The Psychiatric Evaluation of Dangerousness in Two Trial Court Jurisdictions

MARTIN L. FORST, PH.D.*

It is a commonly held view that criminal defendants and offenders who are dangerous to others should be incarcerated for treatment and released only when they no longer pose a threat. The controversial and important question, of course, is how is the evaluation of “dangerousness” made? The legal profession, under whose auspices the disposition of such defendant takes place, has called upon psychiatrists to make that determination, which can result in an involuntary civil commitment to a maximum security mental institution for a period from one day to life.

The concern of this study is with the psychiatric evaluation of dangerousness in criminal offenders. This interest is not a new development for legislation since the 1930’s has provided that some form of alternative sanction can be applied to criminal defendants who are considered dangerous. One frequently cited example is the legislation pertaining to the involuntary civil commitment of sex offenders, which has been passed in over half the states. Though the statutes vary somewhat in content, they generally provide that if a sex offender is diagnosed as being a sexual psychopath (or otherwise mentally disordered) and dangerous, he can be subject to an involuntary civil commitment to a state mental institution. Such legislation also states that while the court must make the final commitment decision, it cannot do so without first obtaining the opinion and recommendation of one or more psychiatrists concerning the mental state and dangerousness of the offender.¹

The legislation which mandates a psychiatric evaluation of dangerousness in the mentally disordered criminal offenders is vague in parts and contains no refined guidelines or specific definitions of terms to aid the psychiatrists in the performance of their duties. Does “dangerousness” imply the possibility that someone will be harmed psychologically or must it refer only to the threat of physical injury? Does it mean dangerous to one’s self or only to others? Is it an assessment of a current mental state or a prediction about future behavior? Must a prediction be made that the individual will commit a serious crime, such as a felony, or any category of crime? The problem facing the psychiatrists is that such legislative vagueness leaves the definition of dangerousness open to numerous interpretations,²⁻⁵ and, therefore, “…allows the experts to substitute their own notions about what kinds of expected or possible behaviors may be classified as ‘dangerous.’”⁶

*Dr. Forst is Post-Doctoral Fellow of the Center for the Study of Law and Society, University of California, Berkeley, California 94720.
Unfortunately, the psychiatric literature is no more successful than the legal literature in defining dangerousness and provides no standard criteria for diagnosis. As Kozol et al. state:

The terms used in standard psychiatric diagnosis are almost totally irrelevant to the determination of dangerousness . . . . The diagnosis of dangerousness is based on inquiry and examinations that extensively pursue areas of concern not fully dealt with in routine psychiatric assessment. There are no rigid criteria of dangerousness; there are only clues gleaned from a meticulous inquiry into multiple aspects of the personality. 1

Other sources agree that concrete guidelines for the evaluation of dangerousness are not available 3,7,8 and that the reliable prediction of dangerousness is a difficult, if not an impossible task. 7,9 Given this, and the fact that the evaluations are still conducted, the important question is how do psychiatrists determine whether or not someone is dangerous?

Few studies systematically attempt to show how psychiatrists evaluate dangerousness in criminal offenders. There are two studies dealing with the prediction of dangerousness in sex offenders,1,10 but in both studies attention was paid to the evaluation of continued dangerousness which was conducted in a mental institution after the offenders had been committed by the court. There also appear to be only two studies in the literature concerning the initial psychiatric evaluation of dangerousness in criminals at the trial court level. In one,11 the author, a psychiatrist with considerable experience in the evaluation of dangerous sex offenders, merely stated the need for better and more consistent evaluation of sex offenders. In the second, Steadman12 analyzed a large statistical sample of psychiatric reports submitted to the trial court concerning the prediction of dangerousness in persons considered too insane to stand trial on criminal charges in the state of New York.

Though these studies are certainly useful, questions remain about the psychiatric evaluation of dangerousness at the trial court level. Most of the studies do not examine a large sample of cases, nor do they offer any comparative data; they merely represent case studies undertaken in one jurisdiction. Even Steadman,12 whose study is by far the best in the field to date, recognizes the paucity of current information and calls for further research. The study presented here attempts to respond to Steadman's call and to improve upon the other studies by undertaking a comparative analysis of a significant sample of psychiatric reports in two trial court jurisdictions in California.

