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IS CASTRATION AN EFFECTIVE DETERRENT TO SEXUAL REOFFENSE?

BACKGROUND AND MEDICAL DATA

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Castration has been known for many centuries--sometimes it occurs accidentally; sometimes it has been done deliberately to produce a desired physiologic effect. Castration of animals has been used to make the animals more docile and in the case of cattle to produce an animal with improved beef characteristics. Castration was often done to boys and men in order to produce males who could guard or serve a king's harem in ancient Middle East, based on the assumption that castrated individuals would have no sexual interest in their charges and could not impregnate them if they did have an interest. Young boys were castrated to prepare them to be adult singers with high voices since removal of the testes would prevent the masculinization of the laryngeal structures which normally results in deepening of the voice. In Italy, the practice continued until the 18th century. Certain religious groups have advocated castration to rid themselves of interest in sexual activities so they could focus more on God. This is mentioned in Matthew 19:12. The Council of Nicaea (325 A.D.) stopped the procedure on its church officers. The first use of castration for therapeutic reasons was by Forel at a Swiss

mental hospital (LeMaire, 1956). Unfortunately, castration has also been used for eugenic purposes as well as punishment. The ethics of those uses have overshadowed its previous consideration as therapy.

The loss of testicular function also occurs as a result of diseases such as mumps or testicular torsion. The signs and symptoms of testicular failure differ with the age of the individual. In children and adolescents testicular failure presents as delay in sexual maturation and a decreased adolescent growth spurt. Adult males with testicular failure characterized by decreased serum testosterone (the male sex hormone) present primarily with complaints of hot flashes and decreased sexual potency and libido (Rousseau, 1988). Often they also have multiple somatic complaints including decreased body hair and slowing of beard growth, vasomotor instability (palpitations, diaphoresis), fatigue and a variety of diffuse aches and pains (Griffin, Wilson, 1985). In addition, the men develop negative nitrogen balance, probably from loss of muscle mass and perhaps the genitourinary tissues. Permanent effects include decreased red blood cell production so that their hemoglobin and hematocrit levels fell to those typical of females. Some men report emotional instability and decreased concentrating ability, but

these are not common. These emotional symptoms are usually depressive in content.

Because of the prominent sexual complaints, castration has been considered for treatment of sex offending behavior with the supposition that decreased sexual activity means decreased offenses and victims. In contrast, others argue that male sex hormone (testosterone) levels are not correlated with sex offending behavior or even aggression (Bradford and McLean, 1984).

The role of testosterone and other androgens in human aggressive behavior is not clear. However, it is clear from animal literature that testosterone plays a significant role in facilitating aggression between males and aggressive sexual activity between males and females. Rose's classical studies in 1972 with Rhesus monkeys demonstrate a significant, positive correlation between aggressive behavior and the levels of plasma testosterone in an all-male group. In addition, in a small study of adolescent prisoners, Kreuz and Rose (1972) documented that those prisoners who had committed more aggressive and violent crimes during their adolescence had higher levels of plasma testosterone than prisoners who had not committed such violent

crimes. Even within the realm of sexual acts, more aggressive acts are often associated with higher testosterone than the less-aggressive acts. In Rada, Laws, and Kellner's study in 1976 comparing sex offenders and rapists versus child molesters, they found that a small group judged the most violent of these had higher testosterone than those who committed less violent crimes. Similar results were observed in a recent survey done in Galveston comparing rapists with child molesters (Meyer et al., 1992). Rapists had a mean testosterone level of 1026 ± 314 ng/dl versus a pedophiles' mean of 711 ± 238 ng/dl and exhibitionists' mean of 597 ± 263 ng/dl. In a recent comprehensive review of the entire subject, John Archer's (1991) literature review of five studies involving different types of violent male offenders concluded that violent male offenders have substantially higher testosterone levels than less violent individuals. However this does not mean that men in the general population with high testosterone are more dangerous than those with low levels.

