Mental Disabilities and Mitigation

by Russell Stetler

Mental disabilities pervade the capital client population. Many lives are spared in sentencing proceedings when jurors come to understand empathetically the disabilities, brain damage, and tormented psyches that help to explain our clients’ behavior. Mental conditions which inspire compassion, without justifying or excusing the capital crime, can be powerful mitigation. But these same disabilities and disorders can be lethal when they interfere with the defense team’s effort to establish trust. Mentally ill clients can be self-destructive. Their paranoia may prevent their accepting sound legal advice about the wisdom of a plea offer. Their bizarre symptomatology may be misunderstood by the defense team as willful uncooperativeness -- or so feared by jurors that the disability becomes an excuse to kill the client (“surgery to excise the cancer”) instead of a basis for reduced moral blame and mercy. This article will attempt to address the unique constellation of problems presented by our clients’ mental disabilities in death penalty cases -- especially in the area of mitigation evidence.

Cynicism about Mental Disabilities

Capital counsel’s ultimate task is to overcome juror cynicism toward mental health issues in criminal cases. But the first task is often to overcome the cynicism within ourselves -- the tendency to view mental conditions as convenient “defenses” in our litigation, rather than tragic disabilities which have caused profound suffering in our clients’ lives.

Shortly after the death penalty was restored in California, two beloved political leaders -- San Francisco’s first openly gay supervisor, Harvey Milk, and its liberal mayor, George Moscone
-- were assassinated by a former member of the board of supervisors, Dan White.

A homophobic archconservative, Dan White opposed everything in politics that Milk and Moscone stood for. His constituency was the working-class Irish Catholic district in which he grew up. Dan White was their all-American boy -- star quarterback at his local high school, then a firefighter and a police officer, and finally an elected official in city government. But his life spiraled downward. When he could no longer tolerate city politics, White abruptly quit his position on the board. When he changed his mind and asked to get his job back, the mayor refused to reappoint him -- and relished the opportunity to replace him with someone more progressive.

Dan White was well known at city hall, but climbed through a basement window on the day of the assassinations to avoid metal detectors. After killing the mayor, he reloaded his service revolver before walking down the hall to kill Supervisor Milk. When the killing was done, he went straight to confession. After finishing with his priest, he surrendered to one of his closest friends, a homicide inspector who’d played on the same softball team when White was an officer, and continued pouring out the story of what he had done.

White’s defense team successfully conveyed his mental deterioration to the jury -- not just through experts, but with lay testimony that vividly captured his desperate downward spiral (former cop and public official reduced to selling baked potatoes to tourists at Fisherman’s Wharf) and bizarre nutritional detour (from athlete with healthful diet to slothful recluse surviving on junk food -- particularly Hostess Twinkies). When the jury agreed with the defense contention that Dan White lacked the requisite mental state for murder, the tabloids responded with the “Twinkie Defense” headline -- and the legislature forever eliminated diminished
capacity from the California penal code.

The popular assumption was that mental-state defenses were cynical concoctions -- the inventions of sleazy defense counsel and their hired-gun experts. The forgotten footnote to this San Francisco tragedy is that Dan White served his manslaughter sentence, remained tormented by the demons of depression, and took his own life shortly after his release. The mental illness was real, but two decades later the headlines still portray this case with callous indifference to that reality.\(^4\) This denial of psychiatric disability deeply infects juror attitudes toward expert witnesses around the country.\(^5\) Sadly, many criminal defense practitioners also view their own experts as little more than mercenaries -- thus often denying or devaluing authentic client disabilities.

**Experts’ Range of Roles**

Unfortunately for capital counsel, there is no quick fix to the complex problems associated with the mental disabilities of capital clients. The solution to the complex problems posed by mental illness in capital cases is not simply to “call a doctor.” Contacting a mental health expert is a litigation decision with many grave implications, which vary widely in different litigation environments. Most capital defense practitioners can now recite the lessons of *Ake v. Oklahoma*.\(^6\) They feel entitled to competent expert assistance. Most capital defense practitioners now recognize that it is disastrous to wait until the eve of trial to consult a mental health expert,\(^7\) but many overcompensate for this risk by consulting experts too early.\(^8\)

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
multigenerational 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 -- or even which information is reliable and credible. 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 disciplines (e.g., psychiatry, neurology, psychology, neuropsychology, pharmacology, addiction medicine), and they have specialized knowledge and experience based on their research and clinical practices. Familiarity with cultural norms for the community in which the client grew up may be critical.

One question that needs to be addressed before retaining any mental health expert is what role the expert is going to play. 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). 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 which were detected and to suggest alternative hypotheses for explaining those behaviors or traits. 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 which might be easily
misinterpreted by jurors. Finally, the consultant might help counsel to recognize the client’s self-
destructive behaviors, and help the team to address those risks.10

Another role for a mental health expert is as a fact gatherer, an investigator with
specialized expertise, someone who can elicit sensitive information which 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.

