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FOREWORD

This issue of the *Bulletin* reflects not only the long interest of The Menninger Foundation in social areas, but also its entry into the problems of delinquency and criminology. These problems have been neglected by psychiatry, and as a result, much of the information about crime and criminals is nonclinical, being derived from sources without a clinical viewpoint, or under conditions making clinical interpretations impossible.

Psychiatric interest in delinquency and criminology has been limited to examination of offenders for the determination of criminal responsibility, in which the potential contributions of psychiatry are almost completely hidden. The papers in this issue bypass the question of criminal responsibility, which is a moral and not a scientific issue; instead they raise the more important question of what psychiatry offers offenders who are considered "responsible" and who continue to go in and out of prison.

The growing interest of psychiatrists in clinical criminology may have two main reasons. One is that they are discovering that patients with disturbed behavior are capable of being treated as outpatients or inpatients on the same basis and with the same principles as patients who have phobias, psychosomatic symptoms, or delusions. The second is that psychiatrists are beginning to discover that the methods for rehabilitating offenders in advanced correctional centers are based on the same principles as treatment methods in good psychiatric hospitals. This is not to say that psychiatry can solve all the problems of delinquency and criminology; some of the limitations of psychiatry are shown in this issue. But it is now recognized that the individual offender, as con-

trasted with the member of a gang or syndicate, is emotionally as well as socially disturbed and is made worse by punitive methods, though he can be successfully rehabilitated, in many instances, when the goal *really* is rehabilitation.

To professional people familiar with the work in Topeka and other psychiatric centers, many of the points made in this issue are so obvious as to represent psychiatric axioms. Other points represent conceptual challenges, for example, the question of whether and to what extent delinquency represents "sickness." Still other points puncture psychiatric myths, namely, that the "psychopath" is untreatable, that treatment is impossible unless entered into without outside pressure, or that psychological treatment is impossible in a correctional setting.

The value of a number such as this is that it presents evidence to demonstrate what psychiatry "knows" from clinical experience—that those who come in conflict with the law are generally driven by the same unconscious conflicts and compromise solutions as are all other patients.

In this context, the action of Governor John Anderson and the Legislature of the State of Kansas in setting up funds for the creation of a Diagnostic and Reception Center in Topeka assumes major significance. It is a recognition that approximately 95 per cent of all offenders committed to penal institutions are eventually released and that, therefore, rehabilitation must be the goal of imprisonment. It is a further recognition that sound diagnosis—in the broad sense—is an essential first step in the development of an adequate rehabilitation program.

The main function of the Center will be to provide a thorough examination of all felony offenders sentenced by the courts in Kansas, so that these individuals can be assigned to institutional programs designed to meet their needs. A secondary function, based on the assumption that the first contacts with the penal system are the most important, will be to begin rehabilitation immediately by properly orienting the men and making the reception period a positive experience for them. The prisoners will be assigned to the Center for approximately thirty to sixty days, for examination by professional personnel, including psychiatrists, psychologists, social workers, educational advisors, and chaplains. At the conclusion of the observation, the staff will recommend a comprehensive program for the prisoners' management.

In joining the ranks of states that examine offenders scientifically, Kansas will offer a unique opportunity and challenge. Diagnostic centers

elsewhere have all suffered from lack of clinical personnel, and as a result, certain compromises in examination have had to be made. It is hoped that the establishment of the Diagnostic Center in Topeka adjacent to a psychiatric center will provide enough trained personnel to do adequate psychiatric examinations. With these as a base, it would then be possible to synthesize psychiatric and sociological concepts so that one could define the relative importance of the internal and external factors contributing to deviant behavior, and from these findings, develop better methods for the reversal of such behavior patterns.

It is hoped and anticipated that this Diagnostic Center, along with the Boys Industrial School—already well-known for its reconstructive work—will join with The Menninger Foundation in forming a complex of institutions dedicated to the study, treatment, and eventually prevention of crime and delinquency.

Joseph Satten, M.D.
Director, Division of Law and Psychiatry

CAN WE PREVENT THE SECOND STEP IN CRIME?*

IRVING BEN COOPER†

I approach my subject in the spirit of those meaningful lines by Calamandrei, "There are times in the career of every lawyer when, forgetting the niceties of the codes, the arts of oratory, the technique of debating, unconscious of his robes or those of the judges, he . . . looks into their eyes and speaks to them in the simple words a man uses to convince his fellow man of the truth. In these moments justice is reborn and he who pronounces the word feels a suppliant tremor in his voice like that in the prayers of the faithful. These moments of humble and solemn sincerity repay the lawyer for all his labor."

This, too, from the late Albert Camus, Nobel Prize winner: "Justice dies from the moment it becomes a comfort, when it ceases to be a burning reality, a demand upon one's self."

As for the judge, I wholeheartedly endorse what was written by one from a distinguished Federal appellate court: "The law does not require a judge to anesthetize his emotional reflexes. Only death yields such complete dispassionateness, for dispassion signifies indifference. Much harm is done by the myth that, merely by putting on a black robe and taking the oath of office as a judge, a man ceases to be human and strips himself of all predilections, becomes a passionless thinking machine."

Within the spirit of these commentaries, I shall consider a throbbing problem that presents an awful challenge and affects daily the peace, dignity and welfare of the national commonweal. How goes it with the courts of the nation with jurisdiction over the personal liberties and destinies of our citizenry? Who comes there nowadays, how are they dealt with, what abuses by overt action or oversight occur? Who really cares?

I am most anxious to make it perfectly clear that my remarks are concerned as much with the safety and protection of the community as with the legal rights of the defendant; each side is entitled to equal justice under law.

The Challenge

What do you do with the brilliant college student who picks up a piece of jewelry in a store so that she can look pretty when she is

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married in a week or two? With the university boy who in a moment of silliness commits an act of exposure that brings him before the criminal bench? With the attractive young lady who has become a drug addict and wants to marry the source of her supply—a man with a long criminal record? What do you say to her parents standing before you wrung white with the anguish resulting from the arrest? Is it sufficient to rule "guilty," "innocent," "fingerprint," "reformatory," "prison"? Are we really coping with the broad problems of human life when we permit the community to believe that a children's, youth or criminal court handles only the "untouchables"?

These problems, these situations, this plea are succinctly summed up in two brief commentaries by two observers. They require no amplification. They constitute the challenge to all citizens who care. The first is contemporary testimony by a 19-year-old city boy:

> "Guys who don't feel like they're countin', who are being shoved around, who feel like they are worthless to everybody, well, they're the guys who go out and try to make names for themselves by being big stick-up guys. It's on account of they feel like they are nobody."

The other, by one of the greatest jurists of our land, former Associate Justice Benjamin N. Cardozo of the Supreme Court of the United States:

> "Run your eyes over the life history of a man sentenced to the chair. There, spread before you in all its inevitable sequence, is a story of the rake's progress more implacable than any that was ever painted by a Hogarth. The Correctional School, the Reformatory, Sing Sing, or Dannemora, and then at last the chair. The heavy hand of doom was on his head from the beginning. The sin, in truth, is ours—the sin of a penal system that leaves the victim to his fate when the course that he is going is written down so plainly. . . ."

Medicine no longer regards its clinics with indifference. There the patients get substantially the same essential hospital services rendered those in private pavillions. Not so with the law. The legal clinics throughout the land are shamefully neglected.

In medicine a few spots on the lung cause alarm and prompt professional attention. It would be unthinkable to wait until the whole lung becomes involved. Why should the law continue its failure to meet head-on that large segment of youthful and early adult defendants who show unmistakable signs of criminal behavior in its early stages? It is unjust to give them scant attention. It simply is impossible to dress deep wounds with Band-Aids. And what of reinfection?

It is these inadequacies that choke off justice at the very threshold of its appearance. We know the effectiveness of the justicial serum. Its application is clearly indicated. The tragedy is that all too frequently there is far from enough to go around. And so it comes about that to an alarming degree justice is daily denied.

The Determined Offender

I shall not discuss the problems presented by the determined offender, except to say that he presents against the "peace and dignity of the people" a challenge not to be evaded. The right to move safe and unmolested through the city, to be secure at work and at home, to be protected against frauds and schemers, is the supreme luxury of civilization. For it the community pays a huge price, and is intolerant of failure or lag on the part of its agents and instruments. It cannot be patient with or primarily concerned about the welfare of offenders while they threaten its security and comfort.

The Young First Offender

My plea is addressed to the plight of children and the young and adult first offenders whose numbers are legion. Generally speaking, every first offender is a potential recidivist. The stake which the community has in the legal process is that he should not actually become one. The object of sentence, then, should be to fit the punishment *not* to the crime, but to the offender.

Young offenders have a long potential for good as well as for evil. But the potential is in them, not in their act. Sentencing the offense rather than the person plunges certain young people headlong into hatred, revolt, community repudiation—into something approaching self-destruction, *i.e.*, moral suicide. Society then has lost a son, and gained a wastrel whose depredations may affect many and cost millions.

I find Erich Fromm's observations in his *Escape From Freedom* strikingly factual:

> "It would seem that the amount of destructiveness to be found in individuals is proportionate to the amount to which expansiveness of life is curtailed. By this we do not refer to individual frustrations of this or that instinctive desire but to the thwarting of the whole of life, the blockage of spontaneity of the growth and expression of man's sensuous, emotional, and intellectual capacities. Life has an inner dynamism of its own; it tends to grow, to be expressed, to be lived. . . The more the drive toward life is thwarted, the stronger is the drive toward destruction; the more life is realized, the less is the strength of destructiveness. *Destructiveness is the outcome of unlived life.*"

It is a matter of grave concern when the Federal Bureau of Investigation informs us that of all the persons arrested in our country and charged with the commission of crime last year, an enormous part had not yet attained their twenty-first birthday! Most of these are first offenders, "little people" in the matter of possessions and what is commonly considered social importance. Most of them, in a moment of excitement, strain, or depression, give vent to impulses whose strength they rarely admit, and become enmeshed in the criminal law.

Suppose we cite a few of them. They are now responsible, well-established and prosperous members of their several communities. Said one, who as a youth had played with the idea of theft by force, "I had an attitude, 'Hooray for me and nobody else.' I always had a wrong attitude."

The second, who as a youth had been similarly inclined, put it this way: "Before I was arrested, I had bad company."

The third, who had committed criminal assault: "I came from a bad neighborhood. I didn't want to listen to anybody or to go to school."

The fourth, who had been convicted of stealing: "Well, I didn't actually have no plans for myself. I was thinking of no job. I probably would have turned out to be a no-good bum; in fact that is what I was just doing, bumming around."

In or out of court, these are marks of delayed adolescence, of failure to accept responsibility, of purposelessness in the face of life and destiny—the temper of generalized irresponsibility. Youth offenses, after all, follow, in the main, patterns of adult desires. Deep in the heart of many an average mature citizen, walled off as an incipient tuberculosis by protective tissue, are the prohibited acts he fortunately escaped or was not caught committing. To consider youthful crime as something foisted on an innocent, a high-minded and law-abiding community, rather than as an aspect of its own thought of itself and its own action, is to be naïve beyond sanity.

And so they come before the court, month in and month out, day after day, an apparently unending line of human misery and tragedy. How are we equipped to handle them?

Groping in the Dark

These are issues that face judges as they approach the fateful act of sentencing. After interminable hours of listening to charges and countercharges, quibbling and evasions, painstaking establishment of self-evident facts, and the final officially established legal description of an act, judges often find themselves merely at the beginning of what they should know in order to act professionally.

What judges want to know at this point is:

Why did he commit his act? Others about him, somewhat similarly placed, have not so acted. What was there in his experience to turn him criminal? What of his home, his relations with parents, siblings, and neighbors? With social institutions? With peer groups? With friends and boon companions? Who has influenced him? After whom did he mold himself? In what variety of activities did he participate? What has work, love, marriage, parenthood meant to him and how has he behaved in these relationships? What interests does he now have? What skills? Whom does he love? Hate?

How normal, in physical health, mentality, emotional stability, and in capacity for sustained effort is he? What were the provocations provided by the complainants and by the community in which he was reared and which set the behavior patterns after which he molded himself? Was strife and thievery, as with the Spartans, the "mode" of the neighborhood, a black eye a decoration and not a reproach? What capacity for sound living has he shown to date? What is his ability to learn to integrate new experiences? What is his moral potential? What resources will be needed to free this potential? Who stands ready to help him? Can he learn faster in the community, or does he require withdrawal from associations and conditions in which he has been formed?

It is inadequate answers to these inquiries that pose the dilemmas of sentencing. Not until the courts which deal with these perilous problems are adequately staffed with the professional skills will we be able to identify the youthful offender with good moral potential, who can be safely returned to the community to line up with the orderly citizen, from the hair-trigger, perverted or psychopathic first offender who needs institutional care. As things stand now, the courts can do little to minimize recidivism; they cannot complete their mission with assurance.

Types of Offenders

Offenders differ in their biological capacities, their family and community background, and how they have integrated these factors into a "character." In some instances their heritage has seemingly been a rich one and they have seemingly misused it. Other offenders seem to have suffered the spite of nature, family, and community.

There is a small but real minority of offenders who exhibit a considerable fund of moral understanding. They themselves reach eagerly for the rod and possess the will to acknowledge, accept, and use the lessons to be learned from their acts. They are eager to make restitution. The steps imposed by the law in bringing the case to settlement have in themselves been severe punishment. The therapeutic impact of this experience may be, and often is, sufficient to stabilize a defendant for the rest of his life against almost any temptation to overt action.

The great mass of offenders consists of persons who have not made very good use of their opportunities and who are prone to give vent to their feelings at slight provocation. They accept the easiest way out of trying situations.

A common factor in most of these cases is that, set against the life situation, the criminal charge lacks major importance. Where there is so much deep-seated misery one additional increment does not seem to matter too much. The life situation may inhere in the defendant's relations to his mother or father, to his family tradition, to his neighborhood associates, to the social situation of his school or shop or other place of employment, to the standards of the community as these are reflected in the magazines, papers, movies, actions of important people, envy of others. Treatment involves dealing with these primary causes.

The need of these defendants for the help of society and the court is greater than that of the morally sensitive and the family-bolstered individuals. For these misguided defendants are in great peril—the peril of rejecting and being rejected by the community. Their own inner resources, often considerable if they can be reached, are blocked by widely publicized community standards which have been hammered into them by print, screen, and radio. In many cases the family, source of moral and sentimental education, has taught them to be immoral and hard. There will be no reinforcement to them or to the court from this source. The neighborhood, that social unit formed of the interaction of families directly and through the schools, churches, recreational activities, shops,

and festivals which they initiate, support and patronize, is in effect nonexistent. Families live side by side, but do not function as families or as neighbors. There is no family or interfamily support of children. The contaminated child of the tainted family passes on his infection without other families knowing, caring, or acting.