SEX OFFENDER RECIDIVISM

The real issue is: what is the likelihood that any offender will reoffend? Critical to the issue of recidivism are several related questions. How many times do sex offenders offend? How often do sex offenders reoffend once caught? Gene Abel (1987)

noted in his classic study of sex offenders to whom he could guarantee confidentiality that the typical sex offender had many more victims than suspected. He found that the incest perpetrator had usually less than two victims, but the non-incest pedophile had many more, with a mean of 19.8 victims for those who preferred female targets and a mean of 150.2 victims for those who preferred male targets. The mean number of rape victims was 7.0. The median number of victims was considerably less than the mean, which indicates that many offenders offend only once.

Recidivism has been measured in a variety of ways: rearrest, reconviction, and self-report. When the measurement of recidivism relies on rearrest or reconviction records, it is usually underestimated. Crimes committed in other counties, states, or countries would not necessarily be counted. In some instances the reports have included self-disclosure of new offenses, but this is probably an under-reporting since the sex offender is usually concerned about rearrest. The length of time of follow-up is critical for assessing recidivism since reoffense may occur years later. Morrow and Peterson (1966) report, based on rearrest records, a steady increase in the recidivism rate from 5 percent at one year to 25 percent at five years. Recent

studies by Marques (1994) revealed that untreated sex offenders tended to reoffend in the first year after discharge more often than treated sex offenders. The treated offenders reoffended more often two or more years after discharge from prison.

The treatment of sex offenders is a very complicated issue, and it is influenced by numerous factors, many of which have not been well sorted out. In most instances, an individual committing one sex crime does not commit a future crime (Abel, 1987). We cannot predict who will reoffend. However, those individuals who do commit the second and third crimes are more likely to continue to commit future crimes. The types of crime tend to be consistent in the individuals, although sometimes there is progression in the seriousness of the crime. Another major variable is the type of crime. Rapists reoffend fewer times than pedophiles and exhibitionists. Rapists and pedophiles offending outside the home are very resistant to treatment. Rapists as a group seem to have less empathy for their victims than pedophiles. The time course of the behavior is important in that rapists tend to rape when they are 20 - 40 years of age and do not commit those crimes after age 50; whereas pedophiles commit the crimes essentially their entire lifetimes. The influence of substance abuse is significant in that those

individuals who are indulging in substance abuse, either alcohol or drugs, are more likely to recommit crimes.

Treatment of sex offender behavior is evaluated by the change in the recidivism rate. For purpose of this paper legal interventions such conditions of probation or parole, restrictions on personal freedom and electronic monitoring are not considered therapy. They may play a vital role in initiating the subject into therapy and keeping that person in therapy. However for purposes of the reported studies, one can assume that most untreated offenders had at least the same legal interventions as those that entered treatment. Treatments range according to the degree in which they are restrictive to a patient. The least restrictive is psychotherapy (individual and group) and behavioral therapy. Psychotherapy can take a variety of different forms, from individual psychoanalytic therapy to cognitive therapies to group therapies. Sometimes these therapies take the form of various kinds of behavioral interventions, some of which even involve aversive therapy. The next most restrictive form of therapy is that which involves the use of medications where the patient either has to take shots or medications over long periods of time. The most restrictive form

of therapy would be that which involves an irreversible type of treatment such as physical castration or lobectomy.

In order to lay the groundwork for understanding the effectiveness of the various castration therapies, first we will discuss some of what is known about recidivism. The last large review of these psycho- and behavioral therapies was done by Furby in 1989 when she attempted to review some 42 studies. She made no real attempt to separate out the various types of studies that she was reviewing, and they ranged the entire gamut from analytic to behavior to group therapies.

Recidivism rates of both treated and untreated sex offenders were presented. The range of follow-up is two months to twenty years. They exclude studies which used only self-report methods or physiological/ psychological measures. They argue that the under-reporting of sex crimes generally indicates that self-reporting is a risky -- perhaps wholly unreliable-- method of assessment in this particular area. A meta analysis is not attempted; Furby et al. (1989) provide mainly a catalog of the "valid" studies. The recidivism rate of untreated sex offenders ranges between 0 and 65 percent, typically around 25 to 35 percent. The overall recidivism rate for treated sex offenders was between 7 and 54 percent. Pedophilia and exhibitionism carry

very high rates of recidivism compared to other types of offenses. Incest offenders of children tend to reoffend less often than non-incest (which fits Abel's findings). Only 13 percent of incest offenders reoffend (Gibbons, 1978). Many of the studies indicate a significant rearrest record for non-sexual crimes as well. In general the studies do not support a beneficial outcome for treatment. Four of five studies report an increase in recidivism rate after treatment.

