The Intersection of Race, Cultural Bias, and Psychiatric Diagnosis

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Antisocial Personality Disorder in Abused and Neglected Children Grown Up

Barbara K. Luntz, M.A., and Cathy Spatz Widom, Ph.D.

Objectives: The authors' goal in this study was to examine the extent to which having been abused and/or neglected in childhood raises a person's risk for having an adult DSM-III-R diagnosis of antisocial personality disorder. Method: Children who had experienced substantiated child abuse and/or neglect from 1967 to 1971 in a Midwestern metropolitan county area were matched on the basis of age, race, sex, and approximate family social class with a group of nonabused and nonneglected children and followed prospectively into young adulthood. Subjects were located and participated in a 2-hour interview consisting of a series of structured and semistructured questions, rating scales, and a psychiatric assessment using the National Institute of Mental Health Diagnostic Interview Schedule. Interviews were completed with 699 young adult subjects (416 abused and/or neglected and 283 comparison subjects).

Results: Childhood victimization was a significant predictor of the number of lifetime symptoms of antisocial personality disorder and of a diagnosis of antisocial personality disorder, despite the fact that controls for demographic characteristics and arrest history were introduced. Conclusions: These findings suggest the importance of inquiring about a patient's childhood history of abuse and/or neglect when antisocial symptoms are evident. In addition to speculation about a possible saturation model for the consequences of childhood victimization, these findings also reinforce a multiple causation model of antisocial personality disorder.

(TAm J Psychiatry 1994; 151:670–674)

The impact of childhood abuse and/or neglect on the victim has been the focus of numerous studies with varying degrees of methodological rigor. Consequences of childhood victimization have included various forms of maladjustment, such as conduct disorder (1), substance abuse (2), aggressiveness (3, 4), antisocial behavior (5, 6), delinquency, criminality, and violent behavior (6–9), low levels of empathy (10), depression (11), and suicidal ideation and suicide attempts (7, 12). Given these reports of aggressiveness and behavior problems in childhood victims of abuse and/or neglect and the research findings on the continuity of antisocial behavior and personality into later life (13, 14), observations of antisocial behavior in adulthood are not surprising. DSM-III-R notes that abuse as a child is one of the predisposing factors of antisocial personality disorder. Nevertheless, little research to date has empirically tested the association between childhood abuse and/or neglect and the diagnosis of antisocial personality disorder in adulthood.

In this paper we examine whether individuals who experienced abuse and/or neglect as children were more likely to be diagnosed with antisocial personality disorder as young adults than individuals in a matched comparison group. Specifically, we hypothesized that childhood victims of abuse and/or neglect would be more likely as young adults to meet the criteria for antisocial personality disorder and to have a greater number of antisocial symptoms than matched comparison subjects. Because childhood victims of abuse and neglect have shown a greater risk of being arrested (9) and the diagnostic criteria for antisocial personality disorder include the performance of antisocial acts for which a person may have been arrested, it is possible that the association between childhood victimization and antisocial personality disorder may be driven by the criminality characteristic. Thus, childhood abuse and neglect may appear to contribute directly to antisocial personality disorder even though criminal history may be the critical mediating variable. Therefore, the second major hypothesis that we tested is that the relationship between childhood victimization and adult antisocial per-
TABLE 1. Lifetime Prevalence of Antisocial Personality Disorder in Child Abuse/Neglect Victims and Comparison Subjects

<table>
<thead>
<tr>
<th>Variable</th>
<th>Subjects Who Had Been Abused/Neglected as Children (N=416)</th>
<th>Comparison Subjects (N=283)</th>
<th>Analysis*</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>With Antisocial Personality Disorder</td>
<td>With Antisocial Personality Disorder</td>
<td></td>
</tr>
<tr>
<td></td>
<td>N</td>
<td>N</td>
<td>%</td>
</tr>
<tr>
<td>Overall Sex</td>
<td>416</td>
<td>56</td>
<td>13.5</td>
</tr>
<tr>
<td>Male</td>
<td>227</td>
<td>46</td>
<td>20.3</td>
</tr>
<tr>
<td>Female</td>
<td>189</td>
<td>10</td>
<td>5.3</td>
</tr>
<tr>
<td>Criminal history</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>159</td>
<td>14</td>
<td>8.8</td>
</tr>
<tr>
<td>Yes</td>
<td>257</td>
<td>42</td>
<td>16.3</td>
</tr>
<tr>
<td>Education (years)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8 or less</td>
<td>48</td>
<td>12</td>
<td>25.0</td>
</tr>
<tr>
<td>9–11</td>
<td>194</td>
<td>24</td>
<td>12.4</td>
</tr>
<tr>
<td>Higher school or higher</td>
<td>174</td>
<td>20</td>
<td>11.5</td>
</tr>
</tbody>
</table>

*Chi-square is Yates corrected when appropriate.

antisocial personality disorder would persist even when official criminal history was controlled for.

METHOD

The data for the present paper are part of a large research project based on a prospective cohorts design study (15, 16): abused and/or neglected children were matched with nonvictimized children and followed prospectively into young adulthood. The prospective nature of this study allows some issues of causality to be examined and helps to disentangle the effects of childhood victimization from other potentially confounding effects. Because of the matching procedure, the subjects are assumed to differ in the risk factor (that is, having experienced childhood sexual or physical abuse and/or neglect). Since it is not possible to randomly assign subjects to groups (and obviously this could not be done), the assumption of equivalency for the groups is an approximation. Complete details of the study design and subject selection criteria are given elsewhere (8).

In the first phase of this research, a large group of children who were abused and/or neglected approximately 20 years ago were followed-up through an examination of official criminal records and compared with a matched group of children (8). The abused and/or neglected group was composed of substantiated cases of childhood physical and sexual abuse and/or neglect processed during the years 1967 through 1971 in the county juvenile or adult criminal court of a metropolitan area in the Midwest. These were cases of early child abuse and/or neglect, restricted to children who were 11 years of age or younger at the time of the abuse or neglect incident.

Physical abuse cases included injuries such as bruises, welts, burns, abrasions, lacerations, wounds, cuts, bone and skull fractures, and other evidence of physical injury. Sexual abuse cases varied from those involving relatively nonspecific charges of "assault and battery with intent to gratify sexual desires" to more specific ones of "fondling or touching in an obscene manner," sodomy, incest, and so forth. Neglect cases reflected a judgment that the parents' deficiencies in child care were beyond those found acceptable by community and professional standards at the time. These cases represented extreme failure to provide adequate food, clothing, shelter, and/or medical attention to children.

A matched comparison group was established. Children who were under school age at the time of the abuse and/or neglect incident were matched with children of the same sex, race, date of birth (plus or minus 1 week), and hospital of birth through the use of county birth records. For children of school age, records of more than 100 elementary schools for the same time period were used to find matches with children of the same sex, race, date of birth (plus or minus 6 months), class in the same elementary school during the years 1967 through 1971, and home address. Overall, there were matches for 74% of the abused and neglected children.

The second phase of the research involved the tracing, locating, and interviewing of the abused and/or neglected individuals (20 years after their childhood victimization) and comparison subjects. Two-hour follow-up interviews were conducted during 1989 and 1990. The interview consisted of a series of structured and semistructured questions and rating scales, measures of IQ and reading ability, and a psychiatric assessment using the National Institute of Mental Health Diagnostic Interview Schedule (17). The diagnosis of antisocial personality disorder has been found to show reasonable reliability and validity in comparisons of physicians and lay interviewers, with kappas ranging from 0.52 to 0.67 (18–20).

Interviewers were blind to the purpose of the study, to the inclusion of an abused and neglected group, and to the participants' group membership. Similarly, the subjects were blind to the purpose of the study. Subjects were told that they had been asked to participate as part of a large group of individuals who grew up in that area during the late 1960s and early 1970s. After the study was described, subjects who agreed to participate signed a consent form indicating their willingness to participate.

The findings described here are based on completed interviews with 699 of the original study group. At the time of the interview, the participants ranged in age from 18 to 35 years, with an average age of 27.53. Included among those interviewed were more white than nonwhite individuals (60% versus 40%) and more men than women (56.5% versus 43.5%). A large percentage of the subjects interviewed in the follow-up had an official criminal history (63% of the abused and/or neglected group and 43% of the comparison subjects).

RESULTS

Bivariate lifetime (current or remitted) prevalence rates of antisocial personality disorder for the abused and/or neglected subjects and the comparison subjects are presented in table 1. As expected, significantly more of the abused and/or neglected subjects than the comparison subjects met the criteria for antisocial personality disorder. Although abused and/or neglected individuals of both sexes were more likely to have antisocial
personality disorder diagnoses than comparison subjects, the difference between abused and/or neglected men and comparison men was statistically significant, whereas statistical significance was not reached for the women. Among individuals with a criminal history, having been abused and/or neglected did not appear to increase the risk of antisocial personality disorder. However, among those without a criminal history, abused and/or neglected subjects were significantly more likely to be diagnosed as having antisocial personality disorder. Among individuals with less formal education (less than a high school diploma), childhood victimization did not appear to increase the risk of being diagnosed as having antisocial personality disorder. However, among individuals who had completed high school, childhood abuse and/or neglect added significantly to the risk of antisocial personality disorder.

To determine whether childhood victimization leads to a greater risk for a diagnosis of antisocial personality disorder regardless of demographic characteristics and criminal history, multiple and logistic regression equations predicting number of antisocial personality disorder symptoms (table 2) and prevalence of antisocial personality disorder diagnosis (table 3) were estimated. Control variables included age, sex, race, socioeconomic status (21), and criminal history.

The results of these regression analyses indicate that group (that is, abused and/or neglected subjects versus comparison subjects) was a significant predictor of the number of antisocial personality disorder symptoms (table 2), even when demographic characteristics and criminal history were controlled for. Based on this multivariate analysis, which provides a more conservative test of the relationship between childhood abuse and/or neglect and adult antisocial personality disorder, we found that childhood victimization was a significant predictor of the number of symptoms of antisocial personality disorder. Similarly, in a more stringent test of the association between childhood victimization and diagnosis of antisocial personality disorder (table 3), using logistic regression with the same control variables, we found that childhood victimization was again significant. Thus, abused and/or neglected individuals were also more likely than comparison subjects to meet the criteria for a diagnosis of antisocial personality disorder, even when sex, race, age, socioeconomic status, and criminal history were controlled for.

**DISCUSSION**

As predicted, we found that abused and/or neglected children were at significantly greater risk of being diagnosed as having antisocial personality disorder when they were adults than a matched comparison group. Childhood victimization was a significant predictor of the number of antisocial personality disorder symptoms and the diagnosis of antisocial personality disorder, even when controls for a number of demographic characteristics (sex, race, age, and socioeconomic status) as well as official criminal history were introduced. These findings thus extend previous knowledge of the long-term consequences of childhood victimization and provide strong empirical support for childhood victimization as an antecedent of antisocial personality disorder.

It should also be noted, however, that the vast majority (about 86%) of the abused and/or neglected group did not meet the criteria for a diagnosis of antisocial personality disorder and that slightly over 7% of the comparison subjects did meet these criteria, suggesting that factors other than childhood victimization play a role in the etiology of antisocial personality disorder. For the abused and neglected children, it is possible that there might have been protective factors (personal attributes, environmental conditions, biological predispositions, or positive life events) to mitigate the negative consequences of their earlier childhood experiences. Among the comparison children, it is possible that some experienced punitive or inconsistent parenting. Although such parenting behavior may not have been severe enough to come to the attention of the authorities at the time, it may have played a role in the development and maintenance of antisocial personality disorder symptoms.

