Current Practice

PRACTICAL PSYCHIATRY

Crime and Delinquency

P. D. SCOTT,* M.D., M.R.C.P., D.P.M.

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Behaviour disorders and crime occupy an increasing proportion of psychiatric practice and carry in their wake a number of ethical and political, as well as clinical, problems. There are professional questions as to the proper limitations of psychiatry, and academic questions concerning what illness might be, but in practice the physician does not ask himself if the offender is a sick man, a psychiatric case, an immoral man, or a deserving man, but whether he has a disorder needing attention which he, either in co-operation with others or alone, by his particular skills can relieve or cure. We can safely leave it to his effectiveness or—more appropriately at the present time—his ineffectiveness to limit his activities.

Classification

No single classification of offenders (a convenient collective term for criminals and delinquents both official and undetected) is satisfactory, but by successively applying a number of quite different classifications, and bearing in mind the significance of each, a working method can be evolved. The individual practitioner is better at this than the computer, though this may not remain so for long. Meanwhile prediction tables are of little use and may even be misleading to the clinician, who will be working at a time and in a place and with a selection of patients quite different from those in which the table was validated. Useful as such tables may be to the administrator who has to consider averages and totals, the individual offender more often than not refuses to be pigeon-holed, and his parents cannot be slotted into the appropriate single word descriptions.

It is as well first to consider (if the court has not already done so) liability to abscond, dangerousness, and severity as a basis for deciding where the offender should be studied—otherwise the process may be interrupted by the occasional tragedy, repetition, or absence of the principal figure.

It is better and kinder to isolate for a while offenders who are still in a fiery state of rebellion not yet cooled down and those who have attempted serious self-destructive acts (including some drug taking) and homicide, even though these are more often than not never repeated. Mutual exasperation, disappointment, and resentment between parents and child is often best dealt with by a temporary separation. Offenders who have been manifestly dangerous in any way are best segregated if only because this ensures that in remand home, centre, or prison they will be assessed by staff who are highly experienced and therefore more able to accept responsibility. The offence may have been effective in discharging tension, testing how far the individual may go, securing attention, control, or recognition of his plight; but, if there is a further offence within the period of investigation, this is a plain message that something more is required, and the case is usually best assessed in the custody of hospital or remand establishment. If there is need for a

period of compulsory observation it is much better that this should be imposed early and by the courts; there is no lasting stigma attached to remand; it is always easier later on to relax restriction, perhaps in carefully planned stages, rather than to impose it anew; and the courts are much better equipped for the role of restrictors of liberty than are doctors.

Next should come a search for primary or coexisting psychiatric disorder, and here the routine history-taking and examination are essential in order to reduce the chance of the unexpected being missed. The unhappy frequency, especially among young people, of toxic delirious states ensures that they will not be misdiagnosed. Schizophrenia and epilepsy tend to be diagnosed too readily—they are both very rare in offenders, and when they do occur their relationship to the crime is usually indirect, so that crime as part of an epileptic phenomenon is exceedingly rare.

Depression and Crime

Depression, too, tends to be overworked; most of us are inclined to miss the endogenous depression and to diagnose reactive depression far too often. Most offenders will see a doctor after they have been caught, so that they are likely to be feeling subdued, or self-pitiful, if not depressed. Florid endogenous depression is obvious enough, but there is a variety especially in young adult offenders in which the patient has little to say, does not excuse his conduct nor complain of sadness, seems to be appealing for help but unable to express himself, neither agitated, obviously retarded, suicidal, nor experiencing ideas of reference, yet doing everything in a rather tense, mechanical, uninvolved manner. A history from a relative would be helpful, but often this is not available. As outpatients these young adults faithfully attend as often as required, yet have nothing much to say. Their subsequent progress, long after the offence has been dealt with, shows that they have in fact been depressed, that they were retarded, and did feel uninvolved (though not classically derealized), and that they did appreciate not being expected to talk during the many attendances of the supportive treatment.

