"DOCTOR DEATH."

THE INSANITY PLEA

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tic and Statistical Manual a statement about the difference between psychiatric and legal concepts of mental illness. If juries are to be permitted to hear psychiatrists, they should also be instructed about those differences.

If racial motives lay behind Robert Torsney's insanity acquittal, the jury was at least able to hide behind a belief that the acquittal would result in "hospital punishment." Had they voted an insanity acquittal in the face of testimony by the state department of mental hygiene psychiatrists that Torsney needed no treatment, was not dangerous, and would be immediately released, they still might have voted for the insanity acquittal. But then, there would be no question of their motives. The insanity defense provides a shield for jurors to hide behind in such instances.

The inconsistent and conflicting concepts of the insanity defense also provide easy excuses and exits for defendants like Robert Torsney. He went home after two and a half years of legal involvement. His plan was to go to court in order to appeal his dismisal from the police force, to recover his back pay, and to be granted a $15,000-a-year medical disability pension. He had learned how to use the legal system and, like anyone with a surprise jackpot, he was right back for another try to beat the odds—and to defeat justice.

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JAMES GRIGSON

The "Hanging Psychiatrist"

OVER THE PAST ONE HUNDRED YEARS, PSYCHIATRISTS, PSYchoanalysts, psychologists, and others in the mental health field have been thrust further and further into every aspect of our public and even our private lives. If they are not the principle decision makers, they are likely to stand next to the presiding officer, making official recommendations. Because life is hard, society has designated mental health practitioners as the experts on all of life's problems.

You want a divorce? The court or your attorney will refer you to "counselors" who can decide whether yours is a truly hopeless case and where you went wrong. Does someone think you've been acting a little unusual lately? A psychiatrist, in a brief exam, will decide whether you are likely to be dangerous to yourself or someone else or perhaps whether you just need treatment. Do you want to be a policeman? Liberals urge you to have a psychiatric exam. Do you want to run for president? Senate? Congress? Many in the therapeutic community urge that all candidates for public office have psy-

chiatric exams and that the results be made public prior to elections.

It would seem to be an impressive safeguard to have these mind specialists (33,000 psychiatrists in the United States, with Los Angeles and New York City having more than their share) checking out our character, personality, and rationality, and making sure that things stay on an even keel. But it doesn't work.

Both within the field of psychiatry and within the medical profession, there is continuing argument and disappointment about psychiatry's failure to be sufficiently scientific. Occasionally, a well-known, highly respected psychiatrist will acknowledge that the practice of psychiatry not only is but should be more an art than a science. But that is not a popular point of view among members of the profession. The development of new drugs and the hope and belief that mental disorders will be controlled eventually by physiological-chemical intervention have given new hope for the scientific status of psychiatry. But initial discoveries have not led to accurate and predictable treatment models, and drug treatment, in most cases, is trial and error, often with regard both to a specific drug and specific dosage.

But if psychiatrists have had difficulty gaining the respect they feel they deserve from the medical community, as well as from society, they have been eminently successful in gaining access and decision-making power in many social institutions and legal forums. In many public settings, the psychiatrist is viewed as the expert on sanity and responsibility. Psychiatrists, however (and allied mental health professionals), while not reluctant to offer themselves as official societal problem solvers, have begun to backtrack in at least one area.

Lawyers and psychiatrists, more often than not, have been at war with one another, but they have made some temporary alliances in order to try to keep psychiatrists from presenting their opinions in some criminal trials. The American Psychiatric Association has decided it should withdraw

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some of its aid to the courts. It has done so while admitting and insisting on its inability to know enough about the human mind to offer proper or justifiable expertise. It is a new sound of humility. Some have suggested that this retreat acknowledges a new realization by psychiatrists that they had overstepped the boundaries of their knowledge; others suggest that it is a single-issue retreat bound up with the fact that most psychiatrists oppose capital punishment; still others—more cynical psychiatrists—argue that it is an economic action of self-interest in which psychiatry is prepared to give up its role in one small area in order not to be held legally liable and financially responsible for the same role in a much larger area.

The focus of these concerns is a Texas psychiatrist named James Grigson and the case of *Estelle* v. *Smith*. One night in September 1973 Ernest Benjamin Smith, Jr., and Howie Ray Robinson held up a convenience store in Dallas. Both Smith and Robinson were carrying guns. During the holdup the cashier made a sudden move. Smith saw the move and fired his gun, yelling at the same time, "Look out, Howie" (or something like that). Robinson then fired his gun straight at the cashier. The cashier fell to the floor and the two robbers cleaned out the cash drawer and fled.

