

Psychopathic Disorder – Concept or Chimera*

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‘A devil, a born devil, on whose nature Nurture can never stick;
on whom my pains Humanely taken, all, all lost, quite lost.’

The Tempest, IV,i.

‘And thus I clothe my naked villainy ...

And seem a saint when most I play the devil.’

Richard III, I,ii.

This paper, which is divided into five parts, has been prompted by the continuing interest in the complex and emotive topic of psychopathic disorder¹ and the possibility of a government Bill aimed at revising the current mental health legislation being introduced in 2003. The unclear nature of the condition and the controversies surrounding it are well encapsulated in the two quotations that head this paper. One or two other literary allusions will also be called in aid later.

Background

Some twenty-five years ago I made the following observations in a paper that appeared in the *Prison Service Journal*.²

Imagine if you can, a top-level conference has been called to discuss the meaning of that much used and abused word *psychopathy*. You are privileged to be an observer at these discussions at which are present psychiatrists, psychologists, sociologists, lawyers, sentencers, theologians, philosophers, staff of penal establishments and special hospitals and social workers. You have high expectations that some total wisdom will come from this well-informed and experienced group of people and that a definition will emerge that will pass the closest scrutiny of all concerned. After all, *this* is a

* The sub-title is taken from Chapter 5 of the first edition of my book *Offenders, Deviants or Patients? – An Introduction to the Study of Socio-Forensic Problems*, (1980, Tavistock), its purpose being to leave readers to judge the extent to which we have moved in our understanding in something over twenty years.

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1 For purposes of brevity and convenience the term ‘psychopathic disorder’ is used here to encompass severe anti-social personality disorder, dissocial personality disorder and, perhaps more controversially, dangerous severe personality disorder (DSPD).

2 Prins, H. (1977) ‘I think they call them Psychopaths’, *Prison Service Journal*, 28: 8–9.

gathering of experts. Alas, your expectations would have a quality of fantasy about them, for in reality you would find as many definitions as experts present. Let me just present one or two examples of this statement. There would be little agreement amongst psychiatrists; for some continental psychiatrists, the term would be used to cover a very wide range of mental disorders, including those we might describe as neuroses in this country; for some psychiatrists (for example, from the United States) the term might include minor disorders of personality and for others, the term might be synonymous with what we would describe as recidivism. The lawyers in the group would disagree also. Some might well accept the definition in the Mental Health Act, 1959 ... [as it then was] ... which describes psychopathy as a 'persistent disorder or disability of mind (whether or not including subnormality of intelligence) which results in abnormally aggressive behaviour or seriously irresponsible conduct on the part of the patient and requires or is susceptible to medical treatment ...' However, they would immediately begin to ask questions about the legal implications of the words 'disability of mind' and 'irresponsible conduct'. At this stage, the philosophers would no doubt chip in and also ask searching questions about the same terms. Later on in the discussion, a theologian might start asking awkward questions about the differences between 'sickness' and 'sin' and 'good' and 'evil'.³ The representative from the field of sociology in the group might usefully remind us that psychopaths lack what they describe as a capacity for role-taking, i.e. seeing yourself in an appropriate role in relation to others in their roles in [their] environment. And so the discussion would go on and on. Don't assume that it has ever been different. For one hundred and fifty years the arguments have raged over definition, classification and management. (pp. 8–9).

Readers of this Journal might well ask 'Have things changed much since you wrote that?' To which I would be forced to answer, 'not that much'. Today, such a group might well be somewhat more representative. We could usefully find space for a geneticist, a developmental paediatrician, representatives from the Home Office and Department of Health, from the voluntary sector (who do so much to cope with these 'hard to like' individuals) and who knows, in this more progressive day and age – a consumer of the service and a victim? A more recent and near parallel to such an hypothetical group can perhaps be seen in the large conference called by the Secretaries of State for Social Services and the Home Department in July 1999, to receive and comment upon their joint proposals for dealing with the management of those persons exhibiting dangerous severe personality disorder (DSPD). As one who was asked to comment upon the proposals at this conference, I was painfully aware of the continuing complexities surrounding the phenomenon we label psychopathic disorder.⁴ It is of particular interest to note that the government (perhaps very wisely) only provided a loose definition of what they understood dangerous severe personality disorder to be and expressed the firm intention to fund major research into the problem – an intention currently being put into practice.⁵ Recent concerns about those individuals posing a

3 For an up-dated discussion of this aspect see Prins, H. (1994) 'Psychiatry and the Concept of Evil: Sick in Heart or Sick in Mind.' *British Journal of Psychiatry*, 165: 297–302.

4 See Home Office and Department of Health (1999) *Managing Dangerous People With Severe Personality Disorder: Proposals For Policy Development*. July 1999. A shortened version of my address may be found in Prins, H. (1999) 'Dangerous Severe Personality Disorder: An Independent View'. *Prison Service Journal*, 126 8–10.

5 Personality disorder is referred to in the document as 'an inclusive term referring to a disorder of the development of personality' ... 'and is not a category of mental illness' (p.5 footnote 1). At page 9, the document states that the phrase 'dangerous severely personality disordered ((DSPD) is used in this paper to describe people who have an identifiable personality disorder to a severe degree, who pose a high risk to other people because of serious anti-social behaviour resulting from their disorder'. These definitions can reasonably be regarded as 'loose'.

serious threat to others and the manner in which successive governments have sought to deal with them have already been addressed by me in this Journal. I shall therefore not repeat them here, but proceed directly to some observations on the development of the concept of psychopathic disorder.⁶

