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I. Introduction

“&!* you, you #&!*ing %*&#! Put the judge’s &*%! in your mouth, you $%&*#!” the client says, in response to your suggestion that his case does not look good. You are stunned and angry — you have worked very hard for this client, for little or no pay. Family and friends have questioned how you could represent such an evil person. The prosecutor frequently gloats to the press about the overwhelming, damning evidence — the videotaped confession, the bloody photographs, the extensive criminal history. The family of the victim will not look at you unless to glare with disdain. You have committed long hours (away from other clients and from loved ones), endured great stress, argued bitterly during pretrial hearings. The judge has threatened you with contempt. You have awakened in the night worrying about this case, all for the guy who is cussing you out. You furiously suppress an urge to scream at the client or just walk out. The death penalty trial starts in two months; you wonder whether you will kill this client before the state can.

If you have ever represented someone who suffers from Borderline Personality Disorder (BPD), this may sound familiar. If you have represented a client with an explosive temper or one
who can enrage you in a matter of seconds, this may have been BPD in action. If you have reasoned and argued for hours with a client who seemed willfully unreasonable, you may have experienced the extreme frustration of working with BPD. It is infuriating and exhausting. Once you get past your own emotions, you wonder why a client who needs your help so desperately would behave this way. Is he just a jerk or is he really that stupid?

Criminal defense attorneys frequently encounter people with BPD.¹ The Personality Disorders Foundation estimates that over half of individuals in the criminal justice system have severe personality disorders, particularly Antisocial Personality Disorder (ASPD) and BPD. See the Personality Disorders Foundation website, http://pdf.uchc.edu/impact.php. Prevalence of BPD is estimated at about 2% in the general population, 10% in outpatient mental health clinics, about 20% in psychiatric inpatients, and ranges from 30% to 60% in clinical populations with personality disorders. Diagnostic and Statistical Manual of Mental Disorders, Text Revision, 708 (4th ed. 2000) (hereafter DSM-IV-TR). Despite this prevalence², our encounters with the BPD sufferer are often unrecognized because of the nature of this disorder. We often perceive them as merely troublesome, obnoxious, difficult, and annoying, rather than as mentally ill clients. A better understanding of this disorder can assist us in recognizing and effectively representing a BPD client.

The essential feature of Borderline Personality Disorder is a “pervasive pattern of instability in interpersonal relationships, self-image, and affects, and marked impulsivity.” DSM-IV-TR at 706. The borderline personality acts “in an unpredictably contrary, manipulative, and volatile manner” and when threatened “becomes mercurially angry and explosive.” Millon, T. & Davis, R., Disorders of Personality: DSM-IV and Beyond, 662 (1996) (hereafter Millon); DSM-IV-TR at 707. “It is difficult for people to be comfortable with individuals with BPD because they so easily become sullen and hurt or obstinate and nasty. These individuals are readily provoked; they are impatient and irritable unless things go their way.” Dual Diagnosis and the Borderline Personality Disorder, http://www.toad.net/~arcturus/dd/borderln.htm. “Individuals with BPD are inclined
to view authority figures with intensified ambivalence, fear, and rage. Those who have authority are both needed and viewed as dangerous.” Id.

Unfortunately for the criminal defense attorney, the attorney is a primary authority figure in the life of a BPD sufferer at a time of maximum stress. Worse still, the attorney often bears the unpleasant message that things are not going to go the client’s way. This combination of factors spells trouble for the effective attorney-client relationship and can become highly stressful to the attorney. A breakdown in the relationship with the BPD client may involve threats to the physical safety of the attorney, actual violence, intrusive phone calls to your home or office, complaints to the judge, or formal complaints to the bar association. An ability to recognize BPD symptoms and work effectively with such a client can assist in preventing such a breakdown and its consequences.

A BPD client is the ultimate challenge in criminal defense — demanding, rude, stubborn, manipulative, limited self-insight, feels victimized even when victimizing others, does not respond to reason, critical, prone to sudden rages, and ungrateful. In a paradox unique to BPD, the greatest fear of BPD sufferers is abandonment, yet their behavior seems specifically designed to assure the rejection they fear. See Millon, supra, at 662-3. An understanding of this paradox, and of other symptoms, can help attorneys gain insight into and sympathy for the BPD client. The identifying characteristics of BPD demonstrate the complexity and deep roots of this condition.

II. Recognizing Borderline Personality Disorder

“Patients categorized as borderline personalities display an unusually wide variety of clinical symptoms.” Millon at 660. Often there is overlap between BPD and other personality disorders — 60% of individuals diagnosed with BPD in one study met the criteria for other personality disorders, including paranoid, schizotypal, histrionic, narcissistic, avoidant, and dependent personality disorders. Beck, Aaron T., & Freeman, Arthur, Cognitive Therapy of Personality Disorders 179 (1990) (cited at the Dual Diagnosis website, supra). Among our clients, we may see behavior consistent with these personality types, as well as the borderline indicators. Only a
A competent mental health professional can tell us the appropriate diagnosis for a client but the following are indicators that your client may suffer from BPD, a possibility which should be explored by an expert:

A. **History of emotional, sexual, and/or physical abuse or neglect as a child** — “Physical and sexual abuse, neglect, hostile conflict, and early parental loss or separation are more common in the childhood histories of those with Borderline Personality Disorder.” DSM-IV-TR at 708. “In the past two decades, there have been persuasive reports suggesting a high incidence of abuse during childhood in the history of borderline patients. Although sexual abuse appears the most prominent of the abusive triad, both verbal and physical abuse may play a role as well. Some investigators have seen an overlap between posttraumatic stress disorder and borderline personalities, noting it is not only abuse that generates the psychic discordance which can give rise to borderline processes. Other investigators suggest that borderline patients experience their parents as emotionally neglectful rather than overtly abusive.” Millon at 680 (citations omitted).

A history of abuse and neglect often is NOT disclosed by the client, especially early in your relationship. Expert assistance may be needed to develop the social history of your client so you can adequately understand his childhood. Closely related to abuse and neglect is a history of drug and/or alcohol abuse. BPD sufferers, more than any of the other personality disorders, are likely to develop addictive disorders. Richards, H., *Therapy of the Substance Abuse Syndromes*, 280-1 (1993) (cited at the Dual Diagnosis website, *supra*). This history can be evidenced by criminal record, self-report, family or friends, or a complete social history prepared by an appropriate expert.

