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THE HABITUAL SEX OFFENDER

Report and Recommendations of the Commission on the Habitual Sex Offender, as formulated by Paul W. Tappan, Technical Consultant

Members of the Commission:

Joseph P. Murphy, Chairman
Anthony J. Cafiero, Senate
Vice-Chairman
F. Lovell Bixby, Ph.D.
Elden Mills, Assembly
J. B. Spradley, M.D.
Walter G. Winne
Sampson G. Smith

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Paul W. Tappan, Ph.D., J.S.D.
Technical Consultant

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February 1, 1950

LETTER OF TRANSMITTAL

In accordance with Senate Joint Resolution No. 7, March 10, 1949, appointing a commission to investigate the problem of the habitual sex offender, the Commission has been duly established and has conducted its inquiries into the several issues as required by the terms of the resolution. A report of the findings of its investigation together with its recommendations for legislative enactment and administrative action, as prepared by the Consultant to the Commission, is respectfully submitted herewith.

Joseph F. Murphy, Chairman
Commission for the Study of
the Habitual Sex Offender

Members of the Commission:

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Anthony J. Cafiero, Senate
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SENATE JOINT RESOLUTION NO. 7

INTRODUCED MARCH 10, 1949

By Mr. VAN ALSTYNE

Referred to Committee on Institutions and Agencies

A JOINT RESOLUTION appointing a commission to investigate the problem of the habitual sex offender; to consider such proposals as may require legislative action and to report thereon to the Legislature; and making an appropriation for the expenses thereof.

WHEREAS, It has come to the attention of the law enforcing agencies of this State that there is a definite trend toward the habitual repetition of sex offenses by a specific group of persons; and

WHEREAS, It is the firm belief of these same agencies that many similar sex offenses remain undisclosed; and

WHEREAS, It is deemed advisable to make a thorough examination of the existing laws of this State and the practices thereunder to determine whether they are adequate to cope with the problem of apprehending the habitual sex offender and thereafter provide either preventive treatment or appropriate institutional confinement of a corrective or therapeutic character; therefore,

BE IT RESOLVED by the Senate and General Assembly of the State of New Jersey:

1. There is hereby created a commission to consist of seven members, one to be appointed from the membership of the Senate by the President thereof, one to be appointed from the membership of the House of Assembly by the Speaker thereof, and five to be appointed by the Governor, with

special regard for their training, experience and ability in the field of psychiatry, psychology, penology and allied branches of the sciences related to the prevention, treatment and cure of habitual sex offenders. All such members shall serve without compensation.

2. The commission shall organize as soon as possible after the appointment of its members and shall elect a chairman and may appoint a secretary who need not be a member of the commission.

3. It shall be the duty of said commission to

(a) Determine whether the problem of the habitual sex criminal, the sexual deviate or the sex psychopath should have specific recognition in our statutes for the prevention, treatment and cure of persons engaged in repetitious sex offenses.

(b) Determine whether any amendments can or should be made to existing statutes or whether new statutes should be enacted to make possible the more adequate scientific treatment of the habitual sex offender or sex deviate.

(c) Establish a concise definition of the sex deviate and sex psychopath.

(d) Determine whether any special or additional measures can be provided for apprehension, prevention, treatment and cure of such persons.

(e) Recommend any new types of institutions or modified adaptation of existing institutional treatment which may appear necessary and proper.

(f) Recommend such other methods or procedures designed to reduce the number of sex offenses within this State directly or indirectly attributed to so-called sex deviates or sex psychopaths.

(g) Make a full and concise report of its investigation and

recommendations for legislative or other action to the Legislature on or before February first, one thousand nine hundred and fifty.

4. The commission shall be entitled to call to its assistance, and avail itself of the services of such employees of any State department, board, bureau, commission or agency as it may require, both as to technical, professional and expert opinion on the matter under investigation and as to such other assistance which the commission may deem necessary to a full study of the problem.

5. For the purpose of carrying into effect the provisions of this joint resolution, there is hereby appropriated the sum of ten thousand dollars ($10,000.00), or so much thereof as shall be necessary, to provide for traveling, incidental and secretarial expenses of the commission.

6. This joint resolution shall take effect immediately.

The attached recommendations relating to policy in the handling of the habitual sex offender are predicated upon the following as important criteria for reasonable and potentially effective handling of the problem:

1. It is desirable to provide preventive and early curative efforts for the sex deviate where this can be done with due consideration to constitutional requirements and the limitations of our treatment resources.

2. Since public feeling and legislative action have been stimulated in the main by serious and aggressive sex crimes, it is desirable if that problem is to be met effectively to concentrate our efforts on the sex offender who is a real menace to the community.

   (a) Thus we may avoid the serious danger observed in other jurisdictions that the policy of the law will be nullified in administrative practice because of a greatly increased severity in the treatment of minor offenders.

   (b) We may also avoid the excessive expenditures of our financial and mental hygiene resources on minor cases, when experience has shown very clearly the need to concentrate more efforts on the seriously and dangerously disturbed (including, of course, non-sex offenders).

   (c) We shall also thus avoid attempting to do a treatment job on minor sex deviates that is utterly impossible because of its size and expense.

3. Our proposals should avoid the violation of civil liberties and constitutional rights. In particular we do well to avoid the civil adjudication of non-offenders (except where they voluntarily ask for help) under the wishful misconception that the danger of serious sex crime can be predicted in advance. It seems clear as well that the mere shifting from a criminal to a civil tribunal for the adjudication of sex cases is an unjustified effort to circumvent the legal problems of due process, thereby to avoid that serious concern which we should continue to give to the essential human rights that are involved.

4. In light of the failures that have marked the efforts elsewhere to treat the habitual sex offender through the laws recently enacted, we should employ methods that are reasonable and realistic to accomplish the objectives for which the Commission was established.

5. We would do well, unlike the other states that have passed hurried and ill considered legislation, to be guided by the counsel of those authorities who have given considerable thought and research to this field. In particular we should profit from the failures in other jurisdictions where these are rooted in methods and policies that we can avoid.

6. It should be stressed that the recommendations proposed are designed only as a <u>supplement</u> to the traditional body of criminal law, that these are designed to provide for new and special treatment approaches only where such change appears feasible and necessary in the public interest.

RECOMMENDATIONS FOR LEGISLATIVE ACTION AND ADMINISTRATIVE POLICY CHANGES

Program of Prevention

1. Provision should be made for the extension of the State Mental Hygiene Clinic facilities serving the several counties. In addition, encouragement should be given to municipalities to set up and develop local mental hygiene facilities.

2. Efforts should be made to acquaint administrators and other personnel in our schools and other agencies more fully with the available mental hygiene facilities.

3. Encouragement should be given to programs of sex and family life education at the adult level throughout the state. If this is conducted under the auspices of the Division of Adult Education of the State Department of Education, its effectiveness may be enhanced.

4. The churches in the State of New Jersey are exhorted to continue to make an active effort to emphasize the development of more adequate family life education. This may be done in part through the encouragement by the church of parents' responsibility for a more effective moral and social education of their children, including the elements of biological information as these relate to wholesome attitudes and habits in the young and to preparation for more normal and healthy marriage adjustment. Beyond this, the church may lend its active cooperation to parents for the improvement of sex and family life education.

5. The development of family life training in the public schools should be encouraged. Such training should be directed toward healthy attitudes and habits of the young as they relate to family living.

6. In the education, selection and in-service training of teachers, more stress should be placed upon the educators' understanding of the principles of mental hygiene and upon his ability to discern evidences of students' need for mental hygiene assistance.

7. Medical and public health authorities throughout the state should be urged to extend their efforts in providing sound public education in regard to sex and mental hygiene. It is recommended that the State Medical Association conduct an intensive campaign among its membership to assure that general practitioners are well informed in the field of sexual aberrations and will include preventive and early treatment measures in dealing with their patients.

8. Voluntary self-commitment of sexual deviates. It is recommended that provision be made so that an individual who seeks to prevent the development in his behavior of unlawful sexual deviation may secure where necessary an appropriate treatment.

   (a) He may apply to the County Adjustor in his county of residence for a voluntary self-commitment for clinical diagnosis and study to be conducted at the New Jersey Diagnostic Center to determine his possible need for psychiatric treatment.

(b) Where there is a finding that such a person does suffer from an aberration from which potentially dangerous sexual behavior is a reasonably probable consequence, he may receive treatment on a voluntary basis in an institution to be designated by the Department of Institutions and Agencies or out-patient treatment.

Treatment Program

9. Upon a conviction for the crimes of rape, sodomy, carnal abuse, impairing the morals of a minor, or an attempt to commit any of these offenses, before sentence the judge shall remand the defendant to the New Jersey Diagnostic Center. If it be determined through clinical findings that the offender's conduct was characterized by

(a) a pattern of repetitive-compulsive behavior and

(b) violence or

(c) an age disparity between a victim (under the age of 15) and the adult defendant-aggressor

it will be the duty of the court to submit the offender to a program of treatment.

10. Such treatment, upon recommendation of the Diagnostic Center, shall include one or more of the following measures:

(a) Probation with out-patient psychiatric treatment.

(b) Commitment to a specialized facility for intensive psychiatric treatment, followed by parole supervision (as provided under 13 (b)).

(c) Commitment for care to a state mental hospital, followed by parole supervision (as provided under 13 (b)).

(d) Commitment to a correctional institution, followed by parole supervision (as provided under 13 (b)).

11. Provision should be made for the establishment of an institution with medical, psychiatric and custodial features to carry on a program of intensive treatment and study designed to develop more effective rehabilitative measures for deviated sex offenders. It should be the objective of this program to provide demonstrable results through the treatment and research developed there.

12. Release from the institution under 10 (b), (c) or (d) shall be when the offender is believed capable of making an acceptable social adjustment. Such release, however, must be on or before the expiration of the maximum term which the offender might have received for the crime of which he was convicted. It will be the duty of the institution of commitment to report to the Department of Institutions and Agencies on each patient committed under this law at six month intervals.

13. It is recommended that the Department of Institutions and Agencies devote efforts specifically to the following major tasks:

(a) Designation of the institution to which a convicted sex offender who is found after diagnosis to be abnormal, as noted under 9 above, will be sent for treatment.

(b) Provision for release of these individuals under supervision of the Central Parole Division, Department of Institutions and Agencies and through the laws, rules and regulations governing parole, when they are believed capable of making an acceptable social adjustment.

(c) Assumption of responsibility for the continuing development of research on the methods of effective treatment of the sex deviate, as provided under 11 above, and to prepare periodic reports of the progress of such research.

(d) Assistance in the development and coordination of the program of education and information, as provided under 2,3,4,5,6,7 and 14 in these recommendations.

14. Thorough-going efforts should be directed to assure that judges, prosecutors, police and other administrative officials are well acquainted with the purposes and procedures of such legislation as may be enacted. It is particularly important that they be familiar with such provisions as may grow out of recommendations 8,9,10,11,12 and 13 above.

15. Local police and courts throughout New Jersey should be encouraged to become acquainted with and to employ the unique modus operandi files on sex offenders presently maintained by the New Jersey State Police at Trenton headquarters. (As emphasized by the officials there, these files will continue to have little use unless information about them filters through the local police departments; they are seldom employed when only the chiefs of police are aware of the available material.)

It is the conviction and affirmation of this Commission that unless such positive steps are taken to implement a real treatment program as those suggested above, its inquiries and Report may be fruitless. Without effective treatment measures, any special legislation on the sex deviate may prove dangerous to the interests of the State of New Jersey through failure to meet its objective of a curative handling of abnormal sex criminals.

INTRODUCTION

This report is based upon several lines of inquiry conducted by the Commission to Investigate the Problem of the Habitual Sex Offender, as authorized under Senate Joint Resolution No. 7 of March 10, 1949:

1. A series of hearings and conferences has been held by the Commission for the purpose of learning the views of numerous authorities concerning the handling of the habitual sex offender. The Commission's report reflects the opinions and information secured through these meetings. An inter-state conference with official representatives from Delaware, Pennsylvania, Massachusetts, New York, Maryland, Connecticut, Rhode Island and New Jersey was assembled by Commissioner Sanford Bates for a meeting on June 29 at Trenton. The experience and plans of these several jurisdictions in handling the problem of the sex offender were discussed and the objective was established to continue to cooperate on an inter-state basis.

2. A three-day session of hearings was held in Atlantic City on September 22, 23 and 24 for which invitations were issued to some 250 authorities in the State of New Jersey, representing the judiciary, prosecutors' offices, probation and parole departments, county and state medical societies, the churches, public schools, and other interested bodies in the southern counties of the State. Testimony was received concerning the operation of the present sex offender laws, the extent of the sex problem, possibilities of improved methods of treatment and prevention, and other germane matters. A similar three-day meeting was held in Newark on October 3, 5 and 7 attended by authorities from the northern counties of New Jersey where further testimony was received concerning the problems of the sex offender. Invitations were issued to some 500 persons and groups to attend these sessions.

3. A conference with outstanding authorities who have specialized in the problems of the sex offender through treatment, research, legislative drafting, and other study was held in Trenton on November 21, 1949. Some 15 experts

representing the fields of psychiatry, law, biology, case work, and sociology addressed the Commission on technical problems, policy considerations, and possibilities of control through legislation and treatments.

4. A detailed, analytical study was conducted by the Advisor to the Commission of the laws and their administrative operation in the thirteen states that have passed specific legislation to deal with the abnormal sex offender. This appears to be the only thorough study that has been made of the experience that has attended the development of the new sex laws. For this purpose he visited and consulted numerous authorities in Illinois, Washington, D.C., New Jersey, New York, Vermont, Colorado, Minnesota and Wisconsin, accompanied by a Commission member on some of these investigations. Supplementary and detailed information was secured from these particular jurisdictions and from those other states that have sex psychopath laws by questionnaires addressed to authorities charged with administration of the laws and of treatment, and by extensive correspondence with many of them, conferences in New Jersey and elsewhere with others. Reports on experience under the laws in the several states were prepared for the Commission. A summary analysis is contained herein and a chart prepared for the legislature.

5. A series of three questionnaires was prepared and distributed by the Advisor to secure information concerning various specialized problems involved in the Commission's investigation. One submitted to 300 psychiatrists, selected on the basis of their familiarity with the problems of sexual deviation, inquired particularly into the desirable and feasible methods of handling these offenders under the law. A second was distributed to principals of the public schools throughout the State of New Jersey to elicit information concerning the extent of the problem of apparent psychological and sexual disturbance among school children and the possibilities of providing more effective preventive treatment. A third, directed to Parent-Teachers groups in the State was similar in purpose. These questionnaires and an analysis of the replies

received are contained herein (see Appendix, pp. i through xvii). The policies recommended by the Commission reflect the replies to these questions and, in many instances, the detailed statements of educators and medical authorities.

6. Extensive research was conducted into the considerable and rapidly growing body of literature on the sexual psychopath and on treatment of the sexual deviate. The material is diverse and of highly variable quality, reflecting the almost utter lack of agreement among "authorities" even on basic issues involved in the causation, treatment, prognosis, and legal handling of sex offenders. Bibliographies are attached to this report (see pp. and some of the more useful literature is referred to at various points herein.

7. Frequent and extended consultations were carried on with certain individuals and groups in New Jersey, New York City, Philadelphia and Washington, D.C. The Commission is particularly indebted for its information and guidance, in addition to those mentioned above, to the following for their most helpful cooperation: The Department of Institutions and Agencies, New Jersey State Police, The New Jersey Diagnostic Center, The Committee on Forensic Psychiatry of the Group for the Advancement of Psychiatry, The American Social Hygiene Association, and to Dr. Alfred C. Kinsey, Professor Edwin H. Sutherland, Dr. Philip Q. Roche, Judge Morris Ploscowe and Dr. Winfred Overholser, among the internationally recognized authorities consulted. Scores of others in the fields of law, medicine, education and the social sciences have contributed invaluably to our considerations.

I

FALLACIES CONCERNING THE SEX OFFENDER

It may be useful at the start to consider a number of the propositions upon which public fears have been fed in relation to the sex offender. These assumptions have been the basis to a large extent of ineffective legislation that has been enacted in a number of states in recent years. The futility of these laws has proceeded from the inaccuracy of views that have been held widely but without real scientific or critical investigation. Their popularity must be attributed in the main not to any foundation in fact for their adoption, but to the exploitation of the peculiarly intense anxieties about sex crime that most people feel: the channels of publicity have been receptive mainly to the rabidly distorted declarations of ill-informed, often hysterical prophets of calamity. Sober evaluation of the problem of sex deviation and of feasible methods of meeting it has been rare indeed, and particularly so through the vehicles of information to which most readers are exposed. Single instances of the crimes of "sex fiends" are given widest currency along with demands for heroic remedies, while more objective studies of the prevalence of such behavior, its possible prevention and treatment, are relegated to specialized technical journals, scholarly monographs--and legislative reports.

Every conceivable variety of approach has been recommended from some quarter in recent months to "meet the sex problem." Most of these have been put into operation somewhere, either legally or extralegally: increased publicity, the death penalty, doubling the prison sentence or life terms, prohibition of parole, castration, sterilization, the administration of sex hormones or goat gland extracts, psychoanalysis, shock treatment, state hospital custody for life or for indeterminate periods, brain surgery, group therapy, and many others. Some "authorities", confused in their oestrus to resolve at once problems of sex control that have beset man throughout the span of human history recommend in one over-

heated breath the greatest possible severity of punishment for all sex deviates and in their next impetuous exhalation declare that the problem is medical and must be turned over at once and in its entirety to the psychiatrists. Some of the more significant and prevalent fallacies are presented below very briefly. They are given more detailed consideration at appropriate points in this report. The immediate purpose is merely to point toward certain crucial areas where error serves only to complicate our difficulties. These are some of the commonly cherished but quite erroneous views that are vitally related to policy considerations:

1. That there are tens of thousands of homicidal sex fiends abroad in the land. In fact the vast majority of the sex deviates are minor offenders, most of whom never come to official attention (e.g., there are sixty million homosexual acts performed in the United States for every twenty convictions in our courts). It has been carefully estimated by Dr. Kinsey that not more than 5% of our convicted sex offenders are of a dangerous variety, exercising force or injury upon a victim. Crime reports support this finding. Homicide associated with sex crimes is unusual. A recent study by the criminologist, Dr. Sutherland, shows that the "danger of murder by relative or other intimate associate is very much greater than the danger of murder by an unknown sex fiend." Nearly 90% of the murders of females he studied were committed by relatives or suitors, and 25% of those who murdered females committed suicide. The sex fiend as portrayed by F. Wittels et al is a rare phenomenon in the criminal history of any state; the tens of thousands that he hypothecates are the much publicized creatures of his well-stirred imagination. Most of those who do occasionally appear are insane, not merely sexual deviates.