Development of the concept

There are numerous accounts of the development of the concept of psychopathic disorder and, at the risk of being accused of a degree of invidious selection, I shall only refer to one or two specifically. For those wishing to pursue this aspect in more depth the references quoted in footnote⁷ may be of assistance. Although the French psychiatrist Pinel is usually credited with the first description of clinical cases of psychopathic disorder in 1806, there must have been persons exhibiting those characteristics we would regard as psychopathic long before Pinel's time. From an historical perspective one could cite such characters as Gilles de Rais – the sexual sadistic murderer of children, Vlad the Impaler and numerous others. An example from Biblical times is said to be that of Samson, described (no doubt somewhat with tongue in cheek) by Dr. Eric Altschuler of the University of California. According to him, Samson had a number of adult psychopathic characteristics; moreover, as a child Samson showed severe personality disorder, 'setting things on fire, torturing animals and bullying other children'. Doctor Altschuler also cites Samson's mother as a possible pathogenic element in his development. Apparently, in the account in the Book of Judges, 'she is warned not to drink while she is pregnant'. Dr. Altschuler concludes that 'Recklessness and a disregard for others may have run in the family.'⁸ To return to Pinel. It is likely that he included a number of cases in his examples that we should not consider today as falling within current classifications. It was in the 1830's that the English alienist (psychiatrist) and anthropologist Prichard formulated his well known concept of 'moral insanity'. He described it thus:–

a madness, consisting of a morbid perversion of the natural feelings, affections, inclinations, temper, habits, moral dispositions and natural impulses, without any remarkable disorder or defect of the intellect or knowing or reasoning faculties, and particularly without any insane illusion or hallucination. (Emphases added). (p.135).⁹

In the context of this quotation we should note that 'moral' meant emotional and psychological and was not intended to denote the opposite of 'immoral' as used in modern parlance. This view of 'moral insanity' rested on the then, fairly widely held, controversial belief that there could be a separate moral sense that could, as it were, be diseased. This early notion finds resonance in

6 See Prins, H. (2002) 'Incapacitating the Dangerous in England and Wales – High Expectations – Harsh Reality.' *Journal of Mental Health Law*, (February: 5–20. (Notably at pp 5–8). For useful commentary on current concerns see also Laing (1999), in this Journal, 'An End to the Lottery? – The Fallon Report on Personality Disordered Offenders'. October, 87–104.

7 A summary of some of the earlier writings on the topic may be found in H. Prins (1980) *Offenders, Deviants or Patients?* Chapter 5 at pp 139–141. Some writers are, of course, seminal; for example, H. Cleckley, in his *Mask of Sanity*. (Fifth Ed), (1975, C.V. Mosby Co.). McCord, W. and McCord, J. *Psychopathy and*

Delinquency. (1956, Grune and Stratton). Lewis, A. (1974) 'Psychopathic Personality: A Most Elusive Category.' *Psychological Medicine*, 4: 133–40. In more recent times the work of Professor Robert Hare has had an important influence in the areas of diagnosis. For a summary see for example, Hare, R. *Without Conscience: The Disturbing World of the Psychopaths Amongst Us*. (1993, Pocket Books).

8 As reported in *The Independent* of February 15th, 2002, citing a paper in *The New Scientist*.

9 Prichard, J.C. *Treatise on Insanity*. (1835, Gilbert and Piper).

Cleckley's later postulation that psychopathy was a particular form of 'illness'. Prichard's views need to be seen against the background of the very rudimentary state of psychiatric and psychological knowledge during his lifetime. In the 1880's, Koch formulated the concept of *constitutional psychopathy*, implying that there was a considerable innate predisposition; a line of thinking much in keeping with the then contemporary interest in hereditary factors in the causation of delinquency. It is interesting to note a comparable re-awakening in more recent times in the study of neuro-physio-psychological processes in the causation of persistent deviancy.¹⁰ In 1910, Mercier laid claim to have been the originator of the terms 'moral defective' and 'moral imbecile' – these eventually finding their way into the Mental Deficiency Act of 1913 (and subsequently changed to somewhat less pejorative descriptions in an amending Act of 1927). Certain trends in the 1930's were of importance. Findings from the disciplines of neurology and physiology were being applied to behaviour disorders – prompted no doubt by the sequelae of the widespread epidemics of disorders such as epidemic encephalitis. Freudian perspectives were also being applied increasingly to deviant behaviour in the work of psycho-analytically orientated medical and non-medical professionals such as Melitta Schmideberg, Kate Friedlander, Anna Freud and August Aichorn; they were all interested in the possible childhood roots of serious anti-social behaviour.¹¹ In 1939, Henderson – a distinguished British psychiatrist – published his famous work *Psychopathic States*. He considered that the psychopath's 'failure to adjust to ordinary social life is not a mere wilfulness or badness which can be threatened or thrashed out ... but constitutes a true illness'.¹² Since the nineteen-sixties attention has been focused on the management of adult psychopathically disordered individuals within institutional settings, notably those adopting a therapeutic community or 'social milieu' approach. Figures eminent in this field include psychiatrists such as Jones and Whiteley.¹³

Summarising the foregoing, it is possible to trace three important themes in the development of the concept. The *first*, as Coid¹⁴ has suggested, was the concept of abnormal personality as defined by social maladjustment – developed in France and later in the UK – leading to the current legal definition of psychopathic disorder (of which more later). The *second* was the concept of mental degeneracy, also originating in France. The *third* was the German notion of defining abnormal psychopathic personality types, as illustrated in the work of Kurt Schneider.¹⁵ In addition, the concept has not been without attention from central government over the years. It was considered by the Butler Committee as long ago as the early nineteen-seventies, subsequently in a joint DHSS and Home Office Consultation Document on the topic in 1986, by the Reed Committee in 1994,

10 See, for example, Blair, J., and Frith, U. (2000) 'Neurocognitive Explanations of the Anti-social Personality Disorders.' *Criminal Behaviour and Mental Health*, 10: S66–S81. (Special Supplement).

11 For an interesting compilation of thirties and forties accounts of work in this field see Eisseler, K.R. (ed) *Searchlights on Delinquency: New Psychoanalytic Studies*. (Imago Publishing, 1949). The later work of Lee Robins is also seminal in this area; see, for example, Robins, L.N. *Deviant Children Grown Up. A Sociological and Psychiatric Study of Sociopathic Personality*. (1966, Williams and Wilkins). The work of Bowlby on attachment theory has been of profound importance; see, for example, Bowlby, J. *The Making and Breaking of Affective Bonds*. (1979, Tavistock).

The work of Sir Michael Rutter has also been of great significance; see Rutter M.L. (1999) 'Psychosocial Adversity and Child Psychopathology.' *British Journal of Psychiatry*, 174: 480–493.

