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# THE PSYCHIATRIST, THE SOCIOPATH AND THE COURTS: NEW LINES FOR AN OLD BATTLE

By  
Gerald F. Uelmen\*

All we psychiatrists can tell the law is that if you think you have trouble with our inconsistencies now, wait and see what the future holds.<sup>1</sup>

If we were going to see a psychiatrist, I am sure he would not let us bring our own couches along. When the psychiatrists come over to see us officially and testify, there is no valid reason I can see that they should not do business on our terms . . . .<sup>2</sup>

## I. INTRODUCTION

The final approval of the third edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-III) by the American Psychiatric Association in June of 1979 marked the beginning of a dramatic new chapter in the history of the American psychiatric profession.<sup>3</sup> DSM-III became available in final published form in February of 1980, and it is now common to see psychiatrists with their noses in the little yellow book,<sup>4</sup> checking to see what new labels have been devised for the symptoms their patients exhibit. DSM-III is a response to increasing criticism of the great divergence in psychiatric diagnosis, whereby

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\* Professor of Law, Loyola Law School, Los Angeles, California. The author wishes to acknowledge the editorial assistance of Douglas Smith, Loyola Law School, and the aid of the Loyola Law School Summer Grant program for the support of faculty research. Valuable insights, suggestions, and criticism were offered by Michael Coburn, M.D., Victor Haddox, M.D., J.D., Professor Frederick J. Lower, Jr., J.D., Seymour Pollack, M.D., and Jean Uelmen, Ph.D., who reviewed an initial draft of this article.

1. Diamond, *From M'Naghten to Currens, and Beyond*, 50 CALIF. L. REV. 189, 197 (1962) [hereinafter cited as Diamond].

2. *Wade v. United States*, 426 F.2d 64, 86 (9th Cir. 1970) (en banc) (Chambers, J., dissenting).

3. AMERICAN PSYCHIATRIC ASS'N, *DIAGNOSTIC, AND STATISTICAL MANUAL OF MENTAL DISORDERS* (3d ed. 1980) [hereinafter cited as DSM-III].

4. The diagnostic criteria of DSM-III have been published in quick reference form in a paperback pocket size edition, hereinafter referred to as the "little yellow book." DSM-III itself is big, blue, and hardbound.

the same patient being examined by two different psychiatrists might be labeled with two completely different mental disorders.<sup>5</sup> DSM-III seeks to remedy this great divergence by specifying very detailed "diagnostic criteria" that must be satisfied before a diagnosis can be made. The array of diagnoses available has also been expanded considerably. DSM-III has 235 independent categories of mental disorders in comparison to 158 in its second edition (DSM-II).<sup>6</sup> Preliminary testing has shown a substantial increase in the reliability of diagnosis with DSM-III criteria,<sup>7</sup> but the real test is yet to come.

The diagnostic labels used by psychiatrists are encountered in a variety of legal settings, and the impact of DSM-III will be felt for years to come by specialists in workers' compensation, tort recovery, and proceedings for compulsory commitment and guardianship. The most immediate impact of DSM-III, however, is already reverberating through the criminal arena. The availability of the insanity defense has been vastly expanded by two decisions of the California Supreme Court in the past three years.<sup>8</sup> The parade of psychiatrists marching into the courtrooms to testify is thus growing, and every one of them is carrying the little yellow book in his briefcase or pocket.

This article will not attempt to assess all of the new diagnostic labels introduced by DSM-III or how these labels fit into our legal conceptions of insanity.<sup>9</sup> It will explore the implications of only one category of mental disorder, the "antisocial personality disorder," more commonly known as the "sociopath" or "psychopath."<sup>10</sup> For the past thirty years, the definition of the term "sociopath" has been the princi-

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5. One early study reported an overall rate of agreement of diagnoses by different psychiatrists to be as low as 17%. Clausen & Kohn, *Schizophrenia and the Social Structure*, in *EPIDEMIOLOGY OF MENTAL DISORDER* 69 (Pasamanick ed. 1959). See also Beck, *Reliability of Psychiatric Diagnosis: A Study of Consistency of Clinical Judgments and Ratings*, 119 AM. J. PSYCH. 351 (1962); Frank, *Psychiatric Diagnosis: A Review of Research*, 81 J. GEN. PSYCH. 157 (1969).

6. AMERICAN PSYCHIATRIC ASS'N, *DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS* (2d ed. 1968) [hereinafter cited as DSM-II].

7. Spitzer, *DSM-III Field Trials*, 136 AM. J. PSYCH. 815, 818 (1979).

8. *People v. Drew*, 22 Cal. 3d 333, 583 P.2d 1318, 149 Cal. Rptr. 275 (1978), adopted the American Law Institute (ALI) test of insanity. *In re Moye*, 22 Cal. 3d 457, 584 P.2d 1097, 149 Cal. Rptr. 49 (1978), limited the automatic commitment following an insanity acquittal to the maximum sentence prescribed for the underlying offense, removing the disincentive to raise the insanity defense where minor offenses are charged.

9. Dr. Seymour Pollack has done a masterful job of that. See S. Pollack, *ALI Insanity in The Insanity Defense* 16-70 (Feb. 6, 1980) (unpublished manual by U.S.C. Institute of Psychiatry, Law and Behavioral Science) [hereinafter cited as Pollack].

10. The terms "sociopath" and "psychopath" are used interchangeably in psychiatric literature.

pal battleground upon which the psychiatric conception of mental disease has differed from the legal conception. Another battle is about to be fought in the California Supreme Court.<sup>11</sup>

When the California Supreme Court abandoned the *M'Naghten* definition<sup>12</sup> of insanity in 1978, and adopted the test proposed by the American Law Institute (ALI), the court deferred "to a later occasion" the question of whether subpart 2 of the test should be adopted.<sup>13</sup> Subpart 2, known as the "caveat" clause, purports to exclude sociopathy from inclusion as a "mental disease or defect."<sup>14</sup> This article will outline the reasons why a diagnosis of antisocial personality which relies solely upon the diagnostic criteria of DSM-III should not qualify as a "mental disease" under the California test of insanity in criminal cases. In order to accomplish this, the California Supreme Court should adopt the "caveat" clause as a rule governing the admission of evidence, rather than as a substantive standard for the jury to apply.

