THE MENTALLY ABNORMAL OFFENDER

A Ciba Foundation Symposium

Edited by
A. V. S. de REUCK
and
RUTH PORTER

J. & A. CHURCHILL LTD.
104 GLOUCESTER PLACE
LONDON, W.1
1968
THE MENTALLY ABNORMAL OFFENDER
THE MENTALLY ABNORMAL OFFENDER

A Ciba Foundation Symposium

Edited by
A. V. S. de REUCK
and
RUTH PORTER

J. & A. CHURCHILL LTD.
104 GLOUCESTER PLACE
LONDON, W.1
1968
Contents

Sir Charles Cunningham  Chairman’s opening remarks  1
G. K. Stürup  Will this man be dangerous?*  5

Antisocial Behaviour and its Treatment and Care

J. Kloek  Schizophrenia and delinquency: the inadequacy of our conceptual framework  19
Discussion  Diamond, Kloek, Roth, Schipkowensky, Stürup, Watson  28

M. Roth  Cerebral disease and mental disorders of old age as causes of antisocial behaviour  35
Discussion  Bittner, Cornil, Diamond, Kempe, Kloek, Rollin, Roth, Schipkowensky, Shapiro, Walker, West  52

N. Schipkowensky  Affective disorders: cyclophrenia and murder  59
Discussion  Cornil, Gibbens, Kloek, Ounsted, Roosenburg, Roth, Schipkowensky, Stürup, Walker, Watson West  67

A. Shapiro  Delinquent and disturbed behaviour within the field of mental deficiency  76
Discussion  Bittner, Goldstein, Marnell, Rollin, Roosenburg, Shapiro, Stürup, West  87

M. J. Craft  The moral responsibility for Welsh psychopaths  91
Discussion  Craft, Cunningham, Diamond, Goldstein, Ounsted, Roosenburg, Shapiro, Stürup, Walker, Watson, West  99

Social Problems

K. O. Christiansen  Threshold of tolerance in various population groups illustrated by results from Danish criminological twin study  107
Discussion  Christiansen, Cornil, Gibbens, Roth, Schipkowensky, Stürup, Walker, Watson  114

P. G. McGrath  Custody and release of dangerous offenders  121
Discussion  Bittner, Craft, McGrath, Marnell, Schipkowensky, Stürup, Watson  126

H. R. Rollin  The conventional mental hospital and the English penal system  130
Discussion  Craft, Cunningham, Diamond, Goldstein, McGrath, Rollin, Stürup, Walker, West  140

* Ciba Foundation Annual Lecture, 1967
<table>
<thead>
<tr>
<th>Authors</th>
<th>Title</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>T. C. N. Gibbens</td>
<td>Psychopathic and neurotic offenders in mental hospitals</td>
<td>143</td>
</tr>
<tr>
<td>O. Briscoe</td>
<td></td>
<td></td>
</tr>
<tr>
<td>S. Dell</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Discussion</strong></td>
<td>Gibbens, Goldstein, McGrath, Roosenburg, Roth, Shapiro, Stürup</td>
<td>149</td>
</tr>
<tr>
<td>G. T. Kempe</td>
<td>Aftercare for mentally abnormal offenders in the Netherlands</td>
<td>152</td>
</tr>
<tr>
<td><strong>Discussion</strong></td>
<td>Bittner, Cornil, Craft, Goldstein, Kempe, Kloek, McGrath, Rollin, Roosenburg, Stürup, Walker, Watson</td>
<td>163</td>
</tr>
<tr>
<td><strong>General discussion</strong></td>
<td>The detention unit for abnormal criminals, Herstedvester</td>
<td>170</td>
</tr>
<tr>
<td></td>
<td>The indeterminate sentence</td>
<td>171</td>
</tr>
<tr>
<td></td>
<td>The penal and mental health systems: mentally normal and abnormal offenders</td>
<td>177</td>
</tr>
<tr>
<td></td>
<td>The psychiatrist’s responsibility to the community</td>
<td>179</td>
</tr>
<tr>
<td></td>
<td>Criteria for the assessment of dangerousness</td>
<td>184</td>
</tr>
<tr>
<td></td>
<td>Bittner, Cornil, Craft, Diamond, Gibbens, Goldstein, Kloek, McGrath, Marnell, Ounsted, Rollin, Roosenburg, Roth, Schipkowensky, Shapiro, Stürup, Walker, Watson, West</td>
<td></td>
</tr>
</tbody>
</table>