In some cases, fact gatherers may become testifying experts-- the story tellers 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. There may be an attempt to explain why
the crime occurred.

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, if any, fits the special 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 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.11

What Will the Expert Do for Your Client and You?

Mental health experts consulted in capital cases are asked to address a wide range of referral questions. They are not simply called upon to “evaluate” the client. When experts are retained, it is essential to be clear and explicit about the absolutely confidentiality of the consultation and the precise referral question or questions to be addressed.12 The legal issues which might be addressed range from all the questions traditionally implicated in noncapital 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,13 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 capitall
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.\textsuperscript{14}

\textbf{Why Mitigation Is 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 \textit{not}. Mitigation is \textit{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 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.\textsuperscript{15}

Even where statutory mitigating factors have been codified, there is no simple legal
standard to guide mental health experts. In New York, for example, four of the six statutory
mitigating factors relate to mental health issues:

“The defendant was mentally retarded at the time of the crime, or the defendant’s mental
capacity was impaired or his ability to conform his conduct to the requirements of law was
impaired but not so impaired in either case as to constitute a defense to prosecution.
“The defendant was under duress or other domination of another person, although not such duress or domination as to constitute a defense to prosecution.

“The defendant was criminally liable for the present offense of murder committed by another, but his participation in the offense was relatively minor although not so minor as to constitute a defense to prosecution.

“The murder was committed while the defendant was mentally or emotionally disturbed or under the influence of alcohol or any drug, although not to such an extent as to constitute a defense to prosecution.”

A fifth factor has the catchall language of *Lockett* and its progeny:

“Any other circumstance concerning the crime, the defendant’s state of mind or condition at the time of the crime, or the defendant’s character, background or record that would be relevant to mitigation or punishment for the crime.”

Mitigation is the biography of mental disability. 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 brain. It is a basis for compassion -- not an excuse.

**Interdisciplinary Teamwork**

Mental health experts study four areas of functioning: cognition (how we understand ideas, intellectual capacity), social functioning (how we understand and respond appropriately to our environment, quality of thought and judgment), emotional functioning (mood control: depression, mania, anger), and behavior (impulsivity, violence, substance abuse, etc.). Their expertise can help a capital defense team identify deficits, describe symptoms, and understand
the interaction of multiple disabling conditions. Sometimes they can communicate effectively to
jurors who the client is and why she behaves as she does.

In the domain of cognitive functioning, experts can vividly convey the impact of mental
retardation or learning disabilities on everyday life. For example, an expert can tell the jury
about the IQ test and go through specific examples of words or concepts your client did not
know, or tasks she could not perform. Jurors can be moved by learning that the client could not
define simple words, explain a proverb, or navigate a city’s public transportation system on his
own.

In the capital jurisdictions where mental retardation is a statutory bar to the death
penalty,18 they will be critical in establishing the three-prong test of (a) significantly subaverage
intellectual functioning, existing concurrently with (b) deficits in adaptive behavior (c )
manifested developmentally (prior to age eighteen).19

Adaptive functioning “refers to how effectively individuals cope with common life
demands and how well they meet the standards of personal independence expected of someone in
their particular age group, sociocultural background, and community setting.”20 It is affected by
education and child rearing, motivation, personality characteristics, social and vocational
opportunities, and the mental disorders and general medical conditions that may coexist with
mental retardation. Other mental disorders are three to four times more prevalent among the
mentally retarded than in the general population, and every variety of mental disorder can coexist
with mental retardation. Diagnosis of either condition, however, may be complicated by the
presence of the other. Severe mental retardation may make mental illness harder to detect.
Phobias and paranoia may interfere with cognitive testing or mask adaptive deficits. Mood
disorders are among the mental disorders commonly associated with mental retardation.

Mental health experts can also explain to jurors the effects of mental diseases and disorders on cognitive functioning or the extent to which psychiatric disabilities are masked by high intellectual functioning. Some psychiatric conditions frequently coexist with high IQ’s, and it is important for jurors to appreciate the distinct disabilities which may lie beneath the surface of the client whose intelligence seems apparent.

But before mental health experts are added to a capital defense team, counsel needs to be clear about why the expert is being retained, and the expert needs to be clear about the rules of the litigation (e.g., confidentiality, discovery, etc.), the referral question, the role the expert is to play, and how that role fits into the needs of the team.

Before the expert joins the team, the team should already have assembled a rich documentary history of the client’s life through painstaking mitigation investigation. This multigenerational inquiry will have uncovered genetic predispositions; toxic exposure in the physical environmental; psychosocial stressors and trauma in the client’s family and surrounding community and culture; head injuries; substance abuse; and the myriad other factors that affect our clients. The social history gathered by the defense team will be more accurate and more complete than the client or any family member could provide. It must also be impeccably corroborated with contemporaneous records and third-party interviews.