2. That sex offenders are usually recidivists. Sex offenders have one of the lowest rates as "repeaters" of all types of crime. Among serious crimes homicide alone has a lower rate of recidivism. Careful studies of large samples of sex criminals show that most of them get in trouble only once. Of those who do repeat, a majority commit some crime other than sex. Only 7% of those

convicted of serious sex crimes are arrested again for a sex crime. Those who recidivate are characteristically minor offenders--such as peepers, exhibitionists, homosexuals--rather than criminals of serious menace.

3. That the sex offender progresses to more serious types of sex crime. It is the consensus of opinion among psychiatrists, confirmed by crime statistics, that sex deviates persist in the type of behavior in which they have discovered satisfaction. Any thoroughly frustrated, rigidly repressed personality may conceivably explode into violence it is true. There is no evidence, however, that this occurs more frequently among sex offenders than others; indeed there is good psychological ground to believe that individuals who experience some outlet of sexual tensions are less likely to need release of rage and aggression. Progression from minor to major sex crimes is exceptional, though an individual may engage at any given time in a variety of forms of sex outlets.

4. That it is possible to predict the danger of serious crimes being committed by sex deviates. Reports from 75 prominent psychiatrists reveal a consensus that it is impossible to predict the occurrence of serious crime with any accuracy. That the behavior sciences have not attained this level of prognostication is attested in these statements by authorities:

Dr. J. B. Gordon, Medical Director, New Jersey State Hospital: "This would require superhuman intelligence and the gift of prophecy."

Dr. Hilding Bengs, Commissioner of Mental Health, Pennsylvania: "It is impossible to predict accurately commissions of serious crimes in a person of certain tendencies. There are the unpredictable facts of circumstance, opportunity, and the timely reaction of the person."

Dr. Philip Q. Roche, Chairman, Committee on Forensic Psychiatry, Group for the Advancement of Psychiatry: "The expedience of the law would call upon unqualified physicians to make guesses or to express prejudices. There are

very few psychiatrists who have sufficient training and experience with offenders."

Dr. Edwin H. Sutherland, Professor of Criminology, Indiana University: "Accurate prediction could not be made in any case or percentage of cases." This inability to predict is of special importance in relation to recent laws that are designed to constrain individuals who have committed no law violations as well as minor sex deviates and even juveniles.

5. That "sex psychopathy" or sex deviation is a clinical entity. Two-thirds of the psychiatric authorities consulted by the writer pointed to the wide disagreement among psychiatrists as to the meaning of the term, sex psychopath. More than half of them maintained that this condition is not a sufficiently clear diagnostic entity to justify legislation concerning the type. Hospital authorities handling cases of "sex psychopaths" committed by the courts find, in fact, a wide variety of psychological types: neurotics, psychotics, schizoids, feebleminded, epileptics, constitutional homosexuals, alcoholics, and many who are normal. In different states the authorities look for different qualities as evidence of dangerous sexual psychopathy; the cases they adjudicate as such display varied forms of sex deviation and assorted types of personality organization.

6. That these individuals are over-sexed. From the point of view of their treatment and their dangerousness, it is important to realize that most of the sex deviates treated under the laws are under-sexed rather than hyper-gonadal types. A majority are passive or non-aggressive. The problem is very rarely one of drives too strong to control, as commonly recommended programs of castration, sterilization and close correctional custody would imply.

7. That effective treatment methods to cure deviated sex offenders are already known and employed. As compared with other types of psychological and constitutional abnormality, we are peculiarly at a loss in the handling of

abnormal sex offenders. Methods of effective treatment have not yet been worked out. The states that have passed special laws on the sex deviate do not even attempt treatment! The "patients" are kept in bare custodial confinement. This point is central to the atrocious policy of those jurisdictions that commit non-criminals and minor deviates for indefinite periods to mental hospitals where no therapy is offered. Most psychiatrists indicate that psychotherapy of some sort should be given to sex offenders, but they are in agreement that professional staffing is not available to perform this work and that an unknown but undoubtedly very high percentage of deviates would not respond to such treatment. In private practice the treatment applied to the sex deviate by many psychiatrists is designed to help him accept his peculiarity without guilt feelings and to be more discrete in its expression. The point should be stressed that commitment of a sex deviate to a state mental hospital does not imply clinical treatment. These institutions lack the space, the personnel, the treatment methods, or even the desire to handle deviated sex offenders who are non-psychotic.

8. That the laws passed recently in one-fourth of the states are getting at the brutal and vicious sex criminal. Data secured from the several jurisdictions reveals that, although the laws have been passed in response to public fears about the dangerous and aggressive offenders, in fact these are the types least frequently brought under the statutes in actual administration. Most of the persons adjudicated are minor deviates, rarely if ever "sex fiends."

9. That civil adjudication of the sex deviate and/or indeterminate commitment to a mental hospital is similar to our handling of the insane and, therefore, human liberties and due process are not involved. This type of thinking has been used in several states to support long-term custody of minor deviates, many of them without a criminal charge. Under these laws the insane and

mentally defective are specifically excluded. Those covered are in fact a variety of psychological types that have never before been exempted from criminal responsibility nor commitable to mental hospitals. No sound reason has ever been advanced for committing a "peeper" to a mental hospital for an indeterminate period (or any period) of time where he will be segregated from his community and family in an unproductive existence at state expense. Nevertheless this has become common practice today under the recent legislation throughout the country. Regardless of the type of court employed to attain this result, it is in effect a serious punishment in which liberty and due process are vitally involved. Reasoning to the contrary is founded in a technical legalism of the most vicious sort.

10. <u>That the sex problem can be solved merely by passing a new law on it.</u> Common sense must indicate to the contrary. Certainly experience with these laws reveals the futility of ineffectual legislation. In general the statutes appear to have served only the purpose of satisfying the public temporarily that "something is being done." In fact, and fortunately, very little is being done under the sex psychopath laws, but that little is worse in effect than leaving the offender to the operation of the traditional criminal law would have been. Thus far no problems have been resolved by the new sex laws that have been enacted. On the contrary, some extremely dangerous precedents have been established 1) for adjudicating individuals without ordinary due process--even in five states without a criminal charge--, 2) for indeterminate commitments to mental hospitals of individuals who are not insane and who deviate little or not at all from normal psychologically, and 3) for providing hospital custody to a growing body of minor sex deviates who are to be held until "cured" though without treatment, at great cost to the taxpayer and with serious diminution of the facilities available for those mental patients who are seriously disturbed.

II

SEX DEVIATION: ITS EXTENT AND TREATMENT

A very practical consideration in any effort to meet the problem of the sex offender, though one that appears usually to have been overlooked, concerns the volume of cases engaging in the various types of behavior and the load that might be expected to be imposed on the courts and treatment program through new legislation. This distinction should be stressed: the numbers of actual sex deviates will exceed the group that will be diagnosed and treated for their offenses. The measure of difference between the offenders and those who would be handled as court cases under a new sex law depends upon the degree of efficiency in enforcement of the statutory policy and the facilities available to handle them. As noted elsewhere in this report,[1] experience under the statutes enacted in the several states with sex psychopath laws reveals a complete ineffectiveness in administration, based apparently on the lack of resources to provide treatment and on the failure of police and prosecuting authorities to get at more than an insignificant proportion of the sex deviates who could be brought under the terms of the laws. Since the operation of the law is, in most of the jurisdictions, completely at the discretion of the prosecutor, it is easy for the state to avoid more than a token application. Cases of sexual aberration--those that are discovered and prosecuted at all--can be and usually are in fact handled outside the provisions of the recent sex laws, either under the ordinary criminal laws relating to sex or by reducing charges to non-sexual offenses (disorderly conduct, assault, etc.). It appears clear that something is wrong with the new legislation where the vast majority of cases intended to be covered avoid its operation. Ordinary principles of justice require that where some individuals are handled by new techniques, others of similar type should be dealt with so far as possible in

1. Page

the same way. More than this, where the purpose of the state is to meet a problem effectively, it must endeavor vigorously to apprehend and treat those cases that are considered to be a sufficiently special problem to justify the innovations in statutory policy.

This brings us to another main problem in relation to the size of the sex problem to be met through new legislation: what types of cases should be covered? This should depend first, it appears, on how many cases the state can reasonably hope to treat under a new program. Secondly, how great a danger to public security and welfare is represented by these cases. As to the latter question, it is our conclusion that a distinction must be made between 1) those sexual deviates whose conduct in the community offends good taste and morals (such as homosexuals, exhibitionists, "peepers," and other minor lewd offenders), and 2) that other group composed of dangerous and aggressive offenders whose behavior is a serious threat to the community (such as aggressive rapists, sadists, sex slayers, and those who attack young children). The latter is obviously a considerably smaller group. It is also the group about which serious concern has quite properly developed throughout the United States, the group against which the public has felt the need for increased protection. Strangely, the laws enacted thus far have made virtually no attempt to distinguish between the types or seriousness of sexual deviates. Under the terms of the statutes all sorts of sex cases are covered. This is believed in itself to set up an insurmountable handicap to any really effective operation of the laws. An effort is made below to appraise the extent of the problem of the sex offender in terms of the distinction suggested here between those who are minor and those who are a menace to the state.

Minor Sex Offenders:

The only comprehensive effort that has been made up to the present to discover the prevalence of sexually deviant behavior is that conducted by Dr.

Alfred C. Kinsey and summarized in Sexual Behavior in the Human Male. As revealed in his data and in his conferences with the Commission, behavior in conflict with our legal and moral codes is exceedingly common:

> In spite of the many centuries during which our culture has attempted to suppress all but one type of sexual activity, a not inconsiderable portion of all the sexual acts in which the human animal engages still fall into the category which the culture rates as "perverse." The specific data show that two-thirds to three-quarters of the males in our American culture, and some lesser number of the females, engage in at least some "perverse" sexual behavior at some time between adolescence and old age. One-half to two-thirds of the males engage in such behavior with appreciable frequency during some period of their lives and a fair number engage in such behavior throughout their lives.[2]

Dr. Kinsey provides evidence from large population samples to show, as to certain specific categories of law violation, that 37 percent of males has had some homosexual experience, that 59 percent has had some experience in oral sodomy, that 17 percent of those bred on farms had had animal contacts. These data are merely illustrative of the size of a part of the problem that the recent sex statutes are held to cover. They do not include those other prevalent types of deviation (such as indecent exposure, peeping, molesting, etc.) which today are being adjudicated for special treatment under the new sex laws. There can be no real doubt that a very large number of the male population of New Jersey has engaged in practices coming within the enumerations of our present abnormal sex offender law, on the basis of which they might be committed to one of our state mental hospitals. As noted elsewhere in this report, more sex deviates are being referred by our courts for psychiatric observation than is true in any of the other twelve jurisdictions that have passed special laws on the subject, approximately twenty cases each month during the first few months of operation

2. Kinsey et al, Concepts of Normality and Abnormality in Sexual Behavior, Psychosexual Development in Health and Disease, p. 28, 1949.

of the 1949 law.[3] It is clear, however, that these are only a minute fraction of the cases engaging in similar behavior either undetected or unprosecuted. This means, too, that the number of cases that could be held under the statute in the future is virtually unlimited. The population of our mental hospitals might be multiplied many times.

Leaving consideration of the numbers who might be held under our law if it operated with maximum efficiency, it may be more realistic to inspect the data on the numbers who are actually prosecuted for sex crimes--those whom we should expect to become a charge upon our diagnostic and treatment resources. It is reasonable to believe that the rate at which sex cases are remanded for diagnostic observation will increase appreciably under our present law as authorities become increasingly familiar with the intent of that statute and with the availability of the Menlo Park diagnostic facility. Even at the current rate, however, we must expect at least 250 sex cases each year to come under psychiatric observation, close to 100 each year to be added to the populations of our already over-crowded mental hospitals, and most of these for extended periods of confinement.[4] The task is impossible to perform without large scale increases in the institutional and personnel facilities of the state, even on a purely custodial basis.

Further confirmation of the size of the problem of known sex offenders has been observed in the data accumulated by the New Jersey State Police and provided to the Commission. Their file of sex reports developed during the past decade reveal a total of nearly 13,000 offenders of the types covered by the 1949 sex statute:

3. Among these one-third are committed to mental hospitals as abnormal offenders.
4. Note, in the discussion, pp. , that such hospitalization does not imply rehabilitative or curative treatment under our existing resources.

TABLE I

SEX FILE OF THE NEW JERSEY STATE POLICE

Number of sex reports received annually:

Cases on hand when file was started -------	3137
Received in:	
1939 ----------	718
1940 ----------	897
1941 ----------	862
1942 ----------	825
1943 ----------	639
1944 ----------	610
1945 ----------	569
1946 ----------	664
1947 ----------	978
1948 ----------	730
1949 (10 months) ---------	651
In 1943 1653 pictures, not previously recorded as sex pictures, were added to the file	1653
	12933

Note: The above includes only males, and does not include Bastardy, Fornication, Adultery, or Unlawful Co-habitation.

The categories employed in the filing of these cases are based upon rather broad definitions to include wide varieties of offenses, but a breakdown into the general types of crime shows something of the distribution. It may be noted that a great majority of the crimes do not involve force upon an unwilling victim. More of the offenses are of a minor character rather than a menace. It would be an egregious folly to add thousands of these cases to our presently large mental hospital populations.

TABLE II

SEX FILE

TOTAL NUMBER OF SUBJECTS IN SEX FILE	12,933
TOTAL NUMBER OF PHOTOGRAPHS ON FILE	8,310

	WHITE	BLACK	TOTAL	PERCENTAGE
EXHIBITIONISM	1842	500	2342	18%
RAPE	3987	1836	5823	45%
PERVERSION	1512	340	1852	14%
COMMERCIAL SEX	735	224	959	7%
UNCLASSIFIED			1944	16%

RAPE

WHITE		BLACK	
Adult	37%	Adult	31%
Minor	63%	Minor	69%
*Under 12	22%	*Under 12	23%
Under 5	8%	Under 5	3%

PERVERSION

WHITE		BLACK	
Adult	46%	Adult	60%
Minor	54%	Minor	40%
*Under 12	73%	*Under 12	60%
Under 5	9%	Under 5	18%

*Figures in the 5 & 12 year age groups represent percentages of the Minor Group only.

Sex Offenders Who Are a Menace:

The more dangerous types of sexual offenders constitute, fortunately, a rather small group in the population. Their "visibility" is high and their threat to public security serious because of the atrocious character of the crimes they commit, but in numbers they are few. Accurate statistics on the subject are impossible to secure since, for example, while some victims of rape and sexual assault fail to report the crime, many others bring charges without justification when no involuntary sex act has actually occurred.

A study was conducted in New York City on the handling of sex crimes in the Court of General Sessions and the county courts, during the ten year period, 1930-1939.[5] It may be noted in the tabulation below from this investigation that, even as to these more serious types of offenses, a majority involve voluntary participation by the parties rather than force or violence. Forcible rape represented only a small proportion (12 percent) of the felonious sex crimes. Also, as in other jurisdictions, a high proportion of the statutory rapes involved relations with females who were matured and experienced, but under the statutory age of consent (18 in New York State). Few of these cases were thought sufficiently serious to justify a state prison sentence (8 percent). It should be observed in addition that during the decade studied the county courts awarded prison terms to only 19 percent of the felonious sex criminals convicted whereas probation or suspended sentences were given in 36 percent. Apparently the courts did not consider very many to be dangerous, habitual, or mentally abnormal criminals.

5. Report of Mayor's Committee for the Study of Sex Offenses, City of New York, p. 61. These figures do not show the minor offenders convicted in other trial courts for the varieties of lewd and disorderly sex conduct. This study is probably the most comprehensive of its sort that has been made.

