

## Chapter 16

### **A Psychosocial Understanding of Personality Disorder: the historical problem of Moral Insanity**

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Various terms such as ‘psychopath’ and ‘antisocial personality disorder’ have been used at different times to describe individuals who act, with no apparent remorse, with great callousness causing disruption and distress around them. Despite being formally described within medical texts for many years the status of these diagnoses remains highly contested both within and outside of psychiatry. It will be argued that a psychosocial perspective can firstly help us to understand why this and related categories of mental disorder have been so contentious and secondly may also point us towards more useful ways of understanding the phenomena. Two points about a psychosocial perspective are raised in this chapter. Firstly, consistent with the premise this book there is the engagement with the social and cultural significance of emotion. Secondly there is the need to cross disciplinary fissures; not only trying to bridge the most obvious gaps between the psychological and the sociological, between the individual and the cultural, but also most notably in this case the analysis benefits from historical context. It can be argued that the set of problems that are described by the varieties of ‘personality disorders’ (such as borderline, narcissistic and anti-social personality disorders) have, despite the great controversy about their status and validity, been visible in slightly different guises since at least the beginning of the 19<sup>th</sup> century when the term ‘moral insanity’ had some currency (eg, Pritchard 1835). Whilst that particular diagnosis had lost much of its influence by the latter half of the 19<sup>th</sup> century, the diagnosis of ‘psychopath’ (used to describe someone whose behaviour was profoundly antisocial) appeared in the early decades of the 20<sup>th</sup> century and received legislative recognition in the UK (in the Mental Health Acts of 1959 and 1983) and in the USA (through various ‘Sexual Psychopath Laws’ that appeared in different States during the 1950s). The term ‘psychopath’ has also now largely fallen out of favour and various versions of

'personality disorder' are recognised by DSM (Diagnostic and Statistical Manual) and ICD (International Classification of Disease) systems of classification, and have been subject to considerable attention from the UK government since the late 1990s.

This chapter will briefly describe the contemporary controversies that surround personality disorder in the UK at the beginning of the twenty-first century. It will then move back in time to explore the emergence of the diagnosis of 'moral insanity' in the early decades of the 19<sup>th</sup> century. In both cases the arena into which the diagnoses have emerged and have been debated was formed at the join of 'psychiatry' and the criminal justice system. The historical context is important because it sheds light on the processes that have put these diagnoses into liminal psychiatric territory. Meaning on the one hand they are viewed as not being legitimate forms of 'madness', yet on the other hand neither have they been completely expelled from the psychiatric domain but have continued to lurk on the fringes, morphing slightly over time, but consistently demanding attention.

It will be argued that these disorders are not well apprehended either by legal discourses of responsibility or by contemporary psychiatric and psychological models of identity and agency. An historical perspective helps us understand these difficulties as products of particular ways of construing the relationship of individual identity and the social body. The questions posed by this group of people are particularly challenging for us, most specifically they are problematic thanks to the disciplinary schisms in the human sciences that have allowed such a gap to appear between psychological and social explanations of human phenomena. They expose deep controversies about the nature of the individual, of selfhood and the relationship between emotion, thought and the social world.

### **Contemporary Controversies**

In 2007 the UK Government introduced the Mental Health (Amendment) Act (DOH 2007), which represented the final admission that they had failed to produce a new Mental Health Act (MHA) after 8 years of effort. This occurred despite widespread agreement that this legislation needed to be renewed. After all, the 1983 MHA itself was

largely a re-drafting of the 1959 MHA. Given the enormous shifts in health and welfare policies, alongside changing ideas about diagnosis and treatment within psychiatry and related professions; the notion that it needed to be renewed was uncontested. One of the main reasons for the failure to agree a new Act was the issue of ‘personality disorders’ and how they should be managed by the National Health Service.

