Personality Disorders and Criminal Law: An International Perspective

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At the International War Crimes Tribunal for the Former Yugoslavia (ICTY), a detention camp guard, charged with acts of murder and torture, advanced a plea of diminished responsibility. Defense psychiatrists testified that he had a personality disorder that influenced his ability to control his behavior, but a prosecution expert testified that the guard did not meet Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM-IV-TR) criteria. Thus, the unresolved question of how the law defines a mental disease or defect for purposes of mitigation or excuse was transposed to an international setting. It has been argued in a variety of jurisdictions and national legal systems that exculpatory mental disorders must be serious, and personality disorders should not qualify. In fact, it has been proposed that the volitional aspect of excuse defenses be eliminated, and definitions of mental disease or defect narrowed. Others have argued that such exclusions are too restrictive and arbitrary. This article examines the criminal defense at ICTY and traces its origin in national jurisdictions. Mental incapacity defenses based on personality disorders are more often used in The Netherlands, England, Germany and Belgium, but seldom in Canada and rarely in the United States and Sweden.

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When a clinician is asked to undertake a legal assessment of mental incapacity, a definition of mental disease or defect is often difficult to achieve because of the simultaneous need to have the concept meet medical criteria for a mental disorder and to have it governed by legal concepts of responsibility and culpability. In *Black's Law Dictionary*,[1] legal insanity is described as "Any mental disorder severe enough that it prevents a person from having legal capacity and excuses the person from criminal or civil responsibility" (Ref. 1, p 810). But what is that degree of mental illness? In different legal jurisdictions, the question is answered in different ways. In the courtroom, a range of diagnostic categories or explanations may be presented that psychiatrists would not consider severe mental disorders, but that some experts claim negate or diminish criminal responsibility.

Historically, the use of the mental incapacity defense has been limited, although not exclusively, to those with a psychotic mental disorder at the time of the crime. The various disorders that constitute mental disease or defect identify only the specific effects that must result as a consequence of the disorder. The Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM-IV-TR)[2] lists over 300 mental disorders. In the introduction to DSM-IV-TR, it is noted that:

> The concept of mental disorder, like many other concepts in medicine and science, lacks a consistent operational definition that covers all situations. . . [and], there is no assumption that each category of mental disorder is a completely discrete entity with absolute boundaries dividing it from other mental disorders or from no mental disorder. There is also no assumption that all individuals described as having the same mental disorder are alike in all important ways [Ref. 2, pp xxi–xxii].

Personality disorders which exist on a separate axis in DSM-IV-TR have often received a negative reception when used in a forensic setting. One reason is their widespread prevalence. Personality disorders are considered an outgrowth of pathological personality traits that are described in DSM-IV-TR as:

> . . .enduring patterns of perceiving, relating to, and thinking about the environment and one's self, exhibited in a wide range of social and personal contexts. Only when personality traits are inflexible and maladaptive and cause sig-

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> nificant functional impairment or subjective distress do they constitute personality disorders [Ref. 2, p 630].

Every human has personality traits and, as a result, the frequency of related disorders has been estimated at 10 percent or more in the general population and 30 to 50 percent in psychiatric clinical populations.[3] The 2001–2002 National Epidemiologic Survey on Alcohol and Related Conditions (n = 43,093) found that 14.79 percent of Americans in the general population had at least one personality disorder.[4] Jail detainees contain disproportionately high rates of severe personality disorders.[5] Bland *et al.*[6] found a prevalence rate of 56.7 percent for antisocial personality disorder in 180 randomly selected male prisoners in Canada and the review of the literature by Metzner *et al.*[7] found that the presence of personality disorders in jails ranged from 8 to 47 percent in the United States.

A host of criticisms have been leveled against the categorical approach to the diagnosis of personality disorders that is based on a disease-oriented/medical model, because it makes a basic assumption that a disorder is either present or absent, even though most personality features occur on a continuum without a clear demarcation of what is normal from what is abnormal.[8] In addition, it has been empirically shown that the diagnosis of personality disorder has the least clinician-to-clinician reliability among the psychiatric diagnostic categories, and they continue to be diagnosed unreliably in general clinical practice.[9] Although some would contend that the reliability problem is lack of adherence to diagnostic criteria, others argue that personality disorders are ubiquitous and rarely involve cognitive deficits, a primary requirement for mental incapacity. As a result, a forensic psychiatric evaluator must carefully document all existing personality traits when trying to determine how personality disorders or their relative components may affect criminal responsibility. It is not surprising then that the use of personality disorders as a basis for a mental incapacity defense has received less than universal acceptance, both nationally and internationally.

As Krug has pointed out:

> . . .the interweaving of legal and psychiatric issues, coupled with the visibility and complexity of the mental incapacity defense, has already made the defense a matter of intense public controversy in domestic legal systems. This same kind of controversy within the international arena and the negative public perception of the defense as an excuse from individual accountability could have implications for the creditability both of the fragile system of international prosecution, and the goal of advancing a culture of legality [Ref. 10, p 319].

The controversy that has dogged excuse defenses is geometrically enhanced when personality disorders are used to diminish or exculpate the criminal from responsibility. This article will examine the internationally controversial practice of using a personality disorder diagnosis to either establish the mental disorder requirement for a mental incapacity defense or to mitigate a sentence.

International Criminal Courts

With the inception of the International War Crimes Tribunal for the former Yugoslavia (ICTY), the principle of individual liability for violations of humanitarian law, long an ideal, was operationalized. After the successful establishment of ICTY, plans for an International Criminal Court (ICC) gathered momentum. In the summer of 1998, the 52nd session of the United Nations General Assembly convened a diplomatic conference to finalize and adopt a convention on the establishment of an ICC.[11] The first statutes of the ICC were drawn up and approved by a majority of the nations present, and in the summer of 2002 the court became official after the completion of the required ratification process by a majority of signatory nations. In drawing up statutes, both the ICTY and ICC have affirmed the principle that separate (or affirmative) defenses to individual culpability are admissible in international criminal law. Grounds for excluding criminal responsibility are found in Article 31 of the Rome statute of the ICC[12] and are listed in the rules of procedure and evidence for ICTY under rule 67(A)(ii)(b),[13] stating that special defenses may be used including diminished or lack of mental responsibility.

