and frontal cortex. This binding blocks the neurotransmitter NMDA (*N*-methyl-D-aspartate), a subtype receptor for the excitatory neurotransmitter glutamate. This explains the behavioral effects observed.

Cocaine

Cocaine is a stimulant. Cocaine can be taken by any of a number of routes (ingestion, inhalation, absorption) and reaches the brain relatively quickly (by inhalation more quickly than intravenous or intranasal).

Chronic cocaine use produces impairments in learning and memory, visuospatial ability, mental flexibility, processing speed and ability to abstract (frontal-subcortical related functions). Chronic use of cocaine has been shown to cause functional and structural changes in the brain, primarily in the frontal cortex and basal ganglia. Chronic use also can cause a variety of medical problems (seizures, optic neuropathy, intracerebral or subarachnoid hemorrhage, myocardial infarction, ischemia, brain atrophy). Cocaine also produces axonal degeneration, especially in areas very high in acetylcholine receptors.

Chronic use may also cause toxic psychosis. Cocaine users develop tolerance that usually leads to the use of increasing amounts to accomplish a similar intoxication. This, in turn, leads to a greater rate of degeneration in brain function and a greater likelihood of developing psychotic symptoms. Cocaine-induced psychosis is characterized by paranoia with ideas of reference, delusions, fear, anxiousness, impaired cognitive functioning, impaired judgment, inappropriate responses to stimuli, impaired impulse control, and hallucinations.

Cocaine, like methamphetamines, works by raising the amount of dopamine released in the brain. It then blocks the process by which dopamine would normally be taken out of the system, resulting in an ongoing stimulation. Chronic cocaine use also causes a kindling effect, which means the brain develops an anticipatory posture and is primed for further dosing. Cocaine use following the development of this kindling state is often seen to have a heightened impact (in contrast to tolerance).

Alcohol

More than any other substance of abuse, alcohol is involved in a tremendous number of injuries and deaths in the United States. Ethyl alcohol is a psychoactive drug that is just as powerful as the more notorious illegal drugs. Physiologically, alcohol produces a general and nonselective depression of the central nervous system. Although it is not completely clear how alcohol works, it appears that alcohol first depresses the neurons in the brain stem that control the higher centers of the cerebral cortex. Thus, alcohol first affects the cerebrum, which in turn controls complex human behavior. The result of low doses of alcohol is therefore impaired perception, thought, judgment, organization, and fine motor processes.

Alcohol produces disinhibition in behavior. With higher doses of alcohol disorientation increases; impairment of judgment and distortion of thought increase in severity. As the user's blood alcohol level increases the individual becomes progressively incapacitated; first fine motor function, and then, gross motor function is affected. The consequence of very high doses of alcohol in the body is the suppression of respiration and, finally, death. Chronic alcohol ingestion may irreversibly destroy nerve cells leading to permanent impairment of cognition, memory, and motor control. Chronic use of alcohol can also produce a specific dementia called "Korsakoff's syndrome."

The long-term consumption of alcohol has psychological consequences for the user. Prolonged drinking produces anxiety and depression. All of the symptoms associated with depression and anxiety (insomnia, irritability, palpitations) often appear. Drinking temporarily relieves these symptoms, thereby increasing the difficulty of maintaining sobriety in the long-term user. Drinking alcohol also exacerbates any pre-existing depression and/or anxiety from which the individual suffered.

Alcohol occasionally produces amnesia or blackouts. The amnesia is anterograde: a failure to make new memories. During a blackout, the individual has relatively intact remote and immediate memory, but experiences a specific short-term memory deficit for which he is unable to recall events that happened five or ten minutes before. Because other intellectual faculties are well preserved, the intoxicant can perform complicated acts and appear normal to the casual observer.

Because many jurors will be familiar with the effects of alcohol, it can be extremely difficult to convince jurors of the significance of the effects related to alcohol use. Alcohol use alone tends not to be a compelling mitigating factor, but as with many conditions, it may be important to telling the client's story and humanizing him. It may also have an interactive effect with psychiatric and neurologic illnesses.

Marijuana

Marijuana is generally believed to have the most limited long-term effects on the brain and to be the most benign of illicit drugs. Recent research has sought to challenge this view because marijuana appears to affect the stress and reward systems in the brain in much the same way as heroin, although not as successfully as heroin. Nevertheless, there is an insubstantial body of research on brain damage from long-term marijuana use.

THC is the active ingredient in marijuana and it passes from the lungs into the bloodstream, and then to the brain. THC connects cannabinoid receptors in the brain. Many cannabinoid receptors are found in the parts of the brain that influence pleasure, memory, thought, concentration, sensory and time perception, and coordinated movement. They are most common in the cerebellum, hippocampus, cerebral cortex (especially the cingulate, frontal, and parietal regions), and the basal ganglia.

Marijuana does cause cognitive, sensory and perception, mood and motor alterations in the period immediately following use. Also in the short term, most users show lowered levels of aggression. Marijuana may also cause long-term memory impairment, although the evidence is not conclusive.

As with alcohol, marijuana alone has not been a compelling mitigating factor, but is important to investigate and consider as part of the overall picture of the client's functioning. It may also have an interactive effect with psychiatric and neurologic illnesses.

Heroin

Somewhere between thirty seconds and two minutes after injection (or inhalation), heroin crosses the blood-brain barrier (ingested or snorted takes slightly longer). Heroin is converted to morphine and binds rapidly to opioid receptors in the brain. The opioid receptors are normally used by endorphins (a sort of endogenous morphine). Endorphins relieve stress and pain. Morphine has an analgesic and sedating effect in the body.

Pure heroin, which is a white powder with a bitter taste, is rarely sold on the streets. Most illicit heroin is a powder varying in color from white to dark brown. The differences in color are due to impurities that have been left from the manufacturing process or the presence of additives. Another form of heroin known as "black tar" heroin is available most often in the western and southwestern U.S. This heroin, which is produced in Mexico and Hawai'i, may be sticky like roofing tar or hard like coal, and its color may vary from dark brown to black. The color and consistency of this type of heroin result from the crude processing methods used to illicitly manufacture this substance. Users typically report feeling a surge of pleasurable sensation, a rush. The intensity of the rush is a function of how much drug is taken, the purity of what is taken, and how rapidly the drug enters the brain and binds to the natural opioid receptors. Heroin is particularly addictive because it enters the brain so rapidly. The intense rush is followed by sedation (which causes the "nodding" effect often observed). The pupils constrict (miosis) and the purity of the heroin is reported to affect how small the pupil becomes (purer heroin leads to greater constriction). A number of hormones are released in response to heroin in the body.

Heroin is very addictive because, as with endorphins, the brain signals for continuing supply of morphine once exposed. Tolerance does occur and increasing amounts of heroin are required to achieve a similar euphoric sensation. Heroin withdrawal is well enough known to have become the focus of numerous popular portrayals in movies and books.

Inhalants (glue/gasoline)

The term inhalant refers to any of almost a thousand different commercially available products that can be sniffed or smelled and which have an intoxicating effect. Inhalant of organic solvents produces a temporary stimulation and reduced inhibitions before the central nervous system (CNS) depressive effects begin causing dizziness, slurred speech, unsteady gait, and drowsiness. Impulsiveness, excitement, and irritability may also occur, along with hallucinations, and delusions. Users report experiences of euphoria culminating in a short period of sleep. Delirium with confusion, psychomotor clumsiness, emotional instability, and impaired thinking are seen. The intoxicated state may last from minutes to an hour or more.

Symptoms associated with inhalant use include belligerence, apathy, impaired judgment, and impaired functioning in work or social situations, dizziness, drowsiness, slurred speech, lethargy, depressed reflexes, general muscle weakness, and stupor. Nearly all inhalants produce anesthesia, a loss of sensation and even unconsciousness. Chronic use causes long-lasting damage to the brain, including damage to the protective sheath (myelin) around certain nerve fibers in the brain and peripheral nervous system. This extensive destruction of nerve fibers is clinically similar to that seen with neurological diseases such as multiple sclerosis. The neurotoxic effects of prolonged inhalant abuse include neurological syndromes that reflect damage to parts of the brain involved in controlling cognition, movement, vision, and hearing. Cognitive abnormalities can range from mild impairment to severe dementia. Other effects can include difficulty coordinating movement, spasticity, and loss of feeling, hearing, and vision.

One of the reasons that inhalant use causes such severe brain damage is that the substances that are inhaled to gain the sense of euphoria also include quite toxic solvents and metals. Huffing gasoline used to be a major cause of lead poisoning. Severity of brain damage depends on the specific substance inhaled. Toluene sniffing (also known as huffing), which has historically been disproportionately prevalent in the Latino and Native American communities, causes this euphoric feeling as a result of changes wrought in the dopamine system. Toluene is a solvent found in many commonly abused inhalants including airplane glue, paint sprays, and paint and nail polish removers. The damage to the brain is diffuse and pervasive from huffing toluene.

MDMA (ecstasy)

Ecstasy (sometimes referred to as X) is widely used as a recreational drug. X is a synthetic, psychoactive drug with both stimulant (amphetamine-like) and hallucinogenic (LSD-like) properties. In the past few years, a great deal of attention has been focused on X, largely because of its use by middle-class, suburban teenagers. X targets brain serotonin. The serotonin system plays a direct role in regulating mood, aggression, sexual activity, sleep, and sensitivity to pain. For people

who take MDMA at moderate to high doses, depletion of serotonin may be long-term, but the research on long-term brain damage is currently confused because of laboratory testing errors in the primary research conducted. Persistent deficits in serotonin would likely be responsible for long-term behavior effects that some users report. New research has now found that X also has a dramatic effect on dopamine in the brain.

Many of the risks users face with MDMA use are similar to those found with the use of cocaine and amphetamines: psychological difficulties (including confusion, depression, sleep problems, drug craving, severe anxiety, and paranoia) and physical symptoms (including muscle tension, involuntary teeth clenching, nausea, blurred vision, rapid eye movement, faintness, and chills or sweating). Research on the long-term effects of X use is still very new and uncertain, but tends to show learning and memory impairments that persist as well as impulsivity.

DUAL DIAGNOSIS (SUBSTANCE USE AND PSYCHIATRIC DISORDERS)

As mentioned elsewhere, there is a very high co-occurrence of psychiatric illness and polysubstance use and neurologic illness and polysubstance use. It is essential to establish, during the development of the social and family history, the onset of both substance use and symptoms of neurologic and psychiatric illnesses. It is important not to confuse this co-occurrence with one or the other disorder, but at the same time, symptoms of one condition (e.g., psychiatric illness) must not be inaccurately considered in support of another condition (e.g., substance use) unless causation is dually occurring. For diagnostic purposes, it is not enough to determine that a symptom occurred and the person was taking drugs and suffered a psychiatric illness. Rather, to diagnose properly, it is important to assess whether it was either the drugs or the psychiatric illness or both that caused the symptom.

A common problem, particularly in historical records, is the phenomenon of *diagnostic overshadowing*, whereby underlying psychiatric symptoms are misattributed to drug use. For example, an emergency room treatment team, having no history except a report from law enforcement that an individual has been abusing methamphetamine, may easily miss the signs and symptoms of an otherwise untreated clinical disorder. Once again, in decoding a client's life-history records, it is important to look for the reported signs and symptoms, not just the conclusory diagnostic labeling.

CHAPTER 9:
PSYCHOLOGICAL TESTING

Including:

- Types of psychological and neurological tests;
- Neuropsychological batteries;
- Neurological examinations;
- Academic tests;
- Intelligence tests;
- Objective personality tests;
- Projective personality tests;
- Malingering tests;
- Brain imaging technologies;
- Summary of testing issues; and
- Some additional issues with brain imaging.

TYPES OF PSYCHOLOGICAL AND NEUROLOGICAL TESTS

Psychological tests are *tools*. The results are only as good as the match between particular testing instruments and the purposes they are intended to serve. Their value has received increased scrutiny in recent years in all forensic settings, as noted in a leading text on court evaluations:

Historically, conventional psychological testing played an important role in justifying the participation of psychologists (as opposed to psychiatrists in the legal process. Further, some clinicians believe that any forensic assessment is incomplete unless a battery of tests that permits insights into all aspects of functioning (cognitive, intellectual, personality) is administered... Recently, however, more critical analyses have identified several limitations of conventional tests... The reviews suggest, and we concur, that conventional diagnostic testing procedures... are of minimal usefulness in many forensic contexts.²³¹

In the context of capital cases, everything is dependent on the scope and depth of the social history investigation. Whether any testing at all is appropriate depends on a number of considerations: What is the referral question? What kind of information can the test provide? How good is the test for the purpose for which it is used? How

²³¹ Melton, G.B., Petrila, J., Poythress, N.G., & Slobogin, C., *PSYCHOLOGICAL EVALUATIONS FOR THE COURTS: A HANDBOOK FOR MENTAL HEALTH PROFESSIONALS AND LAWYERS* (Guilford Press 1997), at 45.

can its results be integrated into the network of data known about the individual? Test results must *always* be contextualized in light of the individual's background and abilities.

Referral questions that might indicate the need for testing include whether the client has impaired intellectual functioning, learning disabilities, or brain damage and dysfunction. The appropriate tests in each case would vary. All would probably need (or even require) a test of intellectual functioning, but an assessment for mental retardation would also require assessment of adaptive functioning, an assessment for learning disabilities would require testing of academic functioning, and an assessment for brain dysfunction would minimally require a comprehensive neuropsychological battery. All three would also require a thorough social history.

No testing protocol works effectively without a comprehensive social and family history. As Adolph Sahs, an eminent neurologist, is reported to have taught, "If you have thirty minutes to see a patient, spend twenty-eight minutes on history, two minutes on the examination, and no time on the skull X-ray or EEG."²³² Similarly: "It may come as a surprise to many that it is generally not the sophisticated imaging studies of the brain nor the complicated neurophysiological testing (bioelectrical testing) that typically leads to the most information about neurologic condition. Rather, it is the history which actually gives the practitioner the most diagnostic information."²³³ A comprehensive social and family history is needed prior to determining whether—and what kind of—testing is appropriate and this history must be provided to the expert to ensure reliable interpretation of the results.

Testing should never be undertaken without a clear understanding of what type of mental impairment or dysfunction you are seeking to substantiate. Choosing the appropriate type of testing protocol requires:

- familiarity with the various types of psychological testing and the scientific literature that describes what different types of testing are capable of doing reliably;
- interaction with experts in a process that is reciprocal, rather than abdicating to experts decisions about what tests should be given, what background evidence they need or the process of evaluation;
- careful review by the expert of any prior testing relevant to the same referral questions;
- generating hypotheses about the client's functioning that can be reliably tested; and
- understanding the cultural, language, education, age, and gender issues that may affect the reliability of any test given and its interpretation.

²³² As cited in Caplan, L., & Hollander, J., *THE EFFECTIVE CLINICAL NEUROLOGIST* (Butterworth/Heinemann 2001), at 25.

²³³ Starzinski, D.T., *The Forensic Neurological Assessment of Traumatic Brain Injury*, in Murrey, *supra*, n.163, at 24.

There must be an open exchange with potential experts about these issues. Mental health experts will not necessarily know the legal standards and issues related to capital litigation, so it is important to provide guidance about the relevant law. It is also essential to ensure that the expert has the appropriate training and expertise in the administration, scoring, and interpretation of whatever test instruments are to be used.

Different types of testing require different types of experts. Physical examination by a medical doctor trained in neurology provides one means of assessing neurological deficits. Brain imaging, discussed in detail below, is another means, requiring highly visible court-ordered removal to a medical facility equipped with the relevant technology for structural or functional imaging. Psychological tests are administered by psychologists. They include the highly specialized tools for cognitive assessment normally administered by neuropsychologists (measuring intellectual, academic, and neuropsychological functioning). Other tests in the psychologist's toolbox focus on personality functioning or risk assessment.

Below is a table that lists the main types of testing. Tests for mental functioning can be considered in three broad categories: neurological and brain imaging tests, neuropsychological tests and psychological tests. Neurological and neuropsychological testing is often useful in capital cases because they provide significantly different ways of talking about your client; have well-established scientific reliability and validity; and limit the focus of potential rebuttal and cross-examination.

Neurological Testing	Neuropsychological Testing	Personality Testing
<p><u>Brain Imaging</u></p> <p>Structural Imaging</p> <ul style="list-style-type: none"> • CT • MRI <p>Functional Imaging</p> <ul style="list-style-type: none"> • fMRI • PET • SPECT • EEG • qEEG <p><u>Physical Exam</u></p> <ul style="list-style-type: none"> • Babinski and Grasp • Snout and Suck • Gait and Posture • Motor Reflexes • Visual Tracking and Eye Movement • Vision, Smell and Hearing • Physical Injury/Malformations • Strength • Lateral Dominance • Nerve Conductance 	<p><u>Halstead-Reitan Battery</u></p> <ul style="list-style-type: none"> • Category • Tactual Performance • Seashore Rhythm • Speech-Sounds Perception • Tapping • Trail Making A and B • Aphasia Screening • Sensory Perceptual • Grip Strength • Tactile Form Recognition <p><u>Luria-Nebraska</u></p> <ul style="list-style-type: none"> • Motor Function • Rhythm • Tactile Function • Visual Function • Receptive Speech • Writing/Reading/Arithmetic • Memory • Intellectual Processes <p><u>Some Other Key Tests</u></p> <ul style="list-style-type: none"> • Wisconsin Card Sort • Dellis-Kaplan Executive Function Scale • Go - No Go • Iowa Gambling Task • Memory Assessment Scales • Pocket Smell Test • Continuous Performance Tests • Rey-Osterreith Complex Figure • Wechsler Memory Scale • WAIS or WISC • Wide Range Achievement Test (WRAT) • Woodcock-Johnson tests • Malingering tests 	<p><u>Common Personality Instruments</u></p> <ul style="list-style-type: none"> • MMPI (Minnesota Multiphasic Personality Inventory) • Rorschach • TAT (Thematic Apperception Test) • PCL-R (Psychopathy Checklist - Revised) • MCMI (Millon Clinical Multiaxial Inventory) • CBCL (Child Behavior Checklist) <p><u>Common Screening Instruments</u></p> <ul style="list-style-type: none"> • Bender-Gestalt • Mini-Mental Status Exam

NEUROPSYCHOLOGICAL BATTERIES

Neuropsychology is the study of brain-behavior relationships. Test instruments identify and measure cognitive deficits, brain dysfunction, and brain damage. Neuropsychological assessment provides a functional description of the cognitive, behavioral, psychological, and emotional consequences of disrupted brain function. A comprehensive neuropsychological assessment measures various aspects of cognitive functioning, including intelligence, academic functioning, attention and concentration, verbal and visual memory, language functioning, visual spatial functioning, motor abilities, sensory-perceptual processing, abstract reasoning and executive functioning (such as planning, self-monitoring, inhibition of impulses, and mental flexibility). Neuropsychology is a sub-specialty of psychology that requires unique training and clinical experience, and has its own professional organizations, journal, credentialing and ethical guidelines. Whenever neuropsychological tests are indicated, it is essential to retain only experts who have this unique training and experience.

There are two types of approaches to neuropsychological testing: standardized batteries and flexible batteries. The two primary standardized batteries are the Halstead-Reitan Neuropsychological Battery and the Luria-Nebraska. The Halstead-Reitan is widely used and well-normed. Research has consistently shown it to be the most reliable such battery in differentiating impaired from non-impaired people.

Flexible batteries are non-standardized. They vary according to the person administering the examination and therefore each examination will vary as to reliability and validity depending on the specific tests given. Additionally, even some well-qualified experts choose idiosyncratic combinations of tests when using flexible batteries that may not fully explore a client's functioning. If an expert insists on a flexible battery (for example, because of new research showing the particular utility of a test that was not available when the Halstead-Reitan battery was developed), it is important to ensure that key areas of brain function are assessed. The most prudent technique is to use the extended Halstead-Reitan battery, plus a flexible set of additional tests to follow up indications of impairment based on results from the social history investigation and other testing.

The Halstead-Reitan battery consists of a number of different tests selected by the examiner on the basis of the reason for the referral. However, the battery is normally constructed around a core of several tests, including: (1) The Category Test; (2) The Tactual Performance Test; (3) The Seashore Rhythm Test; (4) The Speech Sounds Perception Test; (5) The Finger Oscillation or Finger Tapping Test; (6) Trail Making Test A and B; (7) The Sensory Perceptual Exam; and (8) The Aphasia Screening Test. Other tests should be added to augment the core battery, and might include, among others, the Wisconsin Card Sorting Test, the Rey-Osterreith Complex Figure Test, the Dellis-Kaplan Executive Function Scale, the Iowa Gambling Task, the Memory Assessment Scales, and the Pocket Smell Test. Administration of a

comprehensive battery of neuropsychological tests typically requires from six to eight hours. Interpretation of the Halstead-Reitan should include analysis of scores of each test as well as the available index scores (Halstead Impairment Index, General Neuropsychological Deficit Scale, Average Impairment Rating) that can be calculated to provide an indication of overall impairment. In addition, comprehensive analysis of test findings might include evaluation of the overall level of performance, pathognomonic signs, patterns and relationships among test scores, and right-left differences. (Pathognomonic signs are so characteristic of a disorder or condition as to constitute a diagnosis.)

A number of instruments, given in combination with the Halstead-Reitan, will provide significant information about frontal and orbital frontal lobe function assessment, including: Wisconsin Card Sort Test, Rey-Osterreith Complex Figure Test, Go/No-Go and Continuous Performance tests, Dellis-Kaplan Executive Function Scale, Iowa Gambling Test, and Pocket Smell Test.

Some experts, most often clinical psychologists without specialized training in neuropsychology, use screening tests to determine whether to conduct more neuropsychological testing (e.g., Bender-Gestalt or Trails Test alone). None of the screening tests is reliable as an assessment of brain functioning. No determination about brain function should be based on these instruments. Screening tests should not be substituted for a complete battery administered by a trained and qualified neuropsychologist.

Finally, the expert will interpret the *pattern* of functioning across all the tests. Strengths coexist with weaknesses, and the client will almost certainly not perform consistently badly or well across the entire battery. It is essential to understand this pattern and not become overly focused on one or two tests.

NEUROLOGICAL EXAMINATIONS

The standard neurological physical examination is so well established in the literature that little needs to be said about it. Properly performed, the physical examination tests each of the cranial nerves and reflexes. Neurological exams will generally include the following: a mental status assessment, cranial nerve assessment (a test for each of the twelve cranial nerves), motor system testing (including muscle strength and tone, coordination and gait), reflex testing, and sensation testing.²³⁴

Neurological testing for frontal lobe damage has come under attack by prosecutors in a number of cases, however, primarily because of the role of frontal lobe impairment in unrestrained behaviors. Prosecutors sometimes challenge the specificity of neurological tests in determining frontal lobe damage. Frontal lobe dysfunction can and should be assessed by neurological examination as well as neuropsychological

²³⁴ Devinsky, O., & D'Esposito, M., *NEUROLOGY OF COGNITIVE AND BEHAVIORAL DISORDERS* (Oxford University Press 2004); Caplan & Hollander, *supra*, n.232.

testing. Both types of tests are important and can provide corroborating evidence of frontal lobe damage. Assessment of reflexes, gait, posture, muscle tone and olfactory disturbances provide reliable evidence of frontal lobe damage.²³⁵

ACADEMIC TESTS

Academic tests are designed to assess specific skills and knowledge in various areas of academic ability. To assess for the presence of learning deficits or disabilities, an individual's performance on academic tests has traditionally been considered in conjunction with information about his or her current intellectual functioning. According to this method of analysis, one's academic functioning should be commensurate with one's intellectual abilities. Thus, a significant discrepancy between intellectual functioning and academic achievement—with academic achievement lower than expected given measured IQ—can signal the presence of learning problems. The most widely utilized tests for assessing academic level are the WRAT (Wide Range Achievement Test) and the Woodcock-Johnson test instruments. Tests of academic level do not provide much information specifically about brain function, but they are important for interpreting neuropsychological testing that has education-level norms and adjustments. The WRAT and Woodcock-Johnson instruments provide information on actual educational level in specific academic areas, such as arithmetic, spelling and reading.

INTELLIGENCE TESTS

Tests of intellectual abilities are designed to tap a variety of intellectual functions, and they usually consist of a range of individual subtests. Individual subtest scores are typically combined to yield an overall estimate of current intellectual functioning, called the intelligence quotient (IQ). Assessment of an individual's current level of cognitive functioning is one of the primary psychodiagnostic functions of intelligence testing. Patterns of scores and performance on individual subtests may be of interpretive significance as well. Behavior during testing and qualitative aspects of test responses may provide useful clinical information and may suggest hypotheses regarding personality style and functioning.

Nearly everyone has heard of IQ testing, but it is essential to remember that intellectual functioning is only one aspect of brain functioning. The most widely used intelligence tests are the Wechsler series, which include the Wechsler Adult Intelligence Scale-III (WAIS, for ages sixteen to eighty-nine)²³⁶ or the Wechsler Intelligence Scale for Children-III (WISC, for ages six to sixteen) or the Wechsler Preschool and Primary Scale of Intelligence-Revised (WPPSI, for ages three to seven). Many other tests for measuring intelligence are available (Stanford-Binet,

²³⁵ Devinsky & D'Esposito, *supra*, n.234; Damasio, A., *The Frontal Lobes*, in Heilman, K.M., & Valenstein, E. (eds.), *CLINICAL NEUROPSYCHOLOGY* (Oxford University Press 1979).

²³⁶ The fourth version of the WAIS is due to be published as this manual goes to press.

Raven, Shipley or Kaufman), although the Wechsler series is more widely used. These tests are essential to assess intellectual functioning, and are in fact a necessary (though not sufficient) component of an assessment for mental retardation.

The WAIS-III has been the most widely used test of intellectual functioning. The components of the WAIS-III include verbal subtests (vocabulary, similarities, arithmetic, digit span, information, comprehension and sequencing) and performance subtests (picture completion, digit symbol-coding, block design, matrix reasoning, picture arrangement, symbol search and object assembly). The test-taker is given scores on each subtest, overall scores for verbal and performance tests, and a single combined IQ score which includes all subtest scores. Overall, the WAIS-III assesses verbal comprehension, working memory, perceptual organization and information processing speed. Significant differences between verbal and performance scores (more than fifteen points) may be indicative of organic brain damage, but no conclusion can be based on this discrepancy alone. It should only be used to prompt further neuropsychological testing of brain functioning.

The WAIS-IV, to be released in late summer or early fall of 2008, represents the latest version of the tests originally developed by David Wechsler before the Second World War (Wechsler-Bellevue, 1939; Wechsler-Bellevue II, 1946; WAIS, 1955; WAIS-R, 1981; WAIS-III, 1997). The norms for IQ tests need periodic re-anchoring because of a phenomenon known as the Flynn Effect, whereby the average IQ of the U.S. population has increased an average of three points per decade. Use of an instrument at the end of its useful life may lead to an inflation of the IQ score. Tests with norms older than ten to twelve years may produce inflated IQ scores.

All IQ tests have a measurement error, or zone of uncertainty. The Standard Error of Measurement (SEM) is estimated to be three to five points for well-standardized measures of general intellectual functioning, but the SEM varies from one test to another. An obtained IQ score of 70 is best understood not as a precise score, but as a range of possible scores (65 to 75).

OBJECTIVE PERSONALITY TESTS

“Objective” tests are typically highly structured, usually including carefully specified questions and a limited range of answers. They may include questionnaires, self-report measures, inventories, and rating scales. The most commonly used are the Minnesota Multiphasic Personality Inventory II (MMPI-II) and the Millon Clinical Multi-axial Inventory III (MCMI-III). These tests use standardized questions and most often can be computer scored. Results often appear on a chart and in some cases a computer-generated narrative provides interpretation based on psychological characteristics associated with the scores. Computerized narratives typically summarize a vast array of research studies. They provide a composite description based on many people who have answered questions in a similar way rather than an individualized assessment. Computerized narratives are all too frequently adopted by

evaluators as is, contrary to the standard of care for psychologists using this type of information. Thus, evaluations that include computerized narratives frequently result in misleading impressions and erroneous conclusions. The protocols carefully advise, however, that an elevated scale is insufficient to diagnose a person; for example, an elevated “schizophrenia” scale on the MMPI-II does not mean the person is schizophrenic and an elevated “psychopathic deviant” scale on the MMPI-II does not mean the person is psychopathic. These tests do not help to explain a client’s life or experiences in an effective way, and there is a high risk that statements endorsed in the test will be taken out of context to portray the individual negatively.

A typical example of an objective test includes questions posed to the individual involving simple affirmative statements (“At times I am full of energy,” “I am afraid of losing my mind,” “My sex life is satisfactory”) to which the respondent answers “true” or “false.” Another example involves descriptions of behavior (“withdraws from others”) to which the respondent answers on a continuum (from “never happens” to “sometimes happens” to “frequently” happens”).

Recent research that has re-evaluated these instruments in light of admissibility questions suggests significant problems in reliability and validity. Writing about the MCMI-III, Rogers et al. commented that the MCMI-III had fundamental problems in scientific validity and error rates.²³⁷ Similarly, researchers have questioned the forensic use of the MMPI-II because of problems of misuse when applied in forensic settings. Further, numerous questions have been raised in the literature about the scoring procedures, computerized scoring and interpretative cookbooks that are often used to analyze the MMPI-II.²³⁸

A core principle of the literature on psychological assessment is recognition that the setting of the assessment can have a dramatic impact on how a person answers the questions. None of the objective personality tests has been normed or assessed for use in a custodial setting. The MMPI is not normed for use with people with IQs under 80 and is not appropriate for individuals with significant intellectual disabilities, brain damage, learning disabilities, or problems with reading comprehension or language.

PROJECTIVE PERSONALITY TESTS

Projective tests (e.g., the Rorschach, thematic apperception test, draw-a-person) are unstructured and plastic. They rely on highly ambiguous stimuli (e.g., inkblots or pictures), rather than structured questions and answers. They are designed to maximize an individual’s freedom in the range of responses to test stimuli, and they

²³⁷ Rogers, R., Salekin, R.T., & Sewell, K.W., *Validation of the Millon Clinical Multiaxial Inventory for Axis II disorders: Does it meet the Daubert standard?* 23(4) LAW & HUMAN BEHAVIOR 425 (1999); Rogers, R., *Forensic Use and Abuse of Psychological Tests: Multiscale Inventories*, 9(4) JOURNAL OF PSYCHIATRIC PRACTICE 316 (2003).

²³⁸ Senior, G., & Douglas, L., *Misconceptions and misuse of the MMPI-2 in assessing personal injury claimants*, 16 NEUROREHABILITATION 203; Allard, G., & Faust, D., *Errors in scoring objective personality tests*, 7(2) ASSESSMENT 119 (2000).

might also provide the evaluator great subjective latitude in analyzing the response. As such, as a class of tests, they are more difficult to interpret in a reliable and valid manner. According to the principle underlying projective tests, the “projective hypothesis,” characteristic modes of thinking, feeling, and behaving are highlighted in an individual’s response to unstructured test stimuli. Faced with unstructured and plastic stimuli in an undefined and uncertain test situation, an individual is presumed to impose his or her own organization and meanings on the test stimuli.

Projective tests include a number of methodologies. These include association techniques (asking the respondent to generate an association to a verbal, visual, or auditory stimulus), construction techniques (asking the respondent to create a product in response to a verbal or auditory stimulus), completion techniques (asking the respondent to complete a statement or story), or expressive techniques (asking the respondent to generate an artistic or creative product).

The reliability and validity of these tests are questionable under many circumstances, clinical or forensic. Research has suggested that these tests have insufficient scientific merit.²³⁹ To the extent that subjective personality tests offer the greatest degree of interpretative latitude to the person administering them, they are clearly among the least reliable and scientifically weakest of psychological tests.

MALINGERING TESTS

An assessment of malingering is essential in forensic settings. In addition to correctly interpreting the neuropsychological battery itself for evidence of malingering, a standard neuropsychological examination should probably include tests that assess for malingering (e.g., Rey-15, Rey Word Recognition Test, Portland Digit Recognition Test, Dot Counting, Symptom Validity Test). Each of these tests assesses the degree of effort and, theoretically, each can be completed without error by most unimpaired people, with even severely impaired patients performing in the chance error range on symptom validity tests. Malingering may also be detected by scoring patterns on some of the standard neuropsychological batteries. Experts should use these tests as well as clinical judgment based on affect and behavior during the testing sessions to assist in reaching determinations about malingering.

There are a number of increasingly popular, stand-alone instruments that are designed to assess malingering. These include the Test of Memory Malingering (TOMM) and the Structured Interview of Reported Symptoms (SIRS). These tests may be useful to counter prosecution allegations of malingering under certain circumstances. Even seriously ill people may feign symptoms, and it is important that the degree of exaggeration and intent be assessed as best the examiner can. Ultimately, the best

²³⁹ Lilienfeld, S.O., Wood, J.M., & Garb, H.N., *The scientific status of projective techniques*, 1(2) PSYCHOLOGICAL SCIENCE IN THE PUBLIC INTEREST 27 (2000); Wood, J.M., Nezworski, M.T., Garb, H.N., & Lilienfeld, S.O., *Problems with the Norms of the Comprehensive System for the Rorschach*, 8(3) CLINICAL PSYCHOLOGY: SCIENCE AND PRACTICE 397 (2001).

evidence to refute allegations of malingering is the convergence of test results and longitudinal historical data developed in the social history investigation.

BRAIN IMAGING TECHNOLOGIES

EEG is a test of brain function based on electrical activity. If given during seizure activity, it is tremendously useful. However, the EEG fails to discriminate a substantial number of people with seizure disorders. Standard EEGs use leads (which monitor electrical activity) on the outside of the head, but this placement is not particularly efficient for assessing certain parts of the brain. Nasopharyngeal leads (leads placed deep inside the nasal passages) are more effective but uncomfortable and often not available. The qEEG measures brain function in the same way, but uses computerized analysis to compare the data to known standards. It provides information on more subtle forms of dysfunction.

PET scans measure glucose uptake and blood flow by marking glucose with a radioactive agent and tracking how the marked glucose is used in the brain. PET images are analogous to CT and MRI, but demonstrate function rather than structure. PET demonstrates areas of normal and abnormal energy utilization. PET provides excellent resolution and very precise images of the brain's functioning.

MRI (magnetic resonance imaging) and *fMRI* (functional MRI) use the same basic technology to produce images of the brain. MRI provides excellent structural images by subjecting the brain to a magnetic force (which aligns atomic nuclei) and then sending radio wave pulses through the brain that are absorbed by some nuclei and change the energy state of nuclei. For detecting lesions or scar tissue or malformation, MRI is very good. In general, MRI is superior to CT with a few exceptions (e.g., calcification, subarachnoid lesions, skull fractures). *fMRI* assesses the oxygenation status of hemoglobin in the brain. This test is given while the individual is performing certain types of tasks (motor tasks or experiencing sensory stimulus). This provides an excellent and precise image of the brain in action. Resolution of the image using *fMRI* is by far the most subtle and detailed of any imaging technique. This technique also allows for repeated images over a period of time so that assessment can be made of the brain at rest and during performance of tasks. Interpretation of the images remains debated by experts.

MRS (Magnetic Resonance Spectroscopy) works on a similar technology to MRI but provides a better image of neurometabolism and neurochemical functioning. MRS is very good for examining NAA (N-acetyl aspartate), CH (Choline) and Lactate in the brain.

SPECT (Single Photon Emission Computed Tomography), like PET measures blood flow and glucose uptake but the images are not as finely detailed as PET and are often more difficult to interpret. SPECT resolution is poor compared to other techniques and it provides less robust information.

CT (Computer assisted tomography) imaging is inexpensive and many laboratories have the technology. CT is effectively an X-ray of the brain structure and allows for assessment of the integrity of the blood-brain barrier (e.g., stroke, tumors, inflammation and some neurological disorders). It is useful for bone structure abnormalities and calcification. CT scans are not particularly sensitive (meaning, many people with brain dysfunction will appear normal on CT scan). It is also reported to be less effective than MRI for brain stem, cerebellum and temporal lobe imaging.

SUMMARY OF TESTING ISSUES

Neuropsychological and physical neurological testing could be helpful in any case where potential brain damage or dysfunction is suspected based on history (e.g., head injuries, academic deficits, etc.). The reliability and validity of these types of testing are generally well-established and well-documented. For instance, since at least the 1970s, standard neurology textbooks have recommended physical examination of reflexes to assess for frontal lobe brain damage.²⁴⁰ Similarly, there is an extensive literature on neuropsychological testing.²⁴¹ Careful consultation with experts is needed to determine which neuropsychological tests are appropriate and least vulnerable to admissibility challenges.

The types of evidence which neurological and neuropsychological testing provides are the most directly useful because they address both brain and behavior—that is, the client's impairment and how the client functions in the world. These types of testing allow counsel to frame the client's mental functioning in the context of how he functioned in the world.