**Legal Problems**

<table>
<thead>
<tr>
<th>Authors</th>
<th>Title</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. S. Goldstein</td>
<td>The mentally disordered offender and the criminal law</td>
<td>188/1</td>
</tr>
<tr>
<td>E. Bittner</td>
<td>The concept of mental abnormality in the administration of justice outside the courtroom</td>
<td>201</td>
</tr>
<tr>
<td><strong>Discussion</strong></td>
<td>Cornil, Craft, Cunningham, Diamond, Goldstein, McGrath, Roosenburg, Shapiro, Walker, Watson</td>
<td>213</td>
</tr>
<tr>
<td>N. Walker</td>
<td>Hospital Orders</td>
<td>219</td>
</tr>
<tr>
<td>Sarah McCabe</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Discussion</strong></td>
<td>Craft, Gibbens, Kloek, McGrath, Rollin, Roth, Schipkowensky, Shapiro, Walker, West</td>
<td>234</td>
</tr>
<tr>
<td><strong>Final discussion</strong></td>
<td>Psychiatric and legal approaches in the treatment of delinquents</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Bittner, Cornil, Craft, Cunningham, Diamond, Gibbens, McGrath, Marnell, Roosenburg, Roth, Stürup, Walker, Watson, West</td>
<td>241</td>
</tr>
<tr>
<td><strong>Sir Charles Cunningham</strong></td>
<td>Chairman’s closing remarks</td>
<td>251</td>
</tr>
<tr>
<td><strong>Author Index</strong></td>
<td></td>
<td>255</td>
</tr>
<tr>
<td><strong>Subject Index</strong></td>
<td></td>
<td>256</td>
</tr>
</tbody>
</table>
Membership

Symposium on The Mentally Abnormal Offender held 3rd–6th July, 1967

Sir Charles Cunningham (Chairman) United Kingdom Energy Authority, London

E. Bittner Langley Porter Neuropsychiatric Institute, San Francisco, California

K. O. Christiansen Institute of Criminal Science, University of Copenhagen

P. Cornil Ministry of Justice, Brussels

M. J. Craft Oakwood Park Hospital, Conway, North Wales

B. L. Diamond School of Criminology, University of California, Berkeley, California

T. C. N. Gibbens Institute of Psychiatry, The Maudsley Hospital, London

A. S. Goldstein Yale Law School, New Haven, Connecticut

G. T. Kempe Department of Criminology, State University of Utrecht

J. Kloek Department of Forensic Psychiatry, State University of Utrecht

P. G. McGrath Broadmoor Hospital, Crowthorne, Berkshire

G. Marnell Institute for Abnormal Criminals, Södertälje, Sweden

C. Ounsted The Park Hospital for Children, Headington, Oxford

H. R. Rollin Horton Hospital, Epsom, Surrey

A. Maria Roosenburg Dr. H. van der Hoeven Kliniek, Utrecht

M. Roth Department of Psychological Medicine, University of Newcastle upon Tyne

N. Schipkowensky Psychiatric Clinic, Medical Faculty, Sofia

A. Shapiro Harperbury Hospital, nr. St. Albans, Hertfordshire
<table>
<thead>
<tr>
<th>Name</th>
<th>Institution</th>
</tr>
</thead>
<tbody>
<tr>
<td>G. K. Stürup</td>
<td>Detention Institution for Abnormal Criminals, Herstedvester, Albertslund, Denmark</td>
</tr>
<tr>
<td>N. Walker</td>
<td>The Penal Research Institute, Oxford</td>
</tr>
<tr>
<td>A. S. Watson</td>
<td>Department of Psychiatry, University of Michigan, Ann Arbor, Michigan</td>
</tr>
<tr>
<td>D. J. West</td>
<td>Institute of Criminology, University of Cambridge</td>
</tr>
</tbody>
</table>
The Ciba Foundation

The Ciba Foundation was opened in 1949 to promote international cooperation in medical and chemical research. It owes its existence to the generosity of CIBA Ltd., Basle, who, recognizing the obstacles to scientific communication created by war, man's natural secretiveness, disciplinary divisions, academic prejudices, differences of language or separation by distance, decided to set up a philanthropic institution whose aim would be to overcome such barriers. London was chosen as its site for reasons dictated by the special advantages of English charitable trust law (ensuring the independence of its actions), as well as those of language and geography.

The Foundation's house at 41, Portland Place, London, has become well known to workers in many fields of science. Every year the Foundation organizes six to ten three-day symposia and three or four shorter study groups, all of which are published in book form. Many other scientific meetings are held, organized either by the Foundation or by other groups in need of a meeting place. Accommodation is also provided for scientists visiting London, whether or not they are attending a meeting in the house.