TABLE III

SENTENCES IMPOSED IN THE COURT OF GENERAL SESSIONS AND THE COUNTY COURTS BY CRIME - 1930-1939

CRIME	TOTAL	s.s. (No Probation)	Probation	Workhouse	Penitentiary	N.Y.C. Reformatory	State Prison	Elmira	Napanoch	Others
Felonies,										
Abduction	63	4	18	6	10	..	22	2	..	1
Carnal Abuse	333	16	9	39	146	10	84	3	22	4
Incest	98	3	10	1	16	5	58	2	3	..
Forcible Rape	418	44	40	33	63	22	160	41	9	6
Statutory Rape	1948	223	761	252	360	105	161	54	16	16
Seduction	21	3	11	1	1	1	3	..	..	1
Sodomy	414	13	41	33	126	14	145	19	17	6
TOTALS	3295	306	890	365	722	157	633	121	67	34

Professor Edwin H. Sutherland has attempted to evaluate the significance of atrocious sex crimes as measured by the prevalence of rape-murders. The data he has drawn are of particular interest in revealing that the public has been misled in the belief that murder is commonly committed by "sex fiends." In fact rape-murder is very rare in comparison with other types of serious non-sexual crimes:

> Since the statistics of rape are useless as an indication of the extent of the danger of serious sex crimes, another method has been used. Since the rape-murders are the cases which arouse the greatest fear, a tabulation has been made of all cases of murder of females reported in the New York Times for the years 1930, 1935 and 1940, and of the proportion of these murders which were reported as involving rape. In those three years 324 females were reported to have been murdered, of which 110 were in New York City, 32 elsewhere in New York State, 56 in New Jersey, and 126 in other parts of the United States. Only 17 of the 324 murders of females were reported as involving rape or suspicion of rape. This is an average of 5.7 cases of rape-murder per year in the United States as reported in this newspaper. Of these 17 cases of rape-murder, 2 were reported in 1930, 11 in 1935 and 4 in 1940. Only 39 of the total were murders of children, and of these 12 were reported as rape-murders -- 2 in 1930, 6 in 1935 and 4 in 1940.
>
> Of the 324 murders of females, 102 were reported to have been committed by husbands of the victims, 37 by fathers or other close relatives, and 49 by lovers or suitors. Thus nearly 90 percent of the murders of females were committed by relatives or other intimate associates. Only 10 percent were committed by other persons and all of those reported as including rape were in this 10 percent. The danger of murder by relative or other intimate associate is very much greater than the danger of murder by an unknown sex fiend. In fact, in one of the three years as many females were reported to have been murdered by policemen--two cases, both involving drunkenness of the policemen--as by the so-called sex fiends. Also, 25 percent of those who murdered females committed suicide.
>
> While these newspaper reports are certainly not a complete report of all cases of rape-murder, they

> probably include a larger proportion of such crimes than of other murders. The number of rape-murders per year is certainly greater than 5.7 per year, but it is doubtful whether it is greater than 100 per year and may not be more than 25 per year. This is certainly a far cry from Wittels' estimate that tens of thousands of sex killers are abroad in the nation.

Recidivism of Sex Offenders:

One of the fallacies commonly held in regard to sex crime is that a high proportion of the offenders are criminal repeaters. The question of recidivism is one of considerable importance in relation to state policy in handling the problem, since the danger to be anticipated from sex criminals is closely related to their repetition of offenses. The fact is, as revealed by official data, that most sex offenders do not repeat their crimes: they are not "habitual." Statistics from several sources bear out this conclusion.

In the reports of the Federal Bureau of Investigation, data are provided each year for twenty-five types of offenses as to the percentage of persons arrested who had prior criminal records of any kind. Among the recidivism rates reported are those for rape and "other sex offenses." The sex offenders consistently rank very low among the repeaters: rape usually occupies the eighteenth to twentieth place on the list, with "other sex offenses" ranking one or two places higher. Moreover, in most instances of recidivists arrested . for sex offenses, the prior convictions were not for sex crimes.

Federal data are borne out in the more detailed information prepared for the Report of the Mayor's Committee for the Study of Sex Offenses in New York City, on the felonious offenders convicted in the county courts there during the years 1930-1939. That study concludes that most offenders charged with sex felonies are without prior police records and that convicted sex offenders are less inclined to have had police records than other types of felons.[6] Sixty-one percent or 2,001

6. Ibid, pp. 89-90.

out of 3,295 convicted sex offenders, had no criminal records, as against 35 percent for all other types of felons. It was found that the recidivist sex offenders led in abduction (54 percent recidivist rate) and forcible rape (52 percent), whereas statutory rape was rarely committed by recidivists (only 34 percent). Moreover, the youthful age of a high percentage of those convicted for statutory rape and sodomy, along with their relatively low recidivist rates, led the Committee to the conclusion that these were "transitory episodes in the life of a considerable number of sex offenders."

TABLE IV

RECIDIVISM IN RELATION TO INDICTABLE CRIMES

CRIME	CASES	OFFENDERS WITH RECORDS	PER CENT	OFFENDERS WITHOUT RECORDS	PER CENT
Abduction	63	34	54	29	46
Carnal Abuse	333	158	47	175	53
Incest	98	42	43	56	57
Rape-Forcible	418	215	52	203	48
Rape-Statutory	1948	666	34	1282	66
Seduction	21	6	29	15	71
Sodomy	414	173	42	241	58
TOTAL	3295	1294	39%	2001	61%

Even more significant was the finding of this study that, among the 1,294 sex offenders with criminal records, only 23 percent <u>of all recidivists</u> among the sex offenders who had prior records of sex crimes represented only 9 percent of the total of 3,295 offenders studied.[7]

The New York data on prior arrests were supported by a further study of the post conviction careers of 555 offenders convicted of sex crimes in 1930.[8]

7. <u>Ibid</u>, pp. 89-91.
8. <u>Ibid</u>, pp. 93-95.

It was discovered that only one-third of these had reappeared in a police line-up during the ensuing twelve years, "convincing proof that sex crime is not habitual behavior with the majority of sex offenders." Moreover, among the 191 offenders who were rearrested, only one-fifth were again arrested for sex crimes: 93 percent of these 555 offenders avoided further sex crimes during the twelve year period: only 7 percent reverted. Among the 40 offenders rearrested for sex crimes, 9 were acquitted or discharged, and among the remaining 31 only 2 were convicted three times (of indecent exposure), and 4 were convicted twice. The Committee concluded:

> In substance, then, the average sex offender's criminal career seldom is prolonged. Even less seldom is it continuously sexual. When persistent at all, the design is usually criminal, not sexual. The average sex offender is often the less troublesome than the recidivist offender in the non-sexual field, who incidentally becomes involved in a sex crime. These facts indicate that the recommendation that all sex offenders be segregated for life is completely unrealistic and unwise. Such segregation however may be warranted for the abnormal sex offenders who have persistent patterns of sex misbehavior in their records. As we have seen this group is small in number. This makes it possible to segregate them within existing institutions and to provide adequate programs of remedial and custodial care within such institutions.

Another study, conducted by Cason and Pescor with 500 psychopathic inmates in the Federal Medical Unit, is also of some significance relative to the problem of recidivism. They found that 63 percent of these patients who had been released an average of 19.2 months had no subsequent record with the Federal Bureau of Investigation.[9] Among those who were discharged under supervision, 71 percent had had

9. Hulsey Cason and M. J. Pescor, "A Statistical Study of 500 Psychopathic Prisoners," Public Health Reports, 61: 557-574, April, 1946. See also, Cason and Pescor, "A Comparative Study of Recidivists and Non-Recidivists among Psychopathic Federal Offenders," Journal of Criminal Law and Criminology, 37: 236-238, September, 1946.

no subsequent record. This suggests that even among those offenders labeled psychopathic, a great majority are not habitual or repetitive. An interesting observation in this research was that 61 percent of these psychopaths were reported as having been obedient children, although it is usually considered among authorities that the psychopathic traits, when they are to appear at all, develop during childhood.

The limited data from the New Jersey Diagnostic Center at Menlo Park reveals that between 60 percent and 70 percent of the sex cases referred there are first offenders.[10] Similarly, among the psychopaths committed to St. Patrick's under the Minnesota law, it has been shown that only one-third had prior convictions for sex offenses.[11]

Legislation for the Serious Offender:

Among authorities who have devoted considerable attention to the problem of the sex offender, many have communicated to the Commission their expert opinion that it is undesirable and ineffective in new legislation on the deviate to attempt to provide special treatment for those whose offenses are minor or a less serious risk to the community.[12] This opinion has been predicated upon several lines of

10. Information provided by Dr. Ralph Brancale, Superintendent.
11. John A. Wallace, The Minnesota Psychopathic Personality Act: An Examination of its Operation in Hennapin and Ramsey counties. Master of Arts Thesis, University of Minnesota.
12. This advice has come from questionnaires prepared and distributed by the Commission's Advisor to a group of outstanding psychiatrists throughout the United States. The greater number of these specialists hold that new legislation should be directed toward the serious criminal and sexual offenders. Most of them believed, too, that those individuals should be treated neither in an ordinary correctional or psychiatric institution but in a specialized facility where intensive work could be performed on a relatively small group. See summary of questionnaire findings, pp.
In Addition the belief that attention should be concentrated on the more serious cases has been expressed directly to the Commission, among others, by the following distinguished authorities:
Committee on Forensic Psychiatry, Group for the Advancement of Psychiatry.
Dr. Alfred C. Kinsey, Indiana University.
Dr. Lewis H. Loeser, Psychiatrist of Newark.
Dr. W. Overholser, Superintendent, St. Elizabeth Hospital, Washington, D.C.
Hon. Morris Ploscowe, Magistrate's Court, New York City.
Dr. Philip Q. Roche, Chairman, Committee on Forensic Psychiatry, Group for the Advancement of Psychiatry.
Professor Edwin H. Sutherland, Criminologist, Indiana University.

argument: We need to concentrate on the more dangerous criminals and cannot reasonably attempt to cure or detain the great masses of lesser offenders. The latter represent a numerical problem that is too large for effective treatment and a conduct problem too trivial to warrant unusual expenditures. Moreover, other types of cases representing problems both of criminality and of mental abnormality are more in need of special professional attention than are the ordinary run of sex deviates, such as homosexuals, exhibitionists and peepers. In brief, more may be accomplished at lower cost by a program of intensive treatment and research on atrocious types of sex criminals, looking to the development of methods of demonstrable cures through their handling in a small but specialized institution by an expert staff.

In accordance with what appears to be the more realistic and sober thinking of those who have given attention to the problem, the Commission submits its opinion that the State of New Jersey should concentrate its efforts under new legislation upon the demonstrable cure of dangerous and atrocious sex criminals. To that end it is recommended that:

Upon a conviction for the crimes of rape, carnal abuse, impairing the morals of a minor, sodomy, or an attempt to commit any of these offenses, before sentence the judge shall remand the defendant to the New Jersey Diagnostic Center at Menlo Park. If it be determined through clinical observation that the offender's conduct was characterized by

(a) a pattern of repetitive compulsive behavior and

(b) violence or

(c) an age disparity between a victim (under the age of 15) and the adult defendant-aggressor

it will be the duty of the court to submit the offender to a program of specialized treatment for his mental and physical aberrations.

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III

SUMMARY OF ADMINISTRATIVE EXPERIENCE UNDER THE SEXUAL PSYCHOPATH LAWS

An intensive study has been made by the Commission of the sex psychopath statutes that have been enacted in thirteen states and the District of Columbia since 1937, and the experience that has developed in the operation of these laws.* The several statutes have been summarized in detail (see chart in Appendix). The experiences that have come in the operation of these laws were studied mainly through visits made by the Commission's Advisor to the states involved and by interviews with individuals who have acted in a psychiatric, judicial, administrative or legislative capacity in their operation. Additional information has been secured through extended correspondence with others who have had to do with the operation of these laws.

SEXUAL PSYCHOPATH: MEANING

In eight of the jurisdictions the law specifically designates the "sexual psychopath" or the "criminal sexual psychopathic person" as the object of legislation. In three others the psychopathic personality or psychopathic offender is designated, and in one the mentally defective delinquent. New Jersey is alone in referring to "abnormal mental illness" as the basis for applying the law. All of these states have confined the operation of their statutes either entirely or mainly to the sex offender, however. Since the terms sexual psychopath and psychopathic personality are so vaguely and variously defined by medical authorities, it's not surprising to discover wide variation in the definitions established in the statutes and in case law intended to clarify the psychopathic condition. Administrative experience under the laws has shown an even wider variability in types of cases that are being adjudicated as psychopaths. Reports from a number of state hospitals reveal that, in the expert opinion of the clinical staff, only a small proportion of those adjudicated under the statutes are in fact "true

*Since this investigation was conducted Missouri has been added to the list of states employing a sex psychopath law. It is not included on the chart in the Appendix.

psychopaths." Others were diagnosed as psychologically normal, psychotics, feeble-minded, senile deteriorates, schizoids, neurotics, epileptic types, etc. In this connection it is revealing to note that in the first one hundred cases studied at the New Jersey Diagnostic Center, according to reports from Dr. Ralph Brancale, the cases were distributed by his analysis into the following clinical categories:

Psychopaths	9
Fixed Homosexual Deviates	4
Psychotics	6
Mental Defectives	8
Organic Brain Disease	2
Schizoid	14
Neurotic	29
Situational Perversions	10
Normal	18

As noted above the New Jersey law does not specify psychopathic traits as the basis for special treatment, but other states reveal a similarly wide variation in psychiatric conditions diagnosed in spite of the limiting terms in their statutes. The reports show a complete lack of clarity in the sort of mental condition of offenders that is intended to be covered by the law. The point is well illustrated by comments of authorities in the District of Columbia that the findings of the medical staff at St. Elizabeth's Hospital frequently differ from the conclusions of the alienists and judges who make a finding of sexual psychopathy in the courts: the treatment authorities have no power to return patients with a finding that they are not psychopathic, the court decisions being conclusive, however inaccurate when little time has been given to diagnosis. Striking variations may also be noted in Minnesota where the authorities in Hennapin County (Minneapolis) hold that only dangerous and incurable cases are intended to be committed as psychopaths and that there are very few of these. Under this theory they have sent only five or six cases during the past seven years to the asylum for the dangerously insane at St. Peter's Hospital and have consistently refused to release them. In Ramsey County (St. Paul) the law is interpreted to apply to cases

displaying a history of sex offenses, where there are "indications of uncontrollable impulses." These defendants are sent to the ordinary wards at St. Peter's Hospital and are released on the average after ten months of mere custodial confinement without treatment. As Dr. Royal Gray, Chief Medical Officer to the Department of Public Institutions for the State of Minnesota, suggested in conversation with the Commission's Advisor, that in the operation of statutes such as this there are important influencing factors, such as community anger, public pressure on the courts, and attitudes among county attorneys and judges: it is quite probable that the kinds of cases that the psychopath statutes are intended to cover --- the dangerous and aggressive sex deviates --- are the very sorts in which the courts are least prone to employ these non-punitive laws.

BASIS OF JURISDICTION:

An extremely significant shift has suddenly occurred in these states in the policy of the Criminal Law and the Mental Health Law. It appears improbable that the authorities are yet fully aware of the extent and meaning of the change. It will be noted under III-Basis of Jurisdiction (see that in five jurisdictions a person may be adjudicated a psychopath for an indeterminate commitment to a mental hospital without the facts of a crime being shown or a charge placed against the patient. The analogy to the handling of the insane under our traditional law is apparent. But these sex cases are supposed under the law not to be insane, psychoneurotic or feeble-minded. They are committed as cases diagnosed simply as psychopaths by such loose, non-meaningful criteria as emotional instability, impulsiveness, lack of good judgment, habitual sexual misconduct, lack of self-control, etc. These are types of cases that have not gone to mental hospitals in the past. They are cases that a majority of psychiatrists believe do not belong with insane patients (see questionnaire analysis, Appendix). Thus individuals who are non-psychotic and non-defective, against whom no criminal charge has been made, may be confined for long periods or permanently in

hospitals that lack both the space and the treatment facilities to handle them. By the simple but legalistic expedient of shifting jurisdiction to civil courts, these legislators have made it possible to commit minor deviates who are not insane --- many of whom are not upon the record even psychopathic --- to psychiatric institutions where they do not belong. The hazards implicit in this sort of legislative encroachment upon traditional areas of personal freedom is suggested in the opinion of the U. S. Supreme Court which, while it held the Minnesota statute constitutional, pointed nevertheless to the dangers inherent in the administration of such laws:

> We fully recognize the danger of a deprivation of due process in proceedings dealing with persons charged with insanity or, as here, with psychopathic personality as defined in the statute, and the special importance of maintaining the basic interests of liberty in a class of cases where the law though 'fair on its face and impartial in appearance' may be open to serious abuses in administration, and courts may be imposed upon if the substantial rights of the persons charged are not adequately safeguarded at every stage of the proceedings. But we have not occasion to consider such abuses here, for none have occurred. The applicable statutes are not patently defective in any vital respect and we should not assume, in advance of a decision by the state court, that they should be construed so as to deprive appellant of the due process to which he is entitled under the federal constitution. (Minnesota ex rel Pearson v. Probate Court of Ramsey County, 205 Minn. 545, 287 N. W. 297; 60 S. Ct. 523, 84 L. Ed. 477, 309 U.S. 270.)

Unfortunately the injustices that may be done through "serious abuses in administration" cannot be rectified except by appeal in the individual case. Appeals are very rarely taken, for financial reasons, by the cases held under these laws. Moreover, considering the omnibus character of the statutes, it would be easy for an appellate court to find most individuals to be covered under the statutory terminology. That the danger is real may be inferred from the summary below of the first fourteen cases adjudicated in one jurisdiction as psychopaths, some of these without a criminal charge:

1. Public masturbation (without indecent exposure).

2. The following of a white female by a negro (no assault or approach to "victim").
3. A non-aggressive homosexual, convicted of passing bad checks.
4. A patient who touched the breast of a female in a department store.
5. A patient addicted to indecent exposure when he is intoxicated.
6. Another discovered exposed who had been propositioned and manipulated by a wanton female in a movie theatre.

7--9. Three who engage habitually in indecent exposure.

10--12. Three patients who engaged in homosexuality with young males (including fellatio and sodomy).

13. Assault on a young girl.
14. Sex relations with (experienced) juvenile females.

The first cases handled in New Jersey under the new law reveal similarly that it is almost entirely the minor sex cases that are getting attention.

