Approved February 16, 1991
Date

MINUTES OF THE SENATE COMMITTEE ON JUDICIARY.

The meeting was called to order by Senator Wint Winter, Jr. at
Chairperson

10:05 a.m./~~p.m.~~ on January 28, 19 91 in room 514-S of the Capitol.

All members were present except: Senator Feleciano who was excused.

Committee staff present:

Mike Heim, Legislative Research Department
Jerry Donaldson, Legislative Research Department
Gordon Self, Office of Revisor of Statutes
Judy Crapser, Secretary to the Committee

Conferees appearing before the committee:

Steve Zinn, Kansas Appellate Defender
Jerry Wells, Assistant District Attorney of Douglas County
Theron Weldy, Sex Offender Treatment Program
Dr. Tom Locke, Bert Nash Mental Health Center

Chairman Winter reopening the hearings for SB 18, SB 19 and SB 20.

SB 18 - sexually violent offenders.
SB 19 - persons likely to commit sexual acts as mentally ill person under treatment act for mentally ill persons.
SB 20 - required supervision and treatment by mental health professional for sex offenders.

Steve Zinn, Deputy Director, Kansas Appellate Defender, testified in opposition to SB 18. (ATTACHMENT 1)

Jerry Wells, Assistant District Attorney of Douglas County, testified in support of SB 20 stating his beliefs of aftercare as important for pedophilic behavior.

Theron Weldy, Director of the Sex Offender Treatment Program statewide, testified in support of SB 18, SB 19 and SB 20. He expressed his opinion that the need is apparent for some kind of intervention for this category of defendant. He offered materials to support his position. (ATTACHMENTs 2, 3, 4 and 5)

Dr. Tom Locke, Bert Nash Mental Health Center, testified in support of the intent of SB 18, SB 19 and SB 20. In addressing SB 18, he expressed concern with questions of confidentiality and privilege when defendents are placed in treatment programs. He also suggested a change in the definition of "sexual gratification" because of the possibilities of misinterpretations. Dr. Locke stated that SB 19 could be problematic with the inclusion of the sexual offender in the definition of "mentally ill." Dr. Locke concluded his testimony with expressing his concerns about the lack of funding and guideline clarifications in SB 20.

This concluded the hearings on SB 18, SB 19 and SB 20.

Senator Bond requested the committee introduce a state racketeer influence and corrupt organizations (RICO) bill for the express purpose of providing specific legislation to study during the 1991 Interim.

Senator Bond moved to introduce the bill as outlined and recommend that it be suggested for an interim study, Senator Yost seconded the motion. The motion carried.

The meeting was adjourned at 11:10 a.m.

Date 28 Jan '11

VISITOR SHEET
Senate Judiciary Committee

(Please sign)

Name/Company	Name/Company
Mary Mendoza, Assoc Press	
Michelle Sexton (John Peterson & Associates)	
Jerry Wells | Douglas County D.A.	
Julene Masku AG Office	
Chip Wheelen, KS Psychiatric	
PAUL M. KLOTZ, ASSOC OF CMHCs, KS, INC	
Steven R. Zinn Appellate Defender Office	
Pat Lawler Appellate Defender	
Reid T Nelson Appellate Dfy	
Ron Miles, SBIDS	
Darlene Strauss KCAR	
Kelly Kultala NOW	
Jim Clark KCDAA	
Ron Smith KBA	
Tom Locke Bert Nash MHC	
Terry Larson, Ks Alliance for the Mentally Ill	
Kevin Sick KDHR-KCDC	

STATE OF KANSAS

APPELLATE DEFENDER

Chief Appellate Defender
Jessica R. Kunen
Deputy Appellate Defender
Steven R. Zinn

Tel. 913-296-5484
1031 Kansas Ave.
Topeka, Kansas 66612-1326

Kansas Appellate Practice
Clinic
University of Kansas
School of Law
Green Hall
Lawrence, Kansas 66045-2380
(913) 864-4384

Testimony Regarding Constitutional Problems with Senate Bill No. 18

Steven R. Zinn
Deputy Appellate Defender

I. Double Jeopardy

A. While the proceedings provided for by the bill may be labelled as civil involuntary commitment proceedings, United States Supreme Court decisions have looked to the substance rather than the label attached to statutory procedures to determine whether they are criminal or civil in nature.

B. The procedures to find an individual to be a "violent sexual predator" are criminal because they are predicated upon the existence of a criminal charge, prosecuted by the county attorney or attorney general, and apply the procedural safeguards and standards applicable in criminal prosecutions. Further, because the procedures are not to be invoked until the offender is about to be or already has been released from confinement, the purpose of the provision is deterrence rather than treatment, which could be provided for by the Department of Corrections during the offender's term of incarceration. It should also

Senate Judiciary Committee
Attachment 1
1-28-91

be noted that a criminal provision which involuntarily confines an offender based upon a determination that he is a "violent sexual predator" is unconstitutional in that it establishes status offense.

C. Because the procedures are criminal in nature and may be used to prolong the confinement of a sex offender beyond the term provided for in the sentencing statutes, Senate Bill No. 18 violates the constitutional prohibitions against double jeopardy.

D. The determination that an individual is a sexual predator in need of treatment should be made within the context of the criminal proceedings and should be addressed as a part of the initial sentencing process, as is provided for by, for example, Minn. Stat. §609.1351-1352.

II. Ex post facto law

A. Because the procedures set forth in Senate Bill No. 18 are criminal in nature, sections 2(a) and (b) constitute an ex post facto law as applied to individuals whose offenses were committed prior to the effective date of the statute.

B. This problem is particularly acute as to an individual whose sentence "has expired at any time in the past"

under section 2(a). This limitless provision clearly distinguishes the procedures from those involved in civil involuntary commitment proceedings under Chapter 59, which generally require a showing of present dangerousness based upon a recent act. See In re Gatson, 3 Kan. App. 2d 265, 267, 593 P.2d 423 (1979).

III. Due Process of Law

A. Because the procedures set forth in section 5 involve an adjudication of the factual question of guilt or innocence for the offense charged, the suspension of a criminal defendant's "right not to be tried while incompetent" violates due process of law in that it denies the individual the right to assist in his own defense.

IV. Equal Protection of Law

A. The disparity between the rights afforded to individuals who have been found to be "violent sexual predators" in Senate Bill No. 18 and other individuals who have been involuntarily committed under Chapter 59 is an equal protection violation. See Humphrey v. Cady, 405 U.S. 504, 31 L.Ed.2d 394, 92 S.Ct. 1048 (1972).

B. Specific examples of the disparity of rights include:

1) Sections 6 and 8 provide for annual review of the person's status, while K.S.A. 59-2919a provides for 90 or 180 day review of individuals committed for other types of mental illness.

2) Section 9 creates a presumption of frivolousness for a petition submitted by a "violent sexual predator" who has not been approved for release by the Secretary of SRS. No similar presumption exists under Chapter 59 proceedings.

3) Section 8 provides that after the Secretary of SRS has determined that a person is no longer likely to commit predatory acts of sexual violence, the prosecutor is entitled to a hearing in order to challenge such a finding before the person may be released. No similar right to challenge the release of a person involuntarily committed under Chapter 59 is provided in K.S.A. 59-2924.

RESOURCE INFORMATION

KANSAS LEGISLATURE

SENATE JUDICIARY COMMITTEE

SENATE BILLS 18, 19, 20

SEX OFFENDERS

January 28, 1991

Presented, Compliments of
WELDY & ASSOCIATES, INC.
P. O. Box 2488
Hutchinson, Kansas 67504-2488

Senate Judiciary Committee
Attachment 2
1-28-91

ABOUT SEX OFFENDERS -

DID YOU KNOW:

- THAT ONE OUT OF FOUR GIRLS WILL BE SEXUALLY VICTIMIZED BY AGE 18 ?

- THAT ONE OUT OF EIGHT BOYS WILL BE SEXUALLY VICTIMIZED BY AGE 18 ?

- THAT ONLY ONE OUT OF FIFTEEN SEX OFFENSES IS REPORTED ?

- THAT ONLY ABOUT TEN PERCENT OF REPORTED SEX OFFENSES ARE PROSECUTED ?

- THAT ONLY ABOUT TEN PERCENT OF THOSE PROSECUTED ACTUALLY SERVE PRISON TIME ?

- THAT WITHOUT SPECIALIZED TREATMENT, EIGHTY FIVE PERCENT WILL REOFFEND ?

YET -

- SEX OFFENDERS MAKE UP APPROXIMATELY TWENTY FOUR PERCENT OF U.S. PRISON POPULATIONS ?

- APPROXIMATELY SIXTY PERCENT OF SEX OFFENDERS IN PRISON VOLUNTEER TO PARTICIPATE IN SEX OFFENDER TREATMENT ?

- APPROXIMATELY EIGHTY PERCENT OF SEX OFFENDERS CAN BE SUCCESSFULLY TREATED ?

Weldy & Associates, Inc.

INCREASE IN NUMBER OF SEX OFFENSE CONVICTIONS
STATE OF KANSAS

FIVE YEAR PERIOD: 1983 TO 1988

OFFENSE	NUMBER 1983	NUMBER 1988	PERCENT OF INCREASE
RAPE	127	253	199 %
SODOMY	6	141	235 %
INDECENT LIBERTIES	72	368	511 %
OTHER SEX OFFENSES		106	
	205	868	

THE TREND IS THAT THE NUMBER OF CONVICTIONS IN KANSAS HAS INCREASED
AN AVERAGE OF 30 PERCENT PER YEAR FOR INDECENT LIBERTIES,
AN AVERAGE OF 20 PERCENT PER YEAR FOR SODOMY,
AN AVERAGE OF 15 PERCENT PER YEAR FOR RAPE.

Weldy & Associates, Inc.

2-3/3

SECTION I

SEX OFFENDERS AND THEIR TREATMENT

From the Book:

RETRAINING ADULT SEX OFFENDERS: METHODS & MODELS

By: Fay Honey Knopp

For

The Safer Society Program

of the

New York State Council of Churches

Revised, January, 1988

CHAPTER 1
SEX OFFENDERS: WHO ARE THEY? CAN THEY CHANGE?

In a society intimidated by sexual taboos and conditioned to respond punitively to deviancy, the word "sex" and the word "offender" are both potent linguistic symbols. Separately, these words generally evoke beliefs that are oversimplified and distorted; together they are likely to conjure up images of "sex fiends" (as they were described almost 100 years ago by Richard von Krafft-Ebing)[1] or of the largely mythical "dirty old man in the alley" (Sgroi, 1978, p. xv).

