THE PSYCHOPATH AND THE MENTAL HOSPITAL*

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To every mental hospital in any part of the world cases of psychopathy, or rather sociopathy, are admitted with regular monotony. These cases invariably, in one way or another, cause considerable inconvenience and interference with the welfare of the patient-body as a whole. The disrupting influence of the psychopath is well known to every hospital administrator and is a nightmare to both medical and nursing staff. This is due either to their constant demand for attention or to their ability to influence adversely the staff—and sometimes not only the nursing staff (see Minde's case, below). Whatever the cause, the result is detrimental to the treatment and well-being of the other patients.

Many of the sociopaths admitted to our hospitals come as the result of successful defence pleas supported by sympathetic psychiatric opinion. The evidence in these cases is usually given by psychiatrists or other medical men not associated with the hospital. When called upon to submit a report the hospital has to state that the individual is not mentally disordered within the meaning of the Mental Disorders Act.

Before mental hospitals began to change their character from purely custodial institutions or asylums to the hospitals we know today, they may have been suitable abodes for the sociopaths. But owing to the change in their character, which is still taking place, to send a sociopath to a mental hospital is not only inadvisable but wrong from several aspects. Thus, (*a*) with the replacement of custodial functions by therapeutic, the hospital is not equipped to detain him, and (*b*)—more important—is unable to offer him any hope of cure.

DEFINITION OF 'PSYCHOPATH'

The attitude accepted by most administrators is that psychopathy is a non-certifiable condition within the meaning of the Mental Disorders Act, and unless the psychopath is at the same time suffering from a frank mental disorder or defect he is not acceptable in a hospital. To avoid confusion and misunderstanding, the Mental Disorders Act was amended in 1957 and now omits 'Class VI', which catered for socially defective persons. This was the clause under which a defence plea for the admission of a psychopath as an individual suffering from mental disorder used to be made. Its elimination lessens the possibility that a psychopath or, for that matter, a socially defective person, will be admitted unless he is, in addition, a psychotic or a defective.

It is generally agreed that (1) the psychopath is free from all obvious signs and symptoms of a psychosis, but that he is more likely to develop a psychosis than his non-psychopathic brother, and that (2) although he is not certifiable he is as great a menace to society, if allowed a free rein, as any potentially dangerous psychotic allowed the same freedom.

Having discussed these general points, I now come to the definition of a psychopath. The definition which I find most acceptable is that of Dwight L. Moody,[5] of St. Catherine Hospital, Ontario, and is as follows:

> 'condition in which thought processes follow the normal patterns and uninterrupted sequence of mental activity but in which are found gross deficits and exaggeration of certain personality traits which lead to behaviour that is socially unacceptable. Subjects expressing this abnormal reaction to society are devoid of self-assessment, deficient in moral sense as judged by ordinary conventional standards, or in some instances or for other reasons merely incapable of putting simple rules of conduct into practice. Sociopaths are dispositionally biased and lack ability and desire for self-control, discipline and cooperation.'

More simply, Minde[3] defines it as 'emotional instability plus anti-social conduct'. However, I should also like to emphasize the point raised by Minde that occasional emotionability and anti-social conduct should not be accepted as sufficient for the diagnosis, particularly when associated with a crime, and that the condition should be persistent and substantial. Unless there is a long history of behaviour consonant with our ideas of psychopathy, the plea of mental disorder on the grounds of this condition should be avoided. These pleas occur most frequently in cases of murder and, though I fully agree that psychopaths do on occasions murder, it is a rare complication of this condition.

IN THE MENTAL HOSPITAL

I now come to the problem as seen by the mental-hospital authorities. Patients are admitted to a mental hospital as (1) certified or (2) temporary patients or as (3) voluntary boarders or (4) inebriates. In the first 3 groups it is extremely rare to find a psychopath. Amongst the inebriates they appear fairly frequently and in this group of psychopaths one seldom finds an individual who has been guilty of a serious crime. The majority, moreover, are alert. They never show the irrationality of the psychotic, they never accept the blame for their troubles, and they display all the symptoms so ably described by Cleckly.[1]

However, the psychopath as a problem as such is admitted to the hospital directly for observation under sections 27 and 28 of the Act when doubt has been expressed as to his sanity or when at the trial evidence has been led to show that he is insane. There are several possibilities concerning the individual sent for observation, and he may be placed in one of several broad groups:

I. Firstly, he may be suffering from a frank psychosis or defect. These psychotics or defectives are disposed of according to the nature of the crime. In the case of murder, they are invariably committed as 'Governor-General's Decisions' (GGD). In less serious charges the case is dealt with under section 6 of the Act and the individual is treated for his condition according to the nature of his illness. Should he recover, which is often the case, he is discharged and

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allowed to take his place in society as a useful unit once again.

