

BORN TO BE AN OFFENDER? ANTISOCIAL PERSONALITY DISORDER AND ITS IMPLICATIONS ON JUVENILE TRANSFER TO ADULT COURT IN FEDERAL PROCEEDINGS

by
Amanda Tufts*

Antisocial personality disorder (ASPD) has become a common term to describe individuals demonstrating life-long psychopathic tendencies. This use of ASPD is misguided and can result in the permanent stigmatization of individuals so labeled, and it is particularly concerning when used to label juveniles. The diagnostic criteria for ASPD excludes individuals who have not reached the age of 18, and yet ASPD is still a term found in numerous judicial opinions involving juvenile defendants. This Note discusses the DSM-IV-TR criteria for ASPD, potential causes of ASPD, and the societal impact of receiving an ASPD diagnosis, with a specific focus on the use of ASPD within judicial decisions to transfer juveniles to adult court. The transient nature of a majority of juvenile offending, in addition to the potential confusion of ASPD with psychopathy and the inaccurate bias this may cause against juveniles, raises significant concerns regarding any consideration of ASPD within juvenile proceedings.

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* J.D. candidate, Lewis & Clark Law School, 2013; B.A. in Psychology, Whitworth University, 2010. Thank you to Professor Elaine Sutherland for the valuable comments and feedback she provided throughout the writing process, and a special thank you to my Mom and Dad, Dan Fry, and the rest of my family for their unconditional love and support.

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INTRODUCTION

The term “psychopath” is used to describe some of society’s most feared individuals. Serial killers, mass murderers, individuals who lack a conscience or remorse—these are people commonly referred to as psychopaths, and believed to be beyond all possibility of reform. Research does suggest that a small number of individuals demonstrate a continuous pattern of offending throughout their lives, consistent with many common perceptions of psychopathic personalities. However, there is another disorder often confused with psychopathy, a disorder that actually represents a separate group of individuals: antisocial personality disorder, or ASPD.

Although some individuals with ASPD also meet the diagnostic criteria for psychopathy, a majority of such individuals do not. ASPD is a personality disorder included in the current version of the Diagnostic and Statistical Manual of Mental Disorders. ASPD is a common diagnosis among criminal offenders, and as a result it is often used in the evaluation of an offender’s propensity for future dangerousness or amenability to treatment in criminal proceedings. Another, and more concerning use of the diagnosis, is its use in juvenile adjudications.

There are significant issues surrounding a diagnosis of ASPD that counsel against reliance on this diagnosis for purposes of juvenile proceedings. In order to fully explore these issues, it is important to understand the actual diagnosis of ASPD, as well as the various explanations regarding the possible causes of the disorder. The potential effect of labeling a juvenile with ASPD is also an essential aspect of the diagnosis that must be considered.

Juveniles are in a formative period of their lives, and while a diagnosis of ASPD may have some level of predictive validity, not all individuals who exhibit antisocial behavior during adolescence will go on to offend in adulthood or to develop ASPD. Two developmental pathways, described as life-course-persistent antisocial behavior and adolescence-limited antisocial behavior, have been used to explain why some individuals desist from antisocial behavior while others persist in the behavior throughout their lifetimes. An exploration of these two pathways demonstrates the potential consequences of relying on antisocial behavior to predict future behavior, particularly within legal settings.

ASPD is a diagnosis relevant to a variety of legal proceedings, including juvenile transfers to adult criminal court in the federal system. When deciding whether to transfer a juvenile, courts evaluate the juvenile’s present psychological maturity and intellectual development, and this evaluation often involves an assessment of the various mental health diagnoses assigned to the juvenile by mental health professionals.

Consideration of an ASPD diagnosis in juvenile proceedings can have severe consequences for the juvenile. Such a diagnosis may cause a court to incorrectly determine that an individual will continue to offend into adulthood, or that the individual would not be helped by any available treatment programs. In addition, the possible confusion of ASPD with the closely related diagnosis of psychopathy can result in inappropriate and inaccurate bias against the juvenile defendant.

I. ANTISOCIAL PERSONALITY DISORDER

A. *The Diagnosis*

In order to understand how ASPD applies in legal settings, it is important to understand the diagnosis of ASPD itself. ASPD is a diagnosis used in the current version of the Diagnostic and Statistical Manual of Mental Disorders, or the DSM-IV-TR, published by the American Psychiatric Association.¹ The DSM-IV-TR represents the “consensus of current formulations of evolving knowledge in [the psychiatric] field,”² and it is widely used in the psychiatric community for purposes of mental health diagnoses.

To qualify for a diagnosis of ASPD, an individual must meet all of the diagnostic criteria listed in the DSM-IV-TR.³ First, there must be evidence that the individual has had a history of symptoms of conduct disorder before age 15.⁴ As a result, conduct disorder provides an important basis for understanding ASPD.

In order to meet the diagnostic criteria for conduct disorder, the individual must demonstrate a “repetitive and persistent pattern of behavior in which the basic rights of others or major age-appropriate societal norms or rules are violated.”⁵ This pattern is shown when an individual has exhibited three or more specified criteria within the previous year,

¹ AM. PSYCHIATRIC ASS'N, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS 701–06 (4th ed., text rev. 2000) [hereinafter DSM-IV-TR]. The DSM-IV was published in 1994, and the DSM-IV-TR was published in 2000 in order to “bridge the span between DSM-IV and DSM-V.” *Id.* at xxix.

² *Id.* at xxxvii.

³ See DSM-IV-TR, *supra* note 1, at 702–03, 706. The DSM-V is set to be released in May of 2013. The definition of ASPD has changed with every edition of the DSM. See *infra* Part IV.B.1. The concerns discussed in this Note apply equally to the current definition of ASPD and the expected future definition provided in the DSM-V. Essentially, the DSM-V appears to offer a clearer, more in-depth definition of the criteria already outlined in the DSM-IV-TR. However, there is one significant change in the definition: unlike the DSM-IV-TR, the DSM-V does not require any childhood or adolescent manifestation of symptoms in order to qualify for an ASPD diagnosis. The deletion of this criterion only heightens the concerns articulated throughout this Note, as individuals may be diagnosed with ASPD as a result of temporary behavior and find themselves unable to escape the permanent stigma of what is often viewed as an enduring and unchangeable diagnosis.

⁴ *Id.* at 702, 706.

⁵ *Id.* at 98.

with at least one of the criteria being present in the previous six months.⁶ The first set of criteria involves aggression toward other people and animals. Evaluators should pay attention to whether or not the individual:

- (1) often bullies, threatens, or intimidates others
- (2) often initiates physical fights
- (3) has used a weapon that can cause serious physical harm to others (e.g., a bat, brick, broken bottle, knife, gun)
- (4) has been physically cruel to people
- (5) has been physically cruel to animals
- (6) has stolen while confronting a victim (e.g., mugging, purse snatching, extortion, armed robbery)
- (7) has forced someone into sexual activity⁷

The second set of criteria focus on property destruction, and includes whether the individual:

- (8) has deliberately engaged in fire setting with the intention of causing serious damage
- (9) has deliberately destroyed others' property (other than by fire setting)⁸

The third and fourth sets of criteria evaluate instances of the individual's dishonesty or theft, and serious violations of the rules. These criteria include whether or not the individual:

- (10) has broken into someone else's house, building, or car
- (11) often lies to obtain goods or favors or to avoid obligations (i.e., "cons" others)
- (12) has stolen items of nontrivial value without confronting a victim (e.g., shoplifting, but without breaking and entering; forgery) . . .
- (13) often stays out at night despite parental prohibitions, beginning before age 13 years
- (14) has run away from home overnight at least twice while living in parental or parental surrogate home (or once without returning for a lengthy period)
- (15) is often truant from school, beginning before age 13 years.⁹

In addition to meeting three or more of the listed criteria, the "disturbance in behavior [must cause] clinically significant impairment in social, academic, or occupational functioning."¹⁰ If at least one of the cri-

⁶ *Id.* at 98–99.

⁷ *Id.*

⁸ *Id.* at 99.

⁹ *Id.*

¹⁰ *Id.*

teria is met prior to the age of ten, the individual is classified as childhood-onset type. If none of the criteria is met before the age of ten, then the individual is classified as adolescent-onset type. The manual also provides for an unspecified onset. Finally, the disorder may be classified as mild, moderate, or severe, depending on the number of conduct problems and the severity of their effect on others.¹¹

The prevalence rate of conduct disorder in community samples has been found to be from less than 1% to more than 10%.¹² Conduct disorder is generally the most common reason for the referral of a child, and it “is one of the most frequently diagnosed conditions in outpatient and inpatient mental health facilities for children.”¹³ Behaviors indicative of conduct disorder may manifest as early as age three, and familial interactions are one of the primary contributors to the development of such behavior.¹⁴ Psychological defects, environmental influences, and biological factors, such as reduced serotonin, have also been found to correlate with the development of conduct disorder.¹⁵

Conduct disorder is generally considered a difficult disorder to treat, but there are several, largely agreed-upon principles for how such treatment should be approached.¹⁶ Intervention should take place as early in the child’s life as possible, and treatment should encompass as much of the child’s day, every day, as feasible. Treatment should incorporate all caregivers and should remain consistent throughout all circumstances for as long as necessary, which may be for a period of years. Treatment should be multimodal and should also account for any comorbid disorders, such as attention deficit hyperactivity disorder or oppositional defiant disorder. Finally, it should try to address issues that may arise after treatment ceases, such as substance abuse or chronic unemployment.¹⁷ The difficulty in implementing such a treatment plan is apparent, and the effectiveness of most treatment attempts has not been substantial enough to justify widespread programs.¹⁸

Despite the difficulty in treating conduct disorder, early intervention remains essential due to the pervasiveness of the disorder and its high correlation to future delinquency and ASPD. Conduct disorder is highly correlated with adolescent delinquency, as “[d]elinquent youth are 20 times more likely to be diagnosed with conduct disorder than are non-

¹¹ *Id.*

¹² *Id.* at 97.