Open Lewdness	29
Rape	12
Carnal Abuse	12
Sodomy	7
Assault (Attempt to Rape)	3
Indecent Exposure	2
Incest	2
Obscene Pictures	1
Private Lewdness	1
Assault (Attempt Carnal Abuse)	1
Exhibitionism	3
Indecent Assault	3
Fellatio	2
Sex Assault and Battery	2
Attempt Indecent Assault	1
Attempt to Impair Morals of Minor	1
Abetting Male to Solicit Minor for Sex Relations	1

I have noted above that an action may be initiated (upon affidavit of an interested person) to determine whether a person is a sexual psychopath without charging him with any criminal offense in five jurisdictions.[1] In six states action under the statute may be had where there has been a charge or conviction of a criminal offense.[2] In the usual instance the offense involved is a sexual one because of the definitions contained in the law. In three other states sexual offenses are prescribed as the basis of jurisdiction.[3] These discrepancies in the

1. Wisconsin, Minnesota, Massachusetts, New Hampshire, Washington, D.C.
2. Charge of Offense: Illinois, Michigan, California, Indiana.
   Conviction of Offense: Ohio, Vermont.
3. New Hampshire, Washington, New Jersey.

legal basis for the initiation of court action provide further proof of the lack of any uniform policy as to the intended coverage of the various sex offender laws. Extraneous evidence reveals it is the public anxiety in relation to serious sex crimes that has motivated the enactment of new legislation on the sex problem. However, both the content of the laws and their administration display no special focus upon the dangerous group of offenders. On the contrary, the provisions as to substantive jurisdiction reveal a highly ambitious purpose in the laws to cover not only most varieties of sex deviates, but other types of offenders as well, and even persons against whom no criminal charge would lie. In several of the states the defendant may suffer prolonged treatment where there has been only a charge and a finding of psychopathy, without proof of law violation. Further, as revealed in the tables above, the actual experience derived from the administration of the statutes confirms the wide breadth of inclusion, in that so great a proportion of committed cases are minor varieties of sex deviates. These data reveal clearly, too, that the more horrendous varieties of sex criminal are rarely touched in the operation of these laws.

DISCRETION IN INITIATING PROCEEDING:

It is provided in most of the statutes that the initiation of proceedings against an alleged sex deviate is at the discretion of the prosecuting officer. In Ohio and New Jersey, however, the court must automatically remand specified types of sex cases for mental examination, and under the Illinois law it is mandatory for the Department of Public Safety to refer for adjudication those criminals under detention in the state penitentiary who are believed to be sex psychopaths. It must be noted that under the prevailing policy of basing the statutory operation on the discretion of prosecution the effect of the laws has been greatly influenced thereby. (This is in keeping with observations concerning the nullification of the ordinary habitual offender laws, passed some years

ago in response to pressures for more stringent treatment of criminal repeaters.)[4] A number of authorities associated closely with the sex psychopath statutes have emphasized the tendency of prosecution to consider the statute as merely a useful tool to be employed or avoided in accordance with their own convenience. In particular they appear inclined to utilize the law where the state's case is too weak for a criminal conviction but where a civil adjudication is easy. Beyond this, however, the prosecutors are clearly affected by their interpretation of and reaction to the statute: where they disapprove the policy involved they may employ the law little or not at all. Beyond any doubt, the general nullification of the sex psychopath laws may be attributed to their disapproval by prosecuting attorneys and to the lack of available treatment facilities, to be discussed below.

Professor Sutherland comments on the nullification of the statutes in these terms:

> Several reasons have been suggested for the failure to use these laws. One is that the laws were passed in a period of panic, and were forgotten after the emotion was relieved by the enactment. A second reason is that the state has no facilities for the care and custody of sexual psychopaths; the state hospitals are already crowded beyond the normal capacity. A third reason is that the prosecutor and judge, anxious to make records as vigorous and aggressive defenders of the community, favor the most severe penalty available and are unwilling to look upon serious sex criminals as patients. They use the sexual psychopath laws only when their evidence is so weak that they have little chance of convictions under the criminal law. Finally, it is reported that defense attorneys have learned that they can stop the proceedings under this law by advising their clients to refuse to talk to the psychiatrists. The psychiatrists can make a diagnosis only by talking with those who are being investigated. Threats of contempt of court have been made in such cases and the law of the District of Columbia explicitly provides that refusal to talk with the psychiatrist is contempt of court. Aside from the fact that a person can well afford to be punished for contempt of court rather than be confined for an indeterminate period as a sexual psychopath, a psychiatric diagnosis made under threat of punishment will have no validity from

4. Tappan, Habitual Offender Laws in the United States, Federal Probation -

a medical point of view.

TRIBUNAL AND PROCEEDINGS:

Most of the states require that sex psychopath cases be adjudicated in a court of record, though the specific tribunals given jurisdiction vary too widely for detailed analysis here. Several employ civil courts for adjudication to the status of psychopath. Others empower criminal courts or courts with mixed jurisdictions to make the finding. The latter is the case, of course, where the defendant must first be convicted of a crime before he is found to be psychopathic. Five states provide no jury for the hearing.[5] Illinois alone makes the use of a jury mandatory. In five jurisdictions a jury may be employed on the demand of the defendant or at the court's discretion.[6] It is of some interest to note that private hearings in these sex cases may be employed at the discretion of the court in four states, the purpose being apparently to exclude the public from hearings that might appeal to morbid or salacious curiosities.

In two of the thirteen jurisdictions provision was made specifically to cover the juvenile under the sex psychopath law. Authorities consulted in this matter stressed that the purpose of such a provision was to assure the application of preventive efforts to sexually deviated youngsters who might become, but for their early apprehension and treatment, habitual sex criminals. Both of these states provide other "preventive features," in particular for commitment of sex psychopaths without a criminal charge. As numerous psychiatric authorities have noted, there is peculerly great danger in the administration of a sex law relating to juveniles. The natural sexual curiosities of the young, the exploratory phases in their development, the emergence of sexual impulses before the individual has matured socially and emotionally, the common incidence of pre-heterosexual drives

5. Minnesota, Ohio, New Hampshire, Indiana, Vermont.
6. Wisconsin, Michigan, Massachusetts (discretionary with court), Washington, Washington, D.C.

in young individuals who become quite normal as they mature in their sexuality: all of these factors offer insuperable difficulties in attempting to determine whether the apparently sex deviated youngster will become a sex offender in his adulthood. The evidence is clear that most of them do not. There is no fair and accurate method of determining that they will.

MEDICAL EXAMINATION AND TREATMENT FACILITIES:

It is generally required under the statutes that the suspected offender be observed for diagnosis by two qualified psychiatrists or physicians with specialized psychiatric experience. Only New Jersey and Vermont generally employ a state diagnostic facility for more extended observation. In most of the jurisdictions either by statute or case law it is held that the decision as to the psychopathic condition is to be made by the court ultimately rather than by the psychiatrist. In New Jersey the court is apparently bound by the findings of the psychiatric examination.

Commitment of the sex deviate after a finding is to a mental hospital in all states except Washington, New Jersey and Vermont. In the former a correctional institution must be employed and in the latter two either a penal or mental facility may be designated by the Commissioner of Institutions. No state has provided a special psychiatric facility for these cases. It has been generally maintained by medical authorities that the psychopath should not be confined with ordinary psychotic patients: treatment is made more difficult for both categories of cases when they are mixed in the institution. Most of the mental hospitals have not provided even for separate segregation of psychopaths, however. They have simply maintained -- with abundant proof in their statistics -- that they lack the space to receive psychopaths and, in fact, need much larger facilities than they have for their more disturbed psychotics. Along with the attitudes of prosecution and judges noted above, the dearth of resources to receive sex deviates has been a

major reason for the failure of most of the states to put their recent sex laws into operation. In several jurisdictions recommendations have been made for the establishment of a new and specialized hospital to care for cases of this sort but, apparently for financial reasons in the main, the recommendations have not been implemented. The State of Maryland intends, however, to build an institution to receive psychopaths along with various defective types.

Of even greater significance perhaps than the lack of space and of specialized institutions to receive sex psychopaths is the lack of any real treatment efforts to cure or rehabilitate these offenders after they are committed. Their "treatment" is almost purely custodial. An underlying difficulty is the lack of psychiatric knowledge today of methods that can be employed effectively to deal with psychopathic offenders. Such treatment modalities as are considered to be of some potential value -- such as intensive psychotherapy, group therapy and psychiatric counsel -- are generally unavailable for the psychopath in the state mental hospital. Some of these institutions have used shock treatment and surgery to a limited extent on the sexual offender, but there appears in the reports no reason to believe that these methods are effective on such cases. Hospital administrators generally indicate that they are completely impotent to provide even experimental treatment efforts for their sex psychopaths. So far as the Commission's Advisor could discover, intensive treatment efforts have been tried under the sex statutes only at St. Elizabeth's Hospital in the District of Columbia. The work there is being carried on experimentally and with only a very small number of cases.

Experience with hospital commitment under these laws raises a very important policy question: Is there any value in providing for diagnosis of a novel category of mental aberration and for commitment to psychiatric hospitals if these patients are then to be held for prolonged periods without receiving any special treatment? What virtue does such a procedure possess over the more traditional

method of sentence to a correctional institution? If the purpose be mainly to extend the period of custody, this could be done as well -- and probably better -- in the penal system. As one prominent New Jersey psychiatrist has pointed out, however, it is a travesty to assume that by more custodial hospitalization a state can solve either the purposes of rehabilitation or of community protection.

EFFECT OF COMMITMENT ON CRIMINAL PROCEEDINGS:

A strange variety of provisions in these laws relative to the effect of commitment for psychopathy upon proceedings for the crime charged reflects further the lack of any uniform policy in the various states. Although commitment to the state hospital is taken to imply a mental abnormality at the time of the offense, ten jurisdictions provide that the psychopathic status is no defense to the crime charged.[7] Only Michigan, New Hampshire and Indiana provide that commitment as a psychopath will operate as a defense. These latter states have, in effect, gone all the way in equating sexual psychopathy with the traditional insanities as a complete defense. This is done without benefit of the customary rules regarding the sort of mental condition that can be used as a legal defense to crime.[8] Authorities in some of the jurisdictions where commitment is no defense have stated that, in determining whether to re-try and convict psychopaths, they would be guided by the offense that had been committed and the duration of confinement in the state mental hospital.

7. Wisconsin, Illinois, Minnesota, Massachusetts, Ohio, Washington, D.C., Washington, California, New Jersey, Vermont. However, in Minnesota the statute of limitations runs against the crime; in Massachusetts execution of the criminal sentence is stayed; in Washington, D.C. criminal proceeding is suspended until hospital discharge with discretion in the court to renew action for the crime; and in the states mentioned in footnote (2) above, conviction for the crime occurs before the psychiatric diagnosis and treatment.
8. Under the McNaghten rule, it is necessary to prove under an allegation of insanity that the defendant at the time of his offense did not know the nature and quality of his act or that it was wrong. It is obvious that the sexual psychopath could almost never enjoy exemption from criminal responsibility under this rule. For further discussion of this point, see

PROCEDURE FOR RELEASE:

The general principle formulated in most of the laws in regard to release from commitment is that authorities at the institution must find that the patient is cured or is sufficiently recovered so as not to be dangerous. In six of the states the proceedings for release are generally initiated by the committed person.[9] In Washington release is after expiration of sentence in the correctional institution if the prisoner is found to be cured; if the person is believed still to be psychopathic after expiration of his term, he may be committed to a hospital for a further indeterminate period. In Indiana the law provides that the psychopath is to be examined at least once each year with a report sent to the court and the Council for Mental Hygiene on his condition. In New Jersey though the term of confinement is indefinite, the maximum is not to exceed that provided for the crime of which the patient was convicted; earlier release must be by a finding that "the person has recovered sufficiently to make it reasonably certain that a repetition of his offenses is unlikely."

It will be noted that, except for New Jersey, the several statutes provide for an indeterminate commitment without a terminal maximum. This fact together with the tendency to commit a large proportion of minor offenders has resulted in a situation in which individuals whose conduct is no more than a nuisance in the community may be incarcerated for long periods of time, what with the disinclination of hospital authorities to assert that the patient is cured. It is obvious that the traditional policy of fines and short jail sentences for minor sex offenders is no solution to their problem. Query: Is it any better a solution to confine these individuals for long periods in the costly and unproductive custody of mental hospitals that provide no curative treatment? Experience thus far appears to bear out the conclusion that society today offers no solution to the

9. Wisconsin, Illinois, Michigan, Minnesota, Massachusetts, Ohio.

widespread problems of homosexuality, exhibitionism, peeping toms and other minor deviates.

NATURE OF RELEASE:

After release from hospitalization the patient may be returned to stand trial or for sentence in four states.[10] Complete release is provided for in seven others.[11] Ohio provides uniquely that after discharge from the mental hospital the offender is transferred to a penal institution until the total period of his confinement is equal to the sentence applicable for his crime; he may then be released under parole.

ADMINISTRATIVE EXPERIENCE UNDER THE STATUTES:

After careful inquiry into the administrative experience that had developed under the new sex offender laws, it is apparent that they are inoperative or nearly so in most of the jurisdictions. The statute appears to be completely nullified in four states.[12] It has been almost completely ineffective in at least six more.[13] California is apparently the only state that has used its statute fairly extensively throughout the ten years of its operation: they have usually found between thirty and forty cases a year to be sexual psychopaths. However, during its first six months of operation New Jersey has apparently adjudicated more sex psychopaths than any other state in a similar time span.

Further evidence of the inefficacy and the dangers in these laws may be inferred from the statements of administrative authorities who have commented on the operation of the laws in their jurisdictions:

Wisconsin: Law inoperative. "Law is too loosely drawn as to its coverage and treatment facilities."

10. Vermont, California, Washington, D.C., Illinois.
11. Wisconsin, Michigan, Minnesota, Massachusetts, New Hampshire, Indiana, New Jersey. However, parole may be used in the alternative in Wisconsin, Indiana and New Jersey.
12. Wisconsin, Michigan, Massachusetts, Washington.
13. Illinois, Indiana, Vermont, New Hampshire, Washington, D.C., Minnesota.

Illinois: 16 cases in 10 years. ".....requires change; little interest in administering present statute."

Michigan: Law inoperative.

Minnesota: Under 200 cases in 10 years. ".....no triumph for justice or for the protection of society."

Massachusetts: Law inoperative. "Law hurriedly enacted, not completely satisfactory; courts do not like it."

New Hampshire: No commitments under recent statute. "These cases should not be sent to a state hospital. No treatment facilities."

Washington, D.C: 14 cases this year. "A Star Chamber procedure, with inadequate diagnostic and treatment facilities."

Washington: Law inoperative.

California: No data available. "Leaves much to be desired: an ineffectual law."

Indiana: 7 cases. Undesirable in principle, ineffective in operation: is no solution to the problem."

New Jersey: 35 cases in six months. "A temporary measure, inadequate to handle problem."

Vermont: Law virtually inoperative.

IV

THE SEXUAL PSYCHOPATH: PROBLEMS OF DEFINITION

Several methods have been employed by the Commission to determine the types of cases of sex offenders who ought, in the interest of public security, to be given special attention in our laws. Its views have come mainly from four sources:

1. Medical authorities and others who have testified before the Commission during the three sessions of hearings, conducted over a total of seven days in different parts of the state.
2. A careful, detailed analysis of the laws and their administration that have developed in recent years to deal with the deviant sexual offender.[1]
3. A detailed questionnaire distributed to medical and other authorities throughout the United States to discover their interpretation of the term, sexual psychopath, and their reaction to its employment in statutes directed at the habitual sex offender.[2]
4. Research in the clinical literature on the psychopath and sexual deviation.[3]

The recent sex statutes enacted in fourteen jurisdictions have been directed, with the exception of New Jersey, at "sex psychopaths" or "psychopathic personalities."[4] New Jersey is alone in providing in its 1949 law that sexual deviates whose offenses result from a condition of "abnormal mental illness" of any sort should receive special treatment measures. The statutory definitions by which the several jurisdictions have attempted to define the coverage of their psychopath laws have in fact made even more vague what was already quite unclear concerning the sorts of cases that were designed to be included. The general

1. See chart and discussion, Appendix.
2. See questionnaire and its analysis, Appendix.
3. See the variety of definitions under Definitions, below.
4. For the terms and definitions in the statutes, see chart.

reluctance observed in applying these laws may well result in part from uncertainty as to the sorts of cases that should be covered. The descriptive clauses in the enactments leave much to be desired either from the point of view of medical diagnosis or court application.

Insanity and feeble-mindedness are generally excluded by the terms of the laws, but there remains a virtually unlimited area of psychological variability that can be interpreted to come within their intended scope. The concepts employed to define the psychopath, such as mental disorder, mental illness, mental disease, emotional instability, impulsiveness in behavior, and other similar qualities are far from specific in their meaning. This is particularly true if psychological deviation is viewed as a relative matter, with wide gradations from normal to abnormal, with a majority of men somewhere in between. The more functional terms applied in some of the laws, suggesting a "propensity" to sex crimes, or lack of customary standards of good judgment, have very little utility for distinguishing the psychopath or the abnormal sexual offender from other sexual deviates. Such expressions could easily be applied to sex offenders who are non-pathological in their psychological orientation.

Much of the difficulty in definition arises out of the fact that psychiatrists themselves are in wide disagreement as to the connotations of the term psychopath. This lack of consensus among authorities is clearly displayed in the responses they have submitted to the questionnaire prepared by the Commission to discover what measure of agreement there might be as to the types of individuals covered by the term. Sixty-five out of sixty-six psychiatrists replying to the question expressed the belief that there was insufficient accord in the field to justify legislation specifically for the "sexual psychopath." The Committee on Forensic Psychiatry of the Group for the Advancement of Psychiatry, which has been studying policy in this area for several years, has issued a

warning of the dangers implicit in employing in our statutes a concept so variously defined as is the psychopath:

> The Committee cautions against the use of the application, psychopath, in the law on several grounds. There is still little agreement on the part of psychiatrists as to the precise meaning of the term. Furthermore, the term has no dynamic significance. The Committee believes that in statutes the use of technical psychiatric terms should be avoided whenever possible. Psychiatric knowledge and terminology are in a state of flux. Once having become a part of the public law such a term attains a fixity unresponsive to newer scientific knowledge and application.[5]

Similar disparity in usage is displayed in the administration of the recently enacted sex laws by the lack of accord between the psychiatrists who are employed for the diagnostic function in court hearings and those institutional authorities who receive cases after they are adjudicated. The latter have stressed in their comments to the Commission the frequency with which cases committed to them prove not to be in fact psychopaths. They have also maintained quite consistently that the sex deviates should not be classed or treated with the more traditional categories of mental aberration: most of them are not psychotic, defective, nor neurotic and their presence in the institution is undesirable from a therapeutic point of view both in the interest of the other patients and of themselves.

