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DEFECTIVE DELINQUENCY

A STUDY OF TWENTY-EIGHT CASES COMMITTED TO THE STATE HOSPITAL FOR MENTAL DISEASES, HOWARD, RHODE ISLAND FOR OBSERVATION UNDER THE DEFECTIVE DELINQUENT ACT OF 1947

A Thesis

Submitted by

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(A.B. University of Illinois, 1947)

In Partial Fulfillment of Requirements for
the Degree of Master of Science in Social Service

1949

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CHAPTER I

INTRODUCTION

Society is confronted with a difficult and as yet unresolved problem of handling defective habitual offenders, who, though not fully responsible for acts committed, are yet found to be delinquent, anti-social, and dangerous both to themselves and to the community.

How can society best protect its own interests as well as promote the welfare of the individual involved? Are these individuals legally responsible? Should they be confined in an institution for the feebleminded, or should they serve sentence with other criminals? Should these chronic offenders pass through the existing legal framework of arraignment, trial, sentence, and eventually be released only to repeat similar offenses? Should they be deprived of liberty indefinitely due to danger to themselves and to society? These are some of the questions that naturally arise in consideration of the problem.

The answer has not as yet been found, but the Rhode Island Legislature has attempted a solution by the enactment of the Defective Delinquent Act of 1947, which provides a thirty day observation period at the State Hospital for Mental Diseases for suspected defective delinquents and

creates a Division of Defective Delinquents for the care of those so adjudged. The commitment to the Division of Defective Delinquents is in the nature of an indeterminate sentence, with right of appeal and right of petition for hearing for purposes of discharge. This Division is lodged within the responsibility of the Department of Social Welfare and provides full control and authority over the inmates to the superintendent of the state school for the feebleminded.[1]

The primary purpose of this thesis is to evaluate the adequacy of the above law and its use, administration and interpretation in coping with the social problem of defective delinquency. A further purpose of this study is to examine critically the background, developmental factors and personalities, in order to gain a better understanding of the community's concept of defective delinquency. It should be pointed out that cases committed to the hospital by the courts are not definitely labeled defective delinquents, but represent at least a questionable status requiring further observation. The courts wisely recognize their limitations and request clinical study of the offenders in order to determine their psychiatric and legal status. It would be interesting and of value to pursue an etiological quest into the origin of defective delinquency, but it is beyond the extent of this

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1. Rhode Island, Public Laws of 1947, Ch. 1852 (See Appendix A)

study. This aspect of the study can be considered as a descriptive picture of the defective delinquents committed for observation.

The scope of the thesis includes all admittances to the State Hospital for Mental Diseases of cases committed under the above Defective Delinquent Act for a thirty day observation period. The writer has selected an eighteen month period since the inception of the law, namely, from May 1947 through October 1948, as it is believed that this period selected demonstrates the development of the use of the concept of defective delinquency by the courts and society through growing familiarity in its use. As the study is concerned with all admittances over a year and one-half span, it is felt that the overall scope is of sufficient length to point out the value and use of the law in meeting the problem.

The information used has been compiled for the greater part from the records of the State Hospital for Mental Diseases. As each case was intensively studied during the observation of the subjects, the records obtained of hospital adjustment were fairly complete. Shortly after admission each patient was given a thorough physical examination, including blood serology, urinalysis, dental examination, and X-ray if deemed necessary. In addition each patient received a mental status examination, Wechsler-Bellevue adult intelligence test, as well as frequent psychotherapeutic interviews with a ward physician.

Nurses' daily ward notes of patients' adjustment are closely kept during the month and are included in patients' records.

Since not only present adjustive behavior but developmental history as well is considered important, effort was made to secure as full background material as possible for the hospital's better understanding of the cases before returning a recommendation to the court. Besides psychiatric history taken on each case, abstracts are requested and received from other agencies in the community. These frequently include such state agencies as the state's children's division, school for feebleminded, training schools for boys and girls, reformatories and prison. Abstracts from private agencies include the child guidance clinic, private foster home placement agencies, the family service society, a school for problem children and others.

Many of these patients have been problems to social agencies since early childhood; hence, a wealth of background material has been accumulated. The information received is considered valid as the abstracts received (which often duplicate periods in the subjects' lives) have but slight discrepancies in minor details.

A schedule has been devised to facilitate the selection of pertinent material. (See Appendix B.) This material is compared and analyzed with emphasis on descriptive background, common aspects, and significant relationships. It is the

intention of the writer that this aspect will describe the cases of Defective Delinquent Commitments as a group. There may be some etiological significance in the material presented, but the primary purpose is descriptive. Selected cases will be more thoroughly discussed in terms of the main purpose of determining the degree of effectiveness of the law in meeting this social problem.

CHAPTER II

SURVEY OF LITERATURE

A thorough review of literature pertinent to the subject of defective delinquency is manifestly impossible to cover adequately in this report, for it would take one deep into the fields of mental deficiency, psychopathy and psychosis, as well as into the socio-legal aspects of delinquency and criminology. The following review is presented to show the general development of our present thinking in regard to the care of persons we term "defective delinquents."

Human behavior can be judged from various points of view, which often include the following interpretations: moralistic (good or bad) ; psychiatric (normal or abnormal) ; legalistic (law-abiding or criminal).[1] From these points of view the criteria of what satisfactory adjustment consists of is variously conceived. Thus, in the judgment, care and treatment of defective delinquents much confusion exists. Properly, no one aspect alone should be considered sufficient, but rather a wise blending of points of view should be attempted.

A definition of a defective delinquent may be simply stated as a "feebleminded person in whom anti-social and criminal tendencies are found to be so deep-seated as to

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1. J. McV. Hunt, editor, Personality and the Behavior Disorders, Vol. II, p. 794.

require care and treatment quite distinct from that of the usual mental deficiency institution."[2] The Philadelphia Juvenile Court defines a defective delinquent as "one who is mentally defective, a chronic delinquent, lacking ability to conform and who will be difficult to control even in an institution."[3] It has been more narrowly defined as "delinquent individuals who on the basis of intelligence and performance tests fall into the group with intelligence levels below seventy."[4] The criteria established for determining defective delinquency are usually evidence of existence of habitual delinquency and sub-normal mentality in a particular subject.

However, since the concepts and criteria of determining mental deficiency are changing, the problem becomes more complicated. Also, the relation of mentality to delinquency, which seemed so clearly delineated a few years ago, appears now to have changed.

Historically, mental deficiency and criminality have been linked together. It was felt that feebleminded persons were unable to resist adverse influences. For example, the British Royal Commission in its report in 1908 stated that,

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2. Stanley P. Davies, Social Control of the Mentally Deficient, p. 132.

3. Louis A. Lurie, and others, "The Defective Delinquent" American Journal of Orthopsychiatry, 14:95, January 1944.

4. Groves Smith, "Defective Delinquents and the Problem of Personality Deviation in Relation to Crime", American Journal of Mental Deficiency, 52:54, July 1947.

> The evidence points unmistakably to the fact that mentally defective children often have immoral tendencies; that they are greatly lacking in self control, and moreover are peculiarly open to suggestion so that they are at the mercy of bad companions. [5]

The relation of mental deficiency to crime was given great emphasis in 1910 by Goddard, who, using the early Binet-Simon intelligence test, found very high correlation between feeble-mindedness and delinquency. Material was brought forth by Goddard and others which demonstrated that up to 90% of the conduct disorders were a result of mental retardation.

But further studies demonstrated the influence of other factors; such as, unstable home conditions and low economic and social status. Glueck, in a study of a group of delinquent boys, pointed out that 60% of them had marked emotional difficulties, varying from severe normal disturbances to psychopathic disorders and borderline psychoses. [6] William Healy stressed the importance of underlying conflicts and tensions rather than simple retardation as causing delinquent behavior. [7] In his interpretation delinquent behavior was frequently an overt expression or mode of dealing with internal conflict.

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5. Davies, op. cit., 79.

6. Sheldon and Eleanor T. Glueck, One Thousand Juvenile Delinquents, p.109.

7. William Healy, Mental Conflict and Misconduct, p.330.

The early results of Goddard's comparison were challenged some years later following the Army experience with intelligence tests which ostensibly showed the low intelligence level of the American population, but actually revealed the need for greater standardization of tests. In 1939 Tulchin, using the same tests, found that the inmates of an Illinois state prison had very similar intelligence (even slightly superior) to that of the earlier Illinois draft army.[8]

The use of later and more carefully devised intelligence tests have confirmed Tulchin's results. For example, the use of the Wechsler-Bellevue intelligence test demonstrates that the range of intelligence of prison inmates was similar to the general population.[9]

Though it is difficult to estimate the number of mental defectives in this country, it is generally agreed that the number varies from one to two per cent of the general population. In 1945 it was estimated by a research statistical project that, of the total number of feeble-minded persons in Rhode Island both within institutions and in the community, (one to two per cent of general population) only 7% of them could be considered as delinquent or defective in social adjustment.[10] Hence, in actual numbers the problem of

8. Hunt, op. cit., p. 806-7.

9. David G. Schmidt, "Levels of Intelligence of Prison Inmates," American Journal of Mental Deficiency, 51:63-66, July 1946.

10. R.R. Willoughby, "Rhode Island's Experiment in Registration," American Journal of Mental Deficiency, 50:121-125, July 1945.

intellectually deficient delinquents does exist, but in terms of percentages it is not a notable one.

Conceptions of mental deficiency have been changing, also. The emphasis of the importance of an intelligence score which arbitrarily places a person in a normal or subnormal status has slowly changed to one of degree of, or capacity for, social, economic adjustment in which specific intelligence rating is but one factor. There are many feeble-minded persons, as rated by intelligence scores, who are able to adjust successfully in the community.

Strict intelligence quotient classification alone is no longer satisfactory. New findings in psychology, as Wechsler Bellevue adult intelligence scale and Vineland's Adjustment Scale, give new insight into intelligence and social adaptability. According to David Wechsler,

> There are at least two and probably three types of mental deficiency. The first is the intellectual defective, diagnosable as such by the usual psychometric tests; the second, the social defective for whom the life history of the individual is the most satisfactory criterion; and third - the emotional or 'moral' defective whose precise definition is extremely difficult to give, but whose existence, to anyone who has had any first hand experience at a large clinic, is an observable reality. Between all three there is usually a certain degree of correlation, but this correlation is not sufficiently high to make any one an unfailing diagnostic indicator of the other. [11]

Such a discussion as the above brings one deep into the unsettled field of psychopathology. The clinical problem of

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11. David Wechsler: As quoted by:
Anna Shotwell, "A Study of Psychopathic Delinquents." p. 60
American Journal of Mental Deficiency, 51:60, July 1946.

the psychopathic personality has been a most difficult one due to the vagueness of distinguishing diagnostic critera. Some question its use as a clinical diagnosis. Paul Preu writes:

> The conclusion seems warranted that psychopathic personality is not a recognizable entity in the descriptive behavioral sense. The psychopathic group includes an indefinite number of poorly delineated problems of personality development and adjustment which do not happen to fit conveniently into the accepted rigid system of psychiatric diagnosis. [12]

Earlier such types have been variously called "moral defectives," "moral imbeciles," "constitutional psychopathic inferiors," etc., all of which tends to accentuate the vagueness of the concept.

Yet, this term, psychopathic personality, has definite clinical and legal use, and in the passing of time and accumulation of experience greater refinement in its use has been accomplished. Some feel that the current clinical use of the term, psychopathic personality, has already been validated, and may be used with prognostic value. [13]

Henderson, who has devoted much time and study to the problem, has defined psychopathic states sufficiently clear to make it readily apparent that it excludes habitual offenders of a willful nature, who show no other evidence of long-standing

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12. Hunt, op. cit., p. 928

13. Robert B. Van Vorst, "An Evaluation of the Institutional Adjustments of the Psychopathic Offender," American Journal of Orthopsychiatry, 14:493, July 1944.

personality disorder.

> ... The term psychopathic state is the name we apply to those individuals who conform to a certain intellectual standard, sometimes high, sometimes approaching the realm of defect but yet not amounting to it, who throughout their lives, or from a comparatively early age, have exhibited disorders of conduct of an anti-social or asocial nature, usually of a recurrent or episodic type, which, in many instances, have proved difficult to influence by methods of social, penal and medical care and treatment and for whom we have no adequate provision of a preventative or curative nature. The inadequacy or deviation or failure to adjust to ordinary social life is not a mere willfulness or badness which can be threatened or thrashed out of the individual so involved, but constitutes a true illness for which we have no specific explanation. [14]

The State Hospital staff realizes the need to demarcate clearly the patients which come within the above classification, and have been guided by the definition of psychopathic personality prepared by the Committee on Statistics of the American Psychiatric Association.

> Psychopathic personalities are characterized largely by emotional immaturity or childishness with marked defects of judgment and without evidence of learning by experience. They are prone to impulsive reactions without consideration of others and to emotional instability with rapid swings from elation to depression, often apparently for trivial causes. Special features in individual psychopaths are prominent criminal traits, moral deficiency, vagabondage and sexual perversions. Intelligence as shown by standard intelligence tests may be normal or superior, but on the other hand, not infrequently, a borderline intelligence may be present. [15]

The above presentation has attempted to point out that defective delinquency, rather than being a simple classification of determining mental status and degree of delinquency

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14. D. K. Henderson, Psychopathic States, p.18.

15. New York State Department of Mental Hygiene, Statistical Guide (Eleventh Edition, 1934).

has become a complicated, and as yet not clearly settled matter of distinguishing those offenders who are emotionally or intellectually unable to assume full responsibility for their actions. Emotional defect appears to be deeply involved in the problem of defective delinquency. For this reason it was necessary to include in the above a very brief discussion of psychopathic personality.

CHAPTER III

BACKGROUND OF LEGAL PROVISIONS FOR DEFECTIVE DELINQUENTS

A. DEVELOPMENT OF LEGISLATION IN THE UNITED STATES

The first law regarding defective delinquents was originated in Massachusetts by Dr. Fernald as early as 1911. It represented an attempt to "relieve the State schools for mental defectives of the disproportionate burden of their most incorrigible and disturbing elements and to remove definite defectives from prisons by providing a special place for custody of this type." [1] Provisions were made for commitments of defective delinquents by courts for indeterminate sentence.

However, the law did not take effect, and ten years later the problem of care for such offenders had not lessened.

> It is most unfortunate that this criminal type of defective, generally of such mental age that they seem like normal people to the ordinary observer, should complicate the care and training of the ordinary defective without criminal habits or propensities. They have a very bad influence on the ordinary defective who constitutes the legitimate problem of a school for feeble-minded. [2]

In 1922 a division for male defective delinquents was established at Bridgewater, Massachusetts which was followed by an additional division for female defective delinquents in 1926. Admission ages were from seventeen to twenty-five years

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1. Davies, op. cit., p.134

2. Ibid., p.134
(From Annual Report, Mass. State School for Feeble-minded, Waltham, 1921, p.18).

and a maximum intelligence quotient of seventy-five was allowed. In 1928 there were 228 male and eighty female defective delinquents in these separate institutions. The state institution for the feeble-minded immediately felt great relief. Also, a definite increase in efficiency as well as better morale was obtained within the institution.

The State of New York was having similar difficulty with handling defective delinquents in institutions for the feeble-minded and in 1921 created at Napanoch the first separate institution for defective delinquents in the United States. At this time it was intended only for males over sixteen years of age. Features of both prison and institutions for the feeble-minded were retained, as cell blocks for maximum security as well as dormitory provisions for other more easily handled offenders. As early as 1928 a psychiatrist and social worker were added to the staff.[3]

Briefly, in New York all defective delinquents are committed for life. The state recognizes the existence of a defect in personalities of defective delinquents such that they may never be returned safely to the community and therefore, the state sanctions lifelong custody. However, parole under continual supervision is allowed. With a subject who has been given a definite prison sentence, parole is not allowable until such sentence shall have expired. It is their plan,

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3. Ibid., p.139.

through an active program of training, to release as many inmates as possible on parole status. This status is never removed, and inmates are allowed in the community only if behavior is satisfactory. In this state, reformatories as well as schools for the feeble-minded were relieved following the creation of this separate institution for defective delinquents.

