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Chapter 4

‘Thick coming fancies’

As she is troubled with thick coming fancies
That keep her from her rest.

(The doctor to Macbeth concerning his wife’s mental state,
in *Macbeth*, Act 5, Sc. 3)

This chapter considers some of the ‘thick coming fancies’ – namely disturbed mental states – that have been alluded to briefly in earlier chapters. Three other quotations may help readers to focus upon the content of this chapter. Othello says, ‘It is the very error of the moon; She comes more nearer earth than she was wont, and makes men mad’ (*Othello*, Act 5, Sc. 2). King Lear says, ‘Oh, let me not be mad, not mad, sweet heaven! Keep me in temper: I would not be mad!’ (*King Lear*, Act 1, Sc. 5) and Macbeth asks of his wife’s physician: ‘Canst thou not minister to a mind diseas’d?’ (*Macbeth*, Act 5, Sc. 3). The first quotation serves as a reminder of the many myths that surround ‘madness’; the second suggests most powerfully the fear of ‘madness’; and the third is indicative of our attempts to replace madness with sanity in offenders and offender-patients. The myths and fear surrounding madness (particularly if ‘madness’ is linked to ‘badness’) account for many of the problems involved in establishing various forms of community provision for those who have this dual label. In a study carried out by Claire Holden, one of my former students, and her colleagues into the use of public consultation exercises in relation to establishing secure mental health facilities, the authors found that health trusts ‘tended to underestimate the depth of public feeling and this fostered . . . [local] residents’ suspicions and hostility’. To offset these problems, the authors suggest that their findings ‘highlight the need for trusts to be open with all interested parties as early as possible. The maintenance of an on-going dialogue with local residents, politicians, media, service-user groups, community health councils and statutory bodies is essential’ (Holden et al. 2001: 513). In a thought-provoking article which is highly relevant to this problem, Pilgrim and Rogers (2003) critically examine the extent to which politicians (in particular) ‘remain concerned about the
special threat which psychiatric patients allegedly pose to public safety’. They note ‘three contextualising factors: public prejudice; the widening remit of deviance control by psychiatry during the twentieth century; and inconsistent societal sanctions about dangerousness’ (Pilgrim and Rogers 2003: 7). In providing a degree of support for this view, Walsh et al. (2003) found that in a study of some 700 patients with established psychotic disorders, those with psychosis were found to be ‘at considerable risk of violent victimisation in the community’ (Walsh et al. 2003: 233). This is a helpful countervailing view to the political and public notion of the dangers posed by those who are mentally ill. In preceding chapters I made reference to certain forms of mental disturbance and their possible relationship to criminal behaviour. Such reference was in very general terms; in this chapter, I consider aspects of mental disturbance and its relationship to criminality in more detail. The term ‘mental disturbance’ is used here, as in preceding chapters, to include mental disorder as now defined in the Mental Health Act 2007 in England and Wales. The 1983 Act definition included mental illness (not further defined in that Act), mental impairment, severe mental impairment, psychopathic disorder, and any other disability of the mind. The new Act simply defines it as ‘any disorder or disability of mind’. As Fennell (2007) states in his excellent comprehensive discussion of the 2007 Act, ‘Once the Act is in force, a person will be able to be detained if suffering from “any disorder or disability of the mind”, regardless of whether the detention is for a short or long period’ (Fennell 2007: 45). Personally, I prefer, for the purpose of this chapter, to use the term ‘mental disturbance’, since it allows us to consider states of mind that would not necessarily satisfy the strict criteria for compulsory admission to hospital or a community treatment order under the 2007 Act. The term is used in this chapter merely to encompass a range of disordered mental states, but its imperfections are recognized. (For a more detailed definition, see NACRO 1993: 4.) As I hope to demonstrate, it is reasonably easy to define mental illnesses, especially those with clear-cut aetiology (cause); it is harder to define, with a degree of acceptable precision, such conditions as mental handicap (learning disability), particularly in its milder presentations and, to a marked degree, such conditions such as severe personality (psychopathic) disorder. However, what we do know with some degree of certainty, is that mental disturbance is likely to be present in all cultures (though it may present in a variety of ways) and at all levels of society, including political and other leaders. This latter possibility can have frightening possibilities, as Freeman has demonstrated (see, for example, Freeman 1991).

‘Changing the goalposts’

At the outset we are faced with the difficult task of trying to establish any clear causal connections, or even associations, between mental disturbance
and criminality. This is because we are trying to make connections between very complex and different phenomena; and these phenomena are the subject of much continuing debate concerning both definition and substance. It is as though the goalposts for the game are constantly being shifted. Let me take the case of mental illness as an example of this phenomenon. There are those who seek to suggest that some forms of mental illness do not even exist. A well-known proponent of this view is Professor Szasz who, in many of his books and papers, has suggested that persons are often diagnosed as mentally ill on the grounds that they have problems in living and that these problems may affront society. Society then turns to psychiatrists to remove them from public view and conscience (see, for example, Szasz 1987). The foregoing is a somewhat bald and simplistic view of Szasz’s work and, to be fair, he has written substantial rebuttals of his critics (see, for example, Szasz 1993). However, his arguments do have a kernel of truth in that he alerts us to the manner in which psychiatry may be abused. They also have a certain attractive seductiveness, but they also contain a quality of rhetoric which has been criticized by both psychiatrists and non-psychiatrists (see, for example, Sedgewick 1982; Roth and Kroll 1986). In the 1960s, there existed a popular view that much mental illness had its origins in 'conspiracies' and 'mixed messages' within families. This view is exemplified in the work of Ronald Laing and his colleagues (see, for example, Laing and Esterson 1964). (For a challenging perspective on this problem, see Bean 2008: Part Four.) At the other end of the ‘spectrum’ we have the more biologically orientated view that found expression in some of the earlier textbooks of psychiatry. Professor John Gunn put the position into perspective very ably when he stated that:

somewhere in the confusion there is a biological reality of mental disorder . . . this reality is a complex mixture of diverse conditions, some organic, some functional, some inherited, some learned, some acquired, some curable, others unremitting.

(Gunn 1977a: 317)

This complex picture is also compounded by the fact that the prevalence and presentation of mental disturbances appear to change over time. Some investigators such as Hare (1983) and Scull (1984) have concluded, albeit very tentatively, that the schizophrenic illnesses as we now know them possibly did not exist on any large scale in earlier times. However, anecdotal and clinical evidence would suggest that such assertions need to be viewed with a degree of caution (see Bark 1985; Eastman 1993; Gunn 1993). It is worth mentioning here that, in earlier times, there may well have been individuals presenting with psychiatric signs and symptoms in
whom, these days, we would recognize a physical or organic origin. In the Middle Ages, for example, malnourishment produced a pellagric (nutritional deficiency) state with its psychological and psychiatric consequences. The use of bad or adulterated flour could produce ergot poisoning which, in turn, could produce signs and symptoms of mental illness. It has even been suggested that episodes of the so-called ‘dancing mania’ seen in post-medieval Italy and surrounding countries were probably due to such a cause (Camporesi 1989). Lead was commonly used in making cooking utensils, in water pipes and in wine production. This could have had harmful results, which might have produced confused and disturbed behaviour. Some people afflicted by states of so-called ‘possession’ probably may have suffered from similar organic causes. (For discussion of such states, see Prins 1990: Chapter 3; Enoch and Ball 2001: Chapter 11.) Occupations have also been shown to have their hazards. We may infer from Lewis Carroll’s depiction of the ‘Hatter’, at the famous tea party in Alice’s Adventures in Wonderland, that he was ‘mad’, although the author does not say so specifically; people who worked in the hat-making industry were exposed to mercury, and mercurial poisoning can produce signs and symptoms of mental disturbance. It has been suggested that Isaac Newton’s well-known episodes of apparent depression, leading to withdrawal from public life and activity, may have been due to the effect of the mercuric substances with which he experimented (see Klawans 1990; Gleick 2003). Since the 1990s, much concern has been expressed about the effects of lead emissions on children’s behaviour; there is also a school of thought that maintains that poor quality diet (particularly if it contains amounts of ‘junk’ foods and excess additives) may produce not only hyperactivity, but also antisocial behaviour in some children. However, unequivocal evidence of this, both in the United States and in Britain, does not yet appear to be available. It is difficult to provide precise figures for the numbers of people suffering from mental disorders. In a government publication Modernising Mental Health Services (Department of Health 1998), it was suggested that depression in one form 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.

(1.2–1.4)
The rates found in 2000 were much in line with those reported in 1995, but the proportion of people actually receiving treatment had increased considerably. Such statistics can provide only a very rough indicator of the mental health of a nation. This is because there are likely to be not inconceivable numbers of individuals suffering from a degree of mental disturbance or 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, in terms of distress to the sufferers and their families and others close to them, is very considerable. These predicaments are well described by Jeremy Laurance, Health Editor of *The Independent*, in his book on the mental health system (Laurance 2003). Much of it is hidden from view and the figures we have represent only the tip of the iceberg. 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.

