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DANGEROUSNESS AND THE MENTALLY ILL CRIMINAL

JONAS R. RAPPEPORT, M. D.

A quote from the book, "Psychiatry and the Dilemmas of Crime" by Seymour Halleck:

Psychiatry holds an unstable position in the field of criminology. For every zealot who heralds psychiatric concepts and treatment as the only answer to the crime problem, there is a critic who believes that psychiatric contributions to criminology are unscientific and misleading. A realistic assessment of the value of psychiatric criminology must lie somewhere between these two extremes.¹

In 1967 the President's crime commission reports: "It is true, of course, that many kinds of knowledge about crime must await better understanding of social behavior. It is also true that research will never provide the final answers to many of the vexing questions about crime."²

Today I shall speak of the role of psychiatry in the entire area of criminology and our involvement in the treatment of all types of offenders. Unfortunately, I have no specific formulas to offer, but I shall touch on some work that has been done in treating offenders, and I shall then discuss some research I have done on the dangerousness of the mentally ill.

In thinking of the treatment of the criminally ill we must remember that this term is used differently by different people at different times. Judges, juries, lawyers, probation officers, correctional personnel—all think of the ill criminal in a different way. The late Dr. Benjamin Karpman of the St. Elizabeth's Hospital in Washington, D. C. felt that all criminals were insane. He felt that to commit a crime was tantamount to insanity, at least a social insanity. I do not believe that we can freely subscribe to such a definition if we are going to maintain some order to our thinking, and I certainly do not think that the psychiatrist should be responsible for the treatment or rehabilitation of all social offenders. On the other hand, I think we

1. S. HALLECK, *PSYCHIATRY AND THE DILEMMAS OF CRIME* xii (1967).

2. PRESIDENT'S COMMISSION ON LAW ENFORCEMENT AND ADMINISTRATION OF JUSTICE, *THE CHALLENGE OF CRIME IN A FREE SOCIETY* 273 (1967).

should not limit our responsibility or efforts to that small group who are clearly so ill as to be held "not responsible by reason of insanity." In Baltimore, Maryland, in 1966 such a plea was filed in less than 2 percent of all criminal cases, and less than 1 percent were actually found so at trial.³

Let us stop for a moment, however, and focus on the obviously psychotic offender who is found "not guilty by reason of insanity." Our treatment programs for them seem reasonably clear cut. I do not think we need to treat a paranoid schizophrenic patient other than to insure more security for his and our protection until he is well. Of course, it is understood that some of these patients might never respond to treatment and always present a threat; it is here that we have a problem—that is, in deciding when he is to be released. Many times we err on the side of caution and consider patients more dangerous than they are. Then we are in trouble as far as what we are doing to and for the patient. Dr. Thomas Szasz has eloquently pointed out some of the shortcomings which occur when psychiatry is given too much responsibility. He says:

This is a callous game. The court plays by the rule: Heads-I-Win, Tails-You-Lose. If guilty, the defendant is sent to prison. If not guilty but insane, he is sent to a hospital for the criminally insane. Why do I consider this callous? Because were it the intention of the court, or of society, to provide psychiatric treatment for certain offenders, this could be provided in prison. [I doubt this, at least now.] The psychiatric disposition of offenders seems to me a colossal subterfuge. It provides the "offender-patient" neither absolution from criminal guilt nor treatment. It is nothing more than an expedient method for "disposing" of persons displaying certain kinds of antisocial conduct.⁴

I do not completely agree with Szasz, although unfortunately, he may be all too correct in many instances. As you know, Dr. Szasz operates from an entirely different premise than most of us, and I will not go into a discussion of his ideas. But he causes us to pause and think when we are tempted to keep a patient in the hospital longer than may be absolutely necessary.