As a rule, any other psychological testing (objective or projective) is potentially dangerous because the characterological evidence it produces will neither help tell the client's story nor clarify the client's circumstances. In short, it will not assist in the development of mitigating evidence. If the client's records disclose psychological testing from prior evaluations, it is important to investigate fully the circumstances of the evaluation, the background and qualifications of the evaluator, and the accuracy of the interpretation. Expert assistance is clearly needed at every step.

The question of whether to seek brain imaging is more complicated—scientifically, legally, and economically. Structural imaging provides a view of the physical make-up of the brain. Structural imaging does not provide information on how the brain functions. Structural imaging of a corpse may show no malformations and it would not be possible to tell that the brain was dead, only that it was physically intact. Functional imaging provides images of specific types of systems in the brain (for instance, glucose uptake).

²⁴⁰ Heilman & Valenstein, *supra*, n.235.

²⁴¹ See Lezak, M.D., *NEUROPSYCHOLOGICAL ASSESSMENT* (Oxford University Press 3rd ed. 1995).

Legal questions include admissibility issues around any new technology or technique (discussed below) and discovery issues. The need to remove the client from the jail or prison for imaging may disclose otherwise privileged information about defense strategy. Security objections from the custodial authority may prompt hearings in open court even when the initial application has been *ex parte*, confidential, and under seal. Even if the results of the imaging are protected from technical discovery by the law of the jurisdiction, the fact that imaging has been obtained is almost never confidential and the prosecution will easily infer the results are not helpful if the defense does not introduce them. (In contrast, neuropsychological testing or a neurological examination can be done at the custodial facility under the relative protection of *ex parte* orders.)

SOME ADDITIONAL ISSUES WITH BRAIN IMAGING

Despite the apparent appeal of a picture, brain imaging often leads people to believe there are short-cuts to factual mitigation. In fact, quite the opposite is true: to make effective use of brain imaging, the neuroradiologist needs extensive historical information and full neuropsychological tests prior to the imaging. No competent decision can be made as to whether to do imaging without having first undertaken an extensive work-up. Prior to making a decision about imaging, it is imperative to assess whether the evidence of brain impairment is likely to be bolstered by imaging. This assessment involves a multi-step process:

1. Compilation of a complete and comprehensive, multi-generational family, medical and social history;
2. Detailed understanding of the physiological, neurological and psychiatric systems involved in the client's functioning;
3. Neuropsychological testing, using a well-normed battery; and
4. Evaluation of the neuropsychological findings in the context of all the other information and diagnostic impressions.

Additional risks and limitations should also be considered:

1. brain imaging risks distracting the jury from the main mitigation story about the client and how the brain impairments caused or influenced certain behaviors;
2. brain imaging does nothing to humanize the client and risks engaging the jury in technological issues that undermine the effort to re-focus the jury on the human being in the courtroom;
3. brain imaging is not better than neuropsychological examinations for localizing brain impairment and does not explain behavioral functioning

as well as neuropsychological testing does. Neuropsychological assessment permits a description of the behavioral outcome of the deficits which brain imaging is currently unable to do;

4. brain imaging of people with major mental illnesses more often than not appear normal. MRI scans of 6200 psychiatric inpatients at McLean Hospital found positive findings, meaning an abnormal MRI image, in only 1.6 percent of patients;²⁴²
5. as a result of normal differences between brains, brain imaging will almost certainly result in a battle of expert opinion which differs on the question of whether the image is abnormal or normal except in situations where a lesion is present;
6. affect during testing may cause changes in the results, which means that brain imaging of clients with psychiatric illnesses might not be as reliable as needed. Repeated testing is likely to demonstrate differences in the individual if the affect changes between test periods, for instance, if the person is very depressed during one test period and euphoric during the next as is possible with a client with bi-polar disorder;
7. medication effects are serious but not well-known at this point in time for prescribed as well as recreational drugs. Recent research even found changes in brain function among a group of patients given placebo rather than medication;²⁴³
8. significant variations occur based on a person's age. Normal brain function changes with age and can be reflected in imaging, but it is also true that on some tasks, the young use one hemisphere and adults use both hemispheres of the brain;
9. very little is known about brain plasticity, which means that no one can say what a brain should look like in an adult who suffered a childhood traumatic brain injury. The brain may adapt or repair itself in some situations and not in others or may adapt by "recruiting" parts of the brain to do tasks not typically associated with that task;
10. except in certain instances, brain imaging does not address the question of etiology of behaviors, meaning, while brain imaging has the potential to show a specific way in which the brain is malfunctioning or malformed, it cannot answer the question, in most cases, of why or how the brain got that way;

²⁴² Rauch, S.L., & Renshaw, P.F., *Clinical neuroimaging in psychiatry*, 2 HARVARD REVIEW OF PSYCHIATRY 297 (1995).

²⁴³ Mayberg, H.S., et al, *The functional neuroanatomy of the placebo effect*, 159(5) AM. JOURNAL OF PSYCHIATRY 728 (2002).

11. many serious brain diseases cannot be identified with confidence by current technology (such as, Parkinsons, Alzheimers, migraine, depression, bipolar disorder, epilepsy, or many psychotic disorders);
12. most of the brain imaging technologies are very new, and as a result some serious questions remain about how to interpret what is being observed. The state of the science does not support diagnosis of brain impairment or dysfunction solely based on brain imaging. While specificity is high for a handful of conditions (e.g., temporal lobe epilepsy, Alzheimer's disease), sensitivity is very low for brain imaging of these conditions and unknown for many more common conditions (e.g., depression). This means that if the image resembles a pattern known to be Alzheimer's disease or temporal lobe epilepsy, the individual is highly likely to have that disorder; but if the brain image appears different from the standard for those few illnesses, it does not mean the individual is normal. Some people with those illnesses will have brain images that do not appear typical for the condition. This dramatically increases the risk that brain imaging in criminal cases will undermine other evidence of brain dysfunction or impairment when in fact neuropsychological testing has correctly assessed the client as impaired;
13. the images which counsel may want to show a jury are usually composite images or reconstructions of data; for instance Blood Oxygen Level Dependent (BOLD) fMRI relies on measuring oxygenated versus deoxygenated hemoglobin some number of seconds after the neural activity occurs; in most cases, those data are then compared to statistical norms of a small number of people developed by the Montreal Neurologic Institute. Many of these comparisons use "spatial normalization" software to make comparisons. Some of the most commonly used software programs conform the data in such a way as to actually mask or hide lesions that should appear; others of the common software programs conform the brain to a standardized map (spatial normalization) which means the image does not directly correspond to what the individual's brain actually looks like;
14. brain imaging measures, at least theoretically, brain activity; however, research shows that people asked to repeatedly perform the same task use different areas of their brains when the task is novel than after time; imaging technology cannot, at this time, differentiate between efficiency of brain function and deficit; similarly, and probably more importantly, poor performance or disorganized performance in most cases will correlate with *more* brain activity not less—meaning that a damaged area of the brain may "recruit" other parts of the brain to help with tasks that a normal brain would more simply perform; on the image, this will appear to be enhanced brain activity rather than deficit and is difficult to interpret

correctly;

15. finally, scan patterns, no matter what the pattern indicates, do not predict behavior. As with other evidence, many people who have no behavior problems do have brain images that appear abnormal while others, with severe behavior problems have scans that appear within the normal range.

Many jurisdictions have held certain types of brain imaging inadmissible under *Daubert v. Merrell Dow Pharmaceuticals*,²⁴⁴ although the courts have almost always made these determinations on the issue of “fit” rather than reliability. Many of these criticisms are accurate given the state of the science; for instance, based solely on brain imaging, no opinion could reasonably be offered to explain behavior.

A few of the issues can be understood by some simple concepts:

Normal Brain Variance

Intra-individual variance refers to changes in the how the brain responds to tasks during repeated tests. There will be a range of results for each individual across multiple imaging tests even when the individual's brain is “normal.” What “normal” means is a range that fits a probabilistic, normal bell curve. It is not currently possible to reach conclusions about normality or abnormality unless it is significantly outside the range of normal results, and it is not yet possible to know what the precise parameters of the range are. The best example of this comes from one of the innovative bits of information that imaging has provided: the normal brain, when shown novel information, responds differently from when the information is not novel.

Inter-individual variance refers to differences in the imaging of normal brains and also the similarity between images of abnormal people with vastly different impairments. In short, healthy people's brains look different, often significantly so. Individuals functioning normally may have brains that look very different from each other and it is often difficult to interpret the brain image as normal variance or so different as to constitute abnormality.

Inter-group variance refers to differences between normal and abnormal brain images. Although some images allow for firm conclusions, many images will not because there is currently not certainty about what a schizophrenic brain looks like compared to a depressed brain.

²⁴⁴ 509 U.S. 579 (1993).

Fit

Daubert and its progeny establish two key gate-keeping roles for judges: assessing the reliability of the test and assessing case fit. While reliability has been the focus of most law review articles and a great deal of commentary, most judicial opinions to date have focused on fit. Many cases where brain imaging has been excluded never address the issue of reliability, excluding the tests based on whether the science answers the particular question in the specific case. Thus, *United States v. Mezvinsky*,²⁴⁵ rejected PET scans because of case fit (the experts agreed that the impairment shown on the PET did not address the question of whether Mezvinsky was lying: “both [experts] agreed that no study exists that links diminished capacities in various parts of Mezvinsky’s brain to any specific disorder... there is, therefore, no evidence that Mezvinsky’s PET-identified brain abnormalities had any pertinence to his capacity to deceive...”) and in *Jackson v. Calderon*,²⁴⁶ the court found that PET was not generally accepted to diagnose PCP abuse and that the PET image could not answer the legal question of intent (“No evidence was introduced that the PET scan proves that Jackson was unable to premeditate or form a specific intent at the time of the shooting. The PET scan evidence could, at best, only establish that Jackson suffered some PCP-induced brain abnormality, the effect of which on Jackson’s capacity for higher thought is not demonstrated.”).

Little question remains as to whether brain imaging accurately measures what it is supposed to (e.g., PET scans accurately and reliably measure blood-glucose uptake in the brain). The question defense counsel must be prepared to answer is case fit and whether the visual image of blood-glucose uptake is sufficiently related to the mental health issue.

Technological variance

fMRI and PET scans currently provide the best *functional* images available. If your client suffers from schizophrenia or has been poisoned with a pesticide, functional imaging is more likely to be of assistance than structural imaging.

If the client suffered traumatic brain injury or metal poisoning, structural imaging with MRI or CT may provide better evidence.

Different laboratories use different technology, meaning that all PET scans or all MRI scans are not created equal. It is important to investigate the quality of the technology (based primarily on type of equipment, age of equipment, and experience of technicians) before choosing a laboratory to perform the imaging.

Counsel must provide direction to the imaging team about what evidence is sought.

²⁴⁵ 206 F.Supp.2d 661 (E.D.Pa. 2002).

²⁴⁶ 211 F.3d 1148 (9th Cir. 2000).

Different types of impairment may require different images and the referral question is not simply, "do a scan." Not all readers of brain images (neuroradiologists or neuropsychiatrists) are equally trained. There should be no written reports from any technician unless they have been retained and fully briefed about the case.

Brain imaging can be useful in confirming evidence of mental dysfunction or impairment that is factually developed through other investigation. Unfortunately, there is no simple answer to the question of which type of brain imaging will show brain damage compared to other imaging techniques.

Brain imaging almost invariably guarantees rebuttal by a prosecution expert and the risk that, in the battle of the experts, opinions cancel one another out. Effective presentation about brain damage ultimately requires lay witnesses to specific head injuries or trauma; lay witnesses to specific behaviors and onset/course of illness; additional expert witnesses (e.g., if etiology is fetal alcohol, FASD expert); and prior examining professionals who can testify as historical witnesses to what they observed during evaluations which long preceded the capital prosecution.

CHAPTER 10:

PROSECUTION EXPERTS AND HARMFUL EVALUATIONS

Including:

- Prosecution evaluations;
- Prosecution Experts;
- Other harmful evaluations;
- Investigating experts;
- Personality disorders;
- Antisocial Personality Disorder;
- Conduct Disorder; and
- Psychopathy.

PROSECUTION EVALUATIONS

In most capital jurisdictions, when the defense provides notice that it intends to call a mental health expert as a witness, the prosecution will have the opportunity to offer the testimony of its own mental health expert in rebuttal. If the defense expert has evaluated or otherwise interviewed the client, the prosecution expert will usually be granted the same opportunity. Since the law in this area varies from one jurisdiction to the next, it is essential that the capital defense team study all applicable law with great care before making the decision to call a mental health expert to the witness stand—or indeed before introducing any evidence about a mental condition that may open the door to rebuttal testimony and/or hostile evaluation. (In some jurisdictions, the statutory language is so broad that a notice of intent to offer expert testimony “bearing on guilt or punishment” concerning any “mental condition” may trigger an examination by a prosecution expert.) It is also essential to plan a litigation strategy on the scope of the prosecution expert’s access and examination before giving notice of intent to call an expert.

If the law of the jurisdiction permits examination by a prosecution expert, it is important to ensure that the scope of the examination is limited to what is properly required to rebut what the defense intends to offer. The defense will generally be required to provide enough information to enable the prosecution to select the appropriate type of rebuttal expert and to conduct an appropriate examination. Thus, capital defense counsel must engage in a delicate balancing act in determining how much information to provide to the prosecution whenever notice of intent to introduce expert testimony is required. Avoiding specificity may make it more difficult to limit the scope of the prosecution examination (for example, to dispute the relevance of

particular testing).²⁴⁷ Alternatively, providing extensive mental health discovery may provide a roadmap for the rebuttal case and alert the prosecution to potential witnesses and evidence it may not have previously considered or identified.

The scope of rebuttal should not be broader than the original referral question posed to the expert who will testify for the defense. The prosecution expert should be limited to rebutting the opinions or evidence to be presented. Mitigation-based referral questions posed to the defense expert never require a diagnosis, a nexus to the capital offense, or even reference to statutory language concerning mitigation. A defense expert might simply be asked to assess the capital client's intellectual functioning and how his intellectual limitations affect his everyday functioning in conceptual, practical, and social domains. In that case, the prosecution expert should address the same issues—without, for example, inquiring about the capital offense or administering irrelevant objective or projective tests. Another example of a defense referral question would be to ask the expert to describe the familial, medical, psychological, social, environmental, and institutional factors that influenced the client's development and functioning during his childhood, adolescence, and early adulthood. Again, the prosecution expert would have no basis for inquiring about the capital offense or anything else outside the specified timeframe.

Capital defense counsel often assert and litigate their right to be present (or to have their expert present) during the prosecution expert's examination, or to observe the examination, or to record it by videotape. Videotaping has been widely permitted, but it sometimes provides the prosecution expert with the opportunity to utilize excerpts out of context where the client appears in the least favorable light.

PROSECUTION EXPERTS

Separate surveys of judges and lawyers concluded that the biggest problem with expert testimony was that “experts abandon objectivity and become advocates for the side that hires them.”²⁴⁸ One law professor commented, “To put it bluntly, in many professions, service as an expert witness is not considered honest work. The contempt of lawyers and judges for experts is famous. They regularly describe expert witnesses as prostitutes.”²⁴⁹ In capital cases, there have been notorious examples of prosecution expert witnesses whose testimony was both predictable and unreliable. Dr. James

²⁴⁷ Unless challenged, prosecution experts are likely to administer an MMPI. One computer-generated report concluded, “Individuals matching this profile present a difficult challenge to the criminal justice system. They... have long criminal records, they commit violent offenses, they are personally abrasive, tough, insensitive and... incorrigible, they commit crimes out of impulse and for thrills, they happily reject societal values...”

²⁴⁸ Liptak, A., *Experts Hired to Shed Light Can Leave U.S. Courts in Dark*, N.Y. TIMES, August 12, 2008, A1, A16, quoting a study by the Federal Judiciary Center reporting surveys conducted by the center in 1998 and 1999.

²⁴⁹ *Id.*, quoting Professor Samuel R. Gross, writing in the WIS. L. REV. The newspaper article went on to quote a famous trial lawyer, Melvin Belli: “If I got myself an impartial witness, I’d think I was wasting my money.”

Grigson, for example, a Dallas psychiatrist, was ultimately expelled from the American Psychiatric Association and the Texas Society of Psychiatric Physicians for violating their ethics codes by “arriving at a psychiatric diagnosis without first having examined the individuals in question, and for indicating, while testifying in court as an expert witness, that he could predict with 100 percent certainty that the individuals would engage in future violent acts.”²⁵⁰

How prosecutors choose experts varies widely across the country, with cost as a primary variable. Federal prosecutors, for example, appear to have virtually unlimited budgets for multiple mental health experts from all over the country in death-penalty cases, paid at hourly rates well beyond those available through the courts for indigent defendants. Prosecutors in small jurisdictions with limited resources, on the other hand, often simply rely on experts from local forensic facilities. Forensic practice is fundamentally different from clinical practice in its general perspective. Practitioners are trained to be “objective,” rather than empathic. A main goal is not to be fooled by the person being evaluated. The suspicion of malingering is ever present. Forensic training focuses on narrow legal questions (competency and sanity/responsibility). It is important to investigate the practices of the particular jurisdiction to anticipate the likely choice(s) of prosecution expert(s) and usual practice of prosecution expert(s). The rebuttal examination may be brief and superficial, or lengthy and detailed, depending mainly on the available resources.

OTHER HARMFUL EVALUATIONS

In addition to hostile examinations by prosecution experts, capital clients often have a history of prior evaluations that found no evidence of mental disorders or impairments and instead concluded that they were simply antisocial. Such evaluations are particularly common in the context of jails and prisons, where screening interviews are often brief and superficial. However, many clients have had prior evaluations by defense experts who also reached harmful conclusions. In most cases, these experts relied entirely on the client's self-report and did not have the opportunity to review robust and independent social history data. Jail and prison evaluations are particularly problematic in that the conclusions and impressions from one drive-by evaluation tend to be reiterated in successive examinations, creating the illusion of multiple independent evaluations all converging ineluctably in a negative profile of the individual.

In the course of social history investigation, it is important to identify all prior evaluations and to obtain not only the reports but also all the raw data and notes of prior evaluators. (Raw test data may generally only be disclosed to other mental health professionals, so counsel will need to designate a mental health professional, typically a clinical or neuropsychologist, with whom such data may be shared.) It is critical to know as much as possible about the context of any prior evaluation and

²⁵⁰ Bell, L., *Witness Nicknamed “Dr. Death” Says License Won’t Be Affected by Allegations*, DALLAS MORNING NEWS, July 26, 1995, available at <http://www.ccadp.org/DrDeath.htm>.

what information was provided to the expert. In many cases, it will be possible to go back to the prior evaluators once the social history investigation has developed evidence that might prompt them to reconsider their earlier conclusions. An expert who indicates no willingness to consider new information or an insistence that nothing could alter his or her conclusions is likely to be either rigidly biased or simply methodologically unsound.

INVESTIGATING EXPERTS

It is important to investigate the background of all the mental health experts who may testify for either side in a capital case. As noted in Supplementary Guideline 4.1.B, “Counsel has a duty to hire, assign or have appointed competent team members; to investigate the background, training and skills of team members to determine that they are competent; and to supervise and direct the work of all team members. Counsel must conduct such investigation of the background, training and skills of the team members as will determine that they are competent and must ensure on an ongoing basis that their work is of high professional quality.”²⁵¹ Investigating the background of rebuttal witnesses is essential in any litigation. Whether investigating friend or foe, the methodology is the same.

CVs

An expert's CV is a starting point for verifying education and employment history. It is often useful to obtain her CVs from other cases to detect omissions, changes, etc. The CV should also be compared to other biographical listings, such as *Who's Who*. A critical reader asks the following sorts of questions: Are there gaps in the timeline? Is the CV up to date? How does it compare with prior versions? Are there different versions for different audiences? Is the educational record complete? Is there a logical progression? Are the educational institutions themselves legitimate? Does the employment history reflect a natural progression—or does it bounce around? Are the publications peer reviewed? Is the licensure or board certification based on real qualifications and exams? Was there grandfathering? Bogus boards? Checkbook certification? What do the professional memberships require? Can anyone join just by paying dues? Were the invited lectures or presentations peer reviewed? Were there evaluations? Were the continuing education courses graded, or does everyone get a certificate of completion? Are the awards and honors legitimate?

Professional licensing and board certification

Where applicable, licensure should be verified with appropriate state authorities, which also maintain files reflecting any complaints or inquiries about the licensee.

²⁵¹ SUPPLEMENTARY GUIDELINES, at 680.

Prior testimony and reports

Oftentimes, prosecution experts have testified to contrary views in previous cases. In one instance, a well-known and often used prosecution expert testified in one case that the DSM-IV was the “bible” of clinical assessment, while in another case he opined that the DSM-IV was essentially irrelevant to forming opinions and served only as a broad guide with specific clinical applications. Reports, trial and deposition testimony from other cases are the ultimate means of determining whether experts have taken inconsistent or dishonest positions, or simply demonstrated a bias over long years of testifying.

Publications

Experts may not list all their publications on their CVs. A literature search may identify additional articles and books. A review of the publications may disclose both substantive issues and discernible bias.

Media

Media searches will disclose whether the expert also likes to comment on cases. Profiles, feature stories, and news items mentioning the expert may add to the background portrait.

Public records

Court searches of criminal and civil cases involving the expert may reveal the unexpected. In one case, the criminal index turned up a fraud case that was being investigated at the very time the mental health expert was testifying for the prosecution. Because charges were filed only after the capital trial was finished, trial counsel never knew that the expert was attempting to curry favor with the state when he testified. Funding records are also revealing. Contracts with government agencies and research grants are often accessible through the Freedom of Information Act and its state open records counterparts. In addition, there are private information vendors that maintain databases on experts that can be utilized on a fee-per-search basis.

Networking

The Internet has made it possible to reach out to other practitioners around the country to identify others who have encountered particular experts in their own cases. Listservs, bulletin boards, and web sites are important new tools for networking with other capital counsel.

Case-specific discovery

Unsound conclusions can be discovered by meticulously comparing reports to underlying data and notes.

PERSONALITY DISORDERS

As discussed throughout this manual, diagnosis is never required for purposes of mitigation, and disputes over diagnosis frequently result in a “battle of the experts” in which the client’s disabilities are obscured rather than illuminated. If, however, the defense expert has diagnosed a capital client with a major (and treatable) mental illness, disputes with prior or rebuttal experts will often focus on personality disorders. The DSM-IV-TR describes a personality disorder as “an enduring pattern of inner experience and behavior that deviates markedly from the expectations of the individual’s culture, is pervasive and inflexible, has an onset in adolescence or early adulthood, is stable over time, and leads to distress or impairment.”²⁵²

Simply put, personality disorders are traits that compose core, definitional characteristics. Under the DSM multiaxial diagnostic system, the difference between Axis I, often referred to as clinical disorders, and Axis II, often referred to as personality disorders, might best be understood as the difference between a state and a trait. A state involves conditions that could remit (or wax and wane). In contrast, a trait is a core definitional characteristic. The distinction is between a condition that a person has and the definition of who a person is.

Since 1980 when DSM III instituted the multiaxial system, Axis I has been defined generally as comprising “clinical” disorders and Axis II the “personality” disorders. This distinction is crucial to understanding what happens when Axis II diagnoses are brought into court because rather than being conditions that might be effectively treated or which may in fact change over time, the personality disordered individual is instead described for the merit of his character and the essential nature of his personhood. Therefore, rather than a story about a person who has certain experiences, it is a story of the quality of the person predicated on the notion that he is socially disordered.

In short, the reason that personality disorders do not assist in presenting mitigation evidence is because such presentation asks the jury to judge the merit of the client’s character, rather than the more complex story concerning how and why the client has come to this situation. A personality disorder is not regarded as an illness; it cannot be cured. Personality disorders are thought to be recognizable during adolescence or early adulthood, and by definition they are stable over time, although some tend to become less evident (or “to remit with age”).

²⁵² DSM-IV-TR, at 685.

In the pre-DSM-III period (before 1980), clinical descriptions of personality disorders focused on traits rather than behavior. Personality disorders under this view were juxtaposed against a non-theoretical notion of normalcy (the well-adjusted person). There was little empirical work on whether these personality types existed, whether clinicians were identifying the same conditions as deviant or whether the disorders reflected communal concerns or the concerns of a few. For instance, much of the early work on personality disorders focused on immigrant groups (Italians, Irish and European Jews) and the desire to “treat” them in such a way as they became “normal.” The criteria for diagnosis were based on personality traits such as selfishness, lack of remorse, or incapacity for loyalty, seen in the clinical interview. In 1980, the promulgation of DSM-III changed some of this, shifting the focus to observable behaviors rather than traits. This change was purportedly brought on by empirical research. However, extensive debate remains about the empirical support for the criteria and diagnoses on Axis II, particularly those in Cluster B (described below).

The decision in DSM-III to move personality disorders to a separate axis was explained as an effort to keep clinicians from ignoring the personality disorders and to highlight them. DSM-III defined the personality disorders as “inflexible and maladaptive” conditions, causing either “significant functional impairment or subjective distress.” It suggested that combinations or constellations of traits constitute a personality disorder, but only when they are inflexible, maladaptive or cause significant functional impairment.

As a general rule, personality disorders are not helpful as mitigation, and many clients have been previously diagnosed with a personality disorder by experts who did not have access to comprehensive social history data.

DSM-IV-TR recognizes that personality disorders should be considered subsidiary to the clinical disorders. Since the criteria may often overlap between clinical and personality disorders, DSM-IV-TR cautions that a personality disorder should be diagnosed “only when the defining characteristics... do not occur exclusively during an episode of an Axis I disorder.”²⁵³ Thus, Axis I disorders must be considered and ruled out before an expert concludes someone suffers from a personality disorder: “The enduring pattern is not better accounted for as a manifestation or consequence of another mental disorder.” In short, Axis I clinical disorders trump the personality disorders. If a clinical disorder is present and explains the behaviors, no personality diagnosis should be made. Further, the enduring pattern must not occur solely as a result of substance abuse or a medical condition (neurological disease or head trauma), and when the personality changes occur as a result of extreme stress, post-traumatic stress should be considered.²⁵⁴

²⁵³ DSM-IV-TR, at 688.

²⁵⁴ Similarly, it is important to note the relationship between personality disorders and developmental disorders, both of which involve Axis II diagnoses. The developmental disorders, such as mental retardation and related intellectual impairments, are important as mitigation evidence, while the personality disorders are generally harmful, and frequently inaccurate, diagnoses. Personality disorder

Cluster A Personality Disorders

The odd or eccentric disorders include three types: paranoid, schizoid and schizotypal. In general, these are like lesser included conditions of clinical disorders. They are defined by a pervasive pattern of distrust, paranoia and suspiciousness. People with these conditions are said to appear odd or eccentric. Cluster A disorders must not have occurred exclusively during the course of schizophrenia, mood disorder with psychotic features, or psychotic disorder. Therefore, as with the personality disorders overall, every effort should be made to develop facts which will allow the expert to properly evaluate the presence of a clinical disorder that rules out the personality disorder.

Cluster B Personality Disorders

Often called the dramatic disorders, Cluster B disorders include Antisocial Personality Disorder, Borderline Personality Disorder, Histrionic Personality Disorder and Narcissistic Personality Disorder. Serious conceptual and legal problems related to Cluster B are discussed below in the section on Antisocial Personality Disorders. In short, there is poor evidence currently that the four disorders that make up Cluster B are in fact distinct disorders that can be accurately identified. As with all the personality disorders, clinical disorders must be ruled out prior to diagnosis.

Cluster C Personality Disorders

Cluster C disorders include Avoidant Personality Disorder, Dependent Personality Disorder, Obsessive-Compulsive Disorder and Personality Disorder Not-Otherwise-Specified. People with these conditions are said to appear anxious or fearful. The same rule-out provisions apply to these disorders as well.

DSM-IV-TR cautions that personality disorder diagnoses should be based on an evaluation of long-term functioning, through multiple interviews, spaced over time. The conditions should be distinguished from situational stressors or more transient mental states. It is necessary to rule out symptoms as manifestations of other mental disorders, or the effects of drugs or medications, or the effects of medical conditions

diagnoses never rule out developmental disorders. For example, the DSM-IV-TR makes clear that whenever impairments in adaptive behavior would also meet the criteria for another disorder and there is evidence of significantly sub-average intellectual functioning, these impairments should be associated with mental retardation, even if they may also be associated with another disorder. "The diagnostic criteria for Mental Retardation do not include an exclusion criterion; therefore, the diagnosis should be made whenever the diagnostic criteria are met, regardless of and in addition to the presence of another disorder." *Id.*, at 47. *See also Holliday v. Campbell*, 463 F.Supp.2d 1324, 1345 (N.D. Ala. 2006), where the court concluded, "This court rejects the argument that willful and anti-social behavior excludes a mental retardation determination. To the contrary, it suggests that a person whose IQ tests strongly indicate mental retardation has not adapted."

(such as head trauma). When diagnosing during mood or anxiety episodes, PTSD should be considered. Behaviors following intoxication or withdrawal, or activities sustaining a dependency, should be viewed in those contexts. It is necessary to take into account an individual's ethnic, cultural and social background. Behaviors appearing to meet the criteria for personality disorders should not be confused with "the expressions of habits, customs, or religious and political values professed by the individual's culture of origin."

A total lack of discriminant validity currently undermines the Cluster B disorders. Discriminant validity means that the disorder can be accurately and consistently identified and distinguished from other disorders. There is tremendous diagnostic overlap which some people have inaccurately referred to as co-morbidity but which is in fact a failure to systematically describe distinct and identifiable conditions.

Many people qualify for more than one personality disorder based on the same or similar behaviors or based on slight variation in the interpretation of the behavior by a clinician. DSM-IV-TR cautions: "Other Personality Disorders may be confused with Antisocial Personality Disorder because they have certain features in common."²⁵⁵ This overlap is recognized as a failure of the science: "Substantial evidence of the lack of exclusiveness is provided by studies of diagnostic overlap mentioned previously. Overlap is often misleadingly referred to as co-morbidity. However, co-morbidity refers to the co-occurrence of distinct diagnoses and there is no evidence that personality disorder diagnoses are distinct in this sense. When applied to personality disorder, the term 'co-morbidity' simply obscures a fundamental flaw in the system."²⁵⁶

In a review of the existing literature on "co-morbidity" among Axis II disorders under DSM-III-R, researchers found that only 4 of 196 cases of Borderline Personality Disorder (BPD) did not have a co-morbid personality disorder—meaning that nearly every person in these studies diagnosed with BPD was also diagnosed with another personality disorder. Eighty two percent of antisocial diagnoses also were diagnosed with another personality disorder in the studies reviewed.²⁵⁷

ANTISOCIAL PERSONALITY DISORDER

Antisocial personality disorder (ASPD) is a common diagnosis for people who have ever been in contact with the criminal justice system. The DSM cautions that ASPD may be misapplied to individuals in settings in which antisocial behavior may be part of a protective survival strategy. As always, social and economic context should be considered.

²⁵⁵ DSM-IV-TR, at 705.

²⁵⁶ Livesley, W.J., (ed.), *HANDBOOK OF PERSONALITY DISORDERS* (Guilford Press 2001), at 18.

²⁵⁷ Widiger, T.A., et al, *Comorbidity Among Axis II Disorders*, in Oldham, J.M., (ed.), *PERSONALITY DISORDERS: NEW PERSPECTIVES ON DIAGNOSTIC VALIDITY* (American Psychiatric Pub. 1991), at 168.

Under DSM-II, antisocial personality disorder was thought to have a prevalence of about 30 percent in prison populations. The move to place personality disorders onto their own Axis and the shift from trait-based to behavior-based criteria drastically increased the prevalence of the condition to 75 to 80 percent in the prison population, leading some to suggest that ASPD was simply a codification of criminal behavior, no longer predicated on a personality structure.²⁵⁸

Diagnostic Criteria for Antisocial Personality Disorder (DSM-IV-TR)

- A. There is a pervasive pattern of disregard for and violation of the rights of others occurring since age 15 years, as indicated by 3 (or more) of the following:
 - 1) failure to conform to social norms with respect to lawful behaviors as indicated by repeatedly performing acts that are grounds for arrest
 - 2) deceitfulness, as indicated by repeated lying, use of aliases, or conning others for personal profit or pleasure
 - 3) impulsivity or failure to plan ahead
 - 4) irritability and aggressiveness, as indicated by repeated physical fights or assaults
 - 5) reckless disregard for safety of self or others
 - 6) consistent irresponsibility, as indicated by repeated failure to sustain consistent work behavior or honor financial obligations
 - 7) lack of remorse, as indicated by being indifferent to or rationalizing having hurt, mistreated or stolen from another
- B. The individual is at least age 18 years.
- C. There is evidence of Conduct Disorder with onset before age 15.
- D. The occurrence of antisocial behavior is not exclusively during the course of Schizophrenia or a Manic Episode.

Other than a collection of bad acts, serious questions remain as to whether there is any diagnostic reliability or validity to ASPD. The scientific literature points out numerous, ongoing diagnostic problems with ASPD, starting by recognizing that hundreds of thousands of combinations of subcriteria behaviors can lead to the same diagnosis without any relationship between them. This means that all subcriteria are weighted equally, such that armed robbery and rape are equal diagnostically to truancy. They also note that there is poor diagnostic reliability between experts when they assess ASPD.

²⁵⁸ Wulach, J.S., *Diagnosing the DSM-III Antisocial Personality Disorder*, 14(3) PROF. PSYCHOL.: RES. & PRAC. 330 (1983).

Some researchers have also commented that mental health clinicians have no particular expertise in assessing deviation from social norms. This is an often ignored criticism, that the training and expertise of psychologists and psychiatrists renders them no more able than a lay person to opine on “deviance” and to assess the pattern of deviant social behavior. This is critically important in the forensic diagnosis of antisocial personality disorder because under the guise of a psychological classification of disease, experts often diagnose social deviance as a psychological disorder based solely on personal opinion or previous adjudication rather than independent expertise and training. Personal dislike of the patient or moral judgments about the patient's behavior may result in an ASPD diagnosis, but: “If so, the diagnosis may present a pseudo-scientific facade for value judgments.”²⁵⁹

Because the DSM-IV-TR has stayed with the observable behavior criteria, the problems with the model have not improved. First, the empirical research provides support for the idea that personality disorders are more appropriately assessed on a continuum, where people might be viewed as incrementally further from “normal” in some areas and not others.²⁶⁰ DSM-IV-TR discusses this idea, but the criteria for diagnosis remain static and dichotomous (subject does or does not meet criteria).

Unlike schizotypal personality disorder, which research shows clearly relates to the Axis I mental disorder of schizophrenia, ASPD has no corresponding Axis I illness. This suggests that personality disorders are not in fact mental illnesses as currently defined. In addition, the fact that DSM-IV-TR includes a “trumping” of Axis II by Axis I disorders in diagnosis implies a recognition that Axis II—especially Cluster B—identifies character flaws as opposed to mental illness where mental illness is considered a condition that a person has rather than a core definitional characteristic of the person.

Dr. Stephen Hart, a leading forensic psychologist, has written: “As do the mental health professions, however, the law often distinguishes between mental illness and personality disorder. Mental illness can be defined as acute and severe disturbances in psychological functioning—that is, disorders falling on Axis I of the fourth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV; American Psychiatric Association, 1994). In contrast, personality disorders can be defined as chronic disturbances of character or social relations, disorders falling on Axis II of DSM-IV... If the personality disorder is not severe enough to be a mitigating factor in forensic decision making it may be considered, somewhat ironically, an aggravating factor, something that can be used to argue for harsher punishment or imposition of long-term social controls.”²⁶¹

²⁵⁹ Weinstock, R., & Nair, M., *Antisocial Personality—Diagnosis or Moral Judgment?* 29(2) J. FOR. SCIENCE 557 (1984); see also Rogers, R., Dion, K.L., & Lynett, E., *Diagnostic Validity of Antisocial Personality Disorder*, 16(6) LAW & HUMAN BEHAVIOR 677 (1992).

²⁶⁰ Livesley, *supra*, n.256.

²⁶¹ *Id.*, at 556.

Hart's argument is basically that if volition and cognition are not impaired by ASPD, which almost every forensic consultant concludes, and since it is unlikely that *any* personality disorder under the current definitions will impair volition and cognition, it is not mitigating and may be viewed as aggravating. "[W]hereas mental illness is generally considered a mitigating factor in forensic decision making, personality disorder generally is considered to be an aggravating factor."²⁶² Hart comments on capital sentencing and ASPD saying that it denotes a lack of good character (lack of mitigation) and elevated risk for future dangerousness (aggravation).

CONDUCT DISORDER

One of the key diagnostic requirements of ASPD is that conduct disorder existed prior to age fifteen. Many careless evaluators ignore this requirement, making their diagnoses fatally flawed. ASPD is one of the few disorders in DSM that requires childhood onset and which cannot be diagnosed without specific historical markers of the condition. When conduct disorder is assessed retrospectively, the validity and reliability of the diagnosis must be carefully considered. "Many antisocial behaviors emerge in some form over the course of normal development."²⁶³ Thus, the key differentiation between behaviors and disorder are frequency and intensity of the behaviors.