I will not go deeply into the question of the discharge of a GGD patient. Suffice it to say that the duration of his stay following the episode depends on the nature of his illness, the time he has been recovered, the possibility of relapse, and the possibility of his future danger to society.

Seeing that satisfactory remedies are available, the hospital serves a useful function where this type of individual is concerned and is often of the utmost benefit; e.g. where the individual commits a crime while suffering from an infection or exhaustion psychosis, or the mother strangles her child while suffering from a recoverable form of puerperal insanity. Moreover, although less satisfactory, at least suitable custody can be given to the schizophrenic who does not respond to treatment. For him the chronic wards of the hospital will become his home and for the homicidal paranoiac the walls of the Fort at Bloemfontein will prevent his being a menace.

II. The second group sent for observation can be divided into two sub-groups, viz.:

(*a*) Those found not mentally disordered and who are not psychopathic.

(*b*) Those found not mentally disordered, but who are emotionally abnormal, with full insight and, as described by Clarke,[2] quite sane and in full touch with reality; amongst these are many of the pathological liars, sex deviants, misfits and those who commit crimes without sufficient object or motive.

As far as group (*a*) is concerned all that need be said is that any defence is worth trying when a case is hopelessly loaded, and here the mental hospital merely reports that he is neither mentally disordered or defective and does not enter into any argument about psychopathy.

Group (*b*) is a much more serious problem, largely because of the divided opinion on the certifiability of the psychopathic personality and, as already mentioned, the inability of the mental hospital to treat, cure or even give proper custodial care to such persons. To certify such a patient is undoubtedly tantamount to giving those prone to criminal acts a licence to commit crime at will, and I do not believe that such is the function of the mental hospital or the Mental Disorders Act.

To illustrate this point I should like to refer to two cases, one of which is the case of Dr. Minde, quoted with his kind permission. This case was detained at Sterkfontein Hospital.

Case 1

'Last year a psychopath came to Sterkfontein as a GGD patient, whom we shall call 'H'. He had been sent to us, rather reluctantly, by a judge who found him guilty of theft from a hotel room in Germiston.

Before H had been with us for many weeks we discovered that he had organized a dagga-smoking gang in his ward, which involved 6 or 7 of the patients. The dagga was obtained from a Native attendant he had bribed.

A little later he persuaded a young male nurse to leave the door of the ward open for a few minutes one night, and escaped, leaving a most artistically made dummy in his bed; it had completely fooled the night staff. He made his way to a town in the Northern Transvaal, where he posed as the representative of one of the big oil companies. He went to the leading hotel and was so plausible that the proprietor offered him unlimited credit. For the next few weeks he lived on the fat of the land, eating and drinking only of the best, and entertaining the local citizens royally.

There was an attractive receptionist working at the hotel, and H made violent love to her. He soon persuaded her to become engaged to him, quite ignoring the fact that he already had a wife and 2 children in Johannesburg. He gave her a fine diamond ring which he, of course, obtained on credit from the local jeweller. The night the engagement was announced he threw his biggest party yet. All the local gentry were there, and he would allow them to drink nothing but champagne. As he told us afterwards, he almost got writer's cramp signing I.O.Us. that night. He rounded off the evening by seducing his 'fiancee'. Early next morning, while everybody was sleeping off the effects of the party, he quietly slipped downstairs, and to misquote Milton, made for "fresh fields and pastures new".

The police caught up with him in a few days, and then he blandly told them: 'I'm an escaped GGD from Sterkfontein.' When he got back to us he appeared to have turned over a new leaf. He expressed the most unctuous remorse for his dastardly conduct, his behaviour was exemplary, and he even began to take an interest in work, a subject for which he had hitherto shown the most marked aversion. He so impressed the medical officer in charge of his ward that he began to think H quite an ill-used fellow, who had never had a real chance in life. He made himself very useful to the medical officer too, doing various odd jobs for him, and eventually offered to 'duco' his car, which needed a coat of paint badly. He rigged up quite an ingenious apparatus for this purpose, driven from the car's engine. This meant, of course, that he had to be given the car key—which is what he had been aiming at all the time. One fine afternoon, when all was peaceful and the doctor working in a distant part of the hospital, H quietly returned to his own ward, got into the room where the patients' private belongings were stored, picked out the best suit of clothes he could find, and drove off in the piebald car. He did not get far. At the entrance to Krugersdorp he collided with a delivery van and smashed up the car. With his usual luck he did not suffer a scratch, but got out in a towering rage and abused the other driver for ten minutes on end. Then he screamed: 'I'm going to telephone for the police', and stalked off, apparently bursting with indignation. That was the last seen of H, going round the corner with a parcel containing the suit still tightly tucked under his arm.

