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CHAPTER 9

Employing Psychiatric Predictions of Dangerous Behavior: Policy vs. Fact*

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From mid 1973 through early 1974, there were four cases in the courts of Albany County, New York, whose sequelae highlight many of the problems we are addressing in this symposium. John Richards was found incompetent to stand trial in 1970 on charges of stabbing two strangers. He was returned as competent in 1973, but neither victims nor witnesses could be located. Thus, Richards was released after pleading guilty to a weapons charge. The judge did so "reluctantly" and on the condition that Richards would continue to obtain psychiatric care. Within 1 month after this conditional release, Richards was arrested for the fatal stabbing of another man.

The second case involved Andrew Jenkins, who served a prison term in 1969 for the fatal beating of his common law wife. After completing his prison term, he was hospitalized in a civil mental hospital for 2 weeks in July, 1972. Approximately 1 year after his release from that State facility, he was arrested for beating to death his most recent common law wife.

Fred Giorgio allegedly shot two men in the leg while picnicking in a State park in July, 1972. He was found incompetent to stand trial and hospitalized for 1 year before being returned to trial. His first trial ended with the jury unable to reach a verdict. A few hours after his second trial commenced, Giorgio committed suicide by hanging himself in Albany County Jail.

The final case was that of Jeremiah German who was charged with the stabbing of another man in June, 1969. He was determined incompetent to stand trial and was hospitalized until May, 1973.

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Upon return to Albany County, local psychiatrists found him still psychotic and returned him for further hospitalization. In January, 1974, German was returned to stand trial while on medication. At his hearing in March, 1974, for 20 minutes German "fired a machine gun volley of words, many of them obscene, and jumbled sentences. He tapped one foot loudly as he ranted about killing, racism, drugs, and sex. He said he had once seen God" (Albany Times-Union, March 23, 1974). Two Albany psychiatrists testified that German was "dangerously psychotic" and preoccupied with sex and violence, and he was remanded for further hospitalization by the irate judge.

On the day after a story on German's courtroom antics, along with a resume of the other three cases, the following editorial appeared in the Albany newspaper:

> If the Albany County experience with these released psychotics can produce two alleged murders, a suicide and 20-minute court tirade in less than a year, what is going on on a statewide basis? How much crime and violence is there statewide that can be attributed to those who should be in mental hospitals and are not?
>
> The matter raises serious questions about the professional qualifications of those running the State mental health programs and the State facilities. If they are unable to recognize potentially dangerous or violent persons among those they release to society, they should not be in the positions requiring such determinations to be made.

Here is another vivid example of society's expectation that a necessary, albeit insufficient, skill of psychiatry is the prediction of future dangerous behavior. As this newspaper editorial would have it, if psychiatrists in State facilities cannot accurately predict future dangerous behavior, then they are not qualified to provide services.

In evaluating psychiatric roles in society, here specifically that of estimators of dangerousness, one is faced with the situation illustrated by the reactions to these incidents in this New York county. The public, the media, judges, and legislators, almost all assume that psychiatrists by training and experience can predict future dangerous behavior and they want psychiatrists to do just that. Even professional groups who are in the forefront of progressive policy-making often demonstrate similar confidences. The National Council on Crime and Delinquency's Model Sentencing Act, for example, requires that offenders who are determined to be dangerous be more harshly sentenced. A major feature of the determination of dangerousness is that "the judge must remand him to a diagnostic facility for study and report as to whether he is suffering from a

'mental or emotional disorder indicating a propensity toward continuing criminal activity of a dangerous nature' " (NCCD, 1969).

A logical explanation for this pervasive and high level of societal confidence in psychiatric abilities to expertly perform the tasks of predicting future dangerous behavior might be that their past performances warrant it. This group of medical professionals have been granted, or assumed, this powerful position of forecasting because they have been good predictors. Can psychiatric ascendancy as predictors of dangerousness be explained in terms of the expertise they have reflected in the past?

Having looked at the available research data on these critical questions, let us proceed to what may be some even more important questions related to: (1) whether society really cares how accurate psychiatric predictions of future dangerous behavior are; and (2) whether the answers to this latter question indicate that we may need to develop a new area of study — dangerology.