A short time later the Dallas police caught up with the two men and charged them both with felony-murder. Such a charge is one designed to discourage any criminal activity that might result in death. In essence, if anyone takes part in a felony, during which or because of which someone dies, that person is guilty of homicide. Thus, if three people attempt a bank robbery with a cap pistol, and a bank patron has a heart attack and dies while the robbery is going on, the robbers are all liable for homicide. Similarly, if someone drives a murderer to his victim, the driver is as guilty of the homicide as the one who did the killing—even if the driver never left the car or saw the victim. The logic of the charge is that if it had not been for the lesser crime, the death would never have occurred and, therefore (1) all the participants are as guilty of

the person's death as if they had specifically and personally caused it to happen, and (2) they are equally responsible regardless of who (or what) actively caused the death because they acted as a group or as a unit in committing the lesser crime.

Smith and Robinson were tried separately on felony-murder charges. Because a death sentence is possible on such a charge, the judge in the case ordered Smith to submit to a competency evaluation, even though no one, including Smith's lawyer, suggested that Smith was anything but competent. When the competency hearing became a problem later on, the judge explained that he ordered the hearing simply as a precaution, because he didn't want anyone complaining, especially if Smith were found guilty and sentenced to death, on appeal that the defendant was too crazy to have participated properly in the trial. He was, in his view, simply practicing a little defensive judging.

The order was made over the phone and a court-appointed psychiatrist undertook to perform a competency evaluation on Smith. The doctor appeared at the county jail where Smith was being held and spent about ninety minutes with the alleged murderer. He explained that he was a psychiatrist and had been asked by the judge to evaluate Smith's competency to stand trial. Smith was polite, pleasant, and responsive, and cooperated fully with the psychiatrist. During this time, the doctor conducted a five-part exam: (1) general appearance and behavior, (2) production of thought, (3) affect/mood, (4) content of thought, and (5) orientation to time, place, and person.

The general appearance segment, according to the doctor, was "simply observation of how the person walks into the interview room, the way they sit, the attention or lack of attention to personal appearance." In particular, the doctor used this information to determine whether the person was or seemed depressed, agitated, or anxious. The "production of thought" segment involved having Smith talk, after which the

doctor decided whether he made sense, whether his thought was linear, or, conversely, whether it was confused, circular, or obsessive. The affect/mood evaluation attempted to determine whether *how* Smith talked about something matched the subject of his talk. Thus, when talking about a pleasant experience, the person's voice and physical demeanor should reflect the positive quality of the experience. In the "content of thought" segment, Smith was asked about his past and present. The final segment, the "orientation," attempted to determine if Smith knew who he was, where he was, when it was, and whether he could focus, concentrate, and remember from moment to moment what was happening. On the basis of this five-part test, the psychiatrist sent a letter to the judge, indicating that he had conducted the examination and had found Ernest Benjamin Smith, Jr., competent to stand trial.

Smith's attorney was never informed by the court or by the psychiatrist that this competency evaluation had taken place. If he had known, he might have attempted to stop it, or he might have insisted on being present during it. Or he might have taken it at face value and let it happen just as it did. What harm could a competency hearing do to Smith? Any statements he made about the crime itself could not be introduced as evidence in the trial, and if he were found incompetent, he wouldn't have to stand trial. But the attorney knew there was no question of Smith's being found incompetent.

During the trial Smith's attorney was given a list of all the witnesses the prosecution expected to call, as was required by law. He was also given access to prosecution files on the case. It was in these files that he found a copy of the letter stating that Smith was competent to stand trial. He could not have been happy to find that the evaluation had been conducted by Dr. James Grigson, the Dallas psychiatrist the press was fond of referring to as "the hanging psychiatrist" and "the killer shrink." The attorney checked the witness list. Grigson's name was not on it, neither as a witness in the guilt phase of the trial nor in the penalty phase, so the

attorney probably thought that the competency hearing could not harm his client.

Under Texas law, a case that might result in the death penalty is tried in two parts, in what is called a bifurcated trial. During the guilt phase of the trial, the jurors decide whether or not the defendant is guilty. If they find him guilty, the penalty phase is then held, in which they decide on the basis of additional evidence whether to order the death penalty or a term of imprisonment. In order to decide for the death penalty, a Texas jury must consider three factors: (1) whether the murder was deliberate; (2) whether the defendant's conduct was unreasonable in response to the provocation; and (3) whether the defendant is likely to repeat his violent deeds in the future. If the jury answers "yes" to all three questions after they have heard the additional evidence, then the death penalty is automatic. If all three are answered *no*, then only a prison sentence can be given.