Contradictory and sometimes misconceived notions about sex offenders commonly are held among professionals as well as laypeople. Some prevailing attitudes about child sexual abusers are reported by A. Nicholas Groth (1978, pp. 3-4), sex-offender treatment specialist and co-director of the Sex Offender Program at the Connecticut Correctional Institution at Somers[2]:

> The child offender [is imagined] to be a stranger, an old man, insane or retarded, alcohol or drug addicted, sexually frustrated and impotent or sexually jaded, and looking for new "kicks." He is "gay" and recruiting little boys into homosexuality or he is "straight" and responding to the advances of a sexually provocative little girl.... He is sometimes regarded as a brutal sex fiend or a shy, passive, sexually inexperienced person. He is oversexed or he is undersexed,...the product of a sexually permissive and immoral society with lax attitudes and laws regarding sexuality that stimulate and encourage him through the availability of pornography, prostitution, drugs, alcohol, and sex outside of marriage. Some see such behavior as reflective of lower-class mentality and morality, poverty, and the lack of education. Others attribute it to a criminal personality. And still others, when the offender is an adolescent, take the position that this behavior is typical for a sexually maturing male--nothing more than experimentation.

Groth notes that there are case examples that would tend to support each of these notions, but they are the exception rather than the rule. These popular

1. See Brecher (1978, pp. 2-3) for a description of Krafft-Ebing's melding of offenders who committed the most gruesome and sadistic sex offenses, with nonviolent paraphiliacs and homosexuals, directly influencing thinking and public policies to this day. Also see Krafft-Ebing (1965).
2. For a description of this program, see Chapter 14 of this book.

3-2/24

beliefs offer the advantage of making the child offender (or rapist) as different and unlike the ordinary person as possible. These views are appealing because they take a very complex behavior with multiple causes and reduce it to a stereotype with a few very simple causes. "The myths, the stereotypes, the generalizations are easier to understand and accept, and therefore, more satisfying than the reality," says Groth (1978, p. 4).

HETEROGENEITY: THE REALITY

The reality is that the population that commits sexual offenses is extremely heterogeneous. "There is no succinct profile that describes the sex offender," says Irwin Dreiblatt (1982), long-time evaluation and sex-offender treatment specialist associated with the community-based Pacific Psychological Services in Seattle. His empirical findings that "offenders cut across traditional diagnostic categories and vary across demographic variables" is in agreement with conclusions drawn from an overview of descriptive studies (Knight, Schneider, & Rosenberg, in press)[3]:

> The class of "sexual offender," however it has been defined, masks a manifest heterogeneity of offenders and crimes. Offenders with widely varying degrees and kinds of criminal activity, who differ in age, background, personality, psychiatric diagnosis, race, and religion, have all been lumped together simply by the presence of aberrant sexual activity in their criminal histories. Their sexual offenses have also varied markedly with respect to numerous features, such as location and time, the sex and age of the victim, the degree of planning, and the amount of violence. Despite this manifest diversity, sexual offenders have frequently been viewed as a homogeneous class of individuals.

Realistically, then the sex offender may be a close relative, friend, or acquaintance rather than a stranger; an older person or a youth as young as eight years of age; wealthy or poor; a Caucasian or person of color; gay or straight; literate or illiterate; able or disabled; religious or nonreligious; a professional, white- or blue-collar, or unemployed worker; and a person with an extensive criminal record or one with no recorded offense history. Although

3. This valuable study summarizes and synthesizes the relevant empirical findings from the literature, culls the crucial discriminating variables that should form the data base for classification systems, reviews clinical typologies and variables that form the cornerstone of these systems and examines their commonalities, and sketches the strategies necessary to advance the field.

usually male, the offender sometimes is reported to be female.[4]

In addition to such demographic variables, other factors contribute further to the diversity of the detected sex-offender population. These include (1) the prevailing social and cultural attitudes that influence or determine society's tolerance level for certain types of sexual behaviors and whether they are considered offensive[5]; (2) sex-offender statutes that are variously defined and applied in different states; and (3) the criminal justice process that differentially apprehends, selects, convicts, and punishes sex offenders.

This diversity has been masked historically by the broad, overarching labels applied to the various offense categories.[6] That offenders are generally identified in treatment programs primarily by the offense behavior for which they were convicted ("rapist," "child molester," "incest offender," "exhibitionist," and so forth) is a reflection of the lack of satisfactory subcategories that would be more representative. For instance, in some cases, the "child molester" may be a person who has raped a three-year-old child vaginally or a 21 year old who has had sexual relations with a 15 year old.

Admittedly, there are complexities inherent in formulating comprehensive classification schemes; nevertheless, where subgroupings of offense behaviors have been offered, they have been utilized well. For instance, Groth's subclassifications of "power," "anger," and "sadistic" rapists (1979, pp. 12-57) and "fixated" and "regressed" pedophiles (1978, pp. 6-11), typologies based on his clinical observations, are used by many treatment specialists. Other behavioral, sociological, legal, psychiatric, and psychometric typological schemes and data, discussed and reviewed in Knight et al. (in press), portray vividly the enormity of the classification task. An encouraging development is that Robert A. Prentky, Director of Research at the Massachusetts Treatment Center[7] at Bridgewater, and his colleagues currently are involved in developing and validating a sex-offender classification system that is derived from intensive clinical observation of 460 offenders, as well as an empirical data base comprised of

4. There is speculation among some treatment providers that sexual abuse by women is much greater than originally estimated. Like all sexual abuse, it is probably grossly underreported; however, sexual abuse by women probably occurs in about 5 percent of the cases of girl victims and possibly as high as 20 percent in the case of boys. See Finkelhor & Russell (1983).
5. For instance, studies conducted four decades ago included "sexually promiscuous girls" (Markey, 1944) and homosexual men (Apfelberg, Sugar, & Pfeffer, 1944) as sex offenders.
6. Sex offenses are determined legally. The legal terminology is even more vague and uninstructive, including, for instance, "sexual misconduct," "aggravated sexual assault," and so forth.
7. The Community Access Program of the Center is described in Chapter 12 of this book.

3-4/24

1400 variables per offender.[8]

In addition to dispelling myths and misconceptions about "the" sex offender, construction of an adequate typology of offenders could have other desirable benefits. First, it could help to determine appropriate treatment modalities for the offender. Second, critical antecedent and interactive events that differentiate subtypes with respect to outcome could be identified. Third, it could facilitate judicial decision making with respect to recidivism, dangerousness, release dispositions, and so forth.

ARE SEX OFFENDERS "MENTALLY ILL"?

Though the sources of sex-offender behaviors are varied, multiple, and complex, contrary to popular notions, such offenders are only rarely "mentally ill." Whether they are referred to as "patients" or "criminals" may be determined largely by sex-offense statutes or the setting in which convicted sex offenders are treated. Groth frequently is asked whether the sex offenders he works with are all sociopaths:

> I don't like the term, but if people like to use the jargon I'll reply, "No, I think they are sociophobes, rather than sociopaths. But if you are asking me do they have repeated difficulties with the law, the answer is yes. The people I treat do. It is not surprising since the people I work with are in prison. When I worked in a mental hospital, I found most of the sex offenders were psychiatrically disturbed. Now that I work in a prison, I find that most of them have a criminal history."
>
> I do not use diagnostic classifications for sex offenders, nor do I think about them in that fashion. What clinicians are being asked to do is to apply classifications to involuntary or nontraditional clients that have been derived from working with voluntary clients or clients who get hospitalized in more traditional settings. They are being asked to fit the foot to the shoe rather than to construct a shoe that will fit the foot.
>
> Treatment providers may be seeing some offenders in their particular settings and think they constitute the whole universe of perpetrators. We are dealing with a behavior problem rather than a psychiatric condition. Sexual assault is a *behavior* that cuts across all traditional psychiatric classifications and nosologies. You can't equate the offense with any single personality type or psychiatric condition. [Groth, 1983]

Some clinicians (for instance, Abel, Rouleau, & Cunningham-Rathner, in press; Berlin, 1982) categorize sex offenders into three groups: (1) those with major psychiatric diseases, the group having the fewest number of persons charged with such offenses; (2) those with personality disorders ("antisocials"); and (3) the

8. Also see Prentky, Cohen, & Seghorn (in press).

paraphiliacs, the group that contains the majority of sex offenders found in treatment programs. Let us examine each of these.

Medical/Psychiatric Disorders or Diseases

According to most estimates, these disorders account for less than 5 percent (Abel et al., in press) or not more than 8 percent (Laws, 1981) of the underlying disorders of sexually aggressive men charged with such crimes. Sometimes sex crimes are committed by persons who have psychotic illnesses (generally schizophrenia, manic-depressive disease, or organic brain syndromes). Such illnesses may in some cases be a contributory factor to the sexual offense, may compound an existing sexual abuse problem, or create a higher risk for the individual who behaves this way.

Gene G. Abel and his colleagues, behavior specialists, report that individuals who commit sexual offenses *as a result* of psychotic illnesses are easily discernible from others who commit sex offenses and that their behavior is usually not long standing or repetitive. Treatment generally involves treating the primary psychiatric disease with drugs that assist the offenders in controlling their aggressive sexual behaviors.

According to Fred S. Berlin, Co-director of the Biosexual Psychohormonal Clinic at Johns Hopkins Hospital in Baltimore, Maryland, such an offender may have lost the capacity to distinguish fantasy from reality. He may hear voices when nobody is there; he may develop delusions of grandeur and believe he has special powers. "One of the changes that sometimes occurs in this form of mental illness," he reports, "is an increase in sexual appetite and preoccupation. We saw a man, for example, who would expose himself to middle-aged women only when he was ill in this way. When we gave him lithium carbonate, which is a treatment for this kind of illness, he was able to perceive reality accurately and would no longer behave this way" (Berlin, 1982).

Men with Antisocial Personalities

Those in this category who commit sexually aggressive acts are described as usually having long histories of poor impulse control and antisocial behavior that date back to their early teen years. They have difficulty in their social relationships, have been disruptive and truant in school, form few lasting friendships, feel minimal guilt, and, as a result, often commit acts that are against the law or violate community standards. "The hallmark of this category

of sex offender is the pervasiveness of their antisocial behavior," say Abel and his colleagues. "Moreover, their opportunistic nature leads to their committing sexually aggressive crimes during the course of other antisocial acts (e.g., burglary or robbery)" (Abel et al., in press).

Berlin further describes the antisocial sex offender as "a person who doesn't really care very much about the well-being of other people. He is not mentally ill in the ways I have mentioned--he does not necessarily have a drinking problem, he doesn't have a sexual deviation problem. He is just not a very concerned person" (Berlin, 1982).

Abel and his colleagues report that approximately 29 percent of men charged with rape have antisocial personalities (Abel et al., in press). While sexual aggression may not be the *primary* motivation among antisocial sex offenders who rape their victims while burglarizing or robbing a residence or workplace, many are found in prison sex-offender treatment and apparently benefit from the modules and programs offered there.

Marv Rosow, group therapist for sex offenders at the Minnesota Correctional Facility in Stillwater, sees these types of sex offenses as the end product of a number of factors in a person's life; the sexual offense is merely *one* way of acting it out. He recounts (Rosow, 1981) the story of a rapist who had attended the prison's sex-offender group for a period of time and was released to the streets with a very short, supervised parole period. He soon was returned to the prison, not for rape but for a robbery spree in banks in several states. Someone at the prison said to him, "Well, at least you are not back for rape." He said, "What's the difference? So I went around with a gun and violated people by taking things away from them. Before that I also violated people by taking things away from them they didn't want to give me. What's the difference?"

