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Who Are Our Assaultive Juveniles? A Study of 100 Cases[3]

Joe was caught in the act of armed robbery. Kevin, with friends, beat up a man and took his money. When Francis threw his teacher across the room, a knife in his pocket led to the charge of Assault with a Dangerous Weapon. John lost control and killed a peer who was "pushing him around." Mike grabbed an old lady's handbag, she lost her balance and died as a result of her fall; he was found guilty of first degree murder. James threatened little girls that he would hurt them if they did not indulge in sex play with him.

These are a few examples of the kinds of assaultive acts committed by a series of one hundred juvenile boys whom we have studied during the period of July 1971 to June 1972. Youngsters accused of assaultive acts excite much public concern, but once legally categorized and dealt with, are often afforded little understanding. The opportunity to study a group of such boys has produced some pertinent social and psychiatric data. We wish to present our findings in this paper.

Background and Methods

In 1971–72 a child psychiatric diagnostic service was offered to the State Department of Youth Services (D.Y.S.) at the very time when their abolishing their closed institutions required that decisions be made concerning replacement of a large number of assaultive boys. Requesting recommendations which might improve the chances for the boys' personal and social adjustment, and assist parole boards to decide which "assaultive" boys might "safely" be returned to the community, the Department referred one hundred boys who had been charged with assaultive offenses. Taken consecutively, these boys comprise this series. The cases referred might be in one or another stage of the legal-correctional process; many, as noted, had spent varying periods of time in Youth Service institutions and were being considered for parole, some had been in and out of various Youth Service institutions for repeated offenses, and others were newly committed or about to be committed by the courts. Fifty "non-assaultive" boys, referred in the same period for diagnosis and advice for management and planning, comprise a comparative series, as will be seen below.

Each boy was brought by appointment to the Diagnostic Center for his psychiatric interview. His Court and Youth Service records, which varied greatly in the amounts of

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information contained, were reviewed. Medical and neurological examinations, electroencephalograms, and psychological testing, while not routine, were provided in the limited number of cases where they seemed essential to diagnosis. Blood was taken by finger stick in all cases for chromosome studies.

We do not know how, or whether, these boys were prepared for coming to their interviews, but assume that they were not. We noted, however, that those who were being considered for parole, knowing that this examination was a part of the required "special board" proceedings which would pass on their returning to the community, seemed more immediately reactive in the interview situation and apt to make efforts to give a good impression of themselves.

The principal instrument of this study was the individual psychiatric interview, which entailed our special effort to involve the boys, putting them as much as possible at ease within the doctor-patient situation, in an encounter in which certain ego functions and capacities might be expressed and discerned. We were interested in their capacity to relate with us, in the kinds of ego defenses and the positive skills they employed in making human contact, in their capacities for object relationships, and in their attitudes: towards themselves internally, in relation to others (family, friends, peers, adults, figures of authority), and as a member of society and the human race. We explored what their ideas about themselves had been in the past, were now, and would likely be in the future. We looked for assets, aptitudes, and potentials in character structure and in native abilities.

We have tried to keep in mind, in examining these boys, the well-known instability of psychiatric diagnosis in adolescence, and perhaps particularly in delinquent adolescence: for today's schizoid may look like a neurotic character disorder next week; the boy we see as suffering from a character disorder may come back next month, reorganized around a new ideology or identification, as a normal but deprived boy, pulling himself together. Granting such instability, we still felt obliged to make an effort at diagnostic categorization. This obligation came upon us more and more as we proceeded with the series and became increasingly impressed with the wide range of psychological intactness and of psychopathology represented by the boys who crossed our threshhold. They included a boy floridly hallucinating who had not been out of his room for six months; a boy who had never been able to live with his (or any other) family since early childhood; a boy ridden with the impulse to satisfy his needs at all times, without regard for social constraint; and a boy who had participated as an intact adolescent in a delinquent subculture, acceptable in his part of town. We could not do justice to such a wide spectrum of youth without invoking formal diagnostic labels—tentative as they might be.

