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## Mental disorder and violent crime: A problematic relationship

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**Abstract** This article discusses the problems inherent in demonstrating the relationships between mentally-disordered states and crimes of violence. Particular mental states are selected, somewhat arbitrarily, for this purpose. The article argues that such relationships also need to be considered against current social concerns with public protection and risk prevention in the light of media influences. Practice concerns are addressed throughout the article.

**Keywords** media influence and 'moral panics', mental disorder, practice implications, public protection, violence

'Methink'st thou art a general offence, and  
Every man should beat thee.'

*(All's Well that Ends Well, Act II, Sc. iii)*

### Introduction

The title of the original request for this article was expressed as 'Mental Health and Violence'. For a number of reasons I considered this proposed title would present certain problems. First, the words 'health' and 'violence' were somewhat too broad, and might be used to cover all manner of behaviours which could not readily be encompassed within the word limits of even a comparatively substantial article. I suggested, therefore, that it be changed to that now adopted. Second, even this change is not without a number of difficulties. For example, mental 'disorder' could be interpreted as covering only those disorders categorized in current mental health legislation, these being defined in the Mental Health Act 1983 as mental illness, mental impairment, severe mental impairment, and psychopathic disorder. It should be noted here that mental illness is not further defined in the 1983 Act; it is

usually taken to cover the more severe mental illnesses (such as affective disorders and the various presentations of schizophrenia). And psychopathic disorder remains a minefield of interpretation and disposal. The second draft Mental Health Bill now before Parliament will, if it passes into law, significantly change the definitional status of some of these conditions. Third, there are a number of behaviours that would not necessarily bring individuals within the strict criteria for compulsory admission under the mental health legislation. For this reason it is probably preferable to refer to mental 'disturbance'. However, because mental disorder is the commonly used term I shall use it, whilst remaining aware of its limitations. Fourth, I then considered that the word 'violence' standing alone was too non-specific and preferred 'violent crime'. This was because there are acts that can be adjudged as violent but not necessarily as criminal. For the purposes of this article, violent crimes are to be regarded as those 'involving the exercise of physical force so as to injure or damage persons or property' (Archer and Browne, 1989: 3). This is satisfactory up to a point, since it enables us to consider homicide in its various forms, non-fatal assaults (such as GBH) and the destruction of property by fire (arson). But even this definition has its limitations. For example, should serious sexual assaults (such as female and male rape) and indecent assaults be regarded as sexual or violent offences? The recently introduced Criminal Justice Act 2003 (notably Chapter 5) seems to support the view that such offences should be treated as crimes of violence for custodial sentencing and post-custodial sentence supervision. Strictly speaking, our list could be broadened to include offences such as aggravated burglary, terrorism and riotous behaviour. Some offences may not include direct physical assault, but induce considerable fear. For example, unwelcome attentions, such as harassment by stalking, would do so; for this reason I have devoted some attention to this recently 'discovered' crime (see Purcell et al., 2004). In this preliminary consideration of the arbitrariness of inclusion/exclusion we should also remind ourselves of a degree of serendipity in these matters. A serious physical assault may end up as a non-intentional homicide if, say, the victim was frail, had a thin skull or there were delays in the arrival of the emergency services. Some sexual offences, not regarded as violent, may still engender considerable fear, as for example in the cases of (indecent) 'exposure' as redefined in Section 66 of the Sexual Offences Act of 2003 (see Riordan, 1999). Readers of this journal will know that one needs to distinguish between the exposer ('flasher') who exposes at a distance and without erection (flaccid penis) from the exposer who adopts a very aggressive and confrontational position that just stops short of a sexual contact offence. This latter type of exposer is the one most likely to go on to commit a more serious sexual assault. Thus, the actual *modus operandi* of an index offence, or previous offences, may offer very important prognostic clues concerning the likelihood of future violence (see Prins, 2005, Chapters 6 and 8).

### **'Folk devils and moral panics'**

Readers will also be well aware of some of the myths that surround both mental disorders (disturbances) and criminality, particularly violent criminality. I would

suggest that in the case of mental disorder there are three types of myth that cause anxiety. The first concerns uncertainties as to the causes of such disorders. This uncertainty is described somewhat graphically by Othello when he says 'It is the very error of the moon; she comes too near the earth than she was wont and makes men mad' (Act V, Sc. ii). The second is our personal fear of madness as expressed by King Lear: 'O! Let me not be mad, not that sweet heaven; keep me in temper; I would not be mad!' (Act I, Sc. v). Third, there are our very real concerns about the intractability of some of the more serious mental disorders, as for example when Macbeth catechizes his wife's physician with his question 'Canst thou not minister to a mind diseas'd?' These myths have to be borne in mind by those of us who have to deal with the worrying combination of 'madness' and 'badness'; those adjudged by Lady Caroline Lamb as 'mad, bad, and dangerous to know' in her description of Byron (Lamb, 1812). Such irrational, yet understandable, fears give rise to the 'folk devils and moral panics' described so ably by the eminent sociologist Stanley Cohen (Cohen, 1972). Evidence for such phenomena can be seen in the media responses to the rare instances of homicides committed by those suffering from mental illness. There exists a common misunderstanding, shared by politicians and the general public alike, that there has been a marked increase in the number of homicides committed by mentally ill individuals. In the UK, Taylor and Gunn (1999) have provided substantial evidence that this is not the case. In fact, they noted an actual decrease. More recent studies by researchers in New Zealand (Simpson et al., 2004) and in Denmark (Kramp, 2004) have produced comparable findings for their own countries and in other jurisdictions. The frequent assertion by mental health campaigners and politicians that de-institutionalization has led to increased violent activity by mentally ill individuals has not been proven. Such assertions of concern have, no doubt, been responsible for the introduction of a recent (politically coined) diagnosis – Dangerous Severe Personality Disorder (DSPD). As I draft this article the press has added to the continuing clamour about so-called failures in community care, this time in the case of a former mental hospital patient who allegedly killed and seriously injured a number of randomly chosen victims in a London borough (see, for example, *The Independent*, 24 December 2004, p. 5). There is much to be said for regarding violence in all its manifestations as a health problem. In doing so we may avoid over-reaction (see WHO, 2002).

