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Review Article

Criminal Behaviour and Mental Disorder

By JOHN GUNN

The main problem in discussing any relationship between criminal behaviour and mental disorder is that the two concepts are largely unrelated. We are all aware that the very existence of mental illness has been challenged (Szasz, 1962) and that definitions are extremely difficult to formulate (see e.g. Lewis, 1953 and Clare, 1976). Yet most of us believe that somewhere in the confusion there is a biological reality of mental disorder, and that this reality is a complex mixture of diverse conditions, some organic, some functional, some inherited, some learned, some acquired, some curable, others unremitting. It would be surprising if such a mélange had a clear-cut relationship with any social parameter, specially one which is arbitrarily determined by legislation. Criminal behaviour is simply the breaking of the criminal laws in force at any particular time. Crimes embrace everything from murder and treason to riding a bicycle without lights. Over 60 per cent of all crimes dealt with by British courts concern motoring, and almost 6 per cent concern drunkenness. As attitudes change so do laws; suicide attempts were criminal offences until recently in the United Kingdom, male homosexual behaviour was once illegal under all circumstances.

Most discussions on the mentally abnormal offender concentrate on either those who are resident in hospitals or prisons, or on serious offenders, especially those who are violent or sexually deviant. In view of the complexities mentioned above, this selectivity is understandable, but it should always be remembered that it excludes the majority of the mentally disordered and the majority of criminals.

Prison Populations

Prisons are institutions. This truism has to be emphasized, because although prisons are part of the penal system they also form part of the institutional network of most countries, and their population contains a disproportionate number of people in need of chronic institutional care (Gunn, 1974a). Penrose is often quoted as proving that mental hospital and prison populations are inversely related. He did not quite demonstrate that (Penrose, 1939); he simply showed that, before the Second World War in Europe, countries with a large prison population had a small mental hospital population and *vice versa*. To be exact, he found that the homicide rate, the number of prisoners, the birth rate, the suicide rate, and the general death rate were all negatively correlated with the level of mental hospitalization. He concluded that attention to mental health may help to prevent the occurrence of serious crimes, particularly homicide. In Britain 'Penrose's Law' is often cited because as mental hospital populations have fallen since the Second World War so prison populations have risen sharply.

There are surprisingly few systematic studies of the health of British prison populations, but those that have been carried out all indicate high levels of mental disorder. Rarely is the reason for this discussed. It could be due to an association between serious crime and mental disorder. More likely, as Penrose implied, many psychiatric patients and potential psychiatric patients are diverted from one institutional system to another. There could also be an element of prison conditions generating their own psychopathology. A long prison sentence is very debilitating, and few people can take any form of imprisonment with total equanimity.

In 1963 Professor Gibbens published his survey of 200 borstal lads aged 17–21 years. Although all but one psychotic lad had been

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screened out before sentencing, Gibbens regarded 27 per cent of the population as requiring psychiatric treatment. At about the same time, West (1963) examined 100 long-term prisoners and found 2 of them to be epileptic, 10 to be or to have been psychotic and a further 9 to have a history of previous hospitalization. More recently my colleagues and I also examined a consecutive cohort of long-term prisoners taken into the allocation unit of the South East Region of the prison service. The demographic details of this survey have been reported elsewhere (Gunn *et al*, 1973), but it is of interest that we found that 17 of the 90 men examined (19 per cent) had made one or more suicide attempts, and 16 (18 per cent) had at some previous point been admitted to a psychiatric hospital. We diagnosed 33 (37 per cent) as suffering from alcoholism, and using the criteria of Goldberg *et al* (1970) we estimated that 30 or one-third had abnormalities in their mental state, at the time of interview, which required psychiatric attention. In an M.D. thesis, Bluglass (1966) sampled one in four of the total admissions of convicted prisoners to Perth Prison for eleven months. He diagnosed 138 out of 300 (46 per cent) as having a psychiatric disorder, 6 (2 per cent) were psychotic, 7 (2 per cent) were neurotic, 40 (13 per cent) were called 'psychopathic', 33 (11 per cent) were alcoholic, 1 was drug addicted, 43 (14 per cent) were subnormal or borderline subnormal, 3 (1 per cent) were epileptic, and 5 (2 per cent) had other organic states. This is a wide range of pathology and matches our own findings from another survey, this time a census by questionnaire of a 10 per cent sample of all the convicted prisoners in the South East Region of the English prison service (Gunn *et al*, in press). We sent questionnaires to 811 men, randomly selected by the Home Office Research Unit, and received 629 satisfactory replies. The questionnaires were validated against 106 interviews conducted by a team of 11 senior trainee psychiatrists. We devised a weighted system of case identification taking into account desire for treatment, previous psychiatric history, and neurotic symptoms detected on the self-rating GHQ (see Goldberg, 1972). Using this method, we estimated that 31 per cent of the convicted prisoners in the South East Region prisons could be regarded as psychiatric cases. We made no attempt to estimate mental subnormality, as this diagnosis is partially dependent on social variables and partially on cognitive ones, neither of which we could measure. The diagnostic labels given to the 35 psychiatric cases ascertained by the interviewing psychiatrists included 2 psychoses, 9 neuroses, 3 sexual deviations, 13 alcoholic, and 22 personality disorders. (Several patients had more than one diagnosis.) These figures have to be set against the estimate of 14 per cent of the general population consulting their doctors for psychiatric reasons made by Shepherd and his colleagues (1966).