As diagnosed, conduct disorder is "likely to be the end product of complex multifactorial processes operating *within* and outside a given individual, but the relevant causal processes are likely also to differ *across* individuals."²⁶⁴ For some, antisocial behaviors may be internally driven (a mental disorder), but for others those behaviors derive from extrinsic, environmental factors. Some children thought to have conduct disorder could more accurately be diagnosed with an Axis I mental illness.

Longitudinal research indicates that conduct disorder in childhood relates to numerous problems in adulthood: psychiatric symptoms, occupational difficulties, physical illness, criminal contacts (often resulting from substance abuse), social isolation and lowered educational attainment.²⁶⁵ This suggests that some of the symptoms associated with conduct disorder may be markers of the above-noted conditions, each of which could be treated or remediated in childhood or adulthood (as opposed to the conduct disorder diagnosis which does not respond well to treatment or remediation).

²⁶² *Id.*, at 560.

²⁶³ Kazdin, A., CONDUCT DISORDERS IN CHILDHOOD AND ADOLESCENCE (Sage Publications 2nd ed., 1995), at 8.

²⁶⁴ Richters, J., & Cicchetti, D., *Mark Twain Meets DSM-III-R: Conduct Disorder, Development, and the Concept of Harmful Dysfunction*, 5 DEVELOPMENT & PSYCHOPATHOLOGY 5, 15 (1993).

²⁶⁵ Kazdin, *supra*, n.263, at 69.

The behaviors that make up the conduct disorder criteria are extremely heterogenous, describing many behavior patterns which are not alike. Similar outcomes (the patterns of behavior) arise from many different pathways or causes.²⁶⁶ Attention must be paid to the pathway and to whether some pathways provide evidence for an alternative diagnostic picture. Some pathways may better explain the behavior than a persistent pattern of bad acts.

Diagnostic Criteria for Conduct Disorder (DSM-IV-TR)

- A. A repetitive and persistent pattern of behavior in which the basic rights of others or major age-appropriate societal norms or rules are violated, as manifested by the presence of three (or more) of the following criteria in the past 12 months, with at least one criterion present in the past 6 months:

Aggression to people and animals

- 1) often bullies, threatens or intimidates others
- 2) often initiates physical fights
- 3) has used a weapon that can cause serious physical harm to others (e.g., a bat, brick, broken bottle, knife, gun)
- 4) has been physically cruel to people
- 5) has been physically cruel to animals
- 6) has stolen while confronting a victim (e.g., mugging, purse snatching, extortion, armed robbery)
- 7) has forced someone into sexual activity

Destruction of Property

- 8) has deliberately engaged in fire setting with intention of causing serious damage
- 9) has deliberately destroyed others' property (other than by fire setting)

Deceitfulness or theft

- 10) has broken into someone else's house, building or car
- 11) often lies to obtain goods or favors or avoid obligations (i.e., "cons" others)
- 12) has stolen items of non-trivial value without confronting victim (e.g., shoplifting, but without breaking and entering; forgery)

Serious Violations of Rules

²⁶⁶ Cicchetti, D., & Rogosch, F.A., *Equifinality & Multifinality in Developmental Psychopathology*, 8 DEVELOPMENT & PSYCHOPATHOLOGY 597 (1996).

- 13) often stays out at night despite parental prohibitions, beginning before age 13
 - 14) has run away from home overnight at least twice while living with parent or parental surrogate (or once for a lengthy period)
 - 15) is often truant from school beginning before age 13
- B. The disturbance in behavior causes clinically significant impairment in social, academic or occupational functioning.
- C. If the individual is age 18 years or older, criteria are not met for Antisocial Personality Disorder.

Children with organic brain dysfunction are often misdiagnosed with conduct disorder. Brain damage, whether genetic or from injury or insult, may better explain a child's behavior that could mistakenly result in a conduct disorder diagnosis. Similarly, the behaviors associated with many psychiatric illnesses (e.g., psychotic disorders in childhood, attention deficits, traumatic stress, language and learning disabilities, exposure to violence) may resemble conduct disorder and may lead to misdiagnosis. Specific behavioral criteria for conduct disorder (e.g., truancy before age thirteen) may have other contextual explanations (e.g., absence because of neglectful or abusive caretakers). Such differential diagnosis can only be based on thorough family and social history evidence.

PSYCHOPATHY

While the DSM-IV-TR has no subcategories within the diagnosis of antisocial personality disorder, some forensic experts continue to use the labels "psychopath" or "sociopath" to characterize utter depravity. Many prosecution experts seek to use test instruments designed solely to demonstrate irredeemable depravity. One example is the Hare Psychopathy Checklist-Revised (PCL-R), which assigns individuals zero, one or two points on each item of a twenty-item scale. Some evaluators have calculated a score without interviewing the subject, relying solely on criminal history records and third-party reports. In one case, a prosecution expert did not calculate a score, but simply read the twenty items to the sentencing-phase jury, as though the emotive concepts would allow the jurors themselves to rate the defendant on a scale of wickedness.

The use of such instruments in capital proceedings has been challenged on a variety of grounds, ranging from their reliability and validity to norming to ethical issues that are implicated when mental health professionals begin to opine on the moral character of human subjects. Suffice it to say for the purposes of this manual that counsel need to be vigilant about the administration of any testing whose purpose is purely to calibrate a capital client's evil nature.

Hare Psychopathy Check List—Revised

- Glibness/superficial charm
- Need for stimulation
- Conning/manipulativeness
- Shallow affect
- Parasitic lifestyle
- Promiscuous sexual behavior
- No long-term goals
- Irresponsibility
- Many short-term marriages
- Revocation of conditional release
- Grandiose self-worth
- Pathological lying
- Lack of remorse
- Callousness/lack of empathy
- Poor behavioral controls
- Early behavior problems
- Impulsivity
- Failure to accept responsibility
- Juvenile delinquency
- Criminal versatility

CHAPTER 11:
COMPETENCY IN CAPITAL CONTEXTS

Including:

- Counsel's obligations;
- Risks of evaluations in state facilities;
- Standard of care issues;
- A competent client's participation;
- Client capacities in trial context;
- Disabilities leading to incompetence;
- Rational assistance; and
- Post-trial issues.

Half a century ago, the United States Supreme Court set out in simple language the standard for assessing competence to stand trial: whether a criminal defendant has sufficient present ability to consult with counsel with a reasonable degree of rational understanding and has a rational and factual understanding of the proceedings.²⁶⁷ That standard has remained unchanged because it is so fundamental to due process, with an exceptionally long history in common law.²⁶⁸ And “[f]or the defendant, the consequences of an erroneous determination of competence are dire. Because he lacks the ability to communicate effectively with counsel, he may be unable to exercise other “rights deemed essential to a fair trial.”²⁶⁹

Competency is a temporal determination: someone is legally competent, or not, at a particular time. The basic standard applies to all phases of litigation from *Miranda* and consent-to-search waivers to trial and post-conviction proceedings, and, finally, to execution.²⁷⁰ An individual could be incompetent to proceed at point A, restored to competency at point B, and incompetent again (for example, decompensating under the stress of further proceedings) at point C. The range of potential competency issues in a capital case also includes prior offenses offered in aggravation (e.g., competency to plead guilty in the prior offense) and competency to waive post-conviction litigation in order to seek execution.²⁷¹ Recent research on wrongful convictions has

²⁶⁷ *Dusky v. United States*, 362 U.S. 402 (1960).

²⁶⁸ See *Rohan ex rel. Gates v. Woodford*, 334 F.3d 803 (2003), *cert. denied*, for review of the historical precedents of competence.

²⁶⁹ *Cooper v. Oklahoma*, 517 U.S. 348, 364 (1996), citing *Riggins v. Nevada*, 504 U.S. 127, 139 (1992) (Kennedy, J., concurring in judgment).

²⁷⁰ *Godinez v. Moran*, 509 U.S. 389 (1993), noting that there is a single standard for competence, applied to every stage of a case). See also *Ford v. Wainwright*, 477 U.S. 399 (1986), barring execution of the insane.

²⁷¹ See Blume, *supra*, n.29: analysis of 106 “volunteer” executions through 2003 found nearly 88% had struggled with mental illness and/or substance abuse, including 14 with schizophrenia, others with delusions, 23 with mood disorders, 10 with PTSD, and at least 30 with previous suicide attempts).

drawn attention to the high incidence of mental vulnerabilities in false confession cases, raising questions about the competency of those individuals to waive their Fifth and Sixth Amendment rights.²⁷² Similarly, there is anecdotal evidence of executions of individuals who lacked a rational understanding, most notably the case of Ricky Ray Rector, who saved the dessert from his last meal to eat after his execution.²⁷³ Competence, at every stage of the criminal process (and especially in capital cases), is fundamental to due process.²⁷⁴

Because incompetence is predicated on the presence of, and interference from, a mental disorder or impairment of some sort, its determination is informed by expert testimony.²⁷⁵ Nevertheless, the determination of a defendant's competence rests squarely with the trial court because that determination is a legal and factual one.²⁷⁶ Unfortunately, both defense counsel and the trial courts, more often than not, defer to the judgment of mental health professionals to determine competence.²⁷⁷ Defense counsel interactions with the client, while not determinative, can be an essential component of the assessment since defense counsel is in the best position to know whether a client can communicate rationally about the case.²⁷⁸ Yet, the role of the defense team in the determination of competence, both in theory and in practice, is typically absent or at least severely lacking.²⁷⁹ *Dusky* set out a number of abilities and

²⁷² See, for example, Gross, S.R., Jacoby, K., Matheson, D.J., Montgomery, N., & Patil, S., *Exonerations in the United States, 1989 through 2003*, 95 J. CRIM. L. & CRIMINOLOGY 523 (2005): metastudy of wrongful convictions finding 69% of false confessions involved individuals with mental retardation or mental illness.

²⁷³ See Frady, M., *Death in Arkansas*, NEW YORKER (February 22, 1993).

²⁷⁴ *Cooper*, 517 U.S. at 348 (1996).

²⁷⁵ The role of mental health experts in the determination of competency is in assessing how a client functions (his capacities and impairments), not in reaching the ultimate opinion as to competency to proceed. See *Maggio v. Fulford*, 462 U.S. 111, 119 (1983) (White, J., conc. op.): "Our cases have treated the ultimate question whether a defendant is competent to stand trial as at least a mixed question of law and fact," citing *Drope v. Missouri*, 420 U.S. 162 (1975) at 174-175, 175, n. 10, and *Pate v. Robinson*, 383 U.S. 375 (1966). Similarly, the consensus of most forensic mental health evaluators is that experts should refrain from offering opinions on the ultimate legal question, instead describing the symptoms and behaviors relevant to the legal question. Heilbrun, K., *PRINCIPLES OF FORENSIC MENTAL HEALTH ASSESSMENT* (Kluwer 2001), at 219-226; Melton et al, *supra*, n.231, at 17, 129.

²⁷⁶ *Drope v. Missouri*, 420 U.S. at 174-75. In some jurisdictions, competency is determined by a jury trial, and in others by the court.

²⁷⁷ See, e.g., Zapf, P.A., et al, *Have courts abdicated their responsibility for determination of competency to stand trial to clinicians?* 4(1) J. FOR. PSYCHOLOGY PRACTICE 27 (2004): review of research indicating that courts agree with mental health expert recommendations over 90% of the time, and in this study, finding the court endorsed the mental health expert recommendation in 99.7% cases studied.

²⁷⁸ *Hernandez v. Ylst*, 930 F.2d 714, 718 (9th Cir. 1990): "[w]hile the opinion of counsel certainly is not determinative, a defendant's counsel is in the best position to evaluate a client's comprehension of the proceedings". For counsel to have a role presupposes, however, that counsel has attended the appropriate training sessions to learn about mental illness and the identification of symptoms. See also *Medina v. California*, 505 U.S. 437, 450 (1997): "counsel will often have the best-informed view of the defendant's ability to participate in his defense".

²⁷⁹ Philipsborn, J.T., *Searching for Uniformity in Adjudications of the Accused's Competence to Assist and Consult in Capital Cases*, 10(4) PSYCHOLOGY, PUBLIC POLICY AND THE LAW, 417, 428 (2004).

capacities required of a criminal defendant.²⁸⁰ The factual understanding prong is relatively straightforward. The more difficult prong to assess involves the present ability to communicate with counsel based on a reasonable degree of rational understanding.

Very little attention has been paid to the question of what abilities ought to be required for competence, how to assess those abilities, or even who bears responsibility for making the assessment. Most mental health professionals have little legal training; and few have, nor should they be expected to obtain, an understanding or proficiency in criminal defense representation, let alone capital defense representation. Similarly, most lawyers and judges have little training on mental illness or in determining what symptoms are significantly interfering with communication, and may also lack a basic understanding of the cognitive and behavioral processes of decision-making and communication. Moreover, there are significant questions of strategy involved in how and when to raise a doubt about a client's competence.

Once a client can name the players in the courtroom and give a rudimentary statement of what each one does, competence to stand trial determinations rest primarily on the assessment of what a criminal defendant must be able to do *with counsel*. Mental health professionals typically conduct clinical-interview-based assessments or choose from among a small group of competence assessment instruments, some of which address specific rights (e.g., competency to confess)²⁸¹ or specific knowledge (factual, e.g., the role of the judge or the prosecutor in a case)²⁸² or whether by self-report the defendant describes the relationship with counsel as sub-standard.²⁸³ When a defendant is first adjudged to be incompetent, some of these same mental health professionals attempt to "teach" competency.²⁸⁴ But courses designed to educate defendants are aimed at the factual prong of competence, not the communication and decision-making prong.

²⁸⁰ The "test must be whether he has sufficient present ability to consult with his lawyer with a reasonable degree of rational understanding—and whether he has a rational as well as factual understanding of the proceedings against him." *Dusky*, 362 U.S. at 402. It is worth noting that *Dusky* reversed a determination by a federal trial court that the defendant was competent based on mental health testimony that he was oriented to time and place and had some recollection of the events.

²⁸¹ For a review of competence to confess measures, see Rogers, R., Jordan, M., & Harrison, K., *A critical review of published competency-to-confess measures*, 28(6) LAW AND HUMAN BEHAVIOR 707 (2004) and Grisso, T., *Reply*, at 719.

²⁸² For a review of instruments, see Melton et al, *supra*, n.231, at 139-150.

²⁸³ For example, the MACARTHUR COMPETENCE ASSESSMENT TOOL—CRIMINAL ADJUDICATION (1999); Poythress, N.G., et. al., PROFESSIONAL MANUAL, PSYCHOLOGICAL ASSESSMENT RESOURCES INC. (clinical judgment used to assess defendant's reasoning and relationship to counsel) and the EVALUATION OF COMPETENCY TO STAND TRIAL—REVISED (2004); Rogers, R., Tillbrook, C., & Sewell, K., PROFESSIONAL MANUAL, PSYCHOLOGICAL ASSESSMENT RESOURCES INC. ("assess the defendant's perception of the nature and quality" of the relationship with counsel).

²⁸⁴ See, e.g., Bertman, L., et al *Effect of an individualized treatment protocol on restoration of competency in pretrial forensic inpatients*, 31(1) J. AM. ACAD. PSYCHIATRY LAW 27 (2003); Scott, C., *Commentary: A road map for research in restoration of competency to stand trial*, 31(1) J. AM. ACAD. PSYCHIATRY LAW 36 (2003).

It is a significantly more difficult assessment problem to determine whether a defendant with the symptoms and behaviors consistent with a mental disease, defect or other brain dysfunction is impaired in his ability to consult with counsel with a reasonable degree of rational understanding than to assess a person's ability to parrot responses on factual process.

COUNSEL'S OBLIGATIONS

U.S. Supreme Court Justice Kennedy, in defining why the requirement for competence was fundamental, explained: "Competence to stand trial is rudimentary, for upon it depends the main part of those rights deemed essential to a fair trial, including the right to effective assistance of counsel, the rights to summon, to confront, and to cross examine witnesses, and the right to testify on one's own behalf or to remain silent without penalty for doing so."²⁸⁵ In so doing, the Court made it clear that it is not possible to represent an incompetent defendant in a constitutionally effective manner. Counsel's duties include some form of interaction and consultation with a competent client, which, although not spelled out by the court in their competence to stand trial cases, is suggested through the *Strickland* line of cases.²⁸⁶ Therein lies the intersection, for counsel, between counsel's duties and the incompetent client.

These expectations of capital counsel, unlike those of a capital charged defendant, are well established by professional standards and case law.²⁸⁷ First, counsel has the obligation to develop defenses, evaluate the strength of the case, guide the investigation and present the case in the courtroom. Counsel also has the obligation to ensure that the client is involved in decisions, which includes providing advice and information, including advice and information about decisions reserved to the competent client to make in a knowing, intelligent and rational manner.²⁸⁸ Second, the ABA Guidelines recognize that the tasks that, at a minimum, are constitutionally required of counsel in a capital case include engaging in an ongoing interactive dialogue.²⁸⁹ This dialogue must be more than simply keeping the client

²⁸⁵ *Riggins v. Nevada*, 504 U.S. at 139, 140 (Justice Kennedy, concurring), relying in part on *Drope v. Missouri*, 420 U.S. 162 (1975).

²⁸⁶ *Strickland v. Washington*, 466 U.S. 668 (1984).

²⁸⁷ Concerning professional responsibilities in this context, see Fox, *supra*, n.5.

²⁸⁸ See, for example, ABA Guideline 10.7, stating counsel's duty to investigate both guilt and penalty regardless of any statement by the client that such evidence is not to be collected or presented. This Guideline establishes a clear duty to investigate mitigating evidence, in part so that client and counsel can ultimately have a meaningful discussion about what evidence may be presented. In *Schriro v. Landrigan*, 127 S.Ct. 1933 (2007), a complex case involving procedures governing evidentiary hearings under the Anti-terrorism and Effective Death Penalty Act, the Supreme Court approved a client's waiver of mitigating evidence under a unique set of facts where the client actively interfered with counsel and asked for the death penalty in open court, while two potential witnesses refused to testify. The Court carefully distinguished these facts from the case of *Rompilla v. Beard*, 545 U.S. 374 (2005) where the client was uninterested in mitigation, but neither helped nor hindered the counsel's investigation and didn't ask for the death penalty, and the witnesses cooperatively testified.

²⁸⁹ ABA GUIDELINES, ABA Guideline 10.5, Relationship with the Client.

informed or complacent. The notion of interaction sets an expectation of mutuality and dialogue, although not necessarily agreement. The standards do not require that counsel and the client achieve consensus, rather that differences be discussed, understood and decisions made based upon the mutual understanding of the places of agreement and disagreement.

Counsel must engage in a continuing interactive dialogue with the client concerning all matters that might reasonably be expected to have a material impact on the case. These include the factual investigation, legal issues, defense theories, presentation of the defense case, potential dispositions of the case, litigation deadlines and schedules, relevant aspects of the client's life and interactions as well as courtroom presentation and demeanor.²⁹⁰ Counsel's duties in a capital case are clear and specific, involving complexities unique to the bifurcated process and the needs of both phases viewed as a whole.²⁹¹

RISKS OF EVALUATIONS IN STATE FACILITIES

Capital cases present defense teams with a different set of concerns from non-capital cases. Especially in jurisdictions where resources are scarce, defense counsel have been tempted to raise a doubt as to a defendant's competence in order to obtain a free evaluation of their client's functioning with the intent of using that information at a penalty phase or to raise questions of *mens rea*. In fact, based on anecdotal reports and post-conviction records, it has unfortunately been a common practice in some jurisdictions to obtain a “free” mental health evaluation by having a client evaluated for competency. State forensic hospital or federal prison evaluations should never be used as a substitute for the social history investigation that the defense team must do as a first step towards determining whether a client is competent to proceed. Moreover, sending a client to a state hospital or federal medical center to be evaluated for competency may interfere with the development of trust and rapport that is essential to competent representation. Second, the client may well be held and observed for an extended period of time during which the defense has restricted access to the client. Third, competence to stand trial is not a substitute assessment for mitigation development as the questions being clinically assessed are vastly different. Fourth, such a practice puts the client at risk for rebuttal evidence that, although

²⁹⁰ *Id.*

²⁹¹ *Wiggins v. Smith*, 539 U.S. 510 (2003): “[C]ounsel has a duty to make reasonable investigations or to make a reasonable decision that makes particular investigations unnecessary.”; *Williams v. Taylor*, 529 U.S. 362 (2000): defense counsel in a capital case has an “obligation to conduct a thorough investigation of the defendant's background”; *Mayfield v. Woodford*, 270 F.3d 915, 927 (9th Cir. 2000): “To perform effectively in the penalty phase of a capital case, counsel must conduct sufficient investigation and engage in sufficient preparation to be able to ‘present and explain the significance of all the available [mitigating] evidence’”; *Caro v. Calderon*, 165 F.3d 1223, 1227 (9th Cir. 1999): “[i]t is imperative that all relevant mitigating information be unearthed for consideration at the capital sentencing phase”; *Stouffer v. Reynolds*, 168 F.3d 115, 1167 (10th Cir. 1999): “[i]n a capital case the attorney's duty to investigate all possible lines of defense is strictly observed”; *Bell v. Ohio*, 438 U.S. 637 (1978).

limited in scope, can be used by the prosecution.²⁹² Fifth, such evaluations will inevitably be based on less information, and thereby be less reliable, than can be accomplished when the defense investigation is thorough and competently undertaken. Sixth, state hospital opinions are biased towards law enforcement and prosecution. Finally, state hospital doctors are typically not specialists, carry extensive caseloads and are underfunded. They therefore conduct assessments not particular to the symptoms and impairments of a particular client but rather conduct surface assessments without pursuing depth or nuance. Conclusions are frequently drawn with respect to diagnostic issues without benefit of full family and social history information.

STANDARD OF CARE ISSUES

This final point is the most important because when defense counsel chooses to send a client to a state or federal facility for evaluation, it suggests that counsel is seeking short-cuts to the extensive and thorough investigation required of them. As set out in the 1990s, the widely accepted standard for mental health evaluations in capital cases requires at a minimum:

an accurate medical, developmental, psychological and social history. Historical biopsychosocial data must be obtained not only from the accused, but from independent and multiple sources to provide an adequate data base of convergent validity as well as a complete physical and neurological examination, a complete psychiatric examination, and neuropsychological and other medically and psychometrically appropriate tests.²⁹³

Whereas defense counsel must consult about and participate in decisions about the testing and assessment components of a client's evaluation, it is primarily counsel's responsibility to develop the accurate and comprehensive biopsychosocial history on which the mental health professionals rely. In every capital case, malingering is suspected and the best evidence to disprove malingering when it is wrongly suspected is the onset and course of a client's mental illness or intellectual deficit as detailed by records and witnesses other than the client, and documented long before capital charges were pending.²⁹⁴

²⁹² Whenever clients are exposed to state or prosecution experts in the context of a competency evaluation, counsel should obtain protective orders imposing three caveats: (1) the examination and report shall be limited to competency; sanity and/or mental capacity at the time of the alleged offense shall not be addressed nor shall sentencing considerations, such as future dangerousness; (2) the results are to be used solely for the determination of competency and for no other purpose; (3) information obtained regarding the offense or prior criminal or otherwise antisocial conduct shall be used for the determination of competency and for no other purpose.

²⁹³ Liebert & Foster, *supra*, n.79. See also Dudley & Leonard, *supra*, n.21.

²⁹⁴ Malingering, the "intentional production of false or grossly exaggerated physical or psychological symptoms," should be suspected when the assessment is conducted in the medico-legal context according to the DSM-IV-TR (at 739). Evidence that demonstrates that the symptoms predate the medico-legal context is the best rebuttal of such suspicions.

Further, counsel's duty to establish a relationship with the client includes an obligation to observe behavioral, physical and psychological symptoms through interactions with the client. For instance, a client who is unable to retain specific information provided by counsel over time may simply be adverse to the information or the client may be mentally retarded or suffer from memory deficits. Counsel's duties include careful observation over time, efforts to work around such barriers until they can no longer be avoided, and then, identifying the appropriate experts to consult. Perhaps, simply altering the interaction could accommodate some communication problems, repeating the same information in different ways, providing both verbal and written materials, or providing an outline of what the communication would cover. The purpose, of course, is for counsel to have tried, repeatedly, to make progress in the development of the case and the relationship before considering whether the communication is so impaired as to jeopardize effective legal representation.

Moreover, the time spent with the client when these observations are being undertaken is also the time during which the attorney and defense team get to know the client and the ways in which the client sees and experiences the world. This is, in part, what must be presented to the jury (or post-conviction court) as part of the humanizing piece of a capital case, a part which indicates that this client is more than simply the perpetrator of a terrible murder. This time spent with the client is also critical because counsel who suspects a client to be incompetent to stand trial must have concrete and specific examples of how and where the failure in communication impeded the preparation of the case. As with all other areas of capital litigation, counsel and the defense team must think strategically about the consequences of raising a doubt about client competence because the client may then be exposed to court or prosecution expert examination. Extensive litigation to limit access to the client or the scope of prosecutorial testing may be required in competence settings because the state may otherwise gain hours of unprotected access to a client who may still face a penalty proceeding. Such pitfalls must be thoroughly considered and weighed before moving for a competency determination.

Despite counsel's role and constitutionally mandated duties in the adjudication of competence to stand trial, that determination is ultimately an assessment of the capacities of the criminal defendant, not of counsel's performance. Certainly the seriousness of the charges and complexity of the litigation have long been viewed as important to assessing what a defendant must be able to do; but the tasks necessary for a defendant's competent participation have largely been left to counsel to determine and widely ignored in the adjudication of competence.

A COMPETENT CAPITAL CLIENT'S PARTICIPATION

What a competent client must do at the various stages of a capital prosecution depends, of course, on the stage the case has reached, but the courts have given some

guidance on what is expected. Some fundamental rights are reserved by the courts solely to the rational defendant: the right to testify, the right to plead guilty, the right to represent himself.²⁹⁵ These rights are predicated on the client being engaged first in the interactive dialogue with counsel, but they are the rights that a defendant exercises regardless—so long as the defendant is competent.²⁹⁶ These rights, however, are not the beginning and end of a competent defendant's participation in the criminal adjudication. In *Cooper*, the court stated: “With the assistance of counsel, the defendant also is called upon to make myriad smaller decisions concerning the course of his defense.”²⁹⁷ This definition merely restated the original view expressed in *Dusky*. Certainly, “myriad smaller decisions” could include some decisions and not others, but more relevantly, the language about “myriad smaller decisions” implies support for the notion of the interactive dialogue defined by the ABA rather than establishing specific rights and decisions that must be met.²⁹⁸

Sell v. United States, in which the Supreme Court ruled on forcibly medicating a non-dangerous pre-trial defendant, raised the question as to whether antipsychotic medication would “sedate a defendant, interfere with communication with counsel, prevent rapid reaction to trial developments, or diminish the ability to express emotions.”²⁹⁹ This language recognizes two critically important, and previously underacknowledged, pieces of the competency puzzle: can the defendant appropriately communicate with counsel in the real-world setting of a trial and can the defendant appropriately manage his demeanor in the courtroom without decompensating. Although not expressly addressing competence to stand trial, the language in *Sell* provides insight into what is expected of a defendant in order to meet the constitutional threshold of fairness.

When asked, many criminal defense attorneys express a desire for a client who is utterly passive: one who sits quietly by, allows counsel to conduct the preparation, courtroom proceedings and trial, and does as instructed.³⁰⁰ However, both competent and incompetent defendants may do this, the difference being that a competent defendant is engaged, although quiet, until the appropriate time, and an incompetent defendant is not engaged in the interactive dialogue at all. Allowing an attorney to exercise legal judgment is not a hallmark of incompetence, rather it is the failure to engage with the attorney in the process that signals a breakdown. As the Ninth Circuit held: “competence to stand trial does not consist merely of passively observing the

²⁹⁵ In *Indiana v. Edwards*, 128 S.Ct. 2379 (2008), at 2387, the Court distinguished the standard for self-representation from more general competency standards in the interests of dignity and fairness. No criminal trial “can be fair that leaves the defense to a man who is insane, unaided by counsel, and who by reason of his mental condition stands helpless and alone before the court.” See also *Massey v. Moore*, 348 U.S. 105, 108 (1954).

²⁹⁶ Where the client is unable to engage rationally in the interactive dialogue, he would be incompetent to make these decisions.

²⁹⁷ *Cooper*, 517 US at 364.

²⁹⁸ *Godinez*, 509 U.S. at 389: affirming single standard for competence at all stages and that decision-making and rational understanding are indistinguishable.

²⁹⁹ *Sell v. United States*, 539 U.S. 166, 185 (2003).

³⁰⁰ Informal communication between the authors and numerous experienced defense lawyers.

proceedings. Rather, it requires the mental acuity to see, hear and digest the evidence, and the ability to communicate with counsel in helping prepare an effective defense.”³⁰¹

These rulings define the very core of competence to stand trial: the mental acuity to see, hear, digest and communicate in interactive dialogue with counsel, and to make myriad small and large decisions including during the rapidly changing environment of trial. A recent law review article discussed the complex processes of cognitive and emotional functioning necessary for “decisional competence” in the adjudicative setting.³⁰² Decisional competence involves the abilities necessary to meaningfully arrive at a reasoned choice among the options available.³⁰³ Decisional competence can be understood as incorporating both the required “rationality” and the “communicative” prongs of *Dusky*; meaning that the client has both the ability to rationally make decisions that minimally protect his self-interests and the ability to rationally communicate those decisions. This is critical because decision-making then incorporates both the process of making and articulating, not simply the statement of conclusion.³⁰⁴ Thus, for instance, it is not enough for a client to state a willingness to plead guilty without some assessment of his understanding of the factual basis for the plea and its consequences.

Moreover, the tasks that a competent client must be able to perform ultimately amount to a pro-active engagement in the process of litigation. Competent defendants cannot simply be reactive to what happens in court or to documents presented because capital trials require more than a simple testing of the prosecution's pieces of evidence; they are also the presentation of affirmative defenses, of the human qualities of the defendant, of the ways in which he sees and experiences the world, of the fears, hopes and complexity of this one human life, and of how and why the life-course of the individual brought him to this moment of facing a jury that will decide whether he lives or dies. Even for an innocent client, the process of humanizing is a requirement which demands more than a review of the prosecution's case because an explanation must be offered as how this defendant came to be charged even though he is innocent.

What is required of a competent defendant, as the *Odle* court suggests,³⁰⁵ is the interactive dialogue which is built upon a sufficient identification, evaluation, weighing and integration of the pieces of the case as they relate to each other and to the defense strategies. Without this, a capitally charged client is little more than a lamb led to slaughter before a jury. A capital defendant must be able both to rationally identify, review, compare, assess, weigh and integrate pieces of case-

³⁰¹ *Odle v. Woodford*, 238 F.3d 1084, 1089 (9th Cir. 2001).

³⁰² Maroney, T.A., *Emotional Competence, “Rational Understanding,” and the Criminal Defendant*, 43 AM. CRIM. L. REV. 1375 (Fall 2006).

³⁰³ *Id.* citing to *Godinez*, 509 U.S. at 389.

³⁰⁴ Maroney, *supra*, n.302, at 1390–1391.

³⁰⁵ *Odle*, 238 F.3d at 1084.

related information *and* to communicate that to counsel.³⁰⁶ The rational component of this communication is crucial, too, since many defendants are able to repeat back over-learned information, without being engaged with the substance and import of it, in a rational manner.

One way of understanding what a competent defendant must be able to do is to consider the thinking process of decision-making and higher level verbal functioning itself. Courts are very much verbal arenas, fast-paced and often technically driven. A competent client does not need to be or become a lawyer, however, but has to be engaged sufficiently in the process to be able to communicate with counsel based on a rational understanding.

The abilities and capacities necessary to do that include, at a minimum:

1. having an awareness of a problem and its scope, including placing the problem within its broad context;
2. evaluating the problem, including how one piece relates to other pieces of the problem;
3. formulation of steps to resolve the problem or parts of it;
4. choosing between different options by weighing and considering the likely outcome of those steps;
5. weighing and considering the consequences, both positive and negative of those steps;
6. initiating the steps towards resolution of the problem;
7. evaluation and reconsideration of the steps chosen as the process occurs, including how the attempt to resolve one problem may cause others within the broad context;
8. modification of the steps based on the evaluation and re-weighing of the likely outcomes and consequences, the indications of success or failure, and new information gained;
9. comparing the results to the goal; and
10. storing the information gained from this process such that it can be referred to and re-evaluated later when additional problems occur, additional information is added, or the context is altered.³⁰⁷

CLIENT CAPACITIES IN TRIAL CONTEXT

To understand the significance of these ten tasks, it is useful to consider a capital case

³⁰⁶ Bonnie, R., *The competence of criminal defendants: Beyond Dusky and Drope*, 47 UNIVERSITY OF MIAMI LAW REVIEW 539 (1993): describing competence abilities as falling into two categories: decisional competence and competence to assist counsel.

³⁰⁷ See generally on the issue of executive functioning, behavior and dysfunction: Goldberg, *supra*, n.160; Sbordone, R., *The executive functions of the brain*, in Groth-Marnat, G., (ed.), NEUROPSYCHOLOGICAL ASSESSMENT IN CLINICAL PRACTICE: A PRACTICAL GUIDE TO TEST INTERPRETATION AND INTEGRATION (Wiley 2000), at 437-456; Cummings & Mega, *supra*, n.209, at 128-45; Lichter & Cummings, *supra*, n.161; Devinsky & D'Esposito, *supra*, n.234, at 302-329; Miller, B., & Cummings, J., (eds.), THE HUMAN FRONTAL LOBES: FUNCTIONS AND DISORDER (Guilford Press 2nd ed. 2006).

in three general areas: (1) the preservation of constitutional rights; (2) trial preparation, which includes factual development, motions and review of prosecution evidence, development of mitigation and defense themes; and (3) the trial itself, including testimony at guilt and penalty phases, the defense case at guilt and penalty, and courtroom processes.

Dusky and its progeny are clear that the preservation of fundamental rights is one of the cornerstones of the assessment of competence to stand trial, in that the defendant must have both a factual and rational understanding of the process. The ten points above suggest the ways in which defendants must be able to evaluate the options of preserving or waiving their rights. For instance, in deciding whether to testify at the guilt phase or the penalty phase, a defendant must assess how his testimony fits within the overall approach to the case; how his testimony is likely to be received by others; whether he has the verbal capacity and skill to express his thoughts adequately; whether he can withstand cross-examination while maintaining appropriate courtroom behavior; how cross-examination will affect how the testimony is received; how others, especially counsel, perceive these issues and how those views should or could inform the determination being made; and reconsidering the decisions as other evidence is presented at trial. While the decision itself may appear to be a very simple yes or no assertion, or waiver, of constitutionally protected rights, the process of consideration, evaluation and weighing is the predicate to the decision being rational and therefore to competency.

The process of trial preparation is more complicated than the assertion or waiver of rights because it requires many more issues to be considered, weighed and assessed simultaneously, in a rapidly paced and constantly changing environment. For instance, the review of discovery materials is a single component of the preparation of a capital trial. Its purpose may include gaining from and sharing with the client factual information, but it may also be that the process of reviewing discovery with a client establishes trust (in that the investigation which comes from discovery review demonstrates counsel's commitment and honesty); allows the attorney to observe the functioning and abilities of the client; and provides a basis for common understanding of the scope, strengths and weaknesses of the case. This does not mean that counsel and the defendant must come to share a single view of the evidence or arrive at consensus on each issue, but rather, the process of reviewing discovery leads to a way of communicating even when the client and defense team disagree about the significance, or lack thereof, of some evidence.

The review of discovery is a way to develop mutual understandings with or without mutual agreement. For instance, in a non-litigation setting, a doctor could (and should) form an understanding of a patient's delusional system without either talking the patient out of the delusion or coming to share it; at the same time, the patient may come to see the benefits of medication without having to agree that the delusion is a false belief not shared by others. This is a similar common ground to that which counsel establishes with a competent defendant.

Another issue raised about the review of discovery has been that some competent criminal defendants choose not to disclose facts of the offense to counsel. This certainly happens. The question however, is not the end-point—the lack of disclosure—but rather the process from which the lack of disclosure has resulted. Determining competence requires an assessment of whether the decision has been made after the defendant successfully engages counsel in an interactive dialogue and goes through the ten tasks of assessment or not. If so, then a competent client could make a choice, wisely or not, to refuse to discuss the offense or pieces of discovery. If, in the alternative, the failure to disclose results from a decisional and/or communicative incompetence, then the client is not competent to proceed.

In capital cases this is more critical because the standard of care for attorneys has long been settled in requiring that the presentation of guilt and penalty phases be consistent and uniform in strategy and theme.³⁰⁸ This means that the approach to the discovery must be considered in light of the approach to the presentation at penalty phase. The process of reviewing discovery with a client, when that client is competent, is much more importantly about establishing patterns of communication, trust and understanding to move forward than it is about the client's ability to read the discovery itself.

