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## A PIONEER APPROACH IN THE TREATMENT OF OFFENDERS

JACK SOKOL

The author has worked during the past eight years with Dr. Melitta Schmideberg, internationally known psychoanalyst specializing in the treatment of offenders. He is co-founder of the Association for Psychiatric Treatment of Offenders, and has been its Executive Director for the past four years. He is at present at work on a book entitled "Curing Criminal Behavior," co-authorizing with Dr. Schmideberg—EDRROR.

"The Association for Psychiatric Treatment of Offenders," now familiarly known as the APTO, was born of a challenge, which came appropriately enough from a frantic mother who had called Dr. Melitta Schmideberg to get help for her son, a young man of twenty-two who was soon to be released from prison. The mother insisted that her son's need was urgent, saying she knew from the past that he would get into trouble again if he were not to have the attention she could give. Dr. Schmideberg, who was treating offender patients free of charge on a private basis at the time, had to refuse because she had no openings. The woman's pleas turned to indignation. She said it was a shame that there was no organization to handle such cases.

Dr. Schmideberg came to this country from England in 1945. Since 1933 she had been psychiatrist to the "Institute for the Scientific Treatment of Delinquency" in London (ISTD). The ISTD, under the direction of Dr. Edward Glover, the foremost psychoanalyst in England, was the first private clinic to provide treatment exclusively for offenders. During her work with the ISTD, Dr. Schmideberg found that most offender patients, particularly the more serious ones, did not respond to conventional methods of psychotherapy, and as a result she developed her own modified techniques.

At the time of the mother's call in 1949, Dr. Schmideberg had already had considerable knowledge of American offenders and their particular problems. When she became aware of the lack of facilities here, she undertook to treat offender patients privately, accepting for the most part major offenders with serious criminal records and prison experiences. I assisted her in many of these cases. A description of our work would make a paper in itself, or better yet, a book, but since this is the story of the APTO, a detailed account would be out of place here. But our work provided the background and setting for the APTO, establishing the premise that the treatment of offenders differs greatly from that of patients in private practice.

Private practice with law-abiding patients is based on three major principles: 1, punctuality; that is, the patient comes by appointment; 2, willingness; the patient comes because he wants to be helped; and 3, financial, he is willing to pay a fee for the service. None of these hold true for the offender patient of the type we were treating, and for whom we hoped to provide an organization. These patients were usually unreliable as far as appointments were concerned (naturally so, for by definition an offender is unable to fit into social routine); they usually had no money to pay for treatment, even if they wanted it; and for the most part, they were unwilling

patients, in the sense that they did not acknowledge having mental problems. In the majority of cases their motives for coming were more practical than we find with private patients; they wanted to impress their probation officer, or have a friend in court when the occasion arose, although some did come because they were lonely and wanted a friend to talk to. Often it was no more than a gesture to give an appointment, at least in the early stages of treatment. The exception occurred when there was extreme pressure upon them from parole or probation officers or the court. Broken appointments without cancellations were taken for granted; but new ones were given without too much fuss.

#### THE ASSOCIATION TAKES FORM

We visualized our organization as a small loosely knit group, with volunteer doctors treating the offender patients in their own private offices. The patient referrals would be made by telephone through Dr. Schmideberg's office. With this in mind, we contacted a number of psychiatrists in New York City whom we knew through their reputations or writings to be interested in the delinquency field. Seventeen psychiatrists answered the call for the first meeting. Not all of them had time available to take on patients, but they were interested in helping to get such an agency as we planned started, some for the reason that they wanted a forum to discuss the theories and techniques of such treatment.

For our next meeting, we decided to widen our appeal to include psychologists, social workers and trained correctional workers as well as psychiatrists. The turn-out was very large, numbering over forty persons. The principal discussions centered around the choice of a name, which, at first, seemed simple enough, but actually turned out to be quite critical and significant, reflecting much of the prevailing feeling about dealing with offenders. After many pros and cons we decided on "Institute for Psychotherapy of Criminals and Delinquents."