The first concrete application of this defense was found at ICTY in 1998 at the Celebici trial. In an indictment issued on March 21, 1996, a Muslim prison guard named Esad Landzo was charged by the ICTY Chief Prosecutor with willful killing, torture, and cruel treatment while serving as a prison guard in the Celebici Camp in the Central Bosnia municipality of Konjic.[14] One of Mr. Landzo's American defense attorneys decided her client would be best served by advancing a variation of the insanity defense known as diminished responsibility as allowed under the ICTY rules.[15] This defense, an ancient principle borrowed from municipal legal systems in a

variety of jurisdictions, is considered an excuse rather than an indication of absence of the requisite *mens rea*. Unfortunately, the ICTY rules offered no further guidance concerning the specific parameters of the defense. As we have delineated in a separate publication, not only does manifestation of diminished responsibility have different formulations in various national jurisdictions, but the concept is not universally accepted or applied.[16]

At the Celebici trial, Mr. Landzo's lawyers initially argued that their client was driven to commit the acts with which he was charged in part because of his mental condition, which initially was characterized as posttraumatic stress disorder (PTSD) by court-appointed mental health examiners. When it became apparent, however, during subsequent examinations, that his symptoms were not meeting PTSD diagnostic criteria, the defense switched to a personality disorder diagnosis as the qualifying condition, which had also been cited in earlier psychiatric reports.[17]

The Celebici Trial

The arrest warrant for Mr. Landzo was transmitted to the authorities of Bosnia-Herzegovina on March 21, 1996. He was surrendered to the custody of the tribunal by the Bosnian government on June 13, 1996. He was transferred to The Hague, The Netherlands, where he was incarcerated in Scheveningen Prison and assigned a defense team. When the defense notified the prosecution of their intent to raise a diminished-responsibility defense, the Trial Chamber asked a panel of psychiatrists to provide evaluations to answer the following questions: Was diminished or lack of responsibility on the part of the accused present at the time of the alleged crimes in May 1992? Did the mental health of the accused at the time of the alleged events compromise his ability to understand the illegality of his alleged acts or affect his conduct, and if yes, to what extent? All three judges were non-European—hence, the term mental health rather than mental disturbance, the customary European usage. Mr. Landzo, who was a guard at the Celebici Prison camp from approximately May to December 1992, was 19 years old at the time of his alleged crimes. One of the problems that made the panelists' task difficult was his denial of the crimes.

The decision to pursue a diminished-responsibility plea was initially proposed by one defense attorney over the objections of another, and the attorney who favored the strategy eventually prevailed with the defendant.[15] Because of his apparent emotional fragility, Mr. Landzo had been originally examined by three court-appointed psychiatrists to ascertain his fitness to stand trial. The same psychiatrists were then asked by the court to comment about the possible existence of diminished or lack of criminal responsibility. When the defense conceived the diminished-responsibility plea, their concept of his mental abnormality was not well defined.[17] At trial, four psychiatrists and one psychologist—one retained by the defense, another by the prosecution, and the three originally appointed by the court—testified concerning Mr. Landzo's mental state at the time of the acts in question. With the exception of the prosecution's expert, all psychiatrists and the psychologist testified that Mr. Landzo had suffered from one or more mental disorders that putatively diminished his responsibility for the alleged crimes.[18]

For example, the psychiatrist AvL testified that Mr. Landzo had a mixed personality disorder that included borderline, schizoid and "especially dependent traits. . . . [H]e is suffering from lack of mental capacity. . .a mental condition [such] that he had a diminished capacity. . ." (Ref. 19 , pp 14220–1, 14265). When asked whether Mr. Landzo had an antisocial personality disorder, psychiatrist AvL answered "No, definitely not" (Ref. 19 , p 14300). During his testimony, psychologist AV said that he found Mr. Landzo to have "a state of mind that can be called a marginal borderline state [and that Mr. Landzo's] personality is functioning in a very complex and not well-suited way" (Ref. 19 , p 14400). "He is experiencing notable problems with respect to human contacts and also secondary narcissism leading to a tendency to depend [on] and idealize archaic, primitive and intensely loved object(s)" (Ref. 19 , pp 14401–2).

Psychiatrist ML opined that Mr. Landzo has "clearly symptoms of a posttraumatic stress disorder and he has a dependent personality disorder. In addition to that, he has this impulsive behavior and narcissistic behavior. . .you also find schizoid traits. . .we'll have to think in terms of a complex personality picture" (Ref. 19, pp 14566–7). Because of Mr. Landzo's "abnormal personality. . .there is a probability that there is diminished responsibility" (Ref. 19, p 14635).

In 1998, Mr. Landzo was reexamined by psychiatrist ML (for the third time) and psychiatrist EG (for the fourth time). Psychiatrist EG was clearly aware of

the English standard regarding diminished responsibility, particularly the use of the diagnosis of "psychopathy" to reduce murder charges to manslaughter. Using DSM-IV-TR nomenclature psychiatrist EG diagnosed Mr. Landzo with PTSD, moderately severe, and personality disorder, mixed including characteristics of both schizoid and antisocial personality disorder. "You can say schizoid personality disorder, antisocial personality disorder or you can say a mixed personality disorder, meeting criteria for antisocial and schizoid" (Ref. 19, p 15156). There was, however, no systematic delineation of DSM-IV-TR criteria leading to EG's conclusion. Some examiners believed that it was difficult to define Mr. Landzo's degree of diminished responsibility because of his denial of the crime and because they admitted during cross-examination that they were not familiar with the specific charges against him presumably because they had not been told by defense lawyers or had not asked (Ref. 19, pp 14286, 15208–9).

