DELINQUENT DEFECTIVES.

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THE growing incidence of juvenile delinquency during the past years has become a serious concern of the general public and the authorities. Following the lead taken by the Home Office, a number of local authorities, child guidance clinics and welfare agencies have instituted inquiries into the causes and conditioning factors of juvenile crime from the social, economic and medico-psychological points of view. The institutions for the mentally defective have been faced with the same problem through the increasing number of cases referred by the juvenile courts, and Dr. D. Turner, in his Annual Report on the Royal Eastern Counties Institution, Colchester, for the year 1943, called attention to the difficulties of their management within an institution of the usual type. The question calls urgently for a settled policy regarding their disposal and treatment, and it goes without saying that this can only be attained on the ground of a better insight into the psychology of the delinquent defective.

I made a tentative approach to this problem as it confronts us at the R.W.C.I. by a survey of 210 male patients, delinquents and non-delinquents, with special reference to the relation of the existing mental defect to their delinquent behaviour. The group reviewed comprises all ages from 16 to 54, but the majority of patients —four-fifths of them—are of adolescent age. With few exceptions they were admitted to the institution at school age, and the criminal records of most of the offenders among them date back to the pre-war period. They are not, therefore, in any way representative of the present increase of juvenile delinquency. They live in three separate villas at our Langdon Extension, and are engaged in agricultural and garden work, in various industrial occupations and domestic duties. Seventy are on daily outside employment with local gardeners and farmers. In view of the limited objective of the present survey, little can be said regarding their social and economic background, their home conditions, etc. Be it sufficient to remark that the case-records of both the delinquent and the non-delinquent group tell the same story of economic distress, broken homes, illegitimacy, etc., such as are mentioned as the principal conditioning factors of delinquency in the general population.

Their mentality ranges from the low-grade feebleminded to the highest grades, with a few imbeciles and high-grade border-line defectives at both ends of the scale. The group does not comprise idiots or epileptics. Licensed patients are likewise excluded. The top column in Table I gives the mental ratio of the patients reviewed on the Terman-Merrill scale (1937). In some older patients the I.Q. was assessed by the Binet-Simon scale. The second column gives the number of patients in each group, the third shows the aggregate figure of delinquency on the respective levels, whilst the last column indicates the corresponding percentage figures. Here I may remark that the term delinquency is used to indicate patients who have been convicted of a punishable offence by a judicial authority, or in whom the charge was dismissed owing to their mental defect. The offences comprise petty pilfering, larceny, damage to property, violence against persons, sexual misdemeanours, etc., single or recurrent. The aggregate figure of delinquency indicates the incidence of offences, whatever their nature, in the subgroups reviewed. Recurrent delinquency indicates recurrent offences, whatever their nature, in the same patient.

* Based on a paper read to the Conference of Officers of the Five English Voluntary Institutions at Birmingham, October 5, 1944.

TABLE I.—*Grand Total of Patients Reviewed. The Table shows an Increase in the Aggregate Figures of Delinquency with the Rise of the I.Q.*

I.Q.	30–40.	40–50.	50–60.	60–70.	70–80.	80–90.	Total.
Number of patients	14	56	76	34	20	10	210
Delinquents	0	21	39	18	16	9	103
Delinquent per cent.	0	37	51	53	80	90	49

The first fact that emerges from this table is the striking increase of delinquency as we proceed from the lower end to the upper end of the scale. It is zero up to an I.Q. of 40, that is in the group of 14 imbeciles and low-grade feebleminded, whereas 9 out of 10 cases with an I.Q. of 80 to 90, or above, show a history of recurrent offences. However, it goes without saying that conclusions which might be drawn from this state of affairs are subject to a number of qualifications. Quite apart from the exclusion of idiots, epileptics, or licensed patients, our group cannot be regarded as an unselected sample of the general M.D. population. Like the majority of hospital patients, our inmates are largely derived from a special social class. Further, owing to the geographical position of the Royal Western Counties Institution, they are mostly recruited from agricultural areas. This may or may not appreciably affect our figures; but there is another important factor which obviously has a pronounced influence upon the gross increase of delinquency among patients of the higher grades which is suggested by our table. Mental defectives above an I.Q. of 70 are rarely admitted to an institution unless there is another compelling reason for doing so. In most cases this "other" reason is nothing else than their delinquent behaviour. The proportion of delinquents to non-delinquents with an I.Q. round about 70 in the general population cannot be assessed, but the fact is that unless a person of this mental grade gets into conflict with the law, he is unlikely to be included in a statistical survey like the present. From this follows that the figures appearing on the upper end of our scale are "biased" to a considerable degree, and that only the four sub-groups with an I.Q. below 70 can be regarded as a representative sample of the M.D. population of the country (Table II).