Smith was found guilty in the first phase of the trial, which was not a great surprise. His attorney's hopes were pinned on the penalty phase. Smith had several things going for him. First, his only previous conviction had been for possession of less than an ounce of marijuana. He had been charged with some other, more serious crimes, but since he was never found guilty, those charges could not be brought before the jury in this trial. Second, Smith had not done the actual shooting. Third, although he had been carrying a gun, the weapon had misfired and there was some evidence that Smith knew the gun was defective. There was conflicting testimony as to whether Smith had said, "Get him, Howie" (the "him" referring to the cashier) or "Look out, Howie." Therefore, there was a reasonable chance that they could get "no's" from the jury on all three questions.

When the penalty phase began, the prosecution offered no witnesses but requested permission to reopen, which meant that the prosecution could later request the introduction of further testimony. The court granted permission. Smith's

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attorney called three witnesses, each of whom testified to Smith's good character. The testimony was brief and to the point. Once the defense rested, the prosecution wanted to exercise its request to reopen. They had only one witness. The judge agreed. Smith's attorney could hardly believe it when he heard that the one witness they wished to call was Dr. James Grigson.

He objected. He objected strenuously and lengthily. First of all, he had never requested a mental examination of Smith; second, the examination had been conducted without his being informed; third, the results of the exam had not been made available to him; fourth, the purpose of the exam was a competency evaluation, not a penalty recommendation; fifth, Smith had not been told that his statements to Grigson could be used against him at the trial; sixth, Smith had been denied counsel during this evaluation; and seventh, the prosecuting attorney had concealed his plan to have Grigson testify at the trial by omitting his name from the witness lists.

The judge listened to his long list of objections and overruled them all with the warning that Grigson was not to testify to any of the specific statements that Smith had made, and that he could only testify to his opinion on the matter at hand, an opinion that Grigson had come to as a result of listening to Smith's statements. The primary focus of Grigson's testimony to the jury was whether the defendant was likely to repeat his violent deeds in the future. This was not an easy question, since there was no record of previous violent deeds, but Dr. Grigson had little problem with the query. He stated that Smith would repeat his violent deed again and again and again, that violence was all Ernest Benjamin Smith, Jr., knew, and that Smith was now, and always would be, a psychopath, a sociopath, and a man without a conscience. The jury came back with a death sentence.

James Grigson, M.D., has a private psychiatric practice in Dallas. He is a local boy and a graduate of Baylor and Southwestern Medical School (now part of the University of

Texas Health Science Center at Dallas) who did his psychiatric residency at Parkland and Timberlawn hospitals in Dallas. Although he has been accused by a University of Texas law professor of "operating at the brink of quackery," his credentials are in order. He is certified by the American Board of Neurology and Psychiatry and was for some years on the medical faculty of Southwestern Medical School. He has been conducting examinations of criminals since the mid-sixties and, after fifteen years, he estimates that he has interviewed over 8,000 men and women charged with crimes. He has participated in numerous trials and is respected by defense lawyers who have reason to know him to be a formidable witness.

Physicians, including psychiatrists, are often uncomfortable in the courtroom. One physician has suggested this is because the doctor is not in control of the situation. This may be at least part of the explanation. The psychiatrist frequently bristles or becomes defensive under the harsh cross-examination that the adversary method of the courtroom requires. Often, he sounds as if he believes he is being picked on unduly by the attorneys, and he begins to react emotionally, frequently claiming far more certainty than his knowledge genuinely allows. If the opposing attorney is able to provoke him sufficiently, the psychiatrist sooner or later will leap out on the proverbial limb and the lawyer will obligingly cut him down.

An additional cause of psychiatrists' discomfort in the courtroom may be that juries are generally thought to be hostile to them. The psychiatrist often speaks a technical language or a jargon that the juror does not understand. He often appears to be patronizing the jurors, and may be from a different social class than that of the jurors. One criminal defense attorney pointed out that psychiatrists will come into court in weird clothing—for example, a suit, no tie, and tennis shoes—setting themselves apart from and frequently alienating the jury. But none of that is typical of James Grigson.