Virginia was another state to meet early the problem of defective delinquents by creating the State Farm for Defective Misdemeanants in 1926. This state tended to take a broad interpretation of the term, 'defective misdemeanant' by including other than strictly mentally defective offenders; such as, drug addicts, alcoholics, psychopaths and others. It was recognized here that the disturbance was not primarily the function of low intelligence, but rather a severe disturbance of the total personality development. According to a mental hygiene report (1941),[4] this state was planning to establish a prison farm for psychopathic misdemeanants.

In 1946 a questionnaire was sent to the various state institutions concerning the provisions made for the care of defective delinquents in the respective states. Two states had separate institutions for the defective delinquents of both sexes, and two states had separate institutions for male defective delinquents only, one of which was a separate

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4 Frances Ballard and Raymond Fuller, Mental Hygiene Laws in Brief, p. 314.

institution while the other was an annex of a men's reformatory. Three states housed defective delinquents with the criminally insane in state mental hospitals. Four states provided no special facilities for mental defectives, except in mental hospitals. Three states did not reply. Six states at the time of the above report (1946-47) had either bills in legislation or specific plans for the care of defective delinquents.

In the rest of the states defective delinquents were cared for in the state institutions for the feeble-minded. Of these, only one used a cottage of maximum security; a few had locked or segregated cottages; but in most states there was no segregation of defective delinquents from the general population of schools for the feeble-minded.

Yet, the state school for the feeble-minded is planned for non-delinquent defectives. The average inmate is tractable, docile, and easily guided, but is most easily influenced and misled. The delinquent sets a poor example of behavior for defectives with whom he associates and frequently is the chief instigator of trouble. Many schools do not make serious attempts to locate such an inmate when once escaped. Although temporarily solving the problem for the school, the larger problem of an unchecked defective delinquent in society remains. [5]

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5 Arthur W. Pense, "The Problem of the Male Defective Delinquent in the State School," American Journal of Mental Deficiency, 47:472, April 1943.

Several other states, though not coming early on the scene, have passed laws, or are in the stage of more adequate planning for defective delinquents. It is important to note briefly, methods developed by these states in meeting the problem of adequately providing for defective delinquents. Most of the material used has been taken from Mental Hygiene Laws in Brief. [6]

Connecticut plans for the separate establishment of an institution for the male defective delinquent and male vicious feeble-minded, as well as a separate department for similar female offenders. In this state plans have been made for an observation commitment of six months, provision for transfer of defective delinquents from reformatories and institutions for the feeble-minded, and the provision for a conditional release of such a subject from the institution for a one year period by the superintendent of the reformatory.

Illinois uses the following definition:

> All persons suffering from mental disorder, and not insane or feeble-minded, which mental disorder has existed for a period of not less than one year, coupled with criminal propensities toward the commission of sex offenses are declared to be criminal sexual psychopathic persons. [7]

Following examination and certification by two psychiatrists such an offender is sent to the state penitentiary or the state security hospital. When recovered of 'psychopathy'

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6. Ballard, op. cit.

7. Ibid. p.74. (From Illinois Laws, First Special Session, p. 28).

the subject is returned to court for trial; otherwise continuous care and supervision is maintained by the state department of public welfare.

The State of Michigan sentences sex offenders to prison. Following expiration of his term, such an offender is re-examined, and if found to be "psychopathic or a sex degenerate and a menace to public safety" (though not insane, feeble-minded, or epileptic) is held with the criminally insane at the state hospital until adjudged "no longer a public menace."[8]

In 1944, a report concerning the establishment of facilities for the care of defective delinquents in Pennsylvania recommended four separate state controlled institutions for defective delinquents with a total capacity of one thousand patients for men, boys, women, and girls, the dividing age being fifteen years. An alternate proposal was to have one large institution (one thousand population) for the above four classes. A notable feature in this recommendation was the inclusion of psychoneurotic and psychopathic states in which the offender had an intelligence quotient of over eighty but was seriously disturbed emotionally.[9]

As early as 1919 California recognized the need for some program to care for defective delinquents and attempted to

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8. Ibid. p.143

9. J.O. Reineman, "The Problem of the Feeble-minded and the Defective Delinquent Child in Philadelphia", American Journal of Mental Deficiency, 49:488-497, April 1945

legislate the creation of separate institutions. However, the bill was vetoed (due to lack of funds), and it was not until two decades later that the director of institutions was empowered to use existing institutions for the care of defective and psychopathic delinquents. In 1945 a separate maximum security institution was created for defective and psychopathic delinquents which can adequately care for 2500 persons. The above institution filled a long awaited need, as California has been burdened by many psychopathic and defective delinquents due to a large influx of this type from all over the United States.

This state defines a defective or psychopathic delinquent as follows:

> As used in this Chapter 'defective or psychopathic delinquent' means any minor who is mentally deficient or psychopathic and who is an habitual delinquent or has tendencies toward becoming an habitual delinquent, if his delinquency is such as to constitute him a menace to the health, person, or property of himself or of any other person, and the minor is not a proper subject for commitment to a State correctional school, to a State home for the feebleminded as a feeble-minded person, or to a State hospital as an insane person or as a person addicted to the intemperate use of alcoholic beverages or narcotics or stimulant drugs. 10

A minor in the above law is interpreted to mean any person below the age of twenty-one. However, tentative plans have been made to expand facilities to give institutional care to those defective and psychopathic delinquents beyond this age.

10. Welfare and Institutions Code, State of California, Sacremento. 1943, p.220.

At the present, a suspected defective delinquent is committed for a ninety day observation period. If certified as such, the subject is committed for an indeterminate period at the discretion of the institution. Parole is given to some subjects which is continued for at least five years. By March of 1948 a total of 390 cases had been committed for observation and indeterminate sentences. They ranged in ages from seven to twenty years, and in intelligence from high imbecile to above normal.

This state has made admirable progress in adequately handling the emotionally and intellectually blocked offenders. Plans are made to extend the age limits, improve the training and intensive supervision given to these offenders, and to develop more adequate facilities. There is much room for growth. The modern viewpoint of psychiatrically oriented care is well put by one of their psychiatrists.

> The defective and psychopathic delinquent are certainly entitled to general psychiatric treatment rather than penal, for while those in the upper brackets mentally know right from wrong, their instability is such that they cannot properly control themselves. Hence they are in need of special psychiatric assistance by specially trained psychiatrists, psychologist, psychiatric nurses and attendants and lastly by psychiatric social workers who willbe looking after their welfare after they leave the State institutions. 11

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11. Fred O. Butler, "California's Legal Approach and Progress in the Rehabilitation of the Defective and Psychopathic Delinquent." American Journal of Mental Deficiency, 52:79, July 1948.

CHAPTER III

BACKGROUND OF LEGAL PROVISIONS FOR DEFECTIVE DELINQUENTS

B. DEVELOPMENT OF RHODE ISLAND LEGISLATION

"There is no problem of law more difficult than the right of society to incarcerate the mentally sick or the mentally deficient." [1] Particularly is this true in reference to a small, but dangerous group of defectives who have pronounced criminal trends. Though comparatively few in number, their threatening acts have caused concern to all.

The methods of coping with them have varied widely and have not been well integrated. These offenders have been committed to the various training schools, reformatories, and State school for the feeble-minded to little avail. For the most part these defectives have been committed to Exeter School (State school for the feeble-minded). Yet they have been able to escape at will, for the School lacks provisions for even medium security; its function is social education and training.

This lack has been recognized by the community, as it may be noted from the following newspaper editorial:

> More than once in the last decade or more the need has been emphasized for the creation of facilities in connection with Exeter where such persons (defective delinquents) could be kept in custody without escape.

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1. Providence Journal, editorial, April 7, 1945.

> The General Assembly has never provided facilities. Neither has it ever authorized the detention of these persons elsewhere... as a result there has been no protection against the possible depredations by feeble-minded delinquents." [2]

In 1939 the Administrator of the Division of Probation and Parole, realizing the Exeter School was an institution of neither "maximum" nor "medium" security, petitioned the Department of Social Welfare for adequate measures to prevent escape of defectives and urged separation of delinquent defectives from non-delinquent defectives. He suggested use of one of the existing buildings at Exeter as security housing for defective delinquents or an alternate course of confinement at the Rhode Island Training School for Boys. The following year he recommended utilizing one-half of the then new Men's Reformatory for defective delinquents.

The problem was not investigated, however, until October 1942 when state wide attention was drawn to the matter. Within two months following discharge after sentence from the Providence County Jail, a 'defective delinquent' maliciously set fire to Infantry Hall and Holy Rosary Church, causing property damage estimated as worth one-half million dollars. Immediately the governor ordered an intensive investigation of the case of Donald Bennett to determine how the problem had been handled by the Department of Social Welfare. The

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2. Providence Journal, April 6, 1945.

following facts were obtained through the investigation:

> Donald Bennett was born in 1919 of a feeble-minded mother, considered irresponsible, who divorced the boy's father at the time of the boy's birth. At the age of two, Donald's mother was remarried to a sadistic man who abused and beat Donald and his mother. Three years later the step-father murdered Donald's mother with an axe, and Donald lived with his maternal grandmother until the age of fourteen, at which time he was committed to Exeter School because of social inadequacy and mental deficiency.
>
> During the four years that he remained at Exeter School he escaped twelve times, being brought back each time. At the age of eighteen, while on escape, he was convicted of breaking, entering, and larceny and sentenced to one year at the Reformatory for Men. After six months of freedom he was recommitted to Exeter School and during the following year escaped three times. At this time he was faced with two charges of breaking, entering and larceny and was sentenced to two years at Providence County Jail. He served full time and at the age of twenty-two was released with no supervision. A year later he served a fifteen day sentence for disorderliness, and within two months following discharge set fire to the church and hall.

The governor's commission revealed lack of integration and cooperation in the institutional programs in the Department of Social Welfare. It also demonstrated that, under the existing facilities, it was impossible to detain defective delinquents at Exeter School. Reformatories and jail had no provision for the after-care or supervision of those prisoners who had served their full terms. (Bennett had never been paroled as he had been considered a poor risk.)

The commission recommended such changes in the statutes as would provide for permanent and secure institutional treatment for such defective delinquents for the rest of their

natural lives, if necessary. The existing law provided only for the hospitalization of the criminally insane. The following revision was offered in the majority report:

> A person may be said to be "insane" when, on account of mental disease or mental defect, he is a source of danger to himself or to others and needs care, treatment and restraint.
>
> If, during the trial in the Superior Court of a person charged with crime, the trial justice is of the opinion that the defendant committed the offense but is not criminally responsible because of mental defect, said trial justice may, after hearing all of the testimony including that of mental experts, instruct the jury to return a verdict of not guilty on account of mental deficiency, and the trail justice may, notwithstanding said verdict, commit the defendant to the State Hospital for Mental Diseases, there to be detained until discharged or paroled from said State Hospital, upon the recommendation of the superintendent of said Hospital or his duly appointed assistant, if and when such a recommendation is concurred in by a majority of the medical staff of said Hospital then serving, and by the judge who presided at the trial. [3]

However, no legal action was taken. In 1944 the Director of the Department of Social Welfare attempted to accomplish by executive order what the legislature had failed to do itself or specifically authorize him to do. He proposed transfer of the defective delinquents at Exeter School to the Reformatory for Men in order to prevent escape. The following year, when the Director used his authority to commit a subject to the Reformatory for Men as a defective delinquent, legal action was taken by the parents of the subject. After a hearing of the case it was determined that the subject was

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3. Report of State Commission on Public Welfare Institutions, December, 1943, Pp. 29-30.

illegally held, and following a three week psychiatric observation the subject was remanded to Exeter School.

Whereas formerly the public felt incensed that no suitable provisions were made for the incarceration of dangerous individuals for the protection of society, now the public seemed concerned that a man's liberty was deprived without due process of law. A newspaper editorial decried this arbitrary use of power as an individual act wholly outside the sanction of law. No one should be able to transfer a patient not under sentence to a penal instituiton to be subjected to the circumstances of a criminal sentence and for an indeterminate period, perhaps for life. It was recognized that the motive of protecting the public was worthy, but the procedures used were "indefensible." [4]

Although ostensibly a defeat, this incident served to keep before the public the great need for some adequate legal provisions for this type of offender. That same year the formulation of a bill was discussed. The following year, 1946, a bill was introduced in the State legislature providing for defective delinquents, but was unsuccessful.

On April 18, 1947, a similar act was introduced and passed. This act sets up the Division of Defective Delinquents within the Department of Social Welfare and provides authority for the Director to establish within any existing institution a unit as a suitable, secure place for the offenders found to

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4. The Providence Journal, editorial, April 7, 1945.

be defective and habitual delinquents. The complete act is given in Appendix A of this report.

CHAPTER IV

A DESCRIPTIVE STUDY OF TWENTY-EIGHT DEFECTIVE DELINQUENT COMMITMENTS

In this study all cases admitted for the first eighteen months since the inception of the law are included. They demonstrate the development of community and legalistic thinking as to what constitutes a defective delinquent. Each of the twenty-eight cases committed from the various courts was a suspected defective delinquent and was to be intensively studied at the State Hospital. Of the total group studied, only four were female offenders. A general descriptive study will be made of the total group, including family background, home background, and general development. (Refer to Appendix B for schedule used in obtaining information.)

Regarding parental background it was found that the majority of the cases (53.6%) came from families in which both parents were foreign born. Of this group, fourteen parents (46.6%) were Italian, twelve parents (40%) were French-Canadians, and four parents (13.3%) were Portuguese. In addition four cases (14.3%) came from families in which one parent was foreign born. Thus, more than two-thirds of the total group studied had at least one parent born in a foreign country.

TABLE I.

NATIVITY OF PARENTS OF TWENTY-EIGHT PATIENTS

Nativity	No.	Per cent
Both parents foreign born	15	53.57
Both parents native born	8	28.57
One parent foreign born	4	14.29
Unknown	1	3.57
Total	28	100.00

Rhode Island has a somewhat high admixture of foreign born in its population, but it is not proportionate to this ratio. According to the U.S. Bureau of Census, 1940, the population of Rhode Island was composed of 79.1% native born, 19.3% foreign born white, and 1.6% Negroes and others. Thus, the ratio of foreign born parents in this group is significantly higher than that of the general population. The difficult problems facing second generation children, caught in the clash of cultures between the Old World and the New, are well known to sociologists and several studies concerning this have been made. This factor may be operative in the pathological development of these cases.

Classification by religion of the cases reveals twenty-two cases (78.5%) to be Roman Catholics, five cases (17.8%) to be Protestant, and one case (3.5%) to be undetermined. This

indicates the group to be predominantly Roman Catholic, which may partially be explained by national origin of the parents. However, the proportion of Roman Catholics to other religious faiths as found in this study is larger than that found in the general distribution of population according to religion in Rhode Island.

TABLE II
NATURE OF EARLY HOME BACKGROUND
FROM BIRTH THROUGH AGE FIFTEEN

Type of Home		No.	Per cent
Adequate Home: (Lived with both parents)		9	32.14
Broken Home: (Lived with one parent)		6	21.43
	Divorced (2)		
	Death (4)		
Unbroken Inadequate Home:		8	28.57
Mother inadequate	(1)		
Father inadequate	(5)		
Both inadequate	(2)		
No Home:		5	17.86
Only institutional	(4)		
Only foster homes	(1)		
	Total	28	100.00

Included in the above "adequate home" group were minor disharmonies; such as, nervous, solicitous parents, parents who were both employed, and one parent who had formerly been a patient at the State Hospital. Yet none of the above can be

considered as definite criteria of inadequacy. The home is considered adequate in this paper if the parents had lived together with no reports of outstanding uncongeniality or neglect. An inadequate parent is so considered if he or she grossly neglected the children or physically abused members of the family.

The importance of security and love as found in a "normal" home cannot be overvalued in the development of a healthy personality. Yet over two-thirds of the above cases were deprived of adequate homes, only one-seventh of which could be directly attributed to the death of one parent.