Thus Groth (1983) finds curious the attitudes held by some persons in the treatment field who say, "The burglar or robber who rapes is not really a rapist, but a burglar. He is really a burglar because he went into 10 homes and only raped once." Asks Groth, "Suppose he only *killed* once? Would you say he is not a killer? How many times do you have to do it to be a rapist?"

Paraphiliacs

Unlike those described as mentally ill or antisocial sex offenders, paraphiliacs usually commit a sexual offense because they have what is referred to in psychi-

3-7/24

iatric terms as a "paraphilia."[9] Paraphiliacs differ from the prior two groups because of their characteristic *compulsive thoughts and urges to carry out sexually aggressive behaviors*. Only infrequently are they involved in antisocial behaviors outside the sexual sphere; therefore, when paraphiliacs who are well known and have good standing in the community are accused of sexually aggressive behaviors, there is great shock and often disbelief:

> People often confuse issues of traits of character with issues of sexual orientation or the type of sexual interest an individual has. Persons who may be compulsive pedophiles, for instance, may obey the law in other ways, may be responsible in their work, may have concern for other persons. So you can describe character traits independent of sexual orientation. Many people assume if you have a particular sexual orientation, such as the desire for children sexually, that you are "bad" in terms of your traits of character--that you do not care about others, that you are irresponsible in your vocation, that you have perhaps a long history of truancy and delinquency, and so forth. That is not at all necessarily true. You may be a very responsible person but happen to be afflicted, if I can use that word, with a kind of sexual orientation that is going to cause you and others great difficulty. [Berlin, 1982]

Abel (1982) concurs:

> These paraphiliacs are not strange people. They are people who have one slice of their behavior that is very disruptive to them and to others; behavior they cannot control. But the other aspects of their lives can be pretty stable. We have executives, computer operators, insurance salesmen, college students, and people in a variety of occupations in our program. They are just like everyone else, except they cannot control one aspect of their behavior.

From an early age (generally 11 to 12 years) many sex offenders develop specific interest in various deviant sexual behaviors. Though behavioral, psychodynamic, cognitive, biomedical, and other theories abound, it cannot be stated with scientific certainty *why* such patterns develop among some persons and not among others with seemingly similar experiences and characteristics. There is general agreement, however, that such aggressive behaviors are learned primarily through observation and by direct experience. These include cultural influences, the socialization process, the family, imbalances of power and status, and early childhood experiences--particularly those involving early sexual trauma and

9. The essential feature of paraphilias is that "unusual or bizarre imagery or acts are necessary for sexual excitement." They tend to be insistently and involuntarily repetitive. The paraphilias include pedophilia, exhibitionism, voyeurism, sexual masochism, sexual sadism, fetishism, transvestism, zoophilia, and others such as frotteurism and telephone scatalogia (American Psychiatric Association, 1980, pp. 266-267 and 275).

physical and emotional abuse.

Richard Laws, a behaviorist and social-learning theorist (see Bandura, 1973, 1977) and founder of the Sexual Behavior Laboratory at Atascadero State Hospital in California,[10] notes how some early life events become learned behaviors and begin to shape the sexually aggressive patterns of paraphiliacs:

> At one time we used to put a person's social and sexual history on a graduated timeline from year zero to his present age, broken into six-month intervals. We asked him questions about his history. You would find a fairly normal social and sexual history and then a deviant sexual event would occur. There would be a combination of social and sexual deviant activity paralleling for a while. Then all of a sudden there would be this drift away from the nondeviant activity and an increasing variety and intensity in deviant sexual activities. So people who started out engaging in some deviant activity developed into rapists, developed into pedophiles, developed into voyeurs. It is just a highly idiosyncratic thing. No one becomes a full-blown rapist from the first instant they engage in deviant sexual behavior. I am a strong believer in social learning, and these folks *learn* how to become pedophiles, they *learn* how to become rapists. It's like acquiring a taste for Scotch. You can't really find sexual activities with a 12-year-old girl attractive just by thinking about it. You don't have preparation, you haven't been socialized to believe that that behavior is either an acceptable or a desirable thing. You have to really engage in the behavior and learn how to do it.
>
> So as you learn how to do these things, the experiences begin to shape the kind of offender you are going to become. Behaviors that don't produce pleasure are going to get dropped out of a person's repertoire. Behaviors that do--that are successful in achieving the goals in the deviant activity that people want--are going to be retained; they're certainly going to be elaborated, and they are certainly going to be refined. There are also parallel activities going on--the person is masturbating, he is thinking about deviant things. Every time he masturbates, every time he pairs his orgasms with deviant sexual fantasies, that is going to further increase the probability that the next masturbation or the next real sexual act is going to be deviant rather than nondeviant. So the desirability and attractiveness of nondeviant activity begins to sink lower and lower in the hierarchy of probabilities.
>
> These persons spend hours and hours planning sex offenses. They work on these incredible scenarios in their minds and have a whole variety of game plans that they can use. Should an opportunity present itself, they can bring it into play and the whole social-learning process starts again. Ineffective behavior has been dropped out and the effective behavior retained, refined, and elaborated. Escalation is just part of the game. [Laws, 1981]

Groth also observes that some rapists, for instance, repeatedly rehearse their offenses during fantasies; thus he expresses doubt about the validity of

10. For a description of some of the evaluation and treatment procedures used in this laboratory, see Chapter 2 of this book.

3-9/24

the rapist's description of his violent behavior as an "impulsive sexual act":

> He may get into his car in the morning with the intention of going to work, but as he drives along the highway he suddenly spots a hitchhiker, offers the hitchhiker a ride, and the hitchhiker gets into the car. Now his agenda changes and he is not going to work, he is going to abduct and sexually assault the hitchhiker. Why does he take advantage of that opportunity? Because he has rehearsed it in his mind before. Those have been his fantasies, those have been his thoughts. It has been part of his active fantasy life....
>
> And people assume that because it is a "sexual" offense, the offender is doing this to satisfy a sexual need. We find that rapists aren't raping out of sexual desire any more than alcoholics are drinking because they are thirsty. We are really seeing a lot of nonsexual needs being carried out sexually in that assault. Although it involves sexuality and aggression, rape is much more the sexual expression of aggression than the aggressive expression of sexuality. [Groth, 1983]

Since most paraphiliacs begin their deviant sexual interests at an early age and fantasize and reinforce the themes during masturbation, the majority of sex-offender treatment providers are proponents of early adolescent sex-offender treatment. Says Abel (1984),

> Many adolescents start to use these fantasies, masturbate, and have orgasm. That is the key for them developing a *persistent* deviant arousal. That is a very critical issue. When you see these kids by the time they have committed a few crimes, they have started to use and associate those deviant fantasies with orgasm. That has to be disrupted early. They commit these crimes because that is where their sexual interests are moving them. This behavior is incorporated into their sexual fantasies and into their sexual lives. By the time we see some adult child molesters, they may be able to have intercourse with an adult female as long as they fantasize about young children. In other words, it has become chronic. When the problem becomes chronic, it takes on a life in and of itself because now a few activities are used hundreds and thousands of times as they relive those highly erotic experiences. When there is a pairing or association between those fantasies and orgasm, that welding together makes the problem chronic and much more difficult to deal with. Trying to unglue that by the time they are 30 or 40 years old is a major undertaking. It can be done, but if you had your druthers, you wouldn't. It would be better to approach them when they are kids.

Most adult paraphiliacs may attempt to control their urges, say Abel and his colleagues (1983); however, the deviant fantasies continue, their control breaks down, and they eventually act on the urges. After committing the sexually aggressive behavior, most offenders will feel temporarily uncomfortable or guilty and thereby gain some control over their urges. As time passes, the guilt dissipates, their sexual urges again increase, and the cycle begins anew.

Groth (1983) probes the differences between the rapists who have a fantasy

and men who have that fantasy and do not rape:

> What we tend to see with the offender is that it is not *a* fantasy, it is *the* fantasy. What the offenders tell us is that this often takes on the quality of an obsession, of a persistent intrusive thought, the fantasy they always dwell on, the fantasy that accompanies their masturbation and accompanies their sexual activity. Unlike other persons who may have had such a thought at certain times but also have a great many other fantasies, the power rapist has a persistent, predominant, and exclusive one. A second consideration is that the person who doesn't rape recognizes that their fantasy *is* a fantasy but isn't necessarily the way life is, as opposed to the person who desperately needs to believe the fantasy in order to meet certain other needs in his life, such as for feelings of adequacy, competency, desirability, and the need to dominate and control. I think a third differentiating criterion is that the nonrapist is in control of his fantasies and the rapist feels controlled by them. The rapist often feels very helpless at the core of this--very inadequate and compelled by forces within himself and external to himself that he does not understand.

To discover ways for sex offenders to learn how to intervene, control, and manage such deviancies and foster appropriate, nonaggressive lifestyles is the goal of sex-offender treatment and the focus of this book.

Multiple Paraphilias

A sex offender generally does not limit his behavior to a single type of paraphilia. Dreiblatt (1981a), for instance, estimates that 80 percent of persons who rape may start their assaultive patterns with "hands-off" sexual behaviors (exhibitionism, voyeurism, obscene phone calls, frottage, and so forth). Sex offenders in treatment programs share willingly their histories of involvement in such "nuisance" types of offenses. For obvious reasons, however, they may be more reluctant to disclose the range and numbers of sexual behaviors of a more aggressive nature: As prisoners, probationers, or parolees under the control of the criminal justice system, they are vulnerable to additional sanctions or extensions of their period of control. Sex offenders, who characteristically deny or minimize their known sexual crimes, are not likely to volunteer such incriminating information about their unknown crimes.

Though offenders in intensive treatment programs gradually may disclose more offense history as the peer-group culture grows stronger and relationships of trust are established, these disclosures rarely are documented. Studies

undertaken by Abel and his colleagues[11] are important, therefore, not only for their systematic documentation of the numbers and types of paraphilias in which the participants were involved and the age of onset of these behaviors, but also because of the unique conditions under which the data were obtained:

1. The 411 subjects were all outpatient sex offenders, seen by Abel and his staff over a period of 10 years.
2. Each person was a voluntary candidate for treatment, under no treatment mandate from any criminal justice or mental health agency.
3. Each person was completely anonymous, identified only by a number and not a name.[12]
4. Participants were instructed not to provide specifics of any particular sex crime they committed so that identification with a particular crime would not be possible.