The Study

The psychiatric evaluations analyzed in the present study were conducted to determine whether, in the opinion of the psychiatrists, convicted sex offenders should be considered Mentally Disordered Sex Offenders. The definition of a Mentally Disordered Sex Offender (MDSO) is found in the California Welfare and Institutions Code:

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As used in this article "mentally disordered sex offender" means any person who by reason of mental defect, disease, or disorder, is predisposed to the commission of sexual offenses to such a degree that he is dangerous to the health and safety of others. Whenever the term "sexual psychopath" is used in any code, such term shall be construed to refer to and mean a "mentally disordered sex offender."13

It should be noted that the finding of dangerousness is a necessary element of the MDSO designation; the present study focuses on this aspect of the MDSO diagnosis.

California's law pertaining to the involuntary civil commitment of sex offenders was first passed in 1939 and was originally called the Sexual Psychopath Law. The law was changed to the Mentally Disordered Sex Offender law in 1963, as a reaction to the extensive and compelling criticism that there was no such clinical entity as "psychopath" or "psychopathic personality." Briefly, the MDSO Law provides as follows: The trial court must initiate MDSO proceedings if the defendant is convicted of a felony sex offense on a child under the age of fourteen, or if the defendant is convicted of a misdemeanor sex offense on a child under the age of fourteen and has a similar prior conviction. Furthermore, the court may initiate the MDSO proceedings if the court feels that there is probable cause to believe that the convicted offender may in fact be an MDSO, regardless of the crime for which he was convicted.

To start the MDSO proceedings, the court suspends the criminal proceedings after the defendant has been found guilty at trial or pleads guilty to a criminal offense; this suspension holds the imposition of the criminal sentence in abeyance. The court then appoints at least two, but not more than three, psychiatrists (one of whom must be associated with a county or state medical facility) who are paid a standard sum to make the evaluation. The examination of the offender takes place in a jail cell or another secure room inside the jail; the average duration of each psychiatric interview is about one half hour. Each court-appointed psychiatrist must then prepare an opinion and recommendation as to whether the defendant is an MDSO within the meaning of the law; included in the report is to be an opinion regarding the dangerousness of the defendant. The psychiatric reports are then submitted to the court, along with a presentence report from the probation department, and the court must make the final determination as to whether or not the defendant is an MDSO.

If the court deems him not to be an MDSO, then the criminal proceedings are reinstated and the regular criminal sentence is imposed – probation, jail, or state prison. If the defendant is determined to be an MDSO, he is civilly committed to a maximum security mental institution. The vast majority of MDSO's so committed in California are sent to Atascadero State Hospital. Since the commitment is civil in nature, its duration is from one day to life. The exit criteria for MDSO's from Atascadero have been described in some detail by Dix,10 but briefly, the alternatives facing the offender are: 1) indefinite incarceration in the mental institution, 2) release in good standing with a mandatory five-year probationary period, or 3) the standard criminal sentence of jail or state prison after being returned to the court of
original jurisdiction. The time involuntarily spent under the civil commitment is considered treatment and, therefore, does not necessarily reduce the amount of time to be served for the criminal sentence to state prison.

The present study consists of a content analysis of the psychiatric reports that were submitted to the trial court in two jurisdictions in California, one county in southern California (So Cal) and one county in northern California (No Cal). These two jurisdictions were selected because, according to the California Bureau of Criminal Statistics, they had, respectively, the highest and the lowest commitment rates for MDSO's of any of the fifty-eight counties in the state. Both counties are large and urban, with the So Cal county having a population of about 1,500,000 and the No Cal county a population of about 750,000; they are both industrialized and have a high degree of commercial and tourist activity.

The psychiatric reports examined in this study were obtained by securing a sample of criminal cases, in which the reports appeared as part of the civil commitment proceedings. The court records are considered public in nature and therefore are open for inspection. Parenthetically, it is interesting to note that while there is no statute in California making the psychiatric reports of alleged MDSO's confidential, probation reports are sealed thirty days after judgment and cannot be inspected unless a court order is secured.