It is a useful rule never to diagnose reactive depression in offenders before asking oneself whether justified and perhaps chronic disappointment, disillusionment, or discouragement does not fit the situation more accurately. This is not just hair-splitting; a diagnosis of reactive depression leads all too easily to the prescription pad, which at best will relieve without helping the individual to cope with his real life situation, and in those of dependent or inadequate character there will always be the danger of addiction or greater dependency. Again it is unwise to make an unqualified diagnosis of depression where there has been an acquisitive offence in the company of others, especially if the offence involved the expression of appreciable aggressiveness or planning. Depressive offences are almost invariably unaccompanied, do not benefit or gratify the offender except in the relief of tension, and except for the so-called

* Physician, Bethlem Royal and Maudsley Hospitals.

"altruistic" murders of wives and children and the ensuing suicide are not planned; nevertheless, depressed patients often know that they must soon do something to bring their tension to an end. A diagnosis of reactive depression should always be accompanied by an analysis of the circumstances which form the basis of the reaction, as well as by a plan for dealing with them.

There is a great and understandable tendency to dub as depressive any offence which is apparently senseless and not due to other disorder. Careful study of these cases, and this is often possible only after the offence has been dealt with, brings to light hidden real-life frustrations or unsuspected personality defects—or more likely a combination of the two. If an offender has been able to perform adequately at work and to enjoy the company of his mates and showed "depression" only at home, or vice versa, then the progress of the case will show that the primary difficulty was not depression. The really depressed offender experiences difficulty with his work, his leisure, and his home.

Atypical depression in this field usually turns out to be an unsatisfactory diagnosis.

Psychopathic patients can, however, display depressions and short-lived psychotic states which respond quickly to situational treatment (getting the court appearance dealt with, admitting to a psychiatric ward, etc.). These cannot be dismissed as play-acting or simple evasion, for they often result in seriously aggressive or suicidal behaviour, especially if met with punishment, sarcasm, or retribution, as opposed to firm and friendly control.

Juvenile Depression

A similar picture is seen among juveniles: rare but important endogenous depressions on the one hand, while on the other a host of children who could be called reactively depressed but who are more usefully considered through a longitudinal tracing of their development. This usually throws a more meaningful light on their present emotional state than does a cross-sectional label. It is misleading to rely very much on the interview with a child. Children are so labile and variable; the truant from school when admitted to a remand home may present a tearful and apprehensive picture of misery for a couple of days and may then begin to join in all the activities and wonder how he could have been so silly; a child with a lifelong history of insecurity, perhaps with repeated separations from home and severe handling, may be permanently apprehensive, subdued, and defensive, at least over a period of several years; an adolescent may show a picture of morose withdrawal and self-neglect during the morning, followed by a hypomanic-like overactivity (even without amphetamine) in the evening when he has joined his friends. Younger children usually show depression only if they are prevented from discharging their tension through overactivity, which appears to be the preferred response. Although prepubertal children almost never show the characteristics of endogenous depression they nevertheless sometimes commit suicide. Among delinquents this is most likely to happen if the child feels that committal to court or remand home is a repetition of previous dreaded rejection or abandonment. There is another and quite different group of children who have learnt to control their situation and express their anger through suicidal attempts or threats; it is almost impossible for most residential establishments to absorb the great anxiety which these children can cause; they need a very high staff-patient ratio such as can usually be obtained only in hospital.

Subnormality

In this field mental deficiency or subnormality is an administrative term as well as a diagnosis and does not depend only on intelligence. Nevertheless, it is essential for those working with offenders to use an intelligence test which they know by

rote and can personally administer in a relaxed manner without, as it were, setting the stage for a test. The Kent Oral test is ideal for this purpose. Many offenders are so resistant, afraid of failure, or poorly motivated that formal intelligence tests may occasionally be unreliable even when administered by experts. If the psychiatrist is to give evidence in a certificate or in court about a patient's intelligence, then he ought personally to have checked the formal test results. Again, because of variable motivation to co-operate with tests of conventional knowledge, a patient's inability to add up coins and calculate change (even, these days, if from an orphanage or institution) is a very reliable indication either of mental defect or a specific disability; much more so than a low Binet or Wechsler I.Q. or a formal test of reading, for everyone spontaneously wishes to use money.