The families from which the subjects have come have tended to be quite large. The average number of siblings per family is 5.8 members, which is considerably higher than the national average. In two of the three cases of two sibling families, the other sibling was illegitimate and practically unknown to the patient. In the remaining case, the patient, separated from her family at birth, also had no contact with the sibling. Of the total group there were sixteen step-siblings. These have been included in Table III. Two of the step-siblings were illegitimate and not part of the family as mentioned above, the remaining fourteen step-siblings were members in four families.

TABLE III

NUMBER OF SIBLINGS PER FAMILY

No. of Siblings	No. of Cases	Per cent
Only child	1	3.57
2	3	10.71
3	4	14.29
4	4	14.29
5	2	7.14
6	4	14.29
7	1	3.57
8	3	10.71
9	3	10.71
Over 9	3	10.71
Total	28	99.99

It is commonly believed in some quarters that the eldest child and the youngest child in the family have particularly difficult trials of adjustment. Of the twenty-eight cases studied only one was the eldest sibling and eight were the youngest siblings of their families, and in but one case was the patient an only child.

The case histories regarding sibling adjustment were sketchy. In eight of the cases there was no sibling relationship because of separation by placing in foster homes or

institutions, or having no sibling. In four cases there was no mention of sibling relationship. Of the remaining sixteen cases, three had adverse sibling relationships, eleven had fair, and two had good sibling relationships.

It is of significance that a fair percentage of the group had a long institutional life during their formative years, as evidenced by the following table:

TABLE IV.

LENGTH OF ACTUAL INSTITUTIONAL LIFE

Time Span-Yrs.	No.	Per cent
None	8	28.57
Less than 1	2	7.14
1 - 5	12	42.86
6 - 10	1	3.57
11 - 15	3	10.71
16 - 20	2	7.14
Total	28	99.99

The length of stay in institutions represents only actual institutional living. This naturally excludes periods while under the responsibility of an institution, but released on trial visit, foster home placement, parole, etc. From this table it can be seen that over half the group, fifteen cases (53.57%), lived in institutions up to ten years of age. Five

cases (17.86%) lived eleven years or longer in institutional settings. Of this latter group the average length of stay was fourteen and one-half years. The mean age of this latter group of five cases upon admittance was 23.4 years. Sixty percent of the above group spent over three-quarters of their lives in institutions up to the time of their admittance to the State Hospital.

TABLE V

AGE AT ONSET OF BEHAVIOR PROBLEMS

Period of Life	Age Range	No.	Per cent
Infancy	Up to 2	5	17.86
Pre-school	3 - 6	2	7.14
Early school	7 - 10	3	10.71
Later school	11 - 14	4	14.29
Adolescence	15 - 18	3	10.71
Early Adulthood	19 - 22	2	7.14
Adulthood	23 and over	3	10.71
No problem		6	21.43
	Total	28	99.99

The largest single group of those developing behavior problems occurred during the period from birth through two years of age. However, the above table shows that the behavior disorders are fairly evenly distributed through each of the developmental periods of life, indicating that there is

no distinct period when a person is apt to become a problem. The table does tend to show early beginnings of behavior problems. One half of the entire group, which includes first offenders, developed into behavior problems prior to commitment and before the age of fifteen. Yet the mean age of the group at the time of admittance was twenty-five and one-half years. (See Table IX.)

An examination of the educational achievements of this group shows that 75% of the group reached fourth grade or higher. Over two-thirds of the total group ranged between grades four and nine. The over-all average of scholastic achievement was slightly above the sixth grade level.

TABLE VI

EDUCATIONAL ACHIEVEMENT

Grade Obtained	No.	Per cent
Ungraded to 3	7	25.
4 - 6	10	35.71
7 - 9	9	32.14
10 and above	2	7.14
Total	28	99.99

Few defectives of moron level attain higher than the fourth grade in school achievement. The commitments taken as a group demonstrate that scholastically the problem presented is not primarily one of mental defect. Included in

the above are a fair number of cases in which poor motivation and personal problems may account for retarded school achievements, However, taken as a group, they can be considered as retarded though not deficient. There were only two cases (7.14%) of patients who reached tenth grade or above.

The intelligence quotient is an arbitrary rating and may sometimes be applied too rigidly. Although not always an accurate measure of capacity to adjust to environment, it does give a fair indication. Especially is this true in the Wechsler-Bellevue scale which gives equal emphasis to performance and verbal ability. The test results showed four times as many cases had higher performance scores than verbal scores. In one case the difference was as much as thirty-nine points, which significantly raised the combined intelligence rating by eighteen points. The scores obtained have in general tended to be definitely higher than results of former tests of the patients.

A large proportion of these cases, having been known formerly to various social agencies and institutions, have received a number of intelligence ratings which varied to a considerable degree. For this reason, in estimating the range of intelligence of the subjects, the scores used are only those obtained on the Wechsler-Bellevue adult intelligence measurement scale during the month of observation at the State Hospital. It is felt that since these scores are

all obtained under the same testing situation, they are more accurate and related. Also, the test used is considered to be a reliable indicator of intelligence level, as well as a fair indicator of certain trends in patterns of adjustment.

TABLE VII

RANGE OF INTELLIGENCE SCORES

Classification	I. Q. Range	No.	Per cent
Feeble-minded	Below 70	2	7.14
Borderline	70 - 79	9	32.14
Dull Normal	80 - 89	6	21.43
Low Normal	90 - 99	5	17.86
High Normal	100 - 109	3	10.71
Superior	110 - 119	3	10.71
Total		28	99.99

The above table indicates that the intelligence level of the majority of the group (53.5%) lies between the borderline and the dull normal classification and that only 7% as judged by current standards can be considered as mentally defective. It does seem a strange anomaly that of this whole group presumed by the general community to be mentally defective, only a minor percentage can be thus strictly classified according to test results. On the basis of pure test scores without reference to social adjustment, which is a somewhat

unrealistic appraisal, only two could be technically classified as feebleminded.

Yet one can see that the group as a whole is somewhat retarded. Scores of ninety to 110 are usually accepted as "normal" from which further deviations are measured. The study of the group revealed that the scores of seventeen cases (60.7%) fell below the normal range of intelligence, and that the scores of only three cases (10.7%) were above this range. Also, if a normal distribution curve was obtained, one could expect to find an equal representation in the dull normal and superior groupings. The above table indicates that in the testing of this group, twice as many cases were classified in the dull normal range as in the superior. The mean score of intelligence quotients of the entire group studied is slightly above eighty-six or dull normal level. Considering that all of these cases were presumed to be of defective intelligence, the general intelligence level is high.

The statistical diagnostic classification of the group is one of the most illuminating in describing the type of group thought to be defective delinquent. Acknowledgedly, personalities do not exist in types but merge gradually from normality into disorder, or from one disorder, or combination, into others. Yet for statistical and practical purposes it is necessary for the hospital staff to diagnose as accurately and clearly as possible the proper classification for each

patient. Because of accumulated experience and skill obtained on the part of the clinical examiners, it may be considered that the classification listed in the following table is justly representative of the disorders of the patients.

TABLE VIII

CLASSIFICATION OF PATIENTS BY DIAGNOSES

Diagnoses	No.	Per cent
Psychopathic Personality	16	57.14
Mental Disorder	4	14.29
Mental Deficiency	3	10.71
Without Disorder	2	7.14
Mixed: (Psychopathic Personality with Mental Disorder)	1	3.57
Psychoneurosis	1	3.57
Organic Personality Disorder	1	3.57
Total	28	99.99

The above table lists the diagnoses according to the major disorder of each patient. In several cases, there was a combination of factors, ie., mental disorder linked with mental defect, but to avoid duplication only the major disturbance was listed. The one exception was a case in which the dominance of the factors concerned was in question.

One would expect a large number of mental defectives in this grouping, so that it is quite revealing that in only three cases (10.7%) was the chief difficulty found to be mental deficiency. Also, two of these three cases officially classified as defective, were of borderline intelligence. The table shows that numerically mental disorder was a more frequent diagnosis than mental deficiency. The most significant finding, however, is that of the presumed defective delinquents, the majority (57.14%) were diagnosed as psychopathic personalities.

The average intelligence quotient of the psychopathic group was eighty-nine, which is slightly above the mean for the group. This raises the question as to the relative importance of the role of mental deficiency in relation to delinquent behavior. At least in the above group it would appear to be more of a contributing factor than a dominant disorder in the total behavior pattern of pathological development.

For further discrimination, the psychopathic diagnoses are divided into the following categories: mixed group, nine cases; pathologic sexuality, five cases; and borderline intelligence level, two cases. Of the mixed group, six cases were mainly in the nature of pathologic sexuality. Thus the problem of distorted or inadequate sex expression was the chief difficulty in over two-thirds of all cases classed as psychopathic personalities. It is difficult to tell from

these cases whether this is an accurate picture of psychopathic distortion, or whether the commitment of these cases merely reflects social feeling towards socially offensive behavior.

TABLE IX

AGE OF PATIENTS AT ADMITTANCE

Age Range	No.	Per cent
15 - 19	6	21.42
20 - 24	11	39.29
25 - 29	4	14.29
30 - 34	2	7.14
35 - 39	3	10.71
40 - 44	1	3.57
45 and over	1	3.57
Total	28	100.00

The predominant age group (ages 20 - 24) which includes nearly 40% of the total group, would seem to indicate that these years were the most difficult ones for adjustment. However, it is difficult to make a clear appraisal due to the multiple causation involved in behavior. It must be remembered that previously Table V illustrated that the largest number of personality disturbances of this group began during the first few years of life. That such a large number of cases admitted were between ages of twenty and twenty-five, might

be explained as due to public attention. After a long period of maladjustment and inability to profit through penal and reformatory measures, these subjects became conspicuous. The period of turbulent, aggressive adolescence which is apt to be somewhat condoned, had passed, and the subjects apparently remained unchanged, and became a source of irritation to the public.

Three-quarters of the admittances were between the ages of nineteen and thirty. Psychopaths have been compared to unruly children and stormy adolescents, in view of the fact that in other studies many of the so-called "psychopaths" exhibiting full-blown symptoms eventually seemed to settle down to a more conventional, acceptable social adjustment during their more mature years. This may account for the few patients above the age of thirty. This might further be borne out by the fact that of the seven cases of the group over thirty only three were classed as psychopaths.

TABLE X

MARITAL STATUS OF PATIENTS

Status	No	Per cent
Single	22	78.57
Divorced	1	3.57
Married	5	17.86
Total	28	100.00

The marital status of the patients shows a preponderance of single persons. Within this group of single patients (78.57%) were found three patients later diagnosed as defective delinquents. Of the five patients who were married (including one patient who was remarried following divorce) four of the group exhibited major problems in the sexual area. The remaining patient was a behavior problem diagnosed as organic brain disorder. Three-fifths of the married group, all male patients, were on the verge of, or actually were, separated from their wives. None of the four female patients was married.

These findings show the tendency towards poor social and sexual adjustment. Ordinarily one might have expected a larger number of the group to have been married. The group as a whole tended to be of young age, but this does not explain the few marriages, as only six cases (21.42%) of the total group were under the age of nineteen. Also, the sexual adjustment of those married, and to a lesser degree their general inter-personal marriage adjustment, has been highly unsatisfactory.

TABLE XI

MILITARY ADJUSTMENT OF ELEVEN PATIENTS

Patient	Length of Service In Months	Adjustment	Type Discharge [a]
1	22	Fair	C.D.D. Medical
2 [b]	13	Unknown	C.D.D. Medical
3	19	Poor	C.D.D. N-P
4	29	Poor	Dishonorable
5	24	Excellent	Honorable
6	24	Poor	C.D.D. N-P
7	12	Poor	C.D.D. N-P
8	22	Excellent	Unknown (Hon, or Med.)
9	22	Poor	Dishonorable
10	15	Poor	C.D.D. N-P
11	14	Poor	C.D.D. N-P

a. C.D.D. - Certificate of Disability
Med. - Medical
N-P - Neuropsychiatric condition

b. Case No. 2 - Veteran of World War I only

As a group these men had a moderate period of service, averaging approximately nineteen months. The adjustments have been almost uniformly poor, as only two were considered excellent and one fair. Seven of the group received a Certificate of Disability Discharge, five for medical reasons and two for neuropsychiatric reasons. One wonders what effect military service has had on their total adjustment. In most cases, as evidenced by offenses preceding military service, the subjects were already in the process of becoming behavior problems. From observation of this group it would appear that military service aggravated existing conditions and perhaps in a few cases may have precipitated maladjustment.

Six of the group had committed offenses or had clear-cut evidence of social maladjustment prior to military service. Only one of this group conducted himself well throughout service and received an honorable discharge. The remaining five cases were subjects who had had no previous offenses before military service. Of these, two developed psychoses, one of whom received a dishonorable discharge. Another case was that of a dishonorably discharged person who was convicted of an unnatural sex offense, this being his first experience. One man received serious head wounds in combat and exhibited no difficulties until discharge from military service. Military service per se was not an advantage generally to these men.

At this point it might be wise to inquire into the nature of the offense which led to commitment for the purpose

of further understanding what the "community" believes a defective delinquent to be. The community is intended to refer to those responsible individuals, outside groups, or courts, who initiate the request to have a particular person of questionable status studied at this hospital concerning possibility of defective delinquency.

TABLE XII

OFFENSES LEADING TO THE DEFECTIVE DELINQUENT COMMITMENT

Legal Offense	No. Male	No. Female	Per Cent	General Type Offense	No.	Per Cent
Lewd & Wanton	9		32.14			
Disorderly Person	1	3	14.29			
Assault (Sexual)	4		14.29	Sexual	17	60.72
Assault (Intent to kill)	2		7.14	Personal Injury	3	10.71
Manslaughter	1		3.57			
Larceny	3		10.71			
Breaking & Entering	1	1	7.14	Disrespect of Property	8	28.57
Breaking, Entering, larceny	2		7.14			
Arson	1		3.57			
Total	28		99.99	Total	28	100.00

The analysis of the above group is indicative of trends but is hazardous if followed too closely. The offense for which a patient is committed does not always represent the type of maladjustment existing in that person. An example

would be a female offender who was convicted of breaking and entering. This offense was accomplished for the purpose of illicit sex relations with a male companion offender. In another case a larceny offender was convicted of stealing and hiding only women's undergarments as an excitant for masturbatory purposes, clearly an indication of sexual fetishism. With the above exceptions, the general type of offense committed is closely related to the type of behavior disturbance.

The above table indicates the predominance of offenses of a sexual nature. It would appear that sexual difficulties are particularly obnoxious and offensive to the public taste. These offenders are the ones who are most apt to be interpreted as abnormal, deficient in some manner, and in need of psychiatric care.

In general, all of the above offenses indicate either a thwarting or misdirecting of sexual impulses on one hand, or an act of rebellion against others or against society in general. Of the larcenies, no cleverly devised plans were carried out. On the contrary they were impulsive acts of a rather simple and obvious perpetration.

TABLE XIII

COMPARISON OF RECIDIVISM WITH OFFENSE, IMPRISONMENT, AND INTELLIGENCE

No. Offenses	No. Cases	Predominant Offense	Freq. Prev. Imprisonment	Length of Sentence	I.Q.
First	7	Lewdness(minor)	None	None	97
		Sexual Assault			94
		Assault			35
		Assault-Lewd.			117
		Larceny-Fetish			91
		Larceny			64
		Assault(to kill)			104
Average		Sexual			86
Second	4	Homosexual	1	4 yrs	89
		Fire-setting	0	0	77
		Assault-Lewd	0	0	79
		Homosexual	0	0	104
Average		Sexual		1 yr.	87
Third	3	Larceny	1	3yrs.1mo.	84
		Manslaughter	1	2	90
		Lewd-(minor)	1	3 - 1	110
Average		Mixed		Over 2 yrs	94
Fourth	4	Larceny-Assault	1	3 - 2	111
		Lewdness	1	1	85
		Larceny	2	1 - 8	79
		Lewd-(minor)	2	0	77
Average		Mixed;(Lar.&Sex)		Nearly 2yrs	88
Fifth	3	Disord.Person	3	1 - 4	99
		Assault-Lewd	1	2	86
		Lewdness	1	1	74
Average		Sexual		Under 1 yr	86
Six Offenses or More		Larceny	Unk.	Unk.	73
		Prostitution	3	1 - 6	73
		Prostitution	3	1 - 9	88
		Br.,Ent.,&Lar.	2	2 - 3	71
		Lewdness	4	4 - 2	88
		Br. & Enter.	-	2	101
Average		Mixed		2 yrs.	81
Total	27*				

*One suicidal anti-social case - most of life in institutions excluded.