From a theoretical point of view, we have considered the major ego task in adolescence to be "holding things together" while libidinous drives rise and fall in intensity, and change in direction; while relations to parents intensify, then weaken, then are supplanted by new and different bonds outside the family; and while the adolescent looks about him for the various identity options which come easily—or, are worth working for. Accordingly, we have regarded the assaultive offenses for which these boys have been committed as possible failings, at least for the moment, of that crucial central developmental task, namely maintaining the integrity of the personality while waiting for identity formation to be consolidated. The "failure" may be two-fold: impulses were not held in check, and the boy ended up separated from the family and community in which he must eventually work out his destiny. The terms in which to discuss these boys' relative success and failures, it seemed then, were those of ego function. We concluded that we could make a start toward meaningful classification by considering three ego functions: 1) the quality of

interpersonal relations, 2) the quality of impulse control, and 3) the nature of thinking. These were assayed clinically in our interviews and historically through the material brought to us. In other words, we sought to plumb how the ego organized intercourse with people in the service of affective drives, thoughts about the world, as well as their reaction to frustrating life experiences.

Our diagnostic categories are given below. While they are quite within conventional nomenclature, they have been specifically defined for our purposes, setting forth a hierarchy of levels of functioning, in terms of the criteria given above:

Normal: Well endowed individuals, not crippled by severe deprivations or distortions in early childhood emotional development, but in adolescence finding themselves in environments which do not allow for growth into maturity.

Neurotic: A juvenile with demonstrable neurotic mechanisms which usually cope with anxiety and impulses, but which, in a given situation or situations of adolescent stress, are temporarily ineffective for control.

Neurotic Character: Behavior patterns or activities which are an indirect or symbolic expression of unconscious neurotic conflicts in juveniles who are angry about family deprivation, rejection, and lack of support in adolescence.

Antisocial Character: Continual and characteristic self-seeking behavior and actions without regard for human and social values, which seem ego-syntonic and are supported, on confrontation, with primitive and untenable defenses.

Schizoid Character: A juvenile who seems to be characterologically withdrawn, asocial, to lack affective involvement with his peers and others, to be given to fantasy and aberrant or dissocial behavior.

Primitive Emotional Disturbance: Not actually psychotic, but with strong evidence of an emotional disturbance appearing early in life (before age 5), manifesting itself in and complicating all stages of emotional development, showing an unorganized personality with lack of capacity for object relationships, poor impulse control, and faulty reality testing.

Psychotic: A juvenile showing signs and symptoms of thought disorder, whose offenses are the product of delusional thinking.

As we proceeded to apply these diagnostic categories to the series, it soon became apparent that a large percentage of these assaultive boys would fall into the Neurotic Character category, which, in turn could be subdivided further into subgroups defined as follows:

1. Neurotic characters whose delinquencies are *socio-syntonic:* boys who do not appear to show any appreciable defects of impulse control, but whose particular cultural status, environment, and social milieu seem to enable or influence certain kinds of antisocial (assaultive) activity in expression of their inner neurotic conflicts.
2. Neurotic characters who become assaultive in *panic states:* boys of neurotic character who have imperfect and precarious impulse controls and certain brittle ego defenses and can consequently become involved in, or react with, assaultive behavior or acts when they perceive their defenses to be acutely threatened.
3. Neurotic characters who are generally *impulse-ridden:* those boys of neurotic character who have in general poor controls of aggression and who consequently are given to frequent lapses of control in ordinary social situations. Many of this group seem to show minimal neurologic signs, and a few, gross neurological conditions.

At this point we would present some case briefs to illustrate our diagnostic categories.

Case 1: Normal—P, a 16½-year-old black youth from Boston's inner city was referred for evaluation because of an assaultive offense: seeking money to support a heroin habit, he had held up a college student at knife-point. He appeared as a mid-adolescent, soft-spoken, thoughtful and articulate, who related well with the interviewer. His intelligence seemed above average; no sign of thought disorder, nor of underlying depression was noted. He talked readily and established rapport, but seemed less than candid as he strove to minimize his extensive involvement with heroin (up to several bags per day for a year) and denied withdrawal symptoms after—he said—he quit several days before his arrest.

His life as he related it appeared "normal" and actually quite satisfying. He was the only child of a stable marriage, had many friends among his peers, and a steady relationship with a girl. He spoke with enthusiasm about his courses in painting and decorating at Trade School, and how he intended to pursue such a profession. His father's death two years before, in an industrial accident which may have involved a cerebro-vascular insult, stood out as the only apparent disruptive factor in his adolescence, and a likely contributor to his beginning heroin use. This habit was picked up, to be sure, in a community where readily available heroin is the most prevalent anodyne for sorrows and frustrations.

