

An English Psychiatrist Looks at Dangerousness

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Lady Caroline Lamb once wrote in her journal that Lord Byron was mad, bad, and dangerous to know. Presumably she was very angry with him and was searching for an appropriate set of pejorative words with which to describe him. All three words are significant in that we still describe people we don't like by combinations and modifications of these three concepts. Did others share Lady Lamb's view of him? No doubt some did, especially other ladies who were equally rejected. Does the concerted opinion of several individuals who have close knowledge of another one constitute validity? Would we agree that Lord Byron was mad, bad, and dangerous? If we would, how would we reconcile that with our knowledge that Byron was a significant romantic poet, who had a far-reaching influence on European literature and thought? Perhaps Lady Lamb was referring to Byron's temper tantrums. Perhaps the fact that Byron was one of the leaders of romanticism—a revolutionary movement in art, morals, politics, and religion—meant he was incomprehensible and dangerous to the established order of his time. Russell¹ regarded him as the forerunner to Nietzsche and as leaving behind him a legacy of nationalism, Satanism, and hero-worship that became part of the complex soul of Germany. A menace indeed if that were the case. However, it seems unlikely that Lady Lamb was referring to such matters in her little outburst. She probably had his propensity to hurt women's feelings more in mind.

Definition

The word dangerous is common enough, and at various times I have asked students and colleagues to list dangerous objects or situations in an attempt to collect the variety of ideas that underlie the concept. They come up with items such as snakes, rats, heights, airplanes, the dark, politicians, guns, motor cars; only occasionally does someone mention psychiatric patients. According to the *Concise Oxford Dictionary*, danger is "liability or exposure to harm, risk, or peril." No one would quarrel with that, but it misses an important factor. Traveling can be thought of as dangerous; it certainly involves risk. In statistical terms, the risk of air travel is probably at its height on the road to the airport, but most people feel that the flight itself is more dangerous. Why should this be? When we evaluate someone or something as dangerous, we do a lot more than make a statistical prediction. We certainly are making some sort of prediction and of course that prediction is about harm, but another element of danger is fear. We may regard the airplane as more dangerous than the airport bus because we are more fearful of air travel than of land travel. Rational arguments may soothe our fears to

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some extent, but the level of fear aroused by a risk is as important in determining whether we regard that risk as dangerous as is the statistical probability of that risk materializing.

In England recently there has been the case of Peter Sutcliffe, the so-called Yorkshire Ripper. As far as is known he killed thirteen women and attempted to kill six others. This had been carried out over a period of five years, and in view of his strange mental state it was very likely to continue, thus making Sutcliffe a highly dangerous man by anybody's standards. Nevertheless other individuals have killed as many people and are also likely to kill again, for example, the drunken bus driver who drives his coach into a ravine, the negligent engine driver who passes a red signal, the industrialist who by ignoring safety regulations creates a factory explosion or a high death rate from poisoning by a contaminant. Clearly all such people are dangerous, but they are not as high on the public priority list for anti-dangerousness measures as Mr. Sutcliffe. People are more afraid of deranged men who stalk the streets at night for a long period picking off an occasional victim. The level of terror and general distress created in the Bradford area of Yorkshire during the Ripper's activity was phenomenally high. He didn't just kill people, he terrorized the whole community of several million people. Maybe this terror is partly what is meant by the man in the street when he describes the Yorkshire Ripper as "the most dangerous man in England."

Prediction

A few years ago it was the vogue in psychological literature to say that prediction of violent behavior for any given individual was an impossibility, or at least so inaccurate as to be useless. Such a nihilistic approach is now receding. Human beings have always tried to foretell the future, and of course they have never been able to do it exactly. Politicians and statesmen have, since history has been recorded, consulted oracles and fortune tellers to help them make their decisions, and perhaps more importantly, to reassure them. Perhaps the modern equivalent of the oracle is the economic expert or adviser who predicts with amazing inaccuracy what the economy will be like in one year, five years, and so on. Even when simple actuarial predictions (such as the number of births and deaths in a stable population) are made, predictions that have a high degree of accuracy, very little can be said about any particular individual. It is possible to calculate the probability of a single woman aged 30 giving birth to a male child within the next 12 months, but we cannot know who will fall in love with whom, have intercourse with whom, and give birth to which sex. Some of these elements are subject to that chancy process we call individual choice. It is worth noting that the extra randomness introduced by individual choice also gives more predictive power, as it is possible to ask these people about the choices they are likely to make.