The mental health expert will also benefit from a thorough physical examination of the client, including a neurological examination as one means of detecting brain injury. A standard textbook notes that psychiatrists may have other physicians conduct physical examinations, but they “still should be expected to obtain detailed medical history and to use fully their visual,
auditory, and olfactory senses. Loss of skill in palpation, percussion, and auscultation may be justified, but loss of skill in observation cannot be. If the detection of nonverbal psychological cues is a cardinal part of the psychiatrists’ function, the detection of indications of somatic illness, subtle as well as striking, should also be part of their function.” Every member of the defense team should also be aware of physical signs relevant to mitigation -- including needle tracks, scars, tremors, tics, ulcerated nasal passages, facial asymmetry, paralysis, weight fluctuations, etc.

Defense team observations of client behaviors over the life of the case can also 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, 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)

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)

8. Unusual social interactions (isolation/estrangement; difficulty perceiving social cues; suggestibility; emotional withdrawal; disinhibition)

Testing
Whether a client should be tested by a psychologist or other expert is a complex question, affected by the rules of the litigation (e.g., discoverability), cost and budget, the nature of the referral questions being considered (e.g., assessment of intellectual functioning), the richness of the past documentary record (e.g., whether the client has been tested before, and, if so, when and under what circumstances), the client’s own attitude and relationship with the capital defense team, and other case-specific considerations. It is beyond the scope of this article to address testing issues in detail, but it is important to note that decisions about testing have profound litigation consequences and should be made with the greatest care.

One category of test assesses cognitive functioning, including intellectual abilities, academic abilities, and neuropsychological integrity. Mental retardation cannot be established without some measure of intellectual functioning -- the traditional IQ tests such as the Wechsler Adult Intelligence Scale (WAIS, WAIS-R, WAIS-III), the Wechsler Intelligence Scale for Children (WISC, WISC-R, WISC-III), and Stanford Binet Intelligence Scale. These tests include a range of individual subtests whose scores are combined to yield an overall IQ. Learning disabilities are detected by measuring the gap between intellectual ability and academic functioning. Academic tests, such as the Wide Range Achievement Test (WRAT) and Woodcock Johnson Psychoeducational Battery, assess specific skills and knowledge in various areas.

Neuropsychological testing assesses how the brain is functioning, and it is used in a variety of clinical settings to assess a wide range of brain-related conditions, including stroke, head injury, tumors, aneurysms, malformations of the blood vessels in the brain, etc. The same behavioral and mental capacities (such as memory, language functions, orientation) that are
evaluated in neurological examinations can be assessed more precisely and objectively through neuropsychological testing. The tests are standardized and yield quantifiable reproducible results, using scores that can be compared to persons of similar age and demographic background as the person being tested. Test batteries may be fixed (one prespecified group of tests used on every subject, e.g., Halstead-Reitan or Luria Nebraska Neuropsychological Battery) or flexible (subtests selected according to individual history, referral question, and performance on core tests). Even most subtests measure multiple domains of functioning, and each domain of cognitive function consists of overlapping subfunctions. Convergence of data from multiple tasks yields the strongest conclusions.

Neuroscience is evolving rapidly and shifting from a narrow “locationist” (e.g., focal lesion) framework to a more subtle understanding of neural systems and networks. But neuropsychologists are able to draw reliable inferences about lateralization and localization of brain damage, as well as the severity of lesions, from patterns of neuropsychological test scores. This information can be of dramatic importance in understanding how a client’s violence has been influenced by the specific damage his or her brain has suffered. According to current research, “In general, the anterior parts of the brain are more involved in the outflow or ‘expressive behavior,’ whereas the posterior parts regulate sensory perception, computation, understanding of material, and generally ‘receptive’ processing. Thus, the back of one’s brain ‘perceives,’ ‘evaluates,’ and ‘thinks,’ while the front plans and acts. The laterality effects . . . suggest that left hemisphere regions are superior for language analysis and speech production whereas the right hemisphere serves spatial abilities. Other evidence suggests hemispheric asymmetry for emotional processing, although it is generally believed that subcortical regions
play the more prominent role in emotional regulation.**28**

Neuropsychological tests can be administered with relative confidentiality in jail settings because the apparatus is portable. By contrast, the brain-imaging technologies generally cannot be used without court orders to remove clients to the medical centers which offer the testing. These tests are usually ordered and interpreted by a neurologist or neuroradiologist. Interpretation can be controversial (raising the spectre of another battle of the experts), and false negatives can be harmful because absence of discernible damage may be falsely construed as establishing the brain’s integrity. These tests include:

