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THE IMPORTANCE OF RECOGNIZING TRAUMA THROUGHOUT CAPITAL MITIGATION INVESTIGATIONS AND PRESENTATIONS

*Kathleen Wayland**

I. INTRODUCTION

Psychological trauma lies at the heart of death penalty cases. This is most immediately and obviously true because of the unspeakable grief and irrevocably altered lives that follow the loss of a loved one to homicide. But it is also an almost universal feature of the lives of capitally charged and convicted defendants.[1] Assessing the role of trauma is (or should be) an essential component of any competent mitigation investigation and any competent assessment of mental health

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1. A close look at who is on death row in the United States is a helpful starting point in identifying the population of people who are at issue in this Article. Information compiled by the NAACP Legal Defense Fund, as of January 2007, indicates that there were 3350 people under sentence of death in this country. Most of them are men (98%), and 55% of those on death row are people of color (42% African American, 11% Latina/Latino, 1% Native American, and 1% Asian). DEBORAH FINS, NAACP LEGAL DEF. & EDUC. FUND, DEATH ROW U.S.A. 1 (2007). Poverty and exposure to trauma are almost universal facts among the life histories of people on death row. Russell Stetler, *Mitigation Evidence in Death Penalty Cases*, CHAMPION, Jan.-Feb. 1999, at 35, 36-37. Many clients also have multi-generational family histories of mental illness, and themselves suffer from mental illness. *Id.* at 36.

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issues in a capital case. Sadly, many clients on death row across the country—clients with trauma histories of extraordinary severity and chronicity—had little or no information about these histories presented at trial. Others had some limited information provided, but that information was incomplete, poorly developed and presented, and lacked a coherent explanation or expert guidance as to its significance and the unique psychological factors that rendered them so disabled. Still others suffered a complete breakdown in their relationships with defense teams, caused in part by the team's failure to understand the unique aspects of their client's history, background, and culture.[2]

Information about a client's traumatic experiences constitutes legally compelling evidence in the disposition of capital cases. In *Williams v. Taylor*,[3] the United States Supreme Court found that trial counsel was ineffective for failure to investigate and present this kind of trauma history:

> [Counsel] failed to conduct an investigation that would have uncovered extensive records graphically describing Williams' nightmarish childhood . . . . Had they done so, the jury would have learned that Williams' parents had been imprisoned for the criminal neglect of Williams and his siblings, that Williams had been severely and repeatedly beaten by his father, that he had been committed to the custody of the social services bureau for two years during his parents' incarceration (including one stint in an abusive foster home), and then,

2. A comprehensive understanding of a client's social history must always consider the unique aspects of that client's cultural background in its broadest context, including issues of race, ethnicity, gender, sexual orientation, and community. Culture, which has been defined as "local worlds of everyday experience," is realized in daily (intergenerational) patterns of life activities (for example, customs and rituals of social and community life, common cultural models of the world, shared understandings of causality, people, and phenomena such as illness and health). CULTURE AND PSYCHIATRIC DIAGNOSIS: A DSM-IV PERSPECTIVE 16 (Juan E. Mezzich et al. eds., 1996); *see* Scharlette Holdman & Christopher Seeds, *Cultural Competency in Capital Mitigation*, 36 HOFSTRA L. REV. 883 (2008). To fully understand a client's cultural background, multiple levels of analysis are needed. Such an analysis might include fact development within an oral historian/cultural model, which strives for nested levels of understanding about the individual, his or her family, the community or communities in which he or she has lived, and the larger world or worlds. A public mental health model might also be used, where nested levels of risk factors are considered in placing a client's social history within the perspective of political, economic, societal, and demographic variables that influenced his or her life. Overall, while the conceptual framework used may vary from one case to another, a full development and understanding of mental health problems experienced by a particular client can only be understood within the framework of the larger context(s) in which he or she developed.

3. 529 U.S. 362 (2000).

after his parents were released from prison, had been returned to his parents' custody.[4]

Similarly, in *Wiggins v. Smith*,[5] the Supreme Court specifically addressed the trauma history of Mr. Wiggins and the relevance of early trauma to critical legal claims:

> The mitigating evidence counsel failed to discover and present in this case is powerful. . . . Wiggins experienced severe privation and abuse in the first six years of his life while in the custody of his alcoholic, absentee mother. He suffered physical torment, sexual molestation, and repeated rape during his subsequent years in foster care. The time Wiggins spent homeless, along with his diminished mental capacities, further augment his mitigation case. Petitioner thus has the kind of troubled history we have declared relevant to assessing a defendant's moral culpability.[6]

Despite the legal significance of a client's traumatic experiences, barriers to developing and presenting a capital client's trauma history are numerous, and include the too-often negative attitude of the public and fact-finders, who may have a jaded view of trauma and thus minimize or reject trauma-related information. Cynicism about the presentation of trauma and abuse histories in the capital context is perhaps most succinctly captured in the public's mind by the phrase coined by Alan Dershowitz: "the abuse excuse."[7]

Additional barriers to the development and presentation of trauma histories include impairments of individual clients. The United States Supreme Court acknowledged this phenomenon in a recent case, *Rompilla v. Beard*,[8] noting that trial counsel had not investigated obvious signs "that Rompilla had a troubled childhood and suffered from mental illness and alcoholism, *and instead relied unjustifiably on Rompilla's own description of an unexceptional background.*"[9] The court explicitly acknowledged that counsel must not rely simply on

4. *Id.* at 395 (footnote omitted).

5. 539 U.S. 510 (2003).

6. *Id.* at 534-35.

7. ALAN M. DERSHOWITZ, THE ABUSE EXCUSE: AND OTHER COP-OUTS, SOB STORIES, AND EVASIONS OF RESPONSIBILITY 45-47 (1994) (arguing that the use of abuse as a legal defense undercuts the legal system and diminishes concepts of personal responsibility). In introducing the idea that abuse is used as an excuse or evasion of responsibility, Dershowitz contributed greatly to confusion about a core principle of mitigation presentation in capital jurisprudence. Mitigation evidence is *never* a legal excuse of the capital offense. It is the explanation that jurors need to make a reasoned moral decision about whether a client should live or die.

8. 545 U.S. 374 (2005).

9. *Id.* at 379 (emphasis added).

client self report,[10] and must pursue other avenues of inquiry as part of a competent mitigation investigation.[11]

Finally, many barriers to developing trauma histories arise from limitations in the knowledge and skills of defense teams. In this area, problems may include lack of a comprehensive understanding of the dynamics and effects of trauma; failure to fully investigate and assess the wide range of experiences, responses, and symptoms that must be included in a comprehensive trauma history; and failure to integrate that history in the context of existing psychological literature in order to explain its significance for a particular client. Barriers also arise when the defense team is not fully educated about the unique aspects of their client's cultural background and the implications that has for social history investigation and mental health evaluation.

Unfortunately, these barriers can result in the failure of capital defense teams to uncover compelling and reliable mitigating evidence of trauma and its effects on the defendant. In *Rompilla*, for example, defense lawyers hired psychologists and repeatedly interviewed the client's family, but neither Rompilla nor his family disclosed the fact of his upbringing by alcoholic parents, or his mental problems.[12] Consequently, the jury sentenced him to die without the benefit of information that any scrupulous person would consider essential to a fair and reliable verdict.[13] To prevent such deadly mistakes, competent capital defense teams will engage the services of a mitigation specialist who is skilled at conducting investigation in a way that overcomes these often powerful barriers to disclosure. The *Supplementary Guidelines for the Mitigation Function of Defense Teams in Death Penalty Cases* ("Supplementary Guidelines") articulate the long-accepted standards for performance of this crucial and complex function.[14]

The underlying premise of this Article is that a rich understanding of the complexities of psychological trauma is crucial for the development and presentation of mitigation evidence related to exposure to traumatic events. Such an understanding should inform and guide the investigation and presentation of that evidence and will aid in validating

10. *Id.* at 377. This is of particular relevance for people with histories of trauma, given a host of potential barriers to disclosure of traumatic experiences, as will be discussed in detail below.

11. *Id.*

12. Rompilla v. Horn, 355 F.3d 233, 241 (3d Cir. 2004), *rev'd*, 545 U.S. 374 (2005).

13. *Rompilla*, 545 U.S. at 393.

14. SUPPLEMENTARY GUIDELINES FOR THE MITIGATION FUNCTION OF DEFENSE TEAMS IN DEATH PENALTY CASES, Guideline 4.1, *in* 36 HOFSTRA L. REV. 677 (2008) [hereinafter SUPPLEMENTARY GUIDELINES].

and defending mitigation evidence against hostile and uninformed attacks.

Toward that end, I will provide an overview of information from the trauma literature with the goal of helping defense teams anticipate and challenge common myths about trauma encountered in jurors and fact-finders. I will discuss how a working knowledge of factors related to risk and resilience can assist in explaining the particularly debilitating effects of certain forms of traumatic exposures. I will discuss some of the barriers encountered in developing comprehensive and reliable accounts of capital defendants' trauma histories and suggest strategies for overcoming those barriers. Throughout, I will discuss how the Supplementary Guidelines provide a necessary framework and methodology for guiding an inquiry about a client's trauma history.[15]

There is an enormous body of literature from multiple fields—epidemiology, psychology, psychiatry, developmental psychopathology, and neuroscience—that clarifies the process by which exposure to psychological trauma leads to a host of devastating psychological and behavioral consequences—including violence—through multiple common pathways. Central to this body of knowledge is evidence that there is a greater likelihood of psychological and emotional impairments when trauma exposure is severe, prolonged, occurs over several developmental stages, encompasses diverse forms of traumatic experiences, and is accompanied by additional psychiatric, familial, environmental, and social risk factors.[16] In this Article, I will refer to some of the key findings of this literature that illuminate the meaning and significance of many capital defendants' trauma histories.

II. DEFINITION OF TRAUMA AND TRAUMATIC EXPOSURES

What is psychological trauma? The potentially devastating consequences of traumatic experiences were formally recognized as part

15. With respect to the issues discussed above, the Supplementary Guidelines note that capital defense teams must include individuals who are skilled in the investigation, preparation, and presentation of evidence in many areas, including but not limited to trauma, maltreatment and neglect, religious, gender, sexual orientation, ethnic, racial, cultural and community influences, and socio-economic, historical, and political factors. *Id.* at Guideline 5.1(A)-(B). The Supplementary Guidelines also note the need for defense team members whose qualifications fit the unique needs of individual clients and cases. *Id.* at Guideline 4.1(A).

16. It is an assumption of this Article, based on the collective experience of seasoned mitigation specialists and capital defense attorneys, that this description accurately reflects the background of many capital defendants, whose trauma histories are long-standing, complex and have included multiple or sustained forms of exposure.

of psychiatric nomenclature in 1980,[17] with the introduction of the diagnosis of Post Traumatic Stress Disorder ("PTSD") in the third edition of the *Diagnostic and Statistical Manual of Mental Disorders* ("DSM-III").[18] PTSD has been included as a psychiatric diagnosis with each successive publication of the DSM since that time, and each version required the identification of a specific traumatic event (or events) in order to meet the first criterion that must be satisfied in order to make the diagnosis.