Assessments of Psychiatric Predictions

Psychiatrists make predictions of dangerousness under a wide variety of circumstances. These circumstances may be civil or criminal and they may relate to admission, institutional placement (within or between institutions), or discharge. However, regardless of the type of circumstances, by Halleck's conclusion, "If the psychiatrist, or any other behavioral scientist, were asked to show proof of his predictive skills, objective data could not be offered," is still accurate.

In a 1967 work, Rappeport and colleagues reviewed the existing literature on the dangerousness of the mentally ill with a primary emphasis on criminal activity after community release. They concluded that, "There are no articles that would assist us to any great extent in determining who might be dangerous, particularly before he commits an offense" (1967:79). In an extremely comprehensive, integrative review of a wider range of research on psychiatric predictions of dangerousness, Rubin similarly asserted, "This prediction (of probable dangerousness of a patient's future behavior) is expected of the psychiatrist — and psychiatrists acquiesce daily." This belief in the psychiatrists capacity to make such predictions is firmly held and constantly relied upon, in spite of a lack of empirical support (1972:397).

Both of these research reviews were completed before we had reported on our recent work on the "Baxstrom" patients (Steadman and Cocozza 1974). Our 4½ year followup of these 967 criminally insane patients, who were considered among the most

dangerous mental patients in New York in 1966, documented the psychiatric overestimations of their dangerousness and added additional support to the conclusions of Halleck, Rappeport, and Rubin. Of the 967 patients who were transferred from maximum security correctional mental hospitals to civil mental hospitals after the 1966 *Baxstrom* v. *Herold* decision of the U.S. Supreme Court, only 20 percent were assaultive in any way over 4½ years. This included incidents which may not have resulted in injury, but which were violent physical assaults on other persons and were not in self-defense. In this group of patients who had been detained on the average of 14 years in prisons and hospitals for the criminally insane, four times as many people were not assaultive as were. Also, only 24 of the 967 patients were returned to correctional security hospitals between 1966 and 1970.

A widely discussed exception to the consensus on psychiatric inabilities to make predictions of future dangerous behavior is the work of Kozol and co-workers on patients at the Center for the Diagnosis and Treatment of Dangerous Persons, at Bridgewater, Massachusetts. Working with a patient population mostly of convicted sex offenders, Kozol and his co-workers compiled data which they felt justified a conclusion that "It appears that dangerousness can reliably be diagnosed and effectively treated" (1972:392). The empirical basis for this conclusion was an 8 percent recidivism rate for violent offenses among those patients they evaluated and recommended for release by their diagnostic team, but whom the court nevertheless released. While these comparative figures are striking, there is a methodological flaw which raises serious questions about their strong conclusion.

As discussed by Cocozza (1973), 82 of the 386 patients recommended for release were so approved after an average of 43 months of treatment, giving them from 5 to 11 months at risk during the 48- to 54-month followup period. The data on the comparison group of 49 patients included 18 patients who were also treated, but who were at risk from 18 to 24 months, 13 months longer. In addition, there is no way to tell what the period of risk was for the other 304 "nondangerous" or the other 31 "dangerous" patients. Thus, without proper controls for length of time at risk by the patients in each group, it is impossible from the data Kozol and colleagues presented in their original piece, as well as in a subsequent rejoinder (Kozol et al. 1973) and news report (*Psychiatric News* 1973) to validly conclude that dangerousness can be predicted.

The most recent experimental data analyzing ongoing psychiatric predictions of dangerousness have been reported by Cocozza and Steadman (forthcoming). From data gathered on two groups of

incompetent felony defendants in New York State, one group evaluated as dangerous by two court appointed psychiatrists and the other group as not dangerous, a number of criteria behaviors over a 3-year followup period were examined.

In order to determine the accuracy of the psychiatric predictions of dangerousness, we obtained data on the defendants' assaultiveness from five sources: (1) the maximum security hospitals to which both groups were initially sent; (2) civil hospitals to which some members of both groups were transferred immediately after the maximum security facilities; (3) hospital readmission records; (4) inpatient records of all subsequent hospitalization; and (5) subsequent arrest records.