Government interest in personality disorder was prompted by the murder investigations that eventually led to the conviction of Michael Stone (Jones 2008: 61-62), who had previously been diagnosed as suffering from a personality disorder. In July 1996 Lin Russell and her two daughters had been walking home along a quiet country lane in Kent from a school swimming gala. At some point they were tied up and attacked. Lin and her elder daughter were killed, whilst 9 year old Josie was left for dead. The extent of the injuries made it clear that this was a brutal and murderous attack and her subsequent survival was heralded in the press as miraculous. The occurrence of the attack in broad daylight in a picturesque rural area of the ‘Garden of England’ was no doubt part of the reason for the public attention and outrage that led to the government’s interest in the case. There were no moral ambiguities here. The Russells were clearly innocent victims and the attack appeared truly ‘monstrous’. The absence of any tangible motivation for the attack coupled with the lack of witnesses made the case difficult to prosecute, however. A year after the attack, following a national television appeal for information, Michael Stone emerged as a suspect. The lack of forensic or witness evidence, or indeed ostensible motive, meant that Stone’s eventual conviction has been contested (the conviction has been quashed once, only to be re-instated at the subsequent re-trial). It came to light that Stone not only had a history of violence, but he was well known to psychiatric services having been seen as suffering from a ‘personality disorder’. The report<sup>1</sup> into Stone’s care quotes from a psychiatric assessment made in January 1995 some 18 months before the killings:

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<sup>1</sup> *The Report of the Independent Inquiry into the care and treatment of Michael Stone*, (2006) South East Coast Strategic Health Authority, Kent County Council, Kent Probation Area.

A tough minded man... [who] ...at no point displayed any features of a psychotic illness. He had credible explanations for apparently psychotic episodes... [and]...denied ever hearing voices. The most striking abnormality was his extremely callous attitude towards victims and anger and contempt towards several professionals involved with him. . . .My impression is that he has committed major violent crimes in the past and is likely to do so in the future...He fulfills the criteria for anti-social personality disorder and there may also be a paranoid mental illness. (p.196)

The psychiatrist argued that Stone's detention under the MHA was 'highly inappropriate' and that 'it does not appear appropriate to offer [Mr. Stone] a bed as firstly he is no longer mentally ill and secondly he is unlikely to respond to a graded rehabilitation package'. The fact that psychiatrists were allowed by the MHA to distinguish between 'mental illness' and the kinds of difficulties that Stone exhibited came to be a target of Government attention. Although personality disorder did not feature in the 1983 MHA, its diagnostic cousin 'psychopathy' did, having found a place in the 1959 MHA as a distinct category of mental disorder (the other three being mental illness, mental deficiency, and 'other'). Psychopathy was defined as 'a persistent disorder or disability of mind (whether or not including subnormality of intelligence) which results in abnormally aggressive or seriously irresponsible conduct'. The inclusion of psychopathy was controversial (Ramon 1986), with the majority of psychiatrists being reluctant to recognise such problems as falling within their domain. A small but vocal group of psychoanalytically inclined psychiatrists notably David Henderson at the Tavistock Clinic had advocated for the diagnosis (Henderson 1939).

The UK Government has been much exercised by the distinction made between mental illness and 'psychopathy' so clearly evident in the treatment of Michael Stone. They argued that personality disorders ought to be recognised and treated by the National Health Service just like other disorders such as depression and schizophrenia (DOH 2003). They wanted a new mental health act that would not only dissolve the distinction that was being made between 'psychopathy' and 'mental illness' but that could also be used to take pre-emptive action against those who might fall within such categories and who might offer a threat to the public (DOH 2006). Their efforts to do this faced a

barrage of criticism from civil liberty groups (see as Liberty 2000<sup>2</sup>, for example), mental health lobby groups (such as MIND<sup>3</sup>) and from within psychiatry (Buchanan and Leese 2001). It will be argued here that to understand why this continues to be such a contentious category we need to explore the history of the problem.

## **Insanity and Crime**

The belief that leniency ought to be shown to those people who committed offences when they were believed to be ‘insane’ has a long history with good evidence of provisions being made in English law for many centuries (Reznek 1997, Walker 1968). Certainly by the end of the 18<sup>th</sup> century courts in England were well used to hearing and accepting the plea of ‘insanity’ in murder trials (Eigen 1991, Walker 1968). The nascent psychiatric profession began entering the courts as witnesses in some numbers towards the end of the 18<sup>th</sup> century for both prosecution and defence (Smith 1981). They were being asked to give ‘expert evidence’ about the sanity of defendants. It was around this time, and largely within debates about criminal responsibility that attempts to define ‘moral insanity’ were made.