## Cause or association

Further problems confront us when we endeavour to make connections between disturbed mental states and crime, both in general and more specifically in relation to violent crime. This is because the two phenomena are not directly comparable. Behaviours defined as crime may vary over historical time. For example, adult (now defined at 16) consenting male homosexual acts committed in private are now no longer defined as criminal acts; attempted suicide ceased to be an offence in the 1960s. Certain transgressions committed by juveniles have long-since been removed from criminal sanction. However, against this more

'liberal' approach to criminality we need to note certain trends in the opposite direction. For example, in recent years we have seen a considerable increase in the legislation concerning the ingestion, possession and distribution of illicit drugs. We have also introduced highly controversial legislation that enables the detention without trial of alleged terrorists. And at the time of writing, an intransigent government seems determined to subvert the recent decision of the House of Lords that such detention is unlawful and contrary to human rights. The 'traffic' is therefore not all 'one-way'. It can be likened to a 'see-saw' moving up and down according to changes in society's views of lawful and unlawful behaviour. Similar problems arise when we come to determine what constitutes mental disorders (disturbances). There are those who consider that some mental illnesses do not even exist. For example, Professor Szasz is of the opinion that society all too often designates as 'illnesses' certain behaviours that merely affront society (Szasz, 1987, 1993). There are those who have taken the view that most mental illnesses are caused by social and familial pressures (see, for example, the work of Laing and Esterson, 1970). At the other end of the spectrum we have those who espouse a 'biological' causation. There appear to be some mental disorders that would merit such a causal explanation, for example some of the disorders of old age (dementias of one kind or another) and disorders produced by infections, injury or hormonal imbalance. Some forms of affective disorder (notably severe depression and manic disorders) and some schizophrenic illnesses could be categorized in this fashion, as can most forms of learning disability. The truth of the matter lies somewhere between 'biology' on the one hand and 'environment' on the other. Such an interplay is, of course, well known to those who study crime causation (see, for example, Gunn, 1977a and, more recently, Jones and Owen, 2004 and Rutter, 2005).

## Classification of mental disorders (disturbances)

See Table 1 for an outline classification of the main mental disorders. For the sake of brevity, some of the finer points of classification have been omitted. A more detailed account may be found in Prins (2005, Chapter 3). The two most important classificatory texts are *The Diagnostic and Statistical Manual of Mental Disorders* (APA, 2000) and *The ICD 10 – The International Classification of Mental and Behavioural Disorders* (WHO, 1992). Critical information and discussion may be found in one or other of the standard textbooks of psychiatry, a recent good example being the very comprehensive two-volume 2000-page work *The New Oxford Textbook of Psychiatry* (Gelder et al., 2000).

## Epidemiological aspects

It is difficult to provide precise figures for the numbers of people suffering from mental disorders. In the government publication *Modernising Mental Health Services* (Department of Health, 1998), it is suggested that depression in one form

**Table 1** An outline classification of mental disorders (disturbances)

<i>Main categories</i>	<i>Sub-categories</i>
The functional psychoses	The affective disorders Schizophrenic illnesses
The neuroses (psychoneuroses, neurotic reactions)	Mild depression, anxiety states, hysteria (hysterical reactions), obsessive compulsive disorder
Mental disturbance as a result of infection, disease, metabolic and similar disturbance, traumas	Including the epilepsies <sup>a</sup>
Mental disturbance due to the ageing process	For example the dementias, certain unusual psychiatric syndromes ('Eponymous' conditions) <sup>b</sup>
Abnormalities of personality (e.g. psychopathic disorders; some sexual deviations)	
Substance abuse (alcohol, other drugs, solvents)	
Mental impairment (learning disability, mental handicap, mental retardation) <sup>c,d</sup>	Including chromosomal abnormalities

<sup>a</sup> Strictly speaking the epilepsies are neurological disorders, but are included here because of their psychiatric and psychological consequences (sequelae).

<sup>b</sup> 'Eponymous' conditions, so-called after those who first identified them. This is common in both general medicine and psychiatry.

<sup>c</sup> The condition has been the subject of various names over historical time. Some of the older terms were highly pejorative (e.g. feeble-mindedness, idiocy, moral defectiveness).

<sup>d</sup> The classification given here could be slightly misleading, suggesting as it does that the disorders are discrete entities. This is not the case. Disorders may co-exist and such states are known as co-morbidity, leading to the need for dual diagnosis. The importance of this should never be overlooked. For example, a person showing signs of severe personality disorder may also have a depressive illness. An individual suffering from learning disability may develop a mental illness such as schizophrenia.

or another 'will affect nearly half of all women and a quarter of all men in the UK before the age of 70'. They quote from a major survey published in 1995 which showed that 'one in six adults aged 16–64 had suffered from some type of mental health problem in the week prior to being interviewed, the most common being "neurotic" conditions like anxiety and depression; and a very small proportion of the population – less than 1 per cent – had a more severe and complex psychotic mental illness, such as schizophrenia' (Sections 1.2–1.4). Such statistics can only provide a very rough indicator of the mental health of a nation. This is because there are likely to be not inconsiderable numbers of individuals suffering from a degree of mental disturbance/distress who do not present for

treatment at either their general practitioner (the most likely first 'port of call') or at a hospital (unless acutely mentally unwell, suicidal, etc). What we do know is that the cost of mental disorders, both in terms of distress to the sufferers and their families and others close to them, is very considerable (Laurance, 2003). Much of it is 'hidden' from view and the figures we have only represent the 'tip' of the 'iceberg'. (Perhaps it is worth noting here that the same is true for the 'hidden' nature of much criminal activity; the 'iceberg' phenomenon is equally important in this respect.) Since we know that about one in three of the adult male population is likely to be convicted of a standard list offence (i.e. more serious) before the age of about 30, it is not surprising that there will be a number of offenders showing signs of mental disturbance of one kind or another. It is also not surprising that a disturbing number of offenders in remand and other prisons show signs of mental disturbance, sometimes to a serious and worrying degree (see Prins, 2005, Chapters 2 and 3 for recent research findings).

