

Munchausen Syndrome and Psychopathy: Antisociality, Sociology and Mental Pathology (1950-1970)

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Introduction – Outline Arguments – 5 points and conclusion.

Today, I want to discuss the relationship between three categories or ideas: Munchausen syndrome, psychopathy and 'the social setting'. Munchausen syndrome describes chronic and repetitive fabrication of illness in order to obtain medical attention. Psychopathy is a term used in the 1950s and 1960s to describe a supposed disorder of conduct, based around persistent anti-social behaviour **without** significant impairment of intellect. The social setting is a blanket term which I shall use to describe the many and varied efforts – through sociology, social work, community care and so on – to connect people's environments, networks and personal relationships to various illnesses or problems.

I hope to make 5 brief points. First, Munchausen syndrome is initially formulated around an **absence** of discernible motive for the illness fabrication. Second, despite this uncertainty, most doctors are convinced that Munchausen patients are psychopaths. Notably, psychopathy *also* has many definitional problems in this period. Third, despite these absences and uncertainties, these categories prove incredibly useful in policing *social behaviour* – behaviour that is not necessarily illegal, and is ambiguously pathological. That is in fact their principal value in this period. My fourth and fifth points will detail some of the specific ways in which these labels interact with and police 'the social setting' and social (or anti-social) behaviour. First, Munchausen syndrome as a specific 'limit case' of psychopathy. Then we can deal with the umbrella category of psychopathy a little more broadly – as it is understood in the 1950s – and briefly see how it seeks to understand anti-social behaviour psychologically. Then I shall conclude,

and ask whether the uncertainty around these categories is part of their usefulness in their regulatory functions. In short: is this weaponised uncertainty?

Munchausen syndrome's lack of motive – 'the senselessness of it'

Munchausen syndrome was named by London hematologist and polymath Richard Asher in the *Lancet* in 1951. He used the term to describe people who travelled widely and presented deceptive or self-induced symptoms at a large number of hospitals. He claimed that 'most doctors have seen' the condition, but little had been written about it. Asher was unsure what motivated people to behave in this way, providing a list of motivations he called 'scanty', and hypothesized that the behaviour was rooted in a 'strange twist of personality' or a vague 'psychological kink'. The key motivational sticking point for Asher was that these people were prepared to undergo multiple uncomfortable, painful, even dangerous diagnostic tests, with the only discernible gain being free 'board and lodgings' in hospitals. This was broadly considered inadequate to account for the behaviour. Some patients did demand pethidine or morphine for pain, and left when it was refused, but others left despite the liberal provision of painkillers. The lack of motive can properly be called structural (rather than just something 'unknown' about the condition) because it is the *lack* of discernible motive that initially differentiates it from malingering. In malingering, illness or injury is induced or simulated for a clear gain – typically the avoidance of military service or other work. One doctor sums up this differentiation in 1957, retorting angrily to the blithe labeling of Munchausen patients as 'malingerers'. He claimed that people 'had better think again and a little more deeply about malingering. A person who pretends to be ill, and who obtains **no objective gain** by so pretending, is very ill indeed'. The other key factor in Munchausen is the *active* procurement or fabrication of symptoms, which differentiates it from hysteria and hypochondria.

Certainty amidst absence: 'invariably severe psychopaths'

There is, amongst all this uncertainty, one point of general agreement – that these patients are ‘psychopaths’. There is so much of this in the correspondence about Munchausen in the 1950s that three instances will suffice. Eric Frankel from Wanstead Hospital argues in 1951 that ‘[t]hese patients are invariably severe psychopaths, and their psychopathic personality requires treatment.’ Two doctors in 1958 are relieved that ‘these patients have at last been recognised as a special type of psychopathic personality.’ Similarly a doctor in 1960 mentions an ‘underlying psychopathic constitution’, although he admits, the reasons for the development of Munchausen ‘remain uncertain’.

Note that this doesn’t solve the motivation issue: psychopathy is not a motive. It also brings an uncertainty of its own: nobody in the 1950s seems able or willing to offer a firm definition on what a psychopath *is*. This is most obvious in the evidence given to the Percy Commission: the Royal Commission on the Law Relating to Mental Illness and Mental Deficiency (which produces the basis for the Mental Health Act 1959). Numerous witnesses write and speak of the ‘problem of psychopathy’.

