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United States vs. Zacarias Moussaoui

Expert Statement Regarding Adjudicatory Competence

I am a Board-certified psychiatrist, licensed to practice medicine in the Commonwealth of Massachusetts, and have extensive experience in evaluating the psychiatric effects of isolated confinement in prison. My curriculum vitae is separately attached. I was consulted by Attorney Judith Clarke in regard to the above-captioned matter, and have reviewed expert reports prepared by Dr. Raymond Patterson (dated May 23 and June 7, 2002) as well as reports prepared by Drs.. Xavier Amador and William Stejskal (dated May 30 and July 24, 2002).

I use the term isolated confinement (or "segregated" or "solitary" confinement) to describe a situation in which the inmate is confined to his cell for almost the entire day - typically 22 or 23 hours/day - and in which the inmate has very limited access to conjoint recreation and social interaction, and generally has other stringencies imposed, including limited personal possessions, upon educational and occupational opportunities, as well as visitation and social telephone contact; out of cell movement is generally restricted, and often involves the use of shackles and other mechanical restraints. During the course of my professional work, I have had the opportunity to observe a number of different settings of such confinement, including settings in which pretrial detainees were held in federal custody under Special Administrative Measures ("SAMs"). I have had the opportunity to evaluate the psychiatric effects of isolated confinement among pretrial detainees accused of terrorist activities, and of the effect of such confinement among others who committed crimes in furtherance of the goals of radical political groups. It is my understanding that Mr. Moussaoui has been housed

for many months under conditions of isolated confinement fairly typical of those whose effects I have previously described.

I. Introduction.

My observations and conclusions regarding the psychiatric effects of solitary confinement have been cited in a number of federal court decisions, for example: Davenport v. DeRobertis, 844 F.2d 1310, and Madrid v. Gomez, 889 F.Supp. 1146. I prepared a written declaration for Madrid describing the medical literature and historical experience concerning the psychiatric effects of solitary confinement and of other conditions of restricted environmental and social stimulation. I have prepared the general (non-institution specific) and non-redacted (non-inmate specific) portions of that declaration into a general Statement, which I have entitled "Psychiatric Effects of Solitary Confinement"; a copy of this statement is attached to this statement and forms an integral part thereof. It describes the extensive body of literature, including clinical and experimental literature, regarding the effects of decreased environmental and social stimulation, as well as specifically, observations concerning the effects of solitary confinement on prisoners.

II. General Opinions.

I offer here a general overview of the issue:

It has long been known that severe restriction of environmental and social stimulation has a profoundly deleterious effect on mental functioning; this issue has, for example, been a major concern for many groups of patients including, for example, patients in

intensive care units, spinal patients immobilized by the need for prolonged traction, and patients with impairment of their sensory apparatus (such as eye-patched or hearing impaired patients). This issue has also been a very significant concern in military situations and in exploration - polar and submarine expeditions, and in preparations for space travel.

In regard to solitary confinement, the United States was actually the world leader in introducing prolonged incarceration - and solitary confinement - as a means of dealing with criminal behavior; the "penitentiary system" began in the United States in the early 19th century, a product of a spirit of great social optimism about the possibility of rehabilitation of individuals with socially deviant behavior. This system, originally embodied as the "Philadelphia System", involved almost an exclusive reliance upon solitary confinement as a means of incarceration, and also became the predominant mode of incarceration - both for post conviction and also for pretrial detainees - in the several European prison systems which emulated the American model.

The results were catastrophic. The incidence of mental disturbances among prisoners so detained, and the severity of such disturbances, was so great that the system fell into disfavor and was ultimately abandoned. During this process, a major body of clinical literature developed which documented the psychiatric disturbances created by such stringent conditions of confinement. The paradigmatic disturbance was an agitated confusional state which, in more severe cases, had the characteristics of a florid delirium, characterized by severe confusional, paranoid and hallucinatory features, and also by intense agitation and random, impulsive violence - often self-directed.

The psychiatric harm caused by solitary confinement became exceedingly apparent. Indeed, by 1890, in In re Medley, 10 S.Ct. 384, the United States Supreme Court explicitly recognized the massive psychiatric harm caused by solitary confinement: "This matter of solitary confinement is not ... a mere unimportant regulation as to the

safe-keeping of the prisoner .... [E]experience [with the penitentiary system of solitary confinement]demonstrated that there were serious objections to it. A considerable number of the prisoners fell, after even a short confinement, into a semi-fatuous condition, from which it was next to impossible to arouse them, and others became violently insane; others still, committed suicide; while those who stood the ordeal better were not generally reformed, and in most cases did not recover sufficient mental activity to be of any subsequent service to the community." 10 S.Ct. at 386.