The Foundation's many activities are controlled by a small group of distinguished trustees. Within the general framework of biological science, interpreted in its broadest sense, these activities are well summed up by the motto of the Ciba Foundation: *Consocient Gentes*—let the peoples come together.
Preface

In 1964, Dr. Henry Rollin suggested that one of the Ciba Foundation’s small international symposia might be devoted to the problems created by those unfortunate individuals, suffering from a clinically identifiable mental abnormality, whose antisocial behaviour brings them to the notice of the law enforcement authorities. Although at that time the Ciba Foundation’s resources were fully committed for the next couple of years, the Deputy Director warmly seized the opportunity to plant this seed for future germination by discussing with Dr. Rollin—who was now joined by Dr. Nigel Walker, Reader in Criminology at Oxford—the general outlines of a plan for the proposed meeting.

The conference was designed to be essentially intradisciplinary, including psychiatrists, psychologists, sociologists and penologists. We are indebted to Henry Rollin and Nigel Walker for their joint efforts in devising the programme; their personal warmth no less than their generous advice made this collaboration the more pleasurable. The difficult and invidious task of choosing the members from all over the world was lightened for us by the additional wisdom and counsel we obtained from Monsieur P. Cornil, Dr. Andrew Watson, and Dr. Robert Brittain (State Hospital, Carstairs, Lanarkshire), to all of whom we are most grateful.

The Ciba Foundation’s nineteenth Annual Lecture was arranged as an introduction to the symposium and is published in this volume. Dr. Georg Stührup, Medical Superintendent of the Herstedvester Detention Centre for Abnormal Criminals, Albertslund, Denmark, honoured the Foundation by accepting its invitation to deliver the Lecture on the evening before the symposium began. He lectured to an invited audience of about two hundred people, including the members of the symposium, who were privileged to hear him speak on “Will this man be dangerous?”, and to witness him receiving a Ciba Foundation gold medal from the hands of one of our Trustees, Sir George Lloyd-Jacob.

Advantage was also taken of Dr. Stührup’s presence to invite him to address a small group, meeting at the Foundation under the chairmanship of the Rt. Revd. Dr. Ian Ramsey, Lord Bishop of Durham, to discuss “Science and Personality”.

It was our added good fortune to be able to persuade Sir Charles
Cunningham, formerly Under-Secretary of State at the Home Office, to take the chair at this symposium, and it is a sincere pleasure to record how much the proceedings owe to his sympathetic and masterly guidance.
CHAIRMAN’S OPENING REMARKS

SIR CHARLES CUNNINGHAM

I am very glad to be here because although, to my great regret, I have left behind (officially) the problems of mentally abnormal offenders I am not likely ever to lose interest in them. Therefore I look upon it not only as a compliment to be asked to preside over this conference, but as an opportunity of keeping in touch with the subject and with people concerned in it, recalling what has been one of the main parts of my working life.

When I first became a civil servant, in 1929, my list of subjects included what were then known (in Scotland at least) as the Lunacy and Mental Deficiency Acts, and within their scope came such amiable establishments as the Criminal Lunatic Asylum and the State Institution for Defectives, to say nothing of a place called The Inebriate Reformatory. The inmates of these places enjoyed a nomenclature of corresponding directness. But even then reform was in the air; I can recall with satisfaction how much was being done under obsolescent laws to bring constructive influences to bear both upon those offenders who were wholly within the penal system and those who, in the sort of institution I have mentioned, were recognized to be merely on the margins of this system.

That was nearly forty years ago. About five years later I began to work more specifically in the fields of law enforcement and of the treatment and aftercare of offenders. I continued to do this until last year. It was a fascinating job; it has left me with no claim whatever to expertise, but with a very clear and humbling realization of how little we really know and how much remains to be found out. But when we view these years in retrospect, we see what a transformation has taken place in attitudes to crime and criminals in all civilized countries; we see what strides we have made in the methods of assessment, in treatment, in aftercare, and how much our knowledge of forensic psychiatry, criminology and penology has increased; above all, perhaps, we see how completely transformed the approach of the legislature, the courts, the law enforcement services and, happily, of the community has been to the treatment of the offender.

It is encouraging to recall that these great changes have been occurring
throughout the world, and have often been the result of international study and exhortation. In medicine, psychiatry and criminology we already have a common market. The United Nations, the Council of Europe, the Learned Societies and the Universities have provided opportunities for the study and discussion of common problems, the exchange of ideas, and the formulation and recommendation of common policy. Experimental work in one country is known and, if successful, followed in other countries, and this is as it should be. For what we are concerned with are basic weaknesses in human nature which, if we did not treat or control them, could lead to a disruption of orderly living and deprive society of many of the benefits of the full life which, under the rule of law, progress has enabled us to enjoy.

This international conference, for which we are greatly indebted to the Ciba Foundation, is an example of this encouraging approach to a world problem. The eminence of the participants is a guarantee of the quality of the symposium; its scale makes possible the intimacy and freedom of discussion out of which new ideas are most likely to emerge.

Our general topic is the mentally abnormal offender but we do not need to construe these words too strictly. Our symposium is divided into three parts: Antisocial Behaviour and its Treatment and Care; Social Problems; and Legal Problems. We are not limited by any pre-definitions of what we mean either by "mental abnormality" or by "an offence".