During the course of our census we took the opportunity to examine the data for a possible relationship between neurotic symptomatology and crime. All the information collected was put together with social and criminal data collected by the Home Office Research Unit. A principal components analysis was carried out, and two independent factors emerged: (a) psychiatric disturbance, and (b) recidivism. We were particularly interested in the positions of the various categories of offending. Property offences tended to load highly on the recidivist dimension and not at all on the psychiatric, whereas violence offences, sexual offences, and especially drug offences loaded highly on the psychiatric dimension. This suggests that for a prison population stealing has little to do with psychiatric disturbance, although it should be remembered that this is a statistical statement and individual exceptions will be found.

These British findings have been to some extent reinforced by a series of American studies carried out in Missouri by Guze and his colleagues (Guze, 1976). He studied 223 consecutive male and 66 female felons (serious offenders) as they left prison, both 'parolees' and 'flat timers' (no remission). Using a standard interview and criteria set out in his book, he diagnosed 90 per cent of the male population as having a psychiatric disorder, but 70 per cent of the population he described as 'sociopathic'. Even so, he regarded 52 per cent of the population as suffering from a psychiatric disorder other than sociopathy.

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Schizophrenia was detected in only 1 per cent of the men, epilepsy in 1 per cent and mental deficiency in less than 1 per cent. Approximately 85 per cent were described as sociopathic, alcoholic, or drug dependent. Figures for the female felons were of a similar order in that only 12 per cent were regarded as having no psychiatric diagnosis, but this time 41 per cent of the population were regarded as suffering from hysteria, which Guze regards as a female equivalent of sociopathy. He concludes that sociopathy, alcoholism and drug dependence are the disorders associated with serious crime, whereas schizophrenia, affective disorders, neuroses, and brain syndromes are not. Sexual deviations in his estimation, in the absence of sociopathy, alcoholism or drug dependence, are not associated with serious crime.

Court Cohorts

Obviously the best way to determine the level of psychiatric disturbance in a criminal population is to examine a consecutive group of people convicted of criminal offences at a particular court or series of courts. As most convicted offenders are given non-custodial sentences, such as fines, this would be immensely difficult. As far as I know, this type of study waits to be done.

An examination of a recent issue of the criminal statistics for England and Wales (Home Office, 1975) can tell us something about the way in which courts see the relationship between crimes and mental disorder for the more serious offences (Table I). We can see immediately that more violent offenders and fewer property offences are put on hospital orders, and that both sexual offences and criminal damage (which includes arson) are disproportionately dealt with by hospitals. This kind of analysis however, can only tell us how courts, lawyers, and doctors are prepared to dispose of certain types of offender; furthermore it must be appreciated that probation orders with conditions of medical treatment are not included, nor are the bulk of offences because they are less serious (non-indictable). In 1974 there were 107,884 people convicted under intoxicating liquor laws, 6 per cent of the total criminal picture.

Table I

Numbers of offences reported in 1974 compared with the numbers of hospital orders made in the same year

	No. of offences per 100,000 popn*	%	No. of hospital orders (S.60 & S.65)	%
Homicide ..	1	—	50	5·9
Other personal violence	128	3·2	168	19·8
Sexual offences ..	50	1·3	75	8·8
Burglary ..	983	24·6	109	12·9
Robbery ..	18	0·5	8	0·9
Theft and handling	2,419	60·6	182	21·5
Fraud and forgery	238	6·0	48	5·7
Criminal damage	136	3·4	203	23·9
Other offences	17	0·4	5	0·6
Total	3,990	100	848	100

* These totals ×492·2 will give an approximation of the absolute figures, except for homicide where 600 cases were reported.

In 1973 Walker and McCabe published their analysis of a one-year cohort of hospital order cases collected some ten years previously. They showed that approximately 41 per cent were diagnosed schizophrenic, 35 per cent subnormal, 12 per cent personality disordered and 8 per cent affectively disordered.