Glad as we were to be rid of him, we knew that the relief was only temporary unless we could do something about it. Our Superintendent, after consultation with the Commissioner for Mental Hygiene, recommended that H should be unconditionally discharged, and this was duly approved by the Governor-General in Council.

Sure enough, about 2 months later we received a letter from Durban Gaol stating that a man named H, who was serving a sentence of 10 months for fraud, claimed to be an escaped GGD from Sterkfontein. We replied happily that he had been unconditionally discharged from the operation of the Mental Disorders Act and could thus serve any sentence passed on him.

The moral of this story appears to be that when one has to decide whether a psychopath should be sent to a mental hospital, the extent of his mental abnormality is of much greater importance than his anti-social conduct.'

The second case, to whom we shall refer as 'S' shows the difficulties and uselessness of sending a psychopath to a mental hospital. Not only are we unable to treat him effectively under present conditions, but the protection which society demands is not possible, nor is the law able to play its role by removing such an individual from the public. In fact, certifying a psychopath makes the law and psychiatry farcial, as 'S' so well demonstrates.

Case 2

'S' was charged on 20 March 1953 with raping a female Native. From the evidence it would appear that the act, although spontaneous and unpremediated, was carried out by an individual who at the time of the crime was free from all psychotic symptoms. He took the opportunity which offered itself.

It would appear from the evidence that on the evening of 20 March S was travelling on a lorry with several Indians, when a Native female was given a lift. S gave her some gin to drink

and when the lorry stopped and she set off for her home, S followed her and, as shown in the evidence, assaulted her. That he was not disordered at the time of the preliminary examination is also obvious; the following is an extract from the court record: 'Accused states, 'Ek sê niks nie—ek sal my saak in die Hooggeregshof verdedig deur my prokureur'. (Translation: I refuse to comment and I will defend my case in the Supreme Court through my lawyer.')

After making these statements and arrangements, accused accepted short service and immediately applied for bail. What happened to this application I was unable to ascertain, but he was transferred to the local gaol on or after 24 April, on which date the preliminary examination ended. There is no evidence that the magistrate at the time even suspected mental disorder.

On 9 May 1953, S was sent for observation under section 27 of the Act, because he had been displaying symptoms suggesting mental disorder while in custody. The certificate of the District Surgeon which accompanied him was as follows:

> 'Gives irrelevant answers to questions, mumbles to himself, plays with pieces of torn material. He has torn his clothes. He laughs to himself. He keeps pacing the floor.'

The District Surgeon, who was well versed in matters psychiatric, in paragraph 2 of his 'Mental S.2', stated that when last observed several weeks previously S appeared normal.

It was also reported that S was destructive in his cell, and that he cut himself, was dirty in his habits, faced the wall talking to himself, and did not answer questions.

Unfortunately the exact date of onset of his symptoms cannot be established, beyond the fact that he was apparently not disordered at the end of the preliminary examination.

The report which followed his observation and on which he was made a GGD case is as follows:

> 'The patient's mental condition has shown little or no variation during the period of observation. He has remained disorientated in respect of time and place and too confused to give any useful information about himself or engage in relevant conversation. He often mumbles to himself, unheeding of what is said to him, and behaves restlessly, indifferent to his surroundings. Most of the intelligible mutterings made deal with army matters and he often says he has just seen the major or his own wife. He requires care, supervision and treatment.'

He was admitted to the Fort Napier Hospital on 18 June 1953. The report to the Commissioner for Mental Hygiene of 29 July 1953 is as follows:

> 'On admission from Town Hill Hospital, where he had been under observation, he was confused, manneristic and disorientated for time and place. Since admission until 6 July 1953 he had been grossly confused, unable to give any account of himself, and he was disorientated for time and place. On 6 July 1953 it is reported that he fell on his face in the airing court and from that date he has been mentally clear. At that day's interview he remains clear mentally but he has amnesia for events which occured over the past few months.'