## Affective disorders and violent crime

From time to time, persons charged with a grave offence such as homicide are found to be suffering from severe depressive disorder at the time of the offence. West, in his study of cases of *Murder Followed by Suicide*, suggested that sufferers from such (psychotic) depression may:

become so convinced of the helplessness of their misery that death becomes a happy escape. Sometimes, before committing suicide, they first kill their children and other members of the family. . . . Under the delusion of a future without hope and the inevitability of catastrophe overtaking their nearest and dearest as well as themselves, they decide to kill in order to spare their loved ones suffering. (West, 1965: 6)

Schipkowensky also stressed the extent to which the 'patient feels his personality is without value (delusion of inferiority). His life is without sense, it is only [one of] everlasting suffering, and he feels he "deserves" to be punished for his imaginary crimes' (Schipkowensky, 1969: 64–65).

### Case Vignette 1

*The Independent* (16 February 2002, p. 3) reports the case of a young mother who was found dead at the foot of a cliff in Scotland. It was said that she was suffering from severe post-natal depression. She was believed to have thrown her two children over the cliff and then killed herself. It was reported that she had a history of serious mental health problems.

### Case Vignette 2

A young man had become severely depressed and was so convinced that the world was a terrible place in which to live that he attempted to kill his mother, his

sister and then himself. Only swift medical intervention saved all their lives. Following a court appearance, he was made the subject of hospital care; he responded well to treatment and made a good recovery.

Trying to estimate the extent and duration of a depressive illness and its relevance to serious offences such as homicide is very difficult. Gunn et al. (1978) put the position very clearly:

It is very difficult to establish *unless several helpful informants are available* whether a depressed murderer is depressed because he has been imprisoned for life, depressed because of the conditions in which he has been imprisoned, depressed by the enormity of his crime, or whether he committed murder because he was depressed in the first place. (p. 35, emphasis added)

The comment by Gunn et al. emphasizes the importance of the availability of a full social history of the offender and the circumstances in which the crime was committed, a task well within the province of the probation service.

A statement by Higgins is also very important:

Depression may result in serious violence, tension and pre-occupation building up over a protracted period and an assault committed in a state of grave psychological turmoil. The act itself might then act as a catharsis, the individual not afterwards appearing depressed nor complaining of depression *and the diagnosis then being missed*. (Higgins, 1990: 348, emphasis added)

## Hypomanic disorder and violent crime

Hypomanic disorder is characterized by elevation of mood, ideas (delusions) of grandiosity, lack of insight, disinhibition (often sexual) and anger if frustrated in pursuit of the sufferer's aims. From time to time, persons may come to the attention of the courts because of their outrageous, insightful and potentially dangerous behaviour. The following case vignette illustrates the nature of the condition.

### Case Vignette 3

This concerned a car salesman in his twenties. He initially impressed his employer as a bright, energetic and very enthusiastic worker. However, it was not long before his ideas and activities took a grandiose and highly unrealistic turn. For example, he sent dramatic and exaggerated letters daily to a wide range of motor manufacturers. His behaviour began to deteriorate rapidly, he lost weight through not eating (he 'never had time') and he rarely slept. One night, in a fit of rage directed towards his 'unsympathetic' employer, he returned to the car showrooms, smashed the windows and did extensive damage to several very expensive cars. He appeared in court, was remanded for psychiatric reports, and was eventually hospitalized under the Mental Health Act.

The characteristics of this type of patient are worth re-emphasizing, since they justify the 'mental illness' label very clearly. They consider themselves to be



omnipotent and become convinced that their wildest ideas are, in fact, entirely practical. Because there is no impairment of memory, they are capable of giving persuasive rationalized arguments and explanations to support their actions. It is important to stress that such persons are very difficult to treat without the use of compulsory powers, since they fiercely resist the idea that anything is wrong with them. However, though lacking insight, they can appear deceptively lucid and rational; it is this that makes their behaviour a very real risk to others. They can be not only hostile, but also physically aggressive to those they consider are obstructing them in their plans and activities. Persons in full-flight hypomanic states can be some of the most *potentially* dangerous people suffering from a clearly definable mental illness (see also Higgins, 1990).

### **Schizophrenic illnesses**

At one time, it was customary to speak of schizophrenia in the singular; to some extent, this is still the case, but increasingly, the recognition that there are a variety of 'illnesses' within this term has led some to prefer the use of the word in the plural, or the use of the descriptive term the 'schizophrenias'.

There are disagreements concerning both the causes and classification of these illnesses. In brief, it is safe to suggest that environmental and social factors play a significant part in their onset and duration. However, there are certainly likely to be neuro-biochemical factors which may determine the onset and course of the illness in the first instance. In other words, a person may have an 'in-built' predisposition to develop the disorder which may be enhanced or precipitated by environmental stresses (see Murray et al., 2002).

The most important single characteristic feature of schizophrenic illness is the disintegration and, in some cases, apparent destruction of the personality. In the schizophrenic illnesses, we are dealing with what can best be regarded as a 'splintering' of the mind – the personality shatters and disintegrates into a mass of poorly-operating components rather than a neat division into two parts. The main signs and symptoms of the illnesses consist of:

- Disorders of thinking;
- Disorders of emotion;
- Disorders of volition;
- Psychomotor symptoms;
- Hallucinations.

(see Prins, 2005, Chapter 3 for details)

Over the years, psychiatrists and others (with varying degrees of agreement) have tended to classify the schizophrenic illnesses in the following fashion. I have simplified the classification but not, I hope, to the point of over-simplification. However, in practical terms, the divisions I list below are usually more complicated and not so clear-cut; readers should be aware of this. For example, I have not made reference above to those illnesses on the 'borderland' of schizophrenia such as the so-called 'schizo-affective' disorders where, as the term implies, the sufferer may

demonstrate signs and symptoms of both a schizophrenic and an affective (depressive) disorder. It is also very important to recognize that some of the signs and symptoms of schizophrenic illness can be present in other disorders, including certain organic conditions and alcohol or drug induced psychoses. Such 'comorbidity' is very important.

*Simple schizophrenia.* In these cases, the onset appears to be fairly gradual, occurs in early adult life and is so insidious that the initial signs and symptoms may not be recognized by those near to the sufferer. Social behaviour is impoverished and the emotions appear to be 'blunted' or shallow. The course of the illness and its lengthy duration may gradually 'wear away' the personality, involving a schizophrenic 'process' of steady deterioration in which social functioning is seriously impaired. Such warning signs may be missed by the unwary observer.