The Criminality of Psychiatric Populations

It is a surprising fact that in spite of the common belief that crime and mental disorder are related there are very few systematic data available about the criminality of psychiatric populations. There is some information about the criminality of the general population in Britain, and that information suggests that for there to be a special association between crime and mental illness there would have to be a very high level of criminality among psychiatric patients. For example, we learn from the criminal statistics that 374,918 people were convicted of an indictable (serious) offence in England and Wales, and 1,558,731 were convicted of lesser or non-indictable offences in 1974. Taking the population of England and Wales in that year as 49·2 million (which, of course, includes children below the age of criminal

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responsibility) this gives a crime rate of approximately 8/1,000 persons for indictable offences, 32/1,000 for non-indictable offences and 39/1,000 overall. McClintock and Avison (1968) calculated the cumulative risk of being convicted during a life span. They estimated that approximately 1 in 3 of the male population and 1 in 12 of the female population would be convicted of a standard list offence at some time during their life span. The standard list of offences includes all indictable offences and those non-indictable offences which are regarded as of a similar nature to the indictable ones, in other words is a list of serious offences.

Taking these figures as a rough guideline, it would be surprising indeed if, for example, mental hospitals did not contain a large number of patients with a criminal record. No doubt there are good ethical objections to the data collection process involved, but it is a serious omission in our understanding of the population we treat as psychiatrists that we do not know accurately what proportion have been in conflict with the law, and for what reasons.

In 1974 Guze *et al* published an analysis they carried out of 500 patients attending a psychiatric clinic in the United States. They selected their patients to represent a cross-section of the psychiatric clinic population, and found that 22 patients had a history of at least one felony (serious offence); this represented 4 per cent of the total (10 per cent of the males and 1 per cent of the females). The offences committed varied from burglary and robbery (11 cases) to exhibitionism (4 cases) and child molestation (1 case). The offenders were labelled sociopathic (13 cases), alcoholic (9 cases), sexually deviant (6 cases), drug dependent (3 cases), and anxious (1 case). It is very unlikely that these figures are above those expected for an age, class, sex matched United States general population.

One piece of British information we can obtain is the number of patients who are formally admitted to psychiatric hospitals in England and Wales under Part V of the Mental Health Act, 1959. Part V deals with patients convicted of an offence (indictable or non-indictable) but handed over to the Health Service for ordinary in-patient care. The patients are detained under Sections 60, 65, 71 or 72 and are admitted to mental illness hospitals, mental handicap hospitals, or Special Hospitals. The Department of Health and Social Security's Mental Health Enquiry has kindly supplied me with the appropriate figures for 1974. These are given in Table II, from which it can be seen that only 0·7 per cent are admitted in this way. Even if we add the Section 136 admissions (i.e. the direct police admissions of unconvicted patients), the figure only rises to 1·5 per cent, but of course most of the Section 136 patients would not appear in a court of law. It has also to be remembered that these figures do not include those who were given conditional discharges in court so that they could obtain psychiatric treatment, nor those who received probation orders with a condition of medical treatment. Table III breaks down the 1,260 Part V admissions into the type of hospital to which they were sent. Nearly one-fifth went to Special Hospitals, and almost two-thirds went to mental illness hospitals. However, it is clear that mental handicap hospitals were admitting Part V patients at three times the rate of mental illness hospitals. This association between Part V admissions and mental handicap is borne out by an examination of the population of the Special Hospitals, which predominantly take Part V patients. The Special Hospitals Research Unit case register indicates that during the years 1972–74 inclusive 1,007 patients (704 males and 243 females) were admitted, 349 (35 per cent) classified psychopathic, 441 (44 per cent) classified mentally ill, and 257 (26 per cent) classified as subnormal or severely subnormal (the figures do not add up to 1,007 or 100 per cent because some of the cases were

TABLE II

Admissions to psychiatric hospitals 1974

Informal admits	.. ..	159,533 (87·1%)
Part IV admits	.. ..	20,708 (11·3%)
Part V admits	.. ..	1,260 (0·7%)
Sect 136 admits	.. ..	1,542 (0·8%)
Other admits	.. ..	222 (0·1%)
Total admits	.. ..	183,265 (100%)

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TABLE III

The disposal of Part V cases in 1974

	Total admits	Part V cases	Proportion of Part V cases
Mental illness hospitals	170,827 (93·2%)	823 (65·3%)	0·5%
Mental handicap hospitals ..	12,132 (6·6%)	203 (16·1%)	1·7%
Special hospitals	306 (0·2%)	234 (18·6%)	76·5%
Total	183,265 (100%)	1,260 (100%)	0·7%

unclassified and others had more than one designation).