On a day-to-day level, predictions are made about human behavior all

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the time. We know which friends to trust and which we cannot rely upon. We know to whom it is safe to lend money and to whom it is not; we know who will succeed in carrying out a difficult task, and who will fail. The predictive method is quite simple, a forecast of the future is made by referring back to previous behavior. Banks and other businesses formalize this by careful research into an individual's financial and business history. In this way, society goes about its business in an orderly fashion, and although some disasters occur, by and large the predictive system bears fruit.

One successful form of prediction in the modern world is weather forecasting. Even so, as anyone who lives in England will know, it is inevitably concerned with probability not certainty, and the terms of predictive accuracy are usually clearly specified. Forecasts will say something like "There will be scattered heavy showers within the southern half of England during the next 24 hours." A prediction that can be verified in retrospect, but that may seem quite inaccurate to someone who gave up the chance of a day on the beach because of the threat of rain, only to find that their particular part of the country had warm sunshine all day. The problem is that the smaller the geographical limits and the longer the time scale the more inaccurate the forecast becomes. This is especially true when environmental circumstances are as unstable as they are in the British Isles.

Turning to the criminological literature on the problems of prediction of violence, there are several problems. By means of a review of previous work, and a probation study of her own, Simon² showed that criminological prediction studies, whether they relate to recidivism among juvenile offenders, probationers, or persons released from correctional institutions rarely achieve a correlation of more than 0.4 between the predicted and observed probability of recidivism. This means that although small groups of good or bad risks can be distinguished, for many of the cases little discrimination is achieved. She suggested that this very low power is possibly related to the considerable environmental influences that any individual comes under but are not as easily or as systematically measured as demographic details such as age, sex, number of previous convictions. Simon's study, in line with others, also showed that the best predictor of future criminal behavior is early delinquent tendencies.

Narrowing the field to violence, the same sort of proposition holds true: the best predictor of future violence is previous violence. Black³ has recently completed a follow-up study of patients released from Broadmoor, a Special Hospital for the dangerous mentally abnormal offender, and confirms that those who are violent after release are more likely to have been violent before admission. An important problem that relates particularly to the prediction of violent behavior is the rarity of the phenomenon. Even in an individual designated as "violent," aggressive outbursts are unusual, and rare events are very difficult to predict because of their statistical improbability.

A recent, comprehensive, and lucid review of the whole area has been produced by Monahan.⁴ He too notes the special difficulties in predicting violence, but urges that an approach to prediction still be made, that it is made on objective data rather than on hunch, and that a clear distinction is drawn between making the prediction and making the decision to incarcerate or set free a particular offender. He suggests that it is the task of psychology (or even psychiatry) to make predictions about violence, but it is the task of others, such as lawyers, or politicians, to act on the best information that psychologists or psychiatrists can provide. His review indicates that the factors most closely related to the occurrence of violent behavior appear to be past violence, age, sex, race, socioeconomic status, and opiate or alcohol abuse. Estimated IQ, residential mobility, and marital status, are also related to violent behavior. Mental illness does not appear to be related to violence in the absence of a history of violent behavior. He suggests that a surplus of information may actually reduce predictive accuracy and that for the best prediction it may be best to rely on the few hard demographic facts above. Nevertheless he does accept that a disturbance or deficit in a person's support system, particularly the family or at work, may trigger violent mechanisms. The easy availability of victims, weapons, and alcohol in the environment may also heighten the probability of violence. Any assessment should take these issues into account.

