DANGEROUSNESS

by

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Recently, I interviewed a prisoner in the San Diego County Jail. The charges against him were generally descriptive of his long string of threatening acts against his wife. As he began to incorporate them into his too-obvious paranoid delusional system, the threats were also aimed against the courts, the welfare department and "the system" generally. During the interview, he stated, ". . . I am overwhelmed and possessed with ideas of hatred and revenge on my wife, and on getting my baby into a decent home . . ." The obvious articulate qualities of this gentleman make it easy for anyone to determine that he is, indeed, a very dangerous person. The remainder of his verbalizations were similar in their descriptive adequacy, confirming the impression.

Patients such as this one are rare, even in ongoing psychotherapy. Few people have this man's capacity to elucidate their feelings and psychodynamics, even if the material is nowhere near as threatening to others or themselves. It is our function as psychiatrists and psychotherapists to help our patients elaborate on their feelings, and most often this is a more difficult task than with this man. Sometimes, associated tasks are also assigned us. This is because our profession may have been oversold. Great expectations may have been created when, in fact, only somewhat more modest ones are being fulfilled. Some of these associated tasks are assigned us by our cousin institution, the law, which expects us to evaluate alleged offenders and supply clinical judgments which can be helpful to the courts and their officers. Sometimes, we can provide this service. However, our actual ability to help depends upon the variables of time, the capacities of the prisoner to articulate his feelings or our abilities to get him to articulate them, the history available to us, and our capabilities of organizing and utilizing all this data. Sometimes we cannot help. The courts and attorneys continue to ask, though, and we continue to try.

The fundamental problem, of course, is that practically none of the prisoners are as cooperatively articulate as the gentleman quoted above. Few are sufficiently gracious as to tell us wholeheartedly that they are, indeed, dangerous. We are left with the very difficult task of trying to make this determination via means and approaches which are more or less indirect. This results in our having few standards and references for prognostication which the courts can utilize. So often, via the battles in the adversary arenas, the concepts of American psychiatry – descriptive, Meyerian, biologic, analytic and neo-analytic, have been pulled to pieces, leading to irreconcileable testimonial conflicts as well as incredulous stares from all in attendance.

Dangerousness, as a concept, is familiar to psychiatrists and laymen alike. However, like the blind men with the elephant, each person determining dangerousness sees it from the point of view of his personal need. Therefore, we must provide a definition which can be used by all parties engaged in the determination and disposition of alleged offenders or prisoners The following definition appears sufficiently all-inclusive and yet specific enough to be used as a likely standard:

> "Dangerousness is the quality of an individual or a situation leading to the potential or actuation of harm to an individual, community or social order. It is inherent in this definition that dangerousness is not *necessarily* destructive (as 'destructive' is commonly defined) although frequently seen as such by specific individuals or social orders threatened by such a quality."

It is intended that this definition be as subjective and as wide-ranging as it appears. Many forensic psychiatrists hold a much more restrictive view of dangerousness, that of specifically referring to a person's capacity to perform severe physical harm on another individual. Others

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think in more statistical terms, conceptualizing this quality as a probability function. For clinical psychiatrists who work in forensic psychiatry, it is necessary to widen the parameters of this concept. Clinicians who must evaluate alleged offenders or convicted felons applying for parole, probation, etc., need to see a range of variables which are not part of the more restrictive or statistically-oriented definitions. As a predictive concept, dangerousness may be likened to the distinction between potential and kinetic energy. The predictors must see the potential for future behavior; the previous behavior can serve only as data possibly supportive of the prediction of future behavior. Situations can be as dangerous as people; they can lead to susceptible people performing dangerous acts, and therefore situations must be evaluated as part of the over-all evaluation. For example, if we refer to that portion of the definition referring to social orders, we can easily point out that establishments see revolutionaries as dangerous. On the other hand, revolutionaries see establishment governments as dangerous! Sometimes, depending upon the stability of the society in which the determination of dangerousness takes place, the *degree* of dangerousness changes even though the basic accusation remains the same. Obviously, community attitudes may well affect anyone attempting to determine dangerousness, and this may well be the biggest rub of all in most predictive attempts. All of these are critical points of departure important to clinicians who must utilize all avenues of studying a subject and his world in considerable depth before pronouncing him or her dangerous – or not.