We examined whether the patients evaluated as dangerous by the psychiatrists actually displayed more dangerous behavior than those evaluated as nondangerous. They did not. On all of the indicators of dangerous behavior which we examined, the data revealed only slight differences between the two groups. None of the differences which did occur was statistically significant, and, therefore, all could be explained on the basis of chance alone.

On the inpatient indicators, the psychiatrically predicted dangerous group experienced slightly higher rates. Forty-two percent of them, as compared to 36 percent of the nondangerous group, were assaultive during their initial incompetency hospitalization; 8 percent, as compared to 0 percent, were assaultive in the civil hospital of transfer; 3 percent, as compared to 2 percent, were subsequently rehospitalized for a violent act, and 29 percent, as compared to 19 percent, were assaultive in the hospitals to which they were readmitted. None of these differences is statistically significant.

Conversely, the indicators on the dangerousness of the two groups once in the community reveal the nondangerous groups to be more assaultive, but again only slightly more so than the group predicted to be dangerous by the court psychiatrists. The gross measure of community behavior we used was the percentage of those released to the community, at some time, who were rearrested for a crime. It was found that 49 percent of the released dangerous group and 54 percent of the released nondangerous group were rearrested.

Perhaps the single most important indicator of the success of the psychiatric predictions is the number of these patients subsequently arrested for violent crimes. Yet even here only a slight difference is revealed by the data. Of those who had been evaluated as dangerous, 14 percent (13 of 96) of those released to the community were subsequently arrested for a violent crime. Of those who had been evaluated as nondangerous, 16 percent (11 of 70) of those released to the community were arrested for a violent crime.

How accurate, then, were the psychiatric predictions of dangerousness? On the basis of all of these indicators, the answer would be that they were not accurate at all. There was no significant difference between the two groups on any of the measures of assaultiveness examined. Those defendants evaluated by the psychiatrists as dangerous were not any more dangerous than those they felt were nondangerous.

Certainly, a major difficulty in any type of evaluative exercise such as this one is establishing a criterion of success. This difficulty is one of the major factors in many current controversies surrounding the accuracy of psychiatric estimations of dangerousness. Kozol (1973) addresses the criterion problem in a rejoinder to a letter (Monhahn 1973) which followed the publication of the article just discussed. Kozol and co-workers rested their claims, although internally invalid ones, of predictive success by comparing theirs to those of the court. As they recognized and as Monahan discussed, even in the high recidivism group (34.7 percent), the false positive rate of incorrect to correct predictions is nearly two to one — outstanding by some standards and entirely unacceptable by others.

A similar argument for evaluating psychiatric predictions of future dangerous behavior on a relativity standard was recently offered by McGarry (1974). In responding to a colleague whose "concern centered on the frequent inadequacy of the clinical history and the nonexistence of valid instruments for the assessment of danger in the mentally ill . . . [and] the importance of these inadequate assessments in governing the lives and the freedom of human beings," McGarry responded, "Who could do it any better?" This, however, as the author has argued elsewhere (Steadman 1974), is not the significant question. The issue is not whether psychiatrists are better predictors than other poor predictors, but whether they are sufficiently accurate to meet the standards implied in the civil and criminal statutes and procedures which mandate these predictions and permit detention because of them. Thus, the standard by which psychiatric predictions of dangerousness must be evaluated is an absolute one. Do they meet whatever this standard is?

The Irony of Poor Prediction and Public Support

The two major systems of social control in the United States are the criminal justice and the mental health systems. In the criminal justice system, the basic tenet of innocence until guilt is proven and its corollary, better to let 1,000 guilty go free than to imprison one innocent person, are very critical foundations in most procedures.

However, in the mental health system, it would seem that these basic American tenets of criminal justice are not even pretenses when dangerousness somehow becomes linked with mental illness. Although there are no data that seem to address this question, there is wide public support for the detention of large numbers of mentally ill patients under the aegis of dangerousness, far in excess of those who will actually display assaultive behavior. Such support comes to a great extent from the public's assumption that they are being protected, through psychiatric diagnostic expertise, from most of the mentally ill who would be assaultive. Actually, the poor record of psychiatric predictions of future dangerous behavior is masked both by the lack of opportunities to observe the many false positives and by the very small number of mentally ill, called dangerous or not, who exhibit dangerous behavior. Thus, the record of psychiatric overprediction is practically unblemished. With strong public and legislative support, tens of thousands of individuals are detained each year in the United States in various civil and correctional facilities who, were they in the community, would never display the dangerous behavior predicted of them.