12 Henderson, D. *Psychopathic States*. (1939, Norton). p. 13.

13 See, for example, Jones, M. (1963) 'The Treatment of Character Disorders.' *British Journal of Criminology*, 3: 276–282. And, Whiteley, J.S. (1994), 'In Pursuit of the Elusive Category.' *British Journal of Psychiatry Review of Books*, 7: 14–17.

14 Coid, J. 'Current Concepts and Classifications in Psychopathic Disorder.' In P. Tyrer and G. Stein (eds) *Personality Disorder Reviewed*. (Gaskell, 1993).

15 Schneider, K. *Psychopathic Personalities*. (1958 Cassell).

and most recently in the joint Home Office and Department of Health policy development document to which I have already referred.¹⁶ I have provided representation of the stages through which the concept has passed in *Figure I*.

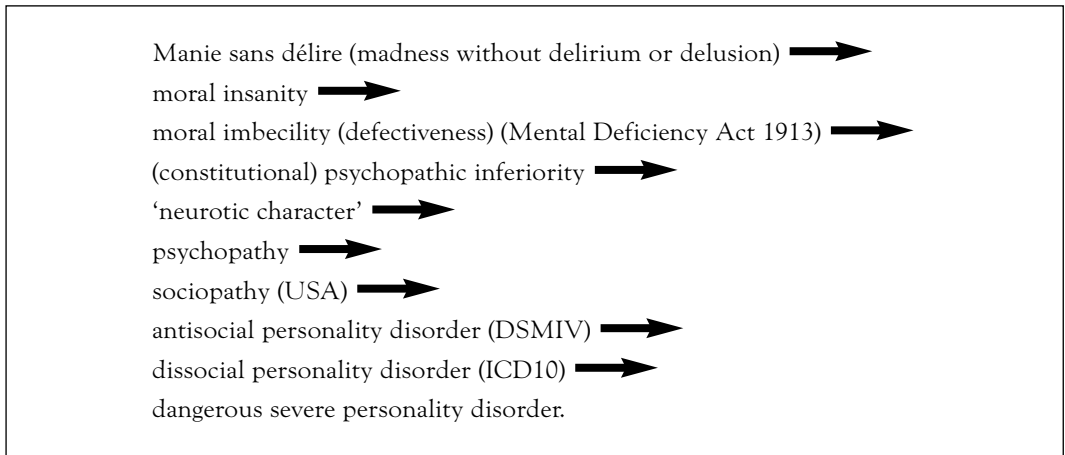


Figure I From Pinel (1806) to Home Office and Department of Health 1999

Causes and characteristics

There is vast literature concerning the postulated origins of psychopathic disorder and an equally vast literature on its characteristic features. No attempt is made here to review this literature at great length, merely to address certain aspects of it as a prelude to some discussion of problems of management.¹⁷ Postulated origins have included genetic and hereditary factors, cortical immaturity showing brain-waves more commonly found in children and close familial and environmental influences. Professor Coid, a respected authority in the field, advocates caution in espousing the notion of psychopathic disorder as a single entity. He suggests that

The sheer complexity and range of psychopathology in psychopathic disorder has previously led to the suggestion that these individuals could be considered to suffer from a series of conditions that would best be subsumed under a broad generic term 'psychopathic disorders' rather than a single entity.¹⁸

16 See Home Office and Department of Health and Social Security, *Report of the Committee on Mentally Abnormal Offenders*. (Chairman, Lord Butler of Saffron Walden). Cmnd. 6244. (HMSO, 1975). Department of Health and Social Security and Home Office, *Consultation Document: Offenders Suffering From Psychopathic Disorder*. (1986, HMSO). Department of Health and Home Office, *Report of the Department of Health and Home Office Working Group on Psychopathic Disorder*. (Chairman, Doctor John Reed, CB. (1994, HMSO). The whole topic was also considered in considerable depth by the Fallon Committee in its inquiry into the Personality Disorder Unit at Ashworth Hospital. See Volume II of the

Report, which contains very extensive expert evidence on the nature of personality disorder. Report of the Committee of Inquiry into the Personality Disorder Unit, Ashworth Special Hospital. Chairman His Honour Judge Fallon, Cm 4195. (1999, TSO).

17 A useful review of all these aspects may be found in Livesley, W.J., (ed), *Handbook of Personality Disorders: Theory, Research and Treatment*. (2001, Guilford Press). For a predominantly UK perspective, see Tyrer, P. and Stein, G. (eds), *Personality Disorder Reviewed*. (1993, Gaskell).

18 Coid, J.W. (1989) 'Psychopathic Disorders.' *Current opinion in Psychiatry*, 2: 750–756.

In recent times, interest has been revived concerning possible 'organic' causes, including both major and minor cerebral 'insults' in infancy and in the consequences of obstetric complications. If such developments subsequently prove to have unequivocally firm foundations, one could envisage a situation where issues of responsibility (and notably diminished responsibility) may well have to be addressed. This is an arena already fraught with problems concerning the relationship between medicine (notably neurology and psychiatry) and the law. The environment has also been held to play a powerful part in the aetiology of the disorder. It may well be, that as with similar mental disorders, such as the schizophrenias, it is the interplay of social forces and pressures acting upon an already vulnerable personality (for whatever reason) that may tend to produce the condition. Some of the highly complicated and sophisticated neuro-physio-chemical research undertaken in recent years fosters speculation that *some* of the answers to the problem of aetiology may eventually be found in the area of brain biochemistry. Other possibilities are of equal interest. For example, one cannot ignore the evidence, admittedly laboratory-based, of such factors as low anxiety thresholds, cortical immaturity, frontal lobe damage and, perhaps most relevant of all, the *true* (as distinct from the wrongly labelled) psychopath's need for excitement – the achievement of a 'high'. Such a need is described very graphically in Wambaugh's account of the case of Colin Pitchfork. Pitchfork was convicted of the rape and murder of two teenage girls in Leicestershire during the period 1983–1986. In interviews with the police, it is alleged he stated that he obtained a 'high' when he exposed himself to women (he had previous convictions for indecent exposure prior to his two major offences); he also obtained a 'high' from the knowledge that his victims or likely victims were *virgo intacta*. He is said to have also described an additional aspect of his excitement, namely obtaining sex outside marriage. As with others assessed as psychopathic, he also demonstrated a great degree of charm; for example, he was able to get his wife to forgive him for a number of instances of admitted unfaithfulness. (Pitchfork's case is also of interest in that it involved the earliest attempt to use DNA profiling – a practice that now seems fairly routine).¹⁹