B. **Suicidal behavior, gestures, threats, or self-mutilation (past or present)** — DSM-IV criteria for 301.83 Borderline Personality Disorder. The client may not necessarily admit to prior suicidal gestures or acts of self-mutilation but a social history should reveal past problems. Check for scars, especially on the hands and arms, and ask about scars elsewhere. BPDs hurt
themselves to gain a release of anxiety and tension. Lifetime risk for suicide in BPD is about 10% and with untreated alcoholism dually diagnosed with BPD the 5-year survival rate is as low as 58%. Gunderson, J. & Links, P., “Borderline Personality Disorder,” Synopsis of Treatments of Psychiatric Disorders, 969-70 (2d ed. 1996) (cited at Dual Diagnosis website, supra). Your client’s suicidal gestures or comments may also be a way of gaining attention and manipulating you, so your response must be carefully considered and reviewed with an expert if possible.

Because your clients may not view cutting themselves as “self-mutilation,” be careful not to use those terms when talking with them. “Some Borderline individuals differentiate between self-mutilation and suicide attempts and will report that cutting on themselves is not a suicidal gesture at all.” Some patients report that cutting is a coping mechanism and describe a sense of relief upon seeing their own blood. Id. This behavior “can be understood symbolically as a reminder of a parent who was conceived of as both abusive (accounting for the pain) and somewhat soothing (accounting for the sense of relief). In fact, many Borderline patients will recall in therapy how abusive parents lost control and hurt them, only to come back later in an apologetic and loving manner.” Id.

C. History of potentially self-damaging impulsivity, for example, spending, substance abuse, binge eating, reckless driving, promiscuity — DSM-IV criteria for BPD. Impulsivity, including aggression, appears to be the product of a combination of genetic disposition, abusive environment, and neurochemistry. “The borderline personality disordered individual appears to have a lower threshold to environmental stimuli, particularly frustrating stimuli, resulting in disinhibited impulsive aggressive behaviors.” Siever, L., The Biology of Borderline Personality Disorder, The Journal of the California Alliance for the Mentally Ill, Vol. 8 No. 1, pp. 18-19, at 19 (1997) (This article is also available at http://www.mhsanctuary.com/borderline/siever.htm).

D. Inappropriate, intense anger or difficulty controlling anger — DSM-IV criteria for BPD. Feelings of anger should be evident in your interaction with the client except perhaps in better controlled, higher-functioning BPDs. The pattern of anger will be apparent in the social history and in the client’s interactions with others in the jail, including guards, and with family, friends,
and loved ones. In a higher functioning BPD client, be sensitive to the possibility that anger toward you is being suppressed or transferred to someone else, because this will interfere with a trusting relationship with the client. Meaningful communication with an angry client is impossible. Your response to the anger is critical to your relationship with the BPD client. Do not respond to anger with anger; it will only escalate tension with the client and signal that he can manipulate you.

**E. Pattern of unstable and intense interpersonal relationships characterized by alternating between extremes of idealization and devaluation (often referred to as “splitting”) — DSM-IV criteria for BPD.** This is a classic sign of BPD. The client quoted at the beginning of this article is at the devaluation stage. Within a few hours, if not minutes, the same client may say that he’s very sorry, you’re the best attorney he’s ever had, and that he can only hope that you can spare some forgiveness for him. The BPD will sing your praises to you and his cellmates, even referring them to you for your legal expertise, when things are going well and he feels good. When things go badly, you will become the enemy who is trying to destroy him. If this occurs, and it is not just a one-time shift from “good” to “bad” or vice-versa, chances are very good that your client is BPD.

"‘Splitting’" is a classic defense mechanism that the Borderline individual has developed in order to cope with a world in which his caretaker is also his abuser. The abused or neglected child is faced with a dilemma. He needs someone to embody his needs for security and stability, yet the abusive/neglectful parent fails to provide these. To cope with this dilemma, as a child, the Borderline individual learns to split off his concept of the good parent from the bad parent. The trauma of abuse and neglect force the child to solidify this immature mechanism for coping with this type of parent. The Borderline individual continues to employ splitting both in his dealings with individual persons and with groups of people."6

**F. Frantic efforts to avoid real or imagined abandonment — DSM-IV criteria for BPD.** Most likely this symptom will not be obvious to us in our relationships with the client — we will see attempts to fire us and not obvious efforts by the client to keep us with him. Fear of abandonment
will appear in more subtle guises — requests for jail visits, constant phone calls, constant letters and demands for replies, and other “pestering” behavior. These are ways in which BPD clients seek to engage our attention and reassurance. Paradoxically, the more they annoy us, the less we want to see them, and thus the behavior can result in what is most feared — abandonment.

G. Identity disturbance: markedly and persistently unstable self-image or sense of self — DSM-IV criteria for BPD. This is difficult for the lay person to detect but can be revealed in personality testing or perceived by an expert. One sign may be found, by history at least, if the client changes his/her look (hair color, clothing type) often — he’s a biker type one day, a cowboy the next. Tattoos can also be indicators, for example, “born to lose”, the ever-popular “ftw”, “love” and “hate” on the fingers, anything that expresses a feeling of being bad or evil.

The BPD’s self-image may vacillate between feeling defective, bad, or victimized at one moment and feeling omnipotent, conceited, or self-righteous later. Akhtar, S., *Quest for Answers: A Primer of Understanding and Treating Severe Personality Disorders* (1995) (as cited at the Dual Diagnosis website, *supra*). Sometimes the vacillation from defective to omnipotent happens in the course of a single conversation. BPDs have been described as “emotional hemophiliacs” in that they are highly vulnerable emotionally, feel intensely, and are unable to control emotions. Kreisman at 7-10. As their emotions shift, so may their self-image, and vice-versa. The shift in self-concept and concomitant shift in the client’s feelings and communication needs to be understood as a defense mechanism so that your response reflects what is occurring. For example, a conversation may begin with the client expressing how he screwed up badly (with the crime) and devolve into a discussion of how you will follow his excellent legal strategy since he knows more than you and he will clearly be acquitted. This will not make sense to a rational person unless understood as a defense mechanism — an attempt to cope with feeling worthless, bad, or helpless. Reminding the client of his previous admissions that he screwed up will NOT improve the situation. Difficult conversations like these are a sign that expert assistance is needed to communicate effectively with your client.
H. Chronic feelings of emptiness — DSM-IV criteria for BPD. This is another subtle indicator best left to the expert, but may become apparent with significant client contact and communication. The client may express this symptom as feeling “dead inside.” “This emptiness may also be understood as a result of being left emotionally drained after the Borderline individual’s many mood swings and angry outbursts. From a psychodynamic standpoint, the Borderline individual never had his dependency needs fulfilled as a developing child and thus will always feel empty.”