There are other definitions, some of them even expressed as parts of various criminal codes. Dr. Henry Steadman[1] quotes the 1971 Revision of the New York State Criminal Procedures Law. In that revision, it is ordered that two psychiatrists must give evidence whether incompetent, indicted felony defendants are dangerous. A dangerous, incapacitated person is defined as, "... An incapacitated person who is so mentally ill or mentally defective that his presence in an institution operated by the Department of Mental Hygiene is dangerous to the safety of other patients therein, to the staff of the institution, or to the community ..." Steadman makes the appropriate point that this definition states that a patient is dangerous if he is dangerous!

Assessing dangerousness is a dubious task at best. Rubin, again quoted by Steadman, bemoans the fact that predictions are unavoidable for forensic psychiatrists. "... Predictions of the likely dangerousness of a patient's future behavior are routinely expected of psychiatrists – and the psychiatrists acquiesce! This belief in the psychiatrist's capacity to make such predictions is firmly held and constantly relied upon in spite of a lack of empirical support ... !" Similar doubts were recently institutionalized in Pennsylvania where the Governor appointed a task force to study the Commonwealth's mental health and retardation laws, and to recommend possible revisions. Steadman quotes the task force which, "... Ascertained to its complete satisfaction that the assumption of this kind of expertise ... is quite unwarranted, and they rejected it after extensive deliberations ..." This same task force also concluded that, "... Since the capacity to predict dangerous conduct is no greater in the case of mentally ill persons than others, preventive detention is no more justified in the case of mental illness than elsewhere ..."

Regardless, psychiatrists will continue to be asked to predict future dangerous behavior. We shall need far more hard data than we have now. We shall also need predictive tools which, like that hard data, are only now being developed. As with all physicians, however, it is on the basis of our clinical findings that most of our impressions are made because, as clinicians, we shall be faced with individual subjects to evaluate. The statistical data from large numbers of subjects may or may not be directly predictive of the behavior of the individual subject we face. Our clinical determinations and searches will have to be more pointed, directed toward finding certain material which has been shown to have a specific relevance to dangerousness.

Hard data, of course, come from studies which are scientifically controlled and observed, and which ought to be able to be duplicated given similar conditions. In many states, a number of studies are being made of prisoners. A great quantity of data are being elaborated but its hardness is yet to be determined.

Very interesting figures have come from New York where a series of class-action suits followed the celebrated decision of the U. S. Supreme Court in the Baxstrom Case. These suits led to the release of 967 inmates from the Dannemora and Matteawan State Hospitals for the Criminally Insane. The prisoners had originally been detained there because they had been determined to be dangerous. These people were transferred to 18 civil facilities operated by the Department of Mental Hygiene instead of the Department of Corrections. They were all followed and studied to some extent. The follow-up reveals that in very few of these cases were the transfers deleterious to the transferred patients, to the other patients in the civil facilities, to the staffs or to the communities to which many were eventually released. This trend, and the low incidence of subsequent re-arrests for dangerous crimes after release, indicate a low incidence of dangerous behavior in this group seen previously as so very dangerous. Between 1966-70, nearly half of the Baxstrom patients were released into the community, and only 26 were returned to a hospital for the criminally insane.

The Baxstrom studies are interesting and provocative, although incomplete. A more exhaustively studied series of convicted, mentally ill offenders originates from Maryland's Patuxent Institution which receives for workup all offenders diagnosed in that state as emotionally or intellectually defective. If, after the workup it is recommended that the offender be committed to the institution, the staff follows him closely in treatment procedures of varied types. The in-house time served by the inmates at Patuxent is indeterminate and is based upon their response to treatment. The statistics from the Patuxent Institution are quite impressive[2]. For example, only 3% of the inmates committed between 1955-64 have needed to be continuously confined – 22 of 638! Coincidentally, this percentage is similar to that of the returned Baxstrom patients who could not "make it" in the community. The percentage there is 2.3%, 26 of 967. The overall recidivism rate for the Patuxent group is only 7% of those patients released upon recommendation of the staff, with in-house and out patient treatment while on parole for three years.