Thus, ironically there is a strong case against ability of psychiatrists to make accurate estimations of dangerousness within acceptable statistical bounds, and yet, there is, apparently, broad support from the American public. How can such an antithesis be explained? What, then, has led to psychiatry's ascendancy to these responsibilities? Let us briefly consider what the history of the relationships between mental illness, dangerousness, and psychiatry in the United States can contribute to an understanding of psychiatry's social control role of predicting future dangerous behavior.

Comments on the Origin of Mental Illness and Dangerousness in the United States

As Deutsch (1949) and Szasz (1970) noted, major forerunners of concepts associated with mental illness were ideas of demonic possession and witchcraft. From the mid-fifteenth through the seventeenth century, the peak of the witch hunting mania in Europe, it is estimated (Deutsch 1949) that over 100,000 people were killed as witches possessed by the devil after having sold their souls to him in return for special powers. During the periods of 1647-1663 and 1688-1693, especially in Salem, Massachusetts, witch hunts and burnings at the stake were frequent. However, with the gradual decline in the impact of religion in secular affairs, and with the evolution of medical knowledge in the seventeenth and eighteenth

centuries, medical explanations and treatments for these behaviors developed. Trials and inquisitions for witchcraft were replaced by commitment as mentally ill and estimations of dangerousness. Torture and executions were gradually replaced by attempts at humane treatment and special institutions for the insane.

While the first mental hospital did not open in the United States until 1756, from colonial times, common law standards allowed for the arrest of seriously disturbed persons or those deemed too dangerous to be left free in society (Deutsch 1949). Such confinement was to be for the duration of the period of dangerousness. As Deutsch noted, "Insane persons recognized as such (namely, the violent and the dangerous) were dealt with by the police powers." In fact, the only type of insane patients specifically considered in early colonial legislation were those seen as furiously mad or dangerous to themselves or others. Deutsch reports as an example of this legislation the 1788 New York State provisions which were copied practically word for word from a 1744 English law:

> Whereas, there are sometimes persons who, by lunacy or otherwise, are furiously mad, or are so far disordered in their senses that they may be too dangerous to be permitted to go abroad; therefore
>
> Be it enacted, that it shall and may be lawful for any two or more justices of the peace to cause such person to be apprehended and kept safely locked up in some secure place, and, if such justices shall find it necessary, to be there chained.

Thus, dangerousness has always been a primary reason for detention. (For more complete coverage of this topic see Robitscher elsewhere in this monograph.)

From the beginning of mental hospitals in the United States through the late nineteenth century, there were few constraints on physicians' commitments of people to these facilities. During the eighteenth and nineteenth centuries, the signature of a physician on a slip of paper saying that the individual should be admitted was all that was required for involuntary admission. An early event in the movement toward some check on these unbridled commitment powers was an 1845 court case in Massachusetts for the release of Josiah Oakes from McLean Asylum in Massachusetts. The decision of the case was:

> The right to restrain an insane person of his liberty is found in that great law of humanity which makes it necessary to confine those who, going at large, would be dangerous to themselves or to others. And the necessity which creates the law creates the limitations of the law. . . .

> The question must then arise in each particular case, whether a patient's own safety, or that of others, requires that he should be restrained for a certain time, and whether restraint is necessary for his restoration, or will be conducive thereto. The restrain can continue as long as the necessity continues. This is the limitation, and the proper limitation (Deutsch 1949: 422-3).

Thus, for the first time in the United States, the justification and limitations implicit in the common law concerning the restraint of the mentally ill were spelled out. If they were dangerous to the safety of themselves and others and were insane, they would be detained indefinitely.

