

## AN INSTITUTIONAL PROGRAM FOR COMMITTED SEX DEVIANTS

BERNARD A. CRUVANT, M. D., MILTON MELTZER, M. D.,

AND

FRANCIS J. TARTAGLINO, M. D.

Washington, D. C.

As a result of community concern following a series of "sexual crimes," "An act to provide for the treatment of sexual psychopaths in the District of Columbia and for other purposes," was approved June 9, 1948.<sup>2</sup> A "sexual psychopath" was defined as a "person, not insane, who by a course of repeated misconduct in sexual matters has evidenced such lack of power to control his sexual impulses as to be dangerous to other persons because he is likely to attack or otherwise inflict injury, loss, pain, or other evil on the objects of his desire." There is no mandatory provision requiring consideration of any sexual offender for determination as a sexual psychopath. Proceedings are initiated by the United States Attorney and the individual need not be under *any* criminal charge, or he may be charged with a sex offense or any other type of crime. The Act specifically excludes individuals charged with rape or assault with intent to rape. An individual committed to Saint Elizabeths Hospital as a sexual psychopath cannot be released until the superintendent of the hospital "finds that he has sufficiently recovered so as not to be dangerous to other persons." If he is under charges he must be returned to the court where he can then stand trial.

The purpose of this paper is to report briefly some experiences and observations during the period October, 1948, to March 1, 1950, in which we received 24 patients under this law.

Clinically, we have noted that the repetitive pattern of misconduct seems to be consistent in each patient studied and the offenses fall into several typical subgroups:

1. Indecent exposure while intoxicated under the guise of urinating. There are 8

<sup>1</sup> Read at the 106th annual meeting of The American Psychiatric Association, Detroit, Mich., May 1-5, 1950.

From St. Elizabeths Hospital.

<sup>2</sup> Public Law 615, 80th Congress, 2d Session.

such patients, each with many arrests and sentences.

2. Indecent exposure while sober. There are 4 of these; one showed limited intelligence and 3 are classical hysterical exhibitionists, one of whom performed indecent acts with children.

3. Various indecent acts with children. There are 7 cases varying from an old man's enticement of girls for sex play to a 20-year-old's immature, slightly coercive homosexual behavior with younger boys.

There are 5 others of disparate nature, including 2 non-coercive homosexuals and 1 aggressive sodomist.

Only a very small percentage of individuals charged with sexual offenses during this period were referred for determination of sexual psychopathy. In 1948 and 1949 there were a total of 636 sex offenses reported. Of these, only about 20 were committed as sexual psychopaths. In a recent radio broadcast the United States Attorney for the District of Columbia stated, "The vast majority of the cases have been handled as strictly criminal prosecutions and, if the man is convicted, the court sentences him to jail. We feel that if it's handled gradually and the extreme cases are referred to the sex psychopath portion of the Act, that will give us some time to develop the best possible solution" (1).

It appears then that our patients are not truly representative of the sexual offenders in the community. Keeping these considerations in mind we want to discuss certain aspects of the problem based on the group that we have received.

### REPRESENTATIVE CASES

A few representative cases are cited by way of illustration:

CASE A.—A 25-year-old, married, colored musician with numerous arrests since adolescence for larceny and 18 arrests for exhibitionism and peep-

He has used alcohol, cocaine, and marijuana since age 12. He came from a broken home and was institutionalized many times before the age of 2. He has never worked more than a month and has been socially irresponsible, and he blames his family for all his troubles. His marital adjustment has been very poor. In the hospital he has been very irritable and circumstantial, and he has claimed to have solved all his problems, although he protests that he is in "double jeopardy" since his commitment as a sexual psychopath occurred while he was awaiting sentence for robbery. He is immature and egocentric but has made a good hospital adjustment.

Case B.—A 70-year-old, white widower who persisted in fellatio while he was drunk with young women to whom he gave gifts. His father died when he was 4 and he was overattached to his mother. When his wife died 3 years ago he made a good hospital and sexual adjustment except for one arrest in 1933 on suspicion of sodomy. He was impotent because of his wife's death and he began to drink heavily and became despairing afterwards. He shows minimal psychotic signs with transient sensorial clouding. His hospital adjustment is exemplary and he makes some requests for discharge, stating he will never misbehave again.