An important aspect of prediction that Monahan stresses is the usefulness of specifying time limits to a predictive judgment. Some observers say that the only prediction they wish to discuss in relation to a violent offender is whether he or she will ever be violent again. In other words they want a prediction until the end of the person's life, which may be forty or fifty years away. If the way in which human personality changes as we grow older or the major environmental changes we are subject to as our life develops are considered, it will be realized that such a long-term forecast is impossible.

Two other important aspects of prediction that Monahan does not touch on are declared intentions and continuous surveillance. An important clinical addition that one can make to the statistical analysis of a violent person is an accurate understanding of the person's wishes and intentions. Lies and changes of mind can never be ruled out but, for example, the terrorist who says that whenever he is released from prison he will take up arms again is far more dangerous than a similar offender who has made plans to start a new life. The environmental factors that Monahan stresses are probably so important that they should be monitored continuously whenever there is any doubt about a potential offender's behavior and, if necessary, manipulated in a way that seems likely to reduce the risk of violence. This is a constructive reason for releasing someone on license rather than releasing them unsupervised, and it can be a means of releasing someone much earlier than would otherwise be wise.

The Role of Psychiatry

Mental illness does not, of itself, predict violence. Why then should psychiatrists be involved at all? Psychiatry is a branch of medicine; it is that branch concerned with psychological illness. The psychiatrist is a physician: he diagnoses mental illness; he specializes in psychiatric treatment such as drugs, ECT, psychotherapy, behavior treatment; he has access to hospital and nursing care. Yet this is not the whole story. Man seems to need to invest his physician with superior, almost superhuman powers. To fail to do so would be alarming when illness comes. Psychiatrists are further endowed with special powers, the special powers of reading and healing minds, powers that are magical. The psychiatrist is also given special legal powers, powers of imprisoning without trial people who are deemed by himself and others to be insane. Who better then to advise us about frightening and frightful behavior in other people; who better to reassure us about dangerousness? The psychiatrist is after all the medicine man who heals anxiety, the man we call upon to take away our fears. This is partly why we give him legal powers to protect us from insane violent people. The psychiatrist will protect us from these terrible people, he will lock them up in his hospital, and make the town in which we live a safer place! He will understand their insanity and by his understanding learn how to control it and render it harmless!

It may be that man's inherent fear of irrationality is intimately mixed with an understandable fear of violence. If this be the case then it is a very short, although unwarranted, step to believe that all violence is a form of madness and alien. It is possibly too painful and disturbing to accept that we owe a good deal of our liberty and our peaceful behavior to organized violence. It is certainly more disturbing to accept that we are capable of indulging in violence ourselves. Violent people are regarded as alien and deserving banishment.

What should our professional response, as psychiatrists, be to all this? Psychiatrists, like any other professional group, are the product of the attitudes and beliefs that govern a society. They do know more about madness than other people, they do help some insane people to recover, they do reassure frightened patients, frightened families, frightened communities; it is not surprising that psychiatrists are summoned to act as agents of reassurance when life becomes disorganized, chaotic, unpredictable. Psychiatrists have special knowledge of human psychology (including normal psychology), nevertheless it is appropriate for them to stick strictly within the limits of their medical skills and to teach a fearful public just how much they *do not* know. It is wrong, and almost certainly counterproductive to be beguiled by the omnipotence myth. Criminology has taught us a lot about the nature of violence, we also know that it is part of normal mammalian behavior, and we should never collude that all violence is mad, even by implication. We should be punctilious, for example, about only offering treatment advice to those who show some form of psychological disturb-

ance. To counterbalance the omnipotence myth we should play a strictly limited role in areas of marginal concern to psychiatry, such as criminology.

Every Parole Board in England has a psychiatrist as a member. Each member, including the psychiatrist, is expected to make comments about the dangerousness or otherwise of each individual presented to the Board. Clearly it is possible for the psychiatrist to comment as a citizen, it is possible for him to take a special interest in criminology and be genuinely better informed than other members of the panel about some matters of prediction, and it is possible for him to use his specialized knowledge of normal human psychology. However would it not be better, in order to avoid confusing medical and non-medical issues if psychiatrists in such settings deliberately narrowed their contribution and thus avoided the tempting role of Board sage?