I am particularly glad that we shall be talking about antisocial behaviour and social problems, and how to deal with them. In the United Kingdom at least, we have a long way to go in organizing our social and medical services in a way which will help us to diagnose and attack mental abnormality, especially in children and the young, at the stage at which we are most likely to be able to help them, and to resist the antisocial behaviour which might otherwise cost both the individual and society dear. We are rightly concerned with those who have come to notice because they have behaved antisocially or criminally, and with how best to ensure that their conduct is not repeated. But it is surely very much better to discover these "offenders" in some other way. Do our means of so doing need to be made stronger and better co-ordinated? Are our social and medical services for the young as closely linked with our educational services as they should be? Above all, have we done enough to educate parents and others in contact with the young both in how to discern the early symptoms of abnormality and in where to seek the necessary help?

We have a long way to go, also, in our attack on general social problems, which will continue until they are solved to contribute to the incidence
of antisocial and criminal behaviour. We need to know the effect of these problems not only on the mentally abnormal but also on those who suffer from what a layman regards as "just an overdose of wickedness". The latter is a great area of special study and we can touch only the fringes of it during this meeting.

It is when we reach the subject of legal problems—and we shall probably do this in the discussion of the first two sessions as well as in the session so described—that we will be faced with the tasks of definition and the formal demarcation of services in which the administrator must work together with the doctor and the lawyer. What areas of mental abnormality can the criminal law, consistently with the discharge of its main function of protecting society, appropriately recognize? In the United Kingdom we have long regarded a person of unsound mind as incapable of committing an offence, but the definition of insanity accepted by the criminal law is not made in terms to which, I imagine, medical opinion would unreservedly subscribe. We have recently adopted the Scottish doctrine of diminished responsibility in England, but not in relation to crime in general. But how is a jury to interpret diminished responsibility in the face of understandably divergent evidence? And how is a court, not itself proficient in psychiatry, to assess the weight which should be given (in deciding how to deal with an offender) to evidence of mental abnormality falling short of legal insanity or diminished responsibility? Here is an area of English law at any rate which is overripe for review. Are there, in the meantime, ways in which better help can be given to the courts in administering the law as it stands?

Finally, there is plainly still room for more, and perhaps different, facilities for treatment. I cannot myself speak—except with respectful admiration—of the dramatic advances, and the prospects of further advance, which have recently been made in the treatment of the mentally ill. But we certainly need still better facilities in some areas—for example for those who are in danger of becoming antisocial, perhaps eventually criminal, because of taking drugs. We need more secure hospitals for the treatment of those who, whether they are technically criminal or not, are a danger to society. We need better facilities within the penal system for the treatment of the mentally abnormal, or we need improved and wider powers to remove such persons for treatment elsewhere.

However successful we are in developing new ways of treating the mentally abnormal person there will remain one further possibility of advance: individuals whose abnormality has been diagnosed and who are being given professional care, and those who have offended and have spent
a period (often a long one) in detention, desperately need the support of
the community. Some will find it in their own homes, but many do not
have any homes able to give such support and must look, for the necessary
understanding of their difficulties, to their fellow-citizens, including
especially those by whom and with whom they are employed. We have
made great advances in this area in the United Kingdom, but we have
still a long way to go in achieving full comprehension of the scale and
nature of the support required.

We in this country will certainly learn much in these three days and I
hope we shall also have something to contribute. This cannot but be of
value, so let us proceed to our discussions.
WILL THIS MAN BE DANGEROUS?*

Georg K. Stürup

Detention Institute for Abnormal Criminals, Herstedvester, Albertslund, Denmark

Administrators and theoretical criminologists are involved with principles and systems of decision making. Clinical criminologists, on the other hand, have personal contact with people, be they perpetrators of crimes or their victims. The administrator must rely on reports of people working in the field to build and operate his systems while the clinician, engaged in trying to understand the life careers of his clients, is concerned with how he can use himself and the machinery he controls to make their lives more acceptable to themselves and to society.

The concept of dangerousness gained importance through the work of system-makers. Enrico Ferri, who for a long time directed the positivist school, considered a criminal’s dangerousness of primary importance to judicial reaction. But he did not make clear what was meant by dangerousness.

Kinberg (1935, p. 73, citing Garofalo) talked about the “constant and active perversity of the criminal and the amount of evil to be feared from him, in other words his criminal capacity.” Concepts like l’état dangereux have been created, but these concepts are not easy for the clinician to apply. In spite of this, the clinician is asked about dangerousness both at the sentencing level and the parole level and even, in some cases, with regard to King’s Mercy.

