MEDICAL PRACTICE

Today's Treatment

Psychological Medicine

Personality Disorders

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"Show me the normal man and I will cure him." This aphorism, attributed to Freud, may or may not be apocryphal, but its wit and perceptiveness certainly bear the imprint of the master. In effect it means that Sir Galahad, the knight in shining white armour, the paragon of all the virtues, is so perfect as to be abnormal by ordinary standards. Conversely it means, without expressing undue cynicism, that we can all indulge in certain minor deviations—peccadilloes if you like—and still remain well within the accepted range of normal behaviour. We can—and who does not?—occasionally lie, occasionally cheat, occasionally get drunk, occasionally gamble, occasionally become aggressive, hurtful, and spiteful, particularly towards those we love best. And as for sexual behaviour, or misbehaviour, conscience in all probability could make cowards of us all.

Deviation from Normal

But there are those among us whose behaviour so deviates from the statistical norm and is so persistently at variance with accepted standards that society must seek to protect itself from their wrongdoing and, if need be, apply sanctions. These deviants, or personality disorders as they are better named, have been described and recorded in the history of all cultures and played their part in the literature of all nations. Their sins, if the moral early-eighteenth century concepts of Dr. James C. Pritchard are applied, are exaggerations or distortions of those

same peccadilloes of which the most "moral" of us have at some time been guilty. Technical terms have been coined to describe them. Thus, occasional lying is translated into pathological lying, or pseudologia fantastica; occasional cheating becomes pathological swindling; social drinking becomes chronic alcoholism or dipsomania; exaggerated manifestations of commonplace aggression become "aggressive psychopathy." The frolics of the boudoir are transmuted into a whole range of sexual perversions collectively known as psychopathia sexualis.

It would be wrong to believe that people with personality disorders show their imperfections in respect of only, say, pathological lying, cheating, aggression, or sexual perversion. Invariably the whole personality is affected. This is particularly demonstrable in what in extreme cases has come to be known as psychopathic personalities, or psychopaths. Psychopaths have certain features in common. They are not necessarily intellectually subnormal; indeed some of them may be exceedingly bright. Their overall conduct smacks of immaturity. Their imperious, "I want it now," is reminiscent of the demands of a spoilt child. They are impetuous and live only for the satisfaction of their immediate needs. Self-fulfilment with them is equated with self-indulgence. Their seriously irresponsible behaviour may, and often does, bring them into conflict with the law, and so they may bring disgrace if not ruin on themselves and their families. They are not necessarily alcoholics or drug addicts, but they may become either or both. They are at the mercy of their environment and are apt to be brought under the influence of or manipulated by more malignant characters.

Classification

Inevitably attempts have been made to classify this heterogeneous assortment of psychopaths. For example, Benjamin Karpman, an American psychiatrist, distinguishes primary or

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inadequate psychopaths from secondary or symptomatic. But the most widely accepted classification is that of the late Sir David Henderson. He recognized three varieties—the predominantly aggressive, the predominantly inadequate, and the predominantly creative. Of the three, the last category is the most controversial and probably the least useful in practice. He identified in this category individuals of great distinction who yet contrive to combine with their undoubted ability certain eccentricities or idiosyncrasies. He gives as examples Joan of Arc, Lawrence of Arabia, and Napoleon. He could have added to his list a whole galaxy of poets, painters, playwrights, and novelists. Indeed, were it not for these same eccentricities, their biographies, or autobiographies, would make dull reading, which for the most part they do not.

Nevertheless, Henderson's other two categories of psychopaths have a degree of usefulness. The predominantly aggressive are obviously those who indulge in assaultive behaviour of one sort or another, in either the physical or sexual sphere. The predominantly inadequate, on the other hand, are less dangerous. They are the swindlers, confidence tricksters, petty delinquents, and imposters. They may also indulge in sexual crimes, but more often than not they are the indecent expositors and the child molesters. It would of course be absurd to maintain that all criminals are psychopaths, or that all psychopaths are criminals, if by that is meant that they have offended against the criminal law. However, psychopaths do make up a proportion of prison inmates estimated variously at between 2% and 15%. What is certain is that the older, incorrigible recidivists include the majority of inadequate psychopaths in any sample of a prison population.