I. Transient, stress-related paranoid ideation or severe dissociative symptoms — DSM-IV criteria for BPD. Paranoia is associated with other DSM-IV diagnoses, including Paranoid Personality Disorder and Schizophrenia. In your relationship with the client, mistrust, hostility, or secretiveness may be signs of paranoia. Dissociative symptoms are also characteristic of other diagnoses, such as Post-Traumatic Stress Disorder. Indicators of dissociation include your client describing himself as feeling unreal, out of his body, in a trance, numb, or in a twilight or dream world. This symptom of BPD is highly relevant to the actions of the client at the time of the crime, as discussed infra in Section IV. However, since we normally see capital clients in a structured environment, it is unlikely that the BPD client will experience these symptoms during the post-crime period unless the stress of the case or another stressor causes an episode. Since capital cases can be extremely stressful to all involved, we should be careful in working with the BPD client to avoid, or at least manage, potentially explosive situations.

III. Working with the Borderline Personality

Client A. A Time-Consuming Challenge

Resources for working with BPD sufferers are primarily written by mental health professionals for therapists or for family and friends but can be instructive to attorneys. “Borderline Personality Disorder is one of the most challenging entities for today’s therapist; in fact, this category originated as a repository for patients who fail to improve with ordinary treatment methods and whose particular pathology is most likely to provoke a negative emotional reaction in the

The attorney-client relationship differs from the BPD’s relationships with therapists or loved ones due to the special obligations of attorneys. “Within the context of our legal system, the duties of defense lawyer are those of a **personal counselor** and advocate.” *Polk County v. Dodson*, 454 U.S. 312, 318 (S.Ct. 1981) (emphasis added). Lawyers are not counselors in the therapeutic sense. Our job is not to heal our clients or treat their mental illnesses. However, it is a part of our job to recognize problems, attempt to understand them, and act as effectively as possible on behalf of our mentally ill clients. If a client suffers a mental condition “that renders him incapable of making a considered judgment on his own behalf” this “casts additional responsibilities upon his lawyer.” [Tennessee Code of Professional Responsibility EC 7-12](http://www.angelfire.com/in/psychdef/BPD.html). See also [Tennessee Formal Ethics Opinion 92-F-129](http://www.angelfire.com/in/psychdef/BPD.html) (attorney’s ethical obligations where a death-sentenced client with a history of mental illness seeks to dismiss legal proceedings and be executed include investigating the client’s ability to make a knowing, intelligent, and voluntary decision and seeking a mental health evaluation when appropriate). BPD symptoms, especially if combined with other illnesses, can compromise a client’s ability to make considered judgments. This is particularly so if the client is 1) actively suicidal, 2) functionally suicidal by virtue of his behavior and choices in a capital case, 3) experiences psychotic rages, or 4) develops paranoid beliefs about counsel.

Although problems with the BPD client are likely to arise early on, especially over disputes about particular motions, investigation, or strategy, they will likely reach crisis when the issue of pleading guilty is broached. This can be a significant problem in capital cases where a guilty plea is often the best possible outcome. Early work with the BPD client can help set the stage for that discussion to go as well as possible. As precious and limited as time is for the criminal defense attorney, time and patience are critical to establishing an effective relationship
with the BPD client. What happens during that time may make the difference between effective advocacy and a disaster.\textsuperscript{13}

\textbf{B. Basic Ground Rules and Communication Suggestions} \\
\textbf{1. Get help immediately} — If you learn that your client was previously diagnosed with BPD or suspect that he suffers from BPD, enlist the help of a mental health professional as soon as possible. Medication can help BPD clients control impulsivity, as well as the depression and anxiety associated with the illness. There is no particular drug appropriate to treatment of BPD. Medication is used to treat the multiple symptoms, so anything from antidepressants to short term use of antipsychotic medication may be appropriate.\textsuperscript{14} “A mental health professional can advise you about strategies for communicating with the particular client.

\textbf{2. Utilize the defense team/united front} — Effective death penalty defense normally involves a team of attorneys, investigator(s), mitigation specialist(s), appropriate mental health experts, and other support staff. Often investigators, mitigation specialists, and support staff have better communication skills than attorneys and can work well with a BPD client. Be cautious, however, to avoid a “divide and conquer” problem with the BPD client.\textsuperscript{15} Present a united front, never argue in front of the client. All members of the team must be aware of what is communicated to the client to avoid confusion. Dr. Caruso suggests “it is often best for the primary contact person to be present when other members meet with the Borderline client to provide a sense of consistency. This may calm the client’s fears that the other team member is now meeting with the client because the primary contact person has abandoned him.”

\textbf{3. Set boundaries and do not cross them} — You need to clearly communicate to the client 1) what your role is 2) when, where, and how he can reach you by telephone and that he can always reach you by mail 3) that his role in the courtroom will be to assist you through notes, talking privately and quietly to you at appropriate moments, and not speaking directly to the judge and prosecutor 4) the when, where, how, and why of every motion, hearing, interview or other action in his case 5) that abusive behavior and language will not be tolerated 6) that the case will necessarily
be a long process and 7) that you want to achieve the best result possible with his assistance. If possible, relate “the rules” as they become relevant, rather than all at once, to avoid the impression that you are attempting to control the client. The BPD client will constantly push the limits of the rules and attempt to cross personal and professional boundaries, re-enacting what his prior abusers have done with him. Do not allow him to do so. For some clients this may mean a rule that he can only call during certain hours and that calls will be terminated immediately if he uses abusive language. BPD clients need to know what consequences will ensue for which behaviors and that you will strictly enforce rules.

Do NOT threaten to withdraw from the case as a consequence for bad behavior, because the abandonment paradox will cause the client to test your threat of abandonment with increasingly bad behavior. The BPD client needs to know that you are with him for the long term and that you will do what you say.