The offenses in the above table include only those for which the subject was apprehended. Through perusal of case records other occasions of delinquencies and crimes equally serious were noted. However, these incidents were excluded as there was no method of ascertaining how many offenses were reported or withheld from the various institutions or case-work agencies.

The above table of recidivism does not show the seriousness of the crimes committed, but rather, points out the unamenability to current methods of treatment. In general the group seems to be fairly evenly distributed as to recidivism, there being as many first offenders as those convicted of six or more offenses. The kind of offense committed by frequent recidivists seems not to vary greatly from those committed by the single offender.

The effect of sentence on recidivism is undisclosed by these figures. A scrutiny of the number of times imprisoned and length of sentence served gives the impression that imprisonment has been in less favor by authorities than pro - bation, and sentences given have tended to be light. An example would be one case in which the subject was convicted of nine offenses, imprisoned twice, and served a little over two years in all. Inadvertently, this may be evidence of a general feeling that penal procedure is not the most adequate means of dealing with these offenders.

A comparison of the relationship of recidivism to the type of childhood home and to diagnoses of patients was originally included in the above table on the supposition that high recidivistic rates would closely correlate with inadequate homes and with psychopathic personalities. However, in these cases studied no significant relationship was found. The proportion of good to fair homes was quite evenly distributed throughout the group. The most flagrant recidivists were as apt to come from poor or good homes as the single offender.

The diagnoses of personality disturbance also had little relation to the frequency of offenses committed by these subjects. One might expect those with psychopathic personality, which usually demonstrates a poor ability to profit from experience, to be high recidivists. Yet psychopathic personalities were found to be evenly distributed. Mental disorder was found among the casual offender group as well as in the highest recidivistic group.

It is interesting to note that in this study the patient having the very lowest intelligence was grouped with the accidental offenders. It would appear that serious mental deficiency in itself does not seem to be a large factor in behavior disorder. However, the above should not be interpreted as meaning that good supervision is unecessary.

One cannot clearly classify personality reactions during so brief a period as thirty days and under an unnatural environment as is a hospital setting. Nevertheless, daily observations of the various individuals' reaction patterns do provide some insight into their particular adjustive difficulties. It is interesting to compare the adjustment of these twenty-eight cases, since all have been subjected to practically the same environment.

The writer has used a general qualitative classification ranging from excellent to disruptive behavior. To decide into which group a particular individual should be placed the following criteria were considered: adequacy of eating and sleeping habits, attention to physical habits and hygiene, degree of cooperation with hospital personnel, expression of attitudes towards hospital personnel and other patients, degree of socialization and type of associates selected, and frequency of maladaptive behavior, ie., temper outbursts, thefts, complaints, etc.

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TABLE XIV

HOSPITAL ADJUSTMENT OF PATIENTS

Adjustment	No.	Per Cent
Excellent	6	21.43
Good	9	32.14
Fair	4	14.29
Poor	5	17.85
Disruptive	4	14.29
Total	28	100.00

Over two-thirds (67.86%) of the group exhibited adjustments ranging from fair to excellent. With the exception of one patient, who was a highly paranoid psychotic, all of the first offenders had either excellent or good adjustments. All of the patients rated as disruptive were recidivists of three or more convictions. The group as a whole tended towards good hospital adjustment. With the exception of the four cases of disruptive behavior, two of whom were psychotic and one a defective delinquent, the hospital adjustment of the group could be considered as acceptable of hospital patients.

TABLE XV

COMPARISON OF HOSPITAL RECOMMENDATION WITH INTELLIGENCE

Classification	No.	Per Cent	Mean Intelligence
Defective Delinquent	4	14.29	77
Non-defective Delinquent	17	60.72	91
Non-delinquent Defective	2	7.14	49
Psychotic:			
Non-defective	3	10.71	101
Defective	1	3.57	73
No Disorder (Dull Normal)	1	3.57	77
Total	28	100.00	

Among those classified as defective delinquent, not one obtained a test score below seventy-one, and one achieved an intelligence rating of eighty-four. The scores of the non-defective delinquents ranged from seventy-seven to one hundred and seventeen which is a fairly normal pattern of distribution. Delinquency seems not to be closely correlated to the degree of intelligence. The non-delinquent defective average is not a clear indicator. There were only two cases in this group, with a large variance in intelligence rating. One was nearly borderline (64) and the other of imbecile intelligence level (35). It is singular that the patient having the most limited mental capacity

had never previously become involved in any behavior difficulty, even though he was working for his living and mixed quite freely for one of his limited mentality.

Above all, this table demonstrates the disparity between the social conception and the psychiatric-medical interpretation of defective delinquent. Out of twenty-eight presumed defective delinquents there have been only four (14.29%), or one out of seven, cases committed that have been recommended to be classified as such by the hospital staff. Cases such as these twenty-eight represent bewildering problems to the public. In some of the cases committed which present little evidence of social maladjustment, one might be inclined to believe that the selection could have been more wisely made. However, it must be recalled that these commitments are for the purpose of psychiatric observation and do not necessarily represent the conviction of an established state of defective delinquency. Single or accidental offenses of minor degree might well have been excluded. Also, one must consider that the presenting behavior was of a disturbing, perverted nature, causing those in authority who questioned the normality of the separate offenders some real concern.

Excluding the above mentioned type there were many cases presenting distinctly abnormal and threatening behavior, which the hospital staff could not fit clinically or legally within the framework or classification of

defective delinquent. That such offenders are not given the right of adequate treatment and protection against themselves is the responsibility of the general public.

One might justly wonder what disposition is made of those offenders who are not classed as defective delinquents. Are they removed from the temptation and possibility of dangerous acts? Unfortunately, it is beyond the scope of this thesis to continue a follow-up study of the subsequent adjustment of these offenders. However, in order to give a fuller picture of the problem, a table listing the court disposition of the offenders following return from observation at the State Hospital for Mental Diseases has been included in the appendix. (See Appendix C.)

CHAPTER V

SELECTED CASE STUDIES

In this chapter the writer proposes, through the case summary method, to depict more clearly how the present defective delinquent law is being used to meet the problem of caring for persons with socially threatening personality disorders. An appraisal of the use of the law in the provision of adequate care for those presumed to be not fully responsible for criminal and malicious acts is the first step in any improvements made.

However, in considering this problem the reader must continually keep in mind that this thesis is limited to the study of the effectiveness of the law as can be observed through a study of cases committed to this hospital as probable defective delinquents. A criticism of facilities of the Division of Defective Delinquents as well as an evaluation of the treatment given by the various institutions, although important, is outside the scope of this study.

The fourteen cases selected are not necessarily representative of the total group studied, but were chosen for the purpose of illustrating the application of the law and significant problems involved. The first four cases depict the developmental background of the defective delinquents and specific problems which they present. Another case was

selected to describe the difficulty in providing adequate care for borderline psychotic delinquents. Two cases point out the problems presented by mentally defective offenders, although not habitual delinquents. One case of a dangerous sexual offender is compared to that of a more mildly disturbed sexual offender. Two cases of borderline disturbances ha have been utilized to portray difficulties encountered in the proper classification of subjects. Three cases of severe psychopathic disorder were selected to emphasize the socially threatening nature of offences committed and to evaluate the adequacy of the present law in meeting the problem.

The first four cases discussed comprise all persons who have been considered by the hospital and courts to be defective delinquents and have been committed to the Division of Defective Delinquents. The case records will give a clearer description of the type of problems and disorders classified as 'defective delinquent.'

Case 1

The first case concerns the adjustment of a patient whose case was diagnosed as a personality disorder due to epidemic encephalitis. He was twenty-six years of age at the time of his offence.

> V.M. was born into difficult circumstances. His mother did not wish to have a child and unsuccessfully tried to produce an abortion. The paternal background was poor; the paternal grandfather abused his wife severely and had uncontrollable fits of temper, while

the paternal grandmother was a religious fanatic and spent her last years at this hospital. The patient's father was high strung, bad tempered, a heavy drinker, and assaultive. Patient's mother was extremely nervous, suffered internal crawling sensations, and severe migraine headaches.

As an infant V.M. was peevish, restless, and a continual source of irritation to his parents. He was the oldest of three siblings, the youngest of whom was mentally deficient. At times patient's mother resorted to paregoric to quiet him. Patient vomited after meals; toilet habits were not established until the age of six. At the age of one and a half years patient contracted measles which was complicated by otitis media. This was followed by a reversal of sleep-rhythm; dullness and drowsiness occurred in daytime and restlessness, nightmares, and wakefulness at night. From this period onward he displayed temper tantrums during which he would tear his clothing. If left alone tantrums subsided in two or three hours, but when the slightest attention was shown, the tantrums would continue for five or six hours.

He was sent to school at the age of six, but within three months was returned to the home as unmanageable. He was stubborn with a low threshold of irritability. He domineered younger children, breaking their toys and physically beating them. At this time patient was sent to the Exeter School for the Feebleminded, but was returned to his mother within six months. The patient's mother reported that the father treated patient brutally, even kicking him in the face on one occasion. Two years later patient's mother separated from the father because of this brutality and patient was placed in the State training school for boys as wayward.

Within a brief period V.M. was again transferred to Exeter School where he remained for five years. Adjustment during this period improved somewhat. Behavior at this time was unpredictable as patient would suddenly change from a model pupil to a disruptive troublemaker. Patient was discharged to his family. He displayed little feeling towards his mother and showed not the slightest affection for his siblings. Strangely, V.M. became attached to his step-father and frequently followed him about.

V.M. attended vocational school for a brief period but was expelled for stealing. From the age of fourteen

to eighteen he was frequently caught stealing. At one time he worked in the Civilian Conservation Corps, but was dishonorably discharged for stealing and "continual misbehavior." At the age of eighteen, after his third conviction for larceny, V.M. was sentenced to four years imprisonment. Within two months after arrival at the Men's Reformatory, patient became overexcited, noisy, resistive, and threw food and urine at the guard. Consequently, patient was transferred to this hospital and continued to be highly disturbed for several days. Patient remained at this hospital over two and one-half years before his return to the reformatory.

V.M. was married at the age of twenty-three. His wife was delivered of a child four months later. The marriage was unsuccessful and his wife sought divorce. At the age of twenty-four, V.M. was readmitted to this hospital for behavior disorder and alcoholism. He remained nearly two years until released on trial visit to his mother and step-father. For the next six months patient worked on two jobs and contributed to the support of the household. Some sibling rivalry existed at this time. While on trial visit patient was convicted of breaking and entering and was detained at the reformatory for four months until the present Defective Delinquent Commitment.

During the month observation period patient was usually sullen, defensive, and yet boastful of past delinquencies. On the whole patient made a fair adjustment. He obtained an intelligence quotient of eighty-four although he has received somewhat lower scores on intelligence tests administered in previous years.

This case provides a wealth of facts of etiological significance. Whether due to organic brain disorder, poor inheritance, or insurmountable environmental barriers, this patient has exhibited continual maladjustive behavior disorders since early infancy. Yet he has obtained an intelligence score as high as eighty-four, which places him in the dull normal intelligence group. The hospital staff, taking all facts into consideration, has judged him to be a defect-

ive delinquent, although the usual intelligence score separating normal from defective mentality varies somewhat above and below an intelligence quotient of seventy. Thus intellectual abilities cannot be considered the sole criteria of mental defect.

This patient began institutional life early and during the course of his life has been an inmate of four institutions. His behavior did not noticeably improve in any of them. He was discharged into the community twice from Exeter School, once from this hospital, and once from the State men's reformatory. On these occasions the patient could not be considered to have become well adjusted. It was while on trial visit from this hospital that the patient was convicted of the offense leading to his hospitalization for the present study. This shunting of the patient of the patient from one institution to another shows clearly the inability of any of the institutions to care properly for such offenders before the creation of the Division of Defective Delinquents.

This case gives evidence of the need for a long period of care under supervision. His chronic maladaption has given no indication of change. At this hospital, he showed no guilt over misdeeds, but rather was inclined to take great pride in past delinquencies. His acts appear impulsive, and his threshold of irritability very low. This patient, regardless of fair intelligence, shows the need for protective care such as can be afforded within the Division of

Defective Delinquents.

Case 2

The following case concerns the only female defective delinquent. She was twenty-one years of age at the time of admission and was diagnosed as psychopathic personality of borderline intelligence.

P.R. was the second child of three siblings born to immigrant Italian parents. Her father was strict though even-tempered; the mother was emotionally unstable, inclined to worry, and considered to be unreliable. P.R.'s younger sister is a mentally defective girl, ten years of age, unable to talk, and has been cared for in the home.

P.R. was a full term normal baby delivered at home. She contracted pneumonia as an infant. At the age of three she fell from a second story piazza, but there was no evidence of severe injury. Otherwise her early development was normal. There were no fears, tantrums, or special behavior difficulties. As a child she was very active and much preferred playing with boys to girls. P.R. left the ninth grade at the age of sixteen in order to work in a mill. Her work record has been poor. Although working during a period of war prosperity she seemed not to be able to hold a job for longer than six months. She was unreliable, not interested in working, and would walk off jobs for slight reasons. At this time she complained of "nervousness".

Relationship within the family began to deteriorate. She resented strict supervision in the home, would contribute nothing to support the home, and then began stealing. Patient remained away from the family most of the time and was easily led by her friends. At the age of nineteen patient was arrested several times and convicted of five charges of larceny. One charge concerned the theft of a diamond ring worth $850 which she had stolen while employed as a domestic, and later resold for $50. During the same year she ran away to New York on several occasions. At this time a Rhode Island court committed her to the psychiatric ward of the city hospital for observation, where she was diagnosed as mentally defective and psychopathic. Her adjustment there was poor. She was childish, bold, sarcastic, uncooper-

ative and profane. Chiefly, she displayed instability and poor social adjustment.

The offense leading to her commitment to this hospital was the charge of soliciting men at a city parking lot. For some time she had been observed driving off with men and returning to the same location.

Her adjustment at the hospital could be considered as only fair. She worked, but grudgingly, and felt imposed upon. She was quick tempered and boisterous. Intelligence test revealed an intelligence quotient of seventy-three.

This patient's case reveals a behavior pattern characterized chiefly by lack of inhibitions, inability to learn from experience, defective judgment, and the self-interest so characteristic of psychopathic personalities.

The various courts in which she was apprehended recognized that more than the regular penal procedure was necessary in her treatment. This is in part demonstrated by the fact that she was not sentenced for offenses. Also, one court felt the need of psychiatric aid, and took the initiative to have her case intensively examined. However, this occurred before passage of the Defective Delinquent Law. At that time there was no set-up for custodial care of such defective delinquents, even if psychiatric findings indicated such.

Case 3

The following case, a further illustration of a defective delinquent, describes the general background of a nineteen year old youth of borderline intelligence, who was considered to be psychopathic with borderline intelligence.

B.D., the youngest of eight siblings born to immigrant Portuguese parents, was catered to and spoiled by all members of the family. B.D., a sickly infant, received much medical care and became the center of attention of the family. From his early childhood he seemed to be always in trouble and was a stubborn, insolent boy. B.D. was spanked and appeared genuinely sorry, but yet never seemed to learn from experience. At the age of five or six years, the patient's father died. His mother had greater difficulty controlling him. At an early age he wandered from home and was inclined to steal. School adjustment was very poor; patient did not progress beyond the fourth grade.

