DECONSTRUCTING ANTISOCIAL PERSONALITY DISORDER AND PSYCHOPATHY: A GUIDELINES-BASED APPROACH TO PREJUDICIAL PSYCHIATRIC LABELS

*Kathleen Wayland**
*Sean D. O'Brien***

I. INTRODUCTION

Randall Dale Adams was on trial for his life for the murder of a Dallas police officer.[1] Under Texas law, the jury can return a sentence of death only if the prosecution proves beyond a reasonable doubt that Adams would be dangerous in the future.[2] To meet this burden, Doctors John Holbrook and James Grigson[3] told the jury that they evaluated Adams, and concluded that he had antisocial personality disorder ("ASPD") and that he was a sociopath—a remorseless killer, devoid of morality, incapable of empathy, and bent on self-gratification.[4] Grigson

* Kathy Wayland, Ph.D., is a clinical psychologist who consults with capital defense teams and specializes in issues related to mitigation themes, psychological trauma, and mental health.

** Sean D. O'Brien is an Associate Professor at University of Missouri-Kansas City School of Law, where he teaches courses in criminal law, the death penalty, and mental health law. We are deeply grateful for the invaluable assistance of the people who reviewed this document and provided thoughtful and valuable edits, suggestions, resources, and assistance: John Edens, Ph.D.; David Freedman, M.Phil., M.S.; James Pultz; Andrew Rowland, Ph.D.; and Russ Stetler. We give a special thanks to our Research Assistants, UMKC School of Law graduate Gregory Doty and student Matthew Miguel Peters, whose excellent, hard work was vital to the quality and integrity of our final product.

1. *See* Adams v. State, 577 S.W.2d 717, 719 (Tex. Crim. App. 1979) (en banc).

2. TEX. CODE CRIM. PROC. ANN. art. 37.071 § 2(a)–(b) (West 2006).

3. In more than one hundred trials that ended in death verdicts, Grigson testified that he found the defendant to be an incurable sociopath who was one hundred percent certain to kill again. *See* RON ROSENBAUM, TRAVELS WITH DR. DEATH AND OTHER UNUSUAL INVESTIGATIONS 206-07 (1991) (analyzing numerous cases Grigson has taken part in). Grigson was sanctioned by the American Psychiatric Association for egregious misconduct in the performance of court-ordered competency evaluations. Mark D. Cunningham & Alan M. Goldstein, *Sentencing Determinations in Death Penalty Cases*, *in* 11 HANDBOOK OF PSYCHOLOGY: FORENSIC PSYCHOLOGY 407, 413 (Alan M. Goldstein ed., 2003).

4. *See Adams*, 577 S.W.2d at 731.

told the jury that, because of his sociopathic personality, Adams would certainly kill again.[5] The prosecutor told the jury that failing to execute Adams would endanger police officers, "the thin blue line" protecting society from anarchy.[6] The jury returned a verdict of death, and the Texas Court of Criminal Appeals affirmed, finding that the testimony of Grigson and Holbrook was sufficient proof of Adams's future dangerousness to justify his execution.[7]

The rest of Adams's story is well known. Only three days before his scheduled capital punishment, the Supreme Court stayed Adams's execution and granted certiorari.[8] Finding that the Texas requirement that capital jurors swear their verdict will not be "affected" by moral reservations about the death penalty is unconstitutional, the Supreme Court ordered a new sentencing trial.[9] It was subsequently revealed that the police manufactured the testimony of the eyewitness who identified Adams as the shooter.[10] She had previously identified someone other than Adams from the line-up, and was told she had selected the wrong person.[11] Her initial written statement to the police, which had been withheld from the defense, described the shooter as a light-skinned Mexican or black male with a three-inch afro.[12] Adams was a balding Caucasian with a pale complexion.[13] Based on this and other new evidence establishing his innocence, Texas courts set aside Adams's conviction and released him.[14] The story of his wrongful conviction is told in the documentary, *The Thin Blue Line*.[15]

Adams was the first of several Texas defendants who were sentenced to death when juries determined that they would kill again, and who were subsequently proven innocent of having ever killed before.[16] These and other cases raise serious concerns about the use of

---

5. *See id.*

6. *See* Charles Musser, *Film Truth, Documentary, and the Law: Justice at the Margins*, 30 U.S.F. L. REV. 963, 974 (1996); *see also* THE THIN BLUE LINE (Miramax Films 1988).

7. *Adams*, 577 S.W.2d at 731.

8. Douglas Martin, *Randall Adams, 61, Dies; Freed with Help of Film*, N.Y. TIMES, June 26, 2011, at A24.

9. Adams v. Texas, 448 U.S. 38, 50-51 (1980).

10. *Ex parte* Adams, 768 S.W.2d 281, 291 (Tex. Crim. App. 1989) (en banc).

11. *Id.* at 286.

12. *Id.*

13. THE THIN BLUE LINE, *supra* note 6.

14. *Ex parte Adams*, 768 S.W.2d at 294.

15. THE THIN BLUE LINE, *supra* note 6.

16. Graves v. Dretke, 442 F.3d 334, 336, 345 (5th Cir. 2006); Graves v. Cockrell, 351 F.3d 143, 146 (5th Cir. 2003); Guerra v. Collins, 916 F. Supp. 620, 623, 636-37 (S.D. Tex. 1995); *Ex parte* Toney, AP-76056, 2008 WL 5245324, at *1 (Tex. Crim. App. Dec. 17, 2008); *Ex parte* Blair, No. AP-75954, 2008 WL 2514174, at *1-2 (Tex. Crim. App. June 25, 2008); *Ex parte* Brandley, 781 S.W.2d 886, 894-95 (Tex. Crim. App. 1989); Skelton v. State, 795 S.W.2d 162, 163, 170 (Tex.

ASPD and related constructs, such as psychopathy, in life-and-death matters. Indeed, diagnostic criteria for personality disorders, including ASPD, have been debated and criticized on many grounds, including lack of validity and reliability.[17] The use of related constructs, such as psychopathy, is also controversial. As shown in Mr. Adams's case, expert testimony about these conditions has potentially enormous prejudicial consequences.

This Article examines the use of evidence about ASPD in death penalty cases, and how compliance with the American Bar Association ("ABA") Guidelines for the Appointment and Performance of Defense Counsel in Death Penalty Cases ("ABA Guidelines")[18] and the Supplementary Guidelines for the Mitigation Function of Capital Defense Teams ("Supplementary Guidelines")[19] (together "ABA and Supplementary Guidelines") reduce the risk that such evidence will result in an unfair sentence of death. In Part II, we examine the construct of ASPD and related concepts, how such testimony is presently used in cases involving the death penalty, and data demonstrating the impact of such testimony on capital decision makers.[20] In Part III, we discuss scientific and ethical controversies within the clinical and research community surrounding ASPD and psychopathy, such as issues related to the subjectivity of these constructs, flaws in the reliability and validity of the constructs, and associated assessment methods and instruments.[21] Part IV explains how a thorough psychosocial history, conducted in accordance with prevailing ABA and mental health standards, can avoid or counter opinions of ASPD.[22] We conclude that constructs of ASPD or psychopathy should not be used in capital sentencing proceedings because they are unreliable and prejudicial.[23] Until courts begin excluding such evidence, capital defendants are best protected when their defense teams strictly comply with the ABA and Supplementary Guidelines.

Crim. App. 1989).

17. Mark D. Cunningham & Thomas J. Reidy, *Antisocial Personality Disorder and Psychopathy: Diagnostic Dilemmas in Classifying Patterns of Antisocial Behavior in Sentencing Evaluations*, 19 BEHAV. SCI. & L. 333, 334 (1998).

18. ABA GUIDELINES FOR THE APPOINTMENT AND PERFORMANCE OF DEFENSE COUNSEL IN DEATH PENALTY CASES (rev. ed. 2003), *in* 31 HOFSTRA L. REV. 913 (2003) [hereinafter ABA GUIDELINES], *available at* http://www.ambar.org/2003Guidelines.

19. SUPPLEMENTARY GUIDELINES FOR THE MITIGATION FUNCTION OF DEFENSE TEAMS IN DEATH PENALTY CASES, *in* 36 HOFSTRA L. REV. 677 (2008) [hereinafter SUPPLEMENTARY GUIDELINES].

20. *See* discussion *infra* Part II.

21. *See* discussion *infra* Part III.

22. *See* discussion *infra* Part IV.

23. *See* discussion *infra* Part V.

II. AN OVERVIEW OF ANTISOCIAL PERSONALITY DISORDER AND PSYCHOPATHY

ASPD is one of ten disorders currently grouped in the personality disorder category.[24] According to the Diagnostic and Statistical Manual of Mental Disorders ("DSM"), "[t]he essential feature of [ASPD] is a pervasive pattern of disregard for, and violation of, the rights of others that begins in childhood or early adolescence and continues into adulthood."[25] Other terms that have historically been used include sociopathy, dissocial personality disorder, and psychopathy. While these terms are often used interchangeably with ASPD in the legal field, they are not identical, and a diagnosis of ASPD is not the same as labeling someone a "psychopath" or "sociopath."[26] Therefore, using these terms as though they are synonymous is incorrect and often causes confusion. "Psychopathy" is not officially recognized in our current diagnostic nomenclature, as defined in the United States by the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition ("DSM-5").[27]

As set forth in the DSM-5, specific diagnostic criteria for ASPD are as follows:

> A. A pervasive pattern of disregard for and violation of the rights of others occurring since age 15 years, as indicated by three (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;

---

24. Personality disorders are defined as "an enduring pattern of inner experience 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." AM. PSYCHIATRIC ASS'N, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS 645 (5th ed. 2013) [hereinafter DSM-5]. The DSM-5 supersedes the *Diagnostic and Statistical Manual of Mental Disorders*, Fourth Edition Text Revision ("DSM-IV-TR"), published in 2000. *See* AM. PSYCHIATRIC ASS'N, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS (4th ed. 2000) [hereinafter DSM-IV-TR]. Despite proposals for significant changes to the existing personality disorder structure, "the categorical listing of personality disorders in the DSM-5 remains virtually unchanged from the previous edition." Mark Moran, *Continuity and Changes Mark New Text of DSM-5*, PSYCHIATRIC NEWS 1 (Jan. 18, 2013), http://psychnews.psychiatryonline.org/newsarticle.aspx?articleid=1558423. Thus, the controversies discussed in this Article will persist with the DSM-5.

25. DSM-5, *supra* note 24, at 659.

26. Norman Poythress et al., *Identifying Subtypes Among Offenders with Antisocial Personality Disorder: A Cluster-Analytic Study*, 119 J. ABNORMAL PSYCHOL. 389, 390 (2010).

27. The DSM-5 text language notes that ASPD has also been referred to as psychopathy. DSM-5, *supra* note 24, at 659; *see also* Poythress et al., *supra* note 26, at 390 (discussing these issues).

(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 18 years of age.

C. There is evidence of conduct disorder[28] with onset before age 15 years.

D. The occurrence of antisocial behavior is not exclusively during the course of schizophrenia or a manic episode.[29]

In addition to the criteria listed above, the DSM-5 describes persons with ASPD as "lack[ing] empathy and tend[ing] to be callous, cynical, and contemptuous of the . . . rights . . . of others."[30] Such persons "may have an inflated and arrogant self-appraisal . . . and may be excessively opinionated, self-assured, or cocky. They may display a glib, superficial charm and can be quite voluble and verbally facile."[31] None of these characteristics engender empathy for a capital defendant, and they are severely prejudicial. Yet, these characteristics are also subjectively judgmental and sufficiently ambiguous in order to mask manifestations of severe mental illness, as discussed below in Part IV.[32] To fully understand the danger of an unreliable diagnosis of ASPD to capitally charged or convicted clients, it is important to know the ways in which ASPD is used by courts and prosecutors.

Recently, prosecution forensic examiners are using the construct of psychopathy, which is not a diagnosis in the DSM-5. While the term psychopathy has had a variety of meanings over the past century, the concept was narrowed in the first half of the twentieth century to focus largely on interpersonal traits.[33] The modern concept of psychopathy is attributed to Hervey Cleckley's *The Mask of Sanity*, which was published in 1941.[34] Canadian psychologist Robert Hare, who attempted

28. DSM-5, *supra* note 24, at 469-70.

29. *Id.* at 659.

30. *Id.* at 660.

31. *Id.*

32. *See* discussion *infra* Part IV.

33. *See infra* note 35 and accompanying text.

34. HERVEY CLECKLEY, THE MASK OF SANITY (1941). Cleckley's work has been criticized for ignoring evidence of severe mental illness among the patients he used to define psychopathy. Dorothy O. Lewis, *Adult Antisocial Behavior, Criminality, and Violence*, *in* KAPLAN & SADOCK'S COMPREHENSIVE TEXTBOOK OF PSYCHIATRY 2258, 2260 (5th ed. 2003) [hereinafter Lewis, *Adult Antisocial Behavior*]. Among Cleckley's white collar criminal case studies, one psychiatrist

to operationalize the work of Cleckley, describes psychopathy as "a specific form of personality disorder with a distinctive pattern of interpersonal, affective, and behavioral symptoms."[35] According to Hare, "psychopaths are grandiose, arrogant, callous, superficial and manipulative; affectively, they are short-tempered, unable to form strong emotional bonds with others, and lacking in guilt or anxiety; and behaviorally, they are irresponsible, impulsive, and prone to delinquency and criminality."[36]

Hare developed the Psychopathy Checklist ("PCL")[37] and the Psychopathy Checklist-Revised ("PCL-R"),[38] which have become widely used in forensic settings. His original objective was to develop an instrument that would operationalize the construct of psychopathy.[39] The PCL-R is a checklist that consists of the following twenty items:

1. Glibness/superficial charm
2. Grandiose sense of self-worth
3. Need for stimulation/proneness to boredom
4. Pathological lying
5. Conning/manipulative
6. Lack of remorse or guilt
7. Shallow affect
8. Callous/lack of empathy
9. Parasitic lifestyle
10. Poor behavioral controls
11. Promiscuous sexual behavior
12. Early behavioral problems
13. Lack of realistic, long-term goals
14. Impulsivity
15. Irresponsibility
16. Failure to accept responsibility for own actions

---

observed that the "flamboyant ways the massive ill-gotten gains were used," such as purchasing mink tuxedos and massive art collections, suggest "more serious psychopathology than mere character disorders." *Id.* at 2259. Another of Cleckley's "so-called psychopaths" was so mentally ill that he "had been confined in mental hospitals for almost half his adult life," and his history of manic episodes included jumping fully clothed into a creek in the middle of winter and running naked through the streets of town. *Id.* at 2260.

35. Robert D. Hare et al., *Psychopathy and Sadistic Personality Disorder*, *in* OXFORD TEXTBOOK OF PSYCHOPATHOLOGY 555, 555 (Theodore Millon et al. eds., 1999).

36. *Id.* at 555-56.

37. Robert D. Hare, *A Research Scale for the Assessment of Psychopathy in Criminal Populations*, 1 PERSONALITY & INDIVIDUAL DIFFERENCES 111, 114-18 (1980).

38. ROBERT D. HARE, THE HARE PSYCHOPATHY CHECKLIST-REVISED 1 (Multi-Health Systems, 2d ed. 1991).

39. Hare has expressed grave reservations about misuses of his instrument, which has been extended far beyond the goals for which it was designed. *See infra* notes 210-24 and accompanying text.

17. Many short-term marital relationships
18. Juvenile delinquency
19. Revocation of conditional release
20. Criminal versatility[40]

The Sixth Circuit Court of Appeals recently relied on fifteen of the PCL-R characteristics to justify a federal prisoner's sentence of death, asserting that the defendant's behavior "fits the checklist for severe psychopathy in the psychiatric literature."[41]

Testimony labeling a capital defendant antisocial or psychopathic has one overriding purpose: to obtain and carry out a sentence of death. In the most general sense, such evidence is dehumanizing. A prosecution expert in one capital trial testified that the defendant was a psychopath, and used an analogy to suggest that the defendant was not actually human:

> The psychopath, as I say, has the ability to look very normal. However, if you know what you are looking for, it is kind of like seeing a bowl of fruit, and you say to yourself, gosh that bowl of fruit looks wonderful, it looks very good. But when you get close to the bowl of fruit and pick it up you realize that it's fake fruit. And the psychopath is a lot that way.[42]

The ASPD or psychopathy label invokes the stereotype of "unfeeling psychopaths who kill for the sheer pleasure of it, or as dark, anonymous figures who are something less than human."[43]

Judicial decisions discussing ASPD and psychopathy almost uniformly reflect reliance on the dehumanizing stereotype. In *Guinan v. Armontrout*,[44] the court affirmed a death sentence by relying on testimony that Frank Guinan's antisocial personality made him "aggressive, impulsive, unreliable in maintaining employment," and resulted in his "getting in trouble with the law again at [an] early age."[45] The court summarized the impact of the ASPD diagnosis on Guinan's sentencing profile:

---

40. Hare et al., *supra* note 35, at 558 tbl.22.1. The core features of the PCL and the PCL-R are taken from Cleckley's 1950 list of the sixteen characteristics he believed to be typical of the psychopath. Lewis, *Adult Antisocial Behavior*, *supra* note 34, at 2260.

41. United States v. Gabrion, 648 F.3d 307, 319 (6th Cir. 2011).

42. United States v. Barnette, 211 F.3d 803, 821, 823 (4th Cir. 2000) (quoting the trial testimony of prosecution expert Doctor Scott Duncan).

43. Craig Haney, *The Social Context of Capital Murder: Social Histories and the Logic of Mitigation*, 35 SANTA CLARA L. REV. 547, 549 (1995) [hereinafter Haney, *The Social Context*].

44. 909 F.2d 1224 (8th Cir. 1990).

45. *Id.* at 1229, 1234.

> In sum, there is simply no evidence in the record or the psychiatric evaluation to suggest that Guinan's mental problems can be characterized as anything more than personality disorders evidenced by violent and inappropriately aggressive behavior. *We suspect that most capital murder defendants are likely to fit this personality profile*. *Whether evidence of this type would be considered mitigating by a jury is highly doubtful*. The psychiatric evaluation portrays Guinan as an individual prone to violent outbursts due to an aggressive personality disorder which is extremely resistant to treatment.[46]

This image fits the stereotype of the "typical criminal" which attributes deviant behavior "exclusively to negative traits, malevolent thoughts, and bad moral character."[47] Craig Haney, a nationally renowned social psychologist with many years of experience in the assessment of persons accused of violent behavior, warns that the fictional stereotype of the psychopathic criminal facilitates the jury's decision to "assign the offender the mythic role of Monster, a move which justifies harsh treatment and insulates us from moral concerns about the suffering we inflict."[48] The gratuitous comment in *Guinan* that most death row inmates are probably antisocial demonstrates the considerable sway that this stereotype holds over capital decision makers, jurors, and judges alike.[49] Thus, if believed, testimony that the defendant has ASPD or is psychopathic diminishes substantially the likelihood that a jury will perceive him or her as a unique, complex human being who is worthy of their mercy.

In addition to appealing to this dehumanizing stereotype, prosecutors often use expert testimony that the defendant is antisocial to

---

46. *Id.* at 1230 (emphasis added). Resistance to treatment is one of the assumptions about ASPD that is open to debate. *See* text accompanying *infra* notes 141-43.

47. Craig Haney, Comment, *Exoneration and Wrongful Condemnations: Expanding the Zone of Perceived Injustice in Death Penalty Cases*, 37 GOLDEN GATE U. L. REV. 131, 145 (2006).

48. *Id.* (quoting Samuel Pillsbury, *Emotional Justice: Moralizing the Passions of Criminal Punishment*, 74 CORNELL L. REV. 655, 692 (1989)). Other researchers have found substantial evidence that there exist considerable differences in how mental illness is conceptualized by the mental health field and the lay public; and laypersons' perceptions of such illnesses are particularly important in the legal field, as jurors' reactions to evidence of mental illness can be stigmatizing and cause the defendant to be perceived as dangerous. *See* John F. Edens et al., *Bold, Smart, Dangerous and Evil: Perceived Correlates of Core Psychopathic Traits Among Jury Panel Members*, 7 PERSONALITY & MENTAL HEALTH 143, 143, 150 (2013). In a study to further investigate layperson perceptions of psychopathy, an ethnically diverse sample of 285 community members attending jury duty reviewed a vignette about a capital murder trial and rated perceptions of the defendant's psychopathic characteristics according to items loosely based on trait labels on the PCL-R. *Id.* Study results indicated that laypersons associate psychopathy with boldness (social dominance and fearfulness), intelligence, violence potential, and "evil." *Id.* The results raise serious questions about the potential for stigmatization of people labeled as psychopaths in forensic settings. *Id.*

49. *Guinan*, 909 F.2d at 1230.

accomplish specific strategic purposes. For example, ASPD is commonly used to imply that the defendant is "a dangerous individual, incapable of rehabilitation in the prison system."[50] Further, prosecutors and courts use ASPD to portray a defendant as "'selfish [and] very impulsive,' showing 'little in the line of responsibility' or concern 'for the needs or wants of others,' and 'hav[ing] little in the line of guilt or remorse.'"[51] This is of considerable significance because it is well established that capital sentencing verdicts are heavily influenced by the jurors' perceptions of the defendant's remorse.[52] Professor Scott Sundby's analysis of Capital Jury Project[53] data shows that "a jury that believes the defendant is truly remorseful is very likely to settle on a life sentence."[54] However, if a jury is convinced that the defendant is antisocial, even his sincere expressions of remorse may be misinterpreted as sociopathic manipulation.[55]

Perhaps most troublesome is the attempt by some forensic examiners to equate ASPD with evil. This has been challenged on both scientific and ethical grounds. Doctor Robert Simon, a clinical professor of psychiatry at Georgetown Medical School, warns that "[d]iagnoses such as psychopathology, personality disorder, and conduct disorder may be used by some as more of a moral judgment than a clinical diagnosis."[56] However, Doctor Michael Welner, who frequently testifies

---

50. *Id.*; *see also* Satterwhite v. Texas, 486 U.S. 249, 253 (1988) (the prosecution presented expert testimony that defendant had "a severe antisocial personality disorder and is extremely dangerous and will commit future acts of violence"); Hammet v. Texas, 448 U.S. 725, 729 (1980) (Marshall, C.J., dissenting) (noting "a customary pattern of conduct" by Texas authorities to present "punishment-stage testimony by the court-appointed psychiatrist that the defendant has an antisocial personality and is likely to commit future violent crimes"); Holsey v. Warden, 694 F.3d 1230, 1252 (11th Cir. 2012) (quoting a prison psychologist's report that defendant's "'Antisocial Personality' . . . suggests a very high risk for being assaultive and/or otherwise violent").

51. Eddings v. Oklahoma, 455 U.S. 104, 126 n.8 (1982) (Burger, C.J., dissenting) (quoting the testimony of the state's mental health expert). Chief Justice Warren E. Burger was also influenced by the same doctor's testimony that "91% 'of your criminal element' would test as sociopathic or antisocial." *Id.*

52. Scott E. Sundby, *The Capital Jury and Absolution: The Intersection of Trial Strategy, Remorse, and the Death Penalty*, 83 CORNELL L. REV. 1557, 1558 (1998) (citing Mark Costanzo & Julie Peterson, *Attorney Persuasion in the Capital Penalty Phase: A Content Analysis of Closing Arguments*, J. SOC. ISSUES, Summer 1994, at 125, 137); *see also* John Blume et al., *Competent Capital Representation: The Necessity of Knowing and Heeding What Jurors Tell Us About Mitigation*, 36 HOFSTRA L. REV. 1035, 1049-50 (2008).

53. *See generally* William J. Bowers, *The Capital Jury Project: Rationale, Design, and Preview of Early Findings*, 70 IND. L.J. 1043 (1995) (describing the background, purposes, and methodology of the Capital Jury Project).

54. Sundby, *supra* note 52, at 1568.

55. In the Capital Jury Project data analyzed by Professor Sundby, some jurors were certain that the defendant was not remorseful "because they believed any indications of remorse were merely hollow acts for the jury's benefit." *Id.* at 1567.

56. James L. Knoll, IV, *The Recurrence of an Illusion: The Concept of "Evil" in Forensic*

on behalf of the prosecution in death penalty cases, claims that evil can be diagnosed and scientifically measured.[57] In defense of his "Depravity Scale," which purports to measure "evil," Welner contends that "[d]efining evil is only the latest frontier where psychiatry . . . will bring light out of darkness."[58] Welner's approach reinforces deeply entrenched and misinformed cultural stereotypes of violent offenders.[59] Simon counters that "psychiatrists don't know anything more about [evil] than anyone else," yet "[o]ur opinions might carry more weight, under the patina or authority of the profession."[60] "Most psychiatrists assiduously avoid the word evil, contending that its use would precipitate a dangerous slide from clinical to moral judgment that could put people on death row unnecessarily and obscure the understanding of violent criminals."[61]

In addition to helping the prosecution establish aggravating, dehumanizing themes, presenting evidence about ASPD and psychopathy can undermine the defense mitigation case in multiple ways. First, an opinion that the defendant has ASPD arguably makes it seem reasonable to dismiss statements of the defendant because antisocial persons "can tell a non-truth or they can tell a lie easily, maybe quickly, and they're not going to feel a lot of hesitation about that, they're not going to feel any pain of conscience about telling that lie."[62] Thus, the client's description of events and life history is often discounted, and both self-reported and observed symptoms of mental illness are often dismissed as the product of malingering.[63]

Psychiatry, 36 J. AM. ACAD. PSYCHIATRY L. 105, 111 (2008).