In attempting to understand the relationship between child abuse and/or neglect and adult antisocial personality disorder, it is also important to consider the influence of the parents' personality and/or psychiatric disorder on the developing child. For example, some abusive parents have been characterized as having low levels of empathy (10, 22), poor self-esteem (22), high levels of impulsivity (22-24), and general behavioral problems and psychological dysfunction (25). There is also evidence that childhood conduct disorder (a neces-

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TABLE 2. Ordinary Least Squares Multiple Regression Predicting Number of Lifetime Antisocial Personality Disorder Symptoms in Child Abuse/Neglect Victims and Comparison Subjects^a^

<table>
<thead>
<tr>
<th>Independent Variable</th>
<th>b</th>
<th>Beta</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Group (abuse/neglect)</td>
<td>0.67</td>
<td>0.09</td>
<td>&lt;0.01</td>
</tr>
<tr>
<td>Sex (male)</td>
<td>1.58</td>
<td>0.21</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Race (nonwhite)</td>
<td>-0.04</td>
<td>-0.01</td>
<td>n.s.</td>
</tr>
<tr>
<td>Age</td>
<td>0.02</td>
<td>0.02</td>
<td>n.s.</td>
</tr>
<tr>
<td>Socioeconomic status</td>
<td>-0.03</td>
<td>-0.12</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Criminal history (yes)</td>
<td>1.80</td>
<td>0.24</td>
<td>&lt;0.001</td>
</tr>
</tbody>
</table>

^aAdjusted R²=0.17, F=24.62, df=6, 671, p<0.001.

TABLE 3. Logistic Regression Predicting Antisocial Personality Disorder Lifetime Diagnosis in Child Abuse/Neglect Victims and Comparison Subjects^b^

<table>
<thead>
<tr>
<th>Independent Variable</th>
<th>b</th>
<th>SE</th>
<th>Odds Ratio</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Group (abuse/neglect)</td>
<td>0.56</td>
<td>0.29</td>
<td>1.75</td>
<td>&lt;0.05</td>
</tr>
<tr>
<td>Sex (male)</td>
<td>1.25</td>
<td>0.33</td>
<td>3.50</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Race (nonwhite)</td>
<td>-0.05</td>
<td>0.26</td>
<td>0.95</td>
<td>n.s.</td>
</tr>
<tr>
<td>Age</td>
<td>0.02</td>
<td>0.04</td>
<td>1.02</td>
<td>n.s.</td>
</tr>
<tr>
<td>Socioeconomic status</td>
<td>-0.02</td>
<td>0.01</td>
<td>0.98</td>
<td>n.s.</td>
</tr>
<tr>
<td>Criminal history (yes)</td>
<td>0.74</td>
<td>0.31</td>
<td>2.09</td>
<td>&lt;0.01</td>
</tr>
</tbody>
</table>

^bModel χ²=43.46, df=6, p<0.001.
sary precursor to antisocial personality disorder) is linked to parental psychopathology, particularly antisocial personality disorder (26, 27). Furthermore, the possibility of a genetic contribution to antisocial personality disorder cannot be dismissed (28–31). Since people with antisocial personality disorder often display behavior characterized by repeated physical fights and assaults, including spouse and child abuse (DSM-III-R), the intergenerational transmission of antisocial personality disorder may overlap substantially with the cycle of violence (8). Clearly, future research needs to test more complicated models that assess the contribution of parental characteristics to the relationship documented here between abuse and/or neglect as children and antisocial personality disorder as adults.

Interestingly, in the bivariate analyses, the greater risk of antisocial personality disorder among childhood victims of abuse and/or neglect was not evident among individuals with a criminal history and those who failed to complete high school. One possible explanation for this finding is that for individuals characterized by multiple risk factors associated with antisocial personality disorder (such as a criminal history, poor school performance, or low educational attainment), the additional negative impact of abuse and/or neglect may be inconsequential. These individuals may already be at such elevated levels of risk for manifesting antisocial behavior that the addition of one more stress factor (i.e., abuse and/or neglect) may not contribute further risk. In contrast, among individuals not characterized by these factors, the negative impact of childhood victimization was striking. For the individuals without these risk factors—noncriminals and high school graduates—childhood victimization was a potent risk factor for the development of antisocial personality disorder.

It is possible that these differential effects of childhood victimization may reflect a saturation model, whereby individuals with multiple risk factors reach a saturation point. Beyond that point, for these individuals, one additional risk factor (no matter how powerful) may have no demonstrable effect. Thus, there may be thresholds or saturation points for causal influences beyond which risk factors do not noticeably contribute. In addition to our speculation about a saturation model to describe the consequences of childhood victimization, our findings also reinforce a multiple causation model of antisocial personality disorder.

Further understanding of how different types of maltreatment affect the child victim with regard to risk for antisocial personality disorder is also needed. Preliminary analyses were attempted, and these results suggest that type of maltreatment makes little difference in the extent of risk for antisocial personality disorder. However, the relatively small numbers in some of the specific maltreatment type groups precludes a definitive conclusion at this time. Additional data collection is in progress, and future papers will address this issue more fully.

Finally, our results have implications for clinical practice in suggesting the importance of inquiring about a patient's childhood history of abuse or neglect. The charm, glibness, lack of affect, and manipulation of others seen in antisocial individuals may mask sequelae of earlier childhood trauma. Interventions undertaken early enough may help to avoid the chronicity of adult antisocial personality disorder.

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Mad or Bad? Some Clinical Considerations in the Misdiagnosis of Schizophrenia as Antisocial Personality Disorder

BY SHELDON TRAVIN, M.D., AND BARRY PROTTER, PH.D.

Some clinicians tend to misdiagnose schizophrenia when there is accompanying antisocial behavior, thus depriving the patient of appropriate treatment. Four factors appear to contribute to this misdiagnosis: the most important of which is the nature of the interaction between examiner and examinee. The authors present a case illustration and discuss the implications for treatment. (Am J Psychiatry 139:1335-1338, 1982)

A patient's manifest antisocial behavior can cause the examining clinician to fail to diagnose more severe underlying psychopathology such as schizophrenia. It is our impression, based on clinical experiences and colleagues' reports, that this type of misdiagnosis occurs more frequently than is generally acknowledged. A variety of factors contribute to the clinician's being misled, but a crucial and often underemphasized one is the nature of the interaction between examiner and examinee. The diagnostic category of antisocial personality is considered by many investigators to be composed of heterogeneous subgroups (1); this paper focuses on the manipulative, aggressive, and hostile types often seen in court clinics or correctional settings.

The correct identification of the more malignant component of the presentation (schizophrenic disorder vs. antisocial personality) is not only important for clinical precision but has relevance in the climate of present mental health trends. Rapid deinstitutionalization has, in effect, caused the criminal justice system to take on some of the burdens and responsibilities formerly assigned to the state mental hospital system. Although questions of methodology have been raised (2, 3), different authors (4-8) have suggested that there are higher rates of arrest for criminal behavior among the discharged mentally ill than in the general population. Steadman and associates (9, 10) and Rabkin (3) attributed this to what seems to be an increase in the number of people in mental hospitals who have a criminal arrest history. Conversely, there is growing recognition of the large number of mentally ill inmates in our prison system (11-13). One can infer that these mentally ill offenders are shunted back and forth between the criminal justice and mental health systems. What emerges in the interface of the two systems is an underlying confusion as to whether the person is sick or criminal (mad or bad): is the person antisocial or schizophrenic? The clinician may react at times as if the two conditions are mutually exclusive.

There is a dearth of literature on the possible connection or interrelatedness between antisocial personality and schizophrenia. Milburn and Goff (14), in an expansion of Hoch and Polatin's concept (15) of the pseudoneurotic schizophrenic, introduced the term 'pseudoneurotic schizophrenia.' They described patients whose marked anxiety is expressed in antisocial behavior that can mask underlying schizophrenic disorganization. Chrzanowski (16) described the treatment of ambulatory schizophrenic patients who manifest a variety of antisocial attitudes as a defensive adaptation to their more severe pathology. Particularly, he stressed these sociopathic traits as a 'potent insulating buffer' against close, intimate relationships. Geller (17) described a group of patients 'who shift the focus of their activity from the manipulation and distortion of internal reality to the idiosyncratic manipulation of their external environments.' He offered the example of a patient who decompensates to get into the hospital and improves on the day that his welfare check is to arrive. According to Geller, the patient has the capacity to 'bend the course of his psychosis to his will, forcing it to serve his practical needs.'

CLINICAL DIAGNOSTIC ISSUES

Two general psychiatric trends, as well as two more specific factors related to the unique interrelationships of schizophrenia and antisocial features, contribute to the incorrect assessment of some patients.

1. For many years American psychiatry was profoundly influenced by Bleuler's conceptualization that...
schizophrenia is fundamentally a disturbance in thinking (18). Eventually some investigators questioned the pathognomonic specificity of making a diagnosis of schizophrenia only on the basis of the patient’s loose associations (19). DSM-III, legitimizing what was already believed by many clinicians, offers multiple criteria for the diagnosis of schizophrenia without the formerly “assumed” criterion of a discernible thinking disorder (providing, of course, that the other basic criteria are met). Hence there should now be fewer instances of misdiagnosing this entity and a greater likelihood of detecting the schizophrenic pathology in a mixed presentation.

2. Counteracting this trend, however, is the current overemphasis on diagnoses other than schizophrenia. It is commonly known that clinicians are influenced by prevailing psychiatric trends in the ways they perceive, categorize, and diagnose psychopathology. Although these trends often reflect progressive clinical and theoretical refinements, they also soon become overused. Psychiatric trends in diagnosis become popularized and serve as new perceptual sets that can lessen the clinician’s alertness to alternative possibilities. In recent years the pendulum appears to have swung away from the former “wastebasket” diagnosis of schizophrenia in the often overzealous climate of focusing on such entities as bipolar disorder and borderline personality disorder.

3. There is a predilection on the part of many clinicians for understanding psychopathology within the framework of recognizable syndromes. The predominant features or symptoms tend to be subsumed under one diagnostic entity, which then makes a lasting unitary impression. This emphasis on clinical “purity” appears especially in instances where the individual is perceived as schizophrenic but also clearly exhibits antisocial characteristics. What is potentially confusing for the clinician is the fact that antisocial behavior, which can be purposeful and goal oriented, can be an adaptation by the schizophrenic person (who is generally considered to be too disorganized) as a way of dealing with his or her external circumstances. In inner city areas (e.g., in the street culture and in hotels where people rent single rooms to live in) antisocial behavior can be seen as almost syntonic with the environment. Indeed, schizophrenia and antisocial behavior can coexist.

4. The antisocial aspect of the patient often evokes a dramatic “response set” in the clinician, who reacts not only to the subject but to the context (i.e., circumstances, location, referral source, etc.) of the examination. Closely allied with this notion is the contemporary “totalistic” view of countertransference, as distinguished from the “classical” (20). Classical countertransference has been understood as the unconscious reaction of the therapist (presumably derived from the therapist’s neurotic conflicts) to the patient’s transference. Totalistic countertransference is defined as “the total emotional reaction of the psychoanalyst to the patient in the treatment situation” (not necessarily based on the therapist’s own conflicts). Kernberg states that, “given reasonably well-adjusted therapists, all hypothetically dealing with the same severely regressed and disorganized patient, their countertransference reactions will be somewhat similar, reflecting the patient’s problems much more than any specific problem of the analyst’s past” (20, p. 43). Hence, countertransference can be used as an important diagnostic tool.

The countertransference concept, of course, has been historically developed in the long-term psychoanalytic treatment context. The clinician’s total set of responses as evoked in the initial interview, where diagnostic considerations are paramount, has been less considered. Presumably, initial reactions to the patient are not as likely to be contaminated as reactions in an intense treatment situation in which the therapist is more personally invested. MacKinnon and Michels (21), in their well-known book on the psychiatric interview, discuss some common countertransference reactions evoked by patients of different diagnostic classifications, including the antisocial personality.

Antisocial characteristics, particularly those of exploitiveness and manipulativeness, can elicit angry feelings and retaliation in the interviewer. When the subject attempts to control the interview in a purposefully underhanded and deceitful manner (referred to in the street vernacular as “getting over”), there is a fundamental undercutting of the authentic role of the examiner. When the clinician senses this, he or she is likely to have a reciprocal response and to dismiss the legitimacy of the examinee’s psychopathologic complaints. This process can have an emotional accomplishment of anger and withdrawal, the outcome of which is all too often the clinician’s overlooking or minimizing of psychotic features and the bestowal of the antisocial label. Conversely, the clinician may seize on the antisocial aspect of the presenting pathology as the more attractive or redeeming feature. This kind of reaction more closely approximates the classical countertransference phenomenon. The examiner is more willing to engage the antisocial than the chaotic side of the patient’s personality. In both of these cases, therefore, the true configuration of the pathology is distorted.