The Challenges Facing the Judge

It is the opportunity and obligation of the community and the court to treat situations and conditions rather than symptoms. The physician who, because of ignorance or lack of facilities, delays his patient's recovery, extends his pain, increases his financial loss, perhaps weakens his basic physical structure, leaves a good deal to be desired, even though his patient lives. And so we must recognize that a legally established degree of offense is an unsatisfactory index of moral potential; that the percentages of so-called cures obtained with our present pharmacopoeia of corrective ingredients and dosages are profoundly discouraging; and that the hazards to courts, communities and offenders in treating offenses rather than persons are considerable.

In the degree that punishment "fits" the offender it will "fit" the crime. But when a judge is constantly beset by fear that a sentence he is about to impose cannot in the nature of things be apposite, his professional sense is outraged. It is not impossible for a sentence to be a greater injustice than the criminal act: equivalent to putting a child with a common cold into a smallpox ward for treatment.

The court's asset as an instrument for prompt hearings can become a liability if it lacks the essential aids needed for determining the circumstances on which crimes are based and out of which they grew, the degree of the defendants' educability, the best and quickest means of returning them to or for removing them from the community. It is all too easy for the court to deteriorate into a swift moving panorama of human misery if the bare facts and the law applicable to those facts are the only elements.

The function of judges is to be aware of, and to contain, the tensions built up through interaction of community, of complainants and their friends, of defendants and their friends, of police, of attorneys, of probation, prison and parole officials. Sentence should safeguard and harmonize the proper interests of all these groups. Because, like physicians, judges can be more aware of the narrow choices possible within given situations than are the persons most vitally affected, the

dilemmas and the drama of sentencing can be almost as distressing to judges as to the sentenced. And like physicians, judges must depend heavily on the recuperative powers of life itself and in appropriate cases trust to a reoriented will to stabilize character. The resources of the court always should be sufficient to line up solidly behind such delinquents as can demonstrate will to moral recovery.

If the local courts had appropriate facilities for determining the nature of the defendant as well as the nature of the act which brought him into court, the judge in a great many cases could employ his unique power to interpret defendants, and in certain cases, complainants as well, to themselves, and to involve the community responsibly in the recuperative process. Then, judges, as representatives of the moral sense of the community, would be in a position to assume this burden as a duty and in many cases seek to save the offender, not from the results of his crime, but from his own greatly increased capacity for self-destruction and from the often unconscious vengeance of the community.

In the few well-equipped tribunals in our land with jurisdiction over these particular matters, the testimony eloquently establishes that the court is a valid instrument of moral re-education capable of bringing substantial numbers of errant children and youth to a degree of generalized responsibility. The proper ending of any truly developmental process—school, hospital, probation, apprenticeship—is to have been freed of some incubus, to be prepared for life's challenges, and to have acquired the assurance of being able to meet them.

Appropriate Sentences

The pride of the legal profession is its guardianship of the general good; its unalterable belief in the equal rights of all human beings to human dignity; its unswerving determination that each defendant, regardless of how offensive, will have his day in court and justice will be done.

Treatment of situations or conditions, rather than of symptoms, is the obligation of law. The court must know the situation of which the "crime" is a symptom. Resources for description, diagnosis and treatment are imperative if sentences are to reflect enlightenment.

A presentence investigation of high order ought to be a routine aspect of treatment for every first offender brought before the court regardless of the degree of crime. The objection that this kind of essential investigation is so costly that there is no hope of its being generally applied cannot be allowed. We continue this policy at our peril, for lack of such

vital services costs millions and untold years of human suffering and community apprehension.

One of the problems presented to courts constantly is to be able to recognize the innate potential of individual offenders for moral rehabilitation, and the kind and extent of family and community support that is available to them in their efforts to re-establish themselves. We must always remember that there is often little difference in the offense and in the superficial attitudes of persons widely different in their human needs. The judge cannot tell by merely looking at them. Until the extent of character deterioration is known and the probable nature of the appropriate measures needed to meet the condition determined, courts will continue helplessly to guess.

Crime is beginning to be understood as an aspect of man's mental-emotional-moral nature. This nature, assailed by many forces both within and without his bodily frame, is susceptible to many infections. Some are capable of destroying their victim, and more important still, of infecting others. Public health authorities have learned to follow a typhoid or other "carrier" from state to state, once it has become aware of his existence. We follow the determined offender through his fingerprints, but not the child or youth in his most infectious stage.

If the courts had adequate staffs, the preliminary report on the offender would detail the facts about family, culture, background, education, degree of intelligence, medical history, mental breakdowns, personality design, social relations, sources of social strain, as indications for treatment. Courts then would be in a position to specify that certain of these needs were to be met by the defendant, or supplied under its authority.

Proper facilities would enable courts to reflect the immutable will of society to be protected against willfulness, and society's readiness to receive those healed of their moral infirmities back into the community, and thus courts could be counted among our most important instruments of moral regeneration.

Over-punishment, suspended sentences where confinement should be prescribed, judicial directions that are inappropriate, are particularly useless in dealing with children and youth who run afoul of the law. Injuries or ineptitude in their treatment can go far in miseducating an entire generation.

Community Standards and Attitudes

The community's attitude with respect to these cases is a mixture of

soft-heartedness, exasperation, wounded resignation and sadistic pleasure in punishment. Nowhere is the common failing of acting first and thinking afterward more evident than in our handling of the social significance of youth crimes or antisocial acts by children. Once a complaint is issued against the young offender the good forces about him shrink and evil forces are alerted. Those he has injured are outraged, the parents of susceptible children become fearful, the godly draw their garments around them, the evil-minded anxious for support welcome an apparent convert, the police close in on a quarry.

Stung by a crime, the community turns not upon itself or the criminal, but against police, courts, lawyers, judges and correction authorities—the professional groups it has employed to protect it. In part, the irritation is justified, for our function is to protect society. Yet it is among the tragic limitations of our humanity that faced with evil we must, willy-nilly, "treat" the condition first, "prevent" it next, and at long last, by understanding, renounce its charms. The community needs to reflect on the wisdom of Dr. Albert Schweitzer's observation to the effect that when it comes to influencing the young, example is not the main thing; it is the *only* thing.

We must recognize, then, that many of the failures of justice are due to the public's inertness and failure to support its courts. Too often, large segments of the population continually oscillate between security—that is, a desire to have adequate protection through its law enforcement agencies—and freedom—in the form of not wanting to be bothered with the necessity of constant vigilance.

Public opinion must be educated to expect courts to look behind the criminal act to the human or social situation which it reflects and of which it is a symptom, and to provide the needed staffs to do this properly. Society has as much at stake as the offender in determining what is needed to protect the community and re-educate the defendant to live in it or to benefit from his confinement.

Youthful First Offenders

Fortunately for the community, the major share of criminal offenses are of less rather than more serious degree. Fortunately, also, first offenders vastly outnumber habitual lawbreakers. They look and act like the people one meets on the streets, in schools, churches, shops. They differ among themselves in moral sensitiveness, in understanding what they have done, in desire to make restitution, in capacity to turn their

experience to ultimate gain. However, without adequate facilities for investigation, how is the judge to know who stands before him? To what extent has character deterioration taken place? Where would it be best to confine him and for how long? Who can be supervised successfully under the court's jurisdiction and incarceration avoided?

These tribunals must be in a position to know which offenders exist at a low degree of mental and emotional tone, which are "high" and "provocative." The stories of some of them resemble a kind of moral tightrope-walking over a precipice. Others are morally immature. Some are truly more ignorant than seems humanly possible. Others are adventurous and foolhardy. Still others are unconvinced that every evil collects a toll, and believe that the lawbreaker who "gets away with it" has profited. Many come from malevolent homes; many who have been constantly so harassed that to them this is a "hollering world."

The irresponsible and cynical attitude of youth on the verge of manhood, womanhood and citizenship toward themselves and the community; their hatred for authority (which is an aspect of their disease); their alternate periods of self-pity and blame which paralyze their wills; their inability to visualize themselves restored and participating in the community—these are among the factors which must enter into the judge's final determination.

Then there are those who need a moral diet rich in responsibilities. They eagerly reach for the slightest assurance that they will not be herded into a kind of stockade for the morally emasculated. They crave community acceptance—belonging.

The most difficult task that confronts courts is early identification of the determined offender. How lessen the period of suffering for the community while he is establishing his intention by a long series of unreported and unpunished offenses?

The development of better instruments for determining these aspects of background and character is as much needed to identify those who are incapable of making good use of the mercy of the community, as it is to locate those who are responsive to moral appeal. Potential determined offenders, recognized early in their careers, by being quickly put under medical and guidance care in institutions, may be saved from what has hitherto been regarded as their inevitable destiny.

Enlightened Sentencing

Applying what has already been pointed out, we find that in the

comparatively few courts across the land, properly staffed, remarkable results are achieved. With regard to the majority of children and youth appearing daily on their calendars, they are enabled to alert the offender's conscience. They find most are suffering from lack of any stabilizing associations with well-grounded and positively oriented human beings. They reach and engage native powers and find the recuperative response of aroused and alerted defendants often amazing.

They find that the first need of this group is immersion in a tepid bath of human acceptance and good will; they are not permitted to conclude that the community has excluded them forever. It is then that the offender acknowledges fault. The steps imposed by law have been searing and the shock of their situation, as much as the shame of their acts, makes a profound impression on them. They emerge from their ordeal with an overwhelming conviction that the nets of the snarer are all about them. They are morally alerted, stabilized and in considerable degree, integrated.

By this enlightened approach, offenders willingly retrace the bitter steps of their downfall, the throbbing pause of uncertainty following arrest when life seemed to stand still, the sorrow of parents and apprehensiveness of friends, the imagined scorn and withdrawal of neighbors, the sense of being trailed by police.

Only such well-equipped courts can participate in the moral rejuvenation of this group: getting jobs and holding them; making new friends; building a value system; the gradual mastery of shame, false pride, fear, hatred; successful participation in socially rewarding activities; the balm of being free of surveillance. This excursus into individual and community self-healing can be encouraging indeed to the degree of excitement.

We would indeed do well to keep uppermost in our minds the warning by Chief Justice of the United States Charles Evans Hughes:

> "The Supreme Court of the United States and the courts of appeal will take care of themselves. Look after the courts of the poor, who stand most in need of justice. The security of the Republic will be found in the treatment of the poor and ignorant; in indifference to their misery and helplessness lies disaster."

And this, too, from Chief Judge Learned Hand of the United States Circuit Court of Appeals, Second Circuit:

> "If we are to keep our democracy there must be one commandment—thou shalt not ration justice."

THE DEVELOPMENT OF A PSYCHIATRIC CRIMINOLOGY*

KARL MENNINGER, M.D. AND JOSEPH SATTEN, M.D.

The word criminology implies a scientific study of lawbreaking. Any word ending in *-ology* tends to command attention because the fact that somebody has made a scientific study of something carries weight with many people today. And the continued evidence of crime in civilized society disturbs many people. It is a paradox, a denial of our cultural philosophy and a kind of persistent, ubiquitous nuisance in which all of us are at least marginally involved. Crimes make good newspaper copy, and we are alerted and shocked by recurring reports of someone having done something terrible somewhere. There is much public deploring and denouncing, but having read the headlines, or perhaps even the lurid details, most readers tend to exclude the problem from consciousness, assuming that it is occupying the attention of a competent army of knowledgeable specialists in criminology.

Who, indeed, *does* constitute this army, and what is this *ology* from which we are expecting some scientific remedy?

Criminology embraces several different kinds of knowledge. On the one hand, there are those who study crime in broad, statistical ways, much like the weather bureau people study rainfall: crimes of this and that kind occur with this and that frequency in this and that country at the hands of an individual of this or that sex and age. Another way of studying crime and criminals is to observe the process of law infraction, detection of the offense and of the offender and his arrest, trial, conviction, sentencing and penalty. The penalty usually involves both detention and various forms of "punishment" such as hard labor, isolation, strict discipline and occasionally worse. Sometimes this study includes the termination of imprisonment, parole supervision and ultimate discharge. This kind of criminology involves police science, crime detection science, legal science and penology.

But for many of us criminology means something quite different, or at least *more*. It is absurd to point the finger at colleagues and say that *their* method of studying crime is not scientific, for it is less a question of method than of concept. Our colleagues who make statistical tables of the seasons of the year in which crimes occur, or those who list devices for trapping a witness in misstatement, or those who try to balance years

* Presented at the American Association for the Advancement of Science, 126th Annual Meeting, Chicago, Illinois, December 28, 1959.

of imprisonment against the seriousness of offenses, may be just as scientific as we psychiatrists and psychologists—but they look at people differently from us. For them people are just people, units of society, all created equal, as the Declaration of Independence says. For psychiatrists, on the other hand, the differences in human beings are more significant than the similarities. Each offender must be studied as an individual on the assumption that while there is much in which he is like other people, there is more in which he is unlike anyone else. The study of these differences became the science of psychiatry, leaning heavily upon psychological science and social science. Psychiatry does not ask what do people do at five o'clock on the afternoon of a fall day if faced with the opportunity to steal a watch. It asks rather what constellation of deprivations, frustrations, and ignorances makes a particular individual vulnerable to a particular temptation, and what is the general pattern of behavior into which this single episode fits?

Let us admit at the outset that the greater bulk of criminal offenders are rarely available for such study. They indulge in the sophisticated crimes of reckless driving while intoxicated, passing off defective merchandise on the government at high prices, working out ingenious plans for evading taxation, accepting bribes of various kinds for plugging a particular rock-and-roll record, or trying to influence the decisions of those who award government defense contracts.

"Yes," the officers of the law might say, "we know about some of these fellows—we know a few of them personally and we admit it is unfair that the little fellows get caught while the rich swindlers and crooks wriggle out. But it is our impression that you psychiatrists almost condone crime. We don't hear a word from you about the rank and file of offenders who get sent up for stealing cars and forging checks, but let a murderer come along and you pop up and say he isn't responsible. Some of your level-headed colleagues are sometimes present to contradict what you say, but why aren't all of you on our side?"

It is true that most psychiatrists do not take very much interest in the study of those who are already labeled criminals, either murderers or any other kind. There are reasons for this. Many psychiatrists feel that they are exploited and put in a false light by the legal process, or at least by lawyers; they are made to appear to have diametrically opposite opinions on sensational issues, and then this disagreement is aired in the headlines. Furthermore, most psychiatrists feel hopeless

about the unscientific routines of the criminal code, and have little patience with the prevalent "cookbook" method of dealing with offenders on the basis of antique recipes.

The position taken by psychiatrists is sometimes confused in the public mind with that of the sociologists, whose general position is that each man does more or less what his culture makes him do rather than what it lets him do. "Crimes grow out of conditions," say the sociologists. "People are products of circumstances and economics and soil fertility rather than malevolent agents of evil. Hence, we must change conditions, the conditions in which the criminal grows up, the conditions in which the crime is committed, and the conditions in which the prisoner lives after he has been confined and released."