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<th>Test</th>
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<td>CT</td>
<td>(Computerized Tomography), which uses X rays passed through the brain from multiple locations to detect density differences and generates three-dimensional images by computer analysis of density information to reveal brain structure only, typically with poor resolution and potential distortion;</td>
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<tr>
<td>MRI</td>
<td>(Magnetic Resonance Imagery), which uses magnetism and radio frequency to trigger resonance in subatomic particles of brain substance and generates images of brain structure by computer analysis of resonance data, with good resolution owing to differences in the imaging parameters of various brain tissues, such as white matter, gray matter, cerebrospinal fluid, blood, and diseased tissue;</td>
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<td>BEAM</td>
<td>(Brain Electrical Activity Mapping), which measures EEG activity and uses a computer to integrate electrical activity to generate topographic mapping of brain electrical activity, typically with poor resolution;</td>
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<td>RCBF</td>
<td>(Regional Cerebral Blood Flow), which uses isotopic techniques to</td>
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measure simultaneous blood flow from both hemispheres and multiple brain regions based on active neurons’ metabolic need for oxygen and glucose;

**PET** (Positron Emission Tomography), which measures metabolic activity (glucose utilization) to reveal functional brain activity during particular tasks, with computerized color imaging and moderate three-dimensional resolution; and

**SPECT** (Single Photon Emission Computerized Tomography), which uses photon-emitting radionuclides that, unlike positron emitters, do not require the availability of a dedicated cyclotron.²⁹

In addition to litigation issues of confidentiality and cost, researchers suggest three main reasons why neuropsychological testing may be preferable to imaging technologies in detecting brain damage:

“First, neuropsychological assessment is a noninvasive essentially risk-free procedure that can be used to aid in the determination of whether there is indication for CT or MRI when the index of suspicion is low.

“Second, lesions with substantial impact on behavior may still be undetected even with the highest resolution of MRI available. This holds for many instances of epilepsy, but also for many other patients likely to come to the attention of psychiatrists following head injuries, substance abuse, or exposure to toxins or to rule out dementia. Some of these lesions are too diffuse to be detectible; some do not involve anatomic destruction but are a result of metabolic aberrations that are not seen on CT or MRI. Even small destructive lesions in ‘strategic’ areas
can have devastating behavioral effects. This is particularly the case in subcortical regions where important functions are regulated by small nuclei.

“Third, the MRI or CT may show the region of anatomic destruction but will tell us nothing about the effect of the lesion on behavior. Neuropsychological deficits may be caused by remote metabolic suppression of brain regions functionally linked to the anatomically damaged area, and there is the ‘domino’ effect in which a behavioral dimension can be impaired because of a lesion affecting an essential component required for its regulation. Conversely, rather sizable lesions in areas that do not play a major role in regulating behavioral functions, or old lesions for which neural plasticity has already enabled the evolution of compensatory processes, may have little behavioral effect. Thus, neuropsychological assessment is essential for the psychiatrist to make the link between brain dysfunction and behavior.”

The other broad category of tests used by psychologists assesses personality functioning to help in the evaluation of intrapsychic organization and conflicts. These include objective tests like the Minnesota Multiphasic Personality Inventory (MMPI), Millon Clinical Multiaxial Inventory (MCMI), and the Child Behavior Checklist (CBCL), which rely on self-reporting on carefully specified questions with a limited range of answers. Examples include inventories of statements which the respondents endorse as true or false (such as, “I am afraid of losing my mind,” “I am full of energy,” or “My sex life is satisfactory”) or behavioral descriptions with answers within a range of choices (such as, “withdraws from others”: “never,” “sometimes,” or “frequently”). These tests are often scored and interpreted based on computer programs.

Personality functioning is also assessed with projective tests like the Rorschach, the Thematic Apperception Test (TAT), Incomplete Sentences, and Projective Drawings (House-
Tree-Person, Draw a Person). These rely on highly ambiguous stimuli (such as inkblots) to maximize freedom to respond uniquely. Faced with unstructured and plastic stimuli in an undefined and uncertain test situation, the individual is assumed to impose organization and meanings on the stimuli. Methodologies include association, construction, completion, and expressive techniques.

Personality testing, whether objective or projective, may be harmful in two ways and should never be administered without a clear, thoughtful reason for doing so in the context of the particular case and client. To the extent that they yield results which are subject to more than one interpretation, they create the “battle of the expert” which removes empathetic focus from the client. To the extent that they create data that a prosecution expert might interpret to support a harmful diagnostic label -- such as any of the so-called personality disorders -- they are a needless risk. (It should be noted that some states specifically identify personality disorders as not satisfying statutory criteria for affirmative defenses based on insanity.)