We were totally unprepared for the strong reaction that this tentative name aroused. The controversy centered around the use of the word criminal. It was felt that this name would stigmatize our patients, but more than that would denote a moral bias against them, and a reactionary philosophy on our part. As a matter of fact, we received a long letter from the editor of a well-known professional journal, expressing his disapproval of the use of the word criminal, which he stated never appeared in their pages. Some of the persons present, who had had experience in dealing with offenders, considered this a trifling matter. They said that the offenders themselves did not feel too badly about being called criminals, and that it was the enlightened, law-abiding people who had misgivings about it. In any event, after much further discussion, we decided on our present name, "The Association for Psychiatric Treatment of Offenders."

Gradually, our position began to clarify. We realized that an important part of our work should be educational. We decided to hold scientific meetings restricted to psychiatrists and a few specially qualified psychologists and social workers and other meetings devoted specifically to social workers, probation and parole officers. A third was the forum type of meeting which was intended for the enlightened laymen. In these meetings the general possibilities of such type of treatment would be emphasized in order to win both encouragement and support for our efforts.

We have held over one hundred meetings of various kinds since the founding of the APTO. We concentrated our clinical meetings on technical problems. Among the subjects discussed were "What Types of Offenders are Amenable to Psychotherapy", and "Two Studies in the Treatment of Holdup Men". Our forum meetings, which were particularly well attended, included addresses by many prominent people in the field. We were fortunate in obtaining the use of an auditorium at the Psychiatric Institute for a number of meetings through the kindness of Dr. Nolan D. C. Lewis, the former Director. We won many friends and volunteers through the medium of these meetings.

#### THE CLINICAL SERVICE DEVELOPS

As we went along we developed our clinical and psychological services. Within six months we had a volunteer staff of fifteen psychiatrists, five psychologists, and ten workers in related fields. All of the patients referred to us were treated in the private offices of the staff. Appointments were given one, two, and even three times a week per patient, according to the needs of the individual.

The majority of our patients were referred to us by official agencies in New York City, among which were Probation Department of the General Sessions Court, Manhattan; Jewish Board of Guardians; New York State Training School for Boys; New York State Training School for Girls; Probation Department of Kings County Court; Juvenile Aid Bureau (Police Department); Legal Aid Society (Criminal Division); Osborne Association; New York State Board of Parole; Community Service Society; Society for the Prevention of Crime; Magistrates Court; Special Sessions Court; and many others.

An Intake Committee, consisting of three psychiatrists, a psychologist and a social worker was originally set up to process these cases for referral, but it turned out to be too unwieldy a procedure and subsequently I was asked to do the initial interview. As it worked out, cases were referred to me by letter or telephone. I conducted the initial interview and then consulted with Dr. Schimideberg about each case and we would decide to which available therapist the patient could best be referred. I would then write to the referring agency and ask them to send a case history or summary to the therapist. After that, I contacted the patient and set up the first appointment.

From there on, the therapist made his own arrangements. In emergencies, when the therapist was not available, the patients were encouraged to get in touch with Dr. Schimideberg. Dr. Schimideberg and I, furthermore, were available to the therapist for the solution of special problems—Dr. Schimideberg for advice or consultations regarding the treatment, and I for contacts with the courts and for practical help if there was trouble with the family, or if the patient needed a job; and also to help induce truant patients to attend regularly for treatments.

While the social workers responded very warmly to our meetings and attended in large numbers, they were less ready to volunteer for our clinical program. Their lack of readiness to give time was caused not by any lack of generosity, I feel, but their reluctance to accept our philosophy and theoretical approach. They were more rigid than the psychiatrists regarding the methods of getting a patient to come for treatment. They also opposed our general elasticity in dealing with the patient, the

probation officer, the courts, the police and other persons in any way connected with the patient.

Our doctors belonged to various schools. They kept their own records, and, in general, the agency gave them a great deal of leeway. We did not strive to create a new school of psychiatry. Our aim was to influence the handling of offender patients, along the lines created by Dr. Schmideberg, with each of the doctors modifying his own particular technique. Only the chance offender, or those with essentially middle-class mentality, we found, were able to fit into the more orthodox approaches.