For a client who, for instance, appears to have great difficulty in weighing and evaluating the significance of pieces of evidence, it may be nearly impossible for counsel to reach a common ground. As the ten points above suggest, identifying the problem is only the first step in rationally considering and communicating, and distinguishing the significant evidence from the insignificant evidence can be understood as the identification of the problem. Without that first step, the next nine steps become impossible.

Finally, as noted in *Sell*, the trial may be rapid and the demeanor of the defendant critical; testimony sometimes feels interminable and the ability of a competent defendant to attend to the issues coming out through direct and cross-examination may be tested. Thus, we return to the interactive dialogue in which clients can ask questions of counsel regarding the testimony and potentially bring to bear their own knowledge and ideas on the course of that testimony.

DISABILITIES LEADING TO INCOMPETENCE

What are the types of functional and behavioral impairments, then, that may put at risk the necessary abilities that divide the competent from the incompetent? Some of the research on incompetency suggests that the most pervasive form of illness found in those adjudicated to be incompetent is psychosis.³⁰⁹ Psychosis is a broad category

³⁰⁸ ABA GUIDELINES, ABA Guideline 10.10.1, Trial Preparation Overall: “Counsel should seek a theory that will be effective in connection with both guilt and penalty, and should seek to minimize any inconsistencies.”

³⁰⁹ Melton et al, *supra*, n.231, at 137.

of illness and certainly not all people with psychosis are incompetent to stand trial. In fact, the simple presence of a mental disorder or impairment is necessary, but not sufficient, in determining incompetence.

Psychosis is a common finding in those ruled incompetent because, for some people with psychotic thinking, the interference with reality is blatantly obvious. Thus, in one of the few studies comparing competency referred and non-referred clients, the most important predictor of referral was disorganized speech.³¹⁰ Grossly disorganized speech is difficult to overlook, even for attorneys who have essentially no training in mental health. Yet, what of more difficult symptoms to identify? For instance, what of the defendant with substantially impaired cognitive functioning? In *Atkins*, the Supreme Court specifically noted that while the diagnosis of mental retardation was a bar to execution, it was not a bar to prosecution.³¹¹ This does not mean that all people with mental retardation are competent to stand trial; rather, it established no bright line, diagnostically driven test for incompetence, leaving in place the functional assessment previously required.

The abilities required to be competent, as noted, may implicate a vast number of symptoms and illnesses. Take psychosis, the diagnosis most often found in those adjudicated incompetent as an example. What are the symptoms that define the illness? DSM-IV-TR defines psychosis as referring to the presence of a set of symptoms, but the symptoms vary across the specific diagnostic categories.³¹² Where a mental health professional must determine which of the symptoms are present so as to arrive at a differential diagnosis, the question that must be answered for competence is instead how the present symptoms interfere with functioning. Thus, disorganized thinking (technically referred to as formal thought disorder), perhaps the hallmark symptom of schizophrenia, manifests in very different ways. Thought disorder may show itself as poverty of speech (a restriction in the amount of spontaneous speech, often coinciding with the negative symptoms of schizophrenia) or as pressured speech (an increase in the amount of spontaneous speech and the pace of that speech) or as poverty of thought content (where there is sufficient or extra production of words but they are unnecessary or not useful in conveying an idea).³¹³ The observable symptoms are very different and the difficulties faced in the interactive dialogue are very different, but the potential for interference in specific settings (and therefore the question of competence) is the same. Thus, how the symptom interferes or does not interfere with the interactive dialogue is critical.

However, while much of the focus in competency determinations has been on psychotic thinking, a plethora of physical and psychological conditions can interfere with competence to stand trial. If the question of competence is, as suggested, one of

³¹⁰ Berman, L., & Osborne, Y., *Attorneys' referrals for competency to stand trial evaluations: Comparisons of referred and nonreferred clients*, 5 BEHAVIORAL SCIENCE AND LAW 373 (1980), cited in Melton et al, *supra*, n.231, at 134-5.

³¹¹ *Atkins v. Virginia*, 536 U.S. 304 (2002)

³¹² DSM-IV-TR, at 297.

³¹³ Andreasen, N., *Scale for the Assessment of Thought, Language, and Communication (TLC)*, 12:3 SCHIZOPHRENIA BULLETIN 473 (1986).

a person's functional ability to engage in the interactive dialogue, a number of conditions must be considered, including, at the least:

Executive functions, which are the neurocognitive processes that affect movement and behaviors, constitute the abilities to plan, initiate new tasks, stop, judge, assess options and consequences, reason, self-monitor and self-regulate, and recognize social cues; they also encompass language processing, mental flexibility, reasoning (deductive and inductive), working memory, abstract thinking, incorporating new information, and strategic inquiry. In short, executive functions are the very capacities necessary to be competent, although, oddly, they are rarely measured or tested when evaluations are conducted.

Mood Disorders, which include symptoms of both depression and mania. Depression has been shown to result in sadness, loss of interest, anxiety, irritability, a sense of hopelessness, attention and concentration impairments, and suicidal thoughts. Similarly, a host of physical symptoms often accompanies depression: fatigue or lethargy, sleep problems, headache, gastrointestinal problems, appetite changes, and general body aches and pains. Mania results in abnormally and persistently elevated or irritable mood that lasts at least a week and includes grandiosity, decreased need for sleep, pressured talking, flights of ideas, distractibility, increased goal directed activity, excessive involvement in pleasurable activities. During manic episodes, clients may be especially difficult to keep focused on the day in and day out work of preparing litigation as well as difficult to communicate with rationally.³¹⁴

Anxiety Disorders, which include both PTSD and other anxiety disorders. With anxiety, people often experience somatic symptoms which can make it difficult to attend to other stimuli, panic attacks, obsessive and/or compulsive behaviors, avoidance, irrational fears (often with awareness of the irrationality), low self-esteem, poor social skills and poor social judgment. For people who have been exposed to significant traumatic events (whether they develop all the symptoms of PTSD or not), functional impairments may include dissociation, a loss of a sense of future, difficulty developing trusting relationship (e.g., with counsel), difficulty interpreting social cues, intrusive thoughts, difficulty comprehending the emotional content of language and situations, difficulty regulating affect, impaired attention and concentration, difficulty believing in or planning of the future, and the development of hypervigilant behaviors.

Language Abilities, which include receptive and expressive language deficits, as well as fluency impairments. Associated with learning and language disorders are slowed information processing speeds, low self-esteem and

³¹⁴ However, see Maroney, *supra*, n.302, for a discussion of how courts have largely rejected depression as a significant contributor to incompetence.

deficits in social skills.

Medications, which, as *Sell* recognized, can have an observable effect which may undermine competency by slowing responses to fast moving proceedings, by altering how the client looks and acts, or by interfering with communication. Medications, not just medications used for restoration to competence purposes as discussed in *Sell*, may have side effects that interfere with competence.

Medical conditions, which can adversely affect a person's ability to undertake the ten necessary steps of rational communication and participation. Among others, Dementia's, Parkinson's, Huntington's, Wilson's, and Fahr's Diseases, strokes, and seizure disorders may all have an adverse impact on functioning.

Cognitive ability, wherein deficits may include both people with mental retardation and people who have IQs higher than the MR cut-off but function in a substantially impaired manner, as well as people with other impairments (traumatic brain injury, exposure to lead, neurotoxins or fetal alcohol, or genetic disorders). Cognitive ability includes such capacities as memory and recall; organizing concepts and understanding how things relate to each other; communication (receptive and expressive language); and flexibility in dealing with new information and a capacity to engage with new information.

Although acknowledging that people with mental retardation may be competent, in *Atkins*, the Court noted:

Because of their impairments, however, by definition they have diminished capacities to understand and process information, to communicate, to abstract from mistakes and learn from experience, to engage in logical reasoning, to control impulses, and to understand the reactions of others.³¹⁵

These are the disabilities that may also render some people with cognitive impairments functionally not competent in the specific context of working with counsel. Typically, cognitively impaired people attempt to mask their illnesses, often by making decisions which have long-term negative consequences but in the short-term permit them to avoid being fully assessed; confabulate (fill in details to construct a coherent story despite not having actual knowledge of details provided); often exhibit passivity, compliance and deference (likely to agree with interviewer in effort to please) in the face of a lack of understanding and competence; exhibit rigidity in the face of contradictory evidence; and, as the hallmark of low cognitive ability, they have a fundamental lack of comprehension.

³¹⁵ *Atkins*, 536 U.S. at 318. As noted *supra*, the Court refused a bright line test for competence, letting stand the functional assessment established by *Dusky*.

RATIONAL ASSISTANCE

For those experienced capital defense representation, this abbreviated list may be familiar to the types of conditions that are uncovered during the investigation into potential penalty phase themes. In fact, the functionality test of *Dusky*, that is, the prong that requires the assessment of how the mental illness causes the inability to communicate with counsel rationally, also goes to explaining how the client experiences and makes sense of the world. This effort to investigate and develop a coherent understanding of the how the client functions, then, is fundamental to the process of preparing for a capital trial as well as grasping whether a client is competent to proceed to trial.

Finally then, the role of mental health professionals changes within this understanding of competence to stand trial: to assess and describe the symptoms of specific mental illness and cognitive and other disorders, and the functional impairments that derive. That is, the mental health professional's role is to tease out the areas in which the observed symptom(s) interferes with functioning and to describe the mechanism by which this occurs and the potential for treatment or remediation. This task is often obscured currently in the process of assessment and opinion forming, but it is the task that only mental health professionals are suited to undertake. Further, it is well in line with the consensus among forensic evaluators and the courts that experts should refrain from offering opinion on the ultimate legal question, instead describing the symptoms and behaviors relevant to the legal question.³¹⁶

This understanding of competence also pulls the role of counsel back to the safety of professional standards and effective assistance as mandated by the constitution. Counsel has a duty both to assess the capacity of a client to engage in the tasks required and also to track the specific places and ways in which the symptoms interfere. Counsel also then has a duty to attempt to work with and around these impediments, with the assistance of mental health consultants, prior to declaring a doubt about the client's competency. And finally, counsel has a duty, once that doubt is declared, to obtain the services of an attorney expert who can assist the court in understanding what is expected both from counsel and the client which is not possible to accomplish in this specific set of circumstances. Such an expert may act like a *Strickland* expert in offering the court insight and guidance both on the expectations of counsel and the client as well as on the barriers in the specific case.³¹⁷

POST-TRIAL ISSUES

This discussion of competence applies to more than trial preparation because the

³¹⁶ See Heilbrun, *supra*, n.275, at 219-226; Melton et al, *supra*, n.231, at 17, 129.

³¹⁷ See *United States v. Duhon*, 104 F. Supp. 2d 663 (2000), appointing an attorney expert and citing to Burt, M., & Philipsborn, J., *Assessment of Client Competence: A Suggested Approach*, THE CHAMPION (June 1998).

standard for competence remains in place throughout all stages of the litigation. Two other areas of capital practice require particular attention: post-conviction and execution competence. The rational understanding standard for competence is the same in these settings. In *Rohan ex rel. Gates*,³¹⁸ the Ninth Circuit Court of Appeals found that a death-sentenced inmate must be competent to assist his counsel during the habeas corpus proceedings. Following a competence hearing in the district court, Oscar Gates was found to be incompetent, but the district court appointed a next friend (attorney Colleen Rohan) to pursue his habeas litigation. Rohan, as next friend, indicated that she could not pursue the habeas litigation because Gates was not competent to assist her. The district court ruled that a competent client was not relevant to habeas, but the circuit court reversed based, in part, on the statutory right to counsel in capital proceedings and the right to seek post-conviction relief, which implied, the court found, a right to be competent to assist counsel. The Ninth Circuit stayed the habeas proceedings due to Gates's incompetence.

That opinion followed the Supreme Court opinion in *Rees v. Peyton*.³¹⁹ Rees was a death-sentenced prisoner who first consented to his counsel's application for certiorari review of the appellate court's order denying his habeas corpus application. Rees then asked his counsel to withdraw the certiorari petition. Counsel refused, raising competency. Although counsel's psychiatrist found Rees competent, state psychiatrists expressed doubt. The Supreme Court refused to rule on the certiorari application until the district court resolved the competency issue. More recently, the Seventh Circuit in *Holmes v. Buss*,³²⁰ remanded a case to the district court which had denied an evidentiary hearing on the defendant's competence during habeas. The Circuit expressed the view that the standard for competence on habeas was and should be the same as that for trial and for execution.

In *Ford v. Wainwright*,³²¹ the Supreme Court upheld the ancient common law rule forbidding the execution of the insane. The Court held that the question is solely the current mental state of the client; thus, the issue is only ripe at the point at which a client is about to be executed. The case was remanded to the trial court for an evidentiary hearing on competency, with full procedural rights (e.g., to counsel and to cross-examination). The opinion was rooted in the Eighth Amendment and the evolving standard of decency which marks the progress of a maturing society.

In *Panetti v. Quarterman*,³²² the Supreme Court upheld the *Ford* standard and rejected the narrow rule relied upon by the Fifth Circuit, which held that so long as a client was aware that he had committed a crime and was aware that he was to be executed, he was competent. The *Panetti* Court held that there must be a rational understanding of the nexus—that the client is aware that the reason the state gives for his execution is that he committed the crime. Only with such an awareness could the

³¹⁸ *Rohan ex. Rel. Gates*, 334 F.3d 803 (9th Cir. 2002).

³¹⁹ *Rees v. Peyton*, 334 U.S. 312 (1966).

³²⁰ *Holmes v. Buss*, 506 F.3d 576 (7th Cir. 2007).

³²¹ *Ford v. Wainwright*, 477 U.S. 399 (1986).

³²² *Panetti v. Quarterman*, 127 S.Ct. 2842 (2007).

penological goal of retribution be served.

Competence to be executed, then, is effectively the same rationality standard as established by *Dusky*. It is a functional test rather than a bright line test, which therefore requires a case and fact specific assessment of a client's abilities in context. While there are serious pitfalls to raising incompetence, and while the decision to do so must be based on the specific ways in which the client's mental illness interferes with specific abilities to communicate with counsel, it is also clear that some capital clients are functionally unable to engage in the interactive dialogue required—that is, they are unable to see, hear and digest the trial-related information and communicate with counsel about that information. Nevertheless, these issues require pursuit in a coherent and thorough manner because the outcome of trying a capital case in which the client is unable to participate is not only an appalling affront to due process, but also to the client's dignity.

CHAPTER 12:

EXTENDING ATKINS

The Supreme Court's decisions in *Atkins v. Virginia*³²³ and *Roper v. Simmons*³²⁴ established categorical exemptions from execution for people with mental retardation and individuals who committed capital offenses prior to their eighteenth birthdays. In both cases, the court determined that the punishment should be proportional not to the crime, but to the moral culpability of the individual offender. The court created protection for people with mental retardation because of their disabilities in reasoning, judgment, and impulse control. These disabilities jeopardize the fairness of the proceedings because people with intellectual disabilities are more likely to confess falsely³²⁵ and less equipped to assist their capital defense teams. Similarly, in the case of juveniles, the court recognized their lack of maturity and underdeveloped sense of responsibility, vulnerability to negative influences, and, finally, their capacity to change as they mature. By implication, the death penalty should be reserved for the truly depraved, the worst offenders for whom there is no possibility of redemption.

All of these vulnerabilities and limitations, of course, apply to many capital clients who committed their offenses as adults and who do not meet the technical diagnostic criteria for mental retardation. In the wake of *Atkins*, a task force of the American Bar Association and the leading associations of the mental health professions studied how other narrow and carefully defined categories might be identified as worthy of protective exemptions. The thoughtful Recommendation and Report of this joint task force are included as an Appendix to this manual. Implementing the task force's recommendations will require legislation and creative litigation in the years ahead. In the meantime, every capital defense practitioner representing an individual with a mental disorder or impairment should be thinking about how to translate the court's reasoning in the landmark Eighth Amendment cases to protect that client at every stage of representation from arrest to clemency (from proffers and plea negotiations to competency-to-be-executed claims and commutation petitions).

When a client is exempted under *Atkins* or *Simmons*, there is no nexus requirement or need to demonstrate how intellectual impairment or youth affected the client's behavior in committing the capital offense. One need only prove that he meets the criteria for mental retardation or that he was under eighteen years of age at the time of the crime. When clients do not fit these exempt categories, one approach is simply to demonstrate that there is a nexus in the individual case; that is, to show how a client's disabilities or limitations explain his participation in the offense and/or make the capital prosecution unfair. It is useful to look at all the details in the court's analysis

³²³ 536 U.S. 304 (2002).

³²⁴ 543 U.S. 551 (2005).

³²⁵ See also Gross et al, *supra*, n.272: meta-analysis of 340 exonerations, finding 69% of false confessions involved individuals with mental retardation or mental illness.

of mental retardation and youth to see how these categories compare to clients with mental disorders or impairments.

In *Atkins*,³²⁶ the court listed numerous specific limitations that were likely to apply to people with mental retardation, including difficulties in understanding and processing information, communication, capacity to abstract from mistakes and learn from experience, impulse control, and understanding the reactions of others. People with mental retardation are more likely to follow than lead. In *Simmons*,³²⁷ the court noted that youths' underdeveloped sense of responsibility leads to reckless behavior. Vulnerability to peer pressure results in part from having "less control, or less experience with control, over their own environment." Transitory, rather than fixed, personality traits constituted the final distinctive quality.

The court found that retribution and deterrence—the accepted penological justifications for capital punishment—are thwarted because of these various limitations. People with intellectual impairments lack the capacity to appreciate the consequences of their actions or to act on this knowledge, so the goal of retribution is not served when people with mental retardation are subject to the death penalty.³²⁸ Likewise, "Retribution is not served if the law's most severe penalty is imposed on one whose culpability or blameworthiness is diminished, to a substantial degree, by reason of youth and immaturity."³²⁹ Deterrence fails because people with mental retardation have diminished capacity to calculate and premeditate.³³⁰ Similarly, "[t]he likelihood that the teenage offender has made the kind of cost-benefit analysis that attaches any weight to the possibility of execution is so remote as to be virtually nonexistent."³³¹ In the event there is residual deterrent effect, "it is worth noting that the punishment of life imprisonment without the possibility of parole is itself a severe sanction, in particular for a young person."³³²

For individual clients, it is essential to enumerate all the ways in which they have the specific characteristics that were identified in *Atkins* and *Simmons* as undermining the goals of retribution and deterrence and rendering capital proceedings unreliable and unfair. Difficulties in understanding and processing information will apply to many clients with Axis I disorders or neurological impairments (such as the Fetal Alcohol Spectrum Disorders). Communication problems abound for people with schizophrenia or the Autism Spectrum Disorders. The capacity to abstract from mistakes and learn from experience will be curtailed by specific neurological deficits (especially, for example, FASD), brain damage or dysfunction, as well as general intellectual impairment in the range of borderline intellectual functioning. Impulsivity will correlate directly with deficits in executive functioning, often amplified by the presence of co-occurring disorders. Misreading social cues and

³²⁶ *Atkins*, 536 U.S. at 318.

³²⁷ *Simmons*, 543 U.S. at 569

³²⁸ *Atkins*, 536 U.S. at 319.

³²⁹ *Simmons*, 543 U.S. at 571.

³³⁰ *Atkins*, 536 U.S. at 320.

³³¹ *Simmons*, 543 U.S. at 572, quoting *Thompson v. Oklahoma*, 487 U.S. 815, 837 (1988).

³³² *Id.*

misunderstanding the reactions of others will be a common problem with traumatized, hypervigilant clients, as well as those suffering from the Autism Spectrum Disorders or delusional disorders. Many disabilities make clients followers rather than leaders. An underdeveloped sense of responsibility and vulnerability to peer pressure and negative influences were associated with the life experience of those who had rarely had the ability to exercise control over their own environments. Social history investigation will disclose the extent to which individual clients have been disadvantaged in their control of their environments. With each of these disabling characteristics, the everyday symptoms will carry more weight than the diagnostic label in showing how and why a client is disadvantaged and, arguably, worse off than the classes of clients excluded under the Eighth Amendment cases.

Many disorders will compromise clients' capacity to appreciate the consequences of their actions—especially the psychotic disorders, but also the mood disorders. The foreshortened sense of future common to traumatized clients likewise impairs capacity to appreciate longer-term consequences. Rational cost-benefit analyses are far removed from the damaged brains and disordered behaviors so common to clients with mental health issues. Just as life without possibility of parole is an especially severe sanction for the young, so is it an extreme punishment for those who live their lives in psychic torment.

For each client with a mental disorder or impairment, regardless of whether a formal diagnosis has been made, it is important to spell out how the disability reduces moral culpability and jeopardizes the fairness of the capital prosecution in concrete, specific terms. Strategically, in litigating on behalf of an individual client, it is critical to develop all the ways in which multiple limitations produce an overwhelming cumulative effect.

Consider the client who is eighteen or nineteen years of age at the time of his offense and who has an intellectual disability that does not quite meet the criteria for mental retardation under post-*Atkins* statutes. If the death penalty is a punishment of last resort to be reserved for the most morally culpable, is it appropriate for someone who is nearly exempt under two different categorical schemes? Is there a cumulative effect of youthful immaturity and intellectual disability that makes this particular individual worse off in overall functioning than the members of either class protected by *Atkins* and *Simmons*?

What are the cumulative effects of other co-occurring disabilities, such as an Axis I psychotic disorder plus an intellectual disability such as dementia or Traumatic Brain Injury acquired after age eighteen?

A client's mental disabilities will haunt a case and provide opportunities for litigation all along the way. Alliances with activists and advocacy groups in the disability communities can change the political atmospherics of a case. Time may also bring scientific progress with unexpected benefits to an individual client. Advances in scientific knowledge, especially neurobiology, over the long life of a case may offer a

post-conviction or clemency team a clearer understanding of the client and an explanation of the crime. Advances in functional neuroimaging may produce more powerful and reliable evidence than what is available today. Improvements in treatment, especially psychopharmacology, may change the client himself. In short, evidence of a capital client's diminished moral culpability—or capacity for redemptive change—may improve or strengthen over time.

We are heartened by the fact that Eighth Amendment jurisprudence has also reflected an evolving standard of decency. All things considered, the evolution has been extremely rapid, in the United States and the wider world. In 1977, as the United States initiated its modern era of capital punishment with the execution of Gary Gilmore in Utah, France was carrying out its last execution in Marseille. In the brief years since then, capital punishment itself has been abolished throughout Europe, and abolition has become a condition of membership in the European Union. In 1989, the Supreme Court declined to prohibit the execution of people with mental retardation in *Penry v. Lynaugh*³³³ or juveniles in *Stanford v. Kentucky*.³³⁴ Within a decade and a half, evolving standards mandated exclusion of both groups. One measure of societal consensus on these issues was legislation in multiple jurisdictions barring execution of the two groups. But equally important was the evidence that the states that did not enact statutory protections were executing so few members of either group. If we are to extend Eighth Amendment protections to the rest of the mentally disordered and impaired either through legislation or Supreme Court litigation, it is first necessary to reduce the number of individuals with mental disorders and impairments who are subject to the death penalty—through zealous representation in individual cases at every stage of litigation. Thus, the hope is that this manual will be of some value to practitioners defending individual clients and, in turn, to that larger purpose of extending societal protection to those whose damaged brains and disordered psyches diminish their culpability and render them least capable of rationally assisting in their own defense.

³³³ 492 U.S. 302 (1989).

³³⁴ 492 U.S. 361 (1989).

CHAPTER 13:

INTERNATIONAL LAW, NORMS, AND INSTRUMENTS PERTAINING TO MENTAL ILLNESS AND CAPITAL PUNISHMENT

Including:

- Introduction;
- International institutions and law;
- Sources of international law;
- Materials relevant to defending the mentally ill;
- Recourse to international and regional institutions;
- Clemency and international intervention;
- Criteria for intervention.

INTRODUCTION

International law, mental illness and capital punishment

International law does not explicitly forbid the use of capital punishment but its restriction—and ultimately its global abolition—is a specific objective of the international community. Most recently, in its 2007/2008 session, the UN General Assembly passed Resolution 62/149, calling for a moratorium on the use of the death penalty. It is worth setting out here in large part:

The General Assembly,

Guided by the purposes and principles contained in the Charter of the United Nations,

Recalling the Universal Declaration of Human Rights, the International Covenant on Civil and Political Rights, and the Convention on the Rights of the Child,

Recalling also the resolutions on the question of the death penalty adopted over the past decade by the Commission on Human Rights in all consecutive sessions, the last being resolution 2005/59 of 20 April 2005, in which the Commission called upon States that still maintain the death penalty to abolish it completely and, in the meantime, to establish a moratorium on executions,

Recalling further the important results accomplished by the former Commission on Human Rights on the question of the death penalty, and

envisaging that the Human Rights Council could continue to work on the issue,

Considering that the use of the death penalty undermines human dignity, and convinced that a moratorium on the use of the death penalty contributes to the enhancement and progressive development of human rights, that there is no conclusive evidence of the deterrent value of the death penalty and that any miscarriage or failure of justice in the implementation of the death penalty is irreversible and irreparable,

Welcoming the decisions taken by an increasing number of States to apply a moratorium on executions, followed in many cases by the abolition of the death penalty,

1. *Expresses its deep concern* about the continued application of the death penalty.
2. *Calls upon* all States that still maintain the death penalty:
 - a. To respect international standards that provide safeguards guaranteeing protection of the rights of those facing the death penalty, in particular the minimum standards, as set out in the annex to the Economic and Social Council resolution 1984/50 of 25 May 1984;
 - b. [...]
 - c. To progressively restrict the use of the death penalty and reduce the number of offences for which it may be imposed;
 - d. To establish a moratorium on executions with a view to abolishing the death penalty;
3. *Calls upon* States which have not abolished the death penalty not to reintroduce it...³³⁵

The former UN High Commissioner for Human Rights, Louise Arbour, expressed a consistent view in 2007.³³⁶ There are no less than four international treaties which provide for the abolition of the death penalty by parties, one of worldwide scope and

³³⁵ UN General Assembly, *Resolution 62/149: Moratorium on the Use of the Death Penalty*. See further UN News, 'General Assembly adopts landmark text calling for Moratorium on Death Penalty,' 18 December 2007, available at <http://www.un.org/News/Press/docs//2007/ga10678.doc.htm>.

³³⁶ *In the Matter of Sentencing Taha Yassin Ramadan*, Application for Leave to Intervene as *amicus curiae* and Application in Intervention as *amicus curiae* of United Nations High Commissioner for Human Rights, Iraqi High Tribunal, 8 February 2007, para. 11.

three applicable to certain geographic regions.³³⁷ **68** states have ratified at least one of these instruments, or roughly 35.2% of the total membership of the UN. A majority of UN members, however—**104**—voted in favour of the moratorium resolution. Amnesty International reports that **89** countries and territories have actually abolished capital punishment, and a further **10** have abolished it for all but exceptional crimes (for example, in wartime). **30** countries retain capital punishment in law but do not impose it in practice.³³⁸

As part of this policy, the international community has developed various restrictions on categories of individuals eligible for the death penalty. In particular, the execution of juveniles (i.e., individuals under the age of 18 at the time of the crime) is almost universally prohibited,³³⁹ as is the execution of pregnant women. There is also a significant and growing body of practice to support the inclusion of the mentally ill and the mentally disabled within the prohibition. This chapter will introduce this material, as well as sign-post other arguments relevant to defending the mentally ill. The present legality of capital punishment is intimately related to compliance with international standards of procedural fairness—as such, not only must account be taken of the developing view that execution of the mentally ill is *ipso facto* unlawful but also the impact that the particular requirements of the mentally ill may have on the trial and penal process.

As early as 1982, the Human Rights Committee—the body which monitors compliance with the *International Covenant on Civil and Political Rights* (ICCPR), a treaty to which approximately 80% of the international community is a party³⁴⁰—wrote of the death penalty:

While it follows from article 6 (2) to (6) that States parties are not obliged to abolish the death penalty totally they are obliged to limit its use and, in particular, to abolish it for other than the "most serious crimes". Accordingly, they ought to consider reviewing their criminal laws in this light and, in any

³³⁷ The *Second Optional Protocol to the ICCPR, aiming at the abolition of the death penalty*, 60 parties worldwide, available at <http://www.ohchr.org/english/law/ccpr-death.htm>; the *Protocol to the American Convention on Human Rights to Abolish the Death Penalty*, 8 parties, available at <http://www.cidh.org/Basicos/English/Basic7.Death%20Penalty.htm>; *Protocol No. 6 to the European Convention for the Protection of Human Rights and Fundamental Freedoms concerning the abolition of the death penalty*, 46 parties, available at <http://conventions.coe.int/Treaty/Commun/QueVoulezVous.asp?NT=114&CM=8&CL=ENG>; *Protocol No. 13 to the European Convention on Human Rights and Fundamental Freedoms concerning the abolition of the death penalty in all circumstances*, 39 parties, available at <http://conventions.coe.int/Treaty/Commun/QueVoulezVous.asp?NT=187&CM=8&CL=ENG>.

³³⁸ Amnesty International, 'Facts and figures on the death penalty,' available at <http://web.amnesty.org/pages/deathpenalty-facts-eng>.

³³⁹ Since 1990, only the Democratic Republic of the Congo (1), Iran (36), Nigeria (1), Pakistan (4), the People's Republic of China (2), Saudi Arabia (3), the Sudan (2), the United States of America (19) and the Yemen (1) have carried out juvenile executions: Amnesty International, 'Executions of child offenders since 1990,' available at <http://www.amnesty.org/en/death-penalty/executions-of-child-offenders-since-1990>.

³⁴⁰ See 'International Covenant on Civil and Political Rights,' available at <http://www.ohchr.org/english/law/ccpr.htm>, especially Articles 6, 7, and 14.

event, are obliged to restrict the application of the death penalty to the "most serious crimes". The article also refers generally to abolition in terms which strongly suggest (paras. 2 (2) and (6)) that abolition is desirable. The Committee concludes that all measures of abolition should be considered as progress in the enjoyment of the right to life within the meaning of article 40, and should as such be reported to the Committee. The Committee notes that a number of States have already abolished the death penalty or suspended its application. Nevertheless, States' reports show that progress made towards abolishing or limiting the application of the death penalty is quite inadequate.

The Committee is of the opinion that the expression "most serious crimes" must be read restrictively to mean that the death penalty should be a quite exceptional measure. It also follows from the express terms of article 6 that it can only be imposed in accordance with the law in force at the time of the commission of the crime and not contrary to the Covenant. The procedural guarantees therein prescribed must be observed, including the right to a fair hearing by an independent tribunal, the presumption of innocence, the minimum guarantees for the defence, and the right to review by a higher tribunal. These rights are applicable in addition to the particular right to seek pardon or commutation of the sentence.³⁴¹

Failure to adopt this approach is itself considered to be a violation of an individual's human rights.³⁴²

It is highly important, therefore, that legal actors and mental illness/disability advocates familiarize themselves with the basic structure of the international legal system and the key norms that may protect those with mental illnesses. This chapter provides a sound introduction to that end. Moreover, the application of these standards extends beyond capital punishment—the immediate concern of this Guide—and maybe relevant to other civil or criminal legal arguments.

Proviso

Please note that, although we suggest potential avenues of legal argument throughout this Guide, these are for the reader's reference only and do not constitute legal advice. Nonetheless, we hope that the following information will—at the very least—allow the reader to consider international law as a supplementary line of reasoning that may bolster legal arguments.

³⁴¹ Human Rights Committee, *General Comment No. 6: the right to life*, 1982, paras 6–7.

³⁴² Human Rights Committee, *Reid v. Jamaica*, Communication No. 250/1987, UN Doc. No. CCPR/C/39/D/250/1987, adopted 20 July 1990, para. 11.5.

Why is International Law Important in a Domestic Context?

Simply stated, law is defined as a body of rules that restrains certain behavior within a society and, to some extent, reflects the ideas and concerns of the society it protects. When expanded to the international realm, the same is largely true. However, one crucial difference exists: instead of focusing on the regulation of individual citizens, international law is intended to govern and restrict the behavior of sovereign States.

Compared to national legal systems, international law may seem a pale and weak imitation. Primarily directed at states rather than individual citizens, it is founded on the notion that obligations emanate from mutual consent rather than external sanction. There is no body with a mandate to enforce the law against states, and there is no system to punish transgressors. As a result, international law is frequently (mis-)conceived as ineffective and hostage to the interests of its subjects.

Precisely because it serves to express the interests of states, however, international law is in fact generally followed. Failure to comply with the law frequently prompts heated public comment, arising at least in part from the perception by other states of threats to their own interests. Although this may seem a weak sanction, politics is the language and currency of international relations. As such, failure to comply with international law has very real consequences for the offending state's standing in the international community. (Thus, although international law arguments may seem of limited use in domestic legal settings, they can lend real weight to a legal argument.)

This approach may sit oddly with the basic concept of legally enforceable rights, particularly as traditionally understood in the domestic context. The classic model of international law described above does not seem compatible with the protection of the individual through the judicial process. On one level, this conclusion is correct. In a significant number of cases, states pay only lip service to the idea of human rights. However, in recent years, a number of states have acted to bind themselves to judicial or quasi-judicial review of their human rights obligations. This trend is by no means universal but is significant.

Moreover, it must be remembered that states are the very entities who gave life to the idea of an international law of human rights at all—at least since 1948, the promotion and protection of human rights has been a matter of state interest. As such, although the trend towards self-interest is the rule in international affairs, it is striking to note that international human rights norms manifest the same 'pull' to compliance as other, more pragmatic (and more obviously 'useful') norms of international law. Although states may deny that a particular norm exists as a matter of law, or attempt to act extra-legally in secret, they remain reluctant to contravene the law flagrantly when that norm has been established. Further, the international community is

generally resistant to the notion that persistent breaches of international law negates its authority or necessity.³⁴³

International law is relevant for two reasons, therefore. First, it has the *potential* (sometimes realized, and sometimes not) for *judicial* application, either by direct or indirect means. Early incorporation of international arguments may also be essential to keep open all possible avenues of appeal (including, perhaps, to international courts). Second, it introduces a *political* dimension into a case which may serve to restrain some of the wilder tendencies of the executive.

'Day-to-day' articulation of international law is important in order to develop its utility further: not only does an international argument remind the state of the nature of its present obligations, protecting the individual at the centre of the case, but it also contributes to the clarification of its obligations for tomorrow, protecting untold numbers of individuals. As with other categories of death penalty litigation, the accumulation of a body of cases evidencing a coherent and consistent line of argument can be useful in setting the stage for future decisions.³⁴⁴ The process of articulating and arguing international law is thus essential in order to foster the accurate recognition of international human rights.

The practice of the United States provides an excellent illustration of these observations. It is ruggedly individualistic in its approach to international human rights, and at present pursues a relatively restrictive policy towards interpretation of existing norms. However, when the law has been definitively established, it generally chooses to abide by it.

International law relates to the domestic law of the United States in two ways, directly and indirectly.

The direct effect of international law is easily understood: the Supremacy Clause of the US Constitution provides that treaties "are the law of the land" and may be relied upon (subject to certain modern restrictions) in federal or state courts.³⁴⁵ The US Supreme Court has held similarly in respect of customary international law:

International law is part of our law, and must be ascertained and administered by the courts of justice of appropriate jurisdiction as often as questions of right depending upon it are duly presented for their determination. For this purpose, where there is no treaty, and no controlling executive or legislative act or judicial decision, resort must be had to the customs and usages of civilized nations...³⁴⁶

³⁴³ Shaw, M.N, INTERNATIONAL LAW (CUP 5th ed. 2003), at 6, and generally 1–13. For a more academic, theoretical analysis, see further Higgins, R, PROBLEMS & PROCESS: INTERNATIONAL LAW AND HOW WE USE IT (Clarendon Press 1994), at 1–16.

³⁴⁴ See, e.g., The Inter-American Commission on Human Rights *infra*.

³⁴⁵ *Foster and Elam v. Neilson*, 27 U.S. (2 Pet.) 253 (1829), at 314; *United States v. Percheman*, 32 U.S. (7 Pet.) 61 (1833).

³⁴⁶ *Paquete Habana*, 175 U.S. 677 (1900), at 700.

The notion of indirect effect is less clear but by no means less important. In respect of the law of human rights, international and national laws are inevitably linked. Even countries with a longstanding and noble tradition of legally guaranteed liberties (like the United States) may, and should, have reference to foreign norms in the interpretation and application of their own laws. Indeed, the U.S. Supreme Court seems to have become more inclined to this approach as a supplemental source of consideration.³⁴⁷ In turn, its practice will inform that of others.

In this fashion, Justice Ruth Bader Ginsburg recently recalled:

We refer to decisions rendered abroad, it bears repetition, not as controlling authorities, but for their indication, in Judge Wald's words, of "common denominators of basic fairness governing relationships between the governors and the governed"...

National, multinational, and international human rights charters and courts today play a prominent part in our world. The U.S. judicial system will be the poorer, I have urged, if we do not both share our experience with, and learn from, legal systems with values and a commitment to democracy similar to our own.³⁴⁸

In a speech at Georgetown University Law School, former Justice Sandra Day O'Connor remarked that the judiciary would be "*negligent*" if it simply disregarded its importance.³⁴⁹

INTERNATIONAL INSTITUTIONS AND LAW

What is International Law?