57. Michael Welner, *Response to Simon: Legal Relevance Demands that Evil Be Defined and Standardized*, 31 J. AM. ACAD. PSYCHIATRY L. 417, 418-19 (2003).

58. *Id.* at 421. Yet another psychiatrist, Doctor Michael Stone of Columbia University, has developed a twenty-two level hierarchy of "evil" behavior. *See* Adam Liptak, *Adding Method to Judging Mayhem*, N.Y. TIMES, Apr. 2, 2007, at A14. Stone argues: "[W]e are talking about people who commit breathtaking acts, who do so repeatedly, who know what they're doing, and are doing it in peacetime . . . . We know who these people are and how they behave [and it's time to give their behavior] the proper appellation." Benedict Carey, *For the Worst of Us, the Diagnosis May Be 'Evil*,*'* N.Y. TIMES, Feb. 8, 2005, at F1 [hereinafter Carey, *For the Worst of Us*] (internal quotation marks omitted).

59. For in-depth discussions of the superficial and erroneous media portrayals of violence, see CRAIG HANEY, DEATH BY DESIGN: CAPITAL PUNISHMENT AS A SOCIAL PSYCHOLOGICAL SYSTEM 38-39 (2005); Craig Haney, *Media Criminology and the Death Penalty*, 58 DEPAUL L. REV. 689, 725-26 (2009).

60. Carey, *For the Worst of Us*, *supra* note 58.

61. *Id.*

62. Sanborn v. Parker, 629 F.3d 554, 572 (6th Cir. 2010).

63. *See, e.g.*, Worthington v. Roper, 631 F.3d 487, 493 (8th Cir. 2011) (explaining that the state's expert concluded that, because Worthington was antisocial, he was malingering symptoms of mental illness); *see also* United States v. Gabrion, 648 F.3d 307, 320 (6th Cir. 2011) (noting that testimony that Marvin Gabrion had ASPD supported a finding that he was malingering and

Second, because most jurisdictions exempt ASPD from the definition of "mental disease or defect,"[64] the diagnosis is used to exclude the possibility of legally cognizable mental impairment.[65] Such examiners give the jury "only superficial and schematic details of the lives of capital defendants, typically only those 'facts' that underscore their deviance and that facilitate their dehumanization."[66] Without question, evidence that the defendant has the characteristics associated with ASPD is significantly harmful to his chances for survival.[67] The overwhelming weight of legal authority views evidence that the defendant has ASPD as inherently aggravating.[68]

Third, ASPD is often used as a counter-narrative to major mental illness evidence presented in mitigation.[69] When the defense presents a

---

therefore mentally competent to proceed).

64. *See* ALASKA STAT. § 12.47.010(C) (2012); ARIZ. REV. STAT. ANN. § 13-502(A) (2012); ARK. CODE ANN. § 5-2-312(b) (2012); CAL. PENAL CODE § 25.5 (West 2012); COLO. REV. STAT. ANN. § 16-8-101(2) (West 2012); CONN. GEN. STAT. ANN. § 53a-13(c) (West 2012); DEL. CODE ANN. tit. 11, § 401(c) (West 2012); FLA. STAT. ANN. § 916.106(13) (West 2013); GA. CODE ANN. § 17-7-131(a)(1)-(2) (2013); HAW. REV. STAT. § 704-400(2) (2012); IDAHO CODE ANN. § 18-207(1) (2013); 720 ILL. COMP. STAT. ANN. 5/6-2(b) (West 2013); IND. CODE § 35-41-3-6(b) (West 2013); KAN. STAT. ANN. § 59-2946(f)(1) (West 2012); KY. REV. STAT. ANN. § 504.020(2) (2012); ME. REV. STAT. ANN. tit. 17-A, § 39(2) (West 2012); MD. CODE ANN. CRIM. PROC. § 3-109(b) (2012); MO. ANN. STAT. § 552.010 (West 2012); MONT. CODE ANN. § 46-14-101(2) (2011); N.D. CENT. CODE § 12.1-04.1-01(2) (2012); OR. REV. STAT. ANN. § 161.295(2) (West 2013); S.C. CODE ANN. § 17-24-10 (2012); TENN. CODE ANN. § 39-11-501 (2012); TEX. PENAL CODE ANN. § 8.01 (2012); VT. STAT. ANN. tit. 13, § 4801 (West 2012); WIS. STAT. ANN. § 971.15 (West 2012); Commonwealth v. McHoul, 226 N.E.2d 556, 563 (Mass. 1967) (holding that Massachusetts follows the Model Penal Code test for defects excluding responsibility, which excludes antisocial conduct from the definition of mental disease or defect) (citing MODEL PENAL CODE § 4.01 (1962)); State v. Lorraine, 613 N.E.2d 212, 224 (Ohio 1993) (stating that, under Ohio law, "a behavior or personality disorder does not qualify as a mental disease or defect").

65. *See, e.g.*, Penry v. Lynaugh, 492 U.S. 302, 309 (1989) (noting that prosecution expert testified that Penry's impulsiveness and "inability to learn from experience" was due to ASPD rather than mental retardation); Hammet v. Texas, 448 U.S. 725, 728-29 (1980) (presuming that a defendant with ASPD was competent to waive appeals and submit to execution without further mental health inquiry); *Sanborn*, 629 F.3d at 562 (explaining that Parramore L. Sanborn's inability to hold a job, plan for his future, and pay his debts was caused by ASPD, not mental impairment); United States v. Paul, 534 F.3d 832, 844-45 (8th Cir. 2008) (presuming that a defendant with ASPD was competent to waive appeals and submit to execution without further mental health inquiry).

66. Haney, *The Social Context*, *supra* note 43, at 549.

67. *Worthington*, 631 F.3d at 503.

68. Kokal v. Sec'y, Dep't of Corr., 623 F.3d 1331, 1349 (11th Cir. 2010); *accord* Suggs v. McNeil, 609 F.3d 1218, 1231 (11th Cir. 2010); Reed v. Sec'y, Dep't of Corr., 593 F.3d 1217, 1248 (11th Cir. 2010); Cummings v. Sec'y, Dep't of Corr., 588 F.3d 1331, 1368 (11th Cir. 2009); Parker v. Sec'y, Dep't of Corr., 331 F.3d 764, 788 (11th Cir. 2003); Weeks v. Jones, 26 F.3d 1030, 1035 n.4 (11th Cir. 1994).

69. *See, e.g.*, Fairbank v. Ayers, 650 F.3d 1243, 1250 (9th Cir. 2011) (noting that, in the closing argument, the prosecution highlighted the fact that defendant did not suffer from a mental illness); *Reed*, 593 F.3d at 1229 (noting on cross-examination that the defendant's psychological evaluator admitted that ASPD "is what really underlies a sociopath").

mitigating social history of the effects that living with mental illness had on the client, the prosecution often rebuts this testimony with a diagnosis of ASPD, arguing that the problems presented by the defense as mitigation are in fact character traits or moral weaknesses, not mental illness.[70]

Because prosecutors easily turn the defense's ASPD evidence against the defendant,[71] no competent capital defense attorney would ever pursue a diagnosis of ASPD or label his client a psychopath in mitigation of punishment. Similarly, it is inherently unreasonable for a post-conviction attorney to claim that trial counsel was ineffective for failing to call a psychologist who diagnosed the defendant as antisocial; the claim is often doomed to failure by the many negative traits associated with ASPD and psychopathy.[72] If left unchallenged in a capital case, ASPD and related constructs are quite literally the "kiss of death." This is particularly true when courts and lawyers view the ASPD label as an immutable fact, rather than a highly questionable opinion.[73]

Defense teams working in compliance with well-established professional norms avoid the ASPD trap by conducting a thorough investigation that will inevitably establish an alternative and humanizing picture of the client. Experience in death penalty cases demonstrates over and over again that diagnoses of ASPD, psychopathy, or related constructs are inherently unreliable and misleading; these labels are applied when the defense fails to conduct a thorough investigation of the client's life circumstances, which provides crucial context for behaviors that are superficially labeled "antisocial." In virtually every case, a thorough investigation conducted according to the ABA and

---

70. *See, e.g.*, *Fairbank*, 650 F.3d at 1249-50; *Reed*, 593 F.3d at 1233-34.

71. *See* Morton v. Sec'y, Dep't of Corr., 684 F.3d 1157, 1164, 1167-68 (11th Cir. 2012) (noting that the defense presented evidence that the defendant's abusive childhood caused him to develop ASPD, and the jury assessed the punishment at death); *Fairbank*, 650 F.3d at 1250 (noting that the prosecution successfully argued that the defendant's evidence that he had ASPD and was genetically predisposed to criminal behavior did not constitute a mental disease and failed to humanize the defendant); Looney v. State, 941 So. 2d 1017, 1028-29 (Fla. 2006) ("[A] diagnosis as a psychopath is a mental health factor viewed negatively by jurors and is not really considered mitigation."); Leavitt v. Arave, 646 F.3d 605, 623-24 (9th Cir. 2011) (Reinhardt, C.J., dissenting) ("[C]ourts generally treat an individual's failure to control a personality disorder, or to suppress an anti-social or psychopathic personality, as more blameworthy than an individual's response to an organic brain disorder."); Sanborn v. Parker, 629 F.3d 554, 572 (6th Cir. 2011) (referring to the defense expert's testimony of Sanborn's ASPD as "perhaps even more damning" than the findings of the state's expert); *Reed*, 593 F.3d at 1246 (11th Cir. 2010) (stating that evidence of antisocial personality disorder is "not 'good' mitigation").

72. *See, e.g.*, *Parker*, 331 F.3d at 788 (holding that it was valid trial strategy not to present damaging psychological evidence that the defendant "was antisocial and a sociopath"); *accord Cummings*, 588 F.3d at 1364-65.

73. We discuss this distinction at length. *See infra* Part IV.B–C.

Supplementary Guidelines provide important data and context that refutes the diagnosis of ASPD and enables the jury to interpret the defendant's past behavior in the context of his life circumstances and impairments. As this Article demonstrates, when an expert concludes that the defendant has ASPD or psychopathy, it is the investigation of the client's life history, not the defendant, which is shallow and superficial.

III. CONTROVERSIES AND LIMITATIONS OF ASPD AND RELATED CONSTRUCTS

As noted, the labels "antisocial" and "psychopath" derive their unique power over judges and juries from invoking dehumanizing stereotypes masquerading as scientific fact. Yet, invariably those labels are exposed as mere epithets, most often applied by experts who rely only upon rudimentary data from a limited set of sources.[74] Therefore, capital defense counsel have a special duty to become familiar with the issues that are raised by the inflammatory and unreliable nature of such evidence.[75] In order to understand the superior power of

74. Capital defendants are frequently diagnosed with ASPD after a single or limited interview, and without critical life history information. Yet, it is well known that "a single diagnostic interview, regardless of how reliable, does not capture the essence of what is happening to a patient. . . . [A]ccurate diagnosis must be part of the ongoing clinical dialogue with the patient." Robert Freedman et al., *The Initial Field Trials of DSM-5: New Blooms and Old Thorns*, 170 AM. J. PSYCHIATRY 1, 3-4 (2013); *see also* Douglas Liebert & David Foster, *The Mental Health Evaluation in Capital Cases: Standards of Practice*, 164 AM. J. FORENSIC PSYCHIATRY 43, 45-46 (1994). In addition, obstacles to client disclosure of sensitive information are often profoundly more pronounced in forensic interviews than in clinical settings, where clients voluntarily seek assistance and the outcome and goals of interviews are dramatically different. *Id.* Because the accuracy of a mental health assessment flows directly from extensive, reliable data, the ABA and Supplementary Guidelines require a thorough investigation of the client's life history, including family history at least three generations back, that follows parallel tracks of client and collateral witness interviews and an exhaustive documentary record. *See* Sean D. O'Brien, *When Life Depends on It: Supplementary Guidelines for the Mitigation Function of Capital Defense Teams in Death Penalty Cases*, 36 HOFSTRA L. REV. 693, 724-32 (2008); *see also* Richard G. Dudley, Jr. & Pamela Blume Leonard, *Getting It Right: Life History Investigation as the Foundation for a Reliable Mental Health Assessment*, 36 HOFSTRA L. REV. 963, 974-77 (2008); George Woods et al., *Neurobehavioral Assessment in Forensic Practice*, 35 INT'L J.L. & PSYCHIATRY 432, 438 (2012) (emphasizing that "a comprehensive perspective must be applied to the forensic inquiry at hand").

75. "Counsel must be experienced in the utilization of expert witnesses and evidence, such as psychiatric and forensic evidence, and must be able to challenge zealously the prosecution's evidence and experts through effective cross-examination." ABA GUIDELINES, *supra* note 18, Guideline 1.1 cmt., at 924. Furthermore, capital defense counsel have a special duty to "raise every legal claim that may ultimately prove to be meritorious." *Id.* at 927; *see id.* Guideline 10.8, at 1028-29. "Counsel should object to anything that appears unfair or unjust even if it involves challenging well-accepted practices." *Id.* Guideline 10.8 cmt., at 1032; *see* Monroe H. Freedman, *The Professional Obligation to Raise Frivolous Issues in Death Penalty Cases*, 31 HOFSTRA L. REV. 1167, 1175-79 (2003).

mitigating narratives, capital defense teams must be aware of the contentious debates surrounding the diagnosis of ASPD and the construct of psychopathy.[76]

ASPD, psychopathy, and personality disorders in general have all been criticized in clinical and research settings on multiple grounds. Some researchers question whether these constructs and instruments to measure them should be precluded in forensic settings, including capital trials.[77] The controversies about these diagnoses and labels of deviance have enormous practical (life and death) implications for forensic practice and capital defense teams. In this Part, we will review some of these controversies and the assessment instruments that are currently used to diagnose psychopathy and predict future dangerousness.[78] We will first discuss personality disorders and ASPD, addressing both scientific and ethical controversies; then we will do the same with psychopathy and related issues. These unresolved controversies, and the ensuing ethical dilemmas, raise serious questions about the use of these constructs in capital trials because their methodology and lack of reliability are incompatible with the ABA Guidelines and with the Eighth Amendment principle that capital sentencing determinations must "aspire to a heightened standard of reliability."[79]

A. Controversies Surrounding Personality Disorders and ASPD

The diagnosis of ASPD has a controversial history in the mental health field, as do most personality disorders, the class of mental disorders in which ASPD is included. Our discussion will focus on scientific and ethical concerns.

---

76. This also applies to mental health experts working in forensic settings. As noted by John Edens, a leading researcher in forensic psychology, "it seems ethically mandated that those who work in [forensic] settings be familiar with relevant empirical literature." John F. Edens, *Unresolved Controversies Concerning Psychopathy: Implications for Clinical and Forensic Decision Making*, 37 PROF. PSYCHOL. RES. & PRAC. 59, 59 (2006) [hereinafter Edens, *Unresolved Controversies*].

77. *See* Donald N. Bersoff, *Some Contrarian Concerns About Law Psychology and Public Policy*, 26 LAW & HUM. BEHAV. 565, 571-72 (2002); Mark D. Cunningham, *Dangerousness and Death: A Nexus in Search of Science and Reason*, 61 AM. PSYCHOLOGIST 828, 835 (2006); Cunningham & Reidy, *supra* note 17, at 338-39; John F. Edens et al., *Predictions of Future Dangerousness in Capital Murder Trials: Is It Time to "Disinvent the Wheel?,"* 29 LAW & HUM. BEHAV. 55, 66, 69, 71, 76-77 (2005) [hereinafter Edens et al., *Predictions*]; Edens, *Unresolved Controversies*, *supra* note 76, at 60-61; John F. Edens et al., *The Impact of Mental Health Evidence on Support for Capital Punishment: Are Defendants Labeled Psychopathic Considered More Deserving of Death?*, 23 BEHAV. SCI. & L. 603, 605-07 (2005) [hereinafter Edens et al., *Impact of Mental Health Evidence*].

78. We are differentiating between the *diagnosis* of ASPD, which is officially recognized in our current diagnostic nomenclature, and the *construct* of psychopathy, which is not officially recognized in current diagnostic manuals such as the DSM-5. *See generally* DSM-5, *supra* note 24.

79. Ford v. Wainwright, 477 U.S. 399, 411 (1986).

1. ASPD: Scientific and Research-Based Controversies

The Diagnostic and Statistical Manual of Mental Disorders, Third Edition ("DSM-III"),[80] published in 1980, represented a significant change in the approach to diagnostic nomenclature in the United States. While the full extent of those changes is beyond the scope of this Article, we note that the DSM-III adopted, for the first time, a five level diagnostic scheme for classifying illnesses and disorders (Axis I through Axis V).[81] Multi-axial assessment was included to better capture various aspects of an individual's functioning in order to facilitate treatment planning and predict outcomes.[82] The five axial scheme included assessment of mental disorders, consideration of medical conditions that have psychiatric components, assessment of exposures to psychosocial stressors, and evaluation of an individual's psychological functioning at the current time and during the past year.[83]

The major mental illnesses were placed on Axis I in DSM-III.[84] The personality disorders were placed on Axis II with Mental Retardation and other developmental disorders.[85] The decision to place the personality disorders on a separate axis has been called "pragmatic,"[86] and has had serious implications for how these disorders are viewed by persons in the mental health field. A British sociologist who has written about mental health and social policy issues noted that "the essence of personality disorder is that it is . . . driven by a number of unique aspects, such as the absence of physical and mental symptoms, lack of biochemical basis for treatment, and rejection as a serious mental disorder by many psychiatrists."[87]

For capital defense teams, this distinction reinforces the importance of conducting a thorough psychosocial history investigation. The absence of historical data establishing physical and mental symptoms

80. AM. PSYCHIATRIC ASS'N, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS (3d ed. 1980) [hereinafter DSM-III].

81. *Id.* at 23.

82. *Id.* at 11-12, 27.

83. *Id.* at 23, 26-28.

84. *See id.* at 15-19 (listing the various disorders listed under Axis I).

85. Thomas A. Widiger & Tracie Shea, *Differentiation of Axis I and Axis II Disorders*, 100 J. ABNORMAL PSYCHOL. 399, 399 (1991).

86. *Id.*; *see also* W. John Livesley et al., *Categorical Distinctions in the Study of Personality Disorder: Implications for Classification*, 103 J. ABNORMAL PSYCHOL. 6, 12-13 (1994).

87. Nick Manning, *DSM-IV and Dangerous and Severe Personality Disorder—An Essay*, 63 SOC. SCI. & MED. 1960, 1961 (2006). While the DSM-IV cautions that the coding of personality disorders on Axis II "should not be taken to imply that their pathogenesis or range of appropriate treatment is fundamentally different from . . . disorders coded on Axis I," clinical and research views have often been contrary to this position. DSM-IV-TR, *supra* note 24, at 26-28.

can mean the difference between a diagnosis of a personality disorder and an Axis I disorder.[88]

Placing the personality disorders on Axis II elevated the importance of the personality disorder category[89] and enlarged their role in the diagnostic process.[90] However, the differentiation of personality disorders from Axis I disorders has been criticized as "often problematic and perhaps at times even illusory."[91] Moreover, it has generated pejorative attitudes towards patients diagnosed with personality disorder, given common assumptions that many of the personality disorder diagnoses are not amenable to treatment.[92] While this assumption has been challenged,[93] it is nevertheless a common belief that often works to patients' and forensic clients' detriment.[94]

---

88. See, for example, *Parkus v. Delo*, 33 F.3d 933, 936 (8th Cir. 1994), in which both prosecution and defense mental health experts testified at trial that Parkus was antisocial, and both changed their opinions when confronted with previously unknown historical records more consistent with symptoms of schizophrenia and dementia. Next, compare *Wilson v. Trammell*, 706 F.3d 1286, 1290 (10th Cir. 2013), in which trial and habeas counsel relied primarily on social history interviews with the defendant and his mother, along with the trial psychologist's computer-scored personality testing. The court found the uncorroborated history unpersuasive, and affirmed Wilson's death sentence "because the description in the valid MMPI-2 of the Defendant's profile—a Type C offender in the Megargee typology—explicitly describes the vision of evil evoked by the word *psychopath*." *Wilson*, 706 F.3d at 1309.

89. *See* Thomas A. Widiger & Alan J. Frances, *Toward a Dimensional Model for the Personality Disorders*, *in* PERSONALITY DISORDERS AND THE FIVE-FACTOR MODEL OF PERSONALITY 23, 24 (Paul T. Costa, Jr. & Thomas A. Widiger eds., 2d ed. 2002); *see also* Manning, *supra* note 87, at 1962.

90. W. John Livesley, *Conceptual and Taxonomic Issues*, *in* HANDBOOK OF PERSONALITY DISORDERS: THEORY, RESEARCH, AND TREATMENT 3, 12 (W. John Livesley ed., 2001).

91. Widiger & Shea, *supra* note 85, at 399. Criticisms have been raised about the lack of adequate discussion of the rationale for this distinction—while the various editions of the DSM say little about the reason for the distinction, researchers have suggested the differentiation of Axes I and II may have been based on the presumption that Axis I disorders have biological origins, whereas Axis II disorders have psychosocial origins. *See generally, e.g.*, DSM-III, *supra* note 80. However, there is evidence of the importance of biogenetic and psychosocial components in both Axis I and II disorders. *See* Richard F. Farmer, *Issues in the Assessment and Conceptualization of Personality Disorders*, 20 CLINICAL PSYCHOL. REV. 823, 829 (2000); Livesley et al., *supra* note 86, at 13.

92. Cunningham & Reidy, *supra* note 17, at 345-46; Manning, *supra* note 87, at 1962-63; Richard Rogers & Ken Dion, *Rethinking the DSM III-R Diagnosis of Antisocial Personality Disorder*, 19 BULL. AM. ACAD. PSYCHIATRY & L. 21, 27 (1991).

93. *See, e.g.*, Roger Mulder & Andrew M. Chanen, *Effectiveness of Cognitive Analytic Therapy for Personality Disorders*, 202 BRIT. J. PSYCHIATRY 89, 89 (2013); K. Roy MacKenzie, *Group Psychotherapy*, *in* HANDBOOK OF PERSONALITY DISORDERS: THEORY, RESEARCH, AND TREATMENT, *supra* note 90, at 504, 504-05; William E. Piper & Anthony S. Joyce, *Psychosocial Treatment Outcome*, *in* HANDBOOK OF PERSONALITY DISORDERS: THEORY, RESEARCH, AND TREATMENT, *supra* note 90, at 326, 326-29; Joel M. Town et al., *Short-Term Psychodynamic Psychotherapy for Personality Disorders: A Critical Review of Randomized Controlled Trials*, 25 J. PERSONALITY DISORDERS 723, 724 (2011).

94. Knoll, *supra* note 56, at 113; Rogers & Dion, *supra* note 92, at 27; *see also* Cunningham

More generally, the literature suggests that many professionals were dissatisfied with the DSM-III's handling of criteria for the entire category of personality disorders.[95] Challenges to the personality disorder classification scheme adopted with the publication of the DSM-III in 1980 appeared almost immediately after its publication[96] and have continued to the present day, through the publications of the Diagnostic and Statistical Manual of Mental Disorders, Third Edition Revised ("DSM-III-R") in 1987, the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition ("DSM-IV") in 1994, the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition Text Revision ("DSM-IV-TR") in 2000, and the DSM-5 in 2013.[97] In spite of contentious debates over a wide range of changes that were proposed for the DSM-5, the personality disorder nomenclature remains virtually unchanged from the DSM-IV-TR, although the multi-axial system has been abandoned.[98]

& Reidy, *supra* note 17, at 333, 345 (noting that the diagnosis of ASPD "may have a profoundly aggravating effect on sentencing considerations, particularly in creating expectations that no rehabilitation is possible and that future criminal violence is inevitable").

95. For example, "a survey of 146 psychologists and psychiatrists in 42 countries on their views of DSM-III reported that 'the personality disorders led the list of psychiatric categories with which respondents were dissatisfied.'" Manning, *supra* note 87, at 1963-64 (citing Jack D. Maser et al., *International Use and Attitudes Towards DSM-III and DSM-III-R: Growing Consensus in Psychiatric Classification*, 100 J. ABNORMAL PSYCHOL. 271, 275 (1991)). Also, "[a] majority of respondents (56%) considered personality disorders problematic, well ahead of the next most cited category, mood disorders, (28%)." Manning, *supra* note 87, at 1964 (citing Michael B. First et al., *Personality Disorders and Relational Disorders*, *in* A RESEARCH AGENDA FOR DSM-V 123, 125 (David J. Kupfer et al. eds., 2002)).

96. Allen Frances, *The* DSM-III *Personality Disorders Section: A Commentary*, 137 AM. J. PSYCHIATRY 1050, 1050-53 (1980).

97. *See* Andrew E. Skodol, *Personality Disorders in DSM-5*, 8 ANN. REV. CLINICAL PSYCHOL. 317, 321 (2012) [hereinafter Skodol, *Personality Disorders in DSM-5*]; Andrew E. Skodol et al., *Personality Disorder Types Proposed for DSM-5*, 25 J. PERSONALITY DISORDERS 136, 140 (2011) [hereinafter Skodol et al., *Personality Disorder Types Proposed*]; Andrew E. Skodol et al., *Proposed Changes in Personality and Personality Disorder Assessment and Diagnosis for* DSM-5 *Part I: Description and Rationale*, 2 PERSONALITY DISORDERS: THEORY, RES. & PRAC. 4, 14 (2011) [hereinafter Skodol et al., *Proposed Changes*].