Many different kinds of events fall within the rubric of "psychological trauma." For purposes of a PTSD diagnosis, traumatic events can involve natural disasters (such as floods and earthquakes); accidental manmade disasters (such as car accidents and airplane crashes); deliberate manmade disasters (such as bombings, combat exposure, torture, and death camps); and violent interpersonal assault (such as rape, physical or sexual assault, physical or sexual abuse, and domestic battering).[19]

According to the fourth revised edition of the DSM ("DSM-IV-TR") definition, traumatic events evoke "intense fear, helplessness or horror," and may be experienced directly, may be witnessed, or may be experienced vicariously (for example, someone might learn about a traumatic event from a person who is close to him).[20] To meet criteria for a PTSD diagnosis, the trauma-related symptoms must cause

17. As a historical footnote, the psychological consequences of exposure to traumatic events have been documented throughout history, including vivid descriptions of post-traumatic sequelae as early as that found in Homer's account of the Trojan War in the *Iliad*. *See, e.g.*, JONATHAN SHAY, ACHILLES IN VIETNAM: COMBAT TRAUMA AND THE UNDOING OF CHARACTER (1995). Many wars have generated unique descriptors of the psychological distress following combat exposure, including "shell shock," "combat fatigue," and "war neurosis." Descriptions of the effects of traumatic experiences have also been provided by pioneers in the mental health field (Sigmund Freud and Pierre Janet, among others) that included many of the symptoms of the disorder that is now recognized as PTSD. *See* Bessel A. van der Kolk et al., *History of Trauma in Psychiatry*, *in* TRAUMATIC STRESS: THE EFFECTS OF OVERWHELMING EXPERIENCE ON MIND, BODY, AND SOCIETY 47, 52-56 (Bessel A. van der Kolk et al., eds., 1996).

18. AM. PSYCHIATRIC ASS'N, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS 236-38 (3d ed. 1980) [hereinafter DSM-III]. The *Diagnostic and Statistical Manual of Mental Disorders* ("DSM") identifies currently recognized categories of mental disorders and the criteria for diagnosing them. Published by the American Psychiatric Association, it is used worldwide by clinicians and researchers, and establishes a common understanding and language for psychiatric diagnoses. The DSM was first published in 1952 and has been revised five times since that time.

19. AM. PSYCHIATRIC ASS'N, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS 463-64 (4th rev. ed. 2000) [hereinafter DSM-IV-TR].

20. *Id.* at 463.

"clinically significant distress or impairment in social, occupational, or other important areas of functioning."[21]

III. PREVALENCE OF TRAUMATIC EVENTS

When PTSD was introduced as a diagnostic category in 1980, traumatic events were described as "generally outside the range of usual human experience."[22] With the publication of the DSM-IV in 1994, that definition was dropped in recognition of research demonstrating that traumatic exposures are far more prevalent in the general population than formerly believed.[23]

Over the past decade a number of epidemiologic studies have consistently found that it is more likely than not that a given individual, over the course of his or her lifetime, will be exposed to a traumatic experience as defined in the DSM. Epidemiologic studies from the United States generally estimate that between 55% to 90% of the population have been exposed to traumatic events.[24] The epidemiological literature demonstrating high rates of trauma exposure in the United States has been replicated in other cultures.[25] There is also evidence that refugees and people in underdeveloped and war-torn countries may be at even higher risk.[26] This research is particularly

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21. *Id.*

22. DSM-III, *supra* note 18, at 236.

23. While traumatic exposures in the general population are more prevalent than first believed, the traumas experienced by the capitally charged client population, as is clear from the discussion below, stand out as are both extreme (outside the range of usual experience in terms of severity and magnitude) and chronic (longstanding).

24. Prevalence rates vary according to differences in definitions of trauma, differences in sampling strategy, and differences in methods used to assess exposure to qualifying events. Despite this variability, there is general agreement in the literature (using conservative estimates) that more than 50% of the general population will experience a traumatic event at some point in their lives. *See* Naomi Breslau, *Epidemiologic Studies of Trauma, Posttraumatic Stress Disorder, and Other Psychiatric Disorders*, 47 CAN. J. PSYCHIATRY 923, 925 (2002); Ronald C. Kessler et al., *Posttraumatic Stress Disorder in the National Comorbidity Survey*, 52 ARCHIVES GEN. PSYCHIATRY 1048, 1052 (1995); Alexander McFarlane, *The Contribution of Epidemiology to the Study of Traumatic Stress*, 39 SOC. PSYCHIATRY & PSYCHIATRIC EPIDEMIOLOGY 874, 876 (2004).

25. *See* Mark Creamer et al., *Post-Traumatic Stress Disorder: Findings from the Australian National Survey of Mental Health and Well-Being*, 31 PSYCHOL. MED. 1237, 1238 (2001); Fran H. Norris et al., *Epidemiology of Trauma and Posttraumatic Stress Disorder in Mexico*, 112 J. ABNORMAL PSYCHOL. 646, 653 (2003); Caron Zlotnick et al., *Epidemiology of Trauma, Post-Traumatic Stress Disorder (PTSD) and Co-Morbid Disorders in Chile*, 36 PSYCHOL. MED. 1523, 1529-31 (2006).

26. *See* Joop T. V. M. de Jong et al., *Lifetime Events and Posttraumatic Stress Disorder in 4 Postconflict Settings*, 286 JAMA 555, 561 (2001); *see also* Mina Fazel et al., *Prevalence of Serious Mental Disorders in 7000 Refugees Resettled in Western Countries: A Systematic Review*, 365 LANCET 1309, 1312 (2005).

important given the significant number of foreign nationals currently under sentence of death in this country.[27]

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

The resilience literature provides some insight about these issues. There is evidence that some people who experience traumatic events are able to cope adaptively. For example, Bonnano described patterns of resilience among adults who, "*in otherwise normal circumstances*" are exposed to "*isolated and potentially highly disruptive events*," and cited "links between resilience and *generally high functioning prior to a potentially traumatic event.*"[28]

The type of resilience discussed above rarely applies to the capitally charged and convicted client population.[29] Years of experience show that many—if not most—capitally charged clients were not living "in

27. *See* Foreign Nationals and the Death Penalty in the US, http://www.deathpenaltyinfo.org/article.php?did=198 (last visited Apr. 14, 2008) (listing 122 reported foreign nationals under a death sentence in the United States as of February 29, 2008). Trauma-focused mitigation investigation and mental health evaluation must be highly sensitive to a wide range of cultural issues. The DSM-IV introduced a framework for culturally-sensitive assessment and included of a glossary of "culture-bound syndromes." DSM-IV-TR, *supra* note 19, at 898-903. Acknowledged in the text was the necessity to address issues that arise in applying DSM-IV criteria in a multicultural environment. Included in the description of the components of a "cultural formulation" is a systematic review of an individual's cultural background; the role of cultural context in the expression and evaluation of symptoms and impairment; and the effect that cultural differences might have on the relationship between client and evaluator. *Id.* at 897-98. Culture-bound syndromes (or culturally-bound "idioms of distress") were defined as recurrent, locality-specific patterns of aberrant behavior and troubling experience that may or may not be linked to a specific DSM-IV diagnostic category. *Id.* at 898-99.

28. George A. Bonanno, *Resilience in the Face of Potential Trauma*, 14 CURRENT DIRECTIONS PSYCHOL. SCI. 135, 135-36 (2005) (emphasis added).

29. *See* Denise LeBoeuf, *Evolving Standards of Decency: Cracks in the Foundation*, 29 U. DAYTON L. REV. 293, 295, 300-04 (2004) (discussing the fact that many capital defendants suffered some form of child abuse and that these defendants are often unable to cope with past maltreatment); *see generally* Mary E. Haskett et al., *Diversity in Adjustment of Maltreated Children: Factors Associated with Resilient Functioning*, 26 CLINICAL PSYCHOL. REV. 796 (2006) (describing the effects of child abuse and concluding that resilience in maltreated children was related to factors such as supportive parenting—parental affection, sensitivity, and support for a child's autonomy; children's positive perceptions of family coherence and stability; close attachments with peers; and strengths in the child, such as ego-control, ego-resilience, positive self-esteem, and social problem-solving abilities). These resilience factors are rarely seen in the life histories of capitally charged defendants. *See* LeBoeuf, *supra*, at 304.

otherwise normal circumstances" at the time of their exposure to traumatic events. Establishing this fact and distinguishing the circumstances that shaped an individual's specific responses should be at the core of the mitigation investigation and presentation. The most common traumatic events experienced by many clients (childhood victimization, physical and sexual assault, severe neglect, ongoing exposure to community violence involving witnessing of physical maiming, mutilation, or death) are profoundly more than "potentially disruptive" and these events (particularly chronic child abuse and community violence) are rarely isolated occurrences. Finally, few of these clients would be considered to be "generally high functioning" or are found to have encountered the protective factors associated with resilience.

On the contrary, a competent social history investigation often reveals that clients are functionally impaired and vulnerable to the effects of trauma. For many, the entire developmental course of childhood and/or adolescence was shaped by a series of profoundly traumatic events, usually within the context of profoundly destructive relationships, often at the hands of caregivers or others who should have provided safety, nurturance, and protection. Eighth Amendment jurisprudence has long recognized the importance of the developmental years. As the United States Supreme Court noted:

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

development of a youthful defendant be duly considered in sentencing.[30]

IV. CONDITIONAL RISK (NON-RANDOM NATURE) OF TRAUMATIC EVENTS

Exposure to traumatic events is not random. An understanding of this phenomenon is critical for capital litigators as the risk factors for heightened exposure apply to various capitally charged clients. This should put defense teams on notice that investigation related to trauma may be particularly important for a client.

Findings from the trauma literature indicate that numerous factors—for example, race, environment, socioeconomic status, education, and gender—may influence risk for exposure to traumatic events. In general, men,[31] and especially African Americans, particularly socio-economically disadvantaged African Americans living in urban areas,[32] people with lower educational levels,[33] and urban youth[34] are at

30. Eddings v. Oklahoma, 455 U.S. 104, 115-16 (1982) (footnotes omitted).

31. *See* Breslau, *supra* note 24, at 925-26 (noting that many studies have found higher overall exposure rates among men, including exposure to traumatic events such as accidents, assaultive violence (mugging, being assaulted or threatened with a weapon), and witnessing violence); Naomi Breslau et al., *Trauma and Posttraumatic Stress Disorder in the Community: The 1996 Detroit Area Survey of Trauma*, 55 ARCHIVES GEN. PSYCHIATRY 626, 627 (1998);.