In addition to the clinician’s individual response, the setting in which the interview takes place is of extreme importance. Essentially, a kind of institutional distortion can be operative. In certain contexts such as a court psychiatric clinic or a prison, in which the contact between client and therapist is initiated by the client’s unlawful behavior, there is a tendency to see the pathology in antisocial terms. This operates as a perceptual set that can constrict the clinician’s overall view of the patient. Hence, there may be a bias related
to the setting even before the patient is formally examined.

Case Illustration

Mr. A, a 32-year-old single, unemployed man, resided with his brother. He had previously been addicted to heroin but was now receiving a daily maintenance dose of methadone at a treatment center. He also admitted to episodic alcohol abuse. He had been referred to the court psychiatric clinic by his probation officer for a treatment evaluation. His original charge was assault, but more recently he had been arrested for impersonating an employee of the hospital to which he had been referred for outpatient psychiatric treatment. During the initial interview, he expressed fears of his neighbors, whom he accused of watching, following, and spreading false rumors about him to set him up for a robbery. He stated that these fears had begun more than a year earlier and that he had been briefly treated with various psychotropic medications at two separate hospitals without any improvement. He was alert, with orientation and memory intact, and coherent, without any disturbance in thought process or evidence of hallucinatory experiences. There were no intrusive emotional fears other than those just mentioned. Cognitive functioning and intelligence were normal.

What impressed the interviewer and everybody else who had contact with Mr. A was his extreme manipulativeness, deviousness, cunning, and outright lying—all in a peculiar and not unappealing manner. As he continued to attend the clinic, he began to be seen as a kind of antisocial “character,” and less attention was paid to his seemingly outlandish complaints about his neighbors. He himself began to speak less of these earlier fears. Eventually, however, Mr. A’s way of relating became increasingly abrasive. What had been benignly tolerable before began to wear thin. He managed to orchestrate his contact with the clinic staff members in such a way that most of them changed from acceptance to outright hostility toward him.

About 9 months after treatment began, coinciding with his recent cessation of methadone use and abandonment by his brother, Mr. A suffered an episode of acute psychosis. He began to hallucinate actively, and his fears enlarged to paranoid delusions about most people and specifically about CIA and FBI agents. When he was admitted to the inpatient psychiatric service, the staff there were reluctant to see this court clinic-referred patient as truly psychotic rather than as a person with a manipulative antisocial personality using “symptoms” to obtain a place to stay. The staff at the court clinic had to convince Mr. A’s doctor on the inpatient service of the validity of his need for psychotropic medication, which he ultimately received and which resulted in an amelioration of his symptoms.

What prevented experienced clinicians from diagnosing this patient earlier as a paranoid schizophrenic? In the first place, he was referred by his probation officer with a history of unlawful behavior and drug addiction. Second, his antisocial behavior was corroborated by his presentation at the clinic. In the absence of evidence of a formal thought disorder, his paranoid fear of his neighbors was viewed as having some basis in reality, although dramatized and exaggerated for manipulative reasons (i.e., getting attention, obtaining extra carfare money). His accumulation of an antisocial veneer increasingly alienated the staff and precluded closer scrutiny of his intrinsic pathology. Third, clinicians may tend to diagnose patients as antisocial for defensive and protective reasons. To acknowledge and engage underlying pathology that is deeply disorganized and confusing can arouse significant feelings of anxiety and helplessness in the therapist. To defend against this, he or she may minimize and overlook the more severe underlying pathology. The antisocial feature becomes, in effect, the more “attractive” aspect of the individual. In some instances the clinician may even vicariously identify with this behavior. There can then ensue a kind of collusion between clinician and patient to the detriment of meaningful treatment.

It is important also to realize that even if the correct diagnosis is made, treatment of these patients is difficult. Many of them clearly lack motivation, and they are usually reluctant to take psychotropic medication, which they fear could stigmatize them as mental patients. Even if they are willing to take medication, they frequently lack treatable target symptoms.

CONCLUSIONS

In recent years mental health professionals, and particularly those associated with the criminal justice system, have been in increased contact with a group of patients who are both seriously mentally disturbed and, at times, compelled to marginally adapt to their environment by sociopathic means. These patients’ sociopathic behavior, which may be somewhat adaptive to their “street” environment, may be maladaptive in terms of being correctly diagnosed and treated. The clinician may have difficulty seeing the antisocial feature as an adaptive mechanism that is only a component of the schizophrenic pathology (as one might, for example, be able to see conversion symptoms in a schizophrenic patient). Thus, patients whose antisocial aspect masks core schizophrenic components may lose out in two senses. They can be too disorganized to effectively negotiate the world in even an antisocial manner and too antisocial to consistently connect with the mental health system.

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Rationale for the Proposed Changes to the Personality Disorders Classification in DSM-5

Part 1 – Reasons for the Changes

In the Introduction to A Research Agenda for DSM-V, Kupfer et al. (2002) questioned the validity of traditional categorical approaches to the diagnosis of mental disorders. Epidemiological and clinical studies showed high rates of co-morbidity between disorders and short-term diagnostic instability. No laboratory marker had been found to be specific for any DSM-defined syndrome and treatment specificity for different types of disorders was rare. Rounsaville et al. (2002) then explicitly focused on personality disorders (PDs): “There is a clear need for dimensional models to be developed and their utility compared with that of existing typologies in one or more limited fields, such as personality.”

The fundamental problem with the PD diagnostic system in DSM-III, III-R, and -IV is that it takes an essentialist “top-down” approach (Kendler, 2009), based on the assumption that there are a small number of personality types, each of which has a fundamental nature. From an empirical point of view, no such set of types has been found, even in large, diverse samples, and using sophisticated statistical modeling strategies designed to reveal latent categories (e.g., Eaton et al., 2011; McCrae et al., 2006). Human personality varies continuously, emerging from the confluence of personality traits that form a robust, hierarchical dimensional structure (Markon et al., 2005) which, in its broad outlines, is culturally universal in both self (McCrae & Costa, 1997) and observer (McCrae et al., 2005) data, suggesting that fundamental biological processes underlie its component dimensions. Because it does not derive from data, critiques of the DSM’s categorical approach to PD diagnosis appeared almost immediately after the publication of DSM-III in 1980 (Frances, 1980; 1982), and these issues were not addressed in the DSM-IV revision process. Since then, considerable research has detailed the nature of the problems inherent in this approach, the most frequent and well-documented of which follow.

Extensive co-occurrence among PDs. Most patients diagnosed with PD meet criteria for more than one (Grant et al., 2005; Oldham et al., 1992; Zimmerman et al., 2005). Given that individuals have but one personality, when that personality is disordered, they ipso facto should have a single personality disorder. That this is not the case using DSM-III through DSM-IV-TR reflects a fundamentally flawed system. In contrast, the DSM-5 PD proposal includes a system to describe individuals’ personalities, highlighting those trait dimensions that are maladaptive in their extremity, and to represent personality disorders by a more restricted number of specific PDs defined by core impairments and pathological personality traits.

Extreme heterogeneity among patients receiving the same diagnosis. It is commonplace in the PD literature to affirm that there are 256 ways to meet DSM-IV-TR criteria for borderline PD (BPD) (Johansen et al., 2004). This is problematic because DSM-IV-TR PDs are heterogeneous manifestations of diverse traits. Individuals can meet the criteria for the same PD while having few and, in some cases (e.g., OCPD), no features in common and present clearly distinct clinical pictures. For example, one individual
may present with ideas of reference, odd beliefs or magical thinking, unusual perceptual experiences, odd thinking and speech, and paranoid ideation, whereas another may have excessive social anxiety, lack close friends, have odd appearance and constricted affect, and be suspicious, yet both individuals meet DSM-IV-TR criteria for schizotypal PD. Treatment implications are significantly different for these two individuals, questioning the utility of the diagnosis, as currently specified in DSM-IV-TR.

In contrast, in the DSM-5 PD proposal, the elevated traits of an individual are noted, so the degree of similarity and difference between individuals can be clearly specified. In the above example, the first individual would have elevated traits in the psychoticism domain, whereas the latter’s prominent trait domains would be detachment and negative affectivity. Because prominent trait elevation is specified, DSM-5 PD diagnosis per se identifies primary targets for intervention (Widiger, 1997), as opposed to conflating distinct personality presentations within arbitrarily delineated categories.

Lack of synchrony with modern medical approaches to diagnostic thresholds. Use of severity dimensions in diagnosis is common in modern medicine (e.g., pre-hypertensive blood pressure, three classes of obesity, and multiple stages of cancer). In contrast, DSM-IV-TR PD diagnosis uses dichotomous classification with thresholds set arbitrarily at simply half or more of the criteria for even numbers of criteria, and more than half for odd numbers, rather than informed by data (for a review, see Skodol et al., 2002b). (As far as the DSM-5 Personality and Personality Disorders Work Group is aware, the threshold of 5 of 9 criteria needing to be present to diagnose BPD was set for DSM-IV-TR simply because 5 is more than half of 9.) The DSM-5 proposal instead reflects the practice in modern medicine of separating severity assessment (Criterion A) from that of the relative elevations of individuals’ traits (Criterion B).

Temporal instability. The average short-term test-retest reliabilities of .54 for specific PDs and .56 for any PD (Zimmerman, 1994) suggest poor “dependability” (large transient error of measurement; Chmielewski & Watson, 2009) for even structured interviews. Longer term test-retest reliabilities of .51 for any PD and .34 for specific PDs, and the finding of significant diagnostic change over as little as 6 months (Shea et al., 2002), indicate diagnostic instability that is inconsistent with the relative stability of personality traits (Roberts & DelVecchio, 2000) and impairment in PD (Gunderson et al., 2011; Skodol et al., 2005b). By making PD diagnoses more trait-based, the DSM-5 proposal is expected to reduce temporal instability.

Poor coverage of personality psychopathology. A comprehensive meta-analysis (Verheul & Widiger, 2004) documented that personality disorder not otherwise specified (PDNOS) is one of the most common PD diagnoses in research settings and the most frequently diagnosed PD in clinical practice. Although officially used only “for disorders of personality functioning that do not meet criteria for any specific PD” (APA, 2000, p. 729), in practice it is applied in diverse ways, for example, to designate “mixed PD,” that is, for an individual who exhibits features of more than one PD, but does not meet full criteria for any specific one; to indicate that an individual meets criteria for a PD that is not included in the official classification (e.g., depressive or passive-aggressive PDs); or to indicate that a person has a PD,
but limitations in information preclude further description (Verheul et al., 2007). Individuals with PDNOS have considerable impairment (Johnson et al., 2005; Verheul et al., 2007; Wilberg et al., 2008), but the diagnosis itself communicates no information about the nature of the personality dysfunction. In contrast, the DSM-5 proposal provides coverage for all individuals with personality dysfunction, even those not meeting criteria for one of the specific types, via its comprehensive personality functioning and trait system. Moreover, the specific nature of individuals’ personality dysfunction is conveyed by noting their levels of personality functioning and their prominent trait elevations in the diagnosis of personality disorder-trait specified (PD-TS).

Poor convergent validity. Perhaps the most serious problem with the current PD diagnostic system is the difficulty in operationalization of the criteria, which has resulted in unacceptably low convergent validity across PD assessments. In an early study, the average kappa across specific PDs between an unstructured clinical interview and the Personality Disorder Questionnaire-Revised (Hyler & Rieder, 1987) was an abysmal .08 (Hyler et al., 1989), whereas a study comparing the LEAD (Longitudinal Evaluation of All Data; Spitzer, 1983) standard to two different structured assessments yielded an average kappa of .25 for any PD, that is, simply whether individuals did or did not have a PD (Pilkonis et al., 1991). Importantly, these are not isolated examples. Meta-analytic convergence between structured interviews, and between structured interviews and personality questionnaires, respectively, was .27 for specific PDs and .29 for any PD (Clark et al., 1997).