Further confirmation of the descriptive and diagnostic difficulties in relation to the psychopath is revealed in the technical literature that has been written on this subject. The most complete studies have been conducted by Dr. Hulsey Cason, who has analyzed over 200 terms that have been applied to the psychopath.[6] He found 54 traits very commonly held to characterize psychopaths, but

5. Group for the Advancement of Psychiatry, Report No. 9
6. Hulsey Cason, "The Psychopath and the Psychopathic," J. Crim. Psychopath., 4: 522-527, January, 1943. See also, Cason, "The Symptoms of the Psychopath," Public Health Reports, 61: 1833-1853, December, 1946. "The Characteristics of the Psychopath," Am. J. Psychiat., 100: 762-770, May, 1944.

in applying them to a group of psychopathic patients at the Federal Medical Unit at Springfield, Missouri, he found that 46 of the 54 traits had no statistical significance in differentiating between those most psychopathic and those least psychopathic. Six of the remaining eight qualities were barely significant. Only two, intolerance and making threats, displayed a clear differentiation: traits that are of no great importance in sex deviation. Cason concluded that the psychopath might be diagnosed by a "reasonable number" of the symptoms in a fairly pronounced form. This provides a most inadequate diagnostic tool for purposes of a legal finding and medical treatment of sex offenders.

A large number of definitions of the psychopath, aside from those employed in the various recent sex statutes, has been assembled by the Commission. These display an almost unlimited range of variation in the psychological disorders described. A selected group of these is listed (in the Appendix) to show the differences in views among clinical authorities.[7] Whether the psychopathic condition results from constitutional or environmental factors, or both, whether it is treatable or untreatable, whether it is widely prevalent or limited to a small part of the population, whether the deviates should be treated in a correctional institution or a mental hospital, whether they are so dangerous as to require close custody or should be treated on an out-patient basis in the community---in all these matters, among others, the authorities are in fundamental disagreement.[8]

The difficulty of definition rests somewhat in the fact that the psychopath is generally interpreted in terms of the allegedly deficient conative (will) powers of the offender, whereas intellectual and emotional deviations are more characteristic of the psychiatric disorders that traditionally have been given special consideration by our courts. Conceptions of "the will" vary considerably between the

7. See Appendix.
8. See report on questionnaires, Appendix. See also Tappan, "The Sexual Psychopath, A Civic Social Responsibility," Journal of Social Hygiene, Vol. 35, pp. 354-368, November, 1949.

legal and the medical professions. Many psychiatrists could not agree on the legal, the moral, or even the psychiatric implications of the expression "deficient powers of self-control", commonly employed in the sex psychopath statutes. It would seem that commonly the only proof that the psychopath cannot control his impulses is the fact that he does not control them. Query: Under a legal system that imposes a duty to control criminal impulses and that has traditionally refused a defense on psychiatric grounds to individuals capable of distinguishing between right and wrong, what justification is there for providing a defense or differentiated treatment to defendants whose intellectual powers are intact, and whose emotional drives may be no stronger than those of the average man? It appears to the Commission that the only sound reason for special consideration of the sex deviate lies in the threat to public security from dangerous offenders and the possibility that methods of effective treatment for them may be worked out. Obviously, if the line of reasoning suggested by some of the statutes in this field were carried forward through the body of our criminal legislation, we would have no justification for treating any offender correctionally: for it is clear that in any crime it might be maintained that the defendant could not inhibit his impulses since in fact he did not do so. Ergo, all law violators should be dispatched to mental hospitals! Nothing is to be gained by inferring mental illness and nonresponsibility in the habitual sex offender merely because he displays "repeated misconduct in sexual matters evidencing a lack of power to control sexual impulses."[9] That a particular psychopath is incapable of repressing his "propensities to commit sexual offenses" is an extremely nice issue of fact upon which psychiatric as well as legal authorities must commonly disagree.

9. See chart and analysis of the various state laws in Appendix.
See also for further discussion of the problem of responsibility and civil adjudication, pp.

It is easy to understand that in the employment of this term "psychopath," used for many years as a convenient psychiatric wastebasket for cases otherwise difficult to classify, and still commonly applied today as a generic term to include all the widely assorted types of individuals who are neither neurotic nor psychotic, there has been a problem both in legal definitions and in statutory application. It is a difficulty completely unresolved in those states that have passed laws on the sex psychopath. With these difficulties in mind, it seems excessively optimistic to assume -- as some medical and administrative authorities have -- that the answer is simply to leave up to the psychiatrists the determination of whether or not an individual is psychopathic, with the idea that statutory specifications are unimportant in an area of behavior where the problem is deemed to be primarily clinical rather than correctional. So long as the primary issue is one of public security from serious sex offenders, it is important that the state should determine the sorts of cases that will be subjected to special treatment. It is therefor the recommendation of the Commission that the State of New Jersey should avoid in its formulation of a statute the vague term "sexual psychopath" and should define as exactly as possible 1) the types of crime to be covered by the law and 2) the conditions of mind and behavior which should subject the offender to special treatment measures. The more specific recommendations on types to be covered are discussed below, pp.

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DEFINITIONS OF SEXUAL PSYCHOPATH:

Dr. Justin K. Fuller, Medical Consultant of the California Youth Authority:
There has been a long drawn out controversy over the definition of the term "psychopath." Until this is settled, it has seemed to me the term should be used to cover a considerable borderline group the members of which are neither frankly psychotic, nor frankly neurotic, nor frankly defective. This is a loosely drawn concept of convenience, designed to meet clinical and administrative purposes, rather than legal ones.

Dr. M. J. Pescor, Warden and Chief Medical Officer, Medical Center for Federal Prisoners at Springfield, Missouri:
There is no general agreement as to what psychopaths are, how they get that way, or what to do with them. --- About the only positive trait common to all psychopaths is that they are non-conformists as judged by the standards of conduct set by a given community at a given time in history.

T. Girard Wharton, County Prosecutor:
We look upon all sexual criminals as potentially dangerous sexual psychopaths.

Dr. T. R. Robie:
There is a vast difference of opinion between able medical authorities on the question of what characteristics constitutes sexual psychopathy -- yet there are some relatively blatant examples wherein more or less unanimous agreement would be found. There is a tremendous difference between a peeping tom and a rapist. Therefore the degree of the crime is the chief question.

Dr. L. H. Tanney (Trenton State Hospital):
Irresponsible and repetitive abnormal sexual conduct along with general psychopathic traits, i.e., emotional instability, impulsiveness of behavior, lack of judgment, blunting of ethical sensibility, and failure to appreciate seriousness of acts.

Dr. J. B. Gordon (Marlboro State Hospital):
Each case has to be evaluated on its own merits, taking into consideration family history, social traditions of the individual, environmental and geographic factors, intelligence, educational achievement, religion, alcohol, drugs and other toxic factors, marital adjustment, etc.

Dr. Joseph C. Hembert:
Sexual psychopathy is a symptom found in several mental illnesses.

Dr. W. Hamburger:
Practice of sexual activities not approved in our culture, in spite of social custom to the contrary.

Dr. D. A. Boyd:
Sexual psychopathy can be distinguished clearly in extreme instances, but in the middle group it runs into other reaction patterns with great overlapping.

Dr. John A. Rose:
Sexually deviated behavior is one form of disturbed behavior.

Dr. D. L. Farnsworth:
Sexual problems are likely to be prominent in many widely varying types of mental illness. It is not an isolated problem, but a part of the whole constellation of mental symptoms of illness.

Dr. L. C. Kolb:
I do not care for the term but would rather deal with the symptomatology and its social implications.

Dr. R. L. Stubblefield:
Regressive neurotic behavior, sexual crimes, failure to profit by experience.

Dr. William H. Haines:
Continued aggressive sexual behavior, not an isolated incident, not alcoholic, not mentally ill nor feeble-minded, not neurotic behavior.

Dr. O. Spurgeon English:
1. Drive to sexually perverse behavior.
2. Accompanied by a strong, even violent urge to carry it out.
3. Rage and violent thoughts about the object when thwarted.

Dr. Ives Hendrick:
Characteristics of sexual psychopathy are appraised with fundamentally different premises: moralistic, legalistic, those of diagnostic psychiatry, and those of dynamic psychiatry.

Dr. L. H. Twyeffort:
Organically oriented psychiatrists and the psychiatrists trained in concepts of dynamic psychology would probably have radically different opinions.

Dr. W. D. Burrow:
Persistence of immature types of sexual impulses with compulsive and repetitive need for expression. These are usually associated with defective personality development in general.

Dr. J. S. Gottlieb:
Sexual psychopathy does not constitute an entity but occurs as a form of behavior or deviation in many individuals, with or without character defect. In addition to the signs of emotional immaturity and instability the sexual offense would be the result of "uncontrolled impulses" or "repetitive compulsive acts," irrespective of the knowledge of the consequences of the acts.

Dr. L. J. Saul:
Chronic or episodic behavior or powerful urges to sexual behavior of any type which is offensive or dangerous to others.

Dr. Hilding Bengs:
I do not believe that there is substantial agreement as to the characteristics of sexual psychopathy. It is quite possible for the aggression of sexual trends to be transferred to other criminal traits.

Henderson and Gillespie, Textbook of Psychiatry:
Mental instability not amounting to a certifiable mental disease or deficiency, but characterized by emotional dullness or instability, together with a lack of perserverance, persistent failure to profit by experience, and persistent

lack of ordinary prudence, often resulting in sexual excess or delinquency.

Arieff and Rotman, Psychopathic Personality, 39 Journal of Criminal Law and Criminology, 158 (1948):

The term has "become the wastebasket of psychiatry, serving as a cover-all for all persons who indulge in antisocial conduct."

Dr. Ralph Brancale:

The medical concept is at variance with lay concept and at times with the concept of the court. The lay concept is inclined to visualize the sexual deviation as an abnormal involvement in an individual somewhat apart from his total personality. Feeling strongly prevails that sexual deviates are pathological only in the sexual sphere and that no other part of the personal make-up is involved. This does not correspond with clinical experience.

Dr. Wright MacMillan:

His abnormal behavior is caused by a disregard for others, but also for over secretion of his testes ---. Penalties and education cannot change this inborn abnormality. These people have a physical defect which makes them different from other men and makes them a menace in the population. They should be confined until their abnormal testicles are removed.

Dr. J. C. Humbert:

Sexual psychopathy is not a disease entity, but a symptom of such mental diseases as schizophrenia, manic-depressive psychosis, psychopathic personality, or mental deficiency. --- Unfortunately, treatment of these conditions is unsatisfactory, and in most cases segregation would have to be for life.

James M. Rinehart and Edward C. Fischer, The Sexual Psychopath and the Law:

In most instances he provides a substantial clue by the recidivist's nature of his perverted acts. There are other warnings available to the accomplished eye: inability to form and hold friendly associations; to work toward normal goals; to sense social responsibility; to maintain coherent interests; to rise above purely biological attachments. There are others which, taken together and in combination with specific manifestations of abnormal sex interests should put society on guard.

Norris S. Barratt, Esq:

The sex offender who comes in conflict with the law is either unable to control his excessive compulsive drives, or is so wanting in moral sense that he obeys his impulses with no regard for the consequences of his acts. In either event he can be classified as a sexual psychopath.

Dr. David G. Schmidt:

Sexual psychopathy may be caused by a number of factors, such as insanity caused by organic lesions, such as brain tumor, infection or the toxic results of disease or poison, or insanity of the functional type such as dementia praecox. Sexual psychopathy may also be found in mental defectives -- another principle group, the neurotic and psychoneurotic with an emotional problem, may find relief in abnormal sexual behavior. In still another group, the psychopathic personality or psychopathic delinquent, abnormal sexual behavior is often dynamic or compulsive. Obviously, it is extremely difficult to formulate a single definition that will cover all of these various factors.

V

SEX OFFENDERS AND CRIMINAL RESPONSIBILITY

One important issue that has been raised repeatedly concerning state policy in the handling of the abnormal sex offender involves a basic issue of procedure and philosophy. Briefly it is this: Should these individuals be spared conviction for their crimes by setting up their abnormal mental states as a defense? The statutes in three states[1] so provide. In seven jurisdictions the law provides for pre-trial or pre-conviction investigations to determine whether the behavior charged against the defendant resulted from some mental abnormality and, where there is an affirmative finding, the person is adjudicated civilly as a psychopath.[2] This philosophy is carried to its most extreme expression in those states where the law permits an investigation into an individual's psychological condition even where there is no crime charged, simply on the affidavit of some person who believes him to be a sex psychopath.[3] These types of statutory provisions are predicated on the assumption that a psychopathic state (or some other condition of psychological deviation) should be handled in a fashion similar to that by which the insane are dealt with in our legal system. In contrast with these laws, other states have persisted in a more traditional interpretation by requiring that a specific criminal charge be made and that the defendant be convicted thereof before an inquiry can be directed to determine whether he suffers from an abnormal mental state requiring treatment.[4] Under such provisions as these, even though the convicted offender may be sent to a psychiatric hospital for treatment or custody, there is no attempt to relieve him of responsibility for his offense. In effect there is a compromise here between the principles of criminal guilt and clinical treatment,

1. Michigan, New Hampshire, Indiana. In California, discretionary with criminal court.
2. Illinois, Michigan, Minnesota, New Hampshire, Washington, D.C., California, Indiana.
3. Wisconsin, Minnesota, Massachusetts, New Hampshire, Washington, D.C.
4. New Jersey, Vermont, Washington, Ohio.

similar to other situations in our criminal jurisprudence where, after conviction for a crime, the offender may be handled in a medical facility for any of a variety of conditions that may be diagnosed after conviction -- insanity, mental defectiveness, epilepsy, etc.

A rather large proportion of psychiatrists today incline to the view that psychopaths and other types of non-psychotic, non-defective offenders should be spared criminal conviction on the basis of their psychiatric deviation, with widely varied criteria as to the nature of these aberrations. This trend of opinion among clinicians is quite understandable in light of their desire to develop a more reasonable philosophy of treatment in place of the punitive motives that are traditionally associated with assumptions of moral guilt implicit in our criminal law. A sizable modification in the doctrine of moral culpability has already occurred with the gradual development of rules on insanity and mental deficiency, through our handling of juvenile and some adolescent offenders, by the "irresistible impulse" rule in a minority of states, and by the developing principles of partial responsibility. However, it appears that the broadening of defenses to a criminal charge to include psychopaths and other deviates is something quite different in basic principle from these other developments. The following points merit consideration before a decision is made to move from criminal to civil procedures:

1. Under the statutory and case law of most states the defenses to crime based upon the defendant's psychological condition are allowed only where his intellectual capacity -- the power to discriminate right from wrong -- is impaired. Such is not the situation with so-called psychopaths and other types of sex deviates, where their powers of understanding and reasoning are generally intact.

2. The defense to a criminal charge is generally precluded in our jurisprudence

where the deviate displays merely emotional and volitional aberrations -- where, for example, there is shown to be instability, impulsiveness, immaturity, deficient self-discipline, etc. It appears that there is a very serious hazard either from a legal or medical point of view in establishing for the sex offender a new and largely unreasoned foundation for non-criminal handling, based on a premise that the individual's emotions are abnormally strong or his volitional capacities are sub-normally weak. There are obvious difficulties in proof of such subtle matters and, in any event, their relevance to the principle of responsibility is not clear.

3. As a result of the above, making the psychopathic state a defense to crime and providing civil in place of criminal adjudication is to permit by indirection what the states have consistently refused to do directly. Courts have manifested a generally conservative inclination in maintaining rather narrow rules on psychiatric defenses. They have already displayed their extreme reluctance to apply the new sex laws in exculpation of the offender where the statutes provide for civil adjudication.

4. The condition of sexual psychopathy -- as well as other varieties of abnormal sex deviation -- is very ill-defined. It appears rather clearly in the studies the Commission has made that this is not a distinct clinical entity, nor even a series of universal recognized types of mental disorder. There is probably more disagreement in the medical profession as to the etiology, nature, and treatment of sexual psychopaths than any other category of deviates. One does <u>not</u> find any measure of consensus among authorities that the psychopath

   (a) suffers from abnormally strong sex drives,

   (b) that he is <u>incapable</u> of controlling these drives,

(c) that he is intellectually unaware of the wrongness of his conduct, or

(d) even that he is incapable of learning by experience (in any ordinary sense of the term "incapable" and "learning").

Most general agreement among authorities would probably be to the effect that these individuals are morally defective, that they do not wish to restrain themselves in conformity with society's requirements. This is the very quality of character that marks in some degree a great majority of the individuals whom we convict as criminals.

5. If and when state legislatures come to consider psychiatric information sufficiently developed to extend further the legal defenses for mental deviations, such defenses should come first to be applied to forms of psychosis and psychoneurosis that are more uniformly agreed upon among medical authorities as psychological states that should exculpate the offender. To select for experimental legislation the very category of cases in which there is most disagreement as to the nature of the condition and its treatability is to invite an extreme and unnecessary confusion in a forensic psychiatry that has more immediate and pressing problems to work out. Reasonable improvements in our rules on criminal culpability can best be effected in areas where medical authorities are in more substantial accord.

6. There appears to be a rapidly developing problem in some jurisdictions where sexual offenders seek treatment as psychopaths simply to avoid criminal conviction or correctional treatment. This can be more easily done in the area of sexual aberration than in that of insanity because of the inadequate clinical criteria for precise determination of the disorder, particularly in the great mass of borderline cases.