Some Key Characteristics

Some of these have already been alluded to above. Sir Martin Roth, a doyen of British psychiatry, has suggested (in summary form) that the key features are egotism, immaturity in various manifestations, aggressiveness, low frustration tolerance and the inability to learn from experience so that social demands and expectations are never met.²⁰ Roth's brief listing encapsulates many of the more detailed characteristics suggested by Cleckley in the various editions of his seminal work *The Mask of Sanity*.²¹ To these items I would add the following three elements. *First*, the curious *super-ego lacunae*, rather than the *total* lack of conscience suggested by some authorities. *Second*, the greater than usual need for excitement and arousal to which I have already referred. *Third*, a capacity to create chaos among family, friends, and those involved in trying to manage or contain them. I would suggest that this last characteristic is one of the most accurate indicators of the *true*, as distinct from the pejoratively labelled, psychopath and is one often attested to by those who have had extensive clinical experience of dealing with the psychopathic. The lack of true feeling content (empathy) exhibited by the psychopath was stated graphically some forty years ago by

19 Wambaugh, J. *The Bleeding*. (1989, Bantam Books).

20 Roth, Sir Martin, 'Psychopathic (Sociopathic) Personality.' In R. Bluglass and P. Bowden (eds),

Principles and Practice of Forensic Psychiatry. (1990, Churchill Livingstone).

21 See footnote 7 *supra*.

Johns and Quay in their comment that psychopaths ‘know the words but not the music’.²² Rieber and Green add four salient characteristics in support of the foregoing. These are thrill-seeking, pathological glibness, anti-social pursuit of power and absence of guilt. They also give great prominence to the element of thrill-seeking. They describe the psychopath as ‘performing a Mephisto Waltz on the tightrope of danger’.²³ It is as though this phenomenon of ‘thrill-seeking’ is necessary to fill the emotional void so often encountered in the psychopathically disordered. This internal ‘emptiness’ has also been stressed by Whiteley. He quotes a former patient writing to him from prison:

I thought everything I said, did and thought was not real, that I was not real, almost as though I did not exist, so I could never affect anyone because I was not real, no-one could possibly take me seriously because I was not real. (p.16).²⁴

If we see psychopathic disorder as a developmental process then we need not rely exclusively upon clinical depictions. Its nature, early onset and manifestations are depicted clearly in the aged Duchess of York’s reviling of her son Richard III in Act IV Sc. iv of Shakespeare’s play.

... Thou cam’st on earth to make the earth my hell.
A grievous burden was thy birth to me;
Tetchy and wayward was thy infancy;
Thy school-days frightful, desp’rate, wild and furious.
Thy prime of manhood daring, bold and venturous;
Thy age confirm’d, proud, subtle, sly and bloody,
More mild, but yet more harmful kind in hatred.
What comfortable hour can’st thou name
That ever grac’d me with thy company?

Here, we have the aged Duchess describing graphically some of the characteristics we regard as important in terms of both aetiology and presentation. For example, an apparently difficult birth, long-standing anti-sociality (a requirement of the DSM-IV(R), the ICD 10 and current mental health legislation in England and Wales), becoming more marked in adulthood; all this accompanied by a veneer of charm and sophistication which only serves to act as a mask for the underlying themes of chaos and potential for destructiveness.²⁵

Describing and trying to delineate a disorder has the advantage of hopefully setting some boundaries to it and creating typologies that may assist in management, even if the latter is highly

22 Johns, J.H. and Quay, H.C. (1962) ‘The Effects of Social Reward on Verbal Conditioning in Psychopathic and neurotic Military Offenders.’ *Journal of Consulting Psychology*, 26: 217–220.

23 Rieber, R.W. and Green, M.R. (1988), *The Psychopathy of Everyday Life*. Unpublished Manuscript. Quoted in Egger, S.Q., *Serial Murder: An Elusive Phenomenon*. (1990, Praeger). (p.82).

24 Whiteley, J.S. (1994) ‘In Pursuit of the Elusive Category.’ *British Journal of Psychiatry Review of Books*, 7: 14–17.

25 American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders. IV(R)*. (1994, Washington DC). World Health Organisation. *The ICD-10 Classification of Mental and Behavioural*

Disorders: Clinical Descriptions and Diagnostic Guidelines. (1992, Geneva). It should be noted that neither the DSM nor the ICD 10 refer to psychopathic disorder; the former refers to anti-social personality disorder and the latter to dissocial personality disorder. Neither descriptions equate exactly with the current legal description – psychopathic disorder – a word that numerous committees have suggested abandoning, preferring personality disorder – which would not be defined further. (See also footnote 17 *supra*). However, we should perhaps be mindful of the reference to ‘naming’ in *Romeo and Juliet*: ‘What’s in a name? That which we call a rose by any other name would smell as sweet.’ (Act II, Sc ii). Changing the name will not necessarily do away with our dislike for such patients/clients/offenders.

problematic (as we shall see shortly). We should also note that a number of authorities feel that the current espousal of the term 'psychopathic' is unhelpful, see for example, Blackburn, Cavadino, Lewis and Appleby.²⁶

Some problems of management

This section of the paper is divided into two parts. *Part One* deals predominantly with legal aspects and *Part Two* with clinical matters. To a great extent the two elements should be seen as a whole, but in an attempt to achieve clarity, I have chosen to split them. Readers should note that this a largely artificial (and somewhat pedantic) distinction.