Unfortunately, Furby et al. (1989) decided that the studies carried out in countries outside North America were not comparable to North American studies because they used different or unknown criteria for offense and reoffense. This eliminated examining the physical castration studies and many chemical castration studies.

Furby et al. (1989) do address the recidivism rates associated with psychotherapies and behavioral therapies, but they do not distinguish between them. The major problem for the analysis is that no two therapies are the same. Several of the approaches used before 1989 are now known to be ineffective. Recently reports have identified some of the therapies such as group therapies involving confrontation, role playing, victim empathy and reoffense cycles as probably more effective (Knopp et

al., 1992; Marshall et al., 1990) Traditional therapies such as those using one-on-one insight-oriented psychotherapy are probably not very effective (Freeman-Longo and Knopp, 1992). One of the most promising models is relapse prevention in conjunction with cognitive behavioral approaches as carried out in Vermont under the direction of William D. Pithers and Janice K. Marques (Pithers et al., 1983). The Vermont data indicate a recidivism rate across all offender types to be 6 percent, with a range from 3 percent for incestuous and "hands off" offenders, to a high of 19 percent for rapists (Freeman-Longo and Knopp, 1992.) All groups had a lower-than-control rate. Similarly, an improved recidivism rate of 4.6 percent has been reported by Marques et al. (in press) in California (see Table 1). Their untreated groups reoffend at rates of 7.4 percent and 8.2 percent. These newer therapies and follow-up routines have produced impressive short-term results and appear to be very effective but lack long-term data.

Table 1: Recidivism rates following cognitive behavioral therapies since 1988 tailored specifically for sex offending behavior.

[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
Freeman-Longo & Knopp, 1992	5	473	6	
Marques et al., 1994	3	76	7.9	10.0
Marques, 1994	4		15.6	14.3
Pithers et al., 1989	6	147	3.0	
Marshall et al., 1991	5-15	23	32.5	57
Maletzky, 1991	1-17	3795	9	
Marshall & Barbaree, 1988	.75-11.5	64	13.2	34.5

CHEMICAL CASTRATION

Can the reoffense records be improved by some method of lowering the male sex hormone testosterone, either temporarily with chemicals (chemical castration) or permanently with physical castration?

The first approach is so-called chemical castration utilizing a medication (hormone) which will inhibit the secretion of testosterone. Initially in the 1940s this was done with

estrogens; but because estrogen causes feminization while lowering the testosterone, estrogen therapy was not acceptable to the patients. Since 1966, following the suggestion of John Money (1968), progestins have been used to lower testosterone since they decrease testosterone without causing feminization.

Medroxyprogesterone acetate (MPA; Depo Provera) and cyproterone acetate (CPA) are progestins/antiandrogens currently being used to reduce the sex drive of sex offenders. They are significantly different. MPA acts only to reduce testosterone production by reducing the stimulation of its production by reducing pituitary luteinizing hormone and by direct action on the testosterone synthesis. CPA does both of these things as well as block the action of testosterone and other androgens at the target tissue receptor level (Bradford, 1985). Generally, the use of either MPA or CPA is accompanied by psychological therapy and counseling. This combination provides the patient with a period of time in which he experiences less sexual drive and therefore can more easily work in psychotherapy on the other aspects of his problem, i.e. his reoffense cycle, interpersonal skills, etc. Treated patients report that they are less distracted from the real task at hand -- learning to not reoffend. This type of castration is reversible and, therefore,

very appealing.

Reoffense rates of antiandrogens have been examined in detail by Bradford in 1968 (see Table 1). These studies were not separated out by type of offense or characterization of the offender. He reports that CPA is very effective; CPA reoffense rates range from 0 to 16.7 percent for 96 offenders from seven studies. The pretreatment reoffense rates were 50 to 100 percent for the studies. CPA is used extensively in Europe and Canada; however, CPA is currently not FDA-approved in the United States. Therefore, there are no American studies using CPA to treat sex offending behavior; other studies in which it was used for prostate cancer include physical castration.