#### WHAT IS CRIME AND WHO ARE THE CRIMINALS

At this point, we should describe what we mean by an offender, or what is crime and who are the criminals. Not long ago a prominent Hollywood producer stabbed a friend. His attorney mentioned in court that his client was being treated psychiatrically. Can we believe that this psychiatrist is treating a criminal? In general terms, yes. In actual terms, no. The person involved was successful and well-to-do. The nearest he was to things criminal was when he produced a Hollywood movie on crime. Again, what is crime? It is not a coordinated conspiracy of an underworld organization. Actually, crime is the sum of many activities, big and small, running the gamut of minor violations of the law to the most shocking and infamous deed. Crime is the community in conflict, the criminal in rebellion against the authority of the law.

But we are not interested in treating all types of crime. Some of it, such as that exposed by the Kefauver Committee, is beyond our purpose. The affluent law-breaker and his conspirators, so-called respectable citizens who work with them, are a matter for our courts of justice. They are doing too well to need any help from us. We are concerned only with the average criminal offender, comprising the vast majority of law-breakers in our land, who is insignificant and unspectacular. He is neither affluent or arrogant. He has no organization; no long range plans. If you passed him on the street, he would not be distinguished from the ordinary person. By and large, though, he is poorer and infinitely unhappier. With some exceptions, this offender lives from day to day; often he is hard put to pay his rent or buy a meal. When he makes a strike, he is apt to splurge the loot in a short-lived imitation of the "big-shot" racketeers. And when he is caught, it is rare indeed that he can pay his lawyer's fee. In most cases, the families come to their rescue until their reserves or their patience is exhausted.

We speak here of the holdup man, the burglar, the roller of drunks, the purse snatcher, the forger, the petty swindler, the panderer and the prostitute, the pick-pocket, the user of drugs and all the other various categories. These are confused, troubled personalities, who usually break the law ineptly without regard for the consequences. The majority are emotionally disturbed.

To treat such offenders we should know a great deal more about the lives they lead and what happens to them after they get caught for committing a crime. Offenders can be dealt with as follows: by law enforcement, which is the function of the police and the court; by correction, which is the function of the prison system, the parole and probation systems; and by treatment, which broadly speaking, implies all possible methods, other than punitive, of altering the personality of an offender. We are con-

cerned with the first two because they influence the effect of the latter. A doctor must know what the offender goes through in his life, and the mores of his culture, before he can hope to make contact with him, let alone attempt to cure him. He must perforce, concern himself with probation, parole, courts, the District Attorney's office, if he is to function in any way as a reality-sense organ to the patient. He should know, for example, in detail, the difference between probation and parole and the conditions under which these are given to an offender.

When a parolee, say, tells his doctor that he had been drinking the night before and shows extreme anxiety over it, the doctor would have to think twice before he passes it off too lightly. He should find out if there is any danger of this patient being committed for a violation, which means his return to prison. In actual practice, parole officers are sensible and overlook many of the minor violations unless they suspect that their parolee is otherwise engaged in criminal activities. However, it is obvious that many apparently paranoid reactions can develop in the parole situation, which the doctor must closely examine in order to discriminate between realistic and irrational anxieties.

#### THE COURTS APPROVE

Many psychiatrists and others believed, before we organized the APTO, that individual treatment would be looked upon with hostility by the courts. This was definitely not borne out by our experience. As a matter of fact, our strongest support comes from court judges, probation and parole departments.

Our work has implications of a wider scope than is usually realized. The courts and the legal minds are aware of it. When treatment for offenders is more widely accepted, radical alteration in the methods of sentencing can result. Enlightened judges and lawyers are aware that a sentence for a crime does not always lead to any positive change in the defendant. Yet it is obvious to all of us that a crime cannot be simply overlooked. Something must be done. A prison sentence is often the only means most courts have at their disposal for offenders who are not suitable for probation. The APTO in a great number of cases was able to provide an alternative. We could offer a positive program; we could give treatment.

Many exhibitionists, for example, are constant repeaters. The courts usually realize, that these people are not real criminals. They are not violent, or, in any sense, dangerous to the community. True, they could upset and shock their unsuspecting victims, in the case of children, by distorting their ideas of sex. And altogether, the morality of the community condemns strongly such behavior. In the past, with such cases, after giving the exhibitionists a chance time and time again, the court finally had no other recourse but to sentence the offender for a shorter or longer term. Today, many judges are ready to regard such minor sex offenders as psychiatric problems, and welcome the chance to refer them to the APTO as a constructive alternative to a sentence. Some judges, of course, while accepting psychiatric treatment for minor sex cases, are still very skeptical about offenders who commit crimes of violence or crimes against property. The APTO has done an immeasurable educational service in convincing such judges that psychiatric treatment can also be effective with this type of offender.