*Hebephrenic schizophrenia* (from the Greek 'youthful'). The onset, which occurs most frequently in late teenage or early adult life, is often quite florid and dramatic and often accompanied by delusions and hallucinations. The individual may deteriorate fairly rapidly and require urgent treatment.

*Catatonic schizophrenia.* The key characteristics of this condition are withdrawal from social intercourse accompanied by muteness, the latter sometimes interspersed with occasional episodes of unprovoked violence. In some cases, the limbs may be rigid and board-like. In others, they take on a curious characteristic known as *flexibilitas cerea* (waxy flexibility) in which the limbs are placed and then left in the most contorted positions almost indefinitely. Attempts to return them to normal merely result in the patient returning them to their original position. However, the violent outbursts shown by such patients are fortunately rare.

*Paranoid schizophrenia and paranoid states.* In these cases, the keynotes are irrational over-suspiciousness and ideas of self-reference. Such persons may be convinced that people are continually talking about them, for example accusing them of sexual indiscretions or persecuting them in other ways. Such ideas are quite irrational and are highly impervious to reasoned explanation and discussion.

### ***Schizophrenic illnesses, violence and dangerous obsessions***

This is an emotive topic and rational discussion is not helped by the manner in which the media tend to 'hype up' individual cases and, in the process, lead the public to extrapolate from these singular and rare events to those suffering from schizophrenic illnesses more generally. However, it has to be acknowledged that research over the last decade has indicated that, given certain conditions, there does seem to be an association between some forms of schizophrenia (notably the paranoid varieties) and violence. Indications of such evidence may be found in numerous contributions summarized in Prins (2005, Chapter 3). See also Walsh

et al. (2002), Moran et al. (2003) and Kramp (2004). Notorious cases tend to 'hit the headlines' as, for example, in the case of Peter Sutcliffe, in which contentious issues of diminished responsibility may arise. It is important to stress that people suffering from this type of disorder may begin to demonstrate 'oddnesses' of behaviour *for some time before the disorder emerges in an acute or very obvious form*. Intervention at this stage might, in some cases, have helped to prevent a tragedy. A number of research studies suggest that certain specific factors may help to contribute to violence in some of these patients. Such factors give the lie to the popular media conception that all schizophrenic patients are potentially violent. In point of fact, they are more likely to harm or suffer harm to themselves than others (Walsh et al., 2003). These factors would appear to be as follows:

- (a) Active delusions seem to be powerful factors where the patient perceives some threat, where there is a lessening of mechanisms of self control and dominance of the patient's mind by perceived forces that seem to be beyond his or her control. These phenomena are sometimes described in the literature as 'perceived threat and control override (TCO) . . . TCO involves the belief that (1) others are controlling one's thoughts by either stealing thoughts or inserting them directly into one's mind; and (2) others are plotting against one, following one and wanting to hurt one physically' (Bjorkly and Havik, 2003: 87).
- (b) There is a greater likelihood of violence when the disorder is associated with the ingestion of drugs or other forms of substance abuse. For example, Wheatley (1998) studied a sample of schizophrenic patients detained under the Mental Health Act in a medium secure unit. His results confirmed a high degree of co-morbidity of alcohol and substance abuse and schizophrenia in detained and forensic patients (see also Marshall, 1998). Similarly, in a large-scale American survey involving patients in the community, Steadman et al. (1998) found the incidence of violence was substantially elevated by the abuse of drugs and alcohol.
- (c) The impact of co-morbid personality disorder on violent behaviour in psychosis has been emphasized by Moran et al. (2003). They examined a sample of 670 patients with established psychotic illness. When screened for the presence of co-morbid personality disorder, they found that 28 per cent exhibited the disorder and these patients 'were significantly more likely to behave violently over the two-year trial period [involved in the study]' (p.129). The importance of co-morbidity and dual diagnosis is also emphasized in a comprehensive review by Crichton. He concluded that 'the more specific that studies have been in comparing particular diagnosis and symptom cluster with specific criminal behaviour, the more useful they have been in establishing causality. An emerging theme is the importance of dual diagnosis, particularly substance misuse and psychosis and violent crime' (Crichton, 1999: 659, emphases added).
- (d) Concurrent social problems such as homelessness tend to contribute to the likelihood of violence.

## Paranoid disorder and 'dangerous obsessions'

As already noted, one of the key characteristics of those suffering from one or other of the forms of paranoid illness is their systematized delusional beliefs (and sometimes hallucinatory experiences). These may take the form of irrational and unshakeable beliefs that they are being persecuted by others, or that they have a need to be the persecutor (as in Sutcliffe's case). Two points of cardinal importance need re-emphasizing here. First, such sufferers may begin to develop certain oddnesses of behaviour for some time *before the disorder emerges in an acute or very obvious form*; again, sensitive observation and possible intervention *might*, in some cases, help to prevent a tragedy. However, it has to be acknowledged that this may be very difficult on both clinical and ethical grounds. Second, persons developing paranoid beliefs may do so in an encapsulated (contained) form; thus, a seriously paranoid person may appear perfectly sane and in command of him or herself in all other respects. The illness may be so well encapsulated that an unwary or unskilled observer may be very easily misled. It is only when the matters which the delusional system has fastened on are broached that the severity of the disorder may be revealed.

The sinister and potentially highly dangerous nature of these forms of disorder are clearly exemplified in a condition known variously as 'morbid jealousy', 'sexual jealousy', 'delusions of infidelity' etc. Such disordered thinking can have highly dangerous consequences and may, of course, underlie such conditions as 'stalking' (see later). Although these conditions are given a variety of titles, it might be more helpful to abandon these discrete categories and consider the totality of these phenomena within a framework of 'dangerous obsessions', irrespective of the focus of the unwanted attentions. In suggesting this, I am conscious that I am dealing here with a highly selected range of dangerous obsessions; others are, of course, equally dangerous, particularly when they are motivated by overwhelming desires for control and subjugation, as in some forms of serious personality (psychopathic) disorder. Jealousy is, of course, a universal phenomenon which varies in intensity from the so-called 'normal' to the intensely pathological. A very useful discussion of the 'generality' of jealousy may be found in Pines (1998) and clinical management of the condition is discussed in a comprehensive account by White and Mullen (1989). Jealousy has, of course, featured in a variety of ways in the world's great literature. There are examples in *The Decameron* and in the work of Tolstoy; one of the best descriptions of its potential lethality and intractability is graphically described by Shakespeare. Emilia, wife to Iago and maid to Desdemona, puts it in these terms:

But jealous souls will not be answered so;  
They are not ever jealous for the cause;  
But jealous for they are jealous; 'tis a monster  
Begot upon itself, born on itself. (*Othello*, Act III, Sc. ii)

And the condition is further depicted by Shakespeare when the irrationally jealous Leontes says:

Were my wife's liver  
 Infected, as is her life, she would not live  
 The running of one glass. (*The Winter's Tale*, Act I, Sc. ii)

In my view, the characterization of Leontes gives a more powerful exemplification of delusional jealousy than the description of Othello – to the extent that I have suggested elsewhere that we might describe the condition as the *Leontes* rather than the *Othello* syndrome (Prins, 1996).