In his early teens his mother gave up punishment as useless discipline. At the age of fifteen, following his mother's death, he left school, went to live with an older sister, but refused to work. For the next two years he became seriously involved with the law and was convicted on five occasions for breaking, entering and larceny. After violation of probation he was committed to the state training school for boys for a six month period. Three months following his release to his sister he was sentenced in New Bedford for a three month term as an adult for auto theft. However, he was transferred to the juvenile court in Rhode Island and was returned to the state training school for boys. He remained at this institution for one and one-half years and was released on parole for six months. One month following the expiration of parole patient was arrested in Fall River on a charge of breaking, entering and larceny. Four months later he was convicted of the offense leading to Defective Delinquent Commitment. At this time he and a girl friend with whom he was planning to have sex relations, were apprehended when patient was attempting to drive off someone's car by crossing the ignition wires.

B.D., a good looking youth, has developed normal heterosexual interests. He has had several girl friends in recent years, one of whom was a woman separated from her husband. Patient is inclined to drink to excess and has shown mildly neurotic symptoms such as fainting spells and stomach trouble.

The patient scored seventy-one on the intelligence test. Planning ability and performance were rated high, but verbal knowledge was poor. Patient was practically a non-reader. His hospital adjustment was almost uniformly poor. He was stubborn, insolent, sullen and

> muttered to himself; his temper was poorly controlled, as evidenced by his hitting a patient and throwing chairs about the room. He made little effort to help in the ward work. A loud, disturbing coughing spell stopped immediately when patient discovered that he was to receive a hypodermic injection. Patient took much pride in his appearance, kept himself clean and neat. He stated that he stole money because he wanted to be a 'big shot'.

The above case shows a long history of petty delinquency and criminality. His disorder may have many roots, including such factors as: an oversolicitous family, early deprivation of parents and parental discipline, retarded mental development, and school failure. He was the only delinquent and mentally retarded member of a stable, large family.

Throughout his life this patient has received much punishment for misdemeanors, but there has been no indication that this has had a deterrent effect. At no time in his development has he evidenced any fair ability to profit from past experiences. Whether the delinquency is due to intellectual limitation, in which an understanding of the consequences of his acts is lacking, or whether it is due to some pathological emotional need for attention or punishment that drives him into conflict with society, is undetermined. One might suspect that both factors are involved. Previous studies have shown that mental defect per se is not a major factor in the development of delinquent and criminal behavior.

Regardless of the importance of causative factors, the fact remains that under the existing framework of legal and reformatory procedure this case has shown no indication of

reformation. Now under an indeterminate sentence, the patient is safely held until clear evidence is shown of an improvement in adjustment.

Case 4

The remaining case classified as a defective delinquent concerns a twenty-one year old male who reveals a long history of delinquency coupled with a fairly low degree of intelligence.

> B.E., the youngest of five siblings born to semi-illiterate Portuguese parents, was subjected to inconsistent discipline. The father was overly strict and the mother was exceedingly lenient. He was most often pampered and "never learned to obey."
>
> The family considered him to be a normal, though somewhat demanding child, until the age of six. He disliked school from the first day and his mother was compelled to accompany him; otherwise, patient truanted frequently. He repeated several grades, showed no interest in academic work, although some in manual activities. He was inclined to develop strong emotional attachments to his teachers and he had frequent emotional outbursts and temper tantrums when thwarted. His erratic, seclusive behavior led his schoolmates to nickname him the "lone wolf" and the "crazy Portuguese." He seemed unhappy, but showed no meanness or deliberate planning to injure others. At the age of twelve patient left grade school to attend trade school as he had some mechanical ability. Improvement was slight, but the patient remained in school until the age of sixteen. Although academically patient reached the sixth grade level, achievement tests given while in school revealed a third or fourth grade level.
>
> B.E. had an unhappy home life during his school years. He was a timid, shy person, though disobedient. His father attempted strict discipline, many times beating him severely. On one occasion at the age of ten, his father struck him on the head continuously with a loud speaker until B.E. was "unable to breathe" (gasping

for breath). Yet the patient did not complain when beaten. The family stated that B.E. "always took the blame for everything" and "didn't know enough to hold a grudge."

B.E.'s work adjustment was notably poor. He had frequent jobs but seldom worked for more than a month. Because of low intelligence he was rejected by both the armed forces and the merchant marines. Patient is unmarried but interested in girls. He has had some sexual affairs with women as well as occasional homosexual relations. At the time of commitment patient had a girl friend who was married and seeking a divorce.

B.E. had a long court record for delinquencies from the age of fifteen until the time of this present commitment. Offenses included: petty larcenies, vagrancy, carrying a concealed weapon, auto thefts, breaking and entering, fugitive from justice, drunkenness, and attempted armed robbery. At the age of sixteen, B.E. was committed to the state training school for boys following an auto theft. His adjustment at this institution was poor as he was emotionally unstable and unable to get along with the other boys.

Patient's social life centered mostly in bowling alleys and pool rooms; he kept late hours, often until two or three o'clock in the morning. The offense leading to commitment to this hospital was the theft of a rifle from a nursery where he had recently been employed.

His adjustment at the hospital was very poor. He was loud, authoritative, suspicious, resentful, had temper tantrums, and was a difficult problem for the attendants. At times B.E. was friendly and good natured towards other patients and hospital personnel, but his behavior was quite unpredictable. The Intelligence test given revealed a large disparity between verbal and performance level (Performance ability was thirty points higher than verbal ability). Intelligence quotient was seventy-nine.

This case presents a picture of a borderline or "low" dull normal individual who seemed not to have been understood or appreciated in his own home. His academic accomplishment was markedly poor in comparison with his four siblings, who completed high school, except for one brother who left in the

third grade of high school. His family has considered patient to be a problem since the age of six, yet one can see earlier roots of disturbance in inconsistent discipline of strictness and pampering. As in each of the three preceding defective delinquents this case also demonstrated a chronic inability to learn or profit from experience. The picture presented of this personality is a shy, timid person, seemingly unwanted. His family has noted his inclination to accept all blame and his apparent unconcern for punishment, and explain it in terms of mental deficiency. However, one can see that punishment may represent to the patient much needed attention from others. If this be the case, a pathological need for punishing experiences induces him to commit obvious, conspicuous delinquencies. One such example would be the occasion upon which he proudly flourished a loaded gun in a small fruit store. Robbery would not seem to have been the chief motive.

That the patient, while in the hospital was loud, authoritative, and boastful, rather than timid as described, may represent more a change of behavior to get attention, than a change in his personality. Both arrogance and timidity represent his social inadequacy. At times the patient exhibited a friendly, good-natured personality; however, the sudden unpredictability of mood shows the instability and poor emotional control existent.

It is an open question whether a psychopathic personality is unable or unwilling to control his emotions and his behavior. From punishment heaped upon him one would be inclined to feel it is an inability due to some constitutional lack or deep unmet emotional need. This patient has been in the state training school for boys as well as the state men's reformatory. This person, though not strictly feeble-minded, has demonstrated his inability to relate to people and to life situations in a normal, socially acceptable way. Until such time as a change can be effected the patient will remain under restraint and supervision of the Department of Social Welfare in its Division of Defective Delinquents.

Of the total group studied, four persons were diagnosed as being psychotic and one as a psychopathic personality with psychotic episodes. Each of the psychotic cases presented a menacing problem of either a sexual or assaultive nature. As previously stated, it is not the prupose of this thesis to evaluate the hospital care and treatment given mental patients, but some attention must be turned to those persons who, following the observation period, have been recommitted as psychotic and who provide a special problem in management. For this reason the following case is discussed in detail.

Case 5

This case is considered by the writer to be inadequately

controlled within a state mental hospital setting. It concerns a thirty-one year old female patient who was diagnosed as dementia praecox, paranoid, with borderline intelligence.

S.M. was the fifth of seven siblings born to Italian immigrant parents of marginal economic status. The family lived in a poor neighborhood and was crowded into a four room flat of a three family tenement. S.M.'s birth and early development were considered by the family to be normal. She entered school at the age of six. Two years later her mother died.

The family seemed to lose control over her activities and she began keeping late hours. Because of uncontrolled behavior, S.M. was sent to the House of the Good Shepard and remained there until returned to the home at the age of sixteen. Within a short time she associated with disreputable girl friends and was in frequent trouble with the police. This same year she was delivered of an illegitimate male infant.

Because of persistent anti-social and sexually delinquent behavior and retarded mental development, S.M. was committed to Exeter School at the age of nineteen. She was described by Exeter School personnel as being profane, obscene, quarrelsome, unwilling to work, and insubordinate to those in authority. Although officially enrolled as a patient for sixteen years, (or until three months preceding admittance to this hospital at the age of thirty-one) S.M. eloped (escaped) from the school and spent many periods at home on visit. Home supervision could not be considered adequate as the patient eloped frequently. On these occasions when the patient was not returned from visit she was discharged to her sister.

At the age of twenty patient received treatment for syphillis and gonorrhea at the state infirmary. Four years later she was delivered of a second illegitimate male infant and was returned to Exeter School. Since the age of twenty-four she has been convicted on four occasions for prostitution and has served three sentences at the reformatory for women, totalling two and one-half years. At one period she was transferred from a reformatory in Boston to a Massachusetts state hospital, from which she eloped. At the age of twenty-eight she was transferred from Exeter School to this hospital for the

delivery of her third illegitimate male infant.

S.M. was committed as a probable defective delinquent following a prostitution charge. She obtained only borderline intelligence (an intelligence quotient of seventy-five). Her adjustment on the ward was notably poor. She did not mingle with the patients, felt herself unjustly held, had much resentment to police and others in authority. Within a week S.M. became combative, destructive, and acted impulsively. She admitted auditory hallucinations in which she was urged to do bad things, but denied obsessive, compulsive tendencies.

Following the recommendation to the court that the patient was mentally ill and in the need of treatment, she was recommitted to the hospital the same day. Patient continued to be defiant, sullen and disobedient. Although without ground privileges, S.M. was drinking and managed to elope from the hospital within two weeks. Then followed several elopements and returns each time with evidence of drinking and suspicion of promiscuity. On one occasion patient served a ten day sentence at the women's reformatory before return to the hospital. Briefly, the above patient has eloped four times since her recommitment to this hospital and at the time of this report is on elopement status.

The social problem presented by the above case is not to be dismissed lightly. In addition to impairment of the general morals through her flagrant sexual promiscuity, this patient of feeble-minded intellect has given birth to three illegitimate children who are now wards of the state.

One alarming factor is that the patient is neither noticeably insane nor feeble-minded, and hence, does not immediately draw the attention or concern of the public. Approximately two weeks before her last escape from the hospital she was considered by her ward physician to be in fair adjustment with no evidence of psychosis.

The problem of adequate care at the state hospital for those patients who are not clearly psychotic, but seriously disturbed psychopathic personalities, is difficult to resolve. Maximum security could be obtained by housing such patients with the criminally insane. Yet this poses the problem of the right of the hospital to hold a patient who has recovered from his psychotic episode and is not under sentence. Can such a person be legally held under the security of the building for the criminally insane? Also, can such a person who has apparently recovered be continually held in the security of the building housing non-criminal, but seriously mentally disturbed patients? The possible results of the alternative of holding such a person within other continued treatment services of the hospital, which do not have maximum security is well demonstrated by the above case. The State Hospital for Mental Diseases as well as Exeter School for the Feeble-minded do not have adequate provision or personnel to care for those difficult offenders, not clearly psychotic, mentally deficient, but of serious disruptive behavior.

It is important to understand the type of personality and disorder to be found in the truly mentally deficient person, at least an understanding as can best be revealed in such a limited study. The two following cases are briefly discussed as they represent the only cases in which the subjects received below seventy in intelligence rating.

Case 6

This case concerns a thirty-one year old offender who was found to be without mental disorder, but mentally deficient, of imbecile level intelligence.

G.N. was the second eldest of five male and one female siblings born to simple, hardworking, immigrant parents. Patient, considered by the family to be of normal birth and early development, entered school at the age of six, did very poorly, and remained in a special room (grade 2) until leaving school at the age of fourteen in order to take an underpaid job with a contractor. Patient seldom complained and worked steadily at various laboring jobs. Social life was circumscribed; at times he would attempt to associate with the corner gang which quickly shunned him. Most of his spare time was spent in the home, a free environment, where the patient was appreciated. G.N. showed no interest in smoking, drinking, or in women.

At the age of eighteen both parents died. An uncle helped the family for a year until the eldest brother reached legal age. As the family was well-knit, the eldest ones helped the younger brothers and the patient. The sister kept house for the brothers. In the succeeding years the siblings pooled their earnings, and all, including patient, became equal co-owners of the house in which they lived.

G.N.'s job for the last three years preceding commitment has been an unpleasant menial task of pouring lead in a manufacturing concern, but from which the patient earned as high as forty to forty-five dollars per week. The patient may have been teased at times by fellow employees, but there has been no evidence of any friction. Prompted by teasing of employees to go dancing and to mix socially, patient attended a large public dance hall. At this dance a man accused patient of stealing his girl friend and a fight ensued in which the patient protected himself by grabbing his opponent's genitals. This was the offense leading to his commitment to this hospital.

There is no record of the patient having been given the Wechsler-Bellevue adult intelligence test at the hospital. However, two other test scores are included in the hospital record.. On the Revised Stanford Binet the

patient received an Intelligence Quotient of thirty-five and on the Cornell-Cox performance scale, an intelligence quotient of forty-seven, indicating better manual than verbal ability.

Hospital adjustment was good. At first patient refused to eat hospital food, as he would eat only food prepared by his sister, which she would bring to him. Later patient ate hospital food well. He was overly fastidious in all activities and was inclined to spend long periods in making himself presentable. Patient was returned to court with the recommendation of a mentally defective, but not an habitual delinquent.

Case 7

The second case is that of a mentally deficient offender without mental disorder, who was considered to be of moron level intelligence.

L.T. was the youngest of four siblings born to immigrant Italian parents. Birth and development were normal. Patient was said to have talked at the age of two and one-half. Entering public school at the age of six patient continued until the age of sixteen, although attendance was irregular. Patient completed the second grade but can neither read nor write.

L.T. left school to work several months in the Civilian Conservation Corps, following which, he worked five or six years in his uncle's ice cream plant, where he was inclined to sneak off the job. Patient worked several years as a machine shop worker and mill worker, but was unsteady and unreliable. Patient was described as boastful, untrustworthy, and a frequent liar, but was seldom openly argumentative or belligerent. Although unmarried he is interested in girls. His chief pleasure is movie attendance. He has complained of bi-weekly dizzy spells, disturbed sleep, and has suffered from discharging ears since infancy.

He was committed to this hospital following an arrest for the theft of a large sum of money from his cousin's house. This has been his only offence. Patient obtained an intelligence quotient of sixty-four, adjusted well within the hospital, and showed initiative and

industry. The hospital staff recommended non-defective delinquent status but suggested commitment to Exeter School.

Of the two obviously mentally defective subjects in this study, delinquency consisted of only a first offense, which in each case was not of a seriously threatening nature. The subject of imbecile level of intelligence has shown admirable life adjustment for one of his limited mental capacities. Although not socially inclined, this patient has derived normal satisfactions from hard, honest work and from the feeling of appreciation within his own family. It is remarkable that a person of such limited intellect would be able to earn steadily an average of forty dollars per week. That his work was satisfactory was attested to by the request of his employer to have him return to work following his release.

One may justly wonder why this person was committed as a probable defective delinquent. In all probability the abnormal sexual nature of his offense, especially in a public dance hall, coupled with his obvious lack of intellect, gave him the appearance to the public of an individual who was dangerous to society. This case represents the public conception of the danger of a defective delinquent. However, closer study revealed an excellent adjustment of this person in spite of severe limitations. In the writer's opinion this case shows the disparity between community thinking as represented by the court commitment as a defective delinquent, and psychiatric understanding.