When we come to consider criminal behaviour we are faced with problems similar to those outlined above. At its simplest, crime is merely that form of behaviour defined by society as illegal and punishable by the criminal law. At various times in our history, acts once judged as criminal have been redefined, or even removed from the statute books – as, for example, in the case of attempted suicide and adult (or now near adult) male consenting homosexual acts committed in private. New offences are also created, particularly in times of war or civil commotion. Moreover, our increasingly complex technological society has required the introduction of a wide range of laws and regulations governing many aspects of our conduct. Since much criminal behaviour is somewhat arbitrarily defined, and there are arguments about the existence and definitions of mental disturbances, it is hardly surprising that we find difficulty in trying to establish the connections between these two somewhat ill-defined and complex behaviours. Be this as it may, there are occasions when some mental disturbances do seem to be closely associated with criminal conduct, and aspects of this connection are now considered in some detail.

Mental disturbances (disorders) have been classified in a variety of ways. The two most widely acknowledged classification systems – particularly for purposes of cross-cultural research – are the *Diagnostic and Statistical Manual of Mental Disorders*, published by the American Psychiatric Association (APA 2005: 4th edn (text revision) DSM-IV-TR) and the *International Classification of Mental and Behavioural Disorders*, published by the World Health Organization (WHO 1992: ICD-10). These substantial texts cover every aspect of diagnosis and classification. Readers should also consult one of the standard textbooks of psychiatry, a good example being the very detailed two-volume work *The New Oxford Textbook of Psychiatry* (Gelder et al. 2009). Table 4.1 provides a much simplified classification of mental disorders followed by some explanatory comment.
Table 4.1 Simplified classification of mental disorders (disturbances)

<table>
<thead>
<tr>
<th>Main categories&lt;sup&gt;a&lt;/sup&gt;</th>
<th>Subcategories</th>
</tr>
</thead>
<tbody>
<tr>
<td>The functional psychoses</td>
<td>Affective disorders</td>
</tr>
<tr>
<td></td>
<td>Schizophrenic illnesses</td>
</tr>
<tr>
<td>The neuroses: psychoneuroses, neurotic reactions, post-traumatic stress disorder (PTSD)&lt;sup&gt;b&lt;/sup&gt;</td>
<td>Mild depression, anxiety states, hysteria (hysterical reactions), obsessive-compulsive disorder</td>
</tr>
<tr>
<td>Mental disturbance as a result of infection, disease, metabolic and similar disturbance, physical trauma</td>
<td>Including the epilepsies&lt;sup&gt;c&lt;/sup&gt;</td>
</tr>
<tr>
<td>Mental disturbance due to the ageing process</td>
<td>For example, the various dementias, certain unusual psychiatric syndromes ('eponymous' conditions)&lt;sup&gt;d&lt;/sup&gt;</td>
</tr>
<tr>
<td>Personality abnormalities: including severe personality (psychopathic) disorder; some sexual deviations</td>
<td></td>
</tr>
<tr>
<td>Substance abuse (alcohol, other drugs, solvents)</td>
<td></td>
</tr>
<tr>
<td>Mental impairment: including learning disability, mental handicap, mental retardation&lt;sup&gt;e&lt;/sup&gt;</td>
<td></td>
</tr>
</tbody>
</table>

Notes: (a) The following general classification could be slightly misleading, implying that the disorders are discrete entities. This is not the case. Disorders may coexist and such states are usually described as co-morbid, leading to the need for a dual diagnosis. The importance of this should never be overlooked. Childhood disorders are not included in this table (for example, childhood depression, autistic spectrum disorders such as Asperger Syndrome); I have confined myself largely to adult disorders. However, where developmental issues are relevant, they are discussed in various parts of the text (for example, in the possible genesis of severe personality disorder). (b) In recent times there has been a marked development of interest in the relationship between post-traumatic stress disorders and criminality. See, for example, Crisford et al. (2008), Friel et al. (2008) and Morel (2008). (c) The epilepsies (note the use of the plural) are essentially neurological disorders, but are included here because of their psychiatric and psychological consequences (sequelae). (d) 'Eponymous' conditions, are named after those who first identified them. This is common in both psychiatry and general medicine. See Table 4.2 (p. 123) for some psychiatric examples (see also Prins 1990: Chapter 2). (e) Mental impairment has been the subject of various titles over historical time. Some of the older terminology was highly pejorative (for example ‘Mongolism’, later called Down’s Syndrome after the doctor who first recognized and described it clinically, feeble-mindedness, idiocy and moral defectiveness).

Some common misnomers

It is not uncommon for some of the specialist terms used in psychiatry to fall into common use or be used in a pejorative fashion. My sometime colleague on the Mental Health Review Tribunal, Dr John Grimshaw, used to make this clear in our induction courses for new MHRT members (John Grimshaw, unpublished course lecture notes, 1997). For example, demented
does not mean agitated, hysterical does not mean excited and noisy, manic does not mean rushing around (although, as we shall see, people in a manic state may act somewhat frenetically). Schizophrenia does not mean split personality as in Robert Louis Stevenson’s story of Dr Jekyll and Mr Hyde in 1886; rather, it refers to a gradual ‘splintering’ or disintegration of the personality. Neurotic does not mean over-fussy or over-anxious, and depression in the clinical sense, means being decidedly unwell and not just ‘pissed off’ or ‘miserable’. Barbara Vine, in her novel *Gallowglass*, provides a wonderful short distinction between the two phenomena (Vine 1990: 14–15).

**The functional psychoses**

This term is used to describe a group of severe mental disorders for which, as yet, no evidence of underlying organic brain disorder has been demonstrated conclusively. However, there is some evidence to suggest that in time a biochemical basis for these disorders may be found. The two illnesses subsumed under this heading are the affective disorders (*bipolar or manic-depressive illness*) and the schizophrenic illnesses. I consider first the affective disorders. In doing so I must emphasize again that only the barest outline is provided of this and the following disorders. Specialist texts should be consulted for detailed accounts of their aetiology and management.

**Affective disorders**

The underlying characteristic of an affective disorder is a basic disturbance of mood (hence the term affective, meaning relating to affect or mood). In cases of mild depressive disorder (see later), the disturbance of mood may be sufficiently slight for it to be almost unnoticeable to those quite close to the person – to such an extent that its onset may be unnoticed. As noted in Chapter 3, this may account for the occasional failure of prison staffs to ‘spot’ depression in a newly remanded prisoner. In severe depressive disorder, the mood disturbance is much more pronounced; a useful aide-memoire is that the main characteristics are those of ‘loss’ (of energy, of libido (sexual drive), weight, appetite, interest in oneself and one’s environment). Such features may be so pronounced that the person concerned may be quite unable to perform normal daily routines and functions. Accompanying characteristics may include varying degrees of tension, severe feelings of guilt, lack of concentration, disturbances in sleep patterns and preoccupation with what the sufferer believes to be disturbed bodily functions (such as bowel or bladder functions). For example, loss of appetite may lead to constipation, which in turn may lead to acute abdominal discomfort; the depressed person may then come to believe that some kind of cancerous tumour is eating away at their bowels – maybe as a punishment for some
imagined ‘sin’. Some forms of depressive disorder are also characterized by agitation, restlessness and irritability; such presentations, being somewhat atypical of depression, can lead to possible misdiagnoses. In very severe states of depression, the degree of retardation of function may be such that suicidal action will be precluded. However, as recovery takes place, such thoughts may become prominent and the person may have enough psychic and physical energy to put them into action. It is therefore of the utmost importance that such patients and their families are counselled as to the risks involved in premature discharge from hospital. This is demonstrated in the following case illustration.

**Case illustration 4.1**

A male patient, aged 45, had developed many of the signs of serious depression over the preceding few months (abnormally high level of anxiety, disturbed sleep pattern, loss of appetite resulting in weight loss and consequent preoccupation with bowel functions, believing he might have a tumour). He took an overdose of sleeping tablets (prescribed by his GP for his insomnia), was admitted to a local hospital and subsequently transferred to a psychiatric unit. Having received some treatment for his depression he felt better; his brother persuaded him to take his discharge (against medical advice). Two days later, he went out alone for a walk, threw himself under an express train and was decapitated.

At the other end of the spectrum is the condition known as mania or hypomania (the latter condition being the more common and is just below ‘full-flight’ mania). The condition is the very opposite of depressive illness. Here, activities are speeded up in gross and frenetic fashion, grandiose ideas are developed and the person becomes uncontrollably excitable, overactive, socially (and sometimes highly sexually) disinhibited, and is totally lacking in insight. Attempts by family, friends and professionals to interfere with what the sufferer believes to be his or her lawful activities may result in serious injury to themselves. This total lack of insight normally demands admission to hospital under compulsory powers. Given treatment (usually drugs like lithium) the condition can be remedied, the mood quietens down and some degree of insight regained.

There is no universal consensus as to the classification and aetiology of affective disorders. Some authorities take the view that two types may be discerned — *endogenous* (that is, where no clear precipitating factors can be seen) and *exogenous* (or *reactive*); in the latter, some stressful life event is thought to have precipitated the illness. When states of depression alternate with episodes of manic illness, the term *manic-depressive psychosis* is sometimes used. Some authorities refer to the depressive phase of this particular illness as bipolar depression, using the term unipolar depression for those cases in which manic illness is not present. Bipolar depressive states need
careful monitoring, since someone may suffer a severe depressive state following a manic episode; in such cases, suicide is always a risk.