Boundaries are important for both the attorney and the client. Borderline Personality Disordered clients can be very intuitive about the personalities, fears, and motivations of others — including defense team members. The BPD client may use this intuition to “push buttons” and manipulate defense team members into behavior that should be avoided — yelling matches with the client, breaking rules to allow extra phone calls or calls at home, revealing personal information about themselves or other team members, or even inappropriate romantic or sexual relationships with the client. The attorneys and team members need to be aware of these issues and of any personal vulnerabilities that could expose them to manipulation by a client. This is a matter of self-protection as well as being an effective advocate for the client.

4. Do not attempt to communicate with the client when he is enraged — When a client is enraged to the extent of the client quoted at the beginning of the article, do not engage in a conversation with him. Quietly inform him that the conversation will be terminated and that you will speak with him soon, when everyone has calmed down. If a client is enraged during a contact visit, attempt to divert him to another topic or tell him that you need to go because of a previous commitment. Responding with anger will only escalate the argument and could be
dangerous. If he walks away, let him go. Make sure you are not between him and the door. Always respond calmly and do not show fear.

5. **Do exactly what you say you will do** — As discussed earlier, the roots of BPD lie in a chaotic, neglectful, abusive childhood in which the client could not depend upon his caregivers. To the extent that the BPD client replays that dynamic with the attorney as authority figure, your ability to be dependable can be extraordinarily meaningful to the client. Any deviation from what you say and what you ultimately do, even something as small as a single promised visit\(^\text{19}\), can trigger abandonment fears (and bad behavior) in the BPD client. Obviously, it is hard for most criminal defense attorneys to do everything they say they will, but recognizing the need not to make promises that cannot be kept is a helpful step. A related issue is the danger of “overselling” the merits of the case in an effort to comfort the client. Although there is a thin line in a capital case between offering absolutely no hope and discussing potential outcomes realistically, it is one we must walk.\(^\text{20}\)

6. **Sharpen communication skills** — A variety of literature is available to help us improve our ability to listen and communicate, even with difficult people. Although criminal defense attorneys tend to avoid “touchy/feely” subjects,\(^\text{21}\) an enhanced understanding and ability to communicate with clients makes our lives easier in the long run — fewer bar complaints to answer, fewer loser trials, fewer arguments with clients, and overall reduced stress. A helpful, if slightly technical, text regarding interviewing techniques, including defusing angry clients and “moving with resistance” is Shea, S., *Psychiatric Interviewing: The Art of Understanding*, (2d ed. 1998).

In Stone, D., et al., *Difficult Conversations: How to Discuss What Matters Most* (2000), the authors describe the reasons why conversations are difficult in terms of the threat the conversation poses to the identity of the participant. *Id.* at 112. They identify three core identities for most individuals: 1) am I competent? (good at anything), 2) am I a good person?, and 3) am I worthy of love? When communicating with the BPD capital client about the charged crime, it is easy to see why the client can feel so threatened, since all three core identities are involved in the
conversation. Our capital clients, especially those who are guilty, have screwed up royally; the press, prosecutors, and witnesses describe them as evil; surely they doubt whether anyone could love them. The defense mechanisms of BPD clients will appear when we begin to have this conversation with them. Thus, the response may range from suicidal depression to omnipotent denial of what is obvious to the attorney (i.e., the jury will convict and give the death penalty) to vicious attacks upon the skills, intellect, moral character, honesty, or appearance of the attorney. An understanding of communication principles can enhance our ability to work effectively with the BPD client by teaching us how to listen and comprehend the unspoken meaning in our conversations with them.

7. **Practice empathy** — BPD clients can be very frustrating, nasty, and hard to like. Even if we cannot like them, an effort to understand them can help 1) dissipate some of our own anger and frustration, 2) communicate with them, 3) advocate effectively for them either at any potential guilt and/or penalty trial or in negotiating a guilty plea with the prosecutor, 4) persuade them to accept our recommendation to plead guilty, and/or 5) prevent punitive actions against us by the client. “Empathy has been broadly defined as ‘understanding the experiences, behavior and feelings of others as they experience them. It means that lawyers must to the best of their abilities, put aside their own biases, prejudices and points of view in order to understand as clearly as possible the points of view of their clients.’” I use the term to capture two different concepts: first, to require the listener not simply to hear her clients, but to understand their problems, and, second, to have compassion for her clients.” Ogletree, C., *Beyond Justifications: Seeking Motivations to Sustain Public Defenders*, 106 Harvard Law Review 1239, 1271-2 (April 1993) (footnotes omitted).

Empathy should be distinguished from sympathy, which implies sharing the feelings of the client and expressing pity. Sympathy may be perceived as condescension by the client and may not be welcome. Even if it is welcomed, sympathy may become a manipulation tool which is ultimately detrimental to the attorney/client relationship. Empathy is understanding what a person is feeling but not necessarily sharing that feeling. The understanding comes from learning
about our clients through them, their family, the life history, mental health experts, and other resources.

Professor Ogletree sees practicing empathy as both effective lawyering and a means of sustaining our own motivations as attorneys. “[E]mpathy enhances a lawyer’s ability to interview and counsel clients, to negotiate with opposing counsel, and to engage in the numerous other types of communication that are demanded of lawyers. Empathy also improves a lawyer’s problem-solving skills, for she is better able to assess the client’s goals and to integrate them into an evaluation of potential solutions. This client contact may in turn have positive effects on one’s motivation to do the work, for when an attorney sees her success rate in terms of improvements in the overall quality of her clients’ lives, she may come to realize that she does much more good on a daily basis than the record of her “wins” and “losses” might indicate....” Id. at 1274-5 (footnotes omitted).

In Zeidman, S., To Plead or Not to Plead: Effective Assistance and Client-Centered Counseling, 3 Boston College Law Review 841, 899 (1998) Professor Zeidman argues:

“It is critical, however, that the training, experience and wisdom [of attorneys] must be combined with compassion and empathy. An attorney motivated by empathy, and acting with compassion, will provide the client with all the reasons, all that she is weighing, as part of a conversation with the client, so that the client will appreciate the grounds for the advice. Counsel must allow ample opportunity for the client to ask questions and voice concerns. Returning to the medical analogy, a patient’s expectation, or hope, is that a doctor will not simply tell her which option to pursue, but instead will define the options, offer an opinion, and explain the bases for that opinion carefully, compassionately and responsively.”

Empathy is an extremely useful tool in capital litigation since it provides a process by which to develop and make sense of mitigating evidence. As we come to know our clients and why they are who they are, we learn the mitigating evidence which will later be provided to the prosecutor, judge, and/or jury. If we can make sense of behavior which is infuriating, frustrating, and unpleasant to us, then we can see a way to explain it to the decision makers in our client’s life.