He was diagnosed as suffering from psychopathic personality and hysteria. From the reports available, the differential diagnosis to be considered would appear to be (1) a Genser syndrome or (2) prison psychosis, or possibly even malingering. The suddenness with which he recovered after the fall on his face on 6 July is rather remarkable, to say the least. He maintained his condition and on 3 October 1953 he effected his escape.

Before his escape he denied that he knew anything of the crime and he stated he became confused because of financial and domestic worries. He also stated that he had been a patient in the Weskoppies Hospital, Pretoria, where he received electroconvulsive therapy. I could not trace any record of this in his file.

He was recaptured in Swaziland, where he was charged with theft and entering Swaziland without permission. He was found guilty of these charges but, as is so typical of these cases, traded on his being a patient at the Fort Napier Hospital, to which institution he was returned on 20 December 1953, only to escape again on 25 March 1954.

Report on his condition to the Commissioner for Mental Hygiene on his return is as follows:

> '. . . At present there are no symptoms of mental disorder. He appears to be a psychopathic personality with occasional attacks of hysteria. He is full of promises and good resolutions which should take him very far if they ever materialized.'

The note before his escape typifies his condition:

> 'He is very well behaved and cooperative. His conversation is rational. He has consistently denied the charge against him, and is anxious either to have his case reviewed or to be transferred from section 30 to chapter 1 of the Act.'

On 1 January 1954 S wrote a letter with a marked emotional appeal to the Minister of Health in which he pleaded his innocence with regard to the rape, but which demonstrates only too well the flaws in his claim of amnesia. The following extract is of particular interest.

'Ek het haar geklap met die vuis, want sy was brutaal nadat sy my drank gesteel het en uitgesuip het. Sy is oorlams en waarskynlik vanweë die drank wou sy eiegeregtig en selfs intiem met my word, vandaar die klappe aan haar toegedien.' Translation: I hit her with my fist, because she was brutal after she had stolen my liquor. She was cheeky and apparently as a result of the drink she became forward and wished to become intimate with me, and as a result the slaps followed.

From the time of his escape in 1954 until May 1957 he was not heard of again as far as we were concerned. Then he was charged with a petty theft and brought to the hospital by the South African Police. Fortunately, the police allowed him to go and his full discharge from the operation of the Act was subsequently obtained. Other points of interest in this case are that he had been known to the police since 1941, and that he was alleged to have been a prisoner of war.

This case, like that of Dr. Minde's, reveals the great difficulties encountered in detaining such an individual and, what is more important, how he has successfully thwarted the course of justice. Suffice it to say that though we must accept that he was disordered for a short period while he was in gaol, he evaded his just punishment and his removal as a potential danger.

Case 3

The patient 'W', to whom I shall refer briefly, has been in and out of mental hospitals and police lock-ups since 1940. She is well educated and went to the best schools. She has the unhappy knack of being able to play off patients against staff and staff against staff and by her knowledge of the Mental Disorders Act is able to exert such pressure on the courts that an investigation was ordered into the legality of her certification when she was in as a certified patient. Her ability to disrupt the welfare of the patient body is so well known that her possible re-admissions are viewed with trepidation. She has been known to break windows deliberately and cut her arms so that she could get the Medical Officer out of bed at midnight to stitch her wounds.

From such cases as the foregoing, there is little doubt in one's mind of the impossibility of detaining the aggressive psychopath in a mental hospital. Not only does he interrupt the welfare and treatment of patients who are capable of recovery, but he disrupts even the peaceful serenity of the chronic dement. He creates an unbearable and unnecessary tension among the staff, who unfortunately, like many others, are nowadays working at two-thirds or half strength. Moreover, these people must be a soul-destroying nightmare to the police; no sooner have they completed their task and got the psychopath safely tucked away in a mental hospital than he makes his escape, society is again exposed to his criminal propensities, and the search starts all over again.

TREATMENT

But although these people are not suitable as patients in a mental hospital, it cannot be denied that they are sick or

handicapped in much the same way as the psychotic or defective. The only question is whose responsibility they are. It is difficult to disagree with Checkley when he refers to the emancipation of the psychotic in his book *The Mask of Sanity*. Here he describes the work of Pinel, and mentions that it took a very long time before any active treatment was instituted for psychotics. His view is that a similar step is necessary for the psychopath, even though it may be a considerable time before successful treatment is available.