MPA in intramuscular depo form has been used extensively in the United States for the treatment of sex offending behavior. Although most reports are anecdotal and not controlled, a few studies have examined the reoffense rates of individuals treated with MPA (see Table 2). At least two types of individuals were usually excluded as potential subjects: those who denied responsibility for their acts and those whose offense was a result of "severe sado-sexual tendencies" (Walker, 1984; Meyer et al. 1992).

offender treatment providers. The panel could also be charged with reviewing the long-term outcome of this procedure.

SUMMARY:

The least restrictive form of treatment is psychotherapy, and this therapy, only in very recent years, has been tailored as cognitive behavioral therapy for the specific needs of the sex offender. Prior to 1985 the results of this form of treatment were abysmal. Since developing more specific forms of treatment, a definite improvement in recidivism rate can be demonstrated. In the 1920s and 30s it became popular to treat these individuals with a permanent form of therapy -- castration -- but, although effective, that is very restrictive. Chemical castration offers a middle ground. Unfortunately, in this country, Depo Provera has been the only medication available. This medication is only partially effective and has a very serious side-effect profile. Medications used in Europe, such as cyproterone acetate, have relatively low side effect profiles, and their effectiveness has just about eliminated the need for physical castration in those countries such as Denmark.

Cognitive behavioral and group therapies that are more specifically tailored to sex-offending behavior are effective in

a vast majority of the individuals and that this type of therapy should be pursued first. The next least-restrictive therapy which should be used is CPA therapy in conjunction with cognitive behavioral therapy. Unfortunately, CPA is not available in this country. Depo Provera offers a less desirable alternative. The most restrictive form of therapy is physical castration, and although there are preliminary findings suggesting it reduces recidivism in some offenders, more definitive results await studies that are more carefully controlled. Further more castration is fraught with numerous ethical and psychosocial concerns. Castration should be offered only to voluntary adult subjects who are repeat offenders, who acknowledge their crimes and who have been appropriately reviewed by at least two mental health professionals.

reoffended. The MPA treated young men had a significant number of side effects: weight gain, 33 percent; hypertension, 8%; gallstones, 10%; diabetes mellitus, 8 percent (Meyer, 1992). Because of these side effects several studies are now ongoing to examine the usefulness of oral MPA in doses up to 100 mg twice a day.

Emphasis cannot be made too often that the benefits of MPA and CPA therapy seem to last only as long as the therapy itself (Bradford, 1988). Also, the success of certain individuals involved in the study may have been due to factors other than the chemical therapy . Lastly, self-referred, highly motivated subjects such as the ones in the study by Meyer et al. (1992) are the ideal candidates to do well in any type of therapy regime, i.e., the subjects appear to be self-selected for success.

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castration for those individuals who find themselves over and over again committing sex crimes which they do not particularly want to commit but feel driven to commit. However one must keep in mind that physical castration is irreversible and that MPA is not.

In spite of its apparent success in Denmark, the castration operation was stopped in 1970 since similar results can be obtained with cyproterone acetate (CPA) or LHRH antagonists (Hansen, 1992). Hansen concluded that it was important to realize that castration does not change the object of sexual desire; it just reduces the urge. The operation is still being done in Germany on 3-5 persons per year.

One new development is the use of replacement testosterone by individuals who are castrated but wish to be able to continue to have sex either consensual or otherwise. Testosterone is available in many pharmacies and as a street drug. It is now more difficult to obtain since its abuse by athletes has been so publicized. Anecdotally, two castrated offenders from Washington State have reoffended after obtaining replacement testosterone (Tim Smith, Seattle, Washington, personal communication). In one of these cases the offender obtained the testosterone from a

physician. This seems on the surface as failure to document the person's medical history.

If voluntary castration is approved, each subject should be carefully examined by two mental health professionals who are listed in the Registry for Sex Offender Treatment. The examination would seek to identify, evaluate and protect offenders who are 1) suffering from a major mental impairment such as mental retardation, major depression, mania or schizophrenia, 2) motivated by self-hate and seeking to self-punish, 3)and do not understand the risks and benefits of the procedure. Voluntary consent should be obtained from the individual and his spouse. The major issue is to assure that the consent is truly voluntary. It may be necessary to appoint a neutral party as an advocate for the prisoner in the consent process. Care must be given to not allow consent to be in lieu of appropriate punishment or as a condition of parole. The state should also address the issue of replacement therapy; perhaps such therapy would be legal only if a review panel agrees. Once the legality of the operation for this purpose is established, the cost of the operation should not be great. Perhaps the entire process should be overviewed by an uninvolved panel staffed by an ethicist, medical personnel and experienced sex-

offender treatment providers. The panel could also be charged with reviewing the long-term outcome of this procedure.