¹³ *Id.*

¹⁴ Ramona R. Reed & Donna L. Sollie, *Conduct Disordered Children: Familial Characteristics and Family Interventions*, 41 FAMILY RELATIONS 352, 353 (1992).

¹⁵ John Scott Werry, *Severe Conduct Disorder—Some Key Issues*, 42 CAN. J. PSYCHIATRY 577, 578–79 (1997).

¹⁶ *Id.* at 581.

¹⁷ *Id.*

¹⁸ *Id.* at 581–82.

delinquent youth,”¹⁹ and studies show that “about 40% to 50% of children with severe conduct disorder become recidivist criminals and/or antisocial personality-disordered adults.”²⁰ This statistic also indicates that conduct disorder is closely related to a diagnosis of ASPD. In addition to being one of the criteria for an ASPD diagnosis, the criteria for conduct disorder specify that if the individual is older than 18, the individual can be diagnosed with conduct disorder only if the criteria for ASPD are not met.²¹ Conduct disorder is often viewed as a precursor to ASPD, and one study found that in a sample of 7- to 12-year-old males diagnosed with best-estimate DSM-III-R conduct disorder, 54% later met the DSM-III-R criteria for ASPD at age 18 to 19.²² However, despite the high correlation between the two disorders, it is also important to keep in mind the significant portion of individuals who did not go on to develop ASPD, even when the diagnostic criteria for conduct disorder were met in childhood.

The diagnostic criteria for ASPD in many ways mirror that of conduct disorder. The individual must demonstrate “a pervasive pattern of disregard for and violation of the rights of others occurring since age 15 years.”²³ Such a pattern is indicated by at least three of the following:

- (1) failure to conform to social norms with respect to lawful behaviors as indicated by repeatedly performing acts that are grounds for arrest
- (2) deceitfulness, as indicated by repeated lying, use of aliases, or conning others for personal profit or pleasure
- (3) impulsivity or failure to plan ahead
- (4) irritability and aggressiveness, as indicated by repeated physical fights or assaults
- (5) reckless disregard for safety of self or others
- (6) consistent irresponsibility, as indicated by repeated failure to sustain consistent work behavior or honor financial obligations
- (7) lack of remorse, as indicated by being indifferent to or rationalizing having hurt, mistreated, or stolen from another²⁴

The individual must also be at least 18 years old, with evidence of conduct disorder beginning before age 15, and the antisocial behavior

¹⁹ Philip C. O'Donnell & Arthur J. Lurigio, *Psychosocial Predictors of Clinicians' Recommendations and Judges' Placement Orders in a Juvenile Court*, 35 CRIM. JUST. & BEHAV. 1429, 1430 (2008).

²⁰ Werry, *supra* note 15, at 582.

²¹ DSM-IV-TR, *supra* note 1, at 99.

²² Benjamin B. Lahey et al., *Predicting Future Antisocial Personality Disorder in Males From a Clinical Assessment in Childhood*, 73 J. CONSULTING & CLINICAL PSYCHOL. 389, 392 (2005).

²³ DSM-IV-TR, *supra* note 1, at 706.

²⁴ *Id.*

must not manifest exclusively during the course of schizophrenia or a manic episode.²⁵

Studies indicate that ASPD has a prevalence rate of between 2–3% among community samples, and that ASPD is diagnosed primarily in males.²⁶ As a result, most studies of ASPD involve primarily male samples and have found that “male sex is a very strong predictor of persistent delinquency.”²⁷ In prison samples, the rate of ASPD is extremely high, with some studies indicating up to a 60% or even 80% prevalence in the male prison population.²⁸ ASPD is also comorbid with numerous other mental health issues such as anxiety, depression, alcohol/drug abuse, post-traumatic stress disorder, and other personality disorders.²⁹

B. Causes of ASPD

Researchers have developed numerous possible explanations as to the cause of ASPD. One such explanation is that ASPD has a primarily biological basis.³⁰ For example, one study involving children who had been adopted at birth focused on the transfer of ASPD through genetics. The study found that, even though they had been adopted into a different family, the children of biological parents who had ASPD and substance abuse issues were more likely to manifest antisocial behaviors during their childhood.³¹ Other studies of ASPD indicate that nearly 20%, or one in five, of first-degree relatives of an individual with ASPD are antisocial.³²

Twin studies also provide strong support for the theory that ASPD has a genetic basis.³³ In one study involving 32 monozygotic (“identical”)

²⁵ *Id.*

²⁶ DONALD W. BLACK & C. LINDON LARSON, *BAD BOYS, BAD MEN: CONFRONTING ANTISOCIAL PERSONALITY DISORDER* xiii (1999) (“ASP is up to eight times more common in men than women.”); P. Moran, *The Epidemiology of Antisocial Personality Disorder*, 34 SOC. PSYCHIATRY & PSYCHIATRIC EPIDEMIOLOGY 231, 232 (1999).

²⁷ Barbara Lay et al., *Juvenile-Episodic, Continued or Adult-Onset Delinquency? Risk Conditions Analysed in a Cohort of Children Followed up to the Age of 25 Years*, 2 EUR. J. CRIMINOLOGY 39, 50 (2005).

²⁸ Moran, *supra* note 26, at 234; James R.P. Ogloff, *Psychopathy/Antisocial Personality Disorder Conundrum*, 40 AUSTL. & N.Z. J. PSYCHIATRY 519, 521–22 (2006).

²⁹ NAT’L INST. FOR HEALTH AND CLINICAL EXCELLENCE, CLINICAL GUIDELINE 77: ANTISOCIAL PERSONALITY DISORDER: TREATMENT, MANAGEMENT AND PREVENTION 23 (2009), available at <http://www.nice.org.uk/nicemedia/pdf/CG77NICEGuideline.pdf>.

³⁰ See Adrian Raine, *The Biological Basis of Crime*, in *CRIME: PUBLIC POLICIES FOR CRIME CONTROL* 43, 48 (James Q. Wilson & Joan Petersilia eds., 2002).

³¹ *Id.*

³² BLACK & LARSON, *supra* note 26, at 106; see also Stacey E. Holmes et al., *Risk Factors in Childhood That Lead to the Development of Conduct Disorder and Antisocial Personality Disorder*, 31 CHILD PSYCHIATRY & HUM. DEV. 183, 188 (2001) (collecting studies).

³³ William M. Grove et al., *Heritability of Substance Abuse and Antisocial Behavior: A Study of Monozygotic Twins Reared Apart*, 27 BIOLOGICAL PSYCHIATRY 1293 (1990); Raine, *supra* note 30, at 45.

sets (twins or triplets) who were reared apart from an early age in unrelated homes, statistically significant heritability was found for "antisocial behavior in both childhood (0.41) and adulthood (0.28)."³⁴ In addition, "combined results of twin studies of ASP and criminal behavior reveal concordance rates of 67 percent in identical twins and 31 percent in non-identical twins, [which] strongly support[s] genetic theories of causation."³⁵

Other biological factors, such as temperament, are also highly relevant.³⁶ Demonstrated aggression at a very young age is predictive of future antisocial behavior.³⁷ There is also a significant correlation between attention deficit hyperactivity disorder and later antisocial behavior.³⁸ The hyperactivity element, as opposed to the inattention element, is believed to be of greater importance in the later manifestation of ASPD.³⁹

The environment surrounding an individual is further believed to be an important factor in the development of ASPD. Several factors, such as "low socioeconomic status (SES), childhood aggression, antisocial peer group affiliation, low bonding to school, and academic failure" have been found to be common risk factors for developing ASPD.⁴⁰ Familial factors such as "inconsistent supervision interspersed with harsh punishment, large family size (usually four or more), institutional living early in life, parental rejection, inconsistent parental figures[,] . . . the presence of an alcoholic father[,] . . . single parenthood, [and] maternal depression" are also related to the development of conduct disorder and ASPD.⁴¹ An individual's exposure to more than one risk factor "significantly increases the risk of maladaptive outcomes,"⁴² and the risk factors may influence one another, resulting in even greater detriment to the individual.⁴³

A variety of other explanations and risk factors for ASPD exist, some of which include birth complications, minor physical anomalies, prefrontal dysfunction and other brain deficits, chronic under-arousal, externalizing behaviors, prenatal smoking or alcohol consumption, child abuse,

³⁴ Raine, *supra* note 30, at 45; *see also* Grove et al., *supra* note 33, at 1299 tbl.3.