The consequences of the Supreme Court's holding were quite dramatic for Mr. Medley. Mr. Medley had been convicted of having murdered his wife. Under the Colorado statute in force at the time of the murder, he would have been executed after about one additional month of incarceration in the county jail. But in the interim between Mr. Medley's crime and his trial, the Colorado legislature had passed a new statute which called for the convicted murderer to be, instead, incarcerated in solitary confinement in the State Prison during the month prior to his execution. Unhappily, simultaneously with the passage of the new law, the legislature rescinded the older law, without allowing for a bridging clause which would have allowed for Mr. Medley's sentencing under the older statute.

Mr. Medley appealed his sentencing under the new statute, arguing that punishment under this new law was so substantially more burdensome than punishment under the old law, as to render its application to him *ex post facto*. The Supreme Court agreed with him, even though it simultaneously recognized that if Mr. Medley was not sentenced under the new law, he could not be sentenced at all. Despite this, the Court held that this additional punishment of one month of solitary confinement was simply too egregious to ignore; the Court declared Mr. Medley a free man, and ordered his release from prison.

Dramatic concerns about the profound psychiatric effects of solitary confinement have

continued into the twentieth century, both in the medical literature, and in the news. The alarm raised about the "brainwashing" of political prisoners of the Soviet Union and of Communist China - and especially of American prisoners of war during the Korean War - gave rise to a major body of medical and scientific literature concerning the effects of sensory deprivation and social isolation, including a substantial body of experimental research.

This literature, as well as my own observations, has demonstrated that, deprived of a sufficient level of environmental and social stimulation, individuals will soon become incapable of maintaining an adequate state of alertness and attention to the environment. Indeed, even a few days of solitary confinement will predictably shift the electroencephalogram (EEG) pattern towards an abnormal pattern characteristic of stupor and delirium.

This fact is, indeed, not surprising. Most individuals have at one time or another experienced, at least briefly, the effects of intense monotony and inadequate environmental stimulation. After even a relatively brief period of time in such a situation, an individual is likely to descend into a mental torpor - a "fog" - in which alertness, attention and concentration all become impaired. In such a state, after a time, the individual becomes increasingly incapable of processing external stimuli, and often becomes "hyperresponsive" to such stimulation; for example, a sudden noise or the flashing of a light jars the individual from his stupor, and becomes intensely unpleasant. Over time, the very absence of stimulation causes whatever stimulation <u>is</u> available to become noxious and irritating; individuals in such a stupor tend to avoid any stimulation, and progressively to withdraw into themselves and their own mental fog.

An adequate state of responsiveness to the environment requires both the ability to achieve and maintain an attentional set - to <u>focus</u> attention - and the ability to <u>shift</u> attention. The impairment of alertness and concentration in solitary confinement leads

to two related abnormalities

The inability to focus, to achieve and maintain attention, is experienced as a kind of dissociative stupor - a mental "fog" in which the individual cannot focus attention, cannot, for example, grasp or recall when he attempts to read or to think.

The inability to shift attention results in a kind of "tunnel vision" in which the individual's attention becomes stuck - almost always on something intensely unpleasant - and in which he cannot stop thinking about that matter; instead, he becomes obsessively fixated upon it. These obsessional preoccupations are especially troubling. Individuals in solitary easily become preoccupied with some thought, some perceived slight or irritation, some sound or smell coming from a neighboring cell, or - perhaps most commonly, by some bodily sensation - tortured by it, unable to stop dwelling on it. I have examined countless individuals in solitary confinement who have become obsessively preoccupied with some minor, almost imperceptible bodily sensation, a sensation which grows over time into a worry, and finally into an all-consuming, life-threatening illness.

In solitary confinement, ordinary stimuli become intensely unpleasant, and small irritations become maddening. Individuals in such confinement brood upon normally unimportant stimuli, and minor irritations become the focus of increasing agitation and paranoia. Not infrequently, inmates experiencing such conditions become agitated, with chaotic violence and self-mutilation or suicidal behavior. Behavior may regress massively in such a setting.

There is, of course, substantial differences in the effects of solitary confinement upon different individuals. Those most severely affected - often individuals with evidence of subtle neurological or attention deficit disorder, or with some other vulnerability -

may suffer from states of florid psychotic delirium, marked by hallucinatory confusion, disorientation, and even incoherence, and by intense agitation and paranoia; these psychotic disturbances often have a dissociative character, and individuals so affected often do not recall events which occurred during the course of the confusional psychosis. Other individuals - generally, individuals with more stable personalities and greater ability to modulate their emotional expression and behavior, and individuals with stronger cognitive functioning - are less severely affected. However, all of these individuals will still experience a degree of stupor, difficulties with thinking and concentration, obsessional thinking, agitation, irritability and difficulty tolerating external stimuli (especially noxious stimuli).

Moreover, individuals who have suffered from prolonged periods of such confinement not uncommonly will suffer lasting effects, including a chronic social isolation and distrust of people, chronic anxiety, hypervigilance and avoidance, and continuing volatility, explosive irritability, and depression.

III. Opinions Regarding Zacarias Moussaoui

I have not personally evaluated Mr. Moussaoui; instead, I have been asked to comment based upon the reports of the other experts - Drs.. Patterson, Amador, and Stejskal. I conclude that there is significant evidence that Mr. Moussaoui is currently mentally impaired, and that this impairment substantially impacts his ability to cooperate in his own legal defense, and also substantially impacts and undermines his competence to choose to fire his attorneys and represent himself at trial.