The importance of these findings cannot be overemphasized. These data mean that the entire PD literature is built upon shifting sands: had each of the thousands of PD studies been conducted with a different PD assessment, the study participants would have been a largely different set of individuals, thus yielding study results that would be different to an unknown degree. In contrast, the proposed DSM-5 personality trait set is based on an extensive research literature whose origins are more than half a century old (e.g., Cattell, 1946), culminating in recent years in a consensual, highly robust personality trait hierarchical structure (Markon et al., 2005) that has a high degree of convergent and discriminant validity across a wide range of measures, primarily questionnaires (O’Connor, 2002b), but also encompassing structured interviews (Stepp et al., 2005). Further, this structure has been shown to be invariant across clinical and non-clinical populations (O’Connor, 2002a), including being influenced by overlapping genetic and environmental factors (Markon et al., 2002), and to be sufficiently comprehensive as to capture the variance in—and thus to provide coverage for—personality disorders (Samuel & Widiger, 2008; Saulsman & Page, 2004).

Part 2 – Magnitude of the Change

Overall, the magnitude of the proposed changes is “substantial.” Significant changes are being proposed in a diagnostic area of DSM-IV that has significant limitations in validity and clinical utility. The proposed DSM-5 model consists of two dimensional assessments: 1) a personality pathology severity scale, the Levels of Personality Functioning, and 2) a 5 domain/25 facet pathological personality trait assessment. Combined, these assessments redefine the core features of a PD and provide the
information needed to rate the major diagnostic inclusion criteria for six specific PD categories and for a diagnosis of personality disorder-trait specified (PD-TS) to replace PD not otherwise specified (PDNOS). The remaining four DSM-IV-TR PD diagnoses, and the two in the Appendix, also can be rendered using the DSM-5 model; how their criteria map onto the DSM-5 trait model may be included in Section III of DSM-5.

The revised general criteria for PD require significant impairment in personality functioning (criterion “A”) and the presence of pathological personality traits (criterion “B”), that are relatively stable across time and consistent across situations, not within the normal range for a person’s developmental stage or socio-cultural environment, and not due to a substance or a general medical condition. All DSM-5 PDs described by specific criterion sets and PD-TS are structured so that they will meet the general criteria. That is, the general criteria do not need to be assessed separately; nonetheless, they are provided because they describe succinctly what is common across all personality disorders.

Part 3 – Evidence for the Changes

The following sections highlight and summarize key evidence in support of the major changes proposed in the DSM-5 hybrid PD model: 1) adopting a hybrid dimensional-categorical model, 2) identifying core impairments in personality functioning and rating them on continuum of severity, 3) specifying an empirically-derived assessment of pathological personality traits, 4) describing with specific criteria only a subset of the DSM-IV-TR PDs, 5) revising the concept of stability with respect to personality pathology, 6) eliminating the adolescent conduct disorder requirement for antisocial PD, and 7) eliminating rule-outs for co-occurring other mental disorders, except for the direct effects of substances.

HYBRID MODEL OF PERSONALITY DISORDER

A hybrid dimensional-categorical model for personality and PD assessment and diagnosis is proposed for DSM-5. Hybrid models combining elements of dimensions and categories have been suggested by PD experts since before the publication of DSM-IV (Benjamin, 1993; Blashfield, 1993). In a recent survey of PD experts, Bernstein et al. (2007) found that a mixed system of categories and dimensions was the most frequently endorsed alternative system for PDs. A number of recent studies support a hybrid model of personality psychopathology consisting of ratings of both disorder and trait constructs, in that each appears to increase the value of the other in predicting important antecedent (e.g., family history, history of child abuse), concurrent (e.g., functional impairment, medication use), and predictive (e.g., functioning, hospitalization, suicide attempts) variables (Morey & Zanarini, 2000; Morey et al., 2007; Hopwood & Zanarini, 2010; Morey et al., in press).

Morey and Zanarini (2000) found that Five-Factor Model (FFM) domains captured substantial variance in the diagnosis of borderline PD with respect to its differentiation from non-borderline PDs, but also that residual variance not explained by the FFM was related significantly to important clinical correlates of BPD, such as childhood abuse history, family history of mood and substance use disorders,
concurrent (especially impulsive) symptoms, and 2- and 4-year outcomes. In the Collaborative Longitudinal Personality Disorders Study (CLPS), dimensional representations of DSM-IV-TR PD diagnoses (i.e., criterion counts) predicted concurrent functional impairment, but their predictive power diminished over time (Morey et al., 2007). In contrast, the FFM (assessed with the NEO PI-R; Costa & McCrae, 1992) provided less information about current behavior and functioning, but was more stable over time and more predictive of future outcomes. The Schedule for Non-Adaptive and Adaptive Personality (SNAP; Clark, 1993; Clark et al., in press) model performed the best, both at baseline and prospectively, because it combines the strengths of a pathological disorder diagnosis and more normal range personality traits by assessing personality traits across the normal-abnormal spectrum and by including clinically important trait dimensions (e.g., self-harm, dependency) that are not included in measures of normal-range personality. In fact, a hybrid model combining FFM and DSM-IV-TR constructs performed much like the SNAP. The results indicated that models of personality pathology that incorporate stable trait dispositions and dynamic, maladaptive manifestations are most clinically informative. Hopwood and Zanarini (2010) found that FFM extraversion and agreeableness were incrementally predictive (over a BPD diagnosis) of psychosocial functioning over a 10-year period and that borderline cognitive and impulse action features had incremental effects over FFM traits. They concluded that both BPD symptoms and personality traits are important long-term predictors of clinical functioning and supported the integration of traits and disorder in DSM-5. Morey et al. (in press) extended their earlier findings comparing the FFM, SNAP, and DSM-IV PDs in a 10-year follow-up of CLPS patients. Baseline data were used to predict long-term outcomes, including functioning, Axis I psychopathology, and medication use. Each model was significantly valid, predicting a host of important clinical outcomes. Overall, approaches that integrate normative traits and personality pathology proved to be most predictive, as the SNAP generally showed the largest validity coefficients overall, and the DSM-IV PD syndromes and FFM traits tended to provide substantial incremental information relative to one another. The results again indicated that DSM-5 PD assessment should involve an integration of characteristic PD features and personality traits, to maximize clinical utility.

CORE IMPAIRMENTS IN PERSONALITY FUNCTIONING

The proposal to change the basic definition of PD and the general criteria is based on observations that the DSM-IV-TR general criteria were not specific to PDs and were introduced into DSM-IV without any theoretical or empirical justification. Furthermore, there was no explicit connection between the general criteria and the criterion sets for individual PDs. Research indicates that generalized severity is the most important single predictor of concurrent and prospective dysfunction in assessing personality psychopathology and that PDs are optimally characterized by a generalized personality severity continuum with additional stylistic elements, derived from both PD symptom constellations (e.g., suicidality) and personality traits (Hopwood et al. 2011). There is wide consensus (e.g., Crawford et al., 2011; Parker et al. 2002, Pulay et al., 2008; Tyrer 2005; Wakefield 1992; 2008) that severity assessment is essential to any dimensional system for personality psychopathology. Moreover, the ICD-11
Personality Disorders Work Group has proposed severity as the central element of PD (Tyrer et al., 2011).

A literature review and secondary analyses revealed that PDs, in general, are associated with distorted and maladaptive thinking about oneself and others and that the components most central to effective personality functioning fall under the rubrics of identity, self-direction, empathy, and intimacy (Bender et al., 2011; Morey et al., 2011). The Levels of Personality Functioning Scale uses each of these elements to differentiate five levels of impairment on a continuum of severity ranging from no impairment, i.e., healthy functioning (Level = 0), to extreme impairment (Level = 4). Neither the DSM-IV-TR general severity specifiers nor its Axis V GAF Scale have sufficient specificity for personality psychopathology to be useful in measuring its severity.

A number of reliable and valid measures to assess personality functioning and psychopathology demonstrate that a self-other dimensional perspective has an empirical basis and significant clinical utility (for a review, see Bender et al., 2011). Reliable ratings can be made on a broad range of self-other constructs, such as identity and identity integration, agency, self-control, sense of relatedness, capacity for emotional investment in and maturity of relationships with others, responsibility, and social concordance. The most reliable (ICC⩾ .75) dimensions among those found in the measures considered in the review were retained for the Levels of Personality Functioning Scale.

Criterion-level reliability studies have found that criteria related to self (e.g., chronic emptiness, identity disturbance) and interpersonal (e.g., unstable or stormy relationships) functioning are rated as or more reliably than other BPD criteria (e.g., affective instability, physically self-damaging acts) with no significant differences between self and interpersonal criteria (Gunderson et al., 1981; Frances et al., 1984; Pfohl et al., 1986, Zanarini et al., 2002; Zanarini et al., 2003; Grilo et al., 2004; Grilo et al., 2007; Gamache et al., 2009). In the DSM-5 Field Trials, the Levels of Personality Functioning scale was rated with adequate test-retest reliability overall (ICC=.416) by untrained, though experienced, clinicians, and rated with higher reliability than a number of other DSM-5 dimensional measures. A two-item self-report measure (Level 1) of personality functioning had good test-retest reliability across four Field Trial sites (pooled ICC=.686).

Numerous studies using measures of self and interpersonal functioning have shown that a self-other approach is informative in determining both the type and the severity of personality pathology (for a review, see Bender et al., 2011). To determine the validity of the core dimensions of personality pathology measured by the Levels of Personality Functioning Scale, Morey et al. (2011) conducted secondary data analyses with over 3000 subjects who had received self-report measures of personality functioning, for example the Severity Indices of Personality Problems (SIPP-118; Verheul et al., 2008), and semi-structured interview diagnoses of DSM-IV PDs. Item Response Theory (IRT) analyses characterized the types of problems associated with different levels of impairment. The results delineated a coherent global dimension of impairment in personality functioning that was related to the likelihood of
receiving any PD diagnosis, two or more PD diagnoses, and one of the more severe PDs (e.g., BPD or ASPD). Longitudinal follow-up also indicates that individual PDs become less differentiated over time, reflecting a shared base of pathology for chronic PDs (Sanislow et al., 2009). Studies using measures of self and interpersonal functioning have shown also that a self-other approach is informative in planning treatment interventions and in anticipating treatment course and outcome (Bender et al., 2011).

Impairment in self and interpersonal functioning is consistent with multiple theories of PD and their research bases, including cognitive/behavioral, interpersonal, psychodynamic, attachment, developmental, social cognitive, and evolutionary theories, and has been viewed as a key aspect of personality pathology in need of clinical attention (e.g., Clarkin & Huprich, 2011, Luyten & Blatt, 2011, Pincus, 2011). A factor analytic study of existing measures of psychosocial functioning found “self-mastery” and “interpersonal and social relationships” to be two of four major factors measured (Ro & Clark, 2009). Furthermore, the Levels of Personality Functioning Scale constructs align well with the NIMH Research Domain Criterion (RDoC) of “social processes” (Sanislow et al., 2010). The interpersonal dimension of personality pathology has been related to attachment and affiliative systems regulated by neuropeptides (Stanley & Siever, 2010), and variation in the encoding of receptors for these neuropeptides may contribute to variation in complex human social behavior and social cognition, such as trust, altruism, social bonding, and the ability to infer the emotional state of others (Donaldson & Young, 2008). Neural instantiations of the “self” and of empathy for others also have been linked to the medial prefrontal cortex (MPFC) and other cortical midline structures (CMS) – the sites of brain’s so-called “default network” (Fair et al., 2008, Northoff et al., 2006, Preston et al., 2007).