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At forty-eight, Grigson is a tall, soft-spoken witness. He always dresses appropriately, like a business or professional man. He is affable, at ease, and confident about his opinions. He explains the examination he gives to the defendant in simple ordinary language, which is appropriate because it's a simple ordinary examination. He states his conclusions with a minimum of psychiatric jargon. He is a model of humility and sincerity. The jury responds very positively to him, since he is not a hired gun, available at a price to mouth any opinion. Jim Grigson really believes what he testifies to, and what he testifies to in more and more cases is that the defendant should receive the death penalty because he is, in Grigson's own language, a sociopath, a man without conscience who will go on throughout his life performing violent acts in his own self-interest. The defendant, Grigson frequently says, is as bad a sociopath as one can be and therefore can't get any worse; but he won't get better either, for psychiatry has nothing to offer the sociopath.

Jim Grigson has testified to the sociopathic personality of the defendant in about sixty capital murder cases in Texas. With one or two exceptions, the jury sentenced the defendant to death, primarily and often exclusively on the basis of Grigson's testimony.

In 1974, when Ernest Benjamin Smith, Jr.'s, attorney objected to Dr. Grigson's testifying during the penalty phase, Grigson had not yet acquired the reputation he has today. But it was well known even then that having Jim Grigson against you was bad news. Grigson says that he doesn't testify *for* anyone. He just tells what he believes to be the truth. He has been hired by federal judges; attorney generals; U.S. attorneys; judicial district judges from Texas, Arizona, and Alaska; district attorneys; and defense attorneys. The defense attorneys who hate to see him on the other side would love to have him on their team because he is such a formidable, unflappable witness. Having Grigson for your witness is like having the only wild card in a poker game; he makes you look like a sure winner.

Grigson's reputation with the press is as a prosecution witness, but he himself points out that in about one-third of the death penalty examinations he conducts, his judgment is not useful to the prosecution because he believes there is hope for the defendant. Newspaper accounts stress that he always testifies to the unredeemable nature and character of the defendant, but of course if he were not prepared to testify to that, the prosecution would not call him to the stand.

His testimony in all these cases is remarkably similar. He describes the five-part, all-purpose examination he conducts and then states his opinion that, based on that exam, the defendant is a sociopath. He then describes and defines sociopathy and explains that it is (a) incurable and (b) not a mental illness of any sort. He postulates a scale of one to ten and places the victim at ten. He speaks with certainty. When asked by the defense lawyer if he is ever wrong about such judgments, he acknowledges that he is sometimes wrong, "but," he continues, "in this case I'm not."

He was absolutely certain about his judgment of Ernest Benjamin Smith, Jr. After explaining that Smith was a severe sociopath (up there at ten on the scale), the prosecuting attorney asked whether Grigson thought Smith felt any guilt or remorse, whether, in effect, Smith had any conscience.

> **A.** No. He has none.
> **Q.** Now. Dr. Grigson, what is your prognosis in this case?
> **A.** Oh, he will continue his previous behavior—that which he has done in the past. He will do it in the future.
> **Q.** All right. So, were he released into society, I take it, then, you would not expect his behavior to differ from what it has been?
> **A.** No. If anything, it would only get worse.
> **Q.** Now, Dr. Grigson, this sociopathic personality that Smith has—is this a condition that will improve with time? I guess what I'm asking you is this: Is this a stage that he is passing through that he will grow out of?
> **A.** No. This is not what you would consider a stage. This

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> is a way of life. Just as you work every day, well, his personality comes out in his behavior, but it is not a stage he is going through. It's only something he will continue.
> **Q.** You said get worse?
> **A.** Yes.
> **Q.** If it can?
> **A.** Right . . . It's my opinion that really, Mr. Smith does not have any regard for another human being's property or for their life, regardless of who it may be. This is what makes him such a very severe sociopath. He has complete disregard for another human being's life.
> **Q.** Dr. Grigson, does the field of medicine—perhaps psychiatric treatment and/or hospitalization of some sort—does that have anything beneficial to offer someone like Ernest Benjamin Smith?
> **A.** We don't have anything in medicine or psychiatry that in any way at all modifies or changes this behavior. We don't have it. There is no treatment, no medicine, nothing that's going to change this behavior.
> **Q.** Now, Dr. Grigson, do you have an opinion as to whether or not there is a possibility that the defendant, Ernest Benjamin Smith, will commit criminal acts of violence that will constitute a continuing threat to society?
> **A.** Yes sir, I have an opinion as to that.
> **Q.** And what is that opinion?
> **A.** That certainly Mr. Smith is going to go ahead and commit other similar or same criminal acts if given the opportunity to do so.
> **Q.** Now, Dr. Grigson, I believe you have stated that this man has no remorse or sorrow for what he has done?
> **A.** No. He has none.