## II. PSYCHIATRIC DISAGREEMENT

The American Psychiatric Association first classified the "sociopathic personality disturbance" as a mental disorder in the first edition of the *Diagnostic and Statistical Manual* (DSM-I) in 1952.<sup>15</sup> Describing the sociopath as "ill primarily in terms of society and conformity with the prevailing cultural milieu,"<sup>16</sup> the diagnosis was differentiated into four separate categories:

(1) The "antisocial reaction" which pertained to:

chronically antisocial individuals who are always in trouble, profiting neither from experience nor punishment, and maintaining no real loyalties to any person, group or code. They are frequently callous and hedonistic, showing marked emotional immaturity, with lack of sense of responsibility, lack of judgment, and an ability to rationalize their behavior so that

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11. *People v. Fields*, Case No. CR-21126. *Fields* is an automatic direct appeal from imposition of a sentence of death. In *People v. Martin*, 114 Cal. App. 3d 739, 170 Cal. Rptr. 840 (4th Dist. 1981), the California Court of Appeal for the Fourth District affirmed a conviction where the jury was instructed in the language of subpart 2 of the ALI test.

12. The *M'Naghten* definition is derived from *M'Naghten's Case*, 8 Eng. Rptr. 718 (H.L. 1843).

13. *People v. Drew*, 22 Cal. 3d 333, 345 n.8, 583 P.2d 1318, 1324 n.8, 149 Cal. Rptr. 275, 281 n.8 (1978).

14. *Id.*

15. AMERICAN PSYCHIATRIC ASS'N, *DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS* 38 (1st ed. 1952) [hereinafter cited as DSM-I].

16. *Id.*

it appears warranted, reasonable, and justified.<sup>17</sup>

- (2) The "dyssocial reaction" which applied to:  
individuals who manifest disregard for the usual social codes, and often come in conflict with them, as the result of having lived all their lives in an abnormal moral environment. They may be capable of strong loyalties. These individuals typically do not show significant personality deviations other than those implied by adherence to the values or code of their own predatory, criminal, or other social group.<sup>18</sup>
- (3) The "sexual deviation" which included deviant sexuality not symptomatic of more serious mental illness. Examples included homosexuality, transvestism and sexual sadism.<sup>19</sup>
- (4) The "addiction to alcohol or drugs."<sup>20</sup>

The breadth of these four categories was widely criticized because only the first category described the "antisocial personality" dealt with in psychiatric literature.<sup>21</sup> As a result, when DSM-II was published in 1968, the use of the term "reaction" was dropped, and the term "antisocial personality" was reserved for individuals described, in language strikingly similar to that used for the "antisocial reaction" in DSM-I. There was, however, one significant addition:

[I]ndividuals who are basically unsocialized and whose behavior pattern brings them repeatedly into conflict with society. They are incapable of significant loyalty to individuals, groups, or social values. They are grossly selfish, callous, irresponsible, impulsive, and unable to feel guilt or to learn from experience and punishment. Frustration tolerance is low. They tend to blame others or offer plausible rationalizations for their behavior. *A mere history of repeated legal or social offenses is not sufficient to justify this diagnosis.*<sup>22</sup>

The last sentence was significant for two reasons. First, it responded directly to the "caveat" clause of the ALI test of insanity, which purported to exclude the sociopath by providing that the terms "mental disease or defect" do not include "an abnormality manifested only by repeated criminal or otherwise anti-social conduct."<sup>23</sup> Sec-

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17. *Id.*

18. *Id.*

19. *Id.* at 38-39.

20. *Id.* at 39.

21. H. CLECKLEY, *THE MASK OF SANITY* 270-71 (3d ed. 1955); L. ROBINS, *DEVIAN'T CHILDREN GROWN UP* 79 (1966) [hereinafter cited as ROBINS].

22. DSM-II, *supra* note 6, at 43 (emphasis added).

23. MODEL PENAL CODE § 4.01(2), Comment (Tent. Draft No. 4, 1955).

ondly, it sought to settle a profound disagreement within the psychiatric profession about how a diagnosis of sociopathic personality should be made. When one penetrates this disagreement, it becomes clear that the term "psychopath" or "sociopath" means very different things to different psychiatrists. Two schools of thought have emerged. The so-called "psychodynamic" school views the disorder as a manifestation of serious underlying disturbances in one's emotional life. These disturbances are similar to the more serious symptoms of psychosis, and would most certainly be revealed in a penetrating psychiatric examination of the patient. The leading exponent of this school was Dr. Harvey Cleckley, from whose work much of the description in DSM-I and DSM-II was apparently drawn.<sup>24</sup> Dr. Cleckley regarded the sociopath as a true clinical entity, with a pattern of symptoms as discernible as any psychosis, including "grave disturbances in the patient's affective life as well as in foresight and the control and organization of behavior."<sup>25</sup> Two other psychiatrists who shared the Cleckley view of the sociopath were Dr. Winfred Overholser,<sup>26</sup> who was Superintendent of St. Elizabeth's Hospital in the District of Columbia, and Dr. Bernard L. Diamond,<sup>27</sup> a prolific lecturer and author on the interaction of law and psychiatry.<sup>28</sup>

Another view is expounded by the so-called "social history" school. This school takes the position that an examination of the patient is unnecessary to diagnose a sociopath. The only thing needed is

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24. Cleckley's influence was described in *United States v. Currens*, 290 F.2d 751, 762 (3d Cir. 1961).

25. *Id.* (quoting R. WHITE, *THE ABNORMAL PERSONALITY* 404 (1948)).

26. In Overholser, *Criminal Responsibility: A Psychiatrist's Viewpoint*, 48 A.B.A.J. 527, 529 (1962) [hereinafter cited as Overholser], Dr. Overholser concluded that "[t]he sociopath is characterized by lack of aim and of foresight, the failure to profit by experience, impulsiveness, egocentricity, a lack of emotional rapport with others, a lack of sympathy, a general immaturity and very little regulatory influence of intellect upon his behavior."

27. Diamond, *supra* note 1, at 198.

[M]any of these unfortunate individuals are suffering from an organic, neuro-physiological disease of the brain, which completely dominates their behavior. Their appearance of normalcy, their apparent ability to exercise free will, choice, and decision (and somehow invariably choose the wrong instead of the right) is purely a facade, an artifact that conceals the extent to which they are victims of their own brain pathology.

*Id.* See also Diamond, *Identification and the Sociopathic Personality*, in *ARCHIVES OF CRIMINAL PSYCHODYNAMICS* 456-65 (1961).

