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Dangerousness in Psychiatry

(A Sample from Khanka Mental Hospital in Egypt)

by H. Ghali

ABSTRACT

A study of the numbers and types of crimes in 704 mental patients committed to Khanka state mental hospital from 1967 till 1977 was made. Out of these, 395 were found to be major crimes, and 297 were found to be minor ones. The commonest diagnostic category involved was that of schizophrenia followed by manic depressive illness. The higher incidence of schizophrenia as a source of dangerousness amongst the mentally disturbed is going in line with the wider prevalence of that disorder in the sample provided and in the population at large.

The assessment and evaluation of dangerousness caused by mental illness is one of the most important and at the same time difficult tasks encountered in the practice of psychiatry. Its importance arises from the dual responsibility imposed on the psychiatrist towards the patient on one hand and towards society on the other hand. It is only through assessment of dangerousness that forcible detention is decided, thus interfering with personal freedom and human rights. The difficulty arises from the fact that up to the present time, there are no definite measurements or standards by which the problem of dangerousness can be evaluated. This is due to the differences of responses, reactions, and interactions of persons which can be as numerous as the number of patients existing. Moreover the conception of dangerousness varies from one society to another and we still lack a definite terminology with definite boundaries, thus we are left with vague statements such as "endangering personal, or public security, and order". Such a state of vagueness results in an increased degree of subjective judgements and

personal opinions, at the expense of objective judgements, thus reducing scientific validity. It also lies behind many of the hazards met with in the practice of psychiatry. Through ambiguity the profession can be, and is actually, abused in certain countries. It is also the cause of doubts and shadows justly or unjustly thrown on psychiatric verdicts, and at times amounting to public resentment and opposition.

I believe that all psychiatrists who have spent sufficient time in practice can recall one or more of such incidents in their practice. Documents of parliaments and justice halls in many countries are full of such debates.

Personal Rights Versus Social Rights

The development of democracy and the increased on asserting human rights and personal freedom on international levels are considered to be some of the greatest achievements of our present civilization. But as a result of increased enthusiasm in this direction to liberate mankind from old time tyrannies and human injustice, certain mistakes or better say imbalance between various important factors has taken place. Societies should be considered as the analogues of living organisms; they are born, they grow, become healthy become sick, and they die. Thus there exists what we call social rights as compared to human rights. This necessitates that during forcing and asserting personal rights, much care and precision should be taken to attain the proper balance between personal rights and social rights. Imbalance in either direction is dangerous and can lead to catastrophic results. No doubt this balance is very difficult and is subject to endless dispute. In the field of psychiatry I believe that during the last decade disturbances of the balance have occurred in both directions. In some countries through favouring social rights, personal rights and freedom were overlooked or even abused, and in other countries through asserting personal rights, social rights and security were seriously endangered. I think that every one of us can recall some or several events in connection with the latter argument. The very recent and painful massacre of Guyana brought by the diabolical

influence of Jim Jones is a vivid example of the dangers of such imbalance. If we have had an agreed upon international definition of dangerousness and international measures of dealing with dangerous psychiatric cases and, if possible, an international mental health act; many of such painful incidents and traumas could have been avoided.

A mentally disturbed person whose consciousness, judgement, and insight are deranged is considered legally as irresponsible for his acts and consequently unpunishable. This means that society cannot get its rights from such a person. It is then quite justifiable for society to take certain legal measures against such a person to ensure its protection and security. Such measures if scientifically and legally adopted do not, in fact, interfere with personal rights. Actually many a time the patient's declared attitude of a will to self destruction but his internal torment and unhappiness betray a "please help me" cry. Thus, the job done by the profession in this field is not solely for the interest and protection of society, but it is as well and sometimes more so for the interest and protection of the patient himself. Thus an important goal custodial care becomes that of preventing the various dangers the patient can expose himself to in all aspects of his life whether physical, financial, familial, or social.