Case C.—A 29-year-old, single, white truck driver who has served 5 sentences for indecent exposure since 1942. The first offense occurred while he was drunk and he was urinating on the street. His family is heavily alcoholic; he is the oldest of 5 siblings and he had enuresis until age 8. He has always been shy and introverted and he shows marked verbal ineptitude. His homosexual behavior has been stereotyped and compulsive. He has been heavily alcoholic since the death of his father 11 years ago and he has been arrested for concealed weapons and 3 other minor offenses since then along with the indecent exposures. He has made a quiet hospital adjustment, but it has not been possible to arouse him to hospital adjustment.

Case D.—A 34-year-old, white, three-times-convicted accountant. He was orphaned at one year and had poor foster home placements until 12 when he made a model adjustment in an orphanage until age 18. His work record is fairly good but his social contacts have been superficial. He has a history of inadequacy, which exacerbated after failures in marriages or jobs. At these times his preoccupation with his unworthiness has resulted in compulsive, seemingly nonlustful touching of young girls in situations where he would be appreciated. Since hospitalization he has been a superficially "good" patient but his self-punishing operations have been very conspicuous. His jobs, therapy, and friendships have all evolved into failures. He has requested castration and lobotomy in similar characteristic moves.

#### SYNDROME OF "INDECENT EXPOSURE"

Observation of our group of exhibitionists has revealed certain clinical characteristics.

In contrast to other offenders, the exposures are frequent and repetitious. As individuals they have shown a limited and stereotyped heterosexual performance with rigid standards of "normality." Common is psychological dependence on medicines with tendencies to go on sprees of analgesics or alcohol. In the history prolonged enuresis is frequently noted and the common explanation for the act of indecent exposure is urinary urgency. They have been superficial and transient in their social relationships. Exposure frequently followed feelings of defiance and disappointment. These people are conspicuously nonverbal in their integrations and on psychological tests.

#### THE INSTITUTIONAL PROGRAM

We approached the problem of therapy with the conception that the sexual performance of an individual is but one manifestation of his total personality structure. In our experience the sexual deviation precipitates commitment and is simply the "tail that wags the dog." Our cases include such nonpsychotic clinical syndromes as mental defectives, organics, compulsive neurotics, ambulatory preschizophrenics, hysterics, and possibly a few "psychopaths."

Individuals committed under this law receive the same type of intensive psychiatric workup as is accorded to all patients in the maximum security division of Saint Elizabeths Hospital. The patients are seen on admission by one of the senior physicians and, after a detailed admission interview, are initially evaluated for therapeutic assignment.

At the time this Act went into operation we had already had for some years a fairly complete program of individual, group, and milieu psychotherapy, which has been described in preliminary papers(2). Fuller aspects of this program are to be published in the near future(3).

Briefly, the program provides for a full schedule of activities occupying the entire day. There are therapeutic group meetings and administrative group meetings, art, drama, and special projects groups, and occupational therapy workshops. There are recreational activities, such as group athletics (baseball, basketball, boxing, volley ball,

ping pong), movies, television, library, and music practice. The patients' newspaper, the Howard Hall Journal, has received much favorable comment.

Within a few months after admission each patient is brought to a conference where his case is fully discussed and evaluated, and patients who appear to be reasonable risks are transferred from maximum to minimum security (thus far, 6 cases). In this latter ward they continue with group therapy and individual therapy in selected cases. The patients admitted under this law are also assigned to a small "special group" because of their expressed feeling that they can discuss their sexual difficulties more freely with those whose problems are similar. In minimum security they have many opportunities to attend the hospital amusements, including dances and parties, and are given some kind of occupational assignment upon the grounds from which they come and go without supervision. This permits them to attend the psychodrama sessions held in another building and also offers them an opportunity to test developing awareness of their problems through contact with others. Throughout the program the over-all therapeutic atmosphere continually exerts a uniform, nonspecific pressure in the direction of health.

The structuring of a therapeutic milieu deserves considerably more discussion than would be possible in this limited account. An important facet of the milieu therapy is the frequent meeting of all members of the staff to discuss and work through any reactions or information they may have and to assist in the selection of specific doctor-patient pairs for therapy. In this connection, the discomforts of attendants in dealing with this group of patients is a source of continuing investigation and occasion for some discussion between physicians and attendants. Preliminary projects include a kind of group therapy seminar for the attendants.