28. *E.g.*, Platt & Diamond, *The Origins of the "Right and Wrong" Test of Criminal Responsibility and Its Subsequent Development in the United States: An Historical Survey*, 54 CALIF. L. REV. 1227 (1966); Diamond, *Criminal Responsibility of the Mentally Ill*, 14 STAN. L. REV. 59 (1961); Diamond, *The Scientific Method and the Law*, 19 HASTINGS L.J. 179 (1967); Diamond, *The Children of Leviathan: Psychoanalytic Speculations Concerning Welfare Law and Punitive Sanctions*, 54 CALIF. L. REV. 357 (1966).

his FBI "rap sheet" or a similar compilation of his social history. This view appears to proceed deductively, on the basis of an assumption that one would not engage in repeated antisocial behavior unless he had an underlying personality disorientation. But no attempt is made to isolate or describe that disorientation. Thus, a psychiatric examination is necessary only to exclude the possibility of some other psychiatric condition being present. A leading textbook following this school of thought instructs the psychiatrist that "[s]ince there are no strong and clear-cut diagnostic criteria, the diagnosis has to be made retrospectively on the basis of a long history of psychopathic behavior."<sup>29</sup> Another psychiatrist from this school advises:

The diagnosis of psychopathy is not made by examination but by a review of the life history. Examination shows nothing. The life history shows a record of trouble, of shiftlessness, of nomadism, of dishonesty, of nonconformity, of mischief or of some similar trait. When this is the history in a [person] of good intelligence and obvious sanity, one has the right to suspect psychopathy.<sup>30</sup>

Thus, as one commentator who extensively reviewed the literature has concluded, under this view "a psychiatrist is not needed to diagnose psychopathy. The policeman or the file clerk keeping criminal records could fully measure up to the task."<sup>31</sup>

The formulation of the definition of anti-social personality in DSM-II did not settle the disagreement between these two schools. Simply stating that a mere history of repeated social offenses is *not* enough to justify a diagnosis of anti-social personality does not indicate what else is required. The only additional thing needed may be an examination to exclude the possibility of another, more serious illness. That was precisely the position taken in a treatise published in 1976, that described the three essential conditions for a diagnosis of antisocial personality as: (1) "the disorder should begin before the age of 15"; (2) "the clinical picture should be of antisocial behavior involving multiple areas of social functioning"; and (3) "there should be no other psychiatric illness that could explain the symptoms."<sup>32</sup> Thus, it was left to DSM-III to settle the argument.

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29. E. STRECKER, *FUNDAMENTALS OF PSYCHIATRY* 182 (5th ed. 1952). See also J. EWALT, E. STRECKER & F. EBAUGH, *PRACTICAL CLINICAL PSYCHIATRY* 258 (8th ed. 1957).

30. Davidson, *How Trustworthy is the Witness?* 2 J. FORENSIC MED. 14, 18 (1955).

31. Hakeem, *A Critique of the Psychiatric Approach to Crime and Correction*, 23 LAW & CONTEMP. PROB. 650, 674 (1958).

32. A. FREEDMAN, H. KAPLAN & B. SADOCK, *MODERN SYNOPSIS OF COMPREHENSIVE TEXTBOOK OF PSYCHIATRY* II 650 (1976).

### III. THE DSM-III CRITERIA

The DSM-III definition of the antisocial personality disorder represents a triumph of the "social history" school. The disorder is defined only in terms of a laundry list of antisocial behavior, with no attempt to describe any underlying disturbances that could be revealed in an examination of the patient. While somewhat more detail is required than would be found in an FBI rap sheet, it is clear that any clerk equipped with some kind of a social history of the patient could make the diagnosis. An examination of the patient is required only to exclude the possibility of severe mental retardation, schizophrenia or manic episodes. The criteria are listed below:

- A. Current age at least 18.
- B. Onset before age 15 as indicated by a history of three or more of the following before that age:
  - (1) truancy (positive if it amounted to at least five days per year for at least two years, not including the last year of school)
  - (2) expulsion or suspension from school for misbehavior
  - (3) delinquency (arrested or referred to juvenile court because of behavior)
  - (4) running away from home overnight at least twice while living in parental or parental surrogate home
  - (5) persistent lying
  - (6) repeated sexual intercourse in a casual relationship
  - (7) repeated drunkenness or substance abuse
  - (8) thefts
  - (9) vandalism
  - (10) school grades markedly below expectations in relation to estimated or known IQ (may have resulted in repeating a year)
  - (11) chronic violations of rules at home and/or at school (other than truancy)
  - (12) initiation of fights
- C. At least four of the following manifestations of the disorder since age 18:
  - (1) inability to sustain consistent work behavior, as indicated by any of the following: (a) too frequent job changes (e.g., three or more jobs in five years not accounted for by nature of job or economic or seasonal



fluctuation), (b) significant unemployment (e.g., six months or more in five years when expected to work), (c) serious absenteeism from work (e.g., average three days or more of lateness or absence per month), (d) walking off several jobs without other jobs in sight (Note: similar behavior in an academic setting during the last few years of school may substitute for this criterion in individuals who by reason of their age or circumstances have not had an opportunity to demonstrate occupational adjustment)

(2) lack of ability to function as a responsible parent as evidenced by one or more of the following: (a) child's malnutrition, (b) child's illness resulting from lack of minimal hygiene standards, (c) failure to obtain medical care for a seriously ill child, (d) child's dependence on neighbors or nonresident relatives for food or shelter, (e) failure to arrange for a caretaker for a child under six when parent is away from home, (f) repeated squandering, on personal items, of money required for household necessities

(3) failure to accept social norms with respect to lawful behavior, as indicated by any of the following: repeated thefts, illegal occupation (pimping, prostitution, fencing, selling drugs), multiple arrests, a felony conviction

(4) inability to maintain enduring attachment to a sexual partner as indicated by two or more divorces and/or separations (whether legally married or not), desertion of spouse, promiscuity (ten or more sexual partners within one year)

(5) irritability and aggressiveness as indicated by repeated physical fights or assault (not required by one's job or to defend someone or oneself), including spouse or child beating

(6) failure to honor financial obligations, as indicated by repeated defaulting on debts, failure to provide child support, failure to support other dependents on a regular basis

(7) failure to plan ahead, or impulsivity, as indicated by traveling from place to place without a prearranged job or clear goal for the period of travel or clear idea

about when the travel would terminate, or lack of a fixed address for a month or more

(8) disregard for the truth as indicated by repeated lying, use of aliases, "conning" others for personal profit

(9) recklessness, as indicated by driving while intoxicated or recurrent speeding

D. A pattern of continuous antisocial behavior in which the rights of others are violated, with no intervening period of at least five years without antisocial behavior between age 15 and the present time (except when the individual was bedridden or confined in a hospital or penal institution).

E. Antisocial behavior is not due to either severe mental retardation, schizophrenia or manic episodes.<sup>33</sup>

While DSM-III provides no official history of the source of these criteria, a comparative table of DSM-II and DSM-III categories does cryptically note that "[t]he DSM-III description and criteria are based on longitudinal studies of children whose antisocial behavior persisted into adult life."<sup>34</sup> The only such study cited is *Deviant Children Grown Up* by Dr. Lee N. Robins.<sup>35</sup> Dr. Robins' study is a classic experiment that was conducted over a thirty-year period. It recorded the life course of 500 patients brought to a mental health clinic as children and compared their performance with a sample of "normal" children from the same neighborhoods. All of the patients were diagnosed by at least two psychiatrists, who were able to agree on a specific diagnosis in 62% of the cases.<sup>36</sup> While detailed criteria bearing a strong resemblance to those found in DSM-III<sup>37</sup> were devised, the criteria were not "automatic" in the sense that a diagnosis was *required* if a minimum number

33. DSM-III, *supra* note 3, at 320-21.

34. *Id.* at 379.