The sample of criminal cases was selected over a five-year period (January, 1968, to December, 1972) from the Register of Actions — an official summary of all criminal cases that are processed in the Superior Court. From this Register, all sex-related cases in both counties were located — 670 in So Cal and 561 in No Cal. Since some of the cases involved multiple defendants, the total population of individual defendants was tallied — 703 persons charged with sex offenses in So Cal and 713 in No Cal. From this total sample of defendants, a study sample of 200 defendants in each county was chosen. The sample was randomly selected and stratified to reflect the proportionate number of rapists, child molesters, exhibitionists, etc., in each county. After removing those cases that resulted in not guilty verdicts, a total of 184 convicted sex offenders in So Cal and 187 in No Cal were examined. Because of the nature of some of the cases, it was not mandatory that the court initiate the MDSO proceedings, nor were all of the crimes of such nature as to arouse the judge's suspicion that the defendant might be an MDSO. Therefore, of the total number of convicted sex offenders in the sample, there were 122 defendants in So Cal and 34 in No Cal for whom the MDSO proceedings were initiated and psychiatrists appointed. Though the total sample of 156 defendants contained a minimum of two psychiatric reports per case (312), the actual number of reports (345) was somewhat higher, since in some of the cases there were conflicting reports between the two initial psychiatrists and a third had to be appointed. Also, in some cases the defense would hire a private psychiatrist to submit an additional report. The total sample of psychiatric reports represented the work of thirteen psychiatrists (seven in So Cal and six in No Cal).

In addition to the content analysis of the psychiatric reports submitted to the court, interviews were also conducted with some of the psychiatrists who were practicing when the study was made in 1973 and 1974. Among other things, the psychiatrists were asked about the criteria they employed in the
determination of dangerousness, the legal and psychiatric definitions of dangerousness, the amount of time they spent interviewing the alleged MDSO's, the extent of their reliance on the offender's criminal history in reaching their opinion, and any special problems they encountered.

Results

One of the initial observations made after analyzing the psychiatric reports was the lack of unanimity in psychiatric opinion regarding both diagnosis and recommendations. These contradictory opinions evidenced in both counties are presented in the following two tables. Table 1 shows the degree of unanimity of psychiatric diagnosis in MDSO cases, which reveals conflicting opinions in 30 per cent of the cases in the So Cal county and in 32 per cent of the cases in the No Cal county. Table 2 presents the degree of unanimity of psychiatric recommendations for MDSO defendants. There were conflicting or mixed recommendations in about 34 per cent of the cases in the So Cal county and 32 per cent in the No Cal county. Some of the diversity of psychiatric opinions can be explained by the differences in orientation of the many schools of psychiatry and the varying training programs throughout the country. Nevertheless, the ambiguity of the statute and the lack of guidelines for psychiatric classification also share the responsibility for the conflicting opinions.

TABLE 1
UNANIMITY OF PSYCHIATRIC DIAGNOSIS OF MDSO DEFENDANTS

<table>
<thead>
<tr>
<th></th>
<th>So Cal</th>
<th>No Cal</th>
</tr>
</thead>
<tbody>
<tr>
<td>N</td>
<td>%</td>
<td>N</td>
</tr>
<tr>
<td>No Diagnosis Made</td>
<td>16</td>
<td>0</td>
</tr>
<tr>
<td>Unanimous Not MDSO</td>
<td>25</td>
<td>17</td>
</tr>
<tr>
<td>Unanimous MDSO</td>
<td>36</td>
<td>6</td>
</tr>
<tr>
<td>Conflicting Opinions</td>
<td>36</td>
<td>11</td>
</tr>
<tr>
<td>No Information</td>
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<td>0</td>
</tr>
<tr>
<td>TOTAL</td>
<td>122</td>
<td>34</td>
</tr>
</tbody>
</table>