3. Personal communication, Mr. Charles Moylan, Jr., State's Attorney, Baltimore, Maryland.

4. T. SZASZ, *LAW, LIBERTY AND PSYCHIATRY* 114 (1963).

I see forensic psychiatry not merely as an evaluation of the criminal responsibility of the "insane" offender, but as a subspecialty of general psychiatry, which applies the expertise of psychiatry and its related fields to the diagnosis, prognosis, and treatment of all who come into contact with the law. I see this as being carried out either directly by diagnosis and treatment or indirectly by consultation, supervision, and training of others more directly involved with the offender. There remains a large area of what I might call practical research-treatment or controlled treatment in which much needs to be done, both in terms of supplying a service, as well as in trying to develop more adequate treatment techniques for these special populations. There are some offenders whom we can treat by our well used individual and group methods. Since 1955 Dr. Joseph Peters has been treating sex offenders on probation via group therapy in conjunction with the Temple University forensic unit at the Philadelphia General Hospital. They are now conducting a controlled study of the effectiveness of this program versus probation only, *i.e.*, without therapy. They have several homogeneous groups—heterosexual pedophiles, exhibitionists, sexual assailants, and homosexuals—and one heterogeneous group. Treatment lasts for 40 weeks with thorough evaluation before and after plus long term follow-up. Cases are assigned to the treatment or no treatment group on a random basis. Although it is too early to determine the results of this controlled experiment, their previous years of experience have indicated that out-patient group therapy can be a useful treatment for such offenders.

For others, however, we need to develop different methods. For instance, what of a project using some of the techniques described by Dr. Marks of the Maudsley Hospital in England. Dr. Marks treated transvestites with an aversion (mild electric shock) treatment and compared his results with a control group therapy program. While his results were not outstanding, there was evidence that such treatment had a place in our armamentarium. Might not such a treatment be applied to voyeurs or pedophiles, or in some unique way to arsonists and kleptomaniacs, or maybe even forgers, robbers, or car thieves? At least this represents a new approach—granted a unique one—but at least they are trying. There seems much to be learned from the proponents of behavior therapy that might be applicable to our criminal offenders.

A more practical application of behavioral techniques might be that suggested to me by Dr. Robert Schwitzgebel. In the case of a man who beat his wife repeatedly, Dr. Schwitzgebel had recommended to the court that the man be placed on probation and that one-half of his weekly salary of \$85 be placed in escrow each pay day. This money would be returned to him at the next pay day, provided that during the ensuing week he did not beat his wife. Since they had a young child and half salary was certainly not very easy to live on, it was hoped that this would provide motivation to the wife not to enrage her husband to beat her and to assist him in controlling his anger if so aroused by such game playing. It is my understanding that this proposal was found a little too far out for the local court to accept. I do think, however, that it represents the kind of new approach and variation that we should seriously begin to consider.

The courts would like to look to us for help. They would like to find a substitute for simple incarceration, which they recognize as being of limited use for the future protection of society.

A group in California is trying to develop a model facility for the treatment of the 18 to 25 year old offender. Resocialization rather than simple incarceration is the goal. The institution is based on a community model—a therapeutic community within the community. Yes, the institution itself is seen as being right in town, in the same neighborhood from which the offender came. It is proposed to even allow the community to use the facilities of the institution, such as the gym and the auditorium. A new concept; yes, so was the community based day hospital a new concept 20 years ago, and 10 years ago so was the Community Mental Health Center. We might even try to develop a new type of correctional worker—the change agent. We have housewife therapists. Why not specially trained guards, probation officers, or new people trained in group work and other therapeutic techniques to work in correctional institutions? Many of the offenders change their behavior patterns with age. Can they be helped to make behavioral changes sooner?

I do not mean to minimize the problems one has in dealing with social offenders, and I do not want to minimize much of the naivety we have as psychiatrists in dealing with these people. There is certainly a great deal of difference between the menopausally depressed woman and the gang-moll or the addict-prostitute. There is certainly a difference between the chronic

schizophrenic and the hedonistic psychopath. But there is probably much less difference between some of our neurotic patients who have been exposed to various emotional deprivations and the auto thief or burglar who has been exposed to socio-economic and emotional deprivations. We have discovered in psychiatry that we can contribute to the desocialization of patients by keeping them in inadequate facilities too long. Also I feel that our society contributes to the recidivism of criminals by their institutionalization in punitive, non-rehabilitative prisons and jails.

I have previously mentioned that one of our goals as in all medicine is prognostication. This, of course, is one of our most difficult tasks since no one really knows how a fellow human being will act in the future. Yet, within certain limits, there is some material already available which will help us to test some of our hypotheses and enable us to establish some relevant criteria for predicting behavior more accurately. Nevertheless, many unanswered questions remain. Have we clarified issues to this point? In 1960 we studied patients who requested sanity hearings or habeas corpus hearings. These were patients committed to one of our state mental hospitals. All had asked to be released, and all had been refused by the hospital and subsequently asked the court to release them. In essence, the hospital had said, we feel you are too dangerous to yourself or the person and property of others to leave. The court released one-third of them after the hearing. Of the remaining two-thirds remanded, one-third subsequently ran away, eloped as we say. The members of the remaining one-third either died, were eventually discharged or are still there. Not one of any of these patients got into any serious difficulty with the law within the 1 to 10 year follow-up period.