35. ROBINS, *supra* note 21.

36. *Id.* at 74-76.

37. *Id.* at 342 app. D. A minimum of five of the following nineteen criteria were required. Of those diagnosed as sociopathic personality in the Robins' study, the median number of criteria met was eleven. Just six percent had symptoms only in the minimum five areas. *Id.* at 80.

#### Criteria for the Diagnosis of *Sociopathic Personality*

- A. POOR WORK HISTORY—at least six of the following: 6+ jobs within ten years, successive jobs at less pay or less prestige, fired for incompetence or personality conflict, unemployment for more than a month at a time, quitting because of fights or arguments, much time out for illness, chronic absenteeism, job troubles from drinking, no jobs of as much as three years' duration in the last ten years.
- B. POOR MARITAL HISTORY—two or more divorces, marriage to wife with severe behavior problems, repeated separations.

were met. The diagnostic process, however, was accomplished without any examination of the patients by the psychiatrist. A standardized "life history interview" was conducted, although not for all patients, and not necessarily by the diagnosing psychiatrist. The process of diagnosis was described as follows:

All diagnoses were overall clinical judgments. While the collection of social and psychiatric history in interview was systematic in the sense that every question was to be asked of

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- C. EXCESSIVE DRUGS—addiction to barbiturates, bromides, morphine, benz-drine, or dexedrine, or a period of experimentation with drugs for non-medical purposes.
  - D. HEAVY DRINKING—medical complications, arrests, firing, serious family complaints due to alcohol, or chronic intake of 3+ drinks at least three times a week or seven drinks per sitting.
  - E. REPEATED ARRESTS—three or more non-traffic arrests.
  - F. PHYSICAL AGGRESSION—arrest record for fighting, reports of wife or child beatings, self-report of many fights.
  - G. SEXUAL PROMISCUITY OR PERVERSION—arrests on charges pertaining to sex, interview claims of extreme promiscuity (e.g. 50 different sexual partners), interview reports of homosexuality.
  - H. SUICIDE (ATTEMPTS)—death by suicide, police record, hospital, or interview reports of suicide attempts.
  - I. IMPULSIVE BEHAVIOR—frequent moving from one city to another, more than one elopement, sudden army enlistment, unprovoked desertion of home.
  - J. SCHOOL PROBLEMS AND TRUANCY—four or more of the following plus repeated truancy: did not leave school at graduation point, two years older than average in the last year at school, attended four or more grammar schools, left school voluntarily before completing expected level, failed one full year or more, complaints *re* discipline from teachers, fights with students, expulsion or suspension.
  - K. PUBLIC FINANCIAL CARE—totally or partially supported by relatives, friends, social agencies, or public institutions.
  - L. POOR ARMED SERVICES RECORD—enlistment of less than one year's duration, demotions, repeated AWOL, court-martial, punishments, desertion, dishonorable discharge.
  - M. VAGRANCY—period of several months or more of travel around the country without prearranged employment.
  - N. MANY SOMATIC SYMPTOMS—at least ten somatic symptoms scored from interview on medical-psychiatric inventory or fewer if severe or disabling.
  - O. PATHOLOGICAL LYING—fantastic history given which does not apparently serve the function of omitting or white-washing reports of antisocial behavior.
  - P. LACK OF FRIENDS—does not participate in activities of any informal social group, sees friends less than once in two weeks, has no or only one close friend, sees less than ten people socially.
  - Q. USE OF ALIASES—interview report or police record showing use of an assumed name.
  - R. LACK OF GUILT ABOUT SEXUAL EXPLOITS AND CRIMES—interviewer's impression from the way in which patient reports his history.
  - S. RECKLESS YOUTH—age span of 18 to 20 years reported as characterized by seven or more of these: feeling carefree, leisure time spent almost entirely in social activity, little time spent at home, self-report as reckless or wild, drove fast, fought, drank excessively, changed jobs frequently, spent money extravagantly.

*Id.* at 342 app. D.

every subject, no automatic diagnosis on the basis of the presence or absence of a given symptom or set of symptoms was used.<sup>38</sup>

In other words, a subjective judgment was made, but it is clear that this judgment was based simply on the evaluation of the patient's social history, and *not* on any insight gained by probing the recesses of the patient's mind. It is interesting to note that one subjective feature, which many experts of the "psychodynamic" school describe as an essential feature of the disease, the lack of guilt, was reported for only 40% of those diagnosed as sociopaths. The explanation given was:

The relatively low rate of lack of guilt results from the fact that evidence for it could be determined only for personally interviewed subjects, and only for them on the basis of the interviewer's overall impressions. Interviewers did not ask subjects whether they felt guilty about the antisocial acts to which they admitted, for fear of endangering the subjects' cooperation by making them feel that the interviewer condemned their behavior. For these reasons, lack of guilt, which many authors feel to be the primary feature of the disease, was especially difficult to establish in any reliable fashion.<sup>39</sup>

It is even more interesting to note that lack of guilt is one of the few criteria used by Dr. Robins which does *not* appear in the DSM-III formula.

In fairness to DSM-III, it should be noted that the criteria they list are not "automatic" either. Many, if not most, psychiatrists will approach the list as a bare minimum which, once met, requires a subjective judgment. But that is precisely the problem. What is being judged? The patient's mental state, as revealed by a probing examination? Or the patient's social history, as revealed by his rap sheet? DSM-III offers no clues, so the answer will probably depend upon what "school" the psychiatrist subscribes to.<sup>40</sup> This may explain why, despite the specificity of the criteria, a low rate of interrater reliability was reported for antisocial personality disorder in the DSM-III field

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38. *Id.* at 78.

39. *Id.* at 81 (footnote omitted).

40. One explanation for the high rate of agreement of diagnosis in the Robins' study was that a few psychiatrists were making all the diagnoses, and they had all been trained or were training other psychiatrists in a single department of psychiatry "which has an unusual degree of interest in differential diagnosis based on natural history findings." *Id.* at 78.

trials.<sup>41</sup> The bottom line is that DSM-III offers no description of the "disease" of antisocial personality disorder; only a laundry list of manifestations of antisocial conduct is presented. To that extent, it is a step backwards from DSM-II and does not even repeat the "mere history" warning of DSM-II. While this laundry list may be sufficient for a research project, it will hardly suffice when the diagnosis has great consequences for the patient and the public.