Classification, even if somewhat crude, is of importance from the point of view of treatment. Generally speaking, endogenous depression, if it is proving intractable, responds best to moderate applications of ECT (electroconvulsive therapy) and exogenous depression seems to respond best to medication supplemented by psychotherapy of some kind. However, I should stress that the modes of treatment I have outlined briefly, and the indicators for them, are not necessarily as clear cut as I have suggested.

Severe depressive disorder and crime

From time to time, we find cases in which a person charged with a grave offence such as homicide is found to be suffering from severe depressive disorder at the time of the crime. West (1965), in an early and informative study of cases of Murder Followed by Suicide, suggested that sufferers from 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 (1969) 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 illustration 4.2

The Independent (16 February 2002) reported 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 postnatal depression. She was believed to have thrown her two children over the cliff and then killed herself. The police reported that the mother and her children had ‘plunged about 100 feet to a ledge on the side of [a] hill. It was reported that she had a history of mental health problems.

Case illustration 4.3

This is the case of a young man under my supervision many years ago during my work as a probation officer. He had become severely depressed and became 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.

(Gunn et al. 1978: 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 detailed circumstances in which the crime was committed.

Finally, in this brief discussion of depression and crime, a significant comment is made by Higgins (1990; see also White 2005):

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 crime**

I have already alluded to some of the main features of this disorder. From time to time, persons suffering from manic disorder of varying degrees of severity may come to the attention of the courts because of their outrageous, insightless and potentially dangerous behaviour. The following two case examples illustrate the nature of the condition; in the second example, the outcome was such that a court appearance was avoided.

**Case illustration 4.4**

This is the case of 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.

**Case illustration 4.5**

A young woman became increasingly convinced that certain members of the Cabinet were her close friends and would assist her in her grandiose schemes for the development of a quite unrealistic business enterprise. When her calls to Downing Street were not reciprocated, she became increasingly angry and threatened with physical violence those she saw as obstructing her. She was quite without insight, did not believe she was ill, and because of her threats to others she was hospitalized, but not before some consideration was given to prosecuting her for threatening behaviour. Following treatment by medication, her mood became slightly less high, though she remained very irritable, somewhat disinhibited and showed little insight. It was envisaged that she would need to remain in hospital for some time until her mood stabilized and her potentially dangerous preoccupations diminished.

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 for support of 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. As already noted, they can be not only verbally 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 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, using the descriptive term, the *schizophrenias*.
Debate exists concerning both the causes and classification of these disorders. Currently, it seems safe to suggest that environmental and social factors play a significant part in the onset and duration of the illnesses, but 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; Gelder et al. 2009).

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 near division into two parts – as lay interpretations of the word would imply (see earlier discussion). In particular, there is likely to be a degree of incongruity between thoughts and emotions. The main signs and symptoms of the illnesses fall under the following broad simplified headings, though they will not necessarily be present in every case. As we shall see, some of them are of considerable forensic importance.

- **Disorders of thinking**: delusions are common; for example, a person may believe that his or her thoughts are being stolen by others.
- **Disorders of emotion**: these may range from excessive anxiety and perplexity, and a flattening of mood (sometimes interrupted by severe outbursts of rage) on the one hand, to complete incongruity of affect (emotion) on the other: for example, giggling at something nonsufferers would consider sad.
- **Disorders of volition**: the key characteristic here is likely to be apathy and a consequent withdrawal from social intercourse. The individual may behave in a very negative fashion – a presentation sometimes described technically as _negativism_.
- **Psychomotor symptoms**: periods of complete lack of emotion or a stuporose state may be interspersed with outbursts of sudden and unpredictable violence.
- **Hallucinations**: in the schizophrenias these are mostly (but not exclusively) of an auditory nature. They may consist of voices which tell the sufferer to do certain things or, alternatively, the person may state that his or her thoughts can be heard and controlled by others. Occasionally, the individual may believe that people are interfering with them: for example, if this supposed interference is sexual, it may result in an unprovoked assault on an innocent stranger.

Over the years, psychiatrists and others (with varying degrees of agreement) have classified the schizophrenic illnesses. For example, one of the two
major textbooks on psychiatric classification and presentation, the DSM-IV-TR (APA 2005: 19), gives a fivefold classification as follows: Paranoid Type, Disorganized Type, Catatonic Type, Undifferentiated Type and Residual Type. I have simplified this classification but not, I hope, to the point of oversimplification. 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 co-morbidity has important implications when we come to consider forensic-psychiatric aspects of the schizophrenias.

- **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.

- **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 accompanied by delusions and hallucinations. The individual may deteriorate fairly rapidly and require urgent treatment.

- **Catatonic schizophrenia:** this condition is seen much more rarely today than in the past; this is due, in part, to the early use of certain drugs that seem helpful in this condition. The key characteristics 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. The violent outbursts shown by such patients are fortunately rare; these, and the violence exhibited in cases of acute hypomania, may account for the small number of incidents of serious violence committed by some psychiatric inpatients.

- **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. As I shall demonstrate shortly, 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 since the late 1960s 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 contributions by McNeil et al. (1988), Linquist and Allebeck (1990), Swanson et al. (1990), Hodgins (1992), Link et al. (1992), Monahan (1992), Gunn (1993), Link and Steuve (1994), Wesseley et al. (1994), Taylor (1995), Hodgins and Muller-Isberner (2001), Monahan et al. (2001), Hodgins and Gunnar-Janson (2002), and Monahan (2002). Two more recent contributions add to the evidence, Walsh et al. (2002) and Moran et al. (2003). Notorious cases tend to ‘hit the headlines’, with Peter Sutcliffe, referred to in Chapter 2, being a case in point. Many years earlier, a man called John Ley – a former Australian senior law officer – was convicted of conspiring to murder a man he deludedly believed to have seduced his wife. Ley was sentenced to death but, after sentence, was found to be suffering from a paranoid illness; he was sent to Broadmoor where he subsequently died. In more recent times, Ian Ball was ordered to be detained in a (special) high security hospital as a result of an elaborate and skilful (yet highly delusional) plan to kidnap Princess Anne in the Mall in London. And, of course, there have been cases in the United States of murderous attacks on political figures by individuals allegedly suffering from some form of schizophrenic illness. 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 may, in some cases, help to prevent a tragedy. Some of the research studies quoted above suggest that certain factors may help to contribute to violence in some schizophrenic patients. It is very important to consider these factors in order to 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). The delusional ideas would appear to be as follows.
First, 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)

Professor Tony Maden describes them very succinctly. ‘The typical scenario is the persecutory delusion in which the sense of threat is used to justify pre-emptive action and overrides a person’s normal inhibitions against violence’ (Maden 2007: 27). However, Monahan (2002) suggests the espousal of a degree of caution in respect of delusions. In the very large-scale MacArthur study of the relationship between psychotic illness (notably schizophrenia) and violence, he and his colleagues found that the presence of delusions [did] not predict higher rates of violence among recently discharged psychiatric patients . . . In particular, the much discussed findings of a relationship between threat/control override delusions and violence were not confirmed . . . on the other hand, non-delusional suspiciousness – perhaps involving a tendency towards misperception of others’ behaviour as indicating hostile intent – does appear to be linked with subsequent violence, and may account for the findings of previous studies. (Monahan 2002: 68–69)

Second, 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.

Third, 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 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]’ (Moran et al. 2003: 129). The importance of co-morbidity and dual diagnosis is also emphasized in a comprehensive review by Crichton (1999). 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)

Finally, concurrent social problems such as loss of family ties and homelessness may tend to contribute to the likelihood of violence.

**Paranoid disorder and ‘dangerous obsessions’**

I am aware that this heading does not bear much relationship to conventional classificatory practice, but I have provided it in order to try to simplify somewhat complex forms of behaviour. I trust any of my psychiatrist colleagues who chance upon this book will afford me a degree of latitude!

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 we saw in Sutcliffe’s case). It is important to emphasize here that such systems of belief are not necessarily peculiar to those suffering from a schizophrenic disorder; they may be part of an affective illness or be associated with chronic alcohol abuse or, in some cases, organic disorder. Two points of cardinal importance need 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; sensitive observation and possible intervention may, 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 delineated in a condition known variously as ‘morbid jealousy’, ‘sexual jealousy’, ‘delusions of infidelity’, the ‘Othello Syndrome’ etc. This disorder will now be used as an example of these particular distortions of thinking and behaviour. Dealing with the phenomena in this way can be used to illustrate by way of extrapolation similar kinds of behaviours in which obsessional preoccupations can become highly dangerous. For this reason, I shall also include a brief discussion of the fairly recently described preoccupation with the phenomenon of ‘stalking’, though of course not all stalkers suffer from mental disorder in a strict medical sense. As indicated above, some of 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. In the 1940s, Lagach (1947) made the important observation that love involved two elements: a desire to dedicate and give oneself to the beloved – ‘amour oblatif’ – and the desire to possess and subjugate, which he called ‘amour captatif’. He considered that those who fell into the second category were especially prone to jealousy. 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 been described in a variety of ways in the world’s great literature. There are examples in Giovanni Boccaccio’s *The Decameron* and in the work of Leo Tolstoy; and, of course, one of the best descriptions of its potential lethality and intractability is graphically described by Shakespeare in *Othello*. Emilia, wife to Iago and maid to Desdemona, puts it in these terms:

> But jealous souls will not be answer’d 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 3, Sc. 4)

And the condition is further depicted graphically by Shakespeare in *The Winter’s Tale*, where the irrationally jealous Leontes says:
Were my wife’s liver
Infected as her life, she would not live
The running of one glass.
(The Winter’s Tale, Act 1, Sc. 2)

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 better describe the condition as the Leontes rather than the Othello Syndrome (Prins 1996). In more modern times, the crime novelist Patricia Cornwell has an apt observation on the nature of dangerous obsessive love:

Attraction turns to obsession, love becomes pathological. When he loves, he has to possess because he feels so insecure and unworthy, is so easily threatened. When his secret love is not returned, he becomes increasingly obsessed. He becomes so fixated his ability to react and function becomes limited.