This makes sense, of course, to the psychiatrist, but he so sharply sees the faults and failures and frustrations of the individual, that the sociologists seem too broad-gauged and Utopian. We can change some aspects of the environments in which underprivileged people grow up—slum clearance, more Boy Scout troops, better schools and churches and all the things which some parts of society have always been trying to do. But how can we reach the particular homes or neighborhoods of all potential offenders? Psychiatrists recognize the deleterious effect of bad environment upon children, but they do not regard these bad effects as occurring only in slums. Many people live under poor conditions, but relatively few of them become criminals. What brings this minority into the limelight? Are the captured ones the stupid fellows who cannot get away or who cannot cover up? Is the whole official machinery of trial and sentence and jail a hollow mockery to keep up a tradition of public intimidation with symbolic gestures?

The environment which the sociologist knows about and the individual whom the psychiatrist knows about are constantly interacting. So long as this interaction is comfortable for both parties nothing happens. If it becomes uncomfortable to the individual he usually betakes himself to a doctor. If it becomes uncomfortable for both the environment and the individual, he is apt to be *taken* to a psychiatrist. But if the injury is felt only by the environment, and if the individual connected with it insists that *he* is not hurt or "hurting," then the official wrath of the environment descends upon him and he goes not to a doctor but to jail. In all three of these types of human failure both the individual and the environment have some responsibility. Both of these responsibilities

must be considered in relation to the end product, the "illness" or the "crime."

But how to explain the diametrically opposite views regarding the identical case expressed by psychiatrists of presumably equivalent professional standing, called by contending attorneys?

It is not that there are two kinds of psychiatrists (good ones and bad ones), but there are two definite schools of thought in psychiatry. They agree about many facts and hold each other in respect, but differ sharply regarding certain terms and definitions and concepts.

One of these "positions" recognizes certain traditional or classical diagnostic entities of mental illness based on proved or presumptive damage to the brain. This point of view was the *only* one a hundred years ago; it was still the standard point of view fifty years ago. But about twenty-five years ago another point of view developed which is now the dominant one—by which we mean that it is held by the great majority of psychiatrists *in this country* (not in Europe). According to this view, disease of the brain *may* be represented by psychological syndromes, but many psychological disturbances, abnormalities in thinking, feeling, perceiving and behaving can occur without any lesions in the brain.

Both of these points of view are recognized by all psychiatrists, and some hold both concepts, applying them to different types of cases. But, when they appear in the courtroom, they are addressed by the judge or the lawyers in a vocabulary which psychiatrists do not use professionally. For example, take the word "insanity." The one school of psychiatry thinks that there never was any such thing, or rather that the way in which the word was once used was unsound; the other school of thought thinks that the word was formerly used to describe something which now has another name (psychosis, for example). It means the behavior manifestations of a disordered brain. Hence, when a lawyer asks the same question about the same case of two psychiatrists, one belonging to each of these two schools of thought, one will think there never was any such thing so there cannot be now, and the other will think, "There really is no such thing, but he means 'psychosis,' so I will make allowance for his ignorance and answer on that basis."

Regardless of what position he takes regarding the nature of mental illness, or the relation of crime to mental illness, all doctors, all psychiatrists, agree regarding procedure. If someone comes or is brought

to him as a prospective patient, what the scientific doctor does *first* is to examine his subject, in order to make a diagnosis of the condition for which a treatment may be available.

Examination does not mean just looking at someone who submits himself. The most skillful and experienced psychiatrist in the world cannot merely *look* at an individual or exchange a few words with him, and from this know what is inside the man, any more than he could visit a community for an hour and from this know all of the pressures, prejudices, cross currents and tensions that exist there. Both the individual and the community have secrets which we shall never learn, but both have some secrets which can be learned if one goes at it right, and takes time enough.

This is a hint, then, of the importance which psychiatrists attach to the clinical examination, the psychiatric case study. Our methods have made enormous progress since the days of M'Naghten, when it was generally considered possible to tell something definitive about another individual's mental processes on the basis of a couple of questions about his "knowledge." Few psychiatrists today would undertake to draw conclusions of any breadth and depth from the answers to a hundred such questions. But by using the many methods now available, psychiatrists today can examine a human being, preferably with his cooperation, and determine a great many things about him. We can discover and describe his physical, chemical and psychological equipment, and the way in which he uses these in the patterns of behavior which characterize him.

The Psychiatric Case Study

To do this we will first obtain from various sources a historical record of his life experience, beginning with his infancy and even before—*i.e.*, his familial and hereditary background. It will continue through childhood and adolescence to his adult life, with his vocational and marital and social achievements. This history we shall correlate with the results of our examinations—physical, chemical, electrical, roentgenological and psychological. These correlations enable us to see the patterns clearly and to understand in some degree how and why they were formed.

It is true that historical data are subject to error and omission. It may be necessary to compare information about various angles of his life coming from different sources and vantage points. It is not at all unusual for a psychiatrist who has spent a hundred or even several hundred hours in exploring past events in a patient's life, in an attempt

to help bring about a change in the patient, to discover many concealments and distortions. But, in spite of omissions and concealments and errors, we are able in most instances to get a reliable clinical history.

After the historical research come the examinations, especially the psychological examination. When a doctor says "examination," some people think of a test tube held in the air or a stethoscope planted on the heart or a percussion hammer thumping a knee. We mean all these things, of course, but we mean something far more intimate and intricate. The phrase "psychological examination" itself is easily misunderstood, and we would like to discuss it at some length.

First, let us say what it is not. A psychological examination is *not* a mere interview. It is *not* a brief or even a long conversation with another individual. It is *not* a series of questions such as: Do you know what day it is? What would you do if you had lost your door key? It is *not* a kind of brainwashing or hypnotizing or lie-detecting. It is *not* a measure of intelligence.

We stress these "nots" because each one of them defines the meaning of "psychological examination" in the thinking of some people. Even some of our own colleagues are careless about the use of the term. A psychological examination, like a physical examination, is a technical inspection of the patient, a testing, an investigation. It is a cross-sectional view of a man as he functions, as it were, under the eyes of the examiner. We observe his method of perceiving things, the accuracy of his perceptions and what he does with what he perceives, *i.e.*, how he reacts both emotionally and intellectually. A subject may perceive things inaccurately or he may be distracted by perceiving too much; his memory storehouse may be defective or his ability to use it impaired. Similarly, his emotional reactions may be excessive or deficient or grossly inappropriate. His way of resolving his emotional and intellectual reactions into actions may be so askew that with the best of intentions he consistently does the "wrong" thing.

Having made these studies of what are called the part-processes of psychological functioning, the psychiatrist, with the aid of the psychologist, addresses himself to the ways in which the one examined uses his psychological equipment to get along in life. He must maintain himself; he must survive; he must obey the rules of the game. Some of these rules are man-made and some of them are implicit in the laws of nature. Man is a social being; he does not live alone, but with many fellow men

more or less like himself. Each one relates himself positively, or negatively, or both and closely or distantly to a number of other people, to many different nonliving objects, to various groups and ideals and situations. These relationships tend to assume patterns which become somewhat fixed or structured. Certain attitudes are established toward these persons and things, and also toward more abstract conceptions such as duty, the law and God. These relationships and attitudes become the subject of our examinations.

From this rather sketchy description of a psychological examination as the most important part of a psychiatric case study it can easily be seen how difficult it is for the psychiatrist to translate his conclusions about an offender into terms that are understandable in those courts of law where only legal terms or anatomical terms are acceptable. Nevertheless, it can be and should be done. A proper case study should enable us to make a diagnosis, and to state certain things definitively about a given subject. We should be able to say, first of all, what has been the nature of the environment to which this patient has attempted to make his life adjustment. Here we mean both the general environment and the immediate neighborhood and relationships. In both there will have been factors pre-eminently injurious, threatening or overstimulating to the patient, as well as factors which have tended to support him. We should know—and say—what those things are which have hurt him. We must likewise know and declare all the ways that can be ascertained in which he has attacked and wounded and threatened his environment. Not merely "a crime" but a criminal program concerns us.

Next, we should be able to say what kind of a physical framework he has—what physical illnesses or defects handicap his proper adjustment to the world, what success his body is having in maintaining a state of balanced health. (This will have been arrived at from neurological tests and laboratory tests and brain wave tests.)

Thirdly, we should have some conclusions about his personality assets and defects, his adjustment patterns and his maladjustment patterns—the psychological (psychopathological) symptoms and syndromes which he has manifested or is manifesting. Such a diagnosis should undertake to say how much disorganization is present in this man's attempted adjustment to the world, what type it is, how severe it is, how long-standing it is, how likely to recur it is. We need to know whether this disorganization is still increasing or whether it is tending to diminish,

and in either case, how rapidly. We want to know, in other words, whether this individual is getting worse, or getting better, or neither.

All this we envisage as comprehended in a proper psychiatric diagnosis. It can be seen from this why the psychiatric case study cannot be made by an hour's interview or an even longer period of observation. The attempt to fathom the intricacies and complexities of the personality by such inspections or questionings is a relic of the era of belief in the magic eye, the wizard, the witch detector, and the official alienist. The senior author recalls the weekly visits of the state alienists to the Boston Psychopathic Hospital as late as 1919. They would walk from patient to patient, guided by recent admission records, and gaze steadfastly at each one for a few minutes, and then nod their heads, sign commitment papers, and pass on down the hall. Most probably they consulted the findings of the psychiatric staff in each case; we young doctors did not *see* this, but by 1917 case study was already indispensable for doctors. But not for judges—not even in 1960 do most offenders get even the semblance of case study before being "adjudged" and sentenced. "This is the horror of it," says Chief Justice Irving Ben Cooper of New York presiding over the busiest criminal courts in the world. "None of us really knows anything about these thousands of young failures, whom we nevertheless size up and sentence. We grind out the docket, hurry 'em along, jail 'em or parole 'em as fast as we can—with our eyes shut. Who can learn anything detailed about personalities and problems of 100 cases a day?"

A word has to be said here about punishment, because it comes up in every discussion about the matter. Psychiatric criminology does not request or suggest that all notions of punishment be excluded from the public mind regarding offenders. Psychiatrists realize that anything done with offenders after they are caught tends to be interpreted as punishment. The trial itself is considered punishment. Examination by the physician is considered punishment. Detention is considered punishment. We should remember that detention in prison was formerly only a matter of inconvenience pending punishment, but now even in the mind of the judge the detention itself represents a punishment. In the mind of a psychiatrist this detention, although inevitably regarded as a punishment, may serve much more important functions. For example, it may serve the function of separating the patient and his wounded environment long enough for both of them to get a new view of the matter. The scientific attitude is not necessarily a soft attitude. Indeed,

in the minds of many prisoners it is just the opposite. It is somehow assumed that because psychiatrists speak out against the *useless* punishment of criminals, they want all offenders to be "let off" easily, and have no control placed over them. The opposite is more true because psychiatrists more than anyone are aware of the slowness of change in personality and the slowness of response to treatment. They are usually not fooled so easily by protestations of "I have learned my lesson," or "I won't do it again," if these are not backed up by other evidences of change in attitude or personality. It is the most difficult thing in the world for any human being to look at himself honestly, take responsibility for what he himself has done, and accept the limitations of the grown-up world. For this reason most criminals who have any choice prefer not to have any treatment, but rather to "do my time."

Unfortunately society is not wholeheartedly interested in the scientific solution of the problem, even to save itself money and injury. It prefers to label the offender as evil and continue to punish him at all costs. It fluctuates between periods of softness and toughness, and desperately tries to grasp at simple solutions for very complex problems.

A member of society usually identifies himself with his fellow citizens rather than with the offender, and feels, therefore, relatively little interest in the offender's fate, providing he (the offender) can no longer injure society. He forgets that the offender is almost certain to return to society, armed now with new techniques of offensiveness, handicapped economically and strongly motivated to get "revenge." The hardboiled "The-hell-with-him" and "lock-'em-up-and-forget-'em" attitude redounds to the subsequent injury of society because it breeds further hate and further anger and further disorganization in the very person for whom we would hope for some improved functioning, some *re*organization.

We believe, in conclusion, that this point of view, this psychiatric criminology which we have outlined, holds certain benefits for society. In the long run it offers the greatest protection from those who have already harmed society and may harm it again. It offers the greatest likelihood of diminishing the numbers of those who are likely to tend in this direction, and it can restore to society, enlisted on society's side against these offenses, many who are now allied against society but supported by society's tax money. It offers a program which is not only safer and more humane, but one which in the long run is far less costly than the present wasteful, futile, unscientific blundering.

THE FOURTH INTERNATIONAL CRIMINOLOGICAL CONGRESS

The International Criminological Congress which met in Holland last September was attended by psychiatrists, psychologists, sociologists, lawyers, penologists and public administrators from nearly a hundred countries. It is not surprising, therefore, that the main contributions and subsequent panel discussions were rather diffuse in their coverage. One or two addresses were outstanding. The administrative planning of the Congress was extraordinarily competent, with workable simultaneous translation, excellent informative expeditions and the most gracious hospitality and sightseeing opportunities.

The sense of the meeting was that many different scientific disciplines are converging with greater interest and greater impact in all countries upon the problem so confusingly oversimplified by the word "crime." Prevention and treatment received about equal emphasis, with a full realization that both depend upon improving understanding of the essence of the matter of the nature of the offender. This is surely timely; in 1959, for example, one American was murdered every hour, one forcible rape was committed approximately every half hour, one robbery every seven minutes, one aggravated assault every four minutes, and one burglary, larceny or car theft every 23 seconds.

Following are some of the resolutions approved by the General Assembly in its terminal session:

1. The concept of mental abnormality is, unless precisely defined, so vague that it cannot form the main basis for judicial decision, prognosis and treatment.
2. Each serious case should be individually investigated and diagnosed by a team of persons trained in the various fields, with a view to the judicial decision and the ensuing treatment.
3. Scientific research should be promoted, especially follow-up studies, to make evaluation of the efficacy of the various therapies possible.
4. Penal policies have various aims, amongst which we find in varying proportions: social readaptation, retribution, deterrence and the upholding of the moral standards including elements of expiation and reparation and reconciliation with society.

This diversity of aims is not only a consequence of conflicting ideologies, but also an outcome of the different standards held and developed in the various professions connected with methods of dealing with offenders.

This conflict finds expression in the various stages of the administration of justice and especially in the sentencing process and execution

of the sentence. Therefore, penal policy should try to reconcile these aims into constructive and coherent methods, abandoning those aims which appear inadequate.

One way to achieve this, is to introduce criminological sciences into the study of law and of other disciplines and to acquaint physicians and specialists in related fields connected with the treatment of offenders with the main principles of criminal law and criminology. Furthermore, magistrates and those who are concerned with criminal law should be encouraged to acquaint themselves with the principles of criminology.

5. The importance of the social structure of the penal institutions has been stressed. It includes not only the relationship of inmates among themselves, but also staff-inmate and family-inmate relationships as well as interstaff relationships. These problems and the social pressure generated in institutions should be further studied.

