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THE MENTAL CONDITION OF JUVENILE DELINQUENTS.

By Isador H. Coriat, M.D.

Boston, Mass.

Parallel with the recent establishment of special juvenile courts, there has arisen a new and more vital interest in juvenile delinquency. What was formerly a purely academical study has now become a psycho-sociological problem of the highest importance. For a thorough comprehension of the subject, the recent studies in the psychology of adolescence and puberty, both in its normal and abnormal aspects, are of great value. The subject is so wide, however, that I can give only briefly a few results of personal observation and shall limit myself, as far as possible, to the mental and nervous disorders of juvenile offenders. I shall attempt to answer the question, tentatively at least, whether these disorders form the basic responsibility of the delinquency, or whether cases exist in which these disorders are merely episodic and accidental. For a more complete account the reader is referred to Morrison's "Juvenile Offender," more particularly to the chapter dealing with the mental condition of juvenile offenders, although this chapter appears to me the weakest portion of an otherwise admirable work, and also to the chapter on juvenile faults, abnormalities and crimes in Vol. I of Hall's "Adolescence."

Stanley Hall says, "In all civilized lands criminal statistics show two sad and significant facts: First, there is a marked increase of crime at the age of twelve to fourteen, not in crimes of one, but of all kinds, and that this increase continues for a number of years. While the percentage of certain grave crimes increases to mature manhood, adolescence is pre-eminently the criminal age when most first commitments occur and most vicious careers are begun. The second fact is, that the proportion of juvenile delinquents seems to be everywhere increasing and crime is more and more precocious." The marked increase in the pre-

cocity of crime, according to Terman, can be explained on three suppositions, "First, increase in criminal precocity may mean that the criminal born reach naturally an earlier maturity than formerely. Second, if we grant with Ferri that criminal precocity is almost an invariable mark of the criminal born, then we now have more born criminals than ever before. Or, third, that modern environment is becoming more and more suited to draw out and exaggerate the criminal propensities." Plotting a curve of juvenile crime as prepared from the statistics of the eleventh census of 1890, I find that this curve runs practically parallel to the time of onset of adolescent insanity (dementia praecox), as shown in my collection of cases; that is, there is a very sudden rise in the curve between the ages of ten and fifteen.

It is not my intention to inquire into the cause of this increase and this remarkable parallel. For the purposes of this paper it is sufficient to state that this may be due to child labor and the exposure by employers of inexperienced children to temptation, to contact with evil companions, the pernicious influence of children's gangs, to many of the sociological factors which make up our complex civilization, to the pubescent outburst of inherited tendencies, the environment of indifferent and neglectful parental conditions, atavistic reversions to savage impulses and, finally, to various mental and nervous diseases. In many cases these latter make the unfortunate juvenile offender irresponsible for his acts. This important field has remained almost totally unexplored by criminologists, sociologists and even psychiatrists. Its great importance as a factor in juvenile crime cannot be overlooked, and it is daily forced upon our attention. The justices of the various newly-established juvenile courts are also becoming alive to its importance, as is witnessed by the increasing number of children who are submitted to the alienist or neurologist for examination. The field is a new one, however, and it is hoped that the few facts I intend to touch upon and elaborate in the course of this paper will stimulate further study and research in this direction. Therefore I shall have little to say on juvenile crime in general, except so far as it will serve to elucidate the facts at hand.

The new Massachusetts act of 1906 (Chap. 413) distinguishes between delinquent and wayward children, but for our purpose the terms juvenile delinquency and waywardness had best be interpreted as synonymous and will be held to comprise all those offenses against law and society committed between the ages of seven and seventeen years. Judge Julius M. Mayer has given us

a very practical working classification of juvenile delinquency. His scheme comprises (1) mischievous children; (2) children who commit crimes because of temptation; (3) children who commit crimes because of environment and bad associations; (4) children who commit crimes because of parental neglect or incompetency; (5) children with what may be called criminal tendencies; (6) children who are runaways and vagrants; (7) disorderly and ungovernable children; (8) children who are neglected or abused by their parents. To this I will add a ninth group, namely: those children who are the victims of an acquired or hereditary nervous or mental disease and who commit crimes either by reason of this disease or by temptation or environment. Of course this will comprise those who are vagrants, who are ungovernable or who have criminal tendencies.