## **Moral Insanity**

A small group of clinicians during the 19<sup>th</sup> century in different countries began to concern themselves with people who seemed not to have totally lost their reason but could act in very antisocial and often aggressive ways. Working from asylums in France Pinel (1806) is credited with the first formal written account of ‘mania without delirium’ (‘manie sans delire’). This might be an intermittent or continuous state, notable for there being ‘no sensible change in the functions of the understanding; but perversion of the active faculties, marked by abstract and sanguinary fury, with a blind propensity to acts of violence’ (Pinel 1806: 156). Whilst Pinel’s work was clearly located in criminological

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<sup>2</sup> Liberty (2000) *Managing People with Severe Personality Disorder: Response to Government Consultation*. January.

<sup>3</sup> MIND (2004) *Submission to the Joint Committee on the Draft Mental Health Bill*.

concerns, as witnessed by the fact that he analysed a number of notorious murder cases, many of the cases that the British medic Prichard described as ‘moral insanity’ are taken to be the first published definitions of more general personality disorders (Elliott and Gillet 1992:53). Prichard was describing people who seemed to have normal intellectual functioning (similar to Pinel’s cases, they were not suffering from delusions or disorders of perception) but their behaviour was clearly abnormally antisocial. In a famous and often quoted passage Prichard (1835) described ‘moral insanity’ in the following terms:

A form of mental derangement in which the intellectual faculties appear to have sustained little or no injury, while the disorder is manifested principally or alone, in the state of the feelings, temper, or habits. . . . [T]he moral and active principles of the mind are strangely perverted and depraved; the power of self government is lost or greatly impaired; and the individual is found to be incapable, not of talking or reasoning upon any subject proposed to him, for this he will often do with great shrewdness and volubility, but of conducting himself with decency and propriety in the business of life . . . (Prichard *A Treatise on Insanity* 1835: 4)

Whilst with hindsight some of the cases described by Prichard might nowadays receive rather different diagnoses such as ‘bipolar affective disorder’, there is little doubt that some of the characteristics highlighted by Prichard are consistent with some of the cases of psychopathy described a hundred years later who might be quite successful, but ruthless, in their careers, for example (Cleckley 1941; Hare 1993). Prichard’s arguments about ‘moral insanity’ were taking place within debates about capital punishment. Prichard argued that sufferers of ‘moral insanity’ who committed murder, ought to escape the gallows and be treated in hospital. Similarly in the United States Isaac Ray was directly concerned with the legal definitions of insanity in arguing that cases of ‘moral mania’ and ‘partial moral mania’ should be recognised. Ray argued that types of partial moral mania included compulsive stealing, lying, erotomania, destructiveness and also ‘homicidal insanity’ (Ray: 1838: 264).

The notion of ‘moral insanity’ began to gather critics, particularly within the medical, and nascent psychiatric profession. Support collected around an opposing cognitive view of

insanity (that is one that accepts only disturbances in the capacity of the mind to perceive and comprehend the world in a rational manner as being legitimate cases of insanity, Robinson 1999). This line of thinking found concrete expression in the legal definition of insanity that was enshrined by the M’Naghten rules of 1844.

### ***Daniel M’Naghten and the Insanity Defence***

Daniel M’Naghten was a Scot who came to believe that he was, thanks to his interest in Scottish nationalism, being persecuted by the Prime Minister Robert Peel. By early 1843, M’Naghten had determined to assassinate Peel. He came to believe that Peel’s secretary Drummond was actually the prime minister and on the 20<sup>th</sup> January 1843 he followed Drummond up Whitehall and shot him fatally in the back. Had M’Naghten not attempted to take the life of the Prime Minister he would have, as was customary, appeared in court in a matter of days (and quite possibly he would have been dispatched from the gallows a couple of days after that). As his crime was considered to be one of treason, there was a delay whilst evidence was collected, witnesses were sought and the trial became a much grander and drawn out affair. At the trial medical testimony and evidence from those who had known M’Naghten before the event was sufficient to convince the jury that he should be found not guilty by reason of insanity. M’Naghten therefore, instead of being executed, was transferred to Bethlem Lunatic Asylum. Twenty years later he was moved to Broadmoor which was opened specifically to cater for the apparently growing numbers of ‘criminal lunatics’ where he died (Allderidge 1974). Despite the fact that the precedence for this outcome was already well established (witnesses were describing M’Naghten having delusions of persecution that would very conceivably be consistent with a contemporary diagnosis of schizophrenia), the high profile and political impact of the case drew a great deal of attention to the verdict. There was public outcry, fanned perhaps by Queen Victoria’s alleged dismay about the apparent leniency of the outcome, which led to a legal review (Walker 1968). The result of this review were the so-called M’Naghten rules which aimed to spell out what conditions had to be met for someone to