Seymour Halleck says: "Unlike most other medical specialists, the psychiatrist has not restricted himself to the treatment of those who seek his services but has sustained a deep involvement in the legal and social problems of controlling disturbed people."⁵ As early as 1838, Isaac Ray, a founder of the American Psychiatric Association wrote his still relevant treatise *Medical Jurisprudence of Insanity*.

There was the time when Dr. Guttmacher, along with the other leaders in forensic psychiatry in this country such as Henry

5. S. HALLECK, *supra* note 1, at 205.

Davidson, Winifred Overholser, Phillip Roche, and many others, needed to devote a great deal of their time to the development of the Model Penal Code Test⁶ and important appellate decisions such as the *Durham* decision.⁷ The modern developments in psychiatry and the psycho-dynamic understandings of human behavior had to be communicated to the courts and lawmakers as well as all of society. The task was Herculean and despite their efforts is certainly far from being completed. The ball is rolling and, I think, moving well of its own momentum—in fact, maybe too well. Now we are asked to assist in rehabilitation of all types of offenders, and yet, our knowledge of their treatment is quite limited. Quite frequently, when a crime is committed it is immediately assumed that something must be emotionally wrong with the offender and that the psychiatrists can “cure” it. At this point the big question appears to be whether society is ready to make some changes in its attitude towards the criminal offender. Before this attitude can be changed, however, certain things need to be done. Mohr and Turner, who have worked extensively with sex offenders, say:

A criminal process which is interested in social regulation rather than in fitting the punishment to the crime depends, however, on information by which the danger of a given offender to society, and conditions and chances of change can be assessed.⁸

What is happening in the present? We have in Maryland an institution that is unique in the United States—The Patuxent Institution. A hospital-prison devoted to the treatment of our worst, most dangerous, antisocial, psychopathic offenders. Under the direction of Dr. Harold Boslow, valiant attempts are being made to change the behavior patterns of these social predators. In Baltimore County the Juvenile Court has established a limited group therapy program for second offender delinquents and their parents, mainly using psychologists as group therapists. In addition some very excellent treatment work has been carried out by the Massachusetts Court Clinic program, and there is the work of Joe Peters at the Philadelphia General Hos-

6. MODEL PENAL CODE § 4.01 (Tent. Draft No. 4, 1955). For a discussion of the Model Penal Code Test as adopted in *United States v. Freeman*, 357 F.2d 606 (2d Cir. 1966), see Comment, *Criminal Law—Insanity—The American Law Institute Formulation and Its Implications for South Carolina*, 18 S.C.L. REV. 661 (1966).

7. *Durham v. United States*, 214 F.2d 862 (D.C. Cir. 1954).

8. J. MOHR & R. TURNER, *PEDOPHILIA AND EXHIBITIONISM* 75 (1964).

pital and the work of the forensic clinic of the Toronto Psychiatric Hospital of the University of Toronto. The latter group has done some very basic work on the evaluation and treatment of pedophilia and exhibitionism. Their research would indicate that the first offender heterosexual pedophile has a recidivist rate of 6 to 8 percent while in second offenders the rate goes up to 30 percent or more. Those whose sexual offenses are multiple and also have non-sexual offense records have a recidivist rate of 55 percent or more as sex offenders. The homosexual pedophile has a higher recidivist rate and is quite resistant to treatment. This looks like good, firm data upon which we can base recommendations.

When a child is murdered, the community immediately describes this as a sex crime and assumes that all pedophiles are potential murderers. The little data that we have would indicate that, first, child murders are rare; second, child sexual murders are rarer; and third, if and when they do occur, they invariably are perpetrated by the psychotic pedophile who represents a very small part of pedophile offenders. As Guttmacher and Weihofen said with reference to the sex offender, "there is doubtless no subject on which we can obtain more definite opinions and less definite knowledge."⁹

We already are being faced with a dilemma. The alcoholic and the addict are now being considered "sick" and should be "treated." Can we effectively treat the alcoholic and addict? It seems obvious, at least to me, that our basic psychiatric treatment model is not adequate to treat these individuals. What of the others, the pedophile, voyeur, exhibitionist, arsonist, and so on? The Community Mental Health Center may well be called upon to treat these people.