The Italian school (Ferri, Lombroso, Marro) divides criminals into (1) criminals by birth or instinct; (2) insane criminals; (3) criminals of passion; (4) occasional criminals; (5) habitual criminals. Groups 1 and 2 comprise the constitutional or born criminals, and what Lombroso calls the criminals by organic defect due to special diseases, drugs (especially alcohol), mental diseases (especially paranoia), epilepsy, degeneration, moral imbecility, idiocy, cretinism. Morrison believes that the mental defect of juvenile offenders as a class originates in a weakened physical basis, in heredity or environment, and that the physical condition of the juvenile offender is worse than that of the ordinary, law-abiding child at the same age. For him, mental anomaly shows itself in defect of intellect, feeling or volition. In itself this is a kind of reversion to the old psychological classification which pigeon-holed human thought in one or another of the above categories. I propose to show in the course of this paper that a juvenile mental disorder may exist without any concomitant physical defect, and, furthermore, that in many cases we are dealing with definite disease processes in the brain and nervous system which will easily explain everything without the necessity of calling to our aid an artificial psychology based on isolated psychic attributes, which we know never exist alone but always in combination with other factors of the complex mental life. It is principally along these lines that I differ from Morrison, hence my statement at the beginning of this paper, that I considered his chapter on the mental condition of juvenile offenders the weakest portion of an otherwise admirable and scholarly study of juvenile criminology.

Stanley Hall, however, recognizes that in adolescent crime we confront the vast field of modern criminology, that many juvenile offenders are the victims of mental disease of hereditary types, such as the so-called moral insanity, that many are degenerate, that crimes committed without any object are usually committed by subjects of mental alienation, and that pathological lying exists among many children. In an unpublished paper on the relation of adolescence and puberty to the problem of dementia praecox, which I read before the Seminar of Clark University in February, 1905, I pointed out that petty crimes were frequently the first symptom of a katatonic deterioration, and later experience has shown that these petty offenses may occur in any of the prepuberal, puberal or adolescent neuroses and psychoses.

Oppenheim, in describing the first signs of the neuroses in childhood, shows that little children are particularly prone to phobias and their motor expression, to hallucinatory delirium, imaginative lying, disorders of sleep and many motor eccentricities. Thomas, in his paper on slightly abnormal children, comprising studies from birth to puberty, points out how cerebral neurasthenia depending on a psychopathic heredity and exhaustion may occur, as also obsessions, impulsions, tics, pathological distraction, morbid dreaming, somnambulism, imaginative romancing, fugues, hysteria, chorea and moral insanity. Trüper has given us a valuable study of feeblemindedness and other mental abnormalities as factors in juvenile crime. Emminghaus, in his monograph on mental disturbances in children, finds that two types of acute dementia, the stuporous and the agitated, are very frequent among them. Karl Wilmanns, in a study of the mental condition of 120 tramps, found that 66 of these were cases of dementia praecox (adolescent insanity). Many of the so-called prison psychoses are some phase of katatonia.

Krafft-Ebing, in discussing the menstrual psychoses, found that the cyclic type, which may take the form of maniacal excitement or of melancholia, is of considerable medico-legal importance, as the subject may entertain violent feelings against society which may lead to criminal acts, such as theft, arson and even murder. One of my patients, a young girl, at each menstrual period, went into a state of great anxiety and agitation, developed hallucinations of hearing, thought she was being poisoned, and spent much of her time in prayer. Many sexual crimes, sadism, masochism, the so-called lust murder, are committed by young adolescents who are the unfortunate victims of a pathological sexual instinct. Of

interest are the many petty larcenies committed as the result of fetischism or fetichistic tendencies, such as the stealing of various parts of female attire, and more especially hair fetichism and the hair despoilers, of which we had recently a prominent example in Boston, who became popularly known in the newspapers as "Jack the Clipper."

Stransky reports a highly interesting case of a youth who was arrested for stealing a pair of shoes, who made no answer when questioned by the police and was therefore suspected of simulating, on examination by physicians was found to be suffering from a severe form of dementia praecox. He had no memory for the crime. The author very pertinently points out that such crimes are quite frequent in dementia praecox, and the course of the disease in the case above cited shows that any idea of simulation on the part of the patient may easily be dismissed.