98. *See, e.g.*, AM. PSYCHIATRIC ASS'N, RATIONALE FOR THE PROPOSED CHANGES TO THE PERSONALITY DISORDERS CLASSIFICATION IN DSM-5, at 1 (2012) [hereinafter AM. PSYCHIATRIC ASS'N, RATIONALE], *available at* http://www.yumpu.com/en/document/view/8702305/rationale-for-the-proposed-changes-to-the-personality-dsm-5; Robert F. Bornstein, *Reconceptualizing Personality Pathology in DSM-5: Limitations in Evidence for Eliminating Dependent Personality Disorder and Other DSM-IV Syndromes*, 25 J. PERSONALITY DISORDERS 235, 240-41 (2011); Michael B. First, *The Problematic DSM-5 Personality Disorders Proposal: Options for Plan B*, 72 J. CLINICAL PSYCHIATRY 1341, 1342 (2011); Skodol et al., *Proposed Changes*, *supra* note 97, at 8, 11-12; Thomas A. Widiger et al., *Proposals for DSM-5: Introduction to Special Section of Journal of Personality Disorders*, 25 J. PERSONALITY DISORDERS 135, 135 (2011); Mark Zimmerman, *A Critique of the Proposed Prototype Rating System for Personality Disorders in DSM-5*, 25 J. PERSONALITY DISORDERS 206, 207 (2011); Mark Zimmerman, *Is There Adequate Empirical Justification for Radically Revising the Personality Disorders Section for DSM-5?*, 3 PERSONALITY

One fundamental problem with the classification of personality disorders has been described as the DSM's "top-down approach," which is based on the assumption that there are a discrete number of personality types, each of which is qualitatively different in nature.[99] A review by the DSM-5 Personality and Personality Disorders Workgroup noted that "no such set of types has been found, even in large, diverse samples, and using sophisticated statistical modeling strategies," and "human personality varies continuously."[100] These and other concerns fueled efforts for a major reconceptualization of the personality disorders classification in the DSM-5.[101] Many critics of the DSM-IV paradigm believe that current personality disorder categories do not do justice to the complexity and continuous nature of personality traits across the human population. As used in the sentencing phase of a capital case, reducing the defendant to a handful of undesirable personality traits runs counter to the Eighth Amendment's "need for treating each defendant in a capital case with that degree of respect due the uniqueness of the individual."[102]

Another significant criticism of the personality disorder criteria for the DSM generally is that they "were not empirically based and are not sufficiently specific, so they may apply equally well to other types of mental disorders (e.g. schizophrenia)."[103] This lack of specificity means that particular behaviors or symptoms may be seen in many conditions, and often in many people with no illness at all, providing little ability to differentiate or parse illnesses. As noted by the Chair of the DSM-5 Personality and Personality Disorders Work Group, "the DSM-IV-TR criteria were poorly defined, not specific to [personality disorders], and were introduced in the DSM-IV without theoretical or empirical

---

DISORDERS: THEORY, RES. & TREATMENT 444, 445, 452 (2012).

99. AM. PSYCHIATRIC ASS'N, RATIONALE, *supra* note 98, at 1.

100. *Id.*

101. *See* Skodol, *Personality Disorders in DSM-5*, *supra* note 97, at 320-24; Skodol et al., *Personality Disorder Types Proposed*, *supra* note 97, at 154-55; Skodol et al., *Proposed Changes*, *supra* note 97, at 5. The DSM-5 retains the structure of the Personality Disorders classification adopted by the DSM-IV-TR. Skodol, *Personality Disorders in DSM-5*, *supra* note 97, at 320-24. This decision occurred after highly contentious debates about how personality disorders should be conceptualized in the DSM-5. *Id.* Doctor Theodore Millon, a leading personality disorder researcher, has stated, "[i]t's embarrassing to see where we're at. We've been caught up in digression after digression, and nobody can agree . . . . It's time to go back to the beginning, to Darwin, and build a logical structure based on universal principles of evolution." Benedict Carey, *Thinking Clearly About Personality Disorders*, N.Y. TIMES, Nov. 27, 2012, at D1 [Carey, *Thinking Clearly*].

102. Lockett v. Ohio, 438 U.S. 586, 605 (1978).

103. Skodol et al., *Personality Disorder Types Proposed*, *supra* note 97, at 137. This problem is of enormous significance in death penalty litigation where, for strategic and political reasons, prosecutors often seek personality disorder diagnoses and dispute the presence of Axis I diagnoses.

justification."[104] Due to this lack of specificity, the same observed behavior or symptom could be said to be part of the basis for a number of conditions, which opens the door to examiner bias and expectation. A psychiatrist who, for whatever reason, does not establish sufficient rapport with a subject may be pre-disposed to diagnose one condition over another. Similarly, cultural and ethnic biases may exert a greater influence where, as in the case of personality disorders, the criteria and definitions provide little differential guidance.[105]

Additional problems with the current personality disorder diagnostic scheme have been identified.[106] These include extensive co-occurrence among personality disorders;[107] excessive within-diagnosis heterogeneity;[108] lack of synchrony with modern medical approaches to diagnostic thresholds;[109] temporal instability;[110] poor coverage of

---

104. Skodol, *Personality Disorders in DSM-5*, *supra* note 97, at 318, 333.

105. *See* Scharlette Holdman & Christopher Seeds, *Cultural Competency in Capital Mitigation*, 36 HOFSTRA L. REV. 883, 894-96 (2008).

106. Paul T. Costa, Jr. & Thomas A. Widiger, *Introduction: Personality Disorders and the Five-Factor Model of Personality*, *in* PERSONALITY DISORDERS AND THE FIVE-FACTOR MODEL OF PERSONALITY 3, 3 (Paul T. Costa Jr. & Thomas A. Widiger eds., 2d ed. 2002); Skodol, *Personality Disorders in DSM-5*, *supra* note 97, at 321; Thomas A. Widiger & Lee Anna Clark, *Toward DSM-V and the Classification of Psychopathology*, 126 PSYCHOL. BULL. 946, 954 (2000).

107. "Most patients diagnosed with [a personality disorder] meet criteria for more than one," and in fact, often meet criteria for several, with some researchers arguing that the co-occurrence may be seven or more. Skodol, *Personality Disorders in DSM-5*, *supra* note 97, at 321; *see* Jonathan Shedler & Drew Westen, *Dimensions of Personality Pathology: An Alternative to the Five-Factor Model*, 161 AM. J. PSYCHIATRY 1743, 1752-53 (2004); Widiger & Frances, *supra* note 89, at 25-26; *see also* AM. PSYCHIATRIC ASS'N, RATIONALE, *supra* note 98, at 1. This has raised serious concerns about the validity of the personality disorder classification. The issue of co-morbidity is explicitly acknowledged in the DSM-IV-TR and DSM-5. DSM-IV-TR, *supra* note 24, at 686; DSM-5, *supra* note 24, at 5. The essence of this problem is that, for clients who are seen by two (or more) clinicians who decide a personality disorder is present, there is little agreement about which personality disorder is correct. This was true of the DSM-IV-TR, and remains a problem as of recently published test-retest reliability results from DSM-5 field trials. Darrel A. Regier et al., *DSM-5 Field Trials in the United States and Canada, Part II: Test-Retest Reliability of Selected Categorical Diagnoses*, 170 AM. J. PSYCHIATRY 59, 65-67 (2013). *See generally* AM. PSYCHIATRIC ASS'N, DSM-IV SOURCEBOOK (Thomas A. Widiger et al. eds., 1998) [hereinafter AM. PSYCHIATRIC ASS'N, DSM-IV SOURCEBOOK].

108. For example, there were over 250 ways to meet diagnostic criteria for borderline personality disorder in the DSM-IV-TR, and, as will be discussed below, an exponentially larger set of symptom combinations are possible with ASPD diagnoses. AM. PSYCHIATRIC ASS'N, RATIONALE, *supra* note 98, at 1. This means that people with markedly different symptom patterns can meet criteria for the same diagnosis, even if they share a small number of behaviors in common (or even only one common behavior). *See* AM. PSYCHIATRIC ASS'N, RATIONALE, *supra* note 98, at 1; Skodol et al., *Personality Disorders in DSM-5*, *supra* note 97, at 332; Widiger & Frances, *supra* note 89, at 26; Skodol et al., *Personality Disorder Types Proposed*, *supra* note 97, at 140; Skodol et al., *Proposed Changes*, *supra* note 97, at 15.

109. Modern medical approaches embrace measures of severity, for example, multiple stages of cancer or levels of hypertension, whereas the DSM adopts a dichotomous classification system that results in a binary decision as to whether a personality disorder is absent or present. This has

personality psychopathology;[111] arbitrary diagnostic thresholds;[112] lack of clear boundaries between pathological and "normal" personality functioning;[113] and poor convergent validity.[114]

The controversies surrounding the personality disorder classification scheme extend equally to ASPD. According to Doctor Richard Rogers, a nationally recognized forensic psychologist, "[p]rofound ambivalence undergirds most professional discussions of antisocial personality disorder."[115] This diagnosis has "sparked controversy and defied consensus for the last three decades," and the notion that there is a unitary ASPD diagnosis is merely an illusion.[116] The final DSM-5 ASPD criteria were not tested despite extensive field

---

been raised as a major concern with the current personality disorder classification, as research suggests that severity may be the most important single predictor in assessing personality pathology, and the DSM does not address this issue in a useful way. *See* Skodol, *Personality Disorders in DSM-5*, *supra* note 97, at 327-28; Skodol et al., *Personality Disorder Types Proposed*, *supra* note 97, at 152-53; Skodol et al., *Proposed Changes*, *supra* note 97, at 5-6.

110. For example, since personality disorders are defined as pervasive and unremitting (i.e., as fixed), it would be expected that ASPD diagnoses of individuals would remain constant over time. DSM-5, *supra* note 24, at 645. However, that assumption has been challenged. *See, e.g.*, Cunningham & Reidy, *supra* note 17, at 335.

111. Considerable evidence shows the "Personality Disorder Not Otherwise Specified" is the most frequently diagnosed personality disorder in clinical practice, and is the most common diagnosis used in research settings. AM. PSYCHIATRIC ASS'N, RATIONALE, *supra* note 98, at 2; Roel Verheul & Thomas A. Widiger, *A Meta-Analysis of the Prevalence and Usage of the Personality Disorder Not Otherwise Specified (PDNOS) Diagnosis*, 18 J. PERSONALITY DISORDERS 309, 314-15 (2004). This belies the theory underlying the concept of personality disorder—that there is a clearly defined personality to be described, and supports concerns that existing diagnoses are inadequate to capture the complexity of personality. *Cf.* AM. PSYCHIATRIC ASS'N, RATIONALE, *supra* note 98, at 2.

112. No clinical or empirical justification was provided for the number of criteria deemed necessary to meet diagnostic criteria for the ten personality disorders included in the DSM. Skodol et al., *Personality Disorder Types Proposed*, *supra* note 97, at 137, 158; *see also* Widiger & Frances, *supra* note 89, at 25-26.

113. The current personality disorder diagnostic scheme has been criticized for inadequately distinguishing between normal and pathological personality functioning, thus leading to additional concerns about the validity of personality disorder diagnoses. *See* Skodol, *Personality Disorders in DSM-5*, *supra* note 98, at 321; Skodol et al., *Personality Disorder Types Proposed*, *supra* note 97, at 137-38; Skodol et al., *Proposed Changes*, *supra* note 97, at 16; Andrew E. Skodol & Donna S. Bender, *The Future of Personality Disorders in DSM-V?*, 166 AM. J. PSYCHIATRY 388, 388 (2009).

114. For example, research shows that significant disagreement has resulted in personality disorder assessments when different methods of assessment are used (for example, unstructured versus structured interviews and personality questionnaires). AM. PSYCHIATRIC ASS'N, RATIONALE, *supra* note 98, at 3. This has been identified as one of the most serious problems with the current personality disorder scheme, and relates to the difficulty of translating criteria into assessments that yield similar results. *Id.* "The importance of these findings cannot be overemphasized. These data mean that the entire personality disorder literature is built upon shifting sands." *Id.*

115. Rogers & Dion, *supra* note 92, at 21.

116. Rogers et al., *Prototypical Analysis of Antisocial Personality Disorder: A Study of Inmate Samples*, 27 CRIM. JUST. & BEHAV. 234, 234, 237 (2000).

trials, and thus "political and nonempirical considerations appear to have overridden . . . diagnostic validity."[117]

ASPD has been criticized on numerous specific grounds, among them the lack of coherence among differing versions of ASPD in various editions of the DSM.[118] There is also what has been called the "innumeracy problem," that is, the seemingly innumerable possibilities for reaching threshold for a diagnosis of ASPD.[119] The innumeracy problem is even more pronounced with ASPD than with other (personality) disorders. Unlike any other diagnosis in the DSM, this diagnosis requires evidence of symptoms of conduct disorder as a prerequisite for finding ASPD, thus greatly enhancing the number of possible combination of symptoms that could result in an ASPD diagnosis.[120] The diagnostic criteria for ASPD overlap with other disorders, a circumstance which raises doubts about the integrity of the inclusion and exclusion criteria and greatly increases the difficulty of accurate diagnosis and assessment.[121]

ASPD is diagnosed in part on criminal history, which means that a large percentage of inmates have been or could be diagnosed with ASPD.[122] The high prevalence of this diagnosis in inmates renders it of

---

117. *Id.* at 236; *see also* Robert Hare, *Psychopathy and Antisocial Personality Disorder: A Case of Diagnostic Confusion*, PSYCHIATRIC TIMES, Feb. 1, 1996, at 39 [hereinafter Hare, *A Case of Diagnostic Confusion*].

118. It has been noted that comparison of criteria listed in sequential versions of the DSM often had little in common. Cunningham & Reidy, *supra* note 17, at 334. These authors questioned whether ASPD diagnosis has sufficient reliability and validity for forensic purposes. *Id.* Other commenters have countered that these dramatically changing diagnostic standards were not driven by research, and noted that they "begin to doubt seriously the usefulness of ASPD as a unitary diagnosis." Rogers & Dion, *supra* note 92, at 24.

119. This is a consequence of the current polythetic classification scheme used in the DSM, in which diagnoses are made by choosing a specified number of required symptoms from a longer list. Many researchers have found it troubling that individuals can be diagnosed with the same disorder, yet have few, if any, features in common. Rogers & Dion, *supra* note 92, at 24, 26. Innumeracy is arguably most problematic with the diagnosis of ASPD, which requires evidence of "conduct disorder symptoms *prior* to the age of 15," and three of seven symptoms of ASPD. *Id.* Thus, in effect, a diagnosis of ASPD requires consideration of two sets of criteria rather than one, as is the case with respect to other mental disorders. *See id.*

120. Linda J. Gerstley et al., *Antisocial Personality Disorder in Patients with Substance Abuse Disorders: A Problematic Diagnosis?*, 147 AM. J. PSYCHIATRY 173, 173 (1990).

121. There is also considerable overlap between criteria for ASPD and substance abuse disorders. *See* Cunningham & Reidy, *supra* note 17, at 336; Gerstley et al., *supra* note 120, at 174-75; Widiger & Shea, *supra* note 85, at 401; *see also infra* notes 314-19 and accompanying text (discussing the diagnostic similarity of ASPD and substance abuse criteria). This is particularly problematic in the context of capital litigation, as many clients have severe and chronic histories of poly-substance abuse. *See infra* note 317.

122. For example, estimates of incarcerated male inmates who meet diagnostic criteria for ASPD range from 49–80%. Cunningham & Reidy, *supra* note 17, at 340. "The diagnosis of [ASPD] alone then describes little about prison behavior and recidivism outcome except that the individual

little value in fulfilling the Eighth Amendment's command that the death penalty "must be limited to those offenders who commit a narrow category of the most serious crimes and whose extreme culpability makes them the most deserving of execution."[123] This illustrates the innumeracy problem: it has been estimated that there are over three million possible symptom variations for the diagnosis of ASPD in the DSM-III-R,[124] and 3.2 million symptom combinations for the DSM-IV.[125] This further illustrates the lack of precision and clarity in the criteria for ASPD.[126]

Imprecise criteria and over-inclusion of symptoms are especially troublesome because they greatly heighten the risk of unreliable assessments, and can render diagnoses meaningless. In addition, excessive focus on antisocial behavior without attention to contextual factors such as trauma history, thought or mood disorders, and neuropsychological dysfunction, may lead to failure to identify relevant diagnostic considerations.[127] For example, language such as "impulsivity," "irritability," or "irresponsibility" can describe symptoms consistent with a range of Axis I disorders, yet they are often labeled antisocial. In the absence of a contextualized understanding of what drove such behaviors, it is difficult (if not impossible) to separate symptoms from subjective judgments.[128]

Axis II personality disorder diagnoses (including ASPD) are based on strictly defined behavioral criteria, even more so than Axis I diagnoses. For this reason, they have been criticized as too narrow.[129] They do not capture the richness and complexity of personality syndromes and deemphasize aspects of mental life and inner experience that are central components of personality syndromes.[130] Yet,

---

is similar to most prison inmates, and thus [ASPD] is not in and of itself an indication of a particularly dangerous or incorrigible inmate within the prison environment." *Id.*

123. Kennedy v. Louisiana, 554 U.S. 407, 420 (2008) (internal quotation marks omitted).

124. Rogers & Dion, *supra* note 92, at 24.

125. Rogers et al., *supra* note 116, at 237.

126. For example, Criterion C of ASPD in the DSM-5 requires "evidence of Conduct Disorder." DSM-5, *supra* note 24, at 659. No further clarity is added, with the exception of text language in two places requiring "some" evidence of conduct disorder. DSM-IV-TR, *supra* note 24, at 702, 705. When one turns to conduct disorder, there is a list of fifteen potential symptoms in Criterion A, with the "guidance" that this must involve a "repetitive and persistent pattern of behavior . . . as manifested by the presence of at least three" of the criteria in the past year, and at least one in the past six months. DSM-5, *supra* note 24, at 459. What constitutes a "repetitive and persistent" pattern of behavior is not further specified. DSM-IV-TR, *supra* note 24, at 702. In highly adversarial litigation settings, this lack of clarity and precision is often a recipe for disaster.

127. *See* Cunningham & Reidy, *supra* note 17, at 337.

128. *See infra* notes 362-68, 374-77 and accompanying text.

129. Shedler & Westen, *supra* note 107, at 1744.

130. *Id.*

the ability to capture this richness and complexity is central to effective capital representation.[131]

Another problem with the diagnosis of ASPD is the absence of symptom weighting, that is, each criterion receives equal weighting regardless of severity. For example, in the DSM-III-R, "stealing newspapers is equated with a bank heist, and having no fixed address for 30 days is treated the same as having no known address for five years."[132] Understanding the context in which a crime was committed—(for instance, stealing food to help feed a family)—is strangely missing from the diagnosis or text language for this and other diagnostic criteria.

Yet another troubling feature of the ASPD diagnosis, only partially addressed in the DSM-IV-TR, is that it "confuses arbitrariness with objectivity"[133] and arguably shows a general insensitivity to social class differences in life experience: "[T]he criterion 'significant unemployment for six months or more within five years when expected to work and work was available' appears more arbitrary than objective. For example, successful business consultants, performers, and entertainers may choose not to work over others' objections and yet remain financially comfortable."[134]

While the above quotes refer to the DSM-III-R, the DSM-IV-TR also fails to provide sufficient guidance; the diagnostic criteria were updated to "sudden changes of jobs, residences, or relationships" or "repeated failure to sustain consistent work behavior or honor financial obligations," which would apply to many responsible individuals in the recent economic downturn, or communities in which unemployment and underemployment are chronically high.[135] Similarly, a cognitively impaired person might need assistance caring for a child, maintaining

131. *See* Eric M. Freedman, *Introduction: Re-stating the Standard of Practice for Death Penalty Counsel: The Supplementary Guidelines for the Mitigation Function of Defense Teams in Death Penalty Cases*, 36 HOFSTRA L. REV. 663, 669-71 (2008).

132. Rogers & Dion, *supra* note 92, at 26. While the specific references to stealing and having no fixed address were not included in the DSM-IV-TR, there is still no language to guide someone in weighing one example of behavior against another with respect to specific diagnostic criteria. *Id.*

133. *Id.*

134. *Id.*

135. DSM-5, *supra* note 24, at 659-60. This is especially problematic in cases involving minority defendants, who are more apt to live in communities in which unemployment is chronically high, typically more than double that of white people, due to poor educational and employment opportunities and discrimination in the job market. *See* Floyd D. Weatherspoon, *The Devastating Impact of the Justice System on the Status of African-American Males: An Overview Perspective*, 23 CAP. U. L. REV. 23, 52-54, 57-58 (1994) (discussing social and economic conditions in segregated minority communities that deny economic opportunity); *see also* MICHELLE ALEXANDER, THE NEW JIM CROW 228 (rev. ed. 2012) ("As unemployment rates sank to historically low levels in the late 1990s for the general population, jobless rates among noncollege black men in their twenties rose to their highest levels ever, propelled by skyrocketing incarceration rates.").

consistent work behavior, or honoring financial obligations.[136] There is still plenty of room for honest disagreement about whether there is evidence for specific symptoms.

To summarize, the personality disorder category generally, and the diagnosis of ASPD specifically, have been the subject of multiple critiques and debate, and these issues are not settled in the mental health field. All of these issues become particularly problematic in the highly adversarial and often emotionally and politically charged context of capital cases, where ASPD and psychopathy become tools in the hands of prosecutors intent on obtaining death verdicts. It has been our experience that in this situation, where the stakes could not be higher, the potential for misdiagnosis is at its peak, as compared to other contexts where mental health assessments and diagnoses occur. All of the debates that surrounded efforts to address these issues in the DSM-5 suggest that these controversies will continue to haunt this contentious category of disorders. Given the high potential for prejudice and mistake, it is especially important that capital defense teams protect clients from unreliable and inflammatory mental health labels.[137]

2. Ethical Controversies

Ethical concerns have been raised about the personality disorder classification system generally, and, in particular, the diagnosis of ASPD. Doctor Gillian Bendelow, a medical sociologist, noted that, with respect to personality disorders, "the vexed question of the value-laden nature of interpreting symptoms, which are unable to be 'measured' in the same manner as high cholesterol or low insulin levels, continues to haunt psychiatric practice and the subsequent provision of evidence-based healthcare."[138] This is part of a larger critique and set of concerns about the potential for psychiatry to be an agent of social control that began over a hundred years ago when mental patients were being placed in paupers' prisons; it continues to the present day when over half of all

136. *See* AD HOC COMM. ON TERMINOLOGY & CLASSIFICATION, INTELLECTUAL DISABILITY: DEFINITION, CLASSIFICATION, AND SYSTEMS OF SUPPORTS 157, 159, 162, 165 (11th ed. 2012).

137. The ABA Guidelines state:

> [T]he defendant's psychological and social history and his emotional and mental health are often of vital importance to the jury's decision at the punishment phase," counsel must "[c]reat[e] a competent and reliable mental health evaluation consistent with prevailing standards . . . . Counsel must compile extensive historical data, as well as obtain a thorough physical and neurological examination. Diagnostic studies, neuropsychological testing, appropriate brain scans, blood tests or genetic studies, and consultation with additional mental health specialists may also be necessary.

ABA GUIDELINES, *supra* note 18, Guideline 4.1 cmt., at 956 (footnotes omitted).

138. Gillian Bendelow, *Ethical Aspects of Personality Disorders*, 23 CURRENT OPINION PSYCHIATRY 546, 546 (2010).

people in jails and prisons in the United States have a recent history or active symptoms of mental disorder.[139] In this context, ASPD is often used to achieve non-therapeutic goals: identifying individuals for isolation and punishment instead of treatment.

Another ethical concern is the highly prejudicial nature of the "personality disorder" label. A recent opinion-editorial purporting to describe individuals diagnosed with personality disorders, published in *The New York Times*, illustrates the oversimplified, dismissive, and prejudicial characterizations of persons with personality disorder diagnoses:

> For years they have lived as orphans and outliers, a colony of misfit characters on their own island: the bizarre one and the needy one, the untrusting and the crooked, and grandiose and the cowardly.
>
> Their customs and rituals are as captivating as any tribe's, and at least as mystifying. Every mental anthropologist who has visited their world seems to walk away with a different story, a new model to explain those strange behaviors.[140]

Besides the stigmatizing stereotype, also ethically troubling is the common assumption that individuals diagnosed with a personality disorder, particularly ASPD, are unchangeable, fixed in their ways, and therefore not amenable to treatment.[141] Personality, in this view, is said to be an immutable character trait that a person is born with and that remains stable throughout life. This assumption has often resulted in stigmatization and denial of treatment options to patients, which is

---

139. At midyear 2005, more than half of all prison and jail inmates had a mental health problem, and fifty-four percent of jail inmates reported symptoms that met the criteria for mania. DORIS J. JAMES & LAUREN E. GLAZE, BUREAU OF JUSTICE STATISTICS, U.S. DEP'T OF JUSTICE, NCJ 213600, MENTAL HEALTH PROBLEMS OF PRISON AND JAIL INMATES 1-3 (2006), *available at* http://www.bjs.gov/index.cfm?ty=pbdetail&iid=789.