Maxwell Jones – a key figure in the therapeutic community movement – submits a memorandum to the commission on what he calls ‘severe character disorder with antisocial trends’. In it he admits: ‘It is probably impossible to find a satisfactory definition for psychopathic states at the present state of our knowledge.’ He states again when questioned: ‘I find it completely impossible to make a definition.’ The British Medical Association’s memorandum says that they ‘considered the question of formulating a definition of “psychopathic offender” but reached the conclusion that it would be unwise to attempt this as such a definition might prove difficult to operate in a court of law.’ The Magistrates’ Association submit with their evidence a report they published in 1947 on psychopaths. It argues that ‘[a]n attempt to clarify the relationship between mental defectiveness and psychopathic personality is apt to reveal only the confusion of thought that exists even among psychiatrists.’

This is **almost** a necessary lack of a definition – this seems like an absence or a fuzziness that gives the category meaning. In the questioning of the representatives of the BMA, one of the Royal Commissioners goes as far as to say that ‘your psychopath is *ex hypothesi* [according to the proposed hypothesis] a person who is **not susceptible** to medical diagnosis’. The Royal College of Physicians submits that ‘Means should be found for dealing, compulsorily if necessary, with psychopaths of any age **not suffering from well-defined mental illness or defect**, but showing behaviour disorders of an anti-social kind.’ So nobody can really define them. An article on psychopathic personality from 1944 opens with a pithy evasion: ‘I can’t define an elephant; but I know one when I see one.’

The labels endure because they are useful

But these labels endure and are discussed over and over because they are **useful**: they encompass, name and manage people whose supposed disorders are neither securely psychological, nor their actions illegal. They provide a language and a disciplinary strategy to police and pathologise *social behaviour*, or more explicitly *anti-social behaviour*. They emerge in the context of renewed responsibilities for the state in this ‘social’ arena: social welfare and socialised medicine, alongside a new blossoming of sociology and social science. The ways in which Munchausen (as a variant) and psychopathy (as an umbrella term) engage with and police the social setting are considered as the final piece of the talk.

Munchausen and ‘the social’

Munchausen syndrome is concerned with the ‘social setting’ in at least two ways: a concern over the exploitation of **socialized** medicine and wastage of public money and slow realization that Munchausen patients might be understood as motivated to adopt a specific **social role**: ‘the sick role’.

Socialised medicine, social welfare

Munchausen syndrome emerges as part of a concern with NHS public funds. A significant number of doctors want to regulate this 'anti-social' behaviour with 'black-lists'. J.S. Chapman, who reports the first Munchausen case in the USA in 1957 is intrigued that no cases have been reported in the USA before his. He speculates that 'Possibly there are more such cases in England because of the **socialistic medical practice** in that country.' A British doctor discussing hypochondria in 1963 voices the opinion that the NHS 'foster[s] the growth of this **spurious ill-health**' – a label which also fits Munchausen.

One doctor laments in 1951 how Munchausen patients 'waste our already overtaxed hospital resources.' Another argues that '[t]he present problem is how to avoid wasting beds on them.' A doctor from Newcastle seeks in 1955 to prevent 'wastage of hospital time and money' Another from Manchester wants a 'better protection of hospitals and public funds.' Social welfare is seen as being abused.

Sociology and social roles

The second way in which Munchausen is involved with the social setting is that it begins – slowly – to be understood as a disorder of social roles: a pathological desire to adopt the 'sick role'. Sociologist Talcott Parsons refined and popularised this concept in his 1951 book *The Social System* (published the same year as Asher's foundational article). Asher does mention in an offhand way possible 'pathological enjoyment from the dramatic role of the patient'. However, the idea of 'illness behaviour' wasn't coined until 1960 (by David Mechanic and Edmund Volkart), and '**abnormal** illness behaviour' was formally analyzed first by Issy Pilowsky in 1969. This has now been securely grafted on to understandings of Munchausen. A 2010 article opens with the unambiguous statement that: 'Munchausen's syndrome is a condition whereby a patient deliberately simulates symptoms of an illness in order to gain admission to hospital and gain the sick role.' So **sociology** is eventually harnessed to Munchausen, as a way of explaining motivations. So we have social medicine,

social roles and sociology all circling and informing Munchausen syndrome – which is itself thought to be a form of psychopathy.