The Celebici Decision

During the course of the proceeding, the Trial Chamber ruled that it would not define the elements of diminished responsibility under Rule 67 (A)(ii)(b), which authorizes the defense but does not define it, before issuance of the final judgment. The Chamber thereby rejected the defense's claim that withholding the definition violated certain rights of the accused under the ICTY statute. Thus, the Chamber's decision reflected the fact that lawmakers and jurists have long been ambivalent about the desirability of formulating discrete separate defenses, and even among those favoring such a step, there has been much disagreement on the defenses to be recognized and on their specific elements.[10] The Trial Chamber did, however, determine that the party offering a special defense of diminished or lack of mental responsibility "carries the burden of proving this defense on the balance of probabilities" (Ref. 18, p 400).

In the final judgment, the Chamber noted that an essential requirement of the defense of diminished responsibility was that the accused's abnormality of mind should substantially impair his ability to control his actions. The Chamber was cognizant of the fact that diminished-responsibility defenses and their progeny are clearly articulated in the laws of several national legal systems and that it was permissible to resort to such systems for guidance. They noted that "[diminished responsibility] is usually hedged with a number of qualifications and does not offer the accused complete protection from the penal consequences of his criminal acts" (Ref. 18, p 397). In some national jurisdictions it reduces the gravity of the offense with which the accused is charged and in a number of others only applies to sentence mitigation.

In particular, it was apparent that the special defense provided for in Subrule 67 (A)(ii)(b) appeared to have its closest analogy in Section 2 (1) of the English Homicide Act,[20] which only allows the defense when the accused "was suffering such abnormality of mind (whether arising from a condition of arrested or related development of mind or any inherent causes, or induced by disease or injury) as substantially impaired his mental responsibility for his acts and omissions in doing or being party to the killing." The Homicide Act requires the impairment of responsibility to be substantial, although it need not be total. The Chamber also noted that a defense of diminished responsibility is more likely to be accepted if there is definitive evidence of mental abnormality.[18] In England, the first attempt to define the phrase abnormality of mind within the meaning of Section 2, was in *R. v. Byrne*,[21] where Lord Chief Justice Parker delivering the judgment of the court stated as follows, ". . .it means a state of mind so different from that of ordinary human beings that the reasonable man would term it abnormal." This cryptic definition avoided fastening a condition to any particular type of mental abnormality.

On the facts, the Chamber accepted that Mr. Landzo suffered from an abnormality of the mind at the time of his acts, but rejected his claim of diminished responsibility, because he failed to satisfy the second part of the test concerning substantial impairment of control of those acts. "Indeed," said the Trial Chamber, it is our "view that, despite his personality disorder, Esad Landzo was quite capable of controlling his actions" (Ref. 18, p 404). In reaching this conclusion, the Trial Chamber did not directly dispute testimony of the expert witnesses, but instead, discredited Mr. Landzo's factual representations to the psychiatrists who interviewed him. Although the Chamber tacitly concluded that a personality disorder qualified as abnormality of the mind, they did not specify which of the disorders described by the expert witnesses were found to be dispositive. It was also not clear whether Mr. Landzo was thought to

have a personality disorder or just pathologic personality traits, as the prosecution expert concluded, because the terms trait and disorder were mixed in the final judgment.

Mr. Landzo was found guilty on 17 counts of war crimes and sentenced to 15 years imprisonment. In pronouncing the sentence, the Chamber cited Mr. Landzo's mental condition as a mitigating factor. When it reduced his sentence, the Chamber cited as one of the mitigating factors the "evidence presented by numerous mental health experts, which collectively reveals a picture of Mr. Landzo's personality traits that contributes to our consideration of appropriate sentence" (Ref. 18, p 438). By expressly referring to Mr. Landzo's personality traits, the Chamber was perhaps indicating that it consciously used expert witness testimony, even though that evidence may not have reached the level of the abnormality-of-mind standard relative to a specific psychiatric diagnosis. By virtue of this approach, the Court could use any evidence of an offender's mental condition, whether or not it satisfied the psychiatric disorder element in the mental incapacity test.[10]

In 2001, Mr. Landzo submitted an appeal stating that the special defense referred to in the ICTY rules had been recognized both in the domestic laws of many countries and by statute of the ICC adopted in 1998, and, as such, should represent a complete mental-incapacity defense. The Appeals Chamber, however, rejected this argument.[22] An examination of other diminished-responsibility domestic laws as well as the ICC Statute did not support Mr. Landzo's contention. For example, the ICC Statute provides that a defendant shall not be criminally responsible if, at the relevant time, he or she "suffers from a mental disease or defect that destroys [his or her] capacity to appreciate the unlawfulness or nature of his or her conduct or capacity to control his or her conduct to conform to the requirements of law."[23] It is not the same as partial or diminished responsibility, as it requires the destruction (and not merely partial impairment) of the defendant's capacity, and leads to an acquittal. In fact, no express provision in the ICC Statute is concerned with partial impairment of mental capacity. Instead, the Appeals Chamber accepted that diminished responsibility may be a matter appropriately considered in mitigation of sentence (Ref. 22, para. 582–90). The ICC, in turn, does provide for a plea of diminished responsibility in its Rules of Procedure and Evidence when it lists "substantially diminished mental capacity" as a mitigating circumstance in determining a sentence.[24]

Mr. Landzo also maintained that the Trial Chamber did not "recognize that [his] responsibility was diminished with respect to the sentence. Merely stating that they took into account his mental traits does not recognize diminished mental responsibility even in application to mitigation of punishment." On the contrary, he submitted, the Trial Chamber should have clearly stated that the sentence was reduced by a certain number of years, due to a finding of diminished responsibility. The Appeals Chamber, however, found that it was clear that the Trial Chamber did take into account Mr. Landzo's personality traits by citing evidence from numerous mental health experts who contributed to consideration of an appropriate sentence. The Appeals Chamber could find no ambiguity in such a finding and held that it is not incumbent on the Trial Chamber, as suggested by Mr. Landzo, to indicate specifically the reduction in years that it makes in relation to each mitigating factor put forward. Instead, it is the duty of the Trial Chamber to make an overall assessment of the circumstances of the case and impose an appropriate sentence, taking into account all relevant factors (Ref. 22, para. 835–42).