THE STAGE ARMY

By now it is clear that disorders such as 'psychopathy', alcoholism, drug addiction, and mental subnormality have particular associations with criminal behaviour, although those associations are not clear cut and refer, on the whole to serious offences. Many a hospital psychiatrist will, however, believe that schizophrenia plays a substantial part in the story of the mentally abnormal offender. This is because there is an important group of patients, mainly men, whose basic problem is that their disorder, whether it is alcoholism, personality disorder or schizophrenia, leaves them vulnerable and in need of asylum in the broadest sense. These men constitute the 'social litter' (Rollin, 1969) of our modern cities, and they move from hospital to prison, to doss house and back again, like a stage army tramping round and round, making a much greater impression than their numbers warrant simply because we have no facilities for them (Gunn, 1974a). They usually commit trivial offences, but serious crimes are not unknown from this group. Horton Hospital, Epsom, near London, has a special problem because it serves a part of the capital that collects more than its fair share of the nation's 'social litter'. Rollin studied the population admitted in 1961 and 1962 (Rollin, 1969), and found that the typical mentally abnormal offender admitted was a man aged 30–50 years, single, of no fixed abode, and very likely suffering from schizophrenia (83 per cent of the sample). He looked in more detail at the unprosecuted offenders, i.e. those admitted directly from the street by the police. Of the 78 cases admitted, 10 per cent had committed sexual offences, almost always indecent exposure, 13 per cent had committed violence, often assaults against the police, and 9 per cent were thieves, but 57 per cent committed offences against public order such as ripping aerials off cars, walking naked down the street, entering the Houses of Parliament to dispense justice and other such clearly 'mad' behaviour.

It emerged, after admission, that 40 per cent of the patients had a previous criminal record, 36 per cent being recidivists. The prosecuted offenders, admitted under Part V of the Mental Health Act 1959, were more often found to be thieves (41 per cent), but again 4 per cent were exhibitionists, 15 per cent were violent and 40 per cent offended against public order by begging, wandering abroad and so on. Of the prosecuted group 63 per cent had previous convictions and 44 per cent had previously served prison sentences.

In 1970 Tidmarsh and Wood (1972 and 1973) conducted a survey of the largest Reception Centre in London. Reception centres are operated by the Department of Health and Social Security, as the successors of the old casual wards, and are supposed to provide temporary accommodation to persons without a settled way of life. In practice they admit the destitute and homeless. Tidmarsh and Wood studied 8,000 cases referred to the centre, 4,000 of whom were old cases who had been there before. Of the old cases, 79 per cent had had convictions and 58 per cent had been in prison. Tidmarsh made psychiatric assessments and found that about 1,200 men diagnosed as mentally ill or mentally subnormal used the

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centre each year. Only just over one-quarter were said to have no psychiatric disorder. Of special relevance to this review is the fact that men with no psychiatric abnormalities were the least likely to have had convictions. Furthermore it emerged that most of those without prison sentences had not been in hospital, and most of whose who had not been in hospital had not been in prison either, while conversely those who had been in either type of institution had usually been in both.

The Role of the Forensic Psychiatrist

These statistical studies are tantalizingly inconclusive. Nevertheless there are a few general beliefs that seem to be supported by the figures. It appears that criminal behaviour is more likely to occur in patients with personality problems, social problems, mental handicap and addictions, especially alcoholism, in other words, those parts of the psychiatric spectrum that border on to social inadequacy and volitional or habit disorders. Does this mean that the forensic psychiatrist is one who specializes in personality problems, mental handicap, sexual problems, alcoholism, and the like? He is going to be a busy man if he takes on the totality of that work! Why not add adolescent behaviour disorders, since they also frequently lead a patient into conflict with the law? Clearly it would be nonsensical to try to separate off this vast lump of general psychiatry and call it forensic psychiatry, and yet there is a growing danger that this could happen. The sub-specialty of forensic psychiatry seems to have mushroomed in the last few years, albeit without an adequate academic base. This has coincided with the demand for 'security' to be re-introduced into the National Health Service. Both the DHSS working party on security units (known as the Glancy Report) and the combined Home Office/DHSS Report of the Committee on Mentally Abnormal Offenders (known as the Butler Report) have recommended that security units should be built in each National Health Service Region and that these units should be directed by forensic psychiatrists. Thus there is a danger that forensic psychiatry will be regarded as that part of psychiatry which is concerned with locking patients up. There is also the danger that hard-pressed general psychiatrists will increasingly say that the difficult cases of personality disorder, alcoholism and the like are somebody else's problem.