Part One – Legal Aspects

The nature of psychopathic disorder and the problems it has presented to courts and counsel, are likely to bring to the fore powerful views as to the nature of the attitudes towards the disorder. This state of affairs is exemplified usefully in two brief quotations. Mr. Bumble, the Beadle in *Oliver Twist*, says 'The Law is a ass, a idiot', and the redoubtable jurist Lord Coke stated that 'The Law is the perfection of reason.' In England and Wales, a legal definition of psychopathic disorder was first introduced in the Mental Health Act, 1959. (In Scotland and Northern Ireland the term is not used directly). In the 1959 Act, treatability was linked to the definition of the disorder ... 'and requires, or is susceptible to treatment'. Section 1(4). The definition of the disorder was left substantially unchanged in the 1983 Act, with the important exception of the removal of the sentence relating to treatability; the latter finds expression in Sections 3,37 and 45A of the Act, where it must be demonstrated that ... 'such treatment is likely to alleviate or prevent a deterioration of his condition'. (Emphasis added). Section 45A of the 1983 Act (inserted by Section 46 of the Crime (Sentences) Act, 1997) makes provision for the so-called 'Hybrid Order'. This enables a Crown Court to impose a sentence of imprisonment upon an offender (but only in cases where the sentence is not fixed by law, e.g. in convictions for murder). The patient must be diagnosed as suffering from psychopathic disorder and the court may direct that such an individual shall be admitted to a specified hospital. The provision is known as a 'Hospital and Limitation Direction'. Should the offender/patient no longer need, or be responsive to, treatment before his or her release date, the Responsible Medical Officer may seek the offender/patient's transfer to prison. The 'limitation' element has the effect of a Restriction Order under Section 41 of the 1983 Act. As far as can be ascertained, at the time of writing, it appears that courts have been slow to utilise this new provision. The change occurred due to a growing and understandable reluctance on the part of psychiatrists to manage such people. In the late nineteen-fifties there was a degree of optimism that psychiatry and psychiatrists had the answers not only to treatable *mental illness* (such as the major psychoses, e.g. the schizophrenias and affective psychoses) but that this optimism (which was not wholly justified or eventually sustainable even for the psychoses) could be extended to forms

26 Blackburn, R. (1988) 'On Moral Judgements and Personality Disorders: The Myth of Psychopathic Personality Revisited.' *British Journal of Psychiatry*, 153: 505-512. Cavadino, M. (1998) 'Death to the

Psychopath.' *Journal of Forensic Psychiatry*, 9: 5-8. Lewis, G. and Appleby, L. (1988) 'Personality Disorder: The Patients Psychiatrists Dislike.' *British Journal of Psychiatry*, 153: 44-49.

of mental *disorder* such as psychopathy.²⁷ Professor John Gunn has suggested an additional reason for the change of emphasis regarding treatability. This lies in the parlous state of general psychiatric provision, more particularly in large conurbations such as London.²⁸ The legal connotations of treatment have resulted in a number of court rulings, both in England and Wales and in Scotland. In the case of *R. v. Canons Park Mental Health Review Tribunal (ex parte A. 1995. QB 60)*, the Court of Appeal held that a mere refusal of a patient to participate in group psychotherapy did not, of itself, indicate untreatability. A case in Scotland *Reid v. Secretary of State for Scotland (1999)* re-opened the whole issue.²⁹ In brief, this case concerned an offender-patient detained without limit of time under the provisions of the Scottish Mental Health Act, 1984. In a ruling, the Law Lords held that under Section 145(1) of that Act, medical treatment was to be given a broad meaning and that supervised care which endeavoured to prevent deterioration of the *symptoms*, but not the *disorder itself*, might in a *particular case* justify liability to continued detention. (Emphases added). In hearing this case the Law Lords decided *inter alia* that the Canons Park case had been wrongly decided. Eldergill summarises the degree of latitude which appears to be allowed currently:

It can be seen that the treatability condition is satisfied if medical treatment in its broadest statutory sense – which includes nursing care – is *eventually* likely to bring some symptomatic relief to prevent the patient's mental health from deteriorating. *There are few (if any) conditions which are not treatable in this sense.* (p.225).³⁰

However, the saga does not end with the decision in that case. There have been continuing concerns about possible loopholes in the law that would allow dangerous psychopaths to obtain their freedom. Again, in Scotland, the case of Ruddle³¹ led the Scottish Parliament to pass, as a matter of urgency, the Mental Health (Public Safety and Appeals) (Scotland) Act, 1999, which has added public safety to the grounds for not discharging patients under Scottish mental health legislation. The main effect of this legislation was to change the definition of mental disorder 'to mental illness (including personality disorder) or mental handicap however caused or manifested' and to require continued detention of a restricted patient 'if the patient is suffering from a mental disorder the effect of which is such that it is necessary in order to protect the public from serious harm, that the patient continues to be detained in a hospital whether for medical treatment or not'.³² 'One of the "incidental" effects of this enactment has been to clarify the fact that personality disorder [had] always been included (but by implication only) within the meaning of mental disorder in Scottish mental health legislation.' (op.cit.). Crichton *et al.* suggest that the Act of 1999 merely plugged 'a

27 As to whether personality disorder (psychopathy) is an illness or a disorder see Kendall. Kendall suggests that 'The historical reasons for regarding personality disorders as fundamentally different from mental illnesses are being undermined by both clinical and genetic evidence. Effective treatments for personality disorders would probably have a decisive influence on psychiatrists' attitudes.' Kendall, R.E. (1999) 'the Distinction Between Personality Disorder and Mental Illness.' *British Journal of Psychiatry*, 180: 110–115.

28 Gunn, J. (1999) 'The Ashenputtel Principle.' *Criminal Behaviour and Mental Health*, 9: 205–206.

29 1999 2 WLR 28.

30 Eldergill, A., *Mental Health Review Tribunals: Law and Practice.* (1997, Sweet and Maxwell).

31 *Ruddle v. Secretary of State for Scotland* 1999 GWD 29 1395.