³⁵ BLACK & LARSON, *supra* note 26, at 106 (citing P.A. Brennan & S.A. Mednick, *Genetic Perspectives on Crime*, 370 ACTA PSYCHIATRICA SCANDINAVICA SUPPLEMENTUM 19, 19–26 (1993)).

³⁶ *See* Holmes et al., *supra* note 32, at 185.

³⁷ *Id.*

³⁸ *Id.*; Rolf Loeber, *Development and Risk Factors of Juvenile Antisocial Behavior and Delinquency*, 10 CLINICAL PSYCHOL. REV. 1, 11 (1990).

³⁹ *See* Holmes et al., *supra* note 32, at 185.

⁴⁰ Amy E. Green et al., *Predicting Delinquency in Adolescence and Young Adulthood: A Longitudinal Analysis of Early Risk Factors*, 6 YOUTH VIOLENCE & JUV. JUST. 323, 324 (2008).

⁴¹ Holmes et al., *supra* note 32, at 187 (footnotes omitted).

⁴² Green et al., *supra* note 40, at 324.

⁴³ Holmes et al., *supra* note 32, at 189–90.

rape, and domestic violence.⁴⁴ Despite the range of possible explanations, no single factor has been identified that allows for an accurate prediction as to which individuals will develop ASPD.⁴⁵

C. *Labeling Theory*

An important consideration in the discussion of conduct disorder and ASPD is the potential impact that the official diagnoses can have on the juvenile being diagnosed. Such diagnoses can result in the imposition of highly detrimental labels on the juvenile. One theory in support of this proposition is labeling theory, which provides that “perceived negative societal reactions lead to the development of negative self-conceptions and greater delinquent involvement.”⁴⁶ The primary basis underlying labeling theory can be characterized by the following:

The attribution of stigmatizing labels, particularly when that attribution process involves formal agents of social control, initiates a social process that results in altered self-conceptions, a reduction in the availability of conventional opportunities, a restructuring of interpersonal relationships, and an elevated likelihood of involvement in the real or imagined conduct which stimulated initial intervention efforts.⁴⁷

Labeling theory considers two types of labeling: formal and informal.⁴⁸ Formal labels are labels given through social control agencies, such as the criminal justice system.⁴⁹ While labeling is only one of many factors correlating with a juvenile’s involvement in the juvenile justice system, studies have found that “official labeling plays a significant role in the maintenance and stability of delinquency and crime at a crucial period in early and middle adolescence.”⁵⁰ Research further indicates that “juveniles who are formally processed through the juvenile justice system and have formal contact with other social control agencies report greater subsequent delinquency.”⁵¹ Formal interactions with the justice system can result not only in formalized labels such as “delinquent” or “criminal,”

⁴⁴ *Id.* at 187–88; O’Donnell & Lurigio, *supra* note 19, at 1431; Raine, *supra* note 30, at 50–63.

⁴⁵ See Holmes et al., *supra* note 32, at 189.

⁴⁶ Mike S. Adams et al., *Labeling and Delinquency*, 38 ADOLESCENCE 171, 171 (2003).

⁴⁷ Charles W. Thomas & Donna M. Bishop, *The Effect of Formal and Informal Sanctions on Delinquency: A Longitudinal Comparison of Labeling and Deterrence Theories*, 75 J. CRIM. L. & CRIMINOLOGY 1222, 1226 (1984) (emphasis omitted).

⁴⁸ Adams et al., *supra* note 46, at 171.

⁴⁹ See *id.*

⁵⁰ Jón Gunnar Bernburg et al., *Official Labeling, Criminal Embeddedness, and Subsequent Delinquency: A Longitudinal Test of Labeling Theory*, 43 J. RES. CRIME & DELINQ. 67, 82 (2006).

⁵¹ Adams et al., *supra* note 46, at 171.

but can also impact the reputation of the juvenile in the community, thus resulting in informal labeling as well.⁵²

Informal labels are labels given by parents, teachers, and peers.⁵³ The negative labeling of juveniles by parents, teachers, and peers is a significant predictor of juvenile delinquency.⁵⁴ Although studies have provided inconsistent results as to the precise impact of labeling, it appears that juveniles who are consistently characterized as a delinquent by outside influences eventually comes to view themselves that same way.⁵⁵ One study found that “[a]s the number of negative descriptive adjectives increased [on a self-report questionnaire], so did the youths’ self-reported involvement in delinquency.”⁵⁶ The results of this study indicate the potential impact of imposing negative labels on juveniles. As those labels are continually reinforced, they essentially become self-fulfilling prophecies: the juvenile comes to believe that the labels are accurate descriptors of him or her, and then proceeds to act in a way that comports with those very labels. Even a juvenile’s subjective belief that parents or teachers view the juvenile as a “bad kid” or someone who “gets into trouble” correlates with “ties to delinquent peers and involvement in delinquency in successive periods.”⁵⁷

The studies surrounding labeling theory have important implications for a diagnosis of ASPD. When a negative label stigmatizes a juvenile, it may cause him or her to be perceived by others as a bad person.⁵⁸ Particularly in the case of ASPD, because the individual can display severe anti-social conduct at a very young age, the juvenile may be termed a “bad seed” and believed to be inherently bad or evil.⁵⁹ The juvenile’s peers, or other actors in the juvenile’s life such as parents and teachers, may in turn treat the juvenile negatively.⁶⁰ The juvenile might be viewed as beyond all hope or beyond the possibility of treatment, and may even be feared or ostracized. The negative treatment imposed on the juvenile then increases the likelihood that the juvenile will engage in future offending.⁶¹

Although labeling theory and its relation to juvenile offending requires further research, the concept serves as an important backdrop for

⁵² Bernburg et al., *supra* note 50, at 70–71.

⁵³ Adams et al., *supra* note 46, at 171.

⁵⁴ *Id.* at 182; Ross L. Matsueda, *Reflected Appraisals, Parental Labeling, and Delinquency: Specifying a Symbolic Interactionist Theory*, 97 AM. J. SOC. 1577, 1602–03 (1992).

⁵⁵ Adams et al., *supra* note 46, at 182.

⁵⁶ *Id.*

⁵⁷ Bernburg et al., *supra* note 50, at 70.

⁵⁸ See ROBERT AGNEW, JUVENILE DELINQUENCY: CAUSES AND CONTROL 146 (3d ed. 2009).

⁵⁹ Terrie E. Moffitt, *Adolescence-Limited and Life-Course-Persistent Antisocial Behavior: A Developmental Taxonomy*, 100 PSYCHOL. REV. 674, 684 (1993).

⁶⁰ AGNEW, *supra* note 58, at 146.

⁶¹ *Id.*

the following discussion regarding APSD, and it should be considered an important factor in any determination to label a juvenile with a formal diagnosis.

II. LIFE-COURSE-PERSISTENT VS. ADOLESCENCE-LIMITED ANTISOCIAL BEHAVIOR

A. *Theory and Definitions*

Antisocial behavior has been theorized to have two developmental pathways: life-course-persistent antisocial behavior and adolescence-limited antisocial behavior.⁶² This theory was developed to account for both the individuals who demonstrate consistent offending throughout their lifetimes, as well as those individuals who demonstrate only temporary and situational offending.⁶³

The life-course-persistent antisocial type is based on the premise that “antisocial behavior has its origins in neurodevelopmental processes, begins in childhood, and continues worsening thereafter. . . . [These individuals] are few, persistent, and pathological.”⁶⁴ Individuals of this type begin offending very early on in life and do not desist upon reaching adulthood.⁶⁵ Behavioral problems manifesting as early as age three have been found to have predictive validity for antisocial behavior and delinquency in early adolescence.⁶⁶ There is also a strong link between the stability of the behavior and its extremity.⁶⁷

Despite the findings indicating that life-course-persistent antisocial behavior begins in childhood, however, even childhood-onset antisocial behavior does not always persist into adolescence or adulthood.⁶⁸ One study found that childhood-limited individuals actually showed “remission of antisocial behavior, peer rejection, academic failure, and even internalizing problems.”⁶⁹ The results of this study indicate that even an individual who demonstrates early childhood antisocial behavior may not in fact be a life-course-persistent type, and further support the conclusion that life-course-persistent individuals make up only a small percentage of the overall population.

⁶² Moffitt, *supra* note 59, at 676.

⁶³ *Id.*

⁶⁴ Terrie E. Moffitt, *Life-Course-Persistent and Adolescence-Limited Antisocial Behavior: A 10-Year Research Review and a Research Agenda*, in CAUSES OF CONDUCT DISORDER AND JUVENILE DELINQUENCY 49, 49 (Benjamin B. Lahey et al. eds., 2003).

⁶⁵ *Id.*

⁶⁶ Jennifer L. White et al., *How Early Can We Tell?: Predictors of Childhood Conduct Disorder and Adolescent Delinquency*, 28 CRIMINOLOGY 507, 518–19 (1990).