Grigson is always sure. He is difficult to cross-examine because of his certainty, even though much of what he says is scientifically questionable or purely speculative. When defense witnesses know he is to testify in the penalty trial, they

can counter with their own psychiatrists who argue that the defendant is not likely to continue to be violent. Except, of course, it's hard to get a psychiatrist to be as certain as Grigson, since most psychiatrists are not convinced that their psychiatric licenses also qualify them to act as fortune-tellers.

As a result, Grigson is often asked no questions at all by the defense counsel. He has acknowledged that he thinks they are somewhat afraid of him and that doubtless pleases him.

After the jury returned with the death penalty in the *Smith* case, the decision was appealed. Smith went to prison in Huntsville, Texas, to wait out the months while the slow appeals process moved along. In 1976 the Texas Court of Criminal Appeals affirmed Smith's conviction and sentence, and in 1977 the U.S. Supreme Court refused to consider the case. Later in 1977 the U.S. District Court for Northern Texas agreed to hear the case and the judge vacated the death sentence on grounds that Smith's attorney had raised during the penalty phase of the trial—namely, that Grigson's failure to inform Smith or his lawyer that information gained during the competency hearing would be used during the trial was a violation of due process, of Smith's right to effective counsel, and of his right to introduce complete evidence. This was, of course, a victory for Smith, and Estelle, or rather the State of Texas (Estelle was the head of the Texas Department of Corrections against whom the original suit had been filed), requested a new trial, but that motion was denied.

Next, Texas-Estelle appealed the U.S. District Court's ruling to the U.S. Court of Appeals for the Fifth Circuit and, in 1979, five years after the original jury verdict, that court upheld the U.S. District Court's judgment for Smith. Texas was not about to give up so easily, however, and in 1980 the U.S. Supreme Court agreed to hear arguments and to make a final ruling on the case during its 1980–1981 season.

By 1981 Smith had spent seven years in the Huntsville prison. He had, so far, failed to live up to Dr. Grigson's billing

of him as a man whose life would be dedicated to violence, unless one counted the fact that he had been knifed by another prisoner while at Huntsville. As Smith himself said, during his time in prison, the "only violent act [he'd] been involved in, [he] was the victim." During those seven years Dr. Grigson testified in many more cases in which the defendant stood a chance of execution. About one-third of the men awaiting execution in Texas prisons had had the "benefit" of Dr. Grigson's testimony. Also during those seven years, University of Texas Law Professor George Dix had begun seriously to study Dr. Grigson's testimony. In 1978 he published his study entitled "Participation by Mental Health Professionals in Capital Murder Sentencing." Dix was appalled by what he had found: Grigson was using a diagnostic category (sociopath) that the American Psychiatric Association had stopped using ten years earlier. Beyond that, Dix thought that the current evidence about psychiatrists' ability to predict violent behavior over the long-run conclusively disproved Grigson's views, and that Grigson's willingness to hinge these life-or-death judgments on a single ninety-minute interview was shocking.

Professor Dix had some considerable support on these issues, including the American Psychiatric Association. The APA is a national professional organization with 26,000 of the 33,000 psychiatrists in the United States as members, including Dr. Grigson. It is also the professional organization that sets the ethical standards for psychiatric practice and determines the officially sanctioned psychiatric diagnoses and mental illnesses. In the Smith case, the APA decided to file a legal brief in support of Smith and in opposition to its own member, Dr. Grigson. They filed their *amicus curiae* (friend of the court) brief with the Fifth Circuit Appellate Court, and when the U.S. Supreme Court agreed to hear *Estelle* v. *Smith*, they filed a second brief with that court.

The APA explained its willingness to be involved in the case by pointing out that it

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has monitored the administration of capital punishment statutes and the role of psychiatric testimony in that process. The instant case specifically involves the use of psychiatric testimony in Texas on the capital sentencing issue of whether a defendant is likely to commit criminal acts in the future. As such, it raises significant issues concerning the role of psychiatrists in capital cases. Resolution of those issues will have an important impact not only on the administration of capital punishment, but also on the quality and integrity of forensic psychiatry. . . . The Association is uniquely qualified to advise this Court as to the reliability of psychiatric predictions of long-term future criminal behavior, which is a key issue under the Texas capital sentencing statute. The Association is also qualified to discuss the potential impact of any restrictions as to such testimony on other criminal law issues concerning competency and sanity determinations. These factors are critically relevant to this Court's consideration of this case, and the American Psychiatric Association believes that they will not be adequately briefed either by petitioner or by respondent.