Our use of the word treatment in this paper has obviously meant *treatment in the*

*community*. Offenders can be treated elsewhere too, as in prisons, or mental institutions. But what is done in such institutions is outside the scope of the APTO. There is, however, another aspect of treatment within the community which we must discuss. Many progressively minded people have long felt that it would be a great step forward for each court to have its own psychiatric clinic, regarding this as the most economical and effective method of providing psychotherapy to offenders. Actually, all that the APTO stands for is directly opposed to any such situation. We feel strongly that a clinic in a court setting cannot do effective therapy because it is inevitable that the patient will identify the clinic and its personnel with the authoritative aspects of the court, and distrust them. The usefulness of the APTO is enhanced considerably by the fact that it functions with private citizens and not with governmental authorities.

#### THE NARCOTIC ISSUE EXPLODES

The nature, or changing character of referrals to the APTO has been, in a sense, a barometer of the types of crimes being committed in the City. For example, soon after we started our clinical service we received many requests to treat drug addicts. At first we were reluctant to take on addicts, because there were no facilities for withdrawal, but in spite of ourselves, we found them on our hands. This occurred when after accepting an ordinary offender patient, we would discover he was a drug user. Often the referring agency, for example, a Probation Department, would not know that the patient was a user. This made our job much harder because we could not get the assistance needed in working with these cases, without giving the patient away. The following account from our newsletter at that time gives our views.

"The APTO was cognizant of the narcotic evil long before the present [1951] hue and cry. There is an obvious close linkage between the illness of addiction and delinquent conduct. This is true not only in the sense of both being a form of social rebellion but also because the demands of addiction frequently can be met only by unlawful acts.

"However, we strongly denounce present tendencies to regard narcotic addicts as criminals. It is a woeful reflection on our community action with narcotic addicts that the shadow of prison bars is cast over every suggested solution including therapy. When all is said and done, imprisonment is the main form of treatment today."

The above was written at the height of the public outcry against the sale and use of narcotics in New York City and elsewhere. The situation was so shocking at that time that the average person was unable to take it in. Drug usage was like a disease which was indiscriminately infecting young and old, rich and poor, good student and truant. I interviewed many youngsters during this period and was told quite frankly that heroin or "junk", as they called it, could be freely bought on the streets of New York, in fact, more easily than, say, cigarettes.

To meet the problem, a stronger and more intelligent law enforcement policy was needed. But equally important, we had to have facilities for treatment. There was the Public Health Service Hospital at Lexington, long famous as the institution for treatment of drug addiction, and a similar hospital-prison at Fort Worth, Texas. There is no point discussing here the published results of these institutions recording their success or failures in permanently weaning the addicts away from the use of narcotics. The facilities were excellent but recidivism remained a problem.

There were few, if any, persons experienced in the treatment of drug addicts. The literature was limited to papers on the bio-chemical effects of narcotics in the body and also some writings on withdrawal. There were a few papers to be found in psychiatric literature, but there were not related to the problem at hand of a more mass type of addiction. They described individual cases of addicts from other countries with different conditions, usually a middle class patient with means to maintain himself in drugs, "support his habit," and have enough left over to pay for his treatment.

The drug addicts that we knew and those known to the authorities were great in number and submerged in the social scale, regardless of their original class background, and generally on the borderline of delinquent behavior, if they had not already crossed over the line. They had to struggle to get money to satisfy their craving, and it would have been unrealistic to expect them to have enough left for payment of treatment, even if they really desired it. Sometimes, though rarely, the families of these addicts would come forward with financial aid, but when one bears in mind the many disillusionments these families have undergone, not to mention the inevitable peculations of the addicts from members of their family, one cannot expect sustained support from this source.

The problem of 1951, and still today, is wholly different from that of the early nineteen-twenties. At that time, the attitude of those dealing with drug addicts was not only pessimistic but absurd. It was the general idea that drug addiction was a diminishing problem and would soon become extinct. Most medical men, at that time, accepted the drug addict's own conclusions, "Once a junky; always a junky!" The drug addicts have always maintained that they could not be cured.