Supporting our impression of a basically well integrated character, we read of his favorable adjustment in the institution: "a rather quiet lad, displaying a certain sense of humor and maintaining good relations with staff and peer group. He is very capable and able to express himself with confidence. In no way a behavior problem, he is rather a positive element in the cottage. In work he is reliable and responsible, cooperative, energetic, and consistent."

From the clinical interview and from the training school report, we formed an impression of a boy differing from any stereotypic "addictive personality." This boy's use of heroin seemed to be related more to a crisis in his life than to an underlying characterological trend and to depend also on heroin's ready availability and endemic use in his milieu. Losing his father just as he was struggling through normal adolescent turmoil towards his own adulthood, P found that heroin held in abeyance his many conflictful feelings, gave a most pleasant, if temporary experience, and was quite acceptable in his peer group. For these reasons we consider that P belongs in a category different from those standard in psychiatric nomenclature: he fits neither "no psychologic pathology" nor any of the usually recognized psychiatric syndromes or pathological conditions, and would thus place him in our Normal category.

Case 2: Neurotic Character—Socio-Syntonic Type—A, almost 17, a black youth from Boston's black ghetto, was seen for pre-parole evaluation because of a number of assaultive offenses (several assaults with intent to rob, and two alleged sexual offenses with girls). He appeared as a solidly built, neatly dressed adolescent who gave the feeling of being nearer 14 than 17, and who was quite ill at ease. Asked about his discomfort, he replied that psychiatric exams were for those who had committed violent crimes, and that he had not. He claimed that, in the one assault he admitted to being charged with, the alleged victim later changed her mind, and he stoutly denied the recent sexual charges. Once having assured the examiner that he was not violent (nor dumb, nor crazy, which he said his mother gave as reasons for seeing a psychiatrist) he relaxed, maintained eye contact, and talked freely with a deceptive pseudo-maturity. He related as a younger boy, needy and sad. There was no sign of thought disorder; his intelligence appeared low normal.

His offenses, going back to age 14½, involved breaking and entering and heroin possession, as well as the assaultive offenses. He either concealed or denied these, or

attributed them to his (recent) expensive heroin habit. He had no insight into the reason for this habit, but recalled a doctor in the Detention Center saying, "You won't get off it until you find out why you got on," and he hoped, rather simply, that having a job and avoiding bad company would keep him "clean." He was angry about his prolonged stay at the Reception Center, but actually preferred it to the training school, for despite the boredom and lack of parties, it was closer to home and easier for mother to visit. His notion of himself, as he related all this, was of a helpless and witless child, passively tossed about by police, courts, and Youth Service, unable to get control of things for himself. Asked about his own wishes, he mentioned wanting to get even with those who have kept him away from home so long, but acknowledged there was no way he could act upon such a wish. He would also like to get a job (but had no idea what kind) and to drive the car he said his mother bought for him. He would also like to finish trade school; we noted that he did well in trades at the training school.

A was the oldest of five children of parents originally from Florida who separated when he was 6. When in trouble, he has sometimes fled to his father, a foreman in Newark, but apparently had not been able fully to identify with him. His mother, "remarried" in a common-law liaison, worked as a nurse's aide and had trained as a beautician. A was enuretic until age 13, repeated the first grade, made mostly C's and D's in recent years, and attended remedial reading classes. I.Q. testing in school in the sixth grade produced a score of 76, and he was said to have perceptual motor problems, but there was no evidence for this diagnosis and we felt that his intellectual potential was at least low normal. His peer culture was summed up in his report that all twenty of the boys he grew up with have been on heroin.

Our impression was of a boy who had long felt himself to be, and relatively was indeed, not up to life's demands. We noted that at present he has functionally borderline intelligence, is emotionally immature and inappropriately dependent on his mother, is beset with feelings of chronic depression and ineptness, and finds little opportunity in family and neighborhood to reconcile his big needs and lean assets. We felt that terms like "overly-dependent" or "socio-syntonic" personality, while telling part of the story, fail to capture the feeling of neediness and inadequacy against which A's swaggering and aggressive acts are a poor defense.