32. *See* Tanya N. Alim et al., *An Overview of Posttraumatic Stress Disorder in African Americans*, 62 J. CLINICAL PSYCHOL. 801, 802-03 (2006) (noting that the results of the National Crime Victimization Survey conducted by the U.S. Department of Justice in 2002 determined that the overall rates of exposure to violent crimes, including sexual assault, physical assault, and robbery, were higher for African Americans than for Caucasians, with rates of sexual assault and rape being particularly disproportionate); Mary Beth Selner-O'Hagan et al., *Assessing Exposure to Violence in Urban Youth*, 39 J. CHILD PSYCHOL. & PSYCHIATRY 215, 221 (1998) (noting that African Americans were also more likely to have witnessed violence—for example, 47% of African Americans versus 13% of whites reported witnessing a shooting—and to have been exposed to other traumatized individuals); *see also* Breslau, *supra* note 31, at 628-29.

33. *See* Breslau, *supra* note 31, at 628; Naomi Breslau et al., *Traumatic Events and Posttraumatic Stress Disorder in an Urban Population of Young Adults*, 48 ARCHIVES GEN. PSYCHIATRY 216, 217-20 (1991);; Arieh Y. Shalev, *Stress Versus Traumatic Stress: From Acute Homeostatic Reactions to Chronic Psychopathology*, *in* TRAUMATIC STRESS, *supra* note 17, at 77, 86.

34. Urban youth are at particularly high risk of violence exposure. Studies conducted in a number of metropolitan areas, including Chicago, Detroit, Los Angeles, and New Orleans, have consistently found that approximately 25% of children have witnessed someone being shot or killed. Selner-O'Hagan, *supra* note 32, at 215. In a study of 320 inner-city adolescents, 93.4% of the sample knew at least one person who had been the victim of a violent act, 79.3% of the sample had witnessed a violent act, and 48.7% of the sample had been the target of at least one violent act. Eric Youngstrom et al., *Exploring Violence Exposure, Stress, Protective Factors and Behavioral Problems Among Inner-City Youth*, 32 AM. J. COMMUNITY PSYCHOL. 115, 122 (2003). In a representative sample of sixth-grade urban students, 31% of boys and 14% of girls had someone

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

V. CUMULATIVE RISK OF TRAUMATIC EVENTS

Within the population of people exposed to trauma, there is a group that has suffered from multiple exposures.[35] For example, a combat veteran may subsequently be the victim of a violent crime or witness a shooting death; someone who was repeatedly sexually assaulted during childhood may then be raped as an adult. People who experience multiple high magnitude exposures,[36] as will be discussed below, are at increased risk for developing profound emotional and behavioral disturbances.[37] Researchers have also found that a prior history of trauma exposure increases risk for subsequent exposure.[38] These findings suggest that people traumatized as children (as is true of many capitally charged defendants) are at higher risk to be retraumatized later

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threaten to kill them in the past; 42% of boys and 30% of girls had seen someone shot; and 87% to 96% of the children had witnessed arrests, heard gunfire, or seen others beaten up. Albert D. Farrell & Steven E. Bruce, *Impact of Exposure to Community Violence on Violent Behavior and Emotional Distress Among Urban Adolescents*, 26 J. CLINICAL CHILD PSYCHOL. 2, 7 fig.2 (1997). In another study, 43.4% of urban youth ages seven to eighteen had witnessed a murder. Kevin M. Fitzpatrick & Janet P. Boldizar, *The Prevalence and Consequences of Exposure to Violence Among African-American Youth*, 32 J. AM. ACAD. CHILD & ADOLESCENT PSYCHIATRY 424, 427 & fig.2 (1993).

35. *See* Kessler et al., *supra* note 24, at 1058; *see also* Breslau et al., *supra* note 33, at 217.

36. The identification and assessment of the full range of traumatic exposures an individual has experienced is a critical part of a competent trauma evaluation. This involves assessment of all "Criterion A" events. *See* Frank W. Weathers & Terence M. Keane, *The Criterion A Problem Revisited: Controversies and Challenges in Defining and Measuring Psychological Trauma*, 20 J. TRAUMATIC STRESS 107, 108-12 (2007) (noting that there is a continuum of stressor severity involved in traumatic events). Dimensions on which stressors vary include the complexity, frequency, and duration of the traumatic stressor; the degree of predictability or control involved; the extent of life threat; the degree of psychological or physical threat of harm involved; and the level of interpersonal loss. *Id.* at 108. "High magnitude" traumatic events refer to events of higher order stressor severity (for example, combat exposure, physical or sexual assault—especially rape—and witnessing a mutilation or death). *Id.* at 109 & tbl.2.

37. *See* Donald A. Lloyd & R. Jay Turner, *Cumulative Adversity and Posttraumatic Stress Disorder: Evidence from a Diverse Community Sample of Young Adults*, 73 AM. J. ORTHOPSYCHIATRY 381, 382-83 (2003).

38. *See* Naomi Breslau et al., *Risk Factors for PTSD-Related Traumatic Events: A Prospective Analysis*, 152 AM. J. PSYCHIATRY 529, 531-32 (1995); *see also* Jeremiah A. Schumm et al., *Cumulative Interpersonal Traumas and Social Support as Risk and Resiliency Factors in Predicting PTSD and Depression Among Inner-City Women*, 19 J. TRAUMATIC STRESS 825, 832-33 (2006).

in their lives. Moreover, the trauma literature clearly shows a "dose response" relationship between traumatic events and outcomes, that is, the greater the number of exposures to traumatic events, the greater the probability of negative physical and psychological health outcomes.[39]

The significance of this for mitigation investigation is that capitally charged clients have often experienced multiple horrific events throughout their lives. *All* of these experiences need to be fully investigated and contextualized, as required in Supplementary Guideline 10.11(B), as separate events and as part of a client's broader life experience and psychological development.

VI. TRAUMA AND ITS EFFECTS

What are the psychological effects of exposure to traumatic events? PTSD is the signature psychiatric disorder that has been widely identified as a consequence of exposure to traumatic events. When the American Psychiatric Association officially recognized a coherent constellation of symptoms that comprise traumatic stress reactions in 1980, it defined PTSD by three symptom clusters: (1) haunted preoccupation with the trauma, expressed in symptoms such as nightmares, intrusive thoughts, flashbacks, and physiological reactivity upon exposure to trauma reminders; (2) avoidance of stimuli associated with the trauma, expressed in symptoms such as psychic numbing, feelings of estrangement from others, decreased interest in activities, inability to feel positive emotions such as love, satisfaction. or happiness; and (3) persistent hyperarousal, expressed in symptoms such as exaggerated startle responses, difficulty concentrating or sleeping, hypervigilance, and affective lability (irritability and anger outbursts).[40]

VII. RISK OF PTSD AMONG PEOPLE EXPOSED TO TRAUMATIC EVENTS

Overall, the literature suggests that despite the high prevalence of exposure to traumatic events in the general population, the number of people who develop PTSD is generally low. For example, Kessler and his colleagues conducted two U.S. population-based studies (called the

39. *See* Robert F. Anda et al., *The Enduring Effects of Abuse and Related Adverse Experiences in Childhood: A Convergence of Evidence from Neurobiology and Epidemiology*, 256 EUR. ARCHIVES PSYCHIATRY & CLINICAL NEUROSCIENCE 174, 180-81 (2006); Vincent J. Felitti et al., *Relationship of Childhood Abuse and Household Dysfunction to Many of the Leading Causes of Death in Adults: The Adverse Childhood Experiences (ACE) Study*, 14 AM. J. PREVENTIVE MED. 245, 251 (1998); Bonnie L. Green et al., *Outcomes of Single Versus Multiple Trauma Exposure in a Screening Sample*, 13 J. TRAUMATIC STRESS 271, 272-74 (2000).

40. *See* DSM-III, *supra* note 18, at 238.

National Comorbidity Studies) of nationally representative samples, with similar results over a ten-year period. The first study estimated the overall lifetime prevalence rate of PTSD as 7.8%[41] and the replication study ten years later found the lifetime prevalence rate for PTSD was 6.8%.[42]

Thus, in light of the high prevalence of exposure to traumatic events in the community at large, it is clear that many, in fact *most*, people who are exposed to traumatic events do not develop PTSD. Why is this relevant to mitigation investigation in capital cases? An understanding of the factors that put people at risk for developing PTSD is absolutely critical to understanding the effects of trauma on specific clients. Many of the factors that increase the risk of PTSD are experienced by the population of people who are capitally charged and convicted.

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

In addition (and beyond the scope of this paper), there is a large and converging body of literature from neuroscience and epidemiology that indicates that exposure to stress during childhood is associated with changes in brain structure, brain chemistry, and brain function. Early childhood stress, especially when it is extreme or prolonged, can impair the development of major neuroregulatory systems, with profound and lasting neurodevelopmental and neurobehavioral consequences over the

41. Kessler et al., *supra* note 24, at 1057.

42. Ronald C. Kessler et al., *Lifetime Prevalence and Age-of-Onset Distributions of DSM-IV Disorders in the National Comorbidity Survey Replication*, 62 ARCHIVES GEN. PSYCHIATRY 593, 596 tbl.2 (2005). Across studies, lifetime prevalence rates of PTSD have been reported to be approximately 5% to 6% in men and 10% to 14% in women. *See* Breslau, *supra* note 24, at 926; Breslau et al., *supra* note 31, at 628; Kessler et al., *supra* note 24, at 1057; *see also* Carla L. Storr et al., *Childhood Antecedents of Exposure to Traumatic Events and Posttraumatic Stress Disorder*, 164 AM. J. PSYCHIATRY 119, 120 (2007).

course of a lifetime.[43] Moreover, literature from the field of developmental psychopathology shows that early childhood adversity and maltreatment is associated with profound and long-lasting developmental derailment. Trauma in the developmental years may compromise a child's ability to master critical developmental milestones at particular junctures in his or her life. Thus compromised—and particularly when harm is not ameliorated—that child's ability to master later milestones is also compromised, setting the stage for a cascade of adverse events and increasing the likelihood of psychiatric distress and adult psychopathology.[44]

VIII. RISK FACTORS FOR PTSD

Convergent data from the trauma literature tell us that trauma represents a wide range of experiences and consequences. Research on the relationship between trauma exposure and PTSD has clearly shown that the risk of developing PTSD varies according to a large number of factors. These factors include a person's prior experiences (who he was before the trauma); the nature and range of trauma(s) he experienced; how he responded during the traumatic experience; at what age or ages and over how many developmental periods the trauma(s) occurred; his family history of psychiatric vulnerability; his own history of cognitive or psychiatric impairments; and the nature and extent of support he received following the traumatic experience(s).[45] All of these factors should be considered as part of a competent mitigation investigation. Several of these factors are addressed below.