TABLE 2
UNANIMITY OF PSYCHIATRIC RECOMMENDATION OF MDSO DEFENDANTS

<table>
<thead>
<tr>
<th></th>
<th>So Cal</th>
<th>No Cal</th>
</tr>
</thead>
<tbody>
<tr>
<td>N</td>
<td>%</td>
<td>N</td>
</tr>
<tr>
<td>Not MDSO, so no Recommendation</td>
<td>25</td>
<td>17</td>
</tr>
<tr>
<td>MDSO but no Danger, so Outpatient Therapy</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>MDSO, Mixed Recommendations</td>
<td>41</td>
<td>11</td>
</tr>
<tr>
<td>MDSO, Unanimous to Atascadero</td>
<td>29</td>
<td>6</td>
</tr>
<tr>
<td>No Recommendation Given</td>
<td>16</td>
<td>0</td>
</tr>
<tr>
<td>No Information</td>
<td>9</td>
<td>0</td>
</tr>
<tr>
<td>TOTAL</td>
<td>122</td>
<td>34</td>
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In analyzing the manner in which the evaluation of dangerousness was conducted by psychiatrists in both jurisdictions, one discovers that general approaches to the task were similar, but specific interpretations and applications of the law were different. The first similarity in the determination was that the psychiatrists did not emphasize the current dangerousness of the offender in the evaluation, i.e., they did not stress
whether or not he was *imminently* dangerous. The fact that the assessment of overt manifestations of dangerousness was de-emphasized can be viewed in contrast to some civil commitment statutes for the mentally ill in which the evaluation of dangerousness pertains directly to the current mental state of the detainee. For example, in California, if the detained mental patient is not assaultive or suicidal directly before or at the time of the examination, then he is — by definition — considered not dangerous and is released. 17 It should be noted, however, that the presence of extreme aggression or assaultive behavior on the part of the type of offender being evaluated as an MDSO is not common. If such behavior were manifested, he would probably be handled by the court in a different manner, *i.e.*, given a different type of civil commitment under a different statutory provision.

Another obvious similarity between the counties was that relatively little space in the reports was devoted to standard psychiatric nosology, particularly in its relation to dangerousness. This was evidenced by the fact that only about 25 per cent of the reports contained references to diagnostic categories that resembled those found in the American Psychiatric Association *Diagnostic and Statistical Manual*. This figure represents references to outdated psychiatric nosology as well, for of those reports that did contain the diagnoses, about 40 per cent were out of date. For example, some psychiatrists would frequently diagnose the defendant as being a "psychopathic personality," a clinical category that was removed from the *Manual* in 1952. The other dated diagnostic category somewhat less frequently used was "sociopathic personality," a label that was omitted from the revised *Manual* in 1968. Of those reports that contained the current diagnostic nomenclature, the following is a typical excerpt:

> The diagnosis in this case is Personality Disorder, Passive Aggressive Type, with Sexual Deviation, Compulsive Rape. This predisposes him to the commission of dangerous sex offenses and classifies him as a mentally disordered sex offender. He is dangerous to others and would benefit from state hospitalization. He should be committed to Atascadero under the appropriate section of the Welfare and Institutions Code.

From an analysis of the contents of the reports, it appears that the traditional clinical approach of the psychiatrist was not generally utilized and that the specific professional techniques and diagnostic tools were not employed to the extent that one might expect. It would seem reasonable that the psychiatrist should check for the clinical indicators of dangerousness or violence, such as the predictive triad of enuresis, firesetting and cruelty to animals. Further, the presence of delusional thinking, temporal lobe disorder or the XYY chromosome syndrome might be investigated. There was, however, no indication that any of these clinical predictors were evaluated. In fact, beyond references to psychiatric nosology in 25 per cent of the reports, there was little to distinguish the evaluations made by the psychiatrists from those presented by the probation officers in their presentence reports.

A partial explanation of the fact that such little emphasis was placed on
current dangerousness of the offenders can be derived from an awareness of the general characteristics of those being considered for the MDSO designation. The type of person found in this legal category does not exhibit the same symptomology as persons subject to other forms of civil commitment; for the most part, they appear relatively free from obvious mental problems.

Because of this, it was sometimes difficult to distinguish what characteristics differentiated the MDSO’s from the non-MDSO’s, as evidenced by reading the psychiatrist’s evaluation of the defendant’s mental status. A comparison of the following two quotations reflects the assertion that overt mental impairment was not obvious. The first example was taken from the mental examination section of the psychiatric report on a person who was found not to be an MDSO:

*Mental Examination:* The defendant was alert, correctly oriented, generally cooperative, and appeared of average intelligence. He seemed somewhat anxious and hyperactive during the examination but his affect was not inappropriate. There was no indication of thought disorder; appeared to have some insight into his longstanding emotional difficulties; judgment appeared adequate.

The second example is from the mental status section of a report on a person who was considered to be an MDSO by the psychiatrist:

Mentally, he is sane, intelligent, and understanding of his situation before the court of law. He knew it was wrong to rape and agrees with the justice of his Youth Authority commitment . . . . He is not anxious and radiates an independent, though not hostile, attitude. He is not paranoid.