⁶⁷ Moffitt, *supra* note 59, at 676.

⁶⁸ René Veenstra et al., *Childhood-Limited Versus Persistent Antisocial Behavior: Why Do Some Recover and Others Do Not? The TRAILS Study*, 29 J. EARLY ADOLESCENCE 718, 734 (2009).

⁶⁹ *Id.*

Adolescence-limited antisocial behavior, in contrast to the life-course-persistent type, is antisocial behavior that “has its origins in social processes, begins in adolescence, and desists in young adulthood.”⁷⁰ There is strong support for the idea that, while some individuals are engaged in an extremely high level of offending during adolescence, this offending is not an engrained part of an individual’s personality and will desist in early adulthood.⁷¹ Unlike in life-course-persistent offenders, “personality disorder and cognitive deficits play no part in the delinquency of adolescence-limited offenders.”⁷² One study found that the most important predictor of “episodic juvenile delinquency was the sum of psychosocial burdens in the environment of the child.”⁷³ As a result, the primary reasons for the stability of antisocial behavior in life-course-persistent individuals are not present in adolescence-limited antisocial behavior, as adolescence-limited behavior is driven by the surrounding environment rather than engrained personality traits. In addition, although a majority of crimes are committed by adolescents, “by the early 20s, the number of active offenders decreases by over 50%, and by age 28, almost 85% of former delinquents desist from offending.”⁷⁴ Incidences of offending tend to escalate until late adolescence and then decrease,⁷⁵ and a significant portion of adolescent offenders “are only temporarily involved in delinquent activities.”⁷⁶

One theory put forth to explain the significant increase and subsequent decrease in the offending of antisocial-limited offenders is that of social mimicry.⁷⁷ Under this theory, adolescent-limited offenders begin to notice the power and independence seemingly gained by their life-course-persistent peers during the teenage years.⁷⁸ Life-course-persistent individuals are often able to get the things they want by theft or other illegal activities, are more sexually experienced, and seem to create their own rules.⁷⁹ Adolescent-limited offenders come to desire this perceived maturity and freedom, and “near adolescence, a few boys join the life-course-persistent ones, then a few more, until a critical mass is reached when almost all adolescents are involved in some delinquency with

⁷⁰ Moffitt, *supra* note 64, at 49.

⁷¹ See Moffitt, *supra* note 59, at 675.

⁷² *Id.* at 691.

⁷³ Lay et al., *supra* note 27, at 58.

⁷⁴ Moffitt, *supra* note 59, at 675.

⁷⁵ David P. Farrington, *Key Results From the First Forty Years of the Cambridge Study in Delinquent Development*, in *TAKING STOCK OF DELINQUENCY: AN OVERVIEW OF FINDINGS FROM CONTEMPORARY LONGITUDINAL STUDIES* 137, 142 (Terence P. Thornberry & Marvin D. Krohn, eds. 2003); Bruce Watt et al., *Juvenile Recidivism: Criminal Propensity, Social Control and Social Learning Theories*, 11 *PSYCHIATRY, PSYCHOL. & L.* 141, 141 (2004).

⁷⁶ Lay et al., *supra* note 27, at 41.

⁷⁷ See generally Moffitt, *supra* note 59, at 686–87.

⁷⁸ *Id.*

⁷⁹ *Id.*

[their] peers.”⁸⁰ However, as adolescent-limited delinquents grow older, the motivation for such delinquency begins to cease.⁸¹ Some of the coveted privileges of adulthood become available at age 18 or 21, and the adolescent begins to realize the potential long-term consequences of future offending.⁸² The activities that were viewed as exhilarating risks during the teenage years become unacceptable risks in the face of adulthood.⁸³ As a result, the antisocial behavior declines and the juvenile transitions away from a life of crime.⁸⁴

The differences between the life-course-persistent and adolescence-limited pathways have important implications for the evaluation and prediction of future antisocial behavior. Most antisocial children do not become antisocial adults,⁸⁵ but one of the problems lies in the difficulty of determining those who will and those who will not. Although in hindsight an individual may have clearly followed one pathway or the other, future predictions that attempt to distinguish whether a juvenile is demonstrating life-course-persistent or adolescent-limited antisocial behavior are much less accurate. The results of one study involving 1,380 adolescents in New Jersey “suggest that many of the neuropsychological risk factors that distinguish early-onset persistent delinquency from adolescence-limited delinquency are not capable of distinguishing adolescence-limited from adolescence-to-adulthood-persistent delinquency.”⁸⁶ As a result, even the assessment of known risk factors is often inadequate to determine which type of antisocial behavior the juvenile is exhibiting.

Some studies have attempted to show consistency between antisocial behavior in late adolescence and antisocial behavior in adulthood. One study that compared 64 adolescents, ages 16–18, who met the criteria for ASPD (not including the 18-year age-of-onset requirement) with 20 males who met all of the criteria for ASPD (including the age-of-onset requirement), did find that there was no significant difference between the two groups on most of the variables.⁸⁷ However, the study also recognized that, “[g]iven the high prevalence of antisocial behavior during adolescence, it may be difficult for parents and professionals alike to determine whether an adolescent is exhibiting normative, transitory antisocial behavior or whether he/she is at risk for a more persistent course.”⁸⁸ The results of such studies provide insight into the difficulty of distinguishing

⁸⁰ *Id.* at 687.

⁸¹ *Id.* at 690.

⁸² *Id.*

⁸³ *See id.*

⁸⁴ *Id.*

⁸⁵ Moran, *supra* note 26, at 235.

⁸⁶ Helene Raskin White et al., *Adolescence-Limited Versus Persistent Delinquency: Extending Moffitt's Hypothesis into Adulthood*, 110 J. ABNORMAL PSYCHOL. 600, 608 (2001).

⁸⁷ Jeanette Taylor et al., *Construct Validity of Adolescent Antisocial Personality Disorder*, 36 J. YOUTH & ADOLESCENCE 1048, 1053 (2007).

⁸⁸ *Id.* at 1056.

between adolescent-limited and life-course-persistent offenders, as well as highlight the concerns that arise from attempted predictions.

B. Implications on the Predictive Validity of ASPD

The research on life-course-persistent and adolescence-limited anti-social behavior demonstrates the problem with diagnosing ASPD during childhood or adolescence. Juveniles are in a formative time of their lives, and there is often no way to accurately distinguish those offenders who are acting out due to an engrained personality schema from those who are only acting out due to peer influences or other situational factors. In one study, while researchers found “that the presence of [oppositional and antisocial personality problems] matters in the etiology of violence in youngsters, even when controlling for a host of other variables[,] . . . the magnitude of this effect . . . was consistently quite small.”⁸⁹

Even when ASPD is accurately diagnosed in individuals over the age of 18, the predictive validity remains low.⁹⁰ ASPD has been found to have “relatively little predictive power, at least with forensic populations.”⁹¹ As one psychologist testified in court, “a diagnosis of ASPD [does] not necessarily suggest criminal behavior per se because *there are plenty of people with ASPD who do not commit crimes*.”⁹² The psychologist went on to note a “high overlap between ASPD and criminal behavior,” but as indicated by his statement, many individuals with ASPD are not engaged in criminal activity despite this overlap. As a result a diagnosis of ASPD in and of itself is not a reliable predictor of future violence or criminal acts.

The low predictive validity of ASPD, in addition to the research demonstrating that a majority of adolescent offending is adolescent-limited antisocial behavior, illustrates the need for concern regarding the use of this diagnosis in juvenile proceedings. First, courts are not likely to be able to distinguish which type of antisocial behavior the adolescent is exhibiting due to the considerable difficulty in determining which life-course an individual will take. In an amicus brief arguing against life imprisonment without possibility of release for crimes committed by individuals under the age of 18, the American Psychiatric Association (APA) stated, “Research has documented that the vast majority of youthful offenders will desist from criminal behavior in adulthood. And the malleability of adolescence means that there is no reliable way to identify the

⁸⁹ Denise Paquette Boots & Jennifer Wareham, *Mental Health and Violent Offending in Chicago Youth: A Multilevel Approach*, NAT’L CRIM. JUST. REFERENCE SERVICE, 80–81 (May 2011), <http://www.ncjrs.gov/pdffiles1/nij/grants/234515.pdf>.

⁹⁰ See Robert D. Hare, *Psychopathy and Antisocial Personality Disorder: A Case of Diagnostic Confusion*, PSYCHIATRIC TIMES, Feb. 1, 1996, at 2–3.

⁹¹ *Id.* at 3.

⁹² United States v. Doe No. 3, 113 F. Supp. 2d 604, 609 (S.D.N.Y. 2000) (emphasis added) (paraphrasing testimony).

minority who will not.”⁹³ If clinicians experience significant difficulties in classifying the antisocial behavior of juveniles, courts are even less likely to accurately predict the likelihood of a juvenile’s future offending based on the limited contact they have with the juvenile.