6. After discussion of the integration of the legal and treatment approach to the problems of crime, the section expresses the wish that this subject should be a main topic for criminological research in the future.

More emphasis should now be placed on analytical and empirical research on criminal policy.

SOME BASIC CONSIDERATIONS UNDERLYING TREATMENT POLICIES*

P. A. H. BAAN, M.D.†

Shortly after the last world war, the Minister of Justice in the Netherlands appointed a commission to investigate how the prison system might best be reorganized. The commission, many of the members of which had themselves been in prison during the war as political offenders, presented an extensively documented report within a year. In order to implement this report, a judge with experience in probation work was appointed head of the prison department of the Ministry of Justice. One of the earliest innovations undertaken was the institution of the Psychiatric Observation Clinic. The Clinic receives cases from all over the Netherlands, most of them before trial. Patients are closely observed by a staff of male and female nurses for a period of six weeks to three months. Psychiatrists, psychologists, a specialist for internal diseases, and social workers carry out investigations. Life histories are carefully compiled and hereditary and family circumstances are described by staff members on the basis of inquiries in the patient's original domicile.

In the Netherlands, where the penal code is based on classical penal law, a person is punished by imprisonment if he is considered fully responsible for his actions. If, however, he is considered less so or not at all, he can be placed at the disposal of the government, to be taken care of on its behalf, *i.e.*, placed in a psychiatric institution. Following the introduction of laws for psychopaths in 1928, the actual care of psychopaths did not make much progress, mainly because of inadequate nursing accommodation, scarcity of efficient workers, and generally adverse conditions for the treatment of the patients. But as the work of the Observation Clinic progressed, it became possible to project new lines for the care of mentally disturbed delinquents, and in 1952 a residential Selection Institute was housed in the same building as the Observation Clinic.

While in the Observation Clinic some 150 persons are examined annually, some 600 patients annually pass through the Selection Institute, the latter being those who have been placed by the judge for an indeterminate period at the disposal of the government.

* Presented in a seminar on the psychiatric treatment of criminals and delinquents at the International Criminological Congress, Copenhagen, Denmark, May 2, 1958.

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Before being sent to the appointed institution, they are required to undergo another examination and selection procedure. The purpose of this examination is to provide the Minister of Justice with the best possible advice on the most suitable institution and method of treatment for the patient.

In recent years the standard of the various institutions in the Netherlands (three State and about 10 private) has much improved. Regular discussions between professionals versed in these matters and cooperation with the Department of Justice have contributed to this work. Yet there is need for more research into the nature of the disturbances underlying criminal behavior in both first offenders and recidivists. Delay in further improvements is caused by the quantitative and qualitative shortage of workers (psychiatrists, psychotherapists, psychologists, trained social workers and nurses).

To show some of the recent developments in the Netherlands, I will describe some basic considerations underlying the observation and treatment policies of my colleagues and myself during the last ten years in the Observation Clinic, the Selection Institute and the Van der Hoeven Clinic.

It is often asked whether it is worth while treating severe delinquents and, in particular, recidivists. Apart from our conviction that it is our duty, from a humane point of view, to treat these seriously disturbed people—often considered up until now as incurable—it seems to be a wise policy, from a material point of view, to study these so-called "unmanageables" in the hope of finding new techniques to render them less dangerous and more adaptable.

This work is comparable to the fight against infectious diseases which, in an earlier age, were a great threat to the community, but which later investigations, perhaps very costly, were able to master, one by one. This is not ancient history, it is quite recent. Consider, for instance, that only between the two world wars did tuberculosis, diabetes, pernicious anemia, and meningitis cease to be incurable diseases, causing intense misery, and costing immense sums of money. The costs of the prevention of, and the fight against, crime in the United States surpassed the entire cost of the Marshall Aid, or for education in that country in any one year, whereas the cost of the care for psychopaths in such a center as the Van der Hoeven Clinic in Utrecht is a mere fraction of

that amount. On economic grounds alone, scientific research must be stimulated as actively as possible.

This has been made clear to us in our work in the Psychiatric Observation Clinic, following the examination of more than 1,000 psychically disturbed delinquents, including the most dangerous criminals and recidivists in our country. So far, the most important finding has been that, after closer contact with these delinquents, very little remains of the divisions, classifications, classical diagnosing, labeling and typologies. Many of the original diagnoses had to be revised during the investigation or the period following it. This trend in psychiatry to label and classify human beings has negated itself. The existing schemes are collapsing, and psychiatry is beginning to see how deeply it has wronged and still wrongs the patients; the emphasis on diagnosis has too often been substituted for therapeutic effort.

As to the so-called hereditary constitutional endogeny: modern genetics has left us completely in the lurch regarding the heredity of mental factors, and we are convinced that the endogenous factor is grossly overestimated. In an accurate anamnesis going back as far as birth, neither psychogeny nor sociogeny can be separated from the presumed components of predisposition.

Diagnostic Labels Reviewed

Psychopathy. Concerning the widespread clinical conception of psychopathy as a constitutional disturbance of the emotional life and of the volitional qualities after a multidisciplinary examination of the 100 persons admitted to the clinic with this diagnosis—mostly based on mere disturbances of behavior and, therefore, medically speaking, premature and often wrongly stated—only a few per cent can be called "psychopaths" in the narrower sense. More than 90 per cent turn out to be not "psychopaths," although their disturbances of adaptation show much resemblance to the symptoms of the original conception of psychopathy.

Even the cases which come under the heading of psychopathic, will reveal to the unprejudiced investigator, who is not too keen on labeling and classifying, a confused tangle of endogenous, psychogenous and sociogenous factors; somatic diencephalic disturbances taken with hereditary, anamnestic, and other data prevail to such an extent that one may admit that endogeny predominates. But the question remains as to whether endogeny can ever be separated from psychogeny and sociogeny.

For further orientation on this matter we are dependent on further scientific research.

Another constitutional disturbance, namely *mental deficiency,* is unfortunately still considered an important "cause" of criminal conduct. Of 100 persons detained under this diagnosis, often together with earlier reports on which the I.Q. was far below 100, again more than 90 proved not to be mentally deficient. The I.Q. had been erroneously taken as the degree of constitutional disturbance. But we are convinced that the I.Q. of mentally deranged or of neglected human beings is of no more value than is the body temperature in somatic medicine. A rise in temperature shows that the organism is upset or sick, and the diagnosis can begin only after this has been determined.

The number of the I.Q. itself is *not* the diagnosis. A low I.Q. should only be an incentive to *start* on a real and more thorough diagnosis in which the whole personality is included. One should, therefore, be cautious in diagnosing mental deficiency as a constitutional disturbance. To be so would lead to a less black prognosis and, finally, be less liable to engender therapeutic defeatism. Among the wrongly labeled psychopaths and the wrongly diagnosed mental defectives—that is in more than 90 per cent of all the cases under these categories—we found an enormous diversity of all kinds of pictures, bodily dysfunctions, psychogenous and sociogenous factors, character deviations and social pathology. The few real cases of psychopathic and mental deficiency seemed to have an organic basis.

So-called *insania moralis* with its amorphia, its emotional dullness, usually turns out on closer investigation to be a mock-phenomenon, a mask, a screen, or armor, concealing an entirely different personality. Henderson and Cleckley* rightly speak of a "mask of sanity" and behind it—and this is what the probings of modern clinical psychology have made so clear to us—there is a frightened, oversensitive, distorted, battered, hurt and over-irritated human being, with often a very warm and very varied, but too delicate, emotional life, with strong feelings of inferiority, of loneliness and an oversevere, often pathological, conscience which have led so tragically to objectionable, immoral and abject behavior.

Neglect, including pampering, proved to be an extremely important factor indeed. "Affective" neglect occurs when the emotional attitude

* Henderson, D. K.: *Psychopathic States.* New York, Norton, 1939.
Cleckley, H. M.: *The Mask of Sanity.* St. Louis, Mosby, 1950.

of the parents, or the parent figures, toward the child is such that it leaves his normal affective needs unsatisfied, needs for which satisfaction is a *conditio sine qua non* for his growing up into a normal human being, and which, if not met, cause disability to form contacts and to adapt himself in the world around him. Whether neglect is a "cause" of criminality can only be shown definitely in the distant future, by control investigations carried out on a large scale by different specialists in different branches. This neglect, it appears, leads to emotional distortion, affective shortage, backward intelligence (even in an I.Q. of, for instance, 130, we often see little really normal intelligence unless we limit it to the proficiency required by a school), and compulsive repetition. This compulsive repetition generally appears to have a neurotic foundation, and, moreover, makes one wonder what can be the connection between neglect and neurosis.

We often find in neglected and "neurotized" persons a decided addictive character, though this probably differs somewhat from the compulsive repetition. Typical in such a person is the "un-freedom," the restraint, in the personality, indicating that he is not able to act in accord with his responsibility, and this leads him continually to repeat the crime. This impoverishment of the personality correlated with the poverty of many other facets brings to mind the "according to pattern" fantasy of swindlers (who are generally supposed to possess a rich imagination!) whose pitiable similarity in their eternal tricks often provides an indication for the police to work on.

It is a difficult question whether these conditions should be called disease. They are certainly disturbances, but we seldom or never see them as psychiatric syndromes of the classical kind (for instance: the diagnostic scheme of Kraepelin); we seldom see psychoses, oligophrenics, and just as few psychopaths. Do they actually exist, or do they belong partly to a social, collective conception dependent on place, time and civilization? Or are they partly the consequences of the defects of an organic nature (post-encephalitic, post-traumatic)? Are the rest, then, neuroses?

Unfortunately, we do not know exactly what are neuroses and what are not. The neurosis concept is ever-changing and offers the same difficulties as the psychosis concept. It is also a social-juridical concept, and the conditions that can lead to psychoses are extremely varied and mutually difficult to compare. We know that in times gone by, 80 per

cent of the so-called psychoses were sent to closed asylums and 20 per cent to the open institutions, whereas nowadays these numbers are reversed. Everything is in a state of change and we cannot yet say anything for certain, except that it is dangerous to rely on labels and classifications. We can state the structural polyconditional diagnosis, case for case, and keep an open mind for the infinite and inexhaustible possibilities in the structure of the personality and more particularly of the personality whose adaptability is disturbed.

Then how do matters stand? One might say, in general, that for man to function optimally in society, an integration and a fine regulation of biological, somatic and psychical components are essential, so that he can hold his own in his world, in his interaction with other people, and can play a positive part in it. The normal and adequate growth of factors, still described in such primitive terms as intellect, feeling, intuition, emotionality—each developed only through contact with the others into definite facets of the personality—leads to an infinitely fine interplay, to a regulating system and to an organism able to realize even such highly abstract concepts as the love of one's neighbor, as fidelity, responsibility, or feelings of guilt. Conceptions of good and evil come very definitely to the fore, for the very reason that a man is a man in a world of men. Concepts of good and evil which dominated psychiatry 150 years ago have since been expelled from medicine but are now returning, on a higher level, not separated from, but *integrated* with, physical science. It may be that some people who do wrong do not possess such a highly integrated regulatory mechanism to develop their sense of responsibility and, therefore, their accountability for their conduct. And here the factor of neglect seems to come in once more.

In the same way that organic neglect, lack of vitamins, albumen, carbohydrates, fats, calories, iron, nitrogen and innumerable other organic constituents can lead to results seriously harmful for a normal physical development, so can the shortage of constituents indispensable for the normal psychical personality, such as love, affection, warmth, care, and safety have the most damaging consequences. The psychic personality, like the physical, can remain defective, deformed and twisted, making it impossible to bear the average normal responsibilities, to love one's neighbor and to be faithful. All this we can see even in the so-called normal persons who never come into contact with the psychiatrist or the judge.

We see it, however, extremely often in criminals, especially in the so-called recidivists. Is it disease? I do not know. It is disturbance. They were all once newborn babies and young children, possessing constitutional factors, as we did. They grew up like we did, but often under circumstances so very much worse than ours. Yet, strange to say, only few of them—and those came often from families badly afflicted as regards heredity and environment—became delinquents. If we, being responsible for them as our fellow men, observe them not only from the outside, but also try to fathom their deeply hidden selves, we shall be struck by the way they differ, and we shall realize how out of place typologies are, how unproved the somatic hypothesis, how faulty all further psychiatric, psychologic and also sociologic speculations are regarding the way they are put into groups. They have, no doubt, some elements in common but that by no means justifies a typology.

The Pattern of Crime

Careful clinical examination of a very great number of persons has shown us a "pattern" that is equally applicable to the child and to the so-called adult criminal. It often begins in the normally sensitive child who, to a certain extent—to what extent is not known, but is the subject of many legends—is born with temperamental and other factors which might be thought responsible for the development of an abnormal sensitivity. But so far nothing is known for certain. We can, however, by working with the utmost care and by going back as far and as deeply as possible, find out in what way such factors as surroundings, or emotional traumata, have turned the sensitiveness of the child into over-sensitiveness, setting up a circle of vulnerability, fear, suspicion, helplessness, feelings of insufficiency, powerlessness, despondency and grief. The urge for self-preservation then mobilizes a defense mechanism such as aggressiveness which, as the child struggles against fresh humiliations and defeat, stimulates in him feelings of guilt, of inferiority and then again—in the ever-deepening groove of the circle—fear, suspicion, frustration, aggressiveness or feelings of guilt. Vague feelings of revenge grow deeper and deeper, and with the revenge, resentment arises out of the frustration. A most crucial element in the young life is wounded.

Similar to the way the sensitive granulative tissue underneath the crust can cause bleeding and fresh inflammation when the scab is removed, and tissue that has been covered for so long has to adapt itself

to new external influences, so can the removal of the metaphorical scabs give rise to extremely dangerous conditions that can even be fatal for the patient, harmful for those in charge and even for the entire community as well, if the treatment is not in expert hands. And so, in the young life of a child the most critical element, the need of contact, is wounded and the crust formation—resistance and defense—combined with a constantly radiating and corroding fear give rise to a sense of loneliness, slight in the beginning, but increasing more and more in intensity: originally a need of contact, later a hunger for contact is felt poignantly, but as the crust grows thicker and thicker this, too, is dismissed from the consciousness. The suffering which is the consequence of all these factors becomes unendurable and, without realizing this mechanism, the patients banish this, too, from their consciousness and conceal it behind the crust. This development also takes place with the so-called psychopaths and with the neuroses and psychoses, the last two showing, to all appearances, totally different pictures.

But to keep to the so-called psychopaths for the moment—is the course of development I have just outlined a "normal" development? May these now full-grown people who in this way have been made conscious or unconscious sufferers and who, in any case, have made their fellow men suffer by their serious disturbances in behavior or adaptability and who are a threat to society, be counted among the normal? Is there after all a fluid transition from normality to disease? Are we too much concerned with the question of what are the typical symptoms of the diseases, whereas it is most important to know what are the criteria of health and what—if we compare the sick with the healthy—is it that the sick ones precisely lack?