Given such rare safeguards of confidentiality, Abel and his colleagues regard these data as dependable. Among the many important findings, these are of particular interest to this book:

1. *The numbers of sex offenses committed by paraphiliacs are considerably higher than are reported to officials or reported in official statistics* (Abel et al., 1983). The sample of 411 paraphiliacs attempted 238,711 sex crimes and completed 218,900 of them (these included nuisance and other types of low-level sexual offenses). On the average, *each* offender attempted 581 crimes, completed 533 crimes, and had 336 victims. Over a period of 12 years following the onset of his deviant arousal, each paraphiliac, therefore, committed an average of 44 crimes a year. Of even greater significance are the incidence

11. These studies are contained in a number of documents, including Abel et al., (1983, in press). These data were presented first to the World Congress of Behavior Therapy, December 10, 1983, by staff of the New York State Psychiatric Institute's Sexual Behavior Clinic. The data also were presented on February 7, 1984, in Albany, New York, by Gene G. Abel, at PREAP's press briefing entitled "The Outcome of Assessment Treatment at the Sexual Behavior Clinic and Its Relevance to the Need for Treatment Programs for Adolescent Sex Offenders in New York State." The relevant documents in this study and the Sexual Behavior Clinic's Treatment Manual are available by sending a self-addressed large manila envelope and $15 in stamps to Dr. Judith V. Becker, Sexual Behavior Clinic, New York State Psychiatric Institute, 722 West 168th Street, New York, New York 10032.

12. The client's record is identified only by an ID number. The list of ID numbers is held by an out-of-country colleague. The program has obtained a Certificate of Confidentiality prohibiting any city, county, state, or federal agency from obtaining information on individuals in this research project. The 411 individuals were interviewed in Memphis, Tennessee and in New York City.

findings among paraphiliacs who committed the more serious offenses of rape and child molestation. These figures indicate that, though rape is a very severe problem, in terms of *incidence*, child molesters are responsible for at least 10 times as many victims (75.8 on average, as opposed to 7.5).

Rapes
(N = 89 rapists)

Attempts and completions	744
Number of victims	667
Victims per offender	7.5

Child Molestations
on Victims Less Than 14 Years Old
(N = 232 molesters)

Attempted molestations	55,250	(Mean 238.2)
Completed molestations	38,727	(Mean 166.9)
Number of victims	17,585	(Mean 75.8)

2. *Paraphiliacs do not fall into discrete offense groups; they are frequently involved in multiple paraphiliac behaviors* (Abel et al., 1983). Approximately 50 percent of the men in the study had multiple deviations. The 89 rapists and 232 child molesters in the study were involved in a range of other paraphilias. The percentages of rapists and child molesters involved in each of these behaviors are as follows[13]:

Paraphilia	% Child Molesters Involved	% Rapists Involved
Pedophilia	100.0	50.6
Rape	16.8	100.0
Exhibitionism	29.7	29.2
Voyeurism	13.8	20.2
Frottage	8.6	12.4
Obscene calls	0	4.5

3. *There is an early age of onset of paraphiliac sexual arousal* (Abel et al., 1983),[14] *and the number of sexually aggressive crimes can increase as the offender*

13. We have listed only the paraphilias most common to participants in treatment programs. See Abel et al. (1983) for additional data.

14. Also see Knopp (1982, pp. 5-7, 16-20) and Jackson (1984, p. 26).

grows from adolescence into adulthood (Abel et al., in press). Forty-two percent of the paraphiliacs in this study had deviant arousal by age 15, and 57 percent by age 19. The earliest-onset paraphilia was same-sex pedophilia (attraction to boys)--53 percent by age 15; 74 percent by age 19.[15] Many of the paraphiliacs developed their interests and fantasies when they were 12 or 13 years old.

An examination of the records of 20 paraphiliacs seen prior to age 18 revealed that on the average they had attempted or completed 7.7 sexual crimes per offender against an average of 6.75 victims. A second group of 240 offenders who also had the onset of deviant sexual arousal prior to age 18 but who were not seen until later in their adult lives (mean age 34.4 years) had attempted or completed on the average 581 deviant acts per offender, against an average of 380 victims each, an increase of at least 70 times in the number of crimes committed and more than 55 times in the number of victims as the offenders moved from adolescence to adulthood (Abel et al., in press). "If you do not get them [in treatment] early, this is what will happen," warns Abel (1984).

TREATMENT OR PUNISHMENT?

For the majority of Americans, social control of the sex offender is usually equated with imprisonment. Incarceration is perceived as a means of both punishing the offender and insuring safety for the community. Sex offender treatment specialists, however, contend that "discovering what goes on in an offender's mind may promote safer methods of control than years of unconstructive detention, leading to the eventual release of men in a state more embittered and antisocial than when they were first sentenced" (West, Roy, & Nichols, 1978, p. xi).

Treatment specialist Robert Freeman-Longo,[16] Director of the Sex Offender Unit at Oregon State Hospital,[17] sees prison punishment alone not only as unproductive but as increasing the sex-offenders' pathology so that they come out with worse fantasies than before their incarceration. "They come out with more violence, they are more angry, and oftentimes their crimes escalate so that more

15. Of four types of child molesters studied, the frequency of molestations of young male victims outside the family (mean 278.7) was more than 11 times greater than the frequency against young female victims outside the home (mean 24.9).

16. Robert Freeman-Longo occasionally is referred to in this book as Robert Longo, in cases where references predate his marriage and resulting change in name.

17. For a description of this program, see Chapter 10 of this book.

3-14/24

harm is done to their victims. Prison is not a cure for this problem, and if we are going to use it as a cure, we had better make laws that say, 'You are locked up the rest of your life until you die,' because, outside of a specialized treatment program for sex offenders, that is the only way to prevent these men from reoffending" (Freeman-Longo, 1983).

Richard Seely, Director of the Intensive Treatment Program for Sexual Aggressives, Minnesota Security Hospital,[18] contends that punishment is a reinforcer to sex offenders, "a reinforcer of his own shame, his own blame, and his own grief, and that serves no purpose. The shame, guilt, and blame are usually the stuff from which the offense comes. You have to deal with it all the time with sex offenders. There is probably no more ashamed group, if you can ever get to it--and if you do not get to it you can forget the treatment. That is one of the most difficult things to get to--the shame and blame model, and punishment just tends to reinforce that" (Seely, 1981).

Groth (1984) is convinced that, whatever the degree of risk a pedophile, for instance, poses to the community, ultimately the best protection for society is some form of treatment:

> The crime is a symptom; the offense may be punished, but the condition must be treated. The offender must be held responsible for his behavior, but he also has to be helped to change that behavior if we want our community to be a safer one. Otherwise, we are simply recycling him back into the community at the same risk he was prior to incarceration. Incarcerating him is only a temporary solution.

Berlin emphasizes that there is no evidence that punishment works and theoretically there is no reason to expect that it would:

> There is nothing about going to jail that makes it any easier for you to resist temptation if what you are tempted to do is have sex with little boys. There is nothing about being punished that diminishes your sexual appetite or your sexual hunger for little boys. We hear over and over again about people who have been in jail for a number of years--they are out on work release for about three months and they are back into their old offending behaviors. It is because their unconventional sex drive is still with them and it is very, very hard for many of them not to respond to that when temptation presents itself. [Berlin, 1982]

CAN SEX OFFENDERS CHANGE THEIR PATTERNS?

The majority of sex-offender treatment specialists believe that many sex offenders can be treated successfully--if evaluation is competent, if placement is

18. For a description of this program, see Chapter 11 of this book.

appropriate, if the treatment mode meets the needs of the client, and if the offender wants to change.

Dreiblatt (1981b) stresses selectivity, particularly in community-based programs, but also advises caution as treatment programs in other settings are contemplated:

> I become concerned that we get carried away with the notion of treatment as the only response to sex offenders. We get too far in viewing treatment as a universal response rather than a selected approach to appropriate individuals. One of the big changes in this big wave seems to be, "Well, now we can do something for the sex offender. Let us get everybody into treatment." I'm scared about that approach. I am not discouraged about the possibility of people changing through treatment, I just think it is a selective thing we should do with proper candidates. There are a lot of sex offenders for whom we do not know what to do, particularly the more violent people. I think the mental health community often oversells its product, and I think everyone needs to be cautious not to oversell. I am not discouraged about *what* we do. I am discouraged about the prospect of trying to provide treatment for everybody who comes along with the problem of sexual aggression.

Groth, on the other hand, contends that no sex offender should be excluded from treatment (see Chapter 14, p. 256). If only those clients that appear to be the best candidates for treatment are selected, he says, only a small number of clients will be admitted to the programs and the larger majority will go untreated:

> The majority of sex offenders are not the popular client; they are not the attractive client, they are not the articulate client. They don't get selected into the programs. They are the ones who don't admit the offense, or they blame the victim or minimize their accountability. They are the ones who get ruled out of being helped when, in fact, it is those people who all the more should be focused on as persons in need of treatment. That is why in our program we don't have exclusionary criteria. I do not think we have sufficient knowledge to know how well a person is going to do prior to his actually becoming involved in treatment. [Groth, 1984]

Roger Wolfe, of the community-based Northwest Treatment Associates in Seattle,[19] with more than 13 years of experience in treating sex offenders in maximum-security and outpatient settings, has become more skeptical with time, believing that there *are* certain sex offenders who will not change their patterns, regardless of their treatment:

> When I look back on my expectations 13 years ago, I am thoroughly embarrassed. I believe I was quite naive at that point in time. The focus

19. For a description of this program, see Chapter 4 of this book.

3-16/24

was on "the cure." I still see that as incredibly necessary but not sufficient. Ten years ago I also placed a relatively high trust in individual sex offenders and saw them as motivated to really deal with the problem. Now I believe that there is real difficulty in anybody giving up pleasurable behavior. These men are just grossly character-disordered and are more prone to staying with that behavior. It is so incredibly easy for them to not deal with that, to pass it off, to make it acceptable to themselves. I used to believe them when they said their behavior was accidental. Sexual offenses are not accidents. The outlet may be an accident, but the fact that they are perverts is not an accident. It comes from their whole developmental history, their whole characterological makeup. I do not think you are going to intervene and make minor little changes in their sexual arousal system. You have to take the view that major changes are needed at every level. We have had about a 10-percent failure rate, and years down the road we may be able to reduce that rate, but that is how it appears now. [Wolfe, 1981]

Seely and Freeman-Longo, both working with serious and chronic offenders in residential settings, emphasize that treatment of the adult sex offender is a comparatively new and rapidly changing science. They are optimistic about the future of treatment. Says Seely (1981),

> I am a lot more optimistic than I was, because we have evidence that people can change if they want to. I started out at Security Hospital clearly under the medical model but fighting with that concept constantly. That model made me feel hopeless because we were going after the wrong thing. It wasn't the men's hypersexuality or their genitals, as the problem was being defined then; it was what was going on between their ears. It was the way they were thinking, the way they were relating. Everything we have to work on is in their heads, in the way they think, and that is a dramatic thing. It is not something they *can't* control. It is not hopeless, as the psychiatrists would have had us believe back then. The sociopath can change and so much of his change has to be his desire to do so. That has given me a lot more hope.