Many of us when faced with a disturbed patient who threatens a serious act, become concerned whether or not he will do it. Newspaper headlines such as mental patient kills wife, do not help calm our anxiety. In order to evaluate the dangerousness of our patients, Dr. George Lassen and I undertook a study¹⁰ which I will now discuss.

9. M. GUTTMACHER & H. WEIHOFEN, *PSYCHIATRY AND THE LAW* 110 (1952).

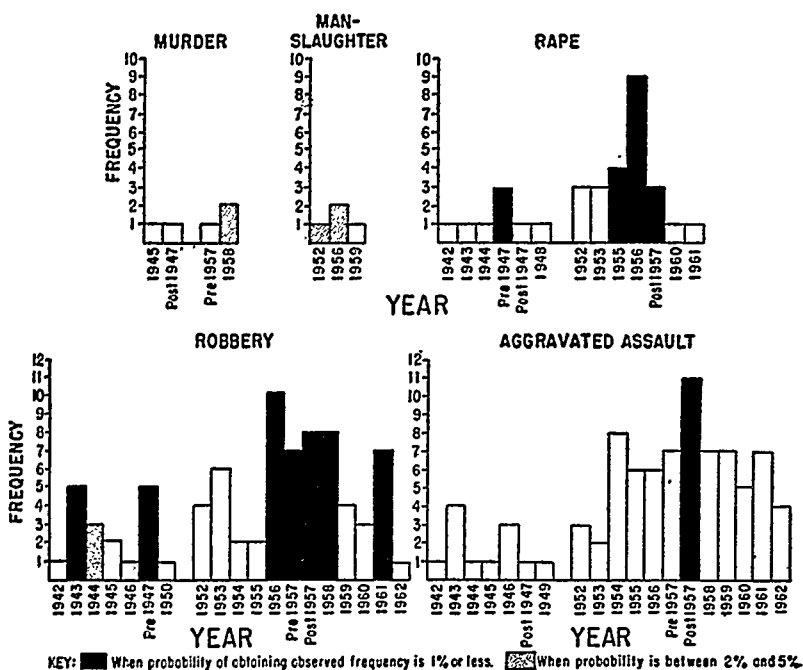
10. The following data and graphs are taken from studies conducted by Dr. J. Rappeport and Dr. G. Lassen as published in the *American Journal of Psychiatry*. The data and graphs are reprinted with the permission of the *Journal* with acknowledgements and notices of copyright as follows:

a. Evaluation and Follow-Up of State Hospital Patients Who Had Sanity Hearings. Reprinted from the *American Journal of Psychiatry*, volume 118,

This was a study of the arrest rates of all patients over 16 discharged from all psychiatric hospitals in the State of Maryland for the fiscal years of 1947 and 1957. The arrest data was obtained by searching the police files of all jurisdictions in Maryland and the District of Columbia. The data deals with the five most serious felonies committed by both men and women against persons: murder, negligent manslaughter, rape, robbery and aggravated assault.

GRAPH 1.

FREQUENCY AND STATISTICAL SIGNIFICANCE OF OBTAINED ARREST RATES



pages 1078-1086, 1962. Copyright 1962, the American Psychiatric Association.
 b. Dangerousness—Arrest Rate Comparisons of Discharged Patients and the General Population. Reprinted from the *American Journal of Psychiatry*, volume 121, pages 776-783, 1965. Copyright 1965, the American Psychiatric Association.
 c. The Dangerousness of Female Patients: A Comparison of the Arrest Rate of Discharged Psychiatric Patients and the General Population. Reprinted from the *American Journal of Psychiatry*, volume 123, pages 413-419, 1966. Copyright 1966, the American Psychiatric Association.

The graph above indicates the frequency of arrest for our populations and its significance compared to that of the general population. The years listed represent the year of arrest for 5 years prior to hospitalization and 5 years afterwards. The bars represent the actual number of arrests for that offense. The solid bars indicate a probability of 1 percent or less, and the checked bars represent a 2 to 5 percent probability for obtaining these observed frequencies in the general population. These probabilities were determined through the use of the Poisson equation.