140. Carey, *Thinking Clearly*, *supra* note 101.

141. Rogers and Dion, *supra* note 92, at 27; *see also* Guinan v. Armontrout, 909 F.2d 1224, 1229 (8th Cir. 1990) (discussing a court-ordered psychiatric evaluation which diagnosed the appellant with ASPD). This issue appears unresolved in the literature. Although it is a common assumption that ASPD is not amenable to treatment, there is evidence that the overall quality of treatment outcome studies is poor and insufficient to allow conclusions to be drawn. *See, e.g.*, Simon Gibbon et al., *Psychological Interventions for Antisocial Personality Disorder (Review)*, *in* 6 COCHRANE LIBRARY 27 (2010); Najat Khalifa et al., *Pharmacologic Interventions for Antisocial Personality Disorder (Review)*, *reprinted in* 9 COCHRANE LIBRARY 23 (2010). In addition, there is some evidence for the efficacy of specific treatment modalities for the personality disorders, including ASPD. *See, e.g.*, Mulder & Chanen, *supra* note 93 at 90; Piper & Joyce, *supra* note 93, at 324; Luis H. Ripoll et al., *Evidence-Based Pharmacotherapy for Personality Disorders*, 14 INT'L J. NEUROPSYCHOPHARMACOLOGY 1257, 1259, 1261 (2011); Town et al., *supra* note 93, at 733. Finally, in contrast to the frequently cited testimony of prosecution experts in capital trials that ASPD is unremitting, it often wanes in symptom intensity with age, particularly in the fourth decade of life. DSM-5, *supra* note 24, at 661; Cunningham & Reidy, *supra* note 17, at 335-36.

especially egregious when patients have been misdiagnosed and other more appropriate (possibly more "treatable") diagnoses have been overlooked. In one study of forensic psychiatric nurses' approach to treatment in a high security psychiatric hospital in the United Kingdom, patients who were described using lay notions of badness (evil) were "excluded from the usual medical, symptom-centered approach."[142] Perhaps ironically, the behaviors that constitute ASPD have been repeatedly demonstrated to recede with aging (decline in aggression and criminality after age forty) but the diagnosis, once the criteria are met, is unaffected by these changes in behavior and the ASPD label persists across time for the individual.[143] This, of course, makes it easier for the prosecutor to argue for the death penalty.

Upon publication of the DSM-III in 1980, the diagnosis of ASPD focused almost exclusively on observable behaviors.[144] This has been described as a "major regressive step" because the "DSM has returned to an accusatory judgment rather than a dispassionate clinical formulation."[145] A sociologist who has focused on legal and ethical issues in biomedicine and mental health noted: "A diagnosis of ASPD is seldom appropriated willingly by individuals to characterize their subjective distress; rather, it is commonly applied to involuntary patients placed in forensic mental health services. Correspondingly, ASPD plays an important role in debates regarding mental health and criminal policy, and especially their intersections."[146]

Given the negative implications of ASPD and the contexts in which it is often diagnosed (that is, adversarial forensic proceedings), it is not surprising that the diagnosis itself is often interpreted as a damning judgment of the individual. In the highly politically and emotionally charged death penalty arena, the diagnosis of ASPD is repeatedly used as a tool to inflame jurors and fact finders into imposing sentences of death.

---

142. Knoll, *supra* note 56, at 113.

143. Cunningham & Reidy, *supra* note 17, at 335-36, 344.

144. Rogers & Dion, *supra* note 92, at 21.

145. *Id.* at 21-22. An example of how the personality disorders and ASPD result in "accusatory judgments" can be clearly seen in the language used by Benedict Carey in *The New York Times*. Carey, *For the Worst of Us*, *supra* note 58.

146. Martyn Pickersgill, *Standardizing Antisocial Personality Disorder: The Social Shaping of a Psychiatric Technology*, 34 SOC. HEALTH & ILLNESS 544, 545 (2012) (citation omitted).

B. Controversies Surrounding Psychopathy and Related Assessment Instruments

Interest in the concept of psychopathy–which, we repeat, is not a DSM diagnostic category—has exploded in the past decade,[147] and the literature is vast.[148] It has become the subject of intense debate, and many questions remain unresolved.[149] Accompanying the renewed interest in psychopathy, research into instruments for assessing the risk of violence has "expanded significantly and has included work on many measures in varied populations and settings."[150] While a number of risk assessment instruments have been developed,[151] the PCL-R is the instrument most often used to assess an individual's risk of future dangerousness.[152] Although the PCL-R "was not "designed to be a risk assessment instrument per se," Doctor John F. Edens and his colleagues

147. There is also a literature that attempts to identify psychopathic characteristics in youths (deemed "fledgling psychopaths" by one researcher in this area). *See* Donald R. Lyman, *Early Identification of the Fledgling Psychopath: Locating the Psychopathic Child in the Current Nomenclature*, 107 J. ABNORMAL PSYCHOL. 566, 567 (1998). Needless to say, this has generated controversy in the mental health field. *See* Daniel Seagrave & Thomas Grisso, *Adolescent Development and the Measurement of Juvenile Psychopathy*, 26 LAW & HUM. BEHAV. 219, 229 (2002). The Supreme Court has noted that, "[f]or most teens, [risky or antisocial] behaviors are fleeting; they cease with maturity as individual identity becomes settled," and that "[i]t is difficult even for expert psychologists to differentiate between the juvenile offender whose crime reflects unfortunate yet transient immaturity, and the rare juvenile offender whose crime reflects irreparable corruption." Roper v. Simmons, 543 U.S. 551, 570, 573 (2005) (quoting Laurence Steinberg & Elizabeth S. Scott, *Less Guilty by Reason of Adolescence: Developmental Immaturity, Diminished Responsibility, and the Juvenile Death Penalty*, 58 AM. PSYCHOLOGIST 1009, 1014-16 (2003)).

148. For example, a PubMed search performed on March 27, 2013 using "psychopathy" and "psychopath" as search terms showed that between 1943 and 1973, these terms were used on average sixty-five times per decade; between 1973 and 1993, they were used on average 167 times per decade; between 1993 and 2003, they were used 316 times; and between 2003 and 2013, they were used 1098 times. U.S. Nat'l Library of Med., PUBMED (Mar. 27, 2013), http://www.ncbi.nlm.nih.gov/pubmed (search "PubMed" for "psychopath and psychopathy" for each publication date range listed).

149. Edens, *Unresolved Controversies*, *supra* note 76, at 60-61; John F. Edens et al., *Psychopathic, Not Psychopath: Taxometric Evidence for the Dimensional Structure of Psychopathy*, 115 J. ABNORMAL PSYCHOL. 131, 131-32 (2006) [hereinafter Edens et al., *Psychopathic*]; John F. Edens & John Petrila, *Legal and Ethical Issues in the Assessment and Treatment of Psychopathy*, *in* HANDBOOK OF PSYCHOPATHY 573, 573 (Christopher J. Patrick ed., 2006).

150. Jay P. Singh & Seena Fazel, *Forensic Risk Assessment: A Metareview*, 37 CRIM. JUST. & BEHAV. 965, 965 (2010) ("Searching for all previously published literature with the term *risk assessment* on the PsychINFO search engine in 1999 would have yielded a total of 1,965 citations, whereas the same search in 2009 gave a total of 6,093 records.").

151. *See, e.g.*, Edens et al., *Predictions*, *supra* note 77, at 65, 68, 71, 73; Scott I. Vrieze & William M. Grove, *Multidimensional Assessment of Criminal Recidivism: Problems, Pitfalls, and Proposed Solutions*, 22 PSYCHOL. ASSESSMENT 382, 382 (2010).

152. Patrick J. Kennealy et al., *Do Core Interpersonal and Affective Traits of PCL-R Psychopathy Interact with Antisocial Behavior and Disinhibition to Predict Violence?*, 22 PSYCHOL. ASSESSMENT 569, 569 (2010).

note that "it has frequently been used to assess the risk of violence and recidivism in civil and forensic settings."[153] The PCL-R has been promoted widely as an instrument that predicts re-offending, and, as a result, many in forensic mental health appear to assume a link between the assessment of psychopathy under the PCL-R and future dangerousness. A growing body of research has challenged this assumption.

Statements by proponents as well as critics of psychopathy and the PCL-R illustrate the widely divergent views of researchers in this area. Proponents of the construct of psychopathy and use of the PCL-R claim that psychopathy is "arguably the single most important clinical construct in the criminal justice system,"[154] that the PCL-R is "unparalleled as a measure for making risk assessments,"[155] and that the "failure to consider psychopathy when conducting a risk assessment may be unreasonable (from a legal perspective) or unethical (from a professional perspective)."[156]

On the other hand, critics argue that psychopathy is "an elusive concept with moral overtones"[157] that "remains a mythical entity," which "should be discarded"[158] because "diagnostic groupings . . . seldom have sharp and definite limits[,] . . . [w]orst of all is psychopathic personality."[159] Critics also argue that "close inspection of available empirical research does not provide much evidence to suggest that psychopathy is associated with the types of future violence that are at issue in death penalty cases."[160] Although proponents of the psychopathy construct, as defined by the PCL-R, strongly advocated for its inclusion

---

153. Edens et al., *Predictions*, *supra* note 77, at 65; *see also* Robert D. Hare, *Psychopathy: A Clinical and Forensic Overview*, 29 PSYCHIATRIC CLINICS N. AM. 709, 710 (2006).

154. Robert D. Hare, *Psychopaths and Their Nature: Implications for the Mental Health and Criminal Justice Systems*, *in* PSYCHOPATHY: ANTISOCIAL, CRIMINAL, AND VIOLENT BEHAVIOR 188, 189 (Theodore Millon et al. eds., 1998).

155. Randall T. Salekin et al., *A Review and Meta-Analysis of the Psychopathy Checklist and Psychopathy Checklist Revised: Predictive Validity of Dangerousness*, 3 CLINICAL PSYCHOL.: SCI. & PRAC. 203, 211 (1996).

156. Stephen D. Hart, *Psychopathy and Risk for Violence*, *in* PSYCHOPATHY: THEORY, RESEARCH, AND IMPLICATIONS FOR SOCIETY 355, 368 (David J. Cooke et al. eds., 1998).

157. John Gunn, *Psychopathy: An Elusive Concept with Moral Overtones*, *in* PSYCHOPATHY: ANTISOCIAL, CRIMINAL, AND VIOLENT BEHAVIOR 32, 32 (Theodore Millon et al. eds., 1998).

158. Ronald Blackburn, *On Moral Judgments and Personality Disorders: The Myth of Psychopathic Personality Revisited*, 153 BRIT. J. PSYCHIATRY 505, 511 (1988).

159. Aubrey Lewis, *Psychopathic Personality: A Most Elusive Category*, 4 PSYCHOL. MED. 133, 139 (1974).

160. Edens et al., *Predictions*, *supra* note 77, at 66 (citation omitted); *see also* David Freedman, *Premature Reliance on the Psychopathy Checklist-Revised in Violent Risk and Threat Assessment*, 1 J. THREAT ASSESSMENT 51, 60-61 (2001) [hereinafter Freedman, *Premature Reliance*].

in DSM-IV, it was rejected following its poor performance in field trials, and has not been recognized as an official diagnosis in any edition of the DSM.[161]

1. Psychopathy: Scientific and Research-Based Controversies

Despite some overlap between the diagnosis of ASPD and the construct of psychopathy, these terms represent distinct concepts that are frequently (and erroneously) used interchangeably. Traditionally, affective and interpersonal traits (for example, egocentricity, shallow affect, manipulativeness, selfishness, and lack of empathy or remorse) have been considered core elements of the construct of psychopathy, whereas ASPD has focused more on behavioral criteria related to violations of social norms.[162] Below, we will summarize some of the more noteworthy debates about the construct of psychopathy, and the reliability and validity of risk assessment instruments, such as the PCL-R.[163]

a. Controversies over the Construct of Psychopathy

A number of intensely debated issues regarding the construct validity of psychopathy remain unresolved. These include the generalizability of psychopathy across gender and ethnic groups, whether variants or subtypes of psychopathy exist, and the nature of the underlying factor structure of the PCL-R.[164] Edens, a national expert in forensic psychology, summarized common assumptions about psychopathy that are controversial and remain unresolved: "Once a Psychopath, Always a Psychopath";[165] "Where the Psychopath Goes,

161. *See* AM. PSYCHIATRIC ASS'N, RATIONALE, *supra* note 98, at 1. *See generally* AM. PSYCHIATRIC ASS'N, DSM-IV SOURCEBOOK, *supra* note 107.

162. *See* Edens et al., *Psychopathic*, *supra* note 149, at 131; Hare, *supra* note 117, at 39.

163. "Risk assessment" refers to predictions about the likelihood that a given individual will or will not be dangerous or violent in the future. The PCL-R is of particular consequence to this Article, as it was developed to make determinations about whether or not an individual is a "psychopath," and has been incorporated into other currently used risk assessment instruments. *See* Freedman, *Premature Reliance*, *supra* note 160, at 52; *see also* Edens et al., *Predictions*, *supra* note 77, at 65.

164. See Edens et al., *Psychopathic*, *supra* note 149, at 164, for a discussion of these issues. See Freedman, *Premature Reliance*, *supra* note 160, at 56-57, for a discussion about the potential influence of race on PCL-R scores, noting that, while data are sparse, available research suggests there are important differences in the performance of African-Americans and Caucasians on PCL-R scores and that certain PCL-R items appear to be particularly subject to race bias.

165. Edens, *Unresolved Controversies*, *supra* note 76, at 60 (noting that, while a lot of literature is based on the belief that psychopathy is an immutable aspect of personality, there is little or no support for this).

Violence Will Surely Follow";[166] "Psychopaths Cannot Be Treated";[167] "Clinical Evaluations of Psychopathy Are Highly Reliable";[168] and "Psychopaths Are Qualitatively Different from Other Offenders."[169]

According to Edens, these assertions "reflect areas in which [he has] observed clinicians and researchers drawing overly forceful, categorical, or sweeping conclusions about psychopathy in the courtroom, in formal or informal talks, and/or in print."[170]

Whether psychopathy represents a "taxon," that is, a fundamentally distinct class of individuals who differ qualitatively from the rest of society, is an issue critical to capital defense. Because psychopathy plays an increasing role in legal decision-making across the world, this question has broad and significant implications.[171] Edens and his colleagues have noted "the increasing role of the highly charged label of *psychopath* in the legal system, where the PCL-R has been used to find indeterminate commitment, rebut insanity defenses, and bolster support for the death penalty in capital murder trials."[172] In the death penalty context, jurors and fact finders may make life-and-death decisions based on the assumption that "psychopaths" are fundamentally different from the rest of humanity.[173]

While earlier research supported the view "that there are fundamental, qualitative differences between psychopaths and nonpsychopaths,"[174] an increasing body of literature indicates that psychopathy is, in fact, a dimensional, rather than categorical, construct (or taxon).[175] In a study specifically examining this question, Edens and

---

166. *Id.* While there is evidence to suggest that elevated PCL-R scores may identify violence-prone individuals, the evidence does not support "absolutist assertions . . . that individuals who are psychopathic will necessarily engage in violent conduct in the future." *Id.*

167. *Id.* at 61-62. Although some early outcome studies concluded that psychopathy was untreatable, these studies were methodologically weak; more recent reviews have challenged these findings. *See id.*

168. *Id.* at 62. There is evidence of significant disagreement in the scoring of the PCL-R, particularly in highly adversarial legal settings. *See* discussion *infra* notes 215-33.

169. Edens, *Unresolved Controversies*, *supra* note 76, at 63. In fact, recent research shows that people who are labeled "psychopaths" do not differ from other offenders in kind; the difference is rather in degree. *See id.*

170. *Id.* at 59. For additional information regarding misperceptions about psychopathy, see Joanna M. Berg et al., *Misconceptions Regarding Psychopathic Personality: Implications for Clinical Practice and Research*, 3 NEUROPSYCHIATRY 63, 65 (2013).

171. *See, e.g.*, Bersoff, *supra* note 77, at 571; Cunningham & Reidy, *supra* note 17, at 340-41; Edens at al., *Predictions*, *supra* note 77, at 64; Edens & Petrila, *supra* note 149, at 573-74.

172. *See* Edens et al., *Psychopathic*, *supra* note 149, at 132 (citation omitted).

173. Edens & Petrila, *supra* note 149, at 575, 582.

174. Edens et al., *Psychopathic*, *supra* note 149 at 132.

175. *See* Edens & Petrila, *supra* note 149, at 583-84; Jean-Pierre Guay et al., *A Taxometric Analysis of the Latent Structure of Psychopathy: Evidence for Dimensionality*, 116 J. ABNORMAL PSYCHOL. 701, 706-08 (2007); Glenn D. Walters et al., *A Taxometric Analysis of the Psychopathy*

his colleagues concluded that their results "offer no compelling support for the contention that psychopathy is a taxonic construct and contradict previous reports that psychopathy is underpinned by a latent taxon."[176] The implications of this debate are potentially enormous, particularly in the context of capital litigation. Prosecution experts employing a taxonic approach portray a purportedly psychopathic defendant as something other than human. If "psychopathy" is in fact a dimensional construct, the idea that a "psychopath" is in effect non-human is erroneous and enormously prejudicial. If it is dimensional, this suggests that many people in our world have some psychopathic traits.

A related concern is whether the mental health "field is in danger of equating the PCL-R with the theoretical construct of psychopathy,"[177] and whether the danger is increased by the use of the "PCL-R as a common metric for psychopathy."[178] Jennifer L. Skeem and David J. Cooke point out that "a PCL-R score is not psychopathy any more than an intelligence score is intelligence itself."[179] To clarify the significance of this issue, it has long been assumed that the construct of psychopathy is primarily defined by the interpersonal-affective domain (for example, egocentricity, shallow affect, manipulativeness, selfishness, or lack of empathy), as captured by Factor 1 of the PCL-R.[180] The specific characteristics included in Factor 1 have been thought to best capture Cleckley's original description of psychopathy. However, the research does not support the predictive validity of Factor 1. Instead, Factor 1 adds almost nothing at all to the predictive strength of the PCL-R, and is less predictive of future violence than Factor 2 (testing behavioral factors more related to violation of social norms).[181] Further, prior

---

Checklist: Screening Version (PCL:SV) Further Evidence of Dimensionality, 19 PSYCHOL. ASSESSMENT 330, 336 (2007). By definition, dimensional means that there are various degrees of severity that exist on a continuum, and that individuals labeled as "psychopaths" are not a discrete class of individuals, thus are not fundamentally different from the rest of society. *See* Edens et al., *Psychopathic*, *supra* note 149, at 131. Conversely, a taxonic construct defines a discrete entity or identifiable class of individuals who are fundamentally different from others. *Id.*

176. Edens et al., *Psychopathic*, *supra* note 149, at 131; *see also* Guay et al., *supra* note 175, at 706-08.

177. Jennifer L. Skeem & David J. Cooke, *Is Criminal Behavior a Central Component of Psychopathy?: Conceptual Directions for Resolving the Debate*, 22 PSYCHOL. ASSESSMENT 433, 433 (2010).

178. *Id.* at 433 (internal quotation marks omitted).

179. *Id.* at 437.

180. *See id.* at 434.

181. Kennealy et al., *supra* note 152, at 569, 574, 576-77; *see also* Edens et al., *Impact of Mental Health Evidence*, *supra* note 77, at 619; John F. Edens et al., *Inter-Rater Reliability of the PCL-R Total and Factor Scores Among Psychopathic Sex Offenders: Are Personality Features More Prone to Disagreement than Behavioral Features?*, 28 BEHAV. SCI. & L. 106, 115 (2010) [hereinafter Edens et al., *Inter-Rater Reliability*]; Glenn D. Walters, *Predicting Institutional*

criminal behavior has been found to predict scores on the PCL-R, with Factor 2 being a better predictor of recidivism than total score (which includes both Factor 1 and Factor 2 combined).[182] Given these findings, the use of the PCL-R for assessing violence risk and conceptualizing psychopathy invites "mistaken assumptions that violence risk reflects detachment, predation, and inalterable dangerousness,"[183] characteristics commonly associated with psychopathy. Arguably, the label "psychopath" should be avoided altogether to circumvent the "emotional baggage" of stigmatization and the perception of untreatability.[184] This issue takes on added significance in the context of death penalty litigation, where the "psychopath" label is prejudicial. Capital jurors and fact finders may assume that this label establishes a high risk of future violence, even though it, in fact, provides little to no predictive information.[185]

b. Do Risk Assessment Instruments Deliver What They Promise?

The recent interest in the construct of psychopathy is accompanied by the use of instruments that purport to quantify the risk of future dangerousness. However, there are troubling warnings from a growing number of studies that question the enthusiastic embrace of these risk prediction instruments and their ability to provide reliable and valid

---

Adjustment and Recidivism with the Psychopathy Checklist Scores: A Meta-Analysis, 27 LAW & HUM. BEHAV. 541, 542, 550, 553 (2003); Glenn D. Walters et al., *Incremental Validity of the Psychopathy Checklist Facet Scores: Predicting Release Outcome in Six Samples*, 117 J. ABNORMAL PSYCHOL. 396, 402 (2008). Arguably, these findings challenge the essence of the construct of psychopathy, such as personality characteristics contained in Factor 1. Kennealy et al., *supra* note 152, at 577. "At first glance, the PCL-R's predictive utility seems consistent with a belief that psychopaths are 'remorseless predators who use charm, intimidation and, if necessary, impulsive and cold-blooded violence to attain their ends.'" *Id.* at 569 (quoting Robert D. Hare, *A Case of Diagnostic Confusion*, *supra* note 117). This belief is more consistent with "public perceptions of psychopathy . . . than empirical evidence." *Id.*

182. Marta Wallinius et al., *Facets of Psychopathy Among Mentally Disordered Offenders: Clinical Comorbidity Patterns and Prediction of Violent and Criminal Behavior*, 198 PSYCHIATRY RES. 279, 282 (2012).

183. Kennealy et al., *supra* note 152, at 577.

184. *Id.* at 570 (citing Paul Gendreau et al., *Is the PCL-R Really the "Unparalleled" Measure of Offender Risk?: A Lesson in Knowledge Cumulation*, 29 CRIM. J. & BEHAV. 397, 413 (2002)). As noted by Canadian forensic psychologists, "[p]sychopathy is commonly equated with untreatability in the professional mind . . . but this widespread belief is perhaps forensic psychology's most clear-cut example of overzealous acceptance of limited research findings." Caleb D. Lloyd et al., *Psychopathy, Expert Testimony, and Indeterminate Sentences: Exploring the Relationship Between Psychopathy Checklist-Revised Testimony and Trial Outcome in Canada*, 15 LEGAL & CRIMINOLOGICAL PSYCHOL. 323, 326-27 (2010) (citation omitted).

185. *See infra* notes 239-51 and accompanying text.

assessments of an individual's risk for future violence and recidivism. Concerns about the PCL-R are of particular interest to this Article.[186] Especially important is the problem of false positive rates—frequently at or above fifty percent in nearly a dozen studies—when the PCL-R is used to try to predict violent recidivism.[187] The data suggests that problems associated with risk assessment conclusions gathered from the PCL-R are so serious that inferences drawn from them could damage the integrity of the adjudicative process.[188] Several authors have questioned the wisdom and ethics of the use of instruments like the PCL-R in forensic examinations in death penalty proceedings where the stakes are so high.[189]

Another issue of the utmost significance in capital litigation is that the PCL-R has demonstrated minimal ability to predict future violence in prison,[190] a prediction that is arguably the only outcome measure relevant to death penalty cases, where sentencing options are most often death or life imprisonment, usually without the possibility of parole. In fact, rates of prison violence are low; most capital defendants do not engage in serious violence in prison, and they are no more likely than other high-security inmates to engage in prison violence.[191] Edens

186. Identified problems include low base-rates of violence in institutional settings; lack of consistency in the literature about scores used to determine what constitutes a high ("psychopathic") score; failure to define severity of violence; unacceptably high false-positive rates; implausible probability values; differences in criteria used to develop different measures; questions about the best methods to arrive at overall probability estimates; failure to consider context; and predictor overlap. *See generally* Freedman, *Premature Reliance*, *supra* note 160; David Freedman, *False Prediction of Future Dangerousness: Error Rates and Psychopathy Checklist-Revised*, 29 J. AM. ACAD. PSYCHIATRY & L. 89 (2001); Vrieze & Grove, *supra* note 151, at 383-86, 388. More generally, studies into test validity and reliability are often conducted by the designer of the instrument; researchers have found such studies authored by tool designers reported predictive validity findings around two times higher than those reported by independent authors. Jay P. Singh et al., *Authorship Bias in Violence Risk Assessment? A Systematic Review and Meta-Analysis*, PLOS ONE, Sept. 2013, at 1, 4-6, *available at* http://www.plosone.org/article/info%3Adoi%2F10.1371%2Fjournal.pone.0072484.

187. Freedman, *Premature Reliance*, *supra* note 160, at 92. These data suggest that, for every person who is correctly identified with the PCL-R, many more are misclassified. *See id.* at 54.