From the examples given, it appears that there are few salient characteristics which distinguished the MDSO from the non-MDSO. This fact is particularly interesting since such grave consequences could result from either designation.

Given the lack of overt symptomology in the offenders, it was necessary for the psychiatrists to look for other predictors of future offenses. This meant relying on the type and number of previous criminal offenses, particularly sex offenses, committed by the offender. In using this record as a predictive device, the psychiatrists seemed to be unintentionally adopting an approach that has been used with some success by social scientists in a slightly different context. While it has been established that there are no reliable predictive devices for dangerousness, there is some indication that concerning a broad range of psychological variables, statistical predictors are better than clinical predictors. Furthermore, it has been suggested that the best statistical predictor of behavior, though admittedly inadequate, is similar past behavior. As Rubin states with specific reference to the prediction of dangerousness, “Given the present reality it is unlikely that dangerousness can be predicted in a person who has not acted in a dangerous or violent way.”
This is not to suggest that the psychiatrists were in fact making accurate and reliable predictions of dangerousness; reliability of prediction has never been tested for MDSQ's in California. Nor is it to suggest that the predictions ought to be taken seriously until actual "experience tables" have been established and proven effective. The point to be made is that for the evaluation of dangerousness in MDSQ's in two trial court jurisdictions in California, psychiatrists were not utilizing their traditional clinical approaches, but rather were using, in a relatively unsophisticated fashion, a quasi-statistical device having moderate face validity.

It is not the purpose of this study to detail the difficulties encountered in the diagnosis of this type of offender, for this has been done in the past. A useful comparison can be made, however, with Steadman's study of the psychiatric reports of persons who were too insane to stand trial on criminal charges. With this type of individual, one sees a relatively high degree of disorientation and personality disintegration because the legal standards prevent only the most psychotic persons from standing trial. Consequently, Steadman found that the most frequently stated reason for a determination of dangerousness in the psychiatric reports was a finding of delusional or impaired thinking. In the absence of such obvious personality disintegration in the defendants being diagnosed as MDSQ's, the resort to the individual's history of criminal behavior is more understandable.

Not only were the psychiatric reports in both counties similar in that the prediction of dangerousness was based on past criminal activity, but they were also similar in their omission of other important information for the court. Consistently in neither county did the psychiatrists answer what Katz and Goldstein consider to be the two most important questions in the prediction of dangerousness, namely, "what kinds of behavior are sufficiently threatening to be called 'dangerous' and ... with what degree of certainty must the prognosis establish the likelihood of the kind or kinds of behavior designated 'dangerous' occurring over what period of time?" Thus, while the psychiatrists in both counties made predictions about future criminality, they did not state with any degree of certainty or in numerical figures the probability that future criminality would occur. And while some reports gave a general indication of the probability of the commission of sexual offenses in the future, they did not state during what time period those offenses were likely to occur. With reference to the possible dangerous act, there was no indication that it was either reasonably foreseen or that it was predicted to occur within the immediate future.

Since the psychiatrists could usually not gather ample clinical data in the half hour (on the average) they spent, the availability of the probation report which summarized the social and legal history, as well as the current offense, provided them with sufficient materials to write the psychiatric reports. The relative space allotted to references to clinical diagnosis compared to probation report information revealed that the psychiatrists relied heavily on the probation information in composing their reports to the court. The average psychiatric report was about two pages in length (single spaced), with one paragraph devoted to the clinical evaluation and the remainder devoted to the current offense and the social and legal history of the defendant.

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In assessing the criminal history of the offender, the psychiatrists did not appear to be concerned with the legal distinction between an allegation and a conviction, but seemed to assume that an alleged offense had, for the purpose of the psychiatric evaluation, in fact taken place. If there had been a single criminal episode in the offender’s past, even if rather serious in nature, it would generally be assumed that the defendant would not commit a subsequent similar crime and he would not be considered dangerous. A pattern of criminality, particularly sex offenses, however, seemed to indicate to the psychiatrist that the offender would probably commit another crime and that he should be classified as dangerous. Dangerousness, then, became almost synonymous with the high probability of future criminality. The following two excerpts from psychiatric reports exemplify the interest in the criminal history of the offender, as well as the relative lack of standard psychiatric phraseology.