Groups of offenders with poor or good prognoses have been identified in prediction studies. These actuarial studies are also important for the psychiatrist as his psychiatric explorations of dangerousness may take place with the guide-lines of parole prediction. The word “dangerousness” is commonly used in two senses. One is the risk of new economic crime, usually of the same type as that previously committed by an offender. The second refers to the more severe aggressive or sexual activity involving

risk to life and health. It is generally supposed that economic crimes—
thief, burglary, fraud and so on—are not physically dangerous. In the Danish
prison system most offenders having committed these types of crimes are
handled in open institutions, and escape is considered of little practical
importance. It is modern to say, “Don’t worry, the insurance pays for the
stolen goods.” I can agree with this but sometimes I feel that the reactions
of the victims are not given enough consideration. Some victims, after
such an experience, dare not go out alone after dark, and this lack of con-
fidence is a serious result of “less serious” crime.

The other two kinds of crime—aggressive (including arson and robbery)
and sexual—are usually considered by everyone, including criminals, as
terrible and to be avoided. In Denmark practically all the offenders I have
known find it reasonable that society should react to such crimes with
severe sanctions; offenders sometimes even suggest stronger sanctions than
the clinician feels are necessary.

All the Scandinavian legal systems have for many years recognized that
the group made up largely of chronic criminals with more or less definite
pathological personalities or personality deviations represents such a threat
to society that special sanctions are necessary. For this group of persons,
belonging to either of these two categories of dangerousness (that is, having
committed aggressive or sexual crimes), an indeterminate and individual-
ized kind of sanction has been developed based on the detention section of
the Danish Criminal Code of 1930. I have described the theory and
practices of these specialized sanctions in my Isaac Ray Lectures (Stürup,
1968a). I will not repeat this material but will base my remarks on clinical
experiences concerning dangerous behaviour.

Dangerousness before sentence

As a clinician I have little interest in systems as such. What is needed is a
method which can help in deciding what advice to give the authorities in
order to limit the risk to society and assist the offender as well as possible.
It is difficult to know what is the right thing to do in an actual case. In our
times, there is more and more interest in people as masses and less interest in
the individual human being. As a clinician I stick to the old-fashioned
question: “Who is this man and how can we help him to avoid committing
a new offence?”

Since 1930, the Danish courts have been able to choose between a series
of different sanctions. The judges have therefore been more and more in
need of detailed technical advice of the kind given by psychiatrists. These
specialists, in our system, base their advice upon lengthy and elaborate
examinations of those awaiting sentence. But the complete career studies and the lengthy follow-ups necessary for clinical evaluation have, until now, been scarce.

Psychiatrists are very familiar with the few psychotic cases which are sentenced by the court to a stay in a mental hospital for care and treatment. These subjects, as well as mental defectives, must be kept in hospital until the same court which sentenced them agrees to their discharge. I shall not further comment on such cases.

Offenders with only personality problems are more difficult to evaluate before sentence as it is difficult to predict their reactions to a certain kind of treatment. Continuity in observation of this type of offender is lacking. One type of doctor sees him when he is before the court, "therapists", occasionally with psychiatric backgrounds but more usually with other types of training, work with him in the institution, and a third group of clinicians handle him after he has been paroled. This means that it is not easy for any one person to gain practical experience over the full range of an offender's development from pre-sentence predictions to parole success. Publication of clinically descriptive studies is handicapped by the necessity of protecting the anonymity of the often-highly-publicized case. As clinicians we have to be careful not to make life more difficult for these very sensitive people—an interest which is not shared by the news-media.

Pre-sentence evaluation of especially serious aggressive offenders is still more complicated. Uncontrolled fright may be the background of many of today's criminal aggressive acts. Hostile activity is in itself frightening to the perpetrator. Faced with a man who has lost control of himself and who is now acting in a frightening way, one asks, "Will he be dangerous again?" Before sentence we do not know when he will again get an opportunity to be dangerous outside an institution, how he will develop during his stay in an institution and how he will react to the opportunities presented to him. We base our advice on an understanding of the man and his situation; not only the situation in which he is observed but on our understanding of the realities behind his reactions. To understand the criminal act itself it is necessary to analyse the offender's patterns of behaviour as they were before and after the act. This must be done in an engaged way, but without becoming too emotionally involved. If the evaluator becomes too emotionally involved he may be tempted not to explore the background of the act further. Commonly the psychiatrist investigating such cases observes a coolness, which seems peculiar, in the patient. He then explains the act as the work of a cold-blooded monster. As I have later seen many of these "cool" murderers show an unusual sensitivity and
even develop depressive reactions, clearly some of these evaluations by
psychiatrists are not correct.