A comparison in the frequency of arrest between our discharged mental hospital population and the general population reveals that for the offense of robbery, both hospital groups have a significantly higher arrest rate than the general population, and therefore, probably is in some way related to some factors connected with persons who are identified with mental illness. We cannot be as statistically unequivocal for the other offenses, but the data suggests that rape has a higher incidence of occurrence in our pre-hospitalization population than in the general population. Murder and negligent manslaughter are less clear-cut, and aggravated assault offenses in the discharged mentally ill are about equivalent to the rates of the general population. (It should be noted that murder, rape, robbery and aggravated assault all show some significant incidence in the immediate post-hospital period.)

A comparison of the frequency of arrests of females between our discharged mental hospital population and the general population reveals that for the offense of aggravated assault, both the 1957 pre- and post-hospitalization groups (particularly the latter) have significantly higher arrest rates than the general population. The incidence of murder and robbery are less frequent and their statistical significance is not apparent. There were no arrests in this female population for rape or negligent manslaughter.

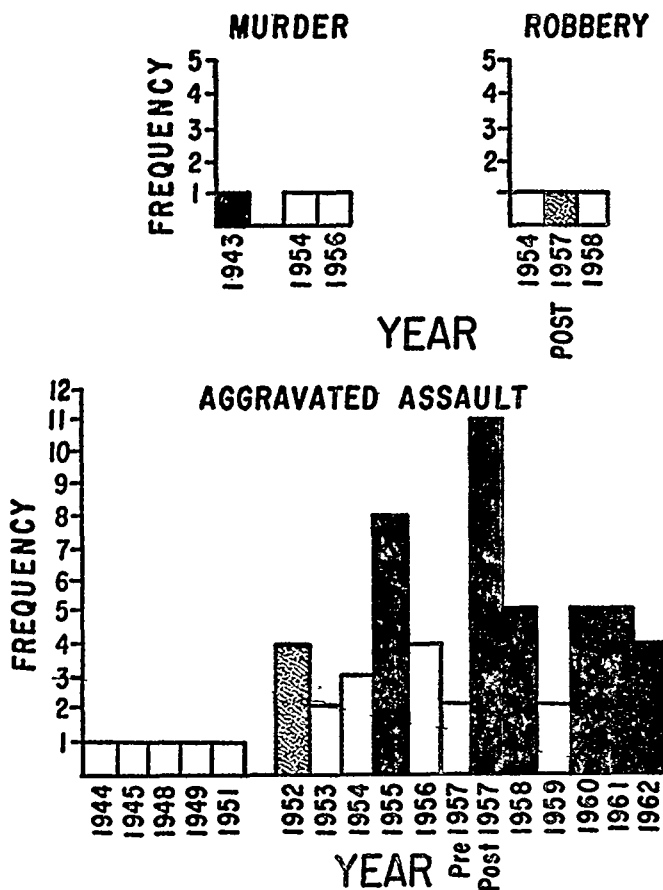
In these two studies we attempted to correlate diagnosis with arrests and generally noted that alcoholics and schizophrenics accounted for about 50 percent of the arrests both before and after hospitalization.

In considering the results recently compiled on our patients discharged in 1957 only, there seemed to be no gross differences

GRAPH 2.

DANGEROUSNESS OF FEMALE PATIENTS

Frequency and Statistical Significance of Obtained Arrest Rates



KEY: ■ When probability of obtaining observed frequency is 1% or less.
 ▨ When probability is between 2% and 5%.

between the 1947 and 1957 groups so we have focused our attention on the latter. In the 1957 population there were 2,152 male patients and 2,123 female patients. When we view their total number of arrests, we are unable to make any comparisons with the general population (in the community) because no such data exists. The total number of patients with arrest records

is quite amazing when viewed from the relatively unarrested perch of the middle class psychiatrists. In our 1957 population there were 2,152 males, of which 58 percent had been arrested at least once. This is consistent with the general finding of females being arrested less frequently than males.

TABLE 1.