The boundary between 'normal' and 'abnormal' in this field is difficult to delineate with precision. Mullen, who has made very significant contributions to the study of 'pathological love', states:

In our culture, jealousy is now regarded not just as problematic or undesirable, but increasingly as unhealthy, as a symptom of immaturity, possessiveness, neurosis and insecurity. (Mullen, 1981: 593)

And in similar fashion, Higgins also believes that 'the boundary between normal and morbid jealousy is indistinct':

Jealousy, or a tendency to be jealous, can be a normal relative transient response in an otherwise well adjusted individual to frank infidelity; one feature in an individual with a paranoid personality disorder . . . or a frankly delusional idea arising suddenly and unexpectedly either as a single delusional idea or one of a number of related ideas in a typical psychosis. (Higgins, 1995: 79)

There is no universal agreement as to the causes of 'encapsulated' delusional jealousy. However, a number of explanations have been offered. For example, the person suffering from the delusion may themselves have behaved promiscuously in the past and have harboured an expectation that the spouse or partner will behave in similar fashion. Other explanations have embraced the possibility of impotence in the sufferer with consequent projection of feeling a failure on to the spouse or partner. Freudian and neo-Freudian explanations stress the possibility of repressed homosexuality resulting in fantasies about the male consort of a spouse or partner. Pines suggests the importance of a 'triggering event'; she states that 'Although jealousy occurs in different forms and in varying degrees of intensity, it always results from an interaction between a certain predisposition and a particular triggering event' (Pines, 1998: 27). She considers that predispositions to jealousy vary widely between individuals. For someone with a high predisposition, a triggering event can be as minor as a partner's glance at an attractive stranger passing by. For most people, however, the trigger for intense jealousy is a much more serious event, such as the discovery of an illicit affair. For others, the trigger can be imagined.

The following two case vignettes (Vignettes 4 and 5) demonstrate the irrational nature of such sufferers' beliefs.

#### **Case Vignette 4**

This is a case described by the 19th-century physician Clouston presented in the first edition of Enoch and Trethowan's classic work *Uncommon Psychiatric Syndromes*:

I now have in an asylum, two quite rational-looking men, whose chief delusion is that their wives, both women of undoubted character, have been unfaithful to them. Keep them off the subject and they are rational. But on that subject they are utterly delusional and insane. (Enoch and Trethowan, 1979: 47)

### Case Vignette 5

A man in his sixties had been detained in hospital without limit of time (Sections 37/41, Mental Health Act, 1983) with a diagnosis of mental illness. He had been convicted of the attempted murder of his wife and had a history of infidelity during the marriage. There was a family history of mental illness. The index (original) offence consisted of an attempt to stab his wife to death and a serious assault on his daughter who tried to intervene to protect her. He gave a history of prolonged, but quite unfounded, suspicions of his wife's infidelity. He arranged to have her followed, interrogated her persistently as to her whereabouts (which were always quite innocent) and searched her personal belongings for proof of her alleged unfaithfulness. He even inspected her underclothing for signs of seminal staining in order to confirm his delusional beliefs. He also believed that neighbours and others were colluding with his wife to aid her in her alleged unfaithfulness. As is so often the case, he was regarded as a model patient, well-liked by staff and other patients and, to the unwary and uninformed observer, presented himself as completely rational and reasonable. It was only when asked about his wife that his delusional ideas about her expressed themselves with ominous intensity. Although he had been detained in hospital for some years and his delusional ideas were not quite so intrusive as they were on admission, they were still easily evoked. The likelihood of his release was remote. It had been suggested to his wife that she sever her connections with him entirely and make a new life for herself. However, as is sometimes the case, she was reluctant to do so, hoping that her husband's attitude would change. The wife's attitude is of considerable importance. This is because, in such cases, the irrational beliefs held by the sufferer are not easily amenable to treatment; the wife is likely, therefore, to be at considerable risk whenever the offender or offender-patient is released. Some somewhat cynical professionals, when asked 'What's the best treatment?', have been known to respond by saying 'geographical', meaning that the spouse or partner would be strongly advised to move home and change her name; it seems that the woman in such an instance is doubly victimized. Supervision of these and similar cases requires the utmost vigilance and a capacity to spot subtle changes in both mood and circumstances. It is well known that sufferers from delusional jealousy and similar delusional states have what the late doctor Murray Cox described as 'unfinished business' to complete. Even if, sadly, the first victim dies as a result of the delusionally-held beliefs, surrogate victims may be sought out and be similarly at risk.