Juvenile offenses and delinquencies are as numerous and varied as those committed by adult criminals, but modified by the many psychic and somatic factors of puberal and prepuberal development, particularly by the predilection of certain neuroses and psychoses to appear first or at least to become greatly accentuated at puberty, such as epilepsy, dementia praecox, moral insanity and the sexual psychopathies.

Murder may be committed by the young adolescent who is the victim of some sexual aberration, by those who have no knowledge of the power of control, through emulation or psychic contagion, or as the feature of an epileptic equivalent. It may be the outcome of the so-called moral insanity, that grave ethical defect, which is foreshadowed in childhood and bursts out to full maturity at puberty.

Below fifteen, the most frequent types of delinquency are theft, truancy, begging, malicious mischief, incorrigibility, nomadic tendencies and vagrancy. On the basis of statistics it has been computed that crimes against property are the most frequent between the ages of twelve and fifteen. The lies of children and their relation to romancing, day-dreaming and reverie, in both their pathological and normal aspects, have been studied by Oppenheim and Stanley Hall. Revenge and anger in children may be pathological and lead to serious crimes. Hall points out that all boys develop an increased propensity to fight at puberty, and therefore advocates boxing as an essential part of the physical education of adolescents, because it forms a wholesome outlet for anger. Envy and jealousy also play a prominent part in juvenile crime.

Child torturing may be an exaggerated form of teasing or it may be a rudimentary sadistic tendency. Petty larcenies are very common, and may be due to an ignorance of what constitutes ownership and personal property, to a desire to possess something dear to the juvenile heart but beyond its material means; to sudden impulsions, or as symptomatic of some form of adolescent insanity, moral imbecility or epilepsy. Pyromania may be an irresistible obsession, a love for excitement, moral insanity or an epileptic equivalent.

Fatigue in school children is a prominent factor in cerebral neurasthenia, of what the French call *surménage*. It plays a great part in the production of the grave mental disorders of puberty. It manifests itself in restlessness, choreiform movements, tremors, exaggerated reflexes, involuntary laughter and irritability. Various fancies may take possession of the mind and degenerate into pathological obsessions.

Many questionnaire returns on peculiar children merely classify them as cruel, lying, ill-tempered, etc. While valuable for statistical purposes, terms such as these are merely symptomatic and descriptive and throw no light on the question. What we need is a complete history of the delinquent and of his crime, the family and personal history, somatic diseases and finally a complete mental and physical examination. Only with this mass of data can we draw any definite conclusions. This method will naturally give us fewer cases than do questionnaire returns when the mental condition is indicated by one or two words, but what studies carried on along these lines lack in quantity they gain in quality. Minute data only are of value for the study of individual cases. Individual study is the most promising and fruitful, for what may be normal in reaction for one delinquent may be abnormal for another, as measured by the standards of heredity, medical history, and physical examination.

A brief summary of some of the cases* will serve to elucidate the subject far better than any didactic or symptomological description. For the sake of clearness, I shall divide the cases into groups, although so far as some of the cases are concerned this classification is merely tentative.

*Some of my cases were observed at the Worcester Insane Hospital, others were examined in the Neurological Clinic of the Mt. Sinai Hospital, having been submitted for examination by Judge Baker, of the Boston Juvenile Court.

I. *The Dementia Praecox Group.*

Here we are dealing with a deterioration disease process, which shows a varying clinical picture, presenting, however, a gradual transition to a characteristic apathetic state of terminal dementia. The following six cases are selected from my collection of 210 cases of dementia praecox, as showing in an admirable manner the relation of crime to one of the gravest forms of adolescent insanity.

Case 1. A youth of nineteen, was indicted for bastardy committed at the beginning of a katatonic deterioration. He became more apathetic and stupid, repeated many peculiar, stereotyped expressions, developed catalepsy, grimacing, echolalia, and finally went into a state of complete dementia and dilapidation, with disappearance of all the automatic symptoms.

Case 2. A case of dementia praecox, ceased school at fifteen, began to lead a vagrant's life and to associate with a gang of young pilferers.

Case 3. A case of recurrent katatonic excitement, began to show criminal tendencies at eighteen years of age, the period of the onset of the disease.