Freeman-Longo (1983) also feels that the community has a stake in the evolution of sex-offender treatment:

> I am very optimistic about treatment when I think that 10 years ago we had a picture that was very blurry and now it is just a little out of focus. We are learning more about this very new science. What we knew five years ago seems almost obsolete today in terms of treatment, and what we know today most likely will seem obsolete five years down the road. We cannot kill an effort that is new in this country, and basically treatment is in its infant stage because we are still gaining knowledge on a daily basis. We are getting more successes and hopefully someday we will find a rehabilitation method that will assure that a man is not going to reoffend. This will take time, but, in the meantime, for at least two reasons these programs need the support of the community: (1) because the men need the treatment and (2) because we must gain the knowledge we need to give to the community, on prevention of sexual assault. So the effort is a reciprocal one.

TREATMENT: CONTROL, NOT "CURE"

Predictably, the specialists who are veterans in treating sex offenders eschew the word "cure." None claim that treatment programs will end the problem, and most draw the parallel between sex offenders and persons involved in other long-term addictive patterns of behavior. Dreiblatt (1982) believes that a sex offender can be worked with effectively if his sexually deviant behavior is viewed as a highly habitual sexual preference, a habit not dissimilar to alcohol abuse.

> One must view the offender as vulnerable to his deviant sexual preference indefinitely; he will fall prey to reoffense if he does not respect this vulnerability and ceases to manage his life in the ways necessary to prevent reoffense. Such a vulnerability model emphasizes that there is no cure but rather relative mastery of a serious behavioral problem. It also focuses on the problems inherent in long-term maintenance and the risk of later relapse.

Dreiblatt also notes that more violent sexual behaviors may be age-related and frequently decline quite rapidly after age 30. More passive sexual behaviors do not seem to be time-related at all, however, with people molesting children at age 70 just as they did at age 30. "We see this frequently with incest offenders," comments Dreiblatt (1981b). "Their opportunities cease for a long time after their children become adults, but then when their grandchildren start to grow up they are back in a situation where their vulnerability is challenged and they fail again. They need to learn to manage that vulnerability on a continuing basis."

Wolfe (1981) says the key word is "control," not "cure," when referring to treatment effects:

> We only talk about *controlling* sexual deviancies, about *reducing* them to minimal levels. Our long-range goal is to eliminate them, but we don't expect realistically to meet that goal and I don't know that we ever do reach it. The closest parallel--it is a good, but not a 100-percent analogy--is alcoholism. You don't talk about "ex-alcoholics," because if someone describes himself as an ex-alcoholic you are going to worry about him. And we do not talk about ex-sex offenders. We talk about alcoholics who don't drink anymore--sober alcoholics. And we talk about sex offenders who do not offend anymore. The conditioning patterns are ingrained in adult clients. We try to educate them to be aware of that, that it is really going to be a lifelong process. If someone in our program tells us, "I'll never do it again," we say, "Hey, you are not ready to leave this program."

Wolfe recalls a sex offender who had been in treatment for about four or five weeks who asked if there were some sort of test he could take to prove that

he would never do it again. "Yes," replied Wolfe, "You just flunked it."

> It took about two sessions for him to understand that. We told him, "You have a weakness. If you are a wise and reasonable person, you will recognize your weakness and compensate for it. You will never be an 'ex.'" Any behavior that is compulsive, heavily patterned, and ritualized always remains in the behavioral repertoire. It is always there, it can be relearned, re-energized, reinitiated at any time. You may learn a new behavior that competes with or suppresses the deviant one, you may unlearn it, but you will not erase it.
>
> If you go back to some basic behavioral principles, you can condition a rat to run down a maze and turn right. It may take 300 trials to do that. Those are mathematically predictable behaviors in organisms that you can totally control. But the same thing applies to human behavior. It is really easy for sex offenders to relearn deviant behaviors they thought they left behind and to put themselves right back in that pattern if they allow themselves to do that. It's just like how easy it is for the alcoholic to take that next drink and to get himself right back to that former state, even though 20 years may have passed. [Wolfe, 1981]

Laws (1981) underscores the need for the sex offender to maintain the control skills he has learned in treatment, skills that he usually can maintain for about six to 12 months after completing his treatment program[20]:

> If a person doesn't try to do any further self-management after that time, even though he has learned the skills to do so, you will find a steady deterioration of the treatment effects. You will find a re-emergence of deviant fantasizing. There is *nothing* we can do with *any* client if he does not continue to practice the procedures we have taught him to keep his behaviors under control; the problems will recur. I had a former client call me not long ago. He was in jail and said, "Well, it looks like your treatment wore off." I said, "Hold it, pal. What wore off was your resolve to do something about your behavior. The treatment worked just fine. It is not my behavior that got you in trouble, it is *your* behavior!"
>
> What sex offenders and, sadly, a number of persons who treat sex offenders fail to understand is that self-control is a full-time job, every waking hour, every day, for the rest of their lives. If I told you that about heroin addicts, alcoholics, or formerly obese persons, you wouldn't give it a second thought. You would say, "Well, of course, if a man isn't going to be an alcoholic, he cannot drink." Well if a sex offender is not going to be a sex offender, he has to stop putting his penis in the places where it doesn't belong.

Seely, who has worked on issues of chemical dependencies as well as sex offenses, draws a parallel between heroin addicts and some rapists he has

---

20. For a description of a relapse prevention (RP) program designed to provide the sex offender with skills to reduce the probability of relapse, see Pithers, Marques, Gibat, & Marlett (1983, pp. 214-239).

3-19/24

observed:

> The heroin addict gets a real high out of thinking about his next hit. Many rapists get a real high out of thinking about rapes. Then they get another rush out of the predatoriness of sneaking around in back alleys and driving around to try to get to see "it." They see the victim (drug addicts see the heroin) and they get another rush. They hold "it" in their hands and both the heroin addict and the rapist get another rush. Then they inject it--the total power they feel gives them another rush--the highest rush, in one sense. They get a rush out of getting by with it and a rush out of getting caught. In the back of the police car, the rapist's and the heroin addict's words are almost identical: "Thank you for catching me, I needed to be caught." They get a rush out of that too. [Seely, 1981]

Maureen Saylor, Director of Western State Hospital's Sex Offender Program at Fort Steilacoom, Washington,[21] recalls that at an earlier time in that program there was the belief that once a sex offender had gone through the program he could resume a "normal" life. Even though the phrase "once a sex offender, always a sex offender" was used commonly, there was confusion about what that meant on a lifelong haul. Now the program spells this out specifically in contract form. The following, in Saylor's words, is what the program expects of a child molester:

> He must avoid situations where kids congregate. He must not go to a kiddie matinee. He must not go near kids' playgrounds and parks. He must have minimal contact with kids and not get himself involved with women who have children. In some respects it raises the question about whether a child molester who marries should have any kids, period, because he can be creating his own outlet victims. While that may sound harsh and cruel, with this particular addiction the individual can fall right back into the same old patterns, given the right set of circumstances.
>
> They also must not put themselves in positions that desensitize them. Our whole issue is teaching people appropriate controls and restructuring their lives to maintain those controls. If they begin to whittle away at those kinds of things, they ultimately are going to desensitize themselves and reoffend. Like cigarette smoking, if you quit smoking and then decide you can chip away at it a little bit and maybe have one cigarette per week, then the next week it is three, and maybe a month later you are back where you were before. You cannot have the first cigarette, because it starts desensitizing you and marching you down the way to becoming a full-fledged smoker again. There are a lot of parallels with the child molester who is on work release or outpatient status and tells us, "Well, I just happened to drive by a school today." We know that is not coincidental.
>
> The real issue is they can control their own lives if they choose. We hope that being responsible people and controlling their behaviors will give them greater rewards and good feelings than what they did before.

21. For a description of this program, see Chapter 9 of this book.

That is why teaching them all the skills necessary to get positive rewards in what they are doing is so important. [Saylor, 1981]

The parallels between sex offenses and other addictive, compulsive behaviors (such as alcohol and drug abuse, overeating, gambling, buying, and shoplifting) were so evident to Patrick Carnes (1983, in press) that he formulated them into a systematic treatment approach for "sexual addicts" in a program for incest offenders and their families, the Family Sexual Abuse Treatment Program at the Fairview Southdale Hospital in Minneapolis.[22] Carnes describes the addiction cycle as four-phased: preoccupation, ritualization, sexual compulsiveness, and despair. Within the addictive system, sexual experience becomes the reason for being, the primary relationship for the addict (Carnes, 1983).

THE RESPONSIBILITY TO TREAT

Sex-offender treatment specialists do not claim that treatment programs will end the problem for the sex offender. They merely recommend that sex offenders be provided with the appropriate and necessary interventionary skills and tools for controlling their behaviors if they want to do so.

Such treatment advocacy is not limited to treatment providers. Similar perspectives are voiced by informed and convinced criminal justice personnel, such as Orville Pung, Minnesota's Commissioner of Corrections, who has established programs at three Minnesota state prisons and has access to a private, neighborhood-based, residential treatment center for sex offenders, as well as a range of outpatient programs.[23] Pung says the programs do not have a bottled and labeled "Cure for Sex Offenders"; to think in those terms would set the programs up for failure. He believes that, as long as the people who go through the programs will be less of a threat to the public than when they came into the system, the treatment efforts are worthwhile. "Don't we have a responsibility to try," he asks, "if there is at least some evidence to indicate that it might moderate behavior?" (Voss, 1983).

Ira Mintz, until recently Superintendent of the Adult Diagnostic and Treat-

22. Because this is an incest treatment program for the entire family, it is not described in this book but will be included in a future Safer Society publication.

23. The program at Lino Lakes Prison is described in Chapter 13 of this book. Alpha Human Services, the private residential treatment center, is described in Chapter 7.

ment Center in Avenel, New Jersey,[24] warns that if men are incarcerated with no treatment they are going to pose a continued and maybe more serious danger to the community, if they have a destructive experience while they are incarcerated:

> If they become more isolated, more tormented, more hostile, and more confused, then what does incarceration accomplish, other than fulfilling the punitive attitudes of society and the courts? I have no problem with society getting angry and wanting to punish. I am not idealistic or foolish or a bleeding heart, but I also eventually have to move down the road and say that this man is going to be released eventually. Now who do we release to the community, a man who is better prepared--has had an increment of growth--or one who has deteriorated? I think eventually a rational person, not even as a psychologist or an administrator, is forced to conclude, "I hope he comes out better," because he is going to be walking down the streets of your community and mine. [Mintz, 1982]

Some correctional officers are also advocates for treatment. Jack Jackson, on staff at the Adult Diagnostic and Treatment Center, who has been trained to fulfill the broader and, for him, more satisfying role of "helper" rather than "keeper," says,

> There is no guarantee that the sex offender can be cured. An alcoholic has to hope and pray every day that he won't take a drink--the same thing with a sex offender. It must be on his mind 24 hours a day. I have seen hundreds of men come and hundreds of men go, and it seems as though the program definitely has been a very favorable asset to the majority of them. Say they were just in a prison or a mental institution where there wasn't any therapy and no good friends or group members to relate to and then they had to go back out into society again. A man may have been in prison on an open lewdness charge and eventually go out and rape and murder because there wasn't any help in the prison. Every state should have a center like this. It would be a great help, a tremendous help. [Johnson, 1982]

24. For a description of this program, see Chapter 8 of this book.

REFERENCES

Abel, G. G. Taped site-interview by F. H. Knopp, J. Rosenberg, and B. Siebens, January 21, 1982.