Accordingly, in Table III Fisher's χ^2 test of significance is being applied to this

TABLE II.—*This Table Shows the Incidence of Delinquency in the Group after Exclusion of the Highest Grades* (*I.Q.* 70–90).

I.Q.	30–40.	40–50.	50–60.	60–70.	Total.
Number of patients	14	56	76	34	180
Delinquents	0	21	39	18	78
Delinquent per cent.	0	37·5	51·3	53	43·3

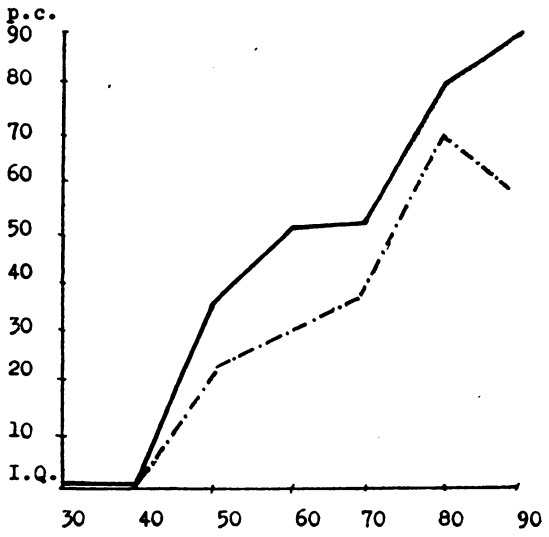
TABLE III.—*Fisher's χ^2 Test of Significance Applied to Figures shown in Table II. The Result Suggests a Degree of Association between I.Q. and Delinquency which is in Excess of the Conventional Level of Significance.*

I.Q.	30–40.	40–50.	50–60.	60–70.	Total.
Actual figures of delinquency	0	21	39	18	78
Expected figures of delinquency	6·06	24·26	32·9	14·73	78
Difference	−6·06	−3·26	+6·1	+3·27	0
Difference^2 ÷ expected number	0·06	0·45	1·13	0·72	$\chi^2 = 8·36$

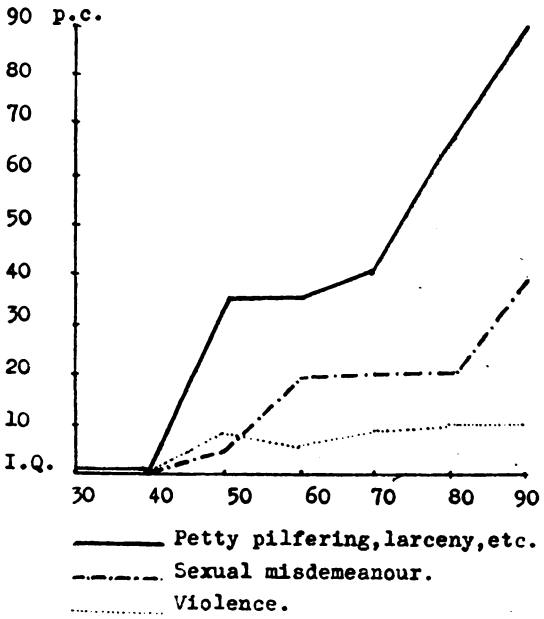
$n = 3$; $P = <0·05$.

unselected sample only. It shows that, on the hypothesis of an average of 43·3 per cent. delinquency in this group, 6·06 delinquents should be expected in the lowest class, 24·26 and 32·9 in the two intermediary classes, and 15·73 in the group with an I.Q. of 60 to 70 per cent. However, the actual figures show a pronounced departure from uniformity amounting to from − 6·06, − 3·26, + 6·1 to + 3·27 respectively. This gives the value of 8·36 for χ^2, which corresponds with a probability of less than 0·05 that the association found between mental defect and delinquency be due to chance alone. In other words, the association suggested in Tables I and II can rightly be regarded as statistically significant.

Graphs 1 and 2 are based on the percentage figures of delinquency in the whole



GRAPH 1.