A psychiatrist must be very careful in the way he expresses himself and
never forget that the offender becomes very emotionally involved in what
he has done. A sudden serious misdeed has repercussions on the perpetrator
himself. After the deed he is changed, his “me” becomes different from the
“me” before the act. Let me explain a man’s more or less conscious way
of thinking at the time of a pre-sentence interview: “I did this. I am now
one of those serious, terrifying criminals whom I, together with other
people, have despised. Other people look at me as a serious criminal. I
must try carefully to participate in explaining what really happened.” In
order to do this he must objectify all his emotional reactions; otherwise it
becomes impossible to repeat the terrible story over and over again. My
explanation for many of the cold-blooded reactions we observe under the
special circumstances before sentence is that they are secondary reactions
to the surprise of suddenly being a serious criminal. This is certainly so
with some offenders (Stürup, 1964), but future research must decide to
what degree secondary reactions are of importance, not only after serious
offences but also after trivial offences.

In most cases it is safe to say that the serious criminal—the murderer,
rapist or arsonist—will represent no danger if the way he is handled after
the deed does not arouse such changes in his pattern of reactions that he
becomes dangerous to society, these changes taking the form of a pro-
pensity to commit offences. New aggressive acts are uncommon. In a
few cases we must say, based on our own psychiatric observation, that the
offender gets out of balance easily, that he is spineless and that we do not
know if he will be aggressive again. This depends largely on the circum-
stances he will meet in the future, on the situations which will burden him
emotionally, and to what extent he will ask for help sufficiently early to
prevent him from committing a new crime.

Conducting psychiatric investigations for the court calls for various
special qualifications. In Sweden, psychiatrists are given special training
to qualify for well-paid forensic work. This special training is not given
in Denmark even though special criminological training and knowledge
are needed if the best advice is to be given concerning treatment.

As an example of the need for special training let us consider sexual
criminals. This is a group much feared by the public even though most
sexual offences are not at all dangerous. Fear of sexual offenders is some-
times unnecessarily stimulated by some purveyors of news who do not
differentiate between the different kinds of sexual offences. The psychia-
trist must not be swayed by this popular fear and should know that a long range follow-up of an unselected group of nearly 3000 criminals in Denmark, sentenced over a 10-year period from 1929–1939 (Christiansen et al., 1965), demonstrated that the results of the usual court practice have been extremely satisfactory as seen from a criminological point of view. First-time sexual offenders relapsed with new sexual offences, usually of the same type they had previously committed, in 6.9 per cent of cases. The ordinary sentence for these cases, which were mostly indecency against children, exhibitionism, indecency against women and a relatively few cases of rape, was usually a short prison sentence or probation and only occasionally was this combined with special treatment. Another interesting fact emerged from this study. Unlike property crimes, the rate of relapse into new sexual offences was the same year after year and it took many years to reach the relapse rate of 7 per cent.

To prove that psychotherapy is of criminological importance for sexual offenders, we need to treat third-time sexual offenders, with a risk of recidivism of 40 per cent. In the immediate future it will not be easy to find devoted psychotherapists for such an experiment. Nor will we be able to convince the courts to grant early parole to the treated group for continued out-patient treatment, as the risk of new sexual offences is too frightening to all of us and to the offenders themselves and their relatives.

The clinician who examines sexual offenders is often in a very difficult situation. In most cases, especially with a first offender who has committed a petty crime, the correct approach is to tell the court, the offender and his relatives that the risk of a new crime is very small. At the same time it may be necessary to give him support and assistance so that his emotional relations with friends and relatives become “normal” again. Further, we must also tell the offender that there is a considerably higher risk for him than for the average population of once more experiencing the same kind of criminal temptation. If contact were to be kept with a sufficient number of these offenders it would be possible to collect research material which might give us the key to a better evaluation of which types of sexual offenders become recidivists.

In the more serious cases, such as sexual offenders who have relapsed into new sexual crimes, or who have committed other serious crimes, we will have to substantiate the risk which may be very serious indeed. In many of these cases the courts will react with long prison sentences; this means that these persons’ contact with normal society will become much more difficult than it was before, even if the prison staff tries to counteract this. In many of the big and more standardized institutions, counteracting the
effects of extended incarceration is very difficult to carry out satisfactorily.

I am not going to elaborate on our approach in some of these serious sexual cases, beyond stating that in Denmark only about ten sexual offenders per year apply for permission to be castrated.* If these persons are carefully selected the results are extremely satisfactory from society's point of view and, what is more important, from the patient's point of view. The patient usually feels that he is completely relieved of the burdensome risk of committing sexual offences. A long-term follow-up of castrates in several countries shows that the results of castration for those offenders in the high-relapse group is a relapse rate of about 2 per cent, and in the Danish material we find that only a few are not personally satisfied with the results of the operation (Stürup, 1968b).