#### IV. THE SOCIOPATH UNDER *DURHAM*

Under the traditional *M'Naghten* test of insanity, a diagnosis that the defendant was a sociopath ordinarily had little consequence. Criminal responsibility was defined in terms of the defendant's knowledge of the nature and quality of his act and its wrongfulness.<sup>42</sup> The capacity of even the most severe sociopath to meet this test was practically assumed because he certainly *knew* what he was doing and *knew* that it was wrong. What he lacked was the kind of control over his behavior that is ordinarily called a "conscience." The sociopath did not become a problem for the law until more expansive legal conceptions of "insanity" were adopted. The first major jurisdiction to take this leap was the District of Columbia, and its grand experiment nearly ran aground on the shoals of the sociopathic diagnosis. In *Durham v. United States*,<sup>43</sup> the United States Court of Appeals for the District of Columbia defined criminal responsibility in terms of whether the unlawful act "was the product of mental disease or defect."<sup>44</sup> No definition of mental disease or defect was attempted, leaving that task in the hands of the psychiatrists.

The new test appeared to make little difference until the psychiatrists played their hand three years later. The bombshell exploded on Monday, November 18, 1957, in a courtroom of the United States District Court for the District of Columbia, where the case of *In re Rosenfield*<sup>45</sup> was being heard. On the Friday before, the assistant superintendent of St. Elizabeth's Hospital testified that the defendant did not meet the *Durham* test of insanity, because he was not suffering from a mental disease. On Monday morning he returned to the witness stand and announced that he wanted to change his testimony, and of-

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41. DSM-III, *supra* note 3, at 468.

42. *M'Naghten's Case*, 8 Eng. Rep. 718 (H.L. 1843).

43. 214 F.2d 862 (D.C. Cir. 1954). This case was subsequently overruled in *United States v. Brawner*, 471 F.2d 969 (D.C. Cir. 1972). See text accompanying notes 77-84 *infra*.

44. 214 F.2d at 875.

45. 157 F. Supp. 18 (D.D.C. 1957).

ferred the opinion that the defendant *was* suffering from a mental disease. When the incredulous judge asked what had happened over the weekend, he learned that the assistant superintendent's diagnosis had not changed. On Monday, as on Friday, he labeled the defendant a sociopath. But over the weekend, in a meeting with the superintendent (Dr. Winfred Overholser) of the hospital, it had been agreed that henceforth the hospital staff would consider the sociopathic personality disorder as a "mental disease."<sup>46</sup> While this was hardly the first time a psychiatrist in the District of Columbia had testified that sociopathic personality was a mental disease,<sup>47</sup> this change had great impact because all court-ordered psychiatric examinations for the District of Columbia were handled by the staff of St. Elizabeth's Hospital. As a result of this change of labels, a ten-fold increase in the number of acquittals on the ground of insanity was reported.<sup>48</sup>

The District of Columbia Court of Appeals first responded to this situation in 1962, with its decision in *McDonald v. United States*:<sup>49</sup>

Our eight-year experience under *Durham* suggests a judicial definition, however broad and general, of what is included in the terms "disease" and "defect." . . . Our purpose now is to make clear that neither the court nor the jury is bound by *ad hoc* definitions or conclusions as to what experts state is a disease or defect. What psychiatrists may consider a "mental disease or defect" for clinical purposes, where their concern is treatment, may or may not be the same as mental disease or defect for the jury's purpose in determining criminal responsibility. Consequently, for that purpose the jury should be told that a mental disease or defect includes any abnormal condition of the mind which substantially affects mental or emotional processes and substantially impairs behavior controls.<sup>50</sup>

Since McDonald was not a sociopath, however, it was left to another case to explain how the sociopath fits into this definition.

That opportunity quickly presented itself in the incredible case of *Williams v. United States*.<sup>51</sup> Dallas Williams had a record of ten con-

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46. The "weekend flip flop case" is described and discussed in *United States v. Brawner*, 471 F.2d 969, 978 (D.C. Cir. 1972), and *Blocker v. United States*, 288 F.2d 853, 860 (D.C. Cir. 1961).

47. See *Taylor v. United States*, 222 F.2d 398, 404 (D.C. Cir. 1955); *Stewart v. United States*, 214 F.2d 879, 881 (D.C. Cir. 1954).

48. Diamond, *supra* note 1, at 192 & n.19.

49. 312 F.2d 847 (D.C. Cir. 1962).

50. *Id.* at 850-51.

51. 312 F.2d 862 (D.C. Cir. 1962).

victions for crimes of violence by the time he was thirty-four years old,<sup>52</sup> when he was charged with an assault with a deadly weapon. He was tried five times on this charge over a period of seven years. Two trials ended in mistrials, and three ended in convictions that were reversed on appeal. While free on bail pending these trials, he was convicted of two more misdemeanor gun charges.<sup>53</sup> The final reversal precluded a retrial,<sup>54</sup> so the government sought to civilly commit him.<sup>55</sup> The petition for civil commitment was held insufficient because it did not allege he was mentally ill.<sup>56</sup> The examining psychiatrist found "no evidence of psychotic thinking today," although he ominously warned that "once [Williams] is released, he is likely to repeat his patterns of criminal behavior, including homicide."<sup>57</sup> Williams was released, and within two weeks was back in court charged with intoxication. This time the judge found him not guilty by reason of insanity, and ordered him committed to St. Elizabeth's Hospital for treatment. That commitment was held invalid for insufficiency of evidence, and once again Williams was released, with the court suggesting that the prosecution try for a civil commitment again.<sup>58</sup> Two years later, all of the dire predictions were fulfilled when Williams shot and killed two men. At his trial on the murder charges, he relied on the defense of insanity as defined in *Durham*.<sup>59</sup> A total of eleven psychiatrists testified. Five of them concluded that the defendant was not suffering from any mental disease, while another five psychiatrists described his condition as a sociopathic personality. The eleventh psychiatrist diagnosed Williams as schizophrenic. Williams was convicted, and on appeal urged that the prosecution had failed to meet its burden of proving his sanity beyond a reasonable doubt. Although the court affirmed his conviction, it did so *not* on the ground that sociopathic personality disturbance does not meet the *McDonald* test of insanity. Instead, it held as follows:

[I]t is clear beyond cavil that appellant's sanity was a legitimate issue in the case. Indeed, five psychiatrists testified that Williams was a "psychopath" or "sociopath" on the day of the killings and at least some of them thought this condition a

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52. His "rap sheet" is summarized in *Williams v. United States*, 250 F.2d 19, 21 n.3 (D.C. Cir. 1957).

53. *Id.*

54. *Id.* at 26.

55. *In re Williams*, 157 F. Supp. 871, 872 n.1 (D.D.C. 1958).

56. *Id.* at 875.

57. *Id.* at 872 n.1.