Our emphasis on a purely psychological approach to therapy is based in part upon a review of the literature that has thus far disclosed no rationale for any specific physical therapy such as castration, hormonal injections, shock, insulin, or lobotomy (4).

#### GENERAL CHARACTERISTICS OF THE GROUP

Although the group is small and variegated and our period of observation brief, certain characteristics seem apparent in these people in their group functioning.

They are passively dependent, covertly and passively hostile characters. There is frequently exhibited an attitude of "injured innocence." Many of them are manipulative, rigid, and have a paradoxical pride in their status as sex deviants. This latter aspect may derive in part from their distortion of the hospital's interest.

By far the greater number are not currently amenable to a type of dynamic and insightful intensive psychotherapy. They are superficial and telegraphic in their communications, show little capacity for introspective or psychological thinking, and give only lip service to the attempts of the therapist to mobilize interest in surmounting their difficulties in living. The most frequent presentation is, "Well, if you say there is something wrong with me, suppose *you* do something about it." The idea of a collaborative effort is quite difficult to establish, although inexperienced therapists might be led astray by the ingratiating and agreeable manner of the manipulative members of the group. There is an unusually high degree of recourse to minimizing and defensive processes such as rationalization and projection. These individuals show a rather poor prognosis for psychotherapy because they almost invariably are unable to assume responsibility for their own treatment and continue indefinitely in a state of either strong latent negative resistance or of passive hostile dependence. There tends to be a marked absence of any "neurotic suffering" as a stimulus toward work in psychotherapy. Those who deny their dependency draw heavily on repressive mechanisms, which further defeats the attempts of the psychotherapist. Notwithstanding, a small proportion (about 6) in our group have indicated some amenability to psychotherapy and are making slight progress.

#### THE PROBLEMS

The problem of how to deal with the sexual psychopath has come into considerable

ominence in recent years. Tappan reports that habitual sex offenders have been the subject of special laws in at least 13 jurisdictions in recent legislative sessions(5).

A number of clinical and administrative problems are created by this group. The law confines a sexual psychopath, requires commitment to Saint Elizabeths Hospital upon judicial determination, and provides that he not to be released until certified as "sufficiently recovered so as not to be dangerous." Technical questions as to the precise psychiatric definition of the term "sexual psychopath" are not within the scope of this paper. The type of therapy most appropriate to achieve the goal set by the law must be determined for the actual patients committed by the law. The decision of the court for commitment as a sexual psychopath is actually a "diagnosis" which is not reviewable by the psychiatrist responsible for the subsequent treatment.

The courts are understandably concerned with the preservation of public peace and the segregation of individuals who are considered dangerous to others. The psychiatrist as a physician is primarily interested in the treatment and amelioration of individual human distress. While these two objectives are not necessarily incompatible, it is our experience that they frequently are divergent and occasionally at cross purposes. If the considerations as to civic responsibility are rather heavily weighted in favor of detention and segregation, then the penologist or correction officer is a more efficient custodian than the psychiatrist.

Given the group of people described, what constitutes the most appropriate therapeutic approach? We believe that insufficient information is available to establish solely the efficacy of any particular psychotherapeutic procedure. It is our general opinion, however, that only a dynamic and insightful type of intensive psychotherapy offers any prospect of modification of personality structure and some insurance against repetition of offense upon discharge of the patient. We recognize, however, that this is impossible in general application because of (a) the prohibitive cost, (b) the lack of fully qualified personnel for the number of patients who are in need of such treatment, and (c) the type of patients being sent to us thus far.

Lacking this, then, an alternate type of program expressing dynamically oriented attitudes toward the problem of psychotherapy seems essential.

We have described thus far an institutional program utilizing an already well-established program of group and individual psychotherapy. We have modified this program in some aspects to fit the special needs of this group but find that there are certain limitations to such modifications when operating within the facilities of an institution primarily designed for the care of psychotic individuals.

#### "SUFFICIENTLY RECOVERED"

The question of what constitutes cure again brings up the problem of whether cure is to be established only on the basis of a dynamic and insightful awareness plus actual personality change or whether cure can occur without "insight." It is recognized that a great many symptomatic improvements occur in such conditions as schizophrenia without the application of anything other than hospital atmosphere. Such cures are always fragile and not necessarily a protection against further difficulties.