In concluding this section I want to say that when the psychiatrist is called upon as an adviser to the court before sentence, it is important that he obtain access to all the facts known about the life-history and criminal history of the man he has to evaluate. He must be able to see the man in relaxed circumstances and see him several times. He must have time to establish satisfactory emotional contact with the offender and he ought to have some criminological experience not only as a court psychiatrist but also with treatment. If all these conditions are possible then his estimate of the future development of the offender may have a reasonably accurate predictive value. Of course the psychiatrist cannot know for certain how this man will develop even if he has done a very careful pre-institutional analysis and even if he has obtained an acceptable emotional and intellectual understanding of why the offender acted as he did: there are too many other important factors which cannot be known at this stage. We may know a man's accessible mental resources; we also may know his demands on his own abilities as these are expressed in the special interview situation, but how they will develop depends on the situations the offender will meet. He may be placed in circumstances in which his resources are sufficient for what he is called on to do. When he is again on his own, his reactions will depend on how he experiences himself after having served his sentence. He may think of himself as a former offender. He may believe that all other people think of him as a former offender, which means that he expects that everyone expects him to react as a criminal. This influences his interpersonal relationships. Our choice of behaviour is not only conditioned by our former experience, and our internal structure (which is already determined), but also by situational stimuli which are dependent on other

* Plus ten to twenty persons who are not offenders or are not recognized as offenders.
WILL THIS MAN BE DANGEROUS?

people’s determined psychological experience. Thus there are important accidental factors influencing behaviour.

Dangerousness before release

After a man has been sentenced, the problem of dangerousness arises again when he is going to leave the prison or specialized treatment institution. I will not comment on the problems of evaluating patients about to be released from mental hospitals, but will concentrate my remarks on the pre-parole situation, when a man is going to be paroled after having served a long sentence. If the potential parolee is serving a life sentence the question of King’s Mercy arises. In Sweden this occurs after about 10 years, in Denmark after about 16 years. If he has a fixed sentence, which in Denmark has a maximum length of 16 years, the question of parole arises after a man has served two-thirds of his time.

In the beginning of the nineteen fifties the Danish Government decided to parole many of the war criminals who had received long sentences. Many people objected to this, and in a Parliamentary debate the Minister of Justice said that he would ask for special psychiatric advice in all of these serious cases before any decision was taken. As psychiatric adviser to the Ministry of Justice it became my job to examine most of these people myself and guarantee that other forensic psychiatrists had examined those I was not able to see. Most of these prisoners, who had committed sometimes atrocious crimes in the special circumstances of the war, appeared quite different from what I had expected after having seen the description of their behaviour before sentence. In practically all of these cases a careful investigation gave me no feeling of insecurity. I could easily advise the Minister to let these people return to normal society, and the result of this procedure has been very satisfactory. In a few cases in which the pattern of behaviour was peculiar I had some doubts. (This is even more common with criminals who have been sentenced for severe crimes in times of peace.) A special problem for the pre-parole adviser is this: if he reports that in his opinion a man is dangerous, or that he behaves so peculiarly that the risk of new dangerous crime seems obvious, the administration will usually not set this man free and the adviser will never know if he was right. The prediction becomes a self-fulfilling prophecy and we gain no experience. Nevertheless, the risk for a new unknown victim is such that we cannot parole these people. This only happens in a few cases, but we know too little to evaluate them correctly which sometimes makes us too cautious.

Let me give an example: A young man in his early twenties had some difficulty with his middle-class family when he was growing up. He
developed sadistic phantasies which frightened him, and then went to a professional social worker who did not take him seriously and thought it was ridiculous to dream of killing someone. Then the young man killed a prostitute. He was found out, given a careful psychiatric examination in a hospital and it was obvious to the psychiatrist that he was psychopathological and not fit for punishment. The Medicolegal Council (Retslægerådet) sustained this opinion but the courts felt otherwise and sentenced him to 12 years' imprisonment. In our legal system the court may choose in such a case between a sentence to prison for a fixed time, a life sentence to prison, or detention for an indeterminate time under psychiatric direction in a special institution such as Herstedvester. If the special institution had been chosen it would have been up to the court to decide when he should be paroled, and to make this decision they would have received advice from both the institution and the Medicolegal Council. The court is not required to follow this medical advice. Instead of the life sentence or the indeterminate sentence, the court chose the limited sentence and the young man was sent to one of our large prisons for 300 inmates. For some years there he continued to indulge in his sadistic phantasies and to develop them further. He made drawings and wrote poems describing his feelings about cutting off the breast of the head nurse in the prison, how wonderful it would be to have his hands in her genitals and dilate them, take out her uterus, crucify her and so on. He distributed these pictures and poems anonymously in the prison but was easily found out—which he seemed to want. He repeated these activities in spite of disciplinary reactions and, finally, it was necessary to transfer him to another prison. I was invited to take him for observation in Herstedvester, but found that he was not psychotic and that what he had done had been foreseen by the psychiatrist who had examined him before sentencing so there was no reason for further institutional observation. The same things happened again in the second prison and as psychiatric consultant to the prison system I again had some psychiatric contact with the young man. But what was more important was that the prison's psychologist became involved in a very engaged and active psychotherapeutic relationship with him. It seemed for a time that this had some influence on the man's pattern of behaviour but when the question of parole come up after he had served two-thirds of his sentence (9 years) he again distributed sadistic pictures and poems in prison. As adviser to the Ministry I was called upon again. I was unable to make real emotional contact with the man and as I supposed that for the time being it was impossible to evaluate his dangerousness I advised against parole. The psychologist was not satisfied but understood my reluctance.
WILL THIS MAN BE DANGEROUS?