Prior Evaluations

Many of our clients, of course, have already suffered from harmful labeling in past evaluations, particularly the cursory, superficial intake evaluations that often occur when people are incarcerated for the first time. Absent a documented and reliable life history, the evaluator probably took the social history entirely from the client’s self-report, augmented only by the antisocial behaviors enumerated in the rap sheet or presentence report. Absent reliable medical history or neuropsychological testing, little consideration has been given to developmental or acquired abnormality in brain function. Given the presenting offense and the absence of floridly
psychotic symptoms, the drive-by evaluator is predisposed to the usual diagnosis: antisocial personality disorder, a pervasive and unremitting maladaptive pattern of behavior viewed as not particularly responsive to any treatment and significantly interfering with functioning or causing marked subjective distress. Estimates of an antisocial personality disorder diagnosis in an incarcerated male population range from 49 to 80 percent of male prisoners.\textsuperscript{35}

It is essential to collect and analyze all prior client evaluations, both to identify major mental illness and related treatment, but also to look behind the misleading and harmful labels which have been applied to the client in the past. Often the evaluator will accurately note symptoms or behaviors, but lack the historical information to understand the context. Drug use, for example, may be accurately documented, but its contextual significance could depend on corrupting influence of caretakers or attempts at self-medication following trauma. Moreover, diagnostic labels will have been applied in their own historical settings, which themselves evolve over time.

The bible of psychiatric diagnosis is the \textit{Diagnostic and Statistical Manual of Mental Disorders}, first published by the American Psychiatric Association in 1952 and last revised in 2000 as the \textit{DSM-IV-TR (Text Revision)}. Since 1980, the DSM has utilized a multiaxial system of diagnosis, which requires simultaneous consideration of a complex set of factors, including major mental illness (Axis I), longstanding and enduring personality traits and/or maturational delays (Axis II), medical illnesses that may affect psychological functioning (Axis III), environmental and psychosocial stressors that may influence psychological functioning (Axis IV), and the delineation of a longitudinal context (the so-called Global Assessment of Functioning, or GAF) for appraising psychological functioning (Axis V).
Noting that, especially in post-conviction death penalty litigation, our clients and their families have often received multiple prior mental health diagnoses, clinical psychologist Kathleen Wayland has pointed out: “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. . . . Thus, a complete, current, and accurate mental health evaluation of a particular client may require a critique of prior evaluations and diagnoses. This may include the ability to identify at what point in time the DSM was consulted, and may also necessitate an understanding of the theories and theoretical assumptions dictating the formulation of prior diagnoses.”36 Elsewhere, Dr. Wayland commented, “It is important to recognize that because changes in the DSM’s were guided by an effort to strengthen its empirical bases, with the goal of increasing reliability and validity, evaluations conducted under older versions of the DSM, particularly DSM-I and DSM-II, may carry a greater likelihood of misdiagnosis, inaccurate diagnosis, or failure to identify the existence of particular mental disorders.”37

Prosecutorial Rebuttal

In addition to preexisting hostile evaluations of capital clients, counsel must be prepared to contend with the likelihood of encountering highly paid rebuttal experts in death penalty cases. The New York Daily News recently noted how New York state courts limit the rates and total amounts which the defense can pay in death penalty cases, but prosecutors “can pay whatever rates they choose.” In New York’s first post-Furman death penalty trial, prosecutors paid California-based neuropsychologist Daniel Martell nearly $50,000 (at $300 per hour) to interview the defendant and “testify that the defendant didn’t suffer an emotional breakdown.”38
In most jurisdictions, evaluations by prosecution mental health experts will be demanded if the defense proffers an expert at any point in the proceeding. Since this area of law varies from one jurisdiction to the next and is still evolving, counsel should assess carefully how to respond to such demands.\textsuperscript{39} Even if the rebuttal expert has no direct access to the client, rebuttal testimony can be expected. The background and qualifications of rebuttal experts should be investigated meticulously.\textsuperscript{40}

Some years ago, the \textit{New Yorker} profiled psychiatrist Park Dietz,\textsuperscript{41} who was then the prosecution’s expert witness in the Long Island trial of an alleged serial killer of prostitutes. Dr. Dietz had already testified in several high-profile cases, including the trials of Jeffrey Dahmer, Arthur Shawcross, and Betty Broderick. Dr. Dietz is now a consultant to the FBI’s Profiling and Behavioral Assessment Unit and the New York State Police Forensic Sciences Unit. He has no clinical practice, but only a lucrative forensic practice billed in 1994 at $3,000 a day or $250 per hour.

In the Long Island case, a defense expert had tested the client and found him “off the scale” for paranoid schizophrenia. The defense expert testified that the alleged serial killer had “an extreme inability to think logically or experience time.” Dr. Dietz countered that the client’s behavior was highly organized, and his memory of what he had done was cogent and precise. According to Dr. Dietz, the alleged killer had acted out asphyxiations inspired by a graphic scene in a Hitchcock film; dismembered his victims; stuffed the parts into barrels and milk crates; and disposed of them in rivers, culverts, and wooden areas -- often after driving around in his pickups with the corpses straddling him.

Dr. Dietz testified that Jeffrey Dahmer knew right from wrong based on Dahmer’s need
to consume alcohol before he killed and dismembered his victims. Dr. Dietz inferred that Dahmer found those acts aversive; he needed alcohol to overcome his moral inhibitions.