If out of the average normal child an abnormal child can develop, then we may say that there is a greatest common denominator; it is based perhaps on fear, or produced by fear, and we shall do well to call it a "sick element," leading to the compulsive behavior, the repetition, correlated to the phenomenon of the feeling of not being free. A feeling of "un-freedom," out of which the patients declare that "it was stronger" than they, that they "could not resist it," that they would have "given their souls to keep out of the hands of Justice," "but cannot understand what" has led them to become recidivists again.

It is important to note that this feeling of "un-freedom,"—this often unconscious, passionate attempt to realize the ideal objective and failure

to do so, the inability to reach the normal, usually easily functioning contacts with and obligations to fellow men—is just as much a central phenomenon in the neurotics.

The study of child criminality has made the concept of psychopathy in that field almost superfluous: I would like to propose that the same be done for the adult. We see the seemingly flat affect, the disturbed contact, the failing integration power, sometimes expressed in terms found especially in the psychoanalytic literature—ego weakness, dominating instinct-life, and a weak ideal ego (superego). Interrogation marks are wanted here. Our present impression is that the ego structure is certainly primitively constructed, or archaically chaotic, but that there is no evidence of a constitutional ego weakness.

If one of the chief characteristics of this kind of patient is "acting-out" to a degree that the doctor-therapists deny their calling and neglect their duty by saying simply that this or that symptom is a contraindication for treatment—whereas society is so endangered by it as to spend energy and time and vast sums of money to put a check to this "acting-out"—then not one of us can believe that such personalities have a *weak* ego.

An ego that is potentially very strong, but insufficiently integrated and regulated, is understandable, but the concept of ego weakness seems to me incorrect and misleading. A further hypothesis that the weak ego is constantly overspread by an overstrong instinct life seems also untenable. Our psychodiagnostical, clinical and biological investigations teach us that the instinct life of criminals seldom shows a hyperquality, but is mostly normal or even exhibits hypofunctions with rather striking frequency. It is, however, clinically and socially known and explained, that normal or weak persons can react too violently to provocative situations. I am thinking of the urge to escape of those too severely restricted; of the very human need to react when one is driven into a corner; and, especially in the case of prisoners, of the idea of "dangerousness," which turns out to be relative and depends mainly on the methods of approach of penitentiary officials; of those delinquents who can change from fairly harmless persons into aggressive and dangerous individuals.

Finally, it is said that in psychopaths there is also an underdeveloped superego, too weak to provide counterimpulses to withstand the overstrong instinct life and to support the ego. Although the function of the conscience of the psychically deranged often appears to be too strongly developed, unfortunately, his functions are inadequate, deformed, ambi-

or polyvalently structured, having grown up among stresses and, with such injuries as defense, crust formation, and fear.

Remarkable is the almost subhuman reaction of many therapists, comparable in every sense to the defense reaction of the "man in the street," toward the criminal, similar to the subhuman reactions of bygone times toward the insane and poor. The subhuman pattern taken from animal psychology, wherein the animal either by flight, or struggle, or with a "Totstell-reflex," reacts in a situation of danger, occurs, sad to say, all too often among psychiatrists.

Responsibility of Psychiatrists

If a diagnosis and prognosis are carried out in the classifying manner of a veterinarian or a botanist, they will, owing to the bareness of the reciprocal approach, have a paralyzing effect on the patient-victim, and may, therefore, be recidivogenous. If we diagnose his case as psychopathic, or amorphic, this will have its effect on him and he will also show this picture. But if, for example, we approach him in an unprejudiced, accepting and sympathetic manner, then our differentiation, though perhaps only after much patience and long waiting and many repeated attempts, will not fail to draw out his own differentiation. Our trust will finally penetrate the mask and slowly but surely bring to light the still intact responsibility which will make him susceptible to therapeutic treatment. And this treatment must be given him both in the prison and in the institution. No so-called "type" of criminal should be excepted.

There must be no threats, no hostility, but a sympathetic approach accepting the delinquent as a fellow man both in the judicial phase and in the carrying out of the punishment or measure, in the humane procedure of the lawyer, psychiatrist, psychologist, sociologist and social worker. These should work in a team at a level where they all have outgrown their professionalism in its narrower sense, and who are moved by their compassion for this fellow man and the legal order he has violated.

Delinquents have certainly this in common that they cannot bear the responsibility for their own behavior in the community. Is that unwillingness? If so, why then do they not conduct their lives in such a way that they can keep the freedom they so urgently crave? Or is it partly, or altogether, powerlessness? We have indeed seen remarkable results with respect to the lack of freedom and compulsive repetition.

Just in recent years we have begun to understand why the so-called psychopaths have been excluded from the indications for deeper psychotherapy. For, up until now, such findings as a faulty integrating power, insufficient functioning of the intelligence, real (or apparent) deficient growth, lack of sufficient insight into what takes place in therapy, and above all, a reluctance to submit oneself to the therapy, were all considered as contraindications to deeper psychotherapeutic treatment.

However right and understandable such an opinion may seem, we always consider it unjustifiable, medically and humanely, because these psychically deranged persons must not, and cannot, be left to fend for themselves. Something has to be done for them and I think that the first results of our experiment have taught us that a deep psychotherapeutic approach, even though it does indeed contain some great dangers, is, nevertheless, worth the time and the trouble, not only for the individuals who need help, but also for the community to whom they have caused so much care and sorrow.

Still more than good institutions, we need good, multidisciplinary, expert, and scientifically well-trained and flexible staffs, for the very reason that a bad institution and a bad staff can again create more conditions for recidivism. The solution to this problem is only realizable after we have learned to know the delinquent properly. For a better understanding, an extremely elaborate and laborious scientific investigation is necessary beforehand. Only this can teach us something more about the ego, the instinct, and the urge, the superego, and innumerable other facets of the psychically neglected.

In our small country we have now a "laboratory" for the kind of work I have described. Observation, selection, therapy and aftercare form links in an unbroken chain of activities. These activities are designed, on the one hand, to increase the curative element and, on the other, to make the preventive element in forensic psychiatry, as well as in penitentiary and penal science, as productive as possible. The most important purpose of all, it seems to me, is, however, that the Mental Health Services are learning to understand their task and to benefit by the results obtained by the different branches of the work just described. For prevention will in the future keep many of those who until now were criminals, and yet who represent such a small percentage of humanity, out of the hands of the Judge, to his own satisfaction and that of his fellow human beings.

THE TREATMENT OF CRIMINALS IN INSTITUTIONS*

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The concept "treatment" presupposes on the one hand an agency that provides it and on the other, someone to be treated. A treatment can only be successful if the person to be treated is willing and able to make a personal effort toward his readjustment. At the same time, however, the agency providing treatment has to make it possible for him to realize his intentions. It may be of use to consider to what extent this is feasible in a penal institution which is also a modern treatment center, the Van der Hoeven Clinic in Utrecht, the Netherlands.

In Van der Hoeven Clinic, we try to trace by psychotherapy the main experiences that have led to the patient's deviations, and to help him to integrate the new insights that he gains. We also attempt to create such a climate that all his still healthy qualities come into play; his personal activity and his sense of responsibility are stimulated, so that self-esteem, usually deeply wounded, can recover and so that he will really be able to take the initiative in his own social rehabilitation. The Van der Hoeven Clinic is built on the grounds of the Willem Arntsz Foundation, wedged in between a treatment center for senile patients, a street housing unstable families, factories and private houses, so that there is no surrounding space and there is close contact with society. At the urgent request of the Minister of Justice, not only mild cases are admitted, but particularly those delinquents who because of constant recidivism or particularly serious crimes have spent a great part of their lives in penal institutions, and remain a constant menace to society and public order.

Many of these patients have spent their lives from early youth in institutions varying from homes for children to approved schools, state reformatories, penal institutions, mental hospitals or asylums. In the Van der Hoeven Clinic no patient is admitted under the age of 18. There is no upper age limit, but so far the oldest patient has been 62 years of age.

The enforced passivity of penal institutions arouses the intense antagonism of its inmates against the authorities and produces the mental

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attitude: "It's for them to take care I do nothing wrong in the future," or "It's their business to see I get a job." Knowing this, we realized that a totally different regime was urgently needed. Accordingly, before opening the Van der Hoeven Clinic, we started discussions with a group of patients already undergoing psychotherapy in the Selection Institute, preparatory to their admittance to the new clinic. These preliminary discussions showed us what difficulties awaited us. They also showed us how powerless these patients were to use their energies in a constructive way, accustomed as they were to destructive outlets. This strengthened our determination to let them do as much as possible for themselves, to compel them to take decisions themselves, to prevent them from withdrawing in an attitude of criticism and opposition to the staff. They would be encouraged to shoulder as much responsibility as possible for their stay in the clinic.

We began by explaining that besides the individual and group therapy which would be given to all of them, life in the clinic would be arranged so that they could lead a reasonable existence without harming their surroundings. They were told there would be no domestic personnel because they were all in good bodily health and quite able to look after themselves. We spoke of the high nursing expenses entailed by the large therapeutic staff, including also the social staff to help them in their daily difficulties and their contacts with relatives and the rest of the world outside. They were shown the ground plans of the new clinic and asked to plan a daily schedule and a set of regulations for the smooth running of the clinic. Their amazement is hard to describe. The effect of the first discussion on this subject appeared to render them speechless.

Self-Government

When the next discussion took place a week later they were incapable of any initiative. All they could say was: "You are giving us the work *you* ought to do. We are the patients; how the house is run is *your* affair and it is *your* job to make the regulations." They were unable to produce a single constructive idea. They were simply panic-stricken by the absolute novelty of the situation. So we explained the idea once more, and when they still showed no initiative, we suggested the most sensible course would be to select from themselves a few (about two or three) who could prepare a program to discuss with the others and then show it to us. They seemed relieved by this suggestion and when

we returned a week later they had, indeed, selected a committee which had shown insight and inventiveness in drawing up a daily program and a list of rules that needed practically no amendment by the staff. This surprised us as much as their helplessness had before, and for a short time it seemed as if the patients were going to *their* clinic, with *their* regulations and *their* daily program and on their own responsibility. However, such a state of affairs was too ideal, though it showed that there were indeed possibilities for cooperation.

From then on we tried to keep in constant touch with the patients' committee and when the first group of 24 men were moved to the new clinic, daily discussions between the staff and this patients' committee were arranged. Of course this did not mean that in a fit of idealism and enthusiasm the patients were ready all at once to give up their asocial behavior. All kinds of difficulties followed. However, we were struck by the way in which the patients' committee, in cooperation with the staff, set about finding solutions for these difficulties. It soon became clear that the committee was unpopular with the other patients who reproached the members with behaving as if they belonged to the staff. Conversation between other patients ceased when committee members entered the room and the latter began to feel as if they were outcasts since they did not belong to the staff either. The committee members also soon saw clearly the difficulties of the staff itself, and realized from their own experience how unpleasant and distressing it is when all one's good intentions are met with suspicion.

After a short time they were recalled by their fellow patients and a new committee was set up that would, of course, do things differently. After about a week it was working just as earnestly and enthusiastically as the former one, and almost immediately grew unpopular among the patients. This state of affairs was continued until the second committee was likewise recalled and a third one elected with the same result. One committee followed on another, and it was difficult at times for the staff, which had only just adjusted itself to this troublesome situation, not to interfere in developments.

The "revolutions" that took place also had a positive effect, in spite of the commotion they caused. Although new patients had been admitted, the number of patients in the clinic remained rather small and, owing to the frequent committee changes, most of the patients had been members of it and had felt for themselves what it meant to have the

conduct of affairs and share responsibility. Moreover, their consultations with the staff had given them an insight into the problems, and into the consequences that could arise from any changes in the clinic, and from anything a patient did. They began to see everything much less simply and the tendency to pure opposition grew less. Besides the discussions with the patients' committee, there was also a weekly gathering of all patients and all the workers in the clinic, where everyone was free to start a discussion on any subject; it then appeared that everyone was willing to see matters from the standpoint of others besides himself.

It was not easy for these patients to share responsibility and to think with the staff. One patient would be more troubled than another, and some had to be excluded from the committee because of their physical condition. Three patients had violent psychosomatic reactions and during the initial period we repeatedly saw tubercular processes flare up, gastric ulcers develop and physical deterioration take place, without being able to detect any definite deviations. However much trouble these arrangements caused the patients, it was obvious that they liked it. This came to light when the first patient escaped from the clinic. The police had to be called in, and the public had to be informed about the unfavorable conditions in the clinic. The community was in a state of excitement, and feared that the Justice Department would interfere in the affairs of the Van der Hoeven Clinic. When further misdemeanors occurred, stealing and other disorders, the agitation took a more constructive turn in the formation of the Supervisory Committee.

This committee of three patients and two members of the staff were to deal with the offenders. The committee genuinely wished to do their work well; they listened to offenders then doled out such punishments as called for prompt intervention. In their opinion the most suitable punishment was to isolate the offender for three months. The most convincing argument against this was that those whom they wanted to lock up had been in prison for years without being any the better for it. On the contrary, their behavior was more asocial than ever; it was obviously not advisable to repeat such measures. It was then not difficult to persuade the committee to take other action.

The Supervisory Committee has subsequently done an extraordinary amount of useful work. Indeed, at times when it is working well, it supplies a need in the house, a place where patients can go and find

genuine interest in themselves and their problems. These are not problems they can talk over with the therapist, but social problems. At times the Supervisory Committee has veered round and, instead of punishing, understood and forgavé everything. As a rule, however, it enters into the difficulties and together with the patient tries to find a way to repair, as far as possible, the damage brought about by wrong deeds. That the patients appreciate this deeply is clear from the fact that many who are simply in distress, and have done nothing wrong, take their grievances to this committee to discuss how to solve their dilemmas.

Before reaching this satisfactory stage, it was evident that things were not going altogether smoothly in the patients' committee. Though at first members had considered it an honor to have been elected, they gradually began to object to serving on it because they saw how difficult it was to govern. With the argument that it would be good for all of them to learn how to govern for a time, and to gain an insight into the administrative questions and problems of the clinic, they decided to construct their committee on other lines. For the future, each patient would be a member of the committee for four weeks and they would take it in turns, by alphabetical order. They increased their number from three to six members and this new committee really did its best. It was, however, too much to expect that when a member of a committee knew his term of office would expire the following week, he would solve a particularly tricky problem and thereby perhaps make himself unpopular among the other patients. He would, of course, prefer to leave that to the incoming committee.

Another drawback was that, in such a short time, the members were not able to work themselves into their task before a new committee was formed. Meanwhile, the house was so organized that the patients fell into five groups—one group for women, and four for the men—centered in the respective common-rooms. Then the Patients' Committee decided to form a new committee consisting of five members who would hold office for three months at a time, and of five temporary members who would stay on the committee for three weeks. A session of three months would be long enough for the members to become really conversant with the work. The shorter sessions of three weeks would give everyone an opportunity to know what was taking place and how decisions were made.