Causation

What makes a psychopath? Inevitably opinions are divided between genetic and environmental factors, and needless to say there are cogent arguments on both sides. Those in favour of genetic determination point to the fact that the ratio of males to females is 5:1. It is claimed too that some psychopaths show characteristic electroencephalographic changes, the so-called "cortical immaturity," which might conceivably be related to the immaturity exhibited in their behaviour. Furthermore, there was a theory popular not many years ago that abnormal chromosome (XYY) inheritance may determine antisocial, particularly aggressive, behaviour. Typically this abnormality was associated with tallness and subnormal intelligence. The theory has been largely discredited for the simple reason that most of the research took place in institutions like the special hospitals. It is a presupposition that pathological aggression is almost invariably the prime reason for the admission of their patients. There are undoubtedly substantial numbers of harmless XYY individuals circulating unrecognized in the general population.

Those who would favour an environmental aetiology lay the blame on adverse emotional factors in childhood. Psychoanalysts would postulate an inadequate or faulty superego, which is related to what is generally accepted as conscience.

As is the case in the aetiological consideration of most psychiatric conditions, psychopathic personality is in all probability the final common pathway reflecting the interaction of genetic, environmental, biochemical, electrophysiological, and endocrine factors.

It will be appreciated from what has been said that personality disorders, and as an extension of the argument, psychopathic personalities (or disorders), are clinically ill defined. And yet in that most important instrument of legislation, the Mental Health Act, 1959, our legislators took it upon themselves to define "psychopathic disorder" and to include it as a category of mental disorder. The definition (Section 4 (4)) is worth quoting. It states: "In this Act 'psychopathic disorder' means a persistent disorder or disability of mind (whether or not including sub-normality of intelligence) which results in ab-

normally aggressive or seriously irresponsible conduct on the part of the patient, and requires or is susceptible to medical treatment."

Treatment

The gravamen of the discontent with the definition is in the reference to treatment. What does "requires" mean? Does it mean "requests," or does it mean "in need of"? And what is meant by susceptible? And what is implied by medical treatment? Can it, for instance, include nursing care? The issues raised are all important but none so crucial as the question, Are psychopaths treatable?

Most psychiatrists would maintain that our personalities, like our physical characteristics, are with us for keeps, and, though they are not immutable, what changes can be effected can only be both limited and slow. The main hope for psychopaths, as they see it, is to support or contain them while the natural process of maturation, delayed in their case, takes place. In some instances it seems evident that psychopaths, weary of banging their heads against the stone wall of authority, find it expedient to make some adjustment. There is no pill, in other words, that will convert Mr. Hyde into Dr. Jekyll. Even the anti-libidinal pill, a form of chemical castration, is designed not to alter the fundamental personality of sexual psychopaths but to render them sexually safe. And even this limited objective is not necessarily always achieved.

Care and Custody

But, if attempts to treat the psychopath are to be made, where is this to be done and by whom? It is well recognized that psychopaths, aggressive and inadequate alike, may benefit from the rigid discipline of the armed Services. The sergeant-major or his equivalent fills the role of psychotherapist. It is by no means uncommon, incidentally, to see time-served soldiers, robbed of the ram-rod the Service provided them to keep them upright, break down after their discharge and take to crime or drink and perhaps become depressed. Psychopaths usually come to the notice of the authorities because of offences against the criminal law. The majority go through the legal process and may be awarded a custodial sentence. One of the functions of prisons or borstals and the like is, or should be, rehabilitation. Staff of all grades and rank should participate. Furthermore, there are today more psychiatrically trained prison medical officers than ever before in addition to an increasing number of visiting psychotherapists, who also play their part at a more specific level. How successful these combined efforts are is impossible to say, but it would be far too cynical to maintain that they always fail. Of even greater significance is the establishment of H.M. Prison, Grendon Underwood, the first, and as yet the only psychiatric hospital in the prison system. It is staffed and equipped for and orientated towards the treatment of personality disorders, including of course psychopaths.