188. *See* Bersoff, *supra* note 77, at 571-72; Edens et al., *Predictions*, *supra* note 77, at 77; Edens et al., *Impact of Mental Health Evidence*, *supra* note 77, at 606-07, 617-18; Freedman, *Premature Reliance*, *supra* note 160, at 54.

189. Bersoff, *supra* note 77, at 571-72; Edens et al., *Predictions*, *supra* note 77, at 77; Willem H. J. Martens, *The Problem with Robert Hare's Psychopathy Checklist: Incorrect Conclusions, High-Risk of Misuse, and Lack of Reliability*, 27 MED. L. 449, 454 (2008).

190. Edens et al., *Predictions*, *supra* note 77, at 66-68; *see also* Bersoff, *supra* note 77, at 572; John F. Edens, *Misuses of the Hare Psychopathy Checklist-Revised in Court: Two Case Examples*, 16 J. INTERPERS. VIOLENCE 1082, 1084-85, 1089 (2001) [hereinafter Edens, *Misuses*]; Freedman, *Premature Reliance*, *supra* note 160, at 89, 91, 94.

191. Mark D. Cunningham & Jon R. Sorensen, *Improbable Predictions at Capital Sentencing: Contrasting Prison Violence Outcomes*, 38 J. AM. ACAD. PSYCHIATRY L. 61, 62 (2010).

suggests that "it would seem hard to defend the PCL-R in an effort to identify inmates who are likely to be violent given the modest relationships in the literature [between PCL-R scores and prison violence]."[192] As a recent study about the utility of the PCL-R concluded:

> a) this checklist is not a reliable tool, b) the conclusions that are linked to these PCL-R scores with regard to the treatability of psychopathy are incorrect, harmful and unethical, c) can easily be misused in legal and forensic psychiatric settings to dispose of problematic psychopaths, and d) the diagnostic category psychopathy should be rejected firmly because some of the items are subjective, vague, judgmental and practically unmeasurable, and the term psychopathy itself seems to be judgmental.[193]

In spite of Hare's advice that accurate diagnosis involves expert observer (clinical) ratings based on a semi-structured interview and review of case history materials supplemented with behavioral observations whenever possible,[194] determinations of psychopathy can be made without a clinician even meeting the test subject.[195] Edens notes that the PCL-R instrument allows it to be scored without an interview if sufficient high-quality file data are available, but "[h]ow exactly one defines 'high-quality' file data is unclear."[196]

A growing body of literature has employed sophisticated methods, including systematic reviews and meta-analyses, to examine these issues. These studies raise additional concerns about the reliability of assessment instruments (including the PCL-R and other instruments) used to predict future violence. One study reviewed data from seventy-three samples that included over 24,000 participants from thirteen countries, and concluded that, "[w]hen used to predict violent offending, risk assessment instrument tools produced low to moderate positive

---

192. Edens, *Unresolved Controversies*, *supra* note 76, at 61.

193. Martens, *supra* note 189, at 449. Edens and colleagues echo similar concerns, especially considering the frequency with which prosecution experts in death penalty cases offer predictions of future violence. Edens et al., *Predictions*, *supra* note 77, at 61-63. "[T]here are strong reasons to question the accuracy of predictions of violence risk by prosecution experts in capital murder trials." *Id.* at 61. "These data clearly call into question the validity of expert testimony asserting that capital defendants are continuing threats to society." *Id.* at 63. "There is little reason to believe that risk statements offered by prosecution experts in [capital murder trials] provided much probative information about the likelihood that a capital defendant will go on to harm others in the future." *Id.* at 77. "This relative absence of probative value should be considered in the context of the likely prejudicial effects that such expert testimony may have." *Id.*

194. ROBERT D. HARE ET AL., OXFORD TEXTBOOK OF PSYCHOPATHOLOGY 557 (Theodore Millon et al. eds., 1999).

195. Walters et al., *supra* note 175, at 336.

196. Edens, *Misuses*, *supra* note 190, at 1090.

predictive values . . . and higher negative predictive values."[197] These researchers wrote that "[o]ne implication of these findings is that, even after 30 years of development, the view that violence, sexual, or criminal risk can be predicted in most cases is not evidence based."[198] Further implications of this research are "that these tools are not sufficient on their own for the purposes of risk assessment," and "that risk assessment tools in their current form *can only be used to roughly classify individuals at the group level, and not to safely determine criminal prognosis in an individual case*."[199]

A meta-review of risk assessment instruments "suggests that the view of some experts who have, in the past, argued that the Psychopathy Checklist measures are unparalleled in their ability to predict future offending . . . should now be reconsidered."[200] Another systematic review, a meta-analysis of sixty-eight studies involving almost 26,000 participants, concluded that, "[t]o date, no single risk assessment tool has been consistently shown to have superior ability to predict offending."[201] Finally, a meta-analysis of nine commonly used risk assessment instruments found that the PCL-R Factor 1 (the factor commonly associated with "psychopathy") predicted violence no better than chance for men.[202] In other words, it performed no better than a coin toss. These authors concluded that "there is no appreciable or clinically significant difference in the violence-predictive efficacy of the nine tools . . . . After almost five decades of developing risk prediction tools, the evidence increasingly suggests that the ceiling of predictive efficacy may have been reached with the available technology."[203]

In sum, there is a significant body of research that consistently indicates that claims about the value of instruments such as the PCL-R to predict future violence were much too optimistic, and at times were

197. Seena Fazel et al., *Use of Risk Assessment Instruments to Predict Violence and Antisocial Behavior in 73 Samples Involving 24,827 People: Systematic Review and Meta-analysis*, 345 BRIT. J. MED. 1, 1 (2012).

198. *Id.* at 5.

199. *Id.* (emphasis added).

200. Singh & Fazel, *supra* note 150, at 981-82. The meta-review consisted of "systematically searching for and descriptively summarizing all available meta-analyses and systematic reviews" to identify inconsistences in study findings. *Id.* at 966.

201. Jay P. Singh et al., *A Comparative Study of Violence Risk Assessment Tools: A Systematic Review and Metaregression Analysis of 68 Studies Involving 25,980 Participants*, 31 CLINICAL PSYCHOL. REV. 499, 500 (2011). The authors note that "[s]uch uncertainties are important given that risk assessment tools have been increasingly used to influence decisions regarding accessibility of inpatient and outpatient resources, civil commitment or preventative detention, parole and probation, and length of community supervision in many Western countries, including the US." *Id.*

202. Min Yang et al., *Efficacy of Violence Prediction: A Meta-Analytic Comparison of Nine Risk Assessment Tools*, 135 PSYCHOL. BULL. 740, 740 (2010).

203. *Id.* at 759.

based on flawed methodology. While there are clearly prominent advocates as well as critics of the constructs of personality disorders, ASPD and psychopathy in the mental health field, empirical support is lacking for key assumptions on which it depends for admission as relevant scientific evidence, particularly in capital cases.[204]

c. Subjectivity and Bias in Forensic Settings

There are increasing concerns about the application of the PCL-R in forensic settings due to the potential for misuse and damage to the integrity of legal proceedings—situations in which the risk of error has severe consequences.[205] Hare, the developer of the PCL-R, has raised numerous concerns about its potential for misuse in forensic settings, including issues related to the qualifications and training of evaluators.[206] Hare notes that "[t]he PCL-R Manual . . . outlines recommended qualifications for clinical use of the instrument."[207] Nevertheless, he cautions that, even if the examiner meets minimum qualifications, "there is no guarantee that he or she has the professional experience, competence, and integrity to score the items in a careful, unbiased manner."[208] Hare raised specific concerns about the substitution of "clinical experience" and "informed opinion" in scoring of the PCL-R, which can result in inaccurate scoring of individual items,[209] and blatant misuse of the PCL-R, "[t]hrough ignorance or misguided intentions, some unqualified individuals have managed to use the PCL-R in court proceedings."[210]

Further, Hare has raised concerns about conceptual confusion, or conflation of the construct of psychopathy, with the diagnosis of ASPD.[211] He noted he had reviewed many forensic reports where clinicians diagnosed clients with ASPD who had not administered the PCL-R, and yet they invoked the PCL-R literature in their testimony.[212] "This is a very misleading practice" because "most individuals with

204. *See* Daubert v. Merrell Dow Pharmaceuticals, Inc., 509 U.S. 579, 593 (1993) ("Ordinarily, a key question to be answered in determining whether a theory or technique is scientific knowledge that will assist the trier of fact will be whether it can be (and has been) tested.").

205. Martens, *supra* note 189, at 454.

206. *See* Robert D. Hare, *The Hare PCL-R: Some Issues Concerning Its Use and Misuse*, 3 LEGAL & CRIMINOLOGICAL PSYCHOL. 99, 107 (1988).

207. *See id.*

208. *Id.*

209. *Id.* at 109.

210. *Id.*

211. *Id.* at 108.

212. *Id.*

antisocial personality disorder are not psychopaths."[213] Hare pointed out that "literature relating the PCL-R to treatment outcome and to the risk for recidivism and violence may have little or no relevance for an individual with a diagnosis of antisocial personality disorder."[214]

In addition to the issue of a given clinician's competence, another important concern raised by Hare involves the potential for inaccurate, biased ratings in applied forensic settings, because of "the assessment biases [the clinician] may have."[215] Hare considers this a serious matter, "particularly in jurisdictions . . . where it is not uncommon for prosecutors and defense lawyers to seek out and retain 'the right expert.'"[216] Although Hare asserts that the scoring criteria are "quite explicit,"[217] he has observed that "experts hired by the defense always seem to come up with considerably lower PCL-R ratings than do experts who work for the prosecution."[218] This is understandably "of considerable concern" to Hare "because a PCL-R rating carries more serious implications for the individual and for the public than do most psychological assessments."[219]

A growing literature has also raised concerns that the PCL-R is less reliable in field (rather than research) settings,[220] due in part to the potential for evaluator bias in PCL-R rating scores.[221] While studies

---

213. *Id.*
214. *Id.*
215. *Id.* at 113.
216. *Id.*
217. *Id.*
218. *Id.*
219. *Id.*
220. *Reliability* and *validity* are critical characteristics of any assessment procedure. Daubert v. Merrell Dow Pharmaceuticals, Inc., 509 U.S. 579, 590 n.9. Reliability refers to the extent to which the same PCL-R scores are obtained for a particular individual, regardless of who administers the instrument; the expectation is that independent evaluators will obtain the same or similar results. *Id.* Validity refers to the ability of the measuring instrument (for example, the PCL-R) to actually measure the property (for example, psychopathy) it is supposed to measure. *See id.*; Dave DeMatteo & John F. Edens, *The Role and Relevance of the Psychopathy Checklist-Revised in Court: A Case Law Survey of U.S. Courts (1991-2004)*, 12 PSYCHOL. PUB. POL'Y & L. 214, 214 (2006); Salekin et al., *supra* note 155, at 204-05.
221. *See, e.g.*, Marcus T. Boccaccini et al., *Do Some Evaluators Report Consistently Higher or Lower PCL-R Scores than Others?: Findings from a Statewide Sample of Sexually Violent Predator Evaluations*, 14 PSYCHOL. PUB. POL'Y & L. 262, 262 (2008); Edens et al., *Inter-Rater Reliability*, *supra* note 181, at 114; Daniel C. Murrie et al., *Does Interrater (Dis)agreement on Psychopathy Checklist Scores in Sexually Violent Predator Trials Suggest Partisan Allegiance in Forensic Evaluations?*, 32 LAW & HUM. BEHAV. 352, 352 (2008) [hereinafter Murrie et al., *Interrater*]; Daniel C. Murrie et al., *Field Validity of the Psychopathy Checklist-Revised in Sex Offender Risk Assessment*, 24 PSYCHOL. ASSESSMENT 524, 524 (2012) [hereinafter Murrie et al., *Field Validity*]. These results raise critical, provocative questions about the use of the PCL-R in extremely high-stakes adversarial legal proceedings such as capital cases. Together, these studies clearly suggest the need for caution and further investigation. *See* John Edens et al., *Taking Psychopathy Measures*

show strong interrater agreement for PCL-R scores in well-designed research settings, conditions in real world settings differ significantly.[222] While "forensic psychologists have traditionally assumed that results from well-designed studies generalize to field settings[,] . . . recent research suggest[s] this assumption may not be safe."[223] Taken together, these findings raise serious questions about the reliability of the PCL-R in adversarial legal proceedings.

"[R]ecent field reliability research suggests that some evaluators assign consistently higher PCL-R scores than others . . . ."[224] Evaluator bias appears to be attributable to at least two independent sources of error.[225] Several studies suggest that individual differences in evaluators may account for some of the variability in PCL-R scores in forensic proceedings.[226] In addition, some PCL-R items are clearly more subjective than others.[227] Although general concerns have been raised about the bias in PCL-R ratings in real-world cases, the inferential personality items (Factor 1), thought to be most central to psychopathy, appear to be particularly susceptible.[228] Possible explanations include differences in raters' own subjective thresholds for Factor 1 items (reflecting interpersonal/affective traits) and differences in how

---

"Out of the Lab" and into the Legal System: Some Practical Concerns, *in* HANDBOOK OF PSYCHOPATHY AND THE LAW 250 (Kent A. Kiehl & Walter P. Sinnott-Armstrong eds., 2013); *see also* Cailey S. Miller et al., *Reliability of Risk Assessment Measures Used in Sexually Violent Predator Proceedings*, *in* PSYCHOLOGICAL ASSESSMENT 944, 944 (2012).

222. Murrie et al., *Interrater*, *supra* note 221, at 354. For example, most reliability values in the PCL-R literature reflect protocols in which two or more clinicians witness the same interview and review the same collateral materials. *Id.* at 353. In applied (adversarial) forensic settings, interviews are more often conducted at different points in time, and evaluators may review different materials. *Id.*

223. Murrie et al., *Field Validity*, *supra* note 221, at 525.

224. *Id.* (citing Boccaccini et al., *supra* note 221, at 263).

225. Boccaccini et al., *supra* note 221, at 276-77; Murrie et al., *Interrater*, *supra* note 221, at 357-58; Daniel C. Murrie et al., *Rater (Dis)agreement on Risk Assessment Measures in Sexually Violent Predator Proceedings: Evidence of Adversarial Allegiance in Forensic Evaluation?*, 15 PSYCHOL. PUB. POL'Y & L. 19, 24 (2009) [hereinafter Murrie et al., *Rater (Dis)agreement*]; *see also* Edens et al., *Inter-Rater Reliability*, *supra* note 181, at 116.

226. Boccaccini et al., *supra* note 221, at 263-64, 276. In this study, researchers found that over thirty percent of the variability in PCL-R scores was attributable to differences among evaluators, regardless of which side of the case they worked on. *Id.* at 276.

227. Studies have consistently demonstrated that there is more subjectivity and room for disagreement on items related to the interpersonal items of the PCL-R (considered more indicative of traditional notions of psychopathy) than on historical items (traditionally associated with antisocial behavior). *See* Miller et al., *supra* note 221, at 950; *see also* Terrence W. Campbell, *The Validity of the Psychopathy Checklist-Revised in Adversarial Proceedings*, 6 J. FORENSIC PSYCHOL. PRAC. 43, 45-47 (2006); Edens et al., *Inter-Rater Reliability*, *supra* note 181, at 107; Murrie et al., *Interrater*, *supra* note 221, at 360.

228. Edens et al., *Inter-Rater Reliability*, *supra* note 181, at 109.

evaluators might evoke different levels of Factor 1 traits due to their own interviewing styles.[229]

A second source of potential PCL-R scoring bias is partisan adversarial allegiance; that is, the tendency for forensic evaluators to reach opinions that support the party who retained them. "For decades, observers have complained – although usually through anecdotes and impressions rather than empirical data – of bias or partisanship by expert witnesses."[230] These concerns are validated by recent evidence of systematic differences in PCL-R rating scores, with scores skewed in the direction supporting the party who retained the evaluator.[231] Similar concerns have been raised by the National Research Council ("NRC") about the reliability of commonly accepted forensic science techniques,[232] and this new evidence of bias in the use of the PCL-R raises specific questions about forensic psychology—an area not addressed in the NRC report.[233]

Evidence of the potential for individual and partisan allegiance bias, and the lack of field reliability of PCL-R application in forensic proceedings, have serious implications for scientifically competent and ethical forensic practice. This raises additional questions about the PCL-R's evidentiary value in highly adversarial capital litigation proceedings.[234] Researchers in this area have concluded that, "as the

---

229. *Id.* at 116. In further support of individual bias, an exploratory study found that raters' PCL-R scoring tendencies related to their own personality traits. Audrey K. Miller et al., *On Individual Differences in Person Perception: Raters' Personality Traits Relate to Their Psychopathy Checklist-Revised Scoring Tendencies*, 18 ASSESSMENT 253, 259 (2011).

230. Murrie et al., *Rater (Dis)agreement*, *supra* note 225, at 46.

231. *See* Murrie et al., *Interrater*, *supra* note 221, at 355; Murrie et al., *Rater (Dis)agreement*, *supra* note 225, at 23. The strongest evidence for partisan adversarial allegiance derives from a recent study that showed a clear pattern of bias in PCL-R scores *in an experimental design*. Daniel C. Murrie et al., *Are Forensic Experts Biased by the Side that Retained Them?*, 24 PSYCH. SCI. 1889, 1890-91, 1893, 1895 (2013) [hereinafter Murrie et al., *Are Forensic Experts Biased*]. This study assessed potential adversarial allegiance and addressed the question of whether forensic experts are biased by the side that retained them. *Id.* The study adds critical and important information to the literature discussed, as the study design involved a random assignment of experts trained in use of two risk assessment instruments (including the PCL-R) to either the defense or the prosecution. *Id.* Partisan adversarial allegiance was found, even in this instance that did not involve real-world settings (e.g., actual retention by the prosecution or defense). *Id.* This study adds further weight to earlier studies based on naturalistic designs, and increases concerns about the objectivity of forensic experts when using instruments such as the PCL-R. *See id.*

232. NATIONAL RESEARCH COUNCIL, STRENGTHENING FORENSIC SCIENCE IN THE UNITED STATES: A PATH FORWARD 184-85 (2009).

233. Murrie et al., *Are Forensic Experts Biased*, *supra* note 231, at 1895.

234. As an important side note, another potential bias involves the threat to academic freedom in resolving disputes about the PCL-R. This was addressed recently by prominent psychologists Norman Poythress and John Petrila. *See* Norman Poythress & John P Petrila, *PCL-R Psychopathy: Threats to Sue, Peer Review, and Potential Implications for Science and Law. A Commentary*, 9 INT'L J. FORENSIC MENTAL HEALTH 3, 4, 9 (2010). These forensic experts discussed the

amount of variance attributable to evaluators approaches the amount of variance attributable to the offender, any score or opinion from the evaluator becomes less useful and fails to serve the purpose for which evaluators serve in court: to provide nonbiasing assistance to the trier of fact."[235]

2. Psychopathy: Ethical Controversies

The use of forensic evidence about psychopathy to persuade judges or juries to execute a defendant raises serious ethical concerns. These include the prejudicial nature of the construct itself, the equation of psychopathy with "wickedness" and "evil," and the implication that psychopathic individuals are subhuman. Consider, for example, Cleckley's assertions in his influential book on psychopathy:

> We are dealing here not with a complete man at all but with something that suggests a subtly constructed reflex machine which can mimic the human personality perfectly. . . . So perfect is this reproduction of a whole and normal man that *no one who examines him in a clinical setting can point out in scientific or objective terms why, or how, he is not real*. And yet we eventually come to know or feel we know that reality, in the sense of full, healthy experiencing of life, is not here.[236]

Similar, dehumanizing language was used more recently by Doctor Reid Meloy, who has written extensively about psychopathy:

> [T]he psychodynamics of the psychopath bring us closer to what we see as [his] evil . . . . It is phylogenetically a prey-predator dynamic, *often viscerally or tactilely felt by the psychiatrist as an acute autonomic fear response in the presence of the patient . . . the hair standing up on the neck, goosebumps, or the more inexplicable "creepy" or "uneasy" feeling. These are atavistic reactions that may signal real danger and should never be ignored* . . . .[237]

---

implications of a recent threat of litigation against the authors of an article that questioned the role of criminal behavior in the construct of psychopathy. *Id.* The editor of the scientific journal that accepted the article for publication (following the peer-review process) was also threatened with litigation. *Id.* Poythress and Petrila cautioned that "litigation threats can have chilling effects on academic freedom." *Id.* Litigation threats, uncommon in the mental health field, have the potential to negatively affect the greatly valued process of peer review as a means of ensuring academic integrity and scientific reliability and validity. *Id.* at 4, 7, 9.

235. Boccaccini et al., *supra* note 221, at 277.

236. ERROL MORRIS, A WILDERNESS OF ERROR: THE TRIALS OF JEFFREY MACDONALD 368-70 (2012) (emphasis added) (citing HERVEY CLECKLEY, THE MASK OF SANITY (5th ed. 1976)).

237. J. Reid Meloy, *The Psychology of Wickedness: Psychopathy and Sadism*, 27 PSYCHIATRIC ANNALS 630, 631 (1997) (emphasis added) (footnotes omitted). Both of these statements present an alarmingly subjective, dehumanizing portrayal of the "psychopath" as non-human, which has been

The use of such inflammatory language, cloaked as medical science, inevitably stigmatizes capital defendants and prejudices capital jurors and fact finders.[238] Because of the PCL-R's susceptibility to producing unreliable results in the hands of biased examiners, ethical concerns are growing about its unreliability and misuse of the PCL-R in forensic contexts.

3. Psychopathy Evidence More Prejudicial than Probative

The PCL-R and the construct of psychopathy have only recently been introduced into the sentencing phase of capital murder trials.[239] Such evidence has quickly taken hold in capital litigation to support expert testimony offered by the prosecution that a defendant will be a continuing threat to society if he is not executed.[240] Accumulating evidence suggests that, when juries perceive capital defendants to present a risk of future dangerousness, they are more likely to return a

---

contradicted by a number of studies indicating that there is no evidence the concept represents a discrete category of individuals. It is noteworthy that Meloy and Cleckley agree that it is difficult to assess clearly whether an individual is a psychopath, except in some "atavistic" or gut-level recognition of this "reality." *See id.* The subjective nature of Meloy's methodology was instrumental in the Colorado homicide conviction of Timothy Lee Masters, who was ultimately proven completely innocent. Miles Moffeit, *Release Likely Today as Missteps Surface*, DENVER POST, Jan. 22, 2008, http://www.denverpost.com/ci_8039377. Without interviewing Masters, but based on interpretation of violent images depicted in Masters's artwork and writings, Meloy testified that the "defendant perceived himself as a warrior character without empathy or feeling who engaged, through fictional narratives and pictures, in a variety of killings." State v. Masters, 33 P.3d 1191, 1196 (Colo. App. 2001). The Colorado Supreme Court found that Meloy's testimony was crucial to Masters's conviction. No physical evidence linked him to the crime, and "Dr. Meloy's testimony provided an explanation for the seemingly inexplicable." Masters v. State, 58 P.3d 979, 991 (Colo. 2002) (en banc). Without it, "lay jurors would be tremendously disadvantaged in attempting to understand Defendant's motivation for killing [Peggy] Hettrick." *Id.* at 992. Based on exonerating DNA tests, and other evidence developed with the assistance of police detectives who always had reservations about his guilt, Masters was released from prison on the motion of prosecuting attorneys in 2008. Moffeit, *supra*.

238. *See, e.g.*, Lloyd et al., *supra* note 184, at 324. Caleb D. Lloyd and his colleagues state:

> Concerns have been raised that expert testimony provided in trial courts, especially testimony in regards to psychopathy, may promote unfounded prejudice or inflate weakly supported research findings to bias criminal justice decision makers . . . minimally, professional integrity requires a measure of caution when considering emotionally charged diagnoses in the courts or applying standardized instruments to situations for which these instruments were not originally intended . . . .

Id.

239. John F. Edens et al., *Psychopathy and the Death Penalty: Can the Psychopathy Checklist-Revised Identify Offenders Who Represent "A Continuing Threat to Society*,*"* 29 J. PSYCHIATRY & L. 433, 434, 439 (2001) [hereinafter Edens et al., *Psychopathy and the Death Penalty*]; *see also* Cunningham, *supra* note 77, at 828, 829-30; Cunningham & Goldstein, *supra* note 3, at 425.