be able to have their behaviour excused by reason of insanity. For the insanity defence to be applicable, it would have to be established that:

. . . at the time of the committing of the act, the defendant was labouring under such a defect of reason, from disease of the mind, as not to know what the nature and quality of the act he was doing; or if he did not know it, that he did not know he was doing what was wrong.

Thus for insanity to be recognised it would have to be proven that the defendant did not 'know' the difference between right and wrong. So long as an individual had a rational view of the world around them, undistorted by delusions, then they were sane. The notion that someone might not be able to control their actions, or may not comprehend their own or others feelings, or could have no grasp of the meaning of the distress they caused to others, for example, were ruled as outside of this definition of insanity. Thus the 'moral insanity' diagnosis which supposed individuals to have a rational perception of the world, unimpeded by delusions was clearly excluded. This might well have been the end of the story for moral insanity, but instead it has re-emerged in rather different forms over the past 100 or so years, firstly as psychopathy and then various forms of personality disorder.

Considered separately each of the categories of moral insanity, psychopathy and personality disorder might well fit alongside Hacking's (1998) examples of 'transient mental illnesses' (such as 'fugues') which need to be understood as interesting phenomena that exist perhaps fleetingly in the very particular niches created at the vectors of various social, historical, cultural and psychological 'forces'. It can be argued, however, that there are common threads between each of these three categories, and there is thus some longevity to this particular niche. This is interesting as these medical categories have survived despite little support, and indeed often great scepticism from medical colleagues (Arieff and Rotman 1948), the legal professions (Hakeem 1958; Hall Williams, Gibbens and Jennings 1960) and academia (Pilgrim 2001). It will be argued that we need to look beyond the discussions of professionals in order to understand the

persistence of these diagnoses. Through understanding the forces that have created and sustained these categories a better understanding of current dilemmas can be built.

It is argued that three overlapping explanations for the emergence of the category of 'moral insanity' can be identified. Each of these help our understanding, but the third, the psychosocial explanation, is necessary for providing a fuller picture. Firstly, there is the largely sociological notion that the diagnosis emerged from concern with social control within a society that was seeking out new ways to isolate and therefore control deviancy. Secondly, there is the idea that the dispute over the category grew from philosophical and, more specifically, psychological debate over the constitution of human nature. Whilst both theories have validity, it will be argued here that a third more psychosocial line of exploration is the most productive. This raises the question of the relation of the individual to the social body and it is here that the benefits of a psychosocial approach become clear.

### *i. New Forms of Social Control: Morality and the Criminal justice System*

Ramon (1986) argued that the interest in 'moral insanity' was in keeping with the more general tendency to try and differentiate, and therefore segregate, forms of 'anti-social' behaviour. It is certainly the case that the 19<sup>th</sup> century witnessed the birth of psychiatry and the mushrooming of asylums for the insane (Jones 1972, Scull 1979) alongside the development of prisons (Gatrell, Lenman and Parker 1980). Rimke and Hunt (2002) also suggest there were parallels between 19<sup>th</sup> century moral concerns (over sexual promiscuity, for example) and the development of such diagnoses. Supporting this argument are the facts that the emergence of moral insanity was tied directly to concern with criminality, indeed Rafter (2004) refers to the medical interest in 'moral insanity' as representing a pre-history of criminology. In France Pinel (1806) analysed many cases involving serious violence as he sought to establish the diagnosis of *manie sans delire*. Eigen (1991) plots some of the arguments between lawyers and medical witnesses in London about insanity between 1825 and 1843 using court records. The prominence of

the criminal justice system (CJS) should not make us think that the issue was simply confined to debates about the nature of criminality, however. It can be argued that the CJS itself was a crucible within which wider concerns about the nature of 'society' and of 'selfhood' were being analysed. The CJS has been described as being in a state of ferment through this period (Hay 1980, Gattrell, Lenman, and Parker 1980), witnessing disputes of authority between juries and judges (Wiener 1999), and between medical men and lawyers (Smith 1981). In part these were perhaps battles of professional power, but they were also taking place within debates about the nature of individual agency.

