(6) MacBride, H. J., and Templeton, W. L.—*Proc. Roy. Soc. Med.*, 1924, xvii, No. 8.
(7) Pilcz, A.—*Lancet*, 1923, i, p. 19.
(8) Rudolf, G. de M.—*Ibid.*, 1924, i, p. 1183.
(9) Scripture.—*Practitioner*, 1923, cxi, p. 367.
(10) Wagner-Jauregg.—*Wien. med. Wochens.*, 1924, No. 13.
(11) *Idem.—Journ. of Nerv. and Ment. Dis.*, 1922, lv, p. 369.
(12) Weygandt.—*Klin. Woch.*, 1923, ii, p. 2164 (cited by MacBride and Templeton).
(13) Yorke, W., and Macfie, J. W.—*Lancet*, 1924, i, p. 1017.
(14) Gerstmann, J.—*Ars Medici*, 1924, ii, p. 345.
(15) Grant, A. R., and Silverston, J. D.—*Journ. of Ment. Sci.*, 1924, lxx, p. 81.
(16) Arroyo, C. F.—*Med. Journ. and Rec.*, 1924, cxix, p. 25.

Observations on Delinquent Mental Defectives.[1] By W. Rees Thomas, M.D., M.R.C.P.Lond., D.P.M., Medical Superintendent, and Cecil H. G. Gostwyck, M.B., F.R.C.P.Edin., Dipl. Psych., Assistant Medical Officer of the Rampton State Institution, near Retford.

The problem of delinquency has a peculiar interest for the alienist as well as the social reformer, for it is now accepted that intelligence and mental disorder have a close relationship with antisocial conduct.

It has long been recognized that those persons in whom intelligence and mental capacity are very highly developed in special directions tend to show a mental instability often amounting to legal insanity, and at the other end of the scale idiopathic imbecility and idiocy are accepted as defects of development resulting in the inability of such subjects to care for themselves. The latitude allowed to the genius and the imbecile was not at first extended to the great mass of the population, faulty conduct being visited by punishment of a character and intensity which varied according to the nature of the delinquency and the prejudice of the period.

Modern ideas have tended to bring more and more to the front the necessity for reformatory measures rather than punitive action, and this kindly attitude has resulted in the differentiation of criminals and delinquents into two classes, *i.e.*, the responsible and the irresponsible. With the former we are not now concerned.

[1] A paper read at a meeting of the Northern and Midland Division held at the Grange, Rotherham, on October 23, 1924.

The latter include those who, while not certifiable under the Lunacy Act, do in fact suffer from defects of intelligence and social capacity of such a degree as to allow the presumption that they are unable effectively to control their antisocial activities. Where there is obvious lack of intelligence a correct diagnosis is not difficult, but where the presumed defect is slight, the physician requires to rely largely on his experience of normals and on his ability to distinguish temporary aberration from permanent defect.

Further, it is found that many people of apparently normal intelligence are guilty of persistent vicious or criminal conduct, and on whom punishment has no deterrent effect. These persons have been held to be suffering from a delay in or a failure of development of the higher mental faculties which produce the inhibitions necessary to our social system. The establishment of the permanence of such a deficiency is a matter of incredible difficulty, and must depend almost entirely on the method of trial and error.

The large class of mental defectives, as apart from the insane, is dealt with by the Mental Deficiency Act, 1913, in which the various grades are separated and defined; in it also provision is made for the establishment of State institutions for those defectives who display tendencies of a dangerous and violent character. Rampton State Institution is the outcome of this Act, and in this paper we give an account of the clinical aspects of the 400 patients who are now detained therein.

Our cases are received from all parts of England and Wales. They represent those defectives who are unfit for association with others, and who are not amenable to control in local institutions and homes. They have demonstrated their violent and criminal tendencies before admission, and have proved themselves to be antisocial characters. With few exceptions the patients belong to the higher grades of defectives, there being no idiots and very few imbeciles under our care. The great majority are under twenty-five years of age, and the youngest is sixteen. The general methods of administration do not differ from those in other institutions, with perhaps the exception that considerable concessions are necessarily made to the idiosyncrasies of our patients. They are naturally allowed as much freedon as may be consistent with proper safeguards against escape. Over 90 *per cent.* are employed in useful work, the remaining 10 *per cent.* being sick or mentally incapacitated.

The antisocial and abnormal behaviour of our patients make individual study essential. No one case can be treated on general lines as the variation in type is great, and a considerable proportion have superimposed on their defects a mental disorder of which the

manifestation, sometimes slight and shadowy, sometimes obvious and severe, is usually recurring and transient.