Prognosis is a traditional medical skill that seems very relevant to the study of dangerousness. It is, after all, a medical prediction. Patients with nasty diseases, such as cancer, wish to know what course their illness will take and how long they have to live. The patient with depression may also ask how long his miseries will last and whether he can expect them to return if they clear up. But notice that it is the patient who wishes to know and the doctor gives him information on which to act. The uncertain predictive information here is a private communication between the doctor and his patient. Sir Francis Chichester, that intrepid British globe encirler, was told on one occasion that he had cancer and only a limited number of months to live. He refused an operation, went mountain climbing, and entered the Fastnet yacht race.⁵ No doctor would have advised him to do this, but he did it, and lived many more years. This is a good example of the uncertainty of prediction and the way in which information is transferred and acted upon.

When it comes to the prognosis of dangerousness, the psychiatrist is asked to do something different. He is asked to say whether a particular person is likely to act violently in the future. But the client in this interaction is not the patient. The client is usually some legal authority or social force. This poses a whole set of ethical questions not inherent in the ordinary medical prognostication. A psychiatric prognosis in a patient who is deemed either dangerous or not responsible may have the result of taking away the patient's liberty. Can this ever be justified? Clearly making predictions about the course of a mental disorder is justified in the abstract sense. Indeed it is part of ordinary psychiatric practice. The questionable behavior is the passing of that information to a third party or acting upon it to imprison someone, if only for a short period.

Behind these ethical questions are more fundamental philosophical issues. Is the controlling paternalistic role that society has given psychiatrists acceptable? Paternalism for the mentally abnormal exists in every society. It is related to the concept of responsibility (or competence). We do not attribute very much responsibility to children, those with poor brain function, those who are under great stress, and the insane. In the nineteenth

century, paternalism went much further than today. John Stuart Mill (1859) wrote in his essay *On Liberty*⁶

It is perhaps, hardly necessary to say that (the doctrine of liberty) is meant to apply only to human beings in the maturity of their faculties. We are not speaking of children or of young persons below the age the law may fix for manhood or womanhood. Those who are still in a state to require being taken care of by others must be protected against their own actions, as well as against external injury. For the same reason we may leave out of consideration those backward states of society in which the race itself may be considered in its nonage. Despotism is a legitimate mode of government in dealing with barbarians, provided the end be their improvement and the means justified by actually effecting that end. Liberty, as a principle, has no application to any state of things anterior to the time when mankind has become capable of being improved by free and equal discussion. Until then, there is nothing for them but implicit obedience to an Akbar or a Charlemagne, if they are so fortunate as to find one.

People of the twentieth century find part of this concept repugnant, and maybe people in the twenty-first century will find some of our practices equally repugnant. Nevertheless it seems likely that in some degree or another paternalism toward the mentally deranged will always exist in a humane society. A society that makes no allowance for mentally abnormal people is not humane. Most of us are prepared to allow that under certain circumstances, patients' self-destructive wishes may, for example, be overridden. What is more controversial is the notion that psychiatrists may, on occasion, take away the liberty of a patient largely for the benefit of other people instead of purely for the benefit of the patient. The dichotomy between benefit to patient and benefit to others is probably a false one. Rarely is it in the interests of a psychologically disturbed individual to harm other people. Preventing such a patient harming other people is almost always for the benefit of the patient as well. However, even if examples can be found in which this is not true then psychiatry still cannot escape the social responsibility with which it is invested. Nevertheless it is probably correct to add that psychiatry should only restrain patients purely for the benefit of others in collaboration with non-medical people who can take a lay view. Such non-medical people might include relatives, social workers, lawyers, and judges.