Law might be simply described as a body of rules to regulate behaviour within a society, often a reflection of the ideas and concerns of the society it protects. The same is true of international law, with the important difference being that its subjects are predominantly States rather than individual citizens.

The apparently "soft" nature of international law can obscure its value, especially when considered by reference to the principal characteristics of domestic law (an

³⁴⁷ See, e.g. *Trop v. Dulles*, 356 U.S. 86 (1958), at 102; *Coker v. Georgia*, 433 U.S. 584 (1977), at 596, n. 10; *Enmund v. Florida*, 458 U.S. 782 (1982), at 796, n. 22; *Thompson v. Oklahoma*, 487 U.S. 815 (1988), at 830-831; *Stanford v. Kentucky*, 492 U.S. 361 (1989), at 389-390; *Atkins v. Virginia*, 536 U.S. 304 (2002), at 316, n.21; *Roper v. Simmons*, 543 U.S. 551 (2005), at 575-578.

³⁴⁸ Ginsburg, R.B., "*A decent respect to the Opinions of [Human]kind*": *The Value of a Comparative Perspective in Constitutional Adjudication*, delivered at the Constitutional Court of South Africa on February 7, 2006, available at http://www.supremecourtus.gov/publicinfo/speeches/sp_02-07b-06.html.

³⁴⁹ Associated Press, October 27, 2004.

established body to legislate or create laws, a hierarchical court system with compulsory jurisdiction to resolve disputes, and an accepted system of enforcement). International law has no legislature, no system of courts or executive branch as traditionally understood, and no cohesive system of punishment or sanction. It is important to recognize that the international legal structure is altogether more “horizontal” in comparison to the vertical hierarchy with which we are more familiar in domestic law. The international community is not without legitimate and respected institutions—most notably the United Nations (UN), which is the global administrative body, and the International Court of Justice (ICJ), the UN’s premier judicial body—but these act more often as peers and intermediaries rather than as instruments of superior authority. A wide variety of other international actors also make significant contributions within particular fields, often organized either on the basis of geographical region or thematic interest.

International law stems from a common international agreement, which establishes rules that are binding on all signatories, and custom, which is determined by consistent State practice. Such practice is recognized by the international community as forming a framework of conduct that must be observed.

We will now look at these two aspects in more detail, the identities of the relevant institutions within the UN system, and the sources of the law itself. The latter is vital to understand the relative significance of the materials we introduce with regard to the protection of the mentally ill; the former is helpful to explain the identities of the principal authors of these materials, and the way in which they relate to one another.

International Institutions

The United Nations

The United Nations (UN) was established on 24 October 1945 by 51 countries committed to preserving peace through international cooperation and collective security. Today, nearly every nation in the world belongs to the UN; membership totals 192 countries, most recently including Montenegro.³⁵⁰

When States become members of the UN, they agree to accept the obligations of the *United Nations Charter*,³⁵¹ an international treaty that sets out basic principles of international relations and the UN’s founding document.³⁵² It serves a constitutional function, creating the organs and bodies of the UN, as well as establishing procedure and confirming the rights and obligations of Member States. The UN Charter,

³⁵⁰ Office of the Spokesperson, ‘Secretary-General’s remarks on the admission of Montenegro to the United Nations,’ available at <http://www.un.org/apps/sg/sgstats.asp?nid=2113>.

³⁵¹ June 26, 1945, 59 Stat. 1031, T.S. 993, 3 Bevans 1153, *entered into force* Oct. 24, 1945.

³⁵² Shaw, *supra*, n.343.

alongside the *Universal Declaration of Human Rights*,³⁵³ adopted by the General Assembly in 1948, forms the basis of modern international human rights law. The UN has gradually expanded human rights law to encompass specific standards for women, children, disabled persons, minorities, migrant workers and other vulnerable groups.³⁵⁴

The UN Charter sets forth the four principal purposes of the UN:

- *To practice tolerance and live together in peace with one another as good neighbors, and*
- *To unite our strength to maintain international peace and security, and*
- *To ensure, by the acceptance of principles and the institution of methods, that armed force shall not be used, save in the common interest, and*
- *To employ international machinery for the promotion of economic and social advancement of all peoples.*

The six principal organs of the United Nations are the General Assembly (GA),³⁵⁵ Security Council (SC), Economic and Social Council (ECOSOC),³⁵⁶ Trusteeship Council (now defunct),³⁵⁷ International Court of Justice (ICJ)³⁵⁸ and Secretariat.³⁵⁹ The newly-established Human Rights Council may come to be considered the seventh.³⁶⁰ The UN family, however, is much larger, encompassing 15 agencies as well as numerous more focused programs and bodies.

With respect to human rights, the most important bodies are the General Assembly, the Economic and Social Council and the International Court of Justice, although other agencies may also take a leading role in specific fields.

The General Assembly

The General Assembly is composed of representatives from all member States. It is the principal decision-making organization within the United Nations. The significance of the General Assembly's role is noted on its website: "*while the decisions of the Assembly have no legally binding force for Governments, they carry*

³⁵³ See UN General Assembly, *Resolution 217 A (III): Universal Declaration of Human Rights*, available at <http://www.un.org/Overview/rights.html>.

³⁵⁴ "[W]hat the UN has done in the fields of... *human rights... development of international law*, and furthering *a set of new community values...* constitutes a great legacy. If the international community is so starkly different from that existing before the Second World War, this is primarily due to the UN": Cassese, A., *INTERNATIONAL LAW* (Oxford University Press 1st ed. 2001), at 295.

³⁵⁵ See UN, 'General Assembly of the United Nations,' available at <http://www.un.org/ga/>.

³⁵⁶ See UN, 'United Nations Economic and Social Council,' available at <http://www.un.org/docs/ecosoc/>.

³⁵⁷ See UN, 'Trusteeship Council,' available at <http://www.un.org/documents/tc.htm>.

³⁵⁸ See ICJ, 'International Court of Justice,' available at <http://www.icj-cij.org/>.

³⁵⁹ See UN, 'Secretariat,' available at <http://www.un.org/documents/st.htm>.

³⁶⁰ See UN, 'Human Rights Council,' available at <http://www2.ohchr.org/english/bodies/hrcouncil/>.

the weight of world opinion on major international issues, as well as the moral authority of the world community."³⁶¹

The General Assembly is a fundamental component in determining the activities undertaken by the UN. However, its size makes it a relatively slow instrument (even unwieldy at times) for the rapid formulation of policy. Smaller bodies, such as ECOSOC, tend to pioneer new initiatives. The UN's approach to capital punishment has demonstrated precisely this approach: although, as we shall see, ECOSOC and other organs have been actively engaged with the issue for some decades, the General Assembly has only recently been able to state the international community's position in straightforward terms.

The Economic and Social Council (ECOSOC)

The Economic and Social Council concerns itself with an extensive range of issues, including aspects of employment, health, education, human rights, culture, society, and economics. ECOSOC is mandated to "encourage universal respect for human rights and fundamental freedoms": it "issues policy recommendations to the UN system and to member States."³⁶² ECOSOC remains concerned with the issue of capital punishment.³⁶³

In turn, ECOSOC presides over 14 specialized UN agencies, ten functional commissions, and five regional commissions. Fifty-four individual governments belong to ECOSOC. The General Assembly elects members, taking into account equitable geographic representation. Membership lasts for a term of three years and elections are held on a staggered basis.

The International Court of Justice

The ICJ, situated in the Hague (the Netherlands), performs the principal judicial functions of the UN,³⁶⁴ resolving disputes between States. The ICJ can only decide cases with the consent of both parties, and does not generally concern itself with the

³⁶¹ UN General Assembly (57th Session), 'Background Information,' available at <http://www.un.org/ga/57/about.htm>.

³⁶² UN Economic and Social Council, 'What ECOSOC Does,' available at <http://www.un.org/esa/coordination/ecosoc/about.htm>.

³⁶³ UN Secretary-General, *Capital punishment and implementation of the safeguards guaranteeing protection of the rights of those facing the death penalty, Seventh Quinquennial Report of the Secretary-General*, UN Doc. No. E/2005/3, available at <http://www.un.org/docs/ecosoc/documents.asp?id=880>.

³⁶⁴ International courts and tribunals are, however, rapidly proliferating, however: *see*, e.g., Shaw, *supra*, n.343, at 1011–1012; Burke-White, W.W., *A Community of Courts: Towards a System of International Criminal Law Enforcement*, 24 MICHIGAN JOURNAL OF INTERNATIONAL LAW 1 (2002); UCL/NYU, 'Project on International Courts and Tribunals,' available at <http://www.pict-pcti.org/>.

enforcement of its decision.³⁶⁵ The ICJ may also provide the Security Council and the General Assembly with advisory opinions, answering legal queries posed to the Court by certain international agencies. The ICJ is made up of 15 judges from different Member States who all serve terms of a predetermined duration.³⁶⁶ The *Statute* of the Court governs its jurisdiction and procedure.³⁶⁷

The Commission on Human Rights and the Human Rights Council

Before it was superseded by the Human Rights Council, the Commission on Human Rights (another subsidiary of ECOSOC) was most relevant to the issue of capital punishment due to its primary concern with human rights. The Commission was entrusted with a number of responsibilities: the address of human rights violations on a global scale, and the “promotion and protection of human rights, including the work of the Sub-Commission, treaty bodies, and national institutions.” The Commission was significant for its contribution to the further development of global human rights standards.

The Commission's work touched upon a number of international treaties and was one of the UN organizational bodies that issued resolutions. The Commission on Human Rights played host to a number of sub-committees, referred to as working groups. These have been transferred into the new Council.³⁶⁸

On 15 March 2006, the General Assembly voted to establish a new Human Rights Council, replacing the Commission; the resulting Council is currently directly responsible to the General Assembly.³⁶⁹ In addition to assuming the duties of the Commission, the Council “assume[s], review[s], and, where necessary, improve[s] and rationalize[s] all mandates, mechanisms, functions and responsibilities of the

³⁶⁵ Art. 94 of the UN Charter requires Member States to comply with the decision of the ICJ in any case to which it is a party (*see* <http://www.un.org/aboutun/charter/index.html>); the ICJ has made clear its own position, saying “[o]nce the Court has found that a State has entered into a commitment concerning its future conduct it is not the Court's function to contemplate that it will not comply with it”: *Nuclear Tests Case (Australia v. France)*, Judgment (Merits), para. 60, available at <http://www.icj-cij.org/docket/index.php?p1=3&p2=3&k=78&case=58&code=af&p3=4>. The recent (16 July 2008) indication of provisional measures in the *Request for Interpretation of the Judgment of 31 March 2004 in the Case concerning Avena and Other Mexican Nationals (Mexico v. United States of America)* (*Mexico v. United States of America*) hints that the Court may, however, be willing to stretch a point on occasion.

³⁶⁶ *See* ICJ, ‘Members of the Court,’ available at <http://www.icj-cij.org/court/index.php?p1=1&p2=2>.

³⁶⁷ *See* ICJ, ‘Statute of the Court,’ available at <http://www.icj-cij.org/documents/index.php?p1=4&p2=2&p3=0>.

³⁶⁸ UN Human Rights Council, ‘Human Rights Council Working Groups,’ available at <http://www2.ohchr.org/english/bodies/chr/workinggroups.htm>.

³⁶⁹ UN General Assembly, *Resolution 60/251: Human Rights Council*; UN News, ‘Assembly Creates New UN Human Rights Council,’ available at <http://www.un.org/apps/news/infocusRel.asp?infocusID=114&Body=human%20rights%20council&Body1=>

Commission on Human Rights in order to maintain a system of special procedures, expert advice and complaint procedure.”³⁷⁰

The Council is composed of 47 Member States, directly elected by the General Assembly, taking into account equitable geographic distribution. Members of the Council serve for a period of three years. A State's contribution to the promotion and protection of human rights is recommended as a factor to be considered in voting. The first elections under these new guidelines were held on 9 May 2006.³⁷¹

The Assembly recommended that ECOSOC request the Commission to conclude its work, and to abolish it on 16 June 2006. The Commission duly complied and concluded its activities on 27 March 2006. The development of the new Council was greeted with much anticipation. Its practical impact, however, is yet to be felt.

SOURCES OF INTERNATIONAL LAW

Legal arguments are commonly structured around three issues: identification of the substantive content of an obligation; identification of the basis of the obligation; and application of the obligation to the facts. In the domestic context, where law emanates from a more rigid structure, this second requirement—identification of the basis of the obligation—is more or less residual. However, whereas national law is generally concerned with what the obligation *is*, controversies in international law turn as frequently on whether the putative obligation has the force of law *at all*.

The key factor in determining the basis of the obligation is the formal source of the law in question. An understanding of the sources of international law and the law of treaties is thus essential. As outlined on the following pages, the two principal sources of international law are distinct in their approaches and raise different issues. It is important to deal with these issues fully. Further, where possible, it is advantageous for the argument to be based on several sources.

Article 38(1) of the *Statute* of the International Court of Justice³⁷² is the classic starting point for consideration of the sources of international law.

The Statute of the International Court of Justice

In formal terms, Article 38(1) only expresses the sources to which the ICJ must have reference. It is generally accepted, however, as an authoritative general statement and provides a convenient framework for organizing international legal arguments or research. It states:

³⁷⁰ *Id.* (Res. 60/251), at para. 6.

³⁷¹ See UN General Assembly (60th Session), ‘Membership of the Human Rights Council,’ available at <http://www.un.org/ga/60/elect/hrc/>.

³⁷² Statute, *supra*, n.367; concluded at San Francisco, 26 June, 1945. Entered into force, 24 October, 1945. 1978 Y.B.U.N. 1052; U.S.T.S. 993,59 Stat.1031; *reprinted in* 1 Weston I.H.2

The Court, whose function it is to decide in accordance with international law such disputes as are submitted to it, shall apply:

- a. international conventions, whether general or particular, establishing rules expressly recognized by the contesting States;
- b. international custom, as evidence of a general practice accepted as law;
- c. the general principles of law recognized by civilized nations;
- d. subject to the provisions of Article 59, judicial decisions and the teaching of the most highly qualified publicists of the various nations, as subsidiary means for the determination of rules of law.

Most international law falls under the first two categories (treaties and customary law); a small amount under the third; the latter may assist in proving the *existence* of a law—and may add weight to an argument—but are rarely conclusive as a single source. Arguments solely advanced on the basis of international judicial precedent or academic opinion are unlikely to succeed.

Customary International Law

Customary international law is generally referred to as the “oldest and original source of international law.”³⁷³ It is a dynamic source of law, particularly important for its broad scope. Being an inevitable consequence of the sum of their actions, States may not always realize that they are creating a new rule of law: custom has been described as “unconscious and unintentional lawmaking.”³⁷⁴ Whereas treaties bind only those States that are party to them, a rule of customary law binds all (with the exception of “persistent objectors”). For these reasons, customary law can be of particular value to an international litigator, where it can be brought to bear. A *jus cogens* norm, discussed below, is a core rule of customary international law, with greater binding force.

The existence of customary law can be deduced from the practice of States. As confirmed by the ICJ in *Nicaragua v. USA (Merits)*,³⁷⁵ custom comprises two main elements:

- (i) The general practice of nations (objective),
- (ii) ...which is ‘accepted as law’ (also known as *opinio juris*) (subjective).

The requirement of the first element is logical, and its nature easily understood. Since customary law is founded on the practice of States, what States actually do is

³⁷³ Steiner, H., & Alston, P., INTERNATIONAL HUMAN RIGHTS IN CONTEXT (OUP 2nd ed. 2000), at 69.

³⁷⁴ Kelsen, H., PRINCIPLES OF INTERNATIONAL LAW (Rinehart & Company 1952), at 307–308.

³⁷⁵ ICJ Reports 14, at 97, available at

<http://www.icj-cij.org/docket/index.php?p1=3&p2=3&k=66&case=70&code=nus&p3=4>.

significant. The test is high: practice must, at least, have a certain consistency,³⁷⁶ although it need not be universal.³⁷⁷

The second element, however, is less easy to define in simple terms. In essence, *opinio juris* means that a State must act under what it perceives to be a legal obligation for its practice to be evidence of a rule of customary international law. However, a State does not always limit its practice to what is required by law: it may act in goodwill, or in hope of some perceived advantage. In other words, one cannot identify *opinio juris* behind every instance of state practice. Even leaving that difficulty aside, at what level should the test be set? The ICJ has held that:

Either the States taking such action or other States in a position to react to it, must have behaved so that their conduct is “evidence of a belief that this practice is rendered obligatory by the existence of a rule of law requiring it. The need for such a belief, i.e. the existence of a subjective element, is implicit in the very notion of the *opinio juris*...”³⁷⁸

This would suggest that the State has to believe that the law as constituted at that moment requires a certain action or inaction. However, it is equally clear that customary law can evolve. In such cases, it is not possible for *opinio juris* to be straightforwardly measured at this highest level: a State would have to comply with the law in order to demonstrate that the law is in fact different; a virtual impossibility. Instead, the best answer is to say that the level at which *opinio juris* is measured varies to a certain extent upon the amount of supporting State practice.³⁷⁹ In other words, the two elements of customary law, practice and *opinio juris*, are related in some manner. This is a tricky concept, but it illustrates the essential flexibility and complexity of customary law. It reflects the vagaries of the real world.

Evidence of custom is numerous, particularly for State practice, and can come in almost any form.³⁸⁰ It can, and often does, include diplomatic correspondence; opinions of official legal advisors; press releases from the nation; international and national judicial decisions; treaties; and resolutions. Obviously, the value of these sources varies and much depends upon the circumstances. A good rule of thumb, however, is to say that “state practice covers any act or statements by a state from which views about customary law may be inferred.”³⁸¹

³⁷⁶ “State practice, including that of States whose interests are specially affected, should... [be] both extensive and virtually uniform.”: *North Sea Continental Shelf Cases*, Judgment of 20 February 1969, ICJ Reports, para. 74.

³⁷⁷ Custom does not require uniform practice: it recognises, for example, that the practice of landlocked states may not be particularly telling with regard to maritime law, as well as the possibility of ‘local customs’. See Shaw, *supra*, n.343, at 87-88.

³⁷⁸ *Military and Paramilitary Activities In and Against Nicaragua*, *supra*, n.**Error! Bookmark not defined.**, para. 207; also *North Sea Continental Shelf Cases* [1969] ICJ Reps, p. 44, available at <http://www.icj-cij.org/docket/index.php?p1=3&p2=3&k=cc&case=52&code=cs2&p3=4>.

³⁷⁹ See further Shaw, *supra*, n.343, at 82-83.

³⁸⁰ *Id.*, at 77-80.

³⁸¹ Akehurst, M., *Custom as a Source of International Law*, 47 BRITISH YEARBOOK OF INTERNATIONAL LAW 1 (1974-1975), at 10.

Evidence of *opinio juris* is likely to be found in the same type of materials, but analyzed instead for insights into why the State acted in the way that it did. For obvious reasons, this is often a more difficult task. It is possible, however, that if one of the elements is proved with great consistency, the other element may not need to be satisfied to the same extent.³⁸² State practice which is universal, or almost so, may itself be grounds for inferring that States feel themselves obliged to act in a uniform way, for example.³⁸³

The 'Persistent Objector'

A State may avoid being bound by customary international law if it has been a "persistent objector" to a particular rule or norm. This objection must be "consistent" and irrespective of disagreement. This is a common argument raised by an opposing party in litigation if confronted with a relevant *prima facie* rule of customary law, and largely turns on the evidence. However, if one looks back at the practice of a State, it is sometimes the case that the argument can be countered due to a lack of consistency. Even a short break in practice may be sufficient.³⁸⁴ Once a State is deemed to have ceased its objection, it cannot subsequently resurrect it.

Treaties

The primary definition of a treaty (commonly also referred to as a *Convention* or *Covenant*) is:

an international agreement concluded between States in written form and governed by international law, whether embodied in a single instrument or in two or more related instruments and whatever its particular designation.³⁸⁵

Treaties may be concluded by States for any number of purposes, and may take all sorts of forms. In the field of human rights, however, the primary purpose is generally to provide some form of legal protection from a perceived wrong, and so the provisions clearly reflect the characteristics of a legally binding international agreement. As a result, identifying human rights treaties as treaties is usually relatively straightforward.

³⁸² See Kirgis, F.L., *Custom on a Sliding Scale*, 81(1) AJIL 146 (1987).

³⁸³ See, e.g., the Dissenting Opinion of Judge Tanaka in the *North Sea Continental Shelf Cases*, *supra*, n.378, at 176, finding in that case that there was "no other way than to ascertain the existence of *opinio juris* from the fact of the external existence of a certain custom and its necessity felt in the international community, rather than to seek evidence as to the subjective motives for each example of State practice."

³⁸⁴ See further Stein, T., *The Approach of the Different Drummer: the Principle of the Persistent Objector in International Law*, 26 HARVARD INTERNATIONAL LAW JOURNAL 457 (1985); Charney, J., *The Persistent Objector Rule and the Development of Customary International Law*, 56 BRITISH YEARBOOK OF INTERNATIONAL LAW 1 (1985).

³⁸⁵ Vienna Convention on the Law of Treaties 1969, Art. 2(1)(a), available at http://untreaty.un.org/ilc/texts/instruments/english/conventions/1_1_1969.pdf.

As a source of international law, treaties are of growing importance: the last 50 years have seen a significant upsurge in the number of treaties made, and a change in the nature of the obligations introduced. Treaties play a major role in promoting the modernization and development of law.

The most basic treaty is an express agreement between parties, which binds only those parties (this is generally considered a classic bilateral treaty).³⁸⁶ Treaties are often used to codify, and even reform or update, rules of customary law in accordance with the legal perceptions and inclinations of their drafters. However, where States wish not only to change the law that regulates their own behavior but also to indicate a general rule of law (a frequent occurrence for human rights law), other States may be invited to become parties (at which point the treaty becomes a multilateral treaty). In order to give full effect to the purpose of the treaty, such treaties require the participation of a large number of States. If sufficient States accept the principles contained in a treaty as general tenets of international law, and act in a manner consistent with this belief, those provisions can become customary law, which will bind all relevant parties. In this fashion, treaties are agents of change, both “crystallizing” existing law and “generating” the new.³⁸⁷

A great many international legal disputes are concerned with the validity and interpretation of an international agreement. All treaties are governed by one set of rules: the law of treaties. The law of treaties is based in customary law, but a significant proportion of it has been encapsulated within the *Vienna Convention on the Law of Treaties* (VCLT).³⁸⁸ The provisions of the Convention are normally regarded as an authoritative source.

Although there may be no direct enforcement mechanism for a treaty (unless one is specified or created through the treaty itself), a treaty is invaluable when preparing an international law argument. The political consequences, both internally and externally, of a State party breaching its obligations can often be enough to ensure compliance.

As a general research point, it is prudent to reference the full text of a treaty, just as you would reference a piece of domestic legislation. For independent research purposes, the following two current sites are incredibly useful:

- The website for the United Nations High Commissioner for Human Rights: <http://www.unhchr.ch/>
- The University of Minnesota Law School Human Rights website: <http://www1.umn.edu/humanrts/>

³⁸⁶ “[A] treaty only creates law as between the States which are parties to it.”: *Certain German Interests in Polish Upper Silesia (Merits)*, Judgment of 25 May 1926, PCIJ, Series A, no. 7, at 29.

³⁸⁷ Cassese, *supra*, n.354, at 136–138.

³⁸⁸ Vienna Convention on the Law of Treaties, *supra* n.385; 1155 U.N.T.S. 331, *entered into force* January 27, 1980.

What are the Legal Effects of a Treaty?

Externally

A treaty is only binding upon a State in international law when it has both consented to be bound by it, and when the treaty has come into force.³⁸⁹ The time of a treaty's entry into force is often as much a practical question as a legal one: certain human rights treaties may, for example, only be of utility when a sufficient number of States become parties (e.g. the Rome Statute of the International Criminal Court was concluded in 1998 but only entered into force in 2002, when 60 States had become parties). When relying upon a treaty in legal argument, it is important to confirm that the treaty has entered into force.³⁹⁰

States can express their consent to be bound by treaty in any way they choose.³⁹¹ The two principal forms, "signing" and "ratifying," are, however, often confused: it is possible both to sign a treaty in a way that is itself sufficient to express consent to be bound, or to sign "subject to ratification."³⁹² For human rights treaties, the latter is far more common. Ratification might best be understood as an "extra step" before the State has given its full consent, often used to provide time for practical difficulties to be resolved (sometimes to comply with domestic law, such as a requirement for parliamentary approval, or perhaps to introduce enabling legislation). It is important to note, however, that ratification itself is a process "on the international plane," distinct from national law:³⁹³

[a]lthough parliamentary approval of a treaty may well be required—and be referred to, misleadingly, as 'ratification'—that is a quite different process.³⁹⁴

This distinction is particularly important in the case of the United States, as will become apparent below.

It is clear that when a State signs subject to ratification, the treaty can have no legally binding effect until that ratification has occurred.³⁹⁵ Accordingly, the period after a treaty has been signed but before it has been ratified is more or less analogous, in principle if not in substance, to the period when a State has fully consented to be bound

³⁸⁹ Vienna Convention on the Law of Treaties, Art. 2(1)(g). Note that, although these are separate processes (often evidently), they can in some circumstances appear to occur simultaneously, where a treaty "enters into force on signature", for example. To avoid doubt, reference to the treaty itself will often clarify the procedure which its parties should follow. See Aust, A., MODERN TREATY LAW AND PRACTICE (CUP 2000), at 75–76, 81–87.

³⁹⁰ On entry into force, see further *id.*, at 131–142.

³⁹¹ Vienna Convention on the Law of Treaties, Art. 11.

³⁹² Aust, *supra*, n.389, at 75–76.

³⁹³ Vienna Convention on the Law of Treaties, Art. 2(1)(b).

³⁹⁴ Aust, *supra*, n.389, at 81.

³⁹⁵ *North Sea Continental Shelf Cases*, *supra*, n. 378 at 25.

by a treaty, but it has not yet come into force. The law treats the obligations of the State in these periods in the same way.

Article 18 [of the Vienna Convention on the Law of Treaties] requires a state 'to refrain from acts which would defeat the object and purpose of a treaty' before its entry into force for that state. When the treaty is subject to ratification... this obligation lasts until the state has made clear its intention not to become a party. When a state has expressed its consent to be bound, the obligation continues pending entry into force of the treaty, provided this event is 'not unduly delayed'.³⁹⁶

Thus, in these circumstances, a State is bound *in good faith*, if not in law, to ensure that nothing is done which would defeat the object and purpose of the treaty, pending a decision on ratification. A signature does not create an obligation to ratify. In fact, the precise extent of the good faith obligation remains a matter of academic debate, although it might reasonably be argued to mean that a State may not act in a way which would invalidate the basic purpose of the treaty.³⁹⁷

Example

A State has signed but not yet ratified a treaty banning the use of the death penalty for the mentally ill. It is probably bound in good faith not to enact a law making execution mandatory for capital crimes, regardless of mental health. Such a law would be clearly contrary to the basic purpose of the treaty, and would lead to inevitable future conflict. It is probably *not* bound in good faith, however, to stay a case where an individual is assessed under domestic law to be mentally competent for execution—even though the treaty might impose different legal standards on its entry into force. This latter scenario, although it would clearly be affected by the treaty were circumstances different, does not deny the basic utility of the treaty but merely recognizes that it does not yet have legal force. The distinction is, perhaps, a sophisticated one.

Once it has ratified a treaty, the State is considered to have consented to be bound.³⁹⁸ When making treaty arguments, it is important to check whether the treaty specifies a particular manner for States to become parties, and whether the State relevant to your case has complied.³⁹⁹

³⁹⁶ Aust, *supra*, n.389, at 93–94.

³⁹⁷ See, e.g., *id.*, at 94–95; McDade, *The Interim Obligation between Signature and Ratification*, NETHERLANDS INTERNATIONAL LAW REVIEW 5 (1985); Rogoff, *The International Legal Obligations of Signatories to an Unratified Treaty*, MAINE LAW REVIEW 263 (1980).

³⁹⁸ It is important to note that where a treaty reflects customary international law, non-parties are still bound. Their obligation does not flow from the treaty itself, but because the treaty provisions mirror and/or reaffirm a rule or rules of customary international law.

³⁹⁹ Information on the ratification status of the major human rights treaties may be found at <http://www.unhchr.ch/pdf/report.pdf>.

Internally

Even if a State has complied with the full requirements of international law, and has become a party to a treaty, it still does not mean that the treaty necessarily has effect in domestic law. As States, not biological individuals, are the actors of international law, the classic view argues that only States can enforce international legal obligations. A State can, as a rule, only give its citizens the right to enforce that law by incorporating it into its own, domestic legal system.⁴⁰⁰ This is an issue of particular relevance to human rights treaties.

States vary in the way in which they approach this issue. In the United States, the Constitution provides that treaties “shall be the supreme law of the land,”⁴⁰¹ a clause which the U.S. Supreme Court has also held applicable to executive agreements (see below).⁴⁰² However, U.S. law draws a distinction between “self-executing” and “non-self-executing” treaties, only the former category is automatically incorporated in domestic law (providing ‘instant’ enforceable rights to individuals) while the latter requires enabling legislation.⁴⁰³

Self-executing treaties may be identified by reference to:

the purpose of the treaty and the objectives of its creators, the existence of domestic procedures and institutions appropriate for its direct implementation, the availability and fairness of alternative enforcement methods, and the immediate and long-range social consequences of self- or non-self-execution.⁴⁰⁴

The United States Senate has purported to apply ‘non-self-executing declarations’ to certain key international human rights treaties precisely to exclude their direct effect under US law,⁴⁰⁵ although the legal basis for such action is questionable.⁴⁰⁶

⁴⁰⁰ Note, however, that although States have, by default, autonomy to choose to assume international obligations to which they do not give full effect in domestic law, this position may slowly be changing. A number of treaties include provisions requiring that States introduce enabling legislation (e.g. Convention on Genocide 1948, Art. 5; ICCPR 1966, Art. 2(2); Convention on Torture 1984, Arts. 4, 5), and recent judicial decisions suggest that *jus cogens* norms (see below) also impliedly require implementation in national law: *Prosecutor v. Furundžija*, Trial Judgment, 1998, paras 148–150, available at <http://www.un.org/icty/cases-e/index-e.htm>.

⁴⁰¹ Constitution of the United States of America, Act. VI, s.2.

⁴⁰² Shaw, *supra*, n.343, at 147.

⁴⁰³ For an introduction, see *id.*, at 147–151; Vazquez, C.M., *The Four Doctrines of Self-Executing Treaties*, 89 AJIL 695 (1995); Buergenthal, T., *Self-Executing and Non-Self-Executing Treaties in National and International Law*, 235 HR, IV, 303 (1992); Paust, J., *Self-Executing Treaties*, 82 AJIL 760 (1986); Aust, *supra*, n.389, at 157–161.

⁴⁰⁴ *Saipan v. US Department of the Interior*, 502 F.2d 90 (9th Cir. 1974), at 97

⁴⁰⁵ *Sosa v. Alvarez-Machain*, 124 S.Ct. 2739 (2004), at 2767.

⁴⁰⁶ See further Halberstam, M., *Alvarez-Machain II: the Supreme Court's reliance on the Non-Self-Executing Declaration in the Senate Resolution giving Advice and Consent to the International Covenant on Civil and Political Rights*, 1 JOURNAL OF NATIONAL SECURITY LAW AND POLICY 89 (2005); Sloss, D., *The Domestication of International Human Rights: Non-Self-Executing Declarations and Human Rights Treaties*, YALE JOURNAL OF INTERNATIONAL LAW 129 (1999); Quigley, J., *Human Rights Defenses in US Courts*, 10 HUMAN RIGHTS QUARTERLY 555 (1998).

Finally, while discussing the position in U.S. law, it is also worth noting the distinction between “treaties” and “executive agreements.” The U.S. Constitution uses only the term “treaty” for all international instruments, and provides that the President may only ratify a treaty with the “advice and consent” of the U.S. Senate. However, a parallel international instrument, not mentioned in the Constitution at all, known as an “executive agreement” has emerged in U.S. law. It is identical to a treaty in every way, recognized by both the U.S. government and the governments of other States, but does not require Senate approval. This distinction is not, perhaps, of significance for most multilateral human rights treaties but is sometimes relevant for certain bilateral instruments. Although the majority of treaties upon which a practitioner may rely in domestic litigation will be the former, bilateral instruments on consular relations may, for example, be “executive agreements.” It is as well, then, to understand both. Certainly, it illustrates why American treaty law is fairly described as “remarkably complex.”⁴⁰⁷

Mindful of the above information, the manner in which a treaty argument is phrased must be adjusted to suit the treaty's legal status. The strongest international legal argument can be made if a treaty is ratified and in force; for those treaties which are (at least arguably) self-executing, domestic legal arguments may also be raised. For those treaties which require ratification, but for which ratification is still pending, it remains possible to argue that the State must not act contrary to the object and purpose of the treaty. The fact of a State's signature to the instrument may, in some cases, also be good evidence in support of a customary law argument.⁴⁰⁸

Examples of Treaties

- *Charter of the United Nations.*
- *Geneva Conventions on the Treatment of Prisoners and the Protection of Civilians.*
- *Vienna Convention on Consular Relations.*
- *International Covenant on Civil and Political Rights (ICCPR).* [Ratified by the United States on 8 June 1992 with a reservations. The ICCPR is perhaps the most consequential human rights treaty in existence. In fact, the U.S. State Department applauded it as "the most complete and authoritative articulation of international human rights law that has emerged in the years following World War II."]
- *Convention on the Rights of the Child (CRC)*⁴⁰⁹
[Signed by the U.S. in 1995, but not yet ratified. 192 nations have ratified the CRC.]

⁴⁰⁷ Aust, *supra*, n.389, at 157–161.

⁴⁰⁸ “[S]igned but unratified treaties may constitute an accurate expression of the understanding of the parties at the time of the signature”: *Qatar v. Bahrain*, 2001, para. 89, available at <http://www.icj-cij.org/docket/index.php?p1=3&p2=3&k=61&case=87&code=qb&p3=4>. On customary law, see further below.

⁴⁰⁹ UN Human Rights Council, ‘Convention on the Rights of the Child,’ available at <http://www.unhcr.ch/html/menu3/b/k2crc.htm>.

- *Convention on the Elimination of all forms of Racial Discrimination (CERD)*
- *Convention against Torture (CAT).*

The UN keeps a record of the principal human rights treaties, and their ratification status.⁴¹⁰

In Summary:

- Treaties only bind parties which have consented to be bound, and for whom they are in force.
- A State which has signed but not ratified a treaty is not legally bound by it.
- However, by signing an international instrument, a State incurs an obligation to refrain from acts which would defeat the instrument's object and purpose, at least to a certain extent. The matter remains controversial but would be a viable legal argument if required.
- A signature does not create an obligation to ratify.
- Even when seeking to rely on a treaty to which a state is a party and which is in force, it is important to check whether domestic enabling legislation is required to provide individually enforceable rights.

Interpretation and Application of Treaties

Like the common law of contract, the majority of disputes concerning treaties relate to their validity and/or interpretation. Certain issues, such as the application of reservations or the relationship with customary *jus cogens* norms, pose particular challenges to this process. The VCLT is widely accepted as codifying the customary rules relating to treaty interpretation and application. Although not without controversial aspects, it provides a useful framework to consider the validity of reservations, and the obligation of a State upon signing a treaty to bind itself in good faith pending ratification.

It should be noted that the U.S. has signed but not ratified the Vienna Convention on the Law of Treaties. In accordance with the principles of international law, as stated above, it may be obliged, however, to bind itself in good faith. The U.S. Department of State, however, has taken the position that the treaty is the authoritative guide to existing treaty law and procedure.⁴¹¹

⁴¹⁰ See Office of the United Nations High Commissioner for Human Rights, 'Status of Ratifications of the Principal International Human Rights Treaties,' available at <http://www2.ohchr.org/english/bodies/docs/status.pdf>; 'Office of the United Nations High Commissioner for Human Rights, 'Ratifications and Reservations,' available at <http://www2.ohchr.org/english/bodies/ratification/index.htm>.

⁴¹¹ See Restatement (Third) of Foreign Relations Law of the United States, Sec. 313(1)(c)(1987).

Reservations

In the process of becoming party to a treaty, either upon signature or ratification, States can attach “reservations”; pronouncements which purport to exclude or modify the legal effect of certain provisions.⁴¹² For example, when ratifying the International Covenant on Civil and Political Rights, the United States made a reservation to Article 6(5), which explicitly provides:

Sentence of death shall not be imposed for crimes committed by persons below eighteen years of age and shall not be carried out against pregnant women.