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43. *See* Anda et al., *supra* note 39, at 180-81; Charles B. Nemeroff et al., *Posttraumatic Stress Disorder: A State-of-the-Science Review*, 40 J. PSYCHIATRIC RES. 1, 7-10 (2006); Martin Teicher, *Wounds that Time Won't Heal: The Neurobiology of Child Abuse*, 2 CEREBRUM 50 (2000); Martin H. Teicher et al., *Neurobiological Consequences of Early Stress and Childhood Maltreatment: Are Results from Human and Animal Studies Comparable?*, 1071 ANNALS N.Y. ACAD. SCI. 313 (2006).

44. *See* J. Lawrence Aber et al., *The Effects of Maltreatment on Development During Early Childhood: Recent Studies and Their Theoretical, Clinical, and Policy Implications*, *in* CHILD MALTREATMENT: THEORY AND RESEARCH ON THE CAUSES AND CONSEQUENCES OF CHILD ABUSE AND NEGLECT 579, 609-10 (Dante Cicchetti & Vicki Carlson eds., 1989); Dante Cicchetti & Sheree L. Toth, *A Developmental Psychopathology Perspective on Child Abuse and Neglect*, 34 J. AM. ACAD. CHILD & ADOLESCENT PSYCHIATRY 541, 554-55 (1995); Dante Cicchetti, *How Research on Child Maltreatment Has Informed the Study of Child Development: Perspectives from Developmental Psychopathology*, *in* CHILD MALTREATMENT, *supra*, at 377, 414-16.

45. Chris R. Brewin et al, *Meta-Analysis of Risk Factors for Posttraumatic Stress Disorder in Trauma-Exposed Adults*, 68 J. CONSULTING & CLINICAL PSYCHOL. 748, 751 & tbl.1 (2000); *see* Breslau et al., *supra* note 33, at 218-19.

A. Type of Traumatic Event

The DSM has long recognized that the effects of traumatic exposures are generally more severe and longer lasting when the stressor is "of human design" (as opposed to natural or accidental disasters).[46] This is consistent with findings from the epidemiologic literature. Inquiry into the relationship between specific types of traumatic events and development of PTSD has shown that people exposed to combat and physical and sexual assault (especially rape) are at particular risk for developing PTSD.[47] PTSD has also been found to be a prevalent outcome following childhood victimization.[48] These findings have been replicated in a number of studies and suggest that intentional interpersonal violence constitutes a particularly potent risk factor for developing PTSD.

B. Social History Factors

At least two meta-analyses[49] have been completed on the trauma literature in efforts to identify factors that predict PTSD. Brewin and colleagues found that three historical risk factors were most uniformly predictive of developing PTSD.[50] These included a prior psychiatric history in the traumatized individual, a history of childhood abuse, and a family history positive for psychiatric disorder.[51] The meta-analysis completed by Ozer and colleagues yielded similar results, indicating that a prior history of trauma, prior psychological adjustment problems, and a family history of psychopathology were predictive of developing PTSD.[52]

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46. DSM-III, *supra* note 18, at 236.

47. For example, Kessler and his colleagues reported that 65% of men and 45.9% of women who reported rape as their "most upsetting trauma" developed PTSD. Kessler et al., *supra* note 24, at 1053 & tbl.4. Breslau and her colleagues found rape and physical or sexual assault were the types of trauma with the highest risk of developing PTSD. Breslau et al., *supra* note 31, at 631 tbl.4.

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

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

50. *See* Chris Brewin et al., *Meta-Analysis of Risk Factors for Posttraumatic Stress Disorder in Trauma-Exposed Adults*, 68 J. CONSULTING & CLINICAL PSYCHOL. 748, 753 (2000) (surveying results from 77 articles that involved combined sample sizes ranging from 1149 to 11,000 subjects).

51. *Id.*

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

These findings have significant implications for capital cases, as experience shows that most capital defendants have at least one—and many have all three—of these risk factors. Trauma-focused mitigation investigations (like any mental health/mitigation investigation) must routinely and closely examine all available evidence of (1) the defendant's prior psychological functioning; (2) his or her prior exposures to trauma, in both childhood and as an adult; and (3) his or her family history of mental illness or emotional impairments, as required by the Supplementary Guideline 10.11.[53]

C. *Subjective Experience: Personal Reactions and Appraisals*

As mentioned above, with the publication of the DSM-IV in 1994, the definition of a traumatic event (Criterion A)[54] was expanded to include the subjective experience of "intense fear, helplessness, or horror" during the traumatic event.[55] Several aspects of an individual's psychological responses during traumatic events have been shown to increase that individual's risk of developing PTSD. These include the perception that one's life is in danger, dissociation during the traumatic event,[56] and heightened emotional responses during the traumatic event.[57] These findings suggest that the in-vivo appraisal and meaning of traumatic stressors play an important role as a risk factor for developing PTSD.[58]

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53. SUPPLEMENTARY GUIDELINES, *supra* note 15, at Guideline 10.11(B); *see* Karestan C. Koenen et al., *Early Childhood Factors Associated with the Development of Post-Traumatic Stress Disorder: Results from a Longitudinal Birth Cohort*, 37 PSYCHOL. MED. 181, 188 (2007) (reporting that low IQ and chronic environmental stressors increased risk for PTSD, and childhood externalizing characteristics and family environmental stressors—maternal distress and loss of a parent—were also associated with increased risk of trauma exposure and risk of developing PTSD).

54. "Criterion A" defines the inclusion criteria for traumatic stressors, DSM-IV-TR, *supra* note 19, at 463, and has been called the "gateway" to a PTSD diagnosis. *See, e.g.*, Liza H. Gold & Robert I. Simon, *Posttraumatic Stress Disorder in Employment Cases*, *in* MENTAL AND EMOTIONAL INJURIES IN EMPLOYMENT LITIGATION 505-06 (James J. McDonald, Jr. & Francine B. Kulick eds., 2d ed. 2002). A competent Criterion A assessment involves investigation of the various types and the range of traumatic events to which an individual has been exposed and an assessment of the circumstances, effects, and responses to those exposures. DSM-IV-TR, *supra* note 19, at 467-68.

55. DSM-IV-TR, *supra* note 19, at 463.

56. This is described in the trauma literature as "peritraumatic dissociation," and might include symptoms such as feeling that one is looking down from above, has left one's body, or that time has been altered. *See* Iris M. Engelhard et al., *Peritraumatic Dissociation and Posttraumatic Stress After Pregnancy Loss: A Prospective Study*, 41 BEHAV. RES. & THERAPY 67, 67-68 (2003).

57. Ozer et al., *supra* note 52, at 61, 63.

58. A word of caution is in order here. Mitigation specialists and mental health professionals conducting trauma assessments must also consider the effects of gender when interviewing clients and family members about traumatic experiences, particularly with respect to the assessment of

D. Cumulative Trauma Exposures

As has been touched on above, consistent findings from the trauma literature show a dose-response relationship with respect to trauma exposure and PTSD: the risk of PTSD and its debilitating symptoms increases progressively with types of traumas experienced and/or the total number of risk factors to which one is exposed.[59] A competent mitigation investigation must include assessment of all "Criterion A" trauma exposures, and include careful attention to the number, type, magnitude, circumstances, and dynamics of traumatic exposures for any individual client.[60]

E. Social Support

The presence or absence of social support has been linked to the risk of developing PTSD following exposure to traumatic events. The presence of social support is protective and lessens risk for PTSD, and the absence of social support increases risk for PTSD.[61] Social support may be particularly important in buffering the effects of trauma for people who have experienced both child abuse and violence in adulthood.[62] Competent mitigation investigation must include an assessment of the quality of interpersonal relationships and support that existed for an individual client at all stages of his or her life; this is a crucial part of the "client's life history" based upon a "broad set of sources" which includes "in-person, face-to-face, one-on-one interviews with the client, the client's family, and other witnesses who are familiar with the client's life, history, or family history."[63] Likewise, mitigation specialists and investigators must note those instances where social support and/or treatment were notably absent, denied, or withheld.

It can be equally important to investigate the social support network available to the client's siblings. While it is quite likely that all members of a household dominated by violence will bear some scars of the experience, it is often the case that siblings may have different levels of exposure to trauma because of birth order or other circumstances, and it

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emotions experienced during traumatic event. This issue is discussed below. *See infra* Part VIII(F); *see also* note 127 and accompanying text.

59. Evelyn Bromet et al., *Risk Factors for DSM-III-R Posttraumatic Stress Disorder: Findings from the National Comorbidity Survey*, 147 AM. J. EPIDEMIOLOGY 353, 359 (1998).

60. *See* SUPPLEMENTARY GUIDELINES, *supra* note 14, at Guideline 5.1(B), 10.11(B), 10.11(E).

61. *See* Brewin et al., *supra* note 50, at 748; Ozer et al., *supra* note 52, at 66.

62. Schumm et al., *supra* note 38, at 832.

63. *See* SUPPLEMENTARY GUIDELINES, *supra* note 14, at Guideline 10.11(B)-(C).

is also important to know whether siblings had effective social support from outside the family.[64] Such investigation can explain why the client might have been more traumatized, or more vulnerable to the lasting effects of trauma, than a sibling who grew up in the same household. The preparation of a chronology that summarizes the client's life history, as described in Supplementary Guideline 10.11(D),[65] can be a very useful tool for recognizing and understanding such relationships.

F. Gender

Numerous studies have found that women have a greater risk of developing PTSD than men.[66] This finding persists when controlling for type of trauma, suggesting that women have a greater vulnerability to the PTSD effects of trauma.[67] This is one reason that the defense team is required under Supplementary Guideline 10.11(B) to investigate the influence of gender in the client's life history.[68]

IX. THE DISABLING EFFECTS OF PTSD

There is considerable evidence that PTSD is a chronic and disabling condition for many who suffer from this disorder. Kessler reported that PTSD may have a duration of many years, and is more likely to be developed by people who are exposed to multiple traumas.[69] He also noted that the degree of impairment of PTSD is comparable to, or greater than, that of other seriously impairing mental disorders.[70] Soloman and Davidson reported that for at least one-third of people who suffer from PTSD, it is a persistent condition lasting for many years.[71] Impairment resulting from PTSD involves multiple domains of

64. *See e.g.*, Alex Kotlowitz, *In the Face of Death*, N.Y. TIMES MAG., July 6, 2003, at 32, 46.

65. SUPPLEMENTARY GUIDELINES, *supra* note 14, at Guideline 10.11(D).

66. *See* Breslau, *supra* note 24, at 926; Breslau et al., *supra* note 31, at 628; Kessler et al., *supra* note 24, at 1053.

67. Breslau, *supra* note 24, at 926. Also, as noted by Norris and her colleagues, these gender differences have been observed far more often than they have been explained. Explanations have included a greater possible physiological reactivity in women, the fact that routine stressors such as poverty, discrimination, and oppression may reduce women's capacity to cope with traumatic stressors, and the view that gender role socialization may increase the likelihood that women disclose symptoms and men suppress them. Norris et al., *supra* note 25, at 654.

68. SUPPLEMENTARY GUIDELINES, *supra* note 14, at Guideline 10.11(B).

69. Ronald C. Kessler, *Posttraumatic Stress Disorder: The Burden to the Individual and to Society*, 61 J. CLINICAL PSYCHIATRY 4, 10 (Supp. 5 2000).