### *ii Shifting notions of self and personality*

Another framework, therefore, for understanding the emergence of 'moral insanity', and the subsequent resistance to acceptance of its existence, is that provided by philosophical debates about the nature of humanity. There were two related aspects to this debate. Firstly, there is the question of the coherence of human consciousness. Are human minds better understood as having a unitary coherence or are we better understood as being made up of a number of separate faculties? Debates over moral insanity were entangled with those over 'partial insanity' (the premise being that there might be aspects of an individual's mind that were insane whilst others were not) and also 'temporary insanity', where an individual might lose their sanity in particular circumstances only. Secondly, there was the issue of the relation between emotion and reason. Are human beings better defined by their capacity to experience emotion, or their capacity for rational thought? An influential line of argument has taken the view that 'the Enlightenment' privileged rational thought, and that this had huge implications for perceptions and treatment of the insane (Foucault 1967, Hodgkin 2007). The hallmark of humanity became the ability to use reason to control the emotions. If an individual appeared to have reason, then it was assumed they could control their passions. Such a view of the nature of insanity had been influentially formalised by John Locke who argued that insanity was caused by mis-associations being made in the mind between sense data and ideas (Porter 2002, for example). The notion of an insanity that affected only the feelings or morals, whilst leaving reasoning intact, was therefore largely anathema.

In contrast, was the belief (exemplified by the various ‘Romantic’ schools in art, music and literature) that it was human beings’ capacity to *feel* that raised us above other species. To feel love, to act upon feelings of care, altruism, imagination, or even hatred were the truly important human capacities (Eichner 1982). Within this framework it is possible to understand why Prichard might envisage ‘moral insanity’ as caused by deficits in these ‘higher’ emotional capacities. The victory of scientific rationalism as the 19<sup>th</sup> century progressed has been very clear, however. An unfortunate side-effect of that victory has been the difficulty of apprehending the emotions and their significance at all (see Rustin *this volume*).

### **iii. The Psychosocial Perspective: the relationship between selfhood and the social body**

A third explanation that can be explored here is that debates over moral insanity were exposing newly emerging puzzles about the relations not only between right and wrong, and between rationality and emotionality, but also the problem of the relationship between these individual characteristics and the social body. Notions of personality, how individuals related to one another were coming to be seen, and would come to be seen as ever more significant to how society functioned (Giddens 1991, Morris 1991).

One plane of this debate was a metaphysical one (Augstein 1996, Glannon 1997). Augstein (1996) suggests that Prichard was motivated by his own religious beliefs to argue that will and morality could not be simply considered as products of brain functions, nor of human reasoning. He was, Augstein suggests, in arguing for ‘moral insanity’ defending the notion of the human soul – autonomous from the brain and from rational thought. Another plane of debate can be understood as consisting of nascent ‘social theory’. Most of what can with hindsight be identified as early social theory that emerged from Enlightenment thinking can be summarised as containing a mechanistic view of the relationship between individuals and the social world (Morris 1991). Beccaria’s (1764) blueprint for the discipline of criminology provides a good example of

this view. Beccaria assumed that individuals were rational calculating creatures, who weighed up the possible benefits of crime against the likely punishment. The idea of the calculating criminal; with the route to controlling crime through gauging crimes and their punishments was extremely influential (Hopkins Burke 2005, and Gelsthorpe *this volume*).

Very different schools of thought were, of course, being developed but they were strikingly less successful in achieving influence. One notable set of ideas came from Bernard Mandeville (1725, 1732) whose contentious view was that society was driven and held together not by rationality at all but by feelings such as pride, shame, envy and greed. The hostility to his views about the significance of feelings to the social world, that challenged the mechanistic one, is highly illuminating. Norman Wilde, writing at the end of the 19<sup>th</sup> century describes him as ‘one of the best hated writers of the [18<sup>th</sup>] century’ (Wilde 1898: 219). His work was condemned by Rousseau, ritually burned by the public hangman in France, and considered by the Grand Jury of Middlesex for offences against public morality (Hundert 1995).