(Cornwell 1995: 221)

She also makes a further compelling and disturbing observation: ‘Murder never emerges full blown from a vacuum. Nothing evil ever does’ (Cornwell 1995: 312). Such an observation has great importance when we attempt to discover and assess risk triggers.

The boundary between ‘normal’ and ‘abnormal’ in this field is difficult to delineate with precision. Mullen (1981), who has made highly 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)

In similar fashion, Higgins (1995; see also Maden 2007) 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 (1998) 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 (as reported by R. Dobson in *The Independent*, 3 September 1998).

The following three case illustrations demonstrate the varied and irrational nature of such sufferers’ beliefs.

**Case illustration 4.6**

This is the case of two men described by the nineteenth-century physician Clouston and presented in the first edition of Enoch and Trethowan’s classic work *Uncommon Psychiatric Syndromes* (1979):

> 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 illustration 4.7**

This case, drawn from my own experience, supports the irrationality of belief so graphically described by Clouston. This concerned a man in his sixties, detained in a high security hospital without limit of time (Mental Health Act 1983, Sections 37/41) 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 at his Mental Health Review Tribunal hearing 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 as intrusive as they were on admission, they were still easily evoked. The likelihood of his release was remote. His wife had been urged to 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 slightly cynical professionals, when asked ‘What’s the best treatment?’, have been known to respond by saying ‘Geographical’, meaning that the woman 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 my friend, Dr Murray Cox, used to describe 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. Careful questioning of the pathologically jealous individual is essential. Mullen (1996) describes it cogently as follows:

The clinician attempting to treat a patient or client in whom jealousy features must keep constantly in mind the possibility of an escalation of conflict producing resort to violence. Careful and repeated questioning of the jealous individual and their partner is advisable, and, wherever possible, informants outside the relationship should be consulted.

(Mullen 1996: 204)

Case illustration 4.8

The third example demonstrates the manifestation of the disorder in a less severe form and is somewhat unusual in that it was described by the sufferer. It demonstrates the possibility of improvement (in a less severe case) and was provided by

http://www.routledgementalhealth.com/offenders-deviants-or-patients-9780415464291
Christine Aziz (1987) in a national newspaper. Her jealousy, which developed in relation to her partner:

came unannounced one warm autumn day; a tight pain in the stomach, sweating and nausea. Still cocooned in the intense early days of love, I discovered Simon [her partner] had slept with someone else and, even more hurtful, had denied it. Jealousy had come to stay. The occasional twinge was bearable, but this torment was the surgeon’s knife without the anaesthetic. It came unannounced and for hours; the evil turned me into a stranger to those who knew and loved me.

(Aziz 1987: 15)

Case illustration 4.9

A near-psychotic state of jealousy was depicted in the BBC’s adaptation of Trollope’s novel He Knew He was Right (April–May, 2004). In the television presentation, Louis develops an unshakeable delusional belief that his wife has been having an affair with a Member of Parliament – a man who, it must be said, has an alleged reputation as a ‘womanizer’. He eventually dies in a severely weakened and highly distressed state.

In Christine Aziz’s case, she was happily able to realize to some degree that her behaviour was irrational; she was eventually helped through behavioural psychotherapy to deal with it and find some peace of mind.

Erotomania

The notion of pathological (obsessive) possessiveness may assist us in linking pathological jealousy on the one hand, and erotomania on the other. It will also act as a useful springboard for a discussion of ‘stalking’. Erotomania (psychose passionelle) is a condition in which the sufferer believes with passionate and irrational conviction that a person, who is usually older and socially quite unattainable (such as an important public figure), is in love with them. The condition is sometimes described eponymously as De Clérambault’s Syndrome (see Table 4.2). Taylor et al. (1983) suggest five criteria for making the diagnosis in the female:

- Presence of the delusion that the woman is loved by a specific man.
- That the woman has previously had very little or no contact with this man.
- The man is unattainable in some way.
- That the man nevertheless watches over, protects or follows the woman.
- That the woman should remain chaste.
Some of the above criteria could, of course, be applied if the sufferer was male. Taylor et al. (1983) found that medication helped their patients to feel more relaxed, but that this did not lead necessarily to an early resolution of their amorous beliefs. As with delusional jealousy, the condition can be a potentially dangerous one, since sufferers may seek to attack those who

Table 4.2 Some less well-known psychiatric and eponymous conditions

<table>
<thead>
<tr>
<th>Syndrome</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Othello Syndrome</td>
<td>The patient (most often male) harbours the delusional belief that their spouse or partner is unfaithful</td>
</tr>
<tr>
<td>Capgras Syndrome</td>
<td>A rare disorder, in which the sufferer believes that a closely related relative has been replaced by a double</td>
</tr>
<tr>
<td>Frégoli’s Syndrome</td>
<td>A disorder in which a false identification of persons connected with the individual occurs in strangers</td>
</tr>
<tr>
<td>De Clérambault’s Syndrome</td>
<td>The patient believes that someone not known to them personally (and usually of some fame) is in love with them</td>
</tr>
<tr>
<td>Cotard’s Syndrome</td>
<td>Sufferer has delusions of nihilism and poverty</td>
</tr>
<tr>
<td>Ekbohm’s Syndrome</td>
<td>Patient has delusions of infestation by insects, maggots, etc</td>
</tr>
<tr>
<td>Munchausen’s Syndrome and</td>
<td>The individual seeks attention by repeated attempts to gain hospital admission for non-existent medical conditions. Munchausen by proxy is similar, but a child is the focus of the ‘false illness’ in order for the parent to gain attention; the harm to the child often being caused by the parent (usually the mother). The preferred, more recently introduced, term is Fabricated and Induced Illness (FII)</td>
</tr>
<tr>
<td>Munchausen by Proxy</td>
<td></td>
</tr>
<tr>
<td>Gilles de La Tourette’s Syndrome</td>
<td>Seen almost exclusively in childhood and adolescence; main features are uncontrollable tics, suggestive, and sometimes obscene, utterances by the patient</td>
</tr>
<tr>
<td>Folie à Deux, Folie à Trois, Folie à Plusieurs</td>
<td>A condition in which beliefs of delusional intensity are transmitted from the patient to significant others in their close environment</td>
</tr>
<tr>
<td>Couvade Syndrome</td>
<td>A husband exhibits the features of pregnancy as being experienced by his wife or partner</td>
</tr>
<tr>
<td>Koro (Shook Yang) genital retraction syndrome</td>
<td>The patient believes that his penis is shrinking</td>
</tr>
</tbody>
</table>

Notes: (a) Syndrome means, in general terms, the signs and symptoms of a disease or combination of behavioural characteristics. (b) Both ‘Couvade’ and ‘Koro’ are best described as ‘culture bound syndromes’; other examples are ‘amok’ and ‘possession’ states. (c) For additional references to a number of these conditions, see Friedmann and Faguet (1982), Prins (1990), Franzini and Grossberg (1995), Bhugra and Munro (1997) and Enoch and Ball (2001).
reject their ‘advances’ and those who they consider to be their rivals for the attentions of those they obsessively love. Some of these activities are characteristic of the behaviour of certain so-called ‘stalkers’; I consider these next.

‘Unwelcome attentions’ – stalking

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’. As Meloy (1998) aptly states: ‘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 . . . author of Little Women . . . also wrote a novel about stalking in 1866. A Long Fatal Love Chase remained undiscovered and unpublished for over a century’ (Meloy 1998: xix). There is a growing recent literature on the topic and in what follows I have been highly selective; readers will find the books and articles referred to helpful in filling in the gaps in my presentation. The UK has been somewhat slower than other countries to introduce legislation to deal with the problem; for example, the North Americas have had anti-stalking (harassment) legislation for some time. The Protection from Harassment Act 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 which amounts to harassment of another, and 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 (i.e. by a magistrates’ court) 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 imposable by a crown court. (For a detailed critical discussion of the Act, see Finch 2002.) 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.

(Harris 2000: 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. Over a half of the convictions were accompanied by a ‘restraining order’; this is 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 (2000) 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’ (Petch 2002: 19). Legal and psychological aspects have also been reviewed by McGuire and Wraith (2000). The extent to which the ‘public’ have a clear perception of what constitutes ‘stalking’ has been explored in an interesting article by Sheridan and Davies (2001).