70. *Id.* at 9.

71. Susan D. Soloman & Jonathan R.T. Davidson, *Trauma: Prevalence, Impairment, Service Use, and Cost*, 58 J. CLINICAL PSYCHIATRY 5, 5 (Supp. 9 1997).

psychological functioning, and many people who suffer from this psychiatric disorder have significant marital, occupational, financial, and health problems.[72] Hidalgo and Davidson reported that traumatic exposures and resulting PTSD have significant negative effects on general functioning and affect health and health care utilization.[73] As such, PTSD poses an important economic burden on both the individual and on society.[74] It is therefore necessary to investigate the client's "trauma history; educational history; employment and training history,"[75] and to interview every witness who might be "familiar with the defendant or his family."[76]

X. PTSD AND OTHER PSYCHIATRIC DISORDERS

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

There is a substantial literature on the extent to which PTSD co-occurs with other symptoms and disorders.[77] Results consistently show that the vast majority of people who meet diagnostic criteria for PTSD also meet diagnostic criteria for one or more additional psychiatric disorders. Overall, results from a number of population-based surveys have yielded comorbidity rates between 62% and 92%.[78] Using the more conservative estimate, this means that over 60% of people with PTSD suffer the effects of at least one other disorder.

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72. *Id.*

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

74. *Id.*

75. SUPPLEMENTARY GUIDELINES, *supra* note 14, at Guideline 10.11(B).

76. *Id.* at Guideline 10.11(E)(2).

77. The existence of two or more psychiatric disorders co-occurring within an individual is described in the psychiatric literature as "comorbidity." *See, e.g.*, Kathleen T. Brady et al., *Comorbidity of Psychiatric Disorders and Posttraumatic Stress Disorder*, 61 J. CLINICAL PSYCHIATRY 22 (Supp. 7 2000).

78. *See* Kessler et al., *supra* note 24, at 1051; Creamer et al., *supra* note 25, at 1238. For example, in the National Comorbidity Study, a representative national sample of 5877 individuals between fifteen and fifty-four years of age, Kessler and his colleagues found that the relative odds of other psychiatric disorders are significantly elevated in people with PTSD, and that 88.3% of men and 79% of women with PTSD had at least one other DSM-III-R psychiatric disorder. Kessler et al., *supra* note 24, at 1055 & tbl.6. This finding has been replicated, with other authors reporting that over 79% of respondents with PTSD suffer from other psychiatric disorders. *See, e.g.*, Breslau et al., *supra* note 33, at 218; Creamer et al., *supra* note 25, at 1238.

Disorders that frequently co-occur with PTSD include mood,[79] anxiety,[80] and substance abuse disorders.[81] In addition, there is increasing evidence of the existence of dissociative[82] and psychotic[83] symptomatology among people who have PTSD.[84]

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79. A disturbance in mood is the predominant feature of this category of disorders. Mood disorders include the Depressive Disorders (for example, symptoms such as depressed mood, markedly diminished interest or pleasure in daily activities, significant weight loss or weight gain, loss of energy, recurrent suicidal ideation) and the Bipolar Disorders (for example, symptoms such as inflated self-esteem, grandiosity, flight of ideas, decreased need for sleep, distractibility). *See, e.g.*, DSM-IV-TR, *supra* note 19, at 345-48.

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

81. The essential feature of Substance Abuse Disorders is a maladaptive and repeated pattern of substance use manifested by recurrent and significant adverse consequences. *See, e.g.*, *id.* at 198. Substance Abuse Disorders are comorbid with PTSD to a very high degree. *See* Breslau, *supra* note 24, at 926; Creamer et al., *supra* note 25, at 1238; Kessler, *supra* note 69, at 8. In many cases, the substance abuse disorder may develop as an attempt to self-medicate the suffering caused by PTSD. Brady et al., *supra* note 77, at 23, 27.

There is an extremely high prevalence rate of comorbid substance abuse disorders in the highly traumatized population of capitally charged defendants. This pattern of comorbidity has significant implications for mental health evaluations. One problem that occurs has been called "diagnostic overshadowing," which refers to diagnostic errors that result from mistakenly attributing signs and symptoms of one disorder or condition to another. Diagnostic overshadowing often results in the failure to identify the presence of co-occurring mental disorders. Evaluators may explain a client's behavior solely in terms of substance abuse, rather than as a consequence of substance abuse that is comorbid with other conditions. In addition, in those relatively infrequent instances where treatment has been recommended, diagnostic inaccuracy may have resulted in a client being denied treatment for additional serious psychiatric conditions, such as PTSD, or in the provision of inappropriate treatment that resulted in failed treatment outcomes. *Id.* at 23, 25.

82. Dissociation describes mental states in which thoughts, emotions, sensations or memories are split off or compartmentalized. THE DICTIONARY OF PSYCHOLOGY 288 (Raymond J. Corsini ed., 1999). The essential feature of dissociative disorders is disruption in the usually integrated functions of consciousness, memory, identity, or perception. Examples of dissociative symptoms might include losing track of the passage of time, feeling one's body does not belong to oneself, feeling that other people or the world is not real, or failure to remember important events in one's life. Extreme forms of dissociation disorders include Dissociative Identity Disorder and Depersonalization Disorder. DSM-IV-TR, *supra* note 19, at 519-20.

83. In very general terms, psychosis refers to a loss of contact with reality. *See* APA DICTIONARY OF PSYCHOLOGY 756 (Gary R. VandenBos ed., 2007). Psychotic symptoms might include delusions (for example, fixed false beliefs that are firmly held despite evidence to the contrary such as falsely believing people are out to get one, believing one is being followed or plotted against, believing others are reading one's mind or stealing one's thoughts); auditory, visual, or olfactory hallucinations (for example, hearing, seeing, or smelling things that other people can not hear, see, or smell); paranoia and suspiciousness, or disorganized thoughts, language and behavior. The psychotic disorders include, among others, Schizophrenia, Schizoaffective Disorder, Delusional Disorder, and Brief Psychotic Disorder. DSM-IV-TR, *supra* note 19, at 297.

84. For example, Wicks and colleagues found that social adversity in childhood was associated with a risk of developing psychoses later in life, and that the risk increased with an increasing number of adversities, suggesting a dose-response relationship. Susanne Wicks et al., *Social Adversity in Childhood and the Risk of Developing Psychosis: A National Cohort Study*, 162

What are the implications of this for capital work? Quite simply: PTSD is not the end of the story; people with PTSD are at high risk for one or more additional psychiatric disorders. A careful investigation of symptoms over time is essential when developing a comprehensive trauma history and evaluation of its mental health consequences. Special focus should be placed on investigating symptoms of substance abuse, depression, anxiety, and psychotic and dissociative symptomatology. These additional symptoms can have profound effects on the unique mental state of a client with PTSD.[85] The presence of psychotic or dissociative symptomatology, in particular, may have major implications for mental state defenses and issues of competency to stand trial. If nothing else, a thorough understanding of a client's symptoms and impairments is essential to developing even minimal trust and communication between the client and defense team.

All too often, mental health evaluations in both trial and post-conviction settings focus simply on the question of whether or not a particular client meets diagnostic criteria for a particular psychiatric disorder. This simplistic approach to a mental health evaluation can lead the defense to overlook significant psychiatric symptoms that may be subthreshold for one or more psychiatric disorders. The result is often an incomplete and inaccurate picture of a client's mental health status, and one which dismisses or underestimates the full extent of that client's impairments. Subthreshold symptomatology may cause or contribute to unique and potentially debilitating manifestations of PTSD and other disorders, and may be associated with significant impairment. A competent mental health evaluation must always focus on symptoms and impairment as well as on discrete disorders, as these are extremely important indicators of current and past functioning.[86] For capital

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AM. J. PSYCHIATRY 1652, 1655-56 (2005). Sareen and colleagues found that there is a significant association between PTSD and endorsement of significant psychotic symptoms, and that co-occurrence with psychotic symptoms was marked by greater severity of PTSD symptoms and higher comorbidity. Jitender Sareen et al., *Co-Occurrence of Posttraumatic Stress Disorder with Positive Psychotic Symptoms in a Nationally Representative Sample*, 18 J. TRAUMATIC STRESS 313, 317-19 (2005). Spauwen and colleagues found that exposure to traumatic events may increase the risk of psychotic symptoms, particularly in people vulnerable to psychosis. Janneke Spauwen et al., *Impact of Psychological Trauma on the Development of Psychotic Symptoms: Relationship with Psychosis Proneness*, 188 BRIT. J. PSYCHIATRY 527, 530 (2006).

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

86. It is for these reasons that Supplementary Guideline 10.11 requires that 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,

sentencing purposes, mitigation investigation differs greatly from other forensic inquiries, such as sanity/responsibility and competency; the determination of specific diagnoses is far less relevant than identification of an individual's functional impairments. That is, whereas competency and sanity evaluations may require a "mental disease or defect," mitigation investigation has no such requirement.[87]

XI. CONSEQUENCES OF TRAUMA: BEYOND PTSD

A correlate to the proposition that diagnosing a client with PTSD is only the beginning of the mitigation and psychological inquiry is the fact that if someone does not meet diagnostic criteria for PTSD, we cannot assume that he has not been severely damaged by his traumatic experiences. It is the obligation of the capital defense team to understand this and to incorporate this knowledge in its mitigation investigation.[88] To do so effectively, it is helpful to turn to an aspect of the trauma literature which describes the impairments and disturbance that often accompany long-term and complex trauma exposure.

Numerous authors have described a complex, coherent, and consistent constellation of symptoms—not captured by the diagnosis of PTSD—frequently seen in people exposed to chronic and severe trauma. Populations studied include people who have been chronically physically or sexually abused during childhood, and people exposed to

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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. Team members acquire knowledge, experience, and skills in these areas through education, professional training and properly supervised experience. SUPPLEMENTARY GUIDELINES, *supra* note 14, at Guideline 10.11(B), (D), (E).

87. Supplementary Guideline 4.1(D) provides guidance in this regard, stating:

> It is counsel's duty to provide each member of the defense team with the necessary legal knowledge for each individual case, including features unique to the jurisdiction or procedural posture. Counsel must provide mitigation specialists with knowledge of the law affecting their work, including an understanding of the capital charges and available defenses; applicable capital statutes and major state and federal constitutional principles; applicable discovery rules at the various stages of capital litigation; applicable evidentiary rules, procedural bars and "door-opening" doctrines; and rules affecting confidentiality, disclosure, privileges and protections.

Id. at Guideline 4.1(D).

88. It should also be noted that the implications of an understanding about trauma extend far beyond evidentiary presentations to a judge or jury. This understanding should be used in multiple arenas of capital defense work, including working more effectively with individual clients (for example, discussion with a despairing client who may be a potential volunteer and discussions with a client around sensitive plea negotiations). This goes hand-in-hand with the requirement that team members have the ability "to establish rapport with witnesses, the client, the client's family and significant others." *Id.* at 5.1(C).

interpersonal violence in adulthood, often within the context of intimate relationships.