Defective development is often expressed in terms of the intelligence quotient, which represents a comparison between the intelligence age and the chronological age. But this form of classification loses its value when mental disorders are taken into account, for the clouding effect of psychical disturbances results in so much variation in the same individual that it is impossible to base any form of classification on such unreliable data.

A grouping based on clinical grounds, however, may be of value, and we find it possible to divide our cases into three main groups:

1. Simple mental defectives.
2. Mental defectives with abnormal emotional instability.
3. Mental defectives with psychoses or psychoneuroses.

Proportions of these Groups at the Present Time.

—	Simple Mental defectives.	Mental defectives with instability.	Mental defectives with psychoses.
M.	21	26	53
F.	5	37	58

1. *Simple Mental Defectives.*

The cases included under this heading refer to a type in which the obvious intellectual defect is unaccompanied by any clinical condition that can be called a supervening disorder, and in whom emotional instability is not a prominent factor.

Judged from the standpoint of behaviour they may be regarded as adolescents and adults with the intellectual level of their age, but possessing only the degree of control properly pertaining to children of their class and experience. The ability to collate cause and effect, *i.e.*, the faculty we call reason, and which is a factor of intelligence, is limited by the complication of the situation at the moment, and those of defective intelligence are not able to deal with the complicated situations which may and do arise in the course of the struggle for existence; in addition to this, their defective capacity forces upon them a consciousness of inferiority which too often finds compensation in an aggressive and antisocial attitude, with the result that they become troublesome and often difficult to manage.

Their emotional reactions, their jealousies, the good effect of encouragement, unfortunately only temporary in its effect, can be cited as the normal reactions of the low mental age to which they belong. The onset of puberty and adolescence gives rise to other

impulses which they cannot control, and which often determine the type of criminal conduct.

Inside institutions they gradually become tractable and often industrious. The steady routine of institutional life acts as a sedative, soothing those passions which the everyday difficulties in their outside life must aggravate. The motherly care and benevolent forethought of a capable nurse shields them from such small adversities as irritate and rouse them to anger. Unfortunately their tendency to imitate other patients, and the fact that they are so impressionable, makes it necessary to segregate them from the other and higher-grade types.

2. *Mental Defectives with Abnormal Emotional Instability.*

In the second group we place those feeble-minded patients in whom emotional instability is a prominent symptom.

This instability occurs in its greatest intensity during the adolescent period, often persisting throughout life, but the importance of this weakness of emotional equilibrium lies in its effect on behaviour. These patients are restless, mischievous, defiant and noisy; too often they are violent and wantonly destructive. No matter how frequently they promise or seem to try to behave well, they are easily upset by the most trivial events; a hasty word from a nurse or fellow-patient, an impossible request refused, or even an omitted "Good morning" by the doctor, is enough to turn them aside from their expressed resolutions, and to produce the most extreme emotional outbreak with concomitant violent actions or spectacular suicidal attempts. Other patients of the same group are affected so easily that prompt segregation is the only possible means of avoiding the rapid establishment of a vicious circle. They are not, however, continually difficult, as for short periods they may make every effort to submit to control, and will earn privileges by their good conduct, industry and work. The duration of these attacks varies from a few hours to several days, but it is always more intense and more prolonged in females.

Such patients are fully conscious of their actions while the attack is in progress; they show no mental confusion, and there is an entire absence of any of the characteristic signs of mania. Conduct is deliberate and directed: a girl will for little apparent reason smash several panes of glass, often cutting her arms and hands severely, then, having thus relieved her feelings, immediately settle down to another period of good behaviour and useful work. She may afterwards explain that she felt unsettled and simply could not help herself.

In the consideration of this class the outstanding factor is emotional instability—a condition which may, and indeed does, occur in all grades of defectives. The low-grade case presents no special difficulty, as the behaviour and antisocial conduct is sufficiently explained by the lack of intelligence and capacity. The higher grade and the numerically greater type cannot be so lightly dismissed. Here the mental capacity is often quite good, its limitations apart from instability being a slight defect of intelligence. They would be expected to show a fairly high degree of reasoning power with the consecutive ability to compare various past experiences and modes of conduct. But although a satisfactory amount of reason, judgment and wisdom is demonstrated by tests carried out under laboratory conditions, a reference to case-histories proves that, judged on the basis of behaviour, none of the faculties have been allowed to find expression in pro-social conduct. It would seem, therefore, that we must look to our clinical symptom of instability for the explanation of the abnormal behaviour which is the main reason for detention in an institution.

A parallel condition of instability arising and persisting for a few years is found during adolescence in normal persons of both sexes. But there the instability differs from the cases under review in that it is neither so highly coloured nor so serious in its character, and further, that its active phase is confined to the period of adolescence.

