

# The treatability requirement in psychopathy: a new ethical dilemma?

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## Editor's note

*The author of this paper argues that trying to meet the treatability requirement contained in the Mental Health Act 1983 in cases of psychopathic disorder poses such problems that it constitutes a new ethical dilemma for psychiatry.*

*His argument turns on the fact that 'this requirement calls not for an assurance about the patient's present state or previous history but rather for a statement about his or her future – a prediction of the outcome of treatment'. And, as the author points out, 'prognosis in medicine is always an uncertain art'.*

A new principle was introduced into the mental health legislation for England and Wales by the *Mental Health (Amendment) Act 1982* and accordingly appears in the *Mental Health Act, 1983* (1). This concerns the relationship between compulsory detention in hospital and the so-called 'treatability' requirement. It appears in the Act in several places but one example will suffice for the argument of this paper. *Section 3 (2) (b)* provides that in making a recommendation to support an application for compulsory admission for treatment, the grounds must include:

'in the case of psychopathic disorder or mental impairment, such treatment is likely to alleviate or prevent a deterioration of his condition;'

Clearly, no detention in hospital is lawful under these provisions unless the psychiatrists who complete the medical recommendation can certify a '... likelihood of benefit from treatment...' (*Explanatory Memorandum to the Mental Health (Amendment) Bill*) (2) – indeed, this was precisely the intention of those who in recent years have advocated this reform. According to the Act 'medical treatment' includes not only the conventional range of pharmacological, physical and surgical interventions but also nursing and '... care, habilitation and rehabilitation under

## Key words

Mental health legislation; psychopathy; psychiatry; psychology; psychiatric ethics.

medical supervision'; we may fairly take this to cover the full gamut of ordinary psychiatric measures. (It may be appropriate to add that the Act requires, for the compulsory admission of psychopaths, not only treatability but also [in section 3 (2)(c)] that the admission is necessary for the health or safety of the patient or for the protection of other persons and that this cannot be provided unless the person is detained.)

The argument of this paper concerns the application of the treatability requirement only to cases of psychopathic disorder; indeed, this application may perhaps be contrasted with that of other categories of mental disorder: mental illness, severe mental impairment or mental impairment. And the argument turns on the fact that this requirement calls not for an assurance about the patient's present state or previous history but rather for a statement about his or her future condition – a prediction of the outcome of treatment. Not only has the doctor to exercise ordinary skill and care, not only has he the usual obligation to do his best but – uniquely, I believe, in a legal context – he must undertake that he will be likely to succeed in either helping to improve the person's condition or at least in preventing its deterioration. Prognosis in medicine is always an uncertain art. But there are reasons for suggesting that the prediction about treatability in the case of psychopathic disorder presents peculiar problems, and that such problems do indeed constitute a new ethical dilemma for psychiatry.

Psychopathic disorder is defined in the 1983 Act as '... a persistent disorder of disability of mind (whether or not including significant impairment of intelligence) which results in abnormally aggressive or seriously irresponsible conduct on the part of the person concerned' (section 1).

In the *Mental Health Act 1959* the corresponding definition, apart from referring to the 'patient', differed in that it had the added words '... and requires and is susceptible to medical treatment'. Leaving aside the rather fruitless debate among psychiatrists as to whether *any* psychopath is treatable, this phrase at least had the merit of referring to characteristics which might be described of the person concerned (or the patient!) *at the time* at which the use of compulsion was under consideration. But before

describing the problems involved in asserting that 'his condition' will be alleviated, or deterioration prevented, by treatment we must first briefly consider the question of medical prediction.