SUMMARY:

The least restrictive form of treatment is psychotherapy, and this therapy, only in very recent years, has been tailored as cognitive behavioral therapy for the specific needs of the sex offender. Prior to 1985 the results of this form of treatment were abysmal. Since developing more specific forms of treatment, a definite improvement in recidivism rate can be demonstrated. In the 1920s and 30s it became popular to treat these individuals with a permanent form of therapy -- castration -- but, although effective, that is very restrictive. Chemical castration offers a middle ground. Unfortunately, in this country, Depo Provera has been the only medication available. This medication is only partially effective and has a very serious side-effect profile. Medications used in Europe, such as cyproterone acetate, have relatively low side effect profiles, and their effectiveness has just about eliminated the need for physical castration in those countries such as Denmark.

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.t Sex Predators Behind Bars, Not on the Couch

By Rael Jean Isaac

rida's legislature passed a law last
a allowing the state to commit to men-
al institutions "sexually violent preda-
tors" even after they have completed their prison terms. The statute, part of a trend sweeping the nation, uses phony, unscientific definitions of mental illness to co-opt the mental health system to further punish criminals whose jail terms the state decides are not long enough. But long prison sentences for sexual offenders and stringent monitoring of paroled sex criminals would better satisfy the demands of public safety. The sexual predator statutes only impair state mental institutions' ability to serve the authentically mentally ill.

The trend toward civil confinement of sexual criminals got a big boost from last year's Supreme Court ruling, *Hendricks v. Kansas*, upholding the constitutionality of such laws. Florida—whose statute is named the Jimmy Ryce Act in honor of a nine-year-old boy raped and murdered in 1995—is the eighth state to pass such a law. Thirteen other states, including Texas and New York, have such proposals on the legislative fast-track. But the Hendricks case shows how such laws are simply crutches to compensate for light sentences and lazy prosecutors.

In 1984, Leroy Hendricks was convicted in Kansas of sexual offenses against children for the fourth time; this time, the victims were two 13-year-old boys. Hendricks could have been charged under the state's habitual-offender statute and imprisoned for life. As one member of the Kansas Supreme Court put it: "Without violating the Constitution, the State could have incarcerated Hendricks until he exhaled his last breath and his spirit departed this Earth, but it did not." Instead prosecutors plea-bargained for a 10-year term.

Casting about for a way to avoid releasing him in 1994, the state made Hendricks the first person to be tried under its new law for committing sexual predators as mental patients. Hendricks, however, was not mentally ill; nor were the other offenders whom the state proposed to target with the statute. Therefore, they could not be committed under existing mental health laws. But the new statute allowed the state to put Hendricks away as a mental patient without proving that he was mentally ill.

Under this new law, to be committable as a sexually violent predator, an individual need only suffer from "a mental abnormality" or "personality disorder." "Mental abnormality," a term foreign to psychiatry, was in turn defined as a condition "which predisposes the person to commit sexually violent offenses." This is circular reasoning: The condition is defined as the behavior which it produces. Since predators, by definition, demonstrated sexually violent behavior before their imprisonment, the commitment procedure must simply show that they still pose a threat to society.

The Kansas Supreme Court threw out the law as unconstitutional. It cited earlier U.S. Supreme Court decisions ruling that mental illness was a precondition for civil commitment, and that a patient who had recovered his sanity could not be held simply on the grounds that his antisocial personality made him a potential danger. The U.S. Supreme Court, in a 5-4 ruling, reversed both the Kansas court and its own previous decisions.

Astonishingly, all the justices agreed on the core issue, that mental illness, as clinicians understand the term—an impairment of the ability to reason—was not a precondition for civil commitment. (The dissenters simply noted that Hendricks' treatment needs had been ignored for the 10 years he was in prison; therefore, the new law, which suddenly required him to be confined for treatment, seemed punitive.) The justices agreed that legislatures were free to make their own definitions of mental illness, and "mental abnormality" and "personality disorder" would do fine.