The prognostic process as applied to dangerousness is, in summary, as follows. The first step is to decide whether the patient concerned has a demonstrable mental disorder. The next is to try and determine the connection, if any, between the aggressive or feared behavior and the mental disorder. If it is clear there is no connection, that should be the end of the prognostic statement. If a connection between the disorder and the violence is hypothesized however, then the details of that connection should be spelled out. The more direct the link between the violence and the mental disorder, the more the prognosis of the disorder becomes the prognosis of the violence. For example, a man is subject to recurrent depressive episodes

during which he becomes deluded to the point where he believes that life is useless, he is worthless, and the only practical remedy is to kill himself and destroy his world. During one such episode he kills his wife and tries to kill himself. He has no other history of violence so it is reasonable to regard him as not dangerous during his well phases, but as potentially suicidal and perhaps homicidal if the psychotic depression returns, and, also to regard a future close relationship with a woman with especial concern.

Such a clinical opinion would help in the discharge and rehabilitation of the man concerned because in a strictly supervised aftercare program, problems in relationships with women or the return of depression could be identified and acted on. Clearly the problems are more difficult when illnesses are less fluctuant and worst of all when the problems are related to abnormal personality traits.

Sometimes we are too concerned about making static predictions and insufficiently concerned about adjusting our predictions to changing circumstances and to altering those circumstances deliberately in the interests of improving prognosis. In other words, we are too much concerned with assessment and not enough with management. The decision to admit or discharge a possibly dangerous patient is in itself a management decision. Even courts are much happier with a promise of long-term care than with a purely static assessment.

Justice

When an individual has been deemed dangerous, society has to decide what to do with him or her. Monahan suggests that those, who by reason of their professional skills, make predictions of dangerousness should not be empowered alone and without challenge to act on those predictions. The response that society may wish to make to a particular predictive judgment is necessarily a lay (that is, a nonprofessional but perhaps political) response. The response will take into account subjective factors—such as the level of fear generated by a particular person—and the balance of harm between the damage that is inflicted on the person deemed dangerous to prevent his destructiveness and the damage (both physical and psychological) that would be inflicted on others if the preventive measures were not invoked.

A great deal is sometimes made of the so-called injustice of a system that detains or imprisons people deemed dangerous to prevent them harming other people. It is portrayed as imprisonment for uncommitted crimes. Most of this is semantic nonsense. Let us take a man such as the Cambridge rapist. He committed a series of nasty, violent rapes over a 12-month period thus terrorizing the female population of an English city. Suppose that he had been given a purely retributive sentence, with no element of preventive detention, that might have meant that he would be out of prison in seven or eight years. Even if his sexual needs had considerably diminished by then it would be difficult to argue that he would do no harm—just by being about he would scare and alter the lives of quite a number of women—women who

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have just as much right to be unharmed as he does. Weighing this, the Judge decided that he should be given life imprisonment. This was almost certainly a protective or preventive sentence. In the British system that means that Mr. Cook may be released, on license, at some unspecified future date (long after the seven or eight years he might otherwise have received), and of course he may never be released at all. Some say that he is thus being imprisoned for offenses he has not yet committed. In practice he is being prevented from causing further psychological stress in the community.

These issues are dealt with in detail, with specific proposals to improve the criminal justice system, in the recent report from the English Howard League committee looking at dangerousness.⁷

Laws in Action

Finally it may be useful to briefly examine the English Mental Health Act that became operational in 1959 after a searching Royal Commission. The basic premises of the Act is that patients should be treated informally on a voluntary basis as far as possible, in other words they should be in medical care on the same footing as they would be for any other disorder, such as a medical or surgical condition. Approximately 90 percent of all psychiatric patients in England and Wales are admitted informally or voluntarily.

The formal procedures for the other 10 percent work roughly as follows. If a patient is diagnosed as suffering from a mental disorder he or she can be admitted to hospital on the application of a close relative (or a social worker in lieu of a close relative) and the recommendation of two doctors, one of whom is a psychiatrist and the other who is usually the family doctor. The criteria for compulsory admission is that "He (or she) ought to be so detained in the interests of his own health or safety with a view to the protection of other persons." The usual period of compulsory admission under these arrangements is for 28 days or less. An extension for longer periods, up to one year in the first instance, can only be made in respect of patients who suffer from mental illness or severe subnormality, the application and recommendations again being written by a relative and two doctors, and the criteria again being "in the interests of the patient's health or safety, or for the protection of other persons." So although the English Mental Health Act does recognize dangerousness as one of the criteria that may allow compulsory admission of an ordinary psychiatric patient to mental hospital, it does not stress this particularly and the main emphasis is on the patient's own health or safety.