240. *See, e.g.*, Bersoff, *supra* note 77, at 571; Cunningham & Reidy, *supr*a note 17, at 333; DeMatteo & Edens, *supra* note 220, at 215, 218; Edens et al., *Impact of Mental Health Evidence*, *supra* note 77, at 616-18; Edens et al., *Psychopathy and the Death Penalty*, *supra* note 239, at 436-37, 439; Edens et al., *Predictions*, *supra* note 77, at 77.

death sentence.[241] The label "psychopath" has a profound effect on lay persons' views of capital defendants, because it tends to obscure and overwhelm other relevant mental health evidence.[242] This may explain the increasing use of such evidence by the prosecution.[243]

Given the prejudicial effect of expert testimony that the defendant is a psychopath who may kill again, mental health researchers recognize that it "has arguably become one of the most controversial types of evidence admitted."[244] Due to the "limited probative value of the PCL-R in capital cases and the prejudicial nature of the effects noted in this study,"[245] Edens and his colleagues "recommend that forensic examiners avoid using it in capital trials."[246] They also argue for ethical guidelines limiting the use of psychopathy evidence:

> Although the courts have typically allowed experts considerable latitude regarding what constitutes admissible evidence in these cases, this by no mean obviates experts' ethical responsibility to "use assessment instruments whose validity and reliability have been established for use with the members of the population tested" or the need to "take reasonable steps to avoid harming their

---

241. John H. Blume et al., *Future Dangerousness in Capital Cases: Always "At Issue,"* 86 CORNELL L. REV. 397, 404 (2001); Mark Constanzo & Sally Costanzo, *Jury Decision Making in the Capital Penalty Phase: Legal Assumptions, Empirical Findings, and a Research Agenda*, 16 LAW & HUM. BEHAV. 185, 196 (1992); Edens et al., *Impact of Mental Health Evidence*, *supra* note 77, at 616, 618; John F. Edens & Jennifer Cox, *Examining the Prevalence, Role and Impact of Evidence Regarding Antisocial Personality, Sociopathy and Psychopathy in Capital Cases: A Survey of Defense Team Members*, 30 BEHAV. SCI. & L. 239, 242, 247 (2012).

242. *See* DeMatteo & Edens, *supra* note 220, at 232; Edens et al., *Impact of Mental Health Evidence*, *supra* note 77, at 607; John F. Edens et al., *Psychopathic Traits Predict Attitudes Toward a Juvenile Capital Murderer*, 21 BEHAV. SCI. & L. 807, 822-24 (2003). As stated by Lloyd and his colleagues:

> Pejorative labeling and adverse effects are accomplished through experts' selective presentation of the concept of psychopathy or exaggeration of its implications. . . . [E]ven when psychopathy is correctly applied, research supports the conclusion that perceptions of dangerousness are heightened beyond an experts' indicated risk level when a diagnostic label is given.

Lloyd et al., *supra* note 184, at 325.

243. DeMatteo & Edens, *supra* note 220, at 232.

244. Edens et al., *Impact of Mental Health Evidence*, *supra* note 77, at 605 (citing Cunningham & Reidy, *supra* note 17, at 336-37); Charles P. Ewing, *"Dr. Death" and the Case for an Ethical Ban on Psychiatric and Psychological Predictions of Dangerousness in Capital Sentencing Proceedings*, 8 AM. J.L. & MED. 407, 412-13, 415 (1983); *see also* Brief for the American Psychological Association & the Missouri Psychological Association as Amicus Curiae Supporting Respondent at 20, Roper v. Simmons, 543 U.S. 551 (2005) (No. 03-633).

245. Edens et al., *Impact of Mental Health Evidence*, *supra* note 77, at 603. This study examined the effects of data about psychopathy on layperson attitudes; test subjects reviewed a capital murder case where results of the defendant's psychological examination were experimentally manipulated. *Id.*

246. *Id.*

> clients/patients . . . and others with whom they work, and to minimize harm where it is foreseeable and unavoidable. Given the minimally probative nature of PCL-R data . . . combined with the likelihood that it would have a prejudicial impact, it is difficult to postulate a scenario in which these two ethical standards would not be in jeopardy if it were introduced . . . ."[247]

It is for these reasons that both the American Psychiatric Association and the American Psychological Association have opposed the use of such evidence in in capital cases.[248]

In sum, serious ethical questions have been raised about whether the PCL-R provides any probative value in capital sentencing procedures.[249] The PCL-R stigmatizes defendants because of its associated label of "psychopath" and the morally damning judgment implicit in many of PCL-R items. "[I]t seems impossible to reconcile the glaring inaccuracy of the prediction made by prosecution experts . . . with the assertion that death sentences have not been meted out in a capricious manner."[250] In fact, when laypersons attribute psychopathic traits to capital defendants, this strongly predicts their support for decisions to execute them.[251]

4. No Intelligent Design: Conceptual Drift Towards "Evil" and "Wickedness"

An ethical debate of particular relevance to capital litigation is whether the mental health field should weigh in on "wickedness" and "evil," which are not clinical constructs (for example, neither are they contained anywhere in the DSM, nor are psychiatrists or psychologists trained to assess or identify these moral characterizations). While the introduction of moral and religious overtones into forensic testimony has

---

247. *Id.* at 619.

248. Edens & Cox, *supra* note 241, at 241; *see also* Brief of Amicus Curiae American Psychological Ass'n in Support of Defendant-Appellant at 9-12, United States v. Fields, No. 04-50393 (5th Cir. Apr. 2, 2007).

249. Edens & Cox, *supra* note 241, at 242-43; *see also* Bersoff, *supra* note 77, at 572 (enumerating six concerns); Cunningham & Goldstein, *supra* note 3, at 424, 426; Edens, *Misuses*, *supra* note 190, at 1085, 1087, 1089 (presenting two case examples); Edens et al., *Impact of Mental Health Evidence*, *supra* note 77, at 605-06. The PCL-R also is likely to have a highly prejudicial effect on perceptions of the defendant. Brief for the American Psychological Ass'n & the Missouri Psychological Ass'n as Amicus Curiae Supporting Respondent at 23-24, Roper v. Simmons, 543 U.S. 551 (2005) (No. 03-633).

250. Edens et al., *Predictions*, *supra* note 77, at 77. Hare, the developer of the PCL-R, has serious concerns about and has disavowed numerous ways in which his instrument has been misused. *See supra* text accompanying notes 206-19.

251. John F. Edens et al., *No Sympathy for the Devil: Attributing Psychopathic Traits to Capital Murderers Also Predicts Support for Executing Them*, 4 PERSONALITY DISORDERS: THEORY, RES. & TREATMENT 175, 175-76 (2012).

been questioned, "[i]nterest in evil is growing. The psychological and psychiatric literature reflects steadily increasing attention to the concept of evil over the past two decades."[252]

One prominent advocate of the view that "evil" and similar terms (for example, "depravity") are within the purview of psychiatric assessment is Welner, a psychiatrist who testifies frequently for the government in death penalty cases.[253] His position is that "legal relevance demands that evil be defined and standardized" because, "[i]n 39 American states, and in federal jurisdictions, statutes allow for judges and juries to enhance penalties for convicted offenders if they decide the crime committed was 'heinous,' 'atrocious,' 'depraved,' 'wanton,' or otherwise exceptional."[254] Welner explains that the purpose of introducing "evil" as a forensic concept in criminal cases is to neutralize evidence of the background and character of the accused, which in his personal opinion has no place in capital decision-making:[255]

> Without standardized direction, jury decisions on whether a crime is depraved are all too often *contaminated by details about the "who" of a crime* (i.e. a person's checkered background or, alternatively virtuous qualities that render a jury unable to fathom how such a privileged person could so dramatically offend), as opposed to focusing on *"what" the defendant actually did*.[256]

Welner contends that, "mingling the 'what' of a crime" with mitigating circumstances "undercuts an unbiased, equal justice."[257] He argues that standardizing depravity (evil) is needed to "insulate [jurors] from emotional manipulation, courtroom theatrics, *and the introduction of factors that should not play a role in sentencing*."[258] Of course, the factor that Welner seeks to neutralize is the Eighth Amendment's "need for treating each defendant in a capital case with that degree of respect due the uniqueness of the individual."[259]

Welner's advocacy of the use of depravity or evil to focus solely on the "what" of the crime, rather than the "who" of the defendant, is particularly misguided in light of the constitutional demand that the

---

252. Knoll, *supra* note 56, at 105 ("Medline and PubMed searches using the phrases 'the concept of evil in forensic psychiatry' and 'evil and psychiatry' revealed significantly more relevant publications beginning in the early to mid 1990s than before this period.").

253. *See Michael Welner, M.D.*, FORENSIC PANEL, http://www.forensicpanel.com/about/out_experts/expert/20835.html (last visited Feb. 16, 2014).

254. Welner, *supra* note 57, at 417.

255. *See generally id.*

256. *Id.* at 417 (emphases added).

257. *Id.* at 417-18.

258. *Id.* at 418 (emphasis added).

259. Lockett v. Ohio, 438 U.S. 586, 605 (1978).

sentencer consider the uniqueness of each individual in weighing the death penalty, which is reserved only for "a narrow category" of the most culpable offenders who commit the worst of crimes.[260] Indeed, the very factors which Welner insists on writing out of the capital sentencing equation—"a person's checkered background or, alternatively virtuous qualities . . . [or] race, orientation, and socioeconomic factors"[261]—are "relevant because of the belief, long held by this society, that defendants who commit criminal acts that are attributable to a disadvantaged background . . . may be less culpable than defendants who have no such excuse."[262] The Eighth Amendment condemns any procedure that "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 penalty of death."[263] Therefore, the Supreme Court requires that a capital sentencer be permitted to consider, "as a mitigating factor, any aspect of a defendant's character or record and any of the circumstances of the offense that the defendant proffers as a basis for a sentence less than death."[264] Welner's admission that evidence about psychopathy is intentionally designed to obscure constitutionally mandated mitigating evidence provides a compelling ethical argument for excluding it altogether.

Contrary to Welner, psychiatrist Doctor Robert Simon articulates the view that "evil" is not within the purview of the science of psychiatry:

> Forensic psychiatrists are ethically required to adhere to the principles of honesty and striving for objectivity in providing opinions and testimony. Evil, however, is a concept too knotted in ambiguity for the application of these principles. The proper métier of the forensic psychiatrist is psychological and clinical. Psychiatrists are medically trained in the scientific method, not in the diagnosis and treatment of evil. They observe cause and effect in human behavior. When a concept is beyond scientific investigation, it is the province of the philosopher and theologian. Introducing the concept of evil into forensic psychiatry hopelessly complicates an already difficult task.

260. Atkins v. Virginia, 536 U.S. 304, 319 (2002).

261. *See also* Welner, *supra* note 57, at 417.

262. Wiggins v. Smith, 539 U.S. 510, 535 (2003) (quoting Penry v. Lynaugh, 492 U.S. 302, 319 (1989)).

263. Woodson v. North Carolina, 428 U.S. 280, 304 (1976).

264. Lockett v. Ohio, 438 U.S. 586, 604 (1978) (emphasis omitted).

> The determination that a particular behavior is or is not evil is a judgment that is heavily influenced by context and subjectivity.[265]

Simon argues persuasively that "[t]he Gordian knot of evil cannot be untied by forensic psychiatry. It is unreasonable to expect forensic psychiatrists to provide credible testimony about evil."[266] He explains, "[l]ay people are just as qualified to identify these individuals as evil," and forensic psychiatrists and psychologists have "an important, but limited consulting role when advising the courts about psychological matters. We are not and should not be asked to offer professional opinions about evil. It's the law's final moral judgment of guilt upon individuals whom society brands as evildoers."[267]

Opponents of using psychiatry to measure evil point out that it is "an entirely subjective concept created by humans."[268] They argue that "[s]ince evil is a subjective moral concept with inextricable ties to religious thought, it cannot be measured by psychiatric science."[269] Further, "attempts by behavioral science to define evil as though it were an objective and quantifiable concept are inherently flawed."[270] To give "evil" quasi-scientific status in the psychiatric study of human behavior would harm patients and impede advancement in the identification and treatment of mental disorders:

> The term evil is very unlikely to escape religious and unscientific biases that reach back over the millennia. Any attempt to study violent or deviant behavior under this rubric will be fraught with bias and moralistic judgments. Embracing the term evil as though it were a legitimate scientific concept will contribute to the stigma of mental illness, diminish the credibility of forensic psychiatry, and corrupt forensic treatment efforts.[271]

To conclude otherwise would threaten the neutrality and objectivity that are essential ingredients of ethical and psychiatrically valid forensic mental health evaluations:

---

265. Robert I. Simon, *Should Forensic Psychiatrists Testify About Evil?*, 31 J. AM. ACAD. PSYCHIATRY & L. 413, 414 (2003) (footnote omitted). In a private communication with Robert I. Simon, Daniel W. Shuman, Professor of Law at Southern Methodist University, wrote: "As to relevance, no legal standard with which I am familiar turns on depravity – to what is this relevant in the forensic world?" *Id.* at 413.

266. *Id.* at 416.

267. *Id.*

268. Knoll, *supra* note 56, at 105.

269. *Id.* Knoll explains that, "evil can never be scientifically defined because it is an illusory moral concept, it does not exist in nature, and its origins and connotations are inextricably linked to religion and mythology." *Id.* at 114.

270. *Id.* at 105.

271. *Id.* at 114.

> Thus, psychiatry already has a tradition of at least attempting to avoid moralistic bias by focusing on concepts such as violence, aggression, or sexual disorders. Terms with value-laden or pejorative connotations are either limited or avoided. The use of such terms is a tradition that places value on the struggle for neutrality and objectivity. Forensic psychiatrists, as expert witnesses, subscribe to the principle in ethics of striving for objectivity. Forensic clinical psychiatrists, who must follow general ethics guidelines for psychiatry, are instructed to avoid any policy that "excludes, segregates or demeans the dignity" of a patient. When treating offenders, psychiatrists must strike a balance between neutrality and beneficence, regardless of how heinous a crime the patient may have committed.[272]

Finally, introducing "evil" into capital sentencing under the guise of medical science will only increase concerns about the arbitrary and capricious infliction of the death penalty:

> [I]t is not difficult to imagine a scenario in which the results of a legal adjudication of evil include discrimination against poor or disadvantaged individuals. . . .
>
> There are strong emotional and psychological forces at play during capital trials that are potentially biasing. It is well known that much more than legal fact is communicated in the courtroom, and that this "much more" has a direct and powerful effect on a jury's punishment decision. For example, it has been found that a defendant's appearance significantly influences whether jurors impose the death sentence. If jurors are unable to discount the physical appearance of a defendant in their deliberations, what is the likelihood that they will remain objective when a word steeped in religious morality is introduced by "experts" as a scientific construct?[273]

In sum, evidence that the defendant has ASPD or psychopathy, and that he will therefore be dangerous in the future, fails the most basic tests of scientific knowledge.[274] The myriad scientific, reliability, and ethical concerns about labeling a person antisocial, psychopathic, and evil cloaked as psychiatric findings should result in this evidence being excluded from the highly-charged adversarial atmosphere of capital trials. Thirty years ago, the Supreme Court rejected a challenge to the

---

272. *Id.* at 112 (citation omitted) (footnote omitted).

273. *Id.* at 110 (footnote omitted).

274. "[S]cientists typically distinguish between 'validity' (does the principle support what it purports to show?) and 'reliability' (does application of the principle produce consistent results?)." Daubert v. Merrill Dow Pharmaceutical, Inc., 509 U.S. 579, 590 n.9 (1993). "Scientific methodology today is based on generating hypotheses and testing them to see if they can be falsified; indeed, this methodology is what distinguishes science from other fields of human inquiry." *Id.* at 593.

use of psychiatric testimony in the penalty phase of a death penalty case that the defendant would pose a future danger if not executed.[275] The Court found that, "[t]he suggestion that no psychiatrist's testimony may be presented with respect to a defendant's future dangerousness is somewhat like asking us to disinvent the wheel."[276] As Edens and his colleagues suggest, perhaps the time has come to do so.[277]

IV. LEGAL GUIDELINES AND MENTAL HEALTH ASSESSMENTS: AVOIDING FATAL MISTAKES

This Part will discuss the "long recognized . . . critical interrelation between expert psychiatric assistance and minimally effective assistance of counsel."[278] Prevailing standards governing the performance of defense counsel in the post-*Furman*[279] era of capital punishment require the capital defense team's active participation and guidance in the assessment of the client's behavior, background, and mental health.[280] Performance standards have never contemplated that defense counsel would be a passive observer in processes and decisions that could determine his or her client's fate. To the contrary, a capital defendant "requires the guiding hand of counsel at every step in the proceedings against him."[281] In the context of a potential death sentence, assessment of the client's mental condition is a critical stage of the proceeding in which the guiding hand of counsel is absolutely essential under the Constitution.[282] To illustrate our point, we will discuss competent mental health assessments and cases that illustrate the importance of counsel's involvement to assure that the client does not fall victim to unreliable findings of ASPD and psychopathy.

---

275. Barefoot v. Estelle, 463 U.S. 880, 883-85, 887, 903 (1983).

276. *Id.* at 896.

277. Edens et al., *Predictions*, *supra* note 77, at 76-77.

278. Blake v. Kemp, 758 F.2d 523, 531 (11th Cir. 1985) (quoting United States v. Edwards, 488 F.2d 1154, 1163 (5th Cir. 1974)).

279. Furman v. Georgia, 408 U.S. 238 (1972).

280. ABA GUIDELINES, *supra* note 18, Guideline 1.1 cmt., at 926-27.

281. Powell v. Alabama, 287 U.S. 45, 69 (1932).

282. "It is central to [the Sixth Amendment] principle that in addition to counsel's presence at trial, the accused is guaranteed that he need not stand alone against the State at any stage of the prosecution, formal or informal, in court or out, where counsel's absence might derogate from the accused's right to a fair trial." Estelle v. Smith, 451 U.S. 454, 470 (1981) (quoting United States v. Wade, 388 U.S. 218, 226-27 (1967)).

A. "Defense Fail"

Justice Ruth Bader Ginsburg observed that "[p]eople who are well represented at trial do not get the death penalty."[283] Her observation holds true a dozen years later, as evidenced by many noteworthy examples in recent memory, including Olympic Park Bomber Eric Rudolph, Unabomber Ted Kaczynski, Atlanta courthouse escapee Brian Nichols, accused September 11th co-conspirator Zacharias Moussaoui, Beltway Sniper Lee Boyd Malvo, and Jared Lee Loughner, the shooter of Congresswoman Gabrielle "Gabby" Giffords and others in Tucson, Arizona. These defendants have three things in common: each was convicted of highly publicized capital crimes that had resulted in the deaths of multiple people; Each had a tragic history of mental illness that played a key role in persuading jurors, judges, or even prosecutors to reject the death penalty; and each was represented by a team of lawyers, investigators, and mitigation specialists who performed consistently with the ABA Guidelines.[284] Experience bears testament to Justice William Brennan's observation that "[t]he evidence is conclusive that death is not the ordinary punishment for any crime."[285]

Without representation consistent with the ABA and Supplementary Guidelines, the outcome of these cases would be different. Evidence supporting Justice Ginsburg's observation is easy to find. Columbia Law Professor James Liebman conducted an exhaustive survey of modern death penalty cases and found that more than two-thirds of death sentences are set aside because of prejudicial error, and that the most common error is ineffective assistance of defense counsel.[286] The vast majority of these cases ended in a more favorable disposition for the defendant after remand.[287] Our research reflects that

---

283. *Justice Backs Death Penalty Freeze*, CBS NEWS (Feb. 11, 2009, 9:27 PM), http://www.cbsnews.com/2100-508_162-284850.html.

284. *See* James Ball, *Ariz. Shooter Gets 7 Life Terms*, WASH. POST, Nov. 9, 2012, at A3; Shaila Dewan, *Olympics Bomber Offers an Apology at Sentencing*, N.Y. TIMES, Aug. 23, 2005, at A15; William Glaberson, *Kaczynski Avoids a Death Sentence with Guilty Plea*, N.Y. TIMES, Jan. 23, 1998, at A1; Jerry Markon & Timothy Dwyer, *Jurors Reject Death Penalty for Moussaoui*, WASH. POST, May 4, 2006, at A1; *Sniper Malvo Sentenced to Life Without Parole*, CNN, May 5, 2004, http://www.cnn.com/2004/LAW/03/10/sniper.malvo.

285. Furman v. Georgia, 408 U.S. 238, 291 (1972) (Brennan, J., concurring).

286. A comprehensive study of capital cases in America between 1973 and 1995 found that sixty-eight percent of all death sentences were set aside by appellate, post-conviction, or habeas corpus courts due to serious error. James S. Liebman et al., *Capital Attrition: Error Rates in Capital Cases, 1973-1995*, 78 TEX. L. REV. 1839, 1849-50 (2000).

287. Following appellate or post-conviction rulings finding serious error in capital cases, eighty-two percent of defendants "were found on retrial not to have deserved the death penalty, including [seven percent] . . . who were cleared of the capital offense." *Id.* at 1852 (emphasis omitted).

capital clients are at an increased risk of being diagnosed with ASPD or psychopathy if they are represented by trial, appellate, or post-conviction defense teams who fail to comply with the ABA and Supplementary Guidelines. This failure contributes significantly to the arbitrary pattern of death sentences and executions in the United States.

The Supreme Court's decision in *Rompilla v. Beard*[288] illustrates how defense counsel's deficient performance heightens the risk of a death sentence by facilitating an erroneous forensic opinion that the client is antisocial or psychopathic.[289] Instead of retaining a qualified mitigation specialist, trial counsel relied on a staff investigator to help investigate and develop mitigation evidence in addition to performing traditional guilt-or-innocence investigative functions.[290] Consequently, the defense team was understaffed and, contrary to prevailing performance standards, no team member was "qualified by training and experience to screen individuals for the presence of mental or psychological disorders or impairments."[291] Inevitably, as a result of this failure, critical information was misinterpreted or overlooked.[292]

A qualified mitigation specialist would have brought to Ronald Rompilla's defense team "clinical and information-gathering skills and training that most lawyers simply do not have."[293] These specialized skills include "the training and ability to obtain, understand and analyze all documentary and anecdotal information relevant to the client's life history,"[294] and the ability to conduct multiple, culturally competent, "in-person, face-to-face, one-on-one interviews with the client, the client's

---

288. 545 U.S. 374 (2005).

289. *See id.*

290. Ronald Rompilla's three-person defense team consisted of two public defenders and "an investigator in the public defender's office." *Id.* at 398 (Kennedy, J., dissenting). This is inconsistent with the ABA Guidelines, which provide that "[t]he defense team should consist of *no fewer than* two attorneys qualified in accordance with Guideline 5.1, an investigator, and a mitigation specialist." ABA GUIDELINES, *supra* note 18, Guideline 4.1(A)(1), at 952 (emphasis added).

291. ABA GUIDELINES, *supra* note 18, Guideline 4.1(A)(2), at 952; *see also id.* Guideline 10.4(C)(2)(a), at 1000 (providing that counsel should select a team that includes "*at least* one mitigation specialist and one fact investigator" (emphasis added)). More recently, the Supplementary Guidelines provided useful context to this requirement:

> 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 GUIDELINES, *supra* note 19, Guideline 5.1(E), at 683.

292. *See Rompilla*, 545 U.S. at 378-80, 382-83.

293. ABA GUIDELINES, *supra* note 18, Guideline 4.1 cmt., at 959.

294. SUPPLEMENTARY GUIDELINES, *supra* note 19, Guideline 5.1(B), at 682.

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."[295] As illustrated in further detail below, this is no small undertaking, but it is critically important to fair and reliable decisions by everyone involved in the litigation of a capital case.[296] Counsel's decision to proceed to trial without a fully qualified defense team practically guaranteed unreliable results, putting Rompilla at a high risk of being wrongly labeled antisocial or psychopathic.[297] Nor was this oversight overcome by retaining three mental health examiners to evaluate Rompilla; without the benefit of a thorough life history examination, all three experts concluded that Rompilla had ASPD.[298]

Rompilla's trial counsel were found ineffective after a team of post-conviction lawyers, functioning consistently with the ABA and Supplementary Guidelines, uncovered persuasive evidence of developmental disability, possible schizophrenia, fetal alcohol syndrome, and chronic childhood trauma severe enough to cause related disabilities in adulthood; this new picture of Rompilla was so compelling and humanizing that virtually no weight was given to the ASPD diagnoses assessed by the misinformed pretrial examiners.[299] It is

---

295. *Id.* Guideline 10.11(C), at 689. The team must also "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." *Id.*

296. See O'Brien, *supra* note 74, at 707, 709-12, for a more in-depth discussion of the prevailing investigation standards described in the ABA Guidelines and commentary.

297. *See generally* Dudley & Leonard, *supra* note 74. Typical criminal case investigators are ill-suited for mitigation work because they simply lack the necessary skills and abilities. William M. Bowen, Jr., *A Former Alabama Appellate Judge's Perspective on the Mitigation Function in Capital Cases*, 36 HOFSTRA L. REV. 805, 817 (2008).

298. *See* Rompilla v. Beard, 545 U.S. 374, 379-80 (2005); *see also* Bowen, *supra* note 297, at 817 (observing that, unlike a mitigation specialist, a psychologist will not "drop in on families, or track down and interview witnesses").

299. *Rompilla*, 545 U.S. at 390-91. The trial team's limited investigation failed to uncover evidence that:

> Rompilla's parents were both severe alcoholics who drank constantly. His mother drank during her pregnancy with Rompilla, and he and his brothers eventually developed serious drinking problems. His father, who had a vicious temper, frequently beat Rompilla's mother, leaving her bruised and black-eyed, and bragged about his cheating on her. His parents fought violently, and on at least one occasion his mother stabbed his father. He was abused by his father who beat him when he was young with his hands, fists, leather straps, belts and sticks. All of the children lived in terror. There were no expressions of parental love, affection or approval. Instead, he was subjected to yelling and verbal abuse. His father locked Rompilla and his brother Richard in a small wire mesh dog pen that was filthy and excrement filled. He had an isolated background, and was not allowed to visit other children or to speak to anyone on the phone. They had no indoor plumbing in the house, he slept in the attic with no heat, and the children were not given clothes and attended school in rags.