In its brief to the Supreme Court, the APA argued three major points. First, they argued that psychiatrists should be forbidden to testify in penalty phases of trials if their testimony was given with respect to predicting future dangerous behavior of the defendant. Second, they urged that if the court chose to permit psychiatrists to testify in the penalty phase of trials, it should require psychiatrists to give notice to the defendant that any statement he made in the interview could be used against him in the trial and that, further, he had the right to remain silent. Third, they urged that attorneys be given full notice of such examinations and of the possibility that testimony would be given as a result of the interview.

Although the APA chose to make its stand with *Estelle v. Smith*, its position applied to many more cases than this one. The use of psychiatric testimony in capital case-penalty

trials was common in Texas and in several other states, with Virginia's procedures being most comparable to those of Texas. Grigson had proffered the same kind of testimony that the APA wanted outlawed in many Texas cases (eighteen of the Texas cases were specifically criticized by the U.S. District Court decision in *Estelle*). But, although Grigson figured prominently in these cases, he was not the only psychiatrist who was providing this kind of testimony. The APA was not apparently on a witch hunt against one of its own members. It did, however, seem to be in the unusual position of arguing that a limit should be placed on its own members' professional activities as a matter of principle. Even Jim Grigson didn't think they were out to get him, but he disagreed entirely with the APA's view of what principle was being defended in the case.

According to the APA, psychiatrists should not testify about probable future violence by defendants because scientifically conducted studies had repeatedly shown that psychiatrists had no particular expertise in making such predictions. In fact, some of the studies showed that psychiatrists were considerably less accurate than other groups, including policemen. Psychiatrists, it turned out, not only tended to overpredict dangerousness, expecting it a lot more frequently than it turned out to exist; they also tended to be fairly inaccurate in their selection as well. For example, suppose a group of one hundred people were to be evaluated for future dangerousness and the fact was that ten of them would actually be violent in the future. Psychiatrists might be likely to predict that twenty members of the group are dangerous (overprediction, since they have included at least ten "false positives," i.e., people who they say are dangerous but are not), and within that twenty that they have specified, only five of the actual dangerous groups of ten are included (thus, an inaccurate selection of 50 percent).

The APA claimed that, because there had been continuous requests for psychiatrists to make predictions about dan-

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gerousness both in civil and criminal matters, it had conducted a lengthy survey regarding violence and psychiatric understanding of "evaluation, management, and prediction of psychiatric behavior." The conclusion of the 1974 study was that psychiatrists had not been able successfully to predict violence at any high rate of reliability except in those instances where the individual had committed a significant number of violent acts over a period of time (for example, a parent who regularly abused a child). But, in those cases in which psychiatrists were fairly accurate, so were other people. It didn't appear that there was any psychiatric expertise that was required to make the prediction. College students had been able to predict it as well as psychiatrists. It was likely that jurors also could do it as well. It was probably a function of common sense.

The APA task force report concluded that "psychiatric expertise in the prediction of 'dangerousness' is not established and clinicians should avoid 'conclusory' judgments in this regard." It was just this kind of "conclusory" judgment that the APA particularly worried about in the testimony of psychiatrists like Grigson, for Grigson and others almost always testified that the defendant was certain to continue to be a danger to society. They spoke without doubts, without uncertainties, without any sense of probabilities in their judgments. The APA was convinced that psychiatry did not have this capability, and, if Grigson had it, it was not by virtue of his being a psychiatrist. They believed he should stop testifying under that heading, because it gave his views a dishonest cloak of greater expertise.

Many APA members, and particularly those involved in the preparation of the *amicus* briefs to the Appellate Court and the Supreme Court, were also appalled at other aspects of Grigson's testimony. But the nature of a legal brief is such that matters not specifically legal often are lost. As a result, the other serious objection about Grigson was cursorily mentioned in a footnote. What many psychiatrists found most

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outrageous about Grigson's behavior was his complete disregard for the authorized views of psychiatry, which were promulgated by the APA. In particular, they were offended by Grigson's repeated use in trial after trial of the term *sociopath*. Psychiatry had cast off that diagnosis in 1968. Grigson was, in effect, dragging up a part of their past they would just as soon forget.