First, witchcraft persecutions faded away, and attributions of insanity and dangerousness replaced them. Then, hospitals, with formal goals of treatment and the specialty of psychiatry, developed. Finally, commitment laws spelling out common law standards were promulgated to check the unfettered commitment power of the psychiatrists that had developed. These commitment laws specified dangerousness to the community, or self, as sufficient rationale for commitment. Since such laws, with their criterion of dangerousness, were developed as checks on psychiatrists, it fell to the psychiatrists to regularly predict dangerousness in order to hospitalize. The psychiatrist became the primary predictor of dangerousness in the United States, not because of any documented skills at such predictions, but because this standard has always been the primary one accepted for committing individuals to institutions run by psychiatrists.

From the first statements of U.S. common law drawn directly from English tradition and from the early precedents on commitment criteria for the mentally ill, dangerousness has been the main standard for involuntary treatment. As psychiatry lobbied in Benjamin Rush's era to become an accepted medical specialty for the treatment of conditions which became classified as mental illness, the prediction of dangerousness was appended to public conceptions of the skills of psychiatry. It was not because psychiatry presented a record of predictive achievement, but because it was taking on some functions of social control which society could no longer rest on the inquisitor and which society apparently demands of someone.

Given the fact that dangerousness has been on the mental health scene for so long and there is no indication that public interest in it is on the wane, the author would like to offer some thoughts and questions (maybe questionable thoughts would be a better way of putting it) for which no real answers are proposed.

Dangerology and Dangerologists

Certainly the psychiatric research which demonstrated the most accurate predictions of dangerousness from the data offered was Kozol's. However, in the efforts, what was more impressive than their weak research methodology was their evaluation program. As they describe it:

> Each diagnostic study is based on clinical examinations, psychological tests, and a meticulous reconstruction of the life history elicited from multiple sources—the patient himself; his family, friends, neighbors, teachers, and employers; and court, correctional, and mental hospitals' records.
>
> The clinical examinations are made independently by at least two psychiatrists, two psychologists, a social worker, and others.

The interdisciplinary nature of these procedures is similar to those at various professional meetings. The participants are psychiatrists, clinical psychologists, sociologists, attorneys, judges, legislators, social workers, and others. Surely the reason for this is that the concept dangerousness is not a psychiatric one; neither is it the exclusive province of any other discipline. It involves the whole person and the situations with which he/she interacts. Through the growing awareness that there is little that is uniquely psychiatric related to dangerousness, there has been recent reemphasis on the significance of situational factors reflected in Kozol's evaluation procedures and the contributions that can be made by the many related disciplines. As Monahan (1974) notes:

> At least part of the inability to predict violent acts may lie with the theoretical paradigms and research strategies which have constricted the psychological and psychiatric fields until very recently. Efforts to predict and modify violent behavior, like efforts to predict and modify all types of problems, have been almost exclusively focused on identifying *persons* who are likely to perform the behavior in the future (Mischel, 1968). It is becoming increasingly documented, however, that behavior is a joint function of personal characteristics and characteristics of the *environment* or *situation* with which a person immediately interacts (Mischel 1973; Moos 1973).

An expanded interest in situational factors, while continuing to study personality and biochemical factors, leads to a consideration of the feasibility of developing a new subfield, dangerology—the study of predicting future dangerous behavior. It would study not only how to make such predictons, but also the prediction processes, the impacts of the predictions on those evaluated, and the

search for the real, operative factors in such decisions beyond those necessarily stated. Dangerology would be an area incorporating segments of psychiatry, psychology, sociology, biology, biochemistry, and many other basic disciplines, as well as also intimately involving policy disciplines related to the applications of such predictions. This idea of dangerology and its specialists, dangerologists, is not a facetious one. The possibility of moving in such a direction must be considered as long as dangerousness remains a concept of social control, through either the mental health or criminal justice system.

Multidisciplinary teams have demonstrated some advantages in current attempts to analyze and predict future dangerous behavior. However, only rarely are any members of such teams actually trained to make such predictions. Instead, they are trained in some traditional discipline and then become employed in various institutional networks which require them to make such predictions as part of their duties. Then, because they are empowered to make such predictions on some assumption of competency, they often proceed without any specific qualifications. *If* we are to continue utilizing dangerousness, might it not be productive to train some people to make such estimations, label their jobs to be that which they are in fact doing, and legislate the necessary checks and balances, after having determined what are legally acceptable standards? While this author does not pretend to know, it seems evident that consideration should be given to where such avenues would lead.