32 Crichton, H.M., Darjee, R., McCall Smith, A. and Chiswick, D. (2001) 'Mental Health (Public Safety and Appeals) (Scotland) Act, 1999: Detention of Untreatable Patients With Psychopathic Disorder.' *The Journal of Forensic Psychiatry*, 12: 647–661.

loophole' and that further developments should wait upon any action that may be taken as a result of the two major reviews of Scottish mental health legislation and practice by the Millan and Maclean Committees.³³

Part Two – Clinical Matters

From all that I have written so far, it should be obvious that those labelled as psychopathic present enormous psycho-socio-legal problems and that their day-to-day management causes the professionals involved both 'headache' and 'heart-ache'. Indeed, the heading of this sub-section of the paper might well have been called 'encounters of an uncomfortable kind'. Some aspects of mental health and criminal justice professionals' engagement in these 'encounters' have already been touched upon and the intention in this section is merely to highlight some of them further. My late friend and colleague – Doctor Peter Scott – addressed some of these issues over twenty-five years ago in a very thought-provoking paper entitled *Has Psychiatry Failed in the Treatment of Offenders?*³⁴ Scott suggested that we most frequently fail those who need us most. These individuals frequently fall into two (perhaps overlapping) categories, the 'dangerous offender' and the 'unrewarding', 'degenerate' and 'not nice' offender. Of the 'embarrassing' patient Scott maintained that he/she is the patient who is 'essentially the one who does not pay for treatment, the coin in which patients pay is '(i) dependence – i.e. being manifestly unable to care for themselves, and thus appealing to the maternal part of our nature; (ii) getting better (responding to our "life-giving" measures); (iii) in either of these processes, showing gratitude, if possible cheerfully'. (p.8) In other words, those patients/clients/offenders that Scott had in mind are just the ones who reject our 'best efforts', are manipulative and delight in giving us a pretext for rejecting them, so that they can continue on their 'unloved' and 'unloving' way. In Scott's terms, 'the "not nice" patients are the ones who habitually *appear* to be well able to look after themselves but don't and, as stated above, reject attempts to help them, break the institutional rules, get drunk, upset other patients, or even quietly go to the devil in their own way quite heedless of nurse and doctor'. Scott went on to suggest other factors which are highly relevant to any consideration of the management of *so-called* psychopaths.³⁵ (Emphasis added). He stated that:

There is a natural philanthropic tendency to extend help to the defenceless – probably an extension of parental caring ... if this fails so that embarrassing people or patients are seen to accumulate, then anxiety is aroused and some form of institution is set up to absorb the problem ... Not all embarrassing patients like being tidied up and these tend to be compulsorily detained ... Within the detaining institution two opposing aims begin to appear – the therapeutic endeavour to cure and liberate on the one hand, and the controlling custodial function on the other. (p.9).

Scott went on to suggest that although these functions should be complementary 'there is a tendency for them to polarise and ultimately, to split, like a dividing cell, into two separate

33 Millan, (Chairman), *Review of the Mental Health (Scotland) Act, 1984: First Consultation*. (1999, S.O.) Maclean, Lord, (Chairman), *Report of the Committee on Serious Violent and Sexual Offenders*. (2000, Scottish Executive). See also, Darjee, R. and Crichton, J.H.M. (2002) 'The Maclean Committee: Scotland's Answer to the "Dangerous People with Severe Personality Disorder" Proposals?' *Psychiatric Bulletin*, 26: 6–8.

34 Scott, P.D., *Has Psychiatry Failed in the Treatment of Offenders?* (1975, Institute For the Study and Treatment of Delinquency (ISTD)).

35 I emphasise the word *so-called* here because Scott did not feel there was much merit in distinguishing psychopaths from hardened chronic (recidivist) criminals – a minority view. See Scott, P.D. (1960) 'The Treatment of Psychopaths.' *British Medical Journal*, 2: 1641–1646.

institutions’. However, he suggests that ‘neither of the two new institutions can quite eliminate the tendency from which it fled, so that the therapeutic institution now begins to miss the custodial function and tries hard to send some of its patients back to custody, and the custodial institution is unable to tolerate being unkind to people all the time and begins to set up a new nucleus of therapy’. (p.10). In time, each institution may divide. It would seem to me that Scott’s perceptive ‘managerial’ observations should be considered carefully by those involved in devising the future institutional care for DSPD individuals envisaged in the policy development paper.³⁶ So, these are the unlikeable clients/patients/offenders. Often the dislike will operate at an unconscious level. Three quotations from the views of psychiatrists are useful in illustrating this problem and their words are applicable to all professionals working in the field of criminal justice and forensic-psychiatry. Maier suggests:

Could it be after all these Freudian years, that psychiatrists have denied the hatred they feel for psychopaths and criminals, and thus have been unable to treat psychopaths adequately because their conceptual basis for treatment has been distorted by unconscious, denied feelings from the start? (p.766).³⁷

A somewhat similar view is proffered by Treves-Brown:

As long as a doctor believes that psychopaths are mostly ‘bad’, his successful treatment rate will be dismal. Since it takes two to form a relationship, an outside observer could be forgiven for suspecting that a doctor who describes a patient as unable to form a relationship, is simply trying to justify his own hostility to this patient. (p.63).³⁸

And the late Doctor Donald Winnicott – doyen of child psychiatry, writing over fifty years ago about the ‘anti-social tendency’, gave further support for such views – as follows:

However much he loves his ... [hard to like] ... patients he cannot help hating them and fearing them, and the better he knows this the less will hate and fear be the motives determining what he does for his patients. (p.71).³⁹

Despite the unattractiveness of such patients and the sometimes unconscious reactions of therapists, a number of forensic-psychiatric and criminal justice professionals have expressed a degree of optimism about treatment. Some years ago Tennent *et al.* sought the opinions of psychiatrists, psychologists and probation officers about treatability. The survey was admittedly small, as was the response rate. However, there was reasonable evidence to suggest that although there were few clear-cut views as to the best treatment modalities, there were clear indications as to those felt to be helpful. For example, there were higher expectations of treatment efficacy with symptoms such as ‘chronically anti-social’, ‘abnormally aggressive’ and ‘lacking control over impulses’ and much lower expectations for symptoms such as ‘inability to experience guilt’, ‘lack of remorse or shame’ and ‘pathological egocentricity’.⁴⁰ Some support for the findings of this modest survey can be found in a more extensive survey by Cope on behalf of the Forensic Section

36 See footnote 5 *supra*.

37 Maier, G.J. (1990) ‘Psychopathic Disorders: Beyond Counter-Transference.’ *Current Opinion in Psychiatry*, 3: 766–769.

38 Treves-Brown, C. (1977) ‘Who is the Psychopath?’ *Medicine, Science and the Law*, 17: 56–63.

39 Winnicott, D.W. (1949) ‘Hate in the Counter-

Transference.’ *International Journal of Psychoanalysis*, 30: 14–17. For a recent very extensive and perceptive study of denial in all its forms, see Cohen, S., *States of Denial: Knowing About Atrocities and Suffering*. (2001, Polity Press).