The United States put forward this reservation in order to permit various U.S. States to continue to execute juvenile offenders.⁴¹³ The *validity* of this particular reservation proved to be extremely controversial.⁴¹⁴

This example neatly illustrates the fundamental problem posed by reservations, and the reason why they continue to be contentious, particularly in the area of human rights.⁴¹⁵ Why should a State be allowed to “contract out” of an instrument which it has accepted as legally binding upon it? The short answer is that, without reservations, very few multilateral treaties would ever be successful because all the parties involved would be required to agree on all points. Instead, through the mechanism of the reservation, each State can accept the treaty as a whole but “opt out” of provisions with which it disagrees.⁴¹⁶ This, of course, does risk making the law significantly less effective as well as particularly complex. The VCLT has attempted to introduce a consistent regime for this area of law,⁴¹⁷ yet the practice of States since it has come into force rather reveals the opposite. The International Law Commission, the body of experts which advises on international legal reform, remains actively involved in this area.⁴¹⁸

When is a Reservation Invalid?

As a rule of thumb, a reservation is invalid when it runs contrary to the *object and purpose* of the treaty, or when the treaty itself expressly excludes the possibility of all

⁴¹² Vienna Convention on the Law of Treaties, Art. 2(1)(d)

⁴¹³ Note that the United States may no longer execute juveniles following the landmark ruling by the Supreme Court in *Roper v Simmons* 543 U.S. 551, 125 S.Ct. 1183 (2005) which decided that executing juveniles violated the Eighth Amendment ban on cruel and unusual punishment.

⁴¹⁴ See Schabas, W., *Invalid Reservations to the International Covenant on Civil and Political Rights: Is the United States Still a Party?* 21 BROOK. J. INT'L L. 277 (1995).

⁴¹⁵ See Gardner, J.P., HUMAN RIGHTS AS GENERAL NORMS AND A STATE'S RIGHT TO OPT OUT: RESERVATIONS AND OBJECTIONS TO HUMAN RIGHTS CONVENTIONS (BIICL 1997); Schabas, W., *Reservations to Human Rights Treaties: Time for Innovation and Reform*, CANADIAN YEARBOOK OF INTERNATIONAL LAW 39 (1994); Higgins, R., *The United Nations: Still A Force for Peace*, MODERN LAW REVIEW 1, at 11–18 (1989).

⁴¹⁶ See Aust, *supra*, n.389, at 107, and more generally, 100–101, 104–130.

⁴¹⁷ Vienna Convention on the Law of Treaties, Arts. 19–23.

⁴¹⁸ See, e.g., International Law Commission, REPORT ON THE WORK OF ITS 57TH SESSION, 2005, A/60/10, p. 140, available at <http://untreaty.un.org/ilc/reports/2005/2005report.htm>.

or some types of reservations.⁴¹⁹ The *Statute of the International Criminal Court* is an example of a treaty to which reservations may not be attached under any circumstances;⁴²⁰ the *Second Optional Protocol to the ICCPR* is an example of a treaty which has a “partial” exclusion of reservations.⁴²¹ An example of a reservation that has failed for being contrary to the object and purpose of a treaty has deliberately not been offered in this section as practice in this area is confused, and the precise application of the rule uncertain. The U.S. reservation to the ICCPR discussed above received objections from no less than 11 European States on the grounds that it was incompatible with the treaty’s object and purpose, yet it still appeared to remain valid.⁴²²

Despite these confusions, it can nonetheless be argued that a reservation worded so vaguely that its precise application cannot be reasonably understood, or that its application could be read so widely as to defeat the object and purpose of the treaty, is also likely to be invalid on the grounds of ambiguity.

What is the difference between a reservation and a declaration?

A reservation is a statement restricting the legal effect of a certain part of a treaty; if valid, it alters the treaty so far as that party is concerned. A declaration, on the other hand, is a statement (often political) of how a State actually understands the treaty. A declaration gives some indication as to how the treaty will be interpreted by that nation, but, of itself, generally has no binding effect.⁴²³

Jus Cogens

While each source of international law is valuable, they generally take priority on the basis of time: a recent treaty will “trump” a purely historic custom, a change in state practice will lead to a new customary norm replacing an old discarded treaty, and so on. However, some international laws are protected, such that they cannot be supplanted in this fashion. They are known as norms of *jus cogens*, or “peremptory” norms of international law.

⁴¹⁹ Vienna Convention on the Law of Treaties, Art. 19; this rule, however, almost certainly subsists in customary law too.

⁴²⁰ Statute of the International Criminal Court 1998, Art. 120, available at http://www.icc-cpi.int/library/about/officialjournal/Rome_Statute_English.pdf/.

⁴²¹ Second Optional Protocol to the International Covenant on Civil and Political Rights, aiming at the abolition of the death penalty, Art. 2, available at <http://www.ohchr.org/english/law/ccpr-death.htm>.

⁴²² The Human Rights Committee (the ICCPR’s “treaty body”) has offered a useful starting point for the analysis of the validity of a purported reservation to a human rights treaty: General Comment No. 24, at

[http://www.unhcr.ch/tbs/doc.nsf/\(Symbol\)/69c55b086f72957ec12563ed004ecf7a?Opendocument](http://www.unhcr.ch/tbs/doc.nsf/(Symbol)/69c55b086f72957ec12563ed004ecf7a?Opendocument).

⁴²³ See Aust, *supra*, n.389, at 101–103.

Article 53 of the VCLT provides that *a treaty will be void "if, at the time of its conclusion, it conflicts with a peremptory norm of general international law."* A similar rule exists with regard to customary law.

The article also offers a useful definition of a *jus cogens* norm as:

a norm accepted and recognized by the international community of States as a whole as a norm from which no derogation is permitted and which can be modified only by a subsequent norm of general international law having the same character.

The Restatement (Third) of the Foreign Relations Law agrees with this standard, asserting that a *jus cogens* norm is established where there is acceptance and recognition by a "large majority" of States, even if over dissent by "a very small number of States."⁴²⁴

In *Domingues v United States*, the Inter-American Commission of Human Rights described a *jus cogens* norm as deriving its status:

from fundamental values held by the international community" and "violations of such pre-emptory norms are considered to shock the conscience of humankind and therefore bind the international community as a whole, irrespective of protest, recognition, or acquiescence."⁴²⁵

The *jus cogens* norm describes such a bare minimum of acceptable behavior that *no* State may derogate from it. It is argued, therefore, that a nation cannot contract out of this peremptory norm or assert its "persistent objector" status as a defense.⁴²⁶

It has been asserted that the prohibitions of slavery, the unlawful use of force, genocide, piracy and perhaps torture are *jus cogens* norms. The list is small, but not closed, although the test is high.⁴²⁷ Accordingly, a *jus cogens* argument is possibly the most difficult to articulate with success, especially as there is a school of academic thought which denies the existence of *jus cogens* for human rights norms entirely. Nevertheless, at the very least, as with all international legal arguments, it

⁴²⁴ Restatement (Third) of Foreign Relations Law, §102, and reporter's note 6 (1986), citing REPORT OF THE PROCEEDINGS OF THE COMMITTEE OF THE WHOLE, May 21, 1968, UN Doc. A/Conf. 39/11 at 471-72.

⁴²⁵ *Domingues v United States* Report No. 62/02, para. 85, Inter-Am. Cm. H.R. (2002), available at <http://www.cidh.org/annualrep/2002eng/usa.12285.htm>.

⁴²⁶ Of note, there are alternative arguments on this particular issue, for the relationship between *jus cogens* and the persistent objector-rule, see Charney, *The Persistent Objector Rule and the Development of Customary International Law*, 56 BRITISH YEARBOOK OF INTERNATIONAL LAW 1 (1985), at 14, n.81; Danilenko, M., LAW-MAKING IN THE INTERNATIONAL COMMUNITY (Martinus Nijhoff 1993), at 234, arguing in favour of persistent objection even for *jus cogens* norms; Tomuschat, *Obligations Arising for States without or against Their Will*, 241 RECUEIL DES COURS (1993-IV) 195, at 284 *et seq.*, arguing against the application of the rule in case of *jus cogens*.

⁴²⁷ See, generally, Cassese, *supra*, n.354, at 138-148.

may well be worth articulating as a supplemental line of reasoning. Indeed, a *jus cogens* argument was asserted in *Roper v Simmons*.⁴²⁸

General Principles of International Law

In any system of law a situation may arise where the court realizes that there is no authority covering a specific point. International law recognizes this, at least in part, by reference to “the general principles of law recognized by civilized nations” in Article 38 (1) of the ICJ Statute. General principles allow international lawyers to rely on themes drawn from national law, the relative influence of such a principle being a product (to a large extent) of the number of domestic legal systems which recognize it. Accordingly, the Anglo-American traditions of the common law may represent an important—but not sufficient—contribution to showing the existence of a general principle.

“Soft” and “Hard” Law Distinctions

Finally, it is useful to note two key pieces of terminology frequently used in discussion of the international legal regime. International law, norms and standards are generally said to fall into one of two categories: “hard” or “soft” law. “Soft” law is technically non-binding or binding yet particularly controversial, while “hard” law is considered to be unmistakably binding. In light of the above pages, it is possible to comprehend the usefulness of these concepts.

Resolutions of international organizations—which are not, as a general rule, formally binding but which may constitute evidence of State practice—generally fall into the “soft” law category; conversely, treaties are considered to be “hard” law. “Soft” law is seen by some as germane to the process of the formation of customary law. Correspondingly, notions of “hard” and “soft” law lend a sort of hierarchical structure to international law. In constructing an argument, “hard” law appears to be most useful at first glance (perhaps particularly to a national lawyer, for whom it may seem more familiar); however, in the areas of contention—where litigation almost always arises—it is difficult to put together a comprehensive submission without using “soft” law sources as evidence of the way the law might be developing. A blend of the two can be a powerful combination.

MATERIALS RELEVANT TO DEFENDING THE MENTALLY ILL

International legal arguments are applicable in a wide range of circumstances—but this fact may not always be readily obvious. As a relatively ‘primitive’ system (although one that is developing with unparalleled speed), it is possible to be certain

⁴²⁸ For additional information and list of briefs filed, see <http://www.internationaljusticeproject.org/juvCSimmons.cfm#briefs>.

only of the most basic principles. Further, the decentralized structure of international law means that particular obligations do not necessarily apply directly to all states. As this guide illustrates, it can be difficult to find a particular norm which precisely addresses the desired point. Instead, a significant part of the international lawyer's art lies in applying established norms in novel contexts.

Moreover, in most cases, the content of the existing rules requires a degree of interpretation; ascertaining the manner in which rules should be applied to a particular situation requires careful reasoning, often by the cautious use of inference. Like the common law, international law is built from an infinite number of incremental, creative steps. It stagnates either when the steps taken are too creative (and cannot be substantiated as 'law' at all) or there is a shortage of increments. It is important to combine creativity with a measure of practical discretion. A distinguished practitioner wrote:

An international lawyer who persists in finding rules of international law which governments, international tribunals and his [or her] lawyer-colleagues never or seldom thereafter treat as law, may be on the side of the angels but will not in the end serve the useful purpose of contributing to the improvement of the quality of relations between States.⁴²⁹

This principle applies equally to human rights arguments. In order for them to be successful, particularly in a domestic context, it is essential that they are seen as credible. Given the importance of politics to international law, the law is always subject to attack as being 'imperialist' or 'foreign' or 'fantasy'. These attacks can only be met by a solid basis of authority and argument that grounds the law in orthodoxy.

In this section, we present some of the most significant materials relevant to the defense of the mentally ill from capital punishment. These are arranged around three key themes, likely to be of the most immediate use: materials relevant to the rights of the mentally ill in general, materials relevant to the punishment and detention of the mentally ill, and materials relevant to fashion in which the prohibition of cruel, inhuman and degrading treatment must take account of the characteristics of the individual in question. Various arguments can be developed from this basis, but it should be noted that this introduction has no aspiration to comprehension. Further research in this area is advised, individually or in concert with the IJP.

Finally, it must be emphasized that the value of these materials does not lie simply in their identification and citation but in the way in which they are presented. Most particularly, it is vital in the judicial context to demonstrate that the judge can—and should—apply international law *as law* and something more than high-minded principle. Pleading the basis of the obligation (*i.e.*, within the framework of the sources of international law, explored briefly above) is key. By example, a treaty-

⁴²⁹ Allott, P., *Language, method and the nature of international law*, 45 BRITISH YEARBOOK OF INTERNATIONAL LAW 79 (1971), at 105.

based argument might be required—quite apart from defining the nature of the relevant obligation and its application to the facts—to consider the following points:

- Was the United States a party at the relevant moment?
 - Was the treaty *ratified* as well as signed by the United States?
 - Was the date of ratification before the relevant moment?
 - Was the treaty in force at the relevant moment?
- Has the United States entered any valid reservations in respect of the relevant provisions of the treaty?
- If so, are these reservations relevant and/or valid in international law?
 - They should be construed narrowly.
 - Are they compatible with the object and purpose of the treaty?
 - Is there a conflict with a *jus cogens* norm?
- Is the treaty self-executing?
 - Does it meet the *Saipan* test, for example?
 - Was a declaration made as to its self-executing status?
- If the United States has entered a non-self-executing declaration, can it be attacked?
 - Is there a constitutional basis for the US Senate to make non-self-executing declarations?
 - Is it incompatible with the object and purpose of the treaty?
 - Is it valid in international law?

A similar process for a customary law argument might consider:

- Does the material presented amount to a consistent practice of States?
 - How much of it is there?
 - How long has it been accumulating?
 - What is its origin? Can it be given special consideration as the product of many State views (such as a resolution of an international body)?
- Is there evidence that the relevant States' considered this practice to be mandated by law (*opinio juris*)?
 - Did the relevant State(s) make any comment in the media as to their motivation for undertaking the relevant practice?
 - Does the practice itself establish an inference as to the State's view?
- Is the United States a persistent objector?
- Is the alleged customary norm also a norm of *jus cogens*?

As these brief checklists illustrate, the use of international law can be rife with ambiguities—it is often very difficult to answer many of these questions definitively. However, this should not dissuade the lawyer from relying upon it. Even if initially unsuccessful, clear articulation of these issues opens the door to appellate review, which would be most welcome. It is, of course, wise for the lawyer not to put ‘all their eggs in one basket’. Accordingly, when a lawyer comes in the door of the courtroom with an international law argument, they should come in the door with as much (of credible quality) as they can: even if a treaty-based argument fails, a customary argument on a similar point may be successful. It should be made absolutely clear that customary arguments are entirely independent of treaty-based arguments, although they may draw on very similar material.

Ultimately, understanding international law is still just the beginning. It may provide valuable additional ammunition but the battle is still won by the skill of the lawyer in talking to the judge, and leading them through a complex (and largely unfinished) area of the law. In this regard, of course, the reader is the expert.

General rights of the mentally ill

To begin, it is useful to identify a basic working definition of mental illness. The term, where used at all, is used loosely in the context of most international law. It includes, therefore, all that a classic dictionary (such as the *American Heritage Dictionary*) might include in the term:

any of the various conditions characterized by impairment of an individual's normal cognitive, emotional, or behavioral functioning, and caused by social psychological, biochemical, genetic, or other factors, such as infection or head trauma. Also called emotional illness, mental disease, mental disorder.

Some of the more common illnesses experienced by inmates on death row include: bipolar disorder, borderline personality disorder, post-traumatic stress disorder, schizoaffective disorder, schizophrenia, and suicidal tendencies.⁴³⁰ This definition allows for a wide interpretation of what constitutes “mental illness.” Within capital punishment cases, this is crucial as it allows for its adaptation to individual cases, particularly when defining the onset of mental illness in relation to the timeframe of the crime and criminal justice process.

Over recent decades, the international instruments relevant to the rights of the mentally ill have demonstrated a progression from the very general to the more particular. In 1975, the UN General Assembly passed a resolution which proclaimed in broad terms that all disabled people—arguably including the mentally ill—are entitled to equal protection of the law, freedom from arbitrary treatment and respect

⁴³⁰ See Death Penalty Information Centre, ‘Mental Illness and the Death Penalty,’ available at <http://www.deathpenaltyinfo.org/article.php?did=782&scid=66>.

for their inherent dignity as human beings.⁴³¹ By 1991, it stated more specifically that:

Principle 1: fundamental freedoms and basic rights

[...]

2. All persons with a mental illness, or who are being treated as such persons, shall be treated with humanity and respect for the inherent dignity of the human person.

[...]

4. There shall be no discrimination on the grounds of mental illness. "Discrimination" means any distinction, exclusion or preference that has the effect of nullifying or impairing equal enjoyment of rights. Special measures solely to protect the rights, or secure the advancement, of persons with mental illness shall not be deemed to be discriminatory. Discrimination does not include any distinction, exclusion or preference undertaken in accordance with the provisions of the present Principles and necessary to protect the human rights of a person with a mental illness or of other individuals.

5. Every person with a mental illness shall have the right to exercise all civil, political, economic, social and cultural rights as recognized in the Universal Declaration of Human Rights, the International Covenant on Economic, Social and Cultural Rights, the International Covenant on Civil and Political Rights and in other relevant instruments, such as the Declaration on the Rights of Disabled Persons and the Body of Principles for the Protection of All Persons under Any Form of Detention or Imprisonment.

[...]

Principle 4: determination of mental illness

1. A determination that a person has a mental illness shall be made in accordance with internationally accepted medical standards.

[...]

Principle 8: standards of care

⁴³¹ UN General Assembly, *Resolution 3447 (XXX): Declaration on the Rights of Disabled Persons*, 1975, especially paras 3-4, available at <http://www.unhchr.ch/html/menu3/b/72.htm>. See also UN General Assembly, *Resolution 2856 (XXVI): Declaration on the Rights of Mentally Retarded Persons*, 1971, para. 7, available at http://www.unhchr.ch/html/menu3/b/m_mental.htm.

1. Every patient shall have the right to receive such health and social care as is appropriate to his or her health needs, and is entitled to such care and treatment in accordance with the same standards as other ill persons.

2. Every patient shall be protected from harm, including unjustified medication, abuse by other patients, staff or others or other acts causing mental distress or physical discomfort.

[...]

Principle 9: treatment

[...]

3. Mental health care shall always be provided in accordance with applicable standards of ethics for mental health practitioners, including internationally accepted standards such as the Principles of Medical Ethics relevant to the role of health personnel, particularly physicians, in the protection of prisoners and detainees against torture and other cruel, inhuman or degrading treatment or punishment, adopted by the United Nations General Assembly. Mental health knowledge and skills shall never be abused.

[...]

Principle 11: consent to treatment

1. No treatment shall be given to a patient without his or her informed consent, except as provided for in paragraphs 6, 7, 8, 13 and 15 of the present principle.

[...]

6. Except as provided in paragraphs 7, 8, 12, 13, 14 and 15 of the present principle, a proposed plan of treatment may be given to a patient without a patient's informed consent if the following conditions are satisfied:

- a.) The patient is, at the relevant time, held as an involuntary patient;
- b.) An independent authority, having in its possession all relevant information, including the information specified in paragraph 2 of the present principle, is satisfied that, at the relevant time, the patient lacks the capacity to give or withhold informed consent to the proposed plan of treatment or, if domestic legislation so provides, that, having regard to the patient's own safety or the safety of others, the patient unreasonably withholds such consent;
- c.) The independent authority is satisfied that the proposed plan of treatment is in the best interest of the patient's health needs.

[...]

Principle 20: criminal offenders

1. The present Principle applies to persons serving sentences of imprisonment for criminal offences, or who are otherwise detained in the course of criminal proceedings or investigations against them, and who are determined to have a mental illness or who it is believed may have such an illness.
2. All such persons should receive the best available mental health care as provided in principle 1 above. The present Principles shall apply to them to the fullest extent possible, with only such limited modifications and exceptions as are necessary in the circumstances. No such modifications and exceptions shall prejudice the persons' rights under the instruments noted in paragraph 5 of principle 1 above.
3. Domestic law may authorize a court or other competent authority, acting on the basis of competent and independent medical advice, to order that such persons be admitted to a mental health facility.
4. Treatment of persons determined to have a mental illness shall in all circumstances be consistent with principle 11 above.

[...] ⁴³²

These rights, although only contained in a 'soft law' instrument, are of obvious relevance to the mentally ill within the criminal justice context. They not only establish the principle that people with mental illnesses should receive care and treatment in the particular context of the obligations which medical staff owe to their patients, but also that criminal offenders retain this right despite their status. Moreover, it is clear that the international community envisages the ultimate development of these principles into binding customary international law.⁴³³ The IACHR described them as "*the most complete, detailed international standards for the protection of the rights of persons with mental illness and... an important guide for States in designing and/or reforming mental health systems.*"⁴³⁴

⁴³² UN General Assembly, *Resolution 46/119: Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care*, 1991, Annex, available at <http://www.un.org/documents/ga/res/46/a46r119.htm>

⁴³³ See, e.g., UN General Assembly, *Resolution 48/96: Standard Rules on the Equalization of Opportunities for Persons with Disabilities*, 1993, Annex.

⁴³⁴ Inter-American Commission on Human Rights, *Recommendation of the Inter-American Commission on Human Rights for the Promotion and Protection of the Rights of the Mentally Ill*, 2000, available at <http://www.cidh.org/annualrep/2000eng/chap.6e.htm>.

As an absolute minimum, the UN Commission on Human Rights joined the instruments noted above in concluding that the mentally ill must not be discriminated against or disadvantaged as a consequence of their health.⁴³⁵

Most recently, both the UN and the OAS have introduced specific conventions to crystallize the international human rights of the disabled.⁴³⁶ Although the United States is not yet a party to either treaty, their introduction is a significant step in arguing the existence of the rights of the mentally ill in customary law. Both treaties are clear that the term “disability” includes a “physical, mental, or sensory impairment” which limits the capacity to perform one or more activities of daily life.⁴³⁷ Both treaties also consolidate the general principles of quality, respect, and non-discrimination. These values have implications for all facets of State activity, including access to justice.⁴³⁸

The Council of Europe has also given some endorsement to the view that the affairs of the mentally ill should be managed for their own protection when they lack capacity to do so.⁴³⁹

Detention and punishment of the mentally ill

As early as 1984, ECOSOC passed a resolution excluding all people suffering with disturbed mental health from the ambit of the death penalty.

Persons below 18 years of age at the time of the commission of the offence shall not be sentenced to death, nor shall the death sentence be carried out on pregnant women, or on new mothers, or on persons who have become insane.⁴⁴⁰

⁴³⁵ UN Commission on Human Rights, *Resolution 2005/65: Human Rights of Persons with Disabilities*, 2005, available at <http://www.un.org/esa/socdev/enable/chr2005-65.htm>.

⁴³⁶ General Assembly of the OAS, *Inter-American Convention on the Elimination of All Forms of Discrimination Against Persons with Disabilities* (“Inter-American Disabilities Convention”), 7 June 1999, entered into force 14 September 2001, available at <http://www.cidh.org/basicos/disability.htm>; *Convention on the Rights of Persons with Disabilities* (“Disabilities Convention”), 13 December 2006, not yet in force, available at <http://www2.ohchr.org/english/law/disabilities-convention.htm>.

⁴³⁷ Inter-American Disabilities Convention, Article 1; Disabilities Convention, Article 1. See also UN General Assembly, *Resolution 48/96: Standard Rules on the Equalization of Opportunities for Persons with Disabilities*, 1993.

⁴³⁸ Disabilities Convention, Article 13.

⁴³⁹ Council of Europe, ‘White Paper’ on the protection of the human rights and dignity of people suffering from mental disorder, especially those placed as involuntary patients in a psychiatric establishment, 3 January 2000, pp. 1, 14, available at [http://www.coe.int/t/e/legal_affairs/legal_co-operation/bioethics/activities/psychiatry_and_human_rights/DIR-JUR\(2000\)2WhitePaper.pdf](http://www.coe.int/t/e/legal_affairs/legal_co-operation/bioethics/activities/psychiatry_and_human_rights/DIR-JUR(2000)2WhitePaper.pdf). See also Council of Europe, *Recommendation of the Committee of Ministers to member states concerning the protection of the human rights and dignity of persons with mental disorder*, Rec. (2004) 10, available at [http://www.coe.int/t/e/legal_affairs/legal_co-operation/bioethics/News/Rec\(2004\)10%20e.pdf](http://www.coe.int/t/e/legal_affairs/legal_co-operation/bioethics/News/Rec(2004)10%20e.pdf).

⁴⁴⁰ UN Economic and Social Council, *Resolution 1984/50: Safeguards guaranteeing protection of the rights of those facing the death penalty*, 1984, para. 3, available at http://www.unhchr.ch/html/menu3/b/h_comp41.htm.

In accordance with the rather loose approach the international community initially adopted in distinguishing different types of mental disability, early ECOSOC resolutions used terms such as “insanity” and “mental retardation” more or less interchangeably.⁴⁴¹ It was made clear, however, that mental disability should be taken into account in all stages of the criminal justice process: not just in the context of competence for trial or sentence, but also for the execution of the sentence itself.

The Commission on Human Rights built upon the ECOSOC resolutions, regularly calling on all States that still impose the death penalty

Not to impose the death penalty on a person suffering from any form of mental disorder or to execute any such person.⁴⁴²

In 2005, the Commission altered its terminology once again, finally drawing a distinction between mental and intellectual disabilities. It called upon States

Not to impose the death penalty on any person suffering from any mental or intellectual disabilities or to execute any such person.⁴⁴³

When the UN Special Rapporteur on extrajudicial, summary or arbitrary executions conducted a mission to the United States in 1998, their report concluded:

Imposition of the death penalty on mentally retarded or insane persons is also prohibited. Paragraph 6 of the Declaration of the Rights of Mentally Retarded Persons, provides that, if prosecuted for any offence, a mentally retarded person shall have the right to due process of law with full recognition of his degree of mental responsibility. Further, paragraph 3 of the Safeguards guaranteeing protection of the rights of those facing the death penalty stipulates that the death penalty shall not be carried out on persons who have become insane. In addition, in paragraph 1 (d) of resolution 1989/64 on

⁴⁴¹ See, e.g., UN Economic and Social Council, *Resolution 1989/64: Implementation of the safeguards guaranteeing protection of the rights of those facing the death penalty*, 1989, para. 1(d), available at http://www.unodc.org/pdf/crime/capital/ecosoc_liv.pdf.

⁴⁴² UN Commission on Human Rights, *Resolution 1999/61: Question of the Death Penalty*, 1999, para. 3(e), available at http://ap.ohchr.org/documents/E/CHR/resolutions/E-CN_4-RES-1999-61.doc; UN Commission on Human Rights, *Resolution 2000/65: Question of the Death Penalty*, 2000, para. 3(e), available at http://ap.ohchr.org/documents/E/CHR/resolutions/E-CN_4-RES-2000-65.doc; UN Commission on Human Rights, *Resolution 2001/68: The Question of the Death Penalty*, 2001, para. 4(e), available at http://ap.ohchr.org/documents/E/CHR/resolutions/E-CN_4-RES-2001-68.doc; UN Commission on Human Rights, *Resolution 2002/77: The Question of the Death Penalty*, 2002, para. 4(f), available at http://ap.ohchr.org/documents/E/CHR/resolutions/E-CN_4-RES-2002-77.doc; UN Commission on Human Rights, *Resolution 2003/67: The Question of the Death Penalty*, 2003, para. 4(g), available at http://ap.ohchr.org/documents/E/CHR/resolutions/E-CN_4-RES-2003-67.doc; UN Commission on Human Rights, *Resolution 2004/67: Question of the death penalty*, 2004, para. 4(c) available at <http://www.unodc.org/pdf/crime/capital/E-CN-4-RES-2004-67.pdf>.

⁴⁴³ UN Commission on Human Rights, *Resolution 2005/59: Question of the death penalty*, 2005, para. 7(c), available at http://ap.ohchr.org/documents/E/CHR/resolutions/E-CN_4-RES-2005-59.doc.

implementation of the safeguards guaranteeing protection of the rights of those facing the death penalty, the Economic and Social Council recommended that States strengthen further the protection of the rights of those facing the death penalty by eliminating the death penalty for persons suffering from mental retardation or extremely limited mental competence, whether at the stage of sentence or execution.⁴⁴⁴

Quite apart from the position under customary law which these materials may evidence, the Human Rights Committee has concluded that the issue of a warrant for the execution of a mentally incompetent person (described as “experiencing auditory hallucinations and... probably suffering from severe mental illness that may be significantly affecting his ability to think and behave normally”) was unlawful under the ICCPR.⁴⁴⁵ In particular, it considered it a violation of the prohibition of cruel, inhuman or degrading treatment (see below).

Similarly, the Human Rights Committee urged the United States to “ensure that persons suffering from severe forms of mental illness not amounting to mental retardation are [...] protected.”⁴⁴⁶

Taken collectively, we can see that through the guidelines detailed above, a growing international consensus against the execution of persons with mental illness exists. Certainly, recent years suggest relatively few states have acted inconsistently with this position (see further below). The vast majority of the world community, largely of its own volition, but also at the urging of various international bodies, including the UN, has enacted legislation or moratoriums to prohibit the practice. Importantly, this position has not just been adopted by states which prohibit the death penalty in general, but of those nations which do still allow for the use of capital punishment, an overwhelming majority proscribes its imposition upon those defendants with mental illness. Such a clear trend may well indicate that, rather than a political fad subject to change, the international community's stance flows from a near-universal conviction that the execution of persons with mental disabilities is an “inhuman, medieval form of punishment unworthy of modern societies.”⁴⁴⁷

Experts appointed by the United Nations have found that the United States' practice of executing those with mental illness contravenes international standards and norms. All such standards call for the humane treatment of persons with mental illness, and

⁴⁴⁴ UN Economic and Social Council, *Report of the Rapporteur on extrajudicial, summary or arbitrary executions, Addendum: Mission to the United States of America*, E/CN.4/1998/68/Add.3, 22 January 1998, para. 36, available at

<http://daccessdds.un.org/doc/UNDOC/GEN/G98/102/37/PDF/G9810237.pdf?OpenElement>.

⁴⁴⁵ Human Rights Committee, *Sahadath v. Trinidad and Tobago*, 2002, paras. 2.6, 7.2, available at http://www.bayefsky.com/html/trinidad_t5_iccpr_684_1996.php.

⁴⁴⁶ Human Rights Committee, *Concluding Observations: United States of America*, 2006, para. 7, available from <http://www.ohchr.org/EN/countries/ENACARegion/Pages/USIndex.aspx>.

⁴⁴⁷ Statement of Rt. Hon. Christopher Patten delivered to the European Parliament, October 25, 2000, cited in Human Rights Watch, *UNITED STATES: BEYOND REASON, THE DEATH PENALTY AND OFFENDERS WITH MENTAL RETARDATION* 18, n. 55 (March 2001).

within the criminal justice system, these standards call for adherence to the due process of law and protection from degrading treatment. Yet, as evidenced by the jurisprudence recently emerging from capital punishment cases in the United States, changes within the American system are developing.

As a member of the Commission on Human Rights in each of the years in which it took action, the US had consistently voted against resolutions on the death penalty. However, this does not negate the transformations that have been taking place in the United States' domestic case law. Beginning in 1986, *Ford v. Wainwright* (477 US 399) barred the execution of the insane. Justice Marshall, delivering the opinion of the Court, concluded that:

[...] such an execution has questionable retributive value, presents no example to others and thus has no deterrence value and [the execution of mentally ill persons] simply offends humanity – these acts have no less logical, moral, and practical force at present.⁴⁴⁸

This judgment is by no means unique. More recently, US Supreme Court decisions have extended the definition of insanity, potentially permitting review for more cases relevant to mental disability. As noted earlier, in *Panetti v. Quarterman*, the Supreme Court rejected the overly restrictive rule relied upon by the Fifth Circuit Court of Appeals, which had held that a simple knowledge of the crime, even without a rational understanding, was sufficient to allow an execution to go forward. The Court in *Panetti* disagreed with the Fifth Circuit and reversed its decision, holding that the person must meaningfully appreciate the connection between his crime and punishment.⁴⁴⁹

The *Panetti* case opens up more claims for the prevention of the application of the death penalty to persons who are mentally ill. As such, there is at least some cause for optimism about the United States' future approach. This should not be forgotten when making legal arguments.

Cruel, inhuman and degrading treatment: taking account of the specific characteristics of the individual

A strong argument for excluding the mentally ill from capital punishment is based on the notion of cruel, inhuman and degrading treatment. In the context of the United States, this approach is perhaps of particular merit as it builds on the existing traditions of the US Supreme Court in testing death penalty practice against the “evolving standards of decency” inherent in the 8th and 14th Amendments to the US

⁴⁴⁸ For the full case, please see

<http://caselaw.lp.findlaw.com/scripts/getcase.pl?court=us&vol=477&invol=399>.

⁴⁴⁹ A full list of resources pertinent to Panetti's case can be found at the Death Penalty Information Center's Mental Illness website, available at <http://www.deathpenaltyinfo.org/article.php?did=782&scid=66>.

Constitution. All significant US restrictions on the use of capital punishment—although sometimes informed by international law, standards or practice—have been grounded in the basic conclusion that inflicting a sentence of death upon the relevant person (juveniles, the mentally retarded, and so on) would amount to a cruel and unusual punishment.

The prohibition of torture or cruel, inhuman, or degrading treatment is fundamental to international human rights law.⁴⁵⁰ The European Court of Human Rights (ECtHR) has developed a long line of case-law which establishes that determining the existence of cruel, inhuman or degrading treatment is not simply a matter of ascertaining whether the relevant conduct reached a general threshold standard but must also take into account the particular circumstances of the alleged victim. As early as 1978, it held that:

[I]ll-treatment must attain a minimum level of severity if it is to fall within the scope of Article 3... The assessment of this minimum is, in the nature of things, relative; it depends on all the circumstances of the case, such as the duration of the treatment, its physical or mental effects and, in some cases, the sex, age and state of health of the victim, etc...⁴⁵¹

In the case of *Victor Rosario Congo*, the IACHR agreed with the position adopted by the ECtHR,⁴⁵² and made express reference to the importance of the victim's state of health. The International Criminal Tribunal for the Former Yugoslavia (ICTY), an *ad hoc* tribunal set up by the UN Security Council, has also recalled the ECtHR's approach with approval.⁴⁵³

By 1989, the ECtHR had expressly applied this principle to the use of capital punishment:

⁴⁵⁰ See, e.g., ICCPR, Article 7; ECHR, Article 3; ACHR, Article 5; UN General Assembly, *Resolution 39/118: Human Rights in the Administration of Justice*, 1984, para. 1, available at <http://www.un.org/documents/ga/res/39/a39r118.htm>; UN General Assembly, *Resolution 43/173: Body of Principles for the Protection of All Persons under Any Form of Detention or Imprisonment*, 1988, Principle 6, available at http://www.unhchr.ch/html/menu3/b/h_comp36.htm.

⁴⁵¹ European Court of Human Rights, *Ireland v. the United Kingdom*, 1978, para. 162; also Separate Opinion of Judge Zekia. Further, European Court of Human Rights, *Tyrer v. the United Kingdom*, 1978, Separate Opinion of Judge Fitzmaurice, para. 3; European Court of Human Rights, *Costello-Roberts v. the United Kingdom*, 1993, para. 30.

⁴⁵² Inter-American Commission on Human Rights, Report N° 63/99, Case N° 11.427 (*Victor Rosario Congo*), Ecuador, 1999, para. 82, available at <http://www.cidh.org/annualrep/98eng/Merits/Ecuador%2011427.htm>; see also Inter-American Commission on Human Rights, *Recommendation of the Inter-American Commission on Human Rights for the Promotion and Protection of the Rights of the Mentally Ill*, 2000, available at <http://www.cidh.org/annualrep/2000eng/chap.6e.htm>.

⁴⁵³ ICTY, *Prosecutor v. Zejnil Delalić*, Judgment, 1998, para. 536; ICTY, *Prosecutor v. Miroslav Kvočka*, Judgment, 2001, para. 143; ICTY, *Prosecutor v. Milorad Krnojelac*, Judgment, 2002, paras. 130-131, 182; ICTY, *Prosecutor v. Radislav Brđanin*, Judgment, 2004, paras. 483-484.

That does not mean however that circumstances relating to a death sentence can never give rise to an issue under Article 3... The manner in which it is imposed or executed, the personal circumstances of the condemned person and a disproportionality to the gravity of the crime committed, as well as the conditions of detention awaiting execution, are examples of factors capable of bringing the treatment or punishment... within the proscription under Article 3...⁴⁵⁴

Moreover, it acknowledged the effect of mental illness as a relevant circumstance (although it remained ambiguous as to whether it referred to mental illness at the time the crime was committed or at the time of execution):

[A]s a general principle the youth of the person concerned is a circumstance which is liable, with others, to put in question the compatibility with Article 3... of measures connected with a death sentence.

It is in line with the Court's case-law... to treat disturbed mental health as having the same effect for the application of Article 3...⁴⁵⁵

In a slightly different context, the ECtHR has offered a basic test for the reconciliation of the demands of punishment with the prohibition of cruel, inhuman and degrading treatment. In a phrase reminiscent of the United States' prohibition of "unusual" punishment, it stated:

[U]nder [Article 3] the State must ensure that a person is detained in conditions which are compatible with respect for his human dignity, that the manner and method of the execution of the measure do not subject him to distress of hardship of an intensity exceeding the unavoidable level of suffering inherent in [it]...⁴⁵⁶

Although the applicant was not successful on the facts of the case, the Court nonetheless accepted that "the very nature of [his] psychological condition made him more vulnerable than the average detainee".