However, some courts still make decisions based on unfounded predictions as to which juveniles will go on to offend in adulthood, despite the expressed concerns of the APA and other mental health professionals. For example, Justice Thomas utilized Terrie Moffitt’s research regarding life-course-persistent and adolescence-limited antisocial behavior in his dissent against the majority’s decision to prohibit administration of life sentences without parole for juveniles who did not commit homicide.⁹⁴ Justice Thomas argued that Moffitt’s research “suggests that violence itself is evidence that an adolescent offender’s antisocial behavior is *not* transient,” and cited to studies that had observed “that ‘life-course persistent’ males ‘tended to specialize in serious offenses (carrying a hidden weapon, assault, robbery, violating court orders), whereas adolescence-limited’ ones ‘specialized in non-serious offenses (theft less than \$5, public drunkenness, giving false information on application forms, pirating computer software, etc.).’”⁹⁵ Although this discussion of research findings was not a substantial part of Justice Thomas’s argument and was essentially used only to challenge assumptions made by the majority, it demonstrates the potential for misuse of research on antisocial behavior and ASPD.

The analysis by Justice Thomas failed to take into account studies by the same researcher indicating that “measures of the frequency or seriousness of adolescent offending will not discriminate very well between life-course-persistent and adolescence-limited delinquents.”⁹⁶ Had Justice Thomas’s reasoning been followed, the Court may have determined that life sentences without parole for juveniles who did not commit homicide are appropriate, despite the studies emphatically indicating the inability of clinicians to predict future offending and the difficulty in distinguishing life-course-persistent from adolescence-limited offenders.⁹⁷ If members of the Supreme Court are willing to determine the likelihood of future offending based on the seriousness of the alleged offense, and will do so even in cases with consequences as severe as a life sentence without parole for a juvenile, it follows that lower courts are even more likely to

⁹³ Brief for the Am. Psychological Ass’n et al. as Amicus Curiae Supporting Petitioners at 4, *Graham v. Florida*, 130 S. Ct. 2011 (2010) (Nos. 08-7412, 08-7621).

⁹⁴ *Graham*, 130 S. Ct. at 2054–55 (Thomas, J., dissenting).

⁹⁵ *Id.* at 2055 (quoting Terrie E. Moffitt, *A Review of Research on the Taxonomy of Life-Course Persistent Versus Adolescence-Limited Antisocial Behavior*, in *TAKING STOCK: THE STATUS OF CRIMINOLOGICAL THEORY* 277, 292–93 (Francis T. Cullen et al. eds., 2006)).

⁹⁶ Moffitt, *supra* note 59, at 678.

⁹⁷ *Id.*

act similarly in proceedings that seem to be of much less consequence, such as juvenile transfers to adult court.

Courts are often limited to the very factors that research has indicated do not accurately distinguish between life-course-persistent and adolescent-limited offenders: the frequency or seriousness of the adolescent's offending.⁹⁸ Some courts choose to base the transfer decision almost entirely on these factors, in particular the seriousness of the offense.⁹⁹ As a result, the court may rely on a factor that is not an accurate predictor of future offending in its determination that a juvenile should be transferred to adult court. Such an outcome has important implications for juvenile defendants, as some juveniles who are actually amenable to treatment may be transferred to adult court based on the inaccurate assumption that they are life-course-persistent offenders.

The Supreme Court itself has recognized the transitory nature of a majority of juvenile offending, noting that "[f]or most teens, [risky or antisocial] behaviors are fleeting; they cease with maturity as individual identity becomes settled."¹⁰⁰ The Court openly accepts the transitory nature of a majority of adolescent offending, and yet personality disorders, which represent part of an individual's fully developed personality, are still being considered within juvenile proceedings.

III. JUVENILE TRANSFER TO ADULT COURT IN FEDERAL CASES

The application of ASPD to juvenile proceedings has particular significance in the context of juvenile transfer to adult court. The transfer of a juvenile from juvenile court to adult criminal court in the federal system is governed by 18 U.S.C. § 5032.¹⁰¹ This statute allows for juveniles 15 years of age, and in some circumstances 13 years of age, to be transferred for adult criminal prosecution if such transfer is in the "interest of justice."¹⁰² Transfer to adult court can result in serious consequences for the juvenile, as "after transfer, youths may be subjected to all of the penalties associated with an adult conviction."¹⁰³ Studies indicate that juveniles charged with serious crimes in adult court are not treated more leniently due to their age, but are instead convicted at approximately the same

⁹⁸ *Id.*

⁹⁹ *See, e.g.,* United States v. Juvenile Male, 754 F. Supp. 2d 569, 578 (E.D.N.Y. 2010).

¹⁰⁰ Roper v. Simmons, 543 U.S. 551, 570 (2005) (second alteration in original) (quoting Laurence Steinberg & Elizabeth S. Scott, *Less Guilty by Reason of Adolescence: Developmental Immaturity, Diminished Responsibility, and the Juvenile Death Penalty*, 58 AM. PSYCHOLOGIST 1009, 1014 (2003)) (internal quotation mark omitted).

¹⁰¹ 18 U.S.C. § 5032 (2006).

¹⁰² *Id.*

¹⁰³ Vanessa L. Kolbe, *A Cloudy Crystal Ball: Concerns Regarding the Use of Juvenile Psychopathy Scores in Judicial Waiver Hearings*, DEV. MENTAL HEALTH L., Jan. 2007, at 1, 10.

rate as adults and receive similar sentences to those of adults.¹⁰⁴ The proportion of juveniles who are prosecuted as adults is increasing, and studies indicate that “more than 200,000 individuals under the age of 18 are prosecuted in criminal [adult] court each year.”¹⁰⁵

In determining whether or not to transfer a juvenile to adult criminal court, six factors are considered:

[T]he age and social background of the juvenile; the nature of the alleged offense; the extent and nature of the juvenile’s prior delinquency record; the juvenile’s present intellectual development and psychological maturity; the nature of past treatment efforts and the juvenile’s response to such efforts; [and] the availability of programs designed to treat the juvenile’s behavioral problems.¹⁰⁶

Courts must consider these six statutory factors in order to decide whether the transfer is in the interest of justice.¹⁰⁷

It is in the evaluation of the fourth factor, the juvenile’s present psychological maturity and intellectual development, that courts most often address any mental health issues of the juvenile. For this reason, this Note addresses the fourth factor and courts’ consideration of ASPD within the context of this factor, although the discussion remains relevant to the other five factors as well.

The full extent to which a diagnosis of ASPD may sway a court in its decision to transfer juveniles to adult court is unclear, as many cases are not published and courts are not required to weigh each of the six factors equally, but may instead balance the factors as they find appropriate.¹⁰⁸ It does appear, however, that a diagnosis of ASPD, when considered under the juvenile’s present psychological maturity and intellectual development, is viewed by the court as weighing in favor of a transfer to adult court.

For example, in a case where the court denied the State’s motion to transfer, when evaluating the “intellectual and psychological development” factor, the court considered the testimony of a psychologist that the defendant was “neurotic rather than psychotic and that . . . the juvenile act[ed] impulsively because he [was] in a depressed state rather than

¹⁰⁴ Elizabeth S. Scott & Thomas Grisso, *The Evolution of Adolescence: A Developmental Perspective on Juvenile Justice Reform*, 88 J. CRIM. L. & CRIMINOLOGY 137, 151 (1997).

¹⁰⁵ Laurence Steinberg, *Should Juvenile Offenders Be Tried As Adults? A Developmental Perspective on Changing Legal Policies* 2 (Joint Ctr. for Poverty Research Working Paper, 2000), available at http://www.ipr.northwestern.edu/jcpr/workingpapers/wpfiles/Steinberg_briefing.pdf; see also James L. Loving & Nicholas S. Patapis, *Evaluating Juvenile Amenability to Treatment: Integrating Statutes and Case Law Into Clinical Practice*, 7 J. FORENSIC PSYCHOL. PRAC. 67, 68 (2007).

¹⁰⁶ 18 U.S.C. § 5032.

¹⁰⁷ E.g., *United States v. Juvenile K.J.C.*, 976 F. Supp. 1219, 1223 (N.D. Iowa 1997) (citing federal appellate court cases requiring consideration of the six factors).

¹⁰⁸ *United States v. Male Juvenile E.L.C.*, 396 F.3d 458, 461 (1st Cir. 2005).

from antisocial bases.”¹⁰⁹ This rationale demonstrates that, had the court determined that the juvenile’s actions were the result of antisocial behavior or ASPD rather than depression, it would have found this factor to weigh in favor of adult transfer. The court’s statement further indicates that, even when an actual diagnosis of ASPD is not provided, antisocial references may still have bearing on its decision.

Although it is difficult to determine the precise degree to which a diagnosis of ASPD influences courts in their determinations, “when clinical advice is provided through court-ordered evaluations, clinicians’ recommendations and judges’ final decisions are often strongly correlated.”¹¹⁰ For example, in a study of 248 adjudicated youths who were referred for a clinical evaluation, O’Donnell and Lurigio found that clinicians’ recommendations accounted for more than half of the variance in judges’ decisions.¹¹¹ Therefore, even if a court does not explicitly rely on a diagnosis of ASPD when making the transfer decision, it can be inferred that the evaluation or recommendation provided by the clinician will have some amount of influence over the court’s determination.