Psychopathy and ‘the social’

Finally, we turn to psychopathy, understood in the 1950s and 60s as an umbrella term for a whole host of supposedly chronic ‘anti-social’ behaviours: from drug addiction to delinquency, even homosexuality (which remained criminalised in the UK until 1967). The literature on psychopathy is vast, so I shall limit myself here to the evidence given to the Percy Commission. This is a great source because the Commissioners seem incredulous that psychiatrists are so unwilling to offer a comprehensive definition of ‘psychopathy’ – so they question them repeatedly.

Psychopathy inseparable from antisociality

Antisociality is right at the core of descriptions of psychopathy in this period. Maxwell Jones’s memorandum to the Commissioners describes psychopathy as ‘social abnormality’ distinguishable from a ‘mental abnormality’. He also talks of a ‘concept of **social** defectiveness as... more realistic than any attempt at a diagnostic classification’. When questioned he remarks that ‘My own feeling is that there is more hope of finding a definition related to social behaviour than to psychiatric classification’. The British Medical Association opens its section on psychopathic states by talking of ‘mental abnormality’ which renders people ‘delinquent or otherwise anti-social’ – which is repeated by the Royal Medico-Psychological Association – the forerunner of the Royal College of Psychiatrists.

Treatment and social science

The connections between psychopathy and social science go deeper. When describing a treatment program run at Belmont hospital, Maxwell Jones reports using ‘many concepts borrowed from the social science field’. Moreover, when questioned, he reveals the extent of ‘social science’ involvement: ‘We have largely dispensed with orthodox nursing help... and orthodox psychiatric

treatment... [A]part from a nucleus of trained nursing staff, **we now use social science personnel**. We have eleven people **most of whom have a social science training** rather than a training in the field of medicine'. The 'social' over the 'medical' is explicit.

An editorial in the magazine *Medical World* on the 1958 Mental Health Bill (based on the Percy Commission's report) puts this in critical terms: 'the criteria of psychopathy are social not medical. Doctors should not be asked to act as the social conscience of society'. Psychopathy is seen – explicitly by some – to be an extension of the social role of medicine: society's social conscience. Finally, an article in a sociological journal that predates Asher's Munchausen article *and* Parsons' *Social System* seeks to understand psychopathy wholly in terms of social roles. The 1948 article 'A Sociological Theory of Psychopathy' by Harrison G. Gough builds on the anthropology of George Herbert Mead and others to argue that 'the psychopathic personality is pathologically deficient in role-playing abilities'. This shows the links between an appreciation of the social setting and newly prominent forms of psychopathology.

Conclusion: useful uncertainty?

As the state's role is fundamentally reimagined post-1945, so the mental health services are rethought by the Percy Commission and Mental Health Act, 1959. The social setting looms large here. It provokes questions about antisociality, socialized medicine and social roles. It raises questions about the legitimacy (or not) of medicine, psychiatry and the law to monitor, police, manage and treat *social* as well as medical and legal problems. Further, it provokes us today to think about how the 'social setting' and 'social problems' are constituted *as problems* and conceptualized as amenable to intervention from medical, psychological and legal perspectives.

Munchausen syndrome shows a particular case (perhaps a limit case) of the social engagement: a disorder perhaps founded on socialized medicine, taking

advantage of social welfare, and eventually understood as a pathology of social roles. Munchausen exists (loosely) underneath the umbrella of psychopathy, which harnesses and labels older problems (such as delinquency, criminality and homosexuality) and attempts to reposition them as problems of 'psychopathic personality'. This is part of expanded concern for, and surveillance of, social life – the post-1945 welfare state.

Both are at the 'bleeding edge' of the advancing efforts to manage and police behaviour that is not quite illegal, and almost impossible to capture psychologically. As one of the Percy Commissioners warns: 'there is still a great reluctance in this country to extend the criminal law to cover all forms of anti-social behaviour... You are still bound, practically speaking, to get a good deal of **antisocial** behaviour which cannot fall into the ambit of any reasonably reformed **criminal law**, so the problem would still, in a sense, remain.' The uncertainties in psychopathy definitions and at the absence at the core of Munchausen syndrome help these conditions to be placed on the expanding terrain of 'the social'.

It is only by acknowledging this expansion into 'the social' that we can decide whether it is legitimate. Only by being aware of the ways through which regulation of social life is achieved and justified can we choose to push back at it in an informed and effective manner – whether through the sociology of the 1950s, the risk assessments of the 1990s or the biomarkers of the new millennium.