Finally, there is some suggestion that States are not only obliged to refrain from cruel, inhuman or degrading treatment but are under a positive obligation to protect the mentally ill from what might be a heightened risk. The Disabilities Convention, for example, provides

States Parties shall take all effective legislative, administrative, judicial or other measures to prevent persons with disabilities, on an equal basis with

⁴⁵⁴ European Court of Human Rights, *Soering v. the United Kingdom*, 1989, para. 104.

⁴⁵⁵ European Court of Human Rights, *Soering v. the United Kingdom*, 1989, paras 108-109.

⁴⁵⁶ European Court of Human Rights, *Kudla v. Poland*, 2000, para. 94, emphasis added.

others, from being subjected to torture or cruel, inhuman or degrading treatment or punishment.⁴⁵⁷

At the very least, the IACHR and ECtHR have emphasized that a heightened level of scrutiny may be appropriate in assessing whether the rights of members of vulnerable groups—like the mentally ill—have been violated.⁴⁵⁸

Limitations to the international legal protection of the mentally ill

It should be immediately apparent that the international law directly pertaining to the protection of the mentally ill is at a very early stage. Although the international community is clearly concerned to protect the rights of all people with any kind of disability, this concern has—until fairly recently—been phrased as broad principle, and largely in soft law instruments with no independent legal force. The restrictions on the use of capital punishment are better entrenched but the application of this law to the mentally ill is not a simple matter, although the notion is in essence well-founded.

A number of countries continue to ignore international standards protecting those with mental illness from the death penalty. These countries include the United States, Morocco, Japan, Mexico, Thailand, El Salvador, Trinidad and Tobago, Belarus, Tajikistan, Kazakhstan, and Kyrgyzstan. While Mexico and Thailand provide provisions for the prohibition of the execution of the mentally ill if a person demonstrates insanity *after* the sentence has been handed down, El Salvador, Japan, Morocco, and Trinidad and Tobago still retain statutes that allow for executing mentally ill persons if they *recover* from their previous insanity. According to a leading Japanese lawyer, at least one person has been executed despite suffering from schizophrenia. In Belarus and Tajikistan, if it is established that the defendant has a mental disorder resulting in an inability to be aware of or control his actions, the court may suspend the execution. Under Kazakhstan and Kyrgyzstan laws, however, there are no provisions in any domestic legislation explicitly prohibiting the execution of persons who suffer from any form of mental disorders.⁴⁵⁹

⁴⁵⁷ Disabilities Convention, Article 15(2).

⁴⁵⁸ Inter-American Commission on Human Rights, Report N° 63/99, Case N° 11.427 (Victor Rosario Congo), Ecuador, 1999, paras. 53-54, available at <http://www.cidh.org/annualrep/98eng/Merits/Ecuador%2011427.htm>; European Court of Human Rights, *Herczegfalvy v. Austria*, 1992, para. 82.

⁴⁵⁹ UN Economic and Social Council, *Capital punishment and implementation of the safeguards guaranteeing protection of the rights of those facing the death penalty—Report of the Secretary-General*, E/2005/3, 9 March 2005: paragraph 86.

Information received from non-governmental sources determines that at least 29 persons with severe mental disabilities have been executed in the United States since the death penalty was reinstated in 1976.⁴⁶⁰

RECOURSE TO INTERNATIONAL AND REGIONAL INSTITUTIONS

International law does not only provide a rich source of substantive content—it may also open additional avenues for litigation in international or regional institutions. These fall into two categories: those which will accept cases brought by individuals, and those which will only accept cases brought by states against other states. Within these categories are contained the following types of procedure:

- *Individual communications to human rights treaty bodies.* Some of the international human rights treaties (ICCPR, CEDAW, CAT and CERD) permit parties to 'opt in' (either by making a declaration (CAT and CERD) or by ratifying an optional protocol (ICCPR and CEDAW)) to a system which allows the treaty body to consider the extent to which the state has met its obligations under the relevant treaty in a particular case. The procedure is not strictly judicial, but more akin to filing papers before an international body of experts. Although the treaty bodies have no power to make orders binding on the state party in its national law, decisions are influential as a matter of international law. The political significance of a favourable finding by a treaty body can be helpful.
- *'Appeals' to regional human rights courts or commissions.* Strictly speaking, these aren't appeals at all, although the courts/commissions will only admit cases in which domestic remedies have been exhausted. The approach adopted by these institutions is thus appellate in style. A number of regional organisations, such as the Council of Europe and the Organization of American States, maintain human rights courts and commissions (European Court of Human Rights, Inter-American Court of Human Rights, etc). They *may*, in some cases, make binding orders, and their decisions are highly authoritative. Obviously, regional courts only have competence to consider cases from consenting member states of the relevant regional organisation. However, the jurisprudence of other regional courts is often considered to be persuasive authority, and so a case brought before the American Court may nonetheless benefit in principle from the approach of the European Court.
- *'1503' procedures.* Individual complaints may also be brought directly before the competent UN organ (now the Human Rights Council) in some, limited cases.⁴⁶¹ The process is known as the '1503' procedure after the Economic and Social Council resolution which originally created it. This avenue is only mentioned here,

⁴⁶⁰ UN Economic and Social Council, *Report of the Rapporteur on extrajudicial, summary or arbitrary executions, Addendum: Mission to the United States of America*, E/CN.4/1998/68/Add.3, 22 January 1998: paragraph 57.

⁴⁶¹ See further <http://www.ohchr.org/english/bodies/chr/complaints.htm>.

however, for the sake of completeness: **it is only open where a “gross and systematic” violation of human rights may be shown (i.e., affecting far more than an individual case)**. Although these complaints are legal in nature, and at least quasi-legal in process, they are of considerable political significance.

- *Inter-state legal action*. States may have recourse to legal action against one another, either to protect their interests in more abstract terms or to protect affected individuals (i.e., nationals whose individual rights have been violated by another state). The classic forum for such cases is the ICJ, but they may also be heard by a number of other international or regional courts. In some cases, as outlined below, individuals may benefit from actions of this type but there is **no means in international law to force states to resort to the courts**. It is also generally the rule that *both* states, claimant and respondent, must express their consent to the jurisdiction of the court. As such, inter-state cases are relatively rare.

As with all international law, it must also be recalled that the state only bears obligations under one or more of these procedures if it has expressed its consent in some way. **The United States has not consented to any individual communication procedure of the treaties to which it is a party (ICCPR, CAT, CERD): none of these options is open with regard to cases heard in the United States**. Although a member of the OAS, as detailed below, it permits only limited review of its cases in that forum. Inter-state actions are available in principle.

In general, therefore, it must be acknowledged that opportunities for recourse to international institutions from US cases are limited. The two avenues most likely to be of relevance to domestic practitioners are explored in the following pages.

Individual complaints: the Organization of American States

The United States is one of the 35 members of the Organization of American States (OAS),²¹³ a regional agency created within the meaning of Article 52 of the United Nations Charter. The OAS is an international organization created to achieve an order of peace and justice, promote solidarity and defend the sovereignty, territorial integrity and independence of the American States that established the OAS through the Charter (Article 1 of the OAS Charter). The Charter of the OAS, which entered into force in 1951, reaffirms that international law is the standard of conduct of States in their reciprocal relations.

The 35 American States have adopted numerous international instruments that have become the foundation for the regional structure for the promotion and protection of human rights. The Inter-American human rights system recognizes and defines those rights and establishes binding rules of conduct, while creating organs to monitor their observance. A number of Latin American nations have abolished the death penalty and

²¹³ See <http://www.oas.org>.

the long-term worldwide trend is towards total abolition. The membership of the OAS includes States who have abolished the death penalty as well as avid supporters of it, including Jamaica and the United States of America.

Inter-American Commission on Human Rights (IACHR)

Established in 1959, the IACHR is the principal organ of the OAS charged with promoting the observance and protection of human rights. It also acts as a consultative organ of the OAS in human rights matters.⁴⁶² The Commission is a seven member body based in Washington DC. Each member is elected by the OAS General Assembly. Upon ratifying the Charter of the OAS in 1951, the United States became a Member State of the Organization and subsequently became subject to the Commission's authority upon the creation of the IACHR's creation in 1959.

The Commission's powers and functions, including its authority to receive and consider individual human rights complaints, are derived from the *OAS Charter*, the *American Declaration of the Rights and Duties of Man* ("the American Declaration"),⁴⁶³ the *American Convention on Human Rights* ("the American Convention"), the Commission's *Statute*,⁴⁶⁴ and the Commission's *Rules of Procedure*.⁴⁶⁵

One of the Commission's primary functions is to receive and take action on petitions and other communications alleging violations of human rights. These can be lodged by any person or group of persons or any non-governmental entity legally recognized in one or more of the Member States of the Organization. It exercises this jurisdiction in two principal respects. With respect to State Parties to the American Convention, the Commission is mandated to act on petitions containing denunciations or complaints of violations of the Convention by a State Party.⁴⁶⁶ In relation to those Member States of the OAS that are not parties to the American Convention, the Commission has jurisdiction to receive and examine communications that contain complaints of alleged violations of human rights set forth in the American Declaration based upon the ratification by those States of the *OAS Charter*.⁴⁶⁷ Although the United States has not ratified the American Convention, consistent with this jurisdictional framework, it is nonetheless subject to the Commission's competence to receive complaints of violations of the American Declaration.

It should be noted, however, that it is unusual for a US court to implement a decision of the Commission directly.⁴⁶⁸

Precautionary Measures

⁴⁶² Charter of the OAS, Article 106. See <http://www.oas.org/juridico/English/charter>.

⁴⁶³ See <http://www.cidh.oas.org/Basicos/basic2.htm>.

⁴⁶⁴ See <http://www.cidh.oas.org/Basicos/basic15.htm>.

⁴⁶⁵ See <http://www.cidh.oas.org/Basicos/basic16.htm>.

⁴⁶⁶ See IACHR Statute, Art. 19.

⁴⁶⁷ See IACHR Statute, Art. 20.

⁴⁶⁸ See, e.g., *Garza v. Lappin*, 253 F.3d 918 (7th Cir. 2001).

As provided under Article 25 of the Commission's *Rules of Procedure*, in "serious and urgent cases", and whenever necessary according to the information available, the Commission may, on its own initiative, or at the request of a party, require that the State concerned adopt *precautionary measures* "to prevent irreparable harm to persons."

These measures are designed to preserve the substance of the matter before the Commission. Upon their issue in a death penalty case, for example, the Commission may request that the State concerned preserve the life of the petitioner in question, pending their investigation of the allegations forwarded in the relevant petition.

The Commission has found that in death penalty complaints, Member States are subject to an international legal obligation not to proceed with an execution until the Commission has had an opportunity to investigate and decide upon the complaint.⁴⁶⁹

Making a claim to the IACHR

To assist in petitioning the IACHR, we have provided a brief walk-through of the formal requirements of the process, including verbatim reference to the relevant provisions.

1. The exhaustion of domestic remedies

The American Convention and the Commission's *Rules of Procedure* provide that, in order for a petition to be considered by the Commission, domestic legal remedies must have been pursued and exhausted. **Petitioners may not lodge a petition until this has been done, and the petition must make an express note to this effect. The petition should also note the process by which the claimant exhausted all available domestic remedies.**

1. In order to decide on the admissibility of a matter, the Commission shall verify whether the remedies of the domestic legal system have been pursued and exhausted in accordance with the generally recognized principles of international law.

⁴⁶⁹ *Juan Raul Garza v. United States*, Case No. 12.243, Report No. 52/01, Annual Report of the IACHR 2000, ¶ 117, *see* <http://www.cidh.oas.org/annualrep/2000eng/ChapterIII/Merits/USA12.243.htm>. Other international tribunals have similarly recognized interim stays of execution as fundamental prerequisites to the efficacy of proceedings pertaining to the imposition of capital punishment. *See e.g. I/A Court H.R., James et al. Case, Order for Provisional Measures of 29 August 1998*; Annual Report 1998, p. 317; *Case Concerning the Vienna Convention on Consular Relations "The LaGrand Case" (Germany v. United States of America)*, Request for the Indication of Provisional Measures, Order of 3 March 1999, I.C.J. General List, N° 104, paras 22-28, available at <http://www.icj-cij.org/docket/index.php?p1=3&p2=3&k=04&case=104&code=gus&p3=4>; European Court of Human Rights, *Ocalan v. Turkey*, Indication of Interim Measures Pursuant to Rule 39 of the Rules of the European Court of Human Rights, 30 November 1999; Human Rights Committee, *Dante Piandiong and others v. The Philippines*, Communication N° 869/1999, U.N. Doc. CCPR/C/70/D/869.1999 (19 October 1999), paras 5.1-5.4.

2. The provisions of the preceding paragraph shall not apply when:
 - a. the domestic legislation of the State concerned does not afford due process of law for protection of the right or rights that have allegedly been violated;
 - b. the party alleging violation of his or her rights has been denied access to the remedies under domestic law or has been prevented from exhausting them; or,
 - c. there has been unwarranted delay in rendering a final judgment under the aforementioned remedies.
3. When the petitioner contends that he or she is unable to prove compliance with the requirement indicated in this article, it shall be up to the State concerned to demonstrate to the Commission that the remedies under domestic law have not been previously exhausted, unless that is clearly evident from the record.

Rules of Procedure, Article 31—Exhaustion of Domestic Remedies

2. When must the petition be filed?

As outlined in Article 32 of the *Rules of Procedure*, the petition must be filed within six months of exhausting available domestic remedies.⁴⁷⁰

3. Who can present a petition?

Article 23 of the Commission's *Rules of Procedure* provides that:

[a]ny person or group of persons or nongovernmental entity legally recognized in one or more of the Member States of the OAS may submit petitions to the Commission, on their own behalf or on behalf of third persons.

Therefore, a petitioner does not have to be a member of any specific bar and does not even have to be an attorney.

4. What violations can be claimed?

⁴⁷⁰ *Article 32 of the Rules of Procedure*

1. The Commission shall consider those petitions that are lodged within a period of six-months following the date on which the alleged victim has been notified of the decision that exhausted the domestic remedies.
2. In those cases in which the exceptions to the requirement of prior exhaustion of domestic remedies are applicable, the petition shall be presented within a reasonable period of time, as determined by the Commission. For this purpose, the Commission shall consider the date on which the alleged violation of rights occurred and the circumstances of each case.

1. The Inter-American Commission on Human Rights is an organ of the Organization of the American States, created to promote the observance and defense of human rights and to serve as consultative organ of the Organization in this matter.
2. For the purposes of the present Statute, human rights are understood to be:
 - a. The rights set forth in the American Convention on Human Rights, in relation to the States Parties thereto;
 - b. The rights set forth in the American Declaration of the Rights and Duties of Man, in relation to the other member states.

Statute of the Inter-American Commission on Human Rights, Article 1

The Commission's competence is limited to interpreting and applying the human rights instruments of the Inter-American system. In deciding upon complaints of violations of relevant Inter-American instruments, however, the Commission has held that it may give due regard to other relevant rules of international law applicable to Member States against which complaints of violations of Inter-American instruments are properly lodged—these rules of international law may include the provisions of other prevailing international and regional human rights instruments.⁴⁷¹ In the event that the Commission finds a Member State responsible for violations of its human rights obligations, the Commission is empowered to make proposals and recommendations with respect to those violations that it deems appropriate.⁴⁷²

5. Filing for precautionary measures

The petition must contain, at least, a brief description of the relevant facts and issues. **It is imperative to note in a petition that the defendant's life is in imminent danger when filing for precautionary measures.**

Once filed, the Commission will then decide whether to issue the precautionary measure or not. The general requirements for information to be included in petitions to the Commission are specified in Article 28 of the Commission's Rules of Procedure (laid out in detail below).⁴⁷³

If precautionary measures are granted, it is essential to notify the Board/Governor of the granting of precautionary measures by the IACHR.

⁴⁷¹ See e.g. *Juan Raul Garza v. United States*, Case No. 12.243, Report No. 52/01, Annual Report of the IACHR 2000, paras 88-89.

⁴⁷² See IACHR Statute, Art. 4. ADD art 43.

⁴⁷³ A sample form that details the type of information required can be found at <http://www.cidh.org/denuncia.eng.htm>. Further information on how to present a petition can be found in an OAS/IACHR resource, HUMAN RIGHTS: HOW TO PRESENT A PETITION IN THE INTER-AMERICAN SYSTEM (Organization of American States, Inter-American Commission on Human Rights).

6. Why file with the Commission and not the Inter-American Court on Human Rights?

In accordance with Article 62 of the American Convention, the contentious jurisdiction of the Inter-American Court of Human Rights is limited to those States that have explicitly recognized the Court's competence to entertain cases concerning the interpretation and application of the provisions of the American Convention in respect of that State. The United States has not recognized the Inter-American Court's jurisdiction under Article 62 and therefore cannot be the subject of a contentious case before the Court.

7. Filing a Petition

For ease of application, a standard form to present a petition can be found at <http://www.cidh.org/denuncia.eng.htm>, or in PDF format at <http://www.cidh.oas.org/petitionform.pdf>

8. All petitions must comply with the requirements set out in Article 28 of the Commission's Rules of Procedure

Petitions addressed to the Commission shall contain the following information:

- a. the name, nationality and signature of the person or persons making the denunciation; or in cases where the petitioner is a nongovernmental entity, the name and signature of its legal representative(s);
- b. whether the petitioner wishes that his or her identity be withheld from the State;
- c. the address for receiving correspondence from the Commission and, if available, a telephone number, facsimile number, and email address;
- d. an account of the act or situation that is denounced, specifying the place and date of the alleged violations;
- e. if possible, the name of the victim and of any public authority who has taken cognizance of the fact or situation alleged;
- f. the State the petitioner considers responsible, by act or omission, for the violation of any of the human rights recognized in the American Convention on Human Rights and other applicable instruments, even if no specific reference is made to the article(s) alleged to have been violated;
- g. compliance with the time period provided for in Article 32 of these Rules of Procedure;

- h. any steps taken to exhaust domestic remedies, or the impossibility of doing so as provided in Article 31 of these Rules of Procedure; and
- i. an indication of whether the complaint has been submitted to another international settlement proceeding as provided in Article 33 of these Rules of Procedure.

Rules of Procedure, Article 28—Requirements for the consideration of petitions
The request can be sent by any means of communication.

Address: *Inter-American Commission on Human Rights*
1889 F Street, N. W.
Washington, D.C. 20006, USA
Fax: (202) 458-3992
E-mail: cidhoea@oas.org
Internet: <http://www.cidh.oas.org/denuncia.eng.htm>

Inter-state cases: the International Court of Justice

Inter-state actions are only feasible where the individual at the centre of the particular case(s) is a foreign national.

In such circumstances, however, States *may* be persuaded to intervene on that national's behalf, and the matter *may* eventually find its way into court. Although examples of this are rare, they are not unknown, especially where the individual complaint touches closely on the rights of the state itself. The most famous examples are the cases before the ICJ of *Avena and Other Mexican Nationals (Mexico v. United States of America)*⁴⁷⁴ and *LaGrand (Germany v. United States of America)*.⁴⁷⁵ Both revolved around the violation of the individuals' right to effective consular access on arrest under Article 36 of the *Vienna Convention on Consular Relations*.⁴⁷⁶

Inter-state actions can be extremely slow, and so are very much a mechanism of last resort.

The key aspect of inter-state actions is the obvious one: **they are brought by the state** and not by the affected individual. As such, taking this step, even if it is open, is a matter of prompting or persuading the state concerned to take action, not taking action on its behalf. It is essentially a political matter. If a practitioner thinks that such an inter-state action may be possible, it should be discussed with their consular contact.

⁴⁷⁴ *Avena and Other Mexican Nationals (Mexico v. United States of America)*, Merits, 31 March 2004, [2004] ICJ Reps. 12, available at

<http://www.icj-cij.org/docket/index.php?p1=3&p2=3&k=11&case=128&code=mus&p3=4>.

⁴⁷⁵ *LaGrand (Germany v. United States of America)*, *supra*, n.469.

⁴⁷⁶ Note: VCCR violations are unlikely to ground further action against the United States at the ICJ; in the wake of *Avena*, the USA has withdrawn from the VCCR Optional Protocol, which made the ICJ's jurisdiction to resolve VCCR disputes compulsory between contracting parties.

The task falling to the domestic practitioner is thus simple: **whenever a client is a foreign national, remind them of their right to contact their consulate.** When consular staff are involved, the practitioner should endeavour to foster a good working relationship with them, in order to monitor the particular issues which may arise from the foreign involvement.

CLEMENCY AND INTERNATIONAL INTERVENTION

International arguments can and should also be presented at the clemency stage. Certain international institutions and Governments may provide support in the form of letters or, in the case of the European Union, *demarches* requesting clemency. Such letters and *demarches* increase pressure on the decision maker(s), as well as enhancing the legitimacy of such claims. In effect, they can be utilized as a tool of persuasion.

International Institutions Overview

Each of the following institutions has previously provided letters or demarches requesting clemency. Individual nations may also consider intervention in certain cases.

European Union

The European Union is a unique regional international institution. It is composed of 27 Member States.⁴⁷⁷ Although the EU is not a unified State, it has created certain institutional bodies that will speak on behalf of the member nations on areas of economic and human rights interests. These interests were agreed upon by all members upon signing the EU formation treaties. The principal objectives of the EU are: to establish European citizenship, to ensure freedom, security and justice, to promote economic and social progress, and to assert Europe's role in the world.

The European Union prohibits its members from the use of the death penalty as a punishment; in fact, it is now a precursor to entry to the European Union.⁴⁷⁸ While this covers the imposition of the death penalty for defendants with mental retardation the extradition of defendants to countries that apply the death penalty poses an additional question. While there is no specific ruling on this point, this may be covered by Article 3 of the European Convention on Human Rights, which prohibits inhuman or

⁴⁷⁷ Austria, Belgium, Bulgaria, Cyprus, Czech Republic, Denmark, Estonia, Finland, France, Germany, Greece, Hungary, Ireland, Italy, Latvia, Lithuania, Luxembourg, Malta, the Netherlands, Poland, Portugal, Romania, Slovakia, Slovenia, Spain, Sweden, and the United Kingdom.

⁴⁷⁸ *Treaty of Amsterdam Amending the Treaty on European Union, the Treaties Establishing the European Communities and Certain Related Acts, Declaration on the abolition of the death penalty* (2 October 1997), available at <http://ue.eu.int>. See generally http://ec.europa.eu/comm/external_relations/human_rights/adp/index.htm.

degrading punishment. The EU is opposed to the death penalty in all cases and accordingly aims at its universal abolition. The EU believes the abolition of the death penalty to contribute to the enhancement of human dignity and the progressive development of human rights. The EU pursues this policy consistently in different international fora such as the United Nations and the Council of Europe, as well as through bilateral contacts with many countries that retain the death penalty.⁴⁷⁹

There are also other European based organizations that have views on the death penalty in general and include the Organization for Security and Co-operation in Europe (the "OSCE"). In particular, at a conference organized by the OSCE it was noted with concern that "executions of mentally retarded persons continue in the OSCE region".

The EU has taken a strong stance against the use of the death penalty in non-member nations and provides demarches requesting clemency in certain categories of capital cases including those involving persons with mental retardation, the mentally ill, juveniles and foreign nationals.⁴⁸⁰

Council of Europe

The Council of Europe, headquartered in Strasbourg, France, is Europe's oldest political organization. Established in 1949 by the Treaty of London, it groups together 46 countries.⁴⁸¹ In addition it has applications from 2 more countries, and has granted observer status to five international entities (the Holy See, the United States, Canada, Japan, and Mexico). The Council of Europe was created in order to defend human rights, parliamentary democracy, and the rule of law. It seeks to develop continent-wide agreements (to date, it has developed 200 legally binding European treaties or conventions) to standardize member countries' social and legal practices, and also seeks to promote awareness of a European identity based on shared values.

The Council of Europe has taken the firm position that everyone's right to life is a basic value and that the abolition of the death penalty is essential to the protection of this right and for the full recognition of the inherent dignity of all human beings. Correspondingly, the Council of Europe provides letters requesting clemency in certain categories of capital cases.⁴⁸²

⁴⁷⁹ See European Union, 'Guidelines to EU Policy Towards Third Countries on the Death Penalty (3 June 1998),' available at <http://www.eurunion.org/legislat/deathPenalty/Guidelines.htm>.

⁴⁸⁰ For examples of demarches and policy statements, see *EU Policy and the Death Penalty* at <http://www.eurunion.org/legislat/DeathPenalty/deathpenhome.htm>.

⁴⁸¹ Albania, Andorra, Armenia, Austria, Azerbaijan, Belgium, Bosnia & Herzegovina, Bulgaria, Croatia, Cyprus, Czech Republic, Denmark, Estonia, Finland, France, Georgia, Germany, Greece, Hungary, Iceland, Ireland, Italy, Latvia, Liechtenstein, Lithuania, Luxembourg, Malta, Moldova, Monaco, Netherlands, Norway, Poland, Portugal, Romania, Russian Federation, San Marino, Serbia and Montenegro, Slovakia, Slovenia, Spain, Sweden, Switzerland, The Former Yugoslav Republic of Macedonia, Turkey, Ukraine, and the United Kingdom. Additionally, an application for membership from Bélarus is currently pending.

⁴⁸² For further information on the Council of Europe, see http://www.coe.int/T/e/Com/about_coe/.

CRITERIA FOR INTERVENTION

If you believe you have a client who is mentally ill and at serious risk of execution, please contact the International Justice Project (“IJP”). The IJP advises Governments and international institutions and provides assistance in obtaining intervention letters and *demarches*. Owing to the complexity of intervention by these institutions and individual nations, documentary evidence such as affidavits and school and medical records are of particular probative value.

Please note that strict criteria are followed in all cases and consideration of intervention is not guaranteed.

APPENDIX:

**RECOMMENDATION AND REPORT ON THE DEATH PENALTY AND
PERSONS WITH MENTAL DISABILITIES**

This Recommendation, which was adopted by the American Bar Association's House of Delegates August 7-8, 2006, had been previously adopted by the American Psychiatric Association, the American Psychological Association, and the National Alliance on Mental Illness. The Task Force on Mental Disability and the Death Penalty prepared the recommendation and report. The Task Force was established by the ABA's Section of Individual Rights and Responsibilities. Ronald J. Tabak is Chair of the Task Force. Both the recommendation and report appeared at 30 MENTAL & PHYSICAL DISABILITY L. REP. 668 (Sept.-Oct. 2006) and are reprinted with the permission of the ABA.

RECOMMENDATION

RESOLVED, That the American Bar Association, without taking a position supporting or opposing the death penalty, urges each jurisdiction that imposes capital punishment to implement the following policies and procedures:

1. Defendants should not be executed or sentenced to death if, at the time of the offense, they had significant limitations in both their intellectual functioning and adaptive behavior, as expressed in conceptual, social, and practical adaptive skills, resulting from mental retardation, dementia, or a traumatic brain injury.
2. Defendants should not be executed or sentenced to death if, at the time of the offense, they had a severe mental disorder or disability that significantly impaired their capacity
 - (a) to appreciate the nature, consequences or wrongfulness of their conduct,
 - (b) to exercise rational judgment in relation to conduct, or (c) to conform their conduct to the requirements of the law. A disorder manifested primarily by repeated criminal conduct or attributable solely to the acute effects of voluntary use of alcohol or other drugs does not, standing alone, constitute a mental disorder or disability for purposes of this provision.
3. Mental Disorder or Disability after Sentencing
 - (a) *Grounds for Precluding Execution.* A sentence of death should not be carried out if the prisoner has a mental disorder or disability that significantly impairs his or her capacity

- (i) to make a rational decision to forgo or terminate post-conviction proceedings available to challenge the validity of the conviction or sentence;
 - (ii) to understand or communicate pertinent information, or otherwise assist counsel, in relation to specific claims bearing on the validity of the conviction or sentence that cannot be fairly resolved without the prisoner's participation; or
 - (iii) to understand the nature and purpose of the punishment, or to appreciate the reason for its imposition in the prisoner's own case. Procedures to be followed in each of these categories of cases are specified in (b) through (d) below.
- (b) *Procedure in Cases Involving Prisoners Seeking to Forgo or Terminate Post-Conviction Proceedings.* If a court finds that a prisoner under sentence of death who wishes to forgo or terminate post-conviction proceedings has a mental disorder or disability that significantly impairs his or her capacity to make a rational decision, the court should permit a next friend acting on the prisoner's behalf to initiate or pursue available remedies to set aside the conviction or death sentence.
- (c) *Procedure in Cases Involving Prisoners Unable to Assist Counsel in Post-Conviction Proceedings.* If a court finds at any time that a prisoner under sentence of death has a mental disorder or disability that significantly impairs his or her capacity to understand or communicate pertinent information, or otherwise to assist counsel, in connection with post-conviction proceedings, and that the prisoner's participation is necessary for a fair resolution of specific claims bearing on the validity of the conviction or death sentence, the court should suspend the proceedings. If the court finds that there is no significant likelihood of restoring the prisoner's capacity to participate in post-conviction proceedings in the foreseeable future, it should reduce the prisoner's sentence to the sentence imposed in capital cases when execution is not an option.
- (d) *Procedure in Cases Involving Prisoners Unable to Understand the Punishment or its Purpose.* If, after challenges to the validity of the conviction and death sentence have been exhausted and execution has been scheduled, a court finds that a prisoner has a mental disorder or disability that significantly impairs his or her capacity to understand the nature and purpose of the punishment, or to appreciate the reason for its imposition in the prisoner's own case, the sentence of death should be reduced to the sentence imposed in capital cases when execution is not an option.

REPORT

Preamble

In *Atkins v. Virginia*, 536 U.S. 304 (2002), the United States Supreme Court held that execution of people with mental retardation violates the Eighth Amendment's ban on cruel and unusual punishment. The Individual Rights and Responsibilities Section of the American Bar Association recognized that *Atkins* offered a timely opportunity to consider the extent, if any, to which other types of impaired mental conditions ought to lead to exemption from the death penalty. To achieve that objective, the Section established a Task Force on Mental Disability and the Death Penalty. The Task Force, which carried out its deliberations from April, 2003 to March, 2005, was composed of 24 lawyers and mental health professionals (both practitioners and academics), and included members of the American Psychiatric Association and the American Psychological Association⁴⁸³. The American Psychiatric Association⁴⁸⁴ and the American Psychological Association⁴⁸⁵ have officially endorsed the Task Force's proposal.⁴⁸⁶ The following commentary discusses the three paragraphs of the proposal.

Paragraph 1

Paragraph 1 of the Recommendation is meant to exempt from the death penalty persons charged with capital offenses who have significant limitations in both intellectual functioning and adaptive skills. Its primary purpose is to implement the United States Supreme Court's holding in *Atkins v. Virginia*,⁴⁸⁷ which declared that execution of offenders with mental retardation violates the cruel and unusual punishment prohibition in the Eighth Amendment. The Court based this decision both on a determination that a "national consensus" had been reached that people with mental retardation should not be executed,⁴⁸⁸ and on its own conclusion that people with retardation who kill are not as

⁴⁸³ The Task Force's members are Dr. Michael Abramsky; Dr. Xavier F. Amador; Michael Allen, Esq.; Donna Beavers; Professor John H. Blume; Professor Richard J. Bonnie; Colleen Quinn Brady, Esq.; Richard Burr, Esq.; Dr. Joel A. Dvoskin; Dr. James R. Eisenberg; Professor I. Michael Greenberger; Dr. Kirk S. Heilbrun; Ronald Honberg, Esq.; Ralph Ibson; Dr. Matthew B. Johnson; Professor Dorean M. Koenig; Dr. Diane T. Marsh; Hazel Moran; John Parry, Esq.; Professor Jennifer Radden; Professor Laura Lee Rovner; Robyn S. Shapiro, Esq.; Professor Christopher Slobogin; and Ronald J. Tabak, Esq. Drs. Paul S. Appelbaum, Howard V. Zonana and Jeffrey Metzner also contributed significantly to the Task Force's deliberations and recommendations.

⁴⁸⁴ See Am. Psychiatric Ass'n, *Diminished Responsibility in Capital Sentencing; Death Sentences for Persons with Dementia or Traumatic Brain Injury; Mentally Ill Prisoners on Death Row*: available at http://www.psych.org/edu/other_res/lib_archives/archives/200406.pdf, 200508.pdf, 200505.pdf.

⁴⁸⁵ See American Psychological Association, *Excerpt from the Council of Representatives 2005 Meeting Minutes* (Feb. 18-20, 2005); *Excerpt from the Council of Representatives 2006 Meeting Minutes* (Feb. 17-19, 2006).

⁴⁸⁶ The recommendation being presented to the House of Delegates is identical to the wording approved by these other groups, except that minor changes have been made to paragraph 3(c) and 3(d) to remove any potential doubt that, where either provision applies, the sentence would be the one that would be applicable in a capital case in situations in which the death penalty is not a sentencing option.

⁴⁸⁷ 536 U.S. 304 (2002).

⁴⁸⁸ *Id.* at 313-17.

culpable or deterrable as the "average murderer," much less the type of murderer for whom the death penalty may be viewed as justifiable.⁴⁸⁹

While the *Atkins* Court clearly prohibited execution of people with mental retardation, it did not define that term. The Recommendation embraces the language most recently endorsed by the American Association of Mental Retardation, which defines mental retardation as a disability originating before the age of eighteen that is "characterized by significant limitations both in intellectual functioning and in adaptive behavior as expressed in conceptual, social, and practical adaptive skills."⁴⁹⁰ The language of the Recommendation is also consistent with the most recent edition of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, which defines a person as mentally retarded if, before the age of 18, he or she exhibits "significantly sub-average intellectual functioning" (defined as "an IQ of approximately 70 or below") and "concurrent deficits or impairments in present adaptive functioning . . . in at least two of the following areas: communication, self-care, home living, social/interpersonal skills, use of community resources, self-direction, functional academic skills, work, leisure, health, and safety."⁴⁹¹ Both of these definitions were referenced (albeit not explicitly endorsed) by the Supreme Court in *Atkins*, and both have been models for states that have defined retardation for purposes of the death penalty exemption.⁴⁹² Both capture the universe of people who, if involved in crime, *Atkins* describes as less culpable and less deterrable than the "average murderer." As the APA's Diagnostic and Statistical Manual indicates, even a person with only "mild" mental retardation, as that term is defined in the Manual, has a mental age below that of a teenager.⁴⁹³

The language in this part of the Recommendation is also meant to encompass dementia and traumatic brain injury, disabilities very similar to mental retardation in their impact on intellectual and adaptive functioning except that they always (in the case of dementia) or often (in the case of head injury) are manifested after age eighteen. Dementia resulting from the aging process is generally progressive and irreversible, and is associated with a number of deficits in intellectual and adaptive functioning, such as agnosia (failure to recognize or identify objects) and disturbances in executive functioning connected with planning, organizing, sequencing, and abstracting.⁴⁹⁴ The same symptoms can be experienced by people with serious brain injury. Of course, people with dementia or a

⁴⁸⁹ *Id.* at 318-20

⁴⁹⁰ MANUAL OF THE AMERICAN ASSOCIATION ON MENTAL RETARDATION 12 (10th ed., 2002).

⁴⁹¹ See AMERICAN PSYCHIATRIC ASSOCIATION, DIAGNOSTIC AND STATISTICAL MANUAL 49 (text rev. 4th ed. 2000) (hereafter DSM-IV-TR).

⁴⁹² 536 U.S. at 308 n.3. DEATH PENALTY INFO. CTR., STATE STATUTES PROHIBITING THE DEATH PENALTY FOR PEOPLE WITH MENTAL RETARDATION, at <http://www.deathpenaltyinfo.org/article.php?scid> (describing state laws).

⁴⁹³ DSM-IV-TR, at 43 (stating that people with a "mild" mental retardation develop academic skills up to the sixth-grade level, amounting to the maturity of a 12 year old). For more on the definition of retardation, see James W. Ellis, *Mental Retardation and the Death Penalty: A Guide to State Legislative Issues*, 27 MEN. & PHYS. DIS. L. REP. 11-24 (2003); Richard J. Bonnie, *The APA's Resource Document on Mental Retardation and Capital Sentencing: Implementing Atkins v. Virginia*, 32 J. AM. ACAD. PSYCHIATRY & L. 304, 308 (2004).