The Supreme Court essentially gave states the power to confine anyone who, as the Kansas law has it, displays "volitional impairment that makes them dangerous beyond their control." Legal scholars like John La Fond have noted that, in principle, this opens the way for the civil commitment of many types of violent felons who have trouble controlling their impulses.

The *Hendricks* decision can be viewed as a logical, if extreme, development in a 30-year-long process: the progressive triumph of the "dangerousness" standard over traditional grounds for civil commitment. In its amicus brief protesting the Kansas law, the American Psychiatric Association complained that sexually violent predator laws abandon the original purpose of civil commitment: the exercise of the state's parens patriae power to intervene on behalf of individuals too mentally impaired to act in their own interests.

MARTIN KOZLOWSKI

The civil confinement of sexual offenders is accelerating the topsy-turvy conversion of mental hospitals into prisons and prisons into mental hospitals.

Since the 1960s, the parens patriae standard has steadily lost ground. Under the influence of civil libertarians and such maverick psychiatrists as Ronald Laing and Thomas Szasz, the law has come to treat mental illness as a kind of alternative life style. Unable to achieve the goal of abolishing civil commitment, the mental health bar succeeded in grafting most of the procedures of criminal law onto civil commitment and in refashioning state statutes to make an individual commitable only when he had deteriorated to the point of being "imminently dangerous" to himself or others. But despite the revolutionary legal changes, prior to *Hendricks*, mental illness remained an essential predicate to commitment.

The practical effect of the Supreme Court decision will be to accelerate the ongoing topsy-turvy conversion of mental hospitals into prisons and prisons into mental hospitals. Take, for example, California. The state has only 4,000 state hospital beds, one-tenth of the number it had in 1955. More than half are taken up by the criminally insane. Under the state's two-year-old sexually violent predator law, 178 felons have already been transferred to Atascadero State Hospital. Los Angeles Superior Court Judge Harold Shabo observes: "You are diverting very scarce mental health resources to what is basically a criminal population."

As traditional mental patients are pushed out of hospitals, they find their way into penal institutions. There are 15,000 severely mentally ill individuals in California's jails, most of them incarcerated for minor misdemeanors, from trespassing to harassment. Ironically, they do not meet the mental health statute's strict requirements for "dangerousness."

State legislatures preparing to pass civil confinement laws would do well to consider all the costs. When Wisconsin passed its law in 1994, the attorney general predicted seven potential cases a year. In fact, there have been more than 100 commitments since then, with almost as many additional cases pending. And while each year produces a new harvest of civilly committed predators, few are likely ever to be released. Washington, which pioneered the legislation in 1990, has only released two sexually violent predators to date.

States can also expect a wave of lawsuits from the committed criminals charging inadequate treatment of their "mental abnormality." Treating sexual offenders is notoriously difficult, a major reason virtually all states abolished the old sexual psychopath laws that had once put sexual offenders in mental hospitals as an alternative to a prison sentence. Already the Washington treatment program operates under a court-appointed master.

Treatment programs likely to survive court challenges will be enormously expensive. Even then, outcome studies give little reason for optimism. A 1989 report on eight studies that directly compared treated and untreated groups of sex offenders found that in 5 of the 8 studies, recidivism was actually higher in the treated group. Preliminary results from the most ambitious program, California's Sex Offender Treatment and Evaluation Project, are equivocal.

Florida's Department of Children and Families estimates it will cost $158.6 million a year to handle the over 1,000 predators it expects to be confined by 2000 under the new law. However, Jimmy Ryce, whose tragic death gives the legislation much of its emotional appeal, would not have been helped by it—his accused attacker is not a repeat offender.

Ms. Isaac is co-author of "Madness in the Streets: How Psychiatry and the Law Abandoned the Mentally Ill" (Free Press, 1990).

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'Daimsler' Is Roadworthy

By Douglas Lavin

Following Wednesday's announcement of the merger between Daimler-Benz AG and Chrysler Corp., everyone should prepare for loads of thoughtless references to the coming culture clash between quick, flexible Americans and sclerotic, hierarchical Germans. That will be followed by predictions that since two big cheeses can't share one CEO job, Chrysler's Robert Eaton and Daimler's Jurgen Schrempp are headed for a showdown.