PATHOLOGICAL PERSONALITY TRAITS

The proposed model represents an extension of the Five Factor Model (FFM; Costa & Widiger, 2002) of personality that specifically delineates and encompasses the more extreme and maladaptive personality variants necessary to capture dispositional features of PDs. The model includes five broad, higher-order personality trait domains – negative affectivity, detachment, antagonism, disinhibition, and psychoticism – each comprised of from 3 to 9 lower-order, more specific trait facets that help flesh out the domains (e.g., manipulativeness and callousness are specific facets in the antagonism domain; Krueger & Eaton, 2010; Krueger et al., 2011a; Krueger et al., 2011b; Krueger et al., in press; Wright et al., in press b). Trait domains and facets are rated by clinicians on 4-point dimensional scales of descriptiveness and patient-report and lay informant-report forms have also been developed. The structural validity of the original 37 trait model was tested in a three-wave community survey (Krueger et al. 2011b, Krueger et al., in press) and subsequently revised to yield the 5 domain/25 trait model on which the newly proposed diagnostic criteria for PDs are based.

Considerable evidence relates current DSM-IV PDs to the five-factor model (FFM) of personality in meaningful ways (O’Connor, 2005; Saulsman & Page, 2004; Samuel & Widiger, 2008). Indeed, the pathological extension of the FFM proposed for DSM-5 captures the reliable variation in DSM-IV PDs;
multiple correlations between the DSM-5 traits and DSM-IV PDs slated for retention in DSM-5 ranged from .62 to .75 (Hopwood et al., in press). In addition, the traits proposed for DSM-5 are consistently associated with generalized interpersonal dysfunction, underlining both their clinical relevance and their direct connection to the core interpersonal aspect of personality pathology. The proposed DSM-5 traits predict specific forms of interpersonal behavior in accordance with the rich clinical and empirical literature on individual differences in clinically relevant interpersonal problems (Wright et al., in press a).

A multi-dimensional system for the description of dispositions that underlie PDs helps to reduce or even resolve excessive comorbidity by acknowledging that individuals meet criteria for multiple PD diagnoses because the personality traits that make up PDs overlap across diagnoses. Traits can combine in any number of ways in specific patients. As a direct result, a PD diagnostic system that uses traits as a substantial component of the diagnostic criteria provides a means to describe the personality pathology of every patient, thus addressing the high prevalence of PDNOS diagnoses. The diagnostic category of PD-TS is designed to accommodate the naturally occurring heterogeneity of PDs, and the personality features within PD-TS can be fully specified.

A trait-based system for PD diagnosis also provides the beneficial option of assessing any patient’s personality (i.e., not just those with PD). Insofar as personality has been shown to be an important modifier of a wide range of clinical phenomena and a source of dysfunction (e.g., Rapee, 2002; Roberts et al., 2007; Lahey, 2009), and is associated with economic costs exceeding those of many mental disorders themselves (Cuijpers et al., 2010), incorporating a dimensional trait model will strengthen not only PD diagnosis, but DSM-5-based assessment as a whole.

Both normal and abnormal personality trait domains are moderately heritable: estimates are usually around 50% (Bouchard & Loehlin, 2001; Jang et al., 1996), but slightly lower for trait facets (Livesley et al., 1993). Traits also show clear temperamental antecedents (Shiner, 2005). By school age, children’s personality structure is similar to adults (Shiner, 2009; Tackett, Balsis, Oltmanns, & Krueger, 2009), and as early as age 3 years, personality traits are moderately stable and their stability increases across the lifespan until at least age 50 (Roberts & DelVecchio, 2000). Basing PD diagnostic criteria on more stable traits, and considering the more state-like features that occur in individuals with PD to be associated symptom expressions of underlying trait dispositions should help eliminate the conceptual-empirical gap in PD temporal stability (Grilo et al., 2004; Shea et al., 2002).

The personality trait domains all had very good test-retest reliability in the Field Trials, as measured by a 36-item self-report Patient Rated Personality Scale (ICCs as follows: negative affectivity=.842, antagonism=.765, detachment=.817, disinhibition=.810, compulsivity=.825, psychoticism=.822, overall score=.857).

PERSONALITY DISORDER TYPES
New diagnostic criteria are proposed for six specific personality disorder types: antisocial (ASPD), avoidant (AVPD), borderline (BPD), narcissistic (NPD), obsessive-compulsive (OCPD), and schizotypal (STPD). Each type is defined by typical impairments in personality functioning (criterion “A”) and particular sets of pathological personality traits (criterion “B”). The other DSM-IV PDs (paranoid, schizoid, histrionic, and dependent), DSM Appendix PDs, and the residual category of PDNOS are diagnosed in the DSM-5 proposal with personality disorder-trait specified (PD-TS) (Skodol, in press), which is represented by significant impairment in personality functioning, combined with specification by pathological personality traits based on individuals’ most prominent descriptive features.

Antisocial, borderline, and schizotypal PDs have the most extensive empirical evidence of validity and clinical utility (Blashfield & Intoccia, 2000, Morey & Stagner, in press). In contrast, there are almost no empirical studies focused explicitly on paranoid, schizoid, or histrionic PDs. The rationales for retaining most of the 6 out of 10 DSM-IV PDs (Skodol et al., 2011) were based on their prevalence (and its consistency) in community and clinical populations, associated functional impairment, treatment and prognostic significance, and for PDs where information is available, neurobiological and genetic studies. Moreover, the DSM-IV-TR PDs for which the P&PD WG elected not to provide full descriptions for these DSM-IV-TR diagnoses were characterized by the simplicity of their trait composition (e.g., the single trait facet of suspiciousness in the DSM-5 model captures all of the DSM-IV-TR paranoid PD criteria).

Avoidant personality disorder (AVPD) and obsessive-compulsive personality disorder (OCPD), are consistently among the most common in both epidemiological (Torgersen 2009) and clinical (Stuart et al. 1998, Zimmerman et al. 2005) samples. BPD has an average prevalence (among the DSM-IV PDs) in community studies, but is one of the most common in clinical settings. STPD has relatively low prevalence in both populations, but is highly impairing. ASPD is less common, but has considerable individual and collective impact on society and related relevance in forensic settings. NPD is among the less common PDs, but constructs of narcissism have utility in treatment planning.

All DSM-IV PDs have moderate heritability (Coolidge et al., 2001; Kendler et al., 2006; Reichborn-Kjennerud et al., 2007; Torgersen et al., 2000; 2008), however estimates are inconsistent across samples. Behavior genetics evidence supports at least 5 of the 6 PD types retained for DSM-5 (the exception being NPD). STPD has been found to have the strongest loadings on genetic and environmental risk factors among DSM-IV Cluster A PDs (Kendler et al., 2006); ASPD and BPD have a second genetic and non-shared environmental factor over and above the genetic factor influencing all Cluster B disorders (Torgersen et al., 2008); and in Cluster C, AVPD has been found to be more heritable than dependent PD and OCPD has disorder-specific genetic influence not found for the other two PDs (Reichborn-Kjennerud et al., 2007). The retained PD types also have been associated with increased rate of various types of abuse and neglect in both prospective (e.g., Johnson et al, 1999; Widom, 1989) and retrospective (e.g., Battle et al., 2004; Zanarini et al., 1997) studies. The PDs are associated with high and persistent degrees of functional impairment (Skodol et al., 2002; 2005) and many are associated with
an increased risk for suicidal behavior (Oldham, 2006). They also are associated with poorer outcomes of a range of mood, anxiety, and substance use disorders (Grilo et al., 2005; 2010; Skodol et al., 2011; Ansell et al., 2011; Hasin et al., 2011; Fenton et al., in press).

The new criteria for borderline PD were rated with moderately good reliability in the DSM-5 Field Trials (pooled interclass kappa = .582), despite a monothetic B criterion requiring 7 of 7 traits for a diagnosis. Subsequent analyses suggest that a polythetic rule for the B criterion requiring 4 or 5 or greater of the trait facets would improve reliability and increase correspondence with DSM-IV diagnosis. It is important to recognize that the DSM-5 proposal provides a scientifically-based framework in which DSM-IV PD concepts can be represented, meaning that validated aspects of these concepts will have continuity under the new system. As a demonstration, a field study is under way that systematically compares patients (using data provided by a national sample of clinicians) on all DSM-IV and DSM-5 specific PD criteria and dimensions. The correlations between rated criterion counts of DSM-IV and DSM-5 diagnostic concepts from the first 83 patients are as follows: borderline, .81; antisocial, .82, avoidant, .78, narcissistic, .67, obsessive-compulsive, .66, and schizotypal, .58 (the last lower correlation due to range restriction from the limited numbers of patients with schizotypal PD at this point in the study).

In most instances, these values are comparable to the established joint interview reliabilities of these diagnoses under DSM-IV, suggesting that the agreement between DSM-IV and DSM-5 PD diagnoses is likely to be as high as the agreement between two diagnosticians on DSM-IV diagnosis. However, the difference is that, in DSM-5, a coherent framework for representing the potential underlying endophenotypic structure of the PDs is provided, in contrast to the mixed collection of signs, symptoms, traits, and behaviors that comprised the DSM-IV diagnostic criteria.

STABILITY OF PERSONALITY DISORDER

The revised criteria for PD require that the core impairments in personality functioning and the pathological personality traits are relatively stable across time and consistent across situations. This change from a concept of stability to relative stability is motivated by data from prospective follow-along studies in non-patient (Johnson et al., 2000; Lenzenweger, 1999; 2004) and patient studies (Zanarini et al., 2010; 2012; Gunderson et al., 2011) that consistently find that the stability of disorder constructs is considerably less than that implied by DSM-IV and that PDs have a clinical course that tends toward improvement or remission. In addition, both normal and pathological personality traits, while more stable than disorders, still change across the lifespan (Roberts & DelVecchio, 2000). Thus, although shifting to a more trait-based set of criteria is expected to increase stability (Zanarini et al., 2007; McGlashan et al., 2005; Morey et al., 2007; Morey et al., in press), allowing for some change is warranted.

ELIMINATING THE ADOLESCENT CONDUCT DISORDER REQUIREMENT FOR ANTISOCIAL PD

Although PDs in adolescence do not always persist into adulthood, there is substantial evidence that adolescent PDs are as stable as PDs in adulthood (Johnson et al., 2000) and are strong risk factors for later psychopathology, including PD, as well as a wide array of poor outcomes (Bernstein et al., 1993;
Crawford et al., 2005; Skodol et al., 2007). Because the general diagnostic criteria for all DSM-5 PDs require that the impairments in personality functioning and the individual’s personality trait expression are relatively stable across time and consistent across situations, and because there is no evidence that antisocial PD is different from any other form of PD in terms of its psychopathological antecedents in childhood or adolescence (e.g., Kasen et al., 2001), there is no justification (other than “tradition”) for a specific requirement for adolescent conduct disorder.

ELIMINATING THE AXIS I DISORDER EXCLUSION

The revised general (and specific) PD criteria do not require that the pattern of impairments and traits is “not better accounted for as a manifestation or consequence of another mental disorder.” DSM-IV was inconsistent in requiring this across all PDs: paranoid, schizoid, schizotypal, and antisocial PDs were excluded by certain Axis I disorders, whereas the other 6 PDs were not. This change is motivated by the pragmatic observation that such attributions are not easily made, the extensive data on the comorbidity of Axis I and Axis II disorders (e.g., Zimmerman et al., 2005), and heterotypic disorder continuity over time (e.g., Johnson et al., 1999b; Kasen et al., 2001). Finally, in a 6-year longitudinal study of the state effects of major depressive disorder (MDD) on the course of PD diagnosed in the presence of MDD at the index evaluation, outcome was more similar to PD without MDD than to MDD without PD, suggesting that PD diagnoses established during depressive episodes are a valid reflection of personality pathology rather than an artifact of depressed mood (Morey et al., 2010).

Part 4 – Critiques of the Proposed Model and Their Impact on Model Evolution

A number of articles by Work Group members have been published on the proposed model at various stages of its development. Most of these articles have been accompanied by commentaries or critiques written by prominent members of the PD research and clinical communities. In the sections that follow, these critiques are summarized, along with brief accounts of how the critiques have or have not impacted the most recent version of the model as presented above (see also Skodol, 2012). As might be expected, there has been little consensus among those who have critiqued the model and sometimes their views have been diametrically opposed.