Case 3: Neurotic Character—Panicky Type—M, a 16-9/12-year-old white youth from a suburban community, was seen for pre-parole psychiatric evaluation because of several assaultive offenses. He appeared as a tall adolescent with features more attractive than robust, nattily dressed, with a choirboy haircut and facial acne. He talked readily, but seemed ill at ease and showed resentment, watching the clock closely, complaining that his girl-friend was to visit him that afternoon at the training school, bringing presents for his birthday. He sought to impress, rather than to engage himself in this interview, by affecting maturity and candidness and stressing his heterosexual orientation. He used his good intelligence defensively, and showed no sign of a thought disorder. His affect seemed rather restricted as he struggled to contain anger evident even now, as he spoke of his assaultive offenses. He had twice severely attacked other boys: he cut one with a knife when he found him in the company of a former girl-friend, and he kneed and kicked another in the abdomen and genitals after the other boy had tried to put all the blame for an auto offense on him. He viewed these assaults with rather more self-justification than insight when he stated that he was upset with excessive controls at home, angry with his parents, and taking drugs to escape all that, but ending up "only hurting myself." However, he has shown himself to have a "short fuse" in his altercations with other boys at the training school as well, and says himself that he is frightened of what he may do to people

should he lose control. We felt that his assaults were more in reaction to situations so perceived as to produce panic in him, than to be the product of generally poor impulse controls. Upon parole he is interested in a construction job.

History revealed that M's father was killed in an auto accident when he was 6 months old. Alleging that the marriage had been unhappy, M's mother conveyed to the growing boy her lack of regret at his passing. A stepfather, according to M, has always been distant, paid him little attention, and has not adopted him. M still bears both surnames: natural and stepfather's. We wondered, however, how much closeness to his mother mitigated against his relating with any new father. According to M, even now there is discussion in the family over whether mother should leave her husband to set up an apartment for M and herself. For the past three years, M has been disruptive at school and at home, been truant, and involved in delinquencies and drug-taking (LSD and other "psychedelics").

We felt that M was a rather severely neurotic character who was undergoing an explosive adolescence. He becomes panicky in relation to male figures, in such proportions as to lead to anger and assaultiveness of dangerous potential.

Case 4: Neurotic Character—Impulse-Ridden Type—L, a 16-year-old black youth from Boston's ghetto, was referred for evaluation because of chronic assaultive tendencies. He appeared as an enormous youth with the proportions of a man, having the imposing size and strength of the mythical John Henry, but not his sense of purpose. In his interviews, L showed no anxiety, was composed and cooperative, and could organize and present his thoughts in a meaningful way. Alert and showing good attention, he displayed, however, very little emotional expression, and did not relate much interpersonally. He did show fleeting contact only in a few instances in response to direct personal approaches by the examiner. He showed little insight about his troubles, and manifested reasoning and judgment of a childish order. He said quite frankly that his problem was his "temper." Numerous examples of this were offered: two years ago he suddenly hit another boy in the mouth with a baseball bat without immediate provocation, but perhaps because the boy had talked L down to a girl-friend several months before. Another time, annoyed with his sister and her friends, he jabbed her on the arm with a fork, causing deep lacerations. Once walking in the "combat zone" he stabbed a youth in the head with a screwdriver (which he was carrying), when he felt the youth was trying to take his money. Other incidents involving racial slurs (which earned the other boy a stab in the abdomen) and an argument with a teacher at school carried out the same pattern of overreaction to situations which others might take more easily, or negotiate more sociably. A remarkable feature of his narration of these assaultive incidents was his feeling of noninvolvement, as if they truly came from outside himself. Other offenses, like a robbery he took part in with other boys, he vigorously (but unconvincingly) denied, but his assaults he just reported, as if they were not involved in any system of potential guilt he might have. Life in the Detention Center, incidentally, was extremely stressful for L, whose size and brittle rage made him a frightening figure to staff and boys alike; he required major tranquilizers to stay under control while there.