GRAPH 2.

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group including the highest grades. They illustrate roughly the same distribution but, for reasons indicated above, likewise tend to exaggerate the true incidence of delinquency above an I.Q. of 70. The analysis of the various classes of delinquency represented in the graph is subject to the same qualification. To this we must add the absence of epileptics and licensed patients from our group, and the tendency to defer licence in sexual offenders for a longer period than in more harmless offences as further selective factors.

What, then, do we learn from our survey? Is it permissible to regard the marked increase in the figures of delinquency with the rise of the intelligence quotient, observed in our group, as indicative of a causal relationship? There is nothing to justify such a contention. It will be noted that, for instance, only 53 per cent. of the patients with an intelligence quotient between 60 and 70 have a record of delinquency. This figure is certainly high enough, but it does not explain why the remaining 47 per cent. have no such record. This can only be due to causes which have so far remained outside our inquiry. Other investigators have in fact called attention to the importance of environmental conditions, social, economic and otherwise, in the causation of juvenile crime. However, I mentioned that a tentative survey of our material has been inconclusive in this respect. Poor parentage, slum conditions, etc., are equally common in the histories of normal delinquents and of mental defectives in general. On the other hand, we found that delinquency is nearly absent in the lowest group of defectives, whereas both environmental and hereditary conditions are known to be at least equally poor in low-grade defectives as in higher grades.

All this goes far to show that the accumulation of statistical data is unlikely to furnish deeper insight into the causes and conditioning factors which are operative in our delinquent group. It may be as well, therefore, to review the principal facts revealed in the light of their psychological appreciation. To begin with, we have to deal with a possible objection. It may be argued that speaking of delinquency in the legal sense in defectives of comparatively low mentality such as were included in our survey is hardly justifiable. They may exhibit a variety of behaviour difficulties such as faulty or destructive habits, uncontrolled motor reactions, etc., but it is a matter of convention that they are not held responsible for such acts. It may be claimed that it is no coincidence that mental defectives have from time immemorial been regarded as the "Holy Innocents," and measured by a different standard of social obligations and responsibilities. In these circumstances it may well be questioned whether it is reasonable to refer to their misdemeanours under the same heading as the behaviour difficulties on a higher level of the intelligence scale, and whether it was justified at all to include them in our material.

However, it is readily understood that from the medico-psychological point of view the discrimination between the two types of behaviour difficulties is purely arbitrary. Every experienced nurse will confirm that in certain essential points the behaviour of the low-grade defective—and of the infant, for that matter—is subject to the same psychological laws as the behaviour of a normal person. An imbecile may soil and wet himself for precisely the same reasons as a problem child of average intelligence would wet his bed. But while the latter is able to resort to alternative ways of asserting his personality against his social environment, the low-grade defective—like the infant—may have hardly more efficient means at his disposal than his inadequate sphincter control. The same is true for the defective of medium grade if only we make allowance for his comparatively greater freedom of action and self-expression. Putting it in terms of Adler's Individual Psychology, we should say that he has more adequate means of compensation for his feeling of inferiority and for his real shortcomings.

Anti-social behaviour in defectives above the imbecile grade can be interpreted in the same vein. A patient of this class need not confine himself to the symbolic act. He can derive both immediate benefit and a feeling of psychological gratification from a bun stolen from his neighbour's plate. Again, the feebleminded of highest grade can resort to yet more subtle means of self-assertion. In fact, he is more likely to seek to restore the balance of his self-respect than a patient of lower mentality who is less sorely aware of his limitations. He may try to sell the farm produce of his employer; he may forge a cheque; he may pose as a doctor or clergyman. But however hard he tries, he will rarely escape the feeling of inade-

quacy that looms at the back of his mind. He will notice the successes of his fellows which were denied to him, and realize his inability to compete with them on equal terms; this is why he may seek to compete with them on unequal terms. He may be aware that he is incapable of flooring his opponent by a straight punch; this is why he may try to hit "below the belt." He may actually develop this kind of technique as his persistent *style of life*, and fall back on it whenever he is frustrated. He may then be described as an incorrigible recidivist or a "moral defective." But apart from the not too frequent cases of true psychopathy of organic origin, such as post-encephalitic conditions, and a few border-line schizophrenics, here, again, the fundamental similarity of the various patterns of anti-social behaviour becomes apparent. Both high grade and low grade defectives respond with the same uniformity of reactions when faced with difficulties. Their means of expression may differ according to their respective levels of intelligence and to their mental equipment in general, but the common denominator of their anti-social behaviour remains their protest against the exigencies of life in the community, or against what Freud called "civilization and its discontents."