Much of the naysaying is due to the fact that Chrysler has been tremendously successful at crafting an image of itself as a bold company that breaks the rules. It created products like the outrageous Dodge Viper as part of a calculated effort to change the image of its clunky, cheap K-car sedans. And Chrysler public-relations officials didn't hesitate to pass out stories about president Robert A. Lutz's decision to buy a military jet for his private flying pleasure, or about his refusal to wear a gray suit for a picture of senior executives in the annual report. This was a company that was proud to defy convention.

Alike

But "Daimsler" is going to work—because the two companies are more alike than they seem.

Robert Eaton

Behind Chrysler's radical image and its love of stunts—like driving a Jeep through a wall of glass to introduce a new product at the Detroit Auto Show—is a staid company that became the most profitable automaker in the world (on a per vehicle basis) by sticking to its knitting.

"My personal ambition is to be the first chairman never to lead a Chrysler comeback," Mr. Eaton, whose friends describe him as "straightforward," said after becoming CEO in 1993. Asked what his vision for the company was, Mr. Eaton told me at the time, "Internally, we don't use the word vision. I believe in quantifiable short-term results—things we can all relate to—as opposed to some esoteric thing no one can quantify."

This doesn't sound too bold. It sounds practical. Ditto the fact that Mr. Eaton named Thomas T. Stallkamp, Chrysler's purchasing manager, as his No. 2. man and heir apparent. Mr. Stallkamp's claim to fame? Cutting costs.

So maybe Chrysler isn't quite as innovative as it wants to appear. What about Daimler? Sure, there are stories of countless layers of middle-management and slow decision-making, but under Mr. Schrempp, Daimler has broken the cautious Germanic mold.

Naysayers will claim that Daimler-Benz is too plodding to merge smoothly with the dashing Chrysler. But appearances can be deceiving.

Philip Rosenzweig, a professor at the Institute for Management Development, in Lausanne, Switzerland, says Daimler made a conscious effort to be less conservative when it built an assembly plant in Alabama—its first outside Germany—and put a young executive in charge. "Daimler used that as an internal example to send a message that things are changing," Mr. Rosenzweig says, calling the plant an effort to "stretch Mercedes and mix some of the good things about American business culture into a more rigid German business model."

Chrysler's done a good job of pushing the efficiency envelope, using software to design and roll out new cars in record time and jumping on the lean production bandwagon to cut costs. But Daimler is the company that's really radical. It is working with the people who brought us the Swatch to turn out the Smart, a tiny new car with an innovative distribution system. It abandoned its financial support for NV Fokker, sold off its stake in Cap Gemini, Europe's largest systems integration firm, and absorbed its Mercedes subsidiary into the mother ship. These were all bold moves.

Daimler has even turned goof ups to its advantage. When it moved away from its image as a maker of luxury cars by bringing out the small A-class car—another radical departure—it got burned. The car rolled over during the so-called Elk test, designed to challenge its ability to make quick turns. But Daimler fixed the problem and took out full-page ads naming an Elk its employee of the month.

What about the supposed clash of the titanic CEO egos? Such conflicts have been the end of more than one merger attempt.

It seems that Mr. Eaton is destined to emerge as the No. 2 man in this new combine. The question then becomes whether he can stomach it. I think he can.

Collection of Egos

Let's not forget that he arrived at Chrysler (from a position as head of General Motors Europe) at a time when Chrysler was seen as an unruly collection of egos. Lee Iacocca's iron rule of the firm and his demand for movie-star treatment had already scared off more than one would-be CEO. And then there was Mr. Lutz, an angry heir apparent who would have to be appeased. It wasn't always smooth sailing. At one point Mr. Iacocca joined with shareholder Kirk Kerkorian to challenge Mr. Eaton, but Mr. Eaton managed to work jointly with Mr. Iacocca and with Mr. Lutz for years. That's because he's the kind of guy who understands that sometimes it pays to be bland.

Juergen Schrempp

So the skeptics deserve a wary eye. For this merger may just work.

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