LEVELS OF PERSONALITY FUNCTIONING

Critiques of the originally proposed DSM-5 revision generally praised the Levels of Personality Functioning Scale as an advance over DSM-IV (e.g., Shedler et al. 2010, Ronningstam, 2011) and suggested that the presence of PD and its severity are the primary distinctions of importance for clinicians (Pilkonis et al. 2011). Some suggested even broader and more complex constructs for the Levels scale (Clarkin & Huprich 2011, Pilkonis et al. 2011) and separate ratings of all components (Pilkonis et al. 2011). The need for reliability testing was suggested (Pincus 2011). Balancing the need for parsimony for general clinical use against the potential added value of a more complex and potentially redundant set of indicators, the Work Group has simplified rather than elaborated on the Levels scale. A single global
rating of self and interpersonal functioning has been retained, rather than separate ratings, because of evidence of the close developmental and empirical relationships of these components of personality functioning (Luyten & Blatt 2011). The reliability of the rating has been tested in the DSM-5 Field Trials and found to be adequate (see above).

PERSONALITY DISORDER TYPES

Critiques of the DSM-5 proposal have almost universally been against the deletion of any of the DSM-IV PD types, arguing that existing types have clinical utility and treatment relevance (Gunderson 2010, Shedler et al. 2010) or have “heuristic value” (Costa & McCrae 2010; Pilkonis et al. 2011). The empirical basis for retaining vs. deleting types has been questioned (Pincus 2011, Widiger 2011a, Bornstein 2011, Clarkin & Huprich 2011) and it has been suggested that a limited research base does not mean a lack of utility (Gunderson 2010) and should not be a criterion for deletion (Shedler et al. 2010). Deletion of types is anticipated to result in loss of coverage of personality pathology (Widiger 2011a), make comparisons of specific types and trait-specified disorders difficult (Clarkin & Huprich 2011), and may lead to coding problems (Widiger 2011a, First 2010). By far the most support for a PD to be reintroduced into the system (including from the comments posted on the Website) has been for narcissistic PD (e.g., Pincus 2011, Ronningstam 2011), but dependent PD has also had advocates (Bornstein 2011), even though the evidence presented for the validity of both of these disorders has often been based on dimensional measures, rather than on the diagnostic category. Proponents for narcissistic PD agree, however, that its current representation in DSM-IV is inadequate and that a revised category should include both grandiose and vulnerable aspects. Pilkonis et al. (2011) argued for the inclusion in DSM-5 of PD types that have appeared in any DSM since DSM-III.

Work Group members have developed the strong, consensus opinion not to include all of the DSM-IV-TR PDs in the official DSM-5 classification. In fact, some members have persisted in wanting to replace all of the current disorders with a dimensional, trait-based model. The majority of the members believe that there are certain types that have particular clinical salience and evidence of validity as types and that other PDs with less evidence supporting them can be adequately represented by traits in combination with impairments in personality functioning, i.e., as PD-trait specified. This convention not only makes the question of inadequate coverage or “false negative” PD diagnoses moot, but also adds potentially useful clinical information about the nature of personality pathology for the prevalent diagnosis of PDNOS, which in DSM-IV-TR was unspecified. As mentioned above, however, a revised category of narcissistic PD has been reintroduced at the time of this writing, despite some ambiguity in the strength of the rationale for doing so. Criteria sets may be developed for other DSM-IV-TR PDs, using the core impairment/trait hybrid model, for DSM-5 Section III, in the hope that they will receive greater research attention in the future.

Reaction to the originally proposed shift from criterion-based to prototype-based diagnosis was more mixed. A number of reviewers supported the prototype approach because it is simple and more
familiar (types than traits) (First 2010), conforms to “what clinicians do” (Clarkin & Huprich 2011), and is judged to be more clinically useful than criterion-based or trait-based diagnosis (First 2010, Shedler et al. 2010), and have suggested that prototypes replace categories in DSM-5. Questions were raised about the reliability of prototype ratings, however, and further testing of their reliability and validity in field trials was recommended (Pilkonis et al. 2011, Widiger 2011a, Zimmerman 2011). In a related vein, since there were originally no “criteria” per se for the PD types, their utility for research was questioned (Widiger 2011, Zimmerman 2011). The derivation of the type descriptions and their relationships to DSM-IV PD criteria sets have been questioned (Pilkonis et al. 2011), as was the impact of a shift to prototypes on prevalence and comorbidity of PDs (Zimmerman 2011).

Most critics believe that the originally proposed linking of traits to types was ambiguous and without an empirical basis and that traits should be rated separately from the types (Costa & McCrae 2010, Pincus 2011, Pilkonis et al. 2011). Some believe that trait ratings should be the basis for rating the types (Costa & McCrae 2010); some believe that the traits needed better “rule-based” methods for translating traits to types and that both types and traits should be “optional,” finer-grained distinctions (after PD presence and severity) (Pilkonis et al. 2011), some suggest they be an optional rating on a separate axis (Axis II) (First 2010, Widiger 2011a), and some thought that they were not needed at all (Gunderson 2010, First 2010, Shedler et al. 2010).

Pilkonis et al. (2011) questioned whether the hybrid model (types and traits) was of limited value or, in fact, had the best potential for representing personality pathology (see also Hallquist & Pilkonis 2010). Livesley (2011) recently questioned whether the combination of categorical types and dimensional traits mixed incompatible approaches to classification. Historically, others (e.g., Benjamin 1993; Blashfield, 1993) have not seen the inconsistency and experts in personality disorder have explicitly endorsed such a model (Bernstein et al. 2007). PD types represent the confluence of clinically relevant personality characteristics – impairments in personality functioning and traits – that have come to facilitate communication between clinicians and have particular developmental, treatment, and prognostic significance.

In the most recent revision of the model, narrative prototypes have been replaced by diagnostic criteria sets, at the request of the DSM-5 Task Force. The new criteria sets incorporate trait ratings (with core impairments) based on empirical data linking traits to types (Samuel & Widiger 2008, Saulsman & Page 2004) and rational methods, which may delight some critics, while discouraging others. It remains possible that further revisions of the criteria sets will be indicated. Furthermore, scoring rules for the new criteria and diagnostic algorithms for the disorders need to be developed and their impact on the prevalence and reliability of the disorders assessed. Data has been and is being collected and analyzed to inform these decisions (see above).

PERSONALITY TRAITS
Published critiques of the originally proposed trait system were predominantly negative. According to Gunderson (2010), the 6 factor/37 facet trait system would be unfamiliar to clinicians and unlikely to be used because the traits lacked an experiential or empirical basis for clinical salience (Gunderson 2010). Although it may represent a factor structure that is scientific, he believed there was an insufficient research base regarding cut-points for diagnosis, the relationship of the model to other trait models, the delineation of the facet level traits, the mapping of the traits onto PDs, a consensus on the optimal number of traits and their definitions, and their use for making clinical inferences (Gunderson 2010). The traits were also criticized for being non-specific in that the same trait may apply to many types (First 2010, Paris 2011), inherently ambiguous, static (as opposed to dynamic) representations of personality, difficult to incorporate into coding systems, and of uncertain clinical utility (First 2010).

Limited clinical utility was also raised as a problem by Shedler et al. (2010), who noted that clinicians judged dimensional trait systems as less useful than DSM-IV, and by Clarkin & Huprich (2011), who believed that clinicians do not assess traits and that traits would impede communication. Bornstein (2011) also bemoaned the loss of useful short-hand diagnostic labels.

Ronninstam (2011) found the trait representation of narcissistic PD to be scattered (across domains) in a way that interfered with the perception of an integrated, clinically meaningful concept, to be missing important traits, and to include facet traits with definitions that were neither clinically meaningful, nor empirically representative. Pincus (2011) echoed that the traits provided for narcissistic PD were too narrow, believed that some trait definitions were confounded with interpersonal elements, and noted that there was no empirical basis for reconstructing deleted types from traits. Shedler et al. (2010) also believed combinations of traits would not easily yield omitted PD types. The recommendation from First (2010) is that a variable-centered trait approach should not replace categories in DSM-5, but could be on a separate axis (Axis II). Costa & McCrae (2010) argued that the notion of personality dimensions as adjuncts to PD types is supported and that traits should be assessed in all patients, not just those with PDs.

Pilkonis et al. (2011) said that, although the emphasis on personality traits as a basis for diagnosis was well-founded, traits (and types) were “finer” distinctions that should be secondary (domain level first, followed by relevant trait facets) to establishing the presence of a PD and its severity. They also found the new trait system and the diagnosis of PD trait-specified to be “jarring.” They found the trait definitions complex and inferential and believe that an assessment tool would be needed. They argued for a detailed translation of traits to types and that PD were not merely extreme traits.

Widiger (2011a) found that the trait definitions were cumbersome and suspected that they would not have official coding. He also argued that there is much redundancy in some of the proposed trait facets, while other key traits were missing, and that the definitions of the traits were very inconsistent, with some defined broadly and others narrowly (Widiger 2011). Both Widiger (2011b) and Shedler et al.
(2010) found the trait system too complex. Paris (2011) wrote that the traits do not map onto biological systems and ignore the emergent properties of cognitive, affective, and behavioral systems in PDs.

The basic structure of the proposed trait system was questioned by several authors. A number of commentators suggested that traits should be bipolar, not unipolar, because pathological personality characteristics exist at both ends of the domain spectra (Costa & McCrae 2010, Widiger 2011a, Widiger 2011b, Pilkonis et al. 2011). The lack of bipolarity to the traits leads to the omission of clinically relevant traits and misplaced (within domains) traits (Widiger 2011a; Widiger 2011b; Pilkonis et al. 2011). Several authors argue that the proposed trait structure does not correspond to the consensus “big 4” and that the domains of compulsivity and schizotypy are not needed (Pincus 2011, Widiger 2011a, Widiger 2011b). Several authors also argue for the importance of including both normal and abnormal traits in DSM-5 and believe that the FFM does a better job at representing important personality variation than the proposed new model (Costa & McCrae 2010, Widiger 2011a, Widiger 2011b). Finally, limitations and ambiguities in factor analytic methods to derive trait structures were mentioned by several authors (Hallquist & Pilkonis 2010, Clarkin & Huprich 2011).

The overall structure of the revised 5 domain/25 facet system does correspond to the “big-four” domains characterizing other trait models, with compulsivity representing the opposite pole of a bipolar domain of disinhibition. Several studies have demonstrated that psychoticism forms an important additional factor in analyses of both normal and abnormal personality (Chmielewski & Watson 2008, Harkness et al. 1995, Tackett et al. 2008, Watson et al. 2008). Therefore, a fifth trait domain was added to the trait model. That there are differences between extant models (including the DSM-5 model) at the facet level should come as no surprise, since there is little consensus on the facet structure of trait domains. Problems with the narcissistic trait representation have been addressed with the new criteria, which combine core “narcissistic” impairments in identity, self-direction, empathy, and intimacy that include both inflated (grandiose) and deflated (vulnerable) expressions and a revised trait of grandiosity that refers to either overt or covert manifestations. PDs are not represented solely by extreme traits in the revised model, since all of the disorder criteria, including those for PD-TS, require impairments in personality functioning as well as the presence of pathological personality traits.

The scoring of traits and diagnostic criteria are open issues. Within the criteria, it is possible that ratings of trait domains will supersede rating of trait facets for diagnostic purposes and that facet ratings will be for more “fine-grained” descriptions. In the Field Trials, raters were asked first to rate domains and only when a domain is rated as relevant are the component facets rated.

An assessment tool for rating DSM-5 personality traits by self-report has been developed: the Personality Inventory for DSM-5 (PID-5) (Krueger et al., in press). This 220-item questionnaire was developed in a three-wave community survey and is currently being tested by a number of research groups across the country. It remains to be seen, however, whether clinicians can rate these traits (and the disorders based on them) reliably and whether they are regarded by clinicians as useful. Both of
these questions are being addressed in the Field Trials. Undoubtedly, training and familiarity will improve reliability. Finally, the clinical salience and utility of pathological personality traits continues to be a topic of debate. Certainly, broad personality trait domains, such as neuroticism (negative affectivity in the DSM-5 proposal) have strong relationships to adverse physical health outcomes (Lahey 2009) and neuroticism, (dis)agreeableness (antagonism in DSM-5) (un)conscientiousness (disinhibition), and extraversion predict both negative and positive psychosocial (Ozer & Benet-Martinez 2006, Roberts et al. 2007) outcomes. Studies of hybrid models of personality disorders (see above) also show that traits increment disorders (and vice versa) in predicting important antecedent, concurrent, and predictive variables. The clinical value of assessing specific trait facets is less established, though theoretically appealing (Verheul, 2005).