The Center for the Diagnosis and Treatment of Dangerous Persons, in Bridgewater, Massachusetts, seems to be a facility quite comparable to the Patuxent Institution, with similar referral processes and indeterminate sentences. Recently, Dr. Harry Kozol[3], Director of the Center, reported a ten-year study of inmates considered dangerous. Of 226 conficted male offenders recommended for release after an average 43 months of treatment, only 6.1% committed crimes of sufficient seriousness to consider reinstitutionalization at the Center. The similarity to the Patuxent Institution's 7% is striking, and the comparison with the usually expected 70+% recidivism rate in untreated groups is even more striking.

According to Kozol, the Massachusetts Center studies each inmate very carefully, elaborating the psychodynamics of the individual and the offense for which he was committed. The assessment of dangerousness depends upon how the dynamics of the specific crime appear to dovetail with the longitudinal dynamic picture of the perpetrator. In many cases, the definitions of dangerousness and anti-social personality appear to overlap heavily, according to the criteria applied by the Center.

The results of the Baxstrom experiences and the studies from the Patuxent Institution and the Massachusetts Center indicate that many people are simply not as dangerous as previously assumed – or, at least, they can be provided with appropriate treatment so that they do not have to be dangerous. However, the appropriateness of such treatment is being called into question frequently these days. Although the arguments of both proponents and opponents of such psychiatric/penal facilities as the Patuxent Institution and the Massachusetts Center may be theoretically tangential to the purposes of this review, there is pertinent overlap. The entire concept of psychiatrists functioning in penal settings where they determine the lengths of study has been questioned. Such milieus are often considered to have philosophical points of departure necessarily antitherapeutic. The comments of such figures as Szasz[4] are well known, but even the "house organ" of the American Psychiatric Association, the APA PSYCHIATRIC NEWS, presented a series of articles implying that viewpoint[5]. Dr. Stanley Willis[6] writes, "... We are dangerously close to dangerous behavior, ourselves, when we adopt the evaluation

role without careful safeguards which take into consideration the rights of patients and our own *fallibility* . . ." He points out that penal settings may stimulate psychiatrists to project their own unacceptable impulses. Referring to Sullivan's "good me," "bad me" and "not me," Willis continues ". . . If I am always thinking my hostility is 'not me' I am more likely to see myself as a potential victim of the other guy or the other group, and I am therefore more likely to consider him or them as dangerous. I am also more likely to justify my own proclivity to endanger the other as justified by religious, philosophic, economic or political considerations . . ." This appears to reflect some of the facets of the definition of dangerousness given previously, especially those referring to situations and social orders.

Arguments have been raised that studies of convicted felons provide only skewed data because comparative studies have not been made of non-offenders. Kozol, in his review, contends that dangerousness cannot be diagnosed without a history of previous dangerous behavior. In opposition to that contention, it can be stated that after the crime has been committed, the *reconstruction* of the psychodynamic and other factors may be different from the anticipatory construction of the situation.

Obviously, extreme caution must be used in determining the actual hardness of data presented as predictive of dangerousness. More data will be forthcoming from the inevitable class action suits following the Stickney vs. Wyatt decision. Patients who have a "right to treatment" will no longer simply be warehoused. Baxstrom, Patuxent and Massachusetts data as well as other findings will be rigorously evaluated, re-evaluated and probably deepened. However, it will still probably all be *ex post facto* material.

Much energy is currently being expended upon the development of special predictive tools. These may provide some help to us in assessing future behavior. Generally, psychological tests have not been very satisfactory[7]. Projective techniques, especially the TAT, have been used in many previous attempts to identify violence-prone individuals. However, no study revealed data truly predictive in nature. Many scales, for instance, have been used with prison populations. The MMPI has probably been used more than any other test of this type[8]. In some cases it appeared that a characteristic MMPI pattern could be determined for dangerous subjects, but in other series this pattern did not emerge. In theory, the use of traditional clinical or symptom-oriented tests with rigidly standardized and validated scales should have provided suitable means to function as discriminatory instruments. In practice, though, the tests turned out to be measuring instruments which were not sensitive enough to discriminate between groups consistently unless they represented clinical extremes.

Recently, several clinical psychologists have developed modifications of these types of procedures, often adapting the structures of the tests and also using computer technology[7]. Most results of these tests appear superficial and suggestive, and possibly these approaches will serve only for screening.