Paranoid States

Paranoid states in otherwise mentally well-preserved offenders need a special mention because they are so chronic, so apt to repeat their offences, even after years of apparently normal behaviour while under treatment, and because the offender often has sufficient insight to conceal his feelings. Spouses are often in great danger. Any report of a person examining the pockets, handbag, underclothes (for seminal stains), or repeatedly going to the police, employing detectives, or personally following or making inquiries at the spouse's place of work, coming home unexpectedly, endless questioning and insisting on confessions, giving bizarre instructions to the children, especially if he or she begins to notice signs which are suddenly and incontrovertibly recognized as proof of the partner's guilt (the position of the front door mat, the fact that a window is half an inch open, the way he hung up his hat)—any one of these should be taken seriously and should lead to inquiries about the others and about any earlier pathological jealousy to this or any previous partner.

Obsessional Features

Whether or not the obsessional patient with an antisocial preoccupation ultimately acts it out is a much discussed problem. The short answer is that very rarely he does, but usually not until the supervision of psychosis has destroyed his control. Patients of mildly obsessional, narcissistic, meticulous, and perfectionistic personality sometimes display emotional crises in which they can be unexpectedly dangerous—e.g., in battering their babies or setting fires.

A great many crimes are described as compulsive which are more properly impulsive; they lack that quality of resistance which the definition requires. This is particularly noticeable in all the perversions, where the patient invariably values his fantasy or practice and covertly derives much pleasure therefrom. Regrets and resistance may, of course, be added after arraignment for a crime, sometimes quite genuinely.

Under this heading also come the two chromosomal abnormalities which most concern the forensic psychiatrist: Klinefelter's syndrome and the double Y, recognized respectively by the atrophic testes and the tall stature.

Doctors are notoriously pessimistic in predicting the course of an offender, and one of the probable reasons for this is that they fail to appreciate that the prognoses for the criminality and for any medical or psychiatric condition which may be present are often quite independent of one another.

Non-psychiatric Offenders

The great majority of offenders have no psychiatric abnormality; even among the selected populations of remand homes and prisons the proportion of psychiatric problems is in the region of 15% to 20%. A useful preliminary sorting of the remaining 80% is into first-timers or recidivists. Most first offenders will not repeat their offence. Some will in fact have

committed many undetected offences, yet it is the reaction to being caught which is the crucial factor rather than the number or even, within limits, the severity of undetected crimes. And many first offenders, even though they will not repeat, may still have a large problem on their hands with which they will need help. A previously sound adjustment and the presence of adequate precipitating troubles in the environment are favourable factors, so that an offence or offences appearing for the first time in the midst of a difficult adolescence or during a personal real-life crisis can be expected to stand a good chance of resolving. However, such crises vary in their responsiveness to help; a man who remains extremely dependent on his parents who are now dead or ill may be in a lastingly difficult situation; the man who has married a dominating replica of his mother, and has just produced a son who is replacing him, is going to need long-term support.

Offences appearing for the first time in later life should lead to a careful search for a primary cause (depression, alcoholism, dementia, arteriosclerosis).

Rebelliousness, being deliberate opposition to and resentment of some form of authority, while retaining good relationships with others, usually has an excellent prognosis, for it is the expression of strength and determination. This has to be distinguished from the broadly aggressive and hostile person who acts out impulsively against any source of frustration, for these are characteristics which are very persistent, especially if accompanied by sensitive, "suspicious" traits.