IV. DANGER OF USING A DIAGNOSIS OF ASPD IN JUVENILE PROCEEDINGS

A. *Current Use of ASPD*

The Supreme Court has recognized the impropriety of diagnosing an individual under the age of 18 with ASPD.¹¹² In *Roper v. Simmons*, the Court stated:

It is difficult even for expert psychologists to differentiate between the juvenile offender whose crime reflects unfortunate yet transient immaturity, and the rare juvenile offender whose crime reflects irreparable corruption. As we understand it, this difficulty underlies the rule forbidding psychiatrists from diagnosing any patient under 18 as having antisocial personality disorder¹¹³

Despite this admonition and the warning of the DSM-IV-TR to refrain from diagnosing an individual with ASPD prior to the age of 18, some courts have chosen to inappropriately rely on a diagnosis of ASPD in juveniles. For example, the Tenth Circuit in *United States v. McQuade Q.* recognized the district court’s explicit findings from expert testimony regarding the juvenile defendant’s diagnosis of ASPD, despite the fact that the juvenile was not yet 18.¹¹⁴ The court recognized that in *Roper v. Simmons*, the Supreme Court indicated that “general rules of psychiatry prohibit psychiatrists ‘from diagnosing any patient under 18 as having anti-

¹⁰⁹ *United States v. Doe*, 94 F.3d 532, 538 (9th Cir. 1996).

¹¹⁰ O’Donnell & Lurigio, *supra* note 19, at 1433.

¹¹¹ *Id.* at 1441.

¹¹² *Roper v. Simmons*, 543 U.S. 551, 573–74 (2005).

¹¹³ *Id.* at 573 (internal citation omitted).

¹¹⁴ *United States v. McQuade Q.*, 403 F.3d 717, 718 (10th Cir. 2005).

social personality disorder.”¹¹⁵ However, the court in *McQuade Q.* went on to say:

The [Supreme] Court’s dicta is irrelevant in this case for three reasons. First, [the psychologist] explicitly testified at the transfer hearing that the rules of psychiatry do not prohibit anything; rather, it “is a guideline for clinicians.” Second, [the psychologist] testified that [the defendant] was never actually diagnosed with an anti-social personality disorder; instead, he simply possesses “all of the behavioral requirements, even though he is not 18.” Lastly, [defendant], in his opening brief, admits he “suffers from severe anti-social personality disorder.”¹¹⁶

Even though the psychologist in the case indicated that the defendant had not actually been diagnosed with ASPD, it is clear from the court’s language that it had nevertheless accepted a diagnosis of ASPD for the defendant.¹¹⁷ This is evidenced by the discussion of the trial court’s conclusion that the defendant had “not corrected or improved his psychological problems, especially his extreme anti-social personality disorder.”¹¹⁸ The appellate court seemed to emphasize the defendant’s self-diagnosis of ASPD,¹¹⁹ but it failed to give any indication as to how the defendant’s self-assessment could be accurate in light of established psychiatric diagnostic criteria to the contrary.

The DSM-IV-TR specifically states, “[t]hese diagnostic criteria and the DSM-IV Classification of mental disorders reflect a consensus of current formulations of evolving knowledge in our field.”¹²⁰ Therefore, while the court is correct that the rules of psychiatry do not prohibit anything per se, the fact that the DSM-IV-TR expressly includes a requirement that the individual is at least 18 years of age, and does so based on the current psychiatric knowledge available, strongly counsels against a use of the diagnosis for individuals who are under the age of 18. The DSM-IV-TR, “[b]y requiring that the diagnosis be applied only to those older than 18, . . . discourages labeling young people with a serious diagnosis that may remain a troublesome aspect of their medical records even if proven to be wrong or if their problems subside.”¹²¹

Other courts have indicated a similar propensity for accepting the diagnosis of ASPD or the predictive validity of psychiatric labels in juvenile proceedings. One trial court concluded that “the defendant [did] not appear to be suffering from significant psychopathology, the kind that would lead one to be concerned that we’re dealing with someone who would—whose personality would indicate a *clear tendency towards fu-*

¹¹⁵ *McQuade Q.*, 403 F.3d at 720 n.2. (quoting *Simmons*, 543 U.S. at 573).

¹¹⁶ *Id.*

¹¹⁷ *See id.* at 720–21.

¹¹⁸ *Id.* at 721.

¹¹⁹ *See id.* at 720 n.2.

¹²⁰ DSM-IV-TR, *supra* note 1, at xxxvii.

¹²¹ BLACK & LARSON, *supra* note 26, at 42.

ture violence.”¹²² This language indicates acceptance of the idea that, had a personality disorder been diagnosed, the court could have accurately predicted future offending on the part of the juvenile, despite the low predictive validity of such diagnoses. In deciding to transfer a 16-year-old defendant to adult status, one court considered a psychologist’s testimony that defendant was “clearly manipulative and *probably* [met] the criteria for a Conduct Disorder.”¹²³ Psychiatric diagnoses, particularly within juvenile proceedings, should be used with the utmost care, and courts should not consider diagnoses in their determinations when psychologists use qualifiers such as “probably” to establish the existence of such diagnoses. In another case, the Ninth Circuit upheld a trial court’s transfer of a juvenile to adult court, considering the fact that the defendant had “observable antisocial characteristics” and refused to reverse based on the trial court’s “allegedly erroneous finding that [the] defendant suffer[ed] from antisocial personality disorder.”¹²⁴ These cases provide support for the idea that ASPD diagnoses are being considered, and even accepted, in juvenile federal court proceedings.

The APA has expressed concern to the Supreme Court about the use of an ASPD diagnosis even in adult cases. In an amicus brief arguing against the use of psychiatric predictions of long-term future dangerousness in capital cases, the APA stated:

[P]sychiatric predictions of long-term future dangerousness—even under the best of conditions and on the basis of complete medical data—are of fundamentally low reliability. . . . We believe, therefore, that diagnoses of “sociopathy” or “antisocial personality disorder,” and predictions of future behavior characterized as “medical opinions,” serve only to distort the factfinding process. Because the prejudicial impact of such assertedly “medical” testimony far outweighs its probative value, it should be barred altogether in capital cases.

The unreliability of psychiatric predictions of long-term future dangerousness is by now an established fact within the profession.¹²⁵

If the organization responsible for developing the diagnostic criteria for ASPD expresses significant concern over the use of ASPD in adult criminal court based on its low predictive validity for future behavior, courts should be even more concerned about its application and potential effects in juvenile proceedings.

¹²² United States v. Nelson, 68 F.3d 583, 588 (2d Cir. 1995) (emphasis added) (quoting the district court’s findings) (internal quotation marks omitted).

¹²³ United States v. TLW, 925 F.Supp. 1398, 1404 (C.D. Ill. 1996) (emphasis added) (quoting testimony).

¹²⁴ United States v. Alfred N., No. 97-10015, 1997 WL 579105, at *1 (9th Cir. Sept. 10, 1997).

¹²⁵ Brief Amicus Curiae for Am. Psychiatric Ass’n at 11–12, Barefoot v. Estelle, 463 U.S. 880 (1983) (No. 82-6080) (footnote omitted).

B. Possibility of Confusing ASPD with More Severe, Stigmatizing Term of Psychopathy

1. Distinguishing the Diagnoses

Another reason for concern regarding the use of ASPD in juvenile proceedings is the potential for confusing ASPD with psychopathy. The term “psychopath” carries with it an extremely negative connotation in the public view, as demonstrated through various article titles such as “Serial Killer—Psychopathic or Psychotic,”¹²⁶ “The BTK Killer: Portrait of a Psychopath,”¹²⁷ and “How to Spot a Psychopath.”¹²⁸ Labeling someone a “psychopath” can result in permanent stigmatization of the individual, and the use of this term should therefore be limited only to contexts in which its definition is entirely understood.

Although the term “psychopath” was used particularly in conjunction with Cleckley’s publication of *The Mask of Sanity*¹²⁹ and his 16 characteristics of psychopathy, the DSM-I characterized this disorder as sociopathic personality disturbance, antisocial reaction.¹³⁰ The DSM-II changed the diagnosis to personality disorder, antisocial type.¹³¹ With the DSM-III, the traditional personality traits previously defining psychopathy were replaced “by persistent violations of social norms, including lying, stealing, truancy, inconsistent work behavior and traffic arrests.”¹³² The DSM-III and subsequent versions of the DSM now classify the diagnosis as antisocial personality disorder.¹³³

In its description of ASPD, the DSM-IV-TR states that ASPD is also known as psychopathy,¹³⁴ seeming to indicate that the two diagnoses are equivalent. Although the terms psychopathy and ASPD are sometimes used synonymously, and controversy remains over their differentiation, in the psychiatric field it is generally accepted that the two terms are not en-

¹²⁶ Debswood, *Serial Killer—Psychopathic or Psychotic*, SCIENCERAY (Nov. 19, 2008), <http://scienceray.com/physics/serial-killer-psychopathic-or-psychotic/>.