This constellation of symptoms has been described in the literature by various names, including "disorders of extreme stress not otherwise specific," or DESNOS,[89] and complex psychological trauma.[90] Impairments are described in the following areas:

> Problems with the regulation of emotion (e.g. increased anxiety and depression, difficulties with aggression and anger);
> Problems with the regulation of behavior (e.g. self-destructive and impulsive behaviors);
> Problems with attention or consciousness, avoidant responses (e.g. dissociative symptoms, depersonalization);
> Problems with relationships (e.g. inability to trust, fearfulness, and suspiciousness of others, idealizing or bonding with one's abuser);
> Problems with a coherent sense of oneself (e.g. identity disturbances, low self esteem, feeling damaged or ineffective);
> Problems interpreting one's environment and the intent and actions of others;

89. Herman and colleagues studied the complex array of symptoms associated with exposure to severe and chronic interpersonal violence under the auspices of field trials undertaken as part of the development of the DSM-IV. Following review of existing literature on victims of chronic interpersonal violence (child abuse, domestic violence, and concentration camp internment), a list of symptoms was generated and called Disorders of Extreme Stress Not Otherwise Specified ("DESNOS"). JUDITH LEWIS HERMAN, TRAUMA AND RECOVERY 118-22 (1992). The DESNOS conceptualization included seven categories of disturbance and noted symptoms of dysregulation in affective, behavioral, cognitive, and somatic domains of functioning, as well as symptoms of disturbance in interpersonal functioning (sense of identity, relationships with others, and schemas about the world). *See* van der Kolk et al., *supra* note 17, at 202, 203 tbl.9.2; Bessel A. van der Kolk et al., *Disorders of Extreme Stress: The Empirical Foundation of a Complex Adaptation to Trauma*, 18 J. TRAUMATIC STRESS 389, 391 (2005); Bessel A. van der Kolk & Christine A. Courtois, *Editorial Comments: Complex Developmental Trauma*, 18 J. TRAUMATIC STRESS 385, 385 (2005).

90. John Briere & Joseph Spinazzolo, *Phenomenology and Psychological Assessment of Complex Posttraumatic States*, 18 J. TRAUMATIC STRESS 401, 402-03 (2005) (describing six prominent and overlapping symptom clusters, including altered self-capacities, cognitive disturbances, mood disturbances, overdeveloped avoidant responses, somatoform distress, and posttraumatic stress); *see also* John Briere, Stacy Kaltman & Bonnie L. Green, *Accumulated Childhood Trauma and Symptom Complexity*, 21 J. TRAUMATIC STRESS 223 (2008). As reported in the Monitor on Psychology, APA Online, Volume 38, No. 3, March, 2007, a working group of the National Child Traumatic Stress Network, a consortium of seventy child mental health centers founded and funded by the Substance Abuse and Mental Health Administration, is proposing that a diagnosis called "developmental trauma disorder" be considered for inclusion in the next version of the Diagnostic and Statistical Manual of Mental Disorders, to address the unique set of symptoms that differs from PTSD and is associated with exposure to multiple, chronic trauma in childhood.

> Problems maintaining a system of meaning (e.g. believing the future holds no promise or hope, profound feelings of despair, helplessness, and hopelessness).[91]

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

> [I]mpaired affect modulation; self-destructive and impulsive behavior; dissociative symptoms; somatic complaints; feelings of ineffectiveness, shame, despair, or hopelessness; feeling permanently damaged; a loss of previously sustained beliefs; hostility; social withdrawal; feeling constantly threatened; impaired relationships with others; or a change from the individual's previous personality characteristics.[92]

Knowledge about the symptoms of both PTSD and of DESNOS/complex psychological trauma should be required of anyone conducting mitigation investigations and evaluations in capital cases.[93] Failure to understand these symptoms and effects results all too often in

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91. The World Health Organization has also recognized posttraumatic changes in psychological functioning. The Tenth edition of the *International Classification of Diseases* (ICD-10) noted a diagnostic category of "lasting personality changes following catastrophic stress," which includes "impairment in interpersonal, social and occupational functioning," and "a hostile and mistrustful attitude towards the world, social withdrawal, feelings of emptiness and hopelessness, a chronic feeling of being 'on the edge' and constantly threatened, and a chronic sense of estrangement." WORLD HEALTH ORGANIZATION, INTERNATIONAL CLASSIFICATION OF DISEASES 232-33 (10th ed. 1992).

92. DSM-IV-TR, *supra* note 19, at 465. Findings from the DSM-IV field trial and from subsequent studies have provided additional empirical support that adaptation to chronic interpersonal violence constitutes a complex, coherent, and consistent pattern of symptoms in both adults and children. *See* Julian D. Ford & Phyllis Kidd, *Early Childhood Trauma and Disorders of Extreme Stress as Predictors of Treatment Outcome with Chronic Posttraumatic Stress Disorder*, 11 J. TRAUMATIC STRESS 743, 745-46 (1998); Susan Roth et al., *Complex PTSD in Victims Exposed to Sexual and Physical Abuse: Results from the DSM-IV Field Trial for Posttraumatic Stress Disorder*, 10 J. TRAUMATIC STRESS 539, 549-53 (1997); van der Kolk & Courtois, *supra* note 89, at 385; Caron Zlotnick et al., *The Long-Term Sequelae of Childhood Sexual Abuse: Support for a Complex Posttraumatic Stress Disorder*, 9 J. TRAUMATIC STRESS 195, 201-04 (1996).

93. De Jong and his colleagues conducted a study of DESNOS symptoms in non-Western samples (Ethiopia, Algeria, and Gaza) and found cultural differences in symptom expression. These authors argue that exposure to extreme traumatic stress results in universal symptoms found across cultures (for example, difficulty modulating emotion and anger, a symptom of the psychobiological process of affect dysregulation) as well as culturally specific symptoms (for example, suicidal ideation was much lower in these samples, which may be attributed to the fact that suicide is taboo in both the Islamic and Coptic religions; the emotions of guilt and shame following exposure to events may be more applicable in some cultures than in others or may result in different behavioral outcomes). Joop T.V.M. de Jong et al., *DESNOS in Three Postconflict Settings: Assessing Cross-Cultural Construct Equivalence*, 18 J. TRAUMATIC STRESS 13, 14, 17-19 (2005). This discussion highlights the critical need for culturally sensitive investigation, as noted by Supplementary Guideline 5.1(C). SUPPLEMENTARY GUIDELINES, *supra* note 14, at Guideline 5.1(C).

misdiagnoses, including misdiagnoses of personality disorders such as Antisocial Personality Disorder ("ASPD").[94] A major problem leading to frequent misdiagnoses of ASPD in the capital setting is that mental health evaluators routinely ignore guidelines of the DSM which suggest the importance of understanding behavior in context in order to properly identify symptoms. For example, the DSM notes, "when personality changes emerge and persist after an individual has been exposed to external stress, a diagnosis of PTSD should be considered," and cautions:

> Concerns have been raised that the diagnosis [of ASPD] may at times be misapplied to individuals in settings in which seemingly antisocial behavior may be part of a protective survival strategy. . . . [I]t is helpful for the clinician to consider the social and economic context in which the behaviors occur.[95]

An evaluator might decide that behaviors signify "irritability and aggressiveness" (a symptom of ASPD) and miss the fact that the behaviors in question are a consequence of the hyperarousal component of PTSD.[96] Similarly, an evaluator might decide that behaviors signify "lack of remorse" (a symptom of ASPD), and miss the fact that the behaviors in question are a consequence of the psychic numbing component of PTSD.[97] Finally, an evaluator might decide that behaviors signify "reckless disregard for safety of self or others" (a symptom of ASPD) and miss the fact that the behaviors in question reflect the DESNOS symptom (and description of associated features of PTSD noted in the DSM-IV) of dysregulated affect and behavior.[98]

The potential for misdiagnoses of ASPD is particularly great when the trauma history has not been sufficiently investigated, such that the capital defense team lacks information that would allow them to

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94. Antisocial Personality Disorder ("ASPD") is described in the DSM as a pervasive pattern of disregard for, and violation of, the rights of others that begins in childhood or early adolescence and continues into adulthood. Symptoms include failure to conform to social norms, deceitfulness, impulsivity or failure to plan ahead, reckless disregard for safety of self or others, consistent irresponsibility, and lack of remorse. DSM-IV-TR, *supra* note 19, at 701-23

95. *Id.* at 703-04. In order to make the diagnosis of ASPD an individual must show evidence of behavioral dysfunction in childhood prior to age fifteen. Often ASPD misdiagnoses are rendered in situations where there has been no social history investigation of a client's childhood behavior and functioning or there is no evidence of conduct problems in childhood.

96. *Compare id.* at 705 (diagnostic criteria for Antisocial Personality Disorder), *with id.* at 468 (diagnostic criteria for Posttraumatic Stress Disorder). This is a core symptom category of PTSD that results in symptoms such as difficulty falling asleep, exaggerated startle response, hypervigilance, difficulty concentrating, or "irritability or outbursts of anger." *Id.* at 464.

97. *Compare id.* at 706, *with id.* at 468.

98. *Compare id.* at 706, *with id.* at 465.

properly contextualize their clients' actions and behaviors, misinterpreting or dismissing them as symptoms of intentional conduct-disordered[99] or antisocial behavior, rather than as trauma responses.[100]

XII. CONTEXT OF INTERPERSONAL VIOLENCE

Just as behaviors must be understood in context for an accurate evaluation of symptoms, an understanding of the context in which interpersonal violence often occurs is also necessary.[101] Recognizable—indeed, predictable—patterns of behavior are seen across situations involving interpersonal violence, particularly when that violence is extensive, ongoing, and involves relationships with an imbalance of power, such as that involved between parent and child or in relationships involving intimate partner violence. In her seminal book on the effects of severe, prolonged and sustained trauma, *Trauma and Recovery*, Judith Herman labeled this "captivity"[102] and provided a succinct description of the dynamics in which chronic abuse occurs:

> Chronic childhood abuse takes place in a familial climate of pervasive terror, in which ordinary caretaking relationships have been profoundly disrupted. Survivors describe a characteristic pattern of totalitarian control, enforced by means of violence and death threats, capricious

99. Conduct Disorder in a condition that is diagnosed in childhood or adolescence, and is described as a "repetitive and persistent pattern of behavior in which the basic rights of others or major age-appropriate societal norms or rules are violated." *Id.* at 93. Symptoms are grouped into four categories, including aggression, property loss or damage, deceitfulness or theft, and serious violation of rules. *Id.* at 93-94. Mischaracterizations of client behaviors frequently occur in death penalty cases, where a client's behavior is taken out of context and labeled "conduct-disordered." One common example involves a child who leaves home to escape physical or sexual abuse and is labeled a "runaway" (a symptom of conduct disorder). *See id.* at 94. Another example involves a child who has not attended school to hide symptoms of abuse (or to care for younger siblings because an alcoholic or depressed parent is disabled) and is labeled a "truant" (another symptom of conduct disorder). *See id.*

100. Supplementary Guideline 5.1(E) specifies that at least one member of the defense team "must have specialized training in identifying, documenting and interpreting symptoms of mental and behavioral impairment," including the "long-term consequences of deprivation, neglect and maltreatment during developmental years," and the "severity and consequences of exposure to trauma." SUPPLEMENTARY GUIDELINES, *supra* note 14, at Guideline 5.1(E).