The relation between degrees of probability in clinical prediction and the broad spectrum of medically significant events is of course familiar. Some significant medical – indeed, psychiatric – events belong essentially to the physical sciences. Individual instances very rarely depart from the statistically normal; prediction is possible with a high degree of probability. Many medical events of a molecular (physio-chemical) or mechanical nature fall at this end of the spectrum. A psychiatrically relevant example might be blood gushing from a cerebral artery will cause damage to surrounding brain tissue. Intermediate in the spectrum are events belonging to the biological sciences and conforming to an organic model. Here, given the (often implicit) inclusion of a *ceteris paribus* condition, the individual instance often conforms to the statistical norm, and the predictions of the knowledgeable and astute practitioner are acceptably accurate. Much research effort goes into progressively refining the boundary conditions so as to allow of even more accurate predictions in the individual case. Many biological part-functions of individuals (the response of pernicious anaemia to Vitamin B12, or – perhaps with less certainty – of recurrent mania to Lithium) and those 'whole-person' statements about the progress of people which we ordinarily call *prognosis* would be examples.

But medical events which belong to the behavioural sciences are at the other extreme of the spectrum. At this point (where psychopathic disorder belongs) prediction is *in principle* at a low level of probability, except under very special conditions; yet it is precisely in such cases that the law requires that, if compulsory admission is contemplated, a statement about the outcome of treatment be made, generally before that treatment itself is instituted.

Returning to the definition given above, we note:

- (i) It is his *behaviour* – '... abnormally aggressive or seriously irresponsible conduct. . . ' – which brings the individual to notice, and may attract a diagnostic label such as psychopathic or anti-social disorder;
- (ii) such behaviour is held to reflect an *intrinsic property* of the individual, namely a '... disorder or disability of mind . . . ', later referred to as '... his condition . . . '; and
- (iii) this condition is '... *persistent*. . . '

The inclusion of this adjective is of course intended to point to the clinically important principle that the diagnosis should not be made without evidence of the broad persistence of the relevant behaviour across varied situations and through the life-span of the individual, at least from adolescence. It need not imply, however, so great a degree of fixity that the person concerned is altogether beyond the influence of 'medical treatment', broadly defined. Nevertheless,

this behaviour is supposed to be:

(iv) *predictable*, at least in the circumstances of '... such treatment . . . ' as the hospital may provide (and also, presumably, in the circumstances of being left untreated); and, we must assume:

(v) the success of such treatment in alleviating or preventing a deterioration in his condition would be manifest in a *change of behaviour* – it would become less abnormally aggressive or seriously irresponsible.' The problem with this line of reasoning arises out of the relationship between the intrinsic mental determinants of behaviour and that outwardly observable behaviour itself. Writing elsewhere about the treatment of people with personality disorder within therapeutic communities, I suggested:

'Those who conduct any sort of therapy generally do so in the expectation that its effects will be relatively long-lasting; ideally, perhaps, that they should persist for life. Where the therapy is psychological this expectation assumes that a lasting psychological change takes place which so influences the individual that behaviours which initially were problematic do not occur afterwards. There is here a further implication, namely that behaviours are in practice determined to a large degree by factors which may be described as "psychological" or (broadly) as "personality factors" or (more precisely) as "P variables". That is, the psychological state in the treatment situation is held to predict something of the patient's behaviour outside it – something occurring, perhaps, after discharge. Yet the present state of personality theory suggests that actual behaviour is not chiefly predicted by such internal factors but rather by characteristics of the individual's environment – that is by situational or "S variables" – or, even more powerfully, by P × S interaction (3).'

Influenced, no doubt, by medical experience of more mechanical or organic problems we tend intuitively to think of personality traits as being something like blood groups – constant through time and across a variety of situations. But the empirical studies of many psychologists, from the famous studies of aspects of 'moral character' by Hartshorne and May in the 1920s (4) down to a wealth of investigations reviewed by Walter Mischel in *Personality and Assessment* (1968) (5), and to more recent work, for example Argyle (1976) (6), cast doubt on such intuitions. Mischel concluded that correlation of about +0.3 on cross-situational studies must indeed be regarded as an established ceiling for most personality traits and reflects 'true behavioural variability' rather than imperfect methodology in the investigations.