GENERAL CRITERIA FOR PERSONALITY DISORDER

As indicated previously, feedback received on the Website posting indicated that these criteria were too complicated, without a sufficiently empirical basis, set at too severe a level of dysfunction, inconsistent with more recent views of personality pathology as developmental “delays” as opposed to “failures,” and not integrated with the other parts of the proposed model. Therefore, these general criteria were simplified and empirically-based assessments of impairment in personality functioning were integrated with pathological personality traits into the new general and specific criteria sets. For all PDs, severity in core impairments can vary on the continuum of the Levels of Personality Functioning Scale. For PD-TS, “significant” impairment is required and a threshold on the Levels scale is being studied in the Field Trials and other data sets.

Integration of the general criteria for PD into the diagnostic process has been viewed as an advance, by distinguishing normality and abnormality separately from describing individual differences (Pincus 2011). The constructs embedded in the proposed general criteria for DSM-5 are consistent with research and many theories of PD, but will require training to be rated reliably. Costa & McCrae (2010) believed that the originally proposed definitions of impairment in self-identity, which emphasized the instability of “borderline” functioning, contradicted data on the internal consistency and stability of self-reported personality traits. All levels of personality functioning are now represented in the A criterion of the general criteria for PD.

Pilkonis and colleagues agreed that PDs should be defined by impairments in functioning and adaptation (not by extreme traits), but thought that the originally proposed criteria were too esoteric, inferential, and narrow (Pilkonis et al. 2011). They advocated for including constructs of agency, community, autonomy, achievement, self-definition (identity vs. confusion), capacity for attachment (intimacy vs. isolation), generativity, and prosocial engagement. Their proposal for general criteria would reflect 1) failure to achieve autonomy and self-direction (with objective markers) and inability to develop consistent and realistic representation of self, 2) failures in interpersonal relatedness manifest by inability to develop and maintain close relationships and general social integration; 3) failures in generativity.
manifest by inability to engage with purpose beyond self-interest and imposition of distress on others. All of the above would be rated separately and the clinician should be able to stop an assessment after establishing presence and severity of PD. Clarkin & Huprich (2011) viewed the originally proposed general criteria as too onerous and lacking a coherent theme, but they believed that a more elaborated rating of severity of impairment in functioning combined with prototypes should be the core of clinical assessment. As in the case of the Levels of Personality Functioning, which now constitute the core impairments central to the personality disorder definition and are represented by the A criteria in the new general and specific diagnostic criteria, the majority of critics favored a simplified, rather than a more elaborated, definition and the empirical support for the four core self and interpersonal elements selected for the revised model has been described above.

FUTURE CHANGES

Following the development of criteria for field testing, no further changes to the model have been made, pending review of new data. Data from the Field Trials and other studies of the trait system and the criteria are now being reviewed with an eye toward “fine tuning” the model, such as by setting optimal and empirically-based thresholds for diagnosis and revisiting the composition of the “B criteria” trait facets for the PD types. This work will be concluded by mid-summer, so that final criteria sets will be available for review by the Task Force before its fall 2012 meeting.

CONCLUSION

The hybrid dimensional-categorical model for PDs proposed for DSM-5 and its components address existing problems with DSM-IV PDs, have considerable evidence supporting their validity, and can be expected to increase clinical utility and promote future research into etiology and treatment.

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

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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 Grigson3 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

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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. The prosecutor told the jury that failing to execute Adams would endanger police officers, “the thin blue line” protecting society from anarchy. 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.

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. 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. It was subsequently revealed that the police manufactured the testimony of the eyewitness who identified Adams as the shooter. She had previously identified someone other than Adams from the line-up, and was told she had selected the wrong person. 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. Adams was a balding Caucasian with a pale complexion. Based on this and other new evidence establishing his innocence, Texas courts set aside Adams’s conviction and released him. The story of his wrongful conviction is told in the documentary, The Thin Blue Line.

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. These and other cases raise serious concerns about the use of

5. See id.
7. Adams, 577 S.W.2d at 731.
11. Id. at 286.
12. Id.
14. Ex parte Adams, 768 S.W.2d at 294.
15. THE THIN BLUE LINE, supra note 6.
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. 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. 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.

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. We conclude that constructs of ASPD or psychopathy should not be used in capital sentencing proceedings because they are unreliable and prejudicial. Until courts begin excluding such evidence, capital defendants are best protected when their defense teams strictly comply with the ABA and 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, dissociative 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.
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\(^\text{28}\) with onset before age 15 years.
D. The occurrence of antisocial behavior is not exclusively during the course of schizophrenia or a manic episode.\(^\text{29}\)

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 contumacious of the . . . rights . . . of others.”\(^\text{30}\) 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.”\(^\text{31}\) 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.\(^\text{32}\) To fully understand the danger of an unreliable diagnosis of ASPD to capitaly 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.\(^\text{33}\) The modern concept of psychopathy is attributed to Hervey Cleckley’s *The Mask of Sanity*, which was published in 1941.\(^\text{34}\) Canadian psychologist Robert Hare, who attempted
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.” 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.”

Hare developed the Psychopathy Checklist (“PCL”) and the Psychopathy Checklist-Revised (“PCL-R”), which have become widely used in forensic settings. His original objective was to develop an instrument that would operationalize the construct of psychopathy. 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.
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

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.”

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.

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.”

Judicial decisions discussing ASPD and psychopathy almost uniformly reflect reliance on the dehumanizing stereotype. In Guinan v. Armontrout, 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.”

The court summarized the impact of the ASPD diagnosis on Guinan’s sentencing profile:

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

This image fits the stereotype of the “typical criminal” which attributes deviant behavior “exclusively to negative traits, malevolent thoughts, and bad moral character.” 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.” 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. 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.


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.” 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 ‘having little in the line of guilt or remorse.” 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. Professor Scott Sundby’s analysis of Capital Jury Project data shows that “a jury that believes the defendant is truly remorseful is very likely to settle on a life sentence.” However, if a jury is convinced that the defendant is antisocial, even his sincere expressions of remorse may be misinterpreted as sociopathic manipulation.

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.” 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.
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. 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.” Welner’s approach reinforces deeply entrenched and misinformed cultural stereotypes of violent offenders. 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.” “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.”

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.” 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.

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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).
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,” the diagnosis is used to exclude the possibility of legally cognizable mental impairment. 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.” Without question, evidence that the defendant has the characteristics associated with ASPD is significantly harmful to his chances for survival. The overwhelming weight of legal authority views evidence that the defendant has ASPD as inherently aggravating.

Third, ASPD is often used as a counter-narrative to major mental illness evidence presented in mitigation. 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(2) (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).


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. McNiel, 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

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⁷⁰See, e.g., Fairbank, 650 F.3d at 1249-50; Reed, 593 F.3d at 1233-34.
⁷¹See 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’”)
⁷²See, 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.
⁷³We 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.\textsuperscript{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.\textsuperscript{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.\textsuperscript{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.”\textsuperscript{79}

\textbf{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.

\textsuperscript{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, \textit{Unresolved Controversies Concerning Psychopathy: Implications for Clinical and Forensic Decision Making}, 37 PROF. PSYCHOL. RES. & PRAC. 59, 59 (2006) [hereinafter Edens, \textit{Unresolved Controversies}].


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

\textsuperscript{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

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

\(\text{81. Id. at 23.}\)

\(\text{82. Id. at 11}-12', 27.\)

\(\text{83. Id. at 23, 26-28.}\)

\(\text{84. See id. at 15-19 (listing the various disorders listed under Axis I).}\)

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

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

\(\text{87. Nick Manning, DSM-IV and Dangerous and Severe Personality Disorder—An Essay, 63 SOC. SCI. & MED. 1960, 1961 (2006). While the DSM-IV cautions that the coding of personality disorders on Axis II “should not be taken to imply that their pathogenesis or range of appropriate treatment is fundamentally different from . . . disorders coded on Axis I,” clinical and research views have often been contrary to this position. DSM-IV-TR, supra note 24, at 26-28.}\)
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 category90 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.


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.


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.\textsuperscript{95} Challenges to the personality disorder classification scheme adopted with the publication of the DSM-III in 1980 appeared almost immediately after its publication\textsuperscript{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.\textsuperscript{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.\textsuperscript{98}

\textsuperscript{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)).

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


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.\(^9\) 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.”\(^1\) These and other concerns fueled efforts for a major reconceptualization of the personality disorders classification in the DSM-5.\(^1\) 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.”\(^1\)

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).”\(^1\) 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

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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].
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.”\textsuperscript{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.\textsuperscript{105}

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

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\bibitem{104} Skodol, Personality Disorders in DSM-5, supra note 97, at 318, 333.
\bibitem{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 comorbidity 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].
\bibitem{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 99, at 26; Skodol et al., Personality Disorder Types Proposed, supra note 97, at 140; Skodol et al., Proposed Changes, supra note 97, at 15.
\bibitem{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,\textsuperscript{111} arbitrary diagnostic thresholds,\textsuperscript{112} lack of clear boundaries between pathological and “normal” personality functioning,\textsuperscript{113} and poor convergent validity.\textsuperscript{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.”\textsuperscript{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.\textsuperscript{116} The final DSM-5 ASPD criteria were not tested despite extensive field

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\textsuperscript{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.

\textsuperscript{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.

\textsuperscript{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).

\textsuperscript{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.

\textsuperscript{115} Rogers & Dion, supra note 92, at 21.

trials, and thus “political and nonempirical considerations appear to have overridden . . . diagnostic validity.”

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. There is also what has been called the “innumeracy problem,” that is, the seemingly innumerable possibilities for reaching threshold for a diagnosis of ASPD. 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. 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.

ASPD is diagnosed in part on criminal history, which means that a large percentage of inmates have been or could be diagnosed with ASPD. 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 commentators 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.


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, [ASPD] 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.” 121

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.\textsuperscript{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.”\textsuperscript{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”\textsuperscript{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.”\textsuperscript{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.\textsuperscript{135} Similarly, a cognitively impaired person might need assistance caring for a child, maintaining


\textsuperscript{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.

\textsuperscript{133} Id.

\textsuperscript{134} Id.

\textsuperscript{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. 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.

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.” 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

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]reate 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).

people in jails and prisons in the United States have a recent history or active symptoms of mental disorder.\textsuperscript{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.\textsuperscript{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.\textsuperscript{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
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.”

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. 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. This has been described as a “major regressive step” because the “DSM has returned to an accusatory judgment rather than a dispassionate clinical formulation.” 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.”

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.
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, and the literature is vast. It has become the subject of intense debate, and many questions remain unresolved. 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.” While a number of risk assessment instruments have been developed, the PCL-R is the instrument most often used to assess an individual’s risk of future dangerousness. 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. ABNORM. 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).


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.”).


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.”\textsuperscript{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,”\textsuperscript{154} that the PCL-R is “unparalleled as a measure for making risk assessments,”\textsuperscript{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).”\textsuperscript{156}

On the other hand, critics argue that psychopathy is “an elusive concept with moral overtones”\textsuperscript{157} that “remains a mythical entity,” which “should be discarded”\textsuperscript{158} because “diagnostic groupings . . . seldom have sharp and definite limits[,] . . . worst of all is psychopathic personality.”\textsuperscript{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.”\textsuperscript{160} Although proponents of the psychopathy construct, as defined by the PCL-R, strongly advocated for its inclusion

\textsuperscript{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).

\textsuperscript{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).


\textsuperscript{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).

\textsuperscript{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).