A close examination of these two important reports reveals that neither intended these interpretations to be put on their recommendations. Such interpretations would defeat the objectives of the Committees, because if carried too far they would mean that a tiny subspecialty would have to deal with a large and difficult slice of general psychiatry in a few security units. Indeed the Butler Committee state categorically that the 'main emphasis in forensic psychiatric services . . . should be on community care and out-patient work . . . (area) psychiatric hospitals should continue to provide a wide range of facilities for forensic patients'. It is worth noting what the holder of the first Chair in Forensic Psychiatry in England and Wales had to say on this subject nearly a decade ago—'whether forensic psychiatry is a sub-specialty on its own is a debatable question . . . the well-trained consultant psychiatrist is as competent as anyone else to deal with the majority of problems in forensic psychiatry, especially of the more serious kind . . . any claim to specialization must lie in being able to cross . . . social and administrative boundaries, as well as in the specialized studies of particular mental conditions' (Gibbens, 1968). Professor Gibbens on more than one occasion has been concerned to stress the educational tasks of the forensic psychiatrist. In the paper just referred to he concludes by emphasizing the importance of all psychiatrists having the opportunity to learn about various penal institutions and methods of social control, and he particularly stresses the importance of close connections between forensic psychiatry and adolescent psychiatry, seeing that crime (other than motoring offences) is principally an adolescent activity.

The major difficulty in discussing forensic psychiatry or the relationship between crime and mental disorder is that neither the subspecialty, nor the relationship can be defined in biological terms. It is not simply a matter of defining age limits, as in child psychiatry, or of

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defining a group of disorders, as in organic psychiatry. Medico-legal problems are determined socially and administratively, and they are steeped in legal concepts which are alien to biology. The most significant of these is responsibility.

Criminal Responsibility

In English law accused persons are presumed to be 'responsible' for their actions unless they can show that this is untrue for any particular act. The factors which will remove criminal responsibility (except in cases of strict liability), if they can be proved by the defence and are present in sufficient degree, are mistake, accident, provocation, duress, and insanity (Whitlock, 1963). A law of strict liability is one in which these factors are no defence; responsibility is always present. Hence, although criminal responsibility is linked to the concepts of free will and choice, in practice it means liability to punishment. Some legal systems (e.g. the Italian) acknowledge this by calling the concept 'imputability'.

As the Butler Committee (Home Office and DHSS, 1975) has indicated, 'the extent to which mental disorder constitutes a defence to a charge or a reason for convicting of a lesser offence depends at present on a complex body of law represented by M'Naghten's case, the defence of diminished responsibility, infanticide and the doctrine of non-insane automatism'. McNaughton was a psychotic who believed he was being persecuted by the Tory party. In 1843 he shot the Prime Minister's secretary, mistaking him for the Prime Minister. He himself was found not guilty by reason of insanity, but the verdict caused a public outcry and the Judges were asked to draw up rules of guidance. (An excellent account of this is to be found in Walker (1968). The famous Rules tell us that 'to establish a defence on the grounds of insanity, it must be clearly proved that at the time of the committing of the act the party accused was labouring under such a defect of reason, from disease of the mind, as not to know the nature and quality of the act he was doing, or if he did know it, that he did not know he was doing wrong'.

These Rules have always been difficult if not impossible to apply indeed it seems likely that McNaughton himself would not have passed the criteria if stringently applied! One of the basic problems, from the psychiatrist's point of view, is that the legal concept of responsibility seems to be all or none, you either have it or you don't, whereas, of course, mental disorder forms a continuum. However, when flexible sentencing is available to the judge insanity is rarely pleaded as a defence against conviction; mental disorder is usually used by the defence to plead mitigation of sentence. In murder, the major crime which still commands a mandatory sentence, some acknowledgement of the continuum of sanity and hence responsibility has been forthcoming in English law in recent years by the introduction of the concept of 'diminished responsibility'. The Homicide Act, 1957 states that where a person kills or is a party to the killing of another, he shall not be convicted of murder 'if he was suffering from such abnormality of mind (whether arising from a condition of arrested or retarded development of mind or any inherent causes or induced by disease or injury) as substantially impaired his mental responsibility for his acts and omissions'. As with the plea of insanity, diminished responsibility has to be raised and proved by the defence. A successful plea has the effect of reducing the charge from murder to manslaughter and thereby giving discretionary sentencing back to the judge.

In British courts in these days questions of responsibility have largely given way to questions of the type and degree of any mental abnormality present, its treatability, its possible mitigating effects on the sentence, and the management problems presented by the offender.

Alcohol and Alcoholism

No matter from which angle the relationship between crime and mental disorder is viewed, the problem of alcoholism always stands out. It will be recalled that Bluglass regarded 11 per cent of his Scottish prisoners as alcoholic; Guze *et al* (1974) reported that of 70 alcoholic

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out-patients, 13 per cent had committed a felony, and in his book Guze (1976) reported that 43 per cent of a consecutive series of male felons were alcoholic. Added to this there are in England and Wales over 100,000 convictions for drunkenness which usually do not result in custodial or serious penalties. Edwards *et al* (1971) reviewed the literature, which showed that the reported prevalence of alcoholism among prisoners varies between 10 per cent and 56 per cent, and they enumerated five basic research problems in this type of epidemiological work. Three of these problems are worth reiterating here because they are central to all aspects of the relationship between crime and mental disorder. Firstly, precise definitions of the disorder in question are hard to come by, Secondly, different samples give different data. e.g. Gibbens and Silberman (1970) showed that different types of prison have different rates of alcoholism. Thirdly, control data concerning the general levels of disorders are often lacking.