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’ (Budd and Mattinson 200: 3), 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 one-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 one-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’ (Budd and Mattinson 2000: 3). 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 life-style as a result of the experience. Women were more likely to have done so than men’ (Budd and Mattinson 2000: 3). 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 Sheridan et al. 2000; Sheridan et al. 2001; Sheridan et al. 2002). There have been numerous attempts to classify stalkers by their motives and behaviour. Kamphuis and Emmelkamp (2000) conducted an extensive review of these aspects. In particular, they noted the work of Zona et al. (1993), Harmon et al. (1995), Wright et al. (1996) and Mullen et al. (1999,
The authors of the review suggest that ‘most authors agree on the importance of the relationship between stalking in the context of some sort of prior relationship and stalking where there has not been a real relationship at all’ (Kamphuis and Emmelkamp 2000: 207). They quote the classification by Zona et al. (1993):

(a) the ‘classic’ erotomanic stalker who is usually a woman with the delusional belief that an older man of higher social class or social esteem is in love with her [see entry under de Clérambault in Figure 4.2], (b) the love-obsessional stalker, who is typically a psychotic stalker targeting famous people or total strangers and, most common, (c) the simple obsessiona"o stalker, who stalks after a ‘real’ relationship has gone sour leaving him with intense resentment following perceived abuse or rejection.

(Kamphuis and Emmelkamp 2000: 207)

They also quote Mullen et al. (1999), who have made significant contributions to this topic. Kamphuis and Emmelkamp (2000) present a slightly different classification under five headings:

(a) the rejected stalker, who has had a relationship with the victim and who is often characterised by a mixture of revenge and desire for reconciliation; (b) the stalker seeking intimacy, which includes individuals with erotomanic 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.

(Kamphuis and Emmelkamp 2000: 207)

It is not difficult to see that the individuals illustrated in both these classifications can prove to be potentially highly dangerous. For this reason Kamphuis and Emmelkamp suggest that

there is a clear need to derive a consensus on a typology of stalkers, with associated diagnostic criteria. At present there is no evidence that one proposed typology is superior to another. The typology eventually agreed upon should have clear implications for treatment.

(Kamphuis and Emmelkamp 2000: 207)

For a contribution to the state of the art on this topic, see Meloy (2007); for a description of a group of patients in high security with a history of stalking behaviour, see Whyte et al. (2008) and for harassment of Members of Parliament in Canada, see Adams et al. (2009); for treatment by means of diale"ational behaviour therapy, see Rosenfeld et al. (2007). Before leaving
this subject, we should note that abuse of Internet facilities has added another dimension in the form of what has been described as ‘cyberstalking’. Interesting examples of this phenomenon have been provided by Bocij and McFarlane (2003), Bocij et al. (2003) and Sheridan and Grant (2007).

**Minor offences**

Those suffering from schizophrenic illnesses sometimes commit minor offences. What forms do these take? In some cases, where the illness is of insidious onset, there is often an accompanying decline in social competence; in which case the sufferer may well succumb to temptations (sometimes prompted by others) that they might well have resisted had they been in good mental health. Those suffering from so-called ‘simple schizophrenia’ may demonstrate a steady diminution of social functioning accompanied by withdrawal from society. Such sufferers may come to the attention of the authorities through offences such as begging, breach of the peace (insulting words and behaviour) or acts of vandalism (criminal damage). They often form part of the sad ‘stage army’ described so aptly in the late 1960s by Rollin (1969), shunted as they are between hospital, prison and community.

**Section summary**

Although, as I have indicated, the contribution of schizophrenic and associated illnesses to criminality is very low, they may be of considerable importance in particular cases, notably when a degree of co-morbidity and substance abuse exists and any delusions experienced are of a persecutory nature. For those who may have professional involvement with the individual concerned (for example, probation officers and other social workers, penal institution and other residential staffs, the police, general practitioners etc.) it is as well to be aware of the significance of even slight changes in behaviour, but also, more importantly, to be aware of atypical behaviour. These may give clues (along with other evidence) to the possibility of an underlying schizophrenic illness (see, for example, Gunn and Taylor 1993: Chapter 8).

**The neuroses, psycho-neuroses, neurotic reactions and crime**

The terms ‘neuroses’ and ‘psycho-neuroses’ (which, for the most part, are used synonymously – psycho-neuroses being the older of the two terms) when used correctly (and not pejoratively – see earlier discussion) describe a wide range of conditions which are characterized by certain specific mental and physical signs and symptoms. It is erroneous to think that the neuroses are less disabling than psychotic conditions. Although the signs and symptoms in neurosis may not be so florid and intrusive, the effects of
some neurotic conditions can be severely disabling, as in obsessive-compulsive states where sufferers are compelled to undertake ritualistic activities which gravely affect their lives. As with the classifications of mental disturbances more generally, there is no absolute consensus as to classification, but for our purposes I trust the following will suffice:

- mild depression
- anxiety states
- hysterical and associated states
- obsessive-compulsive states.

In this section I have concentrated upon mild depression, anxiety states and hysterical and associated states; even this concentration will inevitably be somewhat superficial. Those readers wishing to obtain comprehensive accounts of them should consult works like the two-volume *New Oxford Textbook of Psychiatry*, edited by Gelder et al. (2009). It is also as well to remember that any classification is not discrete; that is, the conditions and their signs and symptoms frequently overlap. We also need to remember an important distinction between (a) common neurotic traits (seen in most of us!); (b) more serious neurotic traits or reactions; and (c) fully developed neurotic illness. The notion of a continuum (as with more serious mental illnesses such as the psychoses) is a useful one.

*Mild depression and crime*

Instances of mild depression may not always be recognized immediately. This is because the behaviour of the sufferer may depart only slightly from the ‘norm’. However, many of the signs and symptoms of serious (psychotic) depression referred to earlier may be present but in less severe form. The following is an example.

**Case illustration 4.10**

A married woman of 60, of impeccable previous character, for no apparent reason (she had plenty of money with her) stole a tin of beans from a supermarket. The offence seemed quite out of character and when she appeared in court she was remanded for a psychiatric examination. This subsequently showed that she had suffered for a considerable time from mild depression. One of the effects of her depression was to leave her confused. She was made the subject of a community rehabilitation order (probation order) with a requirement for outpatient treatment.

In a study carried out in the 1950s, but still relevant, Woddis (1964) cited several cases in which stealing occurred against a background of depressive illness. Most of his examples were of middle-aged or late-middle-aged
women. However, he also cited the unusual case of a young man of 21 charged with the persistent theft of motor vehicles. He had a history of recurrent mild depressive attacks which seemed to be clearly associated timewise with his thefts. Drug-induced abreactive treatment helped him to reveal, while under its influence, that his offences had started at the time his father had been burned to death in a lorry accident. The young man had intense feelings of guilt that he had not reached his father in time to rescue him. When these matters were brought more clearly into consciousness and clarified, the stealing stopped. From time to time, I have come across cases of young men and women who have claimed that they have embarked on a series of crimes because they felt low or fed-up – as though the offending behaviour would supply a buzz or a lift for their low spirits. This element of needing a ‘high’ will be referred to again in relation to individuals who are seriously personality disordered in Chapter 5. Occasionally, the past and recent histories of these young men and women have revealed a number of depressive elements, but it would have been difficult to have applied the clinical label ‘neurotically depressed’ to many of them. Such examples illustrate the need for very careful history-taking so that the relevance of depressive factors may be assessed as accurately as possible.

**Anxiety states and crime**

True anxiety states are characterized by a morbid or pervasive fear or dread. They may occur as a single symptom or in conjunction with other psychiatric disturbances – such as depressive illness. Often, such anxiety can be said to be associated with some specific environmental situation or stress as in the phenomenon of post-traumatic stress syndrome (see Table 4.1). This latter disorder has been the subject of much argument and litigation following war service and natural or human-made disasters of one kind or another. In other cases, the anxiety state is said to be ‘free-floating’ – a nameless and non-specific dread. Symptoms can include palpitations, giddiness, nausea, irregular respiration, feelings of suffocation, excessive sweating, dry mouth and loss of appetite. Anxiety states in ‘pure culture’ rarely account for criminal acts, but morbidly anxious individuals may feel so driven by their anxieties that they may commit an impulsive offence. Such rare offences also seem to occur in individuals where the anxiety is accompanied by, or associated with, an obsessive and perfectionist personality. The following case is an example of such phenomena.

**Case illustration 4.11**

A young man in his early twenties made a serious and unprovoked attack upon an innocent passer-by in the street. As he put it, ‘I just exploded. I don’t know why; the tension I had been feeling lately become unbearable.’ Subsequent psychotherapy
over a long period revealed a very vulnerable personality accompanied by a lack of self-esteem and a compulsive need to work in order to keep unnamed anxieties at bay. Later, as psychotherapy continued, it became apparent that many of his problems were associated with his relationship with his father, which bordered upon hatred. The innocent passer-by just happened to look like his father and, therefore, the assault was in many respects no mere accident. I usually describe this type of offence to my students as the ‘innocent stranger in the street syndrome’. This is dealt with later in Chapter 10 on risk.

Finally, I should emphasize that anxiety has been discussed here in a very specific and narrow sense. I am not referring to situations where an offender or alleged offender is apparently almost pathologically anxious in the context of his or her present predicament (for example, facing a court hearing or being detained in prison). The comments by Gunn et al. (1978) quoted earlier in relation to depression, are equally relevant in this connection.