1957

MALE

TOTAL POPULATION	— 2152	}	58%
TOTAL OFFENDERS	— 1248		
TOTAL OFFENSES	— 8673	}	PRE. HOSP. — 4365
			POST HOSP. — 4308

FEMALE

TOTAL POPULATION	— 2123	}	19%
TOTAL OFFENDERS	— 410		
TOTAL OFFENSES	— 1264	}	PRE. HOSP. — 598
			POST HOSP. — 666

However, our ratio of 1 to 3, females to males, shows a much higher ratio than the F.B.I. 1966 national ratio of 1 to 7. Obviously, our female patients are more arresting. We can see that many of those arrested were arrested numerous times—the 1,248 males accounted for 8,673 arrests, an average of seven arrests per person, and our 410 arrested females accounted for 1,264 arrests, an average of three arrests per person.

Most of these arrests were in two categories—drunkenness and disorderly conduct. In the males these accounted for 71 percent of all offenses and in the females for 74 percent. It should be noted that proportionately fewer of the female arrests were for drunkenness as compared with the males.

With so few patients accounting for so many arrests, one wonders what the relationship might be between arrests and hospitalization. Derbyshire and Brody have shown that a large percentage of the Baltimore Inner City people are hospitalized via the police and the courts. Our data do not clearly show that arrests are clustered around the time of hospitalization although

TABLE 2.

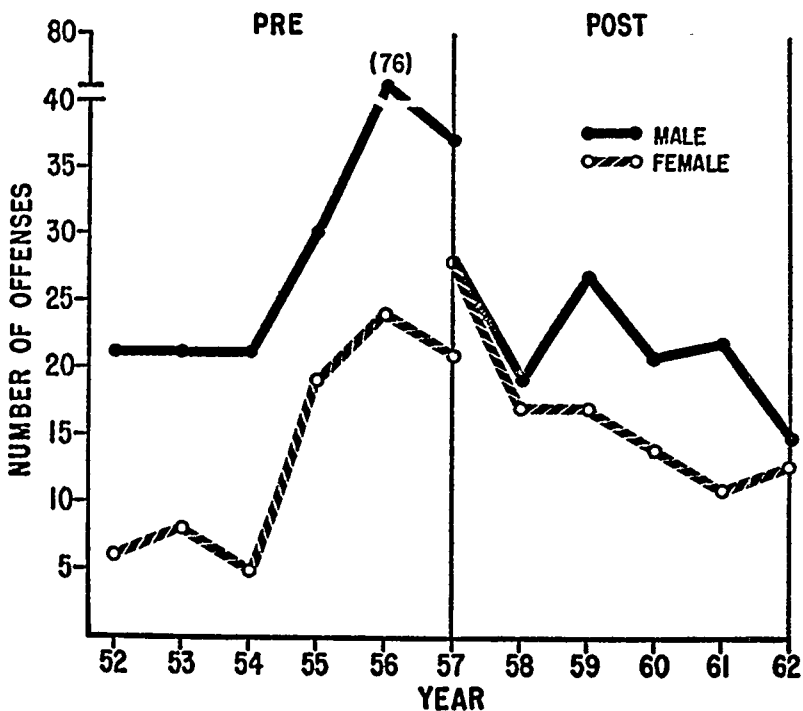
CAUSE OF ARREST 1957

	<u>MALE</u>	<u>FEMALE</u>
DRUNKENNESS OR INTOXICATION (DRIVING INTOXICATED)	3527	238
DISORDERLY CONDUCT OR BREACH OF THE PEACE	<u>2659</u>	<u>709</u>
<u>TOTAL OFFENSES</u>	<u>6186</u>	<u>947</u>
	<u>71%</u>	<u>74%</u>

there may be a slight tendency in this direction. Actually we are able to recognize at least five different individual groups of patients. This will become evident as the next few graphs are considered.

GRAPH 3.

FREQUENCY OF OFFENSES FOR SINGLE OFFENDERS



In table 3 we consider a group of patients who had one arrest each prior to hospitalization, but not after discharge, and another group who had no arrests prior to being hospitalized but subsequently had one arrest each. In the pre-hospitalization group there is a tendency for an increase in single arrests up to the time of hospitalization with no arrests after discharge. The post-treatment group started off with many of them getting arrested after discharge, but this tapered off as time went on. We would expect to see a tapering off since offenses decrease with age in our general population. Parenthetically, we can report that the average age of those arrested prior to hospitalization is older than those whose arrests first appear in the post-hospital period. The implication here is that for this post-hospitalization group there was not a clear-cut relationship between being arrested once only as a means to getting to the hospital. Why should these patients seem to respond to discharge by committing an offense? Maybe they got drunk at their "coming-out" party.

TABLE 3.