Abel, G. G. "The Outcome of Assessment Treatment at the Sexual Behavior Clinic and Its Relevance to the Need for Treatment Programs for Adolescent Sex Offenders in New York State." Paper presented at a PREAP press briefing, Albany, New York, February 7, 1984.

Abel, G. G., Mittelman, M. S., & Becker, J. V. "Sexual Offenders: Results of Assessment and Recommendations for Treatment." Paper presented to the World Congress of Behavior Therapy, December 10, 1983. See footnote 11 of this chapter for availability.

Abel, G. G., Rouleau, J., & Cunningham-Rathner, J. "Sexually Aggressive Behavior." In W. Curran, A. L. McGarry, and S. A. Shah (eds.), Modern Legal Psychiatry and Psychology. Philadelphia: F. A. Davis, in press.

American Psychiatric Association, Task Force on Nomenclature and Statistics. Diagnostic and Statistical Manual of Mental Disorders, 3rd ed. Washington, D.C.: American Psychiatric Association, 1980.

Apfelberg, B., Sugar, C., & Pfeffer, A. Z. "A Psychiatric Study of 250 Sex Offenders." American Journal of Psychiatry, 100, May 1944, 762-770.

Bandura, A. Aggression: A Social Learning Analysis. Englewood Cliffs, N.J.: Prentice-Hall, 1973.

Bandura, A. A Social Learning Theory. Englewood Cliffs, N.J.: Prentice-Hall, 1977.

Berlin, F. S. Taped site-interview by F. H. Knopp, J. Rosenberg, and B. Siebens, January 19, 1982.

Brecher, E. Treatment Programs for Sex Offenders. Washington, D.C.: U.S. Department of Justice, 1978.

Carnes, P. The Sexual Addiction. Minneapolis: CompCare, 1983.

Carnes, P. Counseling the Sexual Addict. Minneapolis: CompCare, in press.

Dreiblatt, I. Training lecture delivered to Child Sexual Abuse Treatment Group, Harborview Medical Center, Seattle, Washington, April 29, 1981.(a)

Dreiblatt, I. Taped site-interview by F. H. Knopp, October 1, 1981.(b)

Dreiblatt, I. "Issues in the Evaluation of the Sex Offender." Paper presented to the Washington State Psychological Association Meetings, May 1982.

Finkelhor, D., & Russell, D. "How Much Child Sexual Abuse is Committed by Women?" Paper available from the Family Violence Research Program, University of New Hampshire, Durham, New Hampshire 03824. November 1983.

Freeman-Longo, R. Taped site-interview by F. H. Knopp, October 17, 1983.

Groth, A. N. "Guidelines for the Assessment and Management of the Offender." In A. W. Burgess, A. N. Groth, L. L. Holmstrom, and S. M. Sgroi, Sexual Assault of Children and Adolescents. Lexington, Mass.: Lexington Books, 1978.

Groth, A. N. with Birnbaum, H. J. Men Who Rape: The Psychology of the Offender. New York: Plenum Press, 1979.

Groth, A. N. "Juvenile and Adult Sex Offenders: Creating a Community Response." A training lecture sponsored by the Tompkins County Sexual Abuse Task Force, Ithaca, New York, June 16-17, 1983.

Groth, A. N. Personal communication to F. H. Knopp, August 31, 1984.

Jackson, I. A Preliminary Survey of Adolescent Sex Offenses in New York: Remedies & Recommendations. Orwell, VT: Safer Society Press, 1984.

Johnson, J. Taped site-interview by F. H. Knopp, October 22, 1982.

Knight, R. A., Schneider, B. A., & Rosenberg, R. "Classification of Sexual Offenders: Perspectives, Methods, and Validation." In A. Burgess (ed.), Rape and Sexual Assault: A Research Handbook. New York: Garland Press, in press.

Knopp, F. H. Remedial Intervention in Adolescent Sex Offenses: Nine Program Descriptions. Orwell, VT: Safer Society Press, 1982.

Krafft-Ebing, R. von. Psychopathia Sexualis. F. S. Klaf (trans.). New York: Stein & Day, 1965.

Laws, R. Taped site-interview by F. H. Knopp, September 23, 1981.

Markey, O. B. "A Study of Aggressive Sex Misbehavior in Adolescents Brought to Juvenile Court." American Journal of Orthopsychiatry, 100, May 1944, 719-731.

Mintz, I. Taped site-interview by F. H. Knopp, October 22, 1982.

Pithers, W. D., Marques, J. K., Gibat, C. C., & Marlett, G. A. "Relapse Prevention with Sexual Aggressives: A Self-control Model of Treatment and Maintenance of Change." In J. G. Greer & I. R. Stuart (eds.), The Sexual Aggressor: Current Perspectives on Treatment. New York: Van Nostrand Reinhold, 1983.

Prentky, R. A., Cohen, M., & Seghorn, T. "Development of a Rational Taxonomy for the Classification of Sexual Offenders: Rapists." Bulletin of the American Academy of Psychiatry and the Law, in press.

Rosow, M. Taped site-interview by F. H. Knopp, October 7, 1981.

Saylor, M. Taped site-interview by F. H. Knopp, September 28, 1981.

Seely, R. Taped site-interview by F. H. Knopp, October 5, 1981.

Sgroi, S. M. "Introduction: A National Needs Assessment for Protecting Child Victims of Sexual Assault." In A. W. Burgess, A. N. Groth, L. L. Holmstrom, & S. M. Sgroi, Sexual Assault of Children and Adolescents. Lexington, Mass.: Lexington Books, 1978.

Voss, M. "Promising Results Seen in Minnesota Sex Offender Program." The Des Moines Register, September 19, 1983.

West, D. J., Roy, C., & Nichols, F. L. Understanding Sexual Attacks. London: Heinemann Educational Books, 1978.

Wolfe, R. Taped site-interview by F. H. Knopp, September 30, 1981.

3-24/24

SECTION III

RESIDENTIAL SETTINGS

From the Book:

RETRAINING ADULT SEX OFFENDERS: METHODS & MODELS

By: Fay Honey Knopp

For

The Safer Society Program

of the

New York State Council of Churches

Revised, January 1988

Senate Judiciary Committee
Attachment 4
1-28-91

4-1/12

CHAPTER 6
PRISON, MENTAL HEALTH, OR AUTONOMOUS ENVIRONMENTS?

The majority of residential sex-offender treatment programs presently are located within prisons or mental health facilities.[1] A few innovative programs, which we will describe, provide admirable models of autonomous and semiautonomous institutions totally devoted to the treatment of the sex offender.

Research aimed at determining the factors involved in the success or failure of adult sex-offender treatment has not yet been undertaken. Some specialists contend, however, that a successful residential program for sex offenders is dependent upon an appropriate environment. "One cannot successfully graft a viable branch onto a dead or weak tree," say Brodsky and West, consultants to the criminal justice and mental health systems; "nor can one simply attach a successful treatment program onto the tense, control-centered structure of a maximum-security penal institution housing many offenders" (Brodsky & West, 1980, p. 10)

While the majority of treatment providers agree that sex offenders should have access to therapeutic remedies in whatever institution or setting to which they may be confined, prisons emerge as the least favored, though more common, residential settings.

MENTAL HEALTH VERSUS PRISON SETTINGS

Richard Seely, Director of Minnesota Security Hospital's Intensive Treatment Program for Sexual Aggressives, finds mental health facilities superior to prisons because

> the purpose of prisons is to punish; there is no other *real* purpose. When you try to provide treatment and growth opportunities in prison programs and a crisis situation arises, security becomes the first priority. On the other hand, the basic purpose of the mental health system is treatment. It is a helping agency and provides the whole

1. Settings include minimum, medium, and maximum security; each may be defined differently by mental health, prison, and judicial authorities.

4-2/12

> conceptual framework from which our program operates. Of course, the security issue is always there, but it is secondary to treatment. [Seely, 1981]

This sentiment is echoed by Richard Boucher, Administrator of the Massachusetts Treatment Center, a sex-offender program operating under the dual and conflicting goals of both the Department of Mental Health and the Department of Corrections.[2] He says, "I personally would prefer all Mental Health control over our program, because I think their whole philosophy is geared toward treatment and deinstitutionalization, as opposed to Correction's philosophy of more security and custodial care" (Boucher, 1982).

Robert Freeman-Longo, Director of Oregon State Hospital's Sex Offender Unit, whose program operates as a rare cooperative effort between the state's mental health and correctional divisions,[3] maintains that both prison and mental health settings are necessary. "The offender who acknowledges his crime and is seeking help may be better suited for a program housed in a mental-health institution," he explains, "while the offender who minimizes his crime may be more appropriately placed in the prison setting" (Longo, 1983, pp. 177-178). He recognizes, however, that, because of limited funding and resources, individual states may not have the option of developing programs in a variety of locations.

Other specialists maintain that the location of a residential treatment program is not as critical as other issues, as long as certain criteria are met. According to William Samek, of A & A Professional Counseling Associates, Hialeah, Florida,

> Whether a treatment program is located in a prison or mental health setting, it should be separate, isolated, and its autonomous unit and staff should be fully dedicated only to the treatment of the sex offenders. Other staff, prisoners, or patients should not be able to have any contact at any time with the sex-offender residents. All administrative and security decisions should be made by the individual who has direct and immediate knowledge of what is happening clinically in the unit. What is of primary importance are the statute and rules under which a sex-offender rehabilitation program operates. [Samek, 1982]

Sex-offender treatment programs located in mental institutions usually involve one of two models. They are housed either in a separate building on the grounds or in a locked ward with special hospital security. Freeman-Longo

---

2. In Massachusetts, both the Department of Corrections and the Department of Mental Health are under the Secretariat of Human Services. Both report to the same secretary.
3. For a description of this program, see Chapter 10 of this book.

advocates separating the sex offender from the general population in mental health settings for a variety of reasons, including (1) the sex offender may take advantage of or victimize other patients; (2) he may suffer from other problems that might have been a primary cause of the sexual offense[4]; and (3) the nonsexual offenders can disrupt treatment procedures, introduce contraband, or destroy property (Longo, 1983, p. 179).