¹²⁷ Denise Mann, *The BTK Killer: Portrait of a Psychopath*, MEDICINET.COM (June 29, 2005), <http://www.medicinenet.com/script/main/art.asp?articlekey=50579>.

¹²⁸ Wynne Parry, *How to Spot a Psychopath: Look for Speech Patterns, Scientists Say*, FOX NEWS (Oct. 24, 2011), <http://www.foxnews.com/scitech/2011/10/24/spotting-psychopath-speech-patterns-give-them-away-scientists-say/>.

¹²⁹ See HERVEY CLECKLEY, *THE MASK OF SANITY: AN ATTEMPT TO REINTERPRET THE SO-CALLED PSYCHOPATHIC PERSONALITY* (1941).

¹³⁰ AM. PSYCHIATRIC ASS’N, *DIAGNOSTIC AND STATISTICAL MANUAL—MENTAL DISORDERS* 38 (1952).

¹³¹ AM. PSYCHIATRIC ASS’N, *DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS* 41, 43 (2d ed. 1968).

¹³² Hare, *supra* note 90, at 1; *see also* AM. PSYCHIATRIC ASS’N, *DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS* 320–21 (3d ed. 1980).

¹³³ For an in-depth analysis as to the history of changes in terminology regarding ASPD in the DSM, *see* Jessica R. Gurley, *A History of Changes to the Criminal Personality in the DSM*, 12 HIST. PSYCHOL. 285 (2009).

¹³⁴ DSM-IV-TR, *supra* note 1, at 701–02.

tirely equivalent.¹³⁵ This argument is advanced by definitive statements of researchers that “the research findings obtained from studies of psychopathy *cannot* and *must not* be simply extended to those diagnosed with [ASPD].”¹³⁶ Researchers have provided evidence to indicate the important differences between the two diagnoses¹³⁷—differences that have important implications within the legal setting.

First, the two diagnoses are actually measuring different traits. ASPD measures focus on criminality and social deviance, while psychopathy measures focus on social deviance as well as the interpersonal and affective traits of the individual.¹³⁸ In other words, ASPD is concerned primarily with behavior, while psychopathy evaluates both personality and behavior. For example, ASPD measures include “failure to conform to social norms with respect to lawful behaviors” and “consistent irresponsibility, as indicated by repeated failure to sustain consistent work behavior or honor financial obligations,”¹³⁹ while the Psychopathy Checklist-Revised (PCL-R) includes criteria such as “[g]libness/superficial charm,” “[c]allous/lack of empathy,” and “[s]hallow affect.”¹⁴⁰

In addition, there is a difference in predictive validity between the two diagnoses. Psychopathy measures have a greater correlation to recidivism and future acts of violence than ASPD diagnoses.¹⁴¹ In one study, scores from the Child Psychopathy Scale taken by males at age 13 were found to predict “the variety of arrests and convictions 5 to 13 years later, even after controlling for other well-established and well-measured risk factors.”¹⁴² Other studies suggest, however, that juvenile psychopathy measures do not predict adult psychopathy with a high level of accuracy.¹⁴³ The APA, in an amicus brief to the Supreme Court, described one study’s findings that, “if diagnostic scores on a measure of juvenile psychopathy were used to predict adult psychopathy, the prediction that juveniles who scored in the top 20 percent of psychopathic traits at age 13 would be psychopathic at age 24 would be wrong in 86 percent of cas-

¹³⁵ Gurley, *supra* note 133, at 285; Ogloff, *supra* note 28, at 521–22.

¹³⁶ Ogloff, *supra* note 28, at 522.

¹³⁷ See Hare, *supra* note 90, at 3.

¹³⁸ Ogloff, *supra* note 28, at 521–22; see also Robert D. Hare et al., *Psychopathy and the DSM-IV Criteria for Antisocial Personality Disorder*, 100 J. ABNORMAL PSYCHOL. 391, 391–94 (1991).

¹³⁹ DSM-IV-TR, *supra* note 1, at 706.

¹⁴⁰ Hare et al., *supra* note 138, at 394. The definition of ASPD in the DSM-V may correct some of this disparity by including more personality-oriented criteria, such as the individual’s identity and self-functioning. However, the predictive validity of the future definition of ASPD will not be known for some time, and if it is interpreted as more closely mirroring psychopathy then the concern between confusing or equating the two diagnoses without examining the implications becomes even more prevalent.

¹⁴¹ See Donald R. Lynam et al., *Psychopathy in Adolescence Predicts Official Reports of Offending in Adulthood*, 7 YOUTH VIOLENCE & JUV. JUST. 189, 190 (2009).

¹⁴² *Id.* at 189.

¹⁴³ See Brief for the Am. Psychological Ass’n et al. as Amicus Curiae, *supra* note 93, at 22 n.44.

es.”¹⁴⁴ Researchers have recognized that, due to “the dearth of longitudinal psychopathy research, we are currently unable to distinguish between phenotypically psychopathic youth with and without a stable disorder.”¹⁴⁵

Despite the results of these studies, psychopathy scales are still generally recognized as having a higher predictive validity than measures of ASPD.¹⁴⁶ Research indicates that “psychopathic offenders or forensic psychiatric patients (as defined by the PCL-R) are as much as three or four times more likely to violently reoffend following release from custody than are nonpsychopathic offenders or patients. ASPD, on the other hand, has relatively little predictive power, at least with forensic populations.”¹⁴⁷ As a result, some researchers have suggested replacing the ASPD criteria of the DSM with the Psychopathy Checklist-Revised.¹⁴⁸

Finally, a diagnosis of ASPD encompasses a substantially higher percentage of individuals than the percentage of those who qualify for a diagnosis of psychopathy. Although a majority of psychopaths do “meet the criteria for ASPD, . . . *most individuals with ASPD are not psychopaths.*”¹⁴⁹ Studies have shown that ASPD has a prevalence rate of 50% to 80% in prison populations.¹⁵⁰ However,

research shows that only 15% of prisoners . . . would receive scores on the PCL-R high enough . . . to be identified as psychopaths. . . . Thus, among prisoners, the criteria for [ASPD] produce three to five times as many people with the diagnoses as compared with the narrower construct of psychopathy, as assessed by the PCL-R.¹⁵¹

The significant differences between ASPD and psychopathy demonstrate that the two diagnoses should not be used interchangeably, and that the results of studies on psychopathy should not be extended to ASPD.

2. *Application in Legal Settings*

The differences between these two diagnoses provide ample reasons for courts to be wary of treating the terms synonymously. However, courts appear to have interpreted the DSM-IV-TR reference to psychopathy to mean that ASPD and psychopathy are synonymous, despite the important and sometimes determinative distinctions previously discussed. For example, in *Roper v. Simmons*, the Court referred to “antisocial personality disorder, *a disorder also referred to as psychopathy or sociopathy*, and which is

¹⁴⁴ *Id.* (citing Donald R. Lynam et al., *Longitudinal Evidence That Psychopathy Scores in Early Adolescence Predict Adult Psychopathy*, 116 J. ABNORMAL PSYCHOL. 155, 160, 162 (2007)).

¹⁴⁵ Michael J. Vitacco & Gina M. Vincent, *Understanding the Downward Extension of Psychopathy to Youth: Implications for Risk Assessment and Juvenile Justice*, 5 INT’L J. FORENSIC MENTAL HEALTH 29, 34 (2006).

¹⁴⁶ See Hare, *supra* note 90, at 3.

¹⁴⁷ *Id.*

¹⁴⁸ Hare et al., *supra* note 138, at 393.

¹⁴⁹ Hare, *supra* note 90, at 2.

¹⁵⁰ Ogloff, *supra* note 28, at 522.

¹⁵¹ *Id.* (footnotes omitted).

characterized by callousness, cynicism, and contempt for the feelings, rights, and suffering of others.”¹⁵² Such language demonstrates the Court’s failure to consider the highly relevant differences between the terms.

Despite the overlap between ASPD and psychopathy, they are in fact separate diagnoses, and a court’s decision to treat them as equivalent can have extremely negative consequences for juvenile defendants. In his article *Psychopathy and Antisocial Personality Disorder: A Case of Diagnostic Confusion*, Robert Hare discusses the danger of equating ASPD and psychopathy within legal settings.¹⁵³ The scenario he presents illustrates the importance of understanding the distinction between the two diagnoses and the possible consequences of failing to do so:

In some states an offender convicted of first-degree murder and diagnosed as a psychopath is likely to receive the death penalty on the grounds that psychopaths are cold-blooded, remorseless, untreatable and almost certain to reoffend. But many of the killers on death row were, and continue to be, mistakenly referred to as psychopaths on the basis of *DSM-III*, *DSM-III-R* or *DSM-IV* criteria for ASPD. We don’t know how many of these inhabitants of death row actually exhibit the personality structure of the psychopath, or how many merely meet the criteria for ASPD, a disorder that applies to the majority of criminals and that has only tenuous implications for treatability and the likelihood of violent reoffending.¹⁵⁴

Courts may allow their decisions to be influenced by the incorrect assumption that a diagnosis of ASPD has the same predictive validity as the diagnostic tools used to measure psychopathy, and therefore view an individual as more likely to offend despite the lower correlation that ASPD has with future violence. Studies have reached varying results with regard to the effect that diagnostic labels may have on judges’ determinations, but the potential for such labels to influence judges demonstrates the need for extreme caution in their use. For example, one study evaluated the effect of psychopathic labels on judges.¹⁵⁵ The participants were 100 judges, including juvenile-court and adult-court judges, who were given one of four scenarios.¹⁵⁶ Each scenario contained the same factual pattern regarding a juvenile charged with aggravated assault, but different mental health information was provided in each scenario: the first scenario included no mental-health information; the second included testimony from a mental-health expert that the juvenile was a psychopath; the third contained testimony from a mental-health expert describing the juvenile as having traits associated with psychopathy but without actually using the

¹⁵² *Roper v. Simmons*, 543 U.S. 551, 573 (2005) (emphasis added).