58. *Williams v. District of Columbia*, 147 A.2d 773, 776 (1959).

59. *Williams v. United States*, 312 F.2d 862, 863 (D.C. Cir. 1962).

"mental disease." Without any evidence relating the abnormality to the offenses, this was enough to raise the issue and require the Government to disprove the claim that the crimes were the product of mental disease or defect beyond a reasonable doubt. We conclude, however, that although the defendant's evidence relating to insanity was sufficient to make the issue, it was not so strong, when considered with the evidence offered by the Government, as to require a directed verdict of acquittal by reason thereof.<sup>60</sup>

Although *Williams* is occasionally cited for its dictum that "[a] long criminal record does not excuse crime,"<sup>61</sup> the case certainly does *not* stand for the proposition that sociopathy does not qualify as mental disease under the *McDonald* definition. On the contrary, the case held that such a diagnosis presents an issue that can only be resolved by the jury.<sup>62</sup>

Thus, despite *McDonald*, the *Durham* rule left the legal status of the sociopath in the hands of the psychiatrist. The only change *McDonald* required is that the psychiatrist be willing to testify that sociopathy "substantially affects mental or emotional processes and substantially impairs behavior controls."<sup>63</sup> Certainly, if a psychiatrist is willing to testify that a crime was the "product" of the defendant's sociopathic personality, as the doctors at St. Elizabeth's Hospital decided they could do in 1957 (and two of them did, in the *Williams* case), it could certainly be concluded that sociopathy meets the *McDonald* definition of mental disease. It must be remembered, however, that the psychiatric staff at St. Elizabeth's Hospital, under Superintendent Winfred Overholser, followed Dr. Cleckley's conception of the sociopath.<sup>64</sup> Most were not followers of the "social history" school. On at least one occasion, where a psychologist at St. Elizabeth's Hospital testified that a defendant was a sociopath solely on the basis of a battery of psychological tests, the trial judge's exclusion of his testimony as "conclusory" was upheld by the court of appeals.<sup>65</sup>

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60. *Id.* at 865.

61. *E.g.*, *United States v. Brawner*, 471 F.2d 969, 993 (D.C. Cir. 1972).

62. 312 F.2d at 867.

63. *Id.* at 851.

64. *See* note 23 *supra*.

65. *United States v. Alexander*, 471 F.2d 923, 967-68 (D.C. Cir. 1972), *cert. denied*, 409 U.S. 1044 (1973). The testimony is reproduced and analyzed in Judge Bazelon's dissenting opinion. 471 F.2d at 952-57 (Bazelon, J., dissenting).



## V. THE SOCIOPATH UNDER THE ALI TEST

In view of the controversy the "sociopath" had already engendered, it is hardly surprising that the ALI proceeded gingerly in drafting the Model Penal Code sections defining the defense of insanity. In the fourth tentative draft issued in 1956, criminal responsibility was defined in terms of a lack of "substantial capacity either to appreciate the [wrongfulness] of his conduct or to conform his conduct to the requirements of law"<sup>66</sup> *as a result of mental disease or defect*. The Model Penal Code offered no definition of the terms "mental disease or defect," however, on the grounds that their definition was "not feasible."<sup>67</sup> As to one category of "mental disease," however, unfeasibility was no obstacle: the "sociopath" or "psychopath" was to be excluded. Section 4.01(2), known as the "caveat" clause, provided that "[t]he terms 'mental disease or defect' do not include an abnormality manifested only by repeated criminal or otherwise anti-social conduct."<sup>68</sup> The comment to this section makes it clear what "abnormality" the drafters had in mind:

Paragraph (2) of section 4.01 is designed to exclude from the concept of "mental disease or defect" the case of so-called "psychopathic personality." The reason for the exclusion is that, as the Royal Commission put it, psychopathy "is a statistical abnormality; that is to say, the psychopath differs from a normal person only quantitatively or in degree, not qualitatively; and the diagnosis of psychopathic personality does not carry with it any explanation of the causes of the abnormality." While it may not be feasible to formulate a definition of "disease", there is much to be said for excluding a condition that is manifested only by the behavior phenomena that must, by hypothesis, be the result of disease for irresponsibility to be established. Although British psychiatrists have agreed, on the whole, that psychopathy should not be called "disease", there is considerable difference of opinion on the point in the United States. Yet it does not seem useful to contemplate the litigation of what is essentially a matter of terminology; nor is it right to have the legal result rest upon the resolution of a dispute of this kind.<sup>69</sup>

Although this comment speaks broadly of completely excluding

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66. MODEL PENAL CODE § 4.01(1) (Tent. Draft No. 4, 1956).

67. *Id.*, Comment.

68. *Id.* § 4.01(2), Comment.

69. *Id.*

the "psychopathic personality," it is clear that this term is being used only in the sense that the "social history" school would use it; i.e., the diagnosis assumes a mental disorder on the basis of a long history of antisocial conduct. Nevertheless, this ambiguity has resulted in a checkered history for the "caveat" clause. While most of the federal courts and all of the state courts adopting the ALI test of insanity have included section 4.01(2), they do not read it as an exclusion of *all* diagnoses of "psychopath" or "sociopath" from the definition of mental disease.

*United States v. Currens*,<sup>70</sup> the first federal case to adopt the ALI test, involved a defendant who was diagnosed as a "sociopathic personality." Yet in holding that the jury should have been instructed according to the ALI test, the court "agree[d] fully" with the "caveat" clause.<sup>71</sup> Noting that the term "psychopath" means different things to different psychiatrists, Judge Biggs concluded that it would be unfair to make availability of the insanity defense hinge on the vagaries of a diagnostic label.<sup>72</sup> If the diagnosis is based merely on a pattern of recurrent criminal behavior, he agreed that "it does not describe a disorder which can be considered insanity."<sup>73</sup> On the other hand, he noted that the psychiatric evidence of Currens' condition went far beyond recurrent criminal behavior:

A reasonable jury could infer that Currens is mentally incapable of ordered social living; that he is subject to hysterical episodes, that under stress he has many symptoms of the incapacitating disease of schizophrenia; and that he is generally subject to depression, fright, and losses of contact with reality. On the basis of such evidence we believe that a jury reasonably could find that he did not possess the necessary guilty mind when he committed the crime of which he is accused.<sup>74</sup>

Similarly, in adopting the "caveat" clause, the Second Circuit stressed the limited nature of its exclusion. Only cases where repeated criminality is the *sole* basis of finding a mental disorder are excluded, thus leaving room for cases where evidence of mental disease augments mere recidivism.<sup>75</sup>

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70. 290 F.2d 751 (3d Cir. 1961).

71. *Id.* at 774 n.32.

72. *Id.* at 761-62.

73. *Id.* at 761.

74. *Id.* at 763.