L's background included a father who defected early in his childhood and whom L regarded as a "bum," and a mother who is described as unstable and perhaps psychotic. Neither of these had helped him, by precept or example, to develop and incorporate reasonable impulse controls in early life. We could not rule out neurological deficiency as well, although his electroencephalogram showed no abnormalities. In any case, L is now afraid of himself and of others, and can manage these fears only through his threatening

attitude and behaviors. While not psychotic, he is almost as severely handicapped as if he were.

Results

The series consisted largely of older adolescents, 81 percent being over 15½ years of age. Fifty-five percent of the boys were white, 42 percent black, and there were three boys of Puerto Rican extraction. Fifty-eight percent lived in disadvantaged areas of larger cities, and less than 10 percent could be considered as coming from "middle-class" families. Table 1 gives the age and geographical distribution of the series.

TABLE 1—*Age and geographical distribution of 100 boys charged with assaultive offenses.*

Geographical Distribution				Age Distribution	
Region I		Region IV		Under 14	5
Springfield	6	Total	6	14	1
Holyoke	3			14½	5
Other	2	Region V		15	8
Total	11	Total	8	15½	17
				16	19
Region II		Region VI		16½	29
Worcester	3	Roxbury	22	17	9
Other	1	Dorchester	15	17½	6
Total	4	Other	6	18	1
		Total	43	Total	100
Region III					
Cambridge	5	Region VII			
Lowell	5	Fall River	7		
Other	4	Other	7		
Total	14	Total	14		

The kinds of assaultive offenses committed are tabulated in Table 2. While most of these boys were referred because of a particular assaultive offense, all but eight of them had had previous juvenile court records of common delinquencies.

TABLE 2—*Breakdown of offenses.*

Assault and Battery, Robbery	21
Assault and Battery with Dangerous Weapon, Robbery	19
Armed Robbery	10
Homicide, Robbery	4
Assault	8
Assault on Teacher	4
Assault on Policeman	3
Indecent Assault	10
Homicide, other	3
Chronic Assaultive Behavior	18
Total	100

As had been foreseen, the largest number (58 percent) of boys in this series fell into the Neurotic Character category. Table 3 gives the percentages according to the diagnostic categories, and shows the comparable series of fifty "non-assaultive" boys referred from the Department of Youth Services during the same period.

TABLE 3—*Diagnostic classification.*

	Assaultive Series	Non-Assaultive Series
Normal	17	6
Neurotic	0	0
Neurotic Character	59	60
Type 1: 22		
Type 2: 29		
Type 3: 8		
Antisocial Character	11	0
Schizoid Character	4	6
Primitive Emotional Disturbance	5	20
Psychotic	4	8
Total	100	100

Considering the severity of these psychiatric findings, it is interesting to note that of the entire series, only fourteen boys had had any previous psychiatric attention of any kind. Of these, two had been observed in state hospitals and only three had been seen in Court Clinics.

Social and other background data are presented in Table 4. We consider that the incidence of these factors is most likely higher than was indicated in our sources of case information.

TABLE 4—*Some salient features of the cases.*

Broken Home		64
Poor Social Milieu		69
Borderline Intelligence		20
Mental Defective		6
Family Pathology:		37
Alcoholism	14	
Criminality	12	
Neurosis	9	
Psychosis	1	
Illness or Death	10	
Defecting Mothers	17	
School Offenses		66
Learning Problems		9
Sexual Deviation		9
Neurological Component		9
Drug Abuse:		42
Drug Involvement	21	
Drug Dependence	15	
Drug Addiction	7	
Chromosome Abnormality		1

Discussion

1. *The Boys*—We draw from this series several conclusions about these particular boys, which may or may not be valid inferences about the larger universe of "assaultive youth." First we note that the majority of those we saw do not come across as frightening or threatening, "dangerous," types. Their offenses were generally not the work of a chronically assaultive malcontent, but more likely an offense common in their milieu, or the result of momentary panic, or "accidental," or even "assaultive" only by legal terminology. The vignettes given on p. 385 highlight just how chancey or happenstance many of these

"assaults" may be. The forbidding legal names of their offenses (Armed Robbery, Assault and Battery with a Dangerous Weapon, Homicide) both represent these boys at their worst and may even over-represent that worst. Reviewing the entire series, we are struck that only a dozen or so fit the notion, derived from adult penology, of an individual with intrinsic psychology or neurological defect severe enough that he is likely to present a continuing assaultive danger in any setting. However, it can easily be predicted that an appreciable number of the boys of this series will go on to spend time in jails or prisons, most not for assaultive acts, but because they are already caught up in a "system" which deals only legally and punitively with their transgressions which have become a way of life for them.