40 Tennent, G., Tennent, D., Prins, H. and Bedford, A. (1993) ‘Is Psychopathic Disorder a Treatable Condition?’ *Medicine, Science and the Law*, 33: 63–66.

of the Royal College of Psychiatrists. Cope surveyed all forensic psychiatrists working in Secure Hospitals, units and similar settings in England and Wales. The majority of her respondents (response rate 91%) were in favour of offering treatment to severely personality disordered (psychopathic) patients.⁴¹ Some explanation for this optimism derives from another source. In a fairly recent attempt to ascertain the motivations of consultant forensic psychiatrists for working in forensic settings, I discovered that one of the attractions of the work was the challenge presented by psychopaths.⁴² Another fact that emerged from my survey was the need for forensic psychiatrists to work with and encourage their colleagues in general psychiatry to deal with such patients; a point made very cogently recently by Professor John Gunn.⁴³

Some of the statements made by my respondents were very illuminating. One of them enjoyed the challenge presented by the severity and complexity of the cases which produced 'a kind of appalled fascination'. Another attraction was the chance to work with a wide range of agencies and disciplines and to pursue a more eclectic approach to patient care. Stimulation was another important factor (a factor shared with the psychopathic – see earlier discussion). One stated 'I could not envisage twenty years of listening to the neurotic and worried well'; 'after forensic psychiatry, other specialities seemed very tame and had much less variety and challenge'.

Whatever form of professional training is eventually formulated in order to deal more effectively with psychopathically disordered individuals, understanding and management will only be successful through the adoption of a truly multi-disciplinary approach (as suggested in the 'imaginary' seminar quoted at the beginning of this contribution). Such an approach would not only serve to take the broadest possible view of the topic but, at a narrower clinical level, should help to obviate potential missed diagnoses (for example, the importance of organic factors such as brain damage). Severely dangerous and deviant behaviour requires calm and well-informed confrontation. In the words of the late George Lyward – a highly gifted worker with severely personality disordered boys – 'Patience is love that can wait'. Coupled to this is the need to tolerate, without loss of temper, the hate, hostility, manipulation, and 'splitting' shown by such individuals and an ability not to take such personal affronts as attacks. The psychiatrist and psychotherapist Penelope Campling has provided an excellent account of the management of such behaviours.⁴⁴ It is essential for professionals to have more than an intellectual understanding of what the patient has done. Sometimes, this can be 'stomach-turning' and offers many opportunities for denial on the part of the professional. Such understanding requires a degree of what has been described in another context as 'intestinal fortitude'.⁴⁵

It is worth emphasising once again the importance of the phenomenon of denial. It is not the sole prerogative of our clients/patients/offenders. For, as Pericles says in Shakespeare's play of that name, 'Few love to hear the sins they love to act', (Act I, Sc i). The more troublesome and anxiety-

41 Cope, R. (1993) 'A Survey of Forensic Psychiatrists' Views on Psychopathic Disorder.' *Journal of Forensic Psychiatry*, 4: 214–235. For a more recent study, dealing in particular with DSPD, see: Haddock, A., Snowden, P., Dolan, M., Parker, J. and Rees, H. (2001) 'Managing Dangerous People With Severe Personality Disorder: A Survey of Forensic Psychiatrists' Opinions.' *Psychiatric Bulletin*, 25: 293–296.

42 Prins, H. (1998) 'Characteristics of Consultant Forensic Psychiatrists: A Modest Survey.' *Journal of Forensic Psychiatry*, 9: 139–149.

43 Gunn, J. (2000) Editorial: 'A Millennium Monster is Born.' *Criminal Behaviour and Mental Health*, 10: 73–76.

44 See Campling, P. (1996) 'Maintaining the Therapeutic Alliance With Personality Disordered Patients.' *Journal of Forensic Psychiatry*, 7: 535–550.

45 An expression used by Michael Davies, Leader of the BBC Symphony Orchestra, in relation to the playing of certain problematic orchestral works. (BBC2 July 10, 1999).

making the relationship, the more the need *not* to go it alone. This is not an area of work that should be characterised by ‘prima donna’ activities by professionals of either sex. There are dangerous workers as well as dangerous clients/patients/offenders. There are three qualities that are of paramount importance in dealing with the severely personality (psychopathically) disordered individual. These are *consistence* (the capacity to take a firm line in the face of deflecting activities on the part of the client); *persistence* (efforts may need to be expended over very considerable periods of time, maybe years – a view that is supported by the belief in the occurrence of cortical maturation in some cases, aided by therapeutic interventions); *insistence* (the capacity to give clear indications that requirements of supervision are to be met in spite of resistance on the part of the client). Such insistence must take priority of place when expectations of what supervision requires of the client are initially set out in the professional/client relationship.

Conclusion – present and future

We should recognise that in strictly scientific terms we have few hard facts concerning the genesis of severe personality (psychopathic) disorder. What we do know is that those suffering from (or, to be more precise, making others suffer from) it are extremely difficult to work with and manage. ‘The diagnosis of personality disorder is used ... [in the government’s policy documents on DSPD] ... with apparent confidence ... and the government’s recommendations rely heavily on the premise that the term refers to a group of patients who can be clearly defined and gathered together ...’.⁴⁶ As I hope this contribution has shown, this is hardly likely to be the case in the present state of our knowledge.

It is my view that a change in name is of itself unlikely to quell anxieties and a reluctance to work with this group of individuals. Nor is the introduction of new or re-designed specially designated services likely to provide a panacea. Better use of existing and much better funding for such services, shared endeavour (and the encouragement of general psychiatry to become more involved), the encouragement of a greater degree of self-examination on the part of all concerned in the criminal justice and mental health systems may be the most productive ways forward. In June 2002, the Government produced its long-awaited Bill on the reform of mental health legislation. Interestingly, the Bill comes as a draft, and is accompanied by two documents – one containing detailed *Explanatory Notes* on the Bill, and the other is a *Consultation Document*. It would seem that the Government wishes to anticipate likely choruses of criticism and to defuse them as much as possible.⁴⁷ It is of interest to note that this highly complex and complicated proposed piece of legislation runs to some 180 sections and 9 schedules; this compares with 149 sections and 6 schedules in the 1983 Act. Implementation of the new legislation is likely to have enormous financial and human resource implications. *The Consultation Document* refers to matters that are not in the Draft Bill but which will also be brought before Parliament when the Bill is introduced. Notably, these matters concern a specialist division of a new Health Care Inspectorate, which will replace the Mental Health Act Commission; this new body will have wider powers and sharper teeth.