A study of the files of 196 mentally disturbed murderers chosen haphazardly from the files of Khanka mental hospital to find out the relation of the victims to the patients has shown that in 90 cases (45.9%) the victims were first degree relatives, and in 62 cases (31.6%) were second, third, or fourth degree relatives, while only in 44 cases (22.5%) the victims were not related or strangers to the patient. Again this shows that it is in the best interest of the patient's family, as the third party involved, that custodial care should be preserved.

Detected Crimes Committed By Mentally Disturbed Offenders In Egypt

In the following paragraphs, a statistical profile is going to be presented that shows the relative involvement of the different psychiatric categories in crime together with a profile of the types of crime

Table I

Numbers of Mentally Abnormal Offenders Detained and Types of Crimes from 1967 through 1977.

Year	No of Pt admitted per year	Murder	Attempted Murder	Assault	Theft	Sexual Crimes	Larcery	Possession or narcotics	Breaking into house	Forgery and Embezzlement	Destruction of properties	Running away from parole control	Beggary	Vagancy	Breaking in prohibed areas	Insult & Threat	Disturbing pub. security	Impersonation	Kidnapping of children	Failure to get ident. card	Disertion of Military services	Inflicting permanent injury	Possession of Unlicenced weapon	Check without block	Using public transport without ticket	Total	Primers
1967	60	15	3	11	0		2	1	1	1	3	2	2			2	4	1		1	1	1	1	1		60	4
1968	47	8	8	9	2	1	2	1		3	1		1			2	2			1		4	1	1		47	5
1969	52	9	2	9	3	3	3	2			2		1		1	1	8					6	1			52	5
1970																											
1971	149	52	8	19	19	6	4	5		5	4		2			1	8	4			4	8				149	11
1972	69	24	5	9	2	4	1	1	1	7	2	1	2				3	1			3	3	2			69	11
1973	80	35	4	8	7	4	3	1		4	3	2	1	2		1	1					2				80	4
1974	45	22	1	9	3	2			1		1					2	1				3		2			45	3
1975	62	20	4	11	8	8	2	2	1	2	4						1	1			2	3	1			62	7
1976	68	21	6	6	9	1		1		2	2					3	5	2			6			1	2	68	4
1977	60	16	1	12	11	2	2	1		2	3					1	2				3			1	1	60	9

N.B.: In the year 1970, the hospital was closed because of an epidemic of cholera.
New admissions were kept at Abbassia Mental Hospital and sent in 1971
(note the increase of admissions in 1971).

committed and their relative frequency (Tables I, II, III) The study is mainly derived from Khanka hospital files, the only center for custodial care of mentally disturbed criminals in Egypt The aim of this presentation is to :

a) Study diagnosis as an important variable in assessing the frequency of criminal behaviour in the mentally disturbed.
b) Provide a profile suitable for more detailed statistical studies and comparative transcultural studies.

Table I shows the numbers and types of various crimes committed by mentally disturbed offenders in Egypt in the year 1967 up to 1977. The total number of detectable crimes in these 11 years was 703 crimes of different natures, an average of 62 crimes yearly. We have to remember that statistical studies in criminology have shown that the number of undetected crimes is far greater than that of detected ones. Accordingly we would expect that many crimes committed by mental patients are unreported.

Out of the 703 crimes, 264 (38%) were crimes of murder and attempted murder (222 and 42 respectively). Next come the crimes of assault which amounted to 130 crimes (18%), then follow the crimes of theft, 72 crimes (10%), then lastly the rest of the other crimes including crimes of threatening public security, sexual crimes, larceny, destructiveness of property, forgery, embezzelments and others.

Tables II and III show the number of mentally disturbed offenders detained at Khanka mental hospital by judicial verdicts and the relation between the different types of crimes and the types of mental illness in 1977. Table II refers to major crimes, and Table III refers to the minor ones. The distinction is made according to the judicial classification of the Egyptian penal law.