Dr. Dietz calls his discipline “medical criminology.” He relies heavily on traditional forensic pathology in homicide cases: for example, proving intent in asphyxiation cases by knowing how much pressure is required to strangle someone, or proving that a shooter aimed carefully by showing that an inaccurate firearm was employed. He prides himself in being interested in physical evidence surrounding the homicide, rather than the client’s life history. He refutes impulsive, spontaneous, ungoverned behavior by showing planning and calculation, consciousness of guilt and self-awareness.

Dr. Dietz’s colleague, psychologist Daniel Martell, has relied heavily on the Hare psychopathy checklist to establish that defendants are cold-hearted and remorseless. His testimony stresses the traditional test of responsibility: that a defendant was able to conform his conduct to the requirements of the law and had no significant impairment in his ability to control his behavior at the time of the offense. He will concede mental and emotional problems, but dispute severity -- to establish that the defendant has not attained a level of “extreme emotional or mental disturbance.”

In a Texas case where Dr. Martell was not permitted to examine the defendant, he based his testimony on 2,000 pages of police reports, witness statements, and the reports and test data of other mental health experts. The defense had presented testimony about child abuse, including neglect, physical maltreatment, and sexual abuse. Dr. Martell’s rebuttal was two-pronged:

1. The defense evidence of abuse was anecdotal, rather than officially documented.
2. Some research suggests that there is little or no correlation between child abuse
and adult violent behavior.

The defense had also presented testimony of brain dysfunction. Dr. Martell used imaging reports to minimize anatomical findings, attributed low cognitive functioning in some neuropsychological tests to the effects of situational depression arising from the capital charges and the conditions of confinement, but conceded, nonetheless, some brain damage in the form of occipital or parietal lobe damage. He found that “limited” brain damage insufficient to cause the defendant not to be able to control his behavior as he carried out the crime.

Dr. Martell exploited defense expert disagreements about the extent of the client’s depression to rule out, in his own diagnosis, severe depression. He then went on for eighteen pages of uninterrupted testimony to offer his “forensic behavior assessment” -- that is, the client’s behavior during the course of the offense as an indication of mental state. His assessment emphasized various points:

1. Preparation and stalking, to show foresight, not impulsivity.
2. Selection of victim.
3. Getaway planning.
4. Cover-up activities.

In a federal death penalty trial in New York, Dr. Martell did not score the Hare Psychopathy Checklist himself, but instead offered its criteria to the jury as a sort of do-it-yourself test of psychopathic evil -- listing glibness, grandiosity, proneness to boredom, pathological lying, manipulativeness, lack of remorse, shallow affect, lack of empathy, parasitic lifestyle, poor behavioral controls, promiscuity, early behavior problems, lack of realistic long-term plans, impulsivity, irresponsibility, multiple marital relationships, failure to accept
responsibility, juvenile delinquency, poor risk for conditional release, and criminal versatility.

Capital defense counsel can anticipate jurors hearing these criteria in some form or other whenever rebuttal experts come forward.

Dr. Dietz discussed five categories among mentally disordered offenders at an ABA panel in 1997:

1. Crime committed in response to psychotic symptoms
2. Crime committed to gratify compulsive desires
3. Crime reflecting a personality disorder
4. Crime that is coincidental with a mental disorder; and
5. True or feigned mental disorder in response to crime.

Dr. Dietz argued that only the first category contains valid insanity, diminished capacity, or mens rea defenses. He went on to suggest that the appropriate professional role for a mental health expert is to function as a forensic scientist, not as an advocate nor as a clinical psychiatrist. According to the report of his presentation, “Whereas the clinical psychiatrist ‘wants to help’ and is not concerned with evidentiary issues or the truth, the forensic psychiatrist is concerned with truth and should not allow empathy to intrude.” [Emphasis added]

Conclusion

Mental disabilities are part of the “diverse frailties of humankind” that need to receive individualized consideration in capital sentencing. They may explain, but never excuse, tragic crimes. They may evoke empathy from jurors without needing to reach the legal standards associated with competency and responsibility. If experts testify, their job is to help the jury to
understand the human context, to see the impact of disability on the range of choices the capital client could make in everyday life, and to trace the origin of the disabilities to biological, environmental, psychological and social influences which the client never chose. They must draw upon all their understanding of the human brain and human behavior to evoke empathy for the individual who suffers the disability and damage of neurological and/or psychiatric deficits. In doing so, they may also help to impart a larger public-health lesson -- one modest case study towards a better understanding of violence and homicide at the dawn of the twenty-first century.

Endnotes

1. I have chosen the term “disability” to encompass the broad range of mental conditions which handicap clients emotionally, intellectually, psychologically, and socially and thus render them potentially less culpable. These incapacitating or diminishing conditions include, but are not limited to, mental “disease” and “defect,” in the traditional legal nomenclature of sanity and responsibility.