1. Vulnerability factors:

From these reports, it is clear that Mr. Moussaoui was at high risk for the development of a serious psychiatric disorder. Severe biological vulnerability is demonstrated by the fact that several first degree relatives have suffered severe,

psychotic, mental illness, resulting variously in repeated psychiatric hospitalization, disability and homelessness. In addition to biological vulnerability, there is clear evidence of childhood psychosocial vulnerability; Mr. Moussaoui grew up in a chaotic and physically abusive home.

2. Premorbid Adjustment:

Although there is no report of a history of psychiatric treatment, there is evidence that in his twenties, Mr. Moussaoui underwent some fairly dramatic "conversion" from a relatively ordinary, secular, non-religious life to a religious zealot and convert to a rageful, paranoid, apocalyptic radicalism. What was there in Mr. Moussaoui that predisposed him towards such a conversion? (It should be noted that major psychotic disorders - such as the disorders which have plagued Mr. Moussaoui's first degree relatives - very commonly have their onset in early adulthood.)

While such conversion is apparently not rare among the adherents to Al Qaeda, this fact does not in any manner vitiate the importance of such conversion to an understanding of Mr. Moussaoui's psychiatric history and premorbid psychosocial adjustment. Indeed, it is clear in general that converts to radical groups often demonstrate underlying psychiatric problems for which the group provides some rationale - some apparent meaning. Paranoid, rageful, apocalyptic groups tend to attract people who are already predisposed towards paranoia, rage, and destructive nihilism.

In his reports, Dr. Patterson seems to dismiss the clinical importance of this conversion, by simply describing it as part of a "cultural paranoia". In my professional opinion, this is an inherently naive opinion. Paranoid, nihilistic, rageful groups tend to attract people who are already predisposed to paranoia, nihilism, and rage.

3. Behavioral observations during Mr. Moussaoui's incarceration.

In regard to the vicissitudes of Mr. Moussaoui's behavior and decision-making during his incarceration, Dr. Patterson once again simply dismisses the clinical significance of Mr. Moussaoui's behavior as simply being "consistent with" his group's belief system. In all due respect to Dr. Patterson, this sweeping dismissal is strikingly lacking in precision and analysis.

Indeed, one of the major points presented in detail by Drs.. Amador and Stejskal is that Mr. Moussauoi's behavior and decisions during his incarceration have been strikingly inconsistent - internally inconsistent, constantly changing, without coherence or cohesion. They have been lacking internally in any coherent logic at all. His legal maneuvers often make no sense at all except as paranoid psychotic thinking. He even alleges that the United States government will try to kill him in order to prevent him from revealing facts about the September 11th terrorist attack. Why would a nation desperate for information about this attack want to kill someone to prevent him from providing such information?

Moreover, Drs.. Amador and Stejskal detail two characteristics of Mr. Moussaoui's behavior which strongly suggest that his mental state has declined as a result of his prolonged confinement in isolation. The first is that he has gradually become increasingly paranoid - the scope of the conspiracy which he envisions as surrounding him has progressively grown. Secondly, Mr. Moussaoui appears to have become increasingly obsessional in his thinking; he focuses on some issue, and becomes fixated upon it, unable to experience any balance or perspective on the relative importance of the particular issue.

In short, Mr. Moussaoui appears to have become increasingly obsessional, and increasingly paranoid, during his incarceration in isolation. These are symptoms extremely typical of the psychopathological effects of solitary confinement.

IV. Conclusions.

Drs.. Amador and Stejskal provide compelling, detailed evidence that Mr. Moussaoui's thinking and behavior are irrational, paranoid, and quite likely, psychotic. His thinking and decisions lack any internal coherence or logic, and seem to reflect a gradually deteriorating mental state.

These detailed observations must also be viewed in light of the extensive history of severe mental illness in Mr. Moussaoui's family, his own history of severe abuse and neglect during childhood, and his sudden "conversion" in early adult life.

Dr. Patterson, on the other hand, concedes that Mr. Moussaoui's thought content is abnormal and paranoid, but - without analysis or detailed exploration - he naively and sweepingly dismisses this finding as being consistent with Mr. Moussaoui's "culture" and political beliefs. In my experience, not all defendants accused of participation in Al Qaeda terrorism have pursued such a chaotic, inconsistent, paranoid and incoherent approach to their legal situation. Moreover, if Al Qaeda is indeed a crystallization of paranoid, vengeful, nihilistic rage, it would seem naive indeed to assume that adherence to that group is any presumptive sign of mental health.

I concur with Drs.. Amador and Stejskal that there is substantial evidence that Mr. Moussaoui is mentally impaired and incompetent to fire his attorneys.

Signed under pains and penalties of perjury, this 24th day of July, 2002.

Stuart Grassian, M.D.