A special problem relating to alcoholism is the consideration of whether it should be regarded as mental disorder at all. Certainly it can produce severe illnesses such as liver cirrhosis, brain damage, peripheral neuritis, and the like. Certainly it can exacerbate mental illnesses such as schizophrenia and depression. Certainly a small proportion of alcoholics take themselves to doctors pleading for assistance and saying that they cannot control their drinking. Alcoholism presents conceptual difficulties which it shares with other addictions. If it is a disorder, it is a habit disorder, perhaps a behaviour disorder, and volition is a very significant factor. This poses difficult problems for the psychiatrist and for the courts. Firstly, there is the question of responsibility. If a man gets drunk and reckless and then commits an offence he may argue 'I'm innocent, I didn't know what I was doing'. Occasionally he will be successful in his plea if he can prove that he was so drunk as to be incapable of forming an intent (see Edwards, 1961, for a discussion). However, such a defence is difficult to sustain and courts show reluctance in allowing drunkenness to be an excuse for antisocial behaviour, mainly because the temporary mental derangement of drunkenness was 'voluntarily' acquired. The Butler Committee faced this problem squarely and pointed out that if the rule about drunkenness were logically applied a person who is habitually violent in drink would escape any criminal charge, and they recommended that courts should be given power to convict those who became violent when voluntarily intoxicated. 'The object', they said 'is not necessarily to punish them. An alcoholic or drug addict may after conviction be persuaded to accept treatment. But not all these offenders are addicts . . . and in any case powers of punishment are necessary for those who will not accept treatment and who cannot otherwise be controlled.'

At this point the Butler Committee were commenting on the second major problem in relation to alcoholism: treatment. As the law stands it could be argued (although it rarely is) that an unwilling drunken person needs compulsory detention in hospital for his own protection or the protection of others. Twenty-four hours later such an argument would be much harder to sustain in the face of a sober patient who says that he knows what he is doing, feels reasonably well, and wishes to decide for himself whether he will drink or not —thank you very much. Many of the severest alcoholics deny their problems when they are sober and even if they accept their drinking as a problem are unwilling to submit to a treatment programme which is irksome and involves abstinence. Some such people may be potential or actual offenders when drunk or in relation to drinking (e.g. stealing money for more drink). Why not regard an habitual drunken offender as suffering from a form of 'psychopathy' and therefore admit him to hospital compulsorily, after conviction, under Section 60 of the Mental Health Act 1959? The Butler Committee is opposed to such an expedient and suggests that much of the problem would be eased if the recommendations of the Weiler Committee (Home Office, 1971) were implemented and more hostels were provided, together with detoxification units. In these arguments the Butler Report is clearly taking the volitional element of drinking disorders into account, accepting the undesirability and the impracticality of forcing treatment for behaviour dis-

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orders on unwilling patients, and allowing the ordinary social (penal) control measures to operate for those patients who express their preference for that method by refusing treatment. This is quite a long way from the paternalistic notion that alcoholism is a disease which must necessarily be treated for the good of the patient.

If this view can be applied to the alcoholic, how much more can it be applied to the 'psychopath'?

Psychopathic Disorder

A review of the vexing subject of psychopathic disorder could well occupy a monograph. All that can be done here is to outline one or two special problems. So far no one has come up with a satisfactory definition for the diagnosis or category, and to make matters worse there are two distinct uses of the term, legal and clinical, which do not necessarily coincide although they affect one another. The legal use is almost entirely confined to England and Wales. Scotland has escaped the problem: the term 'psychopathic disorder' is not used in the Mental Health (Scotland) Act, 1960, although similar distinctions regarding admission and discharge exist for patients described by the same words as define 'psychopathic disorder' in the English Act.

The Mental Health Act definition of psychopathic disorder is somewhat circular 'a persistent disorder or disability of mind (whether or not including subnormality of intelligence) which results in abnormally aggressive or seriously irresponsible conduct on the part of the patient, and requires or is susceptible to medical treatment'. Lady Wootton (1959) has suggested that the psychopath 'makes nonsense of every attempt to distinguish the sick from the healthy delinquent' because 'mental abnormality is inferred from antisocial behaviour while antisocial behaviour is explained by mental abnormality'. Walker and McCabe (1973) point out that this is not entirely fair, as the psychiatrist does not necessarily use matters brought before the court to determine whether or not the patient has a disability of mind. Nevertheless, it must be admitted that there is a serious danger of circular reasoning, a danger that in certain circumstances could lead to very illiberal consequences. There is no evidence in this country of social nuisances who have no psychiatric abnormality being locked up in mental hospitals; on the contrary, psychopaths find that they cannot get into hospital, even when they want to go there (Gunns 1974b). But the point does illustrate the need for vigilance in the interpretation of mental health laws. Walker and McCabe see the main weakness of the legal definition to be the stultifying influence which a supposedly generic legal category has had on the diagnostic habits of psychiatrists.