3. 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.” See Craig Haney, “Violence and the Capital Jury: Mechanisms of Moral Disengagement and the Impulse to Condemn to Death,” Stanford Law Review, v. 49 (July 1997), pp. 801-821, at p. 814.

4. See, for example, Elinor J. Brecher, “The devil (TV, Twinkies) made me to it: Why do so few people take the blame for their actions?” The Journal News (Knight Ridder Newspapers), January 25, 1999, p. 3E.


6. 470 U.S. 68, 105 S.Ct. 1087, 84 L.Ed.2d 53 (1985) (denial of expert psychiatric assistance to indigent defendant where defendant’s sanity was a significant factor at both guilt and penalty phases of trial constituted a denial of due process).

7. See, for example, Bloom v. Calderon (9th Cir. Dec. 24, 1997) 132 F.3d 1267, 1997 WL 786920 (trial counsel’s lack of effort to obtain psychiatric expert until days before capital trial, combined with counsel’s failure to prepare expert adequately and then present him as trial witness, was constitutionally deficient performance).

8. A recent decision from the Ninth Circuit raises another risk in prematurely involving experts. In Pawlyk v. Wood (9th Cir. Jan. 19, 2001) 237 F.3d 1054, the court upheld compelled disclosure of the evaluation of the first defense expert to see the client, even though the defense called only a second expert to testify, noting, “That due process guarantees a defendant access to a single, competent psychiatrist, but does not guarantee a favorable evaluation, leads inevitably to the conclusion that a psychiatrist’s evaluation or opinion may have an adverse, but constitutionally permissible, effect on particular mental status defenses that a defendant might wish to present.”


10. Self-destructive behaviors can include efforts to provoke a death verdict at trial -- or to waive appellate review of a death sentence. Eleven of the sixty-eight prisoners executed in 1998 had dropped their appeals, compared to six in 1997. Six prisoners had executions stayed in 1998 because counsel filed for stays over the prisoners’ objections. Over the preceding four years, one in seven executions had involved a prisoner who “volunteered” by waiving appeals. See Richard Willing, “Death row inmates asking more to end court appeals, be executed,” Ithaca Journal
(Gannett News Service), February 1, 1999, p. 1A. During the first five years of New York’s new death penalty statute, four defendants who faced capital charges took their own lives. During the first twenty years of California’s death penalty statute, more death-sentenced prisoners died by suicide (twelve) than by execution (four). 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 Sara Rimer, “Life After Death Row,” *New York Times Magazine* (December 10, 2000), pp. 100-109. For a brilliant study of the general phenomenon of suicide, see Kay Redfield Jamison, *Night Falls Fast: Understanding Suicide* (New York: Alfred A. Knopf, 1999).

11. Failure to investigate the background of defense experts can have devastating consequences, and the high stakes of capital litigation ensure that every expert is under greater scrutiny than in more routine cases. A defense expert in Ted Bundy’s case was subsequently convicted of perjury for falsely claiming to have a doctorate in clinical psychology. See *Kline v. State*, 444 So.2d 1102 (Fla. Ct. App. 1984) (“Misrepresentations which tend to bolster the credibility of a witness, whether successful or not, are regarded as material for purposes of supporting a perjury conviction.” *Kline* at 1104-5) The client may suffer for counsel’s failure to discover what the prosecutor may learn by running a rap sheet. See *Evans v. New York*, 684 N.Y.S.2d 648 (A.D. 3 Dept. 1999) (no ineffective assistance of counsel where defense failed to inquire about criminal history of its psychiatric expert; no statutory, constitutional or common law authority requiring State to disclose criminal history of defense witness). Or counsel may be found ineffective for repeated use of an incompetent expert. In *Skaggs v. Parker*, 6th Cir., No. 98-6249 (12/18/00), defendant raised a mental illness defense during both the guilt and penalty phases. The defense expert misrepresented during guilt phase that he was a licensed clinical and forensic psychologist. The court found counsel irresponsible for presenting the expert a second time, after viewing his incoherent and fraudulent testimony during the first phase.


14. Capital cases raise other unique mental-disability issues besides those relating to mitigation -- most importantly, competency to be executed. See *Ford v. Wainwright*, 477 U.S. 399, 106 S.Ct. 2595, 91 L.Ed.2d 335 (1986) (Eighth Amendment prohibits the execution of the insane; state procedures which place the ultimate decision wholly within the Executive Branch and deny the condemned the right to submit evidence or challenge or impeach the state-appointed psychiatrists are insufficient; because Ford’s procedures in state court were inadequate, he is entitled to a hearing in federal court on his competency to be executed). See also Kent S. Miller and Michael L. Radelet, *Executing the Mentally Ill* (Newbury Park, Ca.: Sage Publications, 1993), for a full discussion of the issues raised in the case of Alvin Ford. See also Michael L.