If the minor-league quality of most of what pass for "assaults" is the most striking finding from the general point of view, to a clinician the most striking finding is the extent of deprivation in the lives of most of these boys. The frequency of broken homes, poor milieu, abusive or defecting parents, or intellectual or neurological impairment is bad enough reflection of the handicaps these boys have grown up with. Even worse is their coincidence, as occurs in so many of the cases, bringing them to adolescence with several strikes already against them. The personal and social costs of deprivation, hardly news, are nonetheless demonstrated clearly here.

More surprising is the extremely high incidence of seriously emotionally disturbed and defective youth in this series. These boys are tossing about in the correctional system, and often have been for years, without the benefit of any real clinical assessment of their needs, let alone any administrative action to meet them. The four psychotic youths in the series and the five whom we called victims of severe primitive emotional disturbance are the most flagrant examples of this; these boys cannot be expected to take responsibility for their actions, yet their careers in courts and Youth Service up to the point of their evaluation with us were based on the assumption that they can. The six frank mental defectives, and the twenty functionally borderline defectives have also contributed to the large number, 31 percent, thought to require residential care, either short- or long-term, with the Department of Mental Health or Youth Services. The persistence of such a large number of boys with severe mental handicaps, unrecognized, questions not only the juvenile court and youth "correctional" system, but the entire system of child health, education, and welfare.

2. "*Assaultiveness*" *and Psychopathology*—Impaired as the "assaultive" youths may be in their mental development, we found that "assaultiveness" was still not the best index by which to locate the most severely troubled boys in the Department of Youth Services. The "non-assaultive" boys we examined were referred by Department staff, not for parole clearance, but because staff members had questions about management or planning: they themselves recognized these as troubled boys. And indeed, more of this "non-assaultive" group landed in the most severely disturbed categories of ego diagnoses than did the "assaultive" ones: 34 percent versus 13 percent, or breaking it down: Psychotic: 8 versus 4 percent; Primitive Emotional Disorder: 20 versus 5 percent; and Schizoid Character: 6 versus 4 percent. Only the Antisocial Characters had selected themselves into the assaultive group: 11 percent of the assaultive boys; none in the non-assaultive group. The implications here are clearly that psychiatric evaluation should be stressed not only for assaultive juveniles, but should be considered as necessary for many other delinquents as well, and that Youth Services staff may be good judges of which boys need such evaluation.

While we listed, keeping in mind traditional ideas about ego structure, a category of "Neurotic" in our initial diagnostic scheme, we were not surprised to find not a single

representative of this type in either series, although we had looked routinely and diligently in the boys we examined for neurotic styles of coping. We were not surprised to find them missing because *effective* neurotic coping, almost by definition, assumes an efficiency of the mind in mastering conflicts and stress which eliminates the need for *acts* which express impulses or defend against them. Where a few boys initially (especially in the Detention Center) demonstrated obsessive guilt or phobic preoccupations, they may have seemed neurotic, but on taking a longer view of their coping outside, and not just of how they were doing in the shock situation of being incarcerated awaiting trial, we saw that the inadequacy of their neurotic defenses was precisely the companion to "acting-out" activities which we found expressive of Neurotic Character structure.

Finding so many of the boys (58 percent) fitting the rubric of Neurotic Character, but spanning a wider range of personal qualities than seemed appropriate for only one category, we found, as noted above, it helpful to divide this group according to the bio-psycho-social setting in which we saw their impulsiveness occurring. That is, we took note of the meaning of impulsiveness to those around them, and of its apparent resonance with either their characterological or neurological makeup. This further division reflected our gradually increasing conviction that *early character formation* alone, without a consideration of the milieu in which the adolescent must rework his ideas about himself, his parents, and his world, is an inadequate basis on which to understand the delinquency of the boys we have studied. That is, it seemed to have made an important difference to the boy of Case 1 that so many of his peers, in the black ghetto of Boston, express despair about possible life and work opportunities and use drugs—a difference which did more than any "depressive core" in his personality to bring him to the courts. And it made a difference to the boy of Case 2 that he had always felt frustrated and unhelped, in trying to *do* things, in learning at school, and in sports with other boys, in such a way that he came to believe that little good would come from him, and began to feel that he was fundamentally defective. All this befell him in a way his siblings and peers, from similar milieu and background, but with better neurological equipment, were spared.