Personality Disorders in National Jurisdictions

At trial Mr. Landzo's lawyers attempted to utilize principles taken from the British concept of diminished responsibility, while hoping to achieve sentence mitigation via a partial-responsibility finding such as may be seen in some European jurisdictions. Early in the trial, there was even a short-lived attempt to bring the American concept of diminished capacity into the proceedings. The details of these efforts have been extensively described in a previous publication.[16] Internationally, the differences between criminal defendants with personality disorders and those with psychoses have resulted in different solutions in accordance with individual criminal justice systems, legislation, and provisions for forensic psychiatric treatment.

Diagnostic Considerations

In the United States, psychiatric evaluation of a criminal defendant often begins and ends with a diagnosis of antisocial personality disorder (APD) because of specific exclusionary criteria in mental inca-

pacity statutes. Some jurisdictions, however, have expanded their definition of what constitutes a mental disease or defect for forensic purposes and attempted to prohibit all personality disorders. California and Oregon by legislation have respectively excluded from the insanity defense persons suffering from "solely. . .a[n] adjustment or personality disorder"[25] and "solely a personality disorder."[26] Other jurisdictions have contributed a smattering of their own exclusions. Arizona[27] by statute excludes "character defects" and "temporary conditions arising from the pressure of circumstances. . . ." Colorado[28] excludes "moral obliquity, moral depravity or passion growing out of anger, revenge, hatred, or other motives."

In 1983, when the legislature for the State of Oregon amended the statutes governing the insanity defense to eliminate persons with personality disorder, the legislators were responding to several concerns. The insanity defense was perceived by the public as a way to "beat the rap" and prosecutors contested insanity claims involving personality-disordered offenders more often. Juries hearing these cases were confused by the "battle of the experts." Before 1984, approximately 20 percent of people entering the insanity defense system in Oregon had been diagnosed by state hospital psychiatrists as suffering solely from a personality disorder.[29] Legislative reform was an attempt to narrow the application of the insanity defense by restricting it to persons with serious mental illness. Another motivation was to devote scarce state resources to those persons who had the greatest chance of responding favorably to treatment and achieving community placement.

Despite the change, Reichlin *et al.*[30] found that courts were still acquitting personality-disordered individuals as insane. Although the frequency of acquittals fell after the law changed, the decrease was not statistically significant. A review of those who had been diagnosed with personality disorders showed that at least half of the patients whose pretrial reports informed the trial court that retardation, organic disorders, psychosis, or affective disorder was the diagnosis were later found to have personality disorders when evaluated at the state forensic hospital. This diagnostic disparity appeared to be the most significant factor accounting for the continued admission of patients with personality disorders. The authors noted that general psychiatric interrater reliability studies showed that Axis II disorders continue to be diagnosed less reliably than Axis I disorders—in part, because Axis II disorders take longer to uncover.

The American ambivalence about the use of a personality-disorder diagnosis as the basis for a mental-incapacity defense is not unique, and most other national jurisdictions have been reluctant to allow mitigation of responsibility for individuals with a diagnosis of APD, sociopathy, or psychopathy. United States statutes not only avoid explicit inclusion of these disorders, but American psychiatrists generally view psychopathic patients as untreatable and hence unsuitable for hospital admission. One exception is in England where British psychiatrists were, at least initially, more optimistic about their ability to treat some individuals with "psychopathic disorder" and more willing to use their facilities to do so.[31]

In practice, discovered Beck,[32] the legal category of psychopathy in England may refer to a variety of clinically recognized personality disorders. Patients in special hospitals with psychopathic disorders often had antisocial, borderline, paranoid and/or narcissistic Diagnostic and Statistical Manual of Mental Disorders, Third Edition, Revised (DSM-III-R)-diagnosed personality disorders. Many had committed sexual offenses, and females averaged 3.7 Axis II diagnoses. Drug and alcohol abuse was common in both men and women. Psychiatrists debated whether the legal category "psychopathic disorder" referred to any medically recognizable group of diagnoses, how these disorders should be categorized and described, and whether the convicted should be incarcerated in prisons or special hospitals, or whether other involuntary treatment has merit. Beck observed that the law in Great Britain authorizes involuntary treatment for more people than does the law in the United States. In Britain, a person is mentally ill if two psychiatrists say so, because neither the law nor regulations specifically define mental illness and because psychopathic disorders have been defined so broadly as to describe a substantial minority of the population.

In Belgium, when first revised in 1930, the Protection of Society Act was primarily concerned with the means for dealing with mentally disturbed and habitual criminals, extending the instrument of internment (compulsory committal) to cover persons in a serious state of mental disturbance or deficiency. Whether the internment should be restricted to those suffering from acute derangement (e.g., some form of psychosis) or should be extended to those with a

mix of normal and abnormal characteristics or those who have committed an offense, the nature of which suggests a mental problem, was discussed at length.[33]

The total number of offenders serving internment orders in Belgium rose from 2,393 in 1992 to 3,146 in 2000. A study of female internees identified three main diagnostic groups: 44 percent with personality disorders (mostly antisocial, borderline, and narcissistic disorders, all of which the Belgians relate to psychopathy), 18 percent with mental (intellectual) deficiency, and 13 percent with psychotic disorders.[34] As in England, there has been less controversy about those with psychotic disorders and more about those labeled psychopaths who may be seen as "evil" and/or "criminally inclined."