Today, only a thorough clinical examination can elucidate a picture of an individual sufficient for diagnosis and prognosis in depth. Obviously, as part of that total clinical examination, projective and other psychological tests given by a skilled and sensitive examiner are invaluable in fleshing out the findings and clinical impressions gained via depth interviews and observational techniques. It is as clinical psychiatrists who relate with patients in ongoing psychotherapy that we are best equipped to deal with subjects whom we are supposed to evaluate for dangerous potential. Paraphrasing Kubie[9], whether we perform as administrative psychiatrists, research psychiatrists, teaching psychiatrists or forensic psychiatrists, *we must first be psychiatrists!* The tools used routinely by treating psychiatrists remain our best approaches to obtaining the necessary data. The complete clinical examination in depth provides our only route toward developing a historical perspective of the individual's behavior patterns and psychodynamic and other factors involved. Statistics and large population studies aside, we are asked to evaluate a single person at a time. As yet, in order to accomplish that realistic goal, nothing takes the place of a good and thorough, preferably free-flowing anamnesis. The structure provided by historical perspective, deepened by an evaluation of the

way the subject can and does relate, provides most of what we must depend upon today to make predictions of any kind of behavior.

The fact that a person has not acted out hostilely in the past is insufficient *in itself* to provide the basis for a prediction that he will not do so in the future. Similarly, a history of dangerous acting-out in the past is insufficient *in itself* to provide any basis for predicting continued similar behavior. Obviously, more information is needed. Certain clinical and psychodynamic factors are thought by many observers to be especially significant in assessing the quality of dangerousness. Some researchers have developed theoretical formulations regarding dangerousness based upon their discoveries of psychodynamic findings common to a significant proportion of convicted felons. Hellman and Blackman[10] described a triad of enuresis, fire-setting and cruelty to pets in the childhood of a number of men who had committed aggressive, antisocial acts. One must wonder, however, about the possible number of men manifesting such a childhood triad who did not become violent criminals. Correspondingly, Blackman, Weiss and Lamberti[11,12] pointed out that a large number of men unsure of their sexual identity, feeling isolated, insecure and inadequate, and reared by conformity-exacting mothers became sudden murderers. Most psychiatrists have seen many such men in psychotherapy, but the vast bulk of them have not committed murder. Smith[13] described the victims of violent crimes as actual or surrogate parents. He stated that unconscious, infantile rage exploded through the murderers' weak ego structures, leading to the murders. The rage centered about feelings of being unloved or abandoned, or of having the opportunity of identifying with a strong male blocked by the mother. Again, such feelings are often elaborated in psychotherapy. However, we rarely see that rage acted out violently, even when it seemingly erupts through fragile defenses. Most patients in our offices are not murderers. However, it has almost become a truism to say that most people could, given appropriate conditions, commit murder.

The psychodynamics discussed by all of these investigators are undoubtedly critical in creating murderous impulses and dangerous situations. The men they studied *had* demonstrated dangerous behavior. If, in our ongoing psychotherapy with our own patients, we see similar psychodynamic pictures, we have no choice but to interpret them as demonstrating that our patients manifest dangerous potential. This, of course, implies the use of strict terms and concepts – terms which we usually do not apply in routine, daily work with our private patients. Nonetheless, our task is the same with all subjects whom we must evaluate whether they are our private patients or individuals presented to us by the courts or penal institutions. In those same strict terms, the problem is defined as how to predict the placement of the line beyond which dangerous potential can become dangerous behavior. We can elicit an entire range of psychodynamic findings from our subjects. Whether those findings are *predictive* in those subjects is the key question. It can be answered only individually, and only via placing the findings in context of the total perspective. The total perspective is the product solely of intensive clinical evaluation.