The second case of a mentally deficient offender of near borderline intelligence presents a greater problem, though not largely so. This person is of a generally boastful, untrustworthy nature and seems not to assume responsibility on jobs. The theft of money from his cousin may indicate a beginning of more serious behavior, but in the writer's opinion it would appear that this subject could adjust successfully in the community if under adequate supervision of understanding relatives. If such supervision is lacking, the subject might possibly be aided by institutional care at Exeter School, as was recommended by the hospital.

Both the above cases show that mental defect coupled with a delinquent act is not of a sufficiently serious nature to warrant commitment to the Division of Defective Delinquents.

As previously stated in Chapter IV, over sixty per cent of the cases were committed for observation following arrest for offense of a sexual nature. The type of offense included various homosexual and heterosexual unnatural acts, pedophiliac perversions, fetishisms, exhibitionism, prostitution, and sexual assault. A fair proportion were single offenses and many were of a minor but socially disgraceful nature.

In reference to sexual offenses two cases have been selected. The first may be considered typical of the large number of subjects committed following arrest for a minor sex offense. In some of these cases the sexual offense is

the subject's first. The second case discussed represents the more serious social aspects of the problem of inadequate or distorted sexual expression.

Case 8

The following case concerns a twenty-four year old married veteran of psychopathic behavior and low normal intelligence and represents the typical minor sex offender.

F.G. was the eleventh and youngest child born to French-Canadian parents. Early development was normal, though patient was much spoiled. Patient began school at the age of seven as he refused to go earlier. However he was an average pupil and reached the eighth grade at the age of sixteen, at which time he left to aid his family financially by such jobs as bus boy, elevator operator, gasoline station attendant, and factory worker.

F.G. was drafted at the age of eighteen and was in active combat in North Africa, and participated in the invasions of Sicily, Italy, and Normandy. F.G. was wounded by shrapnel and hospitalized on two separate occasions. At the time of his latter hospitalization his letters home were incoherent.

Following discharge from the service at the age of twenty-one the patient's behavior began to change. He was restless, talked infrequently, and suffered severe headaches. When restless, patient would drive his car and on these occasions would steal women's undergarments from clotheslines in order to use them as excitants for masturbatory purposes, which patient claimed relieved his severe headaches.

Within the next year F.G. married the girl to whom he had been engaged prior to service. Marital adjustment was satisfactory. Patient worked steadily and supported the home. Clothes stealing ceased until his wife had dysmenorrhea; again when his wife became pregnant, clothes stealing episodes became more frequent. Patient has stated that when he suffered severe headaches he became confused and committed these acts much against his wishes and better judgment.

> At the hospital the patient secured an intelligence quotient of ninety-one. Test scores revealed the patient to be somewhat impulsive. He was unable to void the first day but the following day was untroubled. Patient was quiet, cooperative, a willing worker, slept and ate well.

This case represents a problem of perversion which is troublesome to the community. It can be seen that the thefts are not maliciously perpetrated, but are impulsive acts characteristic of a disordered personality in need of psychiatric treatment. There is no evidence of habitual delinquency or of a perversion of a seriously threatening nature. The subject's intelligence falls within a normal range. This is one of many examples of commitment of subjects as possible delinquents who, upon close examination, prove to be neither mentally defective nor seriously delinquent.

Case 9

The following case is selected because it represents strong community feelings to have something done to protect itself from sexual perversion and attacks of this type of offender. In comparison with the preceding case, this represents a more serious and openly expressed distortion of sexual impulses, indicating not so much criminal intent as distorted personality. However the classification of this case as defined by law remains a problem.

The subject was a twenty-two year old male offender of dull normal intelligence who was diagnosed as without mental

disorder, psychopathic personality.

L.D. was the fourth and youngest child of Anglo-Saxon parents. At the time of his birth the father and one son were seriously ill with pneumonia. Patient was neglected much of the time. The family was in financial difficulties. The father, poor in health, was unemployed and the mother was compelled to work. L.D. was considered slow in developing. He remained in school from the age of six to sixteen, but did not progress beyond the sixth grade. The family was over-protective and inclined to blame his difficulties on his schoolmates. Teachers considered the boy to be abnormal and advised his removal from school.

Patient has had frequent jobs of a menial nature as dishwashing, electrician's and plumber's helper, and errand boy. In all jobs patient had difficulty due to his sensitive nature. (Example: could not endure vile language) He was slow, shy, morose, and considered only a fair worker. L.D.'s social life was meager. He was seclusive, not interested in sports or girls, and seldom went out unnecessarily. For the greater part of his life, he spent his spare hours at home reading comics and listening to the radio. He would disappear upon the appearance of visitors. His father and sister unsuccessfully tried to interest him in football games, horseback riding, and in girls. As all of his brothers were in the service, patient attempted to enlist and was keenly disappointed when he was rejected (on the grounds of Constitutional Psychopathic Inferiority).

L.D. has exhibited delinquency of a sexual nature since the age of eighteen. His most frequent offense has been impulsive assaults on women in which the patient would flee as impulsively as he attacked. In the last four years he has been arrested for five charges of a sexual nature, has spent two months in county jail and the remainder of the time on continual probation, with the exception of a ten and one-half month period when a patient at this hospital. Following his third offense at the age of twenty, the presiding judge recommended, and his father approved, voluntary commitment to this hospital. Patient's condition was diagnosed the same as at present.

Patient was exhibitionistic. During the month preceding his last commitment to this hospital patient was exposing himself to women three or four times weekly.

On earlier occasions patient has ransacked neighbor's homes and has removed only women's soiled clothing.

The offense leading to commitment was of a particularly alarming nature. One evening L.S., attracted by a passing woman, followed her several blocks. He picked up a stone, caught up to her as she was turning in at her gate. Then from behind, he struck her on the head with the stone. When the girl screamed, patient fled.

Patient made a good adjustment at the hospital. Though shy and sensitive, he was able and willing to work hard. He was meek, submissive, and apparently content, although he did maintain a queer facial expression. Intelligence was rated at eighty-seven, which varied but one point from hospital testing of two years previous.

The above patient was found to be of dull normal intelligence, almost within the normal range. The hospital returned the recommendation that the patient was not a defective delinquent, as he was not mentally deficient. It is apparent that the patient is suffering from a distortion in the sexual sphere which is severe enough, not only to hamper his own life, but is sufficiently serious to cause deep concern to the community.

However there is no provision in the law permitting control over other than mentally defective and habitually delinquent offenders. Following the return of the recommendation of "not a defective delinquent" the hospital received a request from the lawyer of the patient's family to explain a little more fully the meaning of defective delinquent. It was felt by the family as well as by concerned community members that this patient was mentally lacking in some manner

and was a social threat, which the family could not control, and for these reasons believed patient to be a proper subject for the Division of Defective Delinquents.

It has come to writer's attention that several months following patient's return to the court, he was committed to the Division of Defective Delinquents. As this study does not include follow-up of patient after return to court, information is not available as to how this occurred. Conceivably, in this instance, interpretation of the law has been freely made by the court and community in the interests of its own welfare. The writer would judge this as a progressive step in providing for those serious psychopathic offenders not falling strictly within the defective delinquent status, as the law now exists.

Cases do not fall distinctly into clear-cut categories; there are those cases not clearly described as one disorder nor yet another. This becomes a problem, as demonstrated in the two following summaries, when it becomes necessary to classify.

Case 10

The following summary describes the history of a twenty-three year old delinquent male, diagnosed as psychopathic personality of borderline intelligence.

> T.M. was the third child of eight siblings born to an illiterate, often unemployed laborer and his wife was an agreeable, active, alert person. The home is a shack on an isolated farm, difficult to find. A

visiting social worker reported it as messy, dirty, and indicative of sub-marginal economic status.

T.M. was delivered at home. He was said to have walked and talked at age fourteen months. He was an affectionate, quiet child, with no serious illnesses. T.M., never interested in school, found it difficult and completed only the sixth grade at the age of fifteen, at which time he left to work as a farm laborer. He worked steadily though at very poor wages until induction in the armed forces at the age of eighteen. Patient served overseas and received three battle stars, a good conduct medal, and an honorable discharge two years later.

Although T.M. has had a good work record, he has an early history of arrests dating back to the age of thirteen, when he and a companion were convicted of breaking, entering and larceny. At the age of fifteen patient was arrested on four counts of larceny and sentenced to the state training school for boys. As he was considered mentally defective, he was transferred within two weeks to Exeter School. However, T.M. did not appear seriously deficient to authorities at Exeter School and thus was paroled to his family in two weeks.

Following discharge from the service patient began to have frequent sporadic heavy drinking spells. He lacked normal inhibitions, was always willing to accomodate companions, and seemed unable to desist from drinking. When intoxicated he was emotionally unstable and belligerent. Offenses following discharge consisted of auto thefts and lewd behavior. The patient was committed to the hospital following an unnatural act with a woman over sixty years of age.

T.M. obtained an intelligence quotient of seventy-four; test pattern indicated emotional instability, poor social judgment and planning ability. Hospital adjustment was good; patient was quiet, shy, yet friendly, cooperative, and a good worker. Sleep and appetite were good; patient had no complaints.

This man, an habitual delinquent and of borderline intelligence, is on the margin in classification of defective delinquent status. But more is involved than defect and the existence of delinquent behavior. The nature of this subject's

behavior does not appear to be of sufficient seriousness to necessitate its inclusion in a defective delinquent status. Care must be used in making a recommendation for the best interests of all. This case could be classified as defective delinquent or not.

Case 11

L.S., a twenty-one year old male offender was diagnosed as without mental disorder and of borderline intelligence.

L.S. was an illegitimate child born to unstable parents. The father, irresponsible, was a heavy drinker and had deserted the family. The patient's mother exhibited poor social background and adjustment. She had been a ward of the state, sexually promiscuous, and had married three times. An illegitimate son was born during each of her first two marriages.

L.S. was slow in development, walked at fourteen months, and talked at three years of age. At the age of three patient was committed to the state home as a dependent. He was frequently obstinate and energetic. At the age of seven he was placed in a foster home and remained there until the age of sixteen years. During these years he was considered stubborn, deceitful, a poor mixer, and was accused of stealing, both at home and at school.

At the age of sixteen, L.S. stripped and attempted to molest two small girls, was detained at the men's reformatory and then transferred to Exeter School. L.S. remained at Exeter School for two years and was paroled to his mother and step-father for two years, until returned to Exeter School following a "Peeping-Tom" offense. Six months later the patient was again paroled to his parents until the time of commitment to this hospital one year later. Patient secured three jobs during this interval and earned as much as forty dollars per week, but was unable to save money. He was active in sports, was interested in girls, and intended to marry.

> Patient was committed to this hospital for exposing himself to a woman. At the hospital patient was quiet, cooperative, and friendly. He had a good appetite, worked diligently and seemed to enjoy his work. On the intelligence test he received a score of seventy-seven, although earlier tests given elsewhere have been as low as sixty. The results of the test showed uneveness of development, and poor everyday information; yet, judgment and planning ability were normal.

The above case again represents the type of person who is borderline, not only in respect to intelligence, but from a legal, medical, and psychiatric viewpoint. From a clinical point of view, he was not psychotic, feeble-minded, psychopathic, nor criminal. Yet due to a bad environmental situation, long existing maladaption, and repeated sexual offenses, poor prognosis is indicated for good social adjustment. This patient, though providing a poor prognosis, has shown no clear indication of a specific disorder in need of treatment. For this reason, in justice to the subject's individual rights of self responsibility, his return to community life would seem imperative.

The final three cases are those of psychopathic personalities of a severe degree of disorder, and have been selected to demonstrate the great extent of seriousness and danger to society and to the individual himself. Two of the cases are dangerously anti-social and one, inadequate and dangerous to himself. Two have had previous psychotic episodes.

Case 12

L.V., a twenty-nine year old veteran of normal intelligence was diagnosed as without mental disorder, psychopathic personality.

L.V. was the youngest child in a family of seven children. Patient had five half siblings and one full sibling. A younger sibling had died at the age of three months from spinal meningitis. The American Indian and Negro parents of patient were described as being easy-going and intemperate.

L.V. was sickly as a child, suffered earaches, skin eruptions, and had a finicky appetite. He was difficult to manage, ugly if crossed, insistent on having his own way, and extremely sensitive in feelings. He began school at the age of six and completed the sixth grade at the age of fourteen. He was not interested in school and truanted frequently. School reports state that he had sudden bursts of temper in school and was considered purposefully mean to the teachers.

At about the age of twelve, this patient began to hear a strange voice in school. At first he was unable to distinguish the words; then he slowly deciphered words telling him to do "bad things". The patient described the voice as belonging to an old man dressed entirely in grey. He saw the figure wafted about the air, beckoning to him at times. Patient interpreted the figure as Death calling him. Very frequently this voice was contradicted by another voice, which patient believed to be his mothers urging him to do"good things". The conflict was represented in the boy's mind in this manner: "Whenever I do anything, he tells me to do it the other way and gets me all worried. I don't want to do anything bad ...When he tells me to do bad things I cry. He tells me sometimes to kill myself and at other times to hit other people." Patient was becoming confused and depressed because he could not obey both voices.

During this period L.V. was highly irritable, negativistic to teachers, and was often found babbling to himself. This same year patient was thwarted in an attempt to drown himself. The following year he was expelled from school for "continual misbehavior and talking to self." Also, during this time, age thirteen, patient

began his delinquent career. He was arrested several times for petty thievery, was evasive and untruthful to the probation officer, and seemed indifferent when apprehended in his delinquencies.

L.V. was then sent to the state training school for boys for a year's term. Three months later patient was hallucinated and actively suicidal. While at this training school patient again heard the voice of the grey man calling him, which meant to patient that he should kill himself. He tried this first by hanging with a towel in the basement, but the towel slipped and he was caught. He also drank ammonia, kerosene, and ate soap, buttons, paper, and rubbed dirt into self-inflicted wounds in the hope of dying. During a mental examination at the training school, patient became suddenly absorbed in looking out an open window, started to cry, "Mother, I am coming," climbed up on a window sill, and wriggled out head first. Examiner caught his feet and pulled him back into the room.

Patient was transferred at this time to the state hospital where he continued to be actively hallucinated, hearing such strange sounds as bellowing cows and whirring motors and seeing 'visions of the Lord'. Patient was diagnosed as being psychotic with constitutional psychopathic inferiority. It was believed that the patient had schizoid tendencies, a vivid imagination, and probably some mental retardation, but it was believed that the disorder was due to a continual bid for attention in an unhappy home. It was predicted at the time that the patient would probably be psychotic or a criminal at the age of twenty-five, as he was believed unable to withstand the ordinary strains of life.

L.V. remained at this hospital for a little less than one year. Hallucinations of the grey man ceased and the patient made a fair adjustment in the institution. He was discharged to his mother. His social adjustment did not improve and patient continued in minor delinquencies.

He was inducted into the armed forces at the age of twenty-two and saw active service in an infantry division overseas. He drank heavily, developed 'combat fatigue' for which he was hospitalized. He was diagnosed as psychotic with psychopathic personality and was discharged from the service with service-connected disability at the age of twenty-three.

The following year the patient married a girl of

disreputable character who left him within two months. Patient searched unsuccessfully for her, became discouraged, and jumped into the Providence River. The tide was low and patient waded ashore. Patient later stated that he suddenly changed his intentions after hitting the cold water. Two more suicidal attempts by jumping into a local quarry hole were unsuccessfully carried out by patient. Several times patient was arrested for drunkenness and disorderliness. One on occasion while in his cell in a county jail, patient removed and set fire to his clothing. On another occasion he was found flushing the toilet with his head immersed.

L.V. was committed to this hospital for a second time following a drunken spree. At this time patient obtained an intelligence level score of 118. Patient was psychopathic but no evidence of mental disorder was found. He remained at the hospital for two months and was then discharged to his father on trial visit.

The offense leading to the Defective Delinquent Commitment occurred while on trial visit status. Patient was living in his brother's home with a twenty-one year old epileptic girl of whom the family disapproved. Following a family quarrel the patient and companion drank heavily. Patient claimed that while returning to the home, the companion had an epileptic seizure. For this reason patient broke into a deserted'shack.' Patient slept there two nights with his companion and was convicted of breaking and entering.