The new Canadian criminal code implemented in 1992 changed "not guilty by reason of insanity" to "not criminally responsible by reason of mental disorder" (NCRMD).[35,36] Although defense counsel, prosecution, or the judge can raise the issue of fitness, generally only the defense can raise the NCRMD defense. A defendant can be found NCRMD if, at the time of the crime, he or she was "suffering from a mental disorder that resulted in incapability of appreciating the nature and quality of the act or omission, or of knowing it was wrong." Within Canadian case law, mental disorder has been broadly defined. For example, in *Cooper v. The Queen*[37] the court defined it as "any illness, disorder, or abnormal condition which impairs the human mind in its functioning." The courts have debated whether personality disorders form a legitimate basis for either unfitness to plead or for an NCRMD defense. Personality disorders that fall within the legal definition of a mental disorder have been accepted, but rarely result in a finding of NCRMD.[38]

In Germany, the Criminal Code dealing with offenders with mental illness provides that hospitalization should be imposed before or instead of a prison sentence. The convict is immediately confined in a special forensic psychiatric institution. These specialized hospitals are part of the German health system but the patient remains under the control of the prosecutor and a special penal court. Offenders can be released from custody only by a decision of this court. Discharge from hospital confinement in accordance with the law is possible if it is to be expected that the confined convict will not commit a punishable act.[39] Empirical data show that persons with personality disorders adjudicated to have diminished responsibility remain in psychiatric confinement longer than if they had been regarded as fully responsible and had been sentenced only to imprisonment. The largest group of patients within forensic psychiatric facilities is those with schizophrenia (about 50%) but personality disorders represent the second largest cohort (about 40%). Many persons with APD who show exclusively antisocial conduct are taken into forensic psychiatric institutions.[40]

The diminished-responsibility doctrine has important implications for the type of mental disorders found among patients in Dutch forensic psychiatric hospitals. In sharp contrast to the United States, a large proportion of hospitalized offenders have a personality disorder without a concomitant major mental disorder. Hildebrand and de Ruiter[41] found in a sample of 94 forensic psychiatric patients that 66 percent fulfilled diagnostic criteria for a Cluster B personality disorder, 29 percent for Cluster A, and 22 percent for Cluster C. The most frequently diagnosed disorders were antisocial (45%), narcissistic (26%), borderline (24%), and paranoid (18%). A 2004 study by Greeven and de Ruiter[42] of the impact of inpatient treatment on personality-disordered criminal offenders demonstrated that two years of compulsory treatment had a positive impact on at least 23 of 59 patients who showed reliable improvement. Less hopeful was the finding that the most prevalent personality-disordered pathology (Cluster B disorders) showed the least clinically significant improvement. Also, the fact that pathology in this group associated with violence such as impulsivity, narcissistic rage, and sadistic traits, did not change significantly was discouraging.

Sweden abolished the insanity defense in 1965. In its place, it passed legislation applicable to all mentally ill persons, including those charged with committing criminal offenses. New legislation was passed in 1992 specifying the procedure for forensic psychiatric evaluation and setting criteria for who should be considered to have a severe mental disorder. Sweden is one of the few legal systems that does not recognize the defense of either diminished responsibility or insanity.[43] The new legislation made the legal term severe mental disorder a more exclusive requirement for those sentenced to involuntary care within the forensic psychiatric system. Offenders who do not meet this requirement are dealt with by the ordinary correctional system. An offender who, in a forensic assessment unit (RPU), is found to have a severe

mental disorder cannot receive a prison sentence but instead is sentenced to forensic psychiatric care in a facility/hospital provided by the relevant health authority.

The clinical definition of severe mental disorder is not static; it varies over time according to decisions in appeals courts and other courts. When the law was drafted, severe mental disorder was conceived to be a condition of psychotic severity, regardless of etiology. The main criteria include disturbed perception of reality and symptoms of confusion, hallucinations, disturbed thinking, or delusions. It may also encompass severe depression with suicidal impulses, severe personality disorders with impulse control problems, compulsive behavior, and some paraphilias. Most offenders with a diagnosis of personality disorder, such as antisocial or borderline, are not thought to have a severe mental disorder and are sentenced to prison.[44]

Insanity Defense

The M'Naughten rules or a modified version is the most common international standard for determining whether defendants should be held cognitively responsible for their criminal behavior and under that standard a personality disorder diagnosis would rarely, if ever, be used to claim insanity. Some societies, however, add a version of irresistible impulse criteria to their standard such as seen in the American Law Institute's (ALI) model penal code.[45] After the 1982 John Hinckley verdict, the American Psychiatric Association (APA) stated, "Allowing insanity acquittals in cases involving persons who manifest primarily personality disorders, such as APD (sociopathy), does not accord with modern psychiatric knowledge or psychiatric beliefs concerning the extent to which such persons do have control over their behavior" [Ref. 46, p 685]. The APA suggested that any revision of the insanity defense standard should indicate that the mental disorders potentially leading to exculpation must be serious and should usually be of the severity (if not always the quality) of conditions that psychiatrists diagnose as psychoses. Eliminating the volitional arm of the ALI's two-prong test of criminal responsibility was also recommended by the APA and was adopted by Congress as part of federal insanity defense modifications.[47] It was seen as another means of dealing with impulse-prone individuals with personality disorders without specifically excluding a whole diagnostic category from mental-incapacity defenses.[29]

Likewise, the American Bar Association (ABA) recommended that impaired volition, which would be the relevant incapacity standard for personality disorders, should not be utilized for insanity acquittals.[48] The ABA emphasized that mental disease must be attributable to a substantial process of functional or organic impairment, rather than to defects of character or strong passion. Were it otherwise, the ABA noted, the defense would have no threshold and every abnormal defendant or every normal defendant who became abnormally impassioned could be said to have a mental disease. The 20 American jurisdictions that follow the ALI's insanity test[47] may exclude, by definition, psychopathic (sometimes called sociopathic) or antisocial personality from mental disease or defect. In a 1985 caveat paragraph, the ALI test excluded as a mental disability an abnormality manifested only by repeated criminal or otherwise antisocial conduct.[49]