Case 4. A boy committed larceny soon after leaving grammar school and in a short time developed a severe type of hallucinatory dementia praecox.

Case 5. A boy was arrested for assault and battery at twelve years of age, and was sent to a correctional institution. There he became morose, showed a decided loss of mental ability, had periodical attacks of extreme irritability strongly suggesting an epileptic equivalent, and finally developed a typical katatonic stupor with extreme emaciation. At fifteen, recovery, with a moderate degree of dementia.

Case 6. A boy was arrested for drunkenness at sixteen. Examination at the time showed a typical dementia praecox.

II. *The Moral Imbecility Group.*

Pyromania was the prominent feature of this case, but outside of moral imbecility it may also occur as an irresistible obsession, a love for excitement or an epileptic equivalent.

Case 7. A young girl employed as a chambermaid in several hotels, where fires were accidentally discovered, finally confessed that she set the fires from an irresistible impulse, from love of

excitement and in reaction to hallucinations of hearing, claiming that the voice of her dead father commanded her to set the fires. I was inclined to regard the latter either as a pure fabrication or as an illusion of memory. When questioned as to how she knew it was her dead father's voice, if the voice stated it was her father, she claimed to *recognize* the voice as his and not from any hallucinatory confession. However, further in the examination and in the medical history, it developed that the patient's father had died before the patient was born.

III. *The Epilepsy Group.*

In these three cases the epileptic seizures were of the masked, atypical form, and only a careful examination finally established the purely epileptic character of the disease.

Case 8. A boy of thirteen, has an epileptic mother, a father who is a chronic alcoholic, subject to outbursts of irritability and furor, and a brother who is given to pathological lying and petty thievery. The patient is a member of a bad gang at school and, like his brother, is a pathological liar. For a long period and on the average about once a month, he has had dizzy attacks associated with confusion and haziness of memory. Occasionally he wets the bed at night, and at these times will awaken in the morning with the tongue bitten and a severe headache. He was indicted for stealing some electrical apparatus, which he claims was given him by another boy, although knowing at the time that it was stolen. There is a clear memory for the larceny. The moral sense is blunted, and he is quite irritable and surly.

Case 9. A boy aged twelve. Father died of pulmonary tuberculosis; many of the father's relatives are tubercular; the mother suffers from frequent attacks of dizziness, but without loss of consciousness; a sister of the patient, now seventeen years of age, has suffered from a moral deterioration with some paranoiac traits since the establishment of puberty at fifteen. The patient himself had a head injury when young, and has since suffered from frequent fainting spells. He is brought to the Juvenile Court for truancy, says he does not care to go to school, giving as a reason the strict discipline of the schools. An examination showed frequent dizzy attacks, with twitching of lips and slight mental confusion. Occasionally he wakes up in the morning with a severe headache and appears stupid and confused the rest of the day (nocturnal epilepsy). The truancy consists of an impulse to wan-

der aimlessly away (epileptic wandering impulse), and this always occurs after the headache or attack of dizziness. When he has one of the latter in school, there arises an irresistible wandering impulse. Occasionally in these attacks he has fallen (*petit mal*). The attacks are preceded by hallucinations of sight, red-colored horns turning rapidly round and round (visual aura). He is quite irritable.

Case 10. A boy of thirteen, has a younger sister who had probably chorea. He is stupid at school and sometimes is a truant. He is reported because of an irresistible impulse to sleep—will sleep anywhere in school. Once he fell down stairs. These sleepy attacks are followed by headache, a dazed condition and extreme irritability and pugnaciousness. For eight years he has been subject to dizzy attacks, with some twitching, loss of consciousness, and amnesia; sometimes in place of these there are sleepy attacks. In this case we are dealing with a grave type of epilepsy, *grand* and *petit mal* and narcoleptic equivalents.

IV. *The Simple Delinquent Group.*

This group is of the usual class of juvenile offenders.