**Hysterical and associated states and crime**

The clinical condition of hysteria has a long history and can be defined very loosely as the existence of mental or physical symptoms for the sake of some advantage (for example, compensation or attention of some kind), although the sufferer is not completely aware of the motive. As I have already suggested, the term is often used quite incorrectly by lay people. It is not to be taken to mean ‘having hysterics’ or acting histrionically (highly dramatically), though both these characteristics may be demonstrated by hysterics in certain situations. It needs also to be distinguished from hysterical personality. Hysterical symptoms can be classified in a somewhat oversimplified fashion as follows:

- Those associated with the senses, for example deafness or blindness.
- Those associated with motor symptoms, for example paralysis, spasms or tremors (somatization disorder or Briquet Syndrome).
- Those where mental symptoms present, such as memory loss (which may sometimes be associated with a fugue or wandering state), pseudodementia, Ganser Syndrome (see later), stupor, hysterical phobias. These may also present as anxiety and depressive states in which the person may react in difficult or unpleasant situations with symptoms of these latter disturbances of mind. The keynotes in all these disorders are symptoms of *conversion* or *dissociation* (sometimes known nowadays as dissociative states). Conversion symptoms may occur, for example, in hysterical states in the form of fits which may be superficially similar to those produced in epilepsy (see later). Dissociation arises when the
individual has a conflict which produces anxiety as described, for example, in Breuer and Freud’s (1936) early work on hysteria, but the latter is overcome by some manifestation of physical or mental illness which submerges the real anxiety. Because of the processes at work, one may notice in hysterical individuals that the emotions which should accompany events, or memories of them, are often inappropriate; thus an account of an experience given by an hysteric, which one would expect to produce sadness, may be given with a bland smile on the face (la belle indifférence).

From a forensic-psychiatric point of view, it will be fairly obvious that a number of these conditions are of considerable importance – of these, hysterical amnesia, fugues and Ganser Syndrome are the most significant and are now considered in more detail. Amnesias due to organic disorders or disease are dealt with in the section concerned with these states but again, as with other mental conditions, there are degrees of overlap. In some instances, it is difficult, if not impossible, to distinguish a genuine hysterical illness from simulation or malingering. The following are pointers to possible differences:

- In malingering, the motivation is more or less at a conscious level. The symptoms are usually of sudden onset and have some connection with a situation the malingerer is keen to avoid; see Enoch (1990) and Heinze (2003) for the uses of psychological testing. See also Resnick (1994), Pollock (1996) and Kucharski et al. (2006).
- The malingerer’s ‘symptoms’ are usually over-acted and exaggerated, as was the case with John Haigh, the so-called ‘acid bath murderer’, who feigned insanity to avoid conviction and sentence for murder (for details, see Prins 1990: Chapter 5). It is possible for even highly skilled professional workers to be misled occasionally; some chronic mental hospital patients or clinic attenders can become adept at picking up and simulating a range of psychiatric signs and symptoms.
- Symptoms may sometimes be made to order. For example, if the examiner of the suspected malingerer suggests a certain symptom of illness being feigned is absent in the individual’s presentation, the malingerer will sometimes try to produce it.
- When feigning illness, many of the usual signs and symptoms associated with the illness may be missing.
- The signs may be present only when the malingerer is being observed. This is very important from a forensic-psychiatric point of view, as a true picture of the supposed malingerer may emerge only after fairly lengthy and close observation. Generally speaking, it is exceptional for skilled observers to be fooled but, very occasionally, it can happen as in the following case illustration.
Case illustration 4.12

A man was sentenced to be detained in hospital under the Mental Health Act, having been convicted of a series of serious sexual assaults on males. The doctors who examined him had always shared some doubts about the nature of his illness. Over time, it emerged that he had feigned illness. He was discharged from hospital, arrested immediately following discharge, prosecuted and sentenced for perverting the course of justice; the prison sentence passed was of a length commensurate with what he would have received had he been given a penal disposal in the first instance. (For an interesting account of malingered psychosis, see Broughton and Chesterman 2001.)

There are two other conditions allied to malingering that must be mentioned as they are also of forensic-psychiatric interest. The first is pseudo-dementia and the second is Ganser Syndrome. Pseudo-dementia, as the name implies, is closely akin to malingering or simulation of insanity. An individual of normal intelligence may say, for example, that $4+4=9$, or will incorrectly give, or strangely twist, the most simple facts. In these cases, the examiner will usually have the impression that the person knows the right answers. However, differential diagnosis is sometimes very difficult, because pseudo-dementia may coexist alongside a genuine organic defect or illness. Ganser Syndrome is, in many ways, very like pseudo-dementia and takes its name from the physician S.J.M. Ganser, who first described the condition in a lecture given in 1897 — calling it ‘A Peculiar Hysterical State’. Ganser stated that:

The most obvious sign they present consists of their inability to answer correctly the simplest questions which are asked of them, even though by many of their answers they indicate they have grasped, in large part, the sense of the question, and in their answers they betray at once a baffling ignorance and a surprising lack of knowledge which they most assuredly once possessed, or still possess.

(Ganser, translated in Schorer 1965: 123)

Another phenomenon that should be mentioned here is so-called ‘hysterical amnesia’. From time to time, offenders may claim an amnesic episode for their crime or the events leading up to it. A classic example was that of Gunther Podola, tried and convicted in 1959 for killing a police officer (R. v. Podola [1959] 3 All ER 418). There appears to be a consensus that the difference between a genuine and feigned amnesia attack is more likely to be one of degree than of kind. Both conditions may exist in the same person and be serving a common purpose, namely loss of memory for an alleged crime. Power (1977), an experienced prison medical officer, has suggested that the following pointers may help to elicit whether an amnesia is genuine:
An amnesic episode of sudden onset and ending may be suggestive of a feigned loss of memory.

The crime itself may give clues. Motiveless crime may be committed in an impulsive fashion, without any premeditation or attempt to conceal it; it may be committed with unnecessary violence and in the presence of witnesses.

Careful comparisons of the accounts given by police and by the defendant may provide helpful evidence of inconsistencies.

Have there been past amnesic episodes? If so, the current episode may be more likely to be a genuine one. This is also true, of course, in determining the relevance of past episodes of somnambulism in cases where somnambulism is being used as a defence against responsibility for crime (Power 1977).

In an interesting and somewhat provocative article, Stone (1992) suggests that it is often unproductive to try to determine with any degree of exactness whether an amnesia is organic or psychogenic. He also notes that victims, especially of violent crime ‘can suffer from memory loss similar to that seen in . . . perpetrators’ (Stone 1992: 342). He goes on to state that:

> It is perhaps in this direction that the way forward lies in understanding the causes of psychogenic amnesia without the hindrance of having to decide whether the amnesia is genuine or not, a task that is fruitless.

(Stone 1992: 342)

For discussion of amnesia more generally, see Whitty and Zangwill (1977), Lishman (1997) and Porter et al. (2001), and, more specifically, for forensic implications, see Pyszora et al. (2003), Birch et al. (2006) and Vattakatuchery and Chesterman (2006).

Before passing on to ‘organic’ factors, it is important to mention two ‘hysterical-type’ phenomenon that have assumed an increasing degree of interest in recent years. The first concerns the controversial phenomenon of so-called ‘multiple personality disorder’. The currently accepted criteria are, first, the existence within the person of two or more distinct personalities, each with its own relatively enduring pattern of perceiving, relating to and thinking about the environment and self, and second, at least two of these personalities or personality states taking full control of the person’s behaviour. The presentation is likely to be characterized by the coexistence of relatively consistent, but alternate separate, sometimes very numerous, identities with recurring episodes of distortion of memory and frank amnesia. Various studies have suggested that this strange disorder may not be as uncommon as was once thought to be the case. However, an alternative (and somewhat convincing) view is that the medical attention such persons receive merely serves to facilitate the expression of the
symptomology and adds to its proliferation (see Merskey 1992; Wilson 1993; Keyes 1995; James 1998, James and Schramm 1998; Enoch and Ball 2001: Chapter 6).

The second concerns the phenomenon known as Munchausen’s Syndrome and Munchausen’s Syndrome by Proxy or, as it is now known, Fabricated and Induced Illness. As we noted earlier in this chapter, in the first form of the disorder the person complains of, and receives, extensive treatment for various somatic complaints, travelling from one hospital to the next (sometimes they are described as ‘hospital hoboes’ or ‘hospital addicts’). The term Munchausen Syndrome is something of a misnomer. First, because the famous eighteenth-century nobleman, Baron Münchhausen, from whom the name of the condition is derived may have been a great fabricator and wanderer, but he was not addicted to hospitals. Second, the term is considered by some to be too narrow for what is believed to be a wide range of personality disorders. In an interesting article, Hardie and Reed (1998) suggest that conditions such as fantastic lying (pseudologia fantastica) and factitious disorder (Munchausen type syndrome) and what they call impostership, could usefully be subsumed under a new heading of ‘Deception Syndrome’. Gibbon (1998) has described a case of Munchausen’s Syndrome as presenting as an acute sexual assault. In a subsidiary condition, Munchausen’s Syndrome by Proxy (Fabricated and Induced Illness), a mother or significant other may inflict a variety of injuries upon a child, requiring hospital treatment. In such cases, there appears to be a pattern of attention-seeking behaviour and the derivation of vicarious satisfaction from the attention given to the child. In recent times, the methods used by those professionals to detect this particular syndrome have been considered to be somewhat questionable and over-intrusive (see Tantam and Whittaker 1993; Adshead and Bluglass 2005).