75. *United States v. Freeman*, 357 F.2d 606, 625 (2d Cir. 1966).

The two courts which have rejected the "caveat" clause have done so on a false premise. Citing the same two leading exponents of the "psychodynamic" school<sup>76</sup> who criticized the psychiatric soundness of section 4.01(2), the two courts assumed that there is no such thing as an abnormality manifested *only* by repeated criminal or otherwise antisocial conduct. This assumption ignored the fact that not all psychiatrists conceive of the "sociopathic personality" in the same manner as Dr. Overholser and Dr. Diamond. There are clearly many psychiatrists, and DSM-III suggests that they are in the majority, who subscribe to the "social history" school. By rejecting the "caveat" clause, these two courts may have left the door open for a DSM-III diagnosis of "antisocial personality disorder."

Another criticism of the "caveat" clause is more troublesome. In *United States v. Wade*,<sup>77</sup> the Ninth Circuit expressed great concern that it would be "confusing and ambiguous to jurors."<sup>78</sup> Yet, nothing in the Model Penal Code suggests that section 4.01(2) was ever intended as an instruction to jurors. If the only evidence of mental disease presented by a defendant is a diagnosis supported by "repeated criminal or otherwise anti-social conduct," then the issue of insanity should not even be submitted to the jury. Thus seen, the "caveat" clause operates as a rule of evidence rather than a jury instruction. This was the position ultimately taken by the United States Court of Appeals for the District of Columbia in *United States v. Brawner*.<sup>79</sup> In rejecting the *Durham* formula in favor of the ALI test, the court retained its *McDonald* definition of mental disease, concluding that this already provided an adequate guard against an insanity defense based only upon diagnosis from a long criminal record.<sup>80</sup> The "caveat" paragraph was still adopted "as a rule for application by the judge, to avoid miscarriage of justice, but not for inclusion in instructions to the jury."<sup>81</sup> The rule is easily satisfied, however, as noted by the court in its following statement:

[T]he introduction or proffer of past criminal and anti-social actions is not admissible as evidence of mental disease unless accompanied by expert testimony, supported by a showing of

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76. *Wade v. United States*, 426 F.2d 64, 72 (9th Cir. 1970); *United States v. Smith*, 404 F.2d 720, 727 n.8 (6th Cir. 1968). Both *Wade* and *Smith* relied upon Diamond, *supra* note 1, at 193-94, and Overholser, *supra* note 26, at 530.

77. 426 F.2d 64 (9th Cir. 1970).

78. *Id.* at 73.

79. 471 F.2d 969 (D.C. Cir. 1972).

80. *Id.* at 993.

81. *Id.* at 994.

the concordance of a responsible segment of professional opinion, that the particular characteristics of these actions constitute convincing evidence of an underlying mental disease that substantially impairs behavioral controls.<sup>82</sup>

This would apparently allow a "social history" diagnosis such as the one DSM-III allows, as long as it is accompanied by an opinion that the assumed mental disorder "substantially impairs behavior controls." In other words, labels are permissible, but only if those sanctioned by the court are used. This aspect of the *Browner* approach was subsequently criticized and rejected by the District of Columbia Court of Appeals in *Bethea v. United States*<sup>83</sup> on three grounds: (1) the references to a concordance of "a responsible segment of professional opinion" and "convincing" evidence were inherently ambiguous and variable; (2) courts lack competence to make such judgments; and (3) cross-examination could be relied upon to expose the flaws in the experts' opinion and diagnosis.<sup>84</sup>

All of these objections to the "caveat" clause are easily overcome if the clause is directly applied as an evidentiary rule without enshrouding it in the *McDonald* cloud of ink. The admissibility of a psychiatric opinion that the defendant was suffering from a mental disease should not depend upon a separate showing in each individual case that the opinion reflects a "concordance." On the other hand, courts cannot relieve themselves of their responsibility to determine whether a particular mental condition meets the threshold legal prerequisite of being a "mental disease." The "caveat" clause should be read for what it is: a flat rejection of the "social history" school's approach to diagnosing the sociopath. To put it bluntly, if all that the psychiatrist could tell us is that the defendant meets all the diagnostic criteria of DSM-III and therefore, in his opinion the defendant's behavior controls must have been substantially impaired, the psychiatrist should be told to take his little yellow book and go home. His opinion should not be admissible, and if admitted, should be deemed insufficient to either shift the burden of proof to the prosecution or require instructing the jury on the issue of insanity. On the other hand, if the psychiatrist describes the underlying mental processes of the defendant and explains how those processes result in antisocial behavior, the "caveat" clause should be deemed inapplicable because the jury would only be confused by it.

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82. *Id.*

83. 365 A.2d 64 (1976), *cert. denied*, 433 U.S. 911 (1977).

84. *Id.* at 80 n.36.

Whether a condition is a "mental disease" or not would then be treated as a legal question, used to determine the admissibility and sufficiency of evidence. The ultimate determination of whether this condition renders the defendant not responsible for his actions is still left to the jury. The difficulty with the approach used in *Browner* is that the jury is called upon to make this determination twice. First, the jury is asked to decide if the defendant's sociopathic condition is a mental disease, applying the *McDonald* test of whether it substantially impairs behavior controls. Assuming the jury answers that question affirmatively, the jury is then asked whether the defendant should be held responsible by applying the ALI test of whether the defendant "lacks substantial capacity either to appreciate the [wrongfulness] of his conduct or to conform his conduct to the requirements of law."<sup>85</sup> It makes more sense to have the first question answered by the court before deciding whether the second question should even be submitted to the jury. The "caveat" paragraph could serve that purpose well, unencumbered by the *McDonald* definition.

## VI. PREVALENCE

One issue that cannot be ignored in assessing whether the sociopath should be included in the legal definition of "mental disease" is the prevalence of sociopaths in our criminal population. The prospect of turning loose thousands of habitual criminals and immunizing them from punishment is hardly appealing. This argument has been turned around to suggest that acquitting sociopaths on the ground of insanity will allow keeping them locked up even longer under the present laws which automatically commit those acquitted on grounds of insanity for an indeterminate period of treatment.<sup>86</sup> It is not a very convincing rebuttal, though. First, not all jurisdictions allow indeterminate confinement of those acquitted by reason of insanity. California, for example, now limits such confinement to the maximum term for the underlying offense.<sup>87</sup> Secondly, there is no assurance that the psychiatrists who assess the defendant's sanity and dangerousness once he is committed will be applying the same standards used by the psychiatrists who testified at trial. The reality of this risk is strikingly apparent in *Williams v. United States*.<sup>88</sup> Finally, there is no assurance that any "treatment"

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85. MODEL PENAL CODE § 4.01(1) (Tent. Draft No. 4, 1956).