We were even more impressed with the crucial role of the youth's milieu in settling his fate in adolescence as we saw a large part of our assaultive population splitting into two modes. On the one hand were relatively well-endowed and well-integrated personalities from neighborhoods which send many boys to the courts. On the other hand were relatively poorly endowed and poorly developed personalities, who often came from "better" neighborhoods. The predominance of blacks in the former group (most of the boys in the "healthiest" diagnostic groups were black, and most of the blacks were in these groups), and of whites in the latter, suggests that in Massachusetts it takes relatively few defects in character structure for a black to find his way into the youth-correctional system, and relatively more for a white to do the same. We find this difference as full of implications for social policy as for psychiatric understanding of delinquency.

We note also that only 7 percent of our assaultive series were drug addicted. In view of the popular association of drug abuse, especially heroin addiction, with violent crime, we would point out that whatever part of their drug money addicts may get from assaultive crime (and the amount is arguable), such crime, in this series at least, seems to contribute only a small part of the total contemporary burden of assaultive offenses.

Regarding the possible correlation between types of assaultive offenses with diagnostic categories, we observed that the larcenous assaults seem mostly to have been committed by Normal, Neurotic Character types 1 and 2, and Antisocial Character boys. The nonspecific assaults (of peers, teachers, and police) involved mostly Neurotic Character types 2 and 3 and Schizoid boys. Chronic assaultive behavior was seen largely in the Primitive

Emotional Disturbance, Psychotic, and Neurotic Character type 3 boys. The "Indecent Assaults" were often products of Primitive Emotional Disturbance and Schizoid personalities, but some of the so-called "rape" offenses seemed to involve Normal and Neurotic Character type 1 boys.

3. *"Primitive Emotional Disturbance;" Neurology and Psychopathology*—Two important issues present themselves in our study which do not seem appropriate for any detailed discussion in the present paper. They are the Primitive Emotional Disturbance category, and certain neurological aspects and inferences that appear in some of the cases seen.

Children suffering from Primitive Emotional Disturbance are, as a rule, highly visible but not always well understood. Whether they are seen as difficult and "different" children, poor feeders and indifferent learners, or simply as "hyperactive" children, they are often problems from birth, although in disorganized families they may be tolerated until they come to the attention of the community in early school years. Special classes, medication, "residential placements," etc., are often tried in early years. But in adolescence—depending upon the use each child has been able to make of whatever strengths his family and community offered—the boy gets into "public" troubles, and is finally seen as a problem for the courts and the Department of Youth Services. He arrives there despite the fact that psychiatric care and management would be more appropriate. While we considered only 5 percent of our "assaultive" series to fit in this category, we note that 20 percent in the "non-assaultive" series did so. Many of that 20 percent group were considered to be borderline psychotic, and several were persistent fire setters (who were more dangerous, actually, than any of our assaultive boys). As we have noted, they are often as functionally disabled—both in the community and in the courts—as many frankly psychotic individuals.

The possible relationship between some neurologic pathology (due to inherited, intrauterine, perinatal, traumatic, or infectious etiology, or to no known cause) and behavior disorders has been labored and belabored for many a year. Neurological and electroencephalographic examinations of large series of adult and juvenile offenders have failed to produce any conclusive body of evidence. In our study gross neurological syndromes were kept in mind, both in history taking and in examinations. In at least a tenth of the boys, we felt that there was definite neurological impairment. A typical boy might have a history of slightly delayed developmental milestones as a child, "clumsiness" in the preschool years, difficulty in learning and early discouragement with loss of interest in school, and the striking historical admission of never having enjoyed any sport—despite a sports-oriented milieu and a robust physique. A current neurological examination for the signs called "soft" (that is, those involving coordination, involuntary associated movements, balance, and sequencing behaviors), for example, might show the boy *still* to be well below the fifth percentile for motor maturity for his age. Others might have caught up maturationally, but retain the defects in social skills and self-concept formed during their earlier years. We believe that such findings must be relevant to the troubled lives of the boys we've studied.