Case 11. A boy fourteen years of age. The father and mother are dull, the latter being prone to lying; a brother is feeble-minded and has the appearance of a degenerate imbecile. A younger sister has a severe brain disease (polioencephalitis). The patient is bright at school, but misbehaves unless closely watched. He is prone to play with very young children in the streets, whom he likes to dominate and bully. He stole a large number of lead pencils from a store and led another boy into the same trouble. Questioned concerning his offense, at first he states that he intended to buy a pencil for school, then helped himself to a box, but later asserts that another boy stole the box of pencils and gave it to him. No irresistible impulses. He thought at the time that there was nothing wrong in accepting stolen pencils, but thinks differently now. The head is slightly asymetrical, the ears large, the Darwin tubercle prominent, palate high and narrow, with a longitudinal torus.

Case 12. A boy, aged twelve, stole a box of cigars. Was a member of a gang, who he states stole the cigars, but denies any larceny himself. Knows it is wrong to steal. Smokes cigarettes. Slight internal squint of left eye.

Case 13. A boy, aged twelve, in company with another boy,

entered a house and stole a watch and twelve dollars in money. Arrested for "bunking out". He has been a truant several times, smokes cigarettes, reads dime novels and attends cheap variety shows. He says he stole because he needed the money and saw no other means of obtaining it. Knows he has committed a crime. There are no degenerative physical stigmata.

Case 14. A boy, aged fourteen, has had frequent nose-bleeds, and an examination shows the presence of adenoids. He smokes cigarettes and reads dime novels. In company with a gang of boys he stole some cigars from a store. The patient knows it is wrong to steal and is penitent. No degenerative stigmata.

Case 15. A boy of seven, whose father died of tuberculosis, and whose mother is said to be tubercular, for some time has been a persistent truant, attending school only two or three days a week. He is fairly bright, however, and stands well in his studies. There is no mental defect or evidence of epilepsy, the ears are small and have attached lobules, the palate high and narrow. He states that he is tempted by other boys to play truant; usually plays in the street; likes school, and would attend regularly but cannot resist temptation. He has no realization of his offense.

V. *The Imbecility Group.*

Case 16. A boy of sixteen, was a frequent truant at school, and therefore was sent to a corrective institution, where he remained for nine months. At home he would sleep until almost noon; at school he was dull and lazy, and although in one of the lowest grades, yet he was far below the average of his class. Examination showed the head to be small and asymmetrical, the forehead narrow, ears of irregular size, and unequal pupils. He is unable to perform simple problems in arithmetic or to tell the significance of national holidays.

Case 17. A boy of fourteen. The father is sickly, the mother dull and given to ridiculous lying. The patient was arrested for loitering. Mentally he is a pathological liar, is defective and quite stupid in manner. He is in one of the lowest grades in school. No degenerative stigmata, excepting a rather low and broad palate.

Case 18. A boy nine years of age. A brother of the patient in Case 11. He has the appearance of a degenerate imbecile, the speech is thick, the head small and bullet-shaped, the forehead narrow, the ears prominent, the palate low and the palpebral

fissures very narrow, giving him a Mongolian appearance. It is stated that he stole some whiskey. The entire attitude is unintelligent and clownish, and he frequently laughs in a silly manner.

VI. *The Acquired Delinquency Group.*

This title was adopted for want of a better descriptive term, although the patient classified under this heading seems fundamentally to have been morally defective, yet many features of her condition strongly suggest an incipient paranoiac type of dementia praecox. The case is interesting as showing the value of the association tests as devised by Jung, and how a purely psychological conception may be practically utilized for the determination of concealed facts in criminology. When in the midst of the ordinary test words, there are utilized special words pointing to the trend of suspicion, there is immediately a refusal to cooperate, or if an association word is given, there results a marked lengthening of the reaction time (taken with a stop watch to one-fifth of a second). For lack of space, only the most striking associations will be given in the history of the case.

Case 19. The patient is a well-developed girl, seventeen years of age, whose younger brother is the epileptic described in Case 9. The complaint lodged against her was stubbornness. At ten years of age she was delirious for a time, but recovered completely, although there is an obscure history of some "brain trouble." Shortly after puberty, which was established at fifteen, the patient began to show a moral deterioration, associated with evil companions, once ran away with a vaudeville company. She has worked in a number of places, being able to retain a position only a short time. At home she is cross and stubborn, and will frequently remain out until midnight. Occasionally she has outbursts of temper, will strike people and break objects, is very suspicious. Recently there has been a suspicion of sexual irregularities, which the patient absolutely denies. There are no physical degenerative stigmata. The patient is bright and alert, but emotional. She denies all disorderly conduct, but there appears to be a lack of sincerity in her replies. She states that she is maltreated at home, that her mother has hired a detective to follow her about, that once he spoke to her as she was entering a street car. No real hallucinations elicited. Explains her inability to hold positions on the ground that her mother sends people to trouble her while at work. The neighbors confirm the mother's

statement of the bad conduct of the girl, and on account of her manifest untruth and lack of sincerity it was determined to try the association tests, in order to get at the hidden facts of the case. Only a few are given (the normal and abnormal for comparison):