## Unwelcome attentions – stalking

As already noted each era seems to produce its own 'shibboleths', be they adult sexual behaviour (and abuse), child abuse, including child sexual abuse of various kinds (for example, ritual satanic abuse), so-called 'serial killing' and, more recently, errant medical practitioners, internet pornography and violence in the workplace. To this last we must now add the behaviour known popularly as 'stalking'. Meloy (1998) aptly states that 'Stalking is an old behaviour, but a new crime. Shakespeare captured certain aspects of it in the obsessive and murderous thoughts of Othello'. He goes on to remind his readers that 'Louisa May Alcott, wrote a novel involving stalking in 1866, *A Long Fatal Love Chase*, which remained undiscovered and unpublished for over a century' (p. xix). There is now a growing recent literature on the topic and in what follows I have been highly selective. In England we have been somewhat slower than other countries to introduce legislation to deal with the problem; for example, the North Americans have had anti-stalking (harassment) legislation for some time. The Protection from Harassment Act of 1997 came into being because of a growing concern about the phenomenon fostered by the publication of a number of cases of well-known people who had been the subject of what can perhaps best be described as 'unwelcome attentions'. Section 1(1) of the 1997 Act states that a person must not pursue a course of conduct: (a) which amounts to harassment of another, and (b) which he knows, or ought to know, amounts to harassment of another. The Act does not provide a specific definition of harassment and the courts tend to rely on the subjective experiences of victims. The Act creates two 'levels' of the offending behaviour. The first is to be found in Section 2 of the Act and may be dealt with summarily, and is currently punishable by a maximum sentence of six months' imprisonment. The second, and more serious form of the offence, is that of causing fear of violence (Section 4) and is punishable on indictment by a maximum penalty of five years' imprisonment imposed by a crown court. See Finch (2002) for a detailed critical discussion of the Act. Harris (2000) carried out a study into the effectiveness of the legislation. She found that 'the most common reason given for harassment was that the complainant had ended an intimate relationship with the suspect. Victims were often unaware of the existence of the legislation and that [they] had often endured the unwanted behaviour for a significant time before reporting it' (p. 2). Overall, the conviction rate in those cases ending in a court hearing was 84 per cent; a conditional discharge was the most frequent disposal. Something over a half of the convictions were accompanied by a 'restraining order' (an option available to the courts under the Act as a means of endeavouring to prevent a repetition of the harassment). A study by Petch (2002) adds weight to Harris's findings into the effectiveness of the Act. He concluded that:

The Act would be more effective if it was used by police, prosecutors and the courts more consistently. A programme of widespread dissemination of the provisions within the Act is now called for. (p. 19)

Some readers may be surprised to know how widespread the problem is. In a study conducted by Budd and Mattinson (2000), as part of the regular updating

of the *British Crime Survey*, it was estimated that in defining stalking as 'an experience of persistent and unwanted attention' 2.9 per cent of adults aged between 16 and 59 had been stalked in the year of the survey. This, they state, equates to 900,000 victims. An estimated 770,000 victims had been distressed or upset by the experience and 550,000 victims had been subjected to violence, threatened with violence or had been fearful that violence would be used. Risks of these unwanted attentions were particularly high for young women between 16 and 19. About a third of the incidents were carried out by someone who was in an intimate relationship with the victim, a further third involved an acquaintance of the victim and *only a third of incidents involved strangers*. The victims' most common experiences were 'being forced to talk to the offender, silent phone calls, being physically intimidated and being followed' (p. 2). A quarter of male victims and a fifth of the women said the perpetrator had used physical force. 'Seven in ten victims said they had changed their lifestyle as a result of the experience. Women were more likely to have done so than men' (p. 2). Other research carried out into the perceptions of stalking on the part of both men and women tends to add weight to these findings (see, for example, Sheridan et al., 2001 and Sheridan et al., 2002). There have been numerous attempts to classify stalkers by their motives and behaviour.

Mullen et al. (1999) have made highly significant contributions to these aspects. They present a classification under five headings:

- (a) The rejected stalker, who has had a relationship with the victim and who is often characterized by a mixture of revenge and desire for reconciliation;
- (b) The stalker seeking intimacy, which includes individuals with erotomaniac delusions;
- (c) The incompetent stalker – usually intellectually limited and socially incompetent individuals;
- (d) The resentful stalker, who seeks to frighten and distress the victim; and finally
- (e) The predatory stalker, who is preparing a sexual attack.

It is not difficult to see that the individuals illustrated in such a classification can prove to be potentially highly dangerous, and some of the perpetrators may show definable mental disorder. A very recent development has been the phenomenon of 'cyberstalking' (see Bocij et al., 2003).

## 'Organic' disorders and violent crime

For the sake of simplicity I propose to consider all the conditions listed below under the broad but somewhat unscientific rubric of 'organic' disorders. The reason for including them is that although they figure quite rarely in violent criminal activity, *it is their very rarity that makes them important*. This is because professionals without a medical training or orientation are often, understandably, somewhat ill-informed about physical (organic) conditions that may play an important part in a person's behaviour or misbehaviour. This is particularly important for those in



the social work and allied professions, where an understanding of human behaviour is customarily based on an emphasis on psychological, social and emotional influences. The importance of what might be described as 'brain behaviour' in determining responsibility for crime, in an age in which we now have sophisticated devices for measuring such activity (such as a variety of brain scanning techniques), has been described by Buchanan (1994).

### ***Infections***

Such conditions include meningitis, encephalitis and a number of other infections. It is not uncommon for marked changes in behaviour to occur after an infective illness such as encephalitis, particularly in children; these changes may sometimes be accompanied by the development of aggressive and anti-social tendencies. It is also worth noting here that in older or elderly persons infections of the urinary tract (UTIs) may produce confusion, disorientation, and a degree of aggression. Unless a urine analysis is undertaken, the signs and symptoms may be mistaken for a stroke or other cerebral disorder.

### ***Huntington's Disorder (formerly known as Huntington's Chorea)***

This is a comparatively rare, directly transmitted, hereditary condition. The onset of the disorder (which is terminal) is most likely to occur in the middle years of life and is characterized by a progressive deterioration of physical, mental and emotional functioning, including the choreiform (uncontrollable jerky movements) characteristic of the disorder. Sufferers from the condition may sometimes behave unpredictably and anti-socially, though such instances are not common.

### ***General paresis***

This is a form of neurosyphilis and is also known as dementia paralytica or general paralysis of the insane (GPI). The disorder develops as a result of a primary syphilitic infection and attacks the central nervous system (CNS). Symptoms may appear many years after the original infective incident. Individuals suffering from the disorder may begin to behave unpredictably and irritably. Such signs may be accompanied by euphoria and grandiosity; indeed, the presenting signs and symptoms may be mistaken for a hypomanic attack (see earlier discussion). Any acts of 'outrageous' behaviour in a person of previous good character should alert professionals to the possibility of the disorder being present. Today, neurosyphilis is not seen with any degree of frequency (whereas in the 19th and early 20th centuries it was fairly widespread). Its disappearance is due largely to earlier diagnosis and the use of antibiotics.