SINGLE AND MULTIPLE ARRESTS**1957****ONE ARREST**

PRE HOSPITALIZATION	289
POST HOSPITALIZATION	<u>232</u>
	<u>521</u>

MULTIPLE ARRESTS

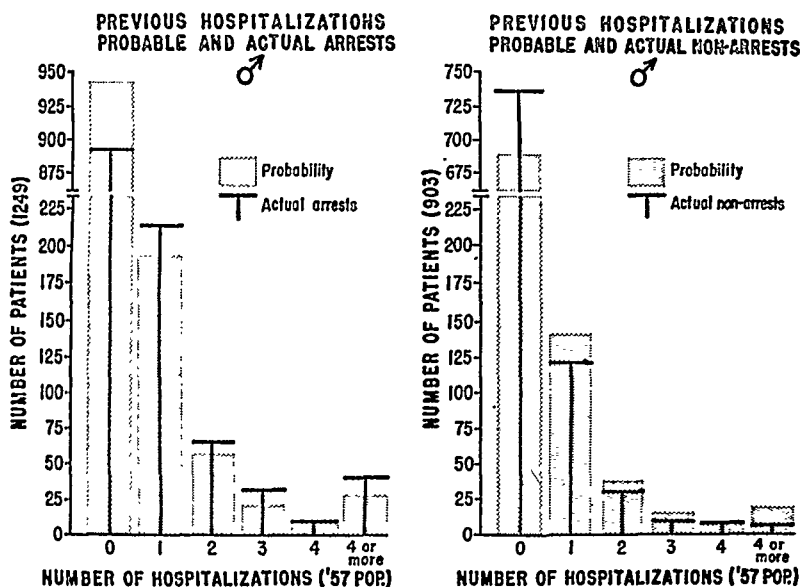
PRE HOSPITALIZATION	175
POST HOSPITALIZATION	118
PRE & POST HOSPITALIZATION	758
MULTIPLE OFFENDERS	1051
TOTAL OFFENDERS	<u>1658</u>

Here we see the five groups I spoke of more clearly defined with the tendency towards multiple arrests. The five groups are: single offenses prior to hospitalization, single offenses subsequent to hospitalization, multiple offenses subsequent to hospitalization and multiple offenses *both* pre- and post-hospitalization. Outstanding in these data is the fact that two-thirds of

the patients have multiple offenses and only one-third a single offense in the study period. This would seem to indicate that once a patient is arrested he is likely to be arrested again.

The next question which arises involves the relationship between a tendency to be arrested as related to the number of hospitalizations.

GRAPH 4.



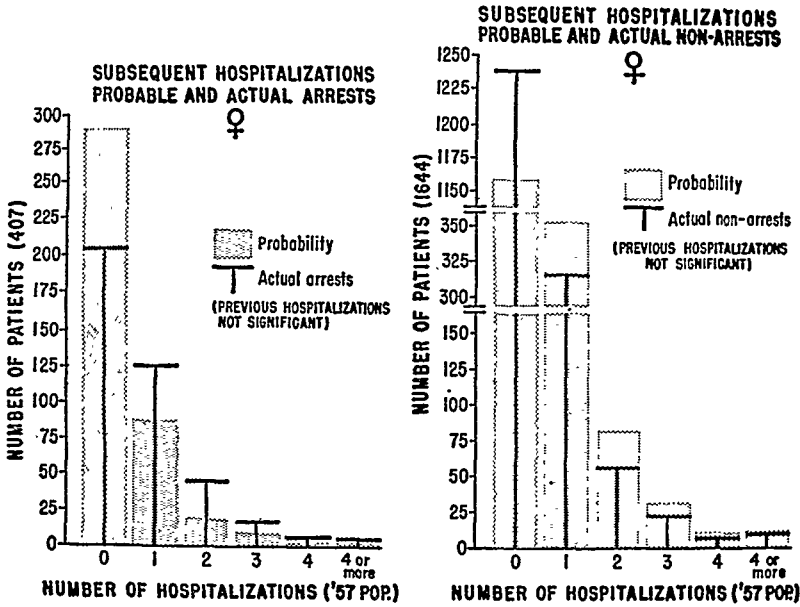
The graph above shows previous hospitalizations of males, that is prior to 1957, as related to the number of patients arrested and not arrested and their expected frequencies as derived from the chi square computation for arrested and non-arrest patients.