In the past, the addicts could be broadly divided into professional persons, mostly medical doctors and others from allied professions, who had easy access to narcotics, and the weaker characters among the criminal elements, with an occasional interspersion of bored, wealthy people. Today, the problem is vastly different. The number of shady personalities using drugs has expanded. The respectable professional group is, we find, rather stationary, but the newer type, youths and young adults, now greatly outnumber the the other two combined. This new type runs the scale from twelve-year old kids in public school to high school boys, some college boys and children from lower middleclass families.

#### NARCOTIC ADDICTS COME FOR GROUP THERAPY

In the fall of 1951, we set up an experimental group therapy program for adult addicts under the direction of a former psychiatrist from the U. S. Public Health Service at Lexington. Working with him in the group was another psychiatrist and a psychologist who not only did the testing but also assisted in the therapy under the direction of the two psychiatrists. Since we had no precedents to go by, our expectations for this group were not very high. The composition of the group was determined largely by the fact that our directing psychiatrist was interested in attempting treatment with the more difficulty type of drug addict, especially those he had got to know at the hospital at Lexington. As a matter of fact, the nucleus of the group consisted of former patients of his.

Our initial contact consisted of six addicts whom we interviewed individually. This initial group all belonged to the shady type of addicts who had no home ties,



and generally lived by their wits. They "supported their habit" by various means, including shoplifting, picking pockets, and selling drugs. All were users when they came to us. These patients brought friends along, some of whom knew of our psychiatrist while others knew of the work of the APTO.

The group was scheduled to meet twice a week. To give an idea of the type of patient we were dealing with, I recall my first interview with one of them who came on behalf of his addict friends to reconnoiter and feel us out. I spoke to him about an hour convenient to the psychiatrists and the patients, and informed him that we decided on 7:00 P.M. The addict objected vehemently to the appointed time, saying that 7:00 and 7:30 were out because this was the time he and his friends had their "meet", which meant that this was the hour they met the drug seller for their drugs. He said if we held the sessions at that time, nobody would appear. At another time, I was interviewing one of the patients before sending him on to our psychiatrist, when he suddenly told me that he had to rush off because he had to meet a friend of his in front of a department store where they were going to do some "boosting", which means shoplifting.

After a while, the composition of the group became more varied. We accepted addicts who lived at home, but even their way of life usually contained elements of delinquency. One of these patients who had appeared only twice in the group, was arrested for stealing doctors' bags from parked cars on Fifth Avenue. He was sentenced to two months in the City Penitentiary. Another was arrested for selling drugs. Still another was arrested for pandering. In the period when our group therapy program was functioning we also had a number of females who were of a similar type. Of the four or five female addicts seen by us three were prostitutes, one was a drug seller, and another, I think, was living as the mistress of an older man.

Our group started in September, 1951, and terminated in June of 1952. The decision to terminate was made by the Executive Committee of the APTO because we felt we should re-evaluate the methods we were using, in the light of the rather unsatisfactory results achieved. As far as I know all of the patients continued to use narcotics, occasionally decreasing and increasing the dosage, which is customary for addicts with or without treatment. As much as one-third of the group was arrested for various offenses. Many of them stayed away after a few sessions. Some stayed away a month or two, then turned up unexpectedly for a session or two and stayed away again. We never heard from a number of them after the first session. While these results are no worse than those of other facilities with this type of patient, we in the APTO felt after a trial period of nine months, that the method was to be questioned. Certainly it did not repay the effort and the time put in.

The directing psychiatrist had been given a relatively free hand in the conduct of the group, in view of his unique experience at Lexington. He allowed the group to set its own pace, and adopted a passive listening role for himself and his associates. There was no deliberate effort made to encourage or enforce withdrawal. The patients became accustomed to coming to the sessions under the effects of narcotics, although later I had to ask the directing psychiatrist to make a rule that no addict was to come to the group so badly under the influence of drugs that he could not participate intelligently. A number of times we suspected the addicts of using the bathroom for

the administration of drugs. We made another rule, therefore, that anyone caught doing this was to be expelled. This again took effect only in the later period of the group.