Meanwhile, contacts with the Patients' Committee had developed into

a sort of social group-activity which became quite intense. The therapeutic and social staffs now meet for one hour every day to discuss everything that is going on in the house. After that hour some of the members of the social staff who form the Daily Committee and guarantee the continuity of decisions, discuss some of the most appropriate points from the staff discussion with the Patients' Committee.

It became evident that, besides these two hard-working committees, other committees were needed and a financial committee was set up. It has now become also an important social governing organ. On admittance to the clinic, patients are made responsible for their clothes. They are consulted about their work and as far as possible are given jobs compatible with their talents. We have fixed a standard wage for some of them; however, only one-fifth of the sum is given to them. Of that they are allowed to keep a small amount for pocket-money. The rest is for clothing repairs, traveling expenses and other acquisitions. A definite amount per patient is laid aside to be spent on new clothing; if he needs still more clothes he must see that he earns extra pay outside his daily work, by handwork or some simple mechanical work for a firm. All the money earned is used in the patient's own interest.

All this naturally gives rise to lengthy consultations with the patients as to how it is to be spent. Many of them make such a tremendous problem of it that a constant committee is necessary, meeting at definite hours and helping the patients practically every week, correcting them, showing them their inaccuracies and discussing with them what can or cannot be done. We have learned that they have innumerable ways of evading the usual methods. This committee tries to make the patient see the consequences of his mistakes without deserting him—in fact, by trying to find *with* him a solution to his difficulty.

Sport clubs and spare-time activities are also organized by the patients, and ways and means are sought with them to carry on their hobbies. The program just described demands the constant attention of the staff, who must be on the *qui vive*, lest one inmate be played off against another, yet they must keep faith (never to lose confidence) in the positive potentialities of the patients. At the same time, such a program evokes the many constructive characteristics in the patients and stimulates them to healthy activity.

Rehabilitation

The Van der Hoeven Clinic keeps close contact with the outside world.

This contact includes the relatives of the patients. The difficulties of the mentally disturbed delinquents and, indeed, of criminals in general, are frequently interwoven with the difficulties of their families, or are a result of the surroundings. There is no sense in treating a patient with the utmost care and then sending him back to the same surroundings which would be intolerable even for a well-integrated, normal human being. If only the patients were not so attached to their families, the solution would be simple. When they return to the community, they should then be placed outside the home for their rehabilitation. However, their ambivalent ties, too strong to be ignored, often render such attempts at rehabilitation a failure. These ties should be discussed with the patient. Both from the psychiatric and the social angle, it is necessary to give the persons with whom he has ties, some idea of the patient's difficulties, and, if possible and where necessary, to give these people help in their own difficulties. Our work is, of course, not always successful. We can only do what is most essential in these cases, and even then we cannot always avoid the necessity at times of submitting a husband, wife, or some other person in those surroundings, to treatment. At least it is necessary to enter into counsel with them.

In recent years we have found that the majority of the patients' relatives are almost as suspicious and antagonistic as the patients toward any authority. This means that our cooperation with relatives has to be well organized and costs much time and care. If a patient has no relatives, or, at best, only ones he will become estranged from during his treatment, then he is practically alone in the world. It is a striking fact that hardly any of the patients have friends. No old school friends ever come to see them, and if anybody should happen to turn up, it is usually a comrade from some other penal institution who has not been able to resocialize himself. Owing to these circumstances, many of our patients have never seen anything of family life and we have come across some who felt so out of place in society that they were in a state of terror whenever they joined a family circle. One patient always had to avoid the traffic lights because he did not know what they were for nor how they worked.

In distressing cases, we made a systematic search for suitable families in town who would take such patients. We first gave the family full information as to the potential danger and the difficulties of the patient in question. It was essential to keep in close contact with these families

to avoid unpleasant consequences. To give an example—an international swindler is brought into a normal family. Because an international swindler necessarily appears at least to be normal and not a swindler, the family may allow themselves to be impressed by, say, his agreeable manners and consequently fall victim to his tricks. This is only one example, but other delinquents can have dangerous qualities that cause dangerous situations.

There is another side to the patient, namely, that his intellectual development has often been disturbed or retarded. Many of them have had such adaptability-disturbances that even when at school they were unable to adapt themselves to the rules and could not benefit by the teaching, although, potentially, their intellects were good. Sometimes they can hardly read or write, and consequently the community thinks them peculiar which makes them ashamed of their insufficiency and backwardness. We try to make up for this backwardness, but ordinary instruction fails. The majority need individual teaching and encouragement; a careful check must also be kept as to whether they are fooling us by pretending to know something when they do not. The clinic demands, moreover, that if a patient wishes further education, he must also accept the responsibility for his lessons. Many of them have drawn up an ambitious study program and when expenses have been incurred for lessons and books, all at once lose heart and abandon their plans. At the clinic the patients themselves invented a way to put a stop to this. They made a rule that not only must everyone make a contribution according to his circumstances, toward study-expenses, but also that anyone giving up his study unnecessarily must pay all the expenses.

A weak point in our work remains the danger of psychic infection. In a house where mentally disturbed delinquents live exclusively, it is impossible to prevent the patients from mutual infection and depression. To counteract this, group talks are held with the patients. Included in the weekly program are common-room gatherings attended by the social staff and therapists to discuss anything upsetting that has come to the notice of the patients or staff. At the same time we talk over anything that might improve the atmosphere in the house and help a patient, whose behavior is exceptionally strange, to adapt himself.

Treatment

Care for physical health in the clinic is, of course, equal in importance to the care for the psychic condition of the patient. There are excep-

tional difficulties due to the psychic strain on the patients. Some of them grow very thin and cannot gain in weight, whatever the diet. All sorts of psychosomatic reactions make it extremely difficult to work with the patient, and require much care and skill in order that he may not be neglected either psychically or physically.

As regards treatment to cure a defect which prevents the patient from holding his own in the community, and may even endanger the community, this is perhaps not the place to go in detail into the actual difficulties of our psychotherapy. However, an intensive psychotherapeutic program is prepared for each patient. We are hampered by a lack of helpers and it has sometimes taken years for the helpers we have to get to know and to help this sort of patient properly. Patients for whom a solely verbal approach is not indicated, we try to help by means of music and of finger painting. Our impression is that methods other than verbal are still inadequately developed, although they offer promising possibilities. Nor have we had enough opportunity to study the uses of new medicines. Of course, we administer tranquilizers in small doses and hasten the psychotherapies by pentothal, but it may well be that more could be done in this field.

The most important ways in which we try to draw upon the healthy elements in a patient, to arouse his dormant constructive potentialities and restore his self-confidence, have been outlined. Our program in the main corresponds with the type of physical care program that seeks to restore the patient's physical health in general, and to give him back the courage to live.

Religion

Finally, particularly confused in the lives of our patients is the religious field, the relation between man, his origin and his ultimate goal. We cannot ignore this real side of their feelings, embracing the whole gamut of intentions and sentiments inherent in normal religion: respect, awe, dependence, submissiveness, obedience and gratitude toward our Maker. At the same time, the vast pathological scope of the deformities to which religious feeling is such an easy prey has to be borne in mind: outward forms and service, hypocrisy, contempt of others whom the patient may think less religious than himself, and finally, caricatured conditions, wherein religious feelings hold a man imprisoned in his fears instead of releasing him from them. Moreover, not infrequently, in potentially religious, gifted persons, the repression of their

religious feelings has an injurious effect. We have, therefore, considered it advisable to provide posts in our clinic for two ministers of religion, one Protestant and one Roman Catholic.

So far, apart from a fragment of religious awakening in more than a few, this seems to have led to socially desirable results, giving rise to a hint of unity, even of sociability, containing a productive interchange of easily managed subject matter; it signifies a great deal when conversation about religion does not degenerate into quibbling or heated dispute, and when those in question listen to one another and try to help. Moreover, it is our impression that the somewhat eccentric position of the two ministers represents for many of the patients an element of safety, which, though they perhaps try to abuse it, can, in the case of a good pastoral-psychological approach, make them more accessible to other human relations.

Conclusion

If it appears that our work is too perfectionist, that we spoil our patients or that we are unpractical idealists, then I must heartily disagree. As for perfectionism, there is no fear of that. Every day our work shows us how little we really know, how much there is that we ought to do and is still left undone, and how far off we still are from achieving the best working methods, let alone perfectionism. As for spoiling the patients, the intensity of their struggle for resocialization, and their physical suffering makes spoiling out of the question. Indeed they sometimes simply run away and give themselves up to the police or to a prison because they cannot bear the responsibility. The patients themselves definitely agree that it is far easier to be in prison than to stay at the Van der Hoeven Clinic. This does not mean, however, that they do not often prefer the latter when once they have regained strength.

WHAT PSYCHIATRY CAN DO FOR CRIMINOLOGY*

MARCEL FRYM, J.D.†

Mr. Justice Benjamin Cardozo,[1] in an address to the New York Academy of Medicine in 1928, declared:

> "I think the students of the mind should make it clear to the lawmakers that the statute is framed along the lines of a defective and unreal psychology. . . . More and more we lawyers are awaking to a perception of the truth that what divides and distracts us in the solution of a legal problem is not so much uncertainty about the law, as uncertainty about the facts—the facts which generate the law. Let the facts be known as they are and the law will sprout from the seed and turn its branches toward the light. . . . (It is my belief that) at a day not far remote, the teachings of biochemists and behaviorists, of psychiatrists and penologists, will transform our whole system of punishment for crime. . . ."

That day has not yet come. Our system of punishment for crime is essentially the same as hundreds of years ago. There is even, from time to time, a flare-up of regressive tendencies—*i.e.*, the reinstatement of capital punishment in some states; increasing, under the pressure of public opinion, sentences for certain crimes, such as narcotic offenses and sex crimes. These reactionary developments usually produce violent attacks on psychiatry.

I shall present my views on what psychiatry can do for criminology, views which have evolved out of a long career as criminal investigator, prosecuting attorney, defense attorney, law professor and psychotherapist.

Criminology is essentially a "policy-science," as Lasswell calls those sciences which help to clarify the process of policy making in society, or to supply data needed for making rational judgments on policy questions. It is dedicated to the study of crime and its prevention, and can be divided into two main fields: first, the scientific approach to law enforcement, *i.e.*, the investigation of crime and the apprehension of offenders and, secondly, the correctional treatment of offenders.

Despite a supposedly common ground and identical purpose, *i.e.*, to protect society from crime, there is antagonism between those whose main task is police work and those who participate in the rehabilitation of offenders. There are enlightened, constructively-thinking law enforcement officers who seriously doubt the efficacy of mere punishment and, on the other hand, there are too many correctional workers who are punishment-minded and only give lip-service to their professional goal. In both fields, law enforcement as well as correction, there is the hard-to-reach core who refuse to listen to any opposing views and rigidly defend the exclusivity of their creed.

* Presented to the faculty and Fellows of the Menninger School of Psychiatry, June 1, 1960, in Topeka, Kansas.

† School of Law, University of Southern California; The Hacker Clinic, Los Angeles, California.

Among correctional workers there is again a schism between the primarily sociologically-oriented and the psychiatrically-interested. Academic intolerance among these, mostly college-trained professional workers, is even worse than between police and those engaged in rehabilitative work. Obviously, the higher educational level does not promote greater willingness to modify preconceived opinions. "Apartheid" exists in our ranks. "Mollycoddlers," "sob sisters," "do-gooders" on one side, and "cops" on the other side, call each other names and are as prejudiced against each other as organicists and psychoanalysts.

I shall briefly list the more or less intelligent criticisms of psychiatry, especially its psychoanalytically-oriented forms, most commonly made by administrators of criminal justice:

1. The obvious and blatant discrepancies of diagnostic opinions regarding the same examined person by different psychiatrists. This is blamed mostly on the vague procedure in obtaining objective information and the lack of respect for reliable procedure. Lawyers know that the main errors in forming judicial opinion, which are reasons for appeal to a higher court, are (a) insufficient evidence, (b) wrong evaluation of presented evidence, *i.e.*, the credibility of a witness, and (c) the incorrect application of a law to the individual case which conflicts with previous opinions handed down by high courts. The same type of procedural omissions and mistakes are, in the opinion of many jurists, committed by psychiatrists in reaching their diagnostic conclusions. You may evaluate this criticism by relating some legal aspects to the field of psychiatry; *i.e.*, "application of a law" changed to "symptoms considered indicative of a syndrome."

   Lawyers with trial-experience are trained to differentiate between one-sided information and accumulated, corroborated evidence. The lack of such conditioning of psychiatrists is often reflected in their a priori assumptions, the weakness of specified arguments for their opinions, and their defensive escape into concepts like "inner" evidence. The "reality-testing" ability of examining and testifying psychiatrists is often open to serious doubt.

2. The use of highly subjective concepts and nosological terms by psychiatrists, which leaves essentially to their individual moral, philosophical, or even political, orientation, what they consider to be in-

appropriate, bizarre, or delusional. Pedestrian caliber and lack of education in the "humanities," especially literature, may *e.g.* qualify *originality* of thinking as *bizarre*. Furthermore, diagnostic concepts like "character disorder," "antisocial personality" are considered as implying moral or social *value judgments*, and as an invasion of a territory foreign to medical judgment. Expecting psychiatrists to function without value judgment, which is impossible for any human being, is, of course, irrational and hypocritical.

3. This relatively new field of medical specialty does not yet meet the requirements for scientific standing, to wit, that the ability of psychiatry to predict future behavior and to assess the danger an offender may constitute to society in the future is dubious.

I cannot entirely disagree with the first two criticisms. But I refer in reply to the third, about psychiatry's ability to predict and to assess a risk, to Max Planck's and Heisenberg's Quantum Theory and to the fact that, even in physics, the future behavior of a particle cannot be predicted without knowing its exact position and velocity at a certain moment. How can a behavioral science be expected to predict with more than a high degree of likelihood, that a human being may behave in a certain manner, provided that excessive strain and stress can be avoided?

A growing realization of the part psychiatry and psychology can play in the protection from crime is signaled by the holding of four international congresses* on the subject from 1958 through 1960. The first such international congress in the United States will be held in Los Angeles in 1962. Another light shining in the darkness comes from the growing number of judges[2-4] of high courts who are writing books and publishing articles, indicting present, outdated concepts of criminal responsibility and the shameful part psychiatry is playing in the diagnostic evaluation and treatment of lawbreakers. Moreover, several state governments, among them New York and California, have appointed special commissions for the study of the concept of criminal responsibility, and insanity in criminal cases.

What can psychiatry do for criminology?

* International Congress of Clinical Criminology, Rome, Italy, 1958; International Congress of the International Society of Social Prophylaxis, Paris, France, 1959; Second United Nations Congress on Crime Prevention and the Treatment of Offenders, London, England, August, 1960; and the Fourth International Congress of Criminology, The Hague, Netherlands, September, 1960, on "Psychopathological Aspects of Criminal Behavior."