Id. at 391-92.

not difficult to find in virtually every capital punishment jurisdiction in America similar cases in which a thorough post-conviction investigation trumped pretrial diagnoses of ASPD that were based on shallow and superficial social history investigations.[300] *Rompilla* and similar cases illustrate differential explanations for allegedly antisocial or psychopathic behaviors.

B. Merging Mental Health and Legal Standards—The Role of Counsel

In this Subpart, we discuss counsel's obligation to participate actively in the investigation of his or her client's background and mental health. Our starting point is the recognition that counsel is obliged to acquire the specialized knowledge necessary to defend his or her client.[301] In capital cases, mental health problems are so common among defendants that "[i]t must be assumed that the client is emotionally and intellectually impaired."[302] Just as a lawyer specializing in the defense of drunk drivers must become familiar with the biological processes of intoxication and the design and functional limits of breathalyzer technology, a capital defense attorney must become knowledgeable about mental health. This includes becoming familiar with the mental health standards and procedures for conducting forensic and clinical evaluations.

The starting point for this discussion is that capital litigators understand that graphs or charts produced by psychometric testing do little to humanize the client:

> A problem with much expert testimony is that it is so focused on test score numbers and their psychometric properties, or diagnostic criteria and categorization, that the individual being evaluated sometimes gets forgotten. This often results in "expert battles" about cut-offs or comorbidity, diminishing the credibility of all the participants in the courtroom, but more significantly, failing to bring into focus the significant ways in which the symptoms of a person's mental illness shaped his/her life experiences, altered his/her options,

---

300. *See, e.g.*, Ferrell v. Hall, 640 F.3d 1199, 1203, 1211-12 (11th Cir. 2011); Cooper v. Sec'y, Dep't of Corr., 646 F.3d 1328, 1346-47 (11th Cir. 2011); Walbey v. Quarterman, 309 F. App'x 795, 796-97, 803-04 (5th Cir. 2009); *see also* O'Brien, *supra* note 74, at 700 n.25 (collecting cases).

301. MODEL RULES OF PROF'L CONDUCT R. 1.1 (2013) ("A lawyer shall provide competent representation to a client. Competent representation requires the legal knowledge, skill, thoroughness and preparation reasonably necessary for the representation.").

302. ABA GUIDELINES, *supra* note 18, Guideline 10.5 cmt., at 1007 (quoting Rick Kammen & Lee Norton, *Plea Agreements: Working with Capital Defendants*, ADVOCATE, Mar. 2000, at 31, 31). More recently, the U.S. Department of Justice reports that over half of the prisoners in the United States suffer some form of mental disease. JAMES & GLAZE, *supra* note 139, at 1.

> choices, and decisions, and brought that person into the courtroom as a subject of testimony.[303]

Psychometric testing in general, and the PCL-R in particular, are unreliable substitutes for a thorough life history investigation into the witnesses and documents that uncover the client's life history and stories that reveal his intrinsic humanity and redeeming qualities that coexist with his mental and emotional impairments.[304]

The mental health field provides important, but often overlooked, criteria for the interpretation of data. Counsel must be aware of the difference between objective behavior (facts or symptoms) and subjective interpretations of that behavior (conclusions or diagnoses). The DSM-5 cautions that, before drawing a conclusion from a person's behavior, many different factors—including his or her social, cultural, and ethnic background—must be taken into account.[305] Competent evaluation requires a thorough patient history, including a family history going back at least three generations.[306] Assessing DSM-5 diagnostic criteria for personality disorders requires evaluation of long-term functioning,[307] and performance standards recognize that it is necessary to conduct multiple interviews over a span of time.[308] Before a behavior

---

303. Woods et al., *supra* note 74, at 433.

304. *Id.*; *see* Dudley & Leonard, *supra* note 74, at 973, 975; *see also* Wilson v. Trammell, 706 F.3d 1286, 1290-94 (10th Cir. 2013) (finding that the trial and post-conviction counsel placed primary reliance on whether a pretrial examiner misinterpreted personality test results which arguably established that the client suffered from schizophrenia). *Wilson* devolved into an argument over what diagnostic label most accurately fit the client, and the courts were not moved to find that he was prejudiced by defense counsel's performance. *Wilson*, 706 F.3d at 1288. This contrasts sharply with cases in which trial counsel were similarly deficient, but the post-conviction investigation focused on the client's life story, not the interpretation of psychometric testing or diagnostic labels. *See, e.g.*, Rompilla v. Beard, 545 U.S. 374, 378 (2005); Wiggins v. Smith, 539 U.S. 510, 514, 535 (2003); *Ferrell*, 640 F.3d at 1203; *Cooper*, 646 F.3d at 1342; *Walbey*, 309 F. App'x at 801.

305. DSM-5, *supra* note 24, at 662.

306. Dudley & Leonard, *supra* note 74, at 966-67; *see also* Lee Norton, *Capital Cases: Mitigation Investigations*, CHAMPION, May 1992, at 43, 44; Daniel J. Wattendorf & Donald W. Hadley, *Family History: The Three-Generation Pedigree*, 72 AM. FAM. PHYSICIAN 441, 447 (2005).

307. DSM-5, *supra* note 24, at 647. Professors of psychiatry train students to "map out the longitudinal course of their patient's illness; this helps pin down the course and give the student a better understanding of the patient." NANCY C. ANDREASEN & DONALD W. BLACK, INTRODUCTORY TEXTBOOK OF PSYCHIATRY 291 (3d ed. 2001).

308. *See* Deana Dorman Logan, *Learning to Observe Signs of Mental Impairment*, *reprinted in* MENTAL HEALTH AND EXPERTS MANUAL ch.19, at 19-1 to 19-6 (8th ed. 2005) (explaining that a subject's symptoms may not be stable over time, so that multiple interviews are necessary for the defense team to fulfill its duty as the observational caretaker of the client's condition); *see also* BENJAMIN JAMES SADOCK & VIRGINIA ALCOTT SADOCK, KAPLAN & SADOCK'S SYNOPSIS OF PSYCHIATRY 6 (9th ed. 2003). Benjamin and Virginia Sadock recommend:

> Psychiatric patients may not be able to tolerate a traditional interview format, especially in the acute stages of a disorder. For instance, a patient suffering from increased

or characteristic of the defendant can be attributed to a personality disorder, multiple alternative factors must be considered and ruled out.[309] Even Cleckley, the influential proponent of the modern construct of psychopathy, argues strongly for differential diagnosis.[310]

As noted above, by definition the diagnostic criteria for any personality disorder must involve traits and behavior that deviate markedly from the expectations of the client's culture.[311] Behavior relied upon to support a personality disorder should not be confused with "the expression of habits, customs, or religious and political values professed by the individual's culture of origin."[312] Therefore, a thorough understanding of the cultural influences in the client's life is essential to an accurate mental health assessment.[313]

Environmental and situational factors must also be considered. The DSM-5 cautions that if a constellation of observed behaviors is better accounted for by another mental disorder, is due to the direct physiological effects of a substance (for example, drug, medication, or toxin exposure), or is caused by a general medical condition (for example, head trauma), a personality disorder should not be diagnosed.[314] A personality disorder diagnosis must also be distinguished from behaviors that emerge in response to situational stressors or more transient mental states, (for example, mood or anxiety

---

> agitation or depression may not be able to sit for 30 to 45 minutes of discussion or questioning. In such cases, physicians must be prepared to conduct multiple brief interactions over time, for as long as the patient is able, then stopping and returning when the patient appears able to tolerate more.

SADOCK & SADOCK, *supra*, at 6. Mitigation specialist Russell Stetler points out that multiple interviews will be necessary simply because "[i]nvestigating the capital client's biography is a sensitive, complex, and cyclical process." Russell Stetler, *Capital Cases*, CHAMPION, Jan.–Feb. 1999, at 35, 38. Thus, if a person has already been interviewed, and new documents or information suggest a new area of inquiry for that individual, it will be necessary to interview that person again. Norton, *supra* note 306, at 45.

309. The discussion that follows points to a number of directives in the DSM-5 that certain factors be considered or ruled out prior to assessing a personality disorder diagnosis. *See infra* text accompanying notes 323-82; *see also* DSM-5, *supra* note 24, at 662-63. As noted above, the DSM has been criticized for giving inadequate guidance on the interpretation of symptoms and application of diagnostic criteria. *See supra* notes 113-37 and accompanying text. Although these problems still persist, the ensuing discussion reveals that the context provided by a thorough life history investigation is essential to the proper interpretation of diagnostic criteria and procedures.

310. *See* Freedman, *Premature Reliance*, *supra* note 160, at 59. In Cleckley's view, conditions such as "mental deficiency or organic brain damage, schizophrenia, psychosis, cyclothymia or paranoia, manic depression, anxiety disorder, or criminality precluded a finding of psychopathy . . . [this] has been quietly forgotten by those who claim his tradition as the theoretical framework in which to assess psychopathy." *Id.*

311. DSM-5, *supra* note 24, at 645.

312. *Id.* at 648.

313. *See generally* Holdman & Seeds, *supra* note 105.

314. DSM-5, *supra* note 24, at 648, 662.

disorders, substance intoxication)[315] or are associated with acculturation after immigration.[316] When personality changes emerge and persist after an individual has been exposed to extreme stress, a diagnosis of posttraumatic stress disorder ("PTSD") should be considered.[317] When an individual has a substance-related disorder, the DSM-5 cautions that it is important not to make a personality disorder diagnosis based solely on behaviors that are consequences of substance intoxication or withdrawal, or that are associated with activities in the service of sustaining a dependency.[318]

A thorough life history investigation is also important to an accurate mental health assessment and differential diagnosis because behavior does not qualify for a personality disorder (or ASPD) diagnosis if it is "part of a protective survival strategy."[319] For example, a child at risk of violence in the home may run away, become truant from school, habitually lie, or engage in other behavior to evade severe maltreatment. Children in impoverished environments may steal food simply to have enough to eat. As noted above, the DSM-IV-TR diagnosis of ASPD requires the existence of conduct disorder prior to age eighteen.[320] In addition, symptoms cannot be attributed to ASPD if the client's behavior occurred exclusively during the course of schizophrenia or a manic

---

315. *Id.* at 647.

316. *Id.* at 648.

317. *Id.* at 649.

318. *Id.* The differential diagnosis of alcohol use disorder and personality disorder is clear when considering the DSM-5 text language for the former, which includes:

> Social and job performance may also suffer either from the aftereffects of drinking or from actual intoxication at school or on the job; child care or household responsibilities may be neglected; and alcohol absences may occur from school or work. The individual may use alcohol in physically hazardous circumstances (e.g. driving an automobile, swimming, operating machinery while intoxicated). Finally, individuals with an alcohol use disorder may continue to consume alcohol despite knowledge that continued consumption poses significant physical (e.g., blackouts, liver disease), psychological (e.g., depression), social or interpersonal problems (e.g., violent arguments with spouse while intoxicated, child abuse).

Id. at 492-99. A thorough life history investigation can also avoid the problem of "diagnostic overshadowing, which refers to diagnostic errors that result from mistakenly attributing signs and symptoms of one disorder or condition to another." Kathleen Wayland, *The Importance of Recognizing Trauma Throughout Capital Mitigation Investigations and Presentations*, 36 HOFSTRA L. REV. 923, 942 n.81 (2008) (internal quotation marks omitted). This is especially important because of the "extremely high prevalence of comorbid substance abuse disorders in the highly traumatized population of capitally charged defendants." *Id.* Without a thorough investigation for trauma history or signs and symptoms of major mental disorders such as schizophrenia or bipolar disorder, "[d]iagnostic overshadowing often results in the failure to identify the presence of co-occurring mental disorders." *Id.*

319. DSM-5, *supra* note 24, at 662.

320. DSM-IV-TR, *supra* note 24, at 702.

episode.[321] Thus, ASPD cannot be diagnosed if the "enduring pattern" of antisocial behavior occurs only during the course of several other serious Axis I disorders.[322]

With these caveats in mind, we will revisit the seven DSM-IV-TR diagnostic criteria for ASPD, and provide a brief discussion with examples of some of the many alternative explanations that could account for the client's behavior. Apropos to this discussion is a caution about the danger of "the subjectivity involved in making a diagnosis which may be based purely on subjective guesswork and interpretations in worst-case scenarios,"[323] issues that we illustrate below.

1. "Failure to conform to social norms with respect to lawful behaviors, as indicated by repeatedly performing acts that are grounds for arrest."[324]

Prior conviction and arrest records are not uncommon among capital defendants, and many examiners will consider this criterion satisfied based solely on a piece of paper summarizing the client's criminal history in a most bare-bones manner. This criterion is inherently flawed, represents circular reasoning, and relates to ethical concerns discussed above; that is, inherent in the criterion is an assumption that "failure to conform to social norms" is by definition an example of antisocial behavior.[325] However, there are a host of reasons why clients may fail to conform to social norms and repeatedly perform acts that are grounds for arrest, or are seemingly violations of pro-social expectations for behavior. Civil rights protesters, such as Rosa Parks and Reverend Doctor Martin Luther King, arguably brought themselves within this criterion through repeated acts of civil disobedience,[326] yet no one would seriously contend that these were antisocial acts.

Among the population of homicide defendants, there are equally valid reasons that an arrest record is not indicative of a personality disorder. For example, a client with limited intellectual functioning may not have the capacity to understand or comply with what society defines as pro-social behavior.[327] Clients with neurodevelopmental disabilities—

321. *Id.* at 688.
322. *See id.* at 688-89.
323. Bendelow, *supra* note 138, at 546.
324. DSM-5, *supra* note 24, at 659.
325. *Id.*
326. *See id.* at 663.
327. "The mentally retarded person might accompany perpetrators or actually commit a crime on impulse or without weighing the consequences of the act; when stopped by the police he might be unable to focus on the alleged crime or appreciate the gravity of his arrest . . . ." James Ellis & Ruth Luckasson, *Mentally Retarded Criminal Defendants*, 53 GEO. WASH. L. REV. 414, 429 (1985).

for example, individuals on the autism spectrum—are often severely impaired in their ability to understand or appreciate social interactions and cues.[328] Traumatized clients may engage in acts that ostensibly fail to conform to social norms, which represent coping attempts to survive perceived or actual threats to life. In general, persons with severe mental illness are simply more likely to be arrested for a multitude of complex reasons that are unrelated to defects in their personalities.[329] By failing to consider and distinguish these and other potential underlying explanations that contextualize reasons for specific behaviors, mental health evaluators may effectively imply intent to violate social norms where no such intent exists.

It would also be inappropriate to find that this diagnostic criterion is satisfied if the client's arrest records are the product of factors external to the client. Factors related to race, ethnicity, and class may also explain what appears to be "failure to conform to social norms."[330] For example, we frequently see clients who have records of multiple arrests, and, after a proper mitigation investigation, learn that they have been targeted at young ages by law enforcement in their local jurisdictions and subjected to racial profiling and discriminatory charging practices.[331] Black and Hispanic youths are arrested four times more often than Caucasian youths, and are far more likely to be prosecuted as adults than Caucasian youths who engage in the same conduct.[332] Similarly, adolescent girls are far more likely than boys to be arrested and punished harshly for running away from home, even though they are more likely than boys to be fleeing sexual abuse in the home.[333] It is also possible that the client may be innocent of an offense listed on his criminal record,[334] or a prior

328. *See* Joseph Jankovic et al., *Tourette's Syndrome and the Law*, 18 J. NEUROPSYCHIATRY & CLINICAL NEUROSCIENCE 86, 90 (2006) (noting that individuals with Tourette's syndrome with behavioral symptoms of comorbid disorders have a significantly higher risk of becoming involved in the criminal justice system).

329. *See* Linda A. Teplin, *Criminalizing Mental Disorder: The Comparative Arrest Rate of the Mentally Ill*, 39 AM. PSYCHOL. 794, 800-01 (1984) (suggesting that mentally ill persons undergo criminalization with adverse public policy consequences).

330. DSM-IV-TR, *supra* note 24, at 706.

331. "Studies of racial profiling have shown that police do, in fact, exercise their discretion on whom to stop and search in the drug war in a highly discriminatory manner." ALEXANDER, *supra* note 135, at 133 (citing DAVID A. HARRIS, PROFILES IN INJUSTICE: WHY RACIAL PROFILING CANNOT WORK 59 (The New Press 2002)).

332. HOWARD N. SNYDER, OFFICE OF JUV. JUST. & DELINQUENCY PREVENTION, JUV. JUST. BULL., JUVENILE ARRESTS 2000, at 10 (2002), *available at* https://www.ncjrs.gov/pdffiles1/ojjdp/191729.pdf; Samuel R. Gross et al., *Exonerations in the United States 1989 Through 2003*, 95 J. CRIM. L. & CRIMINOLOGY 523, 549-50 (2005).

333. *See* Alecia Humphrey, *The Criminalization of Survival Attempts: Locking Up Female Runaways and Other Status Offenders*, 15 HASTINGS WOMEN'S L.J. 165, 173-77 (2004).

334. *See, e.g.*, Harlow v. Murphy, No. 05-CV-039-B, 2008 U.S. Dist. LEXIS 124288, at *49-

conviction may be otherwise invalid.[335] Thus, the proper application of this diagnostic criterion is impossible without the benefit of a thorough life history investigation of the client and the community in which he lives.

Investigation of the circumstances of each of the client's arrests is also critically important. Some clients have falsely confessed to crimes for a multitude of reasons, including the desire to protect others (for example, to protect a sibling or other loved one).[336] Others have been subjected to coercive interrogation procedures, to which highly suggestible, gullible, developmentally delayed, traumatized, and youthful clients are very vulnerable.[337] Even more common examples from our decades of experience in capital work are de facto consequences of the pervasive effects of poverty (for example, "stealing" food to stave off hunger, breaking into a building to obtain necessary shelter or clothing, and similar such arrests stemming from the effects of poverty, homelessness, mental illness, or substance-related disorders). We have seen many instances where prosecutors or government experts have labeled defendants "antisocial," ignoring the fact that they had acted in a protective mode, and "stole" to provide for family members, rather than personal gain or profit.[338]

2. "Deceitfulness, as indicated by repeated lying, use of aliases, or conning others for personal profit or pleasure."[339]

This criterion, if applied without attention to context, constitutes highly subjective language and may give rise to what often amounts to

---

50 (D. Wyo. Feb. 15, 2008) (finding counsel ineffective for failing to investigate his client's prior murder conviction and produce evidence that "forensic evidence surrounding the homicide did not point to [the defendant]" and, in fact, implicated two other boys in the homicide).

335. *See, e.g.*, Johnson v. Mississippi, 486 U.S. 578, 590 (1988) (setting aside a death sentence because defendant's prior conviction, which had been used as an aggravating circumstance, was subsequently reversed).

336. Stuart P. Green, *Uncovering the Cover-Up Crimes*, 42 AM. CRIM. L. REV. 9, 16 n.23 (2005).

337. *See* GISLI H. GUDJONSSON, THE PSYCHOLOGY OF INTERROGATIONS AND CONFESSIONS: A HANDBOOK 408-09 (2003) (noting that verbally impaired individuals are more likely to confess to crimes they did not commit in response to modern interrogation methods); *see also* Roger Kurlan et al., *Non-obscene Complex Socially Inappropriate Behavior in Tourette's Syndrome*, 8 J. NEUROPSYCHIATRY & CLINICAL NEUROSCIENCES 311, 312 (1996) (providing an example of a patient with Tourette's syndrome who spontaneously gave a false confession to police who came to his door to investigate a homicide in the neighborhood).

338. *See* Michael N. Burt, *The Importance of Storytelling at all Stages of a Capital Case*, 77 UMKC L. REV. 877, 898-900, 909-10 (2009) (describing the life story of capital defendant Alan Quinones—whose parents were so mentally ill and poor that he, as a young man, managed to feed his family by selling drugs—and explaining that his jury unanimously rejected the death penalty).

339. DSM-5, *supra* note 24, at 659.

speculation about possible motivations for actions. Many mental health symptoms, in the absence of context, may be interpreted as "lying." Delusions, for example, are fixed false beliefs,[340] but a delusional client's expression of false beliefs is likely to be interpreted as a lie. Dissociative symptoms prevent a client from recalling information, so the client's attempt to fill gaps in memory may produce unintentionally false statements of fact.[341] Mood symptoms, such as grandiosity, may distort the client's perception of self and others.[342] Victims of extreme or chronic trauma, including abuse victims, may make statements that are inconsistent with reality for the purpose of self-protection.[343] As a coping strategy of chronic abuse, victims often learn to "lie" as part of a protective survival strategy.[344] Other factors which may explain a client's false statements include psychotic symptoms—where a client's statements represent the fact that they are out of touch with reality[345]—or symptoms of brain dysfunction—such as memory impairments—where clients may confabulate to mask severe impairments.[346]

In addition to the symptoms of mental illness that might explain a client's perception or expression of facts divergent from reality, other factors may also motivate clients to "lie" in order to protect themselves from the social stigma or shame and embarrassment associated with their condition. In *Rompilla*, for example, the client told counsel that his childhood was "normal . . . save for quitting school in the ninth grade," and he repeatedly sent his lawyers on false leads.[347] He also denied that his parents abused him.[348] Yet, post-conviction counsel's investigation produced a large body of evidence establishing that Rompilla was raised in an impoverished and abusive home, and that he was the victim of extreme neglect and maltreatment.[349] Social service records established,

340. Wayland, *supra* note 318, at 942 n.83.

341. DSM-IV-TR, *supra* note 24, at 520.

342. As noted in the DSM-5 description of a manic episode, "[i]nflated self-esteem is typically present, ranging from uncritical self-confidence to marked grandiosity, and may reach delusional proportions." DSM-5, *supra* note 24, at 128. "The expansive mood, excessive optimism, grandiosity, and poor judgment often lead to reckless involvement in activities such as spending sprees, giving away possessions, reckless driving, foolish business investments, and sexual promiscuity that is unusual for the individual, even though these activities are likely to have disastrous consequences . . . ." *Id.* at 129. Without proper context, an examiner might subjectively and mistakenly interpret such behavior as deceitful, and the DSM-5 provides little specific guidance in this regard.

343. Wayland, *supra* note 318, at 944-45.

344. *Id.* at 947.

345. *See* Logan, *supra* note 308, at 19-4.

346. *See id.*

347. Rompilla v. Beard, 545 U.S. 374, 381 (2005).

348. Rompilla v. Horn, 355 F.3d 233, 243 (3d Cir. 2004).

349. *Rompilla*, 545 U.S. at 391-92.

among other things, that Rompilla's father beat him with "hands, fists, leather straps, belts and sticks," and "locked Rompilla and his brother Richard in a small wire mesh dog pen that was filthy and excrement filled."[350] It is not difficult to imagine a number of reasons that Rompilla "lied" to his lawyers, even when telling the truth would have produced life-saving mitigating evidence.[351] Counsel should be alert to the possibility that a client's expression of false information is simply an attempt to minimize, normalize, or deny mental illness or a tragically painful history.[352] Of course, Rompilla's borderline mental retardation may also explain his failure to provide accurate and correct information about his upbringing.[353]

3. "Impulsivity or failure to plan ahead."[354]

Unless contextualized, a determination that these symptoms are examples of antisocial behavior is often subjective and speculative. Many other possible explanations for these symptoms must be considered and ruled out in order to make an accurate determination. For example, a client with a history of traumatic brain injury or attention deficit hyperactivity disorder ("ADHD") may not have the ability to plan and will often act impulsively.[355] Further, "there is abundant evidence that [clients with intellectual disabilities] often act on impulse rather than pursuant to a premeditated plan, and that in group settings they are followers rather than leaders."[356] A client with PTSD might display hyperarousal responses to traumatic triggers that are immediate and seemingly inexplicable if the context is not understood,[357] or may be displaying behaviors that reflect a foreshortened sense of future, a symptom frequently seen in highly traumatized individuals.[358] "Impulsivity and failure to plan ahead" may also be explained by the

350. *Id.* at 392.

351. Wayland, *supra* note 318, at 942 n.82.

352. John H. Blume & Pamela Blume Leonard, *Capital Cases: Principles of Developing and Presenting Mental Health Evidence in Criminal Cases*, CHAMPION, Nov. 2000, at 63, 64.

353. *See* ROBERT B. EDGERTON, THE CLOAK OF COMPETENCE: REVISED AND UPDATED 134 (1993).

354. DSM-5, *supra* note 24, at 659.

355. Impulsivity is one of the core symptom categories of ADHD, which is categorized as a neurodevelopmental disorder in the DSM-5. DSM-5, *supra* note 24, at 59-60; *see also* AM. PSYCHIATRIC ASS'N, HIGHLIGHTS OF CHANGES FROM DSM-IV-TR TO DSM-5, at 2 (2013), *available at* http://www.psychiatry.org/dsm5.

356. Atkins v. Virginia, 536 U.S. 304, 318 (2002).

357. For example, PTSD symptoms may include self-destructive and impulsive behavior, impaired affect modulation, and difficulty completing tasks. DSM-5, *supra* note 24, at 271-72.