Tests of all kinds have one defect, namely, that they fail to catch and record variations of emotional tone, and so we are unable to measure the degree of affective equilibrium. This instability is probably the factor which determines the uneven conduct, and the failure to pay attention to the phenomena of the external world in proportion to their importance to the social organization.

There is another type of affective disorder which is often difficult to separate from the form described above, and is therefore temporarily included in this class. It is characterized by a degree of emotional detachment, with behaviour which is extremely suggestive of the internal dissociation of dementia præcox. The condition may arise during the course of an ordinary instability and may be transient. We have noticed it particularly in high-grade defectives, and this condition seems worthy of special study. We can only suggest that it is clinically a transition stage from instability to the more severe and apparently different condition of dementia præcox.

3. *Mental Defectives with Psychoses or Psychoneuroses.*

In the third main group are included all those cases that show a persistent or recurring psychosis or psychoneurosis supervening on or causing a legal mental deficiency.

The intellectual deficiency of these cases is not always obvious, and can be demonstrated only during the intermissions of the mental disorder, it being possible that the apparent defect is due to a dementia which arises during the course of a psychosis commencing at an early age. We have often noted in the history of a patient evidence of the gradual and steady development, from the ages of six or seven years, of a mental disorder which when brought under observation is found to have all the clinical characteristics of dementia præcox.

The forms of mental disorder do not differ from those in ordinary alienist practice—hysteria, anxiety, neuroses, manic-depressive states, dementia præcox, either active or non-progressive, paranoia, epilepsy, transient hallucinatory attacks, mostly auditory or visual, and delusions commonly of a persecutory type, as well as attacks of mental confusion often so slight as to be overlooked. Most of these disorders are periodic in their manifestation, for after an exacerbation with acute symptoms lasting for a few short hours or days, they settle down to a comparatively long quiescence or period of intermission. This point is of importance, as it is quite possible, and in many instances certain, that crimes for which the particular patient came under observation have been committed while in a definitely morbid mental state.

The most common associate of the antisocial conduct in the cases of this group is found to be transient ideas and delusions of persecution. They are frequently expressed quite definitely, but are often vague and ill-defined; nevertheless they can be regarded as clearly morbid, and not the too apparent efforts at self-justification so usual in those of defective intelligence and capacity.

Many of the patients remind us of the tramps who find it impossible to settle down in any place because the normal conduct of others becomes distasteful to them. Their antisocial attitude in general seems to be the outcome of a morbid mental state, which when exaggerated forms the delusions of persecution that are now frequently considered to be based on complete or partial repression of homosexual tendencies. It is noteworthy that men committed for crimes of a homosexual nature, and those who are known to possess homosexual desires, are particularly of this type. It is common knowledge amongst our male attendants that in these homosexuals the rigid suppression of their homosexual tendencies

inside the institution leads to fleeting delusions of persecution, and occasionally to the most intense feuds between particular patients who at some time or other have together sought to escape observation in order to satisfy their abnormal cravings.

That half the number of the patients in this institution suffer from morbid mental disorders is important both from the point of view of conduct, and because it raises the question of their certifiability as insane. It must be remembered, however, that they are feeble-minded within the meaning of the Mental Deficiency Act, 1913, and that the psychosis is transient in its manifestation. Many are insane for short periods, but the symptoms subside so rapidly that certification is difficult, and often not possible; in fact most of these patients are regarded as of the borderland type. When obvious and persistent mental disturbance arises, steps are taken to deal with the case under the Lunacy Act.

The psychosis is not always apparent to the ordinary observer, and when a defective comes under the notice of the authorities on account of some crime or antisocial behaviour, possibly committed under the influence of an early and mild psychosis, the acute and outstanding symptoms have disappeared, leaving the mental deficiency as the only ground on which to deal with him. Under these circumstances he is rightly certified under the Mental Deficiency Act, and since the symptoms of the psychosis are mild and transient, they can only be recognized when he is kept under observation for long periods. In a certain number of instances crime is committed only during the periods immediately preceding or following the attacks of those mild and scarcely perceptible mental disorders; were it possible to certify the defective as insane at the time of his misbehaviour, he would necessarily be discharged at an early date and released to continue his career of crime.

The common factor of all our cases is antisocial conduct of such a degree that detention is necessary for the protection of society. The relative importance of mental disorder and mental deficiency in determining this particular type of behaviour is a subject into which we do not propose to enter at present. It may, however, be pointed out that it is not always possible, and, in our opinion, not at all desirable, to neglect the importance of psychical disturbances, and thus to imply that the congenital mental deficiency alone is the determining cause of criminal conduct in mental defectives.