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

102. HERMAN, *supra* note 89, at 74-95.

> enforcement of petty rules, intermittent rewards, and destruction of all competing relationships through isolation, secrecy, and betrayal.[103]

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

XIII. COERCIVE CONTROL

Researchers and clinicians have long recognized that there is a coherent set of strategies that are used to exert control, induce fear, and undermine the sense of autonomy and will in victims living in a situation "which brings the victim into prolonged contact with the perpetrator."[104] These dynamics have been called "coercive control,"[105] "captivity,"[106] and "psychological maltreatment."[107]

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103. *Id.* at 98. In this quote, Herman is describing ongoing child abuse, but the dynamics described have also been seen in the other situations involving "captivity," including domestic violence and abuse within institutional or internment settings.

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

105. LEWIS OKUN, WOMAN ABUSE: FACTS REPLACING MYTHS 113-39 (1986).

106. HERMAN, *supra* note 89, at 74-76.

107. JAMES GARBARINO ET AL., THE PSYCHOLOGICALLY BATTERED CHILD: STRATEGIES FOR IDENTIFICATION, ASSESSMENT, AND INTERVENTION 8 (1986).

"Coercive control" can be summarized as comprising the four key issues, which will be described below, of isolation; domination and destruction of autonomy; a climate of terror (fear arousal and maintenance); and the demand for collusion/illusion of participation.[108] The following description of these concepts and their effects on trauma survivors is not meant to be comprehensive. I include this information to provide a general idea of the various types of recognized abusive strategies and some of their potentially devastating effects on many capital clients and their families.[109]

A. Isolation

Isolation constitutes the undermining or destruction of attachments, either from the external social world or from one's internal sense of self.[110] Children may be prevented from engaging in appropriate peer activities, forced to dress differently or inappropriately (for example, to attend school in tattered or urine-soaked clothes because of neglect), may be scapegoated within the family, or may be subjected to frequent humiliation[111] (for example, be given "nicknames" like "worthless," "zero," or "no name"). They may be forced to renounce ideals or values of importance to them (for example, an adolescent may turn to religion as a source of solace and be attacked for his beliefs). When considered outside the context of abusive relationships, some of these acts on the part of the caregiver may seem mundane. However, contextualized as

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108. For descriptions of "coercive control," see OKUN, *supra* note 105, at 86-89; EVAN STARK, COERCIVE CONTROL: THE ENTRAPMENT OF WOMEN IN PERSONAL LIFE 198-227 (2007). For a description of "psychological maltreatment," see GARBARINO ET AL., *supra* note 107, at 8. For a description of captive subjugation, see HERMAN, *supra* note 89, at 74-76. While the authors describe these issues somewhat differently depending on the population they are describing (for example, adults versus children) the underlying dynamics of the various conceptualizations are very similar.

109. There is evidence that emotional forms of coercion and torture are psychologically devastating, and are as damaging—if not more so—than physical coercion and torture. Many clinicians and researchers who work with victims of domestic battering report that survivors consistently say that the psychological battering they experienced is more distressing than individual acts of violence. LENORE E. WALKER, THE BATTERED WOMAN xiv-xv (1979); OKUN, *supra* note 105, at 106; *see also* STARK, *supra* note 108, at 5, 13-14, 77-78 (noting that "coercive control" and other acts of psychological abuse undermine a victim's integrity). Başoğlu and colleagues reported that "ill treatment" during captivity, such as psychological manipulation and humiliation, is not substantially different from physical torture in the severity of psychological suffering experienced or in the underlying mechanisms of traumatic stress and long-term psychological outcomes. Metin Başoğlu et al., *Torture vs. Other Cruel, Inhuman, and Degrading Treatment: Is the Distinction Real or Apparent?*, 64 ARCHIVES GEN. PSYCHIATRY 277, 277 (2007).

110. *See* GARBARINO ET AL., *supra* note 107, at 27.

111. *See id.* at 36.

part of the larger picture of coercive control, they may have enormous psychological significance.

A key task of child development is to develop a coherent and positive sense of self, and to competently embed oneself in a larger social world. Isolation prevents a child from adaptively engaging in the myriad of seemingly routine daily interactions that form the basis of social competence. These are the building blocks needed to develop a sense of social belonging and social confidence, and to reinforce relatedness with others.[112] When core attachment relationships become primary sources of danger, disillusionment, and betrayal, the victim may lose (or never develop) hope and a sense of trust in the social world. His or her perceptions of reality may be systematically undermined (for example, a sexually abused child may be told the abuse is for his or her own good or is dictated by the Bible), thus making it difficult to develop accurate perceptions of oneself and others. An abused child may reach adulthood with no expectations of healthy relationships, no beliefs that others are trustworthy, and no sense that he or she is worthy of humane treatment.[113]

B. Domination and the Destruction of Autonomy

Violent relationships are often characterized by the absolute, arbitrary, and capricious exercise of power.[114] Examples might include sleep deprivation (for example, waking someone up in the middle of the night to force them to do household tasks), withholding food, or taking control over basic physical functions (for example, controlling use of toilet facilities, grooming, or hygiene). The effects of this can be devastating, particularly for a child. The will of the perpetrator is frequently asserted without regard for the victim's needs, desires, perceptions, aspirations, and goals. Speaking one's thoughts or expressing emotions that are appropriate to the situation at hand may be the catalyst for a physical or psychological attack.

Key tasks of child development are psychological differentiation and self-mastery, and an increasing ability to function autonomously. Repeated experiences with the arbitrary enforcement of power may undermine a child's ability to operate independently and confidently. It may also impair his ability to negotiate the world around him or develop

112. *See id.* at 7-8, 27-28.

113. *See* HERMAN, *supra* note 89, at 101.

114. For example, see Judith Herman's description of the perpetrator's "inconsistent and unpredictable outburst of violence" and "capricious enforcement of petty rules." *Id.* at 77.

a belief that he has any influence over his own circumstances and his treatment by others.

C. Climate of Terror / Fear Arousal and Maintenance

A climate of fear and terror is often established by threats, surveillance, and degradation.[115] For example, the perpetrator may drive wildly when drunk, leading others to feel their lives are in danger; he or she may suddenly and without provocation become physically abusive. As context, consider a time when your life was in danger and you thought you were going to die or be seriously injured, and imagine living with that level of fear. Actual violence is not needed to instill fear; the mere threat of violence is sufficient, especially when it is clear that the perpetrator has the power to carry out those threats. Living in a state of fear narrows one's focus to basic survival, keeps one focused on the person who induces that state of fear, and profoundly distracts one from engaging in normal developmental tasks. Daily life may be dictated and punctuated by the need to focus on the perpetrator's demands and leave the survivor in states of sickening anticipation and dread. Evidence suggests that persistent states of hyperarousal literally recondition the nervous system and change "set points" for arousal.[116]

D. Demand for Collusion / Illusion of Participation

As noted by Herman:

> Once a perpetrator has succeeded in establishing day-to-day bodily control of the victim, he becomes a source not only of fear and humiliation but also of solace. The hope of a meal, a bath, a kind word, or some other ordinary creature comfort can become compelling to a person long enough deprived.[117]

When arbitrary and capricious control is exerted over the victim of chronic interpersonal violence, he or she often becomes focused on the perpetrator, who may be perceived as omnipotent. The perpetrator may demand expressions of loyalty, allegiance, respect, gratitude, and unconditional acceptance of the status quo. This dynamic is particularly destructive from the perspective of childhood psychological development. For example, a sexually abused child may be forced to

115. *Id.*

116. *Id.* at 36. *See also infra* note 120 (describing some of the neurobiological manifestations of exposure to chronic stress).

117. *Id.* at 78.

"participate" in sexual acts, creating the illusion that he or she is complicit. This can systematically undermine a child's ability to accurately assess issues of responsibility and lead him/her to confuse the role of victim and perpetrator. This dynamic can also fundamentally undermine a victim's capacity to assess accurately the motivations of others, and may lead to inordinate interpersonal difficulties in accurately perceiving and relating to people in a position of authority.

XIV. TRAUMATIC BONDING

Why do people remain in abusive relationships or family systems? Why do they continue to enter new abusive relationships? Why is disclosure of abuse so difficult? Why do abuse victims frequently protect their abusers? A seeming contradiction about psychological trauma is that abusive and exploitive relationships, particularly when they are longstanding, can result in extremely powerful and seemingly inexplicable emotional ties, including intense bonds of loyalty expressed by victims towards abuse perpetrators. This phenomenon has been described as "traumatic bonding" and has been particularly noted in family and relationship systems involving violence.[118] Common to these extremely destructive relationship patterns are unequal power dynamics, the exploitation of trust by caregivers or those in positions of power, and the fact that the abuse and exploitation generally occurs on an intermittent basis.[119]

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118. Don Dutton & Susan Lee Painter, *Traumatic Bonding: The Development of Emotional Attachments in Battered Women and Other Relationships of Intermittent Abuse*, 6 VICTIMOLOGY 139, 142-43 (1981); Susan Lee Painter & Don Dutton, *Patterns of Emotional Bonding in Battered Women: Traumatic Bonding*, 8 INT'L J. WOMEN'S STUD. 363, 364 (1985).