Mental disorder (disturbance) as a result of ‘organic’ and allied conditions

For the sake of simplicity I propose to consider all of the above under the broad, but somewhat unscientific, rubric of ‘organic’ disorders. The reason for including them is that although some of them figure but rarely in 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 applies with particular force to those in the probation, social work and counselling professions, where an understanding of human behaviour is frequently, and perhaps understandably, 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) have been described by Buchanan (1994) (see also Howard 2002; Blair et al. 2005). Further reference to this aspect is to be found in Chapter 5 of this volume.

**Infections**

These 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 antisocial tendencies. It is also worth noting here that in older or elderly persons infections of the urinary tract (UTIs) may produce confusion and disorientation, and 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 (jerky) movements characteristic of the disorder. Sufferers from the condition may sometimes behave unpredictably and antisocially, though such instances are uncommon. Because of the hereditary transmission of the disorder and its terminal nature, relatives need active counselling and support.

**General paresis and crime**

This is a form of neurosyphilis and has sometimes been described 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 on the part of a person so afflicted should alert professionals to the possibility of the disorder being present. Nowadays neurosyphilis is not seen with any great

http://www.routledgementalhealth.com/offenders-deviants-or-patients-9780415464291
degree of frequency (whereas in the nineteenth and early twentieth centuries it was fairly widespread). Its disappearance is due largely to early diagnosis and the use of antibiotics.

Alcoholic poisoning and 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 sometimes 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 outbursts. Both chronic alcoholism and alcoholic psychosis are characterized by impairment of memory. Such impairment often results in the person trying to fill in gaps in their accounts of event by use of their imagination – a phenomenon known technically as ‘confabulation’. It is seen in conditions such as Korsakoff’s Syndrome. This particular condition also presents with nutritional deficiency and abnormalities in the peripheral nerve endings. Alcohol acts as a cerebral depressant. The Porter in Macbeth describes it well in relation to sexual matters – as follows. He is asked by Macduff: ‘What three things does drink especially provoke?’ In reply the Porter refers to lechery among other things, and says:

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 him, and it mars him; it sets him on, and it takes him off; it persuades him and disheartens him, makes him stand to and not stand to.

(Macbeth, Act 2, Sc. 3)

Here we have in the most graphic terms the role of strong drink in relation to erectile function and performance. Drink is sometimes consumed in the hope that it will enhance sexual performance; whereas, in fact, as alcohol is a cerebral depressant it has the reverse effect. Anecdotally, it has been said that publicans who abuse alcohol to a chronic extent may lose erectile function – hence the condition known rather crudely as ‘brewer’s droop’. This is defined in The New Partridge Dictionary of Slang and Unconventional English as ‘a temporary inability to achieve an erect penis caused by drinking too much alcohol, especially beer’ (Dalzell and Victor 2006: 263). The source appears to be Australian, circa 1970 (Dalzell and Victor 2006).

The effects of alcohol on individuals who may already have brain damage from other causes may be considerable and have catastrophic consequences, notably of a violent kind.
Other toxic substances

Earlier in this chapter, reference was made to the effects on behaviour of such substances as contaminated flour, mercury etc. In addition, chemicals used in industrial processes where there is inadequate fume extraction may affect behaviour and produce states of confusion; these may lead occasionally to aggressive outbursts. Such instances are, of course, rare, but again, because of their comparative rarity, their importance may be overlooked by the unwary.

Metabolic, other disturbances and 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 antisocial. In recent years, some interest has been focused on the relevance of the menstrual cycle to criminality, particularly violent criminality. Dr Katharina Dalton (1982) was involved in a small number of homicide cases where pleas had been put forward that pre-menstrual syndrome (PMS) constitutes an abnormality of mind within the meaning of the Homicide Act 1957. However, such pleas do not appear to have become widespread (D’Orban 1983).

Brain trauma, tumour, brain diseases and crime

It is important to emphasize that, from time to time, cases of brain trauma or tumour are missed – sometimes with tragic consequences. An injury to the brain (however caused) is quite likely to produce a degree of concussion which may sometimes be prolonged. Such injuries may give rise to mental retardation (learning disability) or to forms of epilepsy (see later discussion of both these phenomena). Such persons may be amnesic, but such amnesia will differ from the amnesia described earlier. Following recovery of consciousness, there may be noisy delirium – a condition not observed in hysterical or malingered amnesia. Organically, amnesic individuals may sometimes appear to be normal initially and only gradually, following careful examination, does it emerge that they have been behaving ‘automatically’ (see Fenwick 1990, 1993; Ebrahim and Fenwick 2008). In contrast, in cases of hysterical amnesia, memory may return spontaneously within twenty-four hours or so. Organically amnesic persons are likely to
want to do their best to remember events and may appear to be annoyed by their defective memory. In contrast, hysterical amnesics may show a complete inability to recall any events before a specific time. In addition, hysterialy amnesic individuals, unlike those showing organic amnesia, may have perfect command of their speech and be well in control of their other faculties (see Williams 1979). The following case illustrates some of the tragic forensic consequences of brain damage.

**Case illustration 4.13**

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 order with a requirement that he undertake medical treatment. (*Leicester Mercury*, 29 September 1984: 11) (see also discussion of Hadfield’s case in Chapter 2).

Occasionally, the dementing processes of developing old age (of which Alzheimer’s Disease is perhaps the best known example) may be associated with behaviour that not only is 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. In respect of the latter, tests are now available which enable even quite small brain tumours to be diagnosed. In addition, clinical and forensic psychologists have developed a range of tests that can determine the presence and extent of a dementing process (see L. Miller 1992; E. Miller 1999). In a timely contribution, Yorston (1999) reminds us that research into elderly people is sparse and, as he states:

> With an ageing population and ever-dwindling continuing care resources, the elderly are going to come into conflict with the law more often. If justice and humanitarian principles are to be upheld, the need for specialist assessment and management of elderly offenders is likely to increase.

(Yorston 1999: 193)

(See also Curtice et al. 2003; Nnatu et al. 2005; O’Sullivan and Chesterman 2007.) We should also note here that increasing attention is being paid to elderly people as victims of aggression and violence (see Brogden and Nijhar 2000; Brogden 2001).
Epilepsies and associated disorders and crime

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 will 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 (1997) in the various editions of his book Organic Psychiatry. Some forms of epilepsy may be caused by head injury or brain damage, others are of unknown origin (idiopathic). There are several types of epileptic phenomena: grand mal (major convulsions); petit mal (often so minor as to be non-discernible to the onlooker); temporal lobe epilepsy (sometimes characterized by sudden unexpected alterations of mood and behaviour – and of particular forensic-psychiatric interest); Jacksonian epilepsy (a form of the disorder named after Hughlings Jackson, himself a sufferer, who first identified it). This is a localized cerebral convulsion following traumatic brain damage; partial seizures and more generalized convulsive seizures. 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) and Gunn et al. (1978) carried out a number of classic and important surveys into the relationship between epilepsy and crime more generally (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 seven or eight per thousand. This is considerably higher than the proportion of epileptics found in the general population. About one-third of Gunn et al.’s (1978) cases were found to be suffering from temporal lobe epilepsy and temporal lobe cases were found to have a higher previous conviction rate. But it was the group suffering from idiopathic epilepsy who had received disproportionately more convictions for violence than any other group.

However, Gunn cautions us not to place too much emphasis on the relationship between epilepsy and crime. In doing so, he makes three important points. First, the epilepsy itself may generate social and psychological problems, which in turn can lead to antisocial 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 antisocial 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. Such disturbances in themselves may produce an excess prevalence of epileptic phenomena. In this respect, it is of interest to note a study by Fearnley and...
Zaatar (2001) in which they explored the presence of a family history of epilepsy in prisoners detained in HM Prison Liverpool. The indications were ‘that prisoners have a high prevalence of family history of epilepsy’. The study also showed that ‘prisoners who report such a history have significantly more psychological problems than those prisoners without such a family history’ (Fearnley and Zaatar 2001: 305). 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 (see Delgado-Escueta et al. 1981). 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 also, as stated earlier, horrendous results may occur if such medication is taken with alcohol (even in small amounts) or with illicit drugs. It is also important to note that repetitive fits over prolonged periods may result in further brain damage.

There is a further collection of signs and symptoms akin to epileptic phenomena, described as the Episodic Dyscontrol Syndrome; sometimes also described as ‘intermittent explosive disorder’ or ‘limbic’ rage. Lucas (1994), in a comprehensive review of the literature on the condition, cites some fifteen or so alternative labels that have been used over the years. The features, found in a very small group of individuals who, in the absence of demonstrable epilepsy, brain damage or psychotic illness, may show explosively violent behaviour without any clearly discernible stimuli, so that the explosive reaction seems out of all proportion to minimal provocation. Lewis and Carpenter (1999), in an article discussing the legal implications of the condition, suggest that:

Episodic dyscontrol is relatively easy to diagnose and responds very well to drug therapy, eliminating any unwanted (by the sufferer as well as society) existing violent behaviour and any possible future ‘criminal’ behaviour. Recognition of the condition may result in justice being meted out for genuine, remorseful sufferers, differentiated from people who choose violence (for whatever reason) or at least have the capacity to choose violence.