Test Word	Association Word	Reaction Time	Remarks
1. Dark	"Night"	1 second	
2. Hard	"Not bent"	3 seconds	
3. Drink	"Water"	1 second	
4. Bad	"Unconscious"	4 seconds	
5. Lie	"Hasty"	$9\frac{2}{5}$ "	Lengthened Time
6. Street	"Walking"	$6\frac{2}{5}$ "	" "
7. Untruth	"Spoken in haste"	$9\frac{2}{5}$ "	" "
8. Deceit	"To speak against"	$14\frac{3}{5}$ "	" "
9. Vaudeville	"Gayety"	$13\frac{3}{5}$ "	" "
10. Conduct	"Don't know"	$16\frac{2}{5}$ "	Refused to cooperate
11. Sweet	"Candy"	$1\frac{2}{5}$ "	

The lengthened reaction time on the special test words 5, 6, 7, 8, 9, and the refusal to cooperate on test word 10, pointed strongly to concealed facts, and when the patient was directly accused of these matters she broke down and confessed that she had been telling an untruth.

VII. *Post-Traumatic Irritability Group.*

Case 20. A boy of seven, always well until struck on the head by a cobblestone two years ago. No fracture of the skull, but there was a severe scalp wound, which bled profusely. He was not unconscious at the time. Since the injury there have been frequent outbursts of irritability without amnesia. There is no intellectual defect, but in school he is very mischievous, plays truant, and draws peculiar pictures. No evidence of epilepsy and no degenerative stigmata.

VIII. *Organic Dementia Group.*

Case 21. A boy, aged thirteen, was brought to the Juvenile Court for the larceny of fifteen ounces of chocolates from a penny-in-the-slot machine. He is also suspected of having stolen a boat some time previously, but for this there is no direct evidence. In school he is stupid, vicious and delights in sticking pins into other boys. The mother of the patient is stated to be quite dull.

Four years ago he had a left otorrhea followed by a facial paralysis. Since then he has been dull and rather backward in his studies, is drowsy a great deal of the time, and is awakened only with great difficulty. The boy seems defective, has a curious, stolid expression, a thick, protruding under lip. He denies torturing boys, stealing chocolates, or the boat episode. Claims that his parents appropriate his savings. There are frequent dizzy spells and headaches. There is a peripheral left facial paralysis, the hearing is diminished on the left, the right facial muscles frequently twitch. It is futhermore stated that his attacks of prolonged sleep frequently last for four days at a time. In this case we are undoubtedly dealing with an organic brain disease, probably a brain abscess (temporo-sphenoidal lobe), following a middle ear disease, the latter also causing the facial paralysis.

To summarize briefly, we can state that so far as our clinical experience is concerned, many juvenile offenders suffer from severe forms of nervous or mental disease. In many of these, crime is one of the first symptoms of a grave psychic disorder, which usually terminates in dementia. In others, the delinquency is merely one of the features of a masked type of epilepsy. Some of these patients belong to the simple delinquent group, are the victims of a bad heredity and show many somatic symptoms of a so-called degeneracy, apart from any mental or moral defect. In others again there is a severe developmental or congenital disorder, either in the intellectual or ethical spheres, in the one case leading to conditions of simple imbecility or idiocy, in others, to the so-called moral insanity. Finally, there are the accidental delinquents, the result of severe head injuries or of grave types of organic brain disease. From the material here presented, it becomes evident in the light of the rapid development of our juvenile courts, that all young offenders in whom there is any suspicion of a nervous or mental disorder or any signs of degeneracy, should be subjected to an expert medical examination by an alienist or neurologist. It is only in this manner that one of the great factors in the production of juvenile crime, from both the medical and sociological standpoints, can be satisfactorily determined.