To understand the importance of the sociopath issue, one must first understand something about how psychiatry, as a profession, developed. Early in the history of the field, psychiatrists were generally called alienists, a term borrowed from the French and indicating a specialist in diseases of the nervous system. "Psychiatrist" was a word the Germans used and it had unpleasant associations for Americans in the field because in Germany the term had heavy metaphysical associations, particularly relating to the soul or the mind (as opposed to the brain). These American doctors thought of themselves as scientists and as physicians to the body no less than other physicians, but physicians concerned with the nervous system. Around the turn of the century, however, there was a separation within the field and it was divided between two groups who became known as neurologists and psychiatrists. The neurologists took over the nervous system and the psychiatrists (no longer alienists) inherited "mental illness." The problem was, however, defining mental illness. No other medical specialist had ever had to face such a problem. With a fine sense of practicality and some sense of *hubris*, the psychiatrists decided that the only way to decide what was and was not a mental illness was for them to sit down and decide, which they did. The results were published in the first edition of the psychiatric blue print, the *Diagnostic and Statistical Manual*, or *DSM I*. This was published in 1952, drawing primarily upon the work of army psychiatrists during World War II. The American Psychiatric Association describes their initial effort as "the first official manual of mental disorders to contain a glossary of descriptions of the

diagnostic categories." *DSM I* told practicing psychiatrists what was a mental disease and what was not (if it was not included, it was not a mental disease), what were the symptoms of particular diseases, and what were the prognoses. It was, in fact, a vitally important and extremely significant initial effort in classification and description of mental illness, but like any early work of that sort, it had many problems and errors. However, the problems that *DSM I* had were unlike the errors of other classification schemes.

Perhaps the diagnostic alteration best known to the public was the APA's decision that homosexuality was not a mental illness. Such an action seriously undercut public appreciation of psychiatry's positive work by suggesting that either psychiatrists' judgments were arbitrary or they had no standards at all. Americans were used to thinking of diseases as fixed entities. They could scarcely imagine doctors deciding that pneumonia, for example, wasn't a disease any more.

Reactions like these were related to the deeply ingrained connection and confusion between mental illness and sin. It was once widely believed that the mentally ill were in the devil's grip and many people still believe that, though their belief takes a somewhat altered form. Homosexuality, seen as a sin, had been caught up by psychiatrists as a mental disease. Then, when they decided that, if anything, it was merely a sin, they dropped it from their categories. From the public's point of view, it suggested that psychiatry thought homosexuality was neither sinful nor a mental illness. Psychiatry, on the other hand, was in the awkward position of having to renounce its belief in the mental illness part of homosexuality and at the same time divorce itself from religious or moral ideas about sinfulness. They didn't care what homosexuality was, as long as it wasn't considered a mental disease.

The story of sociopathy is not unlike that of homosexuality as *DSM I* evolved through *DSM II* and *DSM III*. Up until 1968 the APA included sociopath as a category of mental illness. Then, with the publication of *DSM II* in 1968, the

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term sociopath was dropped and a new classification, "antisocial personality disorder," was introduced. In *DSM III*, published in 1980, antisocial personality disorder continues to be listed as a mental illness and requires for diagnosis "a broad range of the patient's behavior." In the footnote in their brief in *Estelle*, the APA objected to Grigson's use of sociopath as a diagnosis because they don't use it any more, and even more so because his diagnosis was based on a brief examination in which the defendant evinced no remorse.

Grigson's use of the sociopath diagnosis as well as his willingness to be very certain about his judgments of future dangerousness are far more closely related to the idea of mental illness as sin than to the idea of mental illness as disease. And it is perhaps this aspect of his testimony that offended the APA the most.

Grigson, in fact, defended himself against his many critics as handily out of court as in. He finally began to refuse interviews to journalists, giving as his reason that he was tired of seeing himself referred to as "the hanging shrink," "Doctor Death," "the Doctor of Doom," and "the prosecution's hired gun." But in a 1978 interview with a reporter from a Texas magazine, Grigson allowed that the APA's disapproval of his actions was of little concern to him.

> I have been doing this since 1960, and in that time I've examined more murderers and more rapists than the combined number examined by the people who wrote the APA diagnostic manual. And based on my experience, here's *my* definition of a sociopath. First, a sociopath doesn't have a conscience. He feels no remorse about his crime. I say to him, "Hey, how did you feel about killing these people?" And he doesn't hang his head, his cheeks don't flush, he doesn't have any of the normal reactions you or I would have. Two, he repeatedly breaks the rules of society. Three, he cons and manipulates, lies, steals and cheats for the pleasure of it. Most of the district attorneys only prosecute a very specific type of person for these

> death cases. . . . If they prosecute a death case . . . then that guy has already been identified as bad, bad, bad. I think you could do away with the psychiatrist in these cases. Just take any man off the street, show him what the guy's done, and most of these things are so clear cut he would say the same things I do. But I think the jurors feel a little better when a psychiatrist says it—somebody that's supposed to know more than they know.*

Grigson suggests that he is willingly doing exactly what the APA is unwilling to have him do and is accusing him of doing: using the mantle of psychiatric authority to validate opinions that ordinary people would have anyway. But behind Grigson's words lies a more serious objection that the APA might have: that Grigson is using psychiatric authority to talk about sin, and that is really what Grigson is thinking of when he uses the term sociopath. Sociopaths are simply what a more religious culture knew to be unregenerate sinners, and they knew it with no less certainty than Jim Grigson knows it. And what could save a sinner? Not a psychiatrist, surely. That is why there is no treatment. Only God's grace can save a sinner, and grace is not a regular part of psychiatry or of prison rehabilitation.