In 1991, the British criminal code was revised so that the courts had some choice of disposition following a verdict of not guilty by reason of insanity. Before 1991, attorneys rarely raised the insanity defense because the criminal charges remained open, and if the defense succeeded, the only disposition for an insane defendant was involuntary hospitalization without time limit. Since then, the courts have had more latitude and may commit an individual to a hospital for a limited time, or order the person released to the community subject to restrictions. As a result, more defense attorneys began to raise insanity as a defense to criminal charges. Diminished responsibility, on the other hand, was used only as a defense in murder cases and psychopathy was often offered as a credible determinant. A plea or a finding at trial of lesser responsibility reduced the crime of murder to manslaughter. After a manslaughter conviction, the court had a wide range of sentencing options: prison, hospital, or probation. In contrast, conviction for murder carries a mandatory life sentence in prison.[32]

Paragraph 20 of the German Penal Code describes the principle of not guilty by reason of insanity as follows:

> [A] person acts without guilt, if he or she is incapable of recognizing the injustice of the criminal act, or is unable to act according to this insight, because of a pathological mental disorder, or an extreme disturbance of consciousness, or a mental handicap, or another severe mental abnormality that was present during the criminal act.[50]

The legal term pathological mental disorder includes organic brain damage and major mental disorders. The term severe mental abnormality may include personality disorders and paraphilias.[41]

Diminished Responsibility and Partial Responsibility

The English Homicide Act of 1957[21] required courts to be satisfied that the defendant was suffering from an abnormality of mind that substantially impaired his or her culpability for the crime before determining diminished responsibility. Psychopathic disorder was the basis of the first diminished-responsibility case after the Homicide Act became law and the term was first included in the English Mental Health Act of 1959.[51] It was defined as "a persistent disorder or disability of mind (whether or not including subnormal intelligence) that results in abnormally aggressive or seriously irresponsible conduct on the part of the patient, and requires, or is susceptible to, medical treatment." With minor changes, this definition was continued in the 1983 revision of the Mental Health Act[52] that also explicitly excluded persons with "mental disorder by reason only of promiscuity or other immoral conduct, sexual deviancy, or dependence on alcohol or drugs. . . ." Since then, there has been controversy about whether psychopathic disorder should remain in the Mental Health Act and whether psychopaths should be eligible for diminished responsibility, are amenable to treatment, or can be diagnosed accurately.[53] Recently, there was an attempt to quiet the debate by amending the 1983 Act with the Mental Health Act of 2007,[54] which abolishes categories of mental disorders such as psychopathy and replaces the so-called treatability test for detention with a new appropriate medical treatment test.

Before 1998, it was noted by many observers that efforts on the part of British psychiatrists to substantiate an illness model for psychopathy in the forensic context had generated little public approval and, indeed, jurisprudential support was diminishing. Furthermore, there was resistance to the formal extension of the diminished-responsibility plea for the psychopath to crimes beyond homicide. MacKay[55] noted that the number of successful diminished-responsibility pleas had been decreasing and Mitchell[56] reported that there was less support for a plea of diminished responsibility in cases where the psychiatric diagnosis was either a personality disorder or a psychopathic disorder.

In Canada, two major categories of mentally disordered offenders are recognized: individuals found unfit to stand trial and those found not criminally responsible by reason of a mental disorder.[38] Still, many mentally disordered individuals are found guilty and proceed through the correctional system. Some countries, including Germany, England, and The Netherlands, have a formal provision for partial or diminished criminal responsibility. In the United States, in at least 11 states, there exists a rarely used form of diminished responsibility called extreme emotional disturbance. It is usually an affirmative defense and is taken from the Model Penal Code under which intentional homicides that would otherwise be treated as murder are treated as manslaughter when they are "committed under the influence of extreme mental or emotional disturbance [EED] for which there is reasonable explanation or excuse."[57] In formulating the EED defense, the authors of the Model Penal Code sought to revise and expand the scope of the common-law doctrine of the "provocation" (or "heat of passion") defense.[58] In Oregon in determining whether a defendant has acted under the influence of extreme emotional disturbance, personality characteristics or traits are specifically not relevant.[59] In Canada there is no formal provision for diminished or partial responsibility. However, culpable homicide that otherwise would be murder may be reduced to manslaughter if the person who committed it did so in the heat of passion caused by sudden provocation.[60]

In Europe, diminished responsibility is usually formally referred to as partial responsibility because it is broader in scope than the English concept, which applies only to homicide cases. Paragraph 21 of the German Penal Code[61] describes the principle of diminished responsibility as follows: "If an offender's capacity to recognize the injustice of the criminal act or to act according to this insight during the criminal act is severely diminished for any of the reasons named in Paragraph 20 of the Penal Code, the sentence can be reduced." While assessments of major mental disorders and mental retardation are rarely controversial, the assessments of both extreme emotional states of relatively short duration and of personality disorders have been debated at length during the past several decades. The law states that only substantial impairment of criminal responsibility al-

lows for partial culpability. German forensic psychiatrists have even tried to develop psychiatric criteria for diminished criminal responsibility within the grouping of personality-disordered offenders. Most agreed that not every personality disorder substantially diminishes legal responsibility.[40] There is still no consensus, however, among either psychiatrists or jurists on how to judge the legal responsibility of these offenders. It seems that recently German insanity standards are being interpreted more liberally to include more offenders with personality disorders. There are, however, still significant regional differences in the types of offenders sentenced to psychiatric treatment.