First: I believe that psychiatrists should relinquish diagnostic concepts and terms which *in their colloquial meaning* imply value judgments of an ethical or social type.

Second: The more psychiatry follows an existing trend to present to the courts and correctional boards an understandable description of the psychodynamics of an individual offender—assessing his chances for rehabilitation under given and recommended conditions—the better it will serve criminal law enforcement. Toward this goal, criminologists and enlightened criminal lawyers are working to free psychiatric experts from the shackles of the M'Naghten Rule in presenting testimony.[5,6]

A comparative survey of the language of foreign penal codes defining the concepts of criminal responsibility shows that, with very few exceptions, foreign nations have enacted by far more advanced provisions for mental illness as contributing to the commission of crimes than those of our states which still apply the M'Naghten Rule.

This rule which reduces the criterion for criminal responsibility to the question "Did the offender know the wrongfulness of his act at the time he committed the crime, and was he able to appreciate the nature and quality of his act?" is *absolutely unique* in its essential meaning. It constitutes the only instance in which the law instructs an expert as to how he should arrive at his expert opinion setting forth the specific criteria in his professional field and compelling him to apply them, even against his better professional knowledge.

Third: It is a mistake for the therapist to limit himself to a classical, nondirective exploration of unconscious determinants. I believe he must be a consultant for rehabilitative governmental as well as private agencies, and must recognize the decisive part reorganization of the offender's home life and adequate, promising occupation plays in the reintegration of a lawbreaker into society. The sad fact is that both probation and parole services are essentially meaningless, mainly because of their excessive caseload. A convicted offender is left entirely to his own misery, facing a cruelly rejecting society, including his family, without any help and support. Psychotherapy, even if available, operates in a complete vacuum under such circumstances and is, therefore, unrealistic.

A few years ago, a committee of police, probation and parole officers, and representatives of bonding companies and employer organizations made a study of the problem of employment and bonding of people with criminal records. The results of the inquiry were shocking. The

enlightened Director of the Federal Bureau of Prisons, Mr. James V. Bennett, revealed that there were then more than ten million people with *conviction* records in the United States. This figure did *not* include those, probably additional millions of people, arrested and not convicted, often even never prosecuted. The number must have increased substantially since then.

A mere arrest record usually prevents bonding (surety or fidelity bonds), which a growing number of employers require. Bonding companies are selling *blanket-bonds* at relatively low rates to employers, protecting them against any violation of trust by their employees. Questionnaires for employment contain the question: "Have you ever been arrested?" and a positive answer almost automatically excludes them from bonding and employment. How to convince employers and bonding companies that the behavioral sciences can *assist them in selecting* from people with criminal records those who—under normal conditions—do not constitute more than the average risk in a specific type of employment is the subject of a pilot study now in its fourth year.

Fourth: A controversial issue I can present only in the form of a rhetorical question: How many well-trained psychiatrists and clinical psychologists are available for low fees to those who need them most?

Fifth: The greatest and most essential contribution psychiatry can make to criminology is *basic* research. Most of our criminological research is scientifically meaningless, and consists in mailing, usually poorly conceived, questionnaires to persons who mostly never respond. By *basic* research I mean exploration of the following issues, which govern our policy in dealing with lawbreakers:

> *A.* The Deterring Effect of Punishment. Convincing statistics on capital punishment, demonstrate that in states and countries which have abolished capital punishment, there was no increase in the type of crimes formerly punishable by death. This is valid and convincing evidence. Beyond this, a comprehensive depth-psychological investigation of punishment is overdue. The work done in this field has been more or less limited to monographs, stressing such points as the unconscious need for punishment as a factor in many crimes. Almost overlooked has been the deterring effect of measures other than prolonged incarceration. For instance, an extensive psychiatric exploration, which compels the offender to face himself, with concurrent casework and supervision, setting definite limitations as to change of address, employment, or ability to contract, has, in my experience, a much more inhibiting effect on the average lawbreaker than demoralizing, destructive imprisonment.

B. As Freud's work was influenced and partially triggered by his experiences with Charcot and the latter's hypnotic experiments, in the same way experiments on a large scale, inducing ego-alien acts under hypnosis and observing their subsequent rationalizations, will provide additional, valuable information on *compulsive mechanisms.* The interesting but limited work along these lines has not sufficiently focused on the integrating rationalizing mechanisms of those who, posthypnotically, carry out commands received without their conscious knowledge. In these experiments, an order received from the operator plays dynamically a part similar to the *inner* command, compelling the obsessive compulsive neurotic. I expect a great deal from *continuing research* of this type, selecting individuals with good behavior records and seemingly well-adjusted, and inducing in them hypnotically certain social attitudes, opinions and acts, which do not correspond to the person's established concepts of right and wrong. The more we know about the *mode of rationalization,* the better we will be equipped to undo compulsive, criminal behavior and to counteract the detrimental effect of contamination by other "criminal elements."

C. False confessions. In Los Angeles, the amazingly high number of almost forty false confessions were made to the Black Dahlia murder of 1947, in which a prostitute was sadistically tortured and murdered. Theodor Reik[7] paved the way to an understanding of the mechanisms of confessions, but I expect from additional research most illuminating information on the rehabilitative function of confessions made in a non-punitive, although administrative setting, which is constructively oriented.

D. The new fad in criminology is prediction and prediction methods, which means elaborate systems of predominantly sociologically oriented, case-historical investigations, developing criteria for prediction on statistical grounds.[8,9] I am greatly concerned about this trend which has more recently included physical characteristics, reverting to outdated, criminal-anthropological concepts of Lombroso, Hooten and others. Most alarming, there is no meaningful psychiatric examination and psychological testing included in the scheme of these prediction tables. Such an unavoidably bureaucratic, conveyor-beltlike disposition of probation and parole cases will even more reduce the administration of criminal justice to a mechanical, IBM machine procedure.

A statement, made by the Council of the Society for the Psychological Study of Social Issues,[10] expressed the same concern about a report by the New York City Youth Board, verifying a certain procedure for predicting juvenile delinquency. As the statement properly pointed out, already vulnerable human beings may be further harmed by being labeled and discriminated against.

E. Among the hundreds of cases of serious offenders, whom I have

seen in correctional psychotherapy, most were individuals whose parents, especially whose fathers, had been physically handicapped during the formative years of the patient. Whenever a parent cannot fulfill his obligations toward the family and, specifically, if the father cannot comply with the requirements of his masculine role, this must have an extremely disturbing effect on the psychosexual development of a child. This is, of course, not limited to physical handicaps. Any form of incapacitation, which affects the earning capacity of the father (which may be alcoholism, prolonged unemployment, bankruptcy) will influence unfavorably proper identification on the part of male children, although its impact on each individual sibling may be different.

One of the most distressing and alarming problems, affecting psychiatry in the administration of criminal justice, is the *type* and *quality* of psychiatry usually available in court proceedings as well as in correctional systems. The usual scope of psychiatric examinations by court-appointed psychiatrists, is tragically limited. It usually consists of one, at best, two short interviews, almost entirely dedicated to taking a superficial case history and to sometimes almost childish attempts to elicit gross psychiatric symptomatology. By this I mean direct questions as to hallucinations and possibly delusional ideation. Some psychiatrists use elaborate questionnaires, containing hundreds of questions, applying the "right and wrong" or multiple choice method for reaching their diagnostic conclusions.

All this is rationalized and justified by the limitations, described before, of the M'Naghten Rule. A definite progress, which pulls the props away from this type of excuse, is the recent development in certain jurisdictions, *e.g.*, of admitting more complete psychiatric testimony as to the mental condition of the defendant under a simple plea of Not Guilty, if contended that the defendant was mentally unable to maintain a *criminal intent* at the time of the commission of the crime. I systematically train my law students to use this subterfuge because a subterfuge it is. The sections of the Penal Codes, requiring a criminal intent coinciding with the commission of the crime, were meant to exclude unintentional acts of a harmful nature from prosecution and punishment. The lawmakers did not relate these provisions to mental illness and introduced this latter aspect in a completely different context. But, because of the rigid formula of the M'Naghten Rule, enlightened defense lawyers use the requirement of a criminal intent to plead that, although the defendant may not be "insane" in the meaning of the M'Naghten Rule, his mental condition at the time of the crime may have

been so disturbed, that he was unable to entertain a criminal intent in the meaning of the present law. You see, that a "rear entrance" has to be used to permit psychiatric testimony on the general mental condition of the accused.

The more sincere excuse of psychiatrists for the limited and, in my opinion, clinically irresponsible type of examination, is the size of the fee they usually receive. In the County of Los Angeles, for instance, the fee for a psychiatric examination in criminal matters is $40, and this covers the writing of an extensive report to the Court and the time investment for the trip to the county jail, waiting for the prisoner. Since a plea of Not Guilty by Reason of Insanity is usually only entered in first degree murder cases, the defendants are not eligible for release on bail and, therefore, the psychiatrist has to carry out the examination in the county jail, usually under most unfavorable conditions, with continuous interruptions, and in the presence of a deputy.

It is high time for the psychiatric profession to exercise all its influence and educational efforts to convince the courts—and probably more important the public—that this type of psychiatric examination is completely meaningless and degrades the psychiatric profession. It is difficult to understand how any psychiatrist can justify this practice, and many of those who are on panels of criminal divisions of our courts constitute the poorest possible selection of those in their profession. As a matter of fact, there are some among them whose psychiatric training and experience is dubious.

There is another, I hope small, group of psychiatrists, who are obsessively afraid of being *duped* by malingerers. They cling frantically to the M'Naghten Rule, as a satisfactory criterion of criminal responsibility and declare the most obviously psychotic murderers legally sane.

There are two extremes in the attitudes of psychiatrists about the contributions they might make in the correctional field. In regard to the treatment of offenders, most psychotherapists, I believe, are pretty negative. Many are emotionally biased against the offenders because of actual fear of them, due to identification with the victim, or because of unresolved conflicts identical with those of the lawbreaker. On the other hand, some are overenthusiastic and consider correctional psychotherapy, especially group psychotherapy, as a panacea in correctional work. Both groups are, of course, essentially wrong.

There is another challenge to psychiatry: In a hearing of the California State Assembly on capital punishment, I spoke in favor of a bill abolishing the death penalty in California. One legislator, a spokesman of law enforcement and the District Attorneys' Association, insisted that only the "men on the firing line," which meant the arresting officers and prosecutors, really knew the criminals and that only their opinions counted. I replied that important decisions as to over-all strategy—which corresponds to legislation—are not made by those who do the firing in battle, but by strategy-trained, military scientists. Equally, it is not the nurse and the medical technician who is supposed to make a diagnosis, although their work is essential.

All this nonsense about letting arresting officers, prosecutors and usually politically-appointed judges decide in what way society can best be protected against crime, must be stopped and can be stopped by the behavioral sciences if they courageously and persistently educate the public, and especially our legislators. The voice of psychiatry in this regard is either too weak or too shrill.

What seems to be the future? When I attended the Fifth International Congress on Social Defence (which means, crime prevention) in Stockholm, Sweden, I was tremendously impressed with a new philosophy of dealing with offenders. One of the basic principles of the concept of Social Defence, which was set forth in 1954 at the Third International Congress of the Society, held in Antwerp, Belgium was:

"A new type of criminal law should be created which no longer rests on the concept of criminal responsibility and of punishment and expiation of the crime, but which is solely directed towards an individualized evaluation of the offender and which leads to his effective treatment for the purpose of protecting society."

Such a development is overdue. What we are trying to do now, by improving the formula for defining criminal responsibility, be it the Durham Case language or the wording of the Model Penal Code of the American Law Institute, is only patchwork. Only slightly better is the concept of "mental illness" as defined in the Welfare and Institutions Codes, and other statutes of different states. Psychiatry should, in my opinion, be extremely careful not to extend the meaning of the term "mental illness" too far, because of the inherent danger of actually including most of the population. Especially young psychiatrists indulge

in an extensive use of diagnostic terms which imply serious mental disturbances. They thereby damage the prestige of their profession, and leave themselves open to not entirely unjustified criticisms, especially by the legal profession.

After fifteen years of clinical, psychiatric work, I feel sometimes like a lawyer, who, as a Fifth Columnist, has parachuted behind the lines of psychiatry in order to spy. I have learned a great deal. I have seen wonderfully dedicated people at work, with a true desire to cure, and I have seen less wonderful, less dedicated practitioners without any natural endowment for understanding human beings. But, a priest who does not understand the meaning of Christianity does not invalidate the message of his religion. As a spy, I have seen and was convinced about what psychiatry can do for offenders.

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ACTIVITIES OF THE MENNINGER FOUNDATION

Four members of the Foundation's Board of Governors were honored for distinguished service recently and a fifth member was appointed to a United Nations post. They are Mr. Ned Fleming and Mr. Oscar Stauffer, Topeka; Dr. Franklin D. Murphy, Los Angeles; Mrs. Henry Ittleson, New York, and Mrs. Edison Dick, Chicago.

Mr. Fleming, president of the Fleming Company, was awarded a plaque by the Topeka Chamber of Commerce for his leadership in the civic and economic development of Topeka. Mr. Stauffer, president of Stauffer Publications, received an honorary doctor of letters degree from Washburn University of Topeka.

Doctor Murphy, chancellor of the University of California at Los Angeles, was awarded the Samuel J. Crumbine award for outstanding service to Kansas in medicine and public health. Doctor Murphy was chancellor of the University of Kansas at Lawrence from 1951 to 1960.

Mrs. Ittleson was one of six persons to receive the first annual Citizens Award for health service to the community presented by the Medical Society of the County of New York. She was cited for her establishment of the Henry Ittleson Center for Child Research in Riverdale, N.Y., a residential research and treatment center for emotionally disturbed children, and for her establishment of an endowed chair in child psychiatry at the Washington University Medical School in St. Louis.

President Kennedy appointed Mrs. Dick as the United States representative on the social commission of the United Nations Economic and Social Council.

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The annual meeting of the Alumni Association of the Menninger School of Psychiatry was held in Chicago in May. Five persons were elected to honorary membership in the Association: Drs. Paul Pruyser, Ernst Ticho, Richard Tozer, and Robert Woods, The Menninger Foundation; and Dr. George Welscher, Topeka State Hospital.

New officers of the Association elected at the meeting are President, Dr. Thomas Stage, Topeka Veterans Administration Hospital; Vice President, Dr. Lawrence Stross, The Menninger Foundation; Secretary, Dr. Ethel Bonn, Topeka VA Hospital; and Treasurer, Dr. Ali Mebed, Topeka State Hospital.