Based upon the history of previous child molesting incidents as well as the disruptive sexual life the defendant reported, I would conclude that he has a personality disorder which predisposes him to the commission of sexual offenses rendering him a menace [sic] to health and welfare of others.

and,

In Summary: Mr. _________ presents as a young man with a past history of social dysfunction and emotional illness associated with pedophilia and excessive preoccupation with sexual matters. On the basis of the evidence above I am drawn to the conclusion that the subject, Mr. _________, should be regarded as a Mentally Disordered Sex Offender and a danger to others.

In certain obvious cases the psychiatrists in each jurisdiction would agree that a particular sex offender constituted a manifest danger to the health and safety of others. For instance, if a person had been convicted of a forceable child molestation and had several similar prior convictions, almost every psychiatrist in both jurisdictions would consider him to be a danger to others. Demonstrated assaultive criminality weighed very heavily in the minds of the psychiatrists in the determination of dangerousness. The problem facing the psychiatrists was not how to evaluate these obvious cases, but whether or not crimes at the lowest end of the dangerousness spectrum should be included. Specifically, the decision had to be made as to whether the potential for physically injuring someone was a necessary characteristic for an offender to be considered dangerous, or if behavior which might be psychologically harmful should also fall into that category.

It is on this issue that some variation between the psychiatric reports of the two jurisdictions was found. Though there was some intra-county variation, the psychiatrists in the northern county tended to limit their conception and definition of dangerousness to the physical danger to potential victims. The psychiatrists in the southern county, in general, extended their definition of dangerousness to include psychological danger.
to victims. Thus there were cases in which passive child molesters and exhibitionists were determined to be dangerous by the psychiatrists in the southern county; there were no such cases in the northern county.

Examination of the psychiatric reports from the two jurisdictions supports this assertion. The following is an example from a report in the northern county:

Furthermore, the victim in the present offense appears to be over the age of 14, and the evidence does not seem to be overwhelmingly convincing that force or violence or threats were used. It is not clear, therefore, that the defendant's offense represented a physical danger to the health and safety of the victim, and with respect to possible psychological danger, there appears to be very poor consensus among psychiatric experts with respect to the psychological damage, if any, following such incidents.

In such a case, the psychiatrist concluded that the offender was not dangerous to the health and safety of others and not an MDSO.

Though the psychiatrists in the southern county might have agreed that there was no consensus among experts about the psychological consequences of a nonviolent molestation on a child, they were, nevertheless, more likely to include the concept of psychological danger in their interpretation of the MDSO statute. Consequently, the psychiatric reports in the southern county resembled the following report on a person convicted of a child molestation:

Opinion: In my opinion, the defendant is a sexual deviate, associated with pedophilia. He sees his sexual activities with young children as a problem for him, and verbalizes the need for some sort of psychological help. Although he has never apparently been any physical threat to anyone, I do feel that he is a threat to the psychological health of his victims and I feel he should be considered a mentally disordered sex offender.

Thus the psychiatrists in the southern jurisdiction have adopted a much broader interpretation of the MDSO statute than those in the northern county, with the result that a larger variety of offenders are subject to the MDSO designation.

The implications of this finding are significant and certainly offer a partial explanation for the differential county commitment rate of MDSO's to Atascadero State Hospital. In the northern county, where the definition of dangerousness was restricted narrowly to refer to physical danger to others, the lowest commitment rate was observed. In contrast, in the southern county, where the broadest definition of dangerousness (including psychological danger to others) was employed, the highest commitment rate was observed. The result of this broader interpretation of the statute is that judges and attorneys (through the plea bargaining process) have available to them a wider variety of cases which might be subject to the MDSO civil commitment. Although it is difficult to determine the relative importance of all the factors leading to a differential commitment rate between the two counties, it seems apparent that at least one important factor is the different criteria employed to determine dangerousness.

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One final difference between the psychiatric reports of the two jurisdictions concerns the deference paid to the legal construction of the statute. As previously mentioned in the definition of a Mentally Disordered Sex Offender, it is possible to be dangerous and not an MDSO, if the predisposition to commit dangerous sex offenses does not result from a mental disease, defect, or disorder. It is also possible to have a mental disease, defect, or disorder and not be an MDSO, if one is not dangerous to others. It is not legally possible, however, to be an MDSO if the element of dangerousness is absent.