Despite the apparent philosophical dominance of the mechanistic view of personality and its relation to society, the social demands for a different kind of individual were, however, becoming visible. This demand was emerging in the criminal justice system, as recent scholarly work on gender and criminality has noted. Shoemaker (2001), for example, argues that shifting expectations of masculine behaviour led to a reduction in levels of violence over the 18<sup>th</sup> century in London. Wiener (2004) also argues that there was a re-conceptualisation of masculinity that began in the 18<sup>th</sup> century which became ever more overt in the courts through the 19<sup>th</sup> century. Wiener (2004) plots in detail the way that courts showed increasing disapproval of both public and private violence. Men were seen as ‘more than ever in need of external disciplines and, most of all, of self-discipline’ (Wiener 2004: 2). Thus the demands for different types of personality, with the control of emotions being salient were becoming overt, in line with arguments made by Elias (1994/1939) and Stearns (1993) about ‘civilising’ processes. As a consequence

of this so the demand for ideas that helped explain and even control ‘personality’ grew (Rose 1989).

The exploration of the emergence of ‘moral insanity’, and the challenges it faced can be used to inform analysis of the emergence of the related concepts of psychopathy and personality disorder which can only be dealt with briefly here.

### **Psychopathy and Personality Disorder**

Although the term ‘psychopathy’ was first used to describe general mental sickness, and was associated with ideas of congenital mental defects, the development of the concept of ‘psychopathy’ being used to describe those who demonstrated emotional or ethical failings became closely tied to psychoanalytic thought. The publication of David Henderson’s, overtly psychoanalytic work (Henderson 1939), influenced professional practice, but it was Cleckley’s (1941) far more accessibly written book that had the more enduring impact in establishing the idea of the rational but ruthlessly amoral personality type. The influence of psychoanalytic thought on psychiatry and wider culture was important in two ways for creating space for discourse about this type of personality. Firstly, Freudian thought was premised on the idea the mind could be divided into different faculties that were capable of autonomous action and influence. Secondly, psychoanalytic thought privileged emotion, most particularly the significance of sexuality, as being fundamental to identity and relationships. The emergence of the category of psychopathy alongside anxiety and interest in the significance of sexuality was quite clear in the USA as many states adopted ‘Sexual Psychopath Laws’ (Guttmacher and Weihofen 1952). Freedman (1987) argues that these laws were symptomatic of a society both perplexed and fascinated by the possibilities of sexual ‘liberation’. Meanwhile in England and Wales the term psychopath appeared as a category in the 1959 MHA. Although there was no formal link to sexual behaviour, aberrant sexual behaviour loomed large in use of the concept. For example, ‘psychopathic personality’ was successfully used in court for the first time as part of a defence of ‘diminished responsibility’ in the trial of R. vs Matheson who had ‘a long history of

extreme sexual abnormality' and was accused of the murder of a young boy who he had been sexually abusing (Hall Williams 1960; Walker and McCabe 1973: 216). Thus the notion of 'psychopathy' received sufficient support from psychoanalytically influenced psychiatry to enter legislation both in Britain and the US. It remained relatively marginal within mainstream psychiatry (most notably in Britain where psychoanalytic ideas did not have as wide as acceptance as in US psychiatry).