Results And Discussion

It is noticed from the tables that schizophrenia is associated with the greatest number of crimes; Schizophrenics were responsible for 248

Table II: Distribution of Major Crimes (Judicial Verdicts) According to Diagnosis

Diagnosis	Murder & Attempted murder	Sexual crimes	Larceny	Possession of narcotic	Threat and insult	Forgery & embezzelment	Theft	Disertion of milit. service	Disturbing pubblic security	Possessing of unlicenses weapon	Breaking into prohibited areas	Inflicting permanent injury	Breaking into a house	Impersonation	Kidnapping of children	Prisoners*	Total
SCHIZOPHRENIA	173	5	6	3	11	3	3	1	12	5	1	18		2	4	1	248
MANIC DEPRESSIVE	61	2	2	3	3	3	2	1	5	2		14		2		2	105
EPILEPSY	10	1			2												13
ACUTE CONFUSIONAL STATES	2																2
ALCOHOLIC AND DRUG PSYCHOSES	1																1
MENTAL SUBNORMALITY	11	2	1	6	3		2	1	1			5	1		1		37
ORGANIC PSYCHOSES	1											1					2
	259	15	9	10	19	6	7	3	18	7	1	38	1	4	5	4	406

* Cases that developed mental disorder during their imprisonment (coming from prisons for treatment)

Table III: Distributies of Minor Crimes (Judicial Verdicts) According to Diagnosis

Diagnosis	Possession of narcotics	Attempt of murder	Assault	Breaking into a house	Forgery & embezzlement	Theft	Destrict of property	Running away from parole cont.	Beggary	Vagrancy	Breaking into prob	Arson	Sexual crimes	Insulting & threat	Impersonat	Disturbing public security	Using trains	Kidnapping of children	Failure to get identity card	Total
Schizophrenia		4	86	6	36	10	7	3	2	1	1		3	3	2	4				165
Manic depressive		3	37		1	7	6	2	1	1			3	3		2				67
Acute confusional states		1			1															2
Mental subnormality	1		7	2		29	2	3	8	3			1					1	1	54
Senility						1		1												2
Epilepsy			3			2	1		1											7
Total	1	8	135	9	37	45	16	9	12	5	1		7	9	2	6		1	1	297

crimes out of 406 major crimes that is about 60% and 165 crimes out of 297 minor crimes that is 55%. Following schizophrenics come manic depressive patients. They were responsible for 103 major crimes, (about 25%), and 67 minor crimes (about 22%). Next come mental subnormalities which were responsible for 13 major crimes (3%) and 7 minor crimes (2.3%). The rest of the crimes were committed by cases of acute confusional psychoses, alcoholics and drug psychoses, senile psychoses, and organic psychoses.

These figures can be guide lines during our assessment of the degree of dangerousness in mental patients. The results concerning schizophrenia can provide an illuminating example; results of this work have showed that the schizophrenic is a comparatively more dangerous patient. This goes in line with Okasha's finding of high percentage of schizophrenics (50%) in a sample of accused patients together with another high per cent of schizophrenics (14%) among a sample of accused ordinary prisoners (Okasha **et al.**, 1975). However we should not forget that schizophrenia is the commonest form of psychosis, hence these figures are liable to be unduly high in the light of the greater number of schizophrenics in the population. Slater and Roth (1969) support the view that the number of crimes actually executed by schizophrenics is relatively small. A decisive word can be added through work studying the incidence of criminal behaviour in schizophrenics.

Further studies of various symptoms encountered in mental illness with the attempt of making a sort of link or causal relationship between different symptoms and different manifestations of aggression are needed to attain more objective data in the evaluation of dangerousness. For example, delusions are known to be serious symptoms in relation to aggression and dangerousness. The content of delusions, and the different types of delusions vary in their association with aggression. The same can be applied to hallucinations, level of consciousness, and so forth.