The recent legislation in more than one-fourth of the states to cover sex

deviates appears to indicate a readiness to extend the range of psychological aberration for which the defendant should receive some measure of special handling and, in some jurisdictions, absolution from criminal guilt. An anomalous condition has resulted wherein, though the states have persisted steadfastly in a narrow definition of insanity as a defense to crime -- excluding many cases of psychosis from that definition, these states now suddenly, in their anxiety to deal with the sex offender, have thrown wide the gate of psychopathology to allow most any case of psychological deviate to be handled as an exception to the ordinary rules of criminal law. It is difficult to believe that our courts or our psychiatrists would generally tolerate so complete a departure from ordinary conceptions as to allow for hospitalization after a civil adjudication of individuals who, aside from the sexuality in their criminal behavior, differ from other offenders only in such imponderable qualities as "emotional instability" "impulsiveness of action" "lack of customary standards of good judgment" "emotional immaturity" "self-centeredness" and "lack of self-control." Combinations of such traits as these can easily be seen to characterize the vast majority of criminal offenders, yet neither the judge nor the psychiatrist would maintain that these individuals should be either spared or denied the ordinary due process of the criminal court.

In light of the comments above, it would appear that, at least for the present, the state is on sounder grounds in holding serious sexual offenders responsible unless they are insane or defective. Their criminal conviction is probably no more a deterrant to effective treatment in these cases than it is in the handling of any other type of law violator. Indeed, it may well be maintained that, since psychopaths are generally described in terms of their inclination to avoid responsibilities, that court and treatment efforts should focus upon the necessity of the individual assuming responsibility for what he does. Until we

know much more than we do about abnormal sex offenders, it will not be sound or consistent policy to absolve them of criminal responsibility. Sex offenders, like other law violators, should receive a fair trial in a criminal court to determine whether they have in fact committed an offense. They should not, on the one hand, enjoy exemption from criminal responsibility where they are not psychotic nor mentally defective. Nor, on the other hand, should they be subject to extended hospitalization where there has been no clear proof of an offense or of their dangerousness to society. It is the recommendation of the Commission, therefor, that special treatment should be provided in the legislation of the State of New Jersey only where there has been a conviction in a criminal court for a serious sex crime,[5] evidencing the danger of the offender to the security of the community.

5. For a further discussion of the reasoning on which this recommendation is founded, see the discussion on pp.

VI

PROGRAM OF TREATMENT AND PREVENTION

One of the apparent reasons for the failure of recent laws on the sex offender lies in the lack of any effectual treatment program to handle these cases. As we have pointed out previously, the statutes have been formulated generally so as to secure the commitment of sex deviates to state mental hospitals for an indeterminate period of time, until "cured." However, since these cases do not belong in the psychotic classification ordinarily commitable to psychiatric insttutions and since, moreover, the traditional hospital offers neither treatment methods nor sufficient clinical staff to provide therapy, it is difficult to comprehend why this benign result should have been anticipated. Quite possibly the fond hope of easy cure may be traced to the prevalent badly oversimplified formula that sex offenders are "sick people" and that, since mental hospitals are purposed to remedy psychological illness, therefore abnormal sex offenders should find there the resolution of their disturbances. In reality, however, a great majority of the sex deviates, even those who may be considered abnormal psychologically are not sick in the ordinary sense as applied to psychotic patients: psychiatric institutions are not presently suited in their space or methods to receive and treat the "garden varieties" of psychopathic, neurotic, schizoid, and constitutional sex variant. Cures cannot be expected through mere hospitalization -- unless some individuals simply "grow out of" their illness, as those might do more speedily under the active program of a correctional institution.

To put the matter in more affirmative terms: Abnormal sex offenders are of varied types, both as to conduct and as to psychological organization. They require different forms of treatment in accordance with the nature of their individual

problems. If real cures are to be effected, experimental research must be conducted to discover the methods of treatment that will relieve the basic causes that underlie the disordered sex behavior. Such treatment cannot be conducted on large masses of minor offenders, but should be concentrated on those individuals who because of their aggressions are a particular danger to women and children in the community (as in the crimes of rape and carnal abuse). The development of effective therapy for such individuals will be both economical and humane in effect by permitting the eventual release under supervision into productive and responsible community living of individuals who otherwise would remain costly permanent dependents of the state. The problem of treatment we can not resolve by merely thrusting these persons into the concealment of our already overcrowded hospitals. There is no simple, safe and speedy nostrum for our sex deviates! It is the conviction and affirmation of this Commission that unless such positive steps are taken to implement a real treatment program as those suggested above, its inquiries and Report may be fruitless. Without effective treatment measures, any special legislation on the sex deviate may prove dangerous to the interests of the State of New Jersey through failure to meet its objective of a curative handling of abnormal sex criminals.

What then can be done to enhance the effectiveness of our treatment? After extended consultation with authorities who have devoted much thought to these cases and the methods best designed to handle them, it has become clear that sex offenders must be carefully classified into a series of differing programs of control. These may be summarized in the following major classes:

1. Most important is a new and specialized institution, to combine custodial and psychiatric features, with an active and experimental program looking toward methods of demonstrably effective treatment. To such a facility would be sent

those cases investigation of which reveals the need for intensive and continuous work by a clinical staff. It would appear that group and individual psychotherapy, medical care, and a full program of activities should be provided in the institution, quite unlike the routine that is necessary in the usual psychiatric facility. This particular development offers more promise for the effective treatment of disordered sex offenders than has anything that has yet been attempted in any state. Elsewhere the need for it has been recognized, but no jurisdiction thus far has come to implement the alleged objective of curative treatment.

2. Probation under careful supervision should be provided those persons who do not represent too serious a threat to public security. New Jersey, as well as the other states, have failed to provide in their recent sex laws for the employment of probation. However, psychiatric authorities consulted on the point have uniformly agreed that some cases can be safely entrusted in the community under guidance, and with considerably lesser cost than is required for institutional custody. Many such individuals should receive out-patient psychiatric treatment as ambulatory cases to assure their necessary psychological reorientation. Others, where their offense resulted mainly from circumstantial or situational influences, could adjust under probation with little or no psychiatric therapy.

3. State mental hospitals would need to be employed for a minority of individuals where observation and diagnosis revealed that their offenses resulted from severe psychotic disturbances or psychoneuroses amenable to treatment in institutions of this type. Policy should be directed specifically to avoid commitment of offenders whose presence would be unnecessarily disturbing to other patients and non-therapeutic to the sex deviates themselves.

4. Correctional institutions with active programs should be employed for those

offenders who require custody against escape but who display no such serious psychological disturbances as to require specialized treatment in a psychiatric facility. It appears that many cases that today are sent to mental hospitals under the sex laws of various states would have a better prognosis if they were confined with other criminals rather than with psychotics.

5. Release methods are of special importance in dealing with offenders in this program for a number of reasons. First of all, it is essential that the public be protected from the attacks of dangerous sex criminals. It is desirable, however, to provide for the timely release from custody of individuals who do not require continued institutional handling and who may safely be entrusted at large. The latter is significant not only from the point of view of the economical use of our facilities but because the effectiveness of treatment is based to a large extent upon getting the offender into a natural community environment when he is prepared to assume responsibility and avoid further offense. These objectives are very poorly served through the procedure generally employed in the "sex psychopath" laws which require the confinement of individuals in a mental hospital until such time as the authorities there are prepared to assert that they are cured. Institutional superintendents have been rather understandably reluctant to take the risk that their sex cases may lapse into further misconduct, however well behaved some of them may have been under custody. As a result, in some states minor offenders may spend and in fact have spent long periods in hospitalization. The absurdity of the situation is completed by the failure to provide treatment to them during incarceration. It is clear that our program should be designed to provide release procedures that will assure very careful consideration both to the timely discharge under supervision of those who are ready for release and to

community protection as well. The Commission has concluded that this can best be done by vesting responsibility for this task (along with certain other important functions) in the Department of Institutions and Agencies. To that end it is recommended that:

Such treatment, upon recommendation of the Diagnostic Center, may include one or more of the following measures:

(a) Probation with out-patient psychiatric treatment.

(b) Commitment to a specialized facility for intensive psychiatric treatment, followed by parole supervision upon release.

(c) Commitment for care to a state mental hospital, followed by parole supervision upon release.

(d) Commitment to a correctional institution, followed by parole supervision upon release.

Provision should be made for the establishment of an institution with both medical, psychiatric and custodial features to carry on a program of intensive treatment and study designed to develop more effective rehabilitative measures for dangerous sex offenders. It will be the objective of this program to provide demonstrable results through the treatment and research developed there.

Release from the institution under (b), (c) or (d) shall be when the offender is believed capable of making an acceptable social adjustment. Such release, however, must be on or before the expiration of the maximum term which the offender might have received for the crime of which he was convicted. It will be the duty of the institution of commitment to report to the Department of Institutions and Agencies on each patient committed under this law at six month intervals.

It is recommended that the Department of Institutions and Agencies devote efforts specifically to the following major tasks:

(a) Designation of the institution to which a convicted sex offender, who is found after diagnosis to be abnormal, will be sent for treatment.

(b) Provision for release of these individuals under supervision of the Central Parole Division, Department of Institutions and Agencies, and through the laws, rules and regulations governing parole, when they are believed capable of making an acceptable social adjustment.

(c) Assumption of responsibility for the continuing development of research on the methods of effective treatment of the sex deviate, and to prepare periodic reports of the progress of such research.

(d) Assistance in the development and coordination of the programs of education and information, as provided under 2,3,4,5,6,7 and 14 in these recommendations.

PREVENTION PROGRAM:

The Commission is not unmindful of the great importance that should be attached to efforts throughout the State of New Jersey to perform the task of prevention of sex offenses. A most vital part of the work relating to abnormal sexuality should go into a real program of community prophylaxis. Indeed, there is little doubt that any real achievement of our goals depends to a major extent on effective efforts to establish techniques by which the influences promoting sex deviation may be diminished. It appears clear, however, that this objective may not best be instrumented through provisions of the criminal law such as those we would direct at the seriously dangerous criminal: the dangers of error, with resulting hazards to human liberty, are too great in this field. Moreover we should achieve greater success through educative and other non-coercive methods in our dealings both with minor sex deviates and with those who may be considered merely potential sex offenders. It is the considered opinion of the Commission, therefore, that the objectives of prevention will be most fully accomplished through three major types of approach.

Voluntary Self-Commitment:

It is the experience of prosecuting officers, police and other officials that there are many instances in the community of individuals who are aware and fearful of their abnormal sex trends. Many of these persons desire help and are prepared actively to seek it before finding themselves in serious trouble. These individuals do not require punishment or coercion nor a publication of their difficulties that would result in loss of reputation. In fact, their amenability to treatment rests largely in their willingness to submit themselves to diagnostic observation and therapeutic methods on a voluntary basis. Provision should be made specifically to permit and encourage these individuals to seek and find assistance through the psychiatric resources of the state.

It should be recognized in advance that certain dangers inhere in any provisions that can be drafted for voluntary self-commitment. For example, criminal suspects may attempt to evade responsibility for their offenses by seeking commitment to a psychiatric facility. Possibly some courts might attempt to coerce suspects into a "voluntary" commitment where evidence would not support a conviction for an offense. In some instances individuals might seek commitment or treatment where the circumstances would not warrant action. It is imperative therefore that a procedure be established properly to regularize this method. To this end it is recommended that provision be made so that an individual who seeks to prevent the development in his behavior of unlawful sexual deviation may secure where necessary an appropriate treatment.

(a) He may apply to the County Adjustor in his county of residence for a voluntary self-commitment for clinical diagnosis and study to be conducted at the New Jersey Diagnostic Center to determine his possible need for psychiatric treatment.

(b) Where there is a finding that such a person does suffer from an aberration from which potentially dangerous sexual behavior is a reasonably probable consequence, he may receive treatment on a voluntary basis in an institution to be designated by the Department of Institutions and Agencies or out-patient treatment.

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Mental Hygiene Clinics:

Experience in the State of New Jersey provides clear proof of the value of the services that have been provided on a limited scale by the state system of mental hygiene clinics and the similar clinical resources set up in various localities. The contribution of these resources to preventive work with potential sex offenders as well as other psychologically unadjusted individuals is clear. The questionnaire responses that have been received from principals of the public schools and from Parent-Teachers Associations (see Appendix) confirm the special utility of these clinical facilities in the handling of cases of emotional difficulty among school children, at a time when these youngsters may be helped most successfully at least expense. While it was almost unanimously agreed by the principals that psychological and psychiatric treatment facilities are useful in cases of young sex deviates, 67 of these administrators out of a total of 141 replying to the question considered that the available clinical resources were insufficient to handle cases of sex deviation. Similar evidence was presented to the Commission at its public hearings in the state. We are strongly of the opinion that these resources should be extended in the interest specifically of accomplishing a preventive purpose in relation to potential sex offenders as well as to serve a more general objective of improving the mental health of our children, thus to reduce the volume of their later criminality. We therefore suggest: Provision should be made for the extension of the state mental hygiene clinic facilities serving the several counties. In addition, encouragement should be given to municipalities to set up and develop local mental hygiene facilities.

Educational Programs:

The investigations of the Commission, particularly those conducted through its hearings, questionnaires and through other informants, have pointed to the special importance of carrying on a preventive program of community prophylaxis

through several types of educational efforts. More than any other technique, the educational approach may serve to prevent sex deviation by getting at its roots in the improper training of attitudes, habits and values.

In the Schools: One of the signal difficulties in discovering those youngsters whose personality and behavior display maladjustments or potential danger to their future development lies in the common failure of our schools to observe and recognize the "danger signs" in these children. Our evidence indicates also that many of the school authorities are unaware of the available resources for diagnosis and preventive treatment. Since the school is the one resource outside the home where all children spend a great part of their time, it is peculiarly important that there be diligent effort there to assure that youngsters who need guidance or treatment will be discovered and assisted so as to avoid the emergence of more serious problems in their later lives. There is an apparent need in the selection and training of educators that attention be given to securing well balanced personalities that are warm and understanding in their relationships with children. It is believed that their training should include greater emphasis upon the emotional problems, the developmental difficulties, and the symptoms of poor adjustment that may be observed in the school.

Replies received to the questionnaires of the Commission reveal that in fact, aside from exceptional instances, little or no education for family living is being provided by the public schools in the primary grades: 84 of the principals out of 144 expressed the opinion that it would be desirable to develop programs for training in family life in order to prevent the development of unwholesome attitudes and behavior. A considerably larger group of the responding principals, 138, indicated that it would be useful to have a program to enlighten their teachers specifically as to the symptoms of sexual deviation and as to the facilities available to meet these problems. We believe that the trend toward

the development of wholesome education for family living should be encouraged in the public schools of New Jersey.

In the Church: Although the churches display concern about the problems of sex deviation and family breakdown, it appears that they could assume more substantial responsibility for preventive counseling. The spiritual guidance of the church is an indispensable ingredient in wholesome family living. It appears most desirable therefore that our church leaders should encourage and participate in those measures by which family living may be strengthened and moral attitudes preserved.

In the General Public: It is certain that modern parents have a real desire to improve the quality of child rearing and of family relationships. There is a growing number of sources for popular enlightenment and family guidance, as revealed in newspapers and magazines of wide circulation, some of which are of high quality. It remains true, however, that a very substantial part of the population feels unprepared and unable to do an effective job either of sex education or of understanding and helping their children. We believe that encouragement should be given to the further development of programs of adult education and guidance through schools, churches, social agencies and other legitimate channels of information.

In the Medical Profession: There appears to be a general disinclination among general practitioners to assume any real responsibility either for sex instruction specifically or for guidance in mental health generally. Though there is some discussion of the need for the more active participation of the medical profession in family counseling, neither the training nor the tradition has fostered the contributions which doctors should be peculiarly well equipped to make. It is felt that efforts of the County Medical Associations and of our medical schools might greatly enhance the role of the "family doctor" in providing the instruction and counsel concerning sex and family relationships.

In the Courts: Evidence reveals that in some sections of the state there is an insufficient awareness among officers of the courts as to the provisions and intent of our 1949 statute on the abnormal sex offender. It is apparent that it is most desirable for the full enlightenment of the legal profession as to the purposes of our program in this field and the methods by which it is hoped to carry them into operation.

For the carrying out of these several educational objectives the Commission proposes the following:

Efforts should be made to acquaint administrators and personnel in our schools and other agencies more fully with the available mental hygiene resources.

Encouragement should be given to programs of adult sex and family life education throughout the state. If this could be conducted under the auspices of the Division of Adult Education of the State Department of Education, its effectiveness may be enhanced.

The churches in the State of New Jersey are exhorted to continue to make an active effort to emphasize the development of more adequate family life education This may be done in part through the encouragement by the church of parents' responsibility for a more effective moral and social education of their children, including the elements of biological information as these relate to wholesome attitudes and habits in the young and to preparation for more normal and healthy marriage adjustment. Beyond this the church may lend its active cooperation to parents for the improvement of sex and family life education.

Wherever community opinion is favorable the development should be encouraged of further family life training in the public schools, where it can be taught by persons of medical or psychological training who will stress social and moral as well as sex education. Such training should be directed toward healthy attitudes and habits of the young as they relate to sex, marriage and family living.

In the education, selection and in-service training of teachers, more stress should be placed upon the educator's understanding of the principles of mental hygiene and upon his ability to discern evidences of students' need for mental hygiene assistance.

Medical and public health authorities throughout the state should be urged to extend their efforts in providing sound public education in regard to sex and mental hygiene. It is recommended that the State Medical Association conduct an intensive campaign among its membership to assure that general practitioners are well informed in the field of sexual aberrations and will include preventive and early treatment measures in dealing with their patients.

Thorough-going efforts should be directed to assure that judges, prosecutors, police and other administrative officials are well acquainted with the purposes and procedures of such legislation as may be enacted, as may grow out of the several recommendations in this report.

Local police and courts throughout New Jersey should be encouraged to become acquainted with and to employ the unique modus operandi files on sex offenders presently maintained by the State Police at Trenton headquarters. (As emphasized by the officials there, these files will continue to have little use unless information about them permeates the local police departments; they are seldom employed when only the chiefs of police are aware of the available material.)