As it worked out, the average group session was attended by between five and ten patients at a time, although as many as forty were registered. Some weeks, though, only two appeared; at other times, fifteen, which was the largest attendance we had at any one time. Some nodded through the entire session. There was a feeling that many of these patients came to our group, out of loneliness, or sought a place where they could meet their friends in safety. One of our female patients tried to "push" or sell drugs, so we dropped her.

#### IS GROUP THERAPY FEASIBLE WITH ADDICTS OR OFFENDERS?

We concluded from these experiences that, if anything, such groups should be organized and maintained on a more controlled basis. At the time, it was impossible to insist on immediate withdrawal, partly because of the psychological condition of the patients and partly because there were no facilities in the City willing to undertake this withdrawal free of charge. The only exception was the City Penitentiary at Rikers Island, which accepted addicts for "cold turkey", which means abrupt withdrawal rather than gradual. The addicts had to commit themselves for thirty days. Our patients had no stomach for this plan.

Our group showed that something more than a pious hope, or even psychological interpretations, are needed to bring about even a temporary withdrawal. Public facilities must be provided locally to work along with such agencies as ours for withdrawal, and some sort of pressure, say, probation, be used to see that the addicts at least make the attempt. Also the addicts who have stopped using narcotics should be kept separated from those who are still using drugs.

As a matter of fact, the feasibility of treating active addicts in a group is open to question. Perhaps it would be best to do individual therapy with those still using drugs, to work for eventual withdrawal, and then admit those who have withdrawn into the "cleansed group." But even with "cleansed" patients in such a group, individual sessions must be provided for the patient who develops a sudden need for talking it out with someone else. We must bear in mind the culture in which these people live. Many of the things they have to say must be said in the strictest confidence. We cannot always ascribe their reluctance to talk openly in the group to the usual type of resistance or regard it as a difficulty in socializing. They have good reasons for not admitting law-breaking activities openly.

Although there are still misgivings concerning group therapy with offenders, both from within our organization and among people in the field, the principal objection is that such groups provide a place for delinquents to meet and possibly plan delinquent acts. For example, there has been some reluctance on the part of many probation officers to refer convicted homosexuals to such groups because they feel that it will become a meeting place for making "dates." Of course, objections against group therapy with law-abiding patients were also advanced initially, and some feel they have been satisfactorily repudiated. But there are important differences between offenders and non-offender patients in group therapy.

Probation and parole rules prohibit the mingling of persons with criminal records. There is some question as to the status of the probationer or parolee who meets with other probationers and parolees or at least offenders with a record, in the group. Another point of difference is that members of the group cannot be so frank and outgoing as law-abiding patients because, having revealed before a group an offense they have committed, there is a danger that a member of the group might inform on them.

#### PSYCHOTHERAPY WITH OFFENDERS COSTS LITTLE

The cost of psychotherapy for offenders has often been given as an objection to treating offenders in the community. We have heard of high-stepping figures running to \$10,000 per patient. This farfetched estimate, coming from apparently reliable sources, computed the total number of hours necessary for treating offender patients at the rate of one hour per day, every day of the week, and each week of the year. At the current rate of \$15 per session, the cost would come to \$3,800 a year for each individual, and would take three years of treatment as average.

Such estimates do not apply to our cases. With our modified techniques, the offender, except in very severe and exceptional cases is not seen by the psychiatrist every day. Treatment does not match the slow-moving progress of the neurotic in private practice. For the offender, psychiatric help at critical times is essential, but differing from private practice, the psychiatric delinquency expert usually has the assistance of a trained worker, such as a probation officer, a parole officer or a social worker to help the patient in his adjustment.

In view of the obvious failure of prison "treatment" with so many cases, it is strange that there are still many who ignore the impact and cost of such methods. Today, it takes at the least, \$1,000 a year to keep an inmate in prison. Sentences are generally long and we must total the expense of repeated court appearances, police actions, and other expensive procedures relating to apprehending and convicting an offender. The cost of an offender to the community in his lifetime may easily reach the huge sum of \$45,000. This does not include the losses to the victim, insurance companies, dislocation of families and lawyers' fees.