Slightly different arrangements apply to those who have been convicted of offenses in a criminal court. In these cases the relatives have no say in the matter, and the arrangements are made between the doctors as before, the hospital as before, and the court or judge. Patients suffering from mental disorder can be sent to hospital, if all parties are agreed, for up to one year in the first instance after conviction if the court is of the opinion "the most suitable method of disposing of the case is by means of an order." No mention of dangerousness or even the health of the patient here. The patient

is simply handed over, on the recommendations of doctors, to medical care. Such doctors can discharge the patient as soon as they like, or keep the patient in hospital for long periods by repeated renewal of the order after expiration. This may sound illiberal and likely to lead to long-term incarceration. Far from it, court patients, like civil patients, are usually discharged after only short periods of inpatient care, and there are built-in safeguards.

One important safeguard in the Act is that both civil and criminal patients have methods of appeal if they believe they are being detained in hospital incorrectly. During the first month of detention they have an appeal to the Managers of the hospital. After that they have the periodic right to apply to a Mental Health Review Tribunal, which consists of a lawyer, an independent doctor, and a lay person. The patient can present legal and medical evidence to the tribunal and the tribunal has the right to discharge the patient immediately if it is convinced that the patient's case is upheld.

One less liberal aspect of the Act is that it allows a court to convert an ordinary hospital order for a convicted person to a restricted hospital order, if "it appears to the court, having regard to the nature of the offense, the antecedents of the offender and the risk of his committing further offenses if set at large, that it is necessary for the protection of the public so to do, the court may further order that the offender shall be subject to . . . special restrictions." The effects of such a restriction order are to remove the power of discharge from both doctors and tribunals and hand them to the Home Secretary. Patients who receive these restriction orders are more often than not those convicted of severely violent offenses, and more than half are sent to one of the special security hospitals such as Broadmoor or Rampton. They have the right to appeal to a Mental Health Review Tribunal, but the tribunal can only make recommendations to the Home Secretary, who does not necessarily have to act on them.

Perhaps the English Mental Health Act gives a clue as to the way in which disturbed and disturbing patients can be controlled effectively and with justice to both the patients and the community. The underlying principle is a very heavy accent on informality. For the tiny majority who require compulsory or paternalistic care, the primary emphasis is placed on the needs of the patient, although provision is made to take into account the needs of the community. When doctors and relatives (or perhaps social workers, if there is a feeling that relatives might be inclined to collude with medical opinion too readily) have agreed that a particular patient needs hospital care against his wishes, then the initial period of hospital care is brief and the patient has clear rights of appeal to a system that involves not only doctors but also lawyers. The English Act also shows that it is possible to offer the disturbed offender a reasonable alternative to imprisonment by allowing doctors and a judge to have the option of hospitalization for convicted offenders. Again effective systems of appeal are available to the patient.

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On the debit side, the English system has two main flaws. First, and this may be inherent in any liberal mental legislation, it tends to give hospitals the opportunity to reject an increasing number of undesirable patients. As yet there are no remedies for this in Britain. New security systems are being developed to provide a structured environment for the more disruptive patients so that nurses and doctors will accept them more easily. This may not solve the problem entirely. The second flaw in the English system is that for the highly dangerous, or rather those whom a court deems to be highly dangerous, there are no rights of appeal against hospitalization. Patients on restriction orders are in hospital at the whim of the Home Secretary, in exactly the same way as patients on life sentences stay imprisoned at the whim of the Home Secretary. This has been challenged in the European Court at Strasbourg and the British government is developing a new appeal system for this special category.

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