The legal system in The Netherlands is based on an ideology of criminality in which the concept of "responsibility" plays a central role. From the Dutch point of view, a person may commit a crime without being held fully responsible for his acts. One feature of the Dutch legal system is the differentiation of "degrees" (or percentage) of responsibility and the number of reasons for its partial or total absence.[62] In criminal trials, the area between full responsibility and unfit to plead is referred to as diminished responsibility. This term is not in the Statute Book, but is based on Article 37a of the Criminal Code, which states that a person may be sentenced at the discretion of the state (called TBS) to a forensic psychiatric hospital when he or she commits an offense while suffering from developmental deficiencies and pathological mental disturbance as one of the factors leading to the offense.[63,64] The mental disturbance is not further defined.

The stronger the connection between the mental disorder and the offense, the lower the responsibility. There are five levels of responsibility ranging from fully responsible to not responsible (unfit to plead) where the offense is caused entirely by the mental condition of the perpetrator. A prison sentence is imposed for the part that the offender may be held personally responsible. The greater the responsibility imputed by the court, the longer the prison sentence. TBS is always enforced after the prison sentence has been served.[63,64] The court can only impose a TBS order if the defendant has a mental disorder and is thought to present a potential risk to others or to general safety. Theoretically, a TBS order is of indefinite duration. Initially imposed for two years, it may be extended for one- or two-year periods as the courts re-evaluate the patient to determine whether the safety risk is still too high.

Preventive Detention

In the late 1990s, the British government appointed an expert committee to review the Mental Health Act of 1983.[65] At the same time, these issues came to a head after a *cause célèbre* case in which a man who was refused help because he was untreatable was subsequently convicted of the murder of a mother and daughter. The English Home Secretary was openly critical of psychiatry's rejection of the man and the government began a review of mental health legislation, which resulted in the recommendation that a particular group of risky people with so-called dangerous and severe personality disorder (DSPD) be managed by psychiatrists in secure facilities.

The result in 2000 was a white paper (the first step to becoming a statute in Britain) to develop the proposal.[66] The paper ignored the report that was issued in 1999 by an expert committee that had suggested eliminating the term psychopathy but retaining the term personality disorder when new mental health laws were proposed.[31] It was recommended instead that individuals with DSPD be subject to broadened commitment criteria. Citing public protection as one of the key priorities, the white paper noted "individuals who present a risk to others because of their severe personality disorder are rarely detained under the Mental Health Act of 1983 because they are assessed to be unlikely to benefit from the sorts of treatment currently available in hospitals" (Ref. 66, part 2, p 9). Over the objection of many psychiatrists, the government thus developed legislation that eliminated the treatability criteria for the commitment of persons with personality disorders allowing involuntary hospitalizations solely for the purpose of managing problematic behavior.[67] To be eligible for the DSPD program, a person must have a severe personality disorder that renders him or her "more likely than not to commit an offense that might be expected to lead to serious physical or psychological harm from which the victim would find it difficult or impossible to recover."[31,68] The government seemed determined to move dangerous persons with severe personality disorders into quasi-psychiatric facilities. The DSPD program has set up pilot projects in prison and high-security hospital settings to identify, assess, and treat people who meet the DSPD criteria,

which must include a history of violence and a score over 25 on the Psychopathy Checklist-Revised (PCL-R).[69,70]

In support of the DSPD program, the government made international comparisons to other civil commitment schemes describing two models of indeterminate detention currently in use. One model is the medical (or clinical) one, based on the diagnosis and treatment of a psychiatric disorder. After diagnosis and civil adjudication, a person can be detained in a treatment facility, typically a hospital, for treatment of mental illness. Currently, the clinical model of indeterminate detention is used in Sweden and The Netherlands. A second model is community protection, which places a priority on public safety despite encroachments on the detainee's civil rights. Under the community protection model, courts use civil commitment to detain people in prisons or hospitals for indeterminate time periods, provided these people demonstrate a risk to the public. This model has been the basis for recent civil commitment initiatives in Canada (Dangerous Offenders Act, 1997) and Australia, as well as for sexually violent predator (SVP) commitments in the United States. Both models of indeterminate civil commitment provide for some type of periodic review by a parole board or a court. These proceedings, however, typically employ the same civil protections used in criminal procedure.[71] Appelbaum[31] notes that persons who enter the DSPD system may never have been convicted of a crime and may be sent to a secure prison unit based on predictions of uncertain validity about their future behavior and face indefinite detention without strong prospect of therapeutic gain.

Part XXIV of the Canadian Criminal Code[35] concerns dangerous offenders who are defined as persons who have committed serious personal injury offenses and who constitute a threat to the life, safety, or physical or mental well-being of other persons. An individual deemed a dangerous offender automatically receives an indeterminate sentence, subject to a parole review after the first seven years of custody, and every two years thereafter. Canada has a sentencing system in which judges have considerable discretionary power. The diagnosis of psychopathy has been used on numerous occasions both to support the position that an offender is likely to reoffend violently and to justify an indeterminate sentence.[72] The offender may only be released on parole by the National Parole Board, which examines the offender's case initially after a period of three years and thereafter at intervals of two years. In practice, however, a dangerous-offender designation may amount to a life sentence and results in offenders' spending extremely long periods in custody.[73]

Sentencing

Finally, it can be seen that countries differ in the approach to personality disorders as a determining factor in passing a verdict. In The Netherlands, such disorders can lead to a verdict of either no criminal responsibility, one of three different levels of diminished responsibility, or full responsibility. Personality disorders have little or no special influence on judgments in Belgium, Canada, and England, while in Germany and Sweden they are significant only when of a serious degree. It is of further note that Belgium, Canada, and England devote particular attention to the concept of psychopathy. In Canada, sentences can actually be increased for psychopathic offenders, while in England such offenders may be subject to special treatment and in Belgium they may be placed in either medium or high security units. The Netherlands is the only country in which the statute book does not seek to define the type or degree of mental disorder that will give rise to a finding of mental incapacity and lead to a committal order.[75]

Conclusions

Today, laws that define mental disorder vary considerably. Definitions of mental disease or defect sometimes, but not always, accompany insanity-defense standards. Under the U.S. Durham Rule,[75] the product of the mental illness approach, a series of legal cases in the District of Columbia suggested that (for the purposes of criminal insanity) psychopathy or other personality disorders could be productive of insanity. It was assumed by the law that such disorders could impair control of behavior but this is generally not the experience of psychiatry.