Another approach to studying our problem comes from studying the biology and dynamics of innate aggressiveness. In Konrad Lorenz's work (1966) on aggression, he defined two types of aggression namely, benign aggression concerned with defensive and reactive situations, and malignant aggression centered around destructiveness and cruelty. Under

the influence of mental derangement and distortion of mental process, benign aggression may give way to the more deep and primitive malignant leading to an exceeding tendency towards destructive behaviour.

REFERENCES

Lorenz, K. (1966) *On Aggression.* London : Methuen and Co. Ltd.

Okasha, A., Sadek, A. and Abdel Moneim, S. (1975) Psychosocial and electroencephalographic studies of Egyptian murderers. ***Brit. J. Psychiat.*, 126** : 34-40.

Slater, E. and Roth, M. (1960) ***Mayer-Grass Clinical Psychiatry*** 3rd. edition. London : Bailliere, Tindall, and Cassell.

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الملـــوجز

الخطورة (البالغة درجة الاجرام) في المرض النفسي

(عينة مصرية من مستشفى الخانكة للامراض النفسية)

يقدم هذا البحث دراسة لأعداد وانواع الجرائم التى ارتكبها ٦٩٢ مريضا نفسيا من نزلاء مستشفى الخانكة للامراض النفسية فى الفترة من ١٩٦٧ حتى ١٩٧٧ ، ولقد اتضح أن ٣٩٥ من بين تلك الجرائم يعتبر من الجرائم الجسيمة، كما أن ٢٩٧ يعتبر من الجرائز الصغرى ، ويفسر الباحث النسبة المرتفعة لمرض الفصام كمسئول عن الجريمة بنسبة أكثر تواترا من سائر الأمراض بارتفـاع نسبة الفصاميين فى العينة محل الدراسة وكذلك باحتمال ارتفاع نسبة هـذا المرض أصلا فى المجتمع الأوسع .

ABSTRAIT

Le Danger en Psychiatrie

Une étude du nombre et des différents genres de crimes dans 692 patients qui sont mentallement malades et qui sont consignés à l'hôpital mental de l'état, depuis 1961 jusqu'à 1977, a été faite. Parmi ceux-ci, 395 sont des crimes majeurs et 297 des crimes mineurs. Le diagnostic de la catégorie qui y est lu ptus impliquée est la schizophrénie, suivie par les troubles maniaco-depressives. La grande prévalence de la schizophrénie, comme une source de danger parmi les patients qui sont mentallement malades va en ligne avec la plus grande prévalence de ce desordre dans l'échantillon procuré et dans la population toute entière.

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The Lithium Clinic for Treatment and Prevention of Manic Depression: A Cost Benefit Approach

by Ronald R. Fieve

ABSTRACT

Approximately 2-3% of a nation's mental illness is likely to be some form of primary affective disorder. Since the discovery of lithium for treatment and prevention of manic depression, and the discovery and widespread use of antidepressant drugs, the outlook for treatment and prevention of affective illness is extraordinarily good provided that these new discoveries can effectively reach the masses who are afflicted with mood disorders. Cost benefit studies are being used to determine the most efficient means of reaching large numbers of patients with these treatments. In the United States a fast-developing model for the treatment and prevention of affective illness is the Lithium Clinic. Based on the medical model, the Lithium or Affective Disorder Clinic makes use of an expert consultant, paramedicals, rating scales, and drug monitoring to provide safe, effective and inexpensive care for a large number of affectively ill patients.

Although some progress has been made in America and abroad toward the development of community mental health care centers, we continue to hear of the inadequate efforts of local and national departments of mental health to decentralize the large, antiquated hospitals into smaller units. The urgent need to increase the availability of psychiatric services at the community level has been recognized for some time. A master plan established during the Kennedy administration proposed the organization of specific catchment areas in America which would then be served by the community mental health centers. The plan requires that these centers have a number of outpatient facilities and that they provide direct access to an attached inpatient hospital unit where brief hospitalization, day care, and long-term care are available when necessary.