PRISONS AS LEAST-FAVORED SETTINGS

There is substantial agreement among treatment specialists that prisons are inherently inappropriate settings for those sexual aggressives who require structured, secure environments during their period of retraining. Ian Macindoe, former consultant to the Minnesota Department of Corrections, warns against establishing programs for sex offenders inside maximum-security penal institutions:

> The brutalizing and callousness-producing atmosphere of the fortress institution, the con-code ("do your own time"), and the esteem-destroying attitudes towards sex offenders make it impossible to establish the necessary therapeutic atmosphere in prison.... I take it as an incontrovertible fact that prison is degrading, antitherapeutic, psychologically and psychosocially destructive and damaging, and to be avoided at all costs if treatment is to be effective. To believe otherwise is sheer folly. [Macindoe, 1975]

While acknowledging that a great deal can be accomplished with minimal resources in treating the sex offender in a prison population, A. Nicholas Groth, sex-offender treatment authority and Co-director of a program providing part-time treatment in the Mental Hygiene Unit of the maximum-security Connecticut Correctional Institution at Somers, enumerates the following three major antitherapeutic defects in prison-based treatment programs (Groth, 1983, pp. 173-174):

1. *The effects of prison labeling can reinforce the sex offender's minimization and denial of his sex-offense problem and encourage avoidance of therapy.* Sex offenders occupy a low social status in the prison hierarchy and are exposed to considerable verbal or physical (and sometimes sexual) harrassment and abuse from other prisoners. One sex offender in Groth's program says, "We're despised. There's a stepladder of tolerated crimes, and

4. These include psychosis, retardation, and organicity.

4-4/12

rape and child molesting are down at the very bottom. Prisoners can become violent at sex offenders like us--but the program is all we've got right now" (Connecticut, 1982). Another participant comments on the hazards of living in the general population while participating in sex-offender treatment: "I don't want to be seen coming through that door, because the sex-offender program can place you in jeopardy when we go back to our tiers" (Connecticut, 1982).

Groth maintains that this type of harrassment encourages some sex offenders to persist in proclaiming their innocence and/or to avoid treatment in an effort to diminish their visibility. "This is especially true for the child molester who finds adults psychologically intimidating," states Groth. "Such maltreatment only serves to enhance his fear of adults and reinforce his attraction to children whom he sees as physically and psychologically safer and more accepting of him" (Groth, 1983, p. 173).

2. *The sex offender's exposure to the prison's value system is at cross-purposes with treatment.* The prison's violent subculture and value system emphasize aggression as a way of managing one's life. Deception, manipulation, threat, intimidation, coercion, force, and assault are rampant. "Character traits such as warmth, trust, reciprocity, sharing and affection," explains Groth, "are equated with weakness and vulnerability, and prove maladaptive in regard to prison survival where exaggerated masculine behavior in the form of toughness prevails. In prison," he adds, "admitting to a problem and seeking or accepting help are regarded as signs of personal weakness" (Groth, 1983, p. 173). Says one offender in Groth's program, "You've got to be choosy about whom you share with. A lot of guys walk out of this program and they go running off at the lip about the program with the first person they get close to. Before you know it, you are the target for every hassle in the joint" (Connecticut, 1982).

Another participant, while acknowledging the necessity of a controlled environment where the offender isn't a danger to himself or society, decries the violence of the prison setting. "To come to a place like this where you got nothing but people trying to build themselves up by knocking other people down is foolish. I've taken plenty of risks as far as standing my ground, not only for myself but for other people, but things are getting pretty shaky. I've had people come right into my house [living quarters] and try to rough me up" (Connecticut, 1982).

3. *Prison structure and supervision create dependency and an unreal en-*

4-5/12

vironment for the sex offender. The close supervision and structuring of the offender's daily activities in a maximum-security prison remove him from the responsibility of managing his own life and may make him feel erroneously that he has changed or improved his behavior. Much of his perceived improvement, however, may be merely his response to the controlled environment of prison, rather than an indication of internal growth and maturation. For this reason, it is difficult to assess the client's improvement and readiness for release.

Groth notes that the treated sex offender also needs a great deal of help when he is released from prison and is re-entering the life situations he previously had been unable to manage adequately. Since the security problems of most institutions preclude returning to the prison for outpatient treatment, the offender is tragically cut off from the support of the group he has learned to turn to for help.

Other inhibitors to treatment in prison are the problems involved in getting the offender to the unit where the program is offered. William Hobson, Co-director of the Connecticut program, says that, if a man wants to come down to the Mental Hygiene Unit three times a week and he is working in industry, "He is playing havoc with his work situation and is likely to cause some tension with his work supervisor. Also, as a result of institutional overcrowding, there are a number of sex offenders in protective custody. They need to be escorted wherever they go. Most of the officers are busy, so a number of the men have problems getting here to attend the program" (Hobson, 1982).

The issue of confidentiality is an additional reason why prison and treatment goals often are diametrically opposed,[5] according to other specialists. Constance Avery-Clark, formerly Director of the Sexual Offenders Program of the Missouri Department of Social Services at Jefferson City, notes that, while most prisons are not concerned with protecting offender confidentiality, this issue is of primary importance to treatment staff (Avery-Clark, 1982). West, Roy, and Nichols (1978, pp. 151-157) report that sex offenders are conscious of being under surveillance by prison staff who are paid by, regulated by, and owe primary loyalty to penal authorities. Often the opinions and reports of the staff are used by release authorities and the parole board. When confessions to staff are used against the prisoner, it is a struggle for him to bring

5. For a comprehensive discussion of the issues involved, see Monahan (1980, pp. 68-75).

4-6/12

himself to trust anyone again. "That has been our experience," says Judith Becker (1984), Director of the Sexual Behavior Clinic in New York City. "Sex offenders who have been imprisoned feel they could not disclose the nature and frequency of their crimes because it would have prolonged their stay or negatively influenced the parole board."

Finally, the use of behavior modification techniques in the closed involuntary setting of prison raises fears among other specialists. Says Macindoe (1975),

> Clients who want and may need aversive-styled procedures would have to be available (under all the legal and ethical safeguards) for voluntary participation. Prisons are *not* the setting in which to use these techniques.... [B]ehavior-change workers running programs for sex offenders must work with voluntary clients (clients who, although they are involuntarily incarcerated are genuinely motivated to develop themselves along socially desirable lines) and it is not clear whether there can ever be a "real volunteer" in prison, because prisoners may be cooperating with the program for early parole or release to community-based programs.

PRISON-BASED MODELS

Prison-based sex-offender treatment programs generally fall into three categories, differentiated primarily by the degree to which the sex offenders are segregated from the general prison population, as follows:

1. Integrated into the general prison population
2. Housed in a separate wing
3. Housed in a separate building

Integrated Programs

In this first model, sex offenders live in the general population in cell blocks or dormitories and attend the equivalent of outpatient treatment within the institution. Treatment is offered individually and/or in groups for anywhere from one to four or more hours a week. Prisoners go to the hospital, mental health services, or other areas for the treatment sessions. Despite the multiple disadvantages of this model, for obvious reasons it represents the majority of prison-based sex-offender programs. First, it involves the least amount of resources invested in treatment for custodial-minded penal authorities. Second, such programs can be initiated informally by treatment or counseling staff, who are closest to the needs of prisoners.

Brodsky and West observe that such prison program models are rarely worthwhile. "The great rolling momentum of the imprisonment experience overwhelms

and overshadows the relatively brief therapeutic contacts and nullifies their emotional impact," they report (1980, p. 11). Though such part-time treatment may be far from the optimum situation, for many sex offenders this model provides a first opportunity for change. For example, two veterans of the Connecticut Correctional Institution's Sex Offender Program have completed parole and now are involved voluntarily in a community-based sex-offender treatment program in New London, Connecticut, as both participants and occasional facilitators. One, a rapist convicted of two counts of sexual assault, kidnapping, and burglary who spent almost four years in the institution, values his experience in the prison program:

> I'm not saying I had to go to a prison to be re-educated, but it had to be somewhere to get me away from society and the everyday problem. I lived 27 or 28 years one way, and now I've lived seven or eight years another way. It's just like growing all over, like a rebirth. Prison didn't do shit for me. The *program* is what did it--not prisons. The programs were available. Prison isn't the answer. It's what you do with your time and what's available to you. [FMHS, 1982]

Similar feelings are expressed by the second program veteran, who spent 22 months in treatment for risk of injury and sexual assault of his daughter:

> When I went to prison the door shut on me, I went to sleep, and when I woke up, I left prison. But in between time, I had an overhaul. I took a training course to re-educate myself, and it was just like I'd never been taught anything in the world. It was like starting from scratch, right at the bottom, because that is where I was at. And they done took me like a baby and led me by the hand until I got a semi-understanding of the program where I could start developing my own traits, showing that I could do something myself. And the more I did, the more I got approval for it, and the better I felt about myself. The better I felt about myself, the better I did and the more I understood. [FMHS, 1982]

Programs Housed in a Separate Wing

The second type of sex-offender treatment program favors housing offenders in a separate wing or mental health unit in the prison. Freeman-Longo supports this model, as it facilitates peer interaction, develops a cohesive program, and enhances the ability to supervise effectively the overall management and clinical aspects of the program. "The offenders and staff have more time and opportunity to maintain contact with each other," he says, "and therapy sessions can develop in a more spontaneous fashion. Homogeneous housing also provides for continuous peer interaction and peer pressure, two important elements in treating sex offenders. This is especially true when the offenders are interacting in group therapy sessions on a daily basis" (Longo, 1983, pp. 179-180).

4-8/12

Brodsky and West (1980, pp. 12-14) prefer small, autonomous residential units, with 20 to 30 sex offenders per unit. They identify a couple of advantages of this model. First, the "treatable" cases can be separated from the general prison population at a relatively early stage, before identification with the prison "contraculture" inhibits acceptance of treatment. Second, motivation is enhanced (a) if cooperation and satisfactory progress through the treatment program can be rewarded with improved custodial conditions and the prospect of somewhat earlier release and (b) if failure to maintain full participation results in return to the ordinary regime.

Programs Housed in a Separate Building

Finally, a less common model involves housing the sex-offender program in a separate building on the prison grounds. Budget and security restraints usually prohibit separate facilities, but Brodsky and West argue for physically separating the therapeutic communities from prisons as far as is practical. "A surprisingly high degree of security can be attained in a well-developed, self-monitoring community with a favorable staff-client ratio and uninhibited communications between staff and clients," they report (1980, p. 9). For instance, Minnesota's Transitional Sex Offender Program,[6] housed in a separate cottage at the medium-security prison at Lino Lakes, reports that there have been no escapes in the inpatient phase of treatment since the program's inception in 1979 (Steele, 1984).

Usually excluded from such settings are men who present a serious security risk, either because of current behavior or because of the desperate nature of their crimes. Unfortunately, this leaves out of the treatment model the minority of offenders who most need help--those who commit the most serious offenses and those with long sentences to serve (Brodsky & West, 1980, p. 9).

AUTONOMOUS SETTINGS PREFERRED

In the opinion of this author, from a *treatment* perspective, the more self-contained or autonomous the residential sex-offender program setting, the greater the benefits to both staff and residents and the more likely it is that program goals will be met. From this same perspective, then, the least desirable

6. For a description of this program, see Chapter 13 of this book.

treatment model is the part-time maximum-security prison program where sex offenders are housed in the general population or are under protective custody and attend groups or modules on an outpatient basis for a limited number of hours each week.

A model only slightly more preferred involves the housing of the program in a separate wing of a maximum- or medium-security institution, where offenders and clinicians may be involved in quasitherapeutic "communities" but are subject to the host institution's contradictory treatment, custodial, and institutional restrictions.