My own paper suggested that the concept of personality disorder (including psychopathic personality) as generally used by psychiatrists does not escape the critique of trait theories of personality in general as advanced by the psychologists; yet such a

usage persists in practice – and seems to be implied in the Act:

‘Perhaps this difference between the psychologists and the psychiatrists is accounted for by the fact that they are looking at two broadly different populations, the conclusion reached by the psychologists being based on observations of “normal” people and those reached by the psychiatrists on observation of “abnormal”’. Indeed, perhaps what we mean when we speak of “normals” is people whose behaviour is sensitive to situational variables, and when we speak of “abnormals” we mean people whose behaviour is situationally inappropriate. In other words, when we describe someone as “personality disordered” we mean that his behaviour is to an unusual degree influenced by P variables, and that if we succeed in treating him we are moving him along a continuum from predominantly P determination towards predominantly S or  $P \times S$  determination (3).’

Argyle suggests that it is precisely because of the low degree of predictability of human behaviour at different times and between different situations that psychologists have given up the traditional trait model in favour of an interactionist model of human behaviour which can deal with different proportions of P, S and  $P \times S$  variance (6). This is currently an active area of research.

If the condition of the psychopathic patients referred to in the Act is indeed assimilable to this area of study, and the psychologists are correct, the relation between actual behaviour and internal states probably has much more to do with *purposes* and with how we *construe* the world, or with *rules* which generate particular behaviours ( $P \times S$  characteristics) than it has with so called personality (P) characteristics. Plainly, behaviour in one situation (say, as a psychiatric patient) may be quite unlike that in another (outside hospital and after discharge) – indeed, we might think it normally should be. Moreover, the more successful the treatment in encouraging a person to be situationally-sensitive in his behaviour, the less possible will it be to predict that behaviour from knowledge of any characteristic of his personality. It may become specifically less aggressive or irresponsible, and the clinician must certainly hope that it will; but he or she cannot be certain. In addition the clinician will generally be unable to predict with

any accuracy the situations in which the patient is likely to find himself (though this would improve the level of probability of his prognosis) and he certainly cannot control them.

Finally, we should note that the contrast between patients in this group and those falling into the other categories defined in the Act – mental illness, mental impairment, severe mental impairment – is that in these a much greater element of the disorder resides within the individual. The pathology, and substantial elements in the common treatments of those with these conditions, belong to the organic range in the spectrum of medical events. Also, some cases of psychopathic behaviour may be based upon genetic abnormalities or organically determined dysfunction. Clearly none of these cases fall within the scope of the argument presented here.

It is not, I think, intended that the new Act should prevent the detention of patients with psychopathic disorder when this is necessary, but the prediction required by the treatability requirement is by no means so straightforward a matter as it might seem at first sight. The idea that society frequently uses doctors to bear the responsibility for decisions characterised by high levels of uncertainty is very familiar. Thus, in this conflict between the law’s demand for prediction and psychology’s demonstration of its near-impossibility lies a new ethical dilemma for psychiatry.

## References and notes

- (1) *The Mental Health (Amendment) Act 1982* introduced many alterations to the *Mental Health Act 1959*. For the sake of comprehensibility a consolidating act incorporating all these changes was re-enacted as the *Mental Health Act 1983*.
- (2) *Mental Health (Amendment) Bill (H L). Explanatory and Financial Memorandum*. London: Her Majesty’s Stationery Office, 1982.
- (3) Millard D W. Generative rules and the therapeutic community. *British journal of medical psychology*. 1981: 54; 157–165.
- (4) Hartshorne H, May M A, Shuttlesworth P K. *Studies on the nature of character. Vol 3: Studies in the organisation of character*. New York: Macmillan, 1930.
- (5) Mischel W. *Personality and assessment*. New York: Wiley, 1968.
- (6) Argyle M. Personality and social behaviour. In: Harré R, ed. *Personality*. Oxford: Blackwell, 1976.