The intent of this paper was twofold: (1) to update the documentation that psychiatrists are poor predictors of dangerousness when the ratio of false positives or criminal justice system tenets are considered, and (2) to raise for discussion the possibility of actually training some people to perform the task, if dangerousness is employed for social control purposes. Actually, this latter question is more important in the long run, but the questions of developing dangerology may be more realistic, given our political and legislative history.

Some findings pertinent to the issues of psychiatric reporting and criminal charges as evaluated by the author may be seen in Tables 1, 2, and 3.

Table 1. Reasons for findings of dangerous cited in court psychiatric reports

Reasons	N	Percent of cases* citing
Before or leading to arrest		
Current charge	45	30.2
Actual/alleged assaults	26	17.4
Previous mental hospitalization or mental illness	25	16.7
Previous criminal history	15	10.0
Suicide attempts	12	8.0
Impaired thinking	9	6.0
Mental hospital escapes	6	4.0
History of gun possession	5	3.4
Drug use	4	2.6
Other	12	8.0
After arrest		
Delusional/impaired thinking	83	55.7
Inferred assault potential	41	27.5
Unpredictability/impulsiveness	39	26.1
Suicide potential	23	15.4
Management problem	10	6.7
Actual assaults vs. others	9	6.0
Actual assaults on self	5	3.3
Threatened assaults vs. others	5	3.3
Threatened assaults toward self	3	2.0

*Total n = 149 with psychiatric reasons for dangerous. Percentages do not equal 100 percent since many cases listed more than one reason.

Table 2. Psychiatric findings of dangerous by diagnosis controlling for criminal charge*

Criminal charge and psychiatric finding	Diagnosis: Unspecified and acute psychosis		Schizophrenia paranoia		Other schizophrenia		All other diagnoses		Chi square†	P
	N	%	N	%	N	%	N	%		
Violent vs. person									8.2802	$p < .05$
Dangerous	8	88.9	33	84.6	18	52.9	15	71.4		
Not dangerous	1	11.1	6	15.4	16	47.1	6	28.6		
Total	9	100.0	39	100.0	34	100.0	21	100.0		
Potentially violent vs. person									3.9823	N.S.
Dangerous	8	72.7	19	76.0	12	46.2	7	63.6		
Not dangerous	3	27.3	6	24.0	14	53.8	4	36.4		
Total	11	100.0	25	100.0	26	100.0	11	100.0		
Other felonies									2.5412	N.S.
Dangerous	5	83.3	6	35.3	14	51.8	5	50.0		
Not Dangerous	1	16.7	11	64.7	13	48.2	5	50.0		
Total	6	100.0	17	100.0	27	100.0	10	100.0		

*Omitted from the table are 10 cases with no diagnosis and 8 cases diagnosed as mental deficiency whose numbers were too small for analysis.

†Corrected for continuity.

Table 3. Psychiatric findings of dangerous by criminal charge controlling for diagnosis

Diagnosis and psychiatric finding	Criminal charge						Chi square	P
	Violent		Potentially violent		Other felonies			
	N	%	N	%	N	%		
Unspecified and acute psychosis							.0865	N.S.
Dangerous	8	88.9	8	72.7	5	83.3		
Not dangerous	1	11.1	3	27.3	1	16.7		
Total	9	100.0	11	100.0	6	100.0		
Schizophrenia paranoia							14.508	<.001
Dangerous	33	84.6	19	76.0	6	35.3		
Not dangerous	6	15.4	9	2.0	11	64.7		
Total	39	100.0	25	100.0	17	100.0		
Other schizophrenia							.0297	N.S.
Dangerous	18	52.9	12	46.5	14	51.8		
Not dangerous	16	47.1	14	53.5	13	48.2		
Total	34	100.0	26	100.0	27	100.0		
All other diagnoses							3.670	N.S.
Dangerous	15	68.2	8	57.1	5	35.7		
Not dangerous	7	31.8	6	42.9	9	64.3		
Total	22	100.0	14	100.0	14	100.0		

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