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Correspondence

MENTAL ILLNESS UNDER THE MENTAL HEALTH ACT

DEAR SIR,

There has been a fair amount of discussion in the medical press of the interpretation of the Mental Health Act, especially as regards the use of Sections 29 and 30. A more fundamental question however concerns the meaning of the term "mental illness" under the Act, especially under Section 26. What are the criteria that entitle us to decide that a person is mentally ill in this sense? The answer is highly important, both because it involves the fundamental British principle of the liberty of the subject, and, on a more mundane level, because a misinterpretation may render us liable for heavy damages in the Courts. I should therefore be most grateful to any colleagues who may use your columns to argue their views on this.

The Law is clear that we have no right to treat or even to examine a person merely because he is manifestly ill. We are guilty of assault even if we but try to take the pulse of an obviously sick patient against his will. However the Law makes special provisions for the treatment of patients who are mentally ill. It has always been my view that the reason for this is that the Law recognizes that in this case the illness itself obstructs the patient's capacity to recognize for himself his need for treatment.

After we have decided that a patient is indeed "mentally ill" within the meaning of the Act, we are then obliged to consider certain other questions—is he in need of medical care or treatment, is he a danger to himself or others, and is compulsory detention the only appropriate means of dealing with the situation, as opposed for instance to informal admission or out-patient treatment, etc. These questions only arise, however, after we have reached the conclusion that he really is "mentally ill".

Of course, all forms of "mental" disorder—psychosis, psychopathy, psychoneurosis, psychosomatic illness, etc.—can properly be called "mental illness' in a broad sense, but obviously they do not all render a patient liable to compulsory treatment. At the same time "mental illness" in the Act is not co-terminous with "psychosis". In a case in which I was involved as an expert witness, Counsel for the plaintiff argued that the patient had been diagnosed as suffering from "neurotic depression", that this was a neurosis and that therefore the patient, not being psychotic, had been falsely imprisoned for the few days during which compulsory detention had been enforced. I testified, however, that the patient, who was in a distraught condition, unable to sleep, refusing food and uttering veiled threats of suicide, was thereby unable to assess the true state of affairs and consequently the need for treatment. The verdict was given for the defendant, but this did not specifically endorse the criterion I have given. I think another state of neurosis that would justify the diagnosis of "mental illness" under the Act would be a severe degree of obsessional neurosis such that the patient was rendered incapable of making and holding to a decision. In short, I suggest that the sole criterion that entitles us to hold a person to be "mentally ill" within the meaning of the Mental Health Act is that he suffers from an illness that prevents him from taking the necessary decisions for his own proper care.

The view I have outlined is not shared by all British psychiatrists. In particular some hold different views in regard to perversions and kindred states which I would consider to be psychopathic disorders. The Act lays down special limiting conditions for the compulsory detention of patients with psychopathic disorder. These refer to the age of the patient. Obviously these conditions in the Act would be pointless if it were open to us simply to decide to call a psychopathic disorder a "mental illness". The Act means us to draw a clear distinction. At the same time it does not follow that the lines of legal distinction must break along the same divisions as those of scientific classification. Nonetheless I do suggest that the Law has its reasons. The psychopathic disorders which are at all likely to come up for consideration in this context are those which are prone to give rise to criminal behaviour and unlikely to be adequately restrained by penal provisions. Under the Mental Health Act an adult person can only be compulsorily detained for treatment as a sufferer from psychopathic disorder (if he has not already come under detention as a minor) after he has been convicted of an offence, arising out of his psychopathy, that merits such detention in the judgment of the Court. This may bring us often into situations of irritation, frustration and downright alarm. Suppose we have

to deal with a man who complains that he has no interest in adult women but that he is strongly attracted sexually to little girls and that he feels he may yield to temptation if he is not helped. May we not decide that his psychopathic disorder should be more conveniently classified as "mental illness', that he is a danger to others, that out-patient treatment would be too risky, that he might abscond if admitted informally to a hospital, that indeed an ordinary mental hospital might not adequately contain him, and should we not thereon have him clapped straight into a special security hospital? I suggest that we should not, if only because this does not seem to be the intention of the Law. In this situation we are no worse off than the police. It may perhaps be argued that a psychiatrist is more reliable than a detective inspector, but the Law in its ignorance or wisdom seems to be shy of handing over the liberty of the subject to the expert, be he never so expert, and I think we have to keep within it. Were it otherwise, an expert could deliver a life sentence (to be served in a State Hospital) without the commission of an offence and without trial.

I am aware that my outlook may be too limited, and therefore beg the courtesy of your columns for my correction.

Yours faithfully,

F. P. HALDANE,
Consultant Psychiatrist.

CASTRATION PHANTASIES

DEAR SIR,

What one believes oneself to have written and what a reader perceives one to have written are often surprisingly discrepant. Dr. Barton (May issue, p. 440) focuses on one finding for which he can provide a plausible alternative explanation, and mistakes that for the whole, or, at least, the most important of the findings. He has three objections:

1. It is reasonable to think that a man is more likely than a woman to cut off a dog's tail.

2. If a man is more likely to do it, a woman would be more frightening.

3. Questions 4 and 5 do not use the words "father" or "mother", but only "man" or "woman". The responses to questions 6 and 7, which do use the words "father" and "mother", might then be accounted for by a halo effect.

To the first of these, we agree that the cultural expectations might well be such as to account for the fact that the dog's tail is seen as more likely cut off by a male figure (questions 4 and 6).

The second objection, however, does not follow. Why should the less likely aggressor automatically be more frightening, except by looking at the findings? Indeed, why cannot the more likely aggressor be the more frightening? Clearly he can be, since for some subjects this was the case. On questions 4 and 5, there were seven subjects who replied that the male was both more likely and more frightening as the aggressor. On questions 6 and 7, there were four subjects who saw the male as both more likely and more frightening as the aggressor, and three subjects who saw the female as both more likely and more frightening as the aggressor. It is particularly striking that three out of the four subjects who spontaneously remarked that they were answering with their own parents in mind described the same parent as both more likely and more frightening as the aggressor. The tendency to shift is clearly not universal.

The important conclusion was that typically a male aggressor was seen as more likely and a female as more frightening.

A somewhat subtler interpretation of Dr. Barton's second objection might be that while one does not have to see the less likely aggressor as more frightening, nonetheless, if one does shift sexes from the more likely to the more frightening aggressor, the shift will appear to be from the male, as more likely, to the female, as more frightening, simply because males are preponderantly seen as more likely.

Even this argument can be dispelled by examining the data. Of the 49 instances where a male is seen as the more likely aggressor (on question 4 or 6), 33 times (or 67 per cent.) the female is seen as more frightening. But of the eight instances where the female is seen as the more likely aggressor, in only 3 (or 38 per cent.) is the male seen as more frightening. Thus the tendency to see the male as more likely and to shift to the female as more frightening really is the major finding of the study. Within psychoanalytic theories, this suggests that an easily elicited father fantasy serves as a defence against a more frightening mother fantasy.

As for the third objection, one can eliminate the possibility of a "halo" accounting for the answers to questions 6 and 7 by looking only at questions 4 and 5, which in themselves sufficiently clearly demonstrate the modal finding of a male aggressor as more likely and a female as more frightening. The use of the words "mother" and "father" in the questions are not necessary for resolving the issue in question *in the context of the theories examined.*

Yours faithfully,

BERTRAM P. KARON.
Michigan State University,
East Lansing, Michigan, U.S.A.