46 See Mann, A. and Moran, P. (2000) ‘Personality Disorder As a Reason For Action.’ *Journal of Forensic Psychiatry*, 11: 11–16. See also Laing, *op. cit.* (notably at pp. 98 *et seq*) – footnote 6 *supra*.

47 *Draft Mental Health Bill. Cm. 5538-II (2002*

Department of Health); Draft Mental Health Bill: Explanatory Notes, CM 5538-II (2002, Department of Health); Mental Health Bill: Consultation Document, CM. 5538-II. (2002, Department of Health). A consultation period has been established which will run for 12 weeks from June, 25th 2002.

There are also proposals for revised legislation in respect of children and for the protection of health care workers and numerous other matters. This is not the place to comment upon the general proposals in the draft legislation, but merely to refer to those proposals for dealing with persons demonstrating severe personality (psychopathic) disorder, and, in particular, DSPD. The Mental Health Bill was conspicuously absent from the Queen's Speech to Parliament on November 13th. This had led to some speculation that the reforms were not going to be proceeded with as a result of powerful lobbying against them. However, on November 14th, the Health Secretary, Alan Milburn indicated that the Government would press ahead with a Bill when they had finished considering the 2,000 or so responses they had received. "When we have finished considering these responses we will bring forward a Bill during the course of this session" (The Independent, November 15, p10). It will be interesting to see the extent to which some of the more controversial proposals in the present draft Bill receive some modification when the revised Bill is presented. The Government has accepted the definition of mental disorder suggested in the Richardson Review; it is presented as 'any disability or disorder of mind or brain which results in an impairment or disturbance of mental functioning. This new composite definition removes 'psychopathic disorder', and as a result the 'treatability test'. The latter, of course, had the effect of excluding a number of people considered to have a potential for dangerous behaviour towards others. *The Consultation Document* states that 'People with severe responsibility disorders will have access to services in the same way as people with other forms of mental disorder'.(p.1.) In respect of DSPD the document has this to say:

There is no separate legislation for 'DSPD'. The term, which refers to the small group of people with severe personality disorder *who also represent a high degree of risk to the public*, does not appear in the new Bill. (Emphasis added). People with personality disorders will be treated in exactly the same way as patients with other mental disorders and will come under compulsory powers if they meet the same conditions for compulsion. (p.23.)

The Consultative Document goes on to indicate that service developments (for those considered to be dangerous) are not part of legislative proposals but 'are part of the wider agenda to provide better mental health services for everyone.' (p23). However, the document goes on to indicate that services will be provided by specialist units (such as those now being developed at Rampton Hospital and HM Prison Whitemoor). Two further units are planned, one hospital and one prison based.⁴⁸ *The Consultation Document* poses a number of questions to which responses will be welcomed. One significant question in relation to this article is: Will the Legislation allow intermediate detention of dangerous offenders? The answer given is as follows:

The new legislation will allow for the detention of someone with mental disorder for as long as they pose a significant risk of serious harm to others as a result of their mental disorder, thereby meeting the conditions for compulsion. In some cases where the mental disorder, and the behaviours arising from it, are complex and difficult to manage, *and individual may be detained in hospital for a long time*. (Emphasis added). However, to safeguard people from detention where it may not be justified, the new Mental Health Tribunal will regularly review

48 For a very useful and recent account of the regime in the DSPD Unit at HMP Whitemoor see Bennett J (2002) *The Role of Prison Officers in the Dangerous and Severe Personality Disorder Unit at HMP Whitemoor: Prison Service Journal 143 (September)*;9-14. See also

Bowers L (2002) "Working Positively and Productively in a DSPD Unit; *Prison Service Journal 143 (September) 21-22* and Storey L (2002) 'Staff Development in Personality Disorder Services' *Prison Service Journal 143 (September)*: 23-27.

the patient's compulsory treatment order to consider whether the conditions for compulsion continue to be met. (p.23).

In my mind, a further question arises. What happens if staff in one of the new specialist units consider that such a person is 'untreatable' at any stage? I could not find anything in the documentation that seemed to deal with such an eventuality, but, maybe I missed it.

A fitting conclusion for this contribution can be found in a short statement by Walker and McCabe in their seminal study *Crime and Insanity in England*.

... the history of 'psychopathy' begins with the formation of a concept in the minds of philosophers and mad-doctors. Thereafter, the concept becomes linked with a succession of ill-defined terms of art, until one of these is seized on by legislators and bundled into the statute book. The resulting trouble takes half a century to recognise and remedy, and today it remains uncertain whether the remedy is entirely successful.⁴⁹

Readers are left to decide for themselves whether or not this quotation, written nearly thirty years ago, continues to reflect the position today and is also supportive of the contention in the title of this paper.⁵⁰

Acknowledgements

My sincere thanks to my wife for checking my style and grammar, and to Mrs. Janet Kirkwood for preparing the final typescript with her customary skill.

49 Walker, N. and McCabe, S. *Crime and Insanity in England*, Vol. 2. – *New Solutions and New Problems*. (1973, Edinburgh University Press). Quoted in Crichton et al. *op. cit.*

50 Since this paper was accepted, two highly relevant publications have appeared. Sugarman has discussed the meaning of the term 'unsound mind' within the European Convention context in respect of the Human Rights Act 1998 and the *Journal of Criminal*

Behaviour and Mental Health has produced a useful supplement to its current issue focussing on severe personality disorders. (See Sugarman P.A. (2002) *Persons of Unsound Mind, Dangerousness and the Human Rights Act, 1998*, *Journal of Forensic Psychiatry* 13(3): 569-577 and *Criminal Behaviour and Mental Health – Special Supplement* 12(2) December, 2002 (especially papers by Taylor, P.J., Cordess, C and Hinshelwood, R.D.)