The prisoner was not paroled and the question came up again about 2 years later. The situation was more or less unchanged but the psychologist was rather optimistic concerning the man's future. As I felt that perhaps I was biased, having seen the man several times, I arranged for further observation in a mental hospital, promising the local superintendent that we would take the man back into the prison system as soon as he wanted it. It was important to observe this man in contact with female nurses and fellow patients. He used this period in the hospital to get into close contact with a very young psychopathic girl. He wanted to get engaged to her and when this was discovered he was immediately returned to prison, accompanied by a severe warning that he did not understand how to behave in relation to women and that he probably would get into great difficulties in the future. When it was nearly time for him to be discharged, the responsible authorities (in this case the Director of the Prison Department and the Minister of Justice) after long and difficult deliberations decided that it would be more dangerous to society not to parole the young man. Parole would give us an opportunity to supervise his future behaviour for a time and possibly to intervene sufficiently early to prevent serious crimes. This is an opportunity we would not have had if he were returned directly to society without supervision after serving his full sentence. He has now been out for 6 years and we psychiatrists were wrong. He met many difficulties in the beginning but kept contact with his therapist (the prison psychologist) and eventually seemed to settle down.

In this case we were lucky to get an opportunity to see if our predictions were right or wrong. Had this man received an indefinite sentence it probably would have been difficult to parole him before we could make a better prediction about his future dangerousness. Parole worked in this case not only because of good luck, but also because very careful supervision was established and because the psychotherapist who had been of great importance for the development of this prisoner kept in continuous contact with him. But the Minister of Justice took a serious risk and the reactions of the newspapers would probably have been very unkind if something serious had happened.

In ordinary prison routine long-term psychotherapy is unusual. It is possible to appoint psychologists in our prison system but we have great difficulties in getting applicants. But in spite of recruitment problems, a wise and flexible central administration has, in the past 20 years, moved our prison system more and more in the direction of rehabilitation. It is now possible to establish a continuity in the rehabilitative programme of some parolees through supervision from the prison's own social aid
department. Still, when called upon as a consulting psychiatrist, it is difficult to advise the administration in a case which is supposedly dangerous without having continued contact with the offender and without the possibility of following his development to see what happens after he returns to free society.

The prisoners who are most difficult to handle may be transferred to a special unit in Herstedvester for prolonged observation and treatment. Some of these are then paroled directly from Herstedvester and supervised by our own professional staff. In cases where special problems are expected we have now and then discharged a supposedly dangerous person in a very untraditional way.

This was the case with a murderer who had been unbalanced and erratic since early youth. After a long and rather serious criminal career he committed a robbery and murder for which he received a life sentence. In an attempt to escape a few years later, he very seriously attacked and wounded a prison officer. When he was in his late forties and after he had served 8 years for this attack I saw him for the first time for a short interview. The only thing I particularly noticed was that during the interview he moved in his chair in a very peculiar way. I found special treatment unnecessary. Some years later, when a more detailed investigation was undertaken, he was transferred to Herstedvester and it became possible to diagnose Huntington's chorea, which was also found in other members of his family. Because of this slowly developing disease and his many years in prison, where he sometimes behaved peculiarly and was not always peaceful, it was obvious that he could not manage a normal life—in any case not without a special transition period. The 16 plus 8 years of his sentence were nearly finished but he was not psychotic so it was not easy to transfer him to a mental hospital. He had been in my institution for rather a long time for observation but did not like his comrades there just as he did not like them in the state prison. But after having been back in prison for some time he preferred to return to us and then be transferred to our open section. He stayed there for some years without serious conflicts. We tried letting him work in an unsheltered factory nearby as a labourer, and when it became obvious to him that this was too difficult he accepted admittance to our local mental hospital. After some time he was given the King's Mercy.

It is now easy to see that this man, who behaved well during his years with us, probably had been ill when he was sentenced and that his hot temper was related to his Huntington's chorea. Further, it must be stressed that he would have been better handled in our specialized institutions. Many men with life sentences who, due to the traditional practice of the