(Lewis and Carpenter 1999: 21)

They go on to suggest that individuals engaging in this form of behaviour should be able to claim partial exculpation of criminal responsibility by an extension of the existing law as framed under the Homicide Act 1957. However, Lucas (1994), in his extensive review of the topic, is less sanguine 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.

(Lucas 1994: 401)

The debate continues.

Mental impairment (learning disability) and crime

As indicated earlier, various descriptive terms have been used for what we now term learning disability. It is important to emphasize at this point that lay people sometimes confuse mental illness with mental impairment (the term I shall use henceforth); the two conditions are entirely separate, but they can coexist in some individuals. In general and oversimplified terms, it can be said that the mentally ill person starts life with normal intelligence but, for a variety of reasons (as described earlier in this chapter), becomes ill and deviates from the so-called norm. The mentally impaired person never had the endowment of normal intelligence, or lost it in infancy or in early life. This point is demonstrated clearly in the use of the now obsolete descriptive terms for the condition, ‘amentia’ or ‘oligophrenia’, both of which mean lack or absence of mind. It must be stressed that mental impairment is a relative concept. It used to be assumed, quite incorrectly, that the degree of impairment could be assessed purely in terms of intellectual capacity as measured by IQ tests. Though these are still of some importance, it is imperative to have regard for the social functioning of the individual, in particular family and social supports or lack of them.

CAUSAL FACTORS

There are a very large number of known possible causes for mental impairment. Some of the most familiar are listed below:

- Infection in the mother, notably rubella (German measles) contracted in early pregnancy.
- Illness in infancy or early childhood, for example, meningitis or encephalitis (as already discussed).
- Brain damage to the infant before, during or after birth. This may occur as a result of prematurity, or as a result of anoxia (lack of oxygen) due to various causes. Brain damage (mild or severe) after birth may occur as a result of physical child abuse or neglect by parents or others.
- Chromosomal abnormalities, of which the best known is Down’s Syndrome – named after Dr Langdon Down, who first described it as a specific condition.
Other ‘inborn’ causes, for example, the disorder known as phenylketonuria – a condition in which some children are unable to cope with the phenyaliline content of normal diets; failure to observe a correct dietary regime will result in severe mental impairment.

- Exacerbation of an existing mild impairment (from whatever cause) by lack of social and intellectual stimulation, poor nutrition and poor antenatal and postnatal care.
- Exposure to excess alcohol and certain illicit drugs in pregnancy, or occasionally exposure to certain therapeutic drugs and vaccines used in infancy.
- Exposure to radiation.

**Mental impairment and 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 my colleague Dr Ken Day pointed 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)

(See also Reid 1990; Day 1997; Crossland et al. 2005; Hogue et al. 2006; Smith et al. 2008.)

The following is a summary of the ways in which mentally impaired individuals are likely to come to the attention of the criminal justice system:

1. 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 (see earlier comments in this chapter and Chapter 2).
2. The moderately impaired individual may be more easily caught in a criminal act.
3. Such offenders may be used very easily by others (dupes) 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. The initial overture may be rebuffed therefore. This may 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; Green et al. 2003).

Mentally impaired persons may be especially vulnerable to changes in their social environments that would not have the same impact upon their more well-endowed peers. A moderately mentally impaired person may manage perfectly well as long as he or she has the support of parents, other relatives or friends. Should this be interrupted by death, or for any other reasons, such persons may then indulge in delinquent acts as a means of trying to relieve the stresses of their situation.

The following case examples will help to demonstrate the vulnerability of the mentally impaired to changes in circumstances and other pressures. (For epidemiological and related issues, see Kearns 2001; see also special issue of British Journal of Forensic Practice 2001, 3(1); special section of Legal and Criminological Psychology 2003, 8(2): 219–266; Scott et al. 2006; Koolhof et al. 2007.)

Case illustration 4.14

A man of 26 was charged with causing grievous bodily harm to a young woman by hitting her over the head with an iron 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 in (4) above. He had been before the courts on a number of occasions and had eventually been sent to a hospital for mentally handicapped people. 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 would no doubt today be described as ‘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 illustration 4.15**

This case illustrates some of the problems identified under (6) 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 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 with a pitchfork in his chest, 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.

**Suggestibility**

From the foregoing comments it can be seen that the mentally impaired individual may be especially vulnerable to pressures from others. When this takes the form of alleged pressure to commit crimes they may not have committed, the situation can become very serious indeed. Unfortunately, there have been a number of cases in which impressionable and suggestible individuals (some of them formally assessed as mentally impaired) have been the victims of miscarriages of justice. For example, three young men were alleged to have been responsible for the murder of a man named Maxwell Confait. All three were deemed to be vulnerable because of varying degrees of handicap. The same applied to Stefan Kiszko, also accused, convicted of, and sentenced for murder. In upholding his appeal, the court ruled that ‘special care needs to be taken where the defendant suffers from a “significant degree of mental handicap” if the only evidence against him is his confession’ (Kellam 1993: 361). Kellam goes on to make the important point that ‘There seems no reason to think that the court meant to limit (handicap) to lack of mental capacity alone’ (Kellam 1993: 362). The Police and Criminal Evidence Act 1984, and subsequent codes of practice, introduced certain safeguards in respect of police interrogations,
most notably the availability of an ‘appropriate adult’, when vulnerable persons are being interviewed (Pearse and Gudjonsson 1996; Nemitz and Bean 2001). In this context, vulnerability would be held to include both mentally ill and mentally impaired individuals, and those thought for other reasons to be especially suggestible (Pearse and Gudjonsson 1997; Norfolk 2001; Blair 2007; Hartwig et al. 2007). Better formal training for ‘appropriate adults’ and police interrogators is gradually being introduced and clinical and forensic psychologists have made impressive contributions to this work (see, for example, Gudjonsson 1992; Shepherd 1993; McBrien et al. 2003).

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 occasionally 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 crime, particularly violent crime. In a review of a number of studies in this area, Day (1993) concluded that ‘the personal variables of tallness, intelligence and educational grade and the social variables of parental and family background bore closer relations to the possibility of conviction than genotypic abnormalities’. For an excellent account of the complex relationship between genes and behaviour, see Rutter (2006).

A concluding cautionary note

This chapter has had to encompass in brief form a wide range of complex material. Because of this, it would be all too easy for the reader to conclude that we are on sure ground in describing and delineating mental disturbances and disorders. The truth is that there are still vast grey areas in this field, and much more work is needed before we can be at all certain about aetiology (causes) and the best methods of management. Despite this, much valuable work has been, and is being done, notably in the field of brain biochemistry and its allied disciplines. Trying to equate mental disturbances with criminal behaviour is therefore quite hazardous, especially when we remember that crime itself is not a ‘static’ phenomenon. It is also very important to recall that both gender and race play a very important part in
any study of the relationship between mental disturbances and crime. Despite much research, we are still not sure why certain ethnic minority groups (and notably African Caribbeans) seem over-represented in penal and psychiatric populations (Prins et al. 1993). Women, when they offend, tend to receive proportionately more psychiatric disposals than men. Fewer women seem to be assessed as ‘psychopathic’; they seem more likely to be described as having ‘neurotic’ characteristics. Is this because the latter labels are regarded as more clinically correct, or because a male dominated society and criminal justice system tend to label women in this way? Some researchers (for example, Allen 1987) have suggested that the apparent discrepancies in sentencing are less than obvious. Allen’s central thesis is that such divergences cannot be explained entirely by differences in the mental make-up of male and female offenders and that such divergences may occur regardless of their psychiatric symptomatology. She makes the often forgotten point that ‘the importance of the current imbalance lies not so much in the excess of psychiatry in relation to female offenders as its deficiency in relation to males’ (Allen 1987: xii). Some of the behaviours only touched upon in this chapter are now given more detailed treatment in those that follow; I begin in Chapter 5 with the vexed topic of severe personality (psychopathic) disorder.

Note
1 A brief word of explanation concerning normal chromosome distribution may be helpful to those new to this field. Normal human cells contain forty-six chromosomes; these are arranged in twenty-three pairs of different shapes and sizes. They may be seen and classified under high power, for example electron-microscopy, once they have been suitably prepared for examination. Different chromosomes contain different genes. One pair of chromosomes called X and Y determine sex. In the female, these consist of a matched pair, XX, and in the male an unmatched pair, XY. This normal patterning may sometimes become altered (translocated) in a variety of ways, resulting in an extra X or extra Y chromosome or some other variant.

Acts

Homicide Act 1957
Mental Health Act 1983
Mental Health Act 2007

Cases

R. v. Podola [1959] 3 All ER 418

http://www.routledgementalhealth.com/offenders-deviants-or-patients-9780415464291
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NACRO (National Association for the Care and Resettlement of Offenders) (1993) *Community Care and Mentally Disordered Offenders*, Policy Paper no. 1, Mental Health Advisory Committee (Chairman H. Prins), London: NACRO.


**Further reading**

**Brain mechanisms**


**Genetic aspects**


**Psychiatry – general and forensic**


**Historical**


**Fiction**

Novelists such as P.D. James and Ruth Rendell in the UK and Patricia Cornwell and Kathy Reichs in the United States (among many others) shed additional light on some of the issues described and discussed in this chapter. A compelling account of a young army officer’s probable personality change (PTSD) as a result of a war-induced serious head injury may be found in Minette Walters’ (2007) novel *The Chameleon’s Shadow*, London: Macmillan.