Whilst the term 'psychopathy' still survived in the Mental Health Act of England and Wales until 2007, its use in the clinical world had become far less fashionable by the 1970s. The Butler Committee (DSS 1975) recommended that the term be replaced with that of 'personality disorder'. Although this did not happen, and the category of 'psychopathy' remained in the 1983 Act, there are now a plethora of Personality Disorder diagnoses recognised by DSM (the Diagnostic and Statistical Manual, published by the *American Psychiatric Association* and ICD (International Classification of Disease, published by *WHO*). At the heart of the diagnosis is the existence of disturbance of affect and personal relationships. In the UK, government interest in the diagnosis has led to considerable research effort that has attempted to trace the best treatments and most likely causes (Moran and Hagell 2001, for example). Whilst it would be impossible to summarise this work, nevertheless one or two issues are worth highlighting. Whilst definitions are still contentious it is becoming clear that the difficulties that people experience (that are consistent with these diagnoses) have usually to be understood in terms of their life histories (Jones 2008). Clinical studies that have looked specifically at personality disorders emphasise the association with negative life events (Pagano et al. 2004) and deprived childhoods in particular (Bandelow et al. 2005). Hodges (2003) goes as far as to argue that 'borderline personality disorder' might be understood in terms of post-traumatic stress disorder, since those individuals are so likely to have experienced trauma. Looking more widely there is a significant body of criminological literature that has taken a longitudinal approach to understanding the development of criminal and antisocial behaviour. This work points clearly to the roots of behaviour and characteristics that are consistent with personality disorder diagnoses often lying deep within experiences of emotional and social deprivation in childhood, with disrupted

family relationships being prominent (Jones 2008). Recent psychoanalytically informed work on the development of such problems also points the significance of early relationships. Fonagy et al (2003) have argued that the ability to make sense of emotion is a developmental achievement, occurring in the early years of life. Without this capacity individuals are left only with the ability to experience and react to emotion rather than reflect and think about emotion. The unpredictable behaviour, the erratic emotional responses, the difficulties in forming and maintaining relationships are not only the obvious consequences of such disabilities, but they are also the cornerstone of the diagnosis of personality disorder. The developmental achievement that Fonagy et al. emphasise is the ability to 'mentalise'; that is to create a model of the self in the mind. This they argue is an ability that can only be built through close empathic relationships with others. In this formulation the difficulties of personality disorder emerge as truly psychosocial disorders that not only manifest within distorted and dysfunctional relationships with others, but have their beginnings in the emotional timbre of early relationships. It is entirely conceivable that such 'disorders' are becoming more visible as society demands ever more reflexivity and management of the self as many commentators have suggested (Giddens 1991, Rose 1989, Wouters 1999). Such an understanding challenges the more traditional focus of psychiatry that has sought to understand the pathologies of an individual that exist autonomously within that individual. The so-called personality disorders are truly psychosocial disorders that can only be perceived in the interaction between an individual psyche and their particular social relationships, they often seem to have their roots in adverse emotional experiences within childhood. The early life of Michael Stone is certainly consistent with this pattern, being characterised by high levels of disruption. His father and mother had a stormy relationship with a number of splits and reconciliations. His mother remarried another man, and then quickly divorced. He was placed in temporary care at age 7; the case notes from the time contained 'repeated descriptions of Michael being exposed to violence within the home' (ibid: 47) including witnessing his father attack another man with an axe. Stone's his first appearance in court was at age 12, after which he was put into care. Substantial parts of his teen years were spent in various institutions for youth offenders. His first sentence to an adult prison was at age 17; at age 19 he was convicted for robbery

and grievous bodily harm. Even if Stone had not met the Russel family in that country lane in Kent, all the signs were that Stone's life was going to reach another calamitous conclusion. The problem remains about how to understand and intervene in such chaotic lives. As Scanlon and Adlam (2008) argue the difficulties 'we' have in engaging with the 'difficult people' who have been often been physically and psychically rejected and who now refuse 'our' attempts to help and engage with them are immense.

## **Conclusion**

The category of personality disorder remains a terribly problematic one. It is still not entirely accepted that the personality disorders are really psychiatric disorders. Yet it is a category that has persisted for over 200 hundred years. Taken on their own each of the diagnostic categories of moral insanity, psychopathy and personality disorder might well fit with Hacking's descriptions of 'transient' mental states. An historical perspective helps us to see that these categories are more enduring, that they are arising from real needs to understand and get to grips with particularly problematic phenomena – that of individuals who have good cognitive awareness of the world around them but who are poorly equipped to operate at an affective level in human society. It has been argued here that they are problematic for a culture that has privileged rationality and has assumed that emotions belong to a separate and less significant domain. Psychoanalysis has been a language that has allowed for exploration of the experiences of people whose behaviour falls into these categories. Psychoanalysis though, needs the psychosocial dimension so that the relationship between the inner worlds of individuals and how those worlds interact with the social body and clash and fail our expectations of selfhood can more properly be grasped.

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