⁴⁹⁴ DSM-IV-TR, at 135 (describing symptoms of dementia).

traumatic head injury severe enough to result in "significant limitations in both intellectual functioning or adaptive behavior" rarely commit capital offenses. If they do, however, the reasoning in *Atkins* should apply and an exemption from the death penalty is warranted, because the only significant characteristic that differentiates these severe disabilities from mental retardation is the age of onset.⁴⁹⁵

Paragraph 2

Paragraph 2 of the Recommendation is meant to prohibit execution of persons with severe mental disabilities whose demonstrated impairments of mental and emotional functioning at the time of the offense would render a death sentence disproportionate to their culpability. The Recommendation uses the phrase "disorder or disability" because, even though those words are often used interchangeably, some prefer one over the other. The Recommendation indicates that only those individuals with "severe" disorders or disabilities are to be exempted from the death penalty, and it specifically excludes from the exemption those diagnosed with conditions that are primarily manifested by criminal behavior and those whose abuse of psychoactive substances, standing alone, renders them impaired at the time of the offense.

Rationale: This part of the Recommendation is based on long-established principles of Anglo-American law that the Supreme Court recognized and embraced in *Atkins* and recently affirmed in *Roper v. Simmons*,⁴⁹⁶ in which it held that the execution of juveniles who commit crimes while under the age of eighteen is prohibited by the Eighth Amendment. In reaching its holding in *Atkins*, the Court emphasized that execution of people with mental retardation is inconsistent with both the retributive and deterrent functions of the death penalty. More specifically, as noted above, it held that people with mental retardation who kill are both less culpable and less deterrable than the average murderer, because of their "diminished capacities to understand and process information, to communicate, to abstract from mistakes and learn from experience, to engage in logical reasoning, to control impulses, and to understand the reactions of others."⁴⁹⁷ As the Court noted, "[i]f the culpability of the average murderer is insufficient to justify the most extreme sanction available to the State, the lesser culpability of the mentally retarded offender surely does not merit that form of retribution."⁴⁹⁸ Similarly, with respect to deterrence, the Court stated, "[e]xempting the mentally retarded from [the death penalty] will not affect the 'cold calculus that precedes the decision' of other potential murderers."⁴⁹⁹

The Court made analogous observations in *Simmons*. With respect to culpability, the Court stated:

⁴⁹⁵ Compare *id.*, at 135 (describing symptoms of dementia) with *id.* at 46 (symptoms of mental retardation).

⁴⁹⁶ 125 S.Ct. 1183 (2005).

⁴⁹⁷ 536 U.S. at 318.

⁴⁹⁸ *Id.* at 319.

⁴⁹⁹ *Id.*

Whether viewed as an attempt to express the community's moral outrage or as an attempt to right the balance for the wrong to the victim, the case for retribution is not as strong with a minor as with an adult. Retribution is not proportional if the law's most severe penalty is imposed on one whose culpability or blameworthiness is diminished, to a substantial degree, by reason of youth and immaturity.⁵⁰⁰

On the deterrence issue it said, "[t]he likelihood that the teenage offender has made the kind of cost-benefit analysis that attaches any weight to the possibility of execution is so remote as to be virtually nonexistent."⁵⁰¹

The same reasoning applies to people who, in the words of the Recommendation, have a "severe mental disorder or disability" that, at the time of the offense: "significantly impaired their capacity" (1) "to appreciate the nature, consequences, or wrongfulness of their conduct"; (2) "to exercise rational judgment in relation to the conduct"; or (3) "to conform their conduct to the requirements of law." Offenders who meet these requirements, even if found sane at trial, are not as culpable or deterrable as the average offender. A close examination of this part of the Recommendation makes clear why this is so.

The Severe Mental Disorder or Disability Requirement. First, the predicate for exclusion from capital punishment under this part of the Recommendation is that offenders have a "severe" disorder or disability, which is meant to signify a disorder that is roughly equivalent to disorders that mental health professionals would consider the most serious "Axis I diagnoses."⁵⁰² These disorders include schizophrenia and other psychotic disorders, mania, major depressive disorder, and dissociative disorders – with schizophrenia being by far the most common disorder seen in capital defendants. In their acute state, all of these disorders are typically associated with delusions (fixed, clearly false beliefs), hallucinations (clearly erroneous perceptions of reality), extremely disorganized thinking, or very significant disruption of consciousness, memory and perception of the environment.⁵⁰³ Some conditions that are not considered an Axis I condition might also, on rare occasions, become "severe" as that word is used in this Recommendation. For instance, some persons whose predominant diagnosis is a personality disorder, which is an Axis II disorder, may at times experience more significant dysfunction. Thus, people with borderline personality disorder can experience "psychotic-like symptoms ... during times of stress."⁵⁰⁴ However, only if these more serious symptoms occur at the time of the capital offense would the predicate for this Recommendation's exemption be present.

The Significant Impairment Requirement. To ensure that the exemption only applies to offenders less culpable and less deterrable than the average murderer, this part of the

⁵⁰⁰ 125 S.Ct. at 1196.

⁵⁰¹ *Id.* (quoting *Thompson v. Oklahoma*, 487 U.S. 815, 837 (1988)).

⁵⁰² See DSM-IV-TR, at 25-26 (distinguishing Axis I diagnoses from Axis II diagnoses).

⁵⁰³ See *id.*, at 275-76 (schizophrenia); 301 (delusional disorders); 332-33 (mood disorder with psychotic features); 125 (delirium); 477 (dissociative disorders).

⁵⁰⁴ See *id.*, at 652. Other Axis II diagnoses that might produce psychotic-like symptoms include Autistic Disorder, *id.* at 75, and Asperger's Disorder. *Id.* at 84.

Recommendation further requires that the disorder significantly impair cognitive or volitional functioning at the time of the offense. *Atkins* held the death penalty excessive for *every* person with mental retardation, and the Supreme Court therefore dispensed with a case-by-case assessment of responsibility. However, for the disorders covered by this second part of the Recommendation, preclusion of a death sentence based on diagnosis alone would not be sensible, because the symptoms of these disorders are much more variable than those associated with retardation or the other disabilities covered by the Recommendation's first paragraph.

The first specific type of impairment that this part of the Recommendation recognizes as a basis for exemption from the death penalty (if there was a severe disorder at the time of the offense) is a significant incapacity "to appreciate the nature, consequences, or wrongfulness" of the conduct associated with the offense (section (a)). This provision is meant to encompass those individuals with severe disorder who have serious difficulty appreciating the wrongfulness of their criminal conduct. For instance, people who, because of psychosis, erroneously perceived their victims to be threatening them with serious harm would be covered by this language,⁵⁰⁵ as would delusional offenders who believed that God had ordered them to commit the offense.⁵⁰⁶

Section (a) also refers to offenders who fail to appreciate the "nature and consequences" of the crime. This language would clearly apply to offenders who, because of severe disorder or disability, did not intend to engage in the conduct constituting the crime or were unaware they were committing it.⁵⁰⁷ It would also apply to delusional offenders who intended to commit the crime and knew that the conduct was wrongful, but experienced confusion and self-referential thinking that prevented them from recognizing its full ramifications. For example, a person who experiences delusional beliefs that electric power lines are implanting demonic curses, and thus comes to believe that he or she must blow up a city's power station, might understand that destruction of property and taking the law into one's own hands is wrong but might nonetheless fail to appreciate that the act would harm and perhaps kill those who relied on the electricity.

The second type of impairment recognized as a basis for exemption from the death penalty under this part of the Recommendation (in section (b)) is a significant incapacity "to exercise rational judgment in relation to the conduct" at the time of the crime. Numerous commentators have argued that irrationality is the core determinant of diminished responsibility.⁵⁰⁸ As used by these commentators, and as made clear by the

⁵⁰⁵ This is a fairly common perception of people with schizophrenia who commit violent acts. See Dale E. McNiel, *The Relationship Between Aggressive Attributional Style and Violence by Psychiatric Patients*, 71 J. CONSULTING & CLINICAL PSYCHOLOGY 404, 405 (2003).

⁵⁰⁶ Cf. *People v. Schmidt*, 216 N.Y. 324, 110 N.E. 945 (1915) (stating that if a person has "an insane delusion that God has appeared to [him] and ordained the commission of a crime, we think it cannot be said of the offender that he knows the act to be wrong).

⁵⁰⁷ These offenders would not have the *mens rea* for murder, and perhaps not even meet the voluntary act requirement for crime. See WAYNE LAFAYE, CRIMINAL LAW 405 (3d ed. 2000) (describing the voluntary act requirement under the common law).

⁵⁰⁸ See, e.g., HERBERT FINGARETTE & ANN FINGARETTE HASSE, MENTAL DISABILITIES AND CRIMINAL RESPONSIBILITY 218 (1979); MICHAEL MOORE, LAW AND PSYCHIATRY:

Recommendation's threshold requirement of severe mental disability, "irrational" judgment in this context does not mean "inaccurate," "unusual" or "bad" judgment. Rather, it refers to the type of disoriented, incoherent and delusional thinking that only people with serious mental disability experience. Furthermore, as noted above, the Recommendation requires that the irrationality occur in connection with the offense, rather than simply have existed prior to the criminal conduct.

Under these conditions, offenders who come within section (b) would often also fail to appreciate the "nature, consequences, or wrongfulness" of their conduct. But there is a subset of severely impaired individuals who may not meet the latter test and yet who should still be exempted from the death penalty because they are clearly not as culpable or deterrable as the average murderer. For instance, a jury rejected Andrea Yates' insanity defense despite strong evidence of psychosis at the time she drowned her five children. Apparently, the jury believed that, even though her delusions existed at the time of the offense, she could still appreciate the wrongfulness (and maybe even the fatal consequences) of her acts. Yet that same jury spared Yates the death penalty, probably because it believed her serious mental disorder significantly impaired her ability to exercise rational judgment in relation to the conduct.⁵⁰⁹

The third and final type of offense-related impairment recognized as a basis for exemption from the death penalty by this part of the Recommendation is a significant incapacity "to conform [one's] conduct to the requirements of law" (section (c)). Most people who meet this definition will probably also experience significant cognitive impairment at the time of the crime. However, some may not. For example, people who have a mood disorder with psychotic features might understand the wrongfulness of their acts and their consequences, but nonetheless feel impervious to punishment because of delusion-inspired grandiosity.⁵¹⁰ Because a large number of offenders can make plausible claims that they felt compelled to commit their crime, however, enforcement of the Recommendation's requirement that impairment arise from a "severe" disorder is especially important here.

Exclusions. In addition to the severe disability threshold and the requirement of significant cognitive or volitional impairment at the time of the offense, a third way this part of the Recommendation assures that those it exempts from the death penalty are less culpable and deterrable than the average murderer is to exclude explicitly from its coverage those offenders whose disorder is "manifested primarily by repeated criminal conduct or attributable solely to the acute effects of voluntary use of alcohol or other drugs." The Recommendation's reference to mental disorders "manifested primarily by repeated criminal conduct" is meant to deny the death penalty exemption to those

RETHINKING THE RELATIONSHIP 244-245 (1985); Stephen J. Morse, *Immaturity and Irresponsibility*, 88 J. CRIM. L. & CRIMINOLOGY 15, 24 (1997); ROBERT F. SCHOPP, AUTOMATISM, INSANITY AND THE PSYCHOLOGY OF CRIMINAL RESPONSIBILITY: A PHILOSOPHICAL INQUIRY 215 (1991).

⁵⁰⁹ For a description of the Yates case, see Deborah W. Denno, *Who is Andrea Yates? A Short Story About Insanity*, 10 DUKE J. GENDER L. & POL'Y 37 (2003).

⁵¹⁰ DSM-IV-TR, at 332-33.

offenders whose only diagnosis is Antisocial Personality Disorder.⁵¹¹ This language is virtually identical to language in the Model Penal Code's insanity formulation, which was designed to achieve the same purpose.⁵¹² However, the Recommendation uses the word "primarily" where the MPC uses the word "solely" because Antisocial Personality Disorder consists of a number of symptom traits in addition to antisocial behavior, and therefore the MPC language does not achieve its intended effect. Compared to the MPC's provision, then, the Recommendation's language broadens the category of offenders whose responsibility is not considered sufficiently diminished to warrant exemption from capital punishment.

Similarly, the Recommendation denies the death penalty exemption to those offenders who lack appreciation or control of their actions at the time of the offense due "solely to the acute effects of voluntary use of alcohol or other drugs." Substance abuse often plays a role in crime. When voluntary ingestion of psychoactive substances compromises an offender's cognitive or volitional capacities, the law sometimes is willing to reduce the grade of offense at trial, especially in murder cases,⁵¹³ and evidence of intoxication should certainly be taken into account if it is offered in mitigation in a capital sentencing proceeding.⁵¹⁴ However, in light of the wide variability in the effects of alcohol and other drugs on mental and emotional functioning, voluntary intoxication alone does not warrant an automatic exclusion from the death penalty.⁵¹⁵ At the same time, this Recommendation is not meant to prevent exemption from the death penalty for those offenders whose substance abuse has caused organic brain disorders or who have other serious disorders that, in combination with the acute effects of substance abuse, significantly impaired appreciation or control at the time of the offense.⁵¹⁶

How This Recommendation Relates to the Insanity Defense. The language proposed in this part of the Recommendation is similar to modern formulations of the insanity defense.⁵¹⁷ Nonetheless, in light of the narrow reach of the defense in most states (and its abolition in a few),⁵¹⁸ many offenders who meet these criteria will still be convicted

⁵¹¹ *Id.* at 650 et. seq. (defining as a symptom of antisocial personality disorder "failure to conform to social norms with respect to lawful behaviors as indicated by repeatedly performing acts that are grounds for arrest").

⁵¹² See AMERICAN LAW INSTITUTE, MODEL PENAL CODE § 4.01(2) and commentary (draft, 1962) (stating that "'mental disease or defect' as used in the insanity formulation does not include abnormality manifested only by repeated or otherwise anti-social conduct").

⁵¹³ See generally LAFAVE, *supra*, [n.507], at 415-16.

⁵¹⁴ See Jeffrey L. Kirchmeier, *A Tear in the Eye of the Law: Mitigating Factors and the Progression Toward a Disease Model of Criminal Justice*, 83 OREGON L. REV. 631, 679 n.237 (2004) (listing statutes and judicial decisions from over a dozen states that have recognized intoxication as a mitigating circumstance).

⁵¹⁵ In *Montana v. Egelhoff*, 518 U.S. 37 (1996), a plurality of the Supreme Court held that the voluntary intoxication defense is not constitutionally required. *Id.* at 38. At least 13 states now reject the voluntary intoxication defense. See Molly McDonough, *Sobering Up*, 88 A.B.A. J. 28 (2002).

⁵¹⁶ See, e.g., DSM-IV-TR, at 170 (describing dementia due to prolonged substance abuse).

⁵¹⁷ The language in 2(a) and 2(c), for instance, is almost identical to the language in the Model Penal Code's insanity formulation. See MODEL PENAL CODE, *supra*, [n.512], at § 4.01(1).

⁵¹⁸ Today, five states do not have an insanity defense, another twenty-five do not recognize volitional impairment as a basis for the defense, and many states define the cognitive prong in terms of an inability to "know" (as opposed to "appreciate") the wrongfulness of the act or, as is true in federal

rather than acquitted by reason of insanity. Even in those states with insanity formulations that are very similar to the Recommendation's language, these individuals might be convicted, for a whole host of reasons,⁵¹⁹ in such cases, the Recommendation would require juries and judges to consider whether cognitive and volitional impairment removes the defendant from being among the most morally culpable offenders. This approach rests on the traditional understanding that significant cognitive or volitional impairment attributable to a severe disorder or disability often renders the death penalty disproportionate to the defendant's culpability, even though the offender may still be held accountable for the crime.⁵²⁰ It also underlies the various formulations of diminished responsibility that predated the contemporary generation of capital sentencing statutes.⁵²¹

How This Recommendation Relates to Mitigating Factors. This part of the Recommendation sets up, in effect, a conclusive "defense" against the death penalty for capital defendants who can demonstrate the requisite level of impairment due to severe disorder at the time of the offense. However, the criteria in the Recommendation do not exhaust the relevance of mental disorder or disability in capital sentencing. Those offenders whose mental disorder or disability at the time of the offense was not severe or did not cause one of the enumerated impairments would still be entitled to argue that their mental dysfunction is a mitigating factor, to be considered with aggravating factors and other mitigating factors in determining whether capital punishment should be imposed.⁵²²

Paragraph 3

This paragraph of the Recommendation is meant to address three different circumstances under which concerns about a prisoner's mental competence and suitability for execution arise after the prisoner has been sentenced to death. Subpart (a) states that execution should be precluded when a prisoner lacks the capacity (i) to make a rational decision regarding whether to pursue post-conviction proceedings, (ii) to assist counsel in post-conviction adjudication, or (iii) to appreciate the meaning or purpose of an impending execution. The succeeding subparts spell out the conditions under which execution should be barred in these three situations.

Prisoners Seeking to Forgo or Terminate Post-Conviction Proceedings. The United States Supreme Court has ruled that a competent prisoner is entitled to forgo available

court, leave out the word "substantial" in the phrase, "lack of substantial capacity to appreciate" in the Model Penal Code formulation. See RALPH REISNER ET AL., LAW AND THE MENTAL HEALTH SYSTEM: CIVIL AND CRIMINAL ASPECTS 534-36 (4th ed. 2004).

⁵¹⁹ See generally Michael L. Perlin, "The Borderline Which Separated You from Me@: The Insanity Defense, the Authoritarian Spirit, the Fear of Faking, and the Culture of Punishment, 82 IOWA L. REV. 1375 (1997) (exploring reasons for hostility to the insanity defense).

⁵²⁰ See Ellen Fels Berkman, *Mental Illness as an Aggravating Circumstance in Capital Sentencing*, 89 COLUM. L. REV. 291, 297 (1989) (noting that "nearly two dozen jurisdictions list as a statutory mitigating circumstance the fact that the defendant's capacity to appreciate the criminality of her conduct was substantially impaired, often as a result of mental defect or disease and that "an equally high number of states includes extreme mental or emotional disturbance' as a mitigating factor).

⁵²¹ See generally SHELDON GLUECK, MENTAL DISORDER AND THE CRIMINAL LAW (1925).

⁵²² See, e.g., MODEL PENAL CODE, *supra*, [n.512], at § 210.6.

appeals.⁵²³ If the prisoner is not competent, the standard procedure is to allow a so-called "next friend" (including the attorney) to pursue direct appeal and collateral proceedings aiming to set aside the conviction or sentence. Subpart 3(b) of the Recommendation addresses the definition of competence in such cases, providing that a next friend petition should be allowed when the prisoner has a mental disorder or disability "that significantly impairs his or her capacity to make a rational decision."

Reportedly, 13% of the prisoners executed in the post-*Gregg* era have been so-called "volunteers."⁵²⁴ Any meaningful competence inquiry in this context must focus not only on the prisoner's understanding of the consequences of the decision, but also on his or her *reasons* for wanting to surrender, and on the rationality of the prisoner's thinking and reasoning. In *Rees v. Peyton*,⁵²⁵ the U.S. Supreme Court instructed the lower court to determine whether the prisoner had the "capacity to appreciate his position and make a rational choice with respect to continuing or abandoning further litigation or on the other hand whether the prisoner is suffering from a mental disease, disorder or defect which may substantially affect his capacity in the premises."⁵²⁶ Unfortunately, the two alternative findings mentioned by the Court are not mutually exclusive – a person with a mental disorder that "affects" his or her decision-making may nonetheless be able to appreciate his or her position and make a "rational" choice. For this reason, the lower courts have integrated the *Rees* formula into a three-step test: (1) does the prisoner have a mental disorder? (2) if so, does this condition prevent the prisoner from understanding his or her legal position and the options available to the prisoner? (3) even if understanding is unimpaired, does the condition nonetheless prevent the prisoner from making a rational choice among the options?⁵²⁷

Because the courts have adopted a fairly broad conception of mental disorder (the first step) and the prisoner's understanding of his or her "legal position" (the second step) is hardly ever in doubt in these cases, virtually all the work under the *Rees* test is done by the third step.⁵²⁸ Conceptually, the question is relatively straightforward – is the prisoner's decision attributable to the mental disorder or to "rational choice"?

Unequivocal cases of irrationality rarely arise. For example, if an offender suffering from schizophrenia tells his or her attorney to forgo appeals because the future of civilization depends upon the offender's death,⁵²⁹ the "reason" for the prisoner's choice can comfortably be attributed to the psychotic symptom. However, decisions rooted in delusions are atypical in these cases. The usual case involves articulated reasons that may seem "rational" under the circumstances, such as (a) a desire to take responsibility for

⁵²³ See, e.g., *Gilmore v. Utah*, 429 U.S.1012 (1977).

⁵²⁴ John Blume, *Killing the Willing: Volunteers, Suicide and Competency*, 103 MICH. L. REV. 939, 959 (2005).

⁵²⁵ 384 U.S. 312 (1966) (case remanded for competency determination after condemned prisoner directed attorney to withdraw petition for certiorari).

⁵²⁶ *Id.* at 314.

⁵²⁷ See, e.g., *Hauser v. Moore*, 223 F.3d 1316, 1322 (11th Cir. 2000); *Rumbaugh v. Procnier*, 753 F.2d 395 (5th Cir 1985).

⁵²⁸ Richard J. Bonnie, *Mentally Ill Prisoners on Death Row: Unsolved Puzzles for Courts and Legislatures*, 54 CATH. UNIV. L. REV.1169 (2005).

⁵²⁹ Cf. *Illinois v. Haynes*, 737 N.E.2d 169, 178 (Ill. 2000); *In re Heidnick*, 720 A. 2d 1016 (Pa 1998).

one's actions and a belief that one deserves the death penalty or (b) a preference for the death penalty over life imprisonment. The cases that give the courts the most trouble are those in which such apparently "rational" reasons are intertwined with emotional distress (especially depression), feelings of guilt and remorse, and hopelessness. In many cases, choices that may otherwise seem "rational" may be rooted in suicidal motivations. Assuming, for example, that the prisoner is depressed and suicidal but has a genuine desire to take responsibility, how is one to say which motivation "predominates"?

John Blume has studied the prevalence of significant mental disorder among the 106 prisoners who have volunteered for execution. According to Blume, 14 of the "volunteers" had recorded diagnoses of schizophrenia, 23 had recorded diagnoses of depression or bipolar disorder, 10 had records of PTSD, 4 had diagnoses of borderline personality disorder and 2 had been diagnosed with multiple personality disorder. Another 12 had unspecified histories of "mental illness."⁵³⁰ Given this high prevalence of mental illness, the courts should be more willing than they now are to acknowledge suicidal motivations when they are evident and should be more inclined than they are now to attribute suicidal motivations to mental illness when the clinical evidence of such a link is convincing. The third step of the *Rees* test would then amount to the following: Is the prisoner who seeks execution able to give plausible reasons for doing so that are clearly *not* grounded in symptoms of mental disorder?⁵³¹ Given the stakes of the decision, a relatively high degree of rationality ought to be required in order to find people competent to make decisions to abandon proceedings concerning the validity of a death sentence.⁵³²

Prisoners Unable to Assist Counsel in Post-Conviction Proceedings. Subpart 3(c) of the Recommendation addresses the circumstances under which impaired competence to participate in adjudication should affect the initiation or continuation of post-conviction proceedings. The law in this area is both undeveloped and uncertain in many respects. However, some principles have begun to emerge.

Under the laws of many states and the federal Anti-Terrorism and Effective Death Penalty Act (AEDPA), collateral proceedings are barred if they are not initiated within a specified period of time. However, it is undisputed that a prisoner's failure to file within the specified time must be excused if such failure was attributable to a mental disability that impaired the prisoner's ability to recognize the basis for, or to take advantage of, possible collateral remedies. Similarly, the prisoner should be able to lodge new claims, or re-litigate previously raised claims, if the newly available evidence upon which the

⁵³⁰ Blume, *supra*, [n.524], Appendix B, at 989-96. The text refers only to significant mental disorders that could have distorted the prisoner's reasoning process and impaired capacity for Arational choice. In addition to these cases, Blume reports that 20 of these prisoners had histories of substance abuse unaccompanied by any other mental disorder diagnosis, another 6 had personality disorders (with or without substance abuse) and 4 had sexual impulse disorders.

⁵³¹ See Bonnie, *supra*, [n.528], at 1187-88. A more demanding approach would ask whether the prisoner is able to give plausible reasons that reflect authentic values and enduring preferences.

⁵³² See Richard J. Bonnie, *The Dignity of the Condemned*, 74 VA. L. REV. 1363, 1388-89 (1988); Cf. Richard J. Bonnie, *The Competence of Criminal Defendants: Beyond Dusky and Drope*, 47 UNIV. MIAMI L. REV. 539, 579-80 (1993).

claim would have been based, or that would have been presented during the earlier proceeding relating to the claim, was unavailable to counsel due to the prisoner's mental disorder or disability.⁵³³

Assuming, however, that collateral proceedings have been initiated in a timely fashion, the more difficult question is whether, and under what circumstances, a prisoner's mental disability should require suspension of the proceedings. Subpart 3(c) provides that courts should suspend post-conviction proceedings upon proof that a prisoner is incompetent to assist counsel in such proceedings and that the prisoner's participation is necessary for fair resolution of a specific claim.

Thorough post-conviction review of the legality of death sentences has become an integral component of modern death penalty law, analogous in some respects to direct review. Any impediment to thorough collateral review undermines the integrity of the review process and therefore of the death sentence itself. Many issues raised in collateral proceedings can be adjudicated without the prisoner's participation, and these matters should be litigated according to customary practice. However, collateral proceedings should be suspended if the prisoner's counsel makes a substantial and particularized showing that the prisoner's impairment would prevent a fair and accurate resolution of specific claims,⁵³⁴ and subpart 3(c) so provides.

Where the prisoner's incapacity to assist counsel warrants suspension of the collateral proceedings, it should bar execution as well, just as ABA Standards recommend. ABA Standard 7-5.6 provides that prisoners should not be executed if they cannot understand the nature of the pending proceedings or if they "[lack] sufficient capacity to recognize or understand any fact which might exist which would make the punishment unjust or unlawful, or [lack] the ability to convey such information to counsel or to the court."⁵³⁵ As the commentary to Standard 7-5.6 indicates, this rule "rests less on sympathy for the sentenced convict than on concern for the integrity of the criminal justice system."⁵³⁶ Scores of people on death row have been exonerated based on claims of factual innocence, and many more offenders have been removed from death row and given sentences less than death because of subsequent discovery of mitigating evidence. The possibility, however slim, that incompetent individuals may not be able to assist counsel in reconstructing a viable factual or legal claim requires that executions be barred under these circumstances.

⁵³³ See, e.g., *Council v. Catoe*, 359 S.C. 120, 597 S.E.2d 782, 787 (2004); *Commonwealth v. Haag*, 809 A.2d 271, 285 (PA, 2001).

⁵³⁴ *Council v. Catoe*, 359 S.C. 120, 597 S.E.2d 782, 787 (A[T]he default rule is that [post-conviction review] hearings must proceed even though a petitioner is incompetent. For issues requiring the petitioner's competence to assist his [post-conviction] counsel, such as a fact-based challenge to his defense counsel's conduct at trial, the [post-conviction] judge may grant a continuance, staying review of these issues until petitioner regains his competence.); *Carter v. State*, 706 So.2d 873, 875-77 (Fla. 1997); *State v. Debra*, 523 N.W.2d 727 (Wisc. 1994) (non-capital case); *People v. Kelly*, 822 P.2d 385, 413 (Cal. 1992).

⁵³⁵ *ABA Criminal Justice Mental Health Standards* 290 (1989).

⁵³⁶ *Id.*, at 291.

Once the post-conviction proceedings have been suspended on grounds of the prisoner's incompetence to assist counsel, should the death sentence remain under an indefinite stay? The situation is analogous to the suspension of criminal proceedings before trial; in that context, the proceedings are typically terminated (and charges are dismissed) after a specified period if a court has found that competence for adjudication is not likely to be restored in the foreseeable future. In the present context, it would be unfair to hold the death sentence in perpetual suspension. A judicial finding that the prisoner's competence to assist counsel is not likely to be restored in the foreseeable future should trigger an automatic reduction of the sentence to the disposition the relevant law imposes on capital offenders when execution is not an option.

Prisoners Unable to Understand the Punishment or its Purpose. In *Ford v. Wainwright* (1986),⁵³⁷ the U.S. Supreme Court held that execution of an incompetent prisoner constitutes cruel and unusual punishment proscribed by the Eighth Amendment. Unfortunately, the Court failed to specify a constitutional definition of incompetence or to prescribe the constitutionally required procedures for adjudicating the issue.⁵³⁸ The Court also failed to set forth a definitive rationale for its holding that might have helped resolve these open questions. Rather it listed, without indicating their relative importance, a number of possible reasons for the competence requirement. These rationales included the need to ensure that the offenders could provide counsel with information that might lead to vacation of sentence; the view that, in the words of Lord Coke, execution of "mad" people is a "miserable spectacle . . . of extream inhumanity and cruelty [that] can be no example to others"; and the notion that retribution cannot be exacted from people who do not understand why they are being executed.⁵³⁹ Apparently based on the latter rationale, Justice Powell, in his concurring opinion in *Ford*, stated: "I would hold that the Eighth Amendment forbids the execution only of those who are unaware of the punishment they are about to suffer and why they are to suffer it."⁵⁴⁰ Justice Powell pointed out that states are free to preclude execution on other grounds (particularly inability to assist counsel), but most courts and commentators have assumed that the Eighth Amendment requirement is limited to the test stated by Justice Powell. Most commentators have also agreed with Justice Powell's view that the *Ford* competence requirement is grounded in the retributive purpose of punishment.⁵⁴¹

There has been some confusion about the meaning of the idea that the prisoner must be able to understand (or be aware of) the nature and purpose for (reasons for) the execution. In *Barnard v. Collins*,⁵⁴² decided by the Fifth Circuit in 1994, the state habeas court had

⁵³⁷ 477 U.S. 399.

⁵³⁸ State courts have disagreed about the procedures required to make *Ford* competence determinations. This Recommendation does not deal with such procedural issues. For a treatment of this topic, see *ABA Standard 7.5-7* and *Coe v. Bell*, 209 F.3d 815 (6th Cir. 2000), which should be read in conjunction with the *ABA Guidelines for Appointment and Performance of Defense Counsel in Death Penalty Cases* at <http://www.abanet.org/deathpenalty/publications/2005/2003Guidelines.pdf>.

⁵³⁹ *Id.* at 406-08.

⁵⁴⁰ *Id.* at 422 (Powell, J., concurring)

⁵⁴¹ See Barbara Ward, *Competency for Execution: Problems in Law and Psychiatry*, 14 FLA. ST. UNIV. L. REV. 35, 49-56 (1986); Christopher Slobogin, *Mental Illness and the Death Penalty*, 24 MEN. & PHYS. L. REP. 667, 675-77 (2000)

⁵⁴² 13 F.3d 871 (5th Cir, 1994).

found that Barnard's "perception of the reason for his conviction and impending execution is at times distorted by a delusional system in which he attributes anything negative that happens to him to a conspiracy of Asians, Jews, Blacks, homosexuals and the Mafia."⁵⁴³ Despite the fact that Barnard's understanding of the reason for his execution was impaired by delusions, the Fifth Circuit concluded that his awareness that "his pending execution was because he had been found guilty of the crime" was sufficient to support the state habeas court's legal conclusion that he was competent to be executed.⁵⁴⁴

In order to emphasize the need for a deeper understanding of the state's justifying purpose for the execution, subpart 3(d) of the Recommendation would require that an offender not only must be "aware" of the nature and purpose of punishment but also must "appreciate" its personal application in the offender's own case – that is, why it is being imposed *on the offender*. This formulation is analogous to the distinction often drawn between a "factual understanding" and a "rational understanding" of the reason for the execution⁵⁴⁵. If, as is generally assumed, the primary purpose of the competence-to-be-executed requirement is to vindicate the retributive aim of punishment, then offenders should have more than a shallow understanding of why they are being executed.

Whether a person found incompetent to be executed should be treated to restore competence implicates not only the prisoner's constitutional right to refuse treatment but also the ethical integrity of the mental health professions⁵⁴⁶. Some courts have decided that the government may forcibly medicate incompetent individuals if necessary to render them competent to be executed, on the ground that once an individual is fairly convicted and sentenced to death, the state's interest in carrying out the sentence outweighs any individual interest in avoiding medication.⁵⁴⁷ However, treating a condemned prisoner, especially over his or her objection, for the purpose of enabling the state to execute the prisoner strikes many observers as barbaric and also violates fundamental ethical norms of the mental health professions.

Mental health professionals are nearly unanimous in the view that treatment with the purpose or likely effect of enabling the state to carry out an execution of a person who has been found incompetent for execution is unethical, whether or not the prisoner objects, except in two highly restricted circumstances (an advance directive by the prisoner while competent requesting such treatment or a compelling need to alleviate extreme suffering)⁵⁴⁸. Because treatment is unethical, it is not "medically appropriate" and

⁵⁴³ *Id.* at 876.

⁵⁴⁴ *Id.*

⁵⁴⁵ See *Martin v. Florida*, 515 So. 2d 189, 190 (Fla. 1987).

⁵⁴⁶ Kirk S. Heilbrun, Michael L. Radelet, Joel A. Dvoskin, *The Debate on Treating Individuals Incompetent for Execution*, 149 AM. J. PSYCHIATRY 596 (1992); Richard J. Bonnie, *Dilemmas in Administering the Death Penalty: Conscientious Abstention, Professional Ethics and the Needs of the Legal System*, 14 LAW & HUMAN BEHAVIOR 67 (1990).

⁵⁴⁷ *Singleton v. Norris*, 319 F.3d 1018 (8th Cir.) (*en banc*), *cert denied*, 124 S. Ct. 74 (2003).

⁵⁴⁸ See Council on Ethical and Judicial Affairs, American Medical Association, *Physician Participation in Capital Punishment*, 270 JAMA 365 (1993); AMERICAN PSYCHIATRIC ASSOCIATION AND AMERICAN MEDICAL ASSOCIATION, AMICUS BRIEF IN SUPPORT OF PETITIONER IN *PERRY V.*

is therefore constitutionally impermissible when a prisoner objects under the criteria enunciated by the Supreme Court in *Sell v. United States*⁵⁴⁹ and *Washington v. Harper*⁵⁵⁰. As the Louisiana Supreme Court observed in *Perry v. Louisiana*⁵⁵¹, medical treatment to restore execution competence "is antithetical to the basic principles of the healing arts," fails to "measurably contribute to the social goals of capital punishment," and "is apt to be administered erroneously, arbitrarily or capriciously"⁵⁵².

There is only one sensible policy here: a death sentence should be automatically commuted to a lesser punishment (the precise nature of which will be governed by the jurisdiction's death penalty jurisprudence) after a prisoner has been found incompetent for execution⁵⁵³. Maryland has so prescribed⁵⁵⁴, and subpart 3(d) of the Recommendation embraces this view. Once an offender is found incompetent to be executed, execution should no longer be a permissible punishment.

The current judicial practice is to entertain *Ford* claims only when execution is genuinely imminent. Should courts be willing to adjudicate these claims at an earlier time? Assuming that a judicial finding of incompetence – whenever rendered – would permanently bar execution (as proposed above), subpart 3(d) provides that *Ford* adjudications should be available only when legal challenges to the validity of the conviction and sentence have been exhausted, and execution has been scheduled⁵⁵⁵.

Procedures: While this paragraph contemplates that hearings will have to be held to determine competency to proceed and competency to be executed, it does not make any recommendations with respect to procedures. Federal constitutional principles and state law will govern whether the necessary decisions must be made by a judge or a jury, what burdens and standards of proof apply, and the scope of other rights to be accorded offenders. Additionally, in any proceedings necessary to make these determinations, the victim's next-of-kin should be accorded rights recognized by law, which may include the right to be present during the proceedings, the right to be heard, and the right to confer with the government's attorney. Victim's next-of-kin should be treated with fairness and respect throughout the process.

LOUISIANA, 498 U.S. 38 (1990); Richard J. Bonnie, *Medical Ethics and the Death Penalty*, 20 HASTINGS CENTER REPORT, May/June, 1990, 12, 15-17.

⁵⁴⁹ 539 U.S. 166 (2003).

⁵⁵⁰ 494 U.S. 210 (1990).

⁵⁵¹ 610 So.2d 746 (La. 1992).

⁵⁵² *Id.* at 751.

⁵⁵³ A state could try to restore a prisoner's competence without medical treatment, but the prospects of an enduring change in the prisoner's condition are slight.

⁵⁵⁴ MD. CODE CORR. SERVS, 3-904(a)(2), (d)(1).

⁵⁵⁵ This does not mean that no litigation challenging the validity of the sentence can be simultaneously occurring. For all practical purposes, "exhaustion" means that one full sequence of state post-conviction review and federal habeas review have occurred where, as in most jurisdictions, no execution date set during the initial round of collateral review is a "real" date. Given the many procedural barriers to successive petitions for collateral review, an execution date set after the completion of the initial round may be a "real" date, even if a successive petition has been filed or is being planned. In such a case, the state may contest the prisoner's request for a stay of execution. A *Ford* claim should be considered on its merits in such a case, and it should be considered earlier on in a jurisdiction where a "real" execution date is set during the initial round of collateral review.

Respectfully Submitted,

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August 2006

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