### ***Alcoholic poisoning and violent crime***

The prolonged and regular ingestion of alcohol may bring about serious brain damage with consequent behaviour changes. It may lead to disorders of

consciousness, known as 'twilight states'. One such phenomenon has been described as *mania à potu* in which the afflicted individual may react in an extreme manner to even very small amounts of alcohol; such states may result in violent and anti-social outbursts. We should also note that alcohol acts as a cerebral depressant (though people often mistakenly regard it as an effective euphoriant). The Porter in *Macbeth* describes it well in relation to sexual matters – as follows:

. . . Lechery, sir, it provokes, and unprovokes: it provokes the desire, but it takes away the performance. Therefore much drink may be said to be an equivocator with lechery: it makes, and it mars him; it sets him on, and it takes him off . . . makes him stand to and not stand to. . . . (Act II, Sc. iii)

In other words, it may be mistakenly believed to improve sexual performance, whereas in fact it often results in failed erection and incapacity. It is important to recognize that alcohol acts also as a significant disinhibitor, and that its effects on individuals who may already have brain damage from other causes may involve considerable violence.

### ***Metabolic, other disturbances and violent crime***

Low blood sugar (hypoglycaemia) may occur in certain predisposed individuals who have gone without food for a prolonged period. Judgement may become impaired, they may show extreme irritability coupled with a degree of confusion and in such a state they may come into conflict with the criminal justice system. Such states are important in cases such as diabetes or, more particularly, unrecognized diabetes. Prompt action may be necessary before coma or even death intervene(s). Those with untreated excess thyroid levels (thyrotoxicosis) may become irritable, aggressive and occasionally anti-social. In recent years, a good deal of interest has been focused on the relevance of the menstrual cycle to criminality, particularly violent criminality. The late doctor Katarina Dalton (1982) was involved in a small number of homicide cases where pleas had been put forward that pre-menstrual syndrome (PMS) constituted an abnormality of mind within the meaning of the Homicide Act, 1957. However, such pleas do not appear to have become widespread.

### ***Brain trauma, tumour, brain disease and violent crime***

Brain damage of various kinds may bring about behaviour change involving a violent act – sometimes with tragic consequences. The following case illustrates the problem.

### ***Case Vignette 6***

This concerned a former miner, aged 36, whose personality changed after suffering severe head injuries in a pit accident. Following essential brain surgery, he suffered hallucinations and became aggressive towards his family. During one of these episodes, he threw burning coals around the living room, setting fire to the

house. He was charged with arson, convicted, and made the subject of a probation (community rehabilitation) order with a requirement that he undertake medical treatment.

Occasionally, the dementing processes of advancing old age (of which *Alzheimer's Disease* is the most well-known example) may be associated with behaviour that is not only out of character, but also may be highly impulsive, disinhibited and aggressive. Any such behaviour occurring 'out of the blue' in late mid-life that seems odd, out of character, and carried out (perhaps repeatedly) in the presence of witnesses, should alert police, prosecuting and probation authorities to the possibility of a dementing process, or to the presence of a malignancy of some kind.

### ***Epilepsies, associated disorders and violent crime***

As noted in Table 1, the epilepsies in their various presentations are not, strictly speaking, psychiatric illnesses, but neurological disorders manifested primarily by an excessive or abnormal discharge of electrical activity in the brain. Many thousands of people may have an epileptic attack of one kind or another at some stage in their lives; even for those who have major attacks, it is usually possible to lead a perfectly normal life with the aid of medication. There are many forms of epilepsy and they have been reviewed extensively in the standard textbooks, such as that by Lishman in the various editions of his book *Organic Psychiatry* (1997). Fenwick, in a number of papers, has described in some detail the relationship between epileptic seizures and diminishment of responsibility for crime (see, for example, Fenwick, 1993). Gunn (1977b; Gunn et al., 1978) carried out a number of classic and important surveys into the relationship between epilepsy and crime (particularly violent crime). It was found that more epileptic males were taken into custody than would have been expected by chance – a ratio of some 7–8:1000. This is considerably higher than the proportion of epileptics found in the general population. About one-third of cases studied by Gunn et al. (1978) were found to be suffering from temporal lobe epilepsy and temporal lobe cases were found to have a higher previous conviction rate. However, it was the group suffering from idiopathic epilepsy (epilepsy of unknown origin) that had received disproportionately more convictions for violence than any other group.

Gunn cautions us not to place too much emphasis on the relationship between epilepsy and crime. In doing so, he makes three very important points. First, the epilepsy itself may generate social and psychological problems, which in turn can lead to anti-social reactions. Second, harmful social factors, such as overcrowding, parental neglect and allied problems, may lead to a higher than average degree of both epilepsy and anti-social behaviour. Third, environmental factors such as those just described may lead to behavioural disturbances that not only lead to brushes with the law, but may also aggravate accident and illness proneness. Although it has been stated that there is no very strong *proof* of a general relationship between epilepsy and crime (particularly violent crime), *it may well be very important in the individual case*. For this reason, expert assessment is very important as is careful community monitoring. This is particularly the case if the

person is on medication. Not only does this need to be taken regularly, but violent results may occur if such medication is taken with alcohol (even in very small amounts) or with illicit drugs. It is also important to note that repeated fits over prolonged periods may result in further serious brain damage.

There is a further collection of signs and symptoms akin to epileptic phenomena, described as the 'Episodic Dyscontrol Syndrome', and sometimes also described as 'intermittent explosive disorder' or 'limbic' rage. Lucas (1994) cites some 15 or so alternative labels that have been used over the years. The condition is found in a very small group of individuals who – in the absence of demonstrable epilepsy, brain damage or psychotic illness – show explosively violent behaviour without any clearly discernible stimuli, so that the explosive reaction seems out of all proportion to minimal provocation.