119. Decades of research from the attachment literature shows that the quality of relationship between parent and child has enormous implications for virtually every aspect of a child's development and functioning throughout life. Secure attachment in early years provides the foundation for healthy development of affect regulation, self-identity, and schemas about relationships. More recently, convergent data from clinical and pre-clinical studies provides insight about the neuroscience of attachment. Interactions between caregiver and infant structure brain development and growth, and shape the neural substrate for early social and emotional learning. Abuse, neglect, under-stimulation, and prolonged shame increase stress hormones that are toxic to the brain and impair the child's ability to regulate impulses and affect, which are central to success in forming attachments and negotiating the social world. *See* Elizabeth A. Carlson, *A Prospective Longitudinal Study of Attachment Disorganization/Disorientation*, 69 CHILD DEV. 1107, 1122-24 (1998); *see also* LOUIS COZOLINO, THE NEUROSCIENCE OF HUMAN RELATIONSHIPS: ATTACHMENT AND THE DEVELOPING SOCIAL BRAIN 147-48 (2006); BRUCE D. PERRY & MAIA SZALAVITZ, THE BOY WHO WAS RAISED AS A DOG AND OTHER STORIES FROM A CHILD PSYCHIATRIST'S NOTEBOOK: WHAT TRAUMATIZED CHILDREN CAN TEACH US ABOUT LOSS, LOVE, AND HEALING (2006); ALLAN N. SCHORE, AFFECT REGULATION AND THE ORIGIN OF THE SELF: THE NEUROBIOLOGY OF EMOTIONAL DEVELOPMENT 373-76 (1994); Eric R. Kandel, *Biology and the*

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

XV. IMPLICATIONS FOR CAPITAL WORK AND THE SUPPLEMENTARY GUIDELINES

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

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Future of Psychoanalysis: A New Intellectual Framework for Psychiatry Revisited, 156 AM. J. PSYCHIATRY 505, 513 (1999); Eric R. Kandel, *A New Intellectual Framework for Psychiatry*, 155 AM. J. PSYCHIATRY 457, 468 (1998); L. Alan Sroufe, *Attachment and Development: A Prospective, Longitudinal Study from Birth to Adulthood*, 7 ATTACHMENT & HUM. DEV. 349, 353, 356-58, 360 (2005); Teicher, *supra* note 43, at 7; Teicher et al., *supra* note 43, at 317-19.

and range of traumatic experiences will most likely increase the range of post-traumatic symptomatology and the level of impairment.

Development of a full understanding of Criterion A exposures requires extensive documentary evidence,[120] investigation of a client's cultural and institutional history, multiple interviews with an individual client, and multiple interviews with family members, friends, peers, and teachers (among others).[121] It is all too common to see mental health evaluations at the trial level that consisted of a two- or three-hour interview of the client by a court-appointed mental health professional, relying largely on client self-report, conducted in a hostile setting (for example, a jail), without sufficient time to develop rapport. In the typical scenario where this has occurred, the mental health evaluator operated with little or no historical information or documentary evidence, and with little or no information about the client's family, neighborhood, community, and institutional history.[122] In many cases, there was no attempt to corroborate or assess the minimal information disclosed by the client to the evaluator. The result is a substandard, incomplete,

120. *See* SUPPLEMENTARY GUIDELINES, *supra* note 14, at Guideline 10.11(B).

> The defense team must conduct an ongoing, exhaustive and independent investigation of every aspect of the client's character, history, record and any circumstances of the offense, or other factors, which may provide a basis for a sentence less than death. The investigation into a client's life history must survey a broad set of sources and includes, but is not limited to: medical history; complete prenatal, pediatric and adult health information; exposure to harmful substances in utero and in the environment; substance abuse history; mental health history; history of maltreatment and neglect; trauma history; educational history; employment and training history; military experience; multi-generational family history, genetic disorders and vulnerabilities, as well as multi-generational patterns of behavior; prior adult and juvenile correctional experience; religious, gender, sexual orientation, ethnic, racial, cultural and community influences; socio-economic, historical, and political factors.

Id.

121. *See id.* at Guideline 10.11(C).

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

Id.

122. This issue was recently addressed by the U.S. Supreme Court where trial counsel, relying on the defendant's report of an "unexceptional background," failed to do an independent investigation despite "pretty obvious signs" that he had a "troubled childhood." Rompilla v. Beard, 545 U.S. 374, 379 (2005). Post-conviction counsel obtained records, and the court noted that "[t]he prison files pictured Rompilla's childhood and mental health very differently from anything defense counsel had seen or heard." *Id.* at 390.

unreliable mental health evaluation without depth or context, which rarely touches the surface of the trauma history. Thus, even when a client is forthcoming with respect to his trauma history, the resulting information may be easily attacked or minimized by the prosecutor as self-serving and lacking in corroboration. This is particularly distressing given the consistent finding by experienced capital practitioners that many of their clients have suffered multiple and repeated trauma exposures throughout their lives, often far more severe than they themselves reveal. Moreover, many clients' traumatic experiences have occurred within their own families or communities, increasing both the obstacles to data collection and the need for informed and sensitive investigation.

XVI. BARRIERS TO DISCLOSURE OF TRAUMATIC EXPERIENCES

Many factors operate as barriers to disclosure of traumatic experiences, especially in the context of legal investigations. Most often these barriers arise (or are encountered) during interviews with either the client himself or life history witnesses (for example, siblings or other family members), hence the requirements to devote the necessary time to establish a rapport with the client and the client's family.[123] Differences of race, gender, age, ethnicity, class, education, religion, sexual orientation, and language may come into play, hence the requirement for culturally competent interviews.[124] Obstacles to disclosure may be attributable to the nature of traumatic memory, the skills/techniques of the interviewer, distrust/suspicion of the interviewee, or the longstanding effects of the trauma itself. Following is a partial list of barriers to obtaining thorough and credible trauma/social history information:

Psychological

- Unreliable memories of the subject—either old in time (simply forgotten), revisionist, repressed, or the fragmented memories of a trauma victim
- Psychic numbing or flooding
- Confidentiality concerns—*that is,* fear that disclosed information will be repeated to others (especially family members)
- Reluctance to revisit painful experiences
- Normalizing or minimizing one's traumatic experiences

123. *See* SUPPLEMENTARY GUIDELINES, *supra* note 14, at Guideline 5.1(C), 10.11(C).

124. *See id.* at Guideline 5.1(C); *see also* Holdman & Seeds, *supra* note 2, at 906-21.

- Embarrassment, shame, humiliation, or guilt around specific issues or events
- Fear of being judged (for the trauma or his or her response to it)
- Fear of being dismissed, disbelieved, doubted—risk that the interviewer will not be respectful of experiences/feelings that have great significance (positive or negative) to the subject
- The subject's sense of responsibility for (or complicity in) his own victimization
- Desire to safeguard his personal privacy, or the privacy/dignity/reputation of the family
- Distrust of strangers, especially those associated (at least in the mind of the witness) with lawyers or the legal/judicial system; distrust of people generally

Familial

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

Cultural

- Cross-cultural distrust (sometimes compounded by language barriers)
- Communication barriers encountered because of language differences
- Communication barriers posed by use of interpreters
- Colloquial language that differs from region to region
- Different cultural norms around talking with people outside the family or disclosure of traumatic material
- The male ethos of appearing strong, not vulnerable or helpless (certainly not victimized)

- Lack of trust of authority, including attorneys and mental health experts
- Cultural variability in the expression of mental health symptoms
- Cultural differences in the language for mental health symptoms
- Cultural stigma about mental health issues

Institutional

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

Interview Techniques

- Insensitivity, pushiness, arrogance, or sense of entitlement (to the subject's information) conveyed by the interviewer
- Use of a checklist (rather than open-ended questions) to obtain information
- Use of labels to obtain information (for example, "were you (was he) physically abused?" "Sexually abused?")
- Failure to use open-ended questions, instead asking questions that require a "yes" or "no" answer (for example, "did you ever feel afraid of your father," versus "tell me about a time when you were afraid of what your father might do")
- Lack of understanding about trauma on part of interviewer
- Failure of the interviewer to establish a rapport with the subject
- Insufficient time to obtain information (for example, expectation that the information will be readily disclosed in a short period of time)
- Failure of interviewer to establish a framework for the

process and answer questions/doubts about how personal/traumatic history or family dynamics are relevant to the legal case—either (1) "How can that information help?" or (2) "Why should I spill my guts to someone I don't even know?"

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

XVII. INTERVIEWING FOR TRAUMATIC EXPERIENCES

Investigation of traumatic events and other highly sensitive life experiences requires highly specialized knowledge and skills. By virtue of the mandate to investigate and present the "diverse frailties of humankind,"[125] life history investigation in capital cases can often lead mitigation specialists into areas which are potentially experienced as invasive and intrusive. It requires skilled interviewing of clients, family members, and others on a variety of subjects that are highly sensitive, may be cognitively or emotionally difficult to recall, and the telling or retelling of which may be accompanied by overwhelming affect.[126] These issues are intensified greatly when the task at hand is to interview witnesses about their own and others' painful or deeply buried histories of exposure to traumatic events. In many cases, the witness being interviewed (for example, siblings and other family members) may have been a victim or witness to the same or similar traumatic events or be implicated in the client's trauma (as often happens in cases of multigenerational and systemic child abuse).

125. *See* Woodson v. North Carolina, 428 U.S. 280, 304 (1976) (opinion of Stewart, Powell, and Stevens, JJ.).

126. SUPPLEMENTARY GUIDELINES, *supra* note 14, at Guideline 5.1(C).

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

Id.

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

Most clients represented by capital litigators are male, and special issues may arise with respect to interviewing men about psychological trauma. By virtue of differences in gender role socialization, women may be more likely than men to acknowledge vulnerability associated with traumatic events. Men, on the other hand, may be far less likely to acknowledge or articulate feelings of vulnerability (such as intense fear, helplessness, or horror), especially to strangers or in hostile environments. Their reluctance to disclose weaknesses, real or perceived, may be a deeply engrained aspect of social conditioning.[127] In seeking to elicit highly sensitive historical information, effective interviewers (whether attorneys, mitigation specialists, or mental health professionals) must be keenly aware of obstacles to disclosure generally, and must also be cognizant of the particular concerns or barriers to disclosure facing individual clients.

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

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

XVIII. CONCLUSION

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

Experienced capital defense teams understand the great irony of trauma investigation—common symptoms of severe trauma are themselves barriers to disclosure of traumatic events and their aftermath. Mitigation investigation related to psychological trauma must therefore be informed by the trauma literature, including an understanding of the factors that increase risk, knowledge of trauma and its effects, and an

understanding of the dynamics of interpersonal violence. This base of knowledge informs investigation and interviewing strategies with clients and family members, and provides a framework for presenting the psychological significance of this information to fact-finders. It also informs work with clients and their families.

The Supplementary Guidelines offer a necessary and critical framework for the mitigation function of defense teams in death penalty cases, as they reflect prevailing professional standards and provide comprehensive guidance for the development and presentation of mitigation evidence generally, and for that related to trauma specifically. They reflect the well-established understanding of capital defense attorneys, mitigation specialists, and mental health experts that effective investigation of the client's life history will incorporate methods proven to overcome powerful barriers to disclosure. The Supplementary Guidelines recognize the need for members of the capital defense team to have specialized knowledge, training, and skills in a number of areas, including the presence, severity, and consequences of exposure to trauma; the long-term consequences of deprivation, neglect, and maltreatment during developmental years; mental illness and substance abuse; behavioral and cognitive impairments; and the influence of culture, race, and ethnicity. The Supplementary Guidelines also recognize the critical need for capital defense team members to establish the rapport necessary to work effectively with clients and witnesses, the need for in-person, face-to-face, one-on-one interviews, and the need for multiple interviews in order to establish trust and elicit sensitive information. In sum, they are of profound significance as a blueprint for developing competent, reliable, and comprehensive trauma histories and for attacking the results of unreliable trauma-related investigations and presentations.