At the hospital patient secured an intelligence rating of 101, which was somewhat lower than when previously tested at the hospital. The scattered results of sub-test scores were indicative of underlying anxieties and compulsions. Patient's adjustment was good. He was quiet, courteous, cooperative, neat in habits and appearance, and appeared cheerful in mood.

On this case the following subsequent information has been obtained:

Upon return to court as not being a defective delinquent L.V. was sentenced to two years on an old deferred charge of carrying a concealed weapon. Two month's later at the men's reformatory patient made several attempts to harm himself by chewing matches, inflicting eleven superficial cuts on his wrists, and braiding a rope from shredded sheets for the stated

> purpose of hanging himself. The wardens, greatly upset, requested transfer to this hospital. After one month of hospitalization in the building for the criminally insane of this hospital patient was returned as a psychopathic personality, without mental disorder.

The above case shows the self-destructive and pathological nature of this personality. This patient has proven to be a personality problem from his early life to the present time of study, bordering at times on psychosis. This case demonstrates the difficulty in deciding where psychopathy ends and psychosis begins. He was a very imaginative child and it was not clear as to how much of his presenting symptoms were clearly of psychotic development. It is remarkable that of all his suicidal attempts none have been successful. This may be an indication of psychopathic personality, i.e., using threatened suicide as a tool to attract sympathy and attention of others. One psychiatrist remarked that on some occasion one of his suicidal attempts might actually work. Patient did not appear greatly upset by this idea.

However, the persistence and variety of methods used for these sudden, self-destructive impulsive acts do imply a deep personality disturbance beyond the control of the patient the need of psychiatric care. This patient will be discharged within two years from the reformatory and will receive no further supervision. It does not seem likely at this point that he will have improved his personality adjustment or be any less of a threat to himself or society

in withstanding the normal strains of responsible living.

Case 13

The following case of R.S., a seventeen year old youth of low normal intelligence represents a dangerously anti-social individual of severe psychopathic disturbance, but without evidence of mental disorder.

R.S. was an only child. The father, French-Canadian, was an alcoholic, neurotic, army deserter who at times was hallucinated and delinquent and had occasional severe epileptoid convulsions. He was paralyzed in both arms and legs by a toxic neuritis, which was believed to be due to drinking Jamaica ginger. Patient's mother, an overbearing, overprotective woman, was compelled to support the family by outside work.

Delivery of R.S. was difficult and prolonged. At the time of the birth the mother was boarding two children from the state children's agency. These children remained in the home until the patient was two years of age. When patient was three years of age, a five year old boy was boarded for two years. Patient was enuretic and slow in development according to the father, but was said by mother to have been rapid in development, walking at nine months and talking at fourteen months.

Since infancy the patient was hyperactive, slept and ate poorly, and was destructive. At the age of three or four patient was threatened with an axe by an elderly neighboring woman. Patient had a severe convulsion that evening and continued to be agitated for two succeeding weeks. The patient was treated at a private city hospital for calcium deficiency, as behavior was poor and patient was continually putting objects in his mouth. Patient's mother was unable to control him, but his father wielded more influence. Patient would "act up" and try to displease mother when she returned from work. Patient was close to his father and soon imitated his father's teasing of his mother.

In pre-primary school his erratic behavior was soon noted and two months later patient was referred to the

school clinic as antagonistic, overdependent, anti-social, highly irritable, and destructive. Strange behavior consisted of eating chalk, crayons, stuffing small objects in mouth and ears, tearing paper into fine pieces. At the age of eight, patient, who was at that time a pupil in another school, was referred again to the school clinic. It was felt at this time that the mother, who was considered overlenient, felt little responsibility for the child as she was the breadwinner of the home.

During the following summer arrangements were made for a vacation for the patient at a YMCA summer camp. The patient did not adjust and was returned in several days. He did not socialize and was very restless. Patient continually wandered to the lake at night. He was followed there and discovered tearing apart and eating frogs which he had caught.

The following school year, the patient, aged nine, was transferred again and once more referred to the school clinic. The father felt at this time that the patient should be "put away". During the same year patient was hit by a car, dragged twenty feet, suffered cerebral concussion without unconsciousness and was hospitalized for two months. Shortly upon patient's return to the home the father suddenly died of coronary thrombosis. The mother believed patient's main difficulties began at this time.

The family moved in with a maternal aunt. Patient was soon involved in much friction with his aunt. School behavior continued to be poor. It was felt that the patient was emotionally upset rather than mentally retarded. His behavior at this time was disturbing to the neighborhood. One year later he was referred to a protective agency. His offenses during the year had included ringing fire alarms, stealing a bicycle, annoying little girls, beating smaller children, throwing a railroad switch and placing an iron bar on railroad tracks.

Six months later he was referred to a private foster home placing agency but placement was not made. The school, unable to cope with the problem, referred him to the city child guidance clinic. While treatment was attempted at this clinic, destructive behavior remained unabated. Thefts continued; in addition he cut a boy's jacket in a fight with a knife, severely cut a girl's face with a branch, and broke a stained glass

window in a local church. At this clinic his physical health was found to be good, but emotionally he was believed to be sadistic with "hyperphrenic tendencies."

The child guidance clinic then referred R.S. to a private agency caring for disturbed children. An electroencephalogram was taken which was suggestive, but not indicative of petit mal disturbance. His behavior while at this institution was described as "cruel, almost murderous to other children." Patient was noisy, hyperactive, and displayed some perverted sex activity. This home recommended commitment to Exeter School, which the mother would not accept. She placed him in a parochial summer camp. (This camp does not keep case records on members.)

In the Fall of the next year, R.S., aged twelve, was committed by court to Exeter School. He was aggressive and disrespectful of authority. He was never allowed out on extended parole as he was considered a poor risk; yet, during the three years that he remained there, he managed to escape on eight occasions. On the last occasion of escape, R.S., with another inmate, smashed windows, broke a motor, stole guns, knives, and clothing, broke and entered five homes, and set fire to an occupied dwelling which burned to the ground.

For the above behavior, R.S. was transferred to the state training school for boys where adjustment included typical persistent instability, irritability, and sadistic tendencies. Within one year this patient was discharged to the juvenile court from whence he was placed on probation. He returned to live with his mother who was working. Patient himself did sporadic work of a menial type, such as snow shovelling and dishwashing.

Fifteen months following release from the training school, R.S. committed the offense of manslaughter, leading to the Defective Delinquent Commitment. Patient was homosexually approached by an elderly man in a local hobo "jungle", which patient often frequented to beg food. R.S. knocked the man to the ground, picked him up, struck him again in the face, and left him unconscious. The man never regained consciousness. Patient was not apprehended until twelve days later when held for questioning on the charge of a fire-setting.

At the hospital the patient obtained an intelligence quotient of ninety and revealed high performance and low verbal abilities. Impulsiveness was marked. In the hospital adjustment, patient showed poor consideration

for others, was suspected of stealing a knife and money, and displayed violent temper which frightened and upset other patients. Patient was found fondling and kissing younger patients.

The above patient, as the record demonstrates, has been almost a continual source of irritation and threat to society. His intelligence is normal while his personality is obviously warped. Without adequate facilities for this patient the community has been taxed with all of its resources in attempting to deal with this offender. He has been the object of attention and the concern of the services of thirteen different institutions or agencies within the larger community.

Although in great need of treatment, the patient remained, with a single exception, but a short time in any agency or institution. The exception, Exeter School, where he was considered a patient for three years, lacked suitable buildings for necessary security, as is evident from the patient's eight escapes. This case demonstrates that the proper facilities did not exist for the treatment of this emotionally irresponsible, yet not psychotic, chronic offender.

As this patient was of normal mentality, he was returned to court as not being a defective delinquent. Records of the court indicate that R.S. was committed to the state reformatory and then transferred to the state training school for boys. At the time of this study, the patient is held at the training school which has neither maximum security housing nor adequate treatment and custodial measures for this type

of offender.

The implications of the handling of this case are particularly important for social casework agencies. The time and resources used by the various agencies in attempting to help this individual can be considered to be a considerable amount. Such severe personality distortions, as found in the above case, cannot be successfully treated within the separate settings of the various agencies involved. An early removal of such seriously maladjusted individuals from society would release the services of social casework agencies to provide more fruitful service to other community cases. In the same manner, institutional facilities, which are usually understaffed, when once removed from the hampering effects and individual care needed for such offenders, would be freer to perform an already difficult task with more ease and efficiency.

Case 14

The following case concerns a twenty-one year old Negro woman who was diagnosed as psychotic with psychopathic personality. This case was selected primarily because it presents a perplexing problem of discriminating among thoroughly mixed features of psychopathy, psychosis, and mental deficiency. Proper care for such subjects will in all probability remain a problem for some time to come.

K.N. was an illegitimate child born to an irresponsible mother of mixed blood (Negro, American Indian, Spanish) and a Portuguese father of whom little is known. The maternal background was poor. There was a history of mental disease and epilepsy in both maternal grandparents and maternal siblings. The patient has a stepsibling, also illegitimate, with whom she is unaquainted.

K.N., poorly nourished, rachitic, was deserted by the mother six months following her birth, and became a ward of the state. She was placed in her first foster home at the age of two and remained there for four years. During these years she demonstrated willful, selfish behavior. Patient was said to be sulky, stubborn, aggressive toward younger children, disobedient, tempestuous, and infantile. The visiting social worker at this time felt that the child received poor care in the home and was rejected by the foster parents. "These feelings (of rejection) and her past experiences have evidently resulted in accumulated affectional deprivation which resulted in the continuance of infantile behavior and the development of pronounced rebellious, resentful reactions." *

When nearly seven years of age, K.N. was transferred unsuccessfully to three foster homes in a three month's period. The patient was returned to the state children's home where she continued to be unmanageable, being frequently changed from cottage to cottage.

At the age of ten, K.N. was transferred to the state training school for girls, where the same maladaptive behavior continued. Five months later, the patient, being too young for admittance to this hospital, was transferred to Exeter School. Here she proved to be thoroughly disruptive and became a maximum problem to the personnel at Exeter. Her behavior as revealed by Exeter School daily reports included a long list of misdeeds. The patient destroyed bedding, broke windows, tore her own clothes, struck attendants, urinated at pleasure, threatened others with a knife, stuck pins in smaller children, etc. The following examples of self destruction were noted in the daily report; drank Oakite solution, attempted to jump down an air shaft, attempted to choke herself with cord, sewed up the palm of her hand with a needle and thread. Pre-psychotic behavior was suggested by periods of wandering about, talking to herself, and hysterical laughter.

When the patient reached fifteen years of age she

* As quoted from a case record abstract.

was transferred as "a case unsuitable to Exeter School" to this hospital. K.N. adjusted well for a little over a month and then became hyperactive, boisterous, profane, obscene, and disobedient. She was enuretic but refused to be toileted. Patient adjusted well for short periods, but was impulsive, unpredictable,and suddenly violent. On one occasion she beat up a disturbed patient. Ground privileges were abused. She was found fighting in the patient's canteen. Patient appeared overly interested in men, and associated with them when possible. At other times she was usually in the company of other psychopathic women.

Briefly, her four year hospitalization was one of frequent, almost continual transfer from one service to another. On eleven occasions she was transferred to the building for the most seriously disturbed female patients. Also, the patient, deceitful, disobedient, managed to escape from the hospital on seven separate occasions. Following her last elopement and non-return she was placed on family care status, meaning that the patient was still on the books of the hospital but in the community on trial adjustment and under the responsibility of the hospital.

One year later K.N. was delivered of a child. She claimed to be married, but no legal record of a marriage was found. At this time patient was living in a dilapidated home with individuals considered by the community to be immoral and disreputable. Four months following the delivery of the child, patient was arrested for breaking and entering a deserted home with a male companion (L.V., previously discussed above, Case 13) and was committed to this hospital as a probable defective delinquent.

The intelligence test given at the hospital revealed an intelligence quotient of seventy-four. The wide scattering of the test results indicated marked instability. The medical examination revealed that the patient had contracted venereal disease since leaving the hospital one year and one-half previous. Hospital adjustment was fair for the first few days. Later, when K.N. was refused permission to attend a patient's dance, she broke a chair, flower pots, and twenty-eight panes of glass in a burst of temper. She continued threatening and abusive behavior to attendants. Four days later patient had a grand mal epileptic seizure which was followed for the next few days by "continuous seizures" between which the patient was assaultive and aggressive.

> K.N., being of borderline intelligence, was recommended to the court as not being a defective delinquent, but commitment to this hospital was suggested due to the frequent "psychotic episodes". She was recommitted by court to this hospital for proper treatment.

This psychotic, epileptic, mentally retarded, psychopathic personality will undoubtedly remain a source of trouble to those responsible for social welfare. It is hazardous to venture an opinion as to how this or similar cases can best be dealt with. The Division of Defective Delinquents is not intended or prepared for the care of psychotic or epileptic patients. Such a patient may judiciously be cared for in this hospital for psychotic and epileptic behavior. Yet the patient described above is not under sentence, nor legally criminally insane, and thus may be returned to the community when reasonable return to normality is manifested. Her long history of behavior disorder would make continued good adjustment in the community seem unlikely. Her social adjustment while on family care status of the hospital was notably poor.

Even with a greatly extended and improved program for care of defective delinquents such problems as the above will remain. It is well to remember that the establishment of a Division of Defective Delinquents does not provide a panacea for treatment of chronic problems. The above case of severe reactions of several disorders poses a problem of varied specialized treatments needed, which is not to be found within one Division of Defective Delinquents. The important aspect is not where such an offender is held, but whether such a

person can be held in an institution for proper custody and treatment when definite mental deficiency is not in evidence, psychosis has subsided, and yet clear indications exists of continuation of pathological social and emotional adjustment.

CHAPTER VI

SUMMARY AND CONCLUSIONS

Society is faced with the problem of proper care for a class of offenders who, though not clearly psychotic, are yet not fully responsible for acts committed, and thus constitute a threat both to society and to themselves. The Defective Delinquent Act of 1947 has been a step towards the resolution of this problem.

The purpose of this thesis has been twofold: first, to examine commitments of suspected defective delinquents to ascertain more clearly the public conception of what constitutes a defective delinquent; and second, to examine selected cases to observe the effectiveness and adequacy of the present application of the above law. The study was confined to case records on twenty-eight patients, or admittances over a course of eighteen months since the passage of the law.

A brief survey of the literature has pointed out that the problem of the defective delinquent covers a much wider area than intellectual defect and habitually delinquent behavior. It was found that some offenders of apparently normal intelligence have continued anti-social actions, dangerous to community and to themselves, and appear unable to learn from experience or to profit from existing social and penal methods of handling them.

Historically, legal provisions have been made for defective delinquents for several decades, but it has been only since comparatively recent times that a more understanding, dynamic interpretation and approach to these offenders has been ventured. Many states have as yet to provide for the care of these offenders, but a few states are already pointing out what can be done.

Rhode Island, being a small state, does not have the same problem of defective delinquency (at least in numbers) as the larger states. Yet the few defective delinquents already encountered have proved to have caused much difficulty in care in the existing institutions as well as in society at large. The problem was openly recognized following a major fire disaster. After some difficulty a law concerning defective delinquents was approved in 1947. This law provides for the observation of suspected defective delinquents at the State Hospital for Mental Diseases and provides for the commitment of those persons found to be mentally defective and habitual delinquents. Such defective delinquents are to be held under indeterminate sentence and to be released at the discretion of the superintendent of the state school for the feebleminded. (See Appendix A)

The present study has been concerned with the developmental history and hospital adjustment of all cases committed to the State Hospital for Mental Diseases for observation as suspected defective delinquents for the first eighteen months

since the above law has been in effect. An overall descriptive study of these twenty-eight cases was made to reveal community and legal interpretation of what kind of person a defective delinquent was thought to be.