The items determined by intensive clinical evaluation can be divided into longitudinal factors; current, cross-sectional factors; and factors related to community assessment and expectations. Longitudinal factors are, of course, historical. Even more pointed than simply the history of repeated assaultive behavior is a history of *feelings* of explosive rage which may or may not have been acted out. A person whose *preoccupations* are generally with rageful feelings is a person who may more likely explode unexpectedly than a person who has demonstrated previous *episodes* of acting out. Often, the acting out person may do so in situations which can be seen as stimulating of such behavior and in subcultures which promote this. He may speak blandly of his assaults, seeing them in a generally impersonal way. Other significant factors of crucial importance are childhood experiences. A history of parental abuse is obviously significant, especially when it takes the form of overt, physical rejection rather than the more subtle types, e.g., those creating double binds as in schizophrenogenic parent-child groups. The triad of childhood firesetting, enuresis and cruelty to pets has already been discussed. In these cases, investigators have noted that prognosis for social adaptation is extremely poor.

Clinical evaluation of how the subjects operate in the here and now is most crucial in the attempt to determine dangerousness. Consideration of ego strength is the most important factor in determining how the subject handles stress, and especially how he defends against underlying rage. What has the subject done to maintain control before? Does he have the capacity to do this now? These are the critical questions which must be asked about all subjects. They represent the best methods we have at this time to predict the placement of that line described earlier separating dangerous potential from dangerous behavior.

Whether our subject is a convicted felon applying for parole or a first offender sent to us by the court or a defense attorney, we must determine his capacity for change and growth. The ego-adaptive functions are our landmarks here.

Actual diagnostic categorization is, of course, significant, but not for the purpose of establishing the categories *per se.* Instead, it is far more important to develop the concept of how the psychopathology characteristic of the specific category affects the subject. As examples, people with diagnosed paranoid conditions and preoccupied with delusions, such as the man described at the outset of this paper, may be dangerous. So are people manifesting catatonic excitement, although diagnosis is not very helpful for prognosis by the time such a state is seen. We often forget that people with depressive ruminations may manifest dangerousness. On occasion depressed patients may turn their aggression outward instead of inward. A diagnosis of psychomotor seizures in a patient with a history of hostile acting out is a warning signal.

In the evaluation of the subject's mood, one of the most important gauges is the presence of impotent despair. Specifically, this feeling can increase the subject's readiness to perform dangerous behavior. Impotent despair may be the end stage of a descending pattern of ego adaptations to life demands which had been met with descending levels of success. The feeling of desperation may be part of this, but more often the subject is really not aware of how desperate he actually feels. Instead, he sees only hopelessness and a total absence of any positive result from conforming to social norms and continuing social controls.

The effect of public expectation on our ability to predict dangerousness may be the most under-rated factor. Paradoxically, it is also the factor least likely to be evaluated by an examining psychiatrist. The forensic psychiatrist's focus is generally on the internal processes of his subject and not on the usually rejecting world in which that subject must function. In the definition, it was noted that dangerousness was not *necessarily* destructive but that it was often seen as such by specific individuals or social orders that feel threatened by it. It is no news that the general public is still very frightened of psychiatric patients, ideas and practitioners. When a man has been adjudged as dangerous – and a psychiatric patient as well – static will be heard! The effect of what turns out to be a self-fulfilling prophecy cannot be overestimated. The newspapers will continue to print headlines about "former mental patients." If there is public outcry even without public hysteria, the stresses applied to paroled or released offenders, treated or not, will be considerably greater. Levels of acceptance and education in the environment surrounding our subjects must be determined in establishing prognosis. With such developments as the right to treatment and similar alterations in the criminal codes, public response will be an increasingly crucial factor.

Yet, regardless of the direction of public response, psychiatrists will continue to be asked to predict human behavior by the courts and other agencies. We have sometimes not been able to live up to the expectations and the hopes of the courts. In many instances, however, psychiatrists have been able to provide subsequently verifiable prognoses. Often, appropriate dispositions are made on the basis of these prognoses, and the best interests of the subjects, the courts and the communities are shown to be well served.

I have attempted to review some developments which may affect our abilities to make successful prognoses of dangerousness. Beginning attempts are being made to codify the processes necessary to make these predictions. Hopefully hard data are being evolved from large population studies. Whether that data are convertible into material useable in our dealings with individual subjects is still problematic. Specific factors particularly important in the histories

obtained from individual subjects, as well as suggested significant psychodynamic observations, have been noted. The actual prognostic significance of some of these, too, has been questioned. However, their value as critical parts of a still-deficient totality is beyond question. As clinicians, we must try to learn to master all of these and more in our attempts to fulfill the public's realistic expectations and hopes.

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