However, Lucas, in his extensive review of the topic, is somewhat sceptical about the diagnosis, suggesting that:

. . . Despite its 25 year survival, episodic dyscontrol may represent [an] impracticable or obsolete idea . . . and as such may be destined for the compost heap of history . . . The fate of psychiatric concepts, however, is not determined by merit alone and episodic dyscontrol may yet prove another tenacious perennial, which to change metaphors, will long survive its obituaries. (1994: 401)

### ***Mental impairment and violent crime***

Cases of mild or moderate mental impairment are the most likely conditions to come to the attention of the criminal justice system. In any event, as Day points out, 'The contribution of the mentally handicapped to the criminal statistics is small'. He goes on to suggest that:

Although the prevalence of offending in the mentally handicapped appears to have remained unchanged over the years, increase is to be anticipated in the coming years as implementation of Care in the Community policies expose more mentally handicapped people to greater temptations and opportunities for offending and the 'hidden offences' which occur regularly in institutions become more visible. (Day, 1993: 116)

The following is a summary of the ways in which the mentally impaired may become involved in violent crime:

- The degree of impairment may be severe enough to prevent the individual from understanding that his or her act was legally wrong. In such cases, issues of responsibility will arise and decisions will have to be made as to whether or not to prosecute the alleged offender.
- The moderately impaired individual may be more easily caught in a criminal act.
- Such offenders may be used very easily by others in delinquent escapades and find themselves acting as accomplices – sometimes unwittingly, sometimes not.

- An individual's mental impairment may be associated with a disorder that may make him or her particularly unpredictable, aggressive and impulsive.
- Some mentally impaired offenders have problems in making understood their often harmless intentions. Thus, a friendly overture by them may be misinterpreted by an uninformed or unsympathetic recipient as an attempted assault, leading to a rebuff. This may in turn lead to surprise and anger on the part of the mentally impaired individual and he or she may then retaliate with aggression.
- A moderately mentally impaired individual may be provoked quite readily into an uncharacteristic act of violence.
- The attitude to legitimate expressions of sexuality in some of the mentally impaired may be naïve, primitive, unrestrained and lacking in social skills. Such deficits may account for the number of sexual offences that appear to be found in the backgrounds of detained mentally impaired patients in the high security hospitals (see Day, 1997).
- Mentally impaired persons may be especially vulnerable to changes in their social environments that would not have the same impact upon their intellectually more able peers.

Two case vignettes (Vignettes 7 and 8) illustrate some of the problems referred to above.

### **Case Vignette 7**

A man of 26 was charged with causing grievous bodily harm to a young woman by hitting her over the head with a metal bar. She was entirely unknown to him, and though he denied the offence vehemently, he was convicted by the Crown Court on the clearest possible evidence. As a child he had suffered brain damage, which had resulted in a mild degree of mental impairment, accompanied by the kind of impulsive, aggressive and unpredictable behaviour referred to above. He had been before the courts on a number of occasions and had eventually been sent to a hospital for the mentally handicapped. He was discharged some years later to the care of his mother. Subsequent to his discharge, he committed the offence described above and was placed on probation. His response was poor. He was impulsive and erratic, and regressed to very childish behaviour when under stress. The family background was problematic: the parents had divorced (acrimoniously) when the offender was quite small; a brother suffered from a disabling form of epilepsy; and other members of the family showed decidedly eccentric lifestyles. (Such a family today might be called 'dysfunctional'.) Shortly after the probation period expired, he committed a particularly vicious and unprovoked assault on a small girl and was sentenced to a long term of imprisonment.

### **Case Vignette 8**

This case illustrates some of the other problems identified above. For many years, a mildly mentally impaired man in his forties had worked well under friendly but

firm supervision. His work situation changed, with the result that his new employers felt he was being lazy and they did not have much sympathy for his disabilities. In addition, his new workmates teased and picked on him. One day, one of them taunted him about his lack of success with the opposite sex. Goaded beyond endurance, the defendant stabbed his tormentor in his chest with a pitchfork, causing quite serious internal injuries. When the case came to the Crown Court, evidence was given as to his mental condition, his social situation and the manner in which he had been provoked. The court made a Hospital Order under the Mental Health Act.

## Chromosomal abnormalities and crime

In the early 1960s, a considerable degree of interest was aroused by the finding that a number of men detained in high security hospitals and prisons carried an extra Y chromosome (XYY). Such men were often found to be taller than average, came from essentially *non-delinquent backgrounds* and not infrequently had records of violence. Subsequent research has proved inconclusive concerning the prevalence of such abnormalities, not only in penal and similar populations, but also in the community at large. Although the leads offered have potential for further and interesting development, there appears to be no strong evidence to suggest a causal link between specific genetic defects or abnormalities and violent crime.

## Psychopathic disorder

The use of the term in the singular is not really accurate. Its use in the plural indicates an understanding that there are various forms of the disorder. By definition the disorder, whether we use the current legal description (psychopathic disorder), or the clinical (severe anti-social personality disorder) (APA, 2000) or dissocial, personality disorder (WHO, 1992) will have the strongest association with crime and, in particular, violent crime. The aetiology, classification and management of the disorder are highly complex and cannot be discussed in any detail here. Most readers of this journal will be very familiar with them. Suffice it to say that those showing the key characteristics of the disorder are very hard to like ('unloved, unlovable and unlovely'); they are highly manipulative and creators of chaos for all those who try to help/manage them, be they family, friends or criminal justice and forensic-psychiatric professionals. They truly represent the 'Achilles heel' of criminal justice and forensic-psychiatric management. Whether the disorder is a true *illness* or not is a moot point. Cleckley, in his seminal text on the topic, thought it was a true illness, as did Sir David Henderson, a former 'doyen' of British psychiatry (Cleckley, 1976; Henderson, 1939). And, much more recently, Kendall (1999) took a similar view. Whether, as some suggest, we should change the label, we are still going to have to work with such people, and in doing so, the key measures are insistence, consistence and persistence in our encounters with them.

Such approaches require a major effort to confront our own 'demons' (as we also need to do with the categories described earlier in this contribution). Readers wishing to seek elaboration on these brief comments may wish to consult Prins (2005, Chapter 4).

## Conclusion

This contribution has inevitably had to be highly selective in the conditions discussed. For example, I have not referred to important states of mind such as malingering, amnesia, somnambulistic behaviour and how these may affect responsibility for violent crime. All the conditions described in this contribution need to be viewed against the social and political climate prevailing currently. This climate is much preoccupied with public protection, the assessment of risk and the resulting over-hasty implementation of more and more criminal justice measures to deal with our current 'folk devils'. Professionals have a responsibility to keep their heads above these turbulent waters and to remain calm. Indeed, they have a responsibility, whenever they can, to promote better public understanding. However, they can only do this if they have informed knowledge. It is hoped that this article has made a modest contribution in this direction.

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