If this interpretation is true, delinquency in the group reviewed here—and presumably in mentally defectives in general—is nothing else than the specific reaction of the patient to his shortcomings. It is largely due to his attempt to make up—by hook or by crook—for his deficiency. One type of patient may choose ways and means for this end that bring him into conflict with the law. He may resort to indecent exposure, to theft or violence. The other type may content himself with masturbating, with hoarding rubbish or with tearing his clothes. Again, others may refrain from any attempt at compensation, and then present themselves as the simple and inoffensive type of defectives. For obvious reasons this is more likely to be found on the lower than on the upper end of the scale, and this precisely has been revealed by the present survey.

This tentative psychological interpretation of our findings gives at the same time a pointer to the treatment of the delinquent defective. It suggests that the greater incidence of delinquency in patients of higher grades is a feature of promise rather than of despair. Indeed, it may well be regarded as the only evidence of something like a tendency to self-healing in the field of mental deficiency. The low grade defective who has not got "wits" enough to become a delinquent exhibits only a rudimentary tendency in this direction. The defective of high grade shows, by contrast, plenty of this tendency. Actually so much of it that he is likely to overstep his mark and thus to defeat his own purpose. Accordingly, his treatment must be determined by two basic principles. First, we must relieve his sense of inferiority for this is, on the ground of our hypothesis, the main factor that may tip the balance of his behaviour at a given level of the intelligence scale in favour of delinquency. Secondly, we must reduce, as far as this is possible, his real shortcomings, since they are the primary sources of his persistent failures in life.

To achieve our first objective, we have to remove him from his ordinary environment and place him under the sheltered conditions of an institution. Here he is relieved from the unequal task of asserting himself against overwhelming odds in the outer world. He has no longer to try to compete with his fellows on unequal terms. He has to compete with defectives of his own grade, and often with patients below his level of intelligence. This may in turn give him the opportunity of asserting himself on a level of unchallenged superiority, and help him to restore his self-respect without resorting to artful tricks or dodgery.

On the other hand, it need not be emphasized that the judicious control of the patient's tendency to compensation and over-compensation, its direction into the right channels, is another important feature of his proper management. This naturally requires a firm disciplinarian regime, and cannot be achieved without occasional resort to punishment. But in doing so we must avoid pouring fuel into the fire by further increasing his sense of inferiority, and apply punishment in such a way that it does not leave a sting behind. In fact, its administration and dosage should be subject to the same consideration and restrictions as the use of medicines falling under the Dangerous Drug Act.

Our second objective is being pursued by the patient's special tuition, followed by training in various trades and occupations. These must be carefully adjusted to his limited abilities, and designed in such a manner that they provide him with the necessary physical outlets. At the same time they should give him at least a

foretaste of the feeling derived from work well done, and from such small rewards as he may receive for his labours. To this comes the beneficial effect of the various recreational outlets, such as mixed dances, competitive sports in which the higher grades can distinguish themselves and carry "all the prizes"; in short, all the paraphernalia of life within a well organized modern institution. Indeed, life in a colony for the mentally defective run along these lines represents the closest approximation of full adjustment of the patient to his environment. It provides him with natural outlets within his own community, it gives him the semblance of a biologically balanced existence in a quasi-natural social setting, and is therefore best suited to his needs and capabilities. The success of the present system of outside employment and licence of defectives of both the delinquent and the non-delinquent group is the best proof of the efficiency of the methods described.

But two provisos must be made. First, the delinquent defective admitted to an ordinary institution should not be of too high a grade. In the region of an I.Q. above 80 he is likely to resent his detention to such a degree that this is bound to outweigh all the benefits which he may derive from the factors outlined here. Furthermore, it goes without saying that there must be a point of saturation beyond which it is not advisable to increase the proportion of the delinquent to the non-delinquent defective in a given community. The proportion of nearly 1 : 3 recurrent offenders illustrated by Chart 1 marks about the limit of what can satisfactorily be dealt with in colonies of the ordinary type. In any case a continuation of the present rate of admission of patients of this class is bound seriously to upset the balance between the delinquent and non-delinquent groups, and may call for new administrative measures.

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