APPENDIX

ANALYSIS OF PSYCHIATRISTS' QUESTIONNAIRE RESPONSES

In order to determine the present state of expert opinion in relation to the sexual psychopath a questionnaire has been prepared and distributed to authorities throughout the United States who have given considerable attention to the problem. The questions were designed to elicit the views of experts on such matters pertinent to the handling of the psychopath as the definition of the problem, the possibilities of adequate legislation to meet it, and problems of treatment. The information gained from these questionnaires may be helpful, along with other sources of information provided in this report, in illuminating some of the important issues in regard to legislative policy in handling the habitual sex offender. Replies to the questionnaire were received from some 75 authorities, all but 11 of whom were psychiatrists. Ten are practitioners in New Jersey. Although this sample is not large, it is sufficient to reflect both the issues in which there is some consensus in the field and those in which there is wide disagreement.

It appears to be quite generally agreed that there is a sufficient number of dangerous sexual psychopaths in the criminal population to justify special legislation for treatment of them: 55 psychiatrists so indicated, while 11 expressed the belief that there was not a sufficient number and 9 gave no indication of opinion. There was a very wide range of opinion as to the percentage of the convicted criminal population believed to be sexual psychopaths. Opinions on this issue ranged from 1% to 30%, with the largest number of psychiatrists indicating that about 5% of convicted criminals should be considered sexually psychopathic. The mean average shown by the estimates of these authorities was approximately 7%. These psychiatrists displayed an even wider range in their estimates of the proportion of the committed institutional population who should be considered sexual psychopaths: the range here was from 5% to 50%, with a mean average estimate of approximately 8%.

On the basic issue of definition of the term "sexual psychopathy" a number of interesting observations may be gleaned from the responses of the authorities. The respondents were almost evenly split on whether it would be possible to enumerate a series of rather definite characteristics in a diagnosis of sexual psychopathy and to distinguish this condition from other psychological and characterological pathologies. Thirty of the replies indicated that this condition could be clearly distinguished, while 28 indicated that it could not. An even larger proportion of the authorities indicated that there is no substantial agreement among medical authorities as to the characteristics of sexual psychopathy. Forty-two respondents so indicated, while 24 believed that such agreement now exists. There was an even split among these authorities as to whether the criteria for sexual psychopathy are clear and distinct enough to provide a proper foundation for laws directed toward the segregation and treatment of such individuals. Twenty-nine psychiatrists believed that these criteria were not clear enough and twenty-nine held an affirmative opinion. In spite of the recognition of wide diversity among authorities in interpreting the concept of sexual psychopathy, it is interesting to note that 40 out of 66 replies indicated the belief that there is sufficient consensus among psychiatrists that a law directed toward the sexual psychopath could function in accordance with sound principles of justice and with due protections to individual liberty. The great majority of the respondents believed, however, that in a statute designed to provide special treatment for the habitual sex offender, it would be preferable to avoid use of the term "psychopath" and instead to describe the symptomatology of the disorders intended to be covered: 65 psychiatrists so indicated. Forty-one believed, in the alternative, that instead of employing the term psychopath, it would be desirable to enumerate in the statute the criminal offenses under which a medical finding and special treatment might be provided.

Since 5 jurisdictions provide for the civil adjudication as psychopaths of individuals who have not violated any criminal statute, it is interesting

to discover that the great majority of psychiatrists believed that we are not ready as a matter of policy to provide for potentially long term or permanent segregation of individuals diagnosed as sexual psychopaths when they have engaged in no law violation. Fifty-one psychiatrists indicated their belief that such a statutory provision would be poor policy, while 14 held to the contrary that law violation should not be a condition necessary to diagnosis and treatment. Seven of the ten psychiatrists in New Jersey who submitted replies expressed the opinion that a criminal charge should precede a court hearing and treatment of the psychopath. Three prosecutors in this state who returned questionnaires also held with the majority.

One question contained in this questionnaire was designed to determine the state of psychiatric opinion as to the proportion of cases in which it should be possible to predict quite accurately that individuals adjudicated as sexual psychopaths would, if untreated, commit crimes of a serious nature. Replies to this question were interesting mainly in revealing the extremely wide variation in opinion as to the capacity of psychiatrists today to predict the hazard of serious criminality: a number of authorities expressed the belief that no accurate prediction could be made at all, or that it would be possible to make a definite prognosis in no more than 1, 2 or 5 percent of the cases. Other psychiatrists, however, believed that it should be possible to make such accurate predictions in from 75 to 90 percent of the cases. (The average for all replies was 35 percent, but this figure has no real meaning.)

One of the most interesting observations that comes out of this questionnaire is that, while a majority of authorities agree that our conceptions of the sexual psychopath are varied and confused and, while more than half indicated that our criteria of psychopathy are not clear enough to constitute a good foundation for legal enactments, nevertheless most of them consider that committed psychopaths should be subject to longer periods of segregation and treatment than is provided by law for the crimes which they are proven to have committed. This

is, of course, in conformity with the general clinical view that a psychological deviate should be treated until he is cured or adjusted rather than being discharged at the termination of a definite sentence. The significant thing is that 49 out of 62 psychiatrists who answered this question favored longer periods of segregation for psychopaths in spite of recognizing (1) that there is no consensus about this disorder as a diagnostic entity, (2) that the patients who are adjudicated do not receive treatment, and (3) that there are not a sufficient number of trained psychiatrists available to provide such treatment (see below).

Considering that a number of authorities have maintained that true psychopathy is by definition irremediable, it may be surprising to note that only one of the respondents to this questionnaire expressed the view that psychopathy is not remediable through psychiatric treatment, while six held that psychiatric treatment is effective, and sixty-six maintained that it may sometimes be effective.

A number of issues were raised in relation to treatment in this questionnaire. The central question in its bearing upon adequacy of treatment and the feasibility of providing such treatment was directed toward the problem of the extent of professional staffing that would be required in an institution for sexual psychopaths. Of 57 responses, 16 psychiatrists expressed the opinion that it would be necessary to employ one psychiatrist for each ten patients receiving treatment as psychopaths, while 22 respondents believed that a ratio of one psychiatrist to every twenty patients would be necessary. The mean average for those who replied to the question was one psychiatrist for every twenty-three patients. Forty-eight out of sixty-one psychiatrists believed that it would be impossible to secure sufficient psychiatric and other treatment resources to do a successful treatment job on any large proportion of the dangerous sexual psychopaths in this state. The few who considered it possible to obtain enough specialists were those who thought it would be sufficient to employ one psychiatrist for every fifty or sixty patients, thus indicating rather clearly that

these informants did not have in mind the provision of any real treatment program. Moreover, the replies show virtually unanimous agreement that maturation and disciplinary regulation alone are insufficient remedies for the sexually deviated.

The question was raised whether there is any advantage to be gained by segregating the sexual psychopaths before adequate clinical treatment facilities become available. Thirty-nine psychiatrists answered in the affirmative and thirty-three in the negative. Among the affirmative responses, however, a number of respondents indicated that their reply was predicated upon an interest in public security: institutional treatment would prevent the psychopath from persisting in his criminal patterns in the community. Lacking treatment facilities, the public would be as well protected by segregating the sex offender in correctional institutions, under our traditional criminal law, as by holding him in a mental hospital without treatment. A question designed to discover the state of opinion as to the sort of facility in which the sexual deviate should be confined produced further evidence of the spread of opinion as to appropriate treatment for these individuals. Fifty-one replies indicated that these offenders should not be held at the same institution with defective delinquents, while eight believed that they should be housed together. Thirty-five respondents held that psychopaths should not be confined with psychotic patients (in some instances, indicating an exception where the psychopath was also psychotic), while thirteen believed that these sexual deviates should be housed along with psychotic cases.

A question was included in this inquiry to determine the category of cases that psychiatric authorities believe should receive attention through specific legislation or specialized therapy. The largest single group of replies expressed the view that new legislation should be directed toward "any type of serious criminal offender where there has been an expert finding of sexual psychopathy." The next largest number of replies would direct legislation at "serious types of sex offenders where there has been an expert finding of sexual

psychopathy."

There was unanimous agreement in the replies that statutory provision should be made for the voluntary self-commitment for treatment of the individual who, though they have committed no crime, are diagnosed as sexual psychopaths.

QUESTIONNAIRE ON SEXUAL PSYCHOPATH

1. Are there, in your opinion, a sufficient number of dangerous sexual psychopaths in the criminal population to justify specialized legislation for treatment of them? Yes_____ No_____ Comment:

2. How large a percentage of the convicted criminal population do you estimate to be sexual psychopaths? _____%

3. How large a percentage of the committed institutional population do you estimate to be sexual psychopaths? _____%

4. Can a series of rather definite characteristics or criteria be enumerated to diagnose the syndrome of "sexual psychopathy" and to distinguish it clearly from other psychological and characterological pathologies? Yes_____ No _____ What are these characteristics?

5. Do you consider that there is a substantial agreement among medical authorities as to these characteristics of "sexual psychopathy?" Yes_____ No_____ Comment:

6. Are such criterial both clear and distinct enough to constitute a proper foundation for legal enactments designed to provide for the segregation and treatment of individuals alleged to be sexual psychopaths? Yes_____ No_____ Comment:

7. Is there enough consensus among psychiatric authorities so that a law directed toward the sexual psychopath could function in accordance with sound principles of justice and with due protections to individual liberty (i.e., so that non-psychopaths would not be adjudicated and so that a large proportion of psychopaths would be adjudicated and treated)? Yes_____ No_____

8. In view of the possible variation in current interpretations of what sexual psychopathy is and the possibility that the term itself and its connotations may change, would it be preferable in a statute designed to provide special treatment for the disorder to avoid use of the term, sexual psychopath, (as recommended by the Group for the Advancement of Psychiatry), and instead to describe the symptomatology? Yes_____ No_____ or the criminal offenses justifying adjudication? Yes_____ No_____ Comment:

9. Are we ready at this time as a matter of policy to provide for potentially long term or permanent segregation of individuals diagnosed as sexual psychopaths if they have engaged in no violations of the existing criminal law? Yes_____ No_____ Comment:

10. Where individuals were diagnosed and adjudicated as sexual psychopaths, under current conceptions of this disorder, in what proportion of cases do you consider that it would be possible to predict quite accurately that, if untreated, they would in time commit crimes of a serious nature? _____%

11. In light of limitations of knowledge about the character of sexual psychopathy, the probable variations in diagnosis among different psychiatrists, and the extent to which personal liberties are at stake, do you consider that it would be sound legal policy at this time to provide for legal determinations of the fact of "dangerous sexual psychopathy" as to individuals who had not committed criminal offences. Yes_____ No_____
Comment:

12. Do you believe that committed sexual psychopaths should be subject to longer periods of segregation and treatment than is provided by law for the crimes which they are proven to have committed? Yes_____ No_____
Comment:

13. Do you hold that the condition of sexual psychopathy is remediable through psychiatric treatment? Yes_____ No_____ Sometimes_____
Comment:

14. In the professional staffing of an institution for sexual psychopaths, do you consider that it would be necessary to employ one psychiatrist for each 10 patients_____, 20_____, 30_____ or ( )_____? (Please check one or fill in appropriate figure.

15. Would it be possible, in your opinion, to secure sufficient psychiatric and other treatment resources to do a successful treatment job on a large proportion of the dangerous sexual psychopaths in the state? Yes_____ No_____
Comments:

16. Do you believe that maturation and disciplinary regulation alone (under conditions of institutional custody without specialized clinical treatment) are sufficient remedy for sexual psychopathy in a substantial proportion of cases? Yes_____ No_____
Comment:

17. Do you hold that sexual psychopathy originates inconstitutional factors _____, environmental conditioning influences_____, a combination of the two_____.

18. Do you believe that there is any advantage to be gained by segregating the sexual psychopath before adequate clinical treatment facilities become available? Yes____ No____
Comment:

19. Do you believe that sexual psychopaths should be housed at the same institution with defective delinquents? Yes____ No____, with psychotic patients? Yes____ No____
Comment:

20. Do you believe that for the more effective treatment of potentially dangerous sexual psychopaths, specific legislation for specialized therapy should be directed to:

a. ____all sex offenders, including those who commit only single, rare, or occasional sex offenses?
b. ____habitual sex offenders only, but all types of sex offenders, and without regard to a finding of sexual psychopathy?
c. ____only the more serious types of sex offenders, but without regard to a finding of sexual psychopathy?
d. ____serious types of sex offenders, but only where there has been an expert finding of sexual psychopathy?
e. ____any type of serious criminal offender where there has been an expert finding of sexual psychopathy?
f. ____any individual who is found, upon complaint and civil adjudication, to be a sexual psychopath, though he has committed no criminal offense.

Comment:

21. Do you think that provision should be made for the voluntary self-commitment for treatment of individuals who, though they have committed no crime, are diagnosed as sexual psychopaths? Yes____ No____

ANALYSIS OF QUESTIONNAIRE RESPONSES: PRINCIPALS OF PUBLIC SCHOOLS IN NEW JERSEY

Several forms of inquiry have been directed in an effort to determine something about the extent of the problem of the abnormal sex offender which confronts us. One method employed was the distribution of questionnaires to principals from the public schools of New Jersey, containing in the main questions designed to discover how extensive a problem they believe exists among the children attending their schools. It was felt that this information might be of some special interest from the point of view of possible preventive treatment of individuals who are the potential sex offenders of a few years hence. The questionnaire also elicited some response concerning opinions among these principals as to the adequacy of existing treatment resources for juvenile deviates and their views as to the needs for additional facilities. Incidentally, their responses are instructive in revealing the wide variations among these administrators in their understanding of juvenile sexuality and the treatment needed by the deviant.

Through the excellent cooperation of school officials throughout the state replies were received from some 184 principals who have responsibility for 85,309 students. It is difficult to formulate questions concerning apparently deviant child sexuality in a way that will produce dependable replies. In this interrogation questions were asked as to the frequency of apparent sex deviations in three types of cases. From among the students in this sample a total of 382 cases of deviation was noted. The principals believed that approximately 224 children had displayed exaggerated and sexually toned aggressive behavior or sadism during the past year. They believed that 111 of the students had displayed an exaggerated sexual preoccupation. An additional 47 children had, to their knowledge, been the victims of aggressive sexual acts. It is singular that among the approximately 17,000 high school students who made up a fraction of the sample a very small amount of sex deviation was indicated by the responding principals. It is impossible to tell how accurately or adequately the estimates of these administrators may reflect the actual circumstances of sex behavior among

the school children. The comment in some of the replies that the conduct involved was masturbation is in itself an indication that some portion of these 382, alleged to have displayed sexually deviated conduct, had in fact indulged in behavior quite normal to the maturation of the youngster. Kinsey, for example, found that some 95% of the cases studied in his sample had engaged in masturbatory activities. Unfortunately, some of the instances of alleged problems became such only through the attention that was unnecessarily directed toward them.

The apparent need for a wider extension of mental hygiene facilities for school children was revealed in the fact that, while 104 principals indicated that such resources existed in their community, 67 others replied that there were no such facilities available, at least to their knowledge. Sixty-seven principals said that they considered the clinical facilities available insufficient to handle their cases of sex deviates, while 74 believed such facilities adequate. Some principals considered the clinical resources adequate even where none to their knowledge exists.

To the question whether they believed that psychological and psychiatric treatment facilities would be useful in cases of young sex deviates, 147 out of 156 respondents indicated in the affirmative. 122 principals said that they used some method of informing their staff as to the availability of clinical, diagnostic and treatment resources, while 40 said that they did not. The latter were mainly instances where no resources were thought to be available.

It is a matter of some special interest to our inquiry that 138 of the responding principals expressed the belief that a program to enlighten their teachers as to the symptoms of sexual deviation and the facilities to meet the problem would be useful. 28 principals did not believe so. Of equal interest was the discovery that 155 of the schools from which replies were secured do not employ a sex education program for their students, while only 21 do offer such a program. The latter were high schools mainly. 84 of the principals indicated, however, the opinion that it would be desirable to extend such offerings in the

interest of preventing the development of abnormal sex interest and behavior. 60 of them replied in the negative to this question, in a number of instances because they believed no problem to exist. 79 administrators suggested that the facilities of the state mental hygiene clinic serving their counties were insufficient to meet the problem of sex deviates and other types of maladjusted youngsters. 59 others believed these clinical facilities to be adequate. Some who said they did not know indicated that they were unaware of the existence of such facilities. 90 replies suggested that an extension of the Parent-Teachers Association program or of the visiting teacher resources would be useful in attempting to deal with young sex deviates. 73 believed to the contrary. Many of the principals expressed the opinion that a most useful approach to this problem of deviate sexuality would be by way of educating parents so that they might do a better job of inculcating information and values in their children. Others thought that surveillance and strenuous physical activities and moral education should solve the problem.