86. *Donaldson v. O'Connor*, 493 F.2d 507, 522 & n.22 (5th Cir. 1974); *Wade v. United States*, 426 F.2d 64, 72 (9th Cir. 1970); *Overholser*, *supra* note 26, at 531.

87. *In re Moye*, 22 Cal. 3d 457, 584 P.2d 1097, 149 Cal. Rptr. 49 (1978).

88. 312 F.2d 862 (D.C. Cir. 1962). *See* text accompanying notes 51-62 *supra*. In *People*

can be offered to a sociopath. Indeterminate commitment without any treatment raises serious constitutional issues.<sup>89</sup> Many experts have concluded that there simply is no effective way known to modern psychiatry to change the personality of a sociopath.<sup>90</sup> While Dr. Diamond's prediction that a biochemical test for sociopathy would be devised within ten years has proven to be slightly optimistic,<sup>91</sup> there is little dispute about the accuracy of his second prediction "that it will be ten times ten years or even much longer, before the discovery of any consistently effective, thoroughly reliable method of psychiatric treatment for these sick individuals who now plague society with their behavioral disorders."<sup>92</sup>

A very pragmatic question arises as to how many criminals would qualify if the DSM-III criteria for antisocial personality disorder were treated as a "mental disease." Two precautionary observations, however, are in order. First, the number will obviously be much smaller if the diagnosis is limited the way psychiatrists of the "psychodynamic" school limit it. Secondly, mere diagnosis as a sociopath would not require acquittal, even under the ALI test without the "caveat" clause. The jury would still have to find that, as a result of his sociopathic personality, the defendant lacked substantial capacity to appreciate the criminality or wrongfulness of his conduct or to conform his conduct to the requirements of the law. Even under the DSM-III definition, it has been predicted that "the uncomplicated kind and degree of mental impairment in Personality Disorders, as a generalization, will hardly ever, if ever, satisfy the required high level of mental impairment that public policy imposes upon the criminal defendant before he will be excused from criminal responsibility."<sup>93</sup> It is important to note, however, that the psychiatrist making this prediction subscribes to the "psychodynamic" school.<sup>94</sup>

DSM-III itself estimates that the prevalence of antisocial personality disorder for American men is about 3%, and for American women is less than 1%. Higher prevalence is suggested in "lower class popula-

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v. Martin, 114 Cal. App. 3d 739, 746, 170 Cal. Rptr. 840, 843 (4th Dist. 1981), the court noted that a sociopath falls into none of the categories for which civil commitment is available under the Lanterman-Petris-Short Act, CAL. WELF. & INST. CODE § 5150 (West 1972 & Supp. 1981).

89. See *Donaldson v. O'Connor*, 493 F.2d 507, 522 (5th Cir. 1974).

90. See *Blocker v. United States*, 288 F.2d 853, 861 n.12 (D.C. Cir. 1961).

91. Diamond, *supra* note 1, at 198.

92. *Id.* at 199.

93. Pollack, *supra* note 9, at 61.

94. *Id.* at 60.

tions."<sup>95</sup> These estimates are consistent with Robins' study, from which the DSM-III criteria were apparently drawn.<sup>96</sup> Among the control group drawn from the general population, 2% were diagnosed with sociopathic personality. But of the 500 patients who had been referred to the psychiatric clinic as children, 22% were diagnosed as sociopaths.<sup>97</sup> Of greater relevance, however, would be the prevalence among those who are charged with crime, especially those who are charged on a recurring basis.

Such an assessment would require a major research effort. A research project that was recently completed by the Rand Corporation offers some insight.<sup>98</sup> Extensive social histories of forty-nine career criminals, all serving at least their second prison terms, and all convicted of armed robbery in California, were collected and compiled. Not all of the diagnostic criteria of DSM-III were addressed, but among those that were, some interesting findings emerged:

- A. All, of course, were over the age of 18.
- B. Their history as youngsters revealed:
  - (1) 48% were occasional truants, and 5% were habitual truants from school.<sup>99</sup>
  - (2) 75% committed their first serious crime before age 15, and 90% before age 18. The mean age for their first arrest was 15.<sup>100</sup>
  - (3) 24% reported the influence of alcohol or drugs as contributory factors in their juvenile criminal career.<sup>101</sup>
  - (4) The crimes most commonly committed as juveniles were auto theft (48%), burglary (30%) and theft over \$50 (13.5%).<sup>102</sup>
  - (5) While the "initiator" was not assessed, 71% participated in more than three fights as juveniles, and another 16% participated in one or two.<sup>103</sup>
- C. Since the age of 18:
  - (1) 10% had an "antiemployment" history, and another

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95. DSM-III, *supra* note 3, at 319.

96. See ROBINS, *supra* note 21, at 82.

97. DSM-III, *supra* note 3, at 319.

98. J. PETERSILIA, P. GREENWOOD & M. LAVIN, CRIMINAL CAREERS OF HABITUAL FELONS (1978).

99. *Id.* at 74.

100. *Id.* at 74-75.

101. *Id.* at 76 table 47.

102. *Id.* at 75.

103. *Id.* at 95 table 64.

30-40% had poor employment performance.<sup>104</sup>

(2) All had multiple arrests and convictions. The average respondent committed 20 crimes per year of street time.<sup>105</sup>

(3) 63% engaged in fights as young adults, and 45% during their adult period.<sup>106</sup>

(4) In the sample as a whole, crime "planning" was weak, with a high proportion of their criminal activity being done impulsively on the spur of the moment.<sup>107</sup>

Thus, even though most of the DSM-III criteria were not addressed, a very high proportion would meet the minimum criteria for diagnosis as antisocial personality disorder. This should not surprise anyone. Ask any police officer, prosecutor, public defender, or judge how many of those charged in criminal cases every day would meet the diagnostic criteria outlined in DSM-III.

## VII. CONCLUSION

In releasing the third edition of the *Diagnostic and Statistical Manual*, the American Psychiatric Association cautioned that "[t]he use of this manual for non-clinical purposes, such as determination of legal responsibility, competency or insanity, or justification for third-party payment, must be critically examined in each instance within the appropriate institutional context."<sup>108</sup> This article has critically examined the criteria for antisocial personality disorder, and found them inappropriate for inclusion in the legal definition of "mental disease," as that term is used in the prevailing tests of insanity employed in criminal cases. We must insist upon more than the "social history" diagnosis which DSM-III allows before the issue of sanity is even presented to a jury. This goal can be readily accomplished in those jurisdictions which follow the ALI test of insanity by utilizing the "caveat" clause of section 4.01(2) as a rule of evidence, to exclude expert opinions based on nothing more than the defendant's social history.

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104. *Id.* at 87.

105. *Id.* at vii.

106. *Id.* at 95 table 64.

107. *Id.* at 60.

108. DSM-III, *supra* note 3, at 12.