Compared to this, the work done by the APTO is insignificant. As it is, since our therapists are voluntary, our principal expenditure concerns clerical staff, office equipment, telephone, etc. If we could afford to pay our therapists, the average of \$400 a year per average patient would be adequate. The cost per individual may vary, depending on the severity of the case. But it must be constantly borne in mind that such a small outlay of money can have the effect of ending a crime career in the beginning, and thus save all the further the ever mounting costs of apprehending a criminal and bringing him to justice again and again.

#### OFFENDERS ARE TREATABLE

The pioneer efforts of the APTO have shown that psychiatric treatment is an important means of reducing the cost of crime. Some cases seen as few as five times were helped to the point where they did not get into trouble again, even when they stayed away of their own accord. Of those who completed their treatment some sixty percent have remained out of trouble to date.

The evaluation of the success with offenders includes both negative and positive aspects. First, of course, it goes without saying, that the "acting out" of anti-social impulses had to be curtailed. We have to be practical and prevent our patients from being arrested and sent to prison. To achieve an improvement in the patient's personality or neurotic symptoms is poor comfort if he ends up in a cell notwithstanding. On the positive side, an ideal result is one where the offender-patient is relieved of many of his emotional difficulties, can work self-supportingly, enjoying the fruits of his labor, and make friends, have social and sexual contacts with the opposite sex, to the point where he could sustain the obligations and responsibilities of marriage; in effect, live a normal law-abiding life.

But we should also appreciate the milder improvements. If only in terms of savings to the community. If an offender has never done honest work in his life, and now manages to work part time, or if an offender who has committed serious offenses turns to minor larcenies, we must consider this an improvement. We have even had some cases in which the offenders, through treatment, stopped committing crimes, but were unable to go to work. They manage to live minimally by begging or by public assistance, which is at least on a higher social level than their previous behavior. We have had prostitutes who took jobs in a department store to support themselves, but who continued to be sexually promiscuous. In these cases, they at least ceased to be police problems or menaces to the law-abiding community.

#### APTO RECEIVES WIDE PROFESSIONAL SUPPORT

We have been supported by many authorities in our field. Our Advisory Council includes such names as Dr. Franz Alexander, Dr. Benjamin Karpman, Dr. Edward Glover (London), Dr. Harvey Cleckley, Professor Robert H. Gault, Professor Daniel Lagache (Paris), Dr. B. Lovell Bixby and Dr. Charles Chute. Dr. Benjamin Karpman, one of the foremost authorities in the field, made a number of special trips to New York to attend executive meetings and in other ways gave us his moral support. One of the high points was when Dr. Karpman spoke at one of the meetings at the Psychiatric Institute which was attended by many well-known persons from the courts, the psychiatric field and other related disciplines.

In the Fall of 1951, the APTO held a conference in New York City on "Crime and the Scientific Treatment of Offenders." The conference commemorated the fortieth year of Professor Robert H. Gault's editorship of the *JOURNAL OF CRIMINAL LAW, CRIMINOLOGY AND POLICE SCIENCE*. This was particularly appropriate because Professor Gault has encouraged, and in many cases, fostered some of the most significant advances in our era in criminology and its related fields. He has opened the pages of the *JOURNAL* to many of the leading figures in psychiatry and psychology, irrespective of their schools of thought. He was one of the first to recognize the need for an organization such as ours, when it was outlined to him by Dr. Schmideberg, and agreed to head our Board of National Advisors. The conference which was attended by over five hundred persons, was a tremendous success, and served as an important integrating force in advancing the concept of individual psychiatric treatment for offenders.

Many of the above persons were attracted to our work by the personality of Dr. Melitta Schmideberg, one of the pioneers in the treatment of offenders and now

an international authority. Dr. Wladimir G. Eliasberg, authority on forensic psychiatry and the psychology of criminals, was elected president early in the life of our organization. He not only helped in the organizational work, but was extremely generous in giving time for diagnosis and treatment. The APTO is today at a turning point. We no longer have to justify our existence. We have proved that without elaborate setups, the public-spirited members of the psychiatric and psychological disciplines can provide service for the treatment of offenders under the simplest of conditions. The APTO feels that it can continue to be a constructive force in developing this type of work. Though we have won professional support, we have not as yet succeeded in winning over the public. An attitude of indifference still dominates. And more importantly, funds have not been forthcoming. This situation must be met if we are to carry on.