Thus far we have not established any dependable set of criteria to use in predicting the future course of conduct or misconduct in our patients. It appears likely that a problem will eventually be occasioned by the collection of a residual group of individuals who we believe do not form particularly promising therapeutic risks and for whom little more than a high type of custodial care can be offered. In this connection there is a seeming disparity in that individuals who make "good hospital patients" are not infrequently those who form rather poor therapeutic risks. They may fit well into the standard hospital program and quickly assume a fixed, passive dependence. Although such individuals may adjust well in the hospital, this adjustment is no promonitor as to whether they could refrain from reestablishing their socially unwanted activities upon release. In other psychiatric conditions the psychiatrist finds himself, through long experience, with a much better defined set of criteria for predicting such things as suicide, combative be-

havior, and symptomatic exacerbation, and for evaluating recovery.

#### CONCLUSIONS

1. The group of patients reported is not statistically representative of the varieties of sexual offenders in the community.

2. It appears unlikely that very many of our group are sufficiently amenable to therapy so as to be "recovered" as required by law. In this connection, while we believe that their illnesses are psychodynamically determined, it is doubtful whether present techniques are equal to the task of cure.

3. Under the present law, the majority of the cases received have been exhibitionists. Certain characteristics of this group have been described. It is questionable whether the exhibitionist is a sexual criminal of sufficient menace to justify indefinite commitment and whether the incidence of heinous sexual crimes will be reduced by his confinement. In our experience thus far, the exhibitionist is in general a relatively poor risk for intensive therapy and he is likely to remain indefinitely since he cannot be certified as "recovered" as required by the law.

4. Considerably more research is needed into all phases of this problem, particularly with respect to the elaboration of criteria for prediction of behavior in these individuals before and after various therapies.

#### BIBLIOGRAPHY

1. Radio Broadcast, Station WTOP (CBS), April 11, 1950.

2. Abrahams, Joseph. Preliminary report of an experience in the group therapy of schizophrenics. *Am. J. Psychiat.*, 104:10, April 1948. 613-617

Group psychotherapy, remarks on its basis and application. *M. Ann. District of Columbia*, 16:44, Nov. 1947. 612-616

3. Abrahams, Joseph, and Cruvant, Bernard A. *Manual of Group Therapy*. In preparation.

Tartaglino, Francis J., and Cruvant, Bernard A. Forestalling chronicity in the hospitalized patient. Read before Med. Soc. St. Elizabeths Hosp., April 1949.

4. Preliminary Report of the Subcommittee on Sex Crimes. Calif. legis. assembly. March 8, 1950.

Report of the New Jersey Commission for the Study of the Habitual Sex Offender. February, 1950.

Selling, Lowell S. Report of regular meeting Jan. 11, 1940, *Mich. Soc. Neurol. & Psychiat. Arch. Neurol. & Psychiat.*, 43:1276, 1940.

Silverman, Daniel. Treatment of exhibitionism. *Bull. Menninger Clin.*, 5:85, May 1941.

Wile, Ira S. Sex offenders and sex offenses: classification and treatment. *J. Crim. Psychopath.* 3:11, July 1941.

East, Norwood. *Society and the Criminal*. London, His Majesty's Stationery Office, 1949. Chap. 7: Treatment of Sexual Offenders.

Bowman, Karl M. Challenge of the sex offenders: Psychiatric aspects of the problem. *Ment. Hyg.*, 22:10, Jan. 1938.

Golla, F. L., and Hodge, R. Sessions. Hormone treatment of the sexual offenders. *Lancet*, 1:1006, June 11, 1949.

Rubinstein, R. S., et al. The treatment of morbid sex craving with the aid of testosterone propionate. *Am. J. Psychiat.*, 97:703, Nov. 1940.

Report of the Joint Com. on Psychiatry and the Law, appointed by British Med. Assn. The criminal law and sex offenders. *Brit. M. J.*, 1:135, Supplement, March 12, 1949.

5. Tappan, Paul W. The sexual psychopath. A civic-social responsibility. *J. Social Hyg.*, Nov. 1949.