C. Utilizing SET Principles to Improve the Attorney-Client Relationship
In I Hate You — Don’t Leave Me, supra, Kreisman describes a strategy of working with a BPD sufferer which involves a three step process called SET — 1) support 2) empathy and 3) truth. You must establish your support and empathy for the BPD client before he can accept and act rationally upon the truth. The challenge for the defense team in most capital cases is how to move from support and empathy to “truth.” In order to save his life, a client will need to accept difficult truths. As Doyle, Norton, and Kammen note, the passage of time is crucial. Norton and Kammen advise: “Making the relationship with the team as safe a place for the client as possible is one of the best means to manage his stress. Safety translates into predictability, patience, and benevolence. It includes demonstrating reasoned responses and systematic problem solving skills. Over time, the client may become less anxious and therefore be able to use more complex thought.” Plea Agreements, supra. The process of support is the process of demonstrating to the BPD client that he is safe with you. The defense team can extend support through obtaining adequate medical care for our clients and helping to meet his other needs. Non-case related support such as this can be more meaningful than more traditional forms of advocacy.

In the concept of an attorney as advocate, and not as counselor, one could view “support” as conducting an extensive investigation, assembling experts to assist the defense, and filing motions. All of these are important to effective representation and certainly demonstrate your commitment to the client’s case; however, you should also recognize that they can be a fast-track to the truth, a hard place for the BPD client to be. For example, an extensive investigation may lead to increasing certainty that your client is guilty and destruction of any hope that witnesses may have something helpful to offer the client. This can evoke the BPD client’s defense mechanisms, for example, accusing you of coercing witnesses to lie against him, producing a wild goose chase list of new witnesses, dogged insistence that hostile witnesses be made to recant their lies and tell the truth, and angry outbursts. Also, the BPD client will increasingly fear abandonment as evidence of his guilt piles up. He fears that you will not represent him vigorously
if you believe he is guilty. He may demand to test evidence which may very well be incriminating or engage in other self-defeating behavior. Consider this possibility before reflexively acting upon such requests. Keep in mind that support needs to come in the form of both traditional advocacy and client-centered counseling.

Support and empathy offered over time are the foundations for moving the client from heightened BPD symptoms to a calmer state, and thus toward the ability to perceive truth. As attorneys, we are trained to argue and respond to reason and not to emotions, but reason may not be a helpful tool in working with BPD clients. Norton and Kammen caution that reasoning with a stressed, impaired client can be useless. Id. For a BPD client, it may even be counterproductive. These are people ruled by emotions, not reason, so it makes sense that only a positive, supportive, stable relationship with the attorney can result in a positive emotional environment for persuasion.

The last step, truth, is the most difficult for the BPD client, just as it may be for anyone. The truth in most capital cases is that the client is guilty and he will be punished either with life imprisonment or death. This is not easy for anyone to accept and incrementally harder for the BPD client. Accepting this reality and acting rationally upon it may be a step that the client will never take, even with the best efforts of the best attorneys. However, if provided with support and empathy before reaching the truth stage, the BPD client may be in a position to follow the attorney’s advice and make an independent decision in his best interests. After making efforts to know and understand the client, the attorney will be in a better position to offer meaningful advice. At the very least, even if the client makes decisions against advice which are ultimately self-destructive, he will be able to recognize them as his own.

IV. Borderline Personality Disorder and Legal Strategy

A. Personality Testing — The current trend in capital litigation to avoid personality testing in favor of other diagnostic tools focusing upon cognition, organic impairments, and recognition of
the effects of trauma is often justified in the face of persistent diagnoses of our clients as antisocial psychopaths. Sometimes personality testing cannot or should not be avoided, however. See, e.g., The California Death Penalty Defense Manual, Vol. III, Mitigation Workbook, Chapter III Psychological Impairment, Section III(M) Antisocial Personality Disorder and Psychopathy, p. 101-123 (California Attorneys for Criminal Justice and California Public Defenders Association 1998). If our clients do avoid an antisocial personality (ASPD) diagnosis, they may receive a BPD diagnosis.25

Although many of the diagnostic criteria for BPD reflect unflattering behavior or traits of our clients, the presence of transient, stress-related paranoid ideation or severe dissociative symptoms in BPD clients provides a recognized basis for several guilt phase defenses.26 Further, BPD has been described by at least one court as a mitigating mental condition.27 So, if a client appears to merit a diagnosis of BPD, as opposed to ASPD, that should be a consideration in whether or not to subject him to personality testing.

B. BPD and Guilt Phase Defenses — Depending upon the crime facts, a mental health expert could testify that your client was insane, could not have premeditated, or was acting under extreme emotional disturbance, depending upon the law of your state.28

1. Premeditation — “During direct examination, Dr. Engum opined that the defendant had not acted with deliberation or premeditation in killing Slemmer. Instead Dr. Engum said she had acted in a manner consistent with his diagnosis of borderline personality disorder; she had lost control.” State v. Pike, 978 S.W.2d 904, 912 (Tenn. 1998).

2. Extreme Emotional Disturbance/Distress — “He restated his diagnosis that the defendant exhibited signs often associated with borderline personality disorder and post-traumatic stress disorder29 and said that the defendant was under extreme emotional distress when he committed the murder in this case.” State v. Hall, 958 S.W.2d 679, 687 (Tenn. 1997).

3. Insanity — “Kenneth Anchor, Ph.D., a psychologist, testified that Brooks had a borderline personality disorder with paranoid features of chronic substance abuse. Anchor concluded that
Brooks was legally insane at the time of the crime.” State v. Brooks, 880 S.W.2d 390, 392 (Tenn. Crim. App. 1993). “Dr. Michael Stein, a psychologist who had conducted a six-hour clinical interview of and administered two tests to the defendant on March 30, 1984, diagnosed the defendant as suffering from borderline personality disorder, paranoid personality disorder and brief reactive psychosis. He opined that at the time of the killing defendant was suffering from a psychotic episode as the result of a mental disease or defect and could not therefore appreciate the wrongfulness of his acts or conform his conduct to legal norms.” State v. Taylor, 771 S.W.2d 387, 391 (Tenn. 1989).