The Butler Committee believes that so much confusion has arisen over the use of the term that 'personality disorder' should be substituted in the Act for 'psychopathic personality' provided stringent safeguards are included to prevent mere eccentrics being detained compulsorily. In taking its evidence the Butler Committee was confronted with six major arguments for the removal of the clauses about psychopaths from the English Act: (1) psychiatrists disagree about its meaning; (2) it has a circular definition; (3) it is used by some people as a medico-scientific explanation for antisocial behaviour; (4) it stigmatizes those so labelled; (5) the Act covers all 'mental disorder' and therefore specific clauses for psychopaths are redundant; (6) in the Scottish and Northern Irish Acts the term is not used. Nevertheless, the Department of Health has proposed, in its recent consultation document on the Mental Health Act (D.H.S.S., 1976), that the category should remain.

One of the best recent reviews of the clinical use of the term is that by the late Sir Aubrey Lewis (1974); he tells us: 'For 150 years the diagnostic concept called "moral insanity" has been troubling psychiatric nosologists'. He concludes his article: 'The diagnostic groupings of psychiatry seldom have sharp and definite limits. Some are worse than others in this respect. Worst of all is psychopathic personality, within its wavering confines. Its outline will not be firm until much more is known about its genetics, psychopathology, and neuropathology.' Walker and McCabe point out that in clinical

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terms a diagnostic label can have one or more of four functions; explanatory, prognostic, therapeutic, descriptive. They examine each in turn in relation to psychopathy and conclude: 'as a description the diagnosis tells one nothing . . . prognostically it exaggerates the difference between psychopaths and ordinary recidivists on the one hand, or on the other hand schizophrenics and subnormals . . .; it cannot be an explanatory label; and . . . as a method of indicating suitable forms of treatment it tells us only that none have been found very profitable. What cannot be argued away, however, is the fact that psychiatrists seem to feel a need to use it.'

The reasons for this need are not at all clear. Lewis indicated the long-held belief that some individuals have a warped or defective moral sense which makes them non-conforming and antisocial. However, moral sense is an extremely nebulous concept, and it is probably largely culturally determined. During the 150 years in which the concept of psychopathic disorder has been evolving, the moral scene has changed a great deal and it varies between nations. No doubt an intact and efficient central nervous system is required to develop moral sense, but if most of us were to try to devise a model for the biological development of morals we would probably use a learning model. If psychopathic disorder is a defect state then it is surely better viewed as a failure of learning rather than as a disease.

Perhaps this concept of a failure of learning is behind the fact that almost every attempt to define the condition or delineate a sample of subjects relies on social parameters. In this respect American psychiatrists are more candid that European ones because their term for the disorder is 'sociopathic personality'. All kinds of lists of social ineptitudes have been drawn up as typifying the psychopath, one of the best known being that by Lee Robins in her book *Deviant Children Grown Up* (1966). Quite recently Dr Graham Robertson and I had the opportunity to see if we could find a psychopathic factor in a group of prisoners all sent to Grendon prison for treatment with the diagnosis of psychopathic personality (Gunn and Robertson, 1976). We tried to measure a number of social indicators, such as occupational stability, personal relationships, marriage, and so on, and a number of psychological indicators like conscientiousness, anxiety, lying, impulsiveness, together with habit problems like heavy drinking, gambling. Immediately we ran into difficulties, because the ratings we were attempting, in spite of a standardized interview and joint training, proved so subjective that our inter-rater reliability was low for many of the scales. Of our original 19 scales we had to drop 9. From the remaining scales we could not extract an important single factor and it became clear to us that while the 107 prisoners had several characteristics in common, e.g. they had all broken the law, and most had neurotic symptoms of one sort or another, if we wanted to utilize any of the four diagnostic functions set out by Walker and McCabe we had to resort to a diagnostic formulation or description using a number of different parameters. All the men had neurotic problems which required treatment, some had sexual problems, others were deficient in basic social skills and had interpersonal difficulties, occupational instability and so on. In short the term psychopath was unhelpful and had to be amplified. An accurate description of the problems confronting any particular 'psychopath' is essential for effective diagnosis and treatment.

We can perhaps learn from the non-medical team of Walker and McCabe who conclude 'It seems highly likely that current and future research will identify subgroups of "psychopaths" . . . Progress of this kind, however, is not assistant by the assumption that all "psychopaths" have something in common—apart from the label. To categorize someone as psychopathic is all too often to exclude him from the hospitals where research is being most actively carried out; and sometimes it ensures that he is refused *any* hospital vacancy.' This last point is all too true, and if the term 'moral defective', later to become 'psychopath' was introduced to try to explain persistent criminality in medical terms, the hypothesis has not only failed, it has been counterproductive.