But a minority of psychopaths who have committed offences are admitted to mental hospitals under a Hospital Order (Section 60) or a Restriction Order (Sections 60/65) of the Mental Health Act, 1959. But a considerable number of experienced psychiatrists in conventional mental hospitals believe that their institutions have nothing to offer the psychopath. Indeed they would argue that psychopaths are, or can be, so disruptive as to make them unacceptable. Furthermore, to admit psychopaths under restriction orders—and the imposition of such an order implies dangerousness—to a hospital offering only token security is an invitation to disaster. The serious overcrowding of the Special Hospitals, particularly Broadmoor, is well known and is offered as an excuse for not taking more or indeed all people on restriction orders, but this excuse is untenable. It is to be hoped that the building of the promised additional security units will not be long delayed.

Finally, there are hospitals such as the Henderson in Sutton, Surrey, which specialize in the treatment of people with personality disorders who can be either offenders or non-offenders. The principles and philosophy of the therapeutic community obtain. The administration is permissive. Decision making is shared between staff and patients with a view to making the

latter assume some responsibility for shaping the world around them. Some measure of success is claimed. The least that can be said for these hospitals is that they are prepared to go on trying.

Freud, or whoever it was, claimed to be able to cure the abnormal "normal" man. Would that he had left us some clue to how to cure the normal "abnormal" man.

Surgery of Violence

VI. Gunshot Wounds of the Limbs

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This article deals with the management of gunshot wounds of the limbs and it is based on experience gained in the Royal Victoria Hospital, Belfast, since August 1969.

Pathological Anatomy

In gunshot wounds the injuries vary from minor soft-tissue damage to gross disruption of tissues of all types. The degree of severity depends on several factors. The type of gun used is important: the faster the muzzle velocity the greater is the damage caused. The damage will also be greater if the bullet strikes a hard object such as metal on clothing or equipment before entering the body or strikes a bone on entering.

There may be multiple wounds caused by a machine pistol or shot gun. High-velocity rifles such as self-loading and Armalite rifles produce very severe injuries from cavitation caused by an initial positive pressure wave followed by an equally strong negative pressure wave. These pressure waves can be severe enough to cause permanent damage to structures such as the spinal cord even though the bullet does not directly injure the cord.

Diagnosis

Careful inspection of all wounds is essential to determine the type of missile used and if possible its direction of travel through the tissues. Detailed examination must be carried out for damage to major vessels, nerves, bones, and joints.

A history from the patient, if possible, and others involved in the incident may be helpful. From this one may learn the type of weapon used and also acquire some idea of the volume of blood loss.

Early Management

The wounds should be dressed with a large pad and bandaged. If there is considerable bleeding a pressure dressing should be applied, and this usually controls most bleeding. If there is a fracture a temporary splint should be used.

The general management at this stage usually includes treatment for shock and blood loss. Intravenous drips must be started and the patient given adequate fluid and blood.

All wounds must be carefully examined. Small superficial wounds should have the skin edges trimmed and a dressing applied. Superficial through-and-through wounds should also have the skin edges excised and the so called "pull-through technique" may be used. This means that forceps are passed through the wound, and a swab soaked in a mild antiseptic such as cetrimide and chlorhexidine (Savlon) is pulled through the wound. This refers to low-velocity injuries with minimal damage to tissues.

DEEP WOUNDS

These must be thoroughly explored, if necessary by enlarging the wound or in some cases joining the entrance and exit wounds. All dead tissues must be removed, and the dissection may be extensive. The skin edges should be carefully excised. The wound is then left open and packed lightly with tulle. To avoid infection the skin should never be sutured at the initial treatment. Even with the most careful surgery some dead tissue may remain, and there will probably be some haematoma formation. Suturing of wounds at this stage is positively dangerous, and may lead to infection and even to gas gangrene. The wound is normally sutured at five to seven days. This delayed primary suture will produce an excellent result.

WOUNDS OF BONE OR JOINT

Careful débridement is carried out. Small isolated pieces of bone may be removed, but those with soft tissue attachments must be left. The wound is then treated as already described and a splint applied.

Internal fixation is used only if there has been a concomitant vascular injury requiring vascular repair. It is necessary to fix the fracture to make the limb steady, and allow the vascular repair to heal. If internal fixation is not possible, traction should be used with great caution when a vascular repair has been performed. An injudicious pull on a repaired vessel will narrow its lumen and lead to thrombosis.

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