In the disposal of the patient sent for observation it is necessary to be particularly careful before diagnosing him as a psychopath. All other possibilities must have been excluded, amongst which are early schizophrenia, epileptic conditions, high-grade mental deficiency, hysteria, alcoholism, post-traumatic conditions, drug addiction, and even a hypomanic state; and—perhaps even more important—it is necessary to differentiate the psychopath from the 'normal' criminal. In Case 2 the possibility first of schizophrenia and then of hysteria was seriously considered at the time of his admission. Case 3 has on occasions been certified as suffering from hypomania. But on considering the history the diagnosis as a rule becomes obvious.

One is left with little doubt that unless special facilities are provided for the care of psychopaths, a psychopath found guilty of a crime is much more satisfactorily placed in prison than in a mental hospital; though one is left with the unpleasant feeling that we are then placing on the prisons a responsibility which is entirely medical. I know of no countries where such special provision is made for psychopaths except Denmark and Britain.

RECOMMENDATIONS

The opinion I venture as a solution to the problem is that an institution should be provided where such patients can be placed and cared for and where they can receive whatever treatment is considered advisable. A law, known possibly as the Psychopath Act should be enacted giving powers to detain such persons. The decision of placing a psychopath in a hospital should rest with a judge after consideration of both the record and the medical evidence. The sentence should be indeterminate, and discharge should only be considered after agreement by a board of psychiatrists, and should at first be strictly subject to conditions approved by a board of control comprising medical, legal, police and lay representatives.

An Institution of this kind, known as the Psychopathic Prison, has been established at Herstedvester near Copenhagen, Denmark. It is the first sign of the light for a dark and dismal condition.

The functioning of this hospital is described by Stephen Taylor,[4] who points out that the Danes have recognized that hypocritical matrimonial defrauders, brutal child violators and dangerous incendiaries are fit subjects not for punishment but for treatment, 'though treatment to be effective must be a stern discipline'. He discusses the Danish criminal law of 1930, of which section 16 deals largely with recognizable certifiable conditions as we know them, and section 17 with mentally abnormal criminals not covered by section 16. Section 17 covers those who at the time in point were suffering from some more permanent upset, but could not be said to be irresponsible; it also deals with sexual abnormality. Once a person is certified under section 17 he may be sent to an ordinary prison if he is likely to benefit from punishment, or he may be sent to a mental hospital, a home for inebriates or a psychopathic prison. If he is sent to a psychopathic prison the sentence is indeterminate.

Severe as this may seem, Taylor states that the authorities at Herstedvester claim a 50% cure-rate. He foresaw that many undiagnosed psychopaths would be found in prisons or mental hospitals without hitherto having been diagnosed, and therefore that adequate provisions would be necessary for their transfer to the psychopathic prison.

I myself approve of the idea of a psychopathic hospital but I dread the possibility of having anything to do with such an institution. Strange as it may seem, however, the experiences at Herstedvester have been contrary to what most of us would have anticipated. The findings of Dr. G. K. Stürup, the Superintendent of the prison, quoted by Taylor illustrate the point:

> 'At Herstedvester for a number of years we have had from 120 to 180 psychopathic detainees and prisoners, and they have caused considerably less trouble than when they were scattered over various hospital wards and prison wings among more ordinary prisoners. Here the widely divergent personality types hold each other in check, the staff gradually get sufficient training and experience, and modes of treatment can be laid down giving comparatively fixed limits to the individual displays that may occur. He that does not work will not earn money and so must go without tobacco, newspapers, and cakes on Sunday, just as in ordinary life. These are small things, but it is quite unpleasant to watch one's more industrious fellows reaping the benefits of their diligence.'

All the patients, as far as possible, are on piecework. They can earn up to 10s. a week, of which one-half must be saved.

The prison itself is described as being more like a modern mental hospital and having all the facilities which go to make such a hospital. Section 34 of our Mental Disorders Act permits of the transfer of psychiatrically sick prisoners to a mental hospital; as mentioned above, mental disorder develops in the psychopath more frequently than in his normal brother. Herstedvester have seen to it that facilities exist for dealing with this contingency.

Besides Herstedvester, I have heard of only one other institution which caters entirely for psychopaths and that is the Belmont Industrial Unit in Britain.

The answer to the psychopath problem would appear to me to have been given by Herstedvester; and I believe the time has come for us to consider the development of a similar scheme, with the object which Taylor states in expressing the opinion of Dr. Stürup: 'It is not a matter of making criminal psychopaths into normal people, but of making them into nice psychopaths who are capable of adapting themselves to ordinary life'.

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