More desirable are those programs housed in separate wings or buildings on the grounds of institutions where staff are therapeutically trained and security depends primarily on the combined efforts and procedures of staff and residents.

An even more valued example of a sex-offender treatment program is the semi-autonomous, independent facility devoted exclusively to the evaluation and treatment of sex offenders, with its own budget, security controls, and therapeutically trained custodial staff. Such a program could function under either mental health or the department of corrections, as is pointed out by staff of the Adult Diagnostic and Treatment Center, which we describe in Chapter 8 of this book.

The optimum treatment setting is, as we have said, the most autonomous, and it is represented in this book by the exemplary Alpha Human Services program, which we describe in Chapter 7. It is a relatively small, community-based private program, totally therapeutically oriented, with its own effective internal security processes. Its competent staff and residents have access to a wide range of rewards and reinforcements for supporting individual treatment progress. The sex offender has appropriate opportunities to try out new, adaptive behaviors and test new ways of perceiving himself. His family has liberal access to him and, where possible, is involved in therapy with him. Clients are screened carefully and selected for both motivation, impulse control, and amenability to treatment. While these criteria exclude numbers of sex offenders who are not appropriate candidates for community-based residential treatment, if Alpha did not exist, many of their residents would be in the more restrictive, less helpful settings of prisons or other institutions.

RESIDENTIAL PROGRAM DESCRIPTIONS

In the remaining chapters of this section, we will report on a variety of residential treatment programs for sex offenders. A brief listing of the programs

4-10/12

As these models are examined, it is important to keep in mind that program approaches change and that they rarely operate at their highest potential. Cutbacks or burnout of staff, lack of funds, space limits due to overcrowding, undervaluing of treatment programs by the administration, changes in legislation by punishment-oriented lawmakers, and a host of other impediments to quality treatment beleaguer these important treatment efforts. Nevertheless, devoted and committed clinicians constantly are evolving new concepts and reshaping these models as they work with the complex problems of their clients--sexually aggressive offenders.

REFERENCES

Avery-Clark, C. "Sexual Offender Treatment Programs in Corrections: An Alternative." TSA News, 5:1, 1982.

Becker, J. V. Interview by F. H. Knopp, September 2, 1984.

Boucher, R. Taped site-interview by F. H. Knopp & J. Rosenberg, November 30, 1982.

Brodsky, S. L., & West, D. J. A Program for the Treatment of Sex Offenders. Planning report submitted to the Nebraska Department of Correctional Services, 1980.

Connecticut Correctional Institution. Taped site-interview with sex offenders, by F. H. Knopp, December 1, 1982.

FMHS (Forensic Mental Health Services). Taped site-interview with sex offenders, by F. H. Knopp & J. Rosenberg, New London, Connecticut, December 2, 1982.

Groth, A. N. "Treatment of the Sex Offender in a Correctional Institution." In J. G. Greer & I. R. Stuart (eds.), Sexual Aggression: Current Perspectives on Treatment. New York: Van Nostrand Reinhold, 1983.

Hobson, W. Taped site-interview by F. H. Knopp & J. Rosenberg, December 1, 1982.

Longo, R. E. "Administering a Comprenensive Sexual Aggressive Treatment Program in a Maximum Security Setting." In J. G. Greer & I. R. Stuart (eds.), Sexual Aggression: Current Perspectives on Treatment. New York: Van Nostrand Reinhold, 1983.

Macindoe, I. "Reasons for Opposing Sex-Offender Programs in Prison." Unpublished paper, 1975.

Monahan, J. (ed.). Who is the Client? The Ethics of Psychological Intervention in the Criminal Justice System. Washington, D.C.: American Psychological Association, 1980.

Samek, W. "The Clinical/Legal Interface." Poster presentation, Fourth National Conference and Workshops on Sexual Aggression, Denver, Colorado, April 17, 1982.

Seely, R. Taped site-interview by F. H. Knopp, October 5, 1981.

Steele, N. Letter to F. H. Knopp, February 20, 1984.

West, D. J., Roy, C., & Nichols, F. L. Understanding Sexual Attacks. London: Heinemann Educational Books, 1978.

4-12/12

we will describe is as follows:

1. *Alpha Human Services, Minneapolis, Minnesota.* This is the only identifiable model of an autonomous minimum-security residential treatment center, exclusively for sex offenders, based in the community. It is administered by a private corporation and provides a replicable model for remedial treatment.

2. *The Adult Diagnostic and Treatment Center, Avenel, New Jersey.* This represents the only semiautonomous, medium-security prison devoted exclusively to the treatment of sex offenders, and we shall see that it overcomes many of the negative consequences of placing a therapeutic community in a prison setting.

3. *The Sex Offender Program, Western State Hospital, Fort Steilacoom, Washington.* This hospital's program provides the basic therapeutic model for intensive treatment in a mental health facility.

4. *The Sex Offender Unit* and the *Social Skills Unit, Correctional Treatment Programs, Oregon State Hospital, Salem, Oregon.* The Sex Offender Unit is an expanded version of the Western State Hospital model, offering the widest range of treatment modalities available in any single residential setting in the United States. The Social Skills Unit also is modeled somewhat after the Western State Hospital program, but modified for a different clientele. This unit serves the long-neglected low-functioning sex offender in one of the few residential programs of its kind in this country.

5. *The Intensive Treatment Program for Sexual Aggressives, Minnesota Security Hospital, St. Peter, Minnesota.* Also based on the Western State Hospital model, this program offers several innovative approaches and is particularly noteworthy for its positive sexuality component.

6. *The Community Access Program, Massachusetts Treatment Center, Bridgewater, Massachusetts.* Usually the weakest component of residential sex-offender treatment programs is the release/postrelease segment. This program provides a unique model for a long-term, gradual, supervised release procedure.

7. *The Transitional Sex Offender Program, Minnesota Correctional Facility, Lino Lakes, Minnesota.* This program is for imprisoned sex offenders who are to be released to the community within one year.

8. *The Sex Offender Program, Connecticut Correctional Institution, Somers, Connecticut.* Our final program description will provide an example of a part-time, psycho-socioeducational, prison-based, sex-offender treatment model. The curriculum designed for this program has been adapted and embellished by many prison-based programs.

EVALUATION

Participants will be evaluated for significant change in three areas:

* Knowledge / Information
* Attitude / Understanding
* Behavior / Performance

This is accomplished by:

-Psychosexual assessments, pre - post

-Evaluations by facilitators, peers, and self

-Pre/Post tests in educational classes

★ ★ ★ ★ ★ ★

Participants evaluate the SOTP on:

-material - content

-facilitators

-films

-exercises

Senate Judiciary Committee
Attachment 5
1-28-91

S-1-91

PARTNERSHIP

As the Kansas Department of Corrections received increasing numbers of men convicted of sex offenses, the need for structured statewide treatment surfaced. An invitation to bid was published nationwide.
Weldy & Associates Inc., was selected as the successful bidder - October, 1988.

Weldy & Associates, Inc. . . .
. . . have a history of working with Correctional Systems
. . . are International Consultants on sex offender services
. . . conduct training seminars for specialized staff
. . . have a tested multi-modal treatment approach.

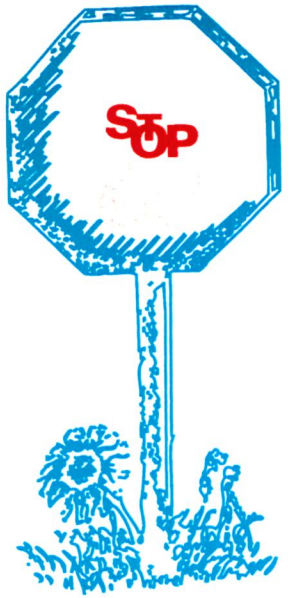
★ ★ ★ ★ ★ ★ ★

The KDOC/SOTP is a cooperative venture:
KDOC provides funding and facilities/
Weldy & Associates, Inc., via contract/
provides the SOTP treatment services in :

HUTCHINSON CORRECTIONAL FACILITY
Robert D. Hannigan, Warden
SOTP / HCF
P.O. Box 1568
Hutchinson, KS 67504-1568
(316) 662-2321 Ext. 516

LANSING CORRECTIONAL FACILITY
Ray Roberts, Warden
SOTP / LCF
P.O. Box 2
Lansing, KS 66043
(913) 727-3235 Ext. 7256

WELDY & ASSOCIATES, INC.
P.O. Box 2488
Hutchinson, KS 67504-2488
(316) 662-2321 Ext. 516



SEX OFFENDER TREATMENT PROGRAM

WELDY & ASSOCIATES, INC.

ARIZONA & KANSAS

funding Provided by:
Kansas Department of Corrections

2B
1-5

KANSAS DEPARTMENT OF CORRECTIONS
Steven J. Davies, Ph.D., Secretary
Dave McKune, Deputy Sec. of Programs

SOP

WELDY & ASSOCIATES, INC.
Theron Weldy, Director & Therapist
Hila Jo Hawk, Co-Director

ADMISSION CRITERIA

Candidates become eligible to apply when they:

1. are convicted of a sex offense,
2. have passed their 120 day call back,
3. have at least 12 months remaining in their sentence,
4. acknowledge the program is 20 hours per week for 12 months,
5. choose to enter voluntarily,
6. agree to complete comprehensive sexual assessments,
7. understand and sign a written commitment to participate,
8. are approved by the local Programs Administrator,
9. agree to maintain 85% or higher attendance rate,
10. have no history of extreme assaultive or psychotic behavior.

PURPOSE . . .
. . . is to create an opportunity . . .

Whereby those who have been convicted of a sex offense may voluntarily seek help and habilitation in a specialized program designed for sex offenders, with psychoeducational classes, with group and individual sessions - working toward emotional health by returning to society and remaining offense free.

GOALS of the Program . . .

1. Habilitate those who have a conviction of sex offense toward emotional health and the successful transition to the community.

2. Demonstrate success in decreasing reoffense rates of the SOTP participants through an efficient and cost effective program.

3. Provide the opportunity for inmates to comply with programmatic requirements of the Kansas Department of Corrections and the Kansas Parole Board as prerequisites for parole considerations.

PROGRAM COMPONENTS

AFFECTIVE DOMAIN

A. Therapy Goals;
Participants will be able to demonstrate ability to:
-explore personal issues and sexual concerns about past and future behavior,
-express feelings about appropriate sexual behavior,
-gain insight from peer & professional feedback, both active and directive in a therapeutic setting,
-recognize and address thinking disorders,
-distinguish deviant patterns of behavior,
-own responsibility for actions and consequences,
-describe chain of events leading to conviction,
-understand the importance of being alert to the Apparently Irrelevant Decisions with potential to contribute to relapse.

COGNITIVE DOMAIN

B. Psychoeducational Goals;
Participants will be able to demonstrate:
-an awareness of their need for learning specific living skills, scheduled in appropriate sequence,
-increased knowledge - release planning and relapse prevention,
-improved attitudes/understanding of self and others,
-strength of preparedness in appropriate behavior for successful transition / return to family / home / community / school and gainful employment.