Epilepsy

The last condition I will use to illustrate the

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nature of the relationship between crime and mental illness is epilepsy. Some years ago I had the opportunity to conduct a total census of epilepsy within the prisons of England and Wales (Gunn, in press). The results indicated a prevalence of at least 7·2 epileptics per 1,000 prisoners, which is considerably above the best estimates of the prevalence of epilepsy in the general population. At first sight this could have been taken as evidence for the traditional belief that epilepsy is in some way related to crime. Such a belief dates back to Lombroso, if not further. However, the institutional nature of the sample has to be remembered, and epileptics have always suffered high levels of institutionalization; there are epileptic colonies still flourishing. When the epileptic prisoners were matched with another sample from the same prison serving the same types of sentences very little difference between the two groups could be discerned. Dr Fenton and I examined the epileptics' records to see if any of the prisoners could have been convicted for committing an offence during a period of disturbed consciousness. One possible case of theft during an episode of post-ictal confusion was found and a survey of the three Special Hospitals, Broadmoor, Rampton and Moss Side, revealed three cases of automatic or unconscious violence (Gunn and Fenton, 1971). Automatism, then, is a very small factor in any association between epilepsy and crime.

There seemed to be four ways in which epilepsy could be related to antisocial behaviour (Gunn, 1974c). In some cases it seemed that brain dysfunction was responsible for both the ictal phenomena and the antisocial behaviour. In others it seemed that the epilepsy had generated social and psychological problems such as rejection, and feelings of inferiority which in their turn led to antisocial reactions. A third type of association seemed to occur in cases where harmful social factors such as overcrowding, parental neglect and the like lead to an excess prevalence of both epilepsy and antisocial behaviour—the battered child is an extreme example of this kind of relationship. Finally, there were cases where a tendency to recklessness and antisocial behaviour not only led to conflict with the law but also to accident and illness proneness which in their turn produced traumatic disorders such as epilepsy. Of course it was possible to find cases in which two or three of these various relationships between epilepsy and crime were mixed together, and others in which the association seemed purely fortuitous.

The aspect of this study which stood out most prominently was that any general statements about the relationship of the epilepsies and all epileptic patients on the one hand and criminality on the other were bound to fail because they did not take into account the wide degree of variation possible within these universes. I suspect that similar models could be constructed for the relationships between other types of disorder, both physical and psychiatric, and antisocial behaviour.

Conclusion

Although there is an increasing interest in forensic psychiatry, crime and mental disorder are difficult to relate together. Both concepts are difficult to define, both are heterogeneous, and crime is clearly a culturally determined phenomenon. Because crimes are committed very frequently, many psychiatric patients will commit them. If prison populations are studied they apparently contain a large number of mentally-disordered individuals, but this may be more closely related to their function as institutions than to any special relationship between crime and mental disorder. The best data on the relationship, if any, should come from court cohort studies, but this information is largely missing. Similarly, very few data are available about the criminality of psychiatric populations. What information exists strongly suggests that mental handicap services are more likely to have offenders referred to them than are mental illness services.

Attempts to discover overall relationships between two heterogeneous populations may be mistaken. There seems to be some support for the view that offending is most likely to be associated with personality problems, with social problems, with addictions (especially alcoholism) and, of course, with mental handicap. These problems constitute a large slice of

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general psychiatric work, and even on a chance basis a general psychiatric service will deal with a large number of offenders. It would be ludicrous and retrograde if all this work were to be pushed in the direction of the small (admittedly growing) number of so-called forensic psychiatrists.

Specific problems such as alcoholism, psychopathic disorder and epilepsy illustrate many of the difficulties faced by psychiatry in the overlap area with criminology. Sometimes there is doubt as to whether the patients categorized are patients at all. It follows from this that it is particularly difficult to decide whether an individual should receive compulsory treatment for a disputed disorder which has only come to light because of an offence. If disabilities such as 'psychopathic disorder' can be recognized at all they are best understood as defects of learning and socialization rather than as illnesses in the discrete sense. Epilepsy leads to social and sometimes to criminal problems. It illustrates the way in which it is possible for a biological disability either to generate special social and psychological difficulties which can lead to conflict with the law, or to result from the same disadvantages that lead to a criminal life, or indeed to result directly from criminal behaviour.

All in all, it is probably better to concentrate upon specific behavioural problems caused by specific disorders and to avoid too many generalizations about the mentally disordered and the criminally convicted. If forensic psychiatry is to have an enlarged role in psychiatry then surely it should be concerned with specialized research and teaching, and assistance with especially difficult or unusual problems.

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