In short it is the capacity and willingness to learn and to adjust that matters, rather than the motive for, or the meaning of, or even the content of, the misbehaviour. An essential consideration is how the individual relates to others, especially under conditions of stress. Interviewers have always more or less consciously utilized the sort of relationship which develops between them and their patients to evaluate this. The technique is least reliable with the intelligent, manipulative patient, so that if ever one begins to feel that this is a thoroughly nice fellow who has been repeatedly sinned against, that is the time to beware and to look at the whole picture in a detached manner. Reliable assessment and effective recommendations are based not so much on brilliant interviewing and profound insights as upon laborious collection of data from as many sources and observers as possible, talking to relatives, probation officers, prison personnel, insisting on seeing the police depositions, writing to hospitals and other institutions in which the offender has been known, thus building up a longitudinal view of his development as well as a detailed assessment of his present state.

Self Evaluation

The offender's view of himself is important, especially if he has a very low self-estimation and high aspirations, for this combination ensures a high level of frustration; it is likely that a great deal of the ineffective, non-adaptive crime that puzzles us all is basically displacement of pent-up frustrations and forced termination of intolerable tension.

The question of what is tolerable introduces the inevitable temperamental differences between people, appreciable soon after birth and persisting perhaps throughout life. For this reason the management of many handicapped chronic offenders is more a question of fitting this individual into a sheltered environment than "curing" him; or at least shepherding him through some particular crisis or rough passage. This is often best accomplished in groups, and for the most inadequate the groups have to be residential. The running of these establishments is not particularly a psychiatric task, though the proximity of a co-operative psychiatric service helps enormously. Many of the dangerous, aggressive, paranoid, and destructive personalities need to be compulsorily detained, and, in general, prisons and the so-called corrective institutions are very much better at this than the hospitals. The prison system is develop-

ing fast and has grasped the essentials of coping with these psychopathic individuals in closed communities: strong enough not to be upset by their behaviour, prepared to control without retribution; with the aid of group pressures gradually to push responsibility towards the patient; and to keep contact during the graded release process. Individual psychotherapeutic techniques and the newer learning theory techniques are most appropriate for those with good personalities, wanting help with their circumscribed conditioned avoidance problems, and with the milder personality disorders and mislearnings of social lessons.

Delinquents

Among juveniles there is a group of delinquents brought by their mothers to the child guidance clinic. Here it is often the parents who have the problem and most need the treatment, and results can be satisfactory if they are able to co-operate. Those referred by the courts or by probation officers can usefully be diagnosed but very rarely benefit from the child guidance approach, and in fact soon cease to attend—the mothers rather more quickly than their children; they never really become patients, nor does group treatment within the clinic help appreciably. The majority of delinquents are best tackled by those who know them in their schools and by probation officers and local community services. If necessary, hostels or approved schools can relieve intolerable pressures. The latter schools regularly take, and very successfully accommodate, a range of extremely difficult boys and girls; it is on the problems of after-care, and returning them to the same unsatisfactory surroundings, that the dismal success rates depend. Even so there is nothing to suggest that adolescent wards in psychiatric hospitals are any more successful with these non-psychiatric patients than are the approved schools.

Policy for the Future

The future of practical psychiatry in this field is to co-operate more closely with probation and child care officers and to narrow the gulf between the psychiatric services on the one hand and corrective institutions and prisons on the other. The best diagnostic services should be located in the remand homes, centres, and prisons, and the last should be further differentiated so that at some points prison establishments may be indistinguishable in function from special hospitals. The plans for the development of custodial arrangements for women and girls, as recently stated by the Home Secretary,¹ envisage replacing the existing women's prison with a secure hospital which shall be "the hub of the female penal system"; its "medical and psychiatric facilities will be its central feature and normal custodial facilities will comprise a relatively small part of the establishment." This may well be the prototype for the entire penal system and would help to solve the hitherto uncertain relationship between psychiatry and the law.

REFERENCE

- ¹ Hansard, 1968, 775, 308.

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