C. BPD as Mitigation

1. Trauma and BPD — BPD, and the current research regarding its origins, can provide a framework for linking the client’s childhood trauma to the negative aspects of his adult behavior. “Many of the most troubling and difficult features of BPD become more comprehensible in the light of a history of early, prolonged, severe childhood trauma. The psychopathology becomes an understandable adaptation to an environment of fear, secrecy, and betrayal rather than an innate defect in the self. Chronic childhood abuse takes place in a familial climate of pervasive terror. The abused child cannot turn to a parent for protection, either because the parent is himself the abuser, or because the abuser has succeeded in alienating the child from his or her primary caretaker....” Millon at 655 (citation omitted). Thus we see our client’s bad or unpleasant behavior as a product of an environment experienced when he was a helpless child rather than innate meanness.

New studies have linked four types of brain abnormalities to child abuse and neglect, establishing that our brain is “hard wired” by our childhood experiences. See, for example, Mclean Researchers Document Brain Damage Linked to Child Abuse and Neglect at http://www/psycport.com/news/2000/12/14/bw/0000-0948-ma-mclean.html. (An article about this research also appears in the Fall 2000 issue of Cerebrum.) Dr. Siever, in The Biology of Borderline Personality Disorder, supra, discusses BPD as the product of the interaction of genetics and environment upon the brain, citing evidence that abuse causes structural changes to the
brain. Dr. Siever concludes “[w]hile we are only beginning to understand the biologic aspects of BPD, it is clear that the development of BPD depends on an interaction of constitutional biologic vulnerabilities with often adverse environmental circumstances during development.”

“In many ways, Borderline Personality Disorder may be conceived of as PTSD that becomes entrenched at a very early developmental stage, with overlapping symptoms such as anger outbursts and mood disturbance. Borderline individuals tend not to present with flashbacks and nightmares, but they frequently manifest intense psychological distress when confronted with internal or external cues that recall prior trauma such as abuse. Borderline individuals differ from patients with PTSD from trauma in later life in that BPD patients have difficulty recognizing how one of these triggering cues is associated with prior trauma, whereas patients with PTSD from trauma later in life are generally well aware of the association.”

2. Inner turmoil/outer manifestations — An understanding of the processes occurring in the BPD’s mind can evoke compassion for the mental agony suffered and go a long way toward offsetting the prosecution’s portrait of a manipulative, devious, selfish person. “The Borderline individual’s unstable relationships are a reflection of his internal chaos. This internal chaos is also manifested in the Borderline individual’s instability in his emotions or affect. Because he has not had consistent caretaking parents, he has not learned to soothe himself or to modulate his own affect in a healthy manner. This emotional instability is what leads to many of his mal-adaptive behaviors.”

“The PTSD/borderline person suffers first and foremost from a disorder of the stream of consciousness. More specifically, the PTSD/borderline person suffers from the inability to turn off a stream of consciousness that has become its own enemy, comprised of actual memories of traumatic events, distorted and fragmented memories, unwelcome somatic sensations, negative self-commentaries running like a tickertape through the mind, fantasied and feared elaborations from childhood of the abuse experiences, and concomitant strongly dysphoric moods of anxiety and anger. Much that the adult PTSD/borderline does....is a response to, or an attempt to terminate or modify, the intolerable presence of this stream of consciousness.” Millon at 656.
3. **Future non-dangerousness** — For purposes of future dangerousness, the jury should be informed that Borderline Personality Disordered people, as is also the case for ASPD, tend to “burn out” as they age. “During their 30s and 40s, the majority of individuals with this disorder attain greater stability in their relationships and vocational functioning. Follow-up studies of individuals identified through outpatient mental health clinics indicate that after about 10 years, as many as half of the individuals no longer have a pattern of behavior that meets full criteria for Borderline Personality Disorder.” DSM IV-TR at p. 709.

4. **Presenting evidence of BPD** — The means of presenting evidence of BPD to a jury in the penalty phase of a capital case can take many forms. Preferably, the defense team would have the assistance of an expert well-versed in the organic, environmental, and hereditary causes of BPD. An expert should also be able to describe the linkage between these causes and specific behavior of the client (assuming no danger to opening the door to other bad acts that would otherwise be inadmissible). As always, the presentation of the abusive, traumatic childhood is best accomplished through friends, family members, neighbors, social service documents and witnesses, etc., in order to provide a complete, detailed portrait of the client’s life at a formative time. It may be that your client has written poetry or other literature to describe his inner torment that could be introduced to the jury through another witness.

D. **Legal Authority for BPD as Mitigation** — The Tennessee Supreme Court has described borderline personality disorder as mitigation in the context of proportionality review. See *State v. Vann*, 976 S.W.2d 93, 107-8 (Tenn. 1998):

The mitigation proof (in *State v. James Lloyd Julian*, 1997 Tenn. Crim. App. LEXIS 702, No. 03C01-9511-CR-00371, (Tenn. Crim. App., at Knoxville, July 24, 1997)) showed that the twenty-three-year-old single male defendant had a longstanding history of drug and alcohol abuse. He had some history of criminal behavior, primarily drug possession and driving under the influence offenses. He had been sexually abused as a child by his maternal grandfather and his mother had been an alcoholic. His parents were divorced and the defendant had an unstable family history. He had emotional problems and had been diagnosed with depressive disorder and a mixed personality disorder with borderline features. The defendant said he had smoked marijuana and consumed a fifth of bourbon in the hours before the murder. The defendant had turned himself into the police for
committing the offense.

Though the means and manner of death in this case are quite similar to the murder in State v. Julian, other differences are apparent and striking. Unlike this case, the jury in Julian did not find that the defendant had been previously convicted of a violent felony offense. Moreover, substantial mitigation proof was introduced regarding Julian’s mental and emotional condition, his abusive and unstable family background, and his drug and alcohol addiction, including proof that he was under the influence of drugs and alcohol at the time of the killing.

Similarly the Court has stated:

In State v. Brimmer, supra, the defendant handcuffed the victim to a tree and strangled him to death with a wire slipknot. He was sentenced to death solely because the killing occurred in the course of a felony. Tenn. Code Ann. ' 39-2-203(I)(7) (1982) [now Tenn. Code Ann. ' 39-13-204(I)(7) (1991)]. There was substantial mitigating evidence indicating that the defendant had a borderline personality disorder, which resulted in impulsive and unpredictable behavior. We held, however, that the evidence was sufficient to find that the single aggravating factor outweighed evidence of mitigating factors and that the penalty, as applied to the defendant under the facts and circumstances of the case, was not disproportionate. 876 S.W.2d at 88. State v. Cauthern, 967 S.W.2d 726, 740 (Tenn. 1998).