358. A sense of foreshortened future may be expressed in an inability to sustain expectations of a career, marriage, children, or normal life span. *Id.* at 277.

hopelessness, despair, and self-destructive behaviors that may be seen in individuals with severe depression.[359] Highly impulsive behavior, which may be interpreted as "failure to plan ahead," is often seen in individuals with bipolar disorder, and only a contextualized understanding can help to make this distinction.[360] An individual with diffuse brain injury, or deficits in frontal or temporal lobe functioning, may also appear to be impulsive and fail to plan for future events. Finally, simply being youthful is associated with impulsive behavior and failure to plan ahead.[361]

4. "Irritability and aggressiveness, as indicated by repeated physical fights or assaults."[362]

Context is critically important to understanding the origins of what may be called "irritability and aggression."[363] Such behaviors may reflect the hyperarousal component of traumatic stress responses,[364] and are often classic symptoms of brain dysfunction, particularly frontal and temporal lobe problems, or classic expressions of mood symptoms as seen in depressive, bipolar, and related disorders.[365] Irritability and aggressiveness can also result from exposure to environmental toxins, such as chemicals, lead or other heavy metals.[366] In addition, evidence of

---

359. *Id.* at 659. For individuals suffering from a major depressive disorder, "[l]oss of interest of pleasure is nearly always present, at least to some degree." *Id.* at 163. This may be expressed as significant withdrawal from many life activities. *Id.*

360. *Id.* at 659. A classic symptom of a manic episode, "increase in goal-directed activity," is often manifested by poor judgment leading to imprudent involvement in activities that may have painful consequences without regard for apparent risks. *Id.* at 124. Impairment may be severe enough to require intervention to protect an individual from the negative consequences of actions resulting from poor judgment. *Id.* at 129.

361. "[A] lack of maturity and an underdeveloped sense of responsibility are found in youth more often than in adults and are more understandable among the young. These qualities often result in impetuous and ill-considered actions and decisions." Roper v. Simmons, 543 U.S. 551, 569 (2005).

362. DSM-5, *supra* note 24, at 659.

363. *Id.* at 660.

364. This is a core symptom category of PTSD that results in symptoms such as difficulty falling asleep, "exaggerated startle response," "hypervigilance," difficulty concentrating, or "irritable behavior and angry outbursts." *Id.* at 272.

365. The DSM-5 indicates that many individuals suffering from mood disorders "report or exhibit increased irritability (e.g., persistent anger, a tendency to respond to events with angry outbursts or blaming others, an exaggerated sense of frustration over minor matters)." *See id.* at 163.

366. *See, e.g.*, David C. Bellinger, *The Protean Toxicities of Lead: New Chapters in a Familiar Story*, 8 INT'L J. ENVTL. RES. PUB. HEALTH 2593, 2593 (2011) (discussing "health endpoints associated with greater early-life lead exposure in children, including [ADHD], conduct disorder, aggression and delinquency"); R.M. Bowler et al., *Neuropsychiatric Effects of Manganese on Mood*, 20 NEUROTOXICOLOGY 367, 367 (1999) (discussing fifteen studies in which "[a]dverse mood effects of overexposure to Manganese (Mn) . . . report an association of Mn exposure with adverse effects in six dimensions of mood: 1) anxiety, nervousness, irritability; 2) psychotic experiences; 3)

"irritability and aggression" used to diagnosis a client with ASPD is often nothing more than a reflection of the cruel reality of life on the streets for many people living in poverty, in dangerous communities, or in the dangerous environments of the jails and prison in this country.[367] Within that cultural context, aggression might be a necessary part of survival, and does not constitute behavior that "deviates markedly from the expectations of the individual's culture."[368]

5. "Reckless disregard for safety of self or others."[369]

Behaviors that appear risky may be better explained by conditions other than ASPD. Such behaviors may reflect the impulsivity seen in clients with attentional problems or deficits in executive functioning. Rash behavior would also be consistent with the dysregulated affect and behavior often seen in people exposed to complex and chronic histories of psychological trauma, or the lack of insight, called "anosognosia," that is sometimes seen in individuals with psychotic or mood disorders.[370] Youth with ADHD also often have poor insight into their actions and are poor reporters of their condition.[371] What is often labeled as "reckless disregard for safety," and therefore considered a symptom of ASPD, might also reflect an inability to accurately perceive one's environment.[372] This can occur in individuals with psychotic disorders, mood disorders, or untreated substance abuse disorders.[373] It also may be a manifestation of the adaptive deficits of an individual with intellectual

---

emotional disturbance; 4) fatigue, lack of vigor, sleep disturbance; 5) impulsive/compulsive behavior; 6) aggression hostility").

367. *See* DSM-5, *supra* note 24, at 59-60.

368. *Id.* at 645; *see, e.g.*, Harlow v. Murphy, No. 05-CV-039-B, 2008 U.S. Dist. LEXIS 124288, at *47 (D. Wyo. Feb. 15, 2008) (explaining that the successful habeas corpus presentation focused on the culture and environment of a maximum security prison and strongly "supported a defense theme that [defendant] is not a dangerous person, but he was in a dangerous place").

369. DSM-5, *supra* note 24, at 659.

370. *See* NATIONAL ALLIANCE ON MENTAL ILLNESS, NAMI COMMENTS IN THE APA'S DRAFT REVISION OF THE DSM-V: ANOSOGNOSIA 1, *available at* http://www.nami.org/Content/ContentGroups/Policy/Issues_Spotlights/DSM5/Anosognosia_Paper_4_13_2010.pdf (noting that "anosognosia" is not referenced in the DSM-5). "Lack of insight is common in schizophrenia. A patient may not believe that he or she is ill or abnormal in any way." ANDREASEN & BLACK, *supra* note 307, at 221 (emphasis omitted).

371. Russel A. Barkley et al., *Adolescents with ADHD: Patterns of Behavioral Adjustment, Academic Functioning, and Treatment Utilization*, 30 J. AM. ACAD. CHILD & ADOLESCENT PSYCHIATRY 752, 732-61 (1991).

372. DSM-5, *supra* note 24, at 659.

373. For example, extremely impaired judgment, disregard for safety, and engagement in risky behaviors are frequently seen in individuals with mood and/or substance abuse disorders. *See id.* "Research has shown that more than 90% of suicide completers had a major psychiatric illness and that half were clinically depressed at the time of the act . . . ." ANDREASEN & BLACK, *supra* note 307, at 555.

or developmental disabilities, or simply the immaturity of a youthful offender.[374] In these cases, understanding the context is critical: yet, so often it is this context which is lost in how a client's behavior is interpreted by the prosecution, jurors, courts, and—unfortunately, all too often—the defense.

6. "Consistent irresponsibility, as indicated by repeated failure to sustain consistent work behavior or honor financial obligations."[375]

Once again, the language of this criterion is highly subjective. Without context, it is impossible to make a reliable and valid determination that the criterion of consistent irresponsibility is indicative of antisocial behavior. Consider just a few examples: someone who has the deficits in adaptive behavior seen in individuals with intellectual or developmental disabilities, or who is impaired by mood or psychotic symptoms, or by the consequences of severe trauma exposure, may well have difficulties meeting the tasks of daily life; difficulties functioning in occupational settings; and, consequently, difficulties meeting financial, occupational, or social obligations.[376] Quite frankly, impairments such as these, and many other supposed symptoms of ASPD, are highly consistent with the severe impairments in daily functioning that are often present in individuals with various Axis I mental disorders, particularly when these disorders are undiagnosed or untreated.[377] Individuals suffering from chronic poverty, underemployment, racial discrimination, and lack of socially sanctioned occupational opportunities are also likely to be described by the consistent irresponsibility criterion for reasons that have nothing to do with antisocial behavior.

374. The Supreme Court has established that children are "constitutionally different from adults for purposes of sentencing" because they have a "'lack of maturity and underdeveloped sense of responsibility,' leading to recklessness, impulsivity, and heedless risk-taking." Miller v. Alabama, 132 S. Ct. 2455, 2464 (2012) (quoting Roper v. Simmons, 543 U.S. 551, 569 (2005)).

375. DSM-5, *supra* note 24, at 659.

376. A person with developmental disabilities, for example, has "significant limitations on an individual's effectiveness in meeting the standards of maturation, learning, personal independence, and/or social responsibility that are expected for his or her age level and cultural group, as determined by clinical assessment and, usually, standardized scales." Ellis & Luckasson, *supra* note 327, at 422 (quoting AM. ASSOC. ON MENTAL DEFICIENCY, CLASSIFICATION IN MENTAL RETARDATION 11 (Herbert J. Grossman ed., 1983)).

377. DSM-5, *supra* note 24, at 662-63.

7. "Lack of remorse, as indicated by being indifferent to or rationalizing having hurt, mistreated, or stolen from another."[378]

A finding that the client lacks remorse is almost always based on an observation that he or she does not display emotion that would be expected in a particular situation, or by a client's failure to voice his or her remorse for a crime or crimes that have occurred and the impact on the victims of those crimes. Failure to display emotional responses that we are societally conditioned to expect, however, is itself often a hallmark feature of a range of mental disorders and other severely disabling conditions.[379] For example, psychic numbing is a hallmark symptom of PTSD.[380] Flat affect is often seen in severe mental disorders such as mood disorders (for example, major depression) or psychotic disorders (for example, schizophrenia).[381] Absence of emotional expression may be seen in people with severe brain dysfunction, people with neurodevelopmental disabilities—such as autism spectrum disorders—and in people who are inappropriately medicated or overmedicated.[382] Absence of emotional expression may reflect cultural norms, for example, individuals from cultures where emotional stoicism is a reflection of loyalty to one's culture and family, and is a sign of pride and decency—rather than a lack of remorse.[383] In addition, someone who has faced a lifetime of racism might not be willing to share his or her emotions with authority figures such as representatives

---

378. *Id.* at 659.

379. Incongruent emotion is commonly misinterpreted in capital clients; counsel must understand that it is a common symptom of mental impairment. Logan, *supra* note 308, at 19-5.

380. DSM-5, *supra* note 24, at 271-72, 275. Psychic numbing is "described as a diminished responsiveness to the external world." Norah C. Feeny et al., *Exploring the Roles of Emotional Numbing, Depression, and Dissociation in PTSD*, 13 J. TRAUMATIC STRESS 489, 489 (2000).

381. DSM-5, *supra* note 24, at 101, 163. For example, "affective flattening" is a common negative symptom of schizophrenia; social withdrawal and lack of interest or pleasure is one of the key manifestations of how a major depressive episode might be expressed. *See* ANDREASEN & BLACK, *supra* note 307, at 219-20.

382. DSM-5, *supra* note 24, at 50, 53. The influence of medications can be so pronounced that the Supreme Court has found that the Due Process Clause is implicated by the involuntary administration of medication to a defendant in a criminal case. *See* Riggins v. Nevada, 504 U.S. 127, 143 (1992) (Kennedy, J., concurring). "By administering medication, the State may be creating a prejudicial negative demeanor in the defendant -- making him look nervous and restless, for example, or so calm or sedated as to appear bored, cold, unfeeling, and unresponsive. . . . That such effects may be subtle does not make them any less real or potentially influential." *Id.*

383. Cultural differences can interfere with the reliability of medical and mental health assessments of the client. *See* DSM-IV-TR, *supra* note 24, at xxxiv. Because culture defines the "'spectrum of 'normal behaviors' as well as thresholds of tolerance for diverse 'abnormalities,'" unfamiliarity "with the nuances of an individual's cultural frame of reference may incorrectly judge as psychopathology those normal variations in behavior, belief, or experience that are particular to the individual's culture." SADOCK & SADOCK, *supra* note 307, at 168-69; *see* DSM-IV-TR, *supra* note 24, at xxxiv.

of law enforcement, or show emotion in a courtroom filled with predominantly majority culture judges, jurors, and spectators.[384] Finally, absence of the expression of remorse may reflect the fact that an individual has been falsely charged or falsely convicted of a crime.[385]

C. Additional Problems with Psychopathy

A similar contextualized analysis is relevant in assessing conclusions that an individual is a psychopath. Such determinations are most often based on the scores from the PCL-R's twenty-item checklist, which, "unfortunately, often lead to misdiagnosis of bipolar patients" because of "the overlap of symptoms of mania and hypomania with the criteria used by Hare to diagnose psychopathy."[386] All clinicians recognize that "during manic or hypomanic episodes, many individuals commit antisocial acts, violent and non-violent."[387]

Three items from the PCL-R commonly attributed to capital defendants are representative of the problem: "[g]libness/superficial charm," "[p]arasitic lifestyle," and "[l]ack of realistic, long-term goals."[388] Willem H. J. Martens notes that Hare does not define "[g]libness/superficial charm" precisely, and asks how it can be "measured in an objective and reliable way": "How does the investigator know if the charm of a particular patient is superficial enough to be pathological?"[389] Martens points out that these characteristics:

> can contribute substantially to academic, vocational and even social success and status and these features are rather common and widely accepted as necessary tools for surviving in this complicated modern

384. ABA GUIDELINES, *supra* note 18, Guideline 10.11(F)(2), at 1055-56 ("Counsel should consider . . . [e]xpert and lay witnesses . . . to provide . . . cultural or other insights into the client's mental and/or emotional state and life history."); *see also id.* Guideline 4.1 cmt., at 957 (noting that "it might well be appropriate for counsel to retain an expert from an out-of-state university familiar with the cultural context by which the defendant was shaped"); *id.* Guideline 10.5 cmt., at 1007-08 ("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."); *id.* Guideline 10.7 cmt., at 1026 ("[C]ounsel must learn about the client's culture.").

385. Since 1973, 142 people have been released from death row based on new evidence establishing innocence. *Innocence and the Death Penalty*, DEATH PENALTY INFO. CENTER, http://www.deathpenaltyinfo.org/innocence-and-death-penalty (last updated Feb. 11, 2013).

386. Lewis, *Adult Antisocial Behavior*, *supra* note 34, at 2260. "Among the manic traits that Hare lists as psychopathic are glibness, superficial charm, grandiosity and exaggerated sense of self-worth, need for stimulation, conning and manipulative behavior, promiscuous sexual behavior, impulsivity, irresponsibility, poor behavioral controls, early behavioral problems, and lack of realistic long-term goals." *Id.*

387. *Id.*

388. Martens, *supra* note 189, at 457-58.

389. *Id.* at 457.

> world. Why should such socially accepted traits (almost every president in the modern world needs and shows such charm and glibness) be rated as pathological?[390]

It is difficult to imagine objective criteria for distinguishing a person who is glib and superficially charming for manipulation purposes from one who is socially fluent and genuinely charming—assuming that there actually is any difference at all. Martens raises similar issues with the "parasitic lifestyle" criterion, explaining:

> Dependence on others . . . might not be a matter of free choice. A parasitic (severely prejudicial term) lifestyle suggests a harmful planning of misuse of other persons. This is not the case in most of the psychopaths we studied. Those who demonstrated a "parasitic lifestyle" are not able to cope with the world, because of their emotional suffering and social-emotional and moral incapacities and they believe that they can only survive in this way. For example, some patients were unable to keep jobs despite their good intentions because of social interaction problems and the consequences of other diagnostic features which are frequently neurobiologically determined.[391]

Finally, Martens is critical of the "[l]ack of realistic, long-term goals" criterion.[392] He asks, "[w]hat are realistic long-term goals?"[393] Martens points out: "In the eyes of normal people many brilliant scientists and artists (until they became famous or recognized) did not have realistic goals."[394] Again, without the context of a complete life history investigation, an examiner might find this criterion met in the case of a client who is exhibiting hallmark features of PTSD, which may often include a foreshortened sense of his or her future stemming from "negative alterations in cognitions and mood associated with the traumatic event(s),"[395] including but not limited to:

> Persistent and exaggerated negative beliefs or expectations about oneself, others, or the world (e.g. "I am bad," "No one can be trusted," "The world is completely dangerous," "My whole nervous system is permanently ruined").

---

390. *Id.*

391. *Id.* at 458 (citations omitted). While this discussion takes as a given that individuals labeled "psychopaths" are indeed so, please see the above discussion contextualizing individual criteria of ASPD for a more thorough discussion of alternative explanations for what is supposedly a "parasitic lifestyle," including intellectual disabilities, executive dysfunction, post traumatic stress symptoms, and symptoms of severe mood or psychotic disorders. *See supra* text accompanying notes 323-82.

392. Martens, *supra* note 189, at 458.

393. *Id.*

394. *Id.*

395. DSM-5, *supra* note 24, at 271.

> Persistent, distorted cognitions about the cause or consequences of the traumatic event(s) that lead the individual to blame himself/herself or others.
>
> Persistent negative emotional state (e.g., fear, horror, anger, guilt, or shame).
>
> Feelings of detachment or estrangement from others.
>
> Persistent inability to experience positive emotions (e.g., inability to experience happiness, satisfaction, or loving feelings).[396]

Indeed, given the life circumstances of many capital defendants, and the pervasiveness of mental and emotional disabilities that are common among our clients, it is difficult to imagine long-term life goals that would be realistic.

Just as with the criteria for diagnosing ASPD, in the absence of meaningful context, the PCL-R checklist often amounts to subjective and demeaning value judgments that are prone to mistaken interpretation. This is particularly the case when assessments are not culturally competent and lack critical context derived from a thorough life history investigation. What is the objective distinction between narcissism and grandiosity, and how can it be drawn reliably in the absence of a thorough life history? When is lying "pathological," and when is it a learned survival strategy? How can a clinician know that a capital defendant lacks remorse, guilt, or empathy, or whether his lack of emotion is better explained by the psychic numbing of PTSD, or flattened affect that accompanies schizophrenia or dementia? Because of the serious consequences of such a mistake in any setting, clinical or forensic, "the psychiatrist given the task of evaluating an offender, especially an offender deemed obnoxious or troublesome, must take care not to write off such an offender as simply psychopathic or antisocial."[397] In each individual case, the difference between telling the client's life story and allowing him or her to fall victim to an unreliable dehumanizing "psychopath" stereotype is simply understanding the difference between objective fact (for example, absence from school) and the subjective interpretation of that fact (for example, truancy, a symptom of conduct disorder).[398] The goal of effective capital representation is to search diligently for the humanizing and mitigating explanation for the client's behavior and demeanor (for example, the client skipped school to protect his sister from their abusive father). "A careful history regarding mood and behaviors, as well as a detailed

396. *Id.* at 272.
397. Lewis, *Adult Antisocial Behavior*, *supra* note 34, at 2260.
398. Bendelow, *supra* note 138, at 546.

family history, will enable the conscientious psychiatrist to determine to what extent, if any, a mood disorder or some other potentially remediable psychiatric disorder may underlie the antisocial behaviors that brought the individual into conflict with the law."[399] It is for this reason that the standards of capital defense practice, as described in the ABA and Supplementary Guidelines, require the defense team to thoroughly investigate the client's life story, and to do so with the assistance of a mitigation specialist who is "qualified by training and experience to screen individuals for the presence of mental or psychological disorders or impairments."[400]

V. CONCLUSION

In summary, there are enormous contextual problems that plague mental health evaluations and prosecutorial characterizations of individuals who are capitally charged and convicted, and who are often inappropriately labeled as antisocial or psychopathic. The motivation for, and recognition of, the need to contextualize is easily lost, in part because capital defendants are overwhelmingly impoverished and disproportionately minorities; and often have multigenerational family histories of racial discrimination and disenfranchisement.[401] The best antidote to the influence of prejudicial psychiatric labels is a compelling mitigating narrative based on a thorough life history investigation which uncovers humanizing conditions and events in the client's life that demonstrate his human complexity, including the mental, emotional, or developmental impairments which he has struggled to overcome.[402] A thorough and methodical ABA and Supplementary Guidelines-based approach to investigating a client's life history will protect the client from the dehumanizing inferences that flow from being labeled antisocial.

---

399. Lewis, *Adult Antisocial Behavior*, *supra* note 34, at 2260.

400. ABA GUIDELINES, *supra* note 18, Guideline 4.1(A)(2), at 952; *see also id.* Guideline 10.4(C)(2)(b), at 1000.

401. *Id.* Guideline 10.5 cmt., at 1007; Haney, *The Social Context*, *supra* note 43, at 562-63, 579.

402. *See* Haney, *The Social Context*, *supra* note 43, at 559 (examining the life histories of capital defendants "leads us to conclusions about the causes of crime and the culpability of capital offenders that are very much at odds with the stereotypes created and nourished by the system of capital punishment that prevails in our society"). For decisions overturning death sentences that had been based in part on diagnoses of ASPD, where post-conviction investigations provided substantial evidence contextualizing and humanizing defendants' life histories, see, for example, Rompilla v. Beard, 545 U.S. 374, 391-93 (2005); Stankewitz v. Wong, 698 F.3d 1163, 1164-65 (9th Cir. 2012); Blystone v. Horn, 664 F.3d 397, 426-27 (3d Cir. 2011); Cooper v. Sec'y, Dep't of Corr., 646 F.3d 1328, 1345-47 (11th Cir. 2011); Goodwin v. Johnson, 632 F.3d 301, 319-21, 324, 326 (11th Cir. 2011).

Haney suggests that the system of capital punishment thrives on procedures that dehumanize the defendant, resulting in "jurors' relative inability to perceive capital defendants as enough like themselves to readily feel any of their pains, to appreciate the true nature of the struggles they have faced, or to genuinely understand how and why their lives have taken very different courses from the jurors' own."[403] Through the inappropriate use of controversial constructs, such as ASPD and psychopathy, prosecutors "demoniz[e] the perpetrators of violence [and] facilitate their extermination at the hands of the state."[404] Haney explains that this "is why 'humanizing' capital clients is so important in penalty trials."[405]

Put simply, every capital defendant possesses "the possibility of compassionate or mitigating factors stemming from the diverse frailties of humankind."[406] Justice Sandra Day O'Connor acknowledged that the process of understanding defendants' disadvantaged backgrounds or their emotional or mental impairments is essential to the constitutionally-required "moral inquiry into the culpability of the defendant."[407] This Eighth Amendment requirement triggers a Sixth Amendment duty, on the part of defense attorneys, to assist jurors with this inquiry by developing mitigation evidence through a detailed, socio-historical analysis of the capital defendant's life.[408] Therefore, "[t]he

---

403. Craig Haney, *Condemning the Other in Death Penalty Trials: Biographical Racism, Structural Mitigation and the Empathic Divide*, 53 DEPAUL L. REV. 1557, 1558 (2004) [hereinafter Haney, *Condemning the Other*].

404. Haney, *The Social Context*, *supra* note 43, at 548.

405. Haney, *Condemning the Other*, *supra* note 403, at 1558, 1581. Ninth Circuit Court of Appeals Judge Alex Kozinski recently derided the importance of humanizing capital clients, suggesting that it "may be the wrong tactic in some cases because experienced lawyers conclude that the jury simply won't buy it." Pinholster v. Ayers, 590 F.3d 651, 692 (9th Cir. 2009) (Kozinski, J., dissenting), *rev'd sub nom* Cullen v. Pinholster, 131 S. Ct. 1388 (2011). To support his view that trial counsel's minimal investigation and pursuit of a "family sympathy defense" was good enough, Judge Kozinski relied on two California cases, *State v. Cooper*, 809 P.2d 865 (Cal. 1991), and *In re Visciotti*, 926 P.2d 987 (Cal. 1996), for the proposition that a "family sympathy defense" was consistent with prevailing standards of performance in capital cases. *Pinholster*, 590 F.3d at 707. Both of those cases ended in death sentences: in *Cooper*, the jury was expressly *not* permitted to consider family sympathy evidence. 809 P.2d at 908-09. In *In re Visciotti*, the trial attorney had never before handled a capital trial, and could point to no case in which a family sympathy defense had succeeded. 926 P.2d at 993. Such anecdotal failures do not evidence a standard of performance. *See* Russell Stetler & W. Bradley Wendel, *The ABA Guidelines and the Norms of Capital Defense Representation*, 41 HOFSTRA L. REV. 635, 677-79 (2013). Further, scrutiny of the complete record in *Pinholster* makes our point; based on trial counsel's superficial and shallow pretrial investigation, the defense psychologist diagnosed him as a psychopath. *See* 590 F.3d at 659-61. A more thorough life history investigation produced evidence that the defendant was severely beaten by his stepfather as a child, and had epileptic seizures, brain damage, and bipolar disorder. *Id.*

406. Woodson v. North Carolina, 428 U.S. 280, 304 (1976).

407. California v. Brown, 479 U.S. 538, 545 (1987) (O'Connor, J., concurring).

408. *See* Wiggins v. Smith, 539 U.S. 510, 519-23, 536 (2003).

social history of the defendant has become the primary vehicle with which to correct the misinformed and badly skewed vision of the capital jury."[409]

The ABA and Supplementary Guidelines establish current and long-established standards of death penalty practice. They provide a necessary road map with which to enhance the fairness and reliability of capital sentencing proceedings in numerous ways that are important to protecting the client from misleading, incomplete, and damaging assessments. The ABA and Supplementary Guidelines help capital defense teams explain to judges and funding authorities why more time and resources are necessary to properly defend the client, particularly when it comes to investigation of the client's life history. They also specify necessary qualifications of capital defense team members, including the admonition that at least one member of the team be qualified, by training or experience, to identify symptoms and characteristics of mental and emotional impairment. If trial counsel fails to assemble a team with the necessary skills, resources, and time, the ABA and Supplementary Guidelines provide a template for post-conviction counsel to challenge substandard work. It is the authors' experience that the client's humanity is established, and the fallacies of the ASPD rubric are exposed, when capital defense teams comply with the ABA and Supplementary Guidelines to conduct a thorough investigation of the client's life history.

409. Haney, *The Social Context*, *supra* note 43, 559-60.