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

\textsuperscript{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.\textsuperscript{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.\textsuperscript{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.\textsuperscript{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.\textsuperscript{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”;\textsuperscript{165} “Where the Psychopath Goes, 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”; “Psychopaths Cannot Be Treated”; “Clinical Evaluations of Psychopathy Are Highly Reliable” and “Psychopaths Are Qualitatively Different from Other Offenders.”

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.”

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. 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.” 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.

While earlier research supported the view “that there are fundamental, qualitative differences between psychopaths and nonpsychopaths,” an increasing body of literature indicates that psychopathy is, in fact, a dimensional, rather than categorical, construct (or taxon). 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. Id. 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 et 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. Id. at 575, 582.
174. Id. 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
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

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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. 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. 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. 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.

Another issue of the utmost significance in capital litigation is that the PCL-R has demonstrated minimal ability to predict future violence in prison, 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.

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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.


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.

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].”\textsuperscript{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 problem 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.\textsuperscript{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,\textsuperscript{194} determinations of psychopathy can be made without a clinician even meeting the test subject.\textsuperscript{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.”\textsuperscript{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

\textsuperscript{192} Edens, \textit{Unresolved Controversies}, supra note 76, at 61.
\textsuperscript{193} Martens, \textit{ 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., \textit{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.” \textit{Id.} at 61. “These data clearly call into question the validity of expert testimony asserting that capital defendants are continuing threats to society.” \textit{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.” \textit{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.” \textit{Id.}
\textsuperscript{194} ROBERT D. HARE ET AL., \textit{OXFORD TEXTBOOK OF PSYCHOPATHOLOGY} 557 (Theodore Millon et al. eds., 1999).
\textsuperscript{195} Walters et al., \textit{ supra} note 175, at 336.
\textsuperscript{196} Edens, \textit{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

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 inconsistencies 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.
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.  

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. 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. Hare notes that “[t]he PCL-R Manual . . . outlines recommended qualifications for clinical use of the instrument.” 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.” 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, 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.”

Further, Hare has raised concerns about conceptual confusion, or conflation of the construct of psychopathy, with the diagnosis of ASPD. 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. “This is a very misleading practice” because “most individuals with

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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.
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. Boeacecini 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. 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.”

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 . . . .”

Evaluator bias appears to be attributable to at least two independent sources of error.” Several studies suggest that individual differences in evaluators may account for some of the variability in PCL-R scores in forensic proceedings. In addition, some PCL-R items are clearly more subjective than others. 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. Possible explanations include differences in raters’ own subjective thresholds for Factor 1 items (reflecting interpersonal/affective traits) and differences in how


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.  

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.” 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. Similar concerns have been raised by the National Research Council (“NRC”) about the reliability of commonly accepted forensic science techniques, 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.

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. 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.


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
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.
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. 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. 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. 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.


240. See, e.g., Bersoff, supra note 77, at 571; Cunningham & Reidy, supra 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.\textsuperscript{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.\textsuperscript{242} This may explain the increasing use of such evidence by the prosecution.\textsuperscript{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.”\textsuperscript{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,”\textsuperscript{245} Edens and his colleagues “recommend that forensic examiners avoid using it in capital trials.”\textsuperscript{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

\textsuperscript{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.
\textsuperscript{243} DeMatteo & Edens, supra note 220, at 232.
\textsuperscript{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).
\textsuperscript{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.
\textsuperscript{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 . . . ."\(^\text{247}\)

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.\(^\text{248}\)

In sum, serious ethical questions have been raised about whether the PCL-R provides any probative value in capital sentencing procedures.\(^\text{249}\) 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.”\(^\text{250}\) In fact, when laypersons attribute psychopathic traits to capital defendants, this strongly predicts their support for decisions to execute them.\(^\text{251}\)

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.

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.”

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. 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.” 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:

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.

Welner contends that, “mingling the ‘what’ of a crime” with mitigating circumstances “undercuts an unbiased, equal justice.” 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.” 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.”

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.”).
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).
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.\textsuperscript{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”\textsuperscript{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.”\textsuperscript{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.”\textsuperscript{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.”\textsuperscript{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.

\textsuperscript{261} See also Welner, supra note 57, at 417.
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 would 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. Id. 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.\textsuperscript{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:

\[\text{[I]t is not difficult to imagine a scenario in which the results of a legal adjudication of evil include discrimination against poor or disadvantaged individuals. . . .}\]

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?\textsuperscript{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.\textsuperscript{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

\textsuperscript{272} \textit{Id.} at 112 (citation omitted) (footnote omitted).

\textsuperscript{273} \textit{Id.} at 110 (footnote omitted).

\textsuperscript{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?)." \textit{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." \textit{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.\textsuperscript{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.”\textsuperscript{276} As Edens and his colleagues suggest, perhaps the time has come to do so.\textsuperscript{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.”\textsuperscript{278} Prevailing standards governing the performance of defense counsel in the post-\textit{Furman}\textsuperscript{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.\textsuperscript{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.”\textsuperscript{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.\textsuperscript{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.

\begin{itemize}
\item \textsuperscript{276} \textit{Id}. at 896.
\item \textsuperscript{277} Edens et al., \textit{Predictions}, supra note 77, at 76-77.
\item \textsuperscript{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)).
\item \textsuperscript{279} \textit{Furman} v. Georgia, 408 U.S. 238 (1972).
\item \textsuperscript{280} \textit{ABA GUIDELINES}, supra note 18, Guideline 1.1 cmt., at 926-27.
\item \textsuperscript{281} Powell v. Alabama, 287 U.S. 45, 69 (1932).
\item \textsuperscript{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)).
\end{itemize}
A. “Defense Fail”

Justice Ruth Bader Ginsburg observed that “[p]eople who are well represented at trial do not get the death penalty.” 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.

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.”

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. The vast majority of these cases ended in a more favorable disposition for the defendant after remand. Our research reflects that

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. Beard288 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

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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.” 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. 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. 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.

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. It is

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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.\textsuperscript{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.\textsuperscript{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.”\textsuperscript{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,

\textsuperscript{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).

\textsuperscript{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.").

\textsuperscript{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.\textsuperscript{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.\textsuperscript{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.\textsuperscript{305} Competent evaluation requires a thorough patient history, including a family history going back at least three generations.\textsuperscript{306} Assessing DSM-5 diagnostic criteria for personality disorders requires evaluation of long-term functioning,\textsuperscript{307} and performance standards recognize that it is necessary to conduct multiple interviews over a span of time.\textsuperscript{308} Before a behavior

\textsuperscript{303} Woods et al., supra note 74, at 433.

\textsuperscript{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.

\textsuperscript{305} DSM-5, supra note 24, at 662.


\textsuperscript{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).

\textsuperscript{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 SYNOPTIC 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. Even Cleckley, the influential proponent of the modern construct of psychopathy, argues strongly for differential diagnosis.

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. 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.” Therefore, a thorough understanding of the cultural influences in the client’s life is essential to an accurate mental health assessment.

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.

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.

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.

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.

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.

See generally Holdman & Seeds, supra note 105.

DSM-5, supra note 24, at 648, 662.
disorders, substance intoxication)\textsuperscript{315} or are associated with acculturation after immigration.\textsuperscript{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.\textsuperscript{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.\textsuperscript{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.”\textsuperscript{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.\textsuperscript{320} In addition, symptoms cannot be attributed to ASPD if the client’s behavior occurred exclusively during the course of schizophrenia or a manic

\textsuperscript{315} Id. at 647.
\textsuperscript{316} Id. at 648.
\textsuperscript{317} Id. at 649.
\textsuperscript{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).

\textsuperscript{319} DSM-5, supra note 24, at 662.
\textsuperscript{320} DSM-IV-TR, supra note 24, at 702.
episode. Thus, ASPD cannot be diagnosed if the “enduring pattern” of antisocial behavior occurs only during the course of several other serious Axis I disorders.

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,” 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.”

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. 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, 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. 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. 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. 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.” 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. 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. 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. It is also possible that the client may be innocent of an offense listed on his criminal record, 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).


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)).


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. 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). Others have been subjected to coercive interrogation procedures, to which highly suggestible, gullible, developmentally delayed, traumatized, and youthful clients are very vulnerable. 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.

2. “Deceitfulness, as indicated by repeated lying, use of aliases, or conning others for personal profit or pleasure.”

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).


337. See GISLI H. GUDJOHNSSON, 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 SUPERFLY APPROPRIATE 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, 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. Mood symptoms, such as grandiosity, may distort the client’s perception of self and others. Victims of extreme or chronic trauma, including abuse victims, may make statements that are inconsistent with reality for the purpose of self-protection. As a coping strategy of chronic abuse, victims often learn to “lie” as part of a protective survival strategy. 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—or symptoms of brain dysfunction—such as memory impairments—where clients may confabulate to mask severe impairments.

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. He also denied that his parents abused him. 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. 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.
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.”\(^\text{350}\) 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.\(^\text{351}\) 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.\(^\text{352}\) Of course, Rompilla’s borderline mental retardation may also explain his failure to provide accurate and correct information about his upbringing.\(^\text{353}\)

3. “Impulsivity or failure to plan ahead.”\(^\text{354}\)

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.\(^\text{355}\) 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.”\(^\text{356}\) A client with PTSD might display hyperarousal responses to traumatic triggers that are immediate and seemingly inexplicable if the context is not understood,\(^\text{357}\) or may be displaying behaviors that reflect a foreshortened sense of future, a symptom frequently seen in highly traumatized individuals.\(^\text{358}\)

“Impulsivity and failure to plan ahead” may also be explained by the

\(^\text{350}\) Id. at 392.
\(^\text{351}\) Wayland, supra note 318, at 942 n.82.
\(^\text{354}\) DSM-5, supra note 24, at 659.
\(^\text{355}\) 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.
\(^\text{357}\) For example, PTSD symptoms may include self-destructive and impulsive behavior, impairs affect modulation, and difficulty completing tasks. DSM-5, supra note 24, at 271-72.
\(^\text{358}\) 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.\textsuperscript{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.\textsuperscript{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.\textsuperscript{361}

4. “Irritability and aggressiveness, as indicated by repeated physical fights or assaults.”\textsuperscript{362}

Context is critically important to understanding the origins of what may be called “irritability and aggression.”\textsuperscript{363} Such behaviors may reflect the hyperarousal component of traumatic stress responses,\textsuperscript{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.\textsuperscript{365} Irritability and aggressiveness can also result from exposure to environmental toxins, such as chemicals, lead or other heavy metals.\textsuperscript{366} In addition, evidence of

\textsuperscript{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.

\textsuperscript{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.

\textsuperscript{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).

\textsuperscript{362} DSM-5, supra note 24, at 659.

\textsuperscript{363} Id. at 660.

\textsuperscript{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.

\textsuperscript{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.

“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).
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. 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.”

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. 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. 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.”

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. For example, psychic numbing is a hallmark symptom of PTSD. Flat affect is often seen in severe mental disorders such as mood disorders (for example, major depression) or psychotic disorders (for example, schizophrenia). 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. 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. 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.
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. Finally, absence of the expression of remorse may reflect the fact that an individual has been falsely charged or falsely convicted of a crime.

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.” All clinicians recognize that “during manic or hypomanic episodes, many individuals commit antisocial acts, violent and non-violent.”

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.” 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?” 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

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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.”).


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.


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? 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.

Finally, Martens is critical of the “[l]ack of realistic, long-term goals” criterion. He asks, “[w]hat are realistic long-term goals?” 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.” 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),” 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).  

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.”

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). 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.
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.”

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.”

V. CONCLUSION

In summary, there are enormous contextual problems that plague mental health evaluations and prosecutorial characterizations of individuals who are capitaly 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.

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. 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.
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.” Haney explains that this “is why ‘humanizing’ capital clients is so important in penalty trials.”

Put simply, every capital defendant possesses “the possibility of compassionate or mitigating factors stemming from the diverse frailties of humankind.” 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.” 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. 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].


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.


The social history of the defendant has become the primary vehicle with which to correct the misinformed and badly skewed vision of the capital jury.\textsuperscript{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.

\textsuperscript{409} Haney, \textit{The Social Context}, \textit{supra} note 43, 559-60.