E. Right to Instruction — Presentation of evidence of borderline personality disorder justifies a specific instruction to the jury that BPD is a mitigating circumstance. “The jury instructions are critical in enabling the jury to make a sentencing determination that is demonstrably reliable. To ensure this reliability, the jury must be given specific instructions on those circumstances offered by the capital defendant as justification for a sentence less than death. In this regard, the party desiring such an instruction must submit the requested instruction in writing to the trial court.” State v. Odom, 928 S.W.2d 18, 31 (Tenn. 1996). A sample instruction might read as follows:

Joe Smith suffers from Borderline Personality Disorder, a mental condition caused by a combination of genetic vulnerability and an abusive and neglectful upbringing. Joe’s father, uncle, and grandmother either suffered or most likely suffered from Borderline Personality Disorder which means Joe was at least five times more likely to develop this condition than someone without his genetic circumstances. During his childhood Joe was neglected, and often abandoned for hours, and at times, days. When they were home, both parents beat Joe, sometimes until he bled. As a consequence of developing Borderline Personality Disorder, Joe was unable to maintain good relationships with other people throughout his life because he was not raised to trust others and had no reason to do so, given his
upbringing. Joe also has engaged in impulsive behavior which has hurt himself and others. This impulsive behavior is a symptom of his illness. Borderline Personality Disorder is a mitigating circumstance which you, the individual juror, shall consider in deciding which punishment to impose upon Joe Smith. A mitigating circumstance is not an excuse for behavior; it is a factor in favor of imposing life rather than death.

V. Conclusion

Sometimes the greatest challenge for us as attorneys in a death penalty case is establishing and maintaining a good relationship with our client. Many of our clients suffer from Borderline Personality Disorder, a condition that is characterized by tumultuous and frustrating relationships. As difficult as these clients are, with expert assistance and an understanding of the dynamics of their relationships, we can improve our ability to effectively represent them and decrease our stress. As we learn about these clients through empathy, their stories will unfold in a way that is compelling to us and to those who will decide whether they live or die.

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'This article focuses upon Borderline Personality Disorder in capital murder cases although these principles are applicable to all cases. Since resolution by plea bargain is normally
the best possible outcome in a death penalty prosecution, the assumption is made that the relationship with a BPD client needs to progress over time to a point where a recommendation to plead guilty is made and followed. Certainly, the BPD client may also be innocent, in which case his trial prospects can only be enhanced by a positive attorney-client relationship.

2 Most people diagnosed with BPD are women — about 75%. DSM-IV-TR, p. 708. However, most capital defendants are men, so the pronoun “he” is generally used herein to refer to BPD sufferers.


4 Interview with Dr. Keith A. Caruso, Treadway Clinic, Forensic Services Section, Dover Centre at Cool Springs, 113 Seaboard Lane, Suite C-150, Franklin, TN 37607 (1/22/01).

5 DSM-IV-TR at 709 (“Borderline Personality Disorder is about five times more common among first-degree biological relatives of those with the disorder than in the general population. There is also an increased familial risk for Substance-Related Disorders, Antisocial Personality Disorder, and Mood Disorders.”)

6 Dr. Caruso, supra.

7 As discussed infra, the trend in capital litigation is away from subjecting a client to personality testing and toward focusing upon cognitive deficits, other organic dysfunction, and the effects of an abusive, traumatic childhood. Decisions regarding a mental health strategy should be based upon a thoughtful analysis of the individual client, the case facts, and relevant caselaw in your jurisdiction.

8 DSM-IV-TR at 707 (“Borderline Personality Disorders usually have a self-image that is based on being bad or evil.”)

9 Dr. Caruso, supra.

10 These multiple overlapping concepts, just as with various personality traits and diagnoses, illustrate the imperfections of the DSM-IV as an aid to understanding and categorizing human behavior. The distinction, and need for a distinction, between “personality disorders” and
organic” illnesses diminishes as the scientific community learns more about the effects of abuse, toxic substances, trauma, and other environmental factors, in combination with heredity, upon the brain and behavior.

Dr. Caruso notes it is not uncommon for a Borderline individual to experience a Brief Psychotic Episode, which would constitute an additional diagnosis... which may be considered the basis of either an insanity defense or diminished capacity.” Further, many, if not most, individuals with BPD have other diagnosis, often PTSD or depressive conditions. Generally Schizophrenia and BPD are mutually exclusive but BPD and Bipolar Disorder or Schizoaffective Disorder are not. Id.


“The ABA Standards for Criminal Justice state that '[d]efense counsel should seek to establish a relationship of trust and confidence with the accused.’ Experienced capital defense attorneys recognize the paramount importance of establishing such a relationship. Most agree that establishing such a relationship is a prerequisite to effective representation. For example, Millard Farmer says, 'Establishing a relationship of trust and respect with the client is the most important thing' a capital defense attorney can do.” White, W., Effective Assistance of Counsel in Capital Cases: The Evolving Standard of Care, 1993 U. Ill. L. Rev. 323, 374 (1993) (footnotes omitted).

The current treatment of choice for unstable Borderline patients is a combination of SSRI medications (Prozac, Zoloft, Paxil, Luvox, Celexa, or Effexor) mood stabilizers (such as Lithium or anti-seizure medicines like Depakote, Neurontin, or Tegretol) and low dose antipsychotic medications. Dr. Caruso, supra.

Dr. Caruso describes this problem as a function of the “splitting” phenomenon described earlier. Borderline individuals are also well known for splitting off members of the defense team (or treatment team in psychiatry) and pitting them against one another. In many ways, this becomes the re-enactment of the chaos that the Borderline individual feels is going on inside himself.” Id.

Withdrawal may be ultimately required in some cases for ethical reasons, but there is no need to draw the client’s attention to that fact.
“The difficulty in working with individuals with BPD is that they will actively coerce nurturance until the service providers burn out.” Dual Diagnosis website, supra.

Using the term “everyone” instead of “you” helps to diffuse blame and calm the client. Pointing out that he is unreasonably angry while you are blameless does not accomplish this.

Dr. Caruso suggests frequent, short (30-60 minute), regularly scheduled meetings to establish a working relationship with the BPD client. “Remember, this is an individual who knows inconsistency all too well. Giving notice of future unavailability for these visits is also advisable, preferably as far in advance as possible.” Id.