15. Psychologist Kathleen Wayland has prepared a bibliography of literary works which illuminate the world as it is experienced by the mentally ill. See Kathleen Wayland, “The Phenomenology of Mental Illness and Organic Impairments: Understanding the Inner Experience and Symptoms of Mental Illness through Non-Fiction, Literature, and (Auto)Biography,” monograph published by the California Appellate Project, San Francisco, California (summer 2000). The bibliography covers psychotic disorders, mood disorders, organic impairments/developmental disorders, anxiety disorders, and substance use disorders.

16. NY Crim Pro § 400.27.9(b) - (e).


‘retrospective falsification, in which the patient changes the reporting of past events or is selective in what is able to be remembered, is a constant hazard of which the psychiatrist must be aware.’ [citation omitted]


25. It is also prudent to note that the rules of litigation change over the long life of a capital case, particularly where post-conviction proceedings may be involved. Even in jurisdictions where test results or reports of nontestifying experts may not be discoverable at trial, counsel should consider the likelihood that they will be exposed to different discovery ground rules in both state and federal post-conviction litigation.

26. For a detailed discussion of individual neuropsychological tests, the standard reference in the field is Muriel Deutsch Lezak, Neuropsychological Assessment, 3rd edition (New York: Oxford University Press, 1995).

27. For an excellent survey of recent research on brain and behavior, see Rita Carter, Mapping the Mind (Berkeley and Los Angeles: University of California Press, 1999). The book is so profusely illustrated that it has been described as a visual guide to the brain. The author is a British medical and science writer, so it is also eminently readable.

28. Ruben C. Gur and Raquel E. Gur, “Methods for the Study of Brain-Behavior Relationships,” in Alan Frazer, Perry B. Molinoff, and Andrew Winokur, eds., Biological Bases of Brain Function and Disease (New York: Raven Press Ltd., 1994), ch. 15, pp. 261-279, at p. 266. In this chapter, see also Table 1, at p. 269, “Deficits in behavioral dimensions and corresponding areas of brain damage associated with these deficits,” identifying which different regions are associated with deficits in abstraction and mental flexibility, memory, face recognition, emotional expression, etc. Brain development is as critical as brain damage, in the sense that the inhibitory functions of the prefrontal cortex are not present at birth and take two decades to be fully operational. According to Daniel R. Weinberger, director of the Clinical Brain Disorders Laboratory at the National Institutes of Health, “. . . the evidence is unequivocal that the prefrontal cortex of a 15-year-old is biologically immature. The connections are not final, the networks are still being strengthened and the full capacity for inhibitory control is still years away.” Weinberger, “A Brain Too Young for Good Judgment,” New York Times, March 10, 2001, p. A13.

29. See Carter, op. cit., pp. 26-27, for color illustrations of MRI, fMRI, PET, and other imaging technologies, as well as a lucid discussion of their diagnostic and research applications.

31. It should be noted that psychiatrists are not trained to administer psychological tests. If there is a thoughtful decision to go forward with testing, it should always be administered by a psychologist with appropriate training and experience.

32. The National Football League has commissioned its own inch-thick questionnaire “to examine the psyches of players they might offer seven-figure contracts,” according to the *New York Times*, December 25, 2000, p. D8. The newspaper reported the favorite questions of an offensive lineman from Alabama: “Have you ever teased animals?” and “Do dirty jokes a) make you laugh or b) embarrass you?”

33. For evolving trends in the approach to these disorders, see “Personality Disorders,” Parts I and II, *Harvard Mental Health Letter*, v. 16, nos. 9 and 10 (March and April 2000).

34. See, for example, California Penal Code § 25.5: “In any criminal proceeding in which a plea of not guilty by reason of insanity is entered, this defense shall not be found by the trier of fact solely on the basis of a personality or adjustment disorder . . .”


40. See Lindh v. Murphy (7th Cir., 1997) 124 F.3d 899 (defendant’s confrontation rights were prejudicially violated at the mental-conviction phase of his murder trial where the trial court prohibited defendant from impeaching the prosecution’s psychiatrist with evidence that the psychiatrist had sexually abused some of his patients, was about to lose his medical license and his prestigious faculty positions, and stood a chance of going to prison, since the prosecution portrayed the expert as an eminent psychiatrist with impeccable credentials).

42. R. D. Hare, *The Hare Psychopathy Checklist -- Revised* (Toronto: Multi-Health Systems, 1991). The psychopathy checklist attempts to identify a small universe of deviants than the broader criteria of antisocial personality disorder, using a structured interview and records review to measure maladaptive personality traits and deviant lifestyle based on twenty items scored 0, 1 or 2 (total score = 0 to 40), with diagnosis of psychopathy requiring score of 30.


46. Ibid., at p. 1541.