

Commentary on “Intelligence and Personality as Predictors of Illness and Death” by Deary, Weiss, and Batty

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Congratulations to Deary, Weiss, and Batty (2010, this issue) for an encyclopedic and judicious survey of the literature and for their sensible recommendations as to how medical practitioners must tailor prescriptions to the personality and cognitive ability of patients they address.

The suggestions for future research are state of the art in terms of analysis of the kind of data psychologists are likely to collect. However, I suggest that we approach sociologists with hypotheses that might motivate them to supplement our knowledge. The curse of any model is that it is underidentified and encourages us to think that we know what human behavior lies behind the numbers it generates. I will comment on what etiology might lie behind the correlation between low IQ and hospitalization for violence-inflicted injury. Others with broader knowledge will I hope make similar contributions.

I was reared in a gang-organized area where gangs were staffed by ethnicity: Blacks versus an alliance of non-Black Catholics (Irish, Italian, Puerto Rican, Filipino). The culture was one of defense of honor and territory by fighting.

Teenagers challenged other teenagers to fight: The path between IQ and injury was not a matter of being too unintelligent to have mediation or coping skills. If challenged, any resort to such was proof of cowardice, and the sanctions for that were to be outcast and bullied. If you won, you might have the high status of the best street fighter in your group; if you lost honorably, you were a member of the group in good standing. Gangs challenged each other: Failure to fight and risk injury meant having no place to “play” and low group esteem. Pub culture was a major leisure-time amusement and going to a pub was likely to lead to challenges. Football (gridiron) was a leisure sport that led to challenges.

In sum, fighting for honor and territory was not a behavioral manifestation of low IQ. Yet as a group we undoubtedly had a

lower mean IQ than Washington, D.C., as a whole. But it was our culture, not low-IQ, that was the active factor. It might seem that allowing for lower socioeconomic status (SES) would capture this etiology. Not entirely: Jewish boys in our neighborhood simply did not go out on the street after school; they socialized through the Synagogue. They would avoid risk because their self-esteem did not include honor as the rest of us defined it. We thought they were cowards, but they did not care.

I doubt Swedish data would pick up any of this, and I am impressed that it shows a correlation between IQ and violence-inflicted injury after SES is allowed for. I suspect that functional or dysfunctional cognition is the answer. I suspect that U.S. data would show a stronger correlation, particularly before SES is allowed for. But it would be wrong to conclude that the extra is necessarily due to cognitive rather than ethnic or cultural factors.

Therefore, let us have some investigation of behavior on the ground if we want a full understanding of our correlations. It is one thing to help people close the gap between functional and dysfunctional intelligence. It is another thing to assume that they will give up what, for them, defines personal self-esteem and a full life. The physician who wishes to communicate with a patient about reducing the incidence of violent injury may need consultation with a case worker familiar with his neighborhood rather than an IQ score.

References

- Deary, I.J., Weiss, A., & Batty, G.D. (2010). Intelligence and personality as predictors of illness and death: How researchers in differential psychology and chronic disease epidemiology are collaborating to understand and address health inequalities. *Psychological Science in the Public Interest*, 11, 51–77.