For suggestions on client strategies in capital cases, see Doyle, Kevin, Heart of the Deal: Ten Suggestions for Plea Bargaining, The Champion (November 1999), and Kammen, Rick & Norton, Lee, Plea Agreements: Working with Capital Defendants, The Advocate (Kentucky Department of Public Advocacy publication), No. 2 (March 2000).

“A willingness to try to persuade involves the assumption of an awesome amount of responsibility. Many lawyers are simply loath to take on such a burden. Some prefer remaining detached rather than getting involved in the emotions and anxiety that attend a decision of this magnitude. Others are motivated by fear of lawsuits or appeals based on allegations of improper coercion. They believe that the more the decision is the client’s, the more they are insulated from potential liability. Perhaps most important of all, many defense lawyers are not invested in, and empathetic toward, their clients. To these attorneys, the client is secondary....” Zeidman, S., To Plead or Not to Plead: Effective Assistance and Client-Centered Counseling, 3 Boston College Law Review 841, 906 (1998) (footnotes omitted). Zeidman’s article discusses Boria v. Keane, 99 F.3d 492 (2d. Cir. 1996), a case finding an attorney to be ineffective for failing to persuade a client to plead guilty. He argues that attorneys’ counseling obligations are mandated by the Constitution, as well as ethical guidelines.

See Heart of the Deal, supra; Plea Agreements, supra; and Zeidman, supra, at 906-7 (“[Effective attorneys] are willing to put in the necessary time, effort and commitment to conduct thorough factual and legal preparation, and to expend the vast amount of energy often needed during counseling of this nature. Return again to the scenario where counsel believes that a plea is necessary to avoid disastrous consequences. Counsel conveys the offer and supplies her opinion and the bases for that opinion, but the client declines to plead guilty. An empathetic lawyer, motivated by concerns for her client, will, rather than responding, ‘Great. Let’s go to trial,’ intervene in the client’s decision and begin the process of trying to persuade. The ensuing counseling is difficult. It is often unpleasant. It is almost always unrewarding. Yet, she does it out
of concern for her client.”)(citations omitted).

See Zeidman, supra, at 902-3: It must also be acknowledged that many criminal defendants, for a variety of reasons, are not well-suited to [making critical choices such as whether to plead guilty]. Numerous studies establish undeniable links between crime and mental illness, and the number of inmates with some form of mental disability is extremely high. The prevalence of chronic alcohol and/or drug abuse among inmates has been documented by countless studies. Given that the urban poor comprise the majority of those who are incarcerated, it is important to acknowledge the effects of what has been referred to as socio-economic deprivation or ‘rotten social background.’ Malnutrition, lead poisoning, inadequate medical care and other by-products of environmental deficits can certainly impact adversely on cognitive development. All these conditions may contribute in whole or in part to the possibility that a defendant may be unable, or ill-equipped, to make a decision of this magnitude. Even for those defendants unaffected by organic or physical impairment, the stress of this critical decision can act as an inhibitor to rational, careful decisionmaking...when the decisionmaking involves anxiety and outcomes that evoke strong emotions, the ability to decide calmly and rationally is compromised.”

The personality disorders are generally found on Axis II. As forensic psychologist Joel A. Dvoskin notes “Axis II is a horrible thing to be. Though DSM IV lists along Axis II a variety of personality disorders, people who are so described are treated as if their disruptive and self-destructive acts are simply evidence of moral weakness, dishonor, and perhaps evil.” Dvoskin, Joel, Sticks and Stones: The Abuse of Psychiatric Diagnosis in Prisons, The Journal of the California Alliance for the Mentally Ill, Vol. 8 No. 1, pp. 20-21, 20 (1997) (emphasis original).

“Using DSM-III-R criteria and family histories, studies have found that BPD could not be readily separated from [Antisocial Personality Disorder] and [Histrionic Personality Disorder] diagnoses and questioned whether the three disorders could validly be considered separate entities.” Mehler, Brock, Antisocial Personality Disorder as Mitigating Evidence, The Champion, p.1926, 23 (June 1990) (footnote omitted). The gender discrepancy between diagnoses of BPD and ASPD may indicate that our male ASPD clients are BPDs who have been misdiagnosed or reflect different approaches in males and females for processing trauma. “Dr. Perry [Bruce Perry, a psychiatrist at Baylor College of Medicine, Civitas Program] has demonstrated that kids protect themselves in two common ways; and that these strategies permanently change the way their brains process certain kinds of information. One ways, often used by boys, is to become chronically hyper aroused, perhaps in an effort to drown out their pain by overwhelming it with other stimuli. The second way, more often used by girls, is to shut down their systems of stimulus input, trying to endure until the threat finally goes away.” Dvoskin, Sticks and Stones,
Mehler describes BPD as having “overtones of psychosis” and notes “use of unstructured projective tests (such as the Rorschach and Thematic Apperception Tests)... can reveal the disturbed functioning and ‘primary process’ thinking characteristic of BPD.” Id. at 23-4 (footnote omitted).

BPD could potentially compromise a client’s competency to stand trial, especially his ability to “consult with his lawyer with a reasonable degree of rational understanding...” as required by Dusky v. United States, 362 U.S. 402, 402 (1960). BPD was among the conditions affecting competency to be executed in Coe v. State, 17 S.W.3d 193, 204 (Tenn. 2000) (“the appellant possibly could become psychotic in the future as a result of his borderline personality disorder...”).

An expert must define Borderline Personality Disorder and/or its symptoms as a mental illness or defect. “‘Mental disease or defect’ [is] any abnormal condition of a mind which substantially affects mental or emotional processes and impairs the behavior controls.” State v. Max, 714 S.W.2d 289, 295 (Tenn. Crim. App. 1986). See State v. Hall, infra, as a guide for the legal requirements for a mental health defense in Tennessee.

The relationship between post-traumatic stress disorder (PTSD) and BPD, see Millon at 680, is significant and appears to be based in the childhood abuse and trauma which are associated with these diagnoses. In terms of defense strategy, PTSD (DSM-IV 309.81) is the more sympathetic diagnosis since it is an Axis I diagnosis which is described in terms of the fear, horror, and helplessness your client has suffered rather than unattractive personality characteristics. When selecting among competent mental health professionals, attorneys should seek an expert who can help the jury understand the origin of BPD in abuse, neglect, trauma, biology, and the lottery of genetics rather than focusing upon the negative aspects of the resulting personality.

Dr. Caruso, supra.