¹⁵³ Hare, *supra* note 90, at 4.

¹⁵⁴ *Id.* (citation omitted).

¹⁵⁵ Shayne Jones & Elizabeth Cauffman, *Juvenile Psychopathy and Judicial Decision Making: An Empirical Analysis of an Ethical Dilemma*, 26 BEHAV. SCI. & L. 151 (2008).

¹⁵⁶ *Id.* at 156.

term “psychopath”; and the fourth included testimony from a mental-health expert consisting of both the psychopathic traits and the psychopathic label.¹⁵⁷ The study found that, when rendering hypothetical dispositions, judges viewed youth who were “both labeled with psychopathy and ascribed as possessing psychopathic traits . . . as less amenable to treatment” than the other youth.¹⁵⁸ The judges were also more likely to recommend that those youth receive a restrictive placement.¹⁵⁹ The results of this study indicate that even judges are not immune from the negative perceptions surrounding these terms, despite the research demonstrating that substantial reliance on them is unfounded.

In contrast, another study found no negative effects due to conduct disorder or psychopathy labels in a study where judges rendered hypothetical dispositions.¹⁶⁰ That study looked at the responses of 273 members of the National Council of Juvenile and Family Court Judges to a hypothetical fact pattern regarding a juvenile charged with assault.¹⁶¹ Each scenario included a mental health evaluation consisting of facts regarding: a history of antisocial behavior, psychopathic personality traits, or a diagnosis (or some combination of the three).¹⁶² The study found that a description of antisocial *history* on the part of the juvenile did significantly impact the judges’ decisions. The presence of a substantial antisocial history most influenced judges to ascribe more severe penalties and to expect future violence from the juvenile.¹⁶³ This finding highlights the concern that judges may make determinations based on an inaccurate belief that the juvenile is a life-course-persistent offender, rather than an adolescent-limited offender, due to the presence of antisocial behavior. However, the study also found that a *diagnosis* of conduct disorder or psychopathy did not significantly influence the hypothetical dispositions rendered by the judges.¹⁶⁴ Although this particular study did not find that the diagnostic label of conduct disorder or psychopathy significantly impacted the judges’ dispositions, the varying results of the available studies indicate that at the very least there is a strong potential for such influence.

Another concern regarding the mischaracterization of ASPD and psychopathy is that a judge who treats ASPD and psychopathy synonymously may allow the terms to be used interchangeably in front of the jury. While the decision to transfer a juvenile to adult court is generally

¹⁵⁷ *Id.* at 156–57.

¹⁵⁸ *Id.* at 159.

¹⁵⁹ *Id.*

¹⁶⁰ Daniel C. Murrie et al., *Diagnostic Labeling in Juvenile Court: How Do Descriptions of Psychopathy and Conduct Disorder Influence Judges?*, 36 J. CLINICAL CHILD & ADOLESCENT PSYCHOL. 228 (2007).

¹⁶¹ *Id.* at 231–32, 240.

¹⁶² *Id.* at 231.

¹⁶³ *Id.*

¹⁶⁴ *Id.*

made by the judge, the potential effect that the terms may have on a jury remains relevant to the overall consideration of the use of ASPD in juvenile proceedings. In a study focusing on the effect of youth psychopathy labels on jurors, researchers found that “regardless of a youth’s antisocial history or psychopathic personality features, participants rated youth named as ‘a psychopath’ as warranting more punishment than youth diagnosed as meeting criteria for psychopathy or conduct disorder.”¹⁶⁵

In some cases, the use of the term “psychopath” may be used intentionally to inflame emotion or prejudice on the part of the fact-finder. For example, in the words of one prosecutor, “when you can argue to a jury that [the defendant] has a high *psychopathic* deviant [sic] scale, just those words alone are a wonderful argument for a jury.”¹⁶⁶ With regard to actions he would have taken at a criminal trial to characterize the defendant as dangerous, the prosecutor further indicated that he “would have equated psychopathy to antisocial personality disorder.”¹⁶⁷ These statements demonstrate the prosecutor’s awareness of the irrevocable harm that the term “psychopath” can cause to a criminal defendant, as well as his intention to exploit this harm as much as possible.

Finally, as discussed previously in the context of labeling theory, there is an inherent danger in giving juveniles a negative label at a time when their personalities are still capable of so much change; they may be unable to escape the label even in adulthood. ASPD is “characterized by a pattern of socially irresponsible, exploitive, and guiltless behavior. For that reason, the diagnosis is generally viewed as pejorative and potentially stigmatizing and ought never to be used lightly.”¹⁶⁸ As a result, labeling an individual with ASPD, and the possible confusion it can cause with regard to psychopathy, may cause courts to incorrectly determine that there are no treatment options for a juvenile. When describing an individual diagnosed with ASPD, one psychiatrist stated, “Persons with this personality structure do not learn from experience and are unlikely to benefit from known medical treatment.”¹⁶⁹ Synonymous treatment of the term “psychopathy” with ASPD further solidifies this belief that the juvenile is beyond the possibility of help or treatment, and a juvenile facing such a determinative label may continue to act out due to the inability to see any alternative.

In addition, the belief that ASPD is synonymous with psychopathy may result in individuals demonstrating characteristics of ASPD being permanently stigmatized with the label of a psychopath, and “[l]abeling

¹⁶⁵ Marcus T. Boccaccini et al., *Describing, Diagnosing, and Naming Psychopathy: How Do Youth Psychopathy Labels Influence Jurors?*, 26 BEHAV. SCI. & L. 487, 502–03 (2008).

¹⁶⁶ *Kimbrough v. Sec’y, DOC*, 565 F.3d 796, 801 (11th Cir. 2009) (second alteration in original) (emphasis added) (quoting testimony of the prosecutor).

¹⁶⁷ *Id.* (paraphrasing testimony).

¹⁶⁸ BLACK & LARSON, *supra* note 26, at xvi.

¹⁶⁹ *Id.* at 168 (quoting letter to court from psychiatrists) (internal quotation mark omitted).

an individual as a *psychopath*—perhaps the quintessential case of ‘bad character’—implies that the individual’s antisocial behavior is due to fixed aspects of his or her personality.”¹⁷⁰ Rather than resulting in greater intervention or treatment options, the negative treatment a juvenile may receive as a result of this label could lead to an even higher level of future offending.

Based on the above considerations, the possibility of confusion between ASPD and psychopathy and the negative consequences of such labels strongly counsels against the use of ASPD in juvenile proceedings.

CONCLUSION

Although the full extent to which a diagnosis of ASPD influences judicial determinations regarding juvenile transfer to adult court remains unclear, federal cases indicate that ASPD does arise in judicial considerations of juveniles’ present psychological maturity and intellectual development. ASPD is not a valid diagnosis for individuals under the age of 18, and for this reason alone the use of an ASPD diagnosis in juvenile proceedings should be prohibited. Further, the precise cause of ASPD is unknown, and the predictive validity of ASPD regarding future violence or offending is low. The research on life-course-persistent and adolescent-limited antisocial behavior indicates the difficulty in determining whether a juvenile is engaged in chronic or only temporary offending, and an inaccurate prediction can have severe consequences for the juvenile. Labeling a juvenile with an ASPD diagnosis may perpetuate the cycle of offending by causing parents, teachers, and peers to treat the juvenile negatively, which in turn increases the antisocial behavior of the juvenile. ASPD may also be confused with psychopathy, a term with even greater negative connotation and which can result in judicial determinations based on the inaccurate attribution of psychopathic traits to the defendant. Due to the often significant consequences to the juvenile as a result of being transferred to adult court, a diagnosis with such a high possibility of inaccurate use and unfair prejudice to the juvenile defendant should not be considered by juvenile courts.

While ASPD is a diagnosis accepted by many clinicians and can be used to understand the overall personality structure of an individual, the potential for abuse or misunderstanding of the term in the juvenile justice system outweighs the potential value, and federal courts should refuse to use or consider this terminology when determining whether to transfer a juvenile to adult criminal court.

¹⁷⁰ Steinberg & Scott, *supra* note 100, at 1015.