The psychiatrists in the northern county tended to be more aware of the precise wording of the statute and to construe it more strictly. For instance, there were no cases in which the psychiatrist found the offender non-dangerous but nevertheless concluded that he was an MDSO within the meaning of the law. The reports from the southern county indicated that the psychiatrists were somewhat less concerned with such a strict interpretation of the Code. For example, though it happened in only 2 per cent of the cases (see Table 2), some psychiatrists in the southern county concluded that a nondangerous person could be classified as an MDSO. The following excerpt illustrates this:

It is my opinion that while the defendant must be categorized as a mentally disordered sex offender because of his pattern of sexual interest in pre-adolescent girls, with on two occasions giving in to his impulses, he does not represent a danger to the community and could best be treated by allowing him to remain in the community and continue with out-patient treatment. I am impressed by his stability in other areas, the lack of violence or threats as part of his pattern and attitude of sincerity, along with a growing understanding of his problems and ability to control his impulses which make it hopeful that there will be no recurrence.

What this psychiatric report posed was, of course, a legal impossibility and would probably be disregarded by the judges. However, it should be mentioned that one possible source of this legal misinterpretation stems from the statutory construction of a previous version of the same law. When the Sexual Psychopath Law was first drafted, the word “danger” was not included. Rather, the legislators constructed the phrase “menace to others” which surely referred to a more general type of harm done to victims. Though this section of the statute was changed from “menace” to “danger” in 1963, remnants of the old way of thinking persist among psychiatrists who conducted this type of evaluation before the law was changed.

Conclusion

The question of the significance of the psychiatric finding of dangerousness for the persons subject to the civil commitment remains. It has been suggested by some that the finding of dangerousness has little effect on the offenders, at least under certain circumstances. Steadman, for instance, concluded that the diagnosis of dangerousness did not make any appreciable
difference to the criminal defendants in his study, for they were subject to at least one-year civil commitment no matter what designation was made, and further, the institutions to which they would be sent were essentially the same.

The current study found that the difference in the diagnosis of dangerousness does matter a great deal to the offenders because being legally designated an MDSO can have significantly different consequences from being found a non-MDSO. If a person is a misdemeanor and found to be an MDSO, he will most likely spend more time incarcerated than if he were found to be a non-MDSO.28 This is so because the civil commitment to a mental institution is indeterminate, while the duration of a criminal commitment for a misdemeanor cannot exceed one year in the county jail. The difference is significant for felons as well. If the felon, particularly a serious offender, is found to be a non-MDSO, he would probably be sent to prison — a fate considered by the inmates themselves to be much worse than being sent to Atascadero State Hospital, since they would probably spend more time in prison.28 Furthermore, the quality of time spent is worse in prison, since sex offenders, particularly child molesters, are at the lowest end of the inmate hierarchy and are often subject to physical and psychological abuse; such abuse is much more rare in the mental hospital.

Not only can the results of the diagnosis be significant, but this study has revealed that it could make a substantial difference whether or not the offenders were evaluated by the psychiatrists in the northern or the southern county. For instance, since the psychiatrists in the southern county include psychological harm to potential victims in their definition of dangerousness, persons convicted in that jurisdiction of committing nonphysical offenses, e.g., exhibitionism to children, might be subject to a one day to life civil commitment in a maximum security mental institution, whereas such offenders from the northern county would not face so severe a sanction.

In conclusion, the efforts made by psychiatrists to perform the legal task of determining whether or not convicted sex offenders are dangerous were inadequate for a variety of reasons — not necessarily under their direct control. Principally, the psychiatrists were forced to interpret vague legislation which offered no specific guidelines to aid them in complying with the task at hand. Furthermore, the psychological make-up of the offenders was such as to make the traditional clinical psychiatric evaluations difficult, especially considering the small amount of time in which they were conducted. In response to this, the psychiatrists tended to base their determination of dangerousness on the criminal history of the defendant, relying heavily on the legal and social history information. This basic response by the psychiatrists was observed in both counties.

It seems apparent that there is a need to standardize and upgrade the psychiatric evaluation of dangerousness, for county borders should certainly not determine the likelihood of a civil commitment. To arrive at such standardization would require: (1) more specific statutory provisions; (2) stricter legal interpretation by the appellate courts; and (3) increased input by local and national psychiatric associations.

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