Special guests at the meeting, held during the annual meeting of the American Psychiatric Association, included Mr. and Mrs. Willard King

and Mrs. Joseph Regenstein of Chicago; Dr. Robert Felix, president of the American Psychiatric Association, and Mrs. Felix; Dr. Mathew Ross, medical director of the APA, and Mrs. Ross; Dr. Marion Kenworthy, president of the Group for the Advancement of Psychiatry; Dr. Earl Bond of Philadelphia, first Sloan Visiting Professor at the Foundation; and Dr. Seward Hiltner of Chicago, consultant to the Foundation's programs in religion and psychiatry. Mr. King, Mrs. Regenstein, and Doctor Kenworthy are members of the Foundation's Board of Governors.

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The first annual Helen D. Sargent Memorial Award will be given posthumously to Dr. David Rapaport for his article "The Structure of Psychoanalytic Theory: A Systematizing Attempt." Dr. Elvira Rapaport, the widow of Doctor Rapaport, will accept the award in Topeka on September 11 at a forum lecture. At the forum, Dr. George Klein of the Research Center for Mental Health at New York University will present a paper, co-authored with Dr. Merton M. Gill, training analyst at the San Francisco Psychoanalytic Institute, in honor of Doctor Rapaport.

The award has been established in memory of Dr. Helen D. Sargent, former chief clinical psychologist at the Topeka Veterans Administration Hospital and a member of the Foundation staff for six years prior to her death in December, 1959. At the Foundation she was a major contributor to the design and execution of the Psychotherapy Research Project. She was internationally known for her work with projective tests and for her book *The Insight Test* (New York, Grune & Stratton, 1953).

Doctor Rapaport was a member of the staff of the Austen Riggs Center in Stockbridge, Massachusetts, at the time of his sudden death last December. He was instrumental in developing the Department of Research at The Menninger Foundation and was its director from 1946 to 1948. The article for which the award was made was first published in *Psychology: A Study of Science,* Vol. III, edited by Sigmund Koch. The article also appeared in *Psychological Issues,* Vol. II, No. 2, 1960.

Members of the award committee are Dr. Gardner Murphy, chairman, Dr. Robert Wallerstein, Dr. Herbert Schlesinger, and Dr. Martin Mayman, all of The Menninger Foundation; Dr. Rudolf Ekstein, coordinator of training and research, Reiss-Davis Clinic for Child Guidance, Los Angeles; Dr. Mary Engel, Michael Reese Hospital, Chicago; and Dr. Lewis L. Robbins, medical director, Hillside Hospital, Glen Oaks, N.Y.

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Two distinguished persons have been at the Foundation recently as Alfred P. Sloan Visiting Professors in the Menninger School of Psychiatry. They are the Honorable David L. Bazelon, judge of the United States Court of Appeals for the District of Columbia, and Dr. Erwin Stengel, director of the department of psychiatry at the University of Sheffield, Sheffield, England.

Judge Bazelon is the author of the opinion of the United States Court of Appeals in *Durham vs. United States* in 1954. In this case he formulated the rule that "an accused is not criminally responsible if his unlawful act was the product of a mental disease or mental defect." In 1957 Judge Bazelon received a certificate of commendation from the American Psychiatric Association for bringing to American jurisprudence through his opinions "the concept that when criminal acts are perpetrated as a result of mental illness, the courts will consider the nature of the illness of the accused."

Judge Bazelon is a lecturer on psychiatry and law at the University of Pennsylvania, a member of the board of trustees of the William Alanson White Psychiatric Foundation, and a member of various committees at universities engaged in research in behavioral sciences and the law.

Doctor Stengel is the author of an extensive list of publications on neuroanatomy, neuropathology, neuropsychiatry, application of psychoanalysis in psychiatry, suicide and attempted suicide, and psychiatric classification.

A native of Vienna, he received his doctor of medicine degree from the University of Vienna in 1926 and was graduated from the Vienna Institute of Psychoanalysis in 1928. He is a member of the British Psychoanalytic Society and has been president of the section of psychiatry of the Royal Society of Medicine and chairman of the medical section of the British Psychological Society.

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Dr. Edward D. Greenwood is president-elect of the American Orthopsychiatric Association. Dr. Greenwood, who is coordinator of training in child psychiatry at the Foundation, will become president in 1962.

BOOK REVIEW

Challenge of Psychical Research: A Primer of Parapsychology. By GARDNER MURPHY with the collaboration of LAURA A. DALE. $6. Pp. 297. New York, Harper, 1961.

This book is an important, thoughtful challenge to scientists to consider evidence and hypotheses concerning a class of events which do not fall easily into the traditional time-space-motion-energy system of established science, but which have been extensively investigated and have produced results demanding evaluation and classification. Dr. Murphy has performed a scientific service of the first magnitude by ordering, sampling, and bringing together the diverse and widely scattered research literature of parapsychology under the headings of various *psi* phenomena; namely, spontaneous cases, experimental telepathy, experimental clairvoyance, precognition, psychokinesis, and survival after death, which have been investigated by reputable scientists of standing. Occult phenomena, "aura," suspended animation, stigmatization, "out-of-the-body" experiences, and pseudo-scientific areas, such as astrology, numerology, and the like, have been excluded.

No attempt is made to present a systematic "case" for parapsychology, but rather a sampling of research efforts worthy of serious consideration. The samples are judiciously selected and the experimental procedures and results are rigorously and impartially reported, so that the reader may have a basis for judging on his own whether or not to look deeper.

The hypotheses that Murphy considers relevant to the data reviewed are, briefly: (1) *psi* phenomena express deep, unconscious processes relating the individual to his environment; (2) these phenomena are motivated; and (3) they represent a dualism between normal and paranormal processes, *i.e.*, one appears when the other is not working. The most favorable states in which these phenomena have been found are (1) those in which normal mental function is limited or blunted, such as semisleeping and sleep, drowsiness, deliria, and toxic states, and (2) those in which the possibility of *psi* being a reality is accepted. The evidence discussed shows the possibility of a hereditary factor favoring *psi* in that positive results have been found in interchanges between relatives and between twins. Fever states, delirium, passivity (*e.g.*, postconcussion), and dissociative states have shown indications of facilitating *psi*, but in Murphy's opinion, they have been inadequately investigated.

Murphy has aimed his presentation at two kinds of audience, professional scientists and thoughtful laymen. His aim is to show what psychical research is "by giving documented examples of the kinds of data available," in relation to the central kinds of problems mentioned above. In every instance he endeavors to put the case up to the jury of thoughtful readers. Although he does not urge, he subtly implies that "here is an area that calls for more and better research."

It is not the function of the reviewer to usurp the position of the jury. It can properly be said, however, that a more persuasive case for support of research in parapsychology has never been presented.

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BOOK NOTICES

The Roots of Crime (Selected Papers on Psychoanalysis, Vol. II). By EDWARD GLOVER. $7.50. Pp. 422. New York, International Universities, 1960.

From his long experience as a psychoanalyst, Doctor Glover offers a magnificent range of articles on the clinical aspects of pathological crime, together with reflections on general problems of crime and punishment. His theoretical formulations remain closely tied to clinical material, but he shows great familiarity with the extra-analytic aspects, for example, interdisciplinary research and sociological and legal approaches to crime and delinquency. He also tasks psychoanalysts with "undisciplined theorizing" in this area, or with being content to emphasize the importance of early events in a child's life to the exclusion of the unconscious or symbolic meaning of such events to the child. His work, Glover feels, is mainly oriented to workers in the field of delinquency, but its main value will be for psychoanalysts and psychiatrists interested in social problems. There are all too few such books and articles, where the legal and sociological aspects of problems are tackled, but the psychoanalytic point of view is not compromised or oversimplified. (Joseph Satten, M.D.)

Delinquency and Opportunity. By RICHARD A. CLOWARD and LLOYD E. OHLIN. $4. Pp. 220. Glencoe, Ill., Free Press, 1960.

This book is an attempt to explore two questions: (1) Why do delinquents' "norms," or rules of conduct, develop? (2) What are the conditions which account for the distinctive content of various systems of delinquent norms—such as those prescribing violence or theft or use of drugs? The authors have developed what they call the theory of differential opportunity systems, contending that the target for preventive action should not be the delinquent individual or group, but the social setting that gives rise to delinquency. It is an informative and thought-provoking presentation for both professionals and laymen. (Jack C. Pulliam)

Americans View Their Mental Health. By GERALD GURIN and others. $7.50. Pp. 444. New York, Basic Books, 1960.

Community Resources in Mental Health. By REGINALD ROBINSON and others. $8.50. Pp. 435. New York, Basic Books, 1960.

These reports of the Joint Commission on Mental Illness and Health describe two exhaustive nationwide studies. One involves interviews of "normal" adults to assess *their own views* of sources, extent, and constraints of satisfaction, happiness, and supports and problems. These are systematically related to marriage, child rearing, job, religious beliefs, education, age, and self-esteem. The other assesses what resources exist and influence mental health in communities.

Among findings: "Nearly one in four . . . has felt sufficiently troubled to need help. One in seven sought it." When help was sought for "personal problems," 42 per cent went to a clergyman, 29 per cent to a nonpsychiatric physician, 28 per cent to a psychiatrist, psychologist, or psychological agency. When facing a "nervous breakdown," a "personal collapse in the face of external stress," four out of five sought help from a nonpsychiatric physician.

Both studies demonstrate that mental health resources cannot be satisfactorily defined by what are usually described as "the mental health professions." An

effective community program for mental health must be "a cooperative effort, seeking to strengthen all the resources involved." These include "public welfare, pupil personnel, probation, child welfare, public health, and recreation." Analyses indicate that our orthopsychiatric manpower resources are and will be inadequate to meet mental health needs unless we work with and through all such "caretakers." (Harold J. Mandl, Ph.D.)

Progress in Neurology and Psychiatry, Vol. XIV. E. A. SPIEGEL, ed. $12. Pp. 656. New York, Grune & Stratton, 1959.

The annual review for 1959 documents with 4,000 references the fact that the clinical disciplines have not kept up with the progress of basic sciences. For example, no new diagnostic or therapeutic progress is recorded in clinical neurology. The biological aspects of schizophrenia are discussed with the conclusion that statistical results are not applicable to a non-homogeneous entity. There is, however, an excellent table of drugs used in the treatment of psychiatric patients with generic names, trade names, and usual daily doses. Also there is described a new method of alcohol determination by estimation of the fingertip quantities of blood. Of medical and social importance is the fact that 40 per cent of the 17,000 suicides yearly had been under medical care within the prior six months. The outstanding problems presented in the book are those of the chronically ill with 40 per cent of the entire mental hospital population resident for more than 10 years. (R. G. St. Pierre, M.D.)

Progress in Neurology and Psychiatry, Vol. XV. E. A. SPIEGEL, ed. $12.75. Pp. 619. New York, Grune & Stratton, 1960.

The task of reviewing a tightly condensed summary of almost 5,000 individual publications is practically impossible; only certain outstanding points can be mentioned. Anticoagulant therapy is still not completely validated in carotid thromboses, while definitely contraindicated in hypertension and recent cerebral infarctions, especially those due to emboli. Twenty-five per cent of stroke syndromes are due to extracranial lesions and 70 per cent can be diagnosed by ophthalmodynamometry. The value of hypothermia in brain surgery is confirmed, but its use may mask intracranial hemorrhage. Caution in the use of attenuated strains of poliomyelitis virus is suggested by genetic changes following host passage and contact with other viruses. Psychosurgery has little to offer in the current treatment of functional mental disorders. The VA 35-hospital comparative survey of the efficacy of drug treatment of schizophrenia reveals chlorpromazine as superior to a placebo, promazine, or barbiturate. Some ideas as to the direction of progress in psychoanalysis can be gleaned from the following statement by Searles regarding countertransference involving patients (sex unspecified) having a favorable prognosis: "I have experienced romantic and erotic desires to marry and fantasies of being married to the patient." (Thomas C. Parsons, M.D.)

The Etiology of Schizophrenia. DON D. JACKSON, ed. $7.50. Pp. 456. New York, Basic Books, 1960.

This book is a unique contribution to the study of the etiology of schizophrenia. It presents primarily the research studies of seventeen well-known specialists representing genetic, biochemical, physiological, psychological and socio-cultural points of view. The editor points out that over five hundred articles on the etiology of schizophrenia have been published over the past

twenty years. Nevertheless, this collection of papers surpasses others I have read because of the richness of its contributions and its attempt to interrelate the new contributions from the various disciplines to the disorder, schizophrenia. The book gives promise of a future in which schizophrenia and its diagnostic categories may be eliminated and the futile search for a specific etiological agent abandoned. Instead, as the editor suggests, schizophrenia may come to be regarded as a cluster of disorders on a continuum from normal, to neurotic, to schizophrenic with interrelated social, psychological, and biochemical etiological factors involved. Even as one reads about the disorder from the vantage point of each investigator, such a picture begins to emerge. (Herbert Klemmer, M.D.)

The Disease Concept of Alcoholism. By E. M. Jellinek. $6. Pp. 246. New Haven, Conn., Hillhouse, 1960.

This is a somewhat redundant but resourceful and authoritative discussion of opinions and attitudes the world over concerning the question whether or not alcoholism is an illness. Defining the condition broadly as "any drinking which results in any damage," Jellinek distinguishes five main "species," some of which he accepts as disease entities, some as symptomatic of other illnesses, and some as not pertaining to an illness at all. (Peter Hartocollis, M.D.)

Shapes of Sanity. By Ainslie Meares. $13.50. Pp. 468. Springfield, Ill., Charles C Thomas, 1960.

The author, an Australian psychiatrist, describes clay modeling ("plastotherapy") as an adjunct to psychotherapy with the aim of shortening it, since he feels that the conflict expression with clay avoids usual verbal defenses and leads to abreaction. Free association is used in connection with the modeling with neurotic and psychotic patients, in spite of his observation of "rage" reactions. Dr. Meares fails to discuss the dynamics of the action of modeling and other aspects such as sublimation, narcissistic gratification and ego-functional aspects, getting organized to form something, learning, but is preoccupied with the content, the conflict-expression, free association, and interpretation. (Gunter Ammon, M.D.)

A Rorschach Study of Child Development. By Nettie H. Ledwith. $6.50. Pp. 336. Pittsburgh, Pa., University of Pittsburgh, 1960.

Since the Rorschach literature on children is still very limited we need the kind of material presented in this book. It consists largely of studies of eleven children based on Rorschach and school and home data for the period between six and eleven. The Rorschach records themselves are presented in detail. No scoring and no step-by-step analysis of the material is given; simply the over-all interpretive summary. This makes use of a rather conventional set of concepts regarding sexual and aggressive drives, degree and pattern of control. There is no use made of the Rapaport concepts or other refinements contributed by modern psychoanalytic ego psychology. However, enough information regarding the external and internal vicissitudes of the children's development is given to make the Rorschach material extremely interesting to anyone who wants to make his own study of it. Especially challenging is the material on a doomed, seriously handicapped child who succeeded incredibly well, with the support of his parents, in living as normal an existence as possible during the fourteen years of his life. (Lois B. Murphy, Ph.D.)