QUESTIONNAIRE FOR PRINCIPALS IN THE PUBLIC SCHOOLS OF NEW JERSEY

Name: _____
School: _____
Location: _____

1. How large a number of students were enrolled in your school last year? _____

2. Please estimate the number of children who displayed exaggerated and sexually toned aggressive behavior or sadism among these students last year? _____

3. How many of these students, would you estimate, displayed an exaggerated sex preoccupation? _____

4. How many of these students, to your knowledge, were the victims of aggressive sexual acts? _____

5. What is your practice, if any, to secure diagnostic or treatment help for these cases? _____
_____
_____

6. Are there any mental hygiene or other clinical facilities available for children in your community to which these cases could be referred? _____

7. Please list these resources. _____
_____

8. Do you believe that the facilities in your community are sufficient to handle cases of this sort among your students? _____

9. How much extension of such facilities do you think is needed for an adequate coverage for your deviant students? _____
_____

10. Do you believe that psychological and psychiatric treatment facilities would be useful in these cases of young sex deviates? _____

11. Do you have any method of informing your staff as to the availability of clinical, diagnostic and treatment resources? _____

12. Do you think a program to enlighten your teachers as to the symptoms of sexual deviation and the facilities to meet the problem would be useful? _____

13. Do you employ a sex education program for the students in your school? _____

14. Do you think it would be desirable to extend such offerings in the interest of preventing the development of abnormal sex interest and behavior? _____

15. Do you consider that the facilities of the state Mental Hygiene Clinic serving your county are now sufficient to meet the problem of sex deviates and other types of maladjusted youngsters? _____

16. Do you believe that an extension of the Parent-Teachers Association or visiting teachers program would be useful in attempting to deal with the problem of children displaying symptoms of sex deviation? _____

17. What methods do you think should be employed to improve our preventive and treatment efforts in relation to these children displaying abnormal sexual tendencies? _____

_____

_____

18. Do you look upon this problem of children with abnormal sex tendencies as one requiring medical attention or correctional treatment? _____

_____

_____

ANALYSIS OF QUESTIONNAIRE RESPONSES: PARENT-TEACHERS ASSOCIATIONS OF NEW JERSEY

A questionnaire was prepared by the Commission for distribution to Parent-Teachers Associations throughout the State of New Jersey. This was designed largely to discover the awareness in these groups of the existence of a problem of sex deviates in the schools and opinions concerning treatment. 81 Parent-Teachers Associations have responded to this questionnaire.

29 respondents expressed the view that there was only a small problem in their community of children displaying abnormal sexual tendencies, while 10 thought that no problem at all existed and several others indicated that they did not know. In no reply was their any indication that the problem was a large one. An even smaller percentage of replies indicated that there was a small problem of children suffering as victims of aggressive sex acts.

As to the adequacy of clinical resources, 36 association officers said that the clinical facilities for diagnosis and treatment of sex deviated children were not adequate in their communities and 13 others indicated that no facilities at all existed. Only 26 thought that sufficient resources of this kind were sufficient. In a number of instances the replies suggested that a considerable increase in resources is necessary.

In reply to an inquiry as to whether the Parent-Teachers Association or a visiting teacher program could do more to deal with this problem, 33 respondents replied in the affirmative and 29 in the negative. An important reflection of community opinion was expressed in the replies of 52 officers of Parent-Teachers Associations who believed that a program in sex education in the public schools would be helpful in preventing the development of sexual deviation among the students. There were 21 responses in the negative on this question. Among other methods that were suggested as possible techniques to employ to improve the preventive treatment efforts, the most common recommendation was education of parents so that they could better perform their task of sex education. In several instances the point was made that if sex education should be introduced more

generally into the schools, it is important that the job be performed properly by individuals especially trained for that function. Other Associations suggested the value of increased recreational and activity programs, extended family welfare work, more psychiatric assistance, and religious inculcation. Most of the replies displayed the opinion that no real problem exists of abnormal sex tendencies among our school children.

From one Parent-Teachers Association came a thoughtful reply that the contents of the questionnaire had been thoroughly discussed at an executive meeting of the group and they "sincerely believe that any symptoms of sex deviation noticed are purely a sign of 'natural growing up.' In other words, there are really no signs of abnormal sexual tendencies." The belief was expressed that a program of sexual education in all public schools should be required, since a majority of the pupils are not taught or given a chance to discuss this matter at home, and that sex deviations may commonly result from lack of the needed training.

QUESTIONNAIRE FOR PARENT-TEACHERS ASSOCIATIONS

1. Do you believe that the clinical facilities for diagnosis and treatment of school children displaying symptoms of sex deviation are adequate in your community? _____

2. How much do you consider that such facilities need to be extended? _____

3. How large do you believe the problem is in your community of children displaying abnormal sexual tendencies? _____

   Of children who are victims of aggressive sex acts? _____

4. Do you believe that the Parent-Teachers Associations and a visiting teacher program could do more to deal with this problem of children with symptoms of sex deviation in your community? _____

5. Do you look upon this problem of children with abnormal sex tendencies as one requiring medical attention or correctional treatment? _____

6. Do you believe that a program in sex education in the public schools would be helpful in preventing the development of sexual deviation among the students? _____

7. What other methods do you think should be employed to improve the preventive treatment efforts in handling these cases? _____

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ADMINISTRATION OF STATE LAWS ON THE HABITUAL SEX OFFENDER

Legal References	WISCONSIN (Chap. 458, Laws of 1947	ILLINOIS C38, Sec. 820, 1938 Supplemented 1947	MICHIGAN Sec. 28.967(1)–28.967(a) 1939, Amended 1947	MINNESOTA Sec. 526.09–11 1945	MASSACHUSETTS Chapter 123A 1947	OHIO Gen. Code (1947 Supp.) Secs. 1345-19–1345-23
I. Designation of Condition	Sexual psychopath.	Criminal sexual psychopathic person.	Criminal sexual psychopathic person.	Psychopathic personality.	Psychopathic personality.	Psychopath offender.
II. Elements of Definition	Irresponsible for sexual conduct and thereby dangerous to himself and others because of 1. Emotional instability; or 2. Impulsiveness of behavior; or 3. Lack of customary standards of good judgment; or 4. Failure to appreciate consequences of acts; or 5. Combination of above.	1. Mental disorder. 2. Not insane or feebleminded. 3. Existing for period of one year. 4. Coupled with criminal propensities toward the commission of sex offenses. (All four elements required.)	1. Mental disorder. 2. Not insane or feebleminded. 3. Existing for period of one year. 4. Coupled with criminal propensities toward the commission of sex offenses. (All four elements required.)	Irresponsible for sexual conduct and thereby dangerous to others by reason of 1. Emotional instability; or 2. Impulsiveness of action; or 3. Lack of customary standards of good judgment; or 4. Failure to appreciate consequences of acts; or 5. Combination thereof.	1. Habitual course of misconduct in sexual matters evidencing utter lack of power to control sexual impulses; and 2. Likely to attack or otherwise inflict injury, loss, pain, or other evil. (Both elements necessary.)	Psychopathic personality. 1. Emotional immaturity and instability; or 2. Impulsive, unruly, irresponsible and reckless acts; or 3. Excessively self-centered attitude; or 4. Deficient powers of self-discipline; or 5. Marked deficiency of moral sense or control.
III. Basis of Jurisdiction	No crime or charge thereof is necessary.	1. Charge of criminal offenses. 2. Detention in state penitentiary.	Charge of criminal offense.	No crime or charge thereof necessary.	No crime or charge thereof necessary.	Conviction of felony.
IV. Discretion in Initiating Proceeding	District Attorney (discretionary).	1. Attorney General (discretionary). 2. State's Attorney (discretionary). 3. Department of Public Safety (mandatory).	1. County Prosecutor. 2. Attorney General. 3. Someone on behalf of person charged with crime. (All discretionary.)	County Attorney (discretionary).	District Attorney (discretionary).	Court after conviction. (Mandatory in some cases; discretionary in others.)
V. Tribunal and Proceedings 1. Type of court. 2. Provision for jury. 3. Provision for private hearing. 4. Time within which hearing must be held. 5. Jurisdiction over juveniles.	1. Court of record (Juvenile court if under 18). 2. Jury on demand. 3. Private hearing in court's discretion. 5. Jurisdiction over juveniles.	1. Court of record. 2. Jury mandatory. 3. No provision for private hearing. 4. Hearing 10 days after service of copy of petition. 5. No jurisdiction over juveniles.	1. Court of record. 2. Jury on demand. 3. No provision for private hearing. 4. Hearing within 15 days after last report. 5. No jurisdiction over juveniles.	1. Probate court. 2. No jury. 3. Private hearing (discretion of court). 5. No jurisdiction over juveniles.	1. Court of record. 2. Jury discretionary with court. 3. Private hearing (discretion of court). 5. No jurisdiction over juveniles.	1. Court record. 2. No jury. 3. No provision for private hearing. 4. Hearing within 30 days of report. 5. No jurisdiction over juveniles.
VI. Medical Examination— 1. Qualifications of examiners. 2. Type of facility employed for treatment.	1. Two duly licensed physicians. (Two years general experience or one year's experience as a psysician in a hospital for the insane.) 2. Mental hospital.	1. Two qualified psychiatrists (reputable licensed physicians who have exclusively limited practice to mental and nervous disorders for five years). 2. Mental hospital.	1. Two qualified psychiatrists (respondent must answer their questions under penalty of contempt of court). Concurrence necessary for affirmative finding. 2. Mental hospital.	1. Two duly licensed doctors of medicine (by decision, held: concurrence of doctors not required). 2. Mental hospital.	1. Two duly licensed qualified physicians certified by Department of Mental Health. 2. Mental hospital.	1. Psychiatrists licensed in state having five years experience in mental diseases. 2. Mental hospital.
VII. Effect of Commitment on Criminal Proceedings	No defense.	Postponed till after release, but not defense.	Defense to crime of which accused at time of filing petition.	No defense, but statute of limitations runs.	No defense, but execution of sentence stayed till release.	No defense.
VIII. Procedure for Release	1. Parole by court upon recommendation of superintendent of institution. 2. Proceedings initiated by committed person, relative or friend.	Proceeding initiated by committed person or other person interested.	1. Parole by State Hospital Commission; or 2. Proceedings initiated by attorney for committed person.	1. Parole by director of public institution; or 2. Proceedings initiated by him or committed person or other interested person.	Proceedings initiated by Department of Mental Health or committed person.	Proceedings initiated by Commission of Mental Hygiene or person committed.
IX. Nature of Release—Whether Complete or Subject to Supervision	1. Complete release. 2. Parole.	To sheriff to stand trial on original charge.	Complete if by court.	Complete if by court.	Complete if by court.	To penal institution until total period of confinement equals applicable sentence; then release subject to supervision.
X. Number of Cases Committed Under the Law Appraisals by administrators.	Law inoperative. "Law is too loosely drawn as to its coverage and treatment facilities."	16 cases in 10 years. ". . . requires change; little interest in administering present statute."	Law inoperative.	Under 200 cases in 10 years. ". . . no triumph for justice or for the protection of society."	Law inoperative. "Law hurriedly enacted, not completely satisfactory; courts do not like it."	

NEW HAMPSHIRE	WASHINGTON, D. C.	STATE OF WASHINGTON	CALIFORNIA	INDIANA	NEW JERSEY	VERMONT
I Chap.—Laws of 1949	Sec. 201–209, Public Law 615, 1949	Chap. 273, Laws of 1947	Chap. 447, 1939, as amended by Chap. 1335, 1949	Laws of 1949, Chapter 1	Supplement to Title 2, Chap. 192, Laws of 1949	Sec. 6699–6709, Chap. 281, 282—Laws of 1943 & 1945
Sexual psychopath.	Sexual psychopath.	Criminal sexual psychopathic person.	Sexual psychopath.	Criminal sexual psychopathic person.	Abnormal mental illness.	Mentally defective delinquents.
Irresponsible with respect to sexual matters and thereby dangerous to himself or other persons because of 1. Emotional instability; or 2. Impulsiveness of behavior; or 3. Lack of customary standards of good judgment; or 4. Failure to appreciate consequences of acts; or 5. Combination of above.	1. Not insane. 2. Repeated misconduct in sexual matters evidencing lack of power to control sexual impulses. 3. Likely to attack or otherwise inflict injury, loss, pain or other evil on objects of desire. (Both elements necessary.)	1. Mental disorder. 2. Not insane or feebleminded. 3. Existing for period of one year. 4. Conviction at least once as sex offender. (All four elements required.)	Affected with 1. Mental disease or disorder; or 2. Psychopathic personality; or 3. Marked departures from normal mentality — in a form predisposing to commission of sexual offenses and in a degree constituting a menace to the health of others.	1. Mental disorder. 2. Not insane or feebleminded. 3. Criminal propensities to the commission of sex offenses. (All three elements required.)	Abnormal mental illness resulting in commission of enumerated sex offenses.	1. Mental deficiency or psychopathic personality. 2. Violate criminal laws or are guilty of gross immoral conduct. (Both required.)
1. Mandatory where certain sex crimes are charged. 2. Discretionary where facts less than a crime are presented.	No crime or charge thereof is necessary.	Charge of sexual offense.	Criminal charge.	1. Charge of criminal offense other than homicide or rape of a female under 12. 2. Conviction of such offense where person has been placed on probation or not yet sentenced.	Conviction of rape, sodomy, incest, lewdness, indecent exposure, obscene literature or pictures, indecent communications to females, carnal abuse or attempt to commit such offenses.	1. Conviction of a felony. 2. Conviction of a misdemeanor for the third time.
1. County Solicitor (mandatory for crime, discretionary upon petition by a person having knowledge of the facts).	1. U. S. Attorney (discretionary).	Prosecuting Attorney (discretionary).	Apparently on affidavit of any person.	1. Prosecuting Attorney. 2. Someone on behalf of the person charged. (Both discretionary.)	Judge before imposing sentence shall order mental examination.	Prosecuting Officer, Commissioner of Institutions or judge of convicting court (discretionary).
1. Superior Court of the county. 2. No jury. 3. Private hearing (discretion of court). 4. Hearing within 30 days after report. 5. Juvenile jurisdiction.	1. District court of the U. S. for the District Municipal Court. 2. Jury on demand. 3. No provision for private hearing. 4. No provision as to time of hearing. 5. No juvenile jurisdiction.	1. Justice Court or Superior Court on original charge; Superior Court for sex psychopath hearing. 2. Jury by petition in writing. 3. No provision for private hearing. 4. Hearing subsequent to conviction for the sex offense (not less than 20 days). 5. No juvenile jurisdiction.	1. Court of record. 2. Persons found to be sexual psychopaths may demand jury trial. Commitment only on finding by three-fourths of jury. 3. No provision for private hearing. 4. Trial in not less than five days or more than ten days from jury demand. 5. No juvenile jurisdiction.	1. All courts having general jurisdiction of criminal cases. 2. No jury. 3. No provision for private hearing. 4. Hearing not less than 10 days after service of copy of petition. 5. No juvenile jurisdiction.	1. Any court with jurisdiction over offenses enumerated. 2. No special hearing on issue of mental illness: commitment is based on report of psychiatrists. 5. No juvenile jurisdiction.	1. Criminal court. 2. No jury. 3. No provision for private hearing. 5. No juvenile jurisdiction.
1. Two psychiatrists, one from medical staff of a state mental hospital. Decision is by court on basis of the hearing. 2. Mental hospital.	1. Two qualified psychiatrists (court determines whether patient is a psychopath if there is a hearing, but patient discharged if both psychiatrists have found that he is not a psychopath. 2. Mental hospital.	1. One or more psychiatrists (physician or surgeon licensed to practice who for not less than three years has practiced exclusively in the diagnosis and treatment of mental and nervous disorders). Decision is by court. 2. Correctional institution.	1. Two or three psychiatrists, one from state or county hospital. (Holders of physician's and surgeon's certificate whose primarily to diagnosis and practice has been directed treatment of mental and nervous disorders not less than five years). By decision, held court not bound by psychiatrist's findings. 2. Mental hospital.	1. Two qualified physicians (respondent must answer questions under penalty of contempt of court). Concurrence necessary to hold a hearing. Determination is by court. 2. Commitment is to Indiana Council for Mental Health (psychiatric facility).	1. Two or more competent physicians (recognized as experts in psychiatry), one attached to Dept. of Inst. & Agencies. Judge may commit person to Diagnostic Center for examination. Decision is based on findings of examination. 2. Judge commits person to inst. designated by Dept. of Inst. & Agencies (psychiatric facility).	1. Commitment for diagnosis to state institution designated by Commissioner for that purpose. 2. Upon due hearing if court finds person a defective delinquent or psychopathic personality, dangerous to public welfare, person committed to penal or mental institution designated by Commissioner.
Defense to crime of which accused at time of filing petition.	Proceeding suspended until person is determined not to be sexual psychopath or until discharge from hospital. No defense.	Finding of sexual psychopathy is subsequent to criminal conviction; person is sentenced to ordinary correctional institution but certified for treatment by a psychiatrist there.	Proceedings suspended.	Defense to crime of which accused at time of filing petition.	Law applies only after conviction of a crime caused by mental illness.	No defense.
Release by Commission of Mental Health recommended to the committing court when director of institution believes he will not be benefited by further treatment and is no longer dangerous.	Superintendent of hospital may release on a finding that patient has sufficiently recovered so as not to be dangerous.	Release after expiration of sentence upon a hearing by the committing court and a finding that he is cured.	Superintendent of hospital certifies to committing court person is no longer a menace to health and safety of others.	1. Release on parole under such conditions as his condition, in judgment of Indiana Council for Mental Health, merits. 2. Discharge only after "fully recovered" any time upon a petition in writing showing recovery filed with court by which he was committed. 3. Psychopath to be examined at least once each year by two physicians, who report findings to court and council.	Term indefinite, maximum not to exceed that provided for crime of which convicted. Release when Commissioner of Dept. certifies to paroling authority that person has recovered sufficiently to make it reasonably certain that repetition of offenses unlikely.	Discharge upon order of the court where commitment was made.
Complete discharge by court.	To court on original criminal charge, if any. Otherwise complete release.	After expiration of sentence or parole, if person is found still to be sexual psychopath he may be committed to state or county hospital with facilities for criminal sexual psychopathic persons.	If within 30 days of certification the court does not order return for criminal proceedings, superintendent of hospital may parole, as in case of insane, for not less than five years.	Parole or complete discharge.	Release by paroling authority after certification upon such terms as appear necessary for safety.	Returned for sentence to committing court after discharge from treatment.
No commitments under recent statute. "These cases should not be sent to a state hospital. No treatment facilities."	14 cases this year. "A Star Chamber procedure, with inadequate diagnostic and treatment facilities."	Law inoperative.	No data available. "Leaves much to be desired: an ineffectual law."	One case. "Undesirable in principle, ineffective in operation: is no solution to the problem."	35 cases in six months. "A temporary measure, inadequate to handle problem."	Law virtually inoperative.