Recommendations Made in Case Reports and Conclusions

As mentioned above, a Psychiatric Evaluation Report was submitted to the Department of Youth Services on all boys examined. These were brief (usually a page) statements in which we tried to give a dynamic picture of the boy's social and personal assets and liabilities—in terms of his needs for optimal development at this point in his life. It was not our practice to put formal diagnoses in these reports, except when attention had to be

TABLE 5—*Recommendations in reports.*

Return Home with Intensive Parole Supervision	48
Parole with Open Placement	21
Closed Rehabilitative Programs	26
Mental Health Institutions	5
Total	100
Mental Health Out-Patient Treatment	22
Special Vocational Programs	23

called to seriously incapacitating psychiatric conditions. Our recommendations were made upon the basis of the boys' individual needs, as indicated by our examinations. In a somewhat generalized fashion, we present the numbers and kinds of recommendations made for the series in Table 5.

From one point of view, our work has been to take one hundred boys referred by the State, arranged in legal-judicial categories (type of offense, point in the legal-correctional process, etc.), and to return them sorted differently: by degree of "ego functioning." How may this use of psychiatry justify itself to the public? What use has a sorting in "doctors' categories" for the purposes of the State? There are two answers. Most simply, our diagnoses were relevant to recommendations regarding the current status and after care of the boys. As we go down the categories of ego functioning, we find fewer and fewer boys recommended for (open) parole, and more and more consigned to (closed) placement. From thirteen of seventeen of the "Normals" recommended for parole, we move to all but one of the four psychotic boys recommended for placement. Similarly, all but one of the boys judged mentally defective were recommended for long-term care with the Department of Mental Health.

Closed placements, as noted above, were recommended for thirty-one boys. The idea of long-term custodial care may not be as popular today, amid fresh concern for the civil rights of those in detention, and at a time when community-based "open" placements are being freshly appreciated and utilized, as it formerly was. But we felt that the need for such care for a certain percentage of boys emerges quite forcefully from our clinical evaluations.

But that kind of justification is self-serving and circular, since we, of course, are responsible for both the diagnoses and the recommendations. How do we justify the recommendations? A fuller justification must go further, to examine how much detention, and how much rehabilitation the D.Y.S. and the Courts are after; and to examine how well a boy's need for detention and his chances for growth may be gauged only by looking at the "externals" of his delinquent career—his age, the number of his offenses, and their legal names—or whether a clinical view of his "insides" might also be helpful. We obviously feel a clinical contribution is often necessary, and feel the present study had demonstrated just how necessary it may become. But there are empirical questions here we have not begun to explore (the reproducibility of our diagnoses, the value of our assessments in predicting the likelihood of recidivism, a boy's ability in the long run to care for himself, and the "effectiveness" of the vaunted "treatments" we recommend so easily) as well as questions of civil liberties, inevitable where clinical discretion supersedes due process. While these questions obviously lie beyond the scope of this paper, this material necessarily raises them, and we feel it appropriate to indicate where further work lies.

Any discussion of boys' needs, Department of Youth Service functions, and our ability as clinicians to help must take account of a certain paradox we appreciated in reviewing the series. For although we gave "psychiatric" diagnosis to more than eighty

percent of the boys in this series, we recommended services through the Department of Mental Health for only slightly more than a quarter of the group. To some extent this reflects how the Department of Youth Services, through its increasing range of programs, is now able to offer varieties of "therapeutic" settings, well suited to a boy's needs for growth and opportunity. But it is also due to less attractive facts: first, that we recognized in making the recommendations, that present day psychiatry in itself does not have much to offer for many of the boys in the most severely troubled categories; and secondly, that many recommendations for psychiatric services for those we might feel able to help, go unheeded because the facilities to meet them do not exist at this time. Recognition of our limitations as healers must quicken all our efforts on behalf of primary and secondary prevention, in cases where these most severe disorders may be preventable, and for more investigation with these most troubled and troubling boys, to see how we can learn better to help them. Also, recognition of the inadequate facilities presently available must make us advocates anew for these boys with so few advocates, and such great needs.

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