Grigson is careful in defining the sociopath (or psychopath—he uses the terms interchangeably) to make sure that no one thinks that what he is talking about is a mental illness. If it were a mental illness, then perhaps some sympathy might appropriately be shown to the defendant. Furthermore, he counsels, a sociopath cannot be cured. The language begins to fall apart a little here, and the jury, unless they are totally spellbound by Grigson, might begin to wonder why something that isn't an illness even might be cured. But Grigson is simply covering all his bases. The defendant is not sick, cannot be cured, and will only get worse. If it were a riddle (what does a

* (*Texas Monthly Reporter*, "Killers and Shrinks," John Bloom, July 1978, pp. 64, 66, 68. Quote from p. 68.)

person have who is not sick, cannot be cured and will only get worse?), the only answer would be "sin."

It is perhaps this about Grigson that organized psychiatry hates the most. He drags psychiatrists backward into the semireligious quagmire from which they have struggled for so long to remove themselves. Grigson, on the other hand, thinks they're out to get him and others who testify as he does because he believes establishment psychiatrists want to eliminate the death penalty. If APA could prevent psychiatrists from testifying in the penalty phase of capital trials, jurors might be too soft-hearted to vote for the death penalty. Grigson is willing to testify because he believes in the death penalty and thinks that the small group at the APA that determines its public positions opposes him in order to oppose the death penalty.

The Supreme Court handed down its decision in *Estelle v. Smith* on May 18, 1981. The victory went to Smith. The APA got part of what it wanted, in that Grigson's style of witnessing was not approved. The Court ruled, first, that Smith's death sentence be vacated and a new penalty trial held. Second, in ruling on the procedures of the case, they held that psychiatrists may testify about future dangerousness where such testimony is permitted (an earlier Supreme Court decision on that question had pointed out that although such predictions were extremely difficult to make, someone, nevertheless, must make them). However, the court also ruled that the defendant must be informed of the purpose of any examination wherein his statements might later be used against him; that the defendant be permitted to invoke the Fifth Amendment; and that the defendant's lawyer be apprised of any such interview and testimony and have the opportunity to advise his client about answering questions.

Jim Grigson can continue to testify in the penalty phase of capital offense trials in Texas (or Idaho, Oklahoma, Virginia, Washington, or wherever else such testimony is allowed). He will have to tell the defendant the purpose of the

interview and lawyers will doubtless urge their clients to be silent. Grigson will no longer be able to testify (as he has in the past) that the very refusal of defendants to answer a single question was evidence of their lack of remorse and of their severe sociopathy. Theoretically, if they will not speak to him, he cannot testify about them.

However, in at least one trial, Grigson had not interviewed the defendant but took the stand anyway. He was asked by the prosecution about a hypothetical case. "Suppose you interviewed a person who . . ." began the prosecuting attorney, who then proceeded to give a run down of the defendant's life. Grigson did not find any difficulty in making a judgment about this hypothetical person. He was a sociopath . . . extreme . . . no hope of change . . . only get worse. The defense attorney, on cross-examination, offered Grigson a second and different hypothetical case. Grigson listened, judged, and said yes, that hypothetical person was another sociopath, with no hope of change, and so on. The defense attorney then explained with subdued pleasure to Grigson and the jury, his hypothetical case was the life history to age nineteen of a well-known, very successful major league baseball player, Ron LeFlore.

Where there is no question of mental illness, there is no need for expert psychiatric witnesses. Doctors like Grigson provide us with excuses for not having to make decisions about capital punishment. To make such a decision is surely one of the hardest choices life can bring, but to make the decision on the basis of false premises or by hiding behind false expertise is immoral. If we cannot bear to make these decisions because they are so hard, then we should learn to get along without executions until we can accept the responsibility for the decision. Someone, says the Supreme Court, has to make these decisions. But it should not be Jim Grigson or psychiatrists; it should be us.

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