Through a descriptive study of the entire group of admittances specified above, it was found that the majority of patients came from parents, both of whom were foreign born. Three-quarters of the group were Roman Catholic by religion. A normal home life, which is usually considered a major force in the development of personality, was definitely lacking. Over two-thirds of the cases came from inadequate or broken homes. The families from which they came tended to be large (5.8, average number siblings). Many have been separated from their families and lived for extended periods in institutions or in foster homes. Over half of the entire group lived in institutions from one to ten years. Slightly over 10% of the group spent the major portion of their lives in institutions.

The age at onset of behavior problems was remarkably early. The largest single group of those developing behavior problems occurred during the period from birth to two years of age. The remaining cases showed no definite age at which behavior problems began, except for a tendency for problems to begin before the age of eighteen.

Scholastically the group as an average reached the sixth grade level, demonstrating that serious intellectual deficiency was not a problem to the group as a whole. Intelligence

tests of the group revealed a tendency for performance abilities to exceed verbal abilities, and slightly higher scores were obtained than on previous intelligence tests. Significantly, the majority of cases ranged between borderline and dull normal intelligence levels. Only two cases were actually mentally defective, as judged by tests.

The diagnostic classification revealed that of the total group of probable defective delinquents the majority were classed as psychopathic personalities. Only four cases were classed as defective delinquents, none of whom tested as being feeble-minded. Three were of borderline intelligence and one was of dull normal intelligence.

The group as a whole tended to be young. The most frequently occurring age group was twenty to twenty-four years; three quarters of the patients were between the ages of fifteen and thirty years.

Sexual adjustment in most cases was poor. Only five subjects were married, of whom but one could be considered to have achieved a satisfactory sexual adjustment. Nearly all of the unmarried group expressed difficulty in sexual adjustment.

Military adjustment of the eleven patients who had been in the armed forces was poor. New stresses may have aggravated pre-existing maladaptive behavior patterns, and in a few cases might have precipitated previous relatively mild disturbances into more severe disorders.

An examination of the type of offense for which subjects were committed for observation showed a predominance of offences of a sexual or perverted nature. It would appear that sex perversions are particularly disturbing to the community moral sense and tend to facilitate the label of "defective delinquent" by community and court. The remaining offenses concern personal injuries and disrespect of property and authority, which are typical of psychopathic behavior.

The amount of recidivism shows no distinctive pattern, except that most offenses are of a sexual nature. No particular current method of treatment or punishment has yet been demonstrated to have a deterrent effect. In this study the degree of intelligence was found to have little or no relationship to the frequency of recidivism.

Hospital adjustments of the probable defective delinquents in general were fair, and in only a few instances revealed serious pathological development. Sexual offenders tended to make a good or excellent adjustment. All of the patients classed as disruptive were recidivists of three or more convictions.

Although the total group committed were presumed to be defective and habitual delinquents, only four were recommended by the hospital as being properly classified as defective delinquents. A comparison of the hospital recommendation with the intelligence scores of patients suggests that intellectual

deficiency was not the main disturbance. Of those classed by the hospital as defective delinquent, not one had an intelligence quotient below seventy-one. It would appear that those presenting the major problems were the patients of retarded, but not deficient intellect.

The above descriptivestudy points out the difference in thinking between community conceptions and psychiatric and legal-medical interpretation. The descriptive summary of probable defective delinquents committed has shown that in the majority of cases, they had psychopathic personalities, were of low normal intelligence who came from generally poor family, social, and economic backgrounds, exhibited long standing anti-social, threatening behavior. In addition there was a small class of offenders of sex perversions, which were believed by the community to be indicative of a disordered personality as expected to be found in a defective delinquent. In the writer's opinion the small proportion of actual defective delinquents committed indicated that to the public, social maladjustment of the strictly intellectually deficient habitual delinquent has not been a major problem.

The second part of this study concerned methods of handling those offenders, who though not fully responsible for acts committed, yet constitute a serious threat to society and to themselves. The main question raised was whether the present defective delinquent law and its interpretation were adequate in coping with this problem, at least as far as could

be ascertained within the limitations of this study.

For the above purpose, fourteen illustrative cases were selected for analysis. Four cases of defective delinquents pointed out the need for long time supervision in a protected environment, the community difficulty in handling such offenders previous to the establishment of the Division of Defective Delinquents, and the unamenability of treatment of earlier school and reformatory measures.

On case of a seriously disturbed psychopathic personality, not continually psychotic, proved to be disruptive within the hospital setting. The hospital lacked the legal right to hold such a person who was not under sentence nor considered insane. This particular case, bordering on feeblemindedness and mental disorder was at the time of the study in the community and under no supervision, although clear evidence existed as to the general undesirability of allowing her unrestricted freedom. At present, proper legal care for such offenders, suffering from no clear-cut disorder, remains a problem.

There were only two admittances of strictly feeble-minded offenders. It was pointed out in their histories that the offenses were relatively mild, and the protection of society and the individual involved could well be obtained without resort to the Division of Defective Delinquents. Mental defect and delinquency are not necessarily socially threatening disorders. Both cases were returned to responsible family supervised life in the community.

One case was utilized to depict the general background and development of a "typical" sex offender. It was pointed out that many such cases were believed socially threatening because of the strange, perverted nature of the disorder, but which upon more thorough examination proved to need psychiatric aid. Their acts were not so threatening as to warrant commitment to the Division of Defective Delinquents. It was this type of case which most clearly demonstrated the difference in community and psychiatric thinking and interpretation as to what constituted a defective delinquent. The above case, typical of many, was not considered seriously dangerous and provision for release to the community was made.

In comparison to the above a case of a seriously threatening sex offender was discussed to demonstrate the need for adequate care and supervision of dangerous, psychosexually disturbed personalities. The law, by restricting the term defective delinquent to mental defectives, excluded this particular offender of dull normal intelligence. For this reason it was considered beyond the hospital's authority to classify this individual as a defective delinquent, however antisocial his behavior. An interesting result followed. The community and court district in which the patient was apprehended, a short period later, took upon itself the authority to declare this individual to be a defective delinquent and to have him committed to the Division of Defective Delinquents. This case demonstrates the need on the part of society to

protect itself from such offenders, even though they are not strictly classifiable as defective delinquents under the present law.

The weighty problem of classifying defective delinquency status becomes an increasingly difficult one in discriminating among minor delinquency and borderline mental defect. Two such cases of borderline status were discussed in order to emphasize the importance of the seriousness of the behavior disorder, rather than the frequency of delinquency or the degree of intellectual retardation as the only criteria. In respect to individual rights of the subjects concerned, only self-evident indications of a socially threatening nature should warrant the deprivation of liberty.

Three cases of severe, dangerous psychopathic disturbance were discussed in relation to the applicability of the defective delinquent law in handling them in the best interests of society. The first case concerned a self-destructive psychopathic personality who bordered at times on psychotic episodes. He has been a continual problem since early childhood. He was found to be of high normal intelligence, and thus not a defective delinquent. Upon release from the reformatory to the community within two years, there is no assurance that his deep personality disturbance has in any way been modified. It is felt by the writer that if the intention of the law is the protection of society and of the individual against himself, the law has not been conceived in sufficiently broad terms to

accomplish this end.

The history of the second case revealed a person who was a continual source of irritation and a threat to society but whowas of normal intelligence. Long, costly, time-consuming efforts of private and public social welfare agencies and welfare institutions have not met this problem successfully in the past. At the present, this subject is held in a juvenile detention agency which does not have maximum security facilities, an institution in which the patient's previous adjustment had been most unsatisfactory. This individual is clearly in need of a therapeutic, yet restraining atmosphere. This type of situation has not been provided for by the above law.

The third case, of a Negro girl of psychopathic disturbance, complicated by psychotic episodes, epilepsy, and borderline mentality, was chosen because of the bewildering problem presented. Her adjustment at no time has been satisfactory, nor has any institution been able to handle the case. The question as to proper care for such offenders as the above is as yet unsettled and undoubtedly will perplex those responsible for her care for some time to come. The Division of Defective Delinquents is not planned to care for psychotic or epileptic subjects, nor is the hospital intended to hold psychopaths who are able to function normally and not under criminal sentence. Commitment of cases to the Division of Defective Delinquents should not be regarded as a final

solution or panacea in the treatment of the most difficult, irresponsible offenders, but should be considered rather as a further tool in the specialized care and treatment of chronic problems.

From the preceding study and summary it is evident that the creation of a Division of Defective Delinquents has not fully met the needs for the care of offenders who are not wholly responsible for offenses committed, yet it has greatly relieved a difficult situation. It was previously argued that Rhode Island is too small a state to provide, as well as financially support, a separate instituiton for defective delinquents. This is quite true if a narrow interpretation is given to the concept of defective delinquency. The courts and the public have demonstrated through the type of cases committed to the hospital for observation that only a small minority could be strictly classified as defective delinquents under the existing law. Many are minor problems, usually of distorted sex expression. The remainder are serious problems of psychopathy and psychosis, quite puzzling to society. The line between psychopathic disturbance and mental disorder is difficult to demarcate in many instances.

Measures for dealing with these offenders have to date been of little avail in the most serious cases. Punishment and prison terms have had little apparent reformative effect on these chronic offenders. Those not considered defective

delinquents and yet constituting serious threatening social problems have been given minor sentences or have been continued on probation. Following release no supervision is given. Thus, it appears that society has neither fully protected itself, nor has the individual been protected against himself.

Developments in other states have previously been discussed. Notably, California, as one example, has already taken steps in this direction by creating separate institutions for "psychopathic and defective delinquents", in which the patients are given indeterminate sentences and are under continual therapeutic care.

Such a program might well be inaugurated in Rhode Island. It is argued understandably that the cost of provisions for such a separate institution may be high, but as measured against the cost of not making such provisions, it becomes of much less significance. In one instance the cost of the depredations of one individual was estimated at one-half million dollars.

Many of these chronically maladapted offenders have long been charges of the State. They have been disruptive elements and impeded the normal functioning of such institutions as the state school for the feeble-minded, state children's division, state hospital, and the various state training and correctional institutions. None of the above institutions have been equipped to handle these special problems, nor do

they have adequate facilities at present. In the outside community these same offenders have presented chronic problems to community public and private social agencies. The efforts of social workers over long periods have shown discouraging results.

It would be the recommendation of the writer that further study be given to this problem, with emphasis on the possibility or advisability of establishing a broader plan and separate institutional division for the care of defective delinquents which would include pathological incorrigibles, irrespective of intelligence. In the cases studied it would seem that the ability to use intelligence properly is of greater importance than intellectual capacity itself. As demonstrated by previous cases, emotional defect can be as crippling as intellectual defect. Spreading seriously maladjusted personalities throughout existing agencies and institutions hardly seems an appropriate solution.

A good institution for defective delinquents can remove pathologically dangerous individuals from society and through use of resources at hand and cooperation of other institutions as a mental hospital, can attempt to treat with the ultimate goal of re-establishing community adjustment. The creation of the Division of Defective Delinquents is a step forward. Despite obvious limitations it does represent public recognition of the existing problem and does provide

for the mentally defective, apparently incorrigible offenders. However, goals are often necessarily limited. Good custodial treatment in itself is of great value. It not only protects society from such offenders, but frees other case-work agencies and treatment centers to perform more efficiently their respective functions.

It is encouraging to know that although many needs are as yet unmet, we at the present stage of development, are steadily progressing towards a greater understanding and improved treatment of the complex problems of the human personality.

Approved,

Richard K. Conant

Richard K. Conant
Dean

APPENDIX A

DEFECTIVE DELINQUENT LAW IN RHODE ISLAND

STATE OF RHODE ISLAND AND PROVIDENCE PLANTATIONS

GENERAL ASSEMBLY

January Sessions, A.D. 1947

CHAPTER 1852

AN ACT ESTABLISHING A DIVISION OF DEFECTIVE DELINQUENTS WITHIN THE DEPARTMENT OF SOCIAL WELFARE.

It is enacted by the General Assembly as follows:

SECTION 1. There is hereby created within the department of social welfare a defective delinquent division for the care and treatment of defective delinquents.

SEC.2. At any time prior to the final disposition of a case in which the court might commit an offender to the state prison, the reformatory for men, the reformatory for women, or any jail or reform school for any offense, an attorney-general probation officer, an officer of a city or town police department, public welfare department, or department of social welfare may file in the court an application for the commitment of the defendant to the state hospital for mental diseases for a period of observation. On the filing of such an application, and if the court after examination of the offender's record, character and personality finds that he has shown himself to be mentally defective and to be an habitual delinquent or shows tendencies toward becoming such, the court may commit said offender to the state hospital for mental diseases for observation for a period not to exceed a thirty-day period with the further provision in said order that the superintendent of the state hospital for mental diseases and the superintendent of the Exeter school shall within the thirty-day period report to the court their diagnosis and findings as to whether said offender is a defective delinquent. If the findings of the said superintendent of the state hospital and the superintendent of the Exeter school for the feeble-minded are that the offender is a defective delinquent, the court shall commit the offender to the division of defective delinquents. If the report of the superintendent of the state hospital and the superintendent of the Exeter school for the feeble-minded is that the offender is not a defective delinquent, the court shall dispose of the case as an ordinary criminal matter.

SEC. 3. Application for the discharge from the said division of defective delinquents of any person so committed may be made by him or some person in his behalf to the court by which such person was committed and a time and place for the hearing of such application shall be appointed by such court to whom such application shall have been made, and such court shall have the power to order the discharge of such person. After application has been made as aforesaid, and prior to the hearing thereon, the applicant shall be permitted to have the person so committed examined by a physician selected by the applicant. The testimony of such physician shall be admissible in evidence at the hearing on said application. Any person aggrieved by the order of any court committing such person to such division or refusing to discharge such person therefrom shall have the same right of appeal which is provided in the judgment of any court in criminal cases.

SEC. 4. The superintendent of Exeter school shall have full control and authority over the inmates of the said division of defective delinquents and may, whenever he may consider it necessary or expedient, discharge any inmate of said division, delivering said discharged inmate to the person or place liable for his support.

SEC. 5. The director of the department of social welfare may establish within any of the existing state institutions under his control, a unit to be used for the custodial care and treatment of defective delinquents.

SEC. 6. This act shall take effect upon its passage.

APPENDIX B

SCHEDULE

1. Age and Birthdate
2. Diagnosis
3. Paternal and Maternal Relatives:
   General Information
4. Father:
   Nativity, Personality, Behavior Adjustment,
   Attitudes toward Subject
5. Mother:
   As above
6. Siblings
   Significant information
7. Birth, Infancy, Early Development
8. Childhood Personality:
   Personality traits, Problems, Fears
9. Education and School Adjustment
10. Significant Childhood Events:
11. Childhood Health
12. Occupational Adjustment
13. Military Service and Post-War Adjustment
14. Psychosexual Adjustment:
15. Marital Status and Adjustment
16. Economic and Social Status
17. Past and Present Physical Disorders
18. Religion:
    Interests, Attitudes
19. Recreation
    Outlets, Interests
20. Personality Traits and Adjustments:
    Interpersonal Relationships
21. Institutions Attended:
    Reason, Length of Stay, Adjustment
22. Delinquency and Criminal Record
23. Offense Leading to Defective Delinquent Commitment
24. Previous Mental Tests:
    Age, Results, Interpretation
25. Mental Tests:
    State Hospital for Mental Diseases
26. Hospital Adjustment
27. Hospital Decision and Recommendation
28. Court Disposition

APPENDIX C

COURT DISPOSITION OF TWENTY-EIGHT PATIENTS RETURNED TO COURT FOR TRIAL

Disposition	No.	Length of Period	Total No.	Per Cent
Division of Defective Delinquents:			4	14.29
Men's reformatory	3	Indef.		
Other	1	"		
Imprisonment:			6	21.42
Men's reformatory	2	2 yrs.		
County jail	2	1 yr.		
	1	8 mos.		
	1	1 mo.		
Other:				
Institutional Care:			7	25.00
State hospital	5	Indef.		
Training school	2	"		
Probation:			7	25.00
Probation	1	2 yrs.		
"	2	1 yr.		
"	4	6 mos.		
Form of Release:			4	14.29
Discontinued	2			
Deferred Sentence	1			
Released	1			
Total	28		28	100.00

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