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PSYCHOTHERAPY · ASSESSMENT · CONSULTATION

FORENSIC PSYCHOLOGICAL ADDENDUM

CLIENT: Christa Gail Pike

DOB: 3/10/1976

DATE OF ADDENDUM: August 4, 2026

In my Addendum dated 6/1, /2026, I was asked by counsel for Christa Pike to consider the impact on Christa of the procedure leading up to and including the execution which is planned for her. I described several factors that I opined would be tremendously distressing for Christa considering her history of severe abuse and repeated rapes by several men. I will summarize those opinions here.

In my prior addendum, I identified three factors that would cause Christa severe psychological harm during her execution: (1) moving her, in her final 48 hours, from the familiarity of the women's prison into an unknown Maximum Security men's prison surrounded by unfamiliar men; (2) barring her, in her final 12 hours, from contact with anyone but her attorney, replicating the abandonment she endured throughout a childhood marked by abuse and neglect; and (3) restraining her on the gurney, physically held down and pinned, reenacting the rapes in which she was restrained and rendered powerless.

Counsel for Christa Pike have subsequently asked me to consider the impact of three additional potential execution scenarios on Christa. I consider those scenarios below.

THE POSSIBILITY OF BEING CLOSELY MONITORED BY MALE GUARDS WHILE AT DJRC

Christa's attorneys have brought to my attention that it is possible she would be observed closely by guards during her isolation period at DJRC before being moved to Riverbend. This could include moments when using the restroom, bathing, or dressing. I believe this would be intolerable to most women. However, a woman with Christa's history of abuse would experience this as retraumatization. During the repeated sexual assaults she endured throughout her childhood, her body was subjected to nonconsensual observation, exposure, and violation. Being watched by staff during these private times, particularly in the final days of her life, would replicate the loss of bodily autonomy and privacy that characterized her original victimizations. The traumatic trigger here is the loss of privacy and control over her own body, not the gender of the observing staff. The experience of being watched without the ability to protect her own bodily privacy would be highly likely to evoke the

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same feelings of exposure, helplessness, and powerlessness she experienced during the rapes.

THE POSSIBILITY OF ATTEMPTED FEMORAL VENOUS ACCESS

If peripheral (arm/hand) venous access cannot be obtained, prison personnel may need to attempt central or femoral venous access, which involves exposure of, and needle insertion in, the groin region. For Christa, with a history of repeated rapes, procedures requiring genital or groin-area exposure, as well as being touched in those private areas by unfamiliar personnel, particularly male personnel, and particularly under conditions of physical restraint, would directly re-trigger the terror, as well as the sensory and situational memories, of being raped. Her terror in this scenario would be distinct from and in addition to the fear response due to the impending execution. Being uncovered and touched in the groin, with a painful insertion of a needle in this sensitive, private area would likely directly cause Christa to experience tremendous distress and quite likely a flashback to being raped. The professional literature describes trauma triggers, including bodily exposure, restraint, and anatomical proximity to prior assault as common and potent triggers for symptoms including severe panic, flashbacks, and dissociation in sexual trauma survivors.

THE POTENTIAL FOR A FAILED EXECUTION

Repeated attempts to execute a condemned prisoner result in exceptionally high levels of stress and symptoms of posttraumatic stress disorder (PTSD). Even a single, successfully completed execution is highly stressful, as the condemned prisoner arrives at the execution chamber already under the imminent threat of death. When an execution does not go smoothly, however, such as when executioners require an extended period to set IV lines, or when the lethal injection does not kill the inmate, the prisoner is highly likely to experience a near-death event of the type known to cause long-term and grave psychological consequences.

The experience of being repeatedly subjected to attempts at execution by the state is strikingly similar to what is documented in the peer-reviewed literature on mock executions, a recognized form of psychological torture (Defrin, Lahav, & Solomon, 2017). The comparison holds not because the state's intent is comparable to torture, but because the psychological mechanism is the same: the trauma associated with mock execution stems from the prisoner's subjective experience of imminent death, prolonged uncertainty, and helplessness, not from whether the threat of death is genuine. Those conditions are precisely what a repeated or extended execution attempt produces.

Trauma survivors subjected to invasive medical procedures, including repeated attempts at physical access, frequently experience re-traumatization marked by disempowerment, loss of control, and reactivation of the responses tied to their original victimization (Schippert, Grov, & Bjørnnes, 2021).

I know from assessing Christa that she suffers from PTSD, Bipolar Disorder, Dissociative Amnesia, and Depersonalization/Derealization Disorder. These diagnoses reflect

significant and longstanding psychological vulnerability rooted in her having been repeatedly raped during her development. If the first attempt to execute her fails, or requires repeated attempts to correctly set an IV, including femoral access (which would expose her groin), she will be highly likely to experience extreme distress, including terror, flashbacks, and dissociation.

When a traumatized person is in this extremely heightened state of terror, they may lose control of their bladder and/or bowels, or vomit, due to the extreme hyperarousal produced by facing death while highly triggered by trauma reminders.

The convergence of these triggering conditions, being closely monitored when her body is exposed, the imminent threat to life inherent in a botched execution, being held down by men, and her groin being exposed during attempts to establish IV or femoral access, together with her history of having been raped, would likely produce extreme psychological harm.

Any of these possibilities would constitute what is described in the literature as retraumatization. Retraumatization occurs when a current situation reactivates the physiological and psychological response associated with a prior trauma, in Christa's case, the multiple rapes she experienced.

Traumatic memories are not stored or retrieved like ordinary recollections. They are encoded as fragmented sensory and motor memories, what the body felt, what the hands did, where the terror was felt, rather than as coherent verbal narratives. As Kearney and Lanius (2024) explain, traumatic memory is neurobiologically distinct from autobiographical memory: it is not deliberately retrieved but involuntarily relived, existing as "unintegrated vestiges of overwhelming events" (p. 1142) that re-emerge as present-day sensory and motor fragments rather than as a story one can tell (see also Herman, 1992). Being physically restrained by a group of men, immobilized and unable to move, would not simply frighten Christa. It would return her, in full sensory and neurobiological force, to the violations she survived, dying in a state of traumatic reliving that is physiologically and psychologically indistinguishable from the rapes she endured.

PROFESSIONAL OPINION

It is my professional opinion that if Christa Pike’s execution required invasively close monitoring, extended efforts to obtain venous access including attempted femoral access, and/or if the execution failed, she would be at substantial risk of extreme psychological retraumatization, resulting in acute nervous system activation and exacerbation of her existing PTSD and dissociative symptoms, and the encoding of new traumatic material layered onto her existing trauma history. Pre-existing PTSD does not protect against further traumatic harm; it heightens vulnerability to it. A nervous system already sensitized by repeated trauma exposure requires less provocation to trigger a full physiological and psychological trauma response, and that response is typically more severe, more prolonged, and more difficult to regulate than it would be in someone without a trauma history. The

retraumatization described above would not simply add to symptoms she already has; it would constitute a distinct and acute worsening of her symptoms, with new intrusive material, increased symptom frequency and severity, and heightened risk of decompensation.

The conclusions stated in this addendum were reached within a reasonable degree of psychological certainty.

Sincerely,

Bethany Brand

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Licensed Psychologist and Professor Emerita

REFERENCES

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Schippert, A. C. S. P., Grov, E. K., & Bjørnnes, A. K. (2021). Uncovering re-traumatization experiences of torture survivors in somatic health care: A qualitative systematic review. *PLOS ONE, 16*(2), e0246074. https://doi.org/10.1371/journal.pone.0246074