In a 1985 explanatory note, the ALI's model penal code advocated explicit exclusion of disorders characterized only by repeated criminal conduct. Although this caveat, which was incorporated into various state laws and judicial decisions, would appear to exclude APD, if not all personality disorders, it did not. As mentioned previously, California and Oregon have excluded from the insanity defense persons who have solely a personality disorder. The American Psychiatric Association (APA) Insanity Defense

Work Group concluded in 1983 that persons who manifest primarily personality disorders such as APD (psychopathy) should, at least for heuristic reasons, be held accountable for their behavior.

An impartial observer might conclude that the mental health testimony at the ICTY Celebici Trial would qualify as "psychobabble," because of the putative diagnoses of numerous personality disorders and the lack of adherence to diagnostic criteria by mental health experts. While the Trial Chamber allowed that Mr. Landzo may have some type of character pathology, they did not believe it prevented him from controlling his actions. Furthermore, the expensive and time-consuming evaluation of the defendant by psychiatrist EG has historical antecedents in the United States. Circuit Court Judge David Bazelon, who championed the Durham "product of mental disease" rule in 1954 as more just, was once told that the in-depth psychiatric defendant evaluations he contemplated would routinely take more than 100 hours. The criminal justice system is rarely, if ever, equipped to provide such resources, and the defense would then be available only to the rich, paradoxically leading to unequal justice and castigation of psychiatry.[76,77] Some would say that British psychiatrists, understandably alarmed by recent DSPD laws and now charged with treatment, have received their just desserts for allowing psychopathy to inhabit criminal responsibility statutes. Griffith *et al.*,[78] have observed that "in over 30 years of focus on dangerousness and risk, we have created powerful pressures on clinicians to become police. . . . And we have only strengthened the perception that mental health care is about the control of dangerousness—a perception that has seen its logical extension in the initiation of the DSPD proposals" (Ref. 78, pp 129–130). In Canada, the United States, and Australia, a personality disorder diagnosis may contribute to a final determination of preventive detention.

In attempting to analyze whether there is a distinction between personality disorder and mental illness, Kendell[79] determined that many, perhaps most, contemporary British psychiatrists do not seem to regard personality disorders as a psychiatric illness. Certainly, states Kendell, it is common for a diagnosis of personality disorder to be used to justify a decision not to admit someone to a psychiatric ward or even to accept them for treatment. Kendell suggests that for forensic purposes at present, it is impossible to decide whether or not personality disorders are mental disorders, and that this will remain so until there is an agreed upon definition of the term. The clinical literature on personality disorders, indeed, the basic concept of personality disorder, has few points of contact with psychological literature on personality structure and development, and little is known of the cerebral mechanisms underlying personality traits. Kendell concludes that, although it is difficult to provide irrefutable arguments that personality disorders are mental disorders, it is also equally difficult to argue with conviction that they are not.

Widiger[80] lists significant problems with respect to personality disorder diagnoses. Among his concerns are pejorative connotations, diagnostic unreliability, and excessive diagnostic co-occurrence (patients who meet diagnostic criteria for more than one personality disorder diagnosis). Other problems include the fact that even patients who share the same personality disorder diagnosis might not be that similar to one another and, finally, lack of systematic empirical studies about certain personality disorders resulting in an inadequate underlying scientific database. Some, however, contend that variation by itself does not disprove either psychopathology or psychological dysfunction. Certainly other psychiatric disorders have a wide spectrum, and it is feasible that severe character pathology in combination with an Axis I mood and/or anxiety disorder may partially or fully negate a defendant's criminal responsibility.

Yet, despite compelling skepticism in the literature, several national jurisdictions have all but embraced bringing personality-disordered criminal offenders into mental health treatment systems. England and The Netherlands in particular, and Germany and Belgium to a lesser extent, have a long history of treating personality-disordered offenders in forensic hospitals, sometimes successfully. Recent studies, for example, have challenged the assumption that psychopaths do not respond to psychological treatment.[81] Skeem *et al.*[82] found that psychopathic patients appeared as likely as nonpsychopathic patients to benefit from adequate doses of treatment in terms of violence reduction. D'Silva[83] performed a comprehensive analysis of existing research on the treatment of psychopaths and found that most studies did not have an appropriate research design. He concluded that the commonly held belief of an inverse relationship between high scores on the PCL-R and treatment response has not been established.

Increasingly, however, these treatment efforts, often at the behest of government policy makers, are being met with resistance by beleaguered psychiatrists in various countries. In 1983, Professor Richard Bonnie,[84] in reaction to the Hinckley controversy, declared that the definition of a mental disease or defect for legal incapacity should refer to "only those severely abnormal mental conditions that grossly and demonstratively impair a person's perception or understanding of reality and that are not attributable primarily to the voluntary ingestion of alcohol or other psychoactive substances" (Ref. 84, p 197). Bonnie believed that the volitional arm of the ALI insanity test was manageable if the defense was permitted only in cases involving psychotic disorders. Nevertheless, U.S. legislative attempts to follow his suggestion and exclude personality disorders from consideration have had mixed success at best. Because personality disorder diagnoses may be largely subjective, idiosyncratic, and treatment response is uncertain, it is important to document carefully and link all manifestations of the suspected disorder or traits to the specific criminal act in question. In the forensic setting, mental health providers should proceed with caution at the risk of squandering public trust, particularly in today's punitive legal climate. Since many criminals have some type of personality disorder, selecting those who enter a mental health treatment system or have their sentence mitigated or even exculpated on the basis of the diagnosis is sometimes a daunting task that may be unavoidably discriminatory and unjust.

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