The following graph shows the subsequent hospitalizations of males, the number of patients arrested and not arrested, and their expected frequencies.

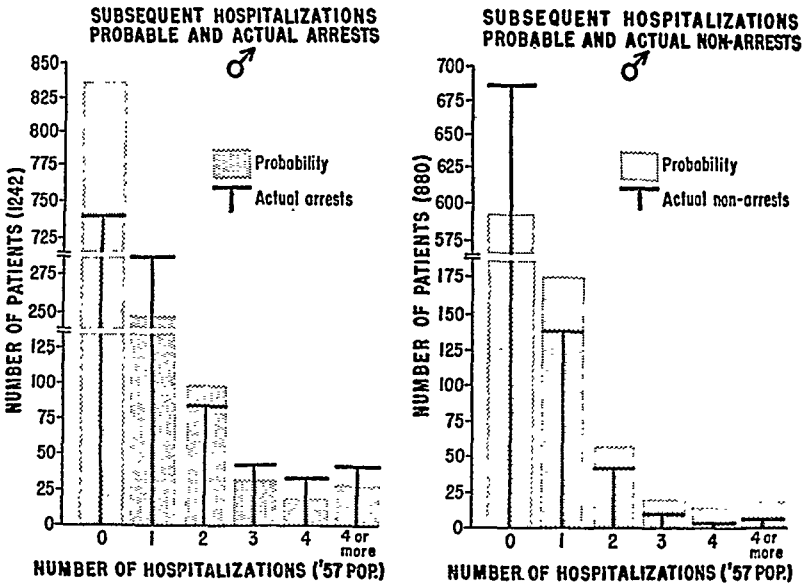
Graph 6 shows the females' subsequent hospitalizations and expected frequencies. The prior hospitalizations of the females were not significant.

In retrospect it should be remembered that in graph 2 the females showed their significant arrests for aggravated assault —post-hospital. From these data it is apparent that the arrested population is also hospitalized frequently. In essence, people

GRAPH 5.



GRAPH 6.



who have trouble seem to have double trouble despite our best efforts in our hospitals. We recognize, of course, that we are not talking about all patients, but only those who get arrested, although they are a large group.

It seems that psychiatric patients act-out a great deal, perhaps more than the rest of the community and are not substantially less dangerous as Brill and Malzberg reported in 1962.

Giovannoni and Gurel in a recent study of a 95 percent schizophrenic population of all males also found a high incidence of arrest for drunkenness. They found a higher rate than in the community for homicide, aggravated assault and robbery. In our more general psychiatric population homicide did not stand out.

We had assumed that somehow antisocial behavior and mental illness were complementary and might cancel out or replace each other. Therefore, we were surprised to see so many offenses in our patients particularly so closely associated with their time of admission or discharge.

Studies like this open the door for other work in prognostication. Much needs to be done so that, if at all possible, we can predict dangerous behavior.

We all have a responsibility. We as psychiatrists have a particular responsibility to produce something more meaningful. Those working specifically in forensic psychiatry have a responsibility to teach others both in law and psychiatry and more specifically to do research into the causes of and treatment of all types of antisocial behavior—be it clearly mental illness, or other types of antisocial behavior. It is our responsibility to develop new techniques and train new “helpers.” I would hope to see the day when we can, beyond a reasonable doubt, predict when a mentally ill patient is dangerous and should be hospitalized and when he is safe to be discharged. We should also strive for the day when we can assure the courts that there is a certain treatment for an offender and that there are trained personnel to carry out this treatment and that if so carried out, there is a reasonable chance that the offender will not commit the same offense again. When that day comes, perhaps not in this millennium, then we can once again devote our efforts towards further changes in the tests of criminal responsibility. Perhaps then we will have met the requirements mentioned in

my quote from Mohr, et al and be ready for the plan proposed by Dr. Guttmacher. Ideally, there would first be a trial to determine guilt, then the experts would decide what treatment is best for the true rehabilitation of the offender and where it should best be carried out. He did not think we or the law were ready for this now.

A fitting conclusion is this quote from President Johnson's "Crime" speech: "Ancient evils do not yield to easy conquest. . . . We cannot limit our efforts to enemies we can see. We must, with equal resolve, seek out new knowledge, new techniques, and new understanding."¹